Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 12, 2013
Region 4/Coastal Bend

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# Section I. RHP Organization

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<td>555 N. Carancahua, Suite 950 Corpus Christi, Texas 78401-0835 (361) 808-3300 <a href="mailto:jonny.hipp@nchdcc.org">jonny.hipp@nchdcc.org</a></td>
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<td>Chuck Norris</td>
<td>PO Box 587 Gonzales, Texas 78629 (830)672-7581 <a href="mailto:cnorris@gonzaleshealthcare.com">cnorris@gonzaleshealthcare.com</a></td>
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<td>Bluebonnet Trails Community Services</td>
<td>Andrea Richardson</td>
<td>1009 N. Georgetown Street, Round Rock, Texas 78664 (512) 244-8305 <a href="mailto:andrea.richardson@bbtrails.com">andrea.richardson@bbtrails.com</a></td>
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<td>Annette Rodriguez</td>
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<td>Diane Lowrance</td>
<td>1630 South Brownlee Corpus Christi, Texas 78404 (361) 886-6900 <a href="mailto:dilowrance@ncmhmr.org">dilowrance@ncmhmr.org</a></td>
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<td>Gulf Bend Center</td>
<td>David Way</td>
<td>6502 Nursery Drive, Suite 100 Victoria Texas 77904 <a href="mailto:dway@gulfbend.org">dway@gulfbend.org</a></td>
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<td>Darryl Stefka</td>
<td>2550 N. Esplanade Cuero, Texas 77954 (361) 275 6191 <a href="mailto:darryls@cuerohospital.org">darryls@cuerohospital.org</a></td>
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<td>137907508</td>
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<td>Citizens Medical Center</td>
<td>Chere Brzozowski</td>
<td>2701 Hospital Drive Victoria Texas 77901 361-573-9181 <a href="mailto:cbrzozowski@cmcvtx.org">cbrzozowski@cmcvtx.org</a>;</td>
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<td>Coastal Plains Community Center</td>
<td>Charles Sportsman</td>
<td>200 Marriott Drive Portland, TX 78374 (361)777-3991 <a href="mailto:Charles@coastalplainsctr.org">Charles@coastalplainsctr.org</a></td>
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<td>3349 S HWY 181 Kenedy, Texas 78118 (830)583-3401 <a href="mailto:david.lee@okmh.org">david.lee@okmh.org</a></td>
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<td>2550 N. Esplanade Cuero, Texas 77954 (361) 275 6191 <a href="mailto:darryls@cuerohospital.org">darryls@cuerohospital.org</a></td>
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<td>Louis Willeke</td>
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<td>Karen Barber</td>
<td>1200 Carl Ramert Drive Yoakum, Texas 77995 (361) 293-2321 <a href="mailto:kbarber@yoakumhospital.org">kbarber@yoakumhospital.org</a></td>
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**UC-only Hospitals**
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<td>Jane O. Stafford, MD</td>
<td>1000 Morgan Avenue Corpus Christi, Texas 78404-2042 (361) 884-5489 <a href="mailto:jos1176@aol.com">jos1176@aol.com</a></td>
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<td>Others (specify type, e.g. advocacy groups, associations)</td>
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<td>County judges; County commissioners; boards</td>
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RHP Plan for Region 4
Section II. Executive Overview of RHP Plan

Overview of Regional HealthCare Partnership 4/Coastal Bend Region

The 18 counties of Regional Healthcare Partnership (RHP) 4 are Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio and Victoria. This rapidly growing population of the Coastal Bend Region, home to 747,000, is relatively young, predominately Hispanic and is characterized by high poverty rates and high rates of adults without a high school education. The number of people in RHP 4 without health insurance ranges from approximately 19% (Aransas County) to 24% (San Patricio County).

Among the counties of the Coastal Bend Region, about 60% live in two counties — Nueces and Victoria. The municipalities of the Coastal Bend Region are very diverse, including some urban, but many very rural communities and numerous “colonias.” Colonias are the unincorporated subdivisions comprised of small housing lots with little or no infrastructure occupied by individuals and families with very low incomes. These “neighborhoods” pose a potentially serious threat to public health and quality of life due primarily to their lack of appropriate infrastructure for wastewater and safe drinking water.

Key Health Challenges Facing RHP 4

The key health challenges of the Coastal Bend Region are rooted in extreme levels of economic and health disparities.

Access Barriers to Care

A lack of access to and utilization of needed health care services—across the region—is exacerbated by low levels of health insurance. In a state with the highest uninsured rate in the country, uninsured rates are even higher in some RHP 4 counties. In Brooks County, 54% of the residents are either uninsured or covered by Medicaid. Additionally, the region faces a shortage of primary care, specialists, behavioral health and dental professionals to serve a growing population, with eight counties in the region having four or fewer PCPs and two counties having none. Residents in rural areas are more likely to perceive barriers to health care access than those who live in urban areas.

These barriers to needed health and behavioral health services limit the capacity of the current delivery system to identify individuals with or at risk for chronic conditions and get them into appropriate programs to help prevent, diagnosis and manage their health conditions.

Chronic Diseases

The extreme levels of economic and health disparities contribute to the unprecedented epidemics of chronic disease—particularly diabetes and related chronic conditions—fueled by high levels of adult and childhood obesity. Federal surveys of the region find that 14.3% of adults have diabetes, compared to 9.7% for the state, and more than 26%\(^1\) are obese. Regional

hospital admissions and related data indicate that the prevalence of these and other chronic conditions including cancer, hypertension and cardiovascular disease lead to preventable hospitalizations.

**Mental Health and Substance Abuse**

In 2009, RHP 4 hospitals reported that schizoaffective disorder and manic depressive disorder were the third and fourth most common principal admission diagnosis for patients aged 18 to 49 years. About 23% of those responding to a telephone survey of residents stated they had depression, and 12.5% reported that one of their children needed mental health services. At the same time, the 12 of the 18 counties in the region are a health professional shortage area for mental health professions, in a state that has the lowest per capita spending on mental health services in the country.

**RHP 4’s Vision for Healthcare Delivery System Transformation**

The RHP 4 partners comprise a wide assortment of public and private institutions coming together to address the region’s heavy burden of chronic disease and health disparities and its demonstrated need for enhanced access to primary and behavioral health care services. The overarching vision for the region includes the following goals:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a growing, yet historically underserved region.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

**RHP 4 DSRIP Projects to Support Delivery System Transformation**

In response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region, RHP 4 has developed DSRIP projects designed to:
1. Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.
2. Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care.
3. Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region’s transformation to a quality-based health care system.

4. Increase the capacity of safety net providers in the region to provide patient-centered care and care management, particularly for patients with chronic conditions, to improve health literacy, self-care management skills, and more effectively access or navigate the health care system appropriately.

### Summary of Categories 1 and 2 Projects

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Brief Project Description</th>
<th>Related Category 3 Outcome Measure(s)</th>
<th>Estimated Incentive Amount (DSRIP) for DYs 2-5</th>
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<tr>
<td><strong>Category 1: Infrastructure Development</strong></td>
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<tr>
<td>020811801.1.1 Implement a chronic disease registry</td>
<td>Chronic disease database will be created by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program</td>
<td>0208811801.3.1 IT-3.2 CHF 30 Day Readmissions</td>
<td>$860,860</td>
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<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020811801.2 Introduce, Expand or Enhance Telemedicine/Telehealth</td>
<td>Introduce PADnet™ Disease Management System for peripheral arterial disease screening and treatment</td>
<td>020811801.3.2 IT-1.11 Diabetes Care – Blood Pressure Control</td>
<td>$1,045,330</td>
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<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020811801.3 Establish more primary care clinics Pass 2</td>
<td>Increase primary care access and capacity on a full time basis by creating a fully operational primary care clinic for Bee and surrounding counties</td>
<td>020811801.3.8 IT 3.2 PPR Reduction in 30 day readmission for CHF</td>
<td>$1,932,593</td>
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<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020973601.1.1 Expand Primary Care Capacity</td>
<td>Expand existing primary care capacity via the Amistad Community Health Center</td>
<td>020973601.3.1 IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%). Standalone measure. 020973601.3.2 IT-1.7 Controlling high blood pressure</td>
<td>$4,662,663</td>
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<td>Corpus Christi Medical Center/020973601.</td>
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<tr>
<td>020973601.1.2 Increase the number of primary care providers: Residency expansion/community health workers</td>
<td>Expand family practice/internal medicine residency program and develop a community health worker program</td>
<td>020973601.3.3 IT-3.2 Congestive Heart Failure 30 day readmission rate 020973601.3.4 IT-5.2 Per Episode Cost of Care – CHF patients 020973601.3.5 IT-9.2 ED Appropriate utilization – Congestive Heart Failure</td>
<td>$4,144,589</td>
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<td>Corpus Christi Medical Center/ 020973601</td>
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RHP Plan for Region 4
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<tr>
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<tr>
<td>020973601.1.3 Expand high impact specialty care in most impacted medical specialties Corpus Christi Medical Center/020973601</td>
<td>Expand family practice/internal medicine residency program to include Fellowship Training in two high impact specialties</td>
<td>020973601.3.6 IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate 020973601.3.7 IT-5.2 Per episode cost of care – COPD patients 020973601.3.8 IT-9.2 ED appropriate utilization – COPD patients</td>
<td>$4,144,589</td>
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<td>020973601.1.4 Enhance Service Availability of Appropriate Levels of Behavioral Health Care Corpus Christi Medical Center/020973601 Pass 2</td>
<td>Expand the outpatient treatment options in the community through additional intensive outpatient program locations and the introduction of a partial hospitalization program</td>
<td>020973601.3.9 IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</td>
<td>$4,403,626</td>
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<td>020973601.1.5 Implement a chronic disease management registry Corpus Christi Medical Center/020973601 Pass 2</td>
<td>Implement and use chronic disease management functionalities</td>
<td>020973601.3.13 IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations</td>
<td>$3,772,045</td>
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<td>020991801.1.1 Expand primary care capacity Refugio County Hospital District/020991801</td>
<td>Expand primary care clinic space, staffing, and hours</td>
<td>020991801.3.1 IT_9.2 ED appropriate utilization – Reduce all ED visits</td>
<td>$1,206,513</td>
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<tr>
<td>094118902.1.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas DeTar Hospital/094118902</td>
<td>Establish an Intensive Outpatient Program for Behavioral Health patients.</td>
<td>094118902.3.1 IT-9-1 Decrease in mental health admissions/readmissions to criminal justice settings such as jails. 094118902.3.2 IT-9-2 Decrease in mental health admissions and readmissions to emergency department or inpatient psychiatric setting</td>
<td>$3,168,349</td>
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<tr>
<td>094118902.1.3 (094118902.1.2) Increase the number of residency/training programs for faculty/staff to support an expanded, more updated program DeTar Hospital/094118902</td>
<td>Establish an ACGME-accredited Family Medicine Residency Program</td>
<td>094118902.3.12 (094118902.3.9) IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically</td>
<td>$5,640,000</td>
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<td>Pass 3b</td>
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<td>underserved area (MUA) 094118902.3.13 (094118902.3.10) IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey 094118902.3.14 (094118902.3.11) IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey</td>
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<tr>
<td>094222902.1.1 Expand primary care capacity CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Increase primary care capacity by expanding clinic hours, space, and staffing</td>
<td>094222902.3.1 IT-9.2 ED appropriate utilization</td>
<td>$1,039,838</td>
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<tr>
<td>094222902.1.2 Implement a Chronic Disease Registry CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Chronic disease database/repository will be created by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program</td>
<td>094222902.3.2 IT-3.2 CHF 30 Day Readmissions</td>
<td>$1,039,838</td>
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<tr>
<td>094222902.1.3 Introduce, Expand or Enhance Telemedicine/Telehealth CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Introduce PADnet™ Disease Management System for peripheral arterial disease screening and treatment</td>
<td>094222902.3.3 IT-1.11 Diabetic Care – Blood Pressure Control</td>
<td>$1,262,660</td>
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<tr>
<td>112673204.1.1 Expand Primary Care Capacity Yoakum Community Hospital/112673204</td>
<td>Expand space and hire primary care physicians and support staff</td>
<td>112673204.3.1 IT 1.11 Diabetes Care: BP control</td>
<td>$788,887</td>
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<tr>
<td>112673204.1.2 Expand Specialty Care Capacity Yoakum Community Hospital/112673204</td>
<td>Expand specialty care services staffing and hours</td>
<td>112673204.3.2 IT-1.10 Diabetes Care: HbA1c Poor Control</td>
<td>$664,326</td>
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<tr>
<td>121775403.1.1 Expand primary care capacity CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Expand primary care clinic hours, space, and staffing</td>
<td>121775403.3.1 IT-9.2 ED appropriate utilization</td>
<td>$7,559,569</td>
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<tr>
<td>121775403.1.2 Implement a Chronic Disease Registry CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Chronic disease database will be created by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners</td>
<td>121775403.3.2 IT-3.2 CHF 30 Day Readmissions</td>
<td>$6,225,528</td>
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<tr>
<td>121775403.1.3 Introduce, Expand or Enhance Telemedicine/Telehealth CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Introduce PADnet™ Disease Management System for peripheral arterial disease screening and treatment</td>
<td>121775403.3.3 IT-1.11 Diabetes care, Blood Pressure</td>
<td>$7,559,569</td>
</tr>
<tr>
<td>121775403.1.4 Expand high-impact specialty care capacity CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Develop and implement a structured critical service model focused on providing intensivists driven services throughout our provider service facilities</td>
<td>121775403.3.4 IT-4.2 Reduce rate of hospital acquired CLABSI</td>
<td>$6,670,208</td>
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<tr>
<td>121775403.1.5 Behavioral Health Crisis Stabilization as alternative to hospitalization CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Develop a Crisis Stabilization/Urgent Care Center to provide screening and assessments to determine the most appropriate level of care and referrals for persons presenting with behavioral health needs</td>
<td>121775403.3.5 IT-9.2 ED appropriate utilization</td>
<td>$8,448,930</td>
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<tr>
<td>121775403.1.6 Expand Specialty Care Capacity CHRISTUS Spohn – Corpus Christi/121775403</td>
<td>Increase the number of Psychiatric Mental Health Nurse Practitioners in the Region</td>
<td>121775403.3.6 IT-1.18 Follow-up After Hospitalization for Mental Illness</td>
<td>$6,670,208</td>
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<tr>
<td>121785303.1.1 Expand Primary Care Capacity Gonzales Healthcare Systems/121785303</td>
<td>Expand the days and/or hours clinic is open</td>
<td>121785303.3.1 IT 9.2 Emergency Department appropriate utilization</td>
<td>$520,908</td>
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<tr>
<td>121785303.1.2 Expand Specialty Care Capacity Gonzales Healthcare Systems/121785303</td>
<td>Expand the days and/or hours current specialists are available and add additional specialties</td>
<td>121785303.3.2 IT 6.1 Improve patient satisfaction/experience scores</td>
<td>$124,989</td>
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<tr>
<td>121785303.1.3 Introduce, Expand, or Enhance Telemedicine/Telehealth Gonzales Healthcare Systems/121785303</td>
<td>Initiate a telemonitoring program for patients with chronic disease using multiple biometric devices</td>
<td>121785303.3.3 IT-9.2 ED appropriate utilization</td>
<td>$347,190</td>
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<tr>
<td>121808305.1.1 Expand Specialty Care Capacity Jackson County Hospital District/121808305</td>
<td>Establish a hospital-based outpatient pulmonary rehabilitation clinic</td>
<td>121808305.3.1 IT 9.2 Emergency Department appropriate utilization</td>
<td>$1,300,000</td>
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<tr>
<td>121990904.1.1 Enhance service availability of appropriate levels of behavioral health care</td>
<td>Enhance access to behavioral health crises services by establishing a Mobile Crisis Outreach Team</td>
<td>121990904.3.2 IT-9.2 ED appropriate utilization: Reduce Emergency Department</td>
<td>$125,339</td>
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<tr>
<td>Project Title</td>
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<td>Camino Real Community Services/121990904 Pass 2</td>
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<td>visits</td>
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<td>130958505.1.1 Expand primary care capacity Corpus Christi - Nueces County Public Health District /130958505</td>
<td>This project will implement the hiring, training, and placement of a Community Health Worker (CHW) as a Care Coordinator at each of seven Community Health Centers and/or Public Health Clinics.</td>
<td>130958505.3.1 IT-12.5 Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention)</td>
<td>$1,751,669</td>
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<tr>
<td>130958505.1.2 Implement a Chronic Disease Management Registry Corpus Christi - Nueces County Public Health District /130958505</td>
<td>Create a diabetes management registry via the implementation of an electronic medical record (EMR) system</td>
<td>130958505.3.2 IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%)</td>
<td>$3,118,375</td>
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<tr>
<td>132812205.1.2 Increase, Expand, and Enhance Oral Health Services Driscoll Children’s Hospital/132812205</td>
<td>Improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s office</td>
<td>132812205.3.2 IT-7.10 Other Outcome Improvement Target: Reduce incidence of severe dental caries that result in operative interventions</td>
<td>$11,272,443</td>
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<tr>
<td>132812205.1.1 Expand primary care capacity Driscoll Children’s Hospital/132812205</td>
<td>Expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll’s Urgent Care Center and selected clinics</td>
<td>132812205.3.1 IT-9.4 ED Prevention: Increase the number of prevented pediatric ED visits.</td>
<td>$11,242,000</td>
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<td>132812205.1.3 Expand specialty care capacity Driscoll Children’s Hospital/132812205</td>
<td>Expand access to specialized pediatric health care services for children in South Texas</td>
<td>132812205.3.4 IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$10,474,040</td>
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<tr>
<td>132812205.1.4 Introduce, expand, or enhance telemedicine/telehealth Driscoll Children’s Hospital/132812205 Pass 2</td>
<td>Expand and enhance tele-psychiatry services in the Driscoll service area</td>
<td>132812205.3.6 IT-1.18 - Follow-Up After Hospitalization for Mental Illness</td>
<td>$4,324,839</td>
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<tr>
<td>Project Title</td>
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<tr>
<td>135233809.1.1 Expand Primary Care Capacity</td>
<td>Expand primary care clinic staffing and hours</td>
<td>135233809.3.1 IT 9.2 Emergency Department appropriate utilization</td>
<td>$297,532</td>
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<td>Lavaca Medical Center/135233809</td>
<td>Expand and enhance the ability to offer 24 hour crisis stabilization services and medical</td>
<td>135254407.3.1 IT-9.1 Decrease in mental health admission and readmissions to the criminal justice</td>
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<td></td>
<td>clearance to those affected by behavioral or mental health illnesses in times of crisis</td>
<td>settings 135254407.3.2 IT-9.2 ED appropriate utilization</td>
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<tr>
<td>135254407.1.1 Development of behavioral health crisis stabilization services</td>
<td>Expand and enhance existing psychiatric and behavioral health telemedicine services.</td>
<td>135254407.3.4 IT- 6.1 Percent Improvement over baseline of patient satisfaction scores</td>
<td>$1,074,410</td>
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<td>as alternatives to hospitalization Gulf Bend Center/135254407</td>
<td>Expand neurology consultations through the establishment of a telemedicine program</td>
<td>136412710.3.1 IT-6.1 – Percent improvement over baseline of patient satisfaction scores</td>
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<td>135254407.1.2 Use telehealth to deliver specialty, psychosocial, and community-</td>
<td>Chronic disease database will be created by heartbase™ to support and sustain management of</td>
<td>136436606.3.1 IT-3.2 CHF 30 Day Readmission rate</td>
<td>$901,467</td>
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<td>based nursing services Gulf Bend Center/135254407 Pass 2</td>
<td>patients in our Care Transitions/Care Partners program</td>
<td>136436606.3.2 IT-1.11 Diabetes Care – Blood Pressure Control</td>
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<tr>
<td>136412710.1.1 Implement telemedicine program to provide or expand specialist</td>
<td>Introduce, Expand or Enhance Telemedicine/Telehealth</td>
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<td>referral services Otto Kaiser Memorial Hospital/136412710</td>
<td>Introduce PADnet™ Disease Management System for peripheral arterial disease screening and</td>
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<td>treatment</td>
<td>137907508.3.1 IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5</td>
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<td>136436606.1.2 Introduce, Expand or Enhance Telemedicine/Telehealth</td>
<td>Expand primary care capacity by collaboration with recently established Federally Qualified Health Clinic (FQHC) in the facility’s service area</td>
<td>137907508.3.2 IT-9.2 ED Appropriate Utilization</td>
<td>$4,579,937</td>
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<td>138911609.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
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<td>136436606.1.1 Implement a chronic disease registry CHRISTUS Spohn Kleberg</td>
<td>Chronic disease database will be created by heartbase™ to support and sustain management of</td>
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<td>Hospital/136436606</td>
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<td>136436606.3.2 IT-1.11 Diabetes Care – Blood Pressure Control</td>
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<td>137907508.1.1 Expand primary care capacity</td>
<td>Contract with additional specialty providers to improve and increase the access for a</td>
<td>138911609.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$2,586,608</td>
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<td>Citizens Medical Center/137907508</td>
<td>targeted population.</td>
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<td>138911609.1.1 Expand Specialty Care Capacity</td>
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<td>Cuero Community Hospital/138911609</td>
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<td><strong>Category 2: Program Innovation and Redesign</strong></td>
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<tr>
<td>020811801.2.1 Improvement in Quality and Safety for patients with Sepsis</td>
<td>Implementation of both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate&gt;4mmol/L (36mg/dl)</td>
<td>020811801.3.3 IT-4.8 Potentially Preventable Complications and Healthcare Acquired Conditions: Sepsis mortality</td>
<td>$676,390</td>
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<tr>
<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020811801.2.2 Medication Management</td>
<td>Implementation of Bedside Medication Verification (BMV) Process</td>
<td>020811801.3.4 IT-4.10 Decrease errors in bedside medication administration</td>
<td>$430,430</td>
</tr>
<tr>
<td>Christus Spohn Beeville Hospital/020811801</td>
<td></td>
<td>020811801.3.5 IT-4.10 Decrease length of stay</td>
<td></td>
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<tr>
<td>020811801.2.3 Medication Management</td>
<td>Implement Computerized Physician Order Management system enabling providers to directly enter orders into our primary Health Information System</td>
<td>020811801.3.7 IT-4.10 Reduction in medication transcription errors, and reduction in medication reconciliation errors</td>
<td>$430,430</td>
</tr>
<tr>
<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020811801.2.4 Expand Care Transitions Program</td>
<td>Addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program</td>
<td>020811801.3.8 IT-3.2 Congestive Heart Failure 30 Day Readmission Rate</td>
<td>$922,350</td>
</tr>
<tr>
<td>CHRISTUS Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020811801.2.5 Care management to integrate primary and behavioral health needs</td>
<td>Implement a screening and treatment protocol to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Target diagnoses are CHF and diabetes.</td>
<td>020811801.3.9 IT-9.2 ED Appropriate Utilization (BH/SA patients)</td>
<td>$922,350</td>
</tr>
<tr>
<td>Christus Spohn Beeville Hospital/020811801</td>
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<tr>
<td>020973601.2.1 Implement/Expand Care Transitions Programs</td>
<td>Implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings</td>
<td>020973601.3.10 IT-3.1 all cause 30 day readmission rate</td>
<td>$4,662,663</td>
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<tr>
<td>Corpus Christi Medical Center/020973601</td>
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<tr>
<td>020973601.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency</td>
<td>Apply process improvement methodology for patients with sepsis</td>
<td>020973601.3.11 IT-4.8 Sepsis mortality</td>
<td>$4,403,626</td>
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<tr>
<td>Corpus Christi Medical Center/020973601</td>
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<td>020973601.3.11 IT-4.9 Average length of stay – sepsis</td>
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<tr>
<td>Project Title</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Estimated Incentive Amount (DSRIP) for DYs 2-5</td>
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<tr>
<td>080368601.2.1 Integrate Primary and Behavioral Health Care Coastal Plains Community Center /080368601</td>
<td>Integrate primary care and behavioral health services into community behavioral health center settings to provide comprehensive, high quality health care to adults with serious mental illness</td>
<td>080368601.3.3 IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 080368601.3.1 IT 1.10 Diabetes Care HbA1c poor control 080368601.3.4 IT 10.7 Other Outcome Improvement Target: 70% of admissions to SA Services successfully complete treatment services 080368601.3.2 IT 1.11 Diabetes Care BP Control</td>
<td>$12,582,690</td>
</tr>
<tr>
<td>094118902.2.1 Redesign outpatient delivery system to coordinate care for patients with chronic diseases DeTar Healthcare System/094118902</td>
<td>Establish multiple outpatient clinics with a focus on chronic disease management</td>
<td>094118902.3.6 IT-3.2 Congestive heart Failure 30-day readmission rate 094118902.3.3 IT-3.3 Diabetes Failure 30-day readmission rate 094118902.3.4 IT-3.5 Acute Myocardial Infarction (AMI) readmission rate 094118902.3.5 IT-3.7 Stroke 30-day readmission rate</td>
<td>$2,737,752</td>
</tr>
<tr>
<td>094118902.2.2 Implement Evidence-based Strategies to Reduce Low Birth Weight and Preterm Birth DeTar Healthcare System/094118902</td>
<td>Provide enhanced prenatal clinics that will also incorporate healthy lifestyle measures that evidence shows lends toward a non-complicated pregnancy and full term births</td>
<td>094118902.3.7 IT-8.1 Timeliness of prenatal/postnatal care 094118902.3.8 IT-8.2 Percentage of low birth-weight births</td>
<td>$1,445,249</td>
</tr>
<tr>
<td>094222902.2.1 Medication Management CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Implementation of Bedside Medication Verification (BMV) Process</td>
<td>094222902.3.4 IT-4.10 Reduction in bedside medication administration errors 094222902.3.5 IT-4.10 Decrease length of stay 094222902.3.6 IT-4.10 Decrease cost of</td>
<td>$519,919</td>
</tr>
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<td>Project Title</td>
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<td>Related Category 3 Outcome Measure(s)</td>
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<tr>
<td>094222902.2.4 Care management to integrate primary and behavioral health needs</td>
<td>Implement a screening and treatment protocol to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Target diagnoses are CHF and diabetes.</td>
<td>094222902.3.9 IT-9.2 ED Appropriate Utilization (BH/SA patients)</td>
<td>$1,188,386</td>
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<tr>
<td>CHRISTUS Spohn Alice Hospital/094222902</td>
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<td>094222902.3.11 IT-9.2 ED appropriate utilization</td>
<td>$1,114,112</td>
</tr>
<tr>
<td>094222902.2.6 Integrate Primary Care and Behavioral Healthcare Services</td>
<td>Provide a Licensed Mental Health Provider for at least one Family Health Clinic to integrate treatment of physical and behavioral conditions in one location</td>
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<tr>
<td>CHRISTUS Spohn Alice Hospital/094222902</td>
<td></td>
<td>121775403.7 IT-1.10 Diabetes care: HbA1c poor control (&gt;9.0%)</td>
<td>$7,114,889</td>
</tr>
<tr>
<td>121775403.2.1 Implement evidence-based health promotion program: Diabetes Cell Phone Application</td>
<td>Adapt and disseminate AT&amp;T’s mobile application that offers instant feedback via text messaging, coaching, and patient/provider web portals as a patient self-management tool to reduce HbA1c in patients with Type 2 diabetes</td>
<td>121775403.8 IT 4.2 Potentially Preventable Complications</td>
<td>$5,336,167</td>
</tr>
<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
<td></td>
<td>12775403.3.9 2.7 Short Term Complication Admission rate</td>
<td>$5,336,167</td>
</tr>
<tr>
<td>121775403.2.2 Redesign primary care access through development of a hospitalist service model</td>
<td>Establish a hospitalist service model that provides continuity of care through clinical integration of services in non-ICU patients</td>
<td>12775403.3.10 IT-9.2 ED appropriate utilization</td>
<td>$7,114,889</td>
</tr>
<tr>
<td>CHRISTUS Spohn – Corpus Christi/121775403</td>
<td></td>
<td>12775403.3.11 IT-9.2 ED Appropriate Utilization (BH/SA patients)</td>
<td>$5,780,847</td>
</tr>
<tr>
<td>121775403.2.3 Cost of Care Delivery: Primary Care Delivery Method Redesign</td>
<td>Redesign of Primary Care Delivery to increase continuity of care, decrease average length of stay, and increase patient satisfaction</td>
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<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.4 Integrate Primary Care and Behavioral Healthcare Services</td>
<td>Provide a Licensed Mental Health Provider for at least one Family Health Clinic to integrate treatment of physical and behavioral conditions in one location</td>
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<td>Christus Spohn – Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.5 Care management to integrate primary and behavioral health needs</td>
<td>Implement a screening and treatment protocol to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Target diagnoses are CHF and diabetes.</td>
<td>12775403.3.11 IT-9.2 ED Appropriate Utilization (BH/SA patients)</td>
<td>$5,780,847</td>
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<tr>
<td>121775403.2.6 Establish Medical Homes</td>
<td>Redesign the current system to a care delivery system more closely aligned to independent primary care practices; i.e. practice with established patients and physician partners practicing in an “office” setting</td>
<td>121775403.3.12 IT-9.2 Inappropriate ED utilization - Reduce all ED visits</td>
<td>$7,114,889</td>
</tr>
<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.7 Medication Management</td>
<td>Implementation of Bedside Medication Verification (BMV) Process</td>
<td>121775403.3.13 IT-4.10 Decrease in bedside medication administration errors 121775403.3.14 IT-4.10 Decrease length of stay 121775403.3.15 IT-4.10 Decrease cost of care</td>
<td>$3,112,764</td>
</tr>
<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.8 Medication Management</td>
<td>Implement Computerized Physician Order Management (CPOM) system enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech</td>
<td>121775403.3.16 IT-4.6 Hospital Acquired VTE</td>
<td>$3,112,764</td>
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<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.9 Improvement in Quality and Safety for patients with sepsis</td>
<td>Implementation of both the Sepsis Resuscitation and Sepsis Management bundles as treatment for severe sepsis, septic shock, and/or lactate &gt;4mmol/L (36mg/dl)</td>
<td>121775403.3.17 IT-4.8 Potentially Preventable Complications and Healthcare Acquired Conditions: Sepsis mortality</td>
<td>$4,891,486</td>
</tr>
<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.10 Expand Care Transitions Program</td>
<td>Addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program</td>
<td>121775403.3.18 IT-3.2 Congestive heart Failure 30 Day Readmission Rate</td>
<td>$6,670,208</td>
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<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403</td>
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<tr>
<td>121775403.2.11 Design, develop, and implement a program of continuous, rapid</td>
<td>Develop and implement standardized safety and efficiency protocols and develop education materials and methods to train providers on the protocols</td>
<td>121775403.3.19 IT-4.5 Patient Fall Rate</td>
<td>$14,887,155</td>
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<td>process improvement that will address issues of safety, quality, and efficiency</td>
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<tr>
<td>CHRISTUS Spohn - Corpus Christi/121775403 Pass 2</td>
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<td>Project Title</td>
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</tbody>
</table>
| 121785303.2.1 Implement a Palliative Care Program                              | Develop, implement and evaluate a palliative care program for patients with chronic conditions                                                                                                                             | 121785303.3.4 IT-13.1 - Pain assessment  
121785303.3.5 IT-13.2 – Treatment preferences  
121785303.3.6 IT-13.5 – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns | 252,000                                        |
<p>| Gonzales Healthcare Systems/121785303 Pass 2                                 |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| 121785303.2.2 – Implement innovative evidence-based strategies to reduce and   | Create and implement a program aimed at developing healthy habits, particularly among adolescents, to reduce and prevent obesity                                                                                               | 121785303.3.7 IT-10.1 Demonstrate improvement in Quality of Life scores                                                                                              | $177,660                                      |
| prevent obesity in children and adolescents                                   |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| Gonzales Healthcare Systems/121785303 Pass 2                                 |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| 121990904.2.1 Integrate Primary and Behavioral Health Care Services           | Integrate psychiatric services into the primary care setting as well as integrate primary care services into the behavioral health setting                                                                                       | 121990904.3.1 IT 6.1 Patient Satisfaction                                                                                                                             | $877,580                                      |
| Camino Real Community Services/ 121990904 Pass 2                             |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| 126844305.2.1 Establish/Expand a Patient Care Navigation Program              | Implement a patient navigation program for persons who are frequent users of the Emergency Department (ED) due to chronic health conditions including behavioral health disorders | 126844305.3.1 IT-3.1 All cause 30 day readmission rate- NQF 1789.                                                                                                    | $1,203,064                                    |
| Bluebonnet Trails Community Mental Health Center 126844305                   |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| 130958505.2.1 Implement an innovative and evidence-based health promotion     | Create Diabetes Care Teams (CDEs and CHWs) to inform and educate patients about disease prevention and treatment to promote improved health outcomes                                                                               | 130958505.3.3 IT-1.10, Diabetes care: HbA1c poor control (&gt;9.0%)                                                                                                     | 2,601,366                                     |
| program                                                                        |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| Corpus Christi - Nueces County Public Health District/130958505              |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| 130958505.2.2 Implement innovative evidence-based strategies to reduce and    | Implement the MEND (Mind, Exercise, Nutrition ... Do It!) obesity prevention program                                                                                                                                         | 130958505.3.4 IT-1.20 Other Outcome Improvement Target: Zone Body Mass Index (zBMI)                                                                                 | 7,401,720                                     |
| prevent obesity in children and adolescents                                   |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |
| Corpus Christi - Nueces                                                      |                                                                                                                                                                                                                            |                                                                                                                                                                      |                                               |</p>
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<tr>
<th>Project Title</th>
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<th>Estimated Incentive Amount (DSRIP) for DYs 2-5</th>
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<tbody>
<tr>
<td>County Public Health District/130958505</td>
<td></td>
<td>132812205.3.5 IT-8.9 Early Detection of Fetal Anomalies</td>
<td>$13,412,500</td>
</tr>
<tr>
<td>132812205.2.1 Implement Evidence-based Disease Prevention Programs Driscoll Children’s Hospital/132812205</td>
<td>Expand Maternal-Fetal Medicine echocardiogram program, clinics, and outreach program</td>
<td>132812205.3.5 IT-8.9 Early Detection of Fetal Anomalies</td>
<td>$13,412,500</td>
</tr>
<tr>
<td>132812205.2.2 Implement Evidence-based Health Promotion Programs Driscoll Children’s Hospital/132812205</td>
<td>Expand a highly successful prenatal program that promotes healthy behavior and provides support to low-income women with high-risk pregnancies</td>
<td>132812205.3.6 IT-8.9 Reduce the Neonatal ICU Average Length of Stay for the targeted population</td>
<td>$11,502,830</td>
</tr>
<tr>
<td>132812205.2.3 Implement/Expand Care Transitions Programs Driscoll Children’s Hospital/132812205 Pass 2</td>
<td>Develop, implement, and evaluate a specialized follow-up clinic program for high-risk infants and young children in the Driscoll Service Area</td>
<td>132812205.3.7 IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$3,925,193</td>
</tr>
<tr>
<td>135254407.2.1 Integrate Primary and Behavioral Health Care Services - Person-Centered Behavioral Health Medical Home Gulf Bend Center/135254407</td>
<td>Develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease</td>
<td>135254407.3.3 IT-2.4 Behavioral Health/Substance Abuse Admission Rate</td>
<td>$5,035,400</td>
</tr>
<tr>
<td>136436606.2.1 Medication Management CHRISTUS Spohn Kleberg Hospital/136436606</td>
<td>Implementation of Bedside Medication Verification (BMV) Process</td>
<td>136436606.3.3 IT-4.10 Decrease errors in bedside medication administration 136436606.3.4 IT-4.10 Decrease length of stay 136436606.3.5 IT-4.10 Decrease cost of care</td>
<td>$450,733</td>
</tr>
<tr>
<td>136436606.2.2 Medication Management CHRISTUS Spohn Kleberg Hospital/136436606</td>
<td>Implement Computerized Physician Order Management system enabling providers to directly enter orders into our primary Health Information System</td>
<td>136436606.3.6 IT-4.10 Compliance with VTE Prophylaxis Core Measure Indicators</td>
<td>$450,733</td>
</tr>
<tr>
<td>136436606.2.3 Improvement in Quality and Safety for patients with Sepsis</td>
<td>Implementation of both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis,</td>
<td>136436606.3.7 IT-4.8 Potentially Preventable Complications and</td>
<td>$708,295</td>
</tr>
<tr>
<td>Project Title</td>
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<tr>
<td>CHRISTUS Spohn Kleberg Hospital/136436606</td>
<td>septic shock, and/or lactate &gt; 4 mmol/L (36 mg/dl)</td>
<td>Healthcare Acquired Conditions: Sepsis mortality</td>
<td></td>
</tr>
<tr>
<td>136436606.2.4 Expand Care Transitions Program CHRISTUS Spohn Kleberg Hospital/136436606</td>
<td>Addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program</td>
<td>136436606.3.8 IT-3.2 Congestive heart Failure 30 Day Readmission Rate</td>
<td>$965,857</td>
</tr>
<tr>
<td>136436606.2.5 Care management to integrate primary and behavioral health needs CHRISTUS Spohn Kleberg Hospital/136436606</td>
<td>Implement a screening and treatment protocol to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Target diagnoses are CHF and diabetes.</td>
<td>136436606.3.9 IT-9.2 ED Appropriate Utilization (BH/SA patients)</td>
<td>$965,857</td>
</tr>
<tr>
<td>137907508.2.1 Design, Develop and Implement a program of continuous, rapid process improvement Citizens Medical Center/137907508</td>
<td>Use Lean methodology to improve safety, quality, patient experience, efficiency, patient flow, and to eliminate waste and redundancies</td>
<td>137907508.3.3 IT-4.8 Sepsis Mortality 137907508.3.4 IT-5.1 Improved Cost Savings</td>
<td>$6,869,906</td>
</tr>
<tr>
<td>138305109.2.1 Integrate Primary and Behavioral Health Care Services MHMR of Nueces County/138305109</td>
<td>Implement an Integrative Care Program (ICP) to improve access to integrated care for persons with behavioral, physical, and substance use needs</td>
<td>138305109.3.2 IT-6.1 Percent improvement over baseline of patient satisfaction scores 138305109.3.1 IT-2.12 Preventable Hospitalizations for Ambulatory Care Sensitive Conditions</td>
<td>$5,478,357</td>
</tr>
<tr>
<td>138305109.2.2 Recruit, train, and support consumers of mental health services to provide peer support services MHMR of Nueces County 138305109</td>
<td>Recruit, train, and support consumers of mental health services who have made substantial progress in managing their own illnesses to provide peer support services</td>
<td>138305109.3.4 IT 6.1 Percent improvement over baseline of patient satisfaction scores 138305109.3.3 IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
<td>$860,962</td>
</tr>
<tr>
<td>138305109.2.3 Engage in programs to promote healthy lifestyles using evidence-based methodologies including social media and</td>
<td>Develop a program to provide outreach and education to target populations which incorporates the internet and social media</td>
<td>138305109.3.5 IT 2.4 Behavioral Health/Substance Abuse admission rate 138305109.3.6</td>
<td>$517,956</td>
</tr>
<tr>
<td>Project Title</td>
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<tr>
<td>text messaging MHMR of Nueces County 138305109</td>
<td></td>
<td>IT 6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>138305109.2.4 Dual Diagnosis Crisis Stabilization Clinic Project MHMR of Nueces County 138305109</td>
<td>Establish an outpatient psychiatric clinic that offers medication and supportive therapies to individuals with a dual diagnosis of intellectual or developmental disability and mental health</td>
<td>138305109.3.7 IT 9.2 ED appropriate utilization 138305109.3.8 IT 9.4 Other Outcome Improvement Target: Reduction in admissions to Small, Medium, or Large ICF-ID</td>
<td>$2,372,665</td>
</tr>
<tr>
<td>0942220902.2.2 Medication Management CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Implement Computerized Physician Order Management (CPOM) system enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech</td>
<td>094222902.3.7 IT-4.10 Compliance with VTE Prophylaxis Core Measure Indicators</td>
<td>$519,919</td>
</tr>
<tr>
<td>0942220902.2.3 Improvement in Quality and Safety for patients with Sepsis CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Implementation of both the Sepsis Resuscitation and Sepsis Management bundles as treatment for severe sepsis, septic shock, and/or lactate &gt;4mmol/L (36mg/dl)</td>
<td>094222902.3.8 IT-4.8 Potentially Preventable Complications and Healthcare Acquired Conditions: Sepsis mortality</td>
<td>$817,016</td>
</tr>
<tr>
<td>0942220902.2.5 Expand Care Transitions Program CHRISTUS Spohn Alice Hospital/094222902</td>
<td>Addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program</td>
<td>094222902.3.10 IT-3.2 Congestive heart Failure 30 Day Readmission Rate</td>
<td>$1,114,112</td>
</tr>
</tbody>
</table>
Section III. Community Needs Assessment

Region Overview

Regional Healthcare Partnership (RHP) 4 is comprised of 18 counties in South Texas including Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria. Most Region 4 counties are located within the Coastal Bend Council of Government (Coastal Bend-COG) geographic area. The Coastal Bend COG includes all the counties of Region 4 except Gonzales, Jackson, Lavaca, and Victoria. The region is a mix of suburban, urban, and rural areas and while it is geographically large (almost twice the size of Region 3 - Harris County) it has a relatively small population of 747,000 (about one-sixth the population size of Region 3). Corpus Christi is the largest city in the region with a population of approximately 308,000².

Region Demographics & Insurance Coverage

The population of Region 4 reflects a diverse race and ethnic distribution. As Table 1 illustrates, the 2010 US Census data show that 56 percent of the population is Hispanic/Latino, followed by 37 percent identified as Anglo/White, and 5 percent who are Black/African American. The remaining 2 percent include individuals who identified themselves as Asian, American Indian, Alaskan, and other race/ethnic populations.

County population ranges from as low as 385 individuals (Kenedy County) to as high as 322,876 individuals (Nueces County). Approximately two-thirds of Region 4’s population resides in three counties (Nueces, Victoria, and San Patricio.)

Table 1. Region 4: Estimated 2010 Population by Race/Ethnicity and County

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>White</th>
<th>%</th>
<th>Hispanic</th>
<th>%</th>
<th>Black</th>
<th>%</th>
<th>Other</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>25,507</td>
<td>18,670</td>
<td>73</td>
<td>5,463</td>
<td>21</td>
<td>376</td>
<td>2</td>
<td>998</td>
<td>4</td>
</tr>
<tr>
<td>Bee</td>
<td>33,196</td>
<td>10,760</td>
<td>32</td>
<td>19,171</td>
<td>58</td>
<td>3,006</td>
<td>9</td>
<td>259</td>
<td>1</td>
</tr>
<tr>
<td>Brooks</td>
<td>7,721</td>
<td>581</td>
<td>7</td>
<td>7,118</td>
<td>92</td>
<td>4</td>
<td>0.05</td>
<td>18</td>
<td>0.23</td>
</tr>
<tr>
<td>DeWitt</td>
<td>20,173</td>
<td>11,351</td>
<td>56</td>
<td>6,378</td>
<td>32</td>
<td>2,316</td>
<td>11</td>
<td>128</td>
<td>1</td>
</tr>
</tbody>
</table>

² U.S. Census Bureau, State and County Quick Facts, 2011.
<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>White</th>
<th>%</th>
<th>Hispanic</th>
<th>%</th>
<th>Black</th>
<th>%</th>
<th>Other</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duval</td>
<td>12,309</td>
<td>1,308</td>
<td>10</td>
<td>10,901</td>
<td>89</td>
<td>50</td>
<td>0.4</td>
<td>50</td>
<td>0.4</td>
</tr>
<tr>
<td>Goliad</td>
<td>7,351</td>
<td>4,273</td>
<td>58</td>
<td>2,744</td>
<td>37</td>
<td>311</td>
<td>4</td>
<td>23</td>
<td>0.3</td>
</tr>
<tr>
<td>Gonzales</td>
<td>19,522</td>
<td>8,956</td>
<td>46</td>
<td>8,783</td>
<td>45</td>
<td>1,665</td>
<td>8</td>
<td>118</td>
<td>0.6</td>
</tr>
<tr>
<td>Jackson</td>
<td>14,862</td>
<td>9,332</td>
<td>63</td>
<td>4,273</td>
<td>29</td>
<td>1,128</td>
<td>7</td>
<td>129</td>
<td>1</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>41,562</td>
<td>8,683</td>
<td>21</td>
<td>32,365</td>
<td>78</td>
<td>206</td>
<td>0.5</td>
<td>308</td>
<td>0.7</td>
</tr>
<tr>
<td>Karnes</td>
<td>15,340</td>
<td>6,050</td>
<td>39</td>
<td>7,804</td>
<td>51</td>
<td>1,395</td>
<td>9</td>
<td>101</td>
<td>0.6</td>
</tr>
<tr>
<td>Kenedy</td>
<td>385</td>
<td>79</td>
<td>20</td>
<td>303</td>
<td>79</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Kleberg</td>
<td>30,657</td>
<td>7,956</td>
<td>26</td>
<td>20,801</td>
<td>68</td>
<td>1,195</td>
<td>4</td>
<td>705</td>
<td>2</td>
</tr>
<tr>
<td>Lavaca</td>
<td>19,457</td>
<td>14,966</td>
<td>77</td>
<td>2,881</td>
<td>15</td>
<td>1,518</td>
<td>8</td>
<td>92</td>
<td>0.5</td>
</tr>
<tr>
<td>Live Oak</td>
<td>12,191</td>
<td>6,890</td>
<td>56</td>
<td>4,983</td>
<td>41</td>
<td>260</td>
<td>2</td>
<td>58</td>
<td>0.5</td>
</tr>
<tr>
<td>Nueces</td>
<td>322,876</td>
<td>98,788</td>
<td>31</td>
<td>203,372</td>
<td>63</td>
<td>12,914</td>
<td>4</td>
<td>7,802</td>
<td>2</td>
</tr>
<tr>
<td>Refugio</td>
<td>7,411</td>
<td>3,212</td>
<td>43</td>
<td>3,606</td>
<td>49</td>
<td>523</td>
<td>7</td>
<td>70</td>
<td>1</td>
</tr>
<tr>
<td>San Patricio</td>
<td>69,169</td>
<td>29,626</td>
<td>43</td>
<td>36,249</td>
<td>52</td>
<td>2,201</td>
<td>3</td>
<td>1,093</td>
<td>2</td>
</tr>
<tr>
<td>Victoria</td>
<td>87,757</td>
<td>39,964</td>
<td>46</td>
<td>41,088</td>
<td>47</td>
<td>5,480</td>
<td>6</td>
<td>1,225</td>
<td>1</td>
</tr>
<tr>
<td>TOTALS</td>
<td>747,466</td>
<td>281,445</td>
<td>37</td>
<td>418,283</td>
<td>56</td>
<td>34,548</td>
<td>5</td>
<td>13,180</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Texas State Data Center, Texas Population 2010

Income

As shown in Table 2 below, the average Median Household Income ranges from a low of $26,027 in Brooks County to a high of $46,566 in Victoria County. Median Income in all of the 18 counties falls below the statewide average of $49,585. Census data also shows that 20 percent of county residents had incomes below the federal poverty level; among children under 18, the rate was even higher at 31 percent. Poverty rates in Region 4 are higher than statewide averages of 18 percent and 26 percent for total population and children, respectively.

Table 2. Region 4: Income and Poverty Status by County--2010

<table>
<thead>
<tr>
<th>County</th>
<th>Median Household Income</th>
<th>Number of People in Poverty</th>
<th>%</th>
<th>Number of Children Under 18 in Poverty</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>$38,516</td>
<td>5,058</td>
<td>22</td>
<td>1,827</td>
<td>41</td>
</tr>
<tr>
<td>Bee</td>
<td>$36,462</td>
<td>6,623</td>
<td>27</td>
<td>2,344</td>
<td>35</td>
</tr>
<tr>
<td>Brooks</td>
<td>$26,027</td>
<td>2,353</td>
<td>33</td>
<td>984</td>
<td>49</td>
</tr>
<tr>
<td>DeWitt</td>
<td>$36,611</td>
<td>3,885</td>
<td>21</td>
<td>1,414</td>
<td>32</td>
</tr>
<tr>
<td>Duval</td>
<td>$30,365</td>
<td>2,994</td>
<td>27</td>
<td>1,165</td>
<td>38</td>
</tr>
<tr>
<td>Goliad</td>
<td>$42,646</td>
<td>1,101</td>
<td>15</td>
<td>404</td>
<td>25</td>
</tr>
<tr>
<td>Gonzales</td>
<td>$31,012</td>
<td>4,061</td>
<td>21</td>
<td>1,670</td>
<td>32</td>
</tr>
<tr>
<td>Jackson</td>
<td>$38,137</td>
<td>2,234</td>
<td>16</td>
<td>887</td>
<td>25</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>$36,404</td>
<td>8,753</td>
<td>22</td>
<td>3,775</td>
<td>32</td>
</tr>
<tr>
<td>Karnes</td>
<td>$34,970</td>
<td>3,026</td>
<td>26</td>
<td>982</td>
<td>33</td>
</tr>
<tr>
<td>Kenedy</td>
<td>$33,502</td>
<td>52</td>
<td>12</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Kleberg</td>
<td>$37,418</td>
<td>7,445</td>
<td>25</td>
<td>2,613</td>
<td>33</td>
</tr>
<tr>
<td>Lavaca</td>
<td>$39,468</td>
<td>2,735</td>
<td>14</td>
<td>916</td>
<td>21</td>
</tr>
<tr>
<td>Live Oak</td>
<td>$36,091</td>
<td>1,932</td>
<td>19</td>
<td>648</td>
<td>28</td>
</tr>
<tr>
<td>Nueces</td>
<td>$41,899</td>
<td>66,978</td>
<td>20</td>
<td>26,953</td>
<td>31</td>
</tr>
<tr>
<td>Refugio</td>
<td>$39,582</td>
<td>1,284</td>
<td>18</td>
<td>466</td>
<td>26</td>
</tr>
<tr>
<td>San Patricio</td>
<td>$44,307</td>
<td>13,444</td>
<td>21</td>
<td>5,680</td>
<td>32</td>
</tr>
</tbody>
</table>
Education

Education rates in Region 4 also vary by county, but, consistent with lower incomes, most counties experience lower high school and college graduation rates than the statewide average. Among 18-24 year olds, high school graduation rates range from 47% in Karnes to 90.5% in Kleberg County. Among adults age 25 and over, high school graduation rates vary from a low of 53.7% in Brooks County to a high of 85.1% in Aransas County. College graduation rates for 18-24 year olds range from a low of 0% to a high of 12.1%; only one county exceeded the statewide average of 7.1%. Among those age 25 and over, high school graduation rates vary from 53.7% to 85.1%; college rates range from 9.2% to 23.9%, all below the statewide average of 26.4%.

Table 3. Region 4: Education by Age and County

<table>
<thead>
<tr>
<th>County</th>
<th>Median Household Income</th>
<th>Number of People in Poverty</th>
<th>%</th>
<th>Number of Children Under 18 in Poverty</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>$46,566</td>
<td>15,537</td>
<td>18</td>
<td>6,336</td>
<td>28</td>
</tr>
<tr>
<td>Statewide</td>
<td>$49,646</td>
<td>4,411,217</td>
<td>17.9</td>
<td>1,746,564</td>
<td>25.7</td>
</tr>
<tr>
<td>United States</td>
<td></td>
<td>15.3</td>
<td>21.6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source:* U.S. Census Bureau, Small Area Income and Poverty Estimates- 2010 County Level Estimations; U.S. Census Bureau, American Community Survey, 2009-2010.

---

**Table 3. Region 4: Education by Age and County**

<table>
<thead>
<tr>
<th>County</th>
<th>Age 18 – 24 Years</th>
<th>Age 25 &amp; Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less Than High School</td>
<td>High School Graduate</td>
</tr>
<tr>
<td>Aransas</td>
<td>25.7%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Bee</td>
<td>37.9%</td>
<td>62.1%</td>
</tr>
<tr>
<td>Brooks</td>
<td>43.6%</td>
<td>56.5%</td>
</tr>
<tr>
<td>DeWitt</td>
<td>31.8%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Duval</td>
<td>23.0%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Golliad</td>
<td>51.1%</td>
<td>48.9%</td>
</tr>
<tr>
<td>Gonzales</td>
<td>36.6%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Jackson</td>
<td>19.5%</td>
<td>80.6%</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>34.4%</td>
<td>65.6%</td>
</tr>
<tr>
<td>Karnes</td>
<td>53.0%</td>
<td>47.0%</td>
</tr>
<tr>
<td>Kenedy</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Kleberg</td>
<td>9.4%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Lavaca</td>
<td>24.0%</td>
<td>75.9%</td>
</tr>
<tr>
<td>Live Oak</td>
<td>23.8%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Nueces</td>
<td>19.1%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Refugio</td>
<td>21.2%</td>
<td>78.9%</td>
</tr>
<tr>
<td>San Patricio</td>
<td>17.5%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Victoria</td>
<td>23.4%</td>
<td>76.6%</td>
</tr>
<tr>
<td>Statewide</td>
<td>19.3%</td>
<td>80.7%</td>
</tr>
</tbody>
</table>

*Source:* U.S. Census Bureau, American Community Survey 5 year Estimates, 2006-1010

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RHP Plan for Region 4
Employment
Employment rate is relatively stable in Region 4. The unemployment rate in the most populous counties (Nueces, Victoria, and San Patricio) ranges from 7.0 to 7.9 percent, which is below the state average of 8.5 percent.

Table 4: Workforce Status of People Aged 16 and Over (2009-2011)

<table>
<thead>
<tr>
<th>County</th>
<th>Total Population</th>
<th>Percentage In Labor Force</th>
<th>Percentage Employed</th>
<th>Percentage Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>19,029</td>
<td>52.0%</td>
<td>48.4%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Bee</td>
<td>26,026</td>
<td>37.5%</td>
<td>34.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Brooks</td>
<td>5,597</td>
<td>49.3%</td>
<td>45.3%</td>
<td>8.1%</td>
</tr>
<tr>
<td>DeWitt</td>
<td>16,242</td>
<td>54.9%</td>
<td>51.5%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Duval</td>
<td>9,193</td>
<td>55.7%</td>
<td>51.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Goliad</td>
<td>5,689</td>
<td>59.8%</td>
<td>58.7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Gonzales</td>
<td>14,900</td>
<td>60.5%</td>
<td>55.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Jackson</td>
<td>10,812</td>
<td>64.6%</td>
<td>61.2%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>30,010</td>
<td>58.5%</td>
<td>54.5%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Karnes</td>
<td>13,612</td>
<td>35.5%</td>
<td>34.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Kenedy</td>
<td>200</td>
<td>57.5%</td>
<td>57.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Kleberg</td>
<td>24,681</td>
<td>59.3%</td>
<td>52.4%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Lavaca</td>
<td>15,273</td>
<td>62.2%</td>
<td>58.3%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Live Oak</td>
<td>9,341</td>
<td>45.0%</td>
<td>43.5%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Nueces</td>
<td>256,930</td>
<td>63.7%</td>
<td>57.6%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Refugio</td>
<td>5,896</td>
<td>49.5%</td>
<td>45.9%</td>
<td>7.2%</td>
</tr>
<tr>
<td>San Patricio</td>
<td>49,600</td>
<td>62.5%</td>
<td>55.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Victoria</td>
<td>65,189</td>
<td>66.7%</td>
<td>61.9%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Statewide</td>
<td>19,117,836</td>
<td>65.4%</td>
<td>59.3%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, 2009-2011 American Community Survey

Health Insurance Status
For more than 15 years, the state of Texas has experienced the highest uninsured rate in the country (approximately 25 percent). This fact is reflected in the high number of uninsured people living throughout Region 4. Of the eight counties for which data is available, the most recent census data available estimates that 117,028 people (21.8%) were uninsured in 2010.3 By county, uninsured rates varied from a low of 17.6% in Bee County to 23.8% in San Patricio.

3 Due to the small population, data is not available for 11 of the 18 counties.
In a 2010 Community Needs Assessment study, focus group participants reported lack of insurance is due primarily to high premium costs, a lack of employment-based coverage, and ineligibility for governmental plans.  

Table 5: Health Insurance Status

<table>
<thead>
<tr>
<th>County</th>
<th>Civilian Non-institutionalized Population</th>
<th>Total Insured</th>
<th>%</th>
<th>Insured with Private Coverage</th>
<th>Insured with Public Coverage</th>
<th>Medicaid Enrollment</th>
<th>Percent Medicaid Enrolled</th>
<th>Total Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>22,294</td>
<td>18,504</td>
<td>80.7%</td>
<td>58.4%</td>
<td>39.4%</td>
<td>2,888</td>
<td>11.3%</td>
<td>4,420</td>
<td>19.3%</td>
</tr>
<tr>
<td>Bee</td>
<td>23,917</td>
<td>19,712</td>
<td>82.4%</td>
<td>59.7%</td>
<td>35.0%</td>
<td>4,284</td>
<td>12.9%</td>
<td>4,205</td>
<td>17.6%</td>
</tr>
<tr>
<td>Brooks</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>DeWitt</td>
<td>18,327</td>
<td>14,134</td>
<td>77.1%</td>
<td>56.0%</td>
<td>36.8%</td>
<td>3,028</td>
<td>15.0%</td>
<td>4,193</td>
<td>22.9%</td>
</tr>
<tr>
<td>Duval</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Goliad</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>808</td>
<td>11.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Gonzales</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>3,271</td>
<td>16.8%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Jackson</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,837</td>
<td>12.4%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>40,252</td>
<td>31,360</td>
<td>77.9%</td>
<td>48.8%</td>
<td>37.4%</td>
<td>8,211</td>
<td>19.8%</td>
<td>8,892</td>
<td>22.1%</td>
</tr>
<tr>
<td>Karnes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,861</td>
<td>12.1%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Kenedy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>54</td>
<td>14.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Kleberg</td>
<td>31,270</td>
<td>24,578</td>
<td>78.6%</td>
<td>56.8%</td>
<td>31.6%</td>
<td>5,051</td>
<td>16.5%</td>
<td>6,692</td>
<td>21.4%</td>
</tr>
<tr>
<td>Lavaca</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,853</td>
<td>9.5%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Live Oak</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,079</td>
<td>8.9%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nueces</td>
<td>335,609</td>
<td>262,201</td>
<td>78.1%</td>
<td>53.9%</td>
<td>33.6%</td>
<td>53,566</td>
<td>16.6%</td>
<td>73,408</td>
<td>21.9%</td>
</tr>
<tr>
<td>Refugio</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>1,016</td>
<td>13.7%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>San Patricio</td>
<td>63,975</td>
<td>48,757</td>
<td>76.2%</td>
<td>52.7%</td>
<td>33.1%</td>
<td>10,290</td>
<td>14.9%</td>
<td>15,218</td>
<td>23.8%</td>
</tr>
<tr>
<td>Victoria</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>12,508</td>
<td>14.3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTALS</td>
<td>536,264</td>
<td>419,246</td>
<td></td>
<td>116,091</td>
<td>15.50%</td>
<td>117,028</td>
<td>21.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Texas State Data Center, Texas Population 2010; Texas Health and Human Services Commission

Description of Regional Health System and Challenges

Region 4 has three main area hospital systems: CHRISTUS Spohn Health System, Corpus Christi Medical Center, and Driscoll Children’s Hospital. There are also hospital district facilities in DeWitt, Gonzales, Jackson, Karnes, Lavaca, and Refugio counties. Aransas, Brooks, Duval, Goliad, Kenedy, and Live Oak counties do not have an acute care hospital. Several hundred physicians are affiliated with the CHRISTUS Spohn, Corpus Christi and Driscoll systems. The

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region has five Local Mental Health Authority providers, all of whom are participants in the Region 4 plan.

Health care infrastructure is largely concentrated in the most populous counties of Nueces and Victoria, and fewer professional and facility services are available in the rural counties. Table 6 below shows that 11 out of the 21 hospitals in the region are located in Nueces and Victoria. The region has only one psychiatric hospital located in Nueces. The region has 488 primary care physicians of which 289 practice in Nueces. In some rural counties, with large percentages of uninsured, there are few primary care physicians (PCPs). Eight counties in the region have four or fewer PCPs. Two counties have none. Based on the ratio of acute care beds to population, Region 4 has roughly one acute care bed for every 290 persons, and one PCP for every 1,495 persons.

### Table 6. Region 4: Hospitals & Primary Care Physicians

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Acute Care Hospitals</th>
<th>Acute Care Beds</th>
<th>Psychiatric Hospitals</th>
<th>Primary Care Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>25,507</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Bee</td>
<td>33,196</td>
<td>1</td>
<td>63</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Brooks</td>
<td>7,721</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>DeWitt</td>
<td>20,173</td>
<td>1</td>
<td>49</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Duval</td>
<td>12,309</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Goliad</td>
<td>7,351</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Gonzales</td>
<td>19,522</td>
<td>1</td>
<td>34</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Jackson</td>
<td>14,862</td>
<td>1</td>
<td>25</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>41,562</td>
<td>1</td>
<td>142</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Karnes</td>
<td>15,340</td>
<td>1</td>
<td>21</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Kenedy</td>
<td>385</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kleberg</td>
<td>30,657</td>
<td>1</td>
<td>77</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Lavaca</td>
<td>19,457</td>
<td>2</td>
<td>50</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Live Oak</td>
<td>12,191</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nueces</td>
<td>322,876</td>
<td>7</td>
<td>1,427</td>
<td>1</td>
<td>289</td>
</tr>
<tr>
<td>Refugio</td>
<td>7,411</td>
<td>1</td>
<td>20</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>San Patricio</td>
<td>69,169</td>
<td>1</td>
<td>75</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Victoria</td>
<td>87,757</td>
<td>4</td>
<td>572</td>
<td>0</td>
<td>83</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>747,466</strong></td>
<td><strong>22</strong></td>
<td><strong>2,555</strong></td>
<td><strong>1</strong></td>
<td><strong>500</strong></td>
</tr>
</tbody>
</table>

*Source: Texas Department of State Health Services; Texas Board of Medical Examiners*

As apparent in Table 7, physician specialists are also concentrated in the counties with the largest population. Two counties, Duval and Kenedy, have no physician specialists. Though not uncommon for rural communities, lack of access to specialty care providers is a critical issue for patients who must often travel a significant distance to obtain care. The issue is particularly challenging for individuals with no reliable source of transportation.

### Table 7. Region 4: Selected Physician Specialists by County

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Cardiology</th>
<th>Family Practice</th>
<th>Internal Medicine</th>
<th>OB/GYN</th>
<th>Pediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>25,507</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bee</td>
<td>33,196</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

RHP Plan for Region 4
In 2010, about one-fifth of the inpatient days in Region 4 hospitals were related to the treatment of Medicaid patients. There were more than one million outpatient visits to regional hospitals with almost half occurring in Nueces County. Hospitals also provided care for nearly 379,000 ER visits, some of which contributed to the more than $500 million in uncompensated care as shown in the following Table.

### Table 8. Region 4: Hospital Utilization--2010

<table>
<thead>
<tr>
<th>County</th>
<th>Staffed Beds</th>
<th>Inpatient Days</th>
<th>Medicaid Inpatient Days</th>
<th>Average Length of Stay</th>
<th>ER Visits</th>
<th>Outpatient Visits</th>
<th>Uncompensated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Bee</td>
<td>63</td>
<td>7,652</td>
<td>1,626</td>
<td>3.8</td>
<td>18,844</td>
<td>34,596</td>
<td>$23,532,704</td>
</tr>
<tr>
<td>Brooks</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>DeWitt</td>
<td>49</td>
<td>7,189</td>
<td>1,276</td>
<td>3.6</td>
<td>7,996</td>
<td>139,966</td>
<td>$4,829,184</td>
</tr>
<tr>
<td>Duval</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Goliad</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Gonzales</td>
<td>32</td>
<td>3,707</td>
<td>674</td>
<td>3.1</td>
<td>8,165</td>
<td>62,174</td>
<td>$4,721,492</td>
</tr>
<tr>
<td>Jackson</td>
<td>25</td>
<td>4,438</td>
<td>1,632</td>
<td>12.2</td>
<td>3,848</td>
<td>12,735</td>
<td>$2,021,688</td>
</tr>
<tr>
<td>Jim Wells</td>
<td>126</td>
<td>17,411</td>
<td>4,461</td>
<td>4.2</td>
<td>28,382</td>
<td>55,767</td>
<td>$40,441,237</td>
</tr>
<tr>
<td>Karnes</td>
<td>21</td>
<td>1,945</td>
<td>52</td>
<td>5.3</td>
<td>6,342</td>
<td>14,914</td>
<td>$3,335,798</td>
</tr>
<tr>
<td>Kenedy</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Kleberg</td>
<td>77</td>
<td>17,264</td>
<td>3,792</td>
<td>4.1</td>
<td>18,244</td>
<td>32,245</td>
<td>$28,345,913</td>
</tr>
<tr>
<td>Lavaca</td>
<td>50</td>
<td>7,583</td>
<td>345</td>
<td>5.0</td>
<td>8,256</td>
<td>43,018</td>
<td>$4,066,605</td>
</tr>
<tr>
<td>Live Oak</td>
<td>0</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Nueces</td>
<td>1,459</td>
<td>329,581</td>
<td>77,391</td>
<td>5.6</td>
<td>195,394</td>
<td>540,693</td>
<td>$307,282,274</td>
</tr>
<tr>
<td>Refugio</td>
<td>20</td>
<td>404</td>
<td>15</td>
<td>3.0</td>
<td>4,025</td>
<td>28,447</td>
<td>$2,045,357</td>
</tr>
<tr>
<td>San Patricio</td>
<td>75</td>
<td>5,769</td>
<td>602</td>
<td>4.3</td>
<td>11,553</td>
<td>22,941</td>
<td>$4,396,352</td>
</tr>
<tr>
<td>Victoria</td>
<td>572</td>
<td>108,969</td>
<td>12,436</td>
<td>5.3</td>
<td>67,825</td>
<td>193,286</td>
<td>$78,098,420</td>
</tr>
<tr>
<td>TOTALS</td>
<td>2,569</td>
<td>511,912</td>
<td>104,302</td>
<td>--</td>
<td>378,874</td>
<td>1,180,782</td>
<td>$503,117,024</td>
</tr>
</tbody>
</table>

Source: Texas Board of Medical Examiners

RHP Plan for Region 4
To better understand the health status and health care needs of the region’s residents, the Coastal Bend’s Community Health Needs Assessment was conducted in 2004, with a follow-up study in 2010 to update the study data.\(^5\) Table 9 provides a summary of the most common reported principal and secondary diagnoses based on an analysis of two years of hospital data (September 1, 2007 through August 31, 2009).

**Table 9. Region 4: Most Common Primary and Secondary Diagnosis in Order of Frequency, All Age Groups -- 2009\(^6\)**

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Number of Patients</th>
<th>Secondary Diagnosis</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>4,612</td>
<td>Urinary Tract Infection</td>
<td>5,194</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>3,221</td>
<td>Essential Hypertension</td>
<td>4,595</td>
</tr>
<tr>
<td>Previous Cesarean Delivery</td>
<td>2,910</td>
<td>Acute Renal Failure</td>
<td>4,036</td>
</tr>
<tr>
<td>Coronary Atherosclerosis</td>
<td>2,059</td>
<td>Pneumonia</td>
<td>3,971</td>
</tr>
<tr>
<td>Normal Delivery</td>
<td>2,053</td>
<td>End Stage Renal Disease</td>
<td>3,822</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>1,947</td>
<td>Diabetes without complications</td>
<td>2,091</td>
</tr>
<tr>
<td>Obstructive Chronic Bronchitis</td>
<td>1,828</td>
<td>Hyposmolality and/or Hypernatemia</td>
<td>1,752</td>
</tr>
<tr>
<td>Dehydration</td>
<td>1,675</td>
<td>Interstitial Emphysema</td>
<td>1,714</td>
</tr>
<tr>
<td>Cellulitis and Abscess</td>
<td>1,513</td>
<td>Dehydration</td>
<td>1,615</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
<td>1,419</td>
<td>Coronary Atherosclerosis</td>
<td>1,228</td>
</tr>
</tbody>
</table>

Many of these identified diagnoses are often associated with “preventable hospitalizations,” which the Texas Department of State Health Services (DSHS) defines as hospitalizations which might have been prevented had the person had access to and cooperated with appropriate outpatient health care services and providers. Data from DSHS illustrates the frequency of these hospitalizations in Region 4 as compared with statewide incidence.

**Table 10. Region 4: Percent (%) of Adult Preventable Hospitalizations as a Percent of Total County Population, 2006 – 2010**

<table>
<thead>
<tr>
<th>County</th>
<th>Asthma</th>
<th>Bacterial Pneumonia</th>
<th>CHF</th>
<th>COPD</th>
<th>Dehydration</th>
<th>Diabetes (Long-term Complications)</th>
<th>UTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>--</td>
<td>1.58</td>
<td>1.57</td>
<td>1.08</td>
<td>--</td>
<td>0.70</td>
<td>0.70</td>
</tr>
<tr>
<td>Bee</td>
<td>--</td>
<td>1.56</td>
<td>1.93</td>
<td>1.01</td>
<td>--</td>
<td>0.65</td>
<td>0.64</td>
</tr>
<tr>
<td>Brooks</td>
<td>--</td>
<td>2.94</td>
<td>3.76</td>
<td>--</td>
<td>--</td>
<td>1.80</td>
<td>1.80</td>
</tr>
<tr>
<td>DeWitt</td>
<td>--</td>
<td>1.35</td>
<td>1.81</td>
<td>--</td>
<td>--</td>
<td>0.75</td>
<td>0.75</td>
</tr>
<tr>
<td>Duval</td>
<td>--</td>
<td>2.83</td>
<td>2.74</td>
<td>1.29</td>
<td>--</td>
<td>1.28</td>
<td>1.28</td>
</tr>
<tr>
<td>Goliad</td>
<td>--</td>
<td>--</td>
<td>2.07</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Gonzales</td>
<td>--</td>
<td>--</td>
<td>0.78</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Jackson</td>
<td>--</td>
<td>1.28</td>
<td>1.68</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

\(^5\) Texas A&M University, 2010.

\(^6\) Reported Diagnostic Related Groups (DRGs) for Coastal Bend Hospitals, January 1 to August 31, 2009. This does not include data from the eight hospitals located in Gonzales, Jackson, Lavaca and Victoria counties.
RHP Plan for Region 4

<table>
<thead>
<tr>
<th>County</th>
<th>Asthma</th>
<th>Bacterial Pneumonia</th>
<th>CHF</th>
<th>COPD</th>
<th>Dehydration</th>
<th>Diabetes (Long-term Complications)</th>
<th>UTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim Wells</td>
<td>0.58</td>
<td>2.29</td>
<td>2.32</td>
<td>0.94</td>
<td>--</td>
<td>0.61</td>
<td>1.06</td>
</tr>
<tr>
<td>Karnes</td>
<td>--</td>
<td>--</td>
<td>1.04</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Kenedy</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Kleberg</td>
<td>2.89</td>
<td>3.10</td>
<td>0.70</td>
<td>0.91</td>
<td>0.58</td>
<td>1.39</td>
<td></td>
</tr>
<tr>
<td>Lavaca</td>
<td>1.72</td>
<td>2.19</td>
<td>0.97</td>
<td>0.83</td>
<td>--</td>
<td>1.41</td>
<td></td>
</tr>
<tr>
<td>Live Oak</td>
<td>1.27</td>
<td>1.47</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Nueces</td>
<td>0.36</td>
<td>1.39</td>
<td>1.72</td>
<td>0.71</td>
<td>0.28</td>
<td>0.58</td>
<td>0.82</td>
</tr>
<tr>
<td>Refugio</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>San Patricio</td>
<td>0.26</td>
<td>1.46</td>
<td>1.76</td>
<td>0.92</td>
<td>0.25</td>
<td>0.50</td>
<td>0.77</td>
</tr>
<tr>
<td>Victoria</td>
<td>0.62</td>
<td>1.75</td>
<td>1.89</td>
<td>0.79</td>
<td>0.82</td>
<td>0.24</td>
<td>1.30</td>
</tr>
<tr>
<td>TEXAS</td>
<td>0.31</td>
<td>1.00</td>
<td>1.18</td>
<td>0.58</td>
<td>0.27</td>
<td>0.18</td>
<td>0.64</td>
</tr>
</tbody>
</table>

Source: Texas Department of State Health Services. The number of hospitalizations was too small to analyze for Kenedy and Refugio counties, which have small populations. Data does not exist for all conditions in all counties.

These and other data in the Community Needs Assessment clearly illustrate the wide range of health care concerns and needs that prevail throughout our community. The selection of DSRIP projects reflects these needs and the priorities established by our stakeholders, and represent a range of diverse projects that are designed to improve the health status of our community members and ensure patients receive the most appropriate care for their condition in the most cost-effective setting and manner possible.

**HPSA Designation**

According to the federal Health Resources and Services Administration (HRSA), all counties in the region are either partially or fully medically underserved and have a shortage of primary care and mental health providers. A Medically Underserved Area (MUA) is defined by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility).

The table below lists the federal designations by county. Unless otherwise noted, the entire county is designated as MUA or HPSA.

**Table 11. Region 4: Medically Underserved Areas and Health Professional Shortage Areas**

<table>
<thead>
<tr>
<th>County</th>
<th>Medically Underserved Area</th>
<th>Health Professional Shortage Area (HPSA) Primary Care</th>
<th>HPSA Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aransas</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bee</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Brooks</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>DeWitt</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Duval</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Goliad</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Jackson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Regional Initiatives funded by the U.S. Department of Health and Human Services (HHS)

According to the U.S. Department of Health and Human Services’ Tracking Accountability in Government Grants System (TAGGS), there are five HHS-funded initiatives operating in the region in 2012 which are directly related to enhancing the region’s health care delivery network.

- Rural Health Network Development program in Goliad County. Recipient is the South Texas Health System.
- Health Center Cluster program in Gonzales County. Recipient is the Community Health Centers of South Texas.
- Health Center Cluster program in Jackson County. Recipient is the Community Action Corporation of South Texas.
- HIV Prevention Projects in Nueces County. Recipient is the Nueces County Community Action Agency.
- Basic Centers program in Victoria County. Recipient is the Gulf Bend Mental Health and Mental Retardation Center.

Projected Major Changes

Regional leaders do not anticipate major changes in the demographic or health care infrastructure characteristics of the region. Should the state implement an expansion of the Medicaid program, as permitted under federal law, there would be an increased need for professional and facility acute care and behavioral health services.

Key Health Challenges

Region 4 confronts a number of health care challenges in meeting the health care needs of its population:

- **Inadequate number of primary and specialty care providers.** As outlined above, many regional residents live in counties with limited access to basic health care services.
Expanded access to these services is a priority for the region and it must be undertaken against the backdrop of constrained resources.

- **High prevalence of chronic disease, including cancer, hypertension, diabetes, and cardiovascular disease.** Regional hospital admissions and related data indicate that there is a prevalence of chronic conditions that lead to preventable hospitalizations, and which require a coordinated care management team approach to maximize patient outcomes.

- **Inadequate access to behavioral health care services.** In 2009, Coastal Bend hospitals reported that schizoaffective disorder and manic depressive disorder were the third and fourth most common principal admission diagnosis for patients aged 18 to 49 years. About 23% of those responding to a telephone survey of Coastal Bend residents stated they had depression, and 12.5% reported that one of their children needed mental health services. Of that group, 33% said they did not receive the mental health services they needed.

- **Urban/rural differences in perception of health care access.** Residents in rural areas are more likely to experience barriers to health care access than those who live in urban areas. Some of the specific challenges faced by our population include transportation to and from health care facilities, excessive time waiting for services, lack of both primary and specialty care providers.

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

- **High number of uninsured patients.** With more than 20% of the population lacking health insurance, the region struggles to keep up with the demand for services. Patients do not receive basic health care services, delay treatment, and often seek primary care services in emergency settings, resulting in millions of dollars in unnecessary spending with no follow-up care or chronic disease management.

**Approach and Sources Used to Complete Needs Assessment**

The RHP 4 providers, stakeholders and other partners comprise a wide assortment of public and private institutions coming together to address the region’s heavy burden of chronic disease, demonstrated need for improved access to primary care services, specialty care services, and behavioral health care services and treatment. The goal of this RHP 4 needs assessment was to guide the health delivery reform strategic planning process by providing information to guide decisions in selecting DSRIP projects for the region. In this process we engaged the community and key partners to identify health concerns, priorities, strengths, and opportunities for DSRIP projects.
Key sources of information that supported this Needs Assessment came from the Texas Department of State Health Services, Center for Health Statistics, which is a major source of information for local community health assessment and public health planning. The Center is a repository of federal health surveys that have demographic, health and workforce statistics available at the state, MSA or county level, as well as state-based surveys and vital statistics at the state and county level. The Coastal Bend’s 2010 Community Health Needs Assessment, prepared by Texas A&M University, located in RHP 4, also provided findings from a health needs assessment conducted in the Coastal Bend counties referenced throughout this document.
### Summary of Community Needs

<table>
<thead>
<tr>
<th>Identification Number</th>
<th>Brief Description of Community Needs Addressed through RHP Plan</th>
<th>Data Source for Identified Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>CN.1</td>
<td>Inadequate access to primary care</td>
<td>1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11; 13</td>
</tr>
<tr>
<td>CN.2</td>
<td>Inadequate access to specialty services.</td>
<td>1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11</td>
</tr>
<tr>
<td>CN.3</td>
<td>Inadequate provision and coordination of health care services for persons with chronic conditions.</td>
<td>1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11</td>
</tr>
<tr>
<td>CN.4</td>
<td>Inadequate access to behavioral health services.</td>
<td>1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11</td>
</tr>
<tr>
<td>CN.5</td>
<td>Inadequate Access to Dental Care</td>
<td>1; 4; 10</td>
</tr>
<tr>
<td>CN.6</td>
<td>High rates of inappropriate emergency department utilization and dissatisfaction of emergency department services</td>
<td>2; 5; 8</td>
</tr>
<tr>
<td>CN.7</td>
<td>High rates of preventable hospital admissions</td>
<td>1; 5; 13; 18</td>
</tr>
<tr>
<td>CN.8</td>
<td>High rates of poor dental health and associated medical issues</td>
<td>15, 16</td>
</tr>
<tr>
<td>CN.9</td>
<td>Shortage of specialty care physicians</td>
<td>1; 2; 4; 8; 9</td>
</tr>
<tr>
<td>CN.10</td>
<td>Shortage of primary care physicians</td>
<td>1; 2; 4; 8; 10</td>
</tr>
<tr>
<td>CN.11</td>
<td>High rates of poor birth outcomes and low birth-weight babies</td>
<td>1; 2; 4; 12; 13; 14</td>
</tr>
<tr>
<td>CN.12</td>
<td>Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services</td>
<td>1; 2; 8; 13</td>
</tr>
<tr>
<td>CN.13</td>
<td>Insufficient access to services for pregnant women, particularly low income women</td>
<td>2; 4; 6; 14</td>
</tr>
<tr>
<td>Identification Number</td>
<td>Brief Description of Community Needs Addressed through RHP Plan</td>
<td>Data Source for Identified Need</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>CN.14</td>
<td>High rates of diabetes, including gestational diabetes</td>
<td>1; 2; 4; 17</td>
</tr>
<tr>
<td>CN.15</td>
<td>Inadequate health care access in rural areas</td>
<td>1; 2; 8; 10</td>
</tr>
<tr>
<td>CN.16</td>
<td>Lack of integration of physical and behavioral health services</td>
<td>1; 13</td>
</tr>
<tr>
<td>CN.17</td>
<td>High incidence, mortality, and cost associated with Chronic Obstructive Pulmonary Disease</td>
<td>1; 2; 4</td>
</tr>
<tr>
<td>CN.18</td>
<td>High incidence and mortality of sepsis and severe sepsis</td>
<td>1; 2</td>
</tr>
<tr>
<td>CN.19</td>
<td>Negative mental health outcomes, such as suicide or mental health admissions in jail/prisons</td>
<td>1;2; 4; 19</td>
</tr>
</tbody>
</table>

2. Tina Fields & Peggy Johnson, *Gonzales County Needs Assessment* (December 2011)
3. Texas Department of State Health Services (DSHS), *Texas Hospitals and Hospital Districts* (Map 2007)
7. National Center for Rural Health Works, Oklahoma State University (NCRHW-OSU), *Demographic and Economic Data for Refugio County Memorial Hospital in Refugio County, Texas* (October 2011)
8. NCRHW-OSU, *Health Survey Results for Refugio County Memorial Hospital Community Health Needs Assessment Process* (January 2012)
11. Texas Workforce Commission, Coastal Bend Workforce Development Area (June 2012)
Section IV. Stakeholder Engagement

RHP Participants Engagement

Participant Engagement by Anchoring Entity
In its role as anchoring entity, the Nueces County Hospital District (NCHD) has directed a comprehensive stakeholder engagement process for Performing Providers and IGT entities. In April 2012, the Region’s hospitals, local mental health authorities, and public health performing providers were invited to participate in an organizational meeting hosted by NCHD. Approximately one month prior to this meeting, weekly standing conference calls were initiated and presently continue. The purpose of these conference calls is to update participants on HHSC activities related to the Section 1115 waiver, discuss the Region’s planned activities and DSRIP projects, develop timelines, and address any questions participants may have at the time of the call. Conference call participants include the Region’s participating hospitals, local mental health authorities, the Corpus Christi-Nueces County Public Health District, the Nueces County Medical Society, and the Office of State Representative Todd Hunter. In addition, NCHD hosted two meetings in July 2012 for performing providers, stakeholders, and the public to collaborate on the Region’s Health Needs Assessment, identify priorities, and solicit public input. These meetings were held in two different cities, Corpus Christi and Victoria, for the convenience of stakeholders and citizens wishing to participate. On November 6-7, 2012, two additional meetings were held to solicit stakeholder and public input on the Region’s Health Needs Assessment and priorities and on Pass 1 DSRIP projects. Again, these meetings were held in different parts of the Region to facilitate attendance by performing providers and the public. On December 20 and 21, 2012, public webinars were conducted to solicit stakeholder and public input on Pass 2 DSRIP projects and the updated RHP plan.

Ongoing engagement with performing providers and IGT Entities will be accomplished via standing weekly conference calls as described above. These calls will continue through the early months of 2013 and as needed thereafter. In addition, performing provider, stakeholder, and public meetings will be conducted as needed to share information and solicit input regarding the Regional Healthcare Partnership (RHP) Plan. Past and future participant engagement activities conducted by NCHD, including participating organizations, possible learning collaboratives, and topics covered, are listed in tables 1 and 2 of the addendum.

Participant Engagement by Other Performing Providers
In addition to the activities organized by NCHD, each performing provider has conducted separate activities to engage participating stakeholders including, but not limited to, County Judges, Commissioner Court members, the performing providers’ board members, planning advisory committee members, physician providers, staff, advocacy organizations, professional organizations, consumers, and potential contractors. Engagement activities have consisted of meetings and conference calls with agendas specific to the projects and planning activities being conducted by each performing provider. Past and ongoing stakeholder engagement
activities conducted by the Region’s performing providers are listed in tables 1 and 2 of the addendum.

**Public Engagement**

**Public Engagement by Anchoring Entity**

NCHD has conducted extensive outreach to engage consumers, community stakeholders, and regional providers who are not performing providers. Individuals and organizations targeted have included the Nueces County Medical Society, Amistad Federally Qualified Health Center (FQHC), Community Health Centers of South Texas, Diabetes Community Coalition, Social Services Community Coalition, Catholic Charities, Goliad County Indigent Health Care, Nueces County Commissioners, the Office of State Representative Todd Hunter and Gaye White, Texas A&M Health Science Center – Coastal Bend, Texas Tech University School of Nursing, Victoria College – Area Health Education Center, local school districts, local health departments, and many other healthcare providers and stakeholders operating within the Region.

Between March 2012 and July 2012, NCHD conducted individual meetings with the Office of State Representative Todd Hunter, the Diabetes Community Coalition, Amistad FQHC, and the Social Services Community Coalition. During these meetings, input was solicited regarding the Region’s Health Needs Assessment and priority issues to be addressed within the RHP Plan. On July 30 & 31, 2012, public meetings were conducted for all community stakeholders and consumers in which an overview of the Section 1115 waiver was presented and input was solicited on community health needs and priorities. These public meetings were held in different areas of the Region, Corpus Christi in the south and Victoria in the north, to increase convenience for interested individuals and organizations. In August and September 2012, additional meetings were conducted with the Nueces County Medical Society and Nueces County Commissioners to solicit input regarding county and regional needs, priority initiatives, and funding.

On October 29, 2012, a Public Notice of Request for Stakeholder and Public Input was released and the RHP Plan including Pass 1 DSRIP projects was posted on the Nueces County Hospital District website. To provide the public with opportunities to comment on the RHP Plan, public meetings were conducted on November 6 in Corpus Christi and on November 7 in Victoria. Additionally, stakeholders and consumers were requested to submit their comments in writing through November 12, 2012. On December 14, 2012, the updated RHP plan including Pass 2 DSRIP projects was posted on the Nueces County Hospital District website and another Public Notice of Request for Stakeholder and Public Input was released. Interested parties were encouraged to submit their comments in writing through December 28. In addition, webinars were hosted on December 20 and 21 for the purposes of sharing information and soliciting stakeholder and public input on the updated RHP plan.

NCHD will continue to conduct outreach activities to engage consumers, community stakeholders, and regional providers. In addition to individual meetings with community stakeholders, public meetings will continue to be held to update the public on the Region’s
activities and to provide an opportunity for public participation. Public engagement activities conducted by NCHD are provided in table 3 of the addendum.

**Public Engagement by Other Performing Providers**

Many of the Region’s performing providers have also worked to engage the public in the development of the RHP Plan. For example, in July and August 2012, MHMR of Nueces County met with representatives from Texas A&M University – Corpus Christi to collaborate on potential DSRIP projects. As another example, CHRISTUS Spohn Health System has presented updates on the Region’s activities to medical leaders in the Corpus Christi community. Other performing providers have provided regular updates at general membership meetings and at monthly board meetings that are open to the public. These providers will continue to update consumers and community stakeholders and to solicit input regarding the Region’s activities during these regularly scheduled public meetings. Past and ongoing public engagement activities conducted by the Region’s performing providers are listed in tables 3 and 4 of the addendum.
Section V. DSRIP Projects

A. RHP Plan Development

Project Selection
Based on the Texas DSRIP Program Funding and Mechanics Protocol requirements, Region 4 is classified as a Tier 3 Regional Health Plan region. As a Tier 3 plan, Region 4 required to select a minimum of 8 projects from Category 1 and 2 combined, with at least 4 of the 8 projects selected from Category 2. This proposal meets these requirements with more than 30 Category 1 projects and more than 40 Category 2 projects.

The selection of projects for both Pass 1 and Pass 2 was a community-wide effort that involved dozens of individuals representing all 18 counties included in the region. The planning process began in February 2012, soon after the Texas Health and Human Services Commission (HHSC) announced plans related to DSRIP and began providing information required to initiate local planning and discussions. Stakeholders began meeting in May to discuss the opportunities and requirements of DSRIP and identify activities that would need to be completed in order to develop a regional plan.

With region-wide input from stakeholders, Region 4 began reviewing community needs and identifying current documentation for Region 4 community needs assessment. A list of specific needs was developed, some of which were common throughout all areas of the region and others that were specific to certain areas. Through Region 4 stakeholder discussions and meetings Region 4 stakeholders collaborated to identify common goals and needs, and ways in which projects could be constructed to leverage existing infrastructure and maximize the use of regional partnerships.

Once the initial list of project concepts was identified, performing providers selected projects that were of interest to them and worked with various stakeholders to develop the specific components. New relationships were formed throughout the region as stakeholders discussed opportunities for coordination and development of initiatives that would have the most impact on the community. Underlying all of these discussions and final decisions were the availability of IGT funds and the protocol requirements for participation. As anchor, the Nueces County Hospital District hosted meetings, facilitated discussions among performing providers and entities with IGT funds, and worked with stakeholders to ensure their participation at all decision levels.

Based on community needs and availability of funding, final decisions were made and Performing Providers began drafting Pass 1 projects. As needed, Performing Providers met with stakeholders to develop specific project components and finalize drafts for submission to the anchor. The region’s projects were reviewed by the anchor to ensure projects met the protocol requirements and were combined into a draft regional plan that was then posted for
public review and comment. Based on requirements within each county and/or public entity participating in the region, project proposals were also subject to review and approval by various governmental organizations. Following conclusion of these steps, the projects were finalized and included in the Pass 1 submission.

With the finalization of Pass 1, the Nueces County Hospital District (anchor for the region) identified funding available from various IGT sources for Pass 2 projects. Performing providers with additional IGT funds available for DSRIP met with stakeholders to identify projects that were not funded in Pass 1, and selected projects for Pass 2. As with Pass One projects, all projects for Pass 2 are posted for public review and comment and are subject to review and approval by appropriate governmental organizations.

**RHP Goals and Community Needs**

The community needs assessment has played a critical role in the development of Region 4’s efforts to focus on projects that will truly transform the delivery of health care to the people served in Region 4. Throughout stakeholder discussions and identification of community needs, one of the criteria used to evaluate various project options is their ability to fulfill specific needs. To further support the planning process, the following overarching goals were established with an emphasis on ensuring patients receive the most efficacious care possible in the right place and at the right time:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a growing, yet historically underserved, region.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

As part of the project development, all project proposals include identification of how their project is related to specific regional goals and how the projects support other initiatives within the region. As described above, identification of community needs was a primary focus throughout this planning process and guided the selection of projects during all phases of plan development. Throughout the planning and drafting phases, participants continually focused on inclusion of project components and implementation activities that are uniquely designed to successfully address specific needs based on the local healthcare conditions and system
infrastructure. The anchor facilitated sharing of information and scheduling of meetings to enable collaboration throughout the entire process to facilitate access by all participants to information and planning activities. As a result, Region 4 stakeholders believe that the selected projects will significantly improve the delivery of health care services throughout the region, and will result in healthier lives and lower health care costs over time.

**Evaluation and Selection of Projects**
As described above, stakeholder participation played a key role in the identification and selection of projects. This process occurred over a six month period and began with a review of community needs and identification of specific projects that providers, consumers, local government officials, and health care advocates identified as areas that needed improvement. Discussions continued over several months, and as more information became available from the State HHSC, participants began focusing more closely on project ideas that met the DSRIP participation criteria. Some projects (such as expansion of emergency transportation services) were dismissed because they did not meet the protocol requirements, and others underwent significant revisions in order to meet the requirements. As Performing Providers drafted final project requirements, they continued to work with stakeholders to refine and edit projects. Projects were continually reviewed and evaluated to ensure the final versions addressed the regional needs, would improve health care delivery, and were realistic endeavors for the project participants.

**Performing Providers Exempt from Category 4:**
The following performing providers are exempt from Category 4 reporting requirements:
- Cuero Community Hospital; TPI 138911609
- Jackson Healthcare Center; TPI 1218083-05
- Otto Kaiser Memorial Hospital; TPI 136412710
- Refugio County Hospital District; TPI 020991801
- Memorial Hospital – Gonzales, Texas; TPI 121785303
- Lavaca Medical Center; TPI 135233809
- Coastal Plains Community Center; TPI 080368601
- Bluebonnet Trails Community Services; TPI 1268443-05
- Gulf Bend Center; TPI 1352544-07
- Camino Real Community Services; TPI 121990904
- MHMR of Nueces County; TPI 138305109
- Corpus Christi-Nueces County Public Health District; TPI 1309585-05

**B. Project Valuation**
Valuation of projects was based on a number of factors, which varied widely across projects. As outlined in the Program Funding and Mechanics Protocol, all performing providers worked with stakeholders and the anchor to identify factors that would impact the value of a project. While the anchor did not prescribe a specific methodology or process, all participants used the same guidelines and factors to determine overall project values and milestone values. While each of these factors was individually considered for each project, it is the unique combination of factors that ultimately determines the value and contributes to wide variations among projects.
The following list identifies and describes each of the primary factors considered for project valuation:

- **Project Scope** – project values reflect the level of complexity and comprehensiveness of the project, the various components that are required in implementation, as well as the number of staff involved in planning and implementation. Projects with a larger scope of activities or that involve multiple levels of activity and coordination may reflect higher values.

- **Community Benefit** – project values will reflect the extent to which the project will both directly and indirectly impact the community as a whole, both in the initial short term and in the long term. For example, improving access to behavioral health care services may reduce the number of patients arrested for criminal violations, or may alleviate demands for services for the homeless. While these are indirect benefits of expanding health care services, they represent significant community benefits that enhance quality of life for the entire community and reduce public costs for other services.

- **Populations served** – each project will vary in the type of population served and the number of individuals, depending in part on the local community in which the project is located and the population typically served by the provider. The value of the project also takes into account anticipated population growth, and the potential to serve larger numbers of people over time.

- **Cost avoidance** – cost avoidance is a critical component that is hard to estimate until baseline information is established. In establishing expected value, providers rely on existing population data, cost information associated with typical episodes of care for the population served, long term impact of the project intervention, and a very general estimation of future costs that may be avoided as a result of the services provided through the project.

- **Community Need Priorities** – all projects address identified community needs, and many projects address multiple community needs. Project values take into account the intensity of the community need and the potential number of individuals who may be served by the project, and the priority of the project across the spectrum of community needs within the region.

All project values also were reviewed to ensure they meet the Program Funding and Mechanics Protocol funding distribution requirements across Categories 1-4 throughout years 2-5 of the waiver. These requirements vary for Hospital Performing Providers and Non-Hospital Performing Providers, which is partly responsible for variations in values of similar projects among various Performing Providers.

Most importantly, project values among Performing Providers for similar project are also impacted by the level of IGT funds allocated to a Performing Provider and the number of projects selected by the provider. Providers with lower allocations and lower levels of IGT available will obviously be more restricted in their project values, particularly if they are involved in multiple projects. These Performing Providers also usually serve smaller populations, which is also a factor that impacts differences in values across Performing Providers with similar projects.
Likewise, Providers with higher allocations and higher levels of IGT generally serve larger numbers of people and will, therefore, often have higher associated values. These projects also may be larger in scope and complexity, and may have more significant community benefit based on the size of the population served. Each of these factors will result in wide variations in value among Performing Providers with similar projects.
C. Category 1: Infrastructure Development
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Beeville/020811801
Unique Identifier - 020811801.1.1

- **Provider:** CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties, averaging 7,600 patient days and 2,000 discharges annually.

- **Intervention(s):** Spohn will implement a Chronic Disease registry to assist Spohn in tracking and managing patients with chronic conditions, which will initially focus on patients with CHF and diabetes. The chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients.

- **Need for the project:** Current documentation by the Care Transitions/Care Partners teams is handwritten paper format and Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. The registry will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams that is untenable under the current documentation system. The registry and repository will link to the EMR and provide the ability to track, trend and alert both inpatient and outpatient care providers to multiple hospitalizations and ED visits regardless of facility or location within the Spohn hospital system. Automated acquisition, storage and access to this data will enhance identification of individual patient needs to analyze and report trends in resource utilization.

- **Target population:** The target population of this project includes charity, Medicaid and self-pay patients with CHF and/or diabetes who are eligible for enrollment in our Care Transitions or Care Partners programs (“target population”). Patients are identified by case managers in the acute care setting with referrals submitted to the Community Outreach department for program enrollment. Based on implementation of the original program at CHRISTUS Spohn Hospital Corpus Christi – Memorial campus and current discharge data for CHF and Diabetes at CHRISTUS Spohn Hospital Beeville, the projected target population will be 130 patients. Each of those patients receives 5 encounters as part of the program, after which an estimated 80% of those patients will be referred into the Care Partners program. Referral rates are estimated based on current referrals at CSHCC – Memorial. For those patients referred and enrolled in Care Partners, an average of 90 additional visits per patient will occur over an additional 18 months (a total of 10,010 patient encounters). This project seeks to enroll the target population into these programs, which Spohn estimates will impact 65 additional enrollees who will receive a total of approximately 5,005 encounters (based on current trends).

- **Category 1 or 2 expected patient benefits:** Spohn expects to have the registry fully implemented by the end of DY3, which Spohn expects to result in at least 50% of targeted patients receiving educational, disease-appropriate information after visits with the Care Transition team by the end of DY5 (an estimated 65 enrollees). These interventions should improve patient self-management skills, short- and long-term health outcomes, and patient satisfaction with the healthcare delivery system.
- **Category 3 outcomes**: IT- 3.2: Our goal is for the use of the registry to result in an 8% reduction from DY2’s CHF patient all-cause 30-day readmission rates for Spohn’s Beeville campus by the end of DY5.
Implement Chronic Disease Registry

Category 1: Infrastructure Development

Identifying Project and Provider Information:
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Beeville (“Spohn”)/020811801
Unique Identifier – 020811801.1.1

Project Description:
CHRSTUS Spohn Hospital Beeville (Spohn) will implement a Chronic Disease registry to assist Spohn in tracking and managing patients with conditions. The project will initially focus on CHF and diabetes. Spohn will enter patient data into the registry, and will then use the information contained in this registry to take a proactive approach to chronic disease management for patients with CHF and diabetes. Proactive, longitudinal management includes engaging these patients in education, community outreach, regular status checks with their primary care providers, an active support system, and self-management of their chronic disease. Upon implementing the registry and using it proactively, Spohn will use the reports generated by the registry to develop and implement a plan for quality improvement in the medical care provided to patients with these chronic conditions. The implementation of this plan will likely include identifying best practices and training staff to expand their use of those practices, discovering why certain patients are “frequent-flyers” and taking steps to provide additional support to those patients, and to determine how many, if any, of the chronic conditions could be better managed with additional input or support from other providers within Spohn’s network.

More specifically, a chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients. heartbase™ is our current vendor for national registries cardiovascular benchmark reporting of AMI, CHF and Open Heart Surgery with expansion to stroke and core measure data to The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS). heartbase™ is a certified vendor by TJC, CMS, American College of Cardiology (ACC) and Society of Thoracic Surgery (STS) with representation on international cardiovascular Health Information Exchange (“HIE”) teams.

This database will combine registry and longitudinal tracking of patients with chronic disease by automating patient documentation currently used by the Care Transitions and Care Partners (CHW) programs. Initial focus will be patients with CHF and diabetes but capability will incorporate all chronic disease and potential co-existing behavioral health diagnoses. The database will utilize a combined set of elements. Data points will not be duplicated but rather shared if they are the same data point, like ICD9 (Future ICD-10) and patient name.

The registry will interface with Meditech, our current inpatient EMR, and Athena, the future EMR for our Family Health Centers (“FHC”) and the Freer Clinic. Automation of the named documents and proposed interfaces will provide a provider and patient portal to a chronic disease repository that is used by all six Spohn facilities, related clinics and doctor offices. The database vision is one where the community stores all related chronic disease information on a server that is shared by hospital, clinics, physicians, and patients that participate in this program at CHRISTUS Spohn Health System.
Access will be via a web-based front end with secured areas for both patients and staff and will also have the ability to interface with the developing health information network of South Texas, HINSTX.

The proposed registry will also have the ability to interface and house future proposed telehealth/telemedicine devices used to remotely access and monitor patients in their homes by the Care Transition and Care Partners teams as well as regional primary care providers.

Project components include the following:
1. Enter patient data into unique chronic disease registry
2. Use registry data to proactively contact, educate and track patients by disease status, risk status, self-management status, community and family need
3. Use registry reports to develop and implement targeted QI plan
4. Conduct quality improvement for project using methods such as rapid cycle improvement

**Project Goals/5 Year Expected Outcome:**
- Registry implemented four local clinics
- At least 50% of targeted patients receiving educational, disease-appropriate information after visits
- Engage in quality improvement by collecting and disseminating best practices from

**Project Challenges:**
- Creating and implementing the actual registry (which will include provider training and assistance from third parties)
- Collecting accurate and current data regarding the health status of FHC patients
- Training providers to engage in effective outreach, support, and management for patients with these chronic diseases
- Maintaining the registry consistently
- Sharing information across FHCs in an organized and effective manner

Spohn will address these challenges by taking deliberate steps towards implementing the registry in an organized and thoughtful manner. The registry will not useful if providers cannot use it properly or do not understand the value of increased patient outreach and education. Thus, creating the registry and training our providers are the most important steps in DYs 2-3. In DYs 4-5, the FHCs can begin taking steps to improve on current practices using the registry for guidance and to stay organized. The registry itself will allow the FHCs to share more information than they may currently be able to do on a day-to-day basis.

**Relationship to Regional Goals:** Region 4 wants to transform care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improve patient satisfaction and outcomes while reducing the systemic costs of treating unmanaged chronic care conditions. This project addresses these goals head on.

**Starting Point/Baseline:**
Current documentation by the Care Transitions/Care Partners teams is handwritten paper format. Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential
discharge. They are often contacted by individual unit staff when patients not identified by CM receive discharge orders. Program expansion is to be implemented under the waiver plan for projected impact on approximately 177 (60%) of the CHF and Diabetes patients by the end of the waiver.

**Rationale:**
On a macro level, Region 4 has a high incidence of chronic disease, as noted in the Region’s Community Needs Assessment: “Regional hospital admissions and related data indicate that there is a prevalence of chronic conditions that lead to preventable hospitalizations, and which require a coordinated care management team approach to maximize patient outcomes.” *RHP Plan, p. 29.* Additionally, chronic diseases including CHF, COPD, Diabetes, and asthma are linked with Bee County having a higher rate of Potentially Preventable Admissions than the statewide average. Avoidable hospitalization has a twofold negative impact on the delivery system: (1) patient health outcomes and satisfaction are reduced in the long- and short-term, and (2) the cost of delivering care is immediately and going forward more expensive when patients’ conditions deteriorate to an acute level.

This project will provide a substantial infrastructure to identification, tracking and monitoring Medicaid/uninsured/Self-pay patients regardless of entry point into the CHRISTUS Spohn Health System. This capability will link patients throughout the region and provide a future avenue for global integration to external HIEs. In addition to access and exchange of information, the registry/repository will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams. This flow of communication does not currently exist. A frequently occurring example of the breakdown in the current system identified by the Care Transitions/Care Partners staff is patients missing their scheduled clinic appointments because they are inpatients at the hospital. Our planned registry will provide patient and hospital alerts to maximize the efficiency of communication and disease management.

Milestones and Metrics: Spohn chose its DY 2-3 milestones in metrics in order to develop, test, and implement the registry, as well as train staff to populate it and use it successfully. Spohn chose its DY 4-5 milestones and metrics in order to effectuate improved care for patients with the targeted chronic conditions and to engage in quality improvement by the end of DY5.

Community Needs Identification Number Addressed by this Project: CN.3, CN.7, CN.12

**Related Category 3 Outcome Measure(s): OD 3: Potentially Preventable Readmissions; Improvement Target 3.2: CHF 30 Day Readmissions**
Automation and integration of Care Transitions and Care Partners programs with interfaces to hospital and clinic EMRs will streamline communication and provide longitudinal tracking and monitoring of chronically ill patients upon discharge from the inpatient setting. Spohn selected this outcome measure because one goal behind developing the registry is to longitudinally track patients with CHF and develop alerts for those who experience frequent readmissions, regardless of cause. This project is intended to help Spohn to identify those patients that are at risk for readmission to the hospital (often multiple times) upon discharge and intervene to prevent the causes of their readmission (including the inability to self-manage CHF in the outpatient setting).
Relationship to other Projects:
This automated infrastructure will finally provide a link between inpatient and outpatient care provided to individual patients in an efficient and streamlined manner to facilitate integrated care coordination in multiple settings. It is related to the following projects also proposed in this waiver plan:

- 020811801.1.2- PADnet – telehealth/telemedicine – This project also addresses streamlining care for chronic conditions and is a related cardiac condition.
- 121775403.2.1 Establish Medical Homes – Part of the Medical Home model involves comprehensive management of patients’ conditions before they deteriorate, which is the specific purpose of the chronic disease registry.
- 121775403.2.3 Cost of Care Delivery – Primary Care Redesign – The hospitalist and resident teams assigned to patients will use the chronic disease registry to track their patients.
- 121775403.2.4. Diabetes Cellphone Application – Diabetes is another chronic condition that will be tracked in the registry, and the information will be used for outreach under this program.
- 020973601.2.1 Expand Care Transitions program – The chronic disease registry will assist the RN Coaches in managing chronically ill patients’ conditions.


This project provides integration of information with all 3 CHRISTUS Spohn Health System community facilities and CSHB. This is crucial to regional patient outcomes as patients transfer to Beeville and Victoria from all remote areas of the RHP. This infrastructure and its ability to interface with future development of HINSTX will support the flow of communication beyond the CSHS boundaries and throughout the lifespan of the patients.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center and Driscoll Children’s hospital.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Beeville (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:
1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

  The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its application to the goals of the Waiver, in that it focuses on improving patient outcomes while reducing the systemic cost of providing care. The registry will allow Spohn to make proactive choices to maintain the health status of chronically ill patients, which will benefit their quality of life and satisfaction with their health care greatly. The high incidence of chronic disease in Nueces County means that the registry addresses known community needs and will serve a broad population of the County’s residents. Finally, creating, implementing, and proactively using the registry will require investment in technology, staff training, project planning, and community outreach.

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7 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
**CHRISTUS SPOHN HOSPITAL BEEVILLE**

**Related Category 3**

**Outcome Measure(s):**

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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1 [P-1]:** Identify 1 or more target patient populations diagnosed with selected diseases or multiple chronic conditions

**Metric 1 [P-1.1]:** Documentation of patient population to be entered into the registry

**Baseline/Goal:** Registry Development for 2 major chronic diseases/conditions; CHF and diabetes

**Data Source:** Performing Provider documents

**Milestone 1 Estimated Incentive Payment (maximum amount):**

$111,265.50

**Milestone 2 [P-2]:** Review current registry capability and assess future needs

**Metric 1 [P-2.1]:** Documentation of review of current registry capability and assessment of future needs

**Baseline/Goal:** Approval of comprehensive proposal to develop electronic infrastructure for longitudinal data registry

**Milestone 2 Estimated Incentive Payment (maximum amount):**

$113,798

**Milestone 3 [P-3]:** Develop cross-functional team to evaluate registry program

**Metric 1 [P-3.1]:** Documentation of personnel assigned to registry evaluations

**Baseline/Goal:** Spohn multidisciplinary team development of chronic disease registry

**Numerator:** number of personnel assigned to enter the registry

**Denominator:** total number of personnel

**Data Source:** Registry Project Management Plan/Proposal

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

$113,622

**Milestone 4 [P-4]:** Implement/expand a functional disease management registry

**Metric 1 [P-4.1]:** Registry functionality is available in X% of Performing Provider’s sites and includes an expanded number of

**Baseline/Goal:** Increase the percentage of patients enrolled in the registry.

**Metric 1 [I-15.1]:** Percentage of patients in the registry with targeted chronic conditions

**Baseline/Goal:** Increase the percentage of diabetic and CHF patients (across the board)

**Milestone 5 [P-8]:** Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases.

**Metric 1 [P-8.1]:** Submitted protocols for the specified conditions and health indicators

**Baseline/Goal:** Spohn will create protocols for using the information stored in the registry to address diabetes and CHF

**Data Source:** Protocols

**Milestone 5 Estimated Incentive Payment (maximum amount):**

$113,622

**Milestone 6 [I-15]:** Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.

**Metric 1 [I-15.1]:** Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.

**Goal:** 50% of patients with diabetes or CHF will receive disease appropriate instructions after appointments at each FHC on how to manage their condition day-to-day (for diabetics, specifically diet information and medication management; for CHF patients, specifically medication management and activity level) – Spohn estimates this to constitute 65 patients.

**Numerator:** the number of patients with chronic disease who receive appropriate disease specific instructions

**Denominator:** number of patients with targeted chronic disease

**Milestone 7 [I-22]:** Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.

**Metric 1 [I-22.1]:** Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.

**Goal:** 50% of patients with diabetes or CHF will receive disease appropriate instructions after appointments at each FHC on how to manage their condition day-to-day (for diabetics, specifically diet information and medication management; for CHF patients, specifically medication management and activity level) – Spohn estimates this to constitute 65 patients.

**Numerator:** the number of patients with chronic disease who receive appropriate disease specific instructions

**Denominator:** number of patients with targeted chronic disease
### 1.3. IMPLEMENT A CHRONIC DISEASE REGISTRY

**A. Enter patient data into unique chronic disease registry**

**B. Use registry data to proactively contact, educate and track patients**

**C. Use registry reports to develop and implement targeted QI plan**

**D. Use selected methodology to conduct QI**

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**CHRISTUS SPOHN HOSPITAL BEEVILLE**

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<tr>
<th>Date</th>
<th>Outcome Measure(s)</th>
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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td>IT 3.2</td>
<td>CHF 30-day readmissions</td>
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**Data Source:** Registry Project Management Plan/Proposal

**Milestone 2 Estimated Incentive Payment (maximum amount):** $111,265.50

**Baseline/goal:** The registry measuring CHF and diabetes will be implemented and used for management and outreach Data source: documentation of installation and adoption of the registry

**Milestone 4 Estimated Incentive Payment (maximum amount):** $113,798

**Data Source:** Registry Project Management Plan/Proposal

**Numerator:** number of CHF and diabetic patients in the registry **Denominator:** number of diabetic and CHF patients assigned to this clinic for routine care

**Baseline/goal:** entered into the registry by 10% over the percentage in the registry in DY3 (if DY3 reflects 100% of these patients are in the registry, then will maintain this percentage by adding all new patients with the targeted condition into the registry by the end of DY4 – Spohn hopes to have 65 enrollees in DY5)

**Milestone 6 Estimated Incentive Payment (maximum amount):** $113,622

**Data Source:** Disease registry or EHR

**Milestone 7 Estimated Incentive Payment (maximum amount):** $91,744.50

**Milestone 8 P-X:** Redesign the processes in order to be more effective, incorporating learnings (Quality Improvement)

**Metric P-X.1:** documentation of redesign assessment and steps taken to make the process more effective

**Baseline/goal:** Identify one best practice from any of the Spohn System FHCs regarding (1) diabetes management, and (2) CHF management, and implement the best practices at each FHC or expand upon the concept

**Data source:** Documentation of assessment of best practices and steps taken to implement the best practices at each FHC

**Milestone 8 Estimated Incentive Payment:** $91,744.50

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**RHP Plan for Region 4**
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<td>1.3. IMPLEMENT A CHRONIC DISEASE REGISTRY</td>
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<tr>
<td>A. ENTER PATIENT DATA INTO UNIQUE CHRONIC DISEASE REGISTRY</td>
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<td>B. USE REGISTRY DATA TO PROACTIVELY CONTACT, EDUCATE AND TRACK PATIENTS</td>
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<td>C. USE REGISTRY REPORTS TO DEVELOP AND IMPLEMENT TARGETED QI PLAN</td>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>Year 3 Estimated Milestone Bundle Amount: $227,596</td>
<td>Year 4 Estimated Milestone Bundle Amount: $227,244</td>
<td>Year 5 Estimated Milestone Bundle Amount: $183,489</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $860,860*
RHP Plan for Region 4

Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
CHRISTUS Spohn Hospital Beeville/ TPI 020811801
Unique project ID number: 020811801.1.2

- **Provider:** CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

- **Intervention(s):** Spohn plans to implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and treatment plans. The PADnet™ Disease Management System provides patients that present at PCP offices with access to specialists to address issues with PAD.

- **Need for the project:** As a screening tool, PADnet is recommended for early detection and intervention in people with symptoms or at risk for peripheral arterial disease (PAD). Currently, diagnostics are performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a specialist for follow-up, diagnostics and treatment plan with or without requisite interventions. Current wait times for indigent patients to see a specialist can exceed 30 days. PAD is very painful and as it progresses undetected or untreated it can result in skin ulcers, gangrene and amputation. The ability to be screened in PCP office or FHC expedites diagnosis and treatment without delays to specialists visit.

- **Target population:** The target population of this project includes Bee and surrounding county’s residents at risk for PAD, who seek treatment in a FHC or FQHC and require cardiovascular services. Major risk factors contributing to PAD include smoking, diabetes and/or hypertension in persons 50 or older with a family history of coronary artery disease. PAD that is asymptomatic has been reported to exist in 80% of the population. Spohn intends to screen its high risk clinic patients with diabetes who are not currently symptomatic for PAD. Spohn’s FHCs and neighboring clinics treat approximately 9,443 patients per year from Bee and surrounding counties, approximately 16% of which are diabetic and many of whom are high risk because of their family history, ethnicity and/or age. Spohn will identify those patients based on ethnicity, diabetes, hypertension and history of smoking and screen them for PAD.

- **Category 1 or 2 expected patient benefits:** Through implementing the use of PADnet™ in the Beeville FHC by the end of DY4, Spohn expects the benefits to patients to include 57 PADnet screenings in DY3, 113 PADnet screenings in DY4, and 170 PADnet screenings in DY5, as well as, a 5% reduction in the wait time experienced by indigent patients for a cardiology consult by the end of DY3, and a 5% increase in telemedicine cardiology consults for patients residing in geographically underserved areas served by Spohn’s clinics from the first year of operation by the end of DY5.

**Category 3 outcomes:** IT-1. 11: Our goal is a 10% increase in the number of diabetic patients with controlled blood pressure, which should decrease those patients’risk of developing PAD.
Introduce PADnet for Peripheral Arterial Disease Screening and Treatment

Category 1: Infrastructure Development

Identifying Project and Provider Information:
Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Option 1.7.6: Implement an electronic consult processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.
CHRISTUS Spohn Hospital Beeville/ TPI 020811801
Unique project ID number: 020811801.1.2

Project Description:
Spohn plans to implement a system for early detection and to mitigate the adverse effects of chronic disease rampant in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and interventions. The PADnet™ Disease Management System provides patients who present at PCP offices with access to specialists to address issues with peripheral arterial disease (PAD). Spohn expects this to result in fewer unnecessary referrals to specialists for treatment the PCP is able to provide personally, earlier detection for patients who need immediate intervention, and greater care coordination between PCPs and cardiac specialists. No federal funds have been received or are being used for this project.

Project Goals/5-Year Expected Outcome:
The remote diagnostic devices can be located in PCP offices and will allow for increased communications through telemedicine with cardiologists or cardiovascular surgeons to interpret, diagnose and prescribe treatment or work in collaboration with the PCP to determine an appropriate follow-up/prevention plan when no interventions are needed. Finally, through quality improvement initiatives, the project will assess the project’s impact, lessons learned and opportunities to scale the project to a broader population.
Implementation of PADnet will help demonstrate the benefits of early detection and intervention for PAD, both for patient quality of life, satisfaction and long-term health outcomes and for the systemic cost of providing care to the chronically ill.
Specific goals include:
- 5% increase in PADnet™ screenings in DY3, over baseline set in DY2; 10% increase over DY2 baseline in DY4; 15% increase over DY2 baseline in DY5
- 5% reduction in wait time to cardiovascular consult for PAD in DY3 (using records from DY2 to measure improvement)
- Implement the use of PADnet™ in the Beeville FHC

This project is related to Region 4 goals in that it seeks to prevent diabetes related complications by allowing rural and indigent patients to access real-time diagnostics and reads by a specialist. These complications are costly to Region 4 communities in that they increase the cost of delivering care (often because they lead to ED visits), reduce productivity in the work-force, and cause ripple-effects for affected families. Any and all providers in the Region can access this network through purchasing the diagnostic equipment, which is fairly low cost.
Project Challenges:
- Identifying cardiac specialists willing to provide electronic consults for patients in Bee County
- Implementing new technology for Beeville FHC and other participating providers
- Training providers in the FHCs to use the PADnet technology
- Educating patients about the benefits of using electronic consults

Spohn will address these challenges by coordinating with stakeholders to identify appropriate partners for the project (i.e. specialists to provide the consults) and by using DY2 to train providers and create processes that are consistent across the participating providers. Finally, Spohn will train providers on how to present the PADnet telemedicine option to patients in a manner that alerts them to the benefits of using this technology.

Starting Point/Baseline:
Diagnostics are currently performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a cardiologist or cardiovascular (CV) surgeon for follow-up, diagnostics or planned interventions. Depending on the severity of the disease, peripheral artery angioplasty, stenting, surgical revascularization and amputation are all possible interventions. For less severe disease or those with high risk factors, minor disease can benefit from medical treatment. In the past year, 4 surgical treatments have been performed on patients for PAD at Spohn Beeville; of those, 1 patient was Medicaid-eligible or self-pay. Data analysis by zip code of patients treated at CSHCC – Memorial and Shoreline indicates that the majority of Bee residents are transferred to Corpus Christi for interventional procedures as CSHB cannot provide it. With a 92% Hispanic population, 62% MCD/UI rate and a 18.2% diabetes rate in Brooks County and a 58% Hispanic population, 46% MCD/UI rate and 12.2% diabetes rate in Jim Wells County, Spohn estimates a target screening population of 1133 across the 2 counties.

Rationale:
Like many diagnostic modalities designed for early detection of potentially life altering diseases, PADnet provides a solution that decreases the cost and burden of diagnostic on the patient and healthcare system. For the Medicaid, charity and self-pay patients in RHP 4, patients suspected of having or at risk for PAD have historically been referred to a Cardiology/CV Surgeon for evaluation. PAD in its moderate to advanced stages is associated with high pain levels especially with weight-bearing patients. Severe circulatory compromise results in swelling of the lower extremities and often open ulcers or wounds. Uninsured/underinsured patients often skip specialist appointments due to expense of the visit, time missed at work for a doctor visit or because they think they can tolerate it a little longer. They are often unaware that the PAD does not go away on its own but can be treated successfully if identified during the early stages. Another identified barrier in our region is the delay obtaining an appointment with these specialties. Current wait times for indigent patients to see a cardiologist ranges from 40-60 days.

One key to determine the precedence for screening in RHP 4 as well as other areas of the state is to analyze current statistics:
- Approximately 5 million Americans in the US are affected by PAD
• Predominant populations include Hispanic blacks, diabetics and elderly (> age 70) with the elderly being the highest at 14.5%
• 66,000 people with diabetes had non-trauma related lower extremity amputations in 2006 (Briggs, 2006)
  o Mean hospital charge was $56,400 accounting for $3.7 billion for amputations alone
• Additional risk factors should also be considered; obesity, age, gender, smoking, cholesterol, blood pressure to name a few
• South Texas also sees a predominant culture of complacency regarding amputations in familial lines. This often lends to delay in seeking treatment early for onset of symptoms associated with the disease

The evidence statement on Peripheral Arterial Disease (PAD) posted by the USPSTF (2005) addresses two patient populations; asymptomatic/low risk and symptomatic/at-risk. Despite the USPSTF statement, numerous studies since 2005 indicate a more rigid investigation of screening in asymptomatic people using the Ankle-Brachial Index (ABI) and may support project expansion to the asymptomatic, low-risk patient population in the future. One study (McDermott et al, 2010) shows a relationship between PAD and walking endurance measured by ABI with or without claudication. Although the USPSTF-endorsed screening statement is outdated, the American College of Preventive Medicine (ACPM) supports their 2005 stance in asymptomatic patients in an ACPM 2011 guideline (Lim et.al, 2011). A Draft Research Plan (Wilt, 2011) has also been posted to the USPSTF site that proposes a more rigid investigation of ABI and asymptomatic patient populations. Despite the views on routine screening in asymptomatic patients, the American Heart Association (AHA) and the American Diabetes Association (ADA) both support screening and early intervention in symptomatic and at-risk patients specifically those with diabetes.

The high prevalence of diabetes in our region and the remote locations with limited accessibility to specialists lend credibility to an early screening routine for the Hispanic, diabetic and high-risk populations. The PADnet diagnostic device located in Primary Care Centers and Medical Homes will provide direct communication to a remote specialist, eliminating the need for delayed appointments and unnecessary visits while still affording the patient and PCP access to the clinical specialist for diagnosis and treatment/prevention options. Patients are more likely to seek screening when done in their primary care setting instead of traveling to a specialist’s office.

The PADnet project will also allow storage of diagnostic information that can be used for longitudinal comparison and eventual incorporation in the patients EHR and regional HIE.

Community Needs Assessment: CN.2 (Inadequate access to specialty services); CN. 3 (Inadequate provision and coordination of healthcare services for persons with chronic conditions); CN.6 (high rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions)

Milestones and Metrics: Spohn chose Milestones 1 and 3 in order to assure that Spohn successfully implements the use of PADnet in the Beeville FHC Milestones 2-6 are intended to measure the increased use of telemedicine consults for patients at risk for PAD over the life of the Waiver.
**Related Category 3 Outcome Measure(s):**
Associated Outcome Measures selected for this project include:
- OD-1: Primary Care and Chronic Disease Management
- IT-1.11 – Diabetic Care – Blood Pressure Control

Spohn developed this outcome measure consistent with studies that demonstrate that early detection of PAD in symptomatic and at-risk populations allows early interventions that can reduce the need for amputations. By increasing the coordination of primary care and specialist physicians through the PADnet technology, Spohn intends that the target population will receive more preventative care at the early stages of this chronic disease.

**Relationship to other Projects:**
This project’s focus on treating chronic disease and increasing access to specialty care and provider training is related to and will enhance the following projects:
- 020811801.1.1- Establish Chronic Disease Management Registry (Spohn intends to expand its tracking and primary care treatment of chronic diseases, including PAD, through comprehensive reform)
- 020811801.2.4 Care Transitions (patients who may be hospitalized with a diagnosis of PAD will benefit from Care Transitions to assist in management of their condition upon discharge)


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing a telemedicine training program, other similar projects will focus on improving access to care, including projects submitted by Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Relationship to Other Performing Providers’ Projects in the RHP:**
This will be a CHRISTUS Spohn Health System initiative impacting our 13 county service area. It has the potential to support the service throughout the RHP 4. Spohn is unaware if similar projects have been proposed by other providers.

**Plan for Learning Collaborative:**
Spohn expects that RHP 4 will encourage participation by all our partners in a learning collaborative that will meet annually to discuss local disparities in care the ways they have successfully gathered relevant data and ultimately services the populations targeted by their projects. In addition to the face-to-face meeting, Spohn expects to participate in an open forum through the Region’s website that will foster communication amongst RHP 4 partners with related projects.
**Project Valuation:**

The Waiver provides the opportunity for CHRISTUS Spohn Hospital Beeville ("Spohn") to support and implement Delivery System Reform Incentive Payment ("DSRIP") projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system.
   c. Improve outcomes while containing cost growth.

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project complies with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

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For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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RHP Plan for Region 4
Spohn valued this particular project with reference to its relationship to Waiver goals. Specifically, this project is patient-centered because it aims to increase and improve access to specialists for patients at risk for PAD, and will also reduce the systemic cost of treating patients with PAD. This project addresses community needs for patients at risk of PAD (including elderly patients, smokers, diabetics, obese patients, and patients with high blood pressure and/or cholesterol) by enabling quicker diagnosis and treatment if they are determined to have PAD. The investment in this project will be substantial, in that equipment/software will need to be purchased, providers trained, and the community educated.
### Early Screening, Diagnosis and Intervention for Peripheral Arterial Disease

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

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

**Milestone 1 [P-3]:** Implement telemedicine program for PAD

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

**Baseline/Goal:** Initiate PADnet program/infrastructure for remote screening and access to cardiovascular specialists in the Beeville FHC

**Data Source:** Program materials and documents

Milestone 1 Estimated Incentive Payment *(maximum amount):* $270,216

**Milestone 2 [P-2]:** Establish a baseline in order to measure improvement over self

**Metric 1 [P-2.1]:** The number of PAD screenings performed subsequent to implementation during DY2

**Baseline/Goal:** Spohn expects to screen at least 63 patients through PADnet in DY3.

Milestone 2 Estimated Incentive Payment *(maximum amount):* $138,183.50

**Milestone 3 [I-14]:** Reduce wait times for cardiovascular specialist for PAD screening/diagnostics

**Metric 1 [I-14.1]:** Number of days until first available time for review and consultation for patient referred telemedicine consults.

**Goal:** 5% reduction in wait time to cardiovascular consult for PAD

**Data Source:** Referral documentation and PADnet reports.

Milestone 3 Estimated Incentive Payment *(maximum amount):* $138,183.50

**Milestone 4 [I-13]:** Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult

**Metric 1 [I-13.1]:** Number of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient

**Denominator:** Number of patients referred to all medical specialties using referral processing system

**Baseline/Goal:** Increase PAD screenings in the Beeville FHC with access to cardiovascular specialists by 94 (157 total estimated)

**Data Source:** PADnet reports.

Milestone 4 Estimated Incentive Payment *(maximum amount):* $275,939

**Milestone 5 [I-13]:** Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult

**Metric 1 [I-13.2]:** Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient

**Denominator:** Number of patients referred to all medical specialties using referral processing system

**Baseline/Goal:** Increase PAD screenings in the Beeville FHC with access to cardiovascular specialists by 126 (503 total estimated)

**Data Source:** PADnet reports.

Milestone 5 Estimated Incentive Payment *(maximum amount):* $111,404

**Milestone 6 [I-17]:** Improved access to cardiovascular care for PAD

**Metric 1 [I-17.2]:** Improved access to health services for residents of communities that did not have such services locally before the program.

**Milestone 6 Estimated Incentive Payment *(maximum amount):* $275,939
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

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

020811801.3.2

**Goal:** 5% increase in telemedicine consults from geographically underserved areas in Bee County and the surrounding area 78102, 78389, 78701, 78022, 77963, 78372

**Data Source:** PADnet reports

Milestone 6 Estimated Incentive Payment (*maximum amount*): $111,404

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: <em>(add incentive payments amounts from each milestone):</em></th>
<th>Year 3 Estimated Milestone Bundle Amount: $276,367</th>
<th>Year 4 Estimated Milestone Bundle Amount: $275,939</th>
<th>Year 5 Estimated Milestone Bundle Amount: $222,808</th>
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<tbody>
<tr>
<td>$270,216</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $1,045,330
Project 1.1: Expand Primary Care Capacity
Project Option 1.1.1: Establish More Primary Care Clinics, Beeville, TX
CHRISTUS Spohn Hospital Beeville / 020811801
Unique Identifier - 020811801.1.3 – Pass 2

- **Provider:** CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

- **Intervention(s):** This project will increase primary care access and capacity in Bee County and neighboring counties. Project goals include site and space allocation for the proposed FHC and employment of clinic providers and staff to support 5 days/week operations.

- **Need for the project:** Beeville, TX is located in Bee County approximately midway between Alice, TX and Victoria, TX. This area has been served by a locally sponsored federally qualified health clinic (“FQHC”) operating 2-3 days per week based on a visiting physician’s availability and the Beeville Community Center, but the FQHC has recently closed due to loss of funding. The closing of the FQHC has shifted care of the uninsured patients to the part time clinic and Spohn’s Beeville ED.

- **Target population:** The target population is Bee, Live Oak and San Patricio County residents that are un-insured and require primary care services. The uninsured rates for these counties are as follows; Bee = 29%, Live Oak = 29% and San Patricio = 25%. Bee County, where CSBH is located, was charged $23,532,704 in 2010 for uncompensated care and experienced 18,844 ED visits (in a county with a population of 33,196) (RHP Plan, Section 3, Tables 1 & 8). Of these ED visits, 81% were by residents of five particular zip codes, with an additional 9% from 8 additional zip codes, accounting for 90% of the ED visits. The top 5 diagnoses during these ED visits were nonspecific abdominal pain, fever, cough, nonspecific chest pain and lower leg injuries. Additional leading diagnoses were shortness of breath, headache and rash. Each of these conditions is often linked to a chronic disease and/or condition that can be successfully treated by primary care providers, when patients have access to their services.

- **Category 1 or 2 expected patient benefits:** The project seeks to establish the clinic, including identifying a suitable space in the community to house the clinic and recruiting and retaining appropriate staff for the clinic. Additionally, Spohn will establish a baseline of clinic volume during DY 3, in order to measure its progress in increasing the clinic’s volume during DYs 4 and 5 (5% and 8%, respectively). We estimate that when fully operational, the clinic will serve more than 1,000 patients a year; at least half of those patients are expected to be Medicaid and/or uninsured.

- **Category 3 outcomes:** IT-9.2 - Our goal is a 5% reduction in all (non-urgent/non-emergent) ED visits by the end of DY4, and a 10% reduction in all (non-urgent/non-emergent) ED visits by the end of DY5, indicating that patients are accessing primary care in the community to maintain their health.
CHRISTUS Spohn Hospital Beeville ("Spohn Beeville") entered into Collaboration Agreements with CHRISTUS Spohn Hospital Alice ("Spohn Alice") and CHRISTUS Spohn Hospital Kleberg ("Spohn Kleberg") in order to allow Spohn Beeville, as the Performing Provider, to undertake a transformative project that will improve access to health care for indigent patients in Region 4 by opening a primary care clinic to operate five days per week in Bee County. Spohn Beeville, Spohn Kleberg and Spohn Alice are each hospitals operating under the same corporate entity and entered into the Collaboration Agreement voluntarily. This project is transformative for Region 4 because it will improve health outcomes and access to care for indigent patients (which is the very heart of the Waiver) and reduce the cost of providing care to these patients, who are often treated in inappropriate care settings. Each of the collaborating hospitals provide care to rural residents of Region 4 and are dedicated to reducing inappropriate use of local emergency departments, assisting patients in managing chronic diseases, and strengthening the network of primary care providers in the Region. The FQHC that historically treated the indigent residents in Bee County has recently closed, meaning that the need for this project is urgent. Spohn Beeville will be responsible for carrying out the full scope of the project, and Spohn Beeville believes that its collaborations are fully consistent with the terms of Section 25(c)(iv) of the Funding and Mechanics Protocol. Spohn Beeville notes that nothing in Section 25(c)(iv) requires both parties to participate in the implementation of the DSRIP projects undertaken pursuant to a collaboration agreement.
Project Option 1.1.1 – Establish more primary care clinics

**Unique RHP Project Identification Number:** 020811801.1.3 – Pass 2

**Performing Provider Name/TPI:** CHRISTUS Spohn Beeville Hospital (“Spohn” or “CSBH”)/TPI 020811801

**Project Description:**
Spohn will establish a primary care clinic (“Family Health Clinic” or “FHC”) in Beeville, TX. The project is intended to increase primary care access and capacity on a full time basis by creating a fully operational primary care clinic for Bee and surrounding counties. A 10% increase in clinic volume from the baseline established in DY3 will be achieved by end of waiver.

**Goals and Relationship to Regional Goals:**

**Project Goals:**
The goal of this project is to improve access to primary care in a rural area of Region 4. Delivery system transformation must include expanding care to areas where residents are traditionally underserved, allowing for improved patient outcomes and satisfaction, and reduced costs for providing care by preventing manageable conditions from reaching an acute stage requiring hospitalization. The specific goals of this project are:

- To employ/contract at least one (1) nurse practitioner (“NP”) in the Beeville clinic and two (2) support staff
- To provide care 5 days per week. Hours will be determined on projected clinic volume and ED utilization from CSBH ED visits for non-urgent/emergent visits during DY2 when the clinic is established.
- To locate a space in which to establish the local clinic.
- To achieve a baseline of clinic volume in DY3 and subsequent 10% increase in clinic volume by end of Waiver.

**This project meets the following Region 4 goals:**

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

**Challenges:**

- Recruiting a qualified NP who is willing to provide care in a rural area and treat Medicaid and uninsured patients
- Identifying new space in which to establish the clinic
- Educating patients about the regular availability of primary care services, and the benefits of accessing the available care

RHP Plan for Region 4
Spohn will address these challenges by offering competitive incentives to the NP and by working with the existing rural providers to engage in patient outreach and education.

**5-Year Expected Outcome for Provider and Patients:**
Spohn expects patients in the Beeville clinic catchment area to experience improved short- and long-term health outcomes as a result of expanded access to primary care services in the local community. Spohn expects the volume of non-emergent visits at CSBH ED to decrease, allowing Spohn to better serve truly emergent patients, while redirecting funds to investing in primary and preventative care in the community.

**Starting Point/Baseline:**
Currently, services are provided on an intermittent basis by a provider who makes visits to the area and sees patients on a “first come, first served” basis. Primary care services for indigent, uninsured/under-insured residents are especially limited due to the sporadic primary care available in the community. Hours are limited to a maximum of 2 days a week, based on the visiting provider’s availability. If the provider is unavailable there are no hours of operation.

**Rationale:**
Documented ED visits for non-urgent/non-emergent primary care diagnoses have been identified from the zip codes associated with Beeville, and cities along the I-35 corridor and Lake Corpus Christi. The counties included in this coverage area are Bee, San Patricio, Live Oak, Goliad and Karnes counties. Additionally, the Community Needs Assessment for Region 4 shows that Bee County residents have a substantial rate of potentially preventable hospital admissions for the following conditions that can be managed through access to primary care: CHF, COPD and bacterial pneumonia (RHP Plan, Section 3, Table 10). Additionally, Bee is a federally designated as a Medically Underserved Area and a Health Professional Shortage Area for primary and mental health care (RHP Plan, Section 3, Table 11). Finally, Bee County, where CSBH is located, was charged $23,532,704 in 2010 for uncompensated care and experienced 18,844 ED visits (in a county with a population of 33,196) (RHP Plan, Section 3, Tables 1 & 8). Of these ED visits, 81% were by residents of five particular zip codes, with an additional 9% from 8 additional zip codes, accounting for 90% of the ED visits. The top 5 diagnoses during these ED visits were nonspecific abdominal pain, fever, cough, nonspecific chest pain and lower leg injuries. Additional leading diagnoses were shortness of breath, headache and rash. Each of these conditions is often linked to a chronic disease and/or condition that can be successfully treated by primary care providers, when patients have access to their services.

The establishment of a local primary care clinic will allow Spohn to establish consistent primary care capacity and provide services to manage chronic conditions, which will reduce the inappropriate utilization of CSBH ED and the rate of potentially preventable admissions (“PPAs”) at Spohn Beeville. Continued analysis and evaluation of clinic expansion will determine future increases in hours, staffing and services while providing continuous quality improvement to meet the needs of this community.
**Project Components:**
N/A

**Milestones & Metrics:** The following milestones and metrics have been chosen for this project based on the needs of the target population and logistical considerations:

**Process Milestones:** Spohn chose P-1.1 and P-5.1 during the DYs 2 and 3 in order to establish the clinic, including identifying a suitable space in the community to house the clinic and recruiting and retaining appropriate staff for the clinic. Additionally, Spohn will establish a baseline of clinic volume during DY 3, in order to measure its progress in increasing the clinic’s volume during DYs 4 and 5.

**Improvement Milestones:** Spohn chose I-12.1 for DYs 4 and 5 because the goal of this project is to increase the number of patients with access to and the community’s capacity for the provision of primary care services.

**Unique community need identification number the project addresses:**
CN.1: Inadequate access to primary care
CN.3: Inadequate provision and coordination of health care services for persons with chronic conditions.
CN.6: High rates of inappropriate emergency department utilization and dissatisfaction of emergency department services
CN.15: Inadequate health care access in rural areas

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project represents a new initiative for CSBH – it has previously been unable to establish a primary care clinic to serve Bee County and the surrounding area.

**Related Category 3 Outcome Measure(s):**
OD 9: Right Care, Right Setting
IT 9.2: ED appropriate utilization

**Reasons/rationale for selecting the outcome measures:**
Spohn selected this outcome based on the volume of non-urgent primary care diagnoses presenting to the CSBH ED from specific zip codes in Beeville and Bee County. This non-urgent volume monopolizes needed space and staff resources required for care delivery to emergent patients presenting at CSBH, and also causes overcrowding and delays in the ED. Thus, a natural outcome of providing access to established primary care capacity should include a reduction in misuse of the ED.

**Relationship to Other Projects:**
This project is related to and complements the following initiatives by other Performing Providers in our region to expand access to primary care services: 137907508.1.1 – Establish
more primary care clinics; 121785303.1.1, 094222902.1.1, 020973601.1.1, 121775403.1.1, 132812205.1.1, 020991801.1.1, 112673204.1.1 – Expand existing primary care capacity.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Christus Spohn Hospital - Alice, Christus Spohn Hospital – Corpus Christi, Corpus Christi Medical Center, Citizens Medical Center, Memorial Hospital, Driscoll Children’s Hospital, Refugio County Hospital District, and Yoakum Community Hospital.

**Project Valuation:**
The Waiver provides the opportunity for CSBH to support and implement Delivery System Reform Incentive Payment ("DSRIP") projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
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      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its direct correlation to the stated goals of the Waiver, including delivery system reform to be patient-centered, increase access to and use of primary care, and reduce the systemic cost of providing care. The residents of Bee County and the surrounding area clearly need increased access to primary care, as the current clinic accessibility is limited and there is misuse of the ED for primary care services. The investment for this project will be steep, in that it requires the recruitment and retention of additional staff, the identification of new space, and patient outreach. However, the investment will create value for the community by improving patient long- and short-term health outcomes and reducing the cost of providing care in this area.

9 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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RHP Plan for Region 4
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020811801.3</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
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<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Milestone 1</strong></td>
<td>[P-1]: Establish primary care clinics</td>
<td></td>
<td></td>
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<tr>
<td>Metric [P-1.1]</td>
<td>Number of additional clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/goal</td>
<td>Spohn will identify a new space in which to locate a Beeville clinic, and will establish the clinic within that space to provide primary care services to the residents of Bee County and surrounding counties. Spohn will open the clinic for business by the end of DY2. Data source: documentation of clinic plans, lease, or other paper evidence of the new clinic</td>
<td></td>
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<td>Milestone 1 Estimated Incentive Payment:</td>
<td>$478,856</td>
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<td></td>
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<tr>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>[P-5]: Hire primary care providers and staff. Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Spohn will recruit at least one NP and two support staff members for full-time employment in the Beeville clinic Data Source: Staffing schedules, HR documents Milestone 2 Estimated Incentive Payment (maximum amount): $253,785</td>
<td></td>
<td>Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: 5% increase in clinic volume of patient visits over baseline Data Source: Clinic scheduler, Clinic records Milestone 4 Estimated Incentive Payment (maximum amount): $506,464</td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong></td>
<td>[P-X] Establish a baseline Metric [P-X.1]: Number of patients utilizing the Beeville clinic Goal: to determine the volume of patient visits and number of patients seen, in order to measure progress in DYs 4-5. Data source: clinic records Milestone 3 Estimated Incentive Payment: $253,785</td>
<td></td>
<td>Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: 8% increase in clinic volume of visits over baseline. Data Source: Clinic scheduler, Clinic records Milestone 5 Estimated Incentive Payment (maximum amount): $434,907</td>
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<td><strong>Year 5</strong></td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount:</td>
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<td>Year 3 Estimated Milestone Bundle Amount:</td>
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<td>Year 4 Estimated Milestone Bundle Amount:</td>
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<tr>
<td>Year 5 Estimated Milestone Bundle Amount:</td>
<td>$427,663</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $1,932,593
Corpus Christi Medical Center
Expand Existing Primary Care Capacity: Amistad Community Health Center
020973601.1.1

- **Provider**: The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention**: This project will expand the number of primary care providers at the Amistad Community Health Center by two from the baseline. Expect to increase the number of visits and the number of unique patients by 25% from the baseline by the end of DY5.

- **Need for the project**: Inadequate access to primary care and lack of primary care providers are some of the key issues facing our region. Our current physician needs assessment indicates a current deficit of approximately 20 family practice and 56 internal medicine physicians in our primary service area. Further compounding this deficit is the fact that 31% of our current primary care physicians are over the age of 62.

- **Target population**: Amistad Community Health Center is an FQHC and serves the uninsured and underinsured patients in the community. The current payor mix for the Health Center is 50% uninsured and 33% Medicaid. Amistad volume prior to expansion is approximately 14,400 visits annually.

- **Category 1 expected patient benefits**: The project expects to increase the number of primary care providers by 2 at the Amistad Community Health Center. This will increase the number of providers by 40% which will allow greater access to preventative care for the uninsured and Medicaid populations. Expect to see an additional 720 visits per year by DY3, 1,440 by DY4, and 3,600 by DY5.

- **Category 3 outcomes**: IT-1.10 and IT-1.7 – Diabetes and high blood pressure control. Effective management of these two conditions should reduce the number of hospitalizations and emergency room visits for the target patient population and improve overall health outcomes.
**Category 1: Infrastructure Development**

**Expand Primary Care Capacity**

**Project Option 1.1.2 – Expand existing primary care capacity: Amistad Community Health Center**

**Project ID – 020973601.1.1**

**Performing Provider/TPI: Corpus Christi Medical Center/020973601**

**Project Description:**

*Corpus Christi Medical Center will support Amistad Community Health Center in expanding their existing primary care capacity.*

Amistad is an FQHC that provides healthcare to the underserved population in the Corpus Christi community regardless of the ability to pay. The clinic is located next to public transportation stops and across the street from the county MHMR facilities. The clinic currently has two primary care physicians, two family nurse practitioners, and one pediatrician. The provider panels are close to capacity and the clinic must add new primary care providers to meet the growing healthcare needs of the community. The additional primary care providers will enable the clinic to accept new patients, expand hours of operation, and further their mission of serving the uninsured/underinsured patients in the community. The Corpus Christi Medical Center (CCMC) and Amistad will work together to ensure that any allowable clinic costs provided for with this project will be properly excluded from the annual submitted cost report. CCMC will also develop coordinated care protocols with the clinic in order to transition patients who are currently using the emergency department for their healthcare needs to a family care provider in the clinic.

CCMC is a 631 bed multi campus teaching facility serving Nueces and the surrounding eleven counties. The total population of the primary and secondary service areas is approximately 559,000 with 56 % White-Hispanic and 37 % White-Non Hispanic. Nineteen percent of the population lives at or below the federal poverty level. Based on the latest community needs assessment over 18% of the area residents lack any healthcare coverage and those that do have coverage often participate in limited or high deductible plans. Access to primary care physicians in our community is limited not only due to lack of healthcare coverage but also due to the limited supply of family practice (FP) and internal medicine (IM) physicians practicing in our community. 2011 data indicates approximately 200 FP/IM physicians in the community with 31% over the age of 62. Using national median data as a benchmark this leaves the community with a deficit of approximately 20 FP and 56 IM physicians for 2011 increasing to a deficit of over 130 FP/IM physicians by 2014. The uninsured/underinsured patients in the community are impacted the most by the shortage of primary care providers due to closed physician panels, limited appointment availability, and clinic locations.

**Starting Point/Baseline:**

Amistad currently sees approximately 1,200 visits/month of which over 50% are patients without any form of insurance.

**Rationale:**

In our community, insufficient number of primary care providers and lack of healthcare coverage has led to increased use of hospital emergency departments for episodic care. This type of care is very costly and is not structured to address the complex medical conditions present in our patient population. Approximately 29% of CCMC’s emergency department visits are classified as triage level 4 or 5 (non-emergent care). The top potentially preventable hospitalizations for our community are...
chronic conditions (CHF, COPD, and Diabetes) that require a consistent and comprehensive focus on patient compliance to manage the disease and to prevent or minimize complications. Increasing the primary care capacity at the Amistad Community Health Center will:

- Enable more uninsured/underinsured patients to access preventive care through an office based practice
- Provide a medical home for patients currently using emergency departments for primary care
- Reduce costly hospital admissions and emergency department care through proper management of chronic conditions (CHF, COPD, and Diabetes).

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

- CN.1 – Inadequate access to primary care
- CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.7 – High rates of preventable hospital admissions
- CN.10 – Shortage of primary care physicians
- CN.14 – High rates of diabetes, including gestational diabetes

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

The key outcome measures that will be used to measure the effectiveness of this project will be:

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

Diabetes disproportionately affects racial and ethnic minorities and is the leading cause of disability and death in the United States. For every 1 percent reduction in results of HbA1c tests, the risk of developing eye, kidney, and nerve disease is reduced by 40 percent while the risk of heart attack is reduced by 14 percent. Continued medical management and patient self-management are required to prevent acute complications and minimize the risk of complications that develop over time.

- IT-1.7 Controlling high blood pressure. Standalone measure.

High blood pressure is a serious condition that can lead to coronary heart disease, heart failure, stroke, and kidney failure. About 1 in 3 adults in the United States has high blood pressure. The condition itself usually has no signs or symptoms so someone can have it for years without knowing it. Individuals whose blood pressure is higher than 140/90 often become patients treated for serious problems. Seventy seven percent of Americans treated for a first stroke have blood pressure over 140/90. Sixty nine percent of Americans who have a first heart attack have blood pressure over 140/90.

**Relationship to other Projects:**

Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, COPD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and
specialty care areas in our community is critical to reducing these local provider deficits. Projects 020973601.1.2 and 020973601.1.3 both address increasing the local training efforts. Increasing the number of primary care providers in the community is only the first step in achieving the overall goals of:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Additional work is needed with care coordination and the management of chronic diseases. Projects 020973601.1.2, 020973601.1.3, 020973601.2.1, and 020973601.2.2 all address chronic disease management, readmission rates, and care transitions. Related Category 4 measures included Potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Christus Spohn, Memorial Hospital, Lavaca medical Center, Yoakum Community Hospital, and Corpus Christi-Nueces County Public Health.

**Project Valuation:**
The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Community Need</td>
<td>5</td>
<td>Significant shortage of FP/IM physicians in the market</td>
</tr>
<tr>
<td>Populations Served</td>
<td>5</td>
<td>FQHC serves low income populations</td>
</tr>
<tr>
<td>Delivery Transformation</td>
<td>3</td>
<td>Improved access is first step in the process</td>
</tr>
<tr>
<td>Outcomes/Cost</td>
<td>4</td>
<td>Improved diabetes control</td>
</tr>
<tr>
<td>Project Investment</td>
<td>4</td>
<td>Recruitment, space, and staff for two additional providers</td>
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</table>

RHP Plan for Region 4
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020973601.3.1</th>
<th>IT-1.10</th>
<th>Diabetes care: HbA1c poor control (&gt;9.0%)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>020973601.3.2</td>
<td>IT-1.7</td>
<td>Controlling high blood pressure</td>
</tr>
</tbody>
</table>

### Milestone 1 [P-1]: Expand existing primary care clinic.

**Metric 1 [P-1.1]:** Provide a report identifying the following:

- Expansion plans for Amistad Community Health Center
- Number and type of additional primary care providers to be added
- Additional space requirements to accommodate new providers
- Timing of space renovations and projected start dates for new providers
- Support personnel required for new providers
- Projected volumes and clinic hours for the new providers

**Goal:** Produce a comprehensive report documenting all points above

**Data Source:** Expansion plan, construction estimates, EHR

**Milestone 1 Estimated Incentive Payment:** $1,146,512

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

**Metric 1 [P-5.1]:** Increase the number of primary care providers and staff at Amistad Community Health Center

- Baseline: 2 Primary Care Physicians, 2 Family Nurse Practitioners, and 1 Pediatrician
- Goal: Increase by one Primary Care provider – either Physician or Family Nurse Practitioner
- Data Source: Employment records

**Milestone 2 Estimated Incentive Payment:** $374,834

### Milestone 3 [P-4]: Expand the hours of Amistad Community Health Center

**Metric 1 [P-4.1]:** Increase the number of hours available to schedule patient visits

- Baseline: 160 available hours/week
- Goal: 10% increase
- Data Source: Clinic records

**Milestone 3 Estimated Incentive Payment:** $300,739

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

**Metric 1 [P-5.1]:** Increase the number of primary care providers and staff at Amistad Community Health Center

- Goal: Increase by an additional one Primary Care provider – either Physician or Family Nurse Practitioner
- Data Source: Employment records

**Milestone 4 Estimated Incentive Payment:** $300,739

### Milestone 6 [P-4]: Expand the hours of Amistad Community Health Center

**Metric 1 [P-4.1]:** Increase the number of hours available to schedule patient visits

- Goal: 20% increase from baseline
- Data Source: Clinic records

**Milestone 6 Estimated Incentive Payment:** $300,739

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

**Metric 1 [I-12.1]:** Increase the number of visits over the baseline

- Goal: Increase visits 25% from baseline
- Data Source: EHR

**Metric 2 [I-12.2]:** Increase the number of unique patients over prior reporting period.

- Goal: Increase number of unique patients by 25%
- Data Source: EHR

**Milestone 8 Estimated Incentive Payment:** $1,188,692
### Related Category 3 Outcome Measure(s):

- **020973601.3.1**
- **020973601.3.2**

#### Year 2 (10/1/2012 – 9/30/2013)

- **Payment:** $374,834
  - **Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking service.
  - **Metric 1** [I-12.1]: Increase the number of visits over prior reporting period.
    - **Baseline:** 2012 data. 1,200 visits/month
    - **Goal:** Increase visits by 5%
    - **Data Source:** EHR
  - **Milestone 4 Estimated Incentive Payment:** $374,835

#### Year 3 (10/1/2013 – 9/30/2014)

- **Year 3 Estimated Milestone Bundle Amount:** $1,124,503
  - **Metric 1** [I-12.1]: Increase the number of visits over prior reporting period.
    - **Goal:** Increase visits 10% from baseline
    - **Data Source:** EHR

#### Year 4 (10/1/2014 – 9/30/2015)

- **Year 4 Estimated Milestone Bundle Amount:** $1,202,956
  - **Metric 1** [I-12.2]: Increase the number of unique patients over prior reporting period.
    - **Baseline:** To be determined
    - **Goal:** Increase number of unique patients by 10%
    - **Data Source:** EHR

#### Year 5 (10/1/2015 – 9/30/2016)

- **Year 5 Estimated Milestone Bundle Amount:** $1,188,692

#### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,662,663
Corpus Christi Medical Center
Increase the number of primary care providers: Residency expansion/community health workers 020973601.1.2

- **Provider**: The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention**: This project will expand the existing family practice/internal medicine residency program by increasing the approved residency positions by 8 and increasing the enrollment by 6. The project will also expand residency coverage to both major campuses and increase the rotations through local continuity of care clinics.

- **Need for the project**: Inadequate access to primary care and lack of primary care providers are some of the key issues facing our region. Our current physician needs assessment indicates a current deficit of approximately 20 family practice and 56 internal medicine physicians in our primary service area. Further compounding this deficit is the fact that 31% of our current primary care physicians are over the age of 62.

- **Target population**: The residents work with the inpatient hospitalist group that covers all of our unassigned emergency room patients and sees over 75% of the medical admissions to the hospital. The residents will be involved in the care for this patient population. Currently the hospitalist group provides inpatient and outpatient care to approximately 3,000 Medicaid eligible patients annually. The increase in the number of residents trained will allow them to see all the Medicaid eligible and uninsured patients currently being provided care under the hospitalist service.

- **Category 1 expected patient benefits**: The project expects to increase the number of primary care residents training in our community with the goal being for a portion of them to stay and set up a practice upon graduation. In addition, the project will add community health workers to enhance the coordination of care. Increasing access to primary care through the addition of new providers is one of the ways to offset our current primary care physician deficit.

- **Category 3 outcomes**: IT-3.2, IT-5.2, and IT-9.2 – Congestive heart failure readmissions, cost of care, and ED appropriate utilization. Effective management of this condition through our Hospitalist group and residents should reduce the number of hospitalizations and emergency room visits for the target patient population and improve overall health outcomes.
Category 1: Infrastructure Development  
Increase Training of Primary Care Workforce  
Project Option 1.2.2 – Increase the number of primary care providers: Residency expansion/community health workers  
Project ID – 020973601.1.2  
Performing Provider/TPI: Corpus Christi Medical Center/020973601

**Project Description:**

*Corpus Christi Medical Center will expand its family practice/internal medicine residency program and develop a community health worker program*

The Corpus Christi Medical Center (CCMC) currently has a three year family practice/internal medicine residency program affiliated with the University of North Texas Health Science Center. The program receives federal funding for 20 residency positions (both GME and IME). Total approved residency training positions by the American Osteopathic Association (AOA) are 24 Internal Medicine and 16 Family Practice residents. Currently CCMC has filled 20 Internal Medicine and 6 Family Practice positions (6 positions above the cap). The residents do extensive training at local continuity of care clinics and with the Hospitalist group that manages the majority of the medical admissions to CCMC. Their curriculum and clinical rotations provide excellent exposure to the chronic diseases and resulting complications that are prevalent in our community. Expanding the number of AOA approved positions for our program and increasing the positions filled will provide many benefits to our patients and the community, including; allow for better management of hospitalized patients, increase the rotations at local continuity of care clinics and increase the potential number of primary care physicians who stay in the community.

CCMC has an inpatient Hospitalist program for medical admissions that started out primarily taking all the unassigned admissions through the emergency department (i.e. those patients with no identified primary care physician). This program has expanded to take any medical admission which allows the primary care physicians to stay in their office seeing patients while the Hospitalist rounds on any inpatients of the practice. The residents are an integral part of the success of the Hospitalist program and in return are exposed to invaluable education and training around chronic disease management. The one component missing from the current program is a consistent link to post discharge care and follow up for the uninsured/underinsured patients under the Hospitalist care. This project also anticipates the training of community health workers to serve as the link between the underserved communities and the healthcare system.

CCMC is a 631 bed multi campus teaching facility serving Nueces and the surrounding eleven counties. The total population of the primary and secondary service areas is approximately 559,000 with 56 % White-Hispanic and 37 % White-Non Hispanic. Nineteen percent of the population lives at or below the federal poverty level. Based on the latest community needs assessment over 18% of the area residents lack any healthcare coverage and those that do have coverage often participate in limited or high deductible plans. Access to primary care physicians in our community is limited not only due to lack of healthcare coverage but also due to the limited supply of family practice (FP) and internal medicine (IM) physicians practicing in our community. 2011 data indicates approximately 200 FP/IM physicians in the community with 31% over the age of 62. Using national median data as a benchmark this leaves the community with a deficit of approximately 20 FP and 56 IM physicians for
2011, increasing to a deficit of over 130 FP/IM physicians by 2014. The uninsured/underinsured patients in the community are impacted the most by the shortage of primary care providers due to closed physician panels, limited appointment availability, and clinic locations.

**Starting Point/Baseline:**
For the education year beginning July 1, 2012, CCMC has 20 IM residents, 6 FP residents, and no community health workers.

**Rationale:**
In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. The rate of Primary Care Physicians per 100,000 population varies by region with Corpus Christi at 42 primary care physicians per 100,000 population in 2012. Resident physicians provide low-cost care to needy populations and tend to remain in the state in which they complete their residency training. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff.

Increasing the number of IM and FP residents and adding community health workers will:
- Provide expanded support for the Hospitalist program to ensure organized/efficient care delivery
- Increase the supply of primary care physicians for Corpus Christi and Texas
- Increase rotations through local continuity of care clinics which should help increase capacity in those participating physician practices

**Unique Community Need Identification Numbers the Project Addresses:**
- CN.1 – Inadequate access to primary care
- CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.7 – High rates of preventable hospital admissions
- CN.10 – Shortage of primary care physicians

**Related Category 3 Outcome Measure(s):**
The key outcome measures that will be used to measure the effectiveness of this project will be:
- IT-3.2 Congestive Heart Failure 30 day readmission rate. Standalone measure.
- IT-5.2 Per Episode Cost of Care – CHF patients. Non-standalone measure.
- IT-9.2 ED Appropriate utilization – Congestive Heart Failure. Standalone measure.

Health care spending in the United States is highly disproportionate, with half of the US health care dollar spent on five percent of the population. Individuals with chronic conditions consume a high proportion of health care services; chronic conditions are expensive to treat and a major driver of increased healthcare spending. Congestive Heart Failure is one of the most prevalent chronic conditions in our community leading to costly interventions when the disease is not managed properly. Increasing our primary care residency program and adding community health workers should enable us to leverage our Hospitalist program and continuity of care clinic rotations so that we are training new physicians on chronic disease management, reducing readmissions and ED utilization, and reducing the overall cost of care for congestive heart failure patients.
**Relationship to other Projects:**

Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, CPOD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and suboptimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and specialty care areas in our community is critical to reducing these local provider deficits. Project 020973601.1.3 also addresses increasing the local training efforts. Project 020973601.1.1 addresses the need for more primary care providers through expansion of a local FQHC. Increasing the number of primary care providers in the community is only the first step in achieving the overall goals of:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Additional work is needed with care coordination and the management of chronic diseases. Projects 020973601.1.3, 020973601.2.1, and 020973601.2.2 all address chronic disease management, readmission rates, and care transitions.

Related Category 4 measures included Potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Christus Spohn, Memorial Hospital, Lavaca Medical Center, Yoakum Community Hospital, and Corpus Christi-Nueces County Public Health.

**Project Valuation:**

The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Community Need</td>
<td>5</td>
<td>Significant shortage of FP/IM physicians in the market</td>
</tr>
<tr>
<td>Populations Served</td>
<td>3</td>
<td>Hospitalist/Continuity of Care Clinic serve low income</td>
</tr>
<tr>
<td>Delivery Transformation</td>
<td>3</td>
<td>Improved access is first step in the process</td>
</tr>
<tr>
<td>Outcomes/Cost</td>
<td>4</td>
<td>Improved CHF management</td>
</tr>
<tr>
<td>Project Investment</td>
<td>4</td>
<td>Resident/Faculty Cost</td>
</tr>
</tbody>
</table>
## RHP Plan for Region 4

### INCREASE TRAINING OF PRIMARY CARE WORKFORCE

<table>
<thead>
<tr>
<th>Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs</th>
<th>Milestone 2 [P-10]: Obtain approval from the American Osteopathic Association (AOA) to increase the number of primary care residents</th>
<th>Milestone 3 [P-2]: Expand primary care training for primary care providers.</th>
<th>Milestone 4 [I-11]: Increase primary care training and/or rotations</th>
<th>Milestone 5 [I-11]: Increase primary care training and/or rotations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-1.1]: Provide a report identifying the following:</strong></td>
<td><strong>Metric 1 [P-1.1]: Provide a report identifying the following:</strong></td>
<td><strong>Metric 1 [P-2.1]: Expand the primary care residency</strong></td>
<td><strong>Metric 1 [I-11.1]: Increase the number of primary care residents over the baseline.</strong></td>
<td><strong>Metric 1 [I-11.2]: Increase the number of primary care rotations at CCMC.</strong></td>
</tr>
<tr>
<td>- Expansion plans for FP/IM residency program to include requested program increases, coverage for both campuses, and additional faculty requirements</td>
<td>- Expansion plans for FP/IM residency program to include requested program increases, coverage for both campuses, and additional faculty requirements</td>
<td>- Baseline: 20 Internal Medicine Residents and 6 Family Practice Residents</td>
<td>- Baseline: Residents rotate through and work directly with the Hospitalists on the Bay Area campus of CCMC.</td>
<td>- Goal: Expand the rotation to include the Doctors Regional campus of CCMC.</td>
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<tr>
<td>- Identification of additional locations for continuity of care clinic rotations</td>
<td>- Identification of additional locations for continuity of care clinic rotations</td>
<td>- Goal: Increase allowable residents by a minimum of 8 from baseline</td>
<td>- Goal: Increase the number of community health workers enrolled in the primary care training program over the baseline.</td>
<td>- Goal: Expand the rotation to include the Doctors Regional campus of CCMC.</td>
</tr>
<tr>
<td>- Additional primary care providers that can help facilitate care post hospital discharge</td>
<td>- Additional primary care providers that can help facilitate care post hospital discharge</td>
<td>- Data Source: Gap Analysis, Recruiting plans, Budget</td>
<td>- Data Source: HR records</td>
<td>- Scheduled hours to be at least 75% of those currently worked at the Bay Area campus. For example if the resident rotation hours are 100/week at the BAMC campus then the rotation hours should be at least 75/week at the DRMC campus.</td>
</tr>
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</table>

### Data Source:
- Expansion plan, interviews, community needs assessment
- Data Source: Gap Analysis, Recruiting plans, Budget
- Data Source: Rotation schedules
- Data Source: HR records
- Data Source: Clinic rotation records

### Year 2 (10/1/2012 – 9/30/2013)
- Milestone 1 Estimated Incentive Payment: $509,561
- Milestone 2 [P-10]: Obtain approval from the American Osteopathic Association (AOA) to increase the number of primary care residents
- Milestone 3 [P-2]: Expand primary care training for primary care providers.
- Milestone 4 [I-11]: Increase primary care training and/or rotations
- Milestone 5 [I-11]: Increase primary care training and/or rotations

### Year 3 (10/1/2013 – 9/30/2014)
- Milestone 3 Estimated Incentive Payment: $499,779

### Year 4 (10/1/2014 – 9/30/2015)
- Milestone 5 [I-11.1]: Increase the number of primary care residents over the baseline.
- Milestone 5 [I-11.2]: Increase the number of primary care rotations at CCMC.

### Year 5 (10/1/2015 – 9/30/2016)
- Milestone 7 [I-11]: Increase primary care training and/or rotations
- Milestone 8 [I-15]: Increase primary care training in Continuity of Care Clinics
- Milestone 9: Increase the number of Continuity of Care Clinic sessions available for primary care trainees

---

**RHP Plan for Region 4**
| Metric 1 [P-10.1]: Documentation of AOA approval for residency position expansion |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Goal: Submit application and obtain approval for at least four additional residency positions for Internal Medicine |
| Data Source: AOA approval letter |
| Milestone 2 Estimated Incentive Payment: $509,561 |

| Metric 2 [I-11.1]: Increase the number of community health workers enrolled in the primary care training program |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Baseline: 0 community health workers |
| Goal: Increase the number of community health workers by a minimum of 1. |
| Data Source: HR records |
| Milestone 3 Estimated Incentive Payment: $499,779 |

| Metric 1 [I-15.1]: Increase the number of Continuity of Care Clinic sessions available for primary care trainees |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Baseline: 16 one-half day sessions per week are currently available for primary care trainees in Continuity of Care Clinics. |
| Goal: 2 additional one-half day sessions per week |
| Data Source: Clinic rotation records |
| Milestone 6 Estimated Incentive Payment: $534,647 |

| Milestone 8 Estimated Incentive Payment: $528,308 |

| Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| 020973601.2 | 1.2.2 | 1.2.2 | INCREASE TRAINING OF PRIMARY CARE WORKFORCE | TPI - 020973601 |
| Related Category 3 Outcome Measure(s): | 020973601.3.3 | IT-3.2 | Congestive Heart Failure 30 day readmission rate |
| | 020973601.3.4 | IT-5.2 | Per Episode Cost of Care – CHF patients |
| | 020973601.3.5 | IT-9.2 | ED Appropriately Utilization – CHF Patients |
| Metric 1 [P-10.1]: Documentation of AOA approval for residency position expansion | Baseline: 20 Internal Medicine Residents and 6 Family Practice Residents |
| Goal: Increase the number of residents enrolled in either the Internal Medicine or Family Practice programs by a minimum of 3 for the education year starting 7/1/2014 |
| Data Source: Rotation schedules |
| Milestone 5 Estimated Incentive Payment: $534,647 |

RHP Plan for Region 4
### RHP Plan for Region 4

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<thead>
<tr>
<th>020973601.1.2</th>
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<td>Year 3 Estimated Milestone Bundle Amount: $999,558</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,069,294</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,056,615</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5)*: $4,144,589
Corpus Christi Medical Center
Expand high impact specialty care in most impacted medical specialties
020973601.1.3

- **Provider**: The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention**: This project will expand the existing family practice/internal medicine residency program to include Fellowship Training in two high impact specialties. The goal is to obtain approval for 8 Fellowship training positions and enroll 6 residents in the Fellowship training by the end of DY5.

- **Need for the project**: In addition to the significant deficit of primary care physicians, our region has a deficit of specialty care providers that are essential to the management of chronic diseases – Cardiology, Pulmonary/Critical Care, and Infectious Disease. This shortage of specialty care providers leads to unacceptable delays in obtaining outpatient appointments and fragmented inpatient care when specialists are not available.

- **Target population**: The residents work with the inpatient hospitalist group that covers all of our unassigned emergency room patients and sees over 75% of the medicine admissions to the hospital. Over 31% of the Hospitalist patients are Medicaid eligible or uninsured. The residents will be involved in the care for this patient population. Approximately 1,885 Medicaid eligible admissions annually could benefit from the increased access to specialty services at CCMC, such as Pulmonary, Critical Care, Cardiology, and Infectious Disease. By the end of year 5 there will be a minimum of 6 Fellowship residents training in the targeted specialties and seeing patients at both of the acute care campuses.

- **Category 1 expected patient benefits**: The project expects to increase the number of specialty care residents training in our community with the goal being for a portion of them to stay and set up a practice upon graduation. Increasing access to specialty care through the addition of new providers is one of the ways to offset our current specialty care physician deficit.

- **Category 3 outcomes**: IT-3.9, IT-5.2, and IT-9.2 – Chronic obstructive pulmonary disease readmissions, cost of care, and ED appropriate utilization. Effective management of this condition through our Hospitalist group and residents should reduce the number of hospitalizations and emergency room visits for the target patient population and improve overall health outcomes.
Category 1: Infrastructure Development
Expand Specialty Care Capacity
Project Option 1.9.1 – Expand high impact specialty care in most impacted medical specialties
Project ID – 020973601.1.3
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Project Description:
*Corpus Christi Medical Center will expand its family practice/internal medicine residency program and to include Fellowship Training in two high impact specialties*

The Corpus Christi Medical Center (CCMC) currently has a three year family practice/internal medicine residency program affiliated with the University of North Texas Health Science Center. The program receives federal funding for 20 residency positions (both GME and IME). Total approved residency training positions by the American Osteopathic Association (AOA) are 24 Internal Medicine and 16 Family Practice residents. Currently CCMC has filled 20 Internal Medicine and 6 Family Practice positions (6 positions above the cap). The residents do extensive training at local continuity of care clinics and with the Hospitalist group that manages the majority of the medical admissions to CCMC. Their curriculum and clinical rotations provide excellent exposure to the chronic diseases and resulting complications that are prevalent in our community. In conjunction with the expansion of the existing program proposed in project 020973601.1.2 this project will further enhance the residency program with the addition of two Fellowship training programs in medical specialties that will have the most significant impact on the health of our community. As with primary care providers, our community also has significant deficits in specialty care providers. The deficits are particularly acute with specialty care providers that are essential to the management of chronic diseases – Cardiology, Pulmonary/Critical Care, and Infectious Disease. Adding Fellowship training to our residency program will provide many benefits to our patients and the community and increase the number of physicians willing to stay and practice in our community.

CCMC has an inpatient Hospitalist program for medical admissions that started out primarily taking all the unassigned admissions through the emergency department (i.e. those patients with no identified primary care physician). This program has expanded to take any medical admission which allows the primary care physicians to stay in their office seeing patients while the Hospitalist rounds on any inpatients of the practice. The residents are an integral part of the success of the Hospitalist program and in return are exposed to invaluable education and training around chronic disease management. Adding Fellowship training in targeted specialties will add key resources to the management of the Hospitalist’s patients, bring additional specialty care resources to the market (faculty/program directors), and provide for a long term solution to the current provider shortages.

CCMC is a 631 bed multi campus teaching facility serving Nueces and the surrounding eleven counties. The total population of the primary and secondary service areas is approximately 559,000 with 56 % White-Hispanic and 37 % White-Non Hispanic. Nineteen percent of the population lives at or below the federal poverty level. Based on the latest community needs assessment over 18% of the area residents lack any healthcare coverage and those that do have coverage often participate in limited or high deductible plans. Access to the appropriate physician providers to manage chronic or acute illnesses continues to be the critical issue for our community. The physician providers in the community are getting older with 32% currently over the age of 60 and expected to retire in the next
five years. Access to specialty care and primary care physicians in our community is limited not only due to lack of healthcare coverage but also due to the limited supply of physicians practicing in our community. The uninsured/underinsured patients in the community are impacted the most by the shortage of physicians due to closed physician panels, limited appointment availability, and clinic locations.

**Starting Point/Baseline:**
CCMC currently has no Fellowship training programs.

**Rationale:**
In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively. The rate of Primary Care Physicians per 100,000 population varies by region with Corpus Christi at 42 primary care physicians per 100,000 population in 2012. Corpus Christi currently has 65 specialty care physicians per 100,000 population compared to the metro areas of Texas which are at 139 specialty care physicians per 100,000. Resident physicians provide low-cost care to needy populations and tend to remain in the state in which they complete their residency training. Adding Fellowship training to an existing residency program elevates the prominence of the overall program from the applicant’s viewpoint and should ensure a greater number and higher caliber of residents applying to the program. Expanding the specialty care workforce will increase access and capacity and help create a comprehensive compliment of primary care and specialty care providers, clinicians, and staff.

Adding two Fellowship training programs will:
- Provide expanded support for the Hospitalist program to ensure organized/efficient care delivery
- Increase the supply of specialty care physicians for Corpus Christi and Texas
- Add specialty care physician resources to the community through additional faculty and program directors

**Unique Community Need Identification Numbers the Project Addresses:**
- CN.2 – Inadequate access to specialty services
- CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.7 – High rates of preventable hospital admissions
- CN.9 – Shortage of specialty care physicians

**Related Category 3 Outcome Measure(s):**
The key outcome measures that will be used to measure the effectiveness of this project will be:
- IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate. Standalone measure.
- IT-5.2 Per Episode Cost of Care - COPD patients. Non-standalone measure.

Health care spending in the United States is highly disproportionate, with half of the US health care dollar spent on five percent of the population. Individuals with chronic conditions consume a high proportion of health care services; chronic conditions are expensive to treat and a major driver of increased healthcare spending. Chronic Obstructive Pulmonary Disease is one of the most prevalent...
chronic conditions in our community leading to costly interventions when the disease is not managed properly. Adding two Fellowship training programs in key specialty care areas should enable us to leverage our Hospitalist program and current specialty care providers so that we are training new physicians on chronic disease management, reducing readmissions and ED utilization, and reducing the overall cost of care for chronic obstructive pulmonary disease patients.

Relationship to other Projects:
Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, CPOD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and specialty care areas in our community is critical to reducing these local provider deficits. Project 020973601.1.2 also addresses increasing the local training efforts. Project 020973601.1.1 addresses the need for more primary care providers through expansion of a local FQHC. Increasing the number of physician providers in the community is only the first step in achieving the overall goals of:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Additional work is needed with care coordination and the management of chronic diseases. Projects 020973601.1.2, 020973601.2.1, and 020973601.2.2 all address chronic disease management, readmission rates, and care transitions.

Related Category 4 measures include Potentially Preventable admissions measures in RD-1, Potentially Preventable complications in RD-3, and Patient Satisfaction in RD-4.1

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Christus Spohn, Memorial Hospital, Cuero Community Hospital, Lavaca Medical Center, Yoakum Community Hospital, Jackson County Hospital District and Corpus Christi-Nueces County Public Health.
Project Valuation:
The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
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<td>Priority Community Need</td>
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<td>Significant shortage of Specialty care physicians in the market</td>
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<td>Populations Served</td>
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<td>Hospitalist/Continuity of Care Clinic serve low income</td>
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<td>Delivery Transformation</td>
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<td>Improved access is first step in the process</td>
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<td>Outcomes/Cost</td>
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<td>Improved COPD management</td>
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<td>IT-9.2</td>
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**Milestone 1 [P-1]:** Conduct a specialty care gap assessment based on community need

**Metric 1 [P-1.1]:** Provide a report identifying the following:

- **Number, age, type of practice, and any other pertinent provider information on the specialty care physician practices in the community**
- **Average length of time to obtain an initial appointment**
- **Primary care provider input and community input on perceived specialty care needs**

**Goal:** Produce a comprehensive report documenting all points above

**Data Source:** Interviews, community needs assessment

**Milestone 1 Estimated Incentive Payment:** $509,561

**Milestone 2 [P-16]:** Obtain approval from the American Osteopathic Association (AOA) to add two Fellowship programs in key specialty areas

**Metric 1 [P-16.1]:** Increase the number of targeted specialty residents

**Goal:** Increase the number of residents enrolled in the two Fellowship programs by a minimum of 2 for the education year starting 7/1/2014

**Data Source:** HR records

**Milestone 2 Estimated Incentive Payment:** $1,056,615

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<th>Year 4</th>
<th>Year 5</th>
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**Milestone 3 [P-14]:** Expand targeted specialty care training

**Metric 1 [P-14.1]:** Expand the targeted specialty care training with the addition of two Fellowship programs

**Baseline:** No Fellowship Programs

**Goal:** Increase allowable Fellowship residents by a minimum of 8 from baseline

**Data Source:** Gap Analysis, Recruiting plans, Budget

**Milestone 3 Estimated Incentive Payment:** $499,779

**Milestone 4 [I-31]:** Increase number of targeted specialty residents

**Metric 1 [I-31.1]:** Increase the number of targeted specialty care residents over the baseline.

**Goal:** Increase the number of residents enrolled in the two Fellowship programs by an additional 4 from the baseline for the education year starting 7/1/2015

**Data Source:** HR records

**Milestone 4 Estimated Incentive Payment:** $1,069,294

**Milestone 5 [I-31]:** Increase number of targeted specialty residents

**Metric 1 [I-31.1]:** Increase the number of targeted specialty care residents over the baseline.

**Goal:** Increase the number of residents enrolled in the two Fellowship programs by an additional 6 from the baseline for the education year starting 7/1/2016

**Data Source:** HR records

**Milestone 5 Estimated Incentive Payment:** $1,056,615

**Milestone 6 [I-31]:** Increase number of targeted specialty residents

**Metric 1 [I-31.1]:** Increase the number of targeted specialty care residents over the baseline.

**Goal:** Increase the number of residents enrolled in the two Fellowship programs by an additional 6 from the baseline for the education year starting 7/1/2016

**Data Source:** HR records

**Milestone 6 Estimated Incentive Payment:** $1,056,615

**Milestone 5 Estimated Incentive Payment:** $1,069,294

**Milestone 6 Estimated Incentive Payment:** $1,056,615
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<td><strong>IT-3.9</strong></td>
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<td><strong>IT-5.2</strong></td>
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- **Metric 1 [P-16.1]:** Documentation of AOA approval for two Fellowship programs
  
  **Goal:** Submit application and obtain approval for two Fellowship programs
  **Data Source:** AOA approval letter
  **Milestone 2 Estimated Incentive Payment:** $509,561

  **Data Source:** HR records
  **Milestone 3 Estimated Incentive Payment:** $499,779

- **Year 2 Estimated Milestone Bundle Amount:** $1,019,122
- **Year 3 Estimated Milestone Bundle Amount:** $999,558
- **Year 4 Estimated Milestone Bundle Amount:** $1,069,294
- **Year 5 Estimated Milestone Bundle Amount:** $1,056,615

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $4,144,589
Corpus Christi Medical Center
Expand the number of community based settings where behavioral health services may be delivered in underserved areas
020973601.1.4

- **Provider:** The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention:** This project will add a partial hospitalization program (PHP) and additional intensive outpatient programs (IOP) to our existing compliment of behavioral health services. The additional IOP locations will be focused on the underserved rural areas of our primary and secondary service areas.

- **Need for the project:** The lack of behavioral health providers and the closure of local programs in our community have led to limited outpatient treatment options, frequent hospitalizations, and long delays to see a healthcare provider. Resources are currently focused on treating the crisis episode instead of long term management and recovery.

- **Target population:** Approximately 70% of our behavioral health patients are Medicaid eligible or uninsured. This is reflective of the overall behavioral health population in our market as well. We expect a slightly lower percentage participation in the PHP and IOP programs as traditional Medicaid does not currently cover IOP but some of the Medicaid managed care companies will cover the service. For the 12 months ended 9/30/12, the market had over 1,800 Medicaid eligible admissions related to behavioral health issues. CCMC, as the only provider who can treat all age categories (child through adult), has the opportunity to impact the readmissions for the market through the expansion of its outpatient programs.

- **Category 1 expected patient benefits:** The project expects to increase participation in both programs (PHP and IOP) which should better prepare patients for the transition back to a home environment. The programs will provide necessary support for the patient’s recovery along with additional support and therapy related to community integration, stress and anger management, and anxiety/relaxation techniques. The five year goal is to expand the outpatient behavioral programs so that the IOP programs have at least 11 patients per week participating and the PHP has at least 7 patients per week participating. In addition, a 10% reduction in inappropriate ED utilization is expected by the end of the five years. The expansion goals by DY are as follows; DY3 – add PHP and one additional IOP location. Increase IOP census by 2/week and establish PHP census of 2 – 4/week. DY4 – one additional IOP location. Increase IOP census by 4/week from baseline and increase PHP census to 4 – 6/week. DY5 – increase IOP census by 6/week from baseline and increase PHP census to at least 7/week.
• **Category 3 outcomes:** IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate. Reducing the readmission rate for behavioral health/substance abuse patients will be a key indicator of the improved focus on recovery, management, and re-integration and of increased access to appropriate resources and providers. The five year goal is a 20% reduction in the behavioral health readmission rate from the baseline.
Category 1: Infrastructure Development
Enhance Service Availability of Appropriate Levels of Behavioral Health Care
Project Option 1.12.2 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas
Project ID – 020973601.1.4
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Project Description:
Corpus Christi Medical Center will expand its behavioral health services to meet the needs of patients post discharge
According to the Kaiser Family Foundation, Texas is ranked 51st in the nation for per capita mental health spending. While mental health funding was not cut as drastically as other healthcare programs in the last legislative session reductions did occur in the adult mental health and abuse prevention/treatment areas. Even with recent state initiatives there are still many barriers to obtaining appropriate behavioral health services in our community. Service fragmentation, multiple funding sources, and inadequate mental health providers all serve to limit the effective and efficient delivery of services and result in poor patient satisfaction and sub-optimal patient outcomes, including frequent readmissions.

The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus teaching facility serving Nueces and the surrounding eleven counties. CCMC has a comprehensive behavioral health inpatient program with a total of 106 beds in two physical locations that treat all age populations; child, adolescent, adult, and geriatric. Outpatient services have been limited with one intensive outpatient program (IOP) currently seeing only 3 – 5 patients per week. Outpatient services across the community are equally limited with a large number of patients traveling outside of the area for treatment (San Antonio). With the limited access to appropriate outpatient programs and providers the result is frequent admission to an inpatient facility for treatment of an acute condition. This project will expand the outpatient treatment options in the community through additional IOP locations and the introduction of a partial hospitalization program (PHP) to enable patients to begin the process of change and recovery. PHP is an alternative to inpatient care and will be offered for both Psychiatric and Chemical Dependency patients. The IOP can be a step down program after completing an inpatient detox or rehabilitation or it can be entered directly as an outpatient for those patients who have not experienced the consequences of chronic substance abuse but realize they need an intervention.

The total population of the primary and secondary service areas is approximately 559,000 with 56 % White-Hispanic and 37 % White-Non Hispanic. Nineteen percent of the population lives at or below the federal poverty level. Based on the latest community needs assessment over 18% of the area residents lack any healthcare coverage and those that do have coverage often participate in limited or high deductible plans. Access to mental health services in our community is limited not only due to lack of healthcare coverage but also due to the limited supply of treatment options, mental health providers, and location and capacity of current treatment programs.
Starting Point/Baseline:
CCMC currently runs a daily census of 3 – 5 patients in its IOP program and has a 15% readmission rate for behavioral health admissions.

Rationale:
The behavioral healthcare services currently provided in the community are generally when the patient has reached a crisis point and needs an intervention. Expansion of intensive outpatient programs and the addition of a partial hospitalization program provide a better transition for patients leaving the acute inpatient setting and an alternative to hospitalization for patients that might otherwise have no alternative. These two programs provide necessary support for the patient’s recovery along with additional support and therapy related to community integration, stress and anger management, and anxiety/relaxation techniques. These programs take a multi-disciplinary approach to the patient’s transition back to a home environment and add needed healthcare options for patients with behavioral health disorders.

Unique Community Need Identification Numbers the Project Addresses:
- CN.4 – Inadequate access to behavioral health services
- CN.7 – High rates of preventable hospital admissions
- CN.15 – Inadequate health care access in rural areas

Related Category 3 Outcome Measure(s):
The key outcome measures that will be used to measure the effectiveness of this project will be: IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate. Standalone measure. The inadequate number of outpatient behavioral health programs in our community lead to frequent use of the hospital emergency departments for care and result in increased readmission rates for behavioral health patients. The 30 day readmission rate will be an effective quality metric to measure the success of our outpatient behavioral health expansion.

Relationship to other Projects:
Access to behavioral health services, both providers and programs, is one of the key items noted in the community needs assessment and a fundamental concern for the health of our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for readmissions. Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and specialty care areas in our community is critical to reducing these local provider deficits. Projects 020973601.1.2 and 020973601.1.3 both address increasing the local training efforts. Increasing the number of primary care providers in the community is a key component to moving towards integration of primary care and behavioral health. Other goals surrounding behavioral health are as follows:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes,
reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
• Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Additional work is needed with care coordination and the management of behavioral health patients. Projects 020973601.2.1 addresses the issues inherent with care transitions. Projects 1268443-05.1.1 and 094118902.1.1 are designed to improve behavioral health care services and will also benefit from the implementation of this project.

Related Category 4 measures included Potentially Preventable Admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Bluebonnet Trails Community Mental Health Center, DeTar Hospital, Gulf Bend Center, and MHMR of Nueces County.

Project Valuation:
The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Community Need</td>
<td>5</td>
<td>Significant shortage of Behavioral Health services</td>
</tr>
<tr>
<td>Populations Served</td>
<td>4</td>
<td>Typically low income population</td>
</tr>
<tr>
<td>Delivery Transformation</td>
<td>3</td>
<td>Controlling readmissions first step</td>
</tr>
<tr>
<td>Outcomes/Cost</td>
<td>4</td>
<td>Readmission reductions</td>
</tr>
<tr>
<td>Project Investment</td>
<td>4</td>
<td>Staffing, outreach programs</td>
</tr>
</tbody>
</table>
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective:</strong></td>
<td><strong>Objective:</strong></td>
<td><strong>Objective:</strong></td>
<td><strong>Objective:</strong></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-2]: Identify licenses, equipment and other components needed to implement and operate options selected.</td>
<td><strong>Milestone 2</strong> [P-6]: Establish behavioral health services in new community-based settings.</td>
<td><strong>Milestone 4</strong> [P-6]: Establish behavioral health services in new community settings.</td>
<td><strong>Milestone 7</strong> [I-11]: Percent utilization of community behavioral healthcare services</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-2.1]: Provide a report identifying the following:</td>
<td><strong>Metric 1</strong> [P-6.1]: Number of new community-based settings where behavioral health services are delivered (IOP).</td>
<td><strong>Metric 1</strong> [P-6.1]: Number of new community-based settings where behavioral health services are delivered (IOP).</td>
<td><strong>Metric 1</strong> [I-11.1]: Percent utilization of community behavioral healthcare services</td>
</tr>
<tr>
<td>- Additional potential locations for intensive outpatient therapy (IOP) programs</td>
<td>- Baseline: One IOP location at Bayview campus</td>
<td>- Goal: Increase by 2 additional IOP locations over baseline</td>
<td>- Goal: Increase to at least 11 patients per week for IOP and at least 7 for PHP.</td>
</tr>
<tr>
<td>- Prioritize locations based on community need</td>
<td>- Goal: Increase by one additional IOP location</td>
<td>- Data Source: Lease agreements, expansion plans, HR records</td>
<td>- Data Source: Patient visit records</td>
</tr>
<tr>
<td>- Determine space and staffing requirements and timing of new IOP and PHP programs</td>
<td>- Data Source: Lease agreements, expansion plans, HR records</td>
<td>- Milestone 4 Estimated Incentive Payment: $378,708</td>
<td>- Milestone 7 Estimated Incentive Payment: $561,327</td>
</tr>
<tr>
<td>- Integration with partial hospitalization program (PHP)</td>
<td><strong>Metric 2</strong> [P-6.1]: Number of new community-based settings where behavioral health services are delivered (PHP).</td>
<td><strong>Milestone 5</strong> [I-11]: Increased utilization of community behavioral healthcare</td>
<td><strong>Milestone 8</strong> [I-12]: Use of Emergency Department Care by individuals with mental illnesses or substance abuse disorders</td>
</tr>
<tr>
<td>- Projected volumes and program hours for both IOP and PHP</td>
<td>- Baseline: No partial hospitalization program exists in the community</td>
<td>- Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services</td>
<td>- Metric 1 [I-12.1]: X percent decrease in inappropriate utilization of Emergency Department</td>
</tr>
<tr>
<td>- Goal: Produce a comprehensive report documenting all points above</td>
<td>- Goal: Establish PHP</td>
<td>- Goal: Increase to 7 – 9 patients per week for IOP and 4 - 6 for PHP.</td>
<td>- Baseline: TBD</td>
</tr>
<tr>
<td>- Data Source: Expansion plan</td>
<td>- Data Source: HR records, clinical protocols, expansion plans</td>
<td>- Data Source: Patient visit records</td>
<td>- Goal: 10% decrease in inappropriate ED utilization over baseline</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $1,082,817</td>
<td>Milestone 2 Estimated Incentive Payment: $531,015</td>
<td>Milestone 5 Estimated Incentive Payment: $378,708</td>
<td>Data Source: EHR</td>
</tr>
</tbody>
</table>
### Expand Community Based Settings for Behavioral Health – PHP/Outreach

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>RHP Plan for Region 4</td>
<td>020973601.1.4</td>
<td>1.12.2</td>
<td>1.12.2</td>
<td>EXPAND COMMUNITY BASED SETTINGS FOR BEHAVIORAL HEALTH – PHP/OUTREACH</td>
<td>Corpus Christi Medical Center</td>
<td>TPI - 020973601</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>020973601.3.9</td>
<td>IT-3.8</td>
<td>Behavioral Health/Substance Abuse 30 Day Readmission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 3 [I-11]: Increased utilization of community behavioral healthcare services.**

**Metric 1 [I-11.1]:** Percent utilization of community behavioral healthcare services (IOP and PHP)

- **Baseline:** 2012 data. Average 3 – 5 patients per week.
- **Goal:** Increase to 5 – 7 patients per week for IOP and 2 – 4 for PHP.
- **Data Source:** Patient visit records

**Milestone 3 Estimated Incentive Payment:** $531,015

**Milestone 6 [I-12]:** Use of Emergency Department Care by individuals with mental illnesses or substance abuse disorders

**Metric 1 [I-12.1]:** X percent decrease in inappropriate utilization of Emergency Department

- **Baseline:** TBD
- **Goal:** 5% decrease in inappropriate ED utilization
- **Data Source:** EHR

**Milestone 6 Estimated Incentive Payment:** $378,709

**Milestone 8 Estimated Incentive Payment:** $561,327

**Year 2 Estimated Milestone Bundle Amount:** $1,082,817

**Year 3 Estimated Milestone Bundle Amount:** $1,062,030

**Year 4 Estimated Milestone Bundle Amount:** $1,136,125

**Year 5 Estimated Milestone Bundle Amount:** $1,122,654

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $4,403,626
Corpus Christi Medical Center

Implement a Chronic Disease Management Registry

020973601.1.5 Pass 2

- **Provider:** The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention:** This project will implement a chronic disease management registry for one or more targeted chronic diseases to help in the identification of at risk patients and the management of the chronic disease across the entire continuum of healthcare providers.

- **Need for the project:** Care coordination across the market is fragmented and inadequate leading to increased costs and admissions, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Diabetes, congestive heart failure, and chronic obstructive pulmonary disease are all chronic conditions with high incident rates for our community. These conditions, if poorly managed, can lead to unnecessary admissions and inappropriate ED utilization. Developing a chronic disease registry will also enhance the data collection and effectiveness of our local Health Information Exchange (HIE) efforts.

- **Target population:** The target population is any patient of CCMC with at least one of the targeted chronic diseases. Approximately 47% of our patients are either Medicaid eligible or indigent so we expect that about half of the patients entered in the registry will be from this population. Over 5,000 admissions, emergency room visits, and outpatient encounters annually are Medicaid eligible patients with one of the targeted chronic diseases that would be eligible for inclusion in the registry.

- **Category 1 expected patient benefits:** The project expects to enroll 50% of patients with the selected chronic diseases in the registry by DY5 and provide appropriate disease specific discharge instructions to 50% of these registry patients by the same time period. The project will also have the disease registry capability implemented in 75% of the performing provider sites by DY5.

- **Category 3 outcomes:** IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations – Chronic Composite – PQI 92. The goal is to reduce the chronic composite admission rate by 10% from the baseline by DY5.
**Project Option 1.3.1- Implement a Chronic Disease Management Registry**

**Unique RHP Project Identification Number:** 020973601.1.5 Pass 2

**Performing Provider Name/TPI:** Corpus Christi Medical Center/020973601

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**Project Description:**

*Implement and Use Chronic Disease Management Functionalities*

Health care spending in the United States is highly disproportionate, with half of health care dollars spent on approximately five percent of the population. Individuals with chronic conditions consume a high proportion of health care services. These patients struggle with multiple illnesses as well as mental health and substance abuse needs, medical frailty, social isolation and homelessness. Unfortunately, these individuals are the least poised to navigate our complex and fragmented health care system. All chronic conditions present with a common set of challenges to the sufferers and their families; dealing with symptoms, disability, emotional impacts, complex medication regimens, difficult lifestyle adjustments, and obtaining coordinated medical care. The goal of this project is to implement a chronic disease registry for patients diagnosed with selected chronic diseases or Multiple Chronic Conditions (MCCs). A disease registry can help 1) identify gaps in a patients care, 2) identify patients who are not meeting care management goals, 3) contribute to regional health information exchange (HIE) initiatives, 4) provide reports on how well the recommended care is delivered to the specific patient populations, and 5) gain valuable data on the impact of the interventions on quality of life and functional status.

CCMC is a 631 bed multi campus teaching facility serving Nueces and the surrounding eleven counties. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. Nineteen percent of the population lives at or below the federal poverty level. Based on the latest community needs assessment over 18% of the area residents lack any healthcare coverage and those that do have coverage often participate in limited or high deductible plans. Our community includes many rural areas with sparse populations, large geographic coverage, and limited healthcare services. This makes the proactive care management of chronic disease patients critical to reducing costly readmissions and improving the quality of life and functional status of the population living with chronic disease.

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**Goals and Relationship to Regional Goals:**

Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, CPOD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and specialty care areas in our community is critical to reducing these local provider deficits. Projects 020973601.1.1, 020973601.1.2, and 020973601.1.3 address the access to primary care and the resulting impact on chronic conditions. Project 020973601.1.4 addresses our current issue with fragmented or incomplete care transitions.
The implementation of a chronic disease registry along with the other projects noted above are key first steps in achieving the overall goals of:

- Transforming health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Developing a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
The primary challenges to the successful achievement of the project goals are the following:

- Collecting and maintaining accurate and current data that can be shared with the local HIE
- Training providers on the proper use of the registry so that they can engage the patients in the self-management of their chronic disease
- Development of the registry and identification of the key data elements that will make the most impact on the patient’s health status
- Consistent data collection and use of the registry by providers

We will maintain our active participation in the local HIE to ensure our data collection efforts are consistent in both format and content with the rest of the region. We will identify the key data elements for collection through the use of existing tools with demonstrated results, modified as appropriate for our patient population. Formal training programs will be developed to ensure consistency in data collection, reporting, and use of the registry.

5-Year Expected Outcome for Provider and Patients:
Expectations for the Chronic Disease Registry project are 1) 75% of all Performing Provider locations will participate in the registry, 2) 50% of all eligible patients will be entered into the registry, 3) 50% of eligible patients will receive the appropriate educational tools specific to their disease, 4) Registry data will be in a format compatible with the local HIE, and 5) Improvements in the self-management of chronic disease which should lead to lower costs of care and improved quality of life.

Starting Point/Baseline:
Currently, a disease registry program does not exist for chronic diseases at the Corpus Christi Medical Center. Therefore, the baseline will be set at 0.

Rationale:
To effectively reduce costs from our current health care delivery system the approach must shift from providing health interventions to improving health outcomes through better self-management and appropriate access to health care resources and other community supports. Development of a chronic disease registry is one of the first steps in the identification of at risk patients and the management of the disease across the entire continuum of healthcare providers. The healthcare delivery changes that are anticipated from this project will extend beyond the targeted patient population and establish best practices that should become standards of care in the community.
**Project Components:**
Through the Chronic Disease Registry, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) *Enter patient data into unique chronic disease registry.* All patients with the identified chronic disease will be informed of the registry and that their data will be included unless they “opt out” of the registry. Patients will be provided information on the registry benefits and the confidential nature of the data to help alleviate any concerns about participation.

b) *Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.* In conjunction with the waiver project on care transitions, the registry data will be used to establish the individual patient needs, develop education to aid in self-management, and identify community/family resources that will enable the patient to function and effectively manage their chronic disease.

c) *Use registry reports to develop and implement targeted QI plan.* Using the registry data and historical performing provider data we will identify the top 5 (or more depending on the data) issues facing patients with the identified chronic diseases that prevent them from effective self-management. From these top identified issues we will develop and implement a quality improvement plan targeting specifically those areas where care transitions are the most fragmented and lead to unnecessary admissions and ED utilization.

d) *Conduct quality improvement for project using methods such as rapid cycle improvement.* Using the plan developed in item c) above we will consistently measure our results against our stated goals and refine/adjust our quality improvement plan as necessary to ensure we attain a measurable improvement in the health of our targeted chronic disease patients.

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the Chronic Disease Registry Project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.1)
- Improvement Milestones and Metrics: I-15 (I-15.1); I-22(I-22.1)

**Unique Community need identification numbers the project addresses:**

- CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.6 – High rates of inappropriate emergency department utilization and dissatisfaction of emergency department services
- CN.7 – High rates of preventable hospital admissions
- CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently, a chronic disease registry is not in place for the Corpus Christi Medical Center. Our chronic disease management efforts are limited to diabetes education while the patient is in-house and education materials given to the patient with their discharge instructions. This initiative will greatly enhance our efforts to include consideration of 1) family resources, 2) community resources, 3)
barriers to effective self-management, 4) effective care transitions, and 5) improved educational materials.

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

- OD-2 Potentially Preventable Admissions
- IT-2.12 – Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

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

The composite selected is the chronic composite – PQI 92. The overall chronic composite captures the key chronic diseases that contribute to the majority of the preventable admissions and re-admissions. This composite can be trended over time and used to compare local data to state and national benchmarks. The Texas Department of State Health Services has published reports by county summarizing the top potentially preventable hospitalizations. The report identified almost 13,000 potentially preventable admissions in Nueces County alone related to Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Diabetes for the five year period 2005 – 2010. These chronic diseases are part of the chronic composite-PQI92. It is estimated that at least 45% of the CHF, COPD, and Diabetes potentially preventable admissions for Nueces County are for either Medicaid eligible or indigent patients. The Agency for Healthcare Research and Quality (AHRQ) has a collection of peer-reviewed resources on disease registries that outline the benefits, challenges, and best practices associated with registry use in transforming health care for a community or population. Examples include; *Information Technology to Support Improved Care For Chronic Illness*. Young AS, Chaney E, Shoai R, et al. and *Building a Computerized Disease Registry for Chronic Illness Management of Diabetes*. Hummel J

**Relationship to other Projects:** Four of our six Pass 1 projects relate to the management of chronic diseases. Project 020973601.1.1 is the expansion of primary care capacity at a local FQHC with the category three improvement measures related to controlling high blood pressure and diabetes. Project 020973601.1.2 is the expansion of the FP/IM residency program and the addition of community health workers with the associated category three improvement measures related to CHF admissions, cost of care, and ED appropriate utilization. Project 020973601.1.3 is the expansion of high impact specialty care with the associated category three improvement measures related to COPD admissions, cost of care, and ED appropriate utilization. Project 020973601.2.1 focuses on the improvement/expansion of care transition programs with the associated category three improvement measures related to all cause 30 day readmission rate.

**Relationship to Other Performing Providers’ Projects in the RHP:**

This project will support and complement all of the projects within our region designed to improve access to care, expand primary and specialty care, and improve patient outcomes for individuals with chronic conditions. Specific projects that will benefit from this project include Expand primary care capacity 130958505.1.1; Expand specialty care capacity 094118902.1.1; Implement a palliative care program 121785303; and Expand Care Transitions program 0942220902.2.5.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this
collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**
The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

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<tr>
<td>Populations Served</td>
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<td>Mix of Medicare/Medicaid/Low Income patients</td>
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<td>Delivery Transformation</td>
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<td>Integrated care coordination</td>
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<tr>
<td>Outcomes/Cost</td>
<td>4</td>
<td>Improved Chronic Disease Management</td>
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<tr>
<td>Project Investment</td>
<td>5</td>
<td>Development of Registry</td>
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<tr>
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<td>1.3.1</td>
<td>1.3.1 (A-D)</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>020973601.3.13</td>
<td>IT-2.12</td>
</tr>
</tbody>
</table>

**Corpus Christi Medical Center**

**Milestone 1 [P-1]:** Identify one or more target patient populations diagnosed with selected chronic conditions.

**Metric 1 [P-1.1]:** Documentation of patients to be entered into the registry:
- Chronic diseases to be included in the registry
- Multiple chronic conditions to be included in the registry
- Patient population sources to be included in the registry
- Potential number of patients

Goal: Produce a comprehensive report documenting all points above.

Data Source: EHR, community needs assessment, Performing Provider historical data

Milestone 1 Estimated Incentive Payment: $445,437

**Milestone 2 [P-2]:** Review current

**Milestone 3 [P-3]:** Develop cross-functional team to evaluate registry program.

**Metric 1 [P-3.1]:** Documentation of personnel assigned to evaluate registry program.

Goal: Demonstrate cross-functional participation with representation from IT, Nursing, Case Management, Social Services, Ancillary, Dietary, and Administration

Data Source: Registry program meeting minutes

Milestone 3 Estimated Incentive Payment: $301,268

**Milestone 4 [P-4]:** Implement/expand a functional disease management registry

**Metric 1 [P-4.1]:** Registry functionality is available in 50% of the Performing Provider’s sites and includes an expanded number of targeted diseases or clinical conditions.

Milestone 4 Estimated Incentive Payment: $321,581

**Milestone 5 [P-5]:** Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of service or not at goal, and preventative care status.

**Metric 1 [P-5.1]:** Documentation of registry automated report.

Goal: Demonstrate automated registry reporting capabilities that include key demographic data, preventive care status, patients not at goal, and other data that will help improve service utilization and clinical outcomes.

Data Source: Registry reports

Milestone 5 Estimated Incentive Payment: $321,581

**Milestone 6 [I-15]:** Increase the percentage of patients enrolled in the registry.

**Metric 1 [I-15.1]:** Percentage of patients in the registry

Baseline: 0 patients in the registry

Goal: Minimum of 2,500 patient encounters chronic diseases are entered in the registry

Data Source: EHR, Registry reports

Milestone 6 Estimated Incentive Payment: $506,313

**Milestone 7 [I-22]:** Increase the percentage of patients with chronic disease entered into registry who received instructions appropriate for their chronic disease or MCC’s, such as: activity level, diet, medication management, etc.

**Metric 1 [I-22.1]:** Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.

Goal: 50% of patients with the selected chronic diseases entered into the registry will receive

Data Source: EHR, Registry reports
### Related Category 3 Outcome Measure(s): 020973601.3.13

**IT-2.12**

**Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-2.1]:</strong> Documentation of review of current registry capability and assessment of future registry needs.</td>
<td><strong>Goal:</strong> Adopt registry at a minimum of 50% of Performing Provider Sites <strong>Data Source:</strong> Registry program meeting minutes and documentation of adoption</td>
<td><strong>Goal:</strong> Adopt registry at a minimum of 75% of Performing Provider Sites <strong>Data Source:</strong> Registry program meeting minutes and documentation of adoption</td>
<td><strong>Goal:</strong> Disease appropriate instructions. <strong>Data Source:</strong> EHR and registry reports. <strong>Milestone 10 Estimated Incentive Payment:</strong> $506,312</td>
</tr>
<tr>
<td>Data elements to be included in the registry</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $445,437</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $301,268</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $321,581</td>
</tr>
<tr>
<td>Required reporting capabilities</td>
<td><strong>Milestone 5 [I-15]:</strong> Increase the percentage of patients enrolled in the registry. <strong>Metric 1 [I-15.1]:</strong> Percentage of patients in the registry. <strong>Baseline:</strong> 0 patients in the registry <strong>Goal:</strong> Minimum of 500 patient encounters with selected chronic diseases are entered in the registry <strong>Data Source:</strong> EHR, Registry reports</td>
<td><strong>Milestone 8 [I-15]:</strong> Increase the percentage of patients enrolled in the registry. <strong>Metric 1 [I-15.1]:</strong> Percentage of patients in the registry. <strong>Baseline:</strong> 0 patients in the registry <strong>Goal:</strong> Minimum of 1,750 patient encounters with selected chronic diseases are entered in the registry <strong>Data Source:</strong> EHR, Registry reports</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $321,581</td>
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<td>Sources and method of data extraction</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $301,267</td>
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<td><strong>Milestone 10 Estimated Incentive Payment:</strong> $506,312</td>
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<td>HIPAA considerations</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $301,268</td>
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<td><strong>Goal:</strong> Produce a comprehensive report documenting all points above. <strong>Data Source:</strong> Final Registry Plan Proposal</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $445,437</td>
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**Corpus Christi Medical Center**

020973601
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $890,874</td>
<td>Year 3 Estimated Milestone Bundle Amount: $903,803</td>
<td>Year 4 Estimated Milestone Bundle Amount: $964,743</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,012,625</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $3,772,045
Refugio County Hospital District/020991801
1.1.2 Expand Primary Care Capacity
020991801.1.1

Provider: Refugio County Memorial Hospital District is responsible for the operation the County’s 20 bed Critical Access Hospital, three Rural Health Clinics, and the Emergency Medical Ambulance Services for the entire county. Refugio County encompasses 818 square miles and has a population of 7,291 according to the 2011 Census data. The county is a designated medically underserved area.

Intervention(s): This project will expand the primary care capabilities of the Refugio County Rural Health Clinic. Specifically, the project will: (1) Increase the number of hours the clinic will be open during the week; (2) Renovate and create space to accommodate additional patients; and (3) Hire an additional physician.

Need for the project: The inability of patients to get timely appointments at the clinic is causing patients to delay/forgo primary care, or to seek treatment at the Emergency Room. In an independent Community Health Needs Assessment of Refugio County completed in January 2012, 11.3% of the patients who responded stated that they were not able to get an appointment with a primary care physician in the Refugio County Memorial Hospital District service area when they needed one. In the same survey, 19.6% of the respondents stated that they or someone in their household delayed healthcare due to a lack of money and or health insurance.

Target population: The target population for this project will be the chronically ill, the elderly, and the indigent patients. There were 1,018 citizens (13.9 percent of the county population) enrolled in the Medicaid program in Refugio County in September 2012. Since there are no other hospitals or primary care clinics within the county, utilization of the Hospital District services by Medicaid recipients is expected to be high. This claim is backed by current payer data from the Rural Health clinic showing the percentage of Medicaid primary payer source patients as 12 percent of the total patient volume. Over the project period we expect the project to allow the Rural Health Clinic to treat an additional 10,300 patients.

Category 1 or 2 expected patient benefits: This expansion of primary care project will allow additional patients to be seen at the rural health clinic. The expected increase in volume is as follows:

- **DY 4** – 2600 additional patient visits (10 pt. a day avg.)
- **DY 5** – 3120 additional patient visits (12 pt. a day avg.)

Category 3 outcomes: IT-9.2 Reduce all E.D. Visits. Our goal is to increase primary care at the clinic in an effort reduce all ER visits by 10% in DY5.
**Category 1: Infrastructure Development**

**Title of Project:** 1.1.2 Expand Primary Care Capacity  
**Unique RHP project ID number:** 020991801.1.1  
**Performing Provider/TPI:** Refugio County Hospital District/020991801

**Project Description:**
Refugio County Hospital District (RCMH) is a small, rural Critical Care Access facility with 25 bed capacity. The mission of Refugio County Hospital District is to provide and promote quality healthcare to the citizens of our county. Through our hospital, rural health clinics, wellness center, and specialty clinic we are striving to provide primary healthcare to our patients in Refugio County.

The hospital’s primary service area is Refugio County but serves patients whose residence is in surrounding cities throughout South Texas. The county is 818 square miles and the population density per square mile is 9.58. Based on the 2011 Census, Refugio County has a population of 7,291. 48% of the population is Hispanic ethnicity. 23.4% are under the age of 17; 19.9% are 65 years of age or older; and 2.5% are 85 years of age and older. The median age is 43. In 2010 the per capita income was $36,937 with 17.8% living below poverty.

This project will expand primary care capacity in Refugio County to better accommodate the needs of the rural patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Expanding primary care capacity for the Refugio community will provide additional access and services to the uninsured, Medicaid, and Medicare population and avoid unnecessary travel and costs associated with seeking care outside of the community.

Expansion of primary care at Refugio County Hospital will require that appropriate personnel and equipment are purchased or improved upon. The primary care expansion includes hiring an additional primary care physician to increase capacity for primary care services in the existing clinic.

**Project Goals:**
- Reduce emergency department visits and hospitalization due to delay and/or minimal preventive care from a primary care provider
- Improve and increase access to primary care services for the Refugio County.
- Increase knowledge and community awareness of the types of services provided and the availability of services in a primary care setting
- Decrease in the number of preventable hospitalizations within Refugio

**Ties to Regional Goals**
Similar to other projects in the Region, this project is focused on providing better access to primary care thus preventing unnecessary hospital admissions and E.D. visits. This increased
access will help reduce the cost of healthcare to patients, their insurance providers and CMS. This is a region wide collaborative effort to manage the rising costs of healthcare, yet deliver essential care to all of the patients of this region. As part of the collaborative effort, there will be a strong push to reeducate the population on proper utilization of E.D. and clinic resources. There too many patients who go to the E.R. simply because they feel that they will be turned away because of limited funds, or because they could not get a timely appointment in with the clinic. The local and regional goals of this project are not just simply to reduce the costs of healthcare, but to educate and inform patients so that we can change the way healthcare is managed.

**Challenges:**
The hospital currently faces challenges in providing sufficient primary care services in a rural community. Like most counties in the region, Refugio County is a designated Medically Underserved Area and Health Professional Shortage Area. The low primary care provider to patient ratio in the region results in many patients not having access to a primary care physician and/or limiting preventive care due to limited access.

Patients not receiving adequate primary and/or preventive care for their chronic conditions and/or otherwise healthy status could lead to undiagnosed or risk for acute exacerbations of their chronic conditions leading to more expensive critical care and/or even hospitalization. The main underlying cause is the recruitment and retaining of physicians to practice medicine in a rural area. In the past, physicians and mid-level providers begin practice here, but move to larger towns.

To meet this challenge, Refugio County Medical Clinic is currently researching and proposing to become a National Health Service Corps site. This will increase recruitment and retention of providers since they will be afforded the opportunity to practice medicine and have their student loans repaid based upon their years of service in the community.

**Five year expected outcome:**
The ultimate goals for expanding the primary care capacity for the Refugio County community are to improve patient care and reduce the overall costs of healthcare by reducing hospitalizations and Emergency Room visits. Each patient that we can keep out of an emergency room or out of an inpatient bed at a hospital saves thousands of dollars in healthcare expense. We also expect to see greater patient satisfaction primarily because patient satisfaction with primary care service is largely related to understanding and utilizing primary care services appropriately. Understanding strengths, needs and receiving patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patients’ needs; thereby improving patient satisfaction throughout the years.

**Starting Point/Baseline:** The baseline for DY 2 is 0.

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10 U.S. Department of Health & Human Services, Health Resources and Services Administration

RHP Plan for Region 4
Rationale:
Inadequate access to primary care has contributed to the increased cost and inadequate care coordination in our health care systems. In our current system, more often than not patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in a primary care setting. This often results in more costly, less coordinated care, and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

Using official state data, there were over $8.1 million in charges due to preventable hospitalizations for diabetes, congestive heart value, and bacterial pneumonia. These are preventable disease that could be avoided if the patient had access to primary care services in the area. Most of these visits occurred through the emergency department. In 2011, there were a total of 3,871 visits at RCMH. Of these visits, 198 were for diabetes, 50 for congestive heart failure, and 46 for pneumonia.

RCMH hospital feels that if there were greater access to primary care services that these visits and hospitalizations would be decreased. Enhanced access to primary care has been proven in numerous research articles to help effectively decrease hospitalizations and emergency department usage, especially in rural areas. The only primary care providers in Refugio County are located within the RCMH clinics. RCMH is not able to meet the demands of the patient suffering from the aforementioned chronic diseases. This places an unnecessary burden upon the hospital and the community. RCMH will be able to alleviate this burden and meet the needs of the patients by expanding its primary care services through the recruitment and hiring of needed staff, expanding clinic service hours, and expanding its clinic spaces through the 1115 project.

Project Components:
We propose to meet all of the required project core components for 1.1.2 Expand existing primary care capacity as follows:

a) Expand primary care clinic space – space is currently available; however it is only large enough to accommodate its current staff. Using the DSRIP funding, RCMH will begin the process of expanding available treatment rooms and exam rooms to accommodate the enhanced primary care services that it will offer as part of the DSRIP projects.

b) Expand primary care clinic hours – RCMH will expand the service hours at its clinic to better meet the needs of the patients. Possible options include extended hours until 7:00 in the evening two times a week and expanded hours of service on the weekend. If there is a demand, RCMH is willing to offer later hours of service to better meet the needs of the patients.
c) Expand primary care clinic staffing – will contract with one additional physician in DY 2. Using the total number of clinic visits in 2011, RCMH was able to determine that the addition of one provider will possibly require the recruiting and training of one support staff to ensure efficient operations within the clinic.

**Milestones and Metrics:**

**Process Milestones:**

- **P-1** Establish additional/expand existing/relocate primary care clinics
  - **P-1.1** Metric: Number of additional clinics or expanded hours or space
- **P-4** Milestone: Expand the hours of a primary care clinic, including evening and/or weekend hours
  - **P-4.1** Metric: Increased number of hours at primary care clinic over baseline
- **P-5** Train/contract with additional primary care providers
  - **P-5.1** Documentation of increased number of providers
- **P-7** Establish a nurse advice line and/or primary care patient appointment unit.
  - **P-7.1** Documentation of nurse advice line and/or primary care patient appointment unit.
- **P-8** Develop an automated tracking system for measuring time to next available offered appointment.
  - **P-8.1** Documentation that providers and staff are aware of next available appointment time using real time scheduling data, to ensure that patients can receive primary care services according to acuity and need

**Improvement Milestones:**

- **I-12** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
  - **I-12.1** Documentation of increased number of visits

**Unique community need identification numbers: CN.1**

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

OD-9 IT-9.2 ED appropriate utilization – reduce all ED visits. Refugio County Memorial Hospital selected this outcome measure due to the high number of level 1 and level 2 non-emergent patients that are seen in the Emergency room. One significant cause of this elevated number of non-emergent patients in the emergency room is the limited access to primary care within the county. The inability of patients to obtain timely appointments in the rural health clinic forces patient to come to the emergency room to receive care. These unnecessary E.R. visits are overwhelming the Emergency Department and driving up the costs of healthcare.

**Relationship to Other Projects:**

This project also will support and enhance other projects within the region, particularly those designed to expand access to care, reduce costs, and assist patients in accessing care from the most suitable setting. Projects that this initiative is related to include project 121775403.12,
project 137907508.1.1, and project 020973601.1.1 – Expand Primary Care Capacity; and 121775403.1.4 – Introduce expand or Enhance Telemedicine/Telehealth; and 130958505.2.1 – Implement an innovative and evidence-based health promotion program.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with whom we will collaborate include Christus Spohn, Memorial Hospital, Corpus Christi Medical Center, Yoakum Community Hospital, Jackson County Hospital District, and Lavaca Medical Center.

**Project Valuation:**
The approach used to value this project is based upon the community need for the expansion of the Hospital District’s primary care service. In order to value this project, The Refugio County Hospital District based its valuation on the current and future community needs for the expansion of its primary care services.

The limited availability of primary care services has been an ongoing problem for the Refugio County Hospital District and the community it serves. This problem is expected to get worse as the community expands due to the recent economic growth. The limited availability of primary care creates an unfortunate situation for the residents of this community who are trying access primary care. These patients are left with one of three options:
- Delay or forgo medical care/treatment
- Seek primary care outside of the county
- Seek primary care at the Emergency room

These three options that are left for those patients who cannot access primary care are not only inconveniencing patients and putting their health at risk, they are unwillingly exacerbating the rising costs of health care in the United States today.

The expansion of the primary care services will allow additional patients to be seen by a primary care physician without having to travel outside of the county or seek costly care at an emergency room. By meeting our milestones and metrics RCMH feels that it can substantially reduce the cost of healthcare in the community and improve patient satisfaction and their quality of life.

Each of the Milestones and Metrics that are put in place all focus on one component: making primary care more available to the citizens of Refugio County.

As was mentioned earlier, using official State data for the years 2005 through 2010 there was an estimated 8.1 million dollars spent at Refugio County Memorial Hospital in potentially preventable hospital stays. This equates to an average of 1.35 million dollars in annual
potentially preventable hospital stays. If RCMH can reduce 20% of preventable hospital stays by the end DSRIP year five then the savings to the community and the healthcare system could be as much as $270,000 annually.

Based upon the current financials for the year 2012 the average costs to a patient who visits the Refugio Clinic is $102.80. The financials for the same reporting period show that the average emergency room bill for a patient who is seen at Refugio Memorial Hospital is $1418.65. Initially, the hospital district expects the new primary care physician to see an average of 8 patients a day which equates to an average of 173 patients per month. This is potentially 173 individuals that will not have to be seen in an ER, travel outside of the county, or delay/neglect their healthcare. If only 26 (15%) of the 173 potential clinic patients had been seen in the Refugio County Memorial Hospital Emergency room the average annual costs to the patients or their health insurance provider would be $442,462. If these same 26 patients had been seen at the clinic, the average annual costs to the patients or their health insurance carrier would be $32,073. The total annual savings with only a 15% utilization of the clinic expansion over the ER would result in $410,389 in annual savings to the patients of this community and their health insurance carriers.
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<tr>
<th>020991801.1.1</th>
<th>1.1.2</th>
<th>1.1.2 a-c</th>
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<td><strong>Refugio County Hospital District</strong></td>
<td><strong>IT-9.2</strong></td>
<td><strong>ED appropriate utilization – Reduce all ED visits</strong></td>
<td><strong>020991801</strong></td>
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### Related Category 3

#### Outcome Measure(s):

- **020991801.3.1**

#### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 P-1**: Milestone: Establish additional/expand existing/relocate primary care clinics

**Metric 1 P-1.1**: Number of additional clinics or expanded hours or space.
- Baseline: Currently only set up for two primary care physicians
- Goal: Reorganize/Remodel to create additional room for the new physician

**Data Source**: Clinic documentation

**Milestone 1 Estimated Incentive Payment (maximum amount)**: $147,535

**Milestone 2 P-5**: Milestone:
- Train/contract with additional primary care providers and staff and/or increase the number of primary care clinics for existing providers
- **Metric 1 P-5.1**: Documentation of increased number of providers and staff and/or clinic sites.
- Baseline: Two full time primary physicians
- Goal: Three full-time primary care physicians by June, DY2

**Data Source**: Clinic documentation

**Milestone 2 P-5 Estimated Incentive Payment (maximum amount)**: $107,302

#### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 P-4**: Expand the hours of a primary care clinic, including evening and/or weekend hours

**Metric 1 P-4.1**: Increased number of hours at primary care clinic over baseline
- Baseline: Clinic is open 40hrs per week
- Goal: expand clinic hours by five to ten hours per week

**Data Source**: Clinic documentation

**Milestone 4 Estimated Incentive Payment (maximum amount)**: $107,302

**Milestone 4 P-7**: Establish a nurse advice line and/or primary care patient appointment unit

**Metric 1 P-7**: Documentation of nurse advice line and/or primary care patient appointment unit
- Baseline: 0
- Goal: Establish advice line to effectively direct patients to the appropriate medical facility.

**Data Source**: Documentation of advice line and appointment unit implementation, operating hours and triage policies. Advise line system

**Milestone 4 Estimated Incentive Payment (maximum amount)**: $322,841

#### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 P-7**: Establish a nurse advice line and/or primary care patient appointment unit

**Metric 1 P-7**: Documentation of increased number of visits from baseline
- Baseline: Clinic Patient volume from DY 2
- Goal: 2600 additional patient visits in DY4

**Data Source**: Registry, EHR, claims or other performing provider source

**Milestone 5 Estimated Incentive Payment (maximum amount)**: $266,696

#### Year 5 (10/1/2015 – 9/30/2016)

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

**Metric 1 I-12.1**: Documentation of increased number of visits.
- Baseline: DY2 clinic patient volume
- Goal: 3120 additional patient visits in DY5

**Data Source**: Clinic scheduler, Clinic records

**Milestone 7 Estimated Incentive Payment (maximum amount)**: $322,841

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

**Metric 1 I-12.1**: Documentation of increased number of visits.
- Baseline: DY2 clinic patient volume
- Goal: 3120 additional patient visits in DY5

**Data Source**: Clinic scheduler, Clinic records

**Milestone 7 Estimated Incentive Payment (maximum amount)**: $322,841
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<th>IT-9.2</th>
<th>ED appropriate utilization – Reduce all ED visits</th>
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<td>Year 3</td>
<td>Milestone 5 P-8 Develop an automated tracking system for measuring time to next available offered appointment.</td>
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<td>(10/1/2013 – 9/30/2014)</td>
<td>Metric 1 P-7.8 Documentation that providers and staff are aware of next available appointment time using real time scheduling data, to ensure that patients can receive primary care services according to acuity and need.</td>
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<tr>
<td>Baseline: 0</td>
<td>Goal: Tracking system developed</td>
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<td>Data Source:</td>
<td>Documentation of Performing Provider policies for assessing and communicating time to next available appointment and response to patient care needs reporting and communication tool.</td>
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<td>Performing Provider administrative records from patient scheduling system</td>
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### Expand Primary Care Capacity

**Refugio County Hospital District**

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**Total Estimated Incentive Payments for 4-Year Period**

(Add milestone bundle amounts over DYs 2-5): $1,206,513
DeTar Healthcare System/ 094118902
1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas
094118902.1.1

Provider: DeTar Healthcare System is a 308-bed two-hospital system in Victoria, Texas that serves Victoria and surrounding counties. We serve a 5,200 square mile area and a population of approximately 164,467.

Intervention(s): This project will provide the first intensive outpatient program (IOP) for behavioral health patients in Victoria County.

Need for the project: Victoria and its surrounding counties are served by only one mental health agency (Gulf Bend). There is a shortage of psychiatrists and programs that provide intensive outpatient services that enable patients to function without the inappropriate use of hospital or criminal justice resources. Many of those who suffer with behavior disorders either have no funds or are funded by Medicaid. This intensifies barriers to accessing care due to the paucity of IOP/providers and also because many have no transportation. This proposed IOP’s location is on a public transportation transit line and serves all payor types.

Target population: The target population includes persons with behavior health issues who need more than routine outpatient visits. They are emotionally unstable, often unfunded or publicly funded, and their behavioral health/medical conditions are so tenuous they cannot remain functional without the structure of a hospital. There is a high rate of those who go to jail when they are disruptive or dangerous to self or others. Fifty percent of these patients will be indigent or funded by Medicaid. This IOP will serve all payor types, is close to public transportation, and will provide intensive outpatient counseling and interventions that will prevent inappropriate use of jail and hospitals. This program will open in DY2 and serve at least 52 patients. This will increase every year (DY 3 78 clients, DY 4 98 clients, and DY 5 104 clients for a total of 332 unique clients).

Category 1 expected patient benefits: This program will provide psychological and medical support to patients currently using ED, the criminal justice system, or in-patient hospitals for care. Twenty-five percent of ED visits in Victoria County are for behavioral health issues and many of these could have been avoided with intensive support. By having these clients in the appropriate setting, they can remain as functional as their disease allows in their normal environment. Hospital and/or jail costs will be reduced.

Category 3 outcomes:
- IT-9-1 Our goal is to decrease mental health admissions/readmissions to the criminal justice system. These patients will be closely followed and supported with criminal justice encounters being reduced for those who are served by this program. We expect this program to result in a 10% reduction in criminal justice encounters in DY2, 13% in DY3, 16% in DY4, and 17% in DY5.
- IT-9-2 Our goal is to decrease ED visits for behavioral health. These patients will be closely followed and supported with hospital encounters being reduced for those who are served by this program. It is anticipated 25% of the behavioral health ED encounters in Victoria County can be avoided with the intensive outpatient program. Statistics show behavioral health patients who use ED usually have more than one visit a year and this program will save 26 ED visits in DY2, 39 in DY3, 49 DY4 and 52 in DY5 for a total of 166 ED visits DY2 through DY5. Because 37% of those presenting to ED are usually hospitalized, 62 inpatient hospitalizations will be prevented through DY5.
Project Option: 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas - Establish an Intensive Outpatient Program for Behavioral Health

Unique RHP Project Identification #: 094118902.1.1
Performing Provider/TPI: DeTar Healthcare System/0941189-02

Project Description:

DeTar Healthcare System will expand the number of community based settings where behavioral health services are delivered to underserved areas by establishing an Intensive Outpatient Program (IOP).

Currently Victoria County has no IOP services. There are individual and group therapy resources on an appointment basis but no program that follows the patient multiple times a day if needed.

In Victoria and surrounding counties, access to psychiatric care is difficult because of a shortage of psychiatrists and behavioral health programs in our county. Currently the only inpatient behavioral health program in Victoria County is operated by DeTar. This is a geriatric centered psychiatric unit; therefore age restrictions prevent accessibility to all patients needing this level of care. Even though it has been opened only a year, the demand for services is greater than the 8-beds we have dedicated to psychiatric services. We consistently have a waiting list of at least three patients necessitating expansion of this service in 2013. However, when patients leave an inpatient psychiatric hospital setting, the only transitional care option available is outpatient appointments. Often this is not enough to prevent re-hospitalizations and there is a continuum of care gap affecting those who need a transitional program.

Victoria is fortunate to have a robust Mental Health Center that provides services to all ages of people requiring behavioral health services. While they treat a broad spectrum of ages and diagnoses in multiple types of settings, there are still absences in provision of intense outpatient therapy to support those whose conditions are so tenuous that they need continual support. DeTar will partner with a Mental Health Agency (MHA) that has such well reputed services to help us develop these missing programs to serve our seven county area. Those counties include: DeWitt, Lavaca, Goliad, Refugio, Jackson, Calhoun, and Victoria.

DeTar Healthcare System is licensed for 308 beds and has stand-alone hospitals in two separate locations in Victoria, Texas. Each separate location has an Emergency Department (ED) where we witness behavioral health patients being in the wrong setting on an ongoing basis. In the base year of 2011 we had 157 ED visits where the chief complaint was related to a behavior disorder. This number represents only DeTar’s patients and is likely equaled at the other Victoria ED in town. In addition, there are hundreds of cases where patients are placed under a different type of diagnosis that has an obvious undetected behavioral health component. These ED patients (who often end up admitted or incarcerated) have no intensive outpatient option that could have maintained them at an optimal level of health and functioning.

The cost and intensity of taking care of these patients in the ED is disproportionate to other non-trauma or physiological arrest patients. The additional costs that are incurred are mostly related to intensity of staffing. We have had cases where the patients had to remain in an ED bed for days with
two security guards in addition to the nursing and medical staff supervision that they required. At least 15% of these types of patients in our ED require 1:1 care where the caregiver cannot leave the bedside because they present a danger to themselves and/or others. Our local Mental Health Center (MHC) has crisis management staff they can send for evaluation of certain classes of these patients. However, they have limits on what payer sources they can see, so there is a segment where even a skilled evaluation is impossible. If the patient does qualify the MHC will try to facilitate moving them to an appropriate inpatient setting, but this can take days because our State Hospitals do not have enough capacity and the behavioral health demand outstrips the supply. The Joint Commission recognizes this as inappropriate ED boarding and has established standards that require appropriate care and attention and improvement in patient flow. It is a struggle to meet these standards because Victoria County has such a dearth of resources. According to a Health Management Associates presentation at Texas Conference of Urban Counties (2011) the average ED cost is $986 per visit, a State Hospital bed $401 per day and a jail bed for an inmate with mental illness is $137. For those patients who end up in an acute care situation because the disorder was not detected the cost is higher – approximately $1500 per day in our own hospital. When the patient is forced to board in ED (>6 hours), the costs increase even more with provision of meals, drugs, security and professional staff, and boarding.

The under-treated behavioral health patient is as problem for our community. Because of the ED patients we treat with behavioral disorders, as well as those who come to our inpatient facility, we routinely tap the resources of our Sherriff’s Department, the Police Department, various nursing homes that have behavioral health patients they cannot manage, our County Commissioners, and our local judges. Too often the only answer to the presenting problems is the wrong setting – ED, incarceration, psychiatric hospitalization, or acute care hospitalization. By having an additional IOP service where behavioral health can be better maintained, the number of these expensive, wrong-setting occurrences could be reduced.

**Project Goals and Relationship to Regional Goals:**

- Increase the number of community-based settings where behavioral health services may be delivered to underserved areas by establishing an IOP treatment center that is accessible to the public and operates during the hours that accommodate this population.
- Recruit professional staffing for this service including one or more psychiatrists, professional counselors, and support staff.
- Recruit one medical doctor with mid-level coverage to serve this program because national statistics demonstrate > 68% of adults with a mental disorder has at least one medical condition
- Reduce inappropriate ED use by behavioral health/substance abuse patients.
- Reduce inpatient psychiatric hospitalizations.
- Reduce incarceration events.

This project supports the regional goals by increasing access to primary and specialty care services, with a focus on individuals with chronic behavioral health conditions to ensure they have access to the most appropriate care for their condition. It also provides improved access and timely utilization of appropriate care including behavioral health services at the right time and in the right setting.
Challenges

- Alignment with community partners for IOP establishment and operations.
- Recruitment of physicians, especially psychiatrist(s) because of known shortage of this specialty interested in a rural Texas area.
- Implement/Development of case management and follow-up programs for patients who need continual monitoring to meet appointments, community resources for support, and care coordination for both behavioral health and physical health conditions.
- Costs.

As the Performing Provider we will overcome these challenges by partnering with an established MHA that has proven success with care of the behavioral health patient on an outpatient basis. As the experts with outpatient care and interventions that prevent decompensation, this partnership would bring an invaluable body of knowledge and experience. We would also partner with the city and county law enforcement agencies to use their experience in planning for this program. In the proposed IOP, the patient would be followed as often as the treatment plan dictates - every day or more often by phone, personal contact, or through other technologies for as many hours as necessary to maintain stability and prevent inappropriate use of more expensive and restrictive settings such as ED, psychiatric or acute hospital, or jail. Research shows 19% of behavioral health patients will be jailed due to their mental illness. The patient will receive appropriate therapy individually and in group, life skills, coping mechanisms, and other interventions as dictated by the treatment plan.

DeTar employs a physician recruiter who will achieve physician and professional staff recruitment. We have broad experience in case management and care coordination. All these experiences will be brought together to meet the goals of this program. Because of our knowledge and experience with health conditions of people of all ages, we would develop triage programs to identify underlying medical conditions on these patients, as well as identifying underlying behavioral health comorbidity on patients in the high-risk categories.

5 Year Expected Outcome:
The expected outcome is to have a community partner and plan for operation in the second Quarter of DY2. The process milestone is project planning – engage stakeholders, identify capacity and needed resources determine timeliness and document implementation plans. The second process milestone will be recruitment and hiring of staff prior to opening service. Improvement measures for DY3, DY4, and DY5 will be a decrease in mental health admissions and readmissions to jail. The second measure will involve appropriate utilization of ED.

Starting Point/Baseline:
- In DY1 there is no intensive outpatient treatment program available for behavioral health patients in DeWitt, Lavaca, Goliad, Refugio, Jackson, Calhoun, or Victoria counties. The baseline is 0 and the goal is to have 1 clinic established by the end of the first quarter DY 2.
- There is a shortage of psychiatrists in this area. The GMENAC Model of physician need based on a conservative level of 180 Physicians/100,000 Population estimates psychiatrist demand for our service area to be 19.7. There are currently three psychiatrists in Victoria and none do hospital practice.
Rationale:
This project was selected because Victoria County has a gap in behavioral health services that provides intensive outpatient care targeted to prevent inappropriate use of jail, ED and inpatient services. The Victoria emergency rooms are seeing 315 patients annually with chief complaints clearly identified as behavioral health. In addition, there are many patients where behavioral health diagnosis is not made, but these symptoms emerge when patients are admitted through ED for acute care services related to the high risk disorders.

Multiple Victoria agencies work together to try to assist this population. DeTar works daily with local law enforcement, the judges, nursing homes, physicians, justices of the peace, and families trying to find a suitable program to provide treatment. Research has shown that alternatives to ED, incarceration and acute inpatient stays are needed due to set-backs experienced by the behavioral health patient, congestion in ED, over-utilization of State and private hospital psychiatric beds, and the high costs involved. This is near crisis throughout the United States. This type of program will provide a lower cost, effective program to manage the behavioral health patient.

Milestones & Metrics:
The following milestones and metrics have been chosen for the Intensive Outpatient Program for Behavioral Health project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-4 (P-4.1); P-6 (P-6.1)
- Improvement Milestones and Metrics:

Unique community need identification number the project addresses:

- CN.4 - Inadequate access to behavioral health services
- CN.6 - High rates of inappropriate emergency department utilization
- CN.7 - High rates of preventable hospital admissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will expand the number of community based settings where behavioral health services are delivered by establishing and Intensive Outpatient Program. This program will provide additional services to prevent inappropriate use of jail, emergency department and inpatient services.

Related Category 3 Measures:
IT-9-1  Decrease in mental health admissions/readmissions to criminal justice settings such as jails

a) Numerator: Number of individuals receiving project intervention who had a potentially preventable admission/readmission to the criminal justice system.
b) Denominator: Number of individuals receiving project intervention.
c) Data Source: Medical Records, criminal justice records
d) Rationale: These types of encounters are disruptive to the client and inhibit recovery and stabilization of behavioral health disorders. Often there will be repeat events and the general health of these patients is poor. Reductions can help improve health of the clients and decrease taxpayer costs.
IT-9-2 ED appropriate utilization – Reduce Emergency Department visits for behavioral health
a) Numerator: Number of individuals receiving project intervention who had an ED visit for behavioral health
b) Denominator: The number of individuals receiving project interventions.
c) Data Source: Claims, hospital records
d) Rationale: An IOP will bring an innovative approach to keeping the behavioral health client at a level of functioning that will reduce inappropriate encounters in ED, jail, and inpatient care. By combining behavioral health, medical care, case management, and intensive monitoring for compliance program, the incidence of wrong-setting encounters will decrease.

These outcome measurements were selected because they promote additional settings for care, bring difficult-to-recruit psychiatrists and other professional resources to treat these patients, and promote right care in the right setting. Costs should be reduced by keeping these clients out of jail, ED or an inpatient hospital.

Relationship to Other Projects:
All of our projects complement each other in providing enhanced and increased access to services for our targeted population. Increasing the number of clinics supports our community needs across projects to include additional capacity for providing prenatal/postnatal care, chronic disease management and behavioral health outpatient care for our targeted population. This project will coordinate with other projects in our region designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1

Relationship to Other Performing Providers Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects who will be sharing ideas through the learning collaborative include Coastal Plains Community Center, Corpus Christi Medical Center, Gulf Bend Center, and CHRISTUS Spohn.

Project Valuation:
This project will enhance access to care and provide a more appropriate, less expensive approach to care. Health Management Associates report reflects that an ED visit costs averages $986 per visit. If a patient has a potentially avoidable admission to the State Hospital it is $401 per day and for an inpatient private hospital $927 a day. The cost of jail is equally prohibitive. Taxpayers pay $177 a day for the behavioral health client who is incarcerated but only $45 a day for the general inmate. It is also proven the behavioral health inmate stays longer than the general population. The average cost of a jail stay for a person with mental illness is $10,960. (ALOS=62 days)
Currently Victoria Hospitals receive about 315 patients a year in ED and it is estimated at least 25% of those could be avoided with the appropriate support. This program will also address those with concomitant physical disorders. Research shows nearly a quarter of adults have a diagnosable behavioral health condition and two-thirds of Medicaid patients with the top five physical illnesses (asthma, COPD, CHF, CAD, Diabetes, and hypertension) also have at least one behavioral health co-morbidity. These are often undetected and patients end up in acute care inappropriately. (Advisory Board, 2012). We believe these hospitalizations would also be reduced. The average cost per stay is $6,280.00. If this is projected out to the other hospitals in our county at least 150 hospitalizations for the high risk medical conditions could be avoided. Based on volumes in the IOP, there will be 10 fewer admissions in DY2, 15 in DY3, 18 in DY4 and 19 in DY5. Finally THCIC data shows 1266 patients in this service area received inpatient care for mental health diseases in 2011 (Q3 data annualized). Based on information from the Agency for Healthcare Research and Quality (AHRQ), 37% of patients discharged from a psychiatric unit will require readmission within one year. According to a study published in the American Journal of Psychiatry, patients who received intensive outpatient treatment for a large cross-section of mental illnesses experienced a reduction of 57% in their rate of admission and readmission to inpatient mental health facilities. Using statistics quoted in the Texas Department of State Health Services report “Another look at mental illness and criminal justice involvement in Texas: Correlates and costs,” 19% of patients enrolled in the IOP will have had a criminal background. After participation in the IOP the recidivism rate is 13%. Thus of the 332 unique patients this program will serve through DY5 there is opportunity to decrease jail encounters, ED stays, psychiatric hospitalizations, and acute care hospitalizations for disease processes that often accompany a behavior disorder.
**Enhance service availability of appropriate levels of behavioral health care - Intensive Outpatient Program for Behavioral Health**

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<thead>
<tr>
<th>DETAR HEALTHCARE SYSTEM</th>
<th>VICTORIA, TEXAS</th>
<th>094118902</th>
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<tbody>
<tr>
<td><strong>Related Category 3</strong></td>
<td>094118902.1.1</td>
<td>IT-9.1</td>
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<td><strong>Outcome Measure(s):</strong></td>
<td>094118902.3.1</td>
<td>IT-9.2</td>
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**094118902.1.1**

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<th>Year 2</th>
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**Milestone 1** P-6 Establish behavioral health services in new community-based settings in underserved areas - Enhance service availability to appropriate level of behavioral health care through establishment of an Intensive outpatient Program for Behavioral Health patients.

**Metric 1 P-6.1** Preparation complete by determining regulations, building program plan, securing location and developing physical plant. Number of new community-based settings where behavioral health services are delivered. Number of patients served.

**Baseline/Goal:** Goal is to have one IOP established in 2013. We will serve 52 patients in DY2.

**Data Source:** Performing Provider evidence of innovational plan.

**Milestone 1 Estimated Incentive Payment:** $740,769

**Milestone 2** P-4: Contract with and train staff to operate and manage projects selected

**Metric 1 [P-4.1]:** Contract with or contract

**Milestone 3** P-6 Establish behavioral health services in new community-based settings in underserved areas

**Metric 1 P-6.1:** Number of new community-based settings where behavioral health services are delivered

**Baseline/Goal:** Baseline is 52 patients in the established IOP. Goal is 78

**Data Source:** Provider Records

**Milestone 3 Estimated Incentive Payment:** $553,969

<table>
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<tr>
<th>Milestone 3 P-6</th>
<th>Milestone 4 P-6</th>
<th>Milestone 6 P-6</th>
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<td>Establish behavioral health services in new community-based settings in underserved areas</td>
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<td>Goal: Continue operation of IOP program that is fully-staffed with increased enrollment.</td>
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<td>Baseline/Goal: 78 clients</td>
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<td>Baseline/Goal: 104 clients</td>
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<td><strong>Data Source:</strong> Provider records</td>
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<td><strong>Estimated Incentive Payment:</strong> $281,094</td>
<td><strong>Estimated Incentive Payment:</strong> $285,327</td>
<td><strong>Estimated Incentive Payment:</strong> $285,327</td>
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**Improvement Milestone 1 I-11:** Increased utilization of community behavioral health care.

**Metric 1 I-11.1:** Percent utilization of community behavioral health care services.

**Goal:** Increase services by 5%

**Data Source:** Claims and encounter data from community behavioral health sites

**Improvement Milestone Incentive Payment:** $281,094

**Improvement Milestone 2 I-11**

Increased utilization of community behavioral health care.

**Metric 1 I-11.1:** Percent utilization of community behavioral health care services.

**Goal:** Increase services by 10%

**Data Source:** Claims and encounter data from community behavioral health sites

**Improvement Milestone Incentive Payment:** $285,327
| 094118902.1.1 | 1.12 | 1.12.2 | **Enhance Service Availability of Appropriate Levels of Behavioral Health Care - Intensive Outpatient Program for Behavioral Health** |
| DETAR HEALTHCARE SYSTEM  | VICTORIA, TEXAS | 094118902 |
| **Related Category 3** | **Outcome Measure(s):** | **Enhance Service Availability of Appropriate Levels of Behavioral Health Care - Intensive Outpatient Program for Behavioral Health** |
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**Performing Provider/TPI:** DeTar Healthcare System/094118902  
**Title:** 1.2.3 – Increase the number of residency/training programs for faculty/staff to support an expanded, more updated program: Establishing a Family Practice Residency Program in South Texas

**Unique RHP Project Identification Number:** 094118902.1.3 (Pass 3b) (094118902.1.2)

- **Provider:** DeTar Healthcare System is a 308-bed two-hospital system in Victoria, Texas that serves Victoria and surrounding counties. We serve a 5,200 square mile area and a population of approximately 164,467.
- **Intervention(s):** This project will implement a family practice residency program in Victoria, Texas. These residents and faculty will help fill an existing shortage with clinical rotation requirements. DeTar’s service area has been designated by the Health Resources and Services Administration as having a medically underserved population. In particular, there is a great need for additional primary care physicians in the area. DeTar intends to establish this residency program, which should add six primary care residents per year and three additional faculty positions to serve DeTar’s medically underserved population. Further, the resident selection process and rural-focused curriculum is designed to encourage graduates to remain in medically underserved areas and to accept Medicaid patients.

Texas A&M Health Sciences Center (TAMHSC) has the expertise and the resources necessary to help DeTar establish a robust primary care residency program. Consequently, DeTar intends to engage TAMHSC to provide certain services, including but not limited to the following:

- Conducting a market analysis
- Conducting a gap analysis to justify the need for the number of residents
- Securing accreditation for the Residency Program
- Recruiting a program director
- Recruiting faculty and adjunct faculty members in various specialties
- Recruiting residents
- Providing program consulting and oversight

DeTar will pay TAMHSC fair market value for these services, which are crucial to DeTar’s effort to establish this program.

- **Need for the project:** Victoria and its surrounding counties have been cited as Medicaid underserved areas by HRSA. We have 2500 admissions to our Hospitalists every year and more than half of these are not aligned with a physician. Follow-up care often cannot be found because of patient’s impoverished status. There are a limited number of physicians in this area that will accept a self-pay or Medicaid patients.

- **Target population:** The target population includes patients with no primary care doctor who need medical providers, and those with chronic diseases that need to be managed. Through October of this year our inpatient Medicaid and Self Pay population is 27.15% of our total inpatient volume and 39.3% of our total outpatient volume. Approximately 50% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from about half of the consults.

- **Category 1 expected patient benefits:** The project seeks to provide 4,000 patient visits in DY4 and 14,000 visits in DY5. This will prevent 300 ED visits in DY4 as well as 15 potentially
preventable admissions. In DY5 it will prevent 1,400 ED visits and 62 potentially preventable admissions.

- **Category 3 outcomes:**
  - **IT-14.6** Our goal is to have one of the six residents who enter this residency program the first year (DY4) have a history of living at least 5-years in an HPSA or MUA. In DY5 this will increased to at least two who are accepted for the next class.
  - **IT-14.7** Our goal is to have one resident who entered in DY4 respond to a systematic survey that they plan to practice in an HPSA or MUA. In the second accepted group of residents entering in DY5, our goal is to have at least two who will plan to practice in an HPSA or MUA.
  - **IT-14.8** Our goal is to have one resident who entered in DY4 respond to a systematic survey that they plan to accept Medicaid patients into their practice. In the second accepted group of residents entering in DY5, our goal is to have at least two who will plan to treat Medicaid patients.
Project Option 1.2.3 – Increase the number of residency/training programs for faculty/staff to support an expanded, more updated program: Establishing a Family Practice Residency Program in South Texas

Unique RHP Project Identification Number: 094118902.1.3 (Pass 3b) (094118902.1.2)
Performing Provider/TPI: DeTar Healthcare System/094118902

Project Description:
The proposed project will establish an ACGME-accredited Family Medicine Residency Program affiliated with the DeTar Healthcare System Victoria and supported by the Texas A&M Health Science Center College of Medicine.

Victoria County Texas, as well as all of its surrounding counties, has been designated by Health Resources and Services Administration (HRSA) as a Medicaid underserved population. Because of the limited access to care by impoverished patients in this area, their care is more costly due to preventable use of Emergency Departments (ED) and potentially preventable inpatient hospitalizations. Without continuity of care by a primary care provider, especially for those with chronic conditions, the patients are not monitored on an on-going basis and their health conditions worsen. To address this lack of access to care, DeTar Healthcare System will establish a Family Medicine Residency program affiliated with Texas A&M Health Science Center College of Medicine (TAMHSC) that will add 6 residents per year and an additional three faculty positions to this Medicaid underserved area. Furthermore, the selection process for residency candidates and a curriculum with a rural focus will facilitate having graduates who are most likely to stay in an underserved area and accept Medicaid patients.

DeTar Healthcare System is a 308-bed, acute care facility in Victoria, Texas that has two separate acute care hospitals and multiple clinics that will support a residency program. We have two Emergency Departments that serve over 37,000 patients annually. Patients are transferred to our Emergency Departments from a 90-mile radius of Victoria, and an average of 11% of the ED patients required admission this past 12-months. Of these admissions almost 5%, or 9244, of them were Medicaid beneficiaries. DeTar Healthcare System delivers the majority of babies in Victoria, with an average of 1,350 deliveries per year. Residents will be supported by our entire staff of primary care physicians, obstetricians, surgeons, specialists, and hospitalists. The hospitalists routinely have 35 to 55 patients on service daily, many diagnosed with complex medical conditions that are not aligned with a primary care provider.

DeTar Healthcare System has a Maternity Clinic, a Senior Care Center and a Family Practice Clinic. Other 1115 projects we have submitted will enable us to have chronic care management clinics and prenatal clinics in four surrounding counties. A Family Practice residency program in Victoria will help increase the number of primary care physicians in this area. We are located in rural Texas where physicians are more difficult to recruit. Several counties in RHP 4 have a shortage of primary care physicians with Jackson County needing two, and Refugio, Bee, Goliad, Karnes, and Gonzales counties all needing one. (Health Access for Texas 2012). This shortage will intensify because of our aging physician workforce, expansion of insurance coverage under the new health care law that will extend coverage to more than 300,000 people by 2014, and growth and aging of the population. The average age of the family practitioners with privileges at DeTar (31 doctors) is

RHP Plan for Region 4
54.84 years. The Association of American Medical Colleges estimates that in 2015 the country will have 62,900 fewer doctors than needed, and it is predicted that this will double by 2025.

The majority of patients admitted to the hospitalist program at DeTar are not aligned with a physician. These patients use ED as their vehicle for fragmented primary medical care. Over 50% of them have chronic illnesses that need to be managed—primarily diabetes, heart failure, CAD, kidney failure, and chronic respiratory illness such as COPD. Often on Medicaid or not insured, they cannot access primary care because of the shortage of doctors that accept these patients. In Victoria County, almost 17% of the population lives below the poverty level. Upon discharge, follow-up care—especially for those with limited resources—often cannot be found. Because there are few outpatient resources with very limited appointment ability, these chronic conditions are not being managed.

**Goals and Relationship to Regional Goals:**

**Project goals:** Over the course of the remaining four years of the 1115 Medicaid Transformation Waiver program, this project aims to achieve six overarching goals:

1. To establish a family practice residency program that attracts students to be trained and continue to practice in the underserved areas and populations of the South Texas area;
2. To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
3. To transition DeTar to be a primary teaching hospital in South Texas;
4. To create a continuity clinic for the residency program to focus on transitions of care and reduce potentially unnecessary emergency department visits and/or readmissions;
5. To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
6. To collaborate with other new and expanding residency training programs in the region to transform the healthcare delivery system of the South Texas region.

The primary goal of this project is to establish a new Primary Care Residency Training Program at DeTar Healthcare System in partnership with Texas A&M Health Science Center College of Medicine.

**This project meets the following Region 4 goals:**

- Improve infrastructure to ensure the health care delivery system will be adequately developed to meet the primary needs of residents throughout a growing, yet historically, underserved region.
- Increase access to primary services in the short-term with focus on individuals with chronic conditions to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.

As a new site for family practice residents, with a training component that prepares him/her for practice in rural underserved areas, this project addresses these RHP 4 goals. The residents will be in clinics where patients are treated regardless of funding. By DY 4 and DY5 both faculty and residents will be managing the ongoing care of patients.

**Challenges:**

Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). Each specialty-specific Residency Review Committee (RRC) of the ACGME meets to review proposals only twice each year. Residency programs must be either near-approval or approved before the programs can begin to recruit fourth-
year medical students. Establishing and achieving program development milestones is critical. It will be a challenge to meet the established time frame.

As the Performing Provider, we will partner with Texas A&M Health Science Center College of Medicine to develop this proposed program. TAMHSC will provide the Program Director for the Family Medicine Residency Program. TAMHSC faculty and staff have experience navigating through the extensive ACGME accreditation process. DeTar and TAMHSC will work together collaboratively to establish an innovative curriculum to address the unique healthcare needs of RHP 4 and to design a healthcare delivery model that helps to improve the quality of care provided to the citizens of the South Texas.

5-year Expected Outcome for Provider and Patients:
DeTar Healthcare System expects to see increased access to care for patients who currently are unable to consistently receive primary care through the establishment of a Family Practice Residency program. In DY-2 DeTar will conduct a primary care gap analysis to determine the workforce needs and recruit a Residency Program Director. Academic faculty, recruited for their advanced practice ability and their academic achievements, will begin laying the foundation for the residency program in DY2. The required work to complete application for ACGME will be addressed so that accreditation can be sought in DY3. Serving as the academic primary care foundation for the region’s newest academic medical center, the family medicine residency will enroll its first class of residents in 2015 (DY4). This initial class of residents will complete the training program and enter independent practice in the South Texas region in 2018. The residency Program Director will dedicate approximately 50% of his/her time to clinical care, while directing their remaining time towards program administration and/or academic research. Primary care capacity and patients’ access to primary care will increase as the program matures to a full complement of both faculty and residents.

Starting Point/Baseline:
Currently a Family Practice residency program does not exist in Victoria or surrounding counties. Therefore, the baseline number for both the total of residents and patients for which care is provided by family medicine residents is zero.

Rationale:
The shortage of primary care workforce personnel is a critical problem that we have the opportunity to address through this waiver program. Expanding the primary care workforce will improve access to healthcare through innovative care delivery models such as those found within structured patient-centered medical homes, providing an organized, coordinated structure of primary care physicians, allied health providers, and staff. Residency training programs expand the capabilities of primary care teams by fostering an environment of learning and through the promotion of team-based care. These teams often focus on systems of healthcare practice, maximizing their return on investment by improving the health of the populations they serve, not just individual patients. In summary, the goal for this project is to train the region’s newest healthcare workforce members, helping to address the substantial primary care workforce shortage experienced in this area.

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 populations with a state ranking of 46 and 47, respectively (comparable ratios for US are 219.5 and 90.5). According to Health Access for Texas, 10 of the 18 counties (44%) in RHP4 are full Health Provider Shortage Areas (HPSA). This correlates with the 2012 county health rankings
published by countyhealthrankings.org/texas that reflect 11 of these counties to have less-than-optimal health outcomes. Only 7 of the 18 counties in RHP 4 are in the top 100 counties for good health outcomes.

**Project Components:**
There are no required project components for this project option.

**Milestones and Metrics:**
The following milestones and metrics have been chosen for the Family Practice Residency project:

- Process Milestones and Metrics: P-1 Conduct primary gap analysis to determine (P-1.1 Gap assessment of workforce shortages); P-2 Expand primary care training for primary care providers including physicians (P-2.1 Expand the primary care residency training program and/or rotation; P-2.2 Hire additional precepting primary care faculty members)
- Improvement Milestones and Metrics: I-11 Increase primary care training and/or rotations (I-11.2 Increase the number of primary care trainees rotating at the Performing Provider’s facilities)

**Unique community need identification number the project addresses:**
- CN.1 – Inadequate access to primary care
- CN.10 – Shortage of primary care physicians
- CN.15 – Inadequate health care access in rural areas

**How the project represents a new initiative or significantly enhances an existing system reform initiative:**
This project will expand the number of primary care training sites for primary care providers. Six residents per year will be trained, for a total of 18 residents at program maturity. These residents will be instrumental in providing care to patients with chronic illness who currently do not have consistent access due to their rural geographical location and/or financial status. Because this program will focus on residents who have interest in practicing in an HPSA/MUA and taking Medicaid patients, it will address the growing shortage of physicians who provide care to this population.

**Related Category 3 Outcome Measure(s):**
OD-14 Outcomes for Workforce Projects:
- IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)
- IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
- IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

**Reasons/rationale for selecting the outcome measures:**
The American Academy of Family Practice (AAFP) recognizes the shortage of family doctors in rural areas and researched methods of encouraging family doctors to practice in these settings. They cite the background of the resident as most important – if the resident lived in a rural area, an underserved area, he/she is more likely to locate in a like area than those with urban backgrounds.
The AAFP supports rural medical school training programs that encourage the physician to choose a rural practice. Their data show practitioners with this background are more likely to stay in a rural practice for a longer period of time. The fact that the residents will train in a rural area is also a factor in a physician choosing this type of practice. Studies show residents felt better prepared, both medically and socially, for practice in a rural area than those unaware of the special characteristics of a rural practice. Those who felt prepared for small-town living were over twice as likely as others to remain in a rural area for at least 6-years. Rural physicians have a broader scope of practice and will need special training in emergencies, obstetrical, and surgical care to feel confident in their abilities to practice in these areas. DeTar has the opportunity to provide the residents these experiences in our smaller community that offers a variety of services. Primary care doctors are 73% more likely to reject Medicaid patients relative to the privately insured (Forbes 2011). This training program will give experience in rural medicine and residents will establish relationships with Medicaid and other payer types in their continuity experiences. The program will provide encouragement to residents to choose a practice in an HPSA/ MUA and accept Medicaid patients.

**Relationship to other projects:** This project relates to other projects submitted by DeTar of redesigning an outpatient delivery system to coordinate care for patients with chronic diseases (094118902.2.1) and implementing a strategy to reduce low birth weight and preterm births (094118902.2.2). Family Practice residency requires each resident provide these types of care. Residents will use clinics in DeTar’s related projects to advance their knowledge and experience. This project also complements projects by other performing providers in our region designed to increase primary care capacity including: 137907508.1.1, 094222902.1.1, 02811801.1.3, 020973601.1.1, 121775403.1.1, 132812205.1.1, 130958505.1.1, 112673204.1.1.

**Relationship to other Performing Providers’ Projects in the RHP:** We plan to participate with other Performing Providers within the region that have similar projects that will facilitate sharing of challenges and testing new ideas/solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**
The value of this project centers on the community needs in RHP 4 for primary care physicians, especially for those who will accept the more impoverished patient. By having additional care givers for those with chronic illnesses, there will be improved management of diseases prevalent in this area - primarily diabetes, heart failure, cardiac illnesses, and respiratory disease. By DY4 and DY5 both faculty physicians and residents will see these chronic patients for outpatient disease management. These doctors will treat patients of all ages with a variety of needs. CDC reported in 2012 that ED usage is most common for those with public health insurance who live outside a metropolitan area.
One of the main reasons cited is lack of care from a provider. This is the situation in our area where physicians who accept Medicaid patients are limited. Thus 4.5% of our ED admissions this past 12-months have been Medicaid patients. An ED visit costs $383 while the national average doctor’s office visit is approximately $60. (Blue Cross 2012). In the past 12 months DeTar had 9,244 Medicaid funded patients in our ED and 412 of these had to be hospitalized. An average hospitalization charge is $10,388.70 (DHSH).

In this valuation, the variance in an ED/office visit is $223 for DY4, which is the year residents will enter our program (starting in July). Care in DY4 will be provided predominantly by the Program Director and faculty staff (1 FTE combined). They will provide 4,000 patient visits, and 25% of these will be Medicaid funded. This will prevent 300 Medicaid-funded ED visits that will be seen in the clinics for a $223 savings each ($66,900). With monitoring by primary care doctors it will also save 15 admissions valued at $10,388.70 ($155,831). Costs will inflate 3% for an ED/Hospitalization visit in DY5. Another faculty will be added; in addition, the six residents will have clinic rotations one-third of their time. This increases primary care providers to 3.5, and these faculty/residents will create 14,000 clinic visits. Using the same ratio, 1,400 ED encounters by Medicaid recipients will be eliminated ($322,100) and 62 admissions per year ($663,400) will be prevented. These numbers will continue to grow in subsequent years by increasing residents and faculty one more year and then by retaining graduates who will practice in this area because they meet the outcome measurements of coming from a rural background, staying in an HPSA or MUA, and taking Medicaid patients. This will perpetuate greater access to care for patients of all payor types.

This project valuation also relates to the cost of establishing a program. This includes staffing of a full time program director, program coordinator, and faculty at the rate of one doctor for every six students. In addition a family practice medicine clinic will have to be developed with cost of building remodeling, equipment, staffing for clinic, EHR, classrooms and consultation space for the practicing residents. A draft budget assumes all costs required to operate a family medicine clinic will be covered by clinical income and are not included in the estimated budget for operations of this program. The initial start-up costs of recruitment, building out, staffing, and implementing a residency program will be $1,312,000 for the first year with major expense being building and physician recruitment. Adding additional faculty will be required both in DY3 and DY5 as the program matures. The cost for implementing and growing this service over the four years has been estimated at $5,640,000.
### DETAR HEALTHCARE SYSTEM

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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Increase number of residency/training programs for faculty/staff to support an expanded, more updated program</th>
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| 094118902.1.3 (094118902.1.2)         | 1.2.3  
| 1.2.3(n/a)                            | IT-14.6  
|                                      | IT-14.7  
|                                      | IT-14.8  

### Year 2 (10/1/2012 – 9/30/2013)

- **Milestone 1**: P-1: Conduct a primary care gap analysis to determine workforce needs
- **Metric 1**: P-1.1: Gap Assessment of workforce shortages
  - **Baseline/Goal**: Completed assessment
  - **Data Source**: Assessment results
- **Milestone 1 Estimated Incentive Payment**: $656,000

- **Milestone 2**: P-2: Expand primary care training
  - **Metric 1**: P-2.2: Hire additional precepting primary care faculty members (Residency Program Director)
  - **Baseline/Goal**: 0 / 1
  - **Data Source**: HR documents
- **Milestone 2 Estimated Incentive Payment**: $656,000

### Year 3 (10/1/2013 – 9/30/2014)

- **Milestone 3**: P-2 : Expand primary care training
  - **Metric 1**: P-2.1: Expand the primary care residency training programs and/or rotations
  - **Baseline/Goal**: 0 Training Programs/Goal is 1
  - **Data Source**: Completed Application for ACGME and agreement for the program with A&M.
  - **Metric 2**: P-2.2: Hire additional precepting primary care faculty.
  - **Baseline/Goal**: Baseline is 1 program director Goal is additional 1 primary care faculty.
  - **Data Source**: Faculty List
- **Milestone 3 Estimated Incentive Payment**: $1,060,000

### Year 4 (10/1/2014 – 9/30/2015)

- **Milestone 4**: I-11 Increase primary care training and/or rotations
  - **Metric 1**: I-11.2: Increase the number of primary care residents rotating at the Performing Provider’s facilities.
  - **Baseline/Goal**: 0 / 6 residents doing rotation in family practice
  - **Data Source**: Program enrollment records
- **Milestone 4 Estimated Incentive Payment**: $603,000

### Year 5 (10/1/2015 – 9/30/2016)

- **Milestone 5**: I-X Increase primary care volume of visits
  - **Metric 1**: I-X.1 Documentation of increased number of visits
  - **Baseline/Goal**: 0/4,000 patient visits
  - **Data source**: Registry, EHR, claims data
- **Milestone 5 estimated incentive payment**: $603,000

- **Milestone 6**: I-11 Increase primary care training /rotations.
  - **Metric 1**: I-11.2 Increase the number of primary care residents rotating at the Performing Provider’s facilities.
  - **Baseline/Goal**: Baseline is 6 residents doing rotation; Goal is increase to 12.
  - **Data Source**: Program enrollment records.
- **Milestone 6 Estimated Incentive Payment**: $687,334

- **Milestone 7**: P-2 Expand primary care training for primary care providers
  - **Metric 1**: P-2.2 Hire additional precepting primary care faculty.
  - **Baseline/Goal**: Baseline 2; Goal 3
  - **Data Source**: Faculty List
- **Milestone 7 Estimated Incentive Payment**: $687,333

- **Milestone 8**: I-X Increase primary care
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<th><strong>Year 5</strong></th>
<th><strong>(10/1/2015 – 9/30/2016)</strong></th>
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</table>
| **Baseline/Goal:** | | | | | | | | $14,000
| **Data source:** | Registry, EHR, claims data | | | | | | | $687,333
| **Metric 1:** | I-X.1 Documentation of increased number of visits | | | | | | | $1,312,000
| **Volume of visits:** | | | | | | | | $1,060,000
| **Year 2 Estimated Milestone Bundle Amount:** | (add incentive payments amounts from each milestone): | **Year 3 Estimated Milestone Bundle Amount:** | $1,060,000 | **Year 4 Estimated Milestone Bundle Amount:** | $1,206,000 | **Year 5 Estimated Milestone Bundle Amount:** | $2,062,000 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** | $5,640,000 | | | | | | |
Project 1.1: Expand Primary Care Capacity
Project Option 1.1.2: Expand Existing Primary Care Capacity, Freer, TX
CHRISTUS Spohn Hospital Alice/094222902
Unique Identifier - 094222902.1.1

- **Provider:** CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s):** This project will increase the space, hours, and staffing of Spohn Alice’s primary care clinic currently located in Freer, TX in Duval County. Expansion of this Family Health Center (FHC) is necessary to serve additional patients, improve timely access to care, and to increase patients’ use of primary and preventative care instead of inappropriate use of the Emergency Department.

- **Need for the project:** Freer, TX is located in Duval County, approximately midway between Alice, TX and Laredo, TX (which are the locations of the closest acute care hospitals). Although Freer has a relatively small total population of just over 3000, it contributed to more than 1100 ED visits registered in the Spohn Alice ED. This town is 80% Hispanic in a county that is 88% Hispanic, with 25% of the county living below poverty level and at high risk for diabetes, vascular and heart disease and other chronic illnesses.

- **Target population:** The target population are residents of Duval, Brooks, Live Oak and McMullen County who are uninsured and require primary care services. The uninsured rates for these counties are as follows; Duval = 26%, Brooks = 27% (33% below poverty level; Live Oak = 29% (21% below poverty level) and McMullen = 27% (13% below poverty level). The Freer FHC averages an estimated 1,250 patients per year (approximately 33% of whom are Medicaid-eligible or uninsured, totaling 411 patients), providing an approximate 4,362 encounters annually (33% of which are Medicaid-eligible or uninsured, totaling 1,424 visits) with a 200 visit increase per year for the last 3 years. With 7,000 uninsured residents across the 4 counties who would be eligible to receive care at the FHC, there is ample need for expanded care, and the project will target providing existing patients with easier access to care and allowing for additional patients to access care.

- **Category 1 or 2 expected patient benefits:** The project seeks to increase the capacity for treating patients in the Freer FHC, reflected by a 10% increase in patient volume by DY5 (an expected increased patient population of 41 patients with an additional 142 encounters.

- **Category 3 outcomes:** IT-9.2 - Our goal is a 10% reduction in all (non-urgent/non-emergent) ED visits by the end of DY4, and a 15% reduction in all (non-urgent/non-emergent) ED visits by the end of DY5.
Expand Primary Care Clinic in Freer, TX for Duval and surrounding counties

Category 1: Infrastructure Development

Identifying Project and Provider Information:
Expand Primary Care Clinic Services, Hours and Staffing; 1.1.2
CHRISTUS Spohn Alice Hospital ("CSAH")/TPI 094222902
Unique Project ID Number: 094222902.1.1

Project Description:
Spohn will expand the capacity in its clinic ("Family Health Clinic" or "FHC") currently located in Freer, TX, which is about 30 miles from Spohn Hospital - Alice. The expansion is intended to increase access to primary care for residents in Duval and surrounding counties by increasing the hours, staffing, and space available for treating patients at the clinic.

Project Goals/5 Year Expected Outcome: The goal of this project is to improve access to primary care in a rural area of Region 4. Delivery system transformation must include expanding care to areas that are traditionally underserved, allowing for improved patient outcomes and satisfaction, and reduced cost of providing care by preventing manageable conditions from reaching an acute stage requiring hospitalization.

The specific goals of this project are:
- To add at least one (1) additional nurse practitioner ("NP") to the staff of the Freer clinic and one additional support staff
- To provide care every other Saturday for at least six (6) hours
- To relocate to a larger space, wherein the clinic will have at least one additional exam room
- To achieve a 10% increase in the Freer clinic volume by end of DY5 (estimated 142 additional visits).

Project challenges:
- Recruiting a qualified NP who is willing to provide care in a rural area and treat Medicaid and uninsured patients
- Identifying new space in which to relocate
- Educating providers on the value of providing Saturday hours
- Educating patients about the increased capacity of the clinic

Spohn will address these challenges by offering competitive incentives to the NP and working with the existing Freer providers to implement the project in the least disruptive manner.

Starting Point/Baseline:
Currently, clinic services are provided by 1 Family Nurse Practitioner and 1 clinic support staff member. These providers are maxed out on patient load and hours, eliminating the possibility of increasing access through the current operations. The Freer Clinic averages 4,362 visits per year, with a 200 visit increase per year for the last 3 years. By DY5 Spohn expects increased patient population of 41 patients with an additional 142 encounters. Review of Spohn ED and Admission data reveals a high prevalence for ED visits and hospital admissions at CSAH from the zip codes identified in the Freer area.
Rationale:
Documented ED visits for non-urgent/non-emergent primary care diagnoses have been identified from the zip codes associated with Freer and Duval County. Clinic services were previously reduced due to low utilization. That trend has reversed and the clinic has reached capacity. Additionally, the Community Needs Assessment for Region 4 shows that Duval residents have a high rate of potentially preventable hospital admissions for the following conditions that can be managed through access to primary care: CHF, COPD, UTI, and bacterial pneumonia (RHP Plan, Section 3, Table 10). Additionally, Duval is a federally designated as a Medically Underserved Area and a Health Professional Shortage Area for primary and mental health care (RHP Plan, Section 3, Table 11). Finally, Jim Wells County, where CSAH is located, was charged $40,441,237 in 2010 for uncompensated care and experienced 28,382 ED visits (in a county with a population of 41,562) (RHP Plan, Section 3, Tables 1 & 8). The addition of 1 FNP and clinic support staff will allow Spohn to increase the Primary Care volume at the clinic and attempt to manage chronic conditions, reduce the inappropriate utilization of CSAH ED, and reduce PPAs at Spohn Alice.

Continued analysis and evaluation of clinic expansion will determine future increases in hours, staffing and services while providing continuous quality improvement to meet the needs of this community.

Unique Community Needs Identifiers: CN.1, CN.3, CN.6, CN.15

Core Components:
   a) Expand primary care clinic space: Spohn will address this component through Milestone 3 in DY3 when it identifies a new space for the Freer clinic that allows for at least one additional exam room and moves into that space
   b) Expand primary care clinic hours: Spohn will address this component through Milestone 1 in DY2 when it begins providing clinic hours for six hours every other Saturday.
   c) Expand primary care clinic staffing: Spohn will address this component through Milestone 2 in DY2 when it recruits and retains one additional NP and one additional support staff to work in the Freer clinic.

Milestones and Metrics: Spohn chose the DY2 and DY3 process milestones in order to expand capacity, and the DY4 and DY5 milestones in order to affect increases in the number of patients seen by the clinics, which are currently providing care at capacity.

Related Category 3 Outcome Measure(s):
   • IT 9.2 Right care in the Right Setting – ED appropriate utilization
     Spohn selected this outcome based on the volume of non-urgent primary care diagnoses presenting to the CSAH ED from specific zip codes in Freer and Duval County. This non-urgent volume monopolizes needed space and staff resources needed for care delivery to emergent patients presenting at CSAH, and also causes overcrowding and delays in the ED. Thus, a natural outcome of providing access to expanded primary care capacity should include a reduction in misuse of the ED.
Relationship to Other Projects:
2.12.1. Care Transitions - CSAH

Relationship to Other Performing Providers’ Projects in the RHP:
This project’s focus on expanding access to will support and enhance these Category 1 and 2 projects in our RHP: 09422902.1.3, Introduce Expand or Enhance Telemedicine/Telehealth; 0208811801.1 – Expand Primary Care Capacity; and 09422902.2.4, Expand Care Transitions program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Alice (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?\(^{11}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its direct correlation to the stated goals of the Waiver, including delivery system reform to be patient-centered, increase access to and use of primary care, and reduce the systemic cost of providing care. The residents of Duval County and the surrounding area clearly need increased access to primary care, as the Freer clinic is currently overloaded and there is rampant misuse of the ED for primary care services. The investment for this project will be steep, in that it requires the recruitment and retention of additional staff, the identification of new space and a move of the clinic, and providing additional clinic hours. However, the investment will create value for the community by improving patient long- and short-term health outcomes and reducing the cost of providing care in this area.

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\(^{11}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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<table>
<thead>
<tr>
<th>094222902.1.1</th>
<th>1.1.2</th>
<th>1.1.2 A-C</th>
<th>1.1.2 – EXPAND EXISTING PRIMARY CARE CAPACITY</th>
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<tr>
<td></td>
<td>CHRISTUS SPOHN ALICE HOSPITAL</td>
<td>094222902</td>
<td></td>
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</table>

**Related Category 3**

**Outcome Measure(s):**

- 094222902.3.1
- 094222902.1.1
- 094222902.1.2

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1]: Expand existing Primary Care Clinic services and hours

**Metric 1** [P-1.1]: Increase number of hours at primary care clinic over baseline

**Baseline/Goal:** The Freer clinic will begin providing six (6) hours of clinic open hours every other Saturday

**Data Source:** Clinic schedules, documentation of service expansion

Milestone 1 Estimated Incentive Payment (maximum amount): $134,398.50

**Milestone 2** [P-5]: Contract with additional primary care providers and staff.

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

**Baseline/Goal:** Spohn will recruit one additional NP and one additional support staff for full-time employment in the Freer clinic

**Data Source:** Staffing schedules, HR documents

**Milestone 3** [P-1]: Relocate primary care clinics

**Metric [P-1.1] Amount of expanded space**

**Baseline/goal:** Spohn will identify a new space in which to relocate the Freer clinic, which will include at least one additional exam room over the existing clinic space

**Data source:** documentation of relocation plans, lease, or other paper evidence of relocation

Milestone 3 Estimated Incentive Payment: $274,915

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

**Metric 1** [I-12.1]: Documentation of increased number of visits.

**Goal:** 5% increase in clinic volume over baseline volume in DY2 (estimated 71 additional Medicaid/self-pay patient visits)

**Data Source:** Clinic scheduler, Clinic records

Milestone 4 Estimated Incentive Payment (maximum amount): $274,489

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

**Metric 1** [I-12.1]: Documentation of increased number of visits.

**Goal:** 10% increase in clinic volume over baseline volume in DY2 (an estimated 41 additional Medicaid/self-pay patients, for a total of 142 Medicaid-eligible/self-pay visits).

**Data Source:** Clinic scheduler, Clinic records

Milestone 5 Estimated Incentive Payment (maximum amount): $221,637

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RHP Plan for Region 4
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>Milestone 2 Estimated Incentive Payment (maximum amount): $134,398.50</td>
<td>Year 3 Estimated Milestone Bundle Amount: $274,915</td>
<td>Year 4 Estimated Milestone Bundle Amount: $274,489</td>
<td>Year 5 Estimated Milestone Bundle Amount: $221,637</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $268,797</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $1,039,838
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Alice/12775403
Unique Identifier - 094222902.1.2

- **Provider:** CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s):** Spohn will implement a Chronic Disease registry to assist Spohn in tracking and managing patients with chronic conditions, and will initially focus on patients with CHF and diabetes. The chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients.

- **Need for the project:** Current documentation by the Care Transitions/Care Partners teams is handwritten paper format and Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. The registry will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams that is untenable under the current documentation system. The registry and repository will link to the EMR and provide the ability to track, trend and alert both inpatient and outpatient care providers to multiple hospitalizations and ED visits regardless of facility or location within the Spohn hospital system. Automated acquisition, storage and access to this data will enhance identification of individual patient needs to analyze and report trends in resource utilization.

- **Target population:** The target population of this project includes charity, Medicaid and self-pay patients with CHF and/or diabetes who are not currently enrolled in our Care Transitions or Care Partners programs (“target population”). Patients are identified by case managers in the acute care setting and referrals submitted to the Community Outreach department for program enrollment. Based on implementation of the original program at CHRISTUS Spohn Hospital Corpus Christi – Memorial campus and current discharge data for CHF and Diabetes at CHRISTUS Spohn Hospital Alice, the projected target population will be 295 patients. Each of those patients receives 5 encounters as part of the program, after which an estimated 80% of those patients will be referred into the Care Partners program. Referral rates are estimated based on current referrals at CSHCC – Memorial. For those patients referred and enrolled in Care Partners, an average of 90 additional visits per patient will occur over an additional 18 months (a total of 44,427 patient encounters). This project seeks to enroll the target population into these programs, which Spohn estimates will impact 177 additional enrollees who will receive a total of approximately 13,575 encounters (based on current trends).

- **Category 1 or 2 expected patient benefits:** Spohn expects to have the registry fully implemented by the end of DY3, which Spohn expects to result in at least 60% of targeted patients receiving educational, disease-appropriate information after visits with the Care Transition team by the end of DY5 (an estimated 177 enrollees). These interventions should improve patient self-management skills, short- and long-term health outcomes, and patient satisfaction with the healthcare delivery system.

- **Category 3 outcomes:** IT- 3.2: Our goal is for the use of the registry to result in an 8% reduction from DY2’s CHF patient all-cause 30-day readmission rates for Spohn’s Alice location by the end of DY5.
Identifying Project and Provider Information:
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Alice/094222902
Unique Identifier - 094222902.1.2

Project Description:
CHRISTUS Spohn Hospital Alice (“Spohn”) will implement a Chronic Disease registry to assist Spohn in tracking and managing patients’ with chronic diseases. By entering patient data in the registry, Spohn will initially focus on CHF and diabetes. Spohn will manage the conditions of patients with CHF and diabetes. This includes engaging these patients in education, community outreach, regular status checks with their primary care providers, maintaining an active support system, and engaging patients to exercise self-management of their conditions. Upon implementing the registry and using it proactively, Spohn will use the reports generated by the registry to develop and implement a plan for quality improvement in the medical care provided to patients with these chronic conditions. The implementation of this plan will likely include identifying best practices and training staff to expand their use of those practices, discovering why certain patients are “frequent-flyers” and taking steps to provide additional support to those patients, and to determine how many, if any, of the chronic conditions could be better managed with additional input or support from other providers within Spohn’s network.

More specifically, a chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients. heartbase™ is our current vendor for national registries cardiovascular benchmark reporting of AMI, CHF and Open Heart Surgery with expansion to stroke and core measure data to The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS). heartbase™ is a certified vendor by TJC, CMS, American College of Cardiology (ACC) and Society of Thoracic Surgery (STS) with representation on international cardiovascular Health Information Exchange (“HIE”) teams.

This database will combine registry and longitudinal tracking of patients with chronic disease by automating patient documentation currently used by the Care Transitions and Care Partners (CHW) programs. Initial focus will be patients with CHF and diabetes but capability will incorporate all chronic disease and potential co-existing behavioral health diagnoses. The database will utilize a combined set of elements. Data points will not be duplicated but rather shared if they are the same data point, like ICD9 (Future ICD-10) and patient name.

The registry will interface with Meditech, our current inpatient EMR, and Athena, the future EMR for our Family Health Centers (“FHC”) and the Freer Clinic. Automation of the named documents and proposed interfaces will provide a provider and patient portal to a chronic disease repository that is used by all six Spohn facilities, related clinics and doctor offices. The database vision is one where the community stores all related chronic disease information on a server that is shared by hospital, clinics, physicians, and patients that participate in this program at CHRISTUS Spohn Health System. Access will be via a web-based front end with secured areas for both patients and staff and will also have the ability to interface with the developing health information network of South Texas, HINSTX.
The proposed registry will also have the ability to interface and house future proposed telehealth/telemedicine devices used to remotely access and monitor patients in their homes by the Care Transition and Care Partners teams as well as regional primary care providers.

Project components include the following:
1. Enter patient date into unique chronic disease registry
2. Use registry data to proactively contact, educate and track patients by disease status, risk status, self-management status, community and family need
3. Use registry reports to develop and implement targeted QI plan
4. Conduct quality improvement for project using methods such as rapid cycle improvement

Project Goals/5 Year Expected Outcome:
- Registry implemented at linking Freer FHC to Spohn’s Nueces County FHCs.
- At least 50% of targeted patients receiving educational, disease-appropriate information after visits to the FHCs
- Engage in quality improvement by collecting and disseminating best practices from each FHC

Project Challenges:
- Creating and implementing the actual registry (which will include provider training and assistance from third parties)
- Collecting accurate and current data regarding the health status of FHC patients
- Training providers to engage in effective outreach, support, and management for patients with these chronic diseases
- Maintaining the registry consistently
- Sharing information across FHCs in an organized and effective manner

Spohn will address these challenges by taking deliberate steps towards implementing the registry in an organized and thoughtful manner. The registry will not useful if providers cannot use it properly or do not understand the value of increased patient outreach and education. Thus, creating the registry and training our providers are the most important steps in DYs 2-3. In DYs 4-5, the FHCs can begin taking steps to improve on current practices using the registry for guidance and to stay organized. The registry itself will allow the FHCs to share more information than they may currently be able to do on a day-to-day basis.

Relationship to Regional Goals: Region 4 wants to transform care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improve patient satisfaction and outcomes while reducing the systemic costs of treating unmanaged chronic care conditions. This project addresses these goals head on.

Starting Point/Baseline:
Current documentation by the Care Transitions/Care Partners teams is handwritten paper format. Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. They are often contacted by individual unit staff when patients not identified by CM receive discharge orders. Program expansion is to be implemented under the waiver plan for projected impact on approximately 177 (60%) of CHF and Diabetes patients by the end of the waiver.
Rationale:
On a macro level, Region 4 has a high incidence of chronic disease, as noted in the Region’s Community Needs Assessment: “Regional hospital admissions and related data indicate that there is a prevalence of chronic conditions that lead to preventable hospitalizations, and which require a coordinated care management team approach to maximize patient outcomes.” RHP Plan, p. 29. Additionally, chronic diseases including CHF, COPD, Diabetes, and asthma are linked with Jim Wells County having a higher rate of Potentially Preventable Admissions than the statewide average. Avoidable hospitalization has a twofold negative impact on the delivery system: (1) patient health outcomes and satisfaction are reduced in the long- and short-term, and (2) the cost of delivering care is immediately and going forward more expensive when patients’ conditions deteriorate to an acute level.

This project will provide a substantial infrastructure to identification, tracking and monitoring Medicaid/uninsured/Self-pay patients regardless of entry point into the CHRISTUS Spohn Health System. This capability will link patients throughout the region and provide a future avenue for global integration to external HIEs. In addition to access and exchange of information, the registry/repository will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams. This flow of communication does not currently exist. A frequently occurring example of the breakdown in the current system identified by the Care Transitions/Care Partners staff is patients missing their scheduled clinic appointments because they are inpatients at the hospital. Our planned registry will provide patient and hospital alerts to maximize the efficiency of communication and disease management.

Milestones and Metrics: Spohn chose its DY 2-3 milestones in metrics in order to develop, test, and implement the registry, as well as train staff to populate it and use it successfully. Spohn chose its DY 4-5 milestones and metrics in order to effectuate improved care for patients with the targeted chronic conditions and to engage in quality improvement by the end of DY5.

Community Needs Identification Number Addressed by this Project: CN.3, CN.7, CN.12

Related Category 3 Outcome Measure(s): OD 3: Potentially Preventable Readmissions; Improvement Target 3.2: CHF 30 Day Readmissions
Automation and integration of Care Transitions and Care Partners programs with interfaces to hospital and clinic EMRs will streamline communication and provide longitudinal tracking and monitoring of chronically ill patients upon discharge from the inpatient setting. Spohn selected this outcome measure because one goal behind developing the registry is to longitudinally track patients with CHF and develop alerts for those who experience frequent readmissions, regardless of cause. This project is intended to help Spohn to identify those patients that are at risk for readmission to the hospital (often multiple times) upon discharge and intervene to prevent the causes of their readmission (including the inability to self-manage CHF in the outpatient setting).

Relationship to other Projects:
This automated infrastructure will finally provide a link between inpatient and outpatient care provided to individual patients in an efficient and streamlined manner to facilitate integrated care coordination in multiple settings. It is related to the following projects also proposed in this waiver plan:
• 121775403.1.4 - PADnet – telehealth/telemedicine – This project also addresses streamlining care for chronic conditions and is a related cardiac condition.
• 121775403.2.1 Establish Medical Homes – Part of the Medical Home model involves comprehensive management of patients’ conditions before they deteriorate, which is the specific purpose of the chronic disease registry.
• 121775403.2.3 Cost of Care Delivery – Primary Care Redesign – The hospitalist and resident teams assigned to patients will use the chronic disease registry to track their patients.
• 121775403.2.4. Diabetes Cellphone Application – Diabetes is another chronic condition that will be tracked in the registry, and the information will be used for outreach under this program.
• 121775403.2.8 Expand Care Transitions program – The chronic disease registry will assist the RN Coaches in managing chronically ill patients’ conditions.


This project provides integration of information with all 3 CHRISTUS Spohn Health System community facilities and CSHA. This is crucial to regional patient outcomes as patients transfer to Alice and Victoria from all remote areas of the RHP. This infrastructure and its ability to interface with future development of HINSTX will support the flow of communication beyond the CSHS boundaries and throughout the lifespan of the patients.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center and Driscoll Children’s hospital.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.

b. Further develop and maintain a coordinated care delivery system

c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:

   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?

   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its application to the goals of the Waiver, in that it focuses on improving patient outcomes while reducing the systemic cost of providing care. The registry will allow Spohn to make proactive choices to maintain the health status of chronically ill patients, which will benefit their quality of life and satisfaction with their health care greatly. The high incidence of chronic disease in Nueces County means that the registry addresses known community needs and will serve a broad population of the County’s residents. Finally, creating, implementing, and proactively using the registry will require investment in technology, staff training, project planning, and community outreach.

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12 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
RHP Plan for Region 4

<table>
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<th>094222902.1.2</th>
<th>1.3.1</th>
<th>1.3.1.A, B, C, D</th>
<th>1.3. IMPLEMENT A CHRONIC DISEASE REGISTRY</th>
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<td><strong>CHRISTUS SPOHN HOSPITAL ALICE</strong></td>
<td>094222902</td>
<td>094222902.3.2</td>
<td>3.IT 3.2 Congestive Heart Failure 30 day readmission rate</td>
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**Related Category 3 Outcome Measure(s):**

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</thead>
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<tr>
<td><strong>Milestone 1 [P-1]:</strong> Identify 1 or more target patient populations diagnosed with selected diseases or multiple chronic conditions</td>
<td><strong>Milestone 3 [P-3]:</strong> Develop cross-functional team to evaluate registry program</td>
<td><strong>Milestone 4 [P-8]:</strong> Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases.</td>
<td><strong>Milestone 6 [I-22]:</strong> Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.</td>
</tr>
</tbody>
</table>

**Metric 1 [P-1.1]:** Documentation of patient population to be entered into the registry  
**Baseline/Goal:** Registry Development for 2 major chronic diseases/conditions; CHF and diabetes  
**Data Source:** Performing Provider documents

Milestone 1 Estimated Incentive Payment (*maximum amount*): $134,398.50

**Milestone 2 [P-2]:** Review current registry capability and assess future needs  
**Metric 1 [P-2.1]:** Documentation of review of current registry capability and assessment of future needs  
**Baseline/Goal:** Approval of comprehensive proposal to develop electronic infrastructure for longitudinal data registry  
**Data Source:** Registry Project Management Plan/Proposal

Milestone 2 Estimated Incentive Payment (*maximum amount*): $274,915

**Milestone 3 [P-3]:** Develop cross-functional team to evaluate registry program  
**Metric 1 [P-3.1]:** Documentation of personnel assigned to registry evaluations  
**Baseline/Goal:** Spohn multidisciplinary team development of chronic disease registry  
**Numerator:** number of personnel assigned to enter the registry  
**Denominator:** total number of personnel  
**Data Source:** Registry Project Management Plan/Proposal

Milestone 3 Estimated Incentive Payment (*maximum amount*): $274,915

**Milestone 4 [P-8]:** Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases.  
**Metric 1 [P-8.1]:** Submitted protocols for the specified conditions and health indicators  
**Baseline/Goal:** Spohn will create protocols for using the information stored in the registry to address diabetes and CHF in the Freer Clinic  
**Data Source:** Protocols

Milestone 4 Estimated Incentive Payment (*maximum amount*): $137,244.50

**Milestone 5 [I-15]:** Increase the percentage of patients enrolled in the registry.  
**Metric 1 [I-15.1]:** Percentage of patients in the registry with targeted chronic conditions  
**Baseline/Goal:** Increase the percentage of the Freer Clinic’s diabetic and CHF patients entered into the registry by 10% over the percentage in the registry in DY3

**Milestone 6 [I-22]:** Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.  
**Metric 1 [I-22.1]:** Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.  
**Goal:** 60% of patients with diabetes or CHF will receive disease appropriate instructions after appointments at the Freer Clinic on how to manage their condition day-to-day (for diabetics, specifically diet information and medication management; for CHF patients, specifically medication management and activity level) – Spohn estimates this to constitute 177 patients.  
**Numerator:** the number of patients with chronic disease who receive appropriate disease specific instructions  
**Denominator:** number of patients with targeted chronic disease entered into the registry.  
**Data Source:** Disease registry or EHR

**Data Source:** Protocols
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $134,398.50</td>
<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount):</strong> $110,818.50</td>
<td><strong>Milestone 5 Estimated Incentive Payment (maximum amount):</strong> $137,244.50</td>
<td><strong>Milestone 7 Estimated Incentive Payment: $110,818.50</strong></td>
</tr>
<tr>
<td><strong>Numerator: number of CHF and diabetic patients in the registry</strong></td>
<td><strong>Metric P-X.1: documentation of redesign assessment and steps taken to make the process more effective</strong></td>
<td><strong>Baseline/goal:</strong> In consultation with Spohn Alice’s sister facilities performing the same project, identify one best practice from any of the 5 FHCs regarding (1) diabetes management, and (2) CHF management, and implement the best practices at each FHC or expand upon the concept. <strong>Data source:</strong> Documentation of assessment of best practices and steps taken to implement the best practices at each FHC.</td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $268,797</strong></td>
</tr>
<tr>
<td><strong>Denominator: number of diabetic and CHF patients assigned to this clinic for routine care</strong></td>
<td><strong>Data Source:</strong> Registry and/or EHR</td>
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Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
CHRISTUS Spohn Hospital Alice/ TPI 094222902
Unique project ID number: 094222902.1.3

- **Provider**: CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s)**: Spohn plans to implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and treatment plans. The PADnet™ Disease Management System provides patients that present at PCP offices with access to specialists to address issues with PAD.

- **Need for the project**: As a screening tool, PADnet is recommended for early detection and intervention in people with symptoms or at risk for peripheral arterial disease (PAD). Currently, diagnostics are performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a specialist for follow-up, diagnostics and treatment plan with or without requisite interventions. Current wait times for indigent patients to see a specialist can exceed 30 days. PAD is very painful and as it progresses undetected or untreated it can result in skin ulcers, gangrene and amputation. The ability to be screened in PCP office or FHC expedites diagnosis and treatment without delays to specialists visit.

- **Target population**: The target population of this project includes Jim Wells, Duval and surrounding counties’ residents at risk for PAD, who seek treatment in a FHCs (Family Health Centers) or FQHC and require cardiovascular surgery. Major risk factors contributing to PAD include smoking, diabetes and/or hypertension in persons 50 or older with a family history of coronary artery disease. PAD that is asymptomatic has been reported to exist in 80% of the population. Spohn intends to screen its high risk clinic patients with diabetes who are not currently symptomatic for PAD. Spohn’s FHCs (1,250 patients) and neighboring clinics (4,250 patients) treat approximately 5,500 patients per year, approximately 17.5% of which are diabetic and many of whom are high risk because of their family history, ethnicity and/or age. Spohn will identify those patients based on ethnicity, diabetes, hypertension and history of smoking and screen them for PAD.

- **Category 1 or 2 expected patient benefits**: Through implementing the use of PADnet™ in FHCs and FQHCs by the end of DY4, Spohn expects the benefits to patients to include a 170 PADnet™ screenings in DY3, 339 PADnet™ screenings in DY4, and 509 Padnet™ screenings in DY5, as well as, a 5% reduction in the wait time experienced by indigent patients for a cardiology consult by the end of DY3, and a 5% increase in telemedicine cardiology consults for patients residing in geographically underserved areas served by Spohn’s clinics from the first year of operation by the end of DY5.

**Category 3 outcomes**: IT-1. 11: Our goal is a 10% increase in the number of diabetic patients with controlled blood pressure, which should decrease those patients’ risk of developing PAD.
Category 1: Infrastructure Development
Identifying Project and Provider Information:
Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Option 1.7.6: Implement an electronic consult processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.
CHRISTUS Spohn Hospital Alice/ TPI 094222902
Unique project ID number: 094222902.1.3

Project Description:
CHRISTUS Spohn Hospital Alice (“Spohn”) plans to implement a system for early detection and to mitigate the adverse effects of chronic disease rampant in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and interventions. The PADnet™ Disease Management System provides patients who present at PCP offices with access to specialists to address issues with peripheral arterial disease (PAD). Spohn expects this to result in fewer unnecessary referrals to specialists for treatment the PCP is able to provide personally, earlier detection for patients who need immediate intervention, and greater care coordination between PCPs and cardiac specialists. No federal funds have been received or are being used for this project.

Project Goals/5-Year Expected Outcome:
The remote diagnostic devices can be located in PCP offices and will allow for increased communications through telemedicine with cardiologists or cardiovascular surgeons to interpret, diagnose and prescribe treatment or work in collaboration with the PCP to determine an appropriate follow-up/prevention plan when no interventions are needed. Finally, through quality improvement initiatives, the project will assess the project’s impact, lessons learned and opportunities to scale the project to a broader population.

Implementation of PADnet will help demonstrate the benefits of early detection and intervention for PAD, both for patient quality of life, satisfaction and long-term health outcomes and for the systemic cost of providing care to the chronically ill.

Specific goals include:
- 5% increase in PADnet™ screenings in DY3, over baseline set in DY2; 10% increase over DY2 baseline in DY4; 15% increase over DY2 baseline in DY5
- 5% reduction in wait time to cardiovascular consult for PAD in DY3 (using records from DY2 to measure improvement)
- Implement the use of PADnet™ in Freer Clinic and FQHC

This project is related to Region 4 goals in that it seeks to prevent diabetes related complications by allowing rural and indigent patients to access real-time diagnostics and reads by a specialist. These complications are costly to Region 4 communities in that they increase the cost of delivering care (often because they lead to ED visits), reduce productivity in the work-force, and cause ripple-effects
for affected families. Any and all providers in the Region can access this network through purchasing the diagnostic equipment, which is fairly low cost.

Project Challenges:

- Identifying cardiac specialists willing to provide electronic consults for patients in Jim Wells County
- Implementing new technology in the Freer Clinic and local PCP offices
- Training providers in the Freer Clinic and local PCP offices to use the PADnet technology
- Educating patients about the benefits of using electronic consults

Spohn will address these challenges by coordinating with stakeholders to identify appropriate partners for the project (i.e. specialists to provide the consults) and by using DY2 to train providers and create processes that are consistent among participating local providers. Finally, Spohn will train providers on how to present the PADnet telemedicine option to patients in a manner that alerts them to the benefits of using this technology.

Starting Point/Baseline:

Diagnostics are currently performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a cardiologist or cardiovascular (CV) surgeon for follow-up, diagnostics or planned interventions. Depending on the severity of the disease, peripheral artery angioplasty, stenting, surgical revascularization and amputation are all possible interventions. For less severe disease or those with high risk factors, minor disease can benefit from medical treatment. In the past year, 197 interventional or surgical treatments have been performed on patients for PAD at Spohn; of those, 9% were Medicaid-eligible or self-pay. Early detection and the option of peripheral interventions for symptomatic or at risk patients has shifted the ratio of amputations to interventions to 50:50 from previous ratios of 70:30 as recent as 2006. With a 89% Hispanic population, 49% MCD/UI rate and a 17.5% diabetes rate in Duval County and similar demographics in Jim Wells County, Spohn estimates a target screening population of 944 in Duval Co. and 2450 in Jim Wells Co for a total target population of 3394 patients (12.5%) across the 2 counties.

Rationale:

Like many diagnostic modalities designed for early detection of potentially life altering diseases, PADnet provides a solution that decreases the cost and burden of diagnostic on the patient and healthcare system. For the Medicaid, charity and self-pay patients in RHP 4, patients suspected of having or at risk for PAD have historically been referred to a Cardiology/CV Surgeon for evaluation. PAD in its moderate to advanced stages is associated with high pain levels especially with weight-bearing patients. Severe circulatory compromise results in swelling of the lower extremities and often open ulcers or wounds. Uninsured/underinsured patients often skip specialist appointments due to expense of the visit, time missed at work for a doctor visit or because they think they can tolerate it a little longer. They are often unaware that the PAD does not go away on its own but can be treated successfully if identified during the early stages. Another identified barrier in our region is the delay obtaining an appointment with these specialties. Current wait times for indigent patients to see a cardiologist ranges from 40-60 days.
One key to determine the precedence for screening in RHP 4 as well as other areas of the state is to analyze current statistics:

- Approximately 5 million Americans in the US are affected by PAD
- Predominant populations include Hispanic, blacks, diabetics and elderly (> age 70) with the elderly being the highest at 14.5%
- 66,000 people with diabetes had non-trauma related lower extremity amputations in 2006 (Briggs, 2006)
  - Mean hospital charge was $56,400 accounting for $3.7 billion for amputations alone
- Additional risk factors should also be considered; obesity, age, gender, smoking, cholesterol, blood pressure to name a few
- South Texas also sees a predominant culture of complacency regarding amputations in familial lines. This often lends to delay in seeking treatment early for onset of symptoms associated with the disease

The evidence statement on Peripheral Arterial Disease (PAD) posted by the USPSTF (2005) addresses two patient populations; asymptomatic/low risk and symptomatic/at-risk. Despite the USPSTF statement, numerous studies since 2005 indicate a more rigid investigation of screening in asymptomatic people using the Ankle-Brachial Index (ABI) and may support project expansion to the asymptomatic, low-risk patient population in the future. One study (McDermott et al, 2010) shows a relationship between PAD and walking endurance measured by ABI with or without claudication. Although the USPSTF-endorsed screening statement is outdated, the American College of Preventive Medicine (ACPM) supports their 2005 stance in asymptomatic patients in an ACPM 2011 guideline (Lim et.al, 2011). A Draft Research Plan (Wilt, 2011) has also been posted to the USPSTF site that proposes a more rigid investigation of ABI and asymptomatic patient populations. Despite the views on routine screening in asymptomatic patients, the American Heart Association (AHA) and the American Diabetes Association (ADA) both support screening and early intervention in symptomatic and at-risk patients specifically those with diabetes.

The high prevalence of diabetes in our region and the remote locations with limited accessibility to specialists lend credibility to an early screening routine for the Hispanic, diabetic and high-risk populations. The PADnet diagnostic device located in Primary Care Centers and Medical Homes will provide direct communication to a remote specialist, eliminating the need for delayed appointments and unnecessary visits while still affording the patient and PCP access to the clinical specialist for diagnosis and treatment/prevention options. Patients are more likely to seek screening when done in their primary care setting instead of traveling to a specialist’s office.

The PADnet project will also allow storage of diagnostic information that can be used for longitudinal comparison and eventual incorporation in the patients EHR and regional HIE.

**Community Needs Assessment:** CN.2 (Inadequate access to specialty services); CN. 3 (Inadequate provision and coordination of healthcare services for persons with chronic conditions); CN.6 (high rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions)
**Milestones and Metrics:** Spohn chose Milestones 1 in order to assure that Spohn successfully implements the use of PADnet during DY2 in the Freer FHC. Milestones 2-6 are intended to measure the increased use of telemedicine consults for patients at risk for PAD over the life of the Waiver.

**Related Category 3 Outcome Measure(s):**
Associated Outcome Measures selected for this project include:
- OD-1: Primary Care and Chronic Disease Management
- IT-1. 11–
  Diabetes Care – Blood Pressure Control

Spohn developed this outcome measure consistent with studies that show that diabetic patients are at increased risk of PAD; high blood pressure also contributes to PAD. Studies also demonstrate that early detection of PAD in symptomatic and at-risk populations allows early interventions that can reduce the need for amputations. By increasing the coordination of primary care and specialist physicians through the PADnet technology, Spohn intends that the target population will receive more preventative care at the early stages of this chronic disease.

**Relationship to other Projects:**
This project’s focus on treating chronic disease and increasing access to specialty care and provider training is related to and will enhance the following projects:
- 094222902.1.2 Establish Chronic Disease Management Registry (Spohn intends to expand its tracking and primary care treatment of chronic diseases, including PAD, through comprehensive reform)
- 121775403.2.8 Care Transitions (patients who may be hospitalized with a diagnosis of PAD will benefit from Care Transitions to assist in management of their condition upon discharge)


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other providers is proposing a telemedicine training program, other similar projects will focus on improving access to care, including projects submitted by Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project.
Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system.
   c. Improve outcomes while containing cost growth.

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its relationship to Waiver goals. Specifically, this project is patient-centered because it aims to increase and improve access to specialists for patients at risk for PAD, and will also reduce the systemic cost of treating patients with PAD. This project addresses community needs for patients at risk of PAD (including elderly patients, smokers, diabetics, obese patients, and patients with high blood pressure and/or cholesterol) by enabling quicker diagnosis and treatment if they are determined to have PAD. The investment in this project

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13 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

#93049
will be substantial, in that equipment/software will need to be purchased, providers trained, and the community educated.
| 094222902.1.3 | **1.7.6** | **EARLY SCREENING, DIAGNOSIS AND INTERVENTION FOR PERIPHERAL ARTERIAL DISEASE PATIENT CONSULTATION BY SPECIALISTS VIA TELECOMMUNICATION CONDUCT QUALITY IMPROVEMENT TO IDENTIFY PROJECT IMPACT** |
|  |  | CHRISTUS SPOHN HOSPITAL ALICE |
|  |  | 094222902 |
| **Related Category 3** | **Outcome Measure(s):** | **094222902.3** | **IT – 1.11** | **IT 1.11: Diabetic Care – Blood Pressure Control** |
| **Year 2** | (10/1/2012 – 9/30/2013) | **Milestone 1 [P-3]:** Implement telemedicine program for PAD **Metric 1 [P-3.1]:** Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and training logs **Baseline/Goal:** Initiate PADnet program/infrastructure for remote screening and access to cardiovascular specialists in Spohn’s Freer Clinic and the local FQHC (Health Center – Laviana) **Data Source:** Program materials and documents **Milestone 1 Estimated Incentive Payment (maximum amount):** $326,396 |
| **Year 3** | (10/1/2013 – 9/30/2014) | **Milestone 2 [P-2]:** Establish a baseline in order to measure improvement over self **Metric 1 [P-2.1]:** The number of PAD screenings performed subsequent to implementation during DY2 **Baseline/Goal:** Spohn expects to screen at least 170 patients through PADnet in DY3 **Milestone 2 Estimated Incentive Payment (maximum amount):** $166,913 |
| **Year 4** | (10/1/2014 – 9/30/2015) | **Milestone 3 [I-14]:** Reduce wait times to cardiovascular specialist for PAD screening/diagnostics **Metric 1 [I-14.1]:** Number of days until first available time for review and consultation for patient referred telemedicine consults **Goal:** 5% reduction in wait time to cardiovascular consult for PAD for patients referred from the Freer Clinic and FQHC **Data Source:** Referral documentation and PADnet reports **Milestone 3 Estimated Incentive Payment (maximum amount):** |
| **Year 5** | (10/1/2015 – 9/30/2016) | **Milestone 4 [I-13]:** Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult **Metric 1 [I-13.2]:** Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient **Denominator:** Number of patients referred to all medical specialties using referral processing system **Baseline/Goal:** Increase PAD screenings in the Freer Clinic and FQHC, using PADNET with access to cardiovascular specialists by 339 (509 total estimated) **Data Source:** PADnet reports **Milestone 4 Estimated Incentive Payment (maximum amount):** $333,308 |
|  |  | **Milestone 5 [I-13]:** Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult **Metric 1 [P-3.2]:** Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient **Denominator:** Number of patients referred to all medical specialties using referral processing system **Baseline/Goal:** Increase PAD screenings in the Freer Clinic and FQHC, using PADNET with access to cardiovascular specialists by 509 (1018 total estimated) **Data Source:** PADnet reports **Milestone 5 Estimated Incentive Payment (maximum amount):** $134,565.50 |
|  |  | **Milestone 6 [I-17]:** Improved access to cardiovascular care for PAD **Metric 1 [I-17.2]:** Improved access to health services for residents of communities that did not have such services locally before the program |

**RHP Plan for Region 4**
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $1,262,660
Yoakum Community Hospital
Infrastructure Development: Expand Primary Care Capacity by Establishing Primary Care Clinics
112673204.1.1

- **Provider**: Yoakum Community Hospital (YCH) is a 25-bed hospital in Yoakum, Texas. YCH primarily serves Lavaca and DeWitt counties, a 2,000 square mile area with a population of approximately 40,000. Over 4,700 residents of Lavaca and DeWitt counties are presently enrolled in the Medicaid program.

- **Intervention(s)**: To improve our ability to ensure patients receive the care they need in the right setting, our project will create an outpatient clinic and hire primary care physicians and other staff necessary to provide comprehensive preventive and primary care services.

- **Need for the project**: YCH is unable to meet the region’s significant need for primary care services. DeWitt and Lavaca Counties only have 25 primary care physicians. Due to an insufficient number of primary care providers, our clients frequently use the emergency department to receive treatment for conditions that could be managed in a primary care setting simply because they have nowhere else to go. Others delay seeking care because they have no physician or medical home, and are reluctant to seek care in the emergency department. Failure to seek treatment in the earlier stage results in the condition becoming more serious and eventually leads to hospitalization.

- **Target population**: YCH anticipates it will be able to assess the total impact of this project following the establishment of the clinic in DY2 and a baseline in DY3. Based on currently available data and our current patient volumes, we expect to be able to serve approximately 250 to 500 patients by DY5 through these services. This project is aimed at Lavaca and Dewitt county residents. Approximately 10% of YCH patients are either Medicaid eligible or indigent, so we expect that our clinic volume will see at least that percentage of Medicaid eligible or indigent patients.

- **Category 1 or 2 expected patient benefits**: Based on currently available data and our current patient volumes, this project seeks to provide approximately 60 new primary care encounters per week by DY5.

- **Category 3 outcomes**: 3.IT-1.11 - Diabetes care: BP control (<140/90mm Hg) – NQF 0061 -
  Our goal is to reduce these measures in an amount determined by the baselines established in DY2.
Category 1: Infrastructure Development
Category 1, Intervention 1.1: Expand Primary Care Capacity by establishing more primary care clinics
Unique Project Identifier: 112673204.1.1
Identifying Project and Provider Information: Yoakum Community Hospital – TPI 112673204

Goal: Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Projects plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care.

Project Description: Yoakum Community Hospital was established in 1922 and has survived numerous challenges over the past 90 years to ensure local residents continue to have access to critical services provided by the hospital. The hospital is located in the town of Yoakum, which is located in both DeWitt and Lavaca counties. Both counties are designated as a Medically Underserved Area and Health Professional Shortage Area for both Primary Care and Mental Health Care. In 2010, the non-profit facility provided services for 4,675 emergency department visits and 20,448 outpatient visits. The hospital had 875 inpatient admissions and provided more than $4 million in uncompensated services.

In addition to inpatient care and operation of an emergency department, our facility also provides imaging services, laboratory testing and services, and comprehensive physical therapy services for patients throughout the region. The hospital also operates a diabetes education program that provides one-on-one nutrition education and lifestyle consultations and patient support. The program is staffed by a dietician; both individual and group support services are provided.

The hospital also operates a highly successful mental health program for adults age 50 and over with mental health symptoms. The New Horizons Geriatric Program begins with a comprehensive patient assessment that is the basis of a personalized treatment plan that addresses such symptoms as depression, social withdrawal, cognitive decline, caregiver stress, and anxiety. The program is staffed by a psychiatrist, a nurse and two social workers. The program stresses family and community education and provides counseling and education services specifically designed to assist caregivers in understanding and assisting family members. Community education is provided on a regular basis to local service organizations, nursing home workers, hospice care providers, home health workers, and other groups that work with older adults.

While these services all provide important community benefits, we are unable to meet the region’s significant need for additional primary care services. DeWitt and Lavaca Counties only have 25 primary care physicians. Due to an insufficient number of primary care providers, our
clients frequently use the emergency department to receive treatment for conditions that could be managed in a primary care setting simply because they have nowhere else to go. Others delay seeking care because they have no physician or medical home, and are reluctant to seek care in the emergency department. Failure to seek treatment in the earlier stage results in the condition becoming more serious and eventually leads to hospitalization. Based on the information maintained by Yoakum Community Hospital and obtained from HHSC, in 2010, the two primary counties we serve (DeWitt and Lavaca) had a total of 501 potentially preventable hospitalizations, including 99 for bacterial pneumonia, 42 for dehydration, 94 for urinary tract infections, and 143 for congestive heart failure.

In addition to receiving delayed or inappropriate care, patients relying on the emergency department for primary care services and chronic care case management do not receive care coordination and case management that is proven to improve patient health and outcomes. Uncoordinated care can be unsafe – even fatal – when test results are not communicated to the patient or providers, patients receive prescription medications that cause serious reactions, or patients fail to receive necessary follow-up care when dismissed from a hospital. Uncoordinated care also adds to duplicative services that increases costs and exposes patients to unnecessary risks associated with certain services. According to a study published in the American Journal of Managed Care, roughly 30 percent of annual health care spending is estimated to be unnecessary. Much of this can be prevented by improving access to primary care and a health home that provides care coordination and cost effective services.

To improve our ability to ensure patients receive the care they need in the right setting, our project will create an outpatient clinic and hire primary care physicians and other staff necessary to provide comprehensive preventive and primary care services. By doing so, we will meet several important community goals, including:

- Increase primary care capacity;
- Improve patient health and treatment outcomes;
- Reduce wait times for primary care appointments;
- Improve care coordination for chronic conditions;
- Improve the patient’s care experience and increase patient satisfaction;
- Reduce inappropriate utilization of the emergency department;
- Reduce potentially preventable hospital admissions; and
- Reduce unnecessary health care expenses

We anticipate that the clinic space will be available by December 2013 and services will be provided in 2014 by one primary care physician and support staff. By 2015, we plan to hire an additional primary care physician and support staff for a total of two physicians over the life of this initiative.

All new staff, including physicians and support staff, will be trained to work closely with the existing hospital staff and patient services to coordinate care and maximize the use of the existing administrative infrastructure. Primary care physicians will be able to refer patients to the hospital-based diabetes education program and the New Horizons Geriatric Program for
older adults with mental health issues. By coordinating services and treatment programs for each of these populations, we expect improvements in health care outcomes, increased patient compliance with nutrition and medication management instructions, improved patient satisfaction, and reduction in unnecessary health care costs.

Starting Point/Baseline: Because this is an entirely new initiative to serve our patient population, we do not have a baseline population or services on which to base our future improvement. During the first year of operation (DY 3) we will establish a baseline number of visits based on patient registry and appointment schedules.

Rationale: In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduction of cost of services.

Currently (DYI), a Medical Office Building (MOB) is being planned and developed adjacent to the current Yoakum Community Hospital. Plans for 2013 (DY2) are to complete the building of the MOB by December 2013 and begin recruitment efforts for primary care physicians and staff to office in such MOB. In 2014 (DY3), one primary care physician and his/her necessary staff recruited. In 2015 (DY4), one additional primary care physician and his/her necessary staff recruited. In 2016 (DY5), retain both primary care physicians and their staff through additional salary guarantees.

Key Challenges: Like other rural area communities, Yoakum Community Hospital and the population we serve face numerous challenges. Many of our patients must travel long distances for care but do not have immediate access to transportation. If care is not available within our community, they are forced to drive much longer distances, which reduces the likelihood that patients will be able to make the trip. The long distance also reduces the likelihood patients will return for follow-up treatment. In some instances, patients have to travel to San Antonio or other areas that are over three hours away. Providing access to primary care within our hospital will reduce the drive for many patients and improve their ability to keep appointments, including follow-up care.

We also serve a diverse population, many of whom have chronic conditions that require significant care coordination and ongoing monitoring to ensure maximum health outcomes. As mentioned above, many of our patients rely on the emergency department for basic health care services, and often do not receive the most appropriate services for their condition. Providing a primary care clinic will improve their ability to obtain care in the right setting. To
ensure they use these services once they become available, we will develop and implement a comprehensive outreach and education program to inform patients of the primary care clinic services and the benefits of using those services for their routine care. We will emphasize the convenience and lower costs of using the clinic, and the importance of establishing a medical home to receive preventive health care, coordinate their treatment across primary care and specialty care providers, and avoid more costly, medically serious conditions.

Our plan to expand primary care capacity also requires that we hire several primary care providers to staff our clinic. Recruiting physicians is a challenge in many areas of our state, but is particularly difficult for rural communities. To address this challenge, we will work with our regional partners to identify potential physicians for the position. We also will develop an outreach and recruitment strategy for hiring physicians and will begin that process early enough to ensure we have the physicians in place as soon as the clinic space is ready for operations.

Because the clinic is attached to the hospital, we also will be well positioned to coordinate the care of patients when they are released from the hospital. As part of our implementation plan, our primary care team will work with the hospital to develop a discharge planning and coordination protocol that ensures each clinic patient receives the follow-up attention and services required for their specific physical condition.

Once the clinic is operational, we will continually monitor and evaluate the availability of services and identify ways of improving and enhancing the services we provide. Services may be adjusted or hours revised to best accommodate the needs of our patients and maximize the effectiveness of the clinic operations.

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

Diabetes care: BP control (<140/90mm Hg) – NQF 0061 (Standalone measure)

**Relationship to other Projects:** This project will support and complement other projects designed to improve patient access to care, reduce inappropriate hospital utilization, improve health outcomes, and improve patient experience. By expanding access to primary care, patients will obtain more timely care which will result in fewer complications and enable patients to get the right care in the right setting. Other projects that will be supported or enhanced by this project include: 1328122051.2.1 – expansion of health promotion; 137907508.1.1 and 1309585095.1.1, and 020973601.1.1 – expansion of primary care capacity; and 121775403.2.3 – Redesign of primary care to improve continuity of care, decrease average length of stay, and increase patient satisfaction. Together these projects will result in decreased emergency department (ED) and hospital visits plus improved clinical outcomes. Related Category 4 measures include RD-1, Potentially Preventable Admissions and RD-4, Patient Centered Healthcare.
**Relationship to Other Performing Providers’ Projects in the RHP:** Our plans to expand primary care services will support the region’s goals to improve access to care and provide better care coordination and treatment of chronic conditions. Our project supports other regional efforts, including projects to enhance availability of urgent medical advice (Category 1.6), and enhance service availability (Category 1.12). By improving the ability of consumers to obtain timely care when they need it and in the most appropriate setting, our project will provide services for patients with urgent medical needs and enhance the region’s ability to meet the community needs for preventive and primary care. As consumers use the services we provide, we anticipate that patients will receive more timely treatment, will be less likely to delay necessary care since they will be able to obtain care from the clinic rather than seeking care in the emergency department, and will receive care coordination for chronic services. These benefits will impact other regional projects, including expansion of medical homes (Category 2.1), improvement in patients’ experience of care (Category 2.4 and Category 3, OD 6), and a reduction in the number of preventable hospital admissions and readmissions (Category 3, OD 2, OD 3, OD 4).

This project addresses Community Needs numbers 1 and 2, inadequate access to primary and specialty care.

**Plan for Learning Collaborative:** Yoakum Community Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. Other providers with whom we will collaborate who have similar projects include Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, Lavaca Medical Center, and Jackson County Hospital District.

**New Initiative for Provider:** Yoakum Community Hospital currently provides acute care, emergency care and certain outpatient services including imaging, physical therapy and diabetes education, but does not provide primary and specialty care services. Development and operation of a primary care clinic is a new initiative. The operation of a primary care clinic will address an unmet community needs by increasing access to primary care services. It will enhance the level of services currently available to our patients and improve patient satisfaction and health outcomes.

**Project Valuation:** The value of this project is based on a number of factors directly associated with the benefits of expanding access to primary care. In stakeholder meetings and in the assessment of our community needs, we determined that many of the consumers in our region do not have a medical home or primary care provider and must drive long distances to see a physician. In some cases, patients turn to the emergency room for services that could be provided by a primary care physician if they could obtain a timely appointment. Adding new providers for primary care services will reduce the travel distance for many consumers, which will reduce the financial burden associated with transportation costs. This project also will
reduce consumers’ reliance on the emergency department for non-emergency medical services, which will allow patients to avoid unnecessary costs, and reduce ED wait times for other patients who have more urgent needs. By enabling consumers to obtain more timely care through the increase in available appointment times, we also will reduce the incidence of delayed diagnoses and treatment, which results in more serious health conditions and higher costs. Finally, we also considered the cost associated with recruiting and staffing the clinic, as well as providing the necessary equipment and supplies. Because this is a rural community, we anticipate that attracting physicians and skilled personnel could be a challenge, making it imperative that this project provide sufficient salaries to attract and retain staff.
### 112673204.1.1

**Yoakum Community Hospital**

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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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**Milestone 1** [P-1]: Establish primary care clinic

**Metric 1** P-1.1 Number of additional clinics

Baseline: No clinic space exists for primary care services in 2012.

Goal: Create space to support 2 PCPs

Data Source: Documentation of detailed expansion plans; New primary care schedule

Milestone 1 Estimated Incentive Payment: $192,934

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

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

Baseline: No primary care providers in 2012

Goal: Recruit and hire a total of one primary care physician and support staff

Data Source: Documentation of contracts/human resource confirmation documents confirming hiring of new staff

Milestone 2 Estimated Incentive Payment (maximum amount): $105,240

**Milestone 3**[P-10]: Establish a baseline in order to measure improvement over self

**Metric 1** P-10.1 Documentation of number of patient visits

Data Source: Patient registry and appointment schedule

Milestone 3 Estimated Incentive Payment (maximum amount): $105,240

**Milestone 4** [P-5]: Hire additional primary care provider and staff

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

Baseline: No primary care providers in 2012

Goal: Recruit and hire a total of two primary care physician and support staff

Data Source: Documentation of contracts/human resource document confirming hiring of new provider and staff

Milestone 3 Estimated Incentive Payment (maximum amount): $105,546

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

**Metric 1** I-12.1: Documentation of increased number of visits.

Demonstrate improvement over prior reporting period.

Baseline: To be established by Milestone 3 in DY3

Goal: Increase of 5% over baseline or an amount to be established in baseline study

Data Source: Patient registry and appointment schedule

Milestone 5 Estimated Incentive Payment: $174,381

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

**Metric 1**: Documentation of increased number of visits.

Baseline: To be established by Milestone 3 in DY3

Goal: Increase of 5% over DY 4 clinic volume or an amount to be established in baseline study

Data Source: Patient registry and appointment schedule

Milestone 6 Estimated Incentive Payment: $174,381
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<td>Data Source: Patient Registry and appointment schedule&lt;br&gt;Milestone 4 Estimated Incentive Payment: $105,546</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $211,092</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>*(add milestone bundle amounts over Years 2-5): $788,887*
Yoakum Community Hospital
Infrastructure Development: Expand Specialty Care Capacity
112673204.1.2

- **Provider**: Yoakum Community Hospital (YCH) is a 25-bed hospital in Yoakum, Texas. YCH primarily serves Lavaca and DeWitt counties, a 2,000 square mile area with a population of approximately 40,000. Over 4,700 residents of Lavaca and DeWitt counties are presently enrolled in the Medicaid program.

- **Intervention(s)**: YCH aims to increase the capacity to provide specialty care services in cardiology, nephrology, gynecology, and/or obstetrics, depending on which specialty care area YCH can best address through available providers and facilities.

- **Need for the project**: Currently, Lavaca and DeWitt counties have very few specialty care providers, including zero cardiologists and obstetricians. Through a gap assessment, YCH plans to establish what are the most high impact specialty areas and work to fill those needs in the community. Overall, this region needs additional specialty care providers outside of traditional population centers as described in the Key Health Challenges Section of the RHP plan. This project aims to increase the availability of specialty care providers to Lavaca and DeWitt counties specifically, but also assist with improving access to care in the region.

- **Target population**: YCH anticipates it will be able to assess the total impact of this project following the DY2 gap assessment. Based on currently available data and our current patient volumes, we expect to be able to serve approximately 50 to 100 patients by DY5 through these expanded services. This project is aimed at Lavaca and Dewitt county residents who might otherwise have to travel to receive these services. Approximately 10% of YCH patients are either Medicaid eligible or indigent, so we expect that same percentage of our total increase in patient services will be Medicaid eligible or indigent.

- **Category 1 or 2 expected patient benefits**: Based on currently available data and our current patient volumes, the overall goal of this project seeks to provide approximately 25 specialty care encounters per week in nephrology, cardiology, or obstetrics by DY5.

- **Category 3 outcomes**: 3.IT-1.10 - Our goal is to reduce the HbA1c Poor Control (>9.0%) measures by DY5 in an amount determined by the baselines established in DY2.
Category 1, Intervention 1.9: Expand Specialty Care Capacity  
Project Option 1.9.2: Improve access to specialty care  
Identifying Project and Provider Information:  
Yoakum Community Hospital – TPI 112673204  
Unique Identifier: 112673204.1.2  

Goal: Expand access to specialty care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.  

Project Description: Yoakum Community Hospital was established in 1922 and has survived numerous challenges over the past 90 years to ensure local residents continue to have access to critical services provided by the Hospital. The hospital is located in the town of Yoakum, which is located in both DeWitt and Lavaca counties. Both counties are designated a Medically Underserved Area and Health Professional Shortage Area for both Primary Care and Mental Health Care. In 2010, the nonprofit facility provided services for 4,675 emergency department visits and 20,448 outpatient visits. The hospital had 875 inpatient admissions and provided more than $4 million in uncompensated services.  

In addition to inpatient care and operation of an emergency department, our facility also provides imaging services, laboratory testing and services, and comprehensive physical therapy services for patients throughout the region. The hospital also operates a diabetes education program that provides one-on-one nutrition education and lifestyle consultations and patient support. The program is staffed by a dietician; both individual and group support services are provided.  

The hospital also operates a highly successful mental health program for adults age 50 and over with mental health symptoms. The New Horizons Geriatric Program begins with a comprehensive patient assessment that is the basis of a personalized treatment plan that addresses such symptoms as depression, social withdrawal, cognitive decline, caregiver stress, and anxiety. The program is staffed by a psychiatrist, a nurse and two social workers. The program stresses family and community education and provides counseling and education services specifically designed to assist caregivers in understanding and assisting family members. Community education is provided on a regular basis to local service organizations, nursing home workers, hospice care providers, home health workers, and other groups that work with older adults.  

YCH aims to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services. In particular, this region has experienced gaps in care for cardiology, nephrology, gynecology, and obstetrics. YCH plans to engage in recruiting, outreach, and retention plans to increase access to specialty care. Currently, Lavaca and DeWitt counties have very few specialty care providers, including zero.
cardiologists and obstetricians. Through a gap assessment, YCH plans to establish the most high impact specialty areas and work to fill those needs in the community. One area of concern is in the treatment and management of diabetes; YCH believes the addition of a nephrologist could help treatment of kidney issues related to diabetes.

The objective of this project is to increase the capacity to provide specialty care services. Additionally, YCH wants to increase the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services, thereby serving more patients locally. This project will follow these core guidelines:

a. Increase service availability with extended hours
b. Increase number of specialty clinic locations
c. Implement transparent, standardized referrals across the system
d. Conduct quality improvement for project using methods such as rapid cycle improvement.

Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

While these services all provide important community benefits, we are unable to meet the region’s significant need for additional services. In addition to receiving delayed or inappropriate care, patients relying on the emergency department for services and chronic care case management do not receive care coordination and case management that is proven to improve patient health and outcomes. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. YCH wants to implement this project to assess the gaps in specialty care and work to address those gaps.

Starting Point/Baseline:
Because this is an entirely new initiative that will expand services to a patient population not fully served with present capacity, we do not have a baseline population or services on which to base our future improvement. During the first year of operation (DY 3) we will establish a baseline number of visits based on patient registry and appointment schedules.

Rationale:
Establish and expand specialty care capacity by assessing specialty care needs and working to fulfill those needs in the community. By way of example, a local nephrology group may be interested in developing and building a clinic and dialysis center adjacent to Yoakum Community Hospital to be completed in the near future. If successful in that endeavor, YCH would work to establish and implement patient education to enhance the utilization of specialty care providers in the local facilities (nephrologists, cardiologists, gynecologists, etc.) to improve patient access, continuity of care and experience by connecting patients to local care
delivery, while reducing the demand for inpatient care and shifting chronic care management from an inefficient ER setting to connect patients to the most appropriate form of care, thereby redesigning and enhancing care delivery.

**Key Challenges:** Like other rural area communities, Yoakum Community Hospital and the population we serve face numerous challenges. Many of our patients must travel long distances for care but do not have immediate access to transportation. If care is not available within our community, they are forced to drive much longer distances, which reduces the likelihood that patients will be able to make the trip. The long distance also reduces the likelihood patients will return for follow-up treatment. Providing access to increased specialty care within our hospital will reduce the drive for many patients and improve their ability to keep appointments, including follow-up care.

We also serve a diverse population, many of whom have chronic conditions that require significant care coordination and ongoing monitoring to ensure maximum health outcomes. Our plan to expand specialty care requires a targeted assessment of the region’s deficiencies in providing specialty care. That information will assist YCH in compliance with the Waiver’s goals as well as moving forward for future expansion and healthcare opportunities. Recruiting physicians is a challenge in many areas of our state, but is particularly difficult for rural communities. To address this challenge, we will work with our regional partners to identify potential providers to assist in this program.

One possible option is the proposed nephrology clinic, which would be adjacent to hospital. This will be well positioned to coordinate the care of patients when they are released from the hospital. As part of our implementation plan, our team will work with the hospital to develop a discharge, planning, and coordination protocol that ensures each clinic patient receives the follow-up attention and services required for their specific physical condition. Once the clinic is operational, we will continually monitor and evaluate the availability of services and identify ways of improving and enhancing the services we provide. Services may be adjusted or hours revised to best accommodate the needs of our patients and maximize the effectiveness of the clinic operations. We also hope that one clinic is a model for other possible avenues for expansion of care.

**Related Category 3 Outcome Measure(s):** [IT-1.10] *Diabetes Care: HbA1c Poor Control (>9.0%)*

**Relationship to other Projects:**
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support a number of other projects within the region, including the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FQHC providers.
Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

**Relationship to Other Performing Providers’ Projects in the RHP:** Overall, this region needs additional specialty care providers outside of traditional population centers as described in the Key Health Challenges Section of the RHP plan. This project aims to increase the availability of specialty care providers to Lavaca and DeWitt counties specifically, but also assist with improving access to care in the region. Our plans to expand specialty care services will support the region’s goals to improve access to care, provide better care coordination, and provide better treatment of chronic conditions. Our project supports other regional efforts, including projects to enhance availability of urgent medical advice (Category 1.6), and enhance service availability (Category 1.12). By improving the ability of consumers to obtain timely care, and in the most appropriate setting, our project will provide services for patients with urgent medical needs and enhance the region’s ability to meet community needs for healthcare. As consumers use the services we provide, we anticipate that patients will receive more timely treatment, will be less likely to delay necessary care since they will be able to obtain care from the clinic rather than seeking care in the emergency department, and will receive care coordination for chronic services. These benefits will impact other regional projects, including expansion of medical homes (Category 2.1), will improve patient’s experience of care (Category 2.4 and Category 3, OD 6), and will reduce the number of preventable hospital admissions and readmissions (Category 3, OD 2, OD 3, OD 4).

This project addresses **Community Needs** numbers 1 and 2, the expansion of primary and specialty care.

**Plan for Learning Collaborative:** Yoakum Community Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center, Memorial Hospital, Cuero Community Hospital, and Driscoll Children’s Hospital.

**New Initiative for Provider:** Yoakum Community Hospital currently provides acute care, emergency care and certain outpatient services including imaging, physical therapy and diabetes education, but does not provide primary and specialty care services. Development, operation, and expanding specialty care are new initiatives. This project will address an unmet community needs by increasing access to healthcare services. It will enhance the level of services currently available to our patients and improve patient satisfaction and health outcomes.

**Project Valuation:** The value of this project is based on a number of factors directly associated with the benefits of expanding access to care. In stakeholder meetings and in the assessment of
our community needs, we determined that many of the consumers in our region do not have a medical home or primary care provider and must drive long distances to see a physician. This problem is amplified when their primary care physician is unable to provide the necessary treatment. In some cases, patients turn to the emergency room for services that could be provided by a primary care physician or specialty care provider if they could obtain a timely appointment. Adding new providers will reduce the travel distance for many consumers, which will reduce the financial burden associated with transportation costs. This project also will reduce consumers’ reliance on the emergency department for non-emergency medical services, which will allow patients to avoid unnecessary costs, and reduce ED wait times for other patients who have more urgent needs. By enabling consumers to obtain more timely and appropriate care, we also will reduce the incidence of delayed diagnoses and treatment, which results in more serious health conditions and higher costs. Finally, we also considered the cost associated with recruiting and staffing the clinic, as well as providing the necessary equipment and supplies. Because this is a rural community, we anticipate that attracting physicians and skilled personnel could be a challenge, making it imperative that this project provide sufficient salaries to attract and retain staff.
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### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1**: [P-1] Conduct specialty care gap assessment based on community need.

**Metric 1** [RHP PP Metric – 1-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

**Data Source**: Needs Assessment

**Rationale/Evidence**: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access.

**Milestone 1 Estimated Incentive Payment**: $162,471

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 2** [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties.

**Metric 1** [P-3.1]: Establish baseline for performance indicators.

**Baseline/Goal**: TBD based on gap assessment

**Data Source**: TBD based on gap assessment

**Milestone 2 Estimated Incentive Payment**: $88,623

**Milestone 3** - P-14: Implement training programs for the most impacted specialties and recruit trainee-providers to provide services in the local clinic.

**Metric**

**P-14.1**: Expand mid-level provider and/or specialized clinician/staff training programs and/or rotations

**Data Source**: P-14b: Training program documentation

**Milestone 3 Estimated Incentive Payment**: $88,624

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4**: [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

- Hire trainees and/or new recruits to increase the procedure hours available for uninsured/indigent patients in the community and to increase the number of specialist providers by at least one (1) provider in at least one (1) of the targeted specialties.

**Metric**

**I-22.1**: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties

- **Numerator**: Number of specialist providers in targeted specialties over baseline as determined by gap assessment in DY1
- **Denominator**: Number of specialist providers in targeted specialties at baseline as determined by gap assessment in DY1

**Data Source**: I-22c: HR documents

**Milestone 4 Estimated Incentive Payment**: $177,762

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 5**: I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

- The specialist providers placed in the local clinic will enable the clinic to see at least 10% more uninsured and indigent patients in the targeted specialties over DY2.

**Metric**

**I-23.1**: Documentation of increased number of unique patients (i.e. uninsured/indigent)

**Data Source**: EHR

**Milestone 5 Estimated Incentive Payment**: $146,847

### Year 2 Estimated Milestone Bundle Amount: $162,471

### Year 3 Estimated Milestone Bundle Amount: $177,247

### Year 4 Estimated Milestone Bundle Amount: $177,762

### Year 5 Estimated Milestone Bundle Amount: $146,847

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $664,326**
PROVIDER: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

INTERVENTION(S): This project will increase the space, hours, and staffing for Spohn Corpus Christi’s primary care clinics in order to serve additional patients, improve timely access to care, and to increase patients’ use of primary and preventative care instead of inappropriate use of the Emergency Department.

NEED FOR THE PROJECT: Currently, 4 of Spohn’s clinics and the Hector P. Garcia clinic where Spohn residents provide care only operate Monday-Friday hours, and only one clinic has expanded hours in the evenings. Our data shows that 21% of Nueces County residents are completely uninsured, meaning that 73,000 residents in the County have no 3rd party payer source and are therefore likely to require access to the clinics intended to provide primary care to patients without an ability to pay for services. Thus, Spohn needs to expand its primary care capacity to treat more patients, and provide hours accessible by working and school-age patients.

TARGET POPULATION: The target population is Nueces County residents with no insurance who require primary care services. Spohn’s Family Health Centers (FHCs) clinics and the neighboring Hector P. Garcia clinic (where Spohn physician-residents provide treatment) typically treat a total of 19,500 patients per year (approximately 83% of whom are Medicaid-eligible or uninsured, totaling 16,200 patients), providing an approximate 67,000 encounters annually (84% of which are Medicaid-eligible or uninsured, totaling 56,000 visits). With 73,000 uninsured residents alone in Nueces County who would be eligible to receive care at these clinics, there is ample need for expanded care, and the project will target providing existing patients with easier access to care and allowing for additional patients to access care.

CATEGORY 1 OR 2 EXPECTED PATIENT BENEFITS: The project seeks to increase the space available for treating patients in Spohn’s Northside Family Health Center from 5,000 square feet to at least 8,000 square feet in DY3, to increase the availability of after-hours/weekend clinic visits by six hours by DY4, to add a total of 4 additional providers in the clinics by DY4, and to increase the volume of visits across the clinics by 15% over DY2’s numbers by DY5 (an expected 10,050 additional encounters for an estimated increased patient population of 2000-3000 patients).

CATEGORY 3 OUTCOMES: IT-9.2 - Our goal is a 5% reduction in all (non-urgent/non-emergent) ED visits by the end of DY4, and a 10% reduction in all (non-urgent/non-emergent) ED visits by the end of DY5.
**Expand Primary Care Hours/Staffing**

**Identifying Project and Provider Information:**

Project 1.1: Expand Primary Care Capacity

Project Option 1.1.2: Expand Existing Primary Care Capacity

CHRISTUS Spohn Hospital Corpus Christi/121775403

Unique Identifier - 121775403.1.1

**Project Description:**

CHRISTUS Spohn Hospital Corpus Christi (Spohn) intends to increase the space, hours, and staffing in five local primary care clinics in order to serve additional patients, improve timely access to care, and to increase patients’ use of primary and preventative care instead of inappropriate use of the Emergency Department.

**Project Goals/5 Year Expected Outcome:**

- Provide an additional 4 providers (total) in the local clinics
- Increase clinic space in FHC from 5000 sq. ft. to at least 8000 sq. ft.
- Increase hours at target locations by at least 2 hours (weekend or after-hours) per week
- 15% increase in primary care visits over baseline established in DY2 of patient volume at Spohn’s FHCs (estimated 10,500 additional visits by end of DY5)

**Project Challenges:**

- Recruiting and retaining additional staff (specifically Community Health Workers)
- Provider cooperation in providing additional hours of availability to an increased patient population
- Identifying strategies for increasing the available amount of space for treating patients in existing FHCs
- Patient education about the increased availability of services

Spohn will address challenges by taking a coordinated approach to making these imperative improvements to the primary care clinic hours, staffing, and space. This includes engaging in provider education, aggressive recruiting, creative strategizing, and reaching out to the community to assure that the increased capacity is followed by increased utilization of the FHC services.

**Relationship to Regional Goals:**

Region 4 intends to transform healthcare delivery to focus on patient outcomes and satisfaction by creating easier access to quality primary and preventative care. This project is 100% patient-focused, and will also improve the institutional cost of providing care throughout the Region by reducing the number of patients seeking primary care treatment in area Emergency Departments.

**Starting Point/Baseline:**

4 of 5 clinics operate Monday-Friday hours; one clinic has expanded hours in the evenings. Spohn’s four Family Health Clinics and Hector P. Garcia where Spohn residents provide care provided approximately 67,000 visits to approximately 19,500 patients in FY 2012.
Rationale:
Spohn chose this project because 20% of Nueces County residents, and 31% of Nueces County children, live in poverty and therefore traditionally suffer from limited access to primary care. Additionally, 21% of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover healthcare bills. Nueces County has a higher percentage of Preventable Hospital Admissions than the statewide average for the following conditions that can be managed through regular access to primary care providers: Asthma, COPD, CHF, bacterial pneumonia, and diabetes long-term complications. These statistics highlight the need for expanded primary care capacity in the existing clinics in Nueces County. The cost (financial and to patient quality of life) of preventable hospital admissions and misuse of the ED have a deep impact on the long-term health outcomes for patients, which Spohn seeks to improve through this project.

Milestones and Metrics: Spohn chose its DY2, DY3, and DY4 milestones in an effort to create infrastructure for improving access to primary care at its clinics. Hiring additional providers, increasing space, and offering increased clinical hours are each core components of this project, but they are also imperative to affecting a meaningful impact for patients. Spohn chose its DY 5 milestone to give effect to the overarching goal of this project, which is to increase the volume of patients using Spohn’s clinics to access primary and preventative care, which will improve patient outcomes and reduce the institutional cost of providing healthcare to the indigent community.

Ties to Community Needs Assessment Unique IDs: CN.1, CN.3, CN.6, CN.7, CN.10, CN.12

Related Category 3 Outcome Measure(s): Right Care, Right Setting (3.9.2 – ED Appropriate Utilization)
Increasing available hours in the community FHCs will increase the number of available primary care appointments to indigent and uninsured patients in the community. Spohn expects this increase in capacity to result in a reduced misuse of the ED. A review of Spohn’s ED admission data for FY12 revealed almost 44,000 ED visits were non-urgent/non-emergent visits that could be handled in the primary care setting. Of those, almost 70% were provided to Medicaid-eligible and uninsured patients (30,000 encounters). The 30-36 day delay to follow-up appointments has been established as a major factor in PPR as patients are discharged with 5-7 days of prescriptions for new and refilled medications.

Relationship to Other Performing Providers’ Projects in the RHP:
Many of the projects in this region are related to expansion of care and improving access to care. This project’s focus on expanding care will support and enhance these Category 1 and 2 projects in our RHP: 094222902.1.3, Introduce Expand or Enhance Telemedicine/Telehealth; 0208811801.1.1 – Expand Primary Care Capacity; 121775403.2.3 – Primary Care Redesign; and 0942220902.2.4, Expand Care Transitions program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges
and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any

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14 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

RHP Plan for Region 4
category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

This project is Spohn’s highest in value because it serves the Triple Aims of the Waiver by focusing on patient satisfaction and health outcomes while also addressing systemic deficits in primary care and addressing the high cost of providing care. The project addresses community needs (as evidenced by the Community Needs Assessment) and serves the entire indigent population of Nueces County who are able to travel to one of Spohn’s FHCs or the Hector P Garcia clinic (as all residents need primary care). This project will take significant investment in transformation, including adding hours, providers, and space, but will ultimately create great value for the Region.
<table>
<thead>
<tr>
<th>121775403.1.1</th>
<th>1.1.2</th>
<th>1.1.2 A</th>
<th>1.1.2 B</th>
<th>1.1.2 C</th>
<th>1.1.2 EXPAND PRIMARY CARE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI</strong></td>
<td>121775403</td>
<td><strong>Right Care Right Setting – ED appropriate utilization-all (non-urgent/non-emergent) ED visits</strong></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Related Category 3 Outcome Measure(s):
- **121775403.3.1**
  - **IT-9.2**

### Year 2 (10/1/2012 – 9/30/2013)
**Milestone 1** [P-4]: Expand hours of one primary care clinic to include evening and weekend hours
**Metric 1** [P-4.1]: Increase number of hours at primary care clinic over baseline
**Baseline/Goal**: Increase clinic hours in at least one FHC to include 2 additional hours per week after 5pm or during the weekend (improvement over baseline, as evidenced by DY1 clinic schedules)
**Data Source**: Clinic schedules

**Milestone 1 Estimated Incentive Payment (maximum amount)**: $977,069.50

### Year 3 (10/1/2013 – 9/30/2014)
**Milestone 2** [P-5]: Hire additional primary care providers and staff.
**Metric 1** [P-5.1]: Documentation of increased number of providers and staff
**Baseline/Goal**: Hire/contract two (2 – total) Community Health Workers to staff Spohn’s primary care clinics.
**Data Source**: Staffing schedules, HR documents

**Milestone 2 Estimated Incentive Payment (maximum amount)**: $977,069.50

### Year 4 (10/1/2014 – 9/30/2015)
**Milestone 3** [P-4]: Expand hours of a primary care clinic to include evening and weekend hours
**Metric 1** [P-4.1]: Increase number of hours at primary care clinics over baseline
**Baseline/Goal**: Increase clinic hours in at least one primary care clinic to include 2 additional hours per week after 5pm or during the weekend over DY2 hours of availability.
**Data Source**: Clinic schedules

**Milestone 3 Estimated Incentive Payment (maximum amount)**: $999,309.50

### Year 5 (10/1/2015 – 9/30/2016)
**Milestone 4** [P-1]: Expand existing primary care clinics.
**Metric 1** [P-1.1]: Expanded space
**Baseline/Goal**: Increase available space for treating patients in Spohn’s Northside FHC from 5000 square feet to at least 8000 square feet
**Data Source**: Documentation of the additional space in the Northside primary care clinic (i.e. evidence of remodeling)

**Milestone 4 Estimated Incentive Payment (maximum amount)**: $1,611,290

**Milestone 5** [P-4]: Expand hours of a primary care clinic to include evening and weekend hours
**Metric 1** [P-4.1]: Increase number of hours at primary care clinic over baseline
**Baseline/Goal**: Increase clinic hours in at least one primary care clinic to include 2 additional hours per week after 5pm or during the weekend over DY3 hours of availability.
**Data Source**: Clinic schedules

**Milestone 5 Estimated Incentive Payment (maximum amount)**: $997,760.50

**Milestone 6** [P-5]: Hire additional primary care providers and staff.
**Metric 1** [P-5.1]: Documentation of increased number of providers and staff
**Baseline/Goal**: Hire/contract 2 additional providers to staff Spohn’s primary care clinics.
**Data Source**: Staffing schedules, HR documents

**Milestone 6 Estimated Incentive Payment (maximum amount)**: $1,611,290

**Milestone 7** [I-12]: Increase Primary Care Clinic volume of visits and evidence of improved
**Metric 1** [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
**Goal**: 15% increase in primary care visits over DY2 numbers, as averaged across Spohn’s four (4) primary care clinics and the Hector P. Garcia clinic (an estimated 10,050 additional Medicaid/self-pay encounters over DY2, for a total of 61,640 Medicaid-eligible/self-pay visits).
**Data Source**: Clinic scheduler, clinic records

**Milestone 7 Estimated Incentive Payment (maximum amount)**: $1,611,290

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**RHP Plan for Region 4**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI</th>
<th>121775403</th>
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<td>121775403.3.1</td>
<td>IT-9.2</td>
<td>Right Care Right Setting – ED appropriate utilization-all (non-urgent/non-emergent) ED visits</td>
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</tbody>
</table>

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2 Estimated Incentive Payment (maximum amount): $977,069.50</td>
<td>Payment (maximum amount): $999,309.50</td>
<td>Payment (maximum amount): $997,760.50</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,954,139</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,998,619</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,995,521</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,611,290</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,559,569
CHRISTUS Spohn Hospital Corpus Christi/121775403
Implement a Chronic Disease Registry, 1.3.1
Unique Identifier - 121775403.1.2

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** Spohn will implement a Chronic Disease registry to assist Spohn in tracking and managing patients with conditions, which will initially focus on patients with CHF and diabetes. The chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients.

- **Need for the project:** Current documentation by the Care Transitions/Care Partners teams is handwritten paper format and Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. The registry will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams that is untenable under the current documentation system. The registry and repository will link to the EMR and provide the ability to track, trend and alert both inpatient and outpatient care providers to multiple hospitalizations and ED visits regardless of facility or location within the Spohn hospital system. Automated acquisition, storage and access to this data will enhance identification of individual patient needs to analyze and report trends in resource utilization.

- **Target population:** The target population of this project includes charity, Medicaid and self-pay patients with CHF and/or diabetes who are not currently enrolled in our Care Transitions or Care Partners programs (“target population”). Patients are identified by case managers in the acute care setting and referrals submitted to the Community Outreach department for program enrollment. Currently, 237 patients covered through the County’s indigent program are enrolled in Care Transitions for CHF/Diabetes. Each of those patients receives 5 encounters as part of the program, after which 80% of those patients are referred into the Care Partners program for 90 additional visits per patient over 18 months (for a total of 18,285 patient encounters). This project seeks to enroll the target population into these programs, which Spohn estimates will impact 1400 additional enrollees who will receive an total of approximately 110,000 encounters (based on current trends).

- **Category 1 or 2 expected patient benefits:** Spohn expects to have the registry implemented in at least 4 clinics with approximately 1400 enrollees by the end of DY4, which Spohn expects to result in at least 50% of targeted patients receiving educational, disease-appropriate information after visits with the Care Transition team by the end of DY5 (an estimated 700 enrollees). These interventions should improve patient self-management skills, short- and long-term health outcomes, and patient satisfaction with the healthcare delivery system.

- **Category 3 outcomes:** IT- 3.2: Our goal is for the use of the registry to result in an 8% reduction from DY2’s CHF patient all-cause 30-day readmission rates for Spohn’s Corpus Christi campuses by the end of DY5.
**Implement Chronic Disease Registry**  
*Category 1: Infrastructure Development*  
**Identifying Project and Provider Information:**  
Implement a Chronic Disease Registry, 1.3.1  
CHRISTUS Spohn Hospital Corpus Christi/121775403  
Unique Identifier - 121775403.1.2

**Project Description:**  
Spohn will implement a Chronic Disease registry to assist Spohn in tracking and managing patients’ conditions. The project will initially focus on CHF and diabetes. Spohn will enter patient data into the registry, and will then use the information contained in the registry to take a proactive approach to managing the conditions of patients with CHF and diabetes. This includes engaging these patients in education, community outreach, regular status checks with their primary care providers, maintaining an active support system, and engaging patients to exercise self-management of their conditions. Upon implementing the registry and using it proactively, Spohn will use the reports generated by the registry to develop and implement a plan for quality improvement in the medical care provided to patients with these chronic conditions. The implementation of this plan will likely include identifying best practices and training staff to expand their use of those practices, discovering why certain patients are “frequent-flyers” and taking steps to provide additional support to those patients, and to determine how many, if any, of the chronic conditions could be better managed with additional input or support from other providers within Spohn’s network.

More specifically, a chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients. heartbase™ is our current vendor for national registries cardiovascular benchmark reporting of AMI, CHF and Open Heart Surgery with expansion to stroke and core measure data to The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS). heartbase™ is a certified vendor by TJC, CMS, American College of Cardiology (ACC) and Society of Thoracic Surgery (STS) with representation on international cardiovascular Health Information Exchange (“HIE”) teams.

This database will combine registry and longitudinal tracking of patients with chronic disease by automating patient documentation currently used by the Care Transitions and Care Partners (CHW) programs. Initial focus will be patients with CHF and diabetes but capability will incorporate all chronic disease and potential co-existing behavioral health diagnoses. The database will utilize a combined set of elements. Data points will not be duplicated but rather shared if they are the same data point, like ICD9 (Future ICD-10) and patient name.

The registry will interface with Meditech, our current inpatient EMR, and Athena, the future EMR for our Family Health Centers (“FHC”) and the current EMR at Hector P. Garcia. Automation of the named documents and proposed interfaces will provide a provider and patient portal to a chronic disease repository that is used by all six Spohn facilities, related clinics and doctor offices. The database vision is one where the community stores all related chronic disease information on a server that is shared by hospital, clinics, physicians, and patients that participate in this program at CHRISTUS Spohn Health System. Access will be via a web-based front end with secured areas for both patients.
and staff and will also have the ability to interface with the developing health information network of South Texas, HINSTX.

The proposed registry will also have the ability to interface and house future proposed telehealth/telemedicine devices used to remotely access and monitor patients in their homes by the Care Transition and Care Partners teams as well as regional primary care providers.

**Project Goals/5 Year Expected Outcome:**
- Registry implemented at four local clinics with 1400 enrollees by the end of DY 4 At least 50% of targeted patients receiving educational, disease-appropriate information after visits to the FHCs (approximately 700 patients)
- Engage in quality improvement by collecting and disseminating best practices from each FHC

**Project Challenges:**
- Creating and implementing the actual registry (which will include provider training and assistance from third parties)
- Collecting accurate and current data regarding the health status of FHC patients
- Training providers to engage in effective outreach, support, and management for patients with these chronic diseases
- Maintaining the registry consistently
- Sharing information across FHCs in an organized and effective manner

Spohn will address these challenges by taking deliberate steps towards implementing the registry in an organized and thoughtful manner. The registry will not useful if providers cannot use it properly or do not understand the value of increased patient outreach and education. Thus, creating the registry and training our providers are the most important steps in DYs 2-3. In DYs 4-5, the FHCs can begin taking steps to improve on current practices using the registry for guidance and to stay organized. The registry itself will allow the FHCs to share more information than they may currently be able to do on a day-to-day basis.

**Relationship to Regional Goals:** Region 4 wants to transform care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improve patient satisfaction and outcomes while reducing the systemic costs of treating unmanaged chronic care conditions. This project addresses these goals head on.

**Starting Point/Baseline:**
Current documentation by the Care Transitions/Care Partners teams is handwritten paper format. Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. They are often contacted by individual unit staff when patients not identified by CM receive discharge orders. Currently 237 patients covered through the County’s indigent program are enrolled in Care Transitions for CHP/Diabetes. Each of those patients receives 5 encounters as part of the program, after which 80% of those patients are referred into the Care Partners program for 90 additional visits per patient over 18 months (for a total of 18,285 patient encounters).
**Rationale:**
On a macro level, Region 4 has a high incidence of chronic disease, as noted in the Region’s Community Needs Assessment: “Regional hospital admissions and related data indicate that there is a prevalence of chronic conditions that lead to preventable hospitalizations, and which require a coordinated care management team approach to maximize patient outcomes.” *RHP Plan, p. 29.* Additionally, chronic diseases including CHF, COPD, Diabetes, and asthma are linked with Nueces County having a higher rate of Potentially Preventable Admissions than the statewide average. Avoidable hospitalization has a twofold negative impact on the delivery system: (1) patient health outcomes and satisfaction are reduced in the long- and short-term, and (2) the cost of delivering care is immediately and going forward more expensive when patients’ conditions deteriorate to an acute level.

This project will provide a substantial infrastructure to identification, tracking and monitoring Medicaid/uninsured/Self-pay patients regardless of entry point into the CHRISTUS Spohn Health System. This capability will link patients throughout the region and provide a future avenue for global integration to external HIEs. In addition to access and exchange of information, the registry/repository will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams. This flow of communication does not currently exist. A frequently occurring example of the breakdown in the current system identified by the Care Transitions/Care Partners staff is patients missing their scheduled clinic appointments because they are inpatients at the hospital. Our planned registry will provide patient and hospital alerts to maximize the efficiency of communication and disease management.

**Milestones and Metrics:** Spohn chose its DY 2-3 milestones in metrics in order to develop, test, and implement the registry, as well as train staff to populate it and use it successfully. Spohn chose its DY 4-5 milestones and metrics in order to effectuate improved care for patients with the targeted chronic conditions and to engage in quality improvement by the end of DY5.

Community Needs Identification Number Addressed by this Project: CN.3, CN.7, CN.12

**Related Category 3 Outcome Measure(s): OD 3: Potentially Preventable Readmissions; Improvement Target 3.2: CHF 30 Day Readmissions**
Automation and integration of Care Transitions and Care Partners programs with interfaces to hospital and clinic EMRs will streamline communication and provide longitudinal tracking and monitoring of chronically ill patients upon discharge from the inpatient setting. Spohn selected this outcome measure because one goal behind developing the registry is to longitudinally track patients with CHF and develop alerts for those who experience frequent readmissions, regardless of cause. This project is intended to help Spohn to identify those patients that are at risk for readmission to the hospital (often multiple times) upon discharge and intervene to prevent the causes of their readmission (including the inability to self-manage CHF in the outpatient setting).

**Relationship to other Projects:**
This automated infrastructure will finally provide a link between inpatient and outpatient care provided to individual patients in an efficient and streamlined manner to facilitate integrated care coordination in multiple settings. It is related to the following projects also proposed in this waiver plan:
• 121775403.1.4 - PADnet – telehealth/telemedicine – This project also addresses streamlining care for chronic conditions and is a related cardiac condition.
• 121775403.2.1 Establish Medical Homes – Part of the Medical Home model involves comprehensive management of patients' conditions before they deteriorate, which is the specific purpose of the chronic disease registry.
• 121775403.2.3 Cost of Care Delivery – Primary Care Redesign – The hospitalist and resident teams assigned to patients will use the chronic disease registry to track their patients.
• 121775403.2.4. Diabetes Cellphone Application – Diabetes is another chronic condition that will be tracked in the registry, and the information will be used for outreach under this program.
• 121775403.2.8 Expand Care Transitions program – The chronic disease registry will assist the RN Coaches in managing chronically ill patients’ conditions.


This project provides integration of information with all 3 CHRISTUS Spohn Health System community facilities and CSHA. This is crucial to regional patient outcomes as patients transfer to Alice and Victoria from all remote areas of the RHP. This infrastructure and its ability to interface with future development of HINSTX will support the flow of communication beyond the CSHS boundaries and throughout the lifespan of the patients.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
b. Further develop and maintain a coordinated care delivery system
c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its application to the goals of the Waiver, in that it focuses on improving patient outcomes while reducing the systemic cost of providing care. The registry will allow Spohn to make proactive choices to maintain the health status of chronically ill patients, which will benefit their quality of life and satisfaction with their health care greatly. The high incidence of chronic disease in Nueces County means that the registry addresses known community needs and will serve a broad population of the County’s residents. Finally, creating, implementing, and proactively using the registry will require investment in technology, staff training, project planning, and community outreach.

15 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### 1.3. IMPLEMENT A CHRONIC DISEASE REGISTRY

**CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI**

<table>
<thead>
<tr>
<th>Milestone 1 [P-1]: Identify 1 or more target patient populations diagnosed with selected diseases or multiple chronic conditions</th>
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</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-1.1]: Documentation of patient population to be entered into the registry</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Registry development for 2 major chronic diseases/conditions; CHF and diabetes</td>
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<tr>
<td><strong>Data Source</strong>: Performing Provider documents</td>
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**Milestone 1 Estimated Incentive Payment (maximum amount):** $804,645.50

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<th>Milestone 2 [P-2]: Review current registry capability and assess future needs</th>
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<tr>
<td><strong>Metric 1</strong> [P-2.1]: Documentation of review of current registry capability and assessment of future needs</td>
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<tr>
<td><strong>Baseline/Goal</strong>: Approval of comprehensive proposal to develop electronic infrastructure for longitudinal data registry</td>
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<tr>
<td><strong>Data Source</strong>: Registry Project Management Plan/Proposal</td>
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**Milestone 2 Estimated Incentive Payment (maximum amount):** $822,961

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<th>Milestone 3 [P-3]: Develop cross-functional team to evaluate registry program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-3.1]: Documentation of personnel assigned to registry evaluations</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Spohn multidisciplinary team development of chronic disease registry</td>
</tr>
<tr>
<td><strong>Numerator</strong>: number of personnel assigned to enter the registry</td>
</tr>
<tr>
<td><strong>Denominator</strong>: total number of personnel</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Registry Project Management Plan/Proposal</td>
</tr>
</tbody>
</table>

**Milestone 3 Estimated Incentive Payment (maximum amount):** $821,685

<table>
<thead>
<tr>
<th>Milestone 4 [P-4]: Implement/expand a functional disease management registry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-4.1]: Registry functionality is available in X% of Performing Provider’s sites and includes an expanded number of targeted diseases or clinical conditions.</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: The registry measuring CHF and diabetes will be</td>
</tr>
</tbody>
</table>

**Milestone 4 Estimated Incentive Payment (maximum amount):** $821,685

<table>
<thead>
<tr>
<th>Milestone 5 [P-5]: Increase the percentage of patients enrolled in the registry.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-5.1]: Percentage of patients in the registry with targeted chronic conditions</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Increase the percentage of the FHCs’ diabetic and CHF patients (across the board) entered into the registry by 10% over the percentage in the</td>
</tr>
</tbody>
</table>

**Milestone 5 Estimated Incentive Payment (maximum amount):** $821,685

<table>
<thead>
<tr>
<th>Milestone 6 [I-15]: Increase the percentage of patients with chronic disease who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [I-15.1]: Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.</td>
</tr>
<tr>
<td><strong>Goal</strong>: 50% of patients with diabetes or CHF will receive disease appropriate instructions after appointments at each FHC on how to manage their condition day-to-day (for diabetics, specifically diet information and medication management; for CHF patients, specifically medication management and activity level) – Spohn estimates this to constitute 700 patients</td>
</tr>
<tr>
<td><strong>Numerator</strong>: the number of patients with chronic disease who receive appropriate disease specific instructions</td>
</tr>
<tr>
<td><strong>Denominator</strong>: number of patients with targeted chronic disease entered into the registry</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Disease registry or EHR</td>
</tr>
</tbody>
</table>

**Milestone 6 Estimated Incentive Payment (maximum amount):** $821,685

<table>
<thead>
<tr>
<th>Milestone 7 [I-22]: Increase the percentage of patients with chronic disease entered into the registry who receive instructions appropriate for their chronic disease, such as: activity level, diet, medication management, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [I-22.1]: Percentage of patients with chronic disease who receive appropriate disease specific discharge instructions.</td>
</tr>
<tr>
<td><strong>Goal</strong>: 50% of patients with diabetes or CHF will receive disease appropriate instructions after appointments at each FHC on how to manage their condition day-to-day (for diabetics, specifically diet information and medication management; for CHF patients, specifically medication management and activity level) – Spohn estimates this to constitute 700 patients</td>
</tr>
<tr>
<td><strong>Numerator</strong>: the number of patients with chronic disease who receive appropriate disease specific instructions</td>
</tr>
<tr>
<td><strong>Denominator</strong>: number of patients with targeted chronic disease entered into the registry</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Disease registry or EHR</td>
</tr>
</tbody>
</table>

**Milestone 7 Estimated Incentive Payment (maximum amount):** $821,685

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**RHP Plan for Region 4**
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>121775403.1.2</td>
<td>1.3.1</td>
<td>121775403.1.2.1, 1.2, 1.3.1.A, B, C, D</td>
<td>121775403.1.2.1, 1.2, 1.3.1.A, B, C, D</td>
</tr>
<tr>
<td><strong>CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI</strong></td>
<td><strong>121775403</strong></td>
<td><strong>121775403.3.2</strong></td>
<td><strong>IT 3.2</strong></td>
</tr>
<tr>
<td><strong>Congestive Heart Failure 30 day readmission rate</strong></td>
<td><strong>Implement a Chronic Disease Registry</strong></td>
<td><strong>Implement a Chronic Disease Registry</strong></td>
<td><strong>Implement a Chronic Disease Registry</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Payment (maximum amount):</strong></td>
<td><strong>implemented and used for management and outreach in at least 80% of Spohn’s FHC sites (4/5 clinics). Data source: documentation of installation and adoption of the registry</strong></td>
<td><strong>registry in DY3 (if DY3 reflects 100% of these patients are in the registry, then the FHCs will maintain this percentage by adding all new patients with the targeted condition into the registry by the end of DY4 – Spohn hopes to have 1400 enrollees in DY5)</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment (maximum amount):</strong></td>
</tr>
<tr>
<td><strong>$804,645.50</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount):</strong></td>
<td><strong>$822,961</strong></td>
<td><strong>$663,472</strong></td>
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<tr>
<td><strong>Numerator:</strong></td>
<td><strong>Number of CHF and diabetic patients in the registry</strong></td>
<td><strong>Denominator:</strong></td>
<td><strong>Data Source:</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td><strong>Registry and/or EHR</strong></td>
<td></td>
<td><strong>Registry and/or EHR</strong></td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount):</strong></td>
<td><strong>$821,685</strong></td>
<td></td>
<td><strong>$821,685</strong></td>
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<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong></td>
<td><strong>$1,609,291</strong></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong></td>
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<tr>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong></td>
<td><strong>$1,643,370</strong></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong></td>
<td><strong>$1,643,370</strong></td>
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<tr>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong></td>
<td><strong>$1,326,945</strong></td>
<td></td>
<td><strong>$1,326,945</strong></td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): **$6,225,528**
CHRISTUS Spohn Hospital Corpus Christi
Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
Unique project ID number: 121775403.1.3

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** Spohn plans to implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and treatment plans. The PADnet™ Disease Management System provides patients that present at PCP offices with access to specialists to address issues with PAD.

- **Need for the project:** As a screening tool, PADnet is recommended for early detection and intervention in people with symptoms or at risk for peripheral arterial disease (PAD). Currently, diagnostics are performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a cardiologist or cardiovascular (CV) surgeon for follow-up, diagnostics and treatment plan with or without requisite interventions. Current wait times for indigent patients in Nueces County to see a cardiologist ranges from 40-60 days. PAD is very painful and as it progresses undetected or untreated it can result in skin ulcers, gangrene, and amputation.

- **Target population:** The target population of this project includes Nueces County residents at risk for PAD who seek treatment in Spohn’s clinics and the Hector P Garcia clinic where Spohn physician-residents provide care, and require cardiovascular referrals. Spohn intends to screen its high risk clinic patients with diabetes who are not currently symptomatic for PAD. Spohn’s FHCs and neighboring clinics treat approximately 19,500 patients per year, approximately 7800 (40%) of which are diabetic and many of whom are high risk because of their family history, ethnicity and/or age. Spohn will identify those patients based on diabetes, hypertension, and history of smoking, and screen them for PAD.

- **Category 1 or 2 expected patient benefits:** Through implementing the use of PADnet™ in local clinics, Spohn expects the benefits to patients to include 1000 PADnet screenings in DY3, 1750 PADnet screenings in DY4, and 2500 PADnet screenings in DY5, as well as a 5% reduction in the wait time experienced by indigent patients for a cardiology consult by the end of DY3, and a 5% increase in telemedicine cardiology consults for patients residing in geographically underserved areas served by Spohn’s clinics from the first year of operation by the end of DY5.

- **Category 3 outcomes:** IT-1.11: Our goal is a 10% increase in the number of diabetic patients with controlled blood pressure, which should decrease those patients’ risk of developing PAD.
**Introduce PADnet for Peripheral Arterial Disease Screening and Treatment**

**Category 1: Infrastructure Development**

**Identifying Project and Provider Information:**
Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Option 1.7.6: Implement an electronic consult processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

CHRISTUS Spohn Hospital Corpus Christi/ TPI 121775403
Unique project ID number: 121775403.1.3

**Project Description:**
Spohn plans to implement a system for early detection and to mitigate the adverse effects of chronic disease rampant in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and interventions. The PADnet™ Disease Management System provides patients who present at PCP offices with access to specialists to address issues with peripheral arterial disease (PAD). Spohn expects this to result in fewer unnecessary referrals to specialists for treatment the PCP is able to provide personally, earlier detection for patients who need immediate intervention, and greater care coordination between PCPs and cardiac specialists. No federal funds have been received or are being used for this project.

**Project Goals/5-Year Expected Outcome:**
The remote diagnostic devices can be located in PCP offices and will allow for increased communications through telemedicine with cardiologists or cardiovascular surgeons to interpret, diagnose and prescribe treatment or work in collaboration with the PCP to determine an appropriate follow-up/prevention plan when no interventions are needed. Finally, through quality improvement initiatives, the project will assess the project’s impact, lessons learned and opportunities to scale the project to a broader population.

Implementation of PADnet will help demonstrate the benefits of early detection and intervention for PAD, both for patient quality of life, satisfaction and long-term health outcomes and for the systemic cost of providing care to the chronically ill.

Specific goals include:
- 5% increase in PADnet™ screenings in DY3, over baseline set in DY2; 10% increase over DY2 baseline in DY4; 15% increase over DY2 baseline in DY5
- 5% reduction in wait time to cardiovascular consult for PAD in DY3 (using records from DY2 to measure improvement)
- Implement the use of PADnet™ in at least 3 FHCs by the end of DY4

This project is related to Region 4 goals in that it seeks to prevent diabetes related complications by allowing rural and indigent patients to access real-time diagnostics and reads by a specialist. These complications are costly to Region 4 communities in that they increase the cost of delivering care (often because they lead to ED visits), reduce productivity in the work-force, and cause ripple-effects for affected families. Any and all providers in the Region can access this network through purchasing the diagnostic equipment, which is fairly low cost.
Project Challenges:
- Identifying cardiac specialists willing to provide electronic consults for patients in Nueces County
- Implementing new technology in the FHCs
- Training providers in the FHCs to use the PADnet technology
- Educating patients about the benefits of using electronic consults

Spohn will address these challenges by coordinating with stakeholders to identify appropriate partners for the project (i.e. specialists to provide the consults) and by using DY2 to train providers and create processes that are consistent across the FHCs. Finally, Spohn will train providers on how to present the PADnet telemedicine option to patients in a manner that alerts them to the benefits of using this technology.

Starting Point/Baseline:
Diagnostics are currently performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a cardiologist or cardiovascular (CV) surgeon for follow-up, diagnostics or planned interventions. Depending on the severity of the disease, peripheral artery angioplasty, stenting, surgical revascularization and amputation are all possible interventions. For less severe disease or those with high risk factors, minor disease can benefit from medical treatment. In the past year, 651 interventional or surgical treatments have been performed on patients for PAD at Spohn; of those, 20% were Medicaid-eligible or self-pay. Early detection and the option of peripheral interventions for symptomatic or at risk patients has shifted the ratio of amputations to interventions to 50:50 from previous ratios of 70:30 as recently as 2006.

Rationale:
Like many diagnostic modalities designed for early detection of potentially life altering diseases, PADnet provides a solution that decreases the cost and burden of diagnostic on the patient and healthcare system. For the Medicaid, charity and self-pay patients in RHP 4, patients suspected of having or at risk for PAD have historically been referred to a Cardiology/CV Surgeon for evaluation. PAD in its moderate to advanced stages is associated with high pain levels especially with weight-bearing patients. Severe circulatory compromise results in swelling of the lower extremities and often open ulcers or wounds. Uninsured/underinsured patients often skip specialist appointments due to expense of the visit, time missed at work for a doctor visit or because they think they can tolerate it a little longer. They are often unaware that the PAD does not go away on its own but can be treated successfully if identified during the early stages. Another identified barrier in our region is the delay obtaining an appointment with these specialties. Current wait times for indigent patients to see a cardiologist ranges from 40-60 days.

One key to determine the precedence for screening in RHP 4 as well as other areas of the state is to analyze current statistics:
- Approximately 5 million Americans in the US are affected by PAD
• Predominant populations include Hispanic blacks, diabetics and elderly (> age 70) with the elderly being the highest at 14.5%
• 66,000 people with diabetes had non-trauma related lower extremity amputations in 2006 (Briggs, 2006)
  o Mean hospital charge was $56,400 accounting for $3.7 billion for amputations alone
• Additional risk factors should also be considered; obesity, age, gender, smoking, cholesterol, blood pressure to name a few
• South Texas also sees a predominant culture of complacency regarding amputations in familial lines. This often lends to delay in seeking treatment early for onset of symptoms associated with the disease

The evidence statement on Peripheral Arterial Disease (PAD) posted by the USPSTF (2005) addresses two patient populations; asymptomatic/low risk and symptomatic/at-risk. Despite the USPSTF statement, numerous studies since 2005 indicate a more rigid investigation of screening in asymptomatic people using the Ankle-Brachial Index (ABI) and may support project expansion to the asymptomatic, low-risk patient population in the future. One study (McDermott et al, 2010) shows a relationship between PAD and walking endurance measured by ABI with or without claudication. Although the USPSTF-endorsed screening statement is outdated, the American College of Preventive Medicine (ACPM) supports their 2005 stance in asymptomatic patients in an ACPM 2011 guideline (Lim et.al, 2011). A Draft Research Plan (Wilt, 2011) has also been posted to the USPSTF site that proposes a more rigid investigation of ABI and asymptomatic patient populations. Despite the views on routine screening in asymptomatic patients, the American Heart Association (AHA) and the American Diabetes Association (ADA) both support screening and early intervention in symptomatic and at-risk patients specifically those with diabetes.

The high prevalence of diabetes in our region and the remote locations with limited accessibility to specialists lend credibility to an early screening routine for the Hispanic, diabetic and high-risk populations. The PADnet diagnostic device located in Primary Care Centers and Medical Homes will provide direct communication to a remote specialist, eliminating the need for delayed appointments and unnecessary visits while still affording the patient and PCP access to the clinical specialist for diagnosis and treatment/prevention options. Patients are more likely to seek screening when done in their primary care setting instead of traveling to a specialist’s office.

The PADnet project will also allow storage of diagnostic information that can be used for longitudinal comparison and eventual incorporation in the patients EHR and regional HIE.

**Community Needs Assessment:** This project addresses the following community needs: CN.2 (Inadequate access to specialty services); CN. 3 (Inadequate provision and coordination of healthcare services for persons with chronic conditions); CN.6 (high rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions)

**Milestones and Metrics:** Spohn chose Milestones 1 and 3 in order to assure that Spohn successfully implements the use of PADnet during DY2 in at least two of its FHCs and in at least one additional FHC by DY4. Milestones 2, 4, and 6 are intended to measure the increased use of telemedicine consults for patients at risk for PAD over the life of the Waiver, while Milestones 3 will incentivize
Spohn providers to use the new telemedicine capability to reduce the wait times for patients to receive a specialty consult for PAD patients.

**Related Category 3 Outcome Measure(s):**
Associated Outcome Measures selected for this project include:
- OD-1: Primary Care and Chronic Disease Management
- IT-1.11 – Diabetes Care, Blood Pressure Control

Spohn developed this outcome measure consistent with studies that show diabetic patients are at increased risk of PAD, and high blood pressure is a condition that also contributes to PAD. Thus, by controlling blood pressure in this population, Spohn hopes to decrease the risk of developing PAD.

**Relationship to other Projects:**
This project’s focus on treating chronic disease and increasing access to specialty care and provider training is related to and will enhance the following projects:
- 121775403.1.3 and 094222902.1.2 - Establish Chronic Disease Management Registry (Spohn intends to expand its tracking and primary care treatment of chronic diseases, including PAD, through comprehensive reform)
- 121775403.2.1 Medical Homes (creating medical homes for patients enables their doctors regular access that will improve the change of diagnosing PAD early)
- 121775403.2.3 Cost of Care Delivery- Primary Care redesign (early intervention for PAD results in improved patient outcomes, which reduces the cost of providing their care)
- 121775403.2.8 Care Transitions (patients who may be hospitalized with a diagnosis of PAD will benefit from Care Transitions to assist in management of their condition upon discharge)
- 130958505.2.1 – Implement an innovative and evidence-based health promotion program


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing a telemedicine training program, other similar projects will focus on improving access to care, including projects submitted by Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for CHRISTUS Spohn Hospital Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission,
we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?\(^{16}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its relationship to Waiver goals. Specifically, this project is patient-centered because it aims to increase and improve access to specialists for patients at risk for PAD, and will also reduce the systemic cost of treating patients with PAD. This project addresses community needs for patients at risk of PAD (including elderly patients, smokers, smokers, smokers).

\(^{16}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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RHP Plan for Region 4
diabetics, obese patients, and patients with high blood pressure and/or cholesterol) by enabling quicker diagnosis and treatment if they are determined to have PAD. The investment in this project will be substantial, in that equipment/software will need to be purchased, providers trained, and the community educated.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-3]: Implement telemedicine program for PAD</td>
<td><strong>Milestone 2</strong> [Additional Process Milestones]: Establish a baseline in order to measure improvement over self</td>
<td><strong>Milestone [I-13]: Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult</strong></td>
<td><strong>Milestone 6</strong> [I-13]: Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and training logs</td>
<td><strong>Metric 1</strong>: The number of PAD screenings performed subsequent to implementation during DY2</td>
<td><strong>Metric 1</strong> [P-3.2]: Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient</td>
<td><strong>Metric 1</strong> [P-3.2]: Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Initiate PADnet program/infrastructure for remote screening and access to cardiovascular specialists in at least 2 of Spohn’s FHCs</td>
<td><strong>Baseline/Goal</strong>: Spohn expects to screen at least 1000 patients through PADnet in DY3</td>
<td><strong>Denominator</strong>: Number of patients referred to all medical specialties using referral processing system</td>
<td><strong>Denominator</strong>: Number of patients referred to all medical specialties using referral processing system</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Program materials and documents</td>
<td><strong>Data Source</strong>: Referral documentation and PADnet reports.</td>
<td><strong>Data Source</strong>: PADnet reports.</td>
<td><strong>Data Source</strong>: PADnet reports.</td>
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount)</strong>: $1,954,139</td>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>: $999,309.50</td>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount)</strong>: $997,760.50</td>
<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount)</strong>: $1,611,290</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [I-14]: Reduce wait times to cardiovascular specialist for PAD screening/diagnostics</td>
<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount)</strong>: $999,309.50</td>
<td><strong>Milestone 5</strong> [I-16]: Expand telemedicine to additional clinics/FQHCs</td>
<td><strong>Milestone 5</strong> [I-16.1]: New PADnet enhanced clinics</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-14.1]: Number of days until first available time for review and consultation for patient referred telemedicine consults.</td>
<td><strong>Goal</strong>: 5% reduction in wait time to cardiovascular consult for PAD</td>
<td><strong>Goal</strong>: Increase in telemedicine-enhanced clinics to at least one</td>
<td><strong>Goal</strong>: Increase in telemedicine-enhanced clinics to at least one</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Referral documentation and PADnet reports.</td>
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<td><strong>Data Source</strong>: PADnet reports.</td>
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</tbody>
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**Related Category 3 Outcome Measure(s):**

- 121775403.3.3
- IT 1.11

**Outcome Measure(s):**

- Diabetes care, Blood Pressure
<table>
<thead>
<tr>
<th>121775403.1.3</th>
<th>1.7.6</th>
<th>EARLY SCREENING, DIAGNOSIS AND INTERVENTION FOR PERIPHERAL ARTERIAL DISEASE PATIENT CONSULTATION BY SPECIALISTS VIA TELECOMMUNICATION CONDUCT QUALITY IMPROVEMENT TO IDENTIFY PROJECT IMPACT</th>
<th>CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI</th>
<th>121775403</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>121775403.3.3</td>
<td>IT 1.11</td>
<td>Diabetes care, Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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<tr>
<td>additional FHC or local clinic</td>
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<td>Milestone 5 Estimated Incentive Payment (maximum amount): $997,760.50</td>
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<td>Data Source: PADnet reports and purchases.</td>
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<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,954,139</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,998,619</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,995,521</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,611,290</td>
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<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,559,569</td>
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Performing Provider Name/TPI: CHRISTUS Spohn Health System/121775403
Project 1.9.3: Expand Specialty Care – Intensivists Program Development
Unique Identifier - 121775403.1.4

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** Spohn intends to develop a team of Intensivists within the hospital to provide care of the critically ill patients. Intensivists are physicians with training in critical care medicine. The critically ill patients will be managed by the Intensivists on a 24 hour basis, 365 days a year. The on-site presence of the Intensivists will improve real time access to specialized care.

- **Need for the project:** Admission and readmission data provides evidence that varied physician practice patterns impact patient outcomes within the hospital and require standardization to improve those outcomes. The July 1 – June 30, 2012, admission data showed a Septicemia readmission rate of 16.10 per 10,000 patient days, Heart Failure with shock readmission rate of 19.58 per 10,000 patient days and pulmonary embolism readmission rate of 23.08 per 10,000 patient days. Review of one day stay data showed a 6% readmission rate of all ICU admissions for the same time period. These factors indicate a pressing need for the development of an Intensivist program. Currently, there are Intensivists 12 hours a day at the CHRISTUS Spohn Memorial campus that provide support of the Level II Trauma Center and to the GME program. Creation of a closed model program that will support all three Spohn Corpus Christi campuses is necessary to meet the demands of the surge in demands for ICU capacity and services. The presence of this trained critical care trained provider who will oversee admissions, discharges, and care delivery will improve critical care patient outcomes, throughput, cost savings, capacity, access to appropriate specialty services and impact admissions and readmission.

- **Target population:** The target population for this project is critically ill patients in the hospital’s ICU. In FY12, there were approximately 6300 critical care admissions totaling approximately 25,600 patient days, and 40% of the admissions were Medicaid or uninsured (approximately 2500 admissions). Of those, 657 were assigned Intensivists at the Memorial facility (10.5% of total admissions) and 351 of those assigned to Intensivists were Medicaid/uninsured (5.5%).

- **Category 1 or 2 expected patient benefits:** Spohn expects to assign 20% of the ICU admissions in DY3 to an Intensivist (approximately 1200 admissions total, 480 Medicaid/uninsured); 30% of the ICU admissions in DY 4 (approximately 1890 admissions, 756 Medicaid/uninsured); and 40% of the ICU admissions to an Intensivist in DY5 (approximately 2520 admissions, 1000 Medicaid/uninsured).

- **Category 3 outcomes:** IT-4.2 Spohn’s goal is a 58% improvement in CLABSI rates for ICU patients by the end of DY5, as a result of increased Intensivist coverage in the hospital.
**Project 1.9. 3– CHRISTUS Spohn Hospital Corpus Christi (CSHCC): Expand Specialty Care – Intensivist Program Development**

*Category 1: Infrastructure Development*

**Identifying Project and Provider Information:**

Unique Identifier - 121775403.1.4

Performing Provider Name/TPI: CHRISTUS Spohn Health System (“Spohn”)/121775403

**Project Description:** Spohn intends to develop and implement a structured critical care service model focused on providing intensivist-driven services throughout its facilities.

Specifically, the proposed project would allow for care of the critically ill patient to be managed by hospital intensivists on a 24 hour basis, 365 days a year. The on-site presence of the critically trained physician would improve real time access to specialized care. A system champion has been identified to further these efforts and facilitate the analysis and the development of a clinically integrated model for Spohn. The Regional Medical Director for Critical Care Services is responsible for reviewing regional needs and heading a team of hospital associates and physician providers in planning and implementation of the “Intensivist Program Development.” The use of a dedicated critical care team with physicians, physician extenders and multidisciplinary team members provides a goal and outcome oriented care delivery system that promotes an effective decision making process. As a multi-year effort there is a need for resource recruitment, development and allocation in order to assure the sustainability and success of this much needed service.

Spohn serves as the largest hospital where an array of Trauma, Medical intensive care unit (ICU), Surgical ICU and Neuro ICU services are provided in Region 4. Currently the methodologies by which critical care services are provided are varied and multiple in design. The need for standardized practice models is evident by the current outcome data. Admission and readmission data provides evidence that practice patterns are varied and the need for standardization is present. The July 1 – June 30, 2012, admission data showed a Septicemia readmission rate of 16.10, Heart Failure with shock readmission rate of 19.58 and Pulmonary embolism readmission rate of 23.08. Review of one day stay data showed a 6% readmission rate of all ICU admissions for the same time period. With over 40% of its patients either Medicaid eligible or uninsured, Spohn anticipates this project will have a beneficial impact on the quality of hospital care provided to Medicaid and uninsured patients at its facilities.

**Project Goals/5 Year Expected Outcome:**

- 25% of Spohn’s Corpus ICU patients referred to Intensivists
- Increase ICU capacity using Intensivist Model of Care Delivery

**Project Challenges:**

- Provider and staff cooperation in participating in additional training to implement the program.
- Development of training materials on processes, guidelines and technology for referrals and consultations to Intensivists.

RHP Plan for Region 4
• Educating patients regarding the program.

Relationship to Regional Goals:
Region 4 intends to transform healthcare delivery to increase patient health care outcomes. This project aims to further this goal by improving the quality of critical care at Spohn, and is solely focused on improving patient welfare at its facilities.

Starting Point/Baseline: TBD

Rationale:
Spohn chose this project because of the high rates of chronic conditions in the Region and the accompanying demand for sophisticated critical care services. According to the Region 4 Community Needs Assessment, the top two primary diagnoses in the Region are pneumonia and heart failure, both of which often require skilled intensive care services. Additionally, 21% of Nueces County residents are completely uninsured, meaning they have no source of third party payment to cover healthcare bills. These factors indicate a pressing need for the development of an intensivist program.

Furthermore, national shortages in critical care provider specialties have created an urgent need to provide crucial services. A structured hospital-based critical care delivery model will provide a mechanism for an effective delivery system that will impact patient care, clinical workflow, regulatory compliance, patient and physician satisfaction, and improvement in both economic and qualitative outcomes. According to the white paper on “Five Best Practices for Effective Critical Care Management,”

1) Approximately, five million adults are admitted to intensive care units every year and the number is growing annually. As a result, hospitals are turning to in-house intensivists to care for critically ill patients.
2) Critical care patients consume more resources than any other type of hospital admission.

The development and redesign of the intensivists’ services will provide regional support in that the limitation of provider resources throughout the region has stressed all provider entities. The regional services provided by Spohn solidify service availability for the entire region, including: trauma, regional chest pain center, and the regional stroke center among others.

Milestones and Metrics: Spohn chose its DY3, DY4, and DY5 milestones in order to systematically build the program. The metrics provide a mechanism to accurately gauge the development of the program and the number of Region patients that benefit from the program. Spohn chose its DY 2 milestone to lay the groundwork for the subsequent development and success of the project through the creation of the specialty care access plan. The plan will ensure that an expansive number of patients access the critical care program.

Ties to Community Needs Assessment Unique IDs: CN.3, CN.12, CN.13
Related Category 3 Outcome Measures: IT 4.2 Improvement in central line-associated bloodstream infections (CLABSI)
Spohn chose this outcome because one goal behind using an intensivist model is to prevent hospital-based complications that can arise from inconsistent or disorganized critical care delivery. Spohn expects patients to experience a reduced rate of CLABSI when the intensivist program is operational and specially-trained providers are the primary care givers assigned to treat patients in critical condition.

Relationship to Other Performing Providers’ Projects in the RHP:
The Intensivist critical care program will benefit a number of projects throughout the region through indirect support or enhancement of related services. Projects that will be impacted include: 121775403.2.2: Redesign of primary care through the development of a clinically integrated hospitalist service model; 020973601.2.2: Apply Process Improvement Methodology to Improve Sepsis mortality and length of stay; 121775403.2.7 - Medication Management, and 0942220902.2.1 and 121775403.2.5 – Improvement in Quality and Safety for patients with sepsis, Through the implementation of the intensivists’ project, related category 4 measures that will be impacted are RD-3 Potentially Preventable Complications, RD-4 Patient satisfaction, and RD-5 Emergency Department.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing an identical program, other similar projects will focus on improving health care outcomes and reducing the cost of care, including projects proposed by Corpus Christi Medical Center, Citizens Medical Center, and Driscoll Children’s Hospital.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, Spohn implemented an objective, reasonable, and equitable method for valuing its DSRIP projects using a valuation template to value each of its projects. The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
b. Further develop and maintain a coordinated care delivery system
c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? CSHCC considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?\(^\text{17}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn specifically considered the Region’s high rate of chronic care conditions, as evident in the Community Needs Assessment, in evaluating this project. Spohn also examined the number of potential patients who would be able to utilize the intensivist critical care program. The rural nature of the Region results in many patients traveling to the hospital for care, thus indicating that this program will improve the quality of care for many patients residing throughout the Region.

\(^{17}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>121775403.4</th>
<th>IT-4.2</th>
<th>CHRISTUS Spohn Hospital Corpus Christi</th>
<th>121775403</th>
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| **Year 2** (10/1/2012 – 9/30/2013) | **Year 3** (10/1/2013 – 9/30/2014) | **Year 4** (10/1/2014 – 9/30/2015) | **Year 5** (10/1/2015 – 9/30/2016) | **Milestone 1** [P-12]: Implement a Specialty Care Access plan  
**Metric 1** [P-12.1]: Documentation of specialty care access plan  
**Baseline/Goal**: Expand Intensivist Model of Care Delivery to facilitate care coordination of critically ill patients  
**Data Source**: Documentation of Provider plan | **Milestone 1 Estimated Incentive Payment (maximum amount):** $862,120 |
| **Milestone 2** [P-2]: Train providers and staff on processes, guidelines and technology for referrals and consultations to Intensivists  
**Metric 1** [P-5.1]: Documentation of training materials  
**Baseline/Goal**: Training curriculum completed  
**Data Source**: Training schedules and sign in logs  
**Metric 2** [P-5.1]: Number of staff trained  
**Baseline/Goal**: 80%  
**Data Source**: Training schedules and sign in logs | **Milestone 2 Estimated Incentive Payment:** $1,763,488 |
| **Milestone 3** [I-33]: Increase ICU capacity using Intensivist Model of Care Delivery  
**Metric 1** [I-33.1]: Increased percentage of ICU patients referred to Intensivists  
**Baseline/Goal**: Spohn estimates approximately 6000 critical care admissions to its Corpus facilities annually, of which approximately 650 are assigned to Intensivists. The goal is to assign 20% of ICU admissions to an Intensivist (approximately 1200 admissions) during DY3.  
**Data Source**: Hospital reports, EMRs | **Milestone 3 Estimated Incentive Payment:** $1,763,488 |
| **Milestone 4** [I-33]: Increase ICU capacity using Intensivist Model of Care Delivery  
**Metric 1** [I-33.1]: Increased percentage of ICU patients referred to Intensivists  
**Baseline/Goal**: Spohn’s goal is to assign 30% of ICU admissions to an Intensivist in DY4 (approximately 1800 admissions)  
**Data Source**: Hospital reports, EMRs | **Milestone 4 Estimated Incentive Payment:** $1,760,754 |
| **Milestone 5** [I-33]: Increase ICU capacity using Intensivist Model of Care Delivery  
**Metric 1** [I-33.1]: Increased percentage of ICU patients referred to Intensivists  
**Baseline/Goal**: Spohn’s goal is to assign 40% of ICU admissions to an Intensivist in DY5 (approximately 2400 admissions)  
**Data Source**: Hospital reports, EMRs from DY2 and DY5 | **Milestone 5 Estimated Incentive Payment:** $1,421,727 |
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<th>Related Category 3 Outcome Measure(s):</th>
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<th>IT-4.2</th>
<th>Reduce rate of hospital acquired CLABSIs</th>
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<td>Payment: $862,120</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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**Year 2 Estimated Milestone Bundle Amount:** $1,724,240

**Year 3 Estimated Milestone Bundle Amount:** $1,763,488

**Year 4 Estimated Milestone Bundle Amount:** $1,760,754

**Year 5 Estimated Milestone Bundle Amount:** $1,421,727

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,670,208
1.13.1. Behavioral Health Crisis Stabilization as alternative to hospitalization
CHRISTUS Spohn Hospital Corpus Christi (“CSHCC”) /121775403
Project unique identifying number: 121775403.1.5

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s)**: Spohn intends to relocate the Psychiatric Assessment Services (PAS) unit currently located at CSHCC - Memorial to the Hector P. Garcia Family Health Center located on Morgan Ave. In addition, the relocated crisis stabilization unit will pool resources with the existing MHMR mobile crisis stabilization team in order to comprehensively redesign the provision of behavioral health (BH) care in the community. The proposed center will be separate from a hospital setting/facility, and integrate BH into a community Family Health Center (FHC) currently providing primary care services to the indigent and uninsured population in Nueces County.

- **Need for the project**: The Spohn – Memorial ED currently sees the highest volume (66%) of BH patients in the Nueces County area among the three providers offering BH services. This volume would shift to the free standing crisis stabilization/urgent care center, reducing the burden on the ED and allowing emergent patients to receive quicker, more efficient care. This integration will allow MHMR and clinic providers to take an immediate role in treatment and disposition of these patients, which is a limitation of treatment provided in the ED. Additionally, the new center will allow behavioral health patients to receive streamlined, comprehensive services outside of the busy and stressful ED setting with structured disposition instead of automatic hospital inpatient admission.

- **Target population**: The target population is uninsured and Medicaid-eligible patients currently receiving behavioral health services in Spohn’s ED and patients with behavioral health needs who currently do not access any services. The Spohn-Corpus Christi EDs experienced approximately 7000 ED visits in FY 2012 with a behavioral health diagnosis, 53% of which were to Medicaid-eligible or uninsured patients (approximately 3800 visits). Those 7000 visits were provided to approximately 5800 unique patients who were also 53% Medicaid/uninsured.

- **Category 1 or 2 expected patient benefits**: Spohn seeks to provide 1000 encounters in the Crisis Stabilization Unit by DY4, with an increase of 1000 additional encounters in DY4 (for a total of 2000 encounters) and an additional 750 encounters in DY5 (for a total of 2750 encounters).

- **Category 3 outcomes**: IT-9.2 – By DY5, Spohn expects a 15% reduction in ED visits at Spohn for BH/SA patients, who are instead able to receive the care they need at the center.
**Behavioral Health Crisis Stabilization/Urgent Care Services as alternative to hospitalization**

**Identifying Project and Provider Information:**

1.13.1. Behavioral Health Crisis Stabilization as alternative to hospitalization

*Core components: a) convene community stakeholders, b) analyze current system of crisis stabilization in community, c) assess behavioral needs of patients currently receiving crisis services in the ED, d) explore potential alternative models, and e) review the interventions’ impact on access to an quality of behavioral health crisis stabilization services and identify lessons learned*

CHRISTUS Spohn Hospital Corpus Christi (“CSHCC” or “Spohn”) /121775403

Project unique identifying number: 121775403.1.5

**Project Description:**

Spohn intends to relocate the Psychiatric Assessment Services (PAS) unit currently located at CSHCC - Memorial to the Hector P. Garcia clinic (the “HPG”) located on Morgan Ave. In addition, the relocated crisis stabilization unit will pool resources with the existing MHMR mobile crisis stabilization team in order to comprehensively redesign the provision of behavioral health care in the community. The new clinic crisis stabilization unit will provide screening and assessments to determine the most appropriate level of care and referrals for persons presenting with behavioral health needs and persons detained by a Peace Officer as per the Mental Health Code. Services will occur in this setting instead of Emergency Departments, which will reduce the systemic cost of providing crisis stabilization services. The proposed center will be separate from a hospital setting/facility, and instead integrated into a community clinic that provides primary care services to the indigent and uninsured community in Nueces County. The clinic will contract to provide services such as mental health and substance abuse screening and assessment in addition to primary care screening and assessments. Telemedicine technology will be used to provide services from psychiatrists, which will reduce the wait-time for patients requiring immediate diagnosis and treatment. College/university students/residents will also have the opportunity to conduct internships/fellowships for clinical training in psychiatric services at the FHC.

**Project Goals/5 Year Expected Outcome:**

Spohn hopes and expects that this project will benefit behavioral health patients by integrating the crisis services they require into a community setting where they also access primary care. Patient satisfaction with the level of care they receive and the timeliness of their care is expected to improve, as patients will be triaged to the appropriate setting for care, and will avoid the lengthy waits associated with being admitted to the Emergency Room (which is often overrun with emergent and non-emergent patients). Additionally, Spohn expects this project to allow providers to furnish earlier intervention and reduce the cost of providing stabilization services to indigent and uninsured patients by seeing them in a community setting outside of the ED. Specific goals include:

- A 20% increase in the use of the Crisis Stabilization/Psychiatric Urgent Care Center by the end of the Waiver period.
- Reduction in healthcare costs for patients presenting in the crisis stabilization setting.

**Project Challenges:**

- Developing operational protocols and clinical guidelines for crisis services
- Provider cooperation in relocating the Crisis Center and PAS, and in streamlining care.
• Identifying effective strategies in improving crisis center.
Spohn will address these challenges by working with community stakeholders and the existing PAS to craft protocols and guidelines that are effective and workable in the FHC setting. Spohn will educate providers as to the benefits of relocating to/providing care in the FHC setting, and will engage patients and providers alike for input of improving the service.

**Relationship to Regional Goals:**
Region 4 intends to reduce health care costs while also improving patient outcomes. This project is focused on improving patient outcomes through a streamlined process that comprehensively assesses each patient’s behavioral health needs in one location. Additionally, this project will reduce health care costs by providing a cost effective alternative for patients to seek behavioral health care outside of the Emergency Department, which is associated with higher health care costs.

**Starting Point/Baseline:**
Three independently functioning entities are located within a 5 mile radius with minimal coordination or integration of patient care. The CSHCC – Memorial ED currently sees the highest volume (66%) of BH patients in the Nueces County area. In FY 2012, Spohn provided approximately 7000 ED visits to approximately 5800 unique patients with a behavioral health diagnosis. This volume would be shifted to the free standing crisis stabilization/urgent care center.

**Rationale:**
Access to Psychiatrists and BH providers has been identified as an area for extreme shortage throughout the State of Texas and the United States. The Community Needs Assessment reports that Region 4 has only one psychiatric hospital, located in Nueces County, and that Nueces County is designated as a partial Health Professional Shortage Area in the domain of mental health services (RHP Plan, Section 3, Table 11). Additionally, 22% of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover behavioral healthcare bills.

Relocating the PAS to the Medical Office Building currently housing the HPG FHC will facilitate the coordination of integrated care for BH patients by providing crisis assessment and intervention with psychiatric assessment/treatment planning and primary care screening/assessment in one location. This will streamline the processes for the BH patient by affording access to all levels of care in a controlled environment separate and apart from the busy Trauma Center ED. The project will also facilitate increased communication between providers, a more efficient method of tracking a BH patient’s care between different service entities (including law enforcement), and will create a more appropriate setting in which patients may receive care.

**Milestones and Metrics:** Spohn chose its DY3, DY4, and DY5 milestones in order to relocate and improve the Crisis Center. The metrics provide a mechanism to accurately gauge the improvement of the Crisis Center and the number of Region patients that benefit from the program. Spohn chose its DY 2 milestone to lay the groundwork for the subsequent development and success of the project through the development plan for the Crisis Stabilization/Urgent care services. The plan will ensure that patients requiring services have access the critical care program.

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**Project core components:** Project option 1.1.13 includes five (5) required core components. However, the DSRIP Planning Protocol allows a provider to bypass certain requirements if the provider can offer a reasonable justification for doing so. Spohn has already convened community stakeholders (including the local MHMRs, the psychiatric hospital located in Nueces County, which is operated by Corpus Christi Medical Center, and representatives from law enforcement) to discuss the redesign of behavioral health crisis stabilization services in the County, and to create a plan of action to address community needs. Consequently, Spohn will not include core component (a) in its DSRIP project. Spohn has recently created an assessment of the existing crisis services capabilities in Nueces County and assessed the behavioral needs for patients currently receiving services in its ED (which it will disseminate through Milestones 1 and 2), which means that Spohn will not include Core Components (b) and (c) in the project milestones.

Spohn will address core component (d) by exploring the practical implications of relocating the PAS and Crisis Stabilization Unit to HPG clinic and will determine an acceptable model for implementation of the new service model in the community clinic that addresses the need for urgent behavioral health care services in a more appropriate environment. Spohn anticipates that the alternative service model will include providing comprehensive care to BH patients requiring crisis stabilization services (instead of solely treating the immediate condition), providing community education about available services, risks, and warning signs, and establishing a comprehensive triage process for assisting patients in obtaining the right care in the right setting. Spohn will address core component (e) by reviewing the access to and quality of the crisis stabilization services provided at the clinic and drafting a report that identifies lessons learned toward expanding the scope of the project and identifying key challenges for expanding the scope of this program to touch additional indigent and uninsured patients requiring crisis stabilization services.

**Ties to Community Needs Assessment Unique IDs:** CN.4, CN.12, CN. 16, and CN.19

**Related Category 3 Outcome Measure(s):**
- Outcome Domain 9: Right Car, Right Setting; Improvement Target 9.2: ED appropriate utilization – reduce ED visits for Behavioral Health/Substance Abuse

Spohn chose this outcome measure because the natural consequence of removing the crisis stabilization unit from the ED should be to reduce the number ED visits for behavioral health/substance abuse related conditions. This outcome is important to affecting the goals of the Waiver, which are to increase access to primary care outside hospital emergency departments, to provide patient-centered healthcare, and to reduce the systemic cost of providing healthcare to the indigent and uninsured population. Additionally, the crisis stabilization services provided at the FHC are intended to prevent patients’ conditions from reaching an acute level wherein ED admission is the appropriate setting for treatment. Early intervention in the community is one way to improve and stabilize behavioral health patients’ outcomes.

**Relationship to other Projects:**
This project is closely related to the global vision for redesigning Primary and Behavioral Health Services. It’s focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within
the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**

This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**

The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, CSHCC prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to CSHCC’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? CSHCC considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to CSHCC’s other proposed projects, to what extent does the project address community needs? CSHCC considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** CSHCC considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the CSHCC’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on CSHCC’s allocation of funding and each project’s Value Weight, relative to the Value Weights of CSHCC’s other projects. After each project is valued, CSHCC will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of CSHCC’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project after evaluating the number of patients that would be served through a Crisis Stabilization Urgent Care Clinic. Spohn’s EDs treated over 5800 unique patients with a behavioral health diagnosis in FY 2012. These patients would benefit tremendously from having access to regular services in the community and outside of the ED. Providing behavioral health services in the community allows providers to build relationships with the patients and to more effectively and consistently manage their conditions, which will lead to increased patient satisfaction and quality of life, along with reduced costs in treating these patients. Spohn analyzed the long-term investment this clinic would require to reduce health care costs by relocating patients from the Emergency Department, including expanding the current patient capacity at the FHC, relocating providers to a new care setting, and educating the community about the availability of this new behavioral health unit. Additionally, Spohn assessed the Region’s goal of improving patient outcomes and the affect this project would have in achieving that goal through a streamlined, patient-centered clinic.

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18 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
**Crisis Stabilization Services – Psychiatric Urgent Care Center**

**CHRUS Spohn Hospital Corpus Christi**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>121775403.3.5</th>
<th>IT-9.2</th>
<th>ED appropriate utilization – reduce ED visits for BH/SA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-2]: Conduct mapping and gap analysis of current crisis system</td>
<td><strong>Milestone 3</strong> [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services</td>
<td><strong>Milestone 5</strong> [P-6]: Evaluate and continuously improve crisis services</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-2.1]: Produce written analysis of community needs for crisis services</td>
<td><strong>Metric 1</strong> [P-5.1]: Completion of policies and procedures</td>
<td><strong>Metric 1</strong> [P-6.1]: Project planning and evaluation documentation demonstrate PDSA quality improvement cycle</td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal: Identify gaps in current crisis stabilization system exiting in Corpus Christi and produce report and analysis of findings</td>
<td>Data Source: Spohn will create and implement an Operations Manual for the crisis stabilization/urgent care system that incorporates existing best practices and alternative care models to the unit currently in existence</td>
<td>Baseline/goal: To produce comprehensive reports that demonstrate improvements to the crisis stabilization services, and which identify key challenges to expanding the provision of services and the lessons learned in DYs 2-4</td>
<td></td>
</tr>
<tr>
<td>Data Source: Report of gap analysis</td>
<td>Milestone 3 Estimated Incentive Payment: $1,116,875.50</td>
<td>Data Source: Project reports with real time data to demonstrate rapid cycle improvements to guide quality improvement</td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $1,109,019</td>
<td>Milestone 4 Estimated Incentive Payment: $1,116,875.50</td>
<td>Milestone 5 Estimated Incentive Payment: $1,115,144</td>
<td></td>
</tr>
</tbody>
</table>

**Year 4** (10/1/2014 – 9/30/2015) | **Year 5** (10/1/2015 – 9/30/2016) |
| **Milestone 2** [P-3]: Develop implementation plan for Crisis Stabilization/Urgent care services at the Hector P Garcia clinic | **Milestone 4** [P-4]: Hire and train staff to implement identified crisis stabilization services. |
| Metric 1 [P-3.1]: Produce data-driven written action plan for development of Urgent Care Center | Metric 1 [P-4.1]: Number of staff hired and trained |
| Baseline/Goal: Development of plan to implement the behavioral health crisis stabilization/urgent care services at the HPG clinic | Baseline/goal: Spohn will hire and/or relocate existing PAS staff to the HPG clinic and train them to implement the stabilization crisis services and operationalize the protocols and clinical guidelines |
| Data Source: Written plan | Milestone 6 Estimated Incentive Payment: $1,115,144 |
| Milestone 2 Estimated Incentive Payment: $1,092,019 | Milestone 6 [I-12]: Utilization of Crisis Stabilization/Urgent Care Center |
| **Milestone 5** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services | Metric 1 [I-12.2]: Percent increase in utilization of Crisis Stabilization/Urgent Care Center |
| **Milestone 5** Estimated Incentive Payment: $1,115,144 | Baseline/Goal: Spohn anticipates providing 1000 encounters in the Crisis Stabilization/Urgent Care site by the end of DY3. In DY4, Spohn is targeting an increase of 1000 additional encounters with BH/SA patients from the baseline |
| Milestone 7 Estimated Incentive Payment: $1,800,854 | Data Source: Crisis center claims data, encounters and clinical record data. |

**Milestone 6** [I-12]: Utilization of Crisis Stabilization/Urgent Care Center

**Milestone 7** [I-12]: % increase in utilization of Crisis Stabilization/Urgent Care Center

**Baseline/goal:** Spohn is targeting an increase of 750 additional encounters with BH/SA patients from baseline established in DY3 (estimated 2750 encounters)

**Data Source:** Crisis center claims data, encounters and clinical record data.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>121775403.3.5</th>
<th>IT-9.2</th>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>established in DY3 (for a total of 2000 encounters).</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>Data Source:</strong> Crisis center claims data, encounters and clinical record data.</td>
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<tr>
<td></td>
<td></td>
<td>Milestone 6 Estimated Incentive Payment: $1,115,144</td>
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</tbody>
</table>

Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,184,038

Year 3 Estimated Milestone Bundle Amount: $2,233,751

Year 4 Estimated Milestone Bundle Amount: $2,230,288

Year 5 Estimated Milestone Bundle Amount: $1,800,854

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $8,448,930
11275403.1.9.1. Expand Specialty Care Capacity – Psychiatric Mental Health Nurse Practitioner (“PMHNP”)
CHRISTUS Spohn Hospital Corpus Christi/ 121775403
Unique Identifier - 121775403.1.6

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** Working with Texas A&M University’s Corpus Christi’s (TAMUCC) College of Nursing, Spohn will seek to increase the number of psychiatric mental health mid-levels in the Region through expanding TAMUCC’s existing MSN – NP program to include the Psychiatric Mental Health track.

- **Need for the project:** A PMHNP program does not currently exist in the region or in the Texas A&M University Health System. Nueces County has only 12 Mental Health NPs, and there is a shortage of other levels of local psychiatric providers: 16 psychiatrists yielding a psychiatrist to population ratio of 1:20,307, and an LPC to population ratio of 1:1052. Only one psychiatric hospital is located in the County to serve patients requiring inpatient services.

- **Target population:** The direct target population of this project includes future providers who would be willing to practice in Nueces County and have an interest in providing mental health services. The broader target population of this project includes residents in Nueces County who have limited access to the mental health services they require, including patients currently receiving behavioral health services in Spohn’s ED and patients with behavioral health needs who currently do not access any services. The Spohn EDs saw 5800 patients and provided over 7000 ED visits to patients with a behavioral health diagnosis in FY 2012, approximately 53% of which were Medicaid/uninsured. Those patients and others will benefit from additional psychiatric practitioners established in the community during student rotations and upon graduation.

- **Category 1 or 2 expected patient benefits:** The project seeks to implement a MSN-NP program locally, to increase the number of students in the program by 10% in DY5 (over baseline year of operation), and to increase the number of psychiatric mid-level providers in the Region. These outcomes will result in increased access to psychiatric care for uninsured/Medicaid eligible residents in Nueces County.

- **Category 3 outcomes:** IT-1.20 - Spohn’s goal is to increase the number of mid-levels who work in a BH setting with a high Medicaid share that reflect the distribution of Medicaid in the population by the end of the Waiver. Spohn has not identified a number yet, as the program is not yet in operation, but will determine a reasonable goal in DY3.
Identifying Project and Provider Information:
11275403.1.9.1. Expand Specialty Care Capacity – Psychiatric Mental Health Nurse Practitioner (“PMHNP”)
CHRISTUS Spohn Hospital Corpus Christi (“Spohn“)/ 121775403
Unique Identifier - 121775403.1.6

Project Description:
Working with TAMUCC’s College of Nursing, Spohn will seek to increase the number of psychiatric mental health mid-levels in the Region through expanding TAMUCC’s existing MSN – NP program to include the Psychiatric Mental Health track. Spohn will identify/provide incentives to support enrollment and successful completion of this program such as paid tuition, housing, stipends, employment assurances and other possibilities, with the goal that the psychiatric professionals remain in the Region following graduation. The project will assist to address the critical shortage of Psychiatric and Mental Health providers not only in RHP 4 but across the State of Texas and the country.

Project Goals/5 Year Expected Outcome:
- Increase the number of psychiatric mental health mid-levels in the Region
- Implement and expand a PHMNP program in collaboration with TAMUCC
- 10% increase in number of students enrolled in PMHNP program by DY 5

Project Challenges:
- Limited faculty resources – recruitment of successful faculty is a leading challenge that may be addressed through the private practice mid-levels or remotely via telecommunication. Both entities have telecommunication capabilities and can provide remote access to a wide variety of faculty support.
- Obtaining approval from NLNAC to increase number of PMHNP providers for the state.
- Recruiting new PMHNP students to the program (need at least 10 students to implement the program).

Spohn will address these challenges through careful planning and a reasoned approach to expanding the MSN – NP program, to include aggressive recruiting of faculty to support the expansion, education and outreach to potential students about the prospect of a career as a psychiatric mental health provider, and creating incentives for students to study and settle in Region 4.

Relationship to Regional Goals:
Region 4 intends to improve access to specialty serves, and the Region also aims to increase access to mental health services. This project directly addresses this goal by instituting a program to increase the number of midlevel psychiatric and mental health midlevels through a comprehensive support program.

Starting Point/Baseline:
A PMHNP program does not currently exist in the region or in the Texas A&M University Health System. The 4 programs in the state are: UTHSC-San Antonio School of Nursing, Midwestern State University in Wichita Falls, TX, UT-Arlington and UT Austin. Five programs previously existed in the
state until the UTHSC-Houston program closed in the spring of 2012 due to insufficient enrollment to meet class load requirements for graduate courses.

Rationale:
Access to Psychiatrists and BH providers has been identified as an area for extreme shortage throughout the State of Texas and the United States. The Community Needs Assessment reports that Region 4 has only one psychiatric hospital, located in Nueces County. Additionally, 21% of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover healthcare bills.

The ability to establish Psychiatric GME is extensive and difficult to achieve with the time constraints of this Waiver. Based on Spohn’ location in the state and the proximity of an established College of Nursing at TAMUCC with a remarkable success rate for enrollment and completion of the Family Nurse Practitioners (FNP) program, a PMHNP program will be a valuable asset to RHP 4 and the State of Texas. Spohn has two established GME programs in Emergency Medicine and Family Practice and provides clinical site training for a large variety of healthcare professionals. Inpatient psychiatric services and close proximity to outpatient services, Psychiatric Assessment Services and MHMR Crisis Intervention services all support the training of PMHNPs.

The following provides an overview of the high demand for mental health services in the community:

- Current mid-levels in the county that are in private practice = 4 total
- Current practicing psychiatrists = 16:
  - 3 provide services at Spohn-Memorial
  - 2 provide part-time services at MHMR
- Nueces County Psychiatrist to population ratio = 1:20,307
- Nueces County LPC ratio to population = 1:1052

Milestones and Metrics: Spohn chose its DY2, DY3, and DY4 milestones in an effort to establish a successful PMHNP program that addresses the following core components of this project:

- Identifying high impact/most impacted specialty services and gaps in care and coordination;
- Undertaking steps necessary to increase the number of residents/trainees choosing psychiatric specialties;
- Designing workforce enhancement initiatives to support access to specialty providers in underserved markets, including recruitment and retention; and
- Conducting quality improvement for the project to assess options for improvement and/or expansion of the program.

Hiring PMHNP faculty and recruiting at least 10 students willing to specialize in mental health is imperative to establishing the program and remain essential steps in securing the long term effectiveness of the program. Spohn chose its DY 5 metric of increasing the students recruited to the program as a mechanism of measuring the longevity and success of the program.

Ties to Community Needs Assessment Unique IDs: CN.2, CN.19
Related Category 3 Outcome Measure(s):
Outcome measure selected for this project is: IT-1.18 (Increased Follow-Up After Hospitalization for Mental Illness). Spohn chose this outcome measure because the main goal behind expanding the MSN-NP program to include a psychiatric mental health track is to train and retain more midlevel providers to treat indigent patients in the community. As a result of increasing the number of psychiatric providers, we anticipate an improvement in our capacity to ensure patients discharged from hospitalization receive appropriate follow-up care. Spohn acknowledges that this outcome may need re-evaluation depending on approval timelines for the program implementation and the success of student recruitment/program completion.

Relationship to other Projects:
This project is closely related to the global vision to redesign Primary and Behavioral Health Service. Its focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services; and 020973601.2.1 and 121775403.2.8 – Implementation of Care Transition Programs. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD-2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
This project will enhance coordination of efforts with LMHAs and other providers that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects. The valuation template considers four criteria for each project:
1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system.
   c. Improve outcomes while containing cost growth.

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment.
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

In valuing this project, Spohn reviewed the program’s investment in future psychiatric mental health mid-levels and the long term impact these mid-levels would have on the community. Additionally, Spohn considered the community need for mental health services, considering the few providers of such services in the area. Spohn also examined the broad array of the population that would benefit from increased access to behavioral health services.

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19 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### RHP Plan for Region 4

**CHRISTUS Spohn Hospital Corpus Christi**

**Follow-up After Hospitalization for Mental Illness**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>121775403.3.6</th>
<th>IT-1.18</th>
<th>Follow-up After Hospitalization for Mental Illness</th>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Conduct specialty care gap assessment based on community need. <strong>Metric 1</strong> [P-1.1]: Documentation of gap assessment. <strong>Baseline/Goal</strong>: Provide basis to support addition of PMHNP program at TAMUCC. <strong>Data Source</strong>: Gap assessment document.</td>
<td><strong>Milestone 2</strong> [P-16]: Obtain approval from TAMU Regents and NLNAC to increase number of PMHNP providers for the state. <strong>Metric 1</strong> [P-16.1]: NLNAC approval for NP program expansion. <strong>Baseline/Goal</strong>: Approval for PMHNP program at TAMUCC. <strong>Data Source</strong>: Documentation of TAMU and NLNAC for program expansion</td>
<td><strong>Milestone 3</strong> [P-14]: Implement PMHNP training. <strong>Metric 1</strong> [P-14.2]: Hire additional precepting PMHNP faculty-TAMUCC College of Nursing. <strong>Baseline/Goal</strong>: Provide faculty according to NLNC guidelines. <strong>Data Source</strong>: HR records. Milestone 3 Estimated Incentive Payment <em>(maximum amount)</em>: $881,744</td>
<td><strong>Milestone 4</strong> [P-14]: Implement PMHNP training. <strong>Metric 1</strong> [P-14.1]: PMHNP cohort enrollment <strong>Goal</strong>: PMHNP minimum enrollment of at least 10 students necessary for program <strong>Data Source</strong>: Program documentation, Cohort documentation Milestone 4 Estimated Incentive Payment: $881,744</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $862,120</td>
<td></td>
<td><strong>Milestone 5</strong> [I-31]: Develop PMHNP student rotations <strong>Metric 1</strong> [I-31.2]: Number of PMHNP students rotating at Spohn. <strong>Goal</strong>: At least 75% of PMHNP students rotate to Spohn. <strong>Data Source</strong>: Student rotation schedules Milestone 5 Estimated Incentive Payment: $1,760,754</td>
<td><strong>Milestone 6</strong> [I-32]: Recruit more students to the PMHNP program <strong>Metric 1</strong> [I-32.1]: Number of students enrolled in PMHNP program <strong>Goal</strong>: 10% increase in number of students enrolled in PMHNP program <strong>Data Source</strong>: Program documentation, class/mentor lists Milestone 6 Estimated Incentive Payment: $1,421,727</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $1,724,240 | Year 3 Estimated Milestone Bundle Amount: $1,763,488 | Year 4 Estimated Milestone Bundle Amount: $1,760,754 | Year 5 Estimated Milestone Bundle Amount: $1,421,727 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5)*: $6,670,208

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**PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS (PMHNP)**
Performing Provider: Gonzales Healthcare Systems (Waelder Medical Clinic)
Project Name: 1.1.2 Expand existing primary care capacity
Project Identifier: 121785303.1.1

**Provider:** Gonzales Healthcare Systems is comprised of a number of entities including Memorial Hospital, a 34-bed acute care facility with the only emergency room located in the county, and two rural health clinics. One of these clinics, the Waelder Medical Clinic, provides primary care services to the residents of Waelder and surrounding communities with an average of 135-140 patient visits each month. Both entities fall under the Gonzales Healthcare Systems’ umbrella. For Medicaid billing purposes, Gonzales Healthcare Systems’ TPI is 121785303 and Waelder Medical Clinic’s is 130781104.

**Intervention(s):** This project will increase primary care capacity by expanding the service hours of the Waelder Medical Clinic.

**Need for the project:** The emergency department at Memorial Hospital has experienced a 19.4% increase in the number of annual visits since 2008 and a significant number of these visits each month are for non-emergent, primary care-related conditions. Currently, 12 to 15 patients a month on average come to the Memorial Hospital emergency room for non-emergent diagnoses. These non-emergent visits primarily occur on days or during hours when the clinic is not open. Every effort to increase primary care capacity in our communities will help to reduce the strain on the emergency room. Establishing routine primary care with a regular provider, particularly for patients with chronic conditions, will improve the overall health of the patient.

**Target population:** The target population is all patients in the Waelder Medical Clinic service area who require primary healthcare services. By DY5, this project will have resulted in approximately 125 additional patient visits to the clinic. Historically, 70% of the patients coming to the emergency department from the Waelder area are either Medicaid recipients or are unfunded. Therefore, these populations are expected to benefit significantly from this project.

**Category 1 or 2 expected patient benefits:** The project seeks to increase the volume of patient visits to the clinic to 1600 in DY3, 1650 in DY4, and 1700 in DY5.

**Category 3 outcomes:** IT-9.2 ED appropriate utilization. Our goal is to decrease the use of the Memorial Hospital emergency room for non-emergent care by patients with a Waelder zip code by 5% in DY4 and 10% in DY5.
Category 1: Infrastructure Development

1.1 Expand Primary Care Capacity

1.1.2 Expand existing primary care capacity
   a) Expand primary care clinic space
   b) Expand primary care clinic hours
   c) Expand primary care clinic staffing

Identifying Project and Provider Information:
PROJECT TITLE – Expand Primary Care Capacity
RHP IDENTIFICATION NUMBER – 121785303.1.1
PERFORMING PROVIDER – Gonzales Healthcare Systems/121785303 (Waelder Medical Clinic/130781104)

Project Description:
Gonzales Healthcare Systems intends to expand the days and/or hours Waelder Medical Clinic is open in order to reduce dependence on use of the only emergency room in the county for non-emergency, primary care services. The 5-year goal is to increase the number of hours the clinic is open each week by 80% and decrease non-emergent emergency room visits from the Waelder area by 50%.

Goals and Relationship to Regional Goals:
Project goals:
- Reduce the volume of patient visits to the emergency department for non-emergency, primary care services
- Expand availability of primary care services at the Waelder Medical Clinic
- Increase volume of patient visits to Waelder Medical Clinic for primary care services
- Improve patient health outcomes and continuity of care

This project meets the following Region 4 goals:
- Expand access to primary care providers and services
- Improve provision and coordination of healthcare services for persons with chronic conditions
- Reduce inappropriate emergency department utilization

Challenges:
There are a number of challenges including limited space and capacity in the current location which may require relocation of the current clinic. Patient education about the appropriate use of primary care clinic services versus emergency room services will be essential for acceptance of this project. Securing providers willing to work in this somewhat remote location on the days or hours necessary may be difficult. To address these challenges, we will coordinate with emergency department staff to educate patients and redirect them to the primary care clinic as appropriate. In addition, we will evaluate our current recruitment strategies and those of other regional providers to identify and implement those that have been most successful.

Five year expected outcome:
The 5-year goal is to increase the number of hours the clinic is open each week by 80% and decrease non-emergent emergency room visits from the Waelder area by 50%.
Starting Point/Baseline:
The existing rural health clinic in Waelder is currently open an average of 20 hours per week (Monday through Friday, 8:00 a.m. to noon). One physician or mid-level practitioner sees patients during these hours. An average of 135-140 patient encounters occur in the clinic each month. This schedule has been in effect since the clinic opened more than 15 years ago.

Rationale:
The City of Waelder and surrounding communities represent 15-20% of the population of Gonzales County. Currently, 12 to 15 patients a month on average come to the Memorial Hospital emergency room for non-emergent diagnoses. Historically, 55-60% of all the patients seen in the Memorial Hospital emergency room are Medicaid, Medicaid Managed Care or unfunded patients. However, we are currently seeing a 10% increase in emergency room visits for these patients. These non-emergent visits primarily occur on days or during hours when the clinic is not open. The emergency department at Memorial Hospital has experienced a 19.4% increase in the number of annual visits since 2008 and a significant number of these visits each month are for non-emergent, primary care-related conditions. Every effort to increase primary care capacity in our communities will help to reduce the strain on the emergency room. Establishing routine primary care with a regular provider, particularly for patients with chronic conditions, will improve the overall health of the patient.

According to a report from the Washington State Department of Social and Health Services and the Washington State Health Care Authority, “that one of the primary reasons cited for using the ED both by users and ED physicians, is not as a “last resort”, but due to the lack of adequate or accessible primary care providers, particularly outside business hours or inability to obtain same day or next day appointments.” 20 In addition, patients require an “interpersonal relationship with a primary care provider who customizes care to the patient’s or family’s particular needs”. 21 The expansion of days and hours per week that the Waelder Medical Clinic will be open as a result of this project addresses both of these concerns.

Project Core Components:
• Expand primary care clinic space. As previously noted, there is limited space at the clinic’s current location. Therefore, the clinic will be expanded or relocated as is needed to meet the needs of patients and providers.
• Expand primary care clinic hours. The days and/or hours the Waelder Medical Clinic is open will be expanded to better serve our patients.
• Expand primary care clinic staffing. Additional staff will be hired as needed to support expanded clinic hours.

Milestones & Metrics:
• Process Milestones and Metrics: P-4(P-4.1)
• Improvement Milestones and Metrics: I-12(I-12.1)

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20 Washington State Department of Social and Health Services & Washington State Health Care Authority. 2007.
Unique community need identification numbers the project addresses:
CN.1 – Inadequate access to primary care
CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
CN.6 – High rates of inappropriate emergency department utilization

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project enhances the region’s existing delivery system by expanding capacity of an existing primary care clinic. This project does not include another federal funding source.

Related Category 3 Outcome Measure(s):
OD-9 – Right Care, Right Setting, IT-9.2 – Emergency department appropriate utilization.

Reason for selecting the outcome measure: Implementation of this project is intended to reduce the use of the Memorial Hospital emergency department for non-emergent care by patients in the Waelder Medical Clinic service area. In addition, having patients establish a relationship with a primary care provider will improve continuity of care and reduce the impact of chronic conditions on the patient’s overall health.

Relationship to other Projects: This project will support and complement other projects designed to improve patient access to care, reduce inappropriate hospital utilization, improve health outcomes, and improve patient experience. By expanding access to primary care, patients will obtain more timely care which will result in fewer complications and enable patients to get the right care in the right setting. Other projects that will be supported or enhanced by this project include:
- 1328122051.2.1 – expansion of health promotion;
- 137907508.1.1 and 1309585095.1.1, and 020973601.1.1 – expansion of primary care capacity;
- and 121775403.2.3 – Redesign of primary care to improve continuity of care, decrease average length of stay, and increase patient satisfaction.
Togetherness these projects will result in decreased emergency department (ED) and hospital visits plus improved clinical outcomes.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center, Driscoll Children’s Hospital, Yoakum Community Hospital and Christus Spohn.

Project Valuation:
The cost of adding four hours a week to the clinic schedule is estimated at $156,900 per year. This includes salaries for an additional mid-level practitioner, nurse and clerical staff as well as additional rent, supplies and utilities. The City of Waelder is considering collaborating on the building of a new clinic space but costs would be incurred in furnishing and supplying this space. The benefits to the community, however, would be considerable. The amounts associated with achieving the outcomes identified for this project for each year are $141,210 for DY2 and DY3, $133,365 for DY4, and $105,123 in DY5 for a total of $520,908.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>121785303.3.1</th>
<th>IT-9.2</th>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Milestone 1 – P-4.</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 2 – P-4.</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 4 – P-4.</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 6 – P-4.</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
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<tr>
<td><strong>Metric 1 – P-4.1.</strong> Increased number of hours at primary care clinic over baseline.</td>
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<td>Baseline/Goal: Increase number of hours from 20 to 24 hours per week.</td>
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<td>Baseline/Goal: Increase number of hours from 28 to 32 hours per week.</td>
<td>Baseline/Goal: Increase number of hours from 32 to 36 hours per week.</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment: $141,210</td>
<td>Milestone 2 Estimated Incentive Payment: $70,605</td>
<td>Milestone 4 Estimated incentive payment: $66,683</td>
<td>Milestone 6 Estimated incentive payment: $52,562</td>
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<tr>
<td><strong>Milestone 3 – I-12.</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 5 – I-12.</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 7 – I-12.</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Metric 1 – I-12.1.</strong> Documentation of increased number of visits. Demonstrate improvement over prior period.</td>
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<td><strong>Metric 1 – I-12.1.</strong> Documentation of increased number of visits. Demonstrate improvement over prior period.</td>
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RHP Plan for Region 4
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $520,908*
Performing Provider: Gonzales Healthcare Systems (Memorial)
Project Name: 1.9.2 Improve access to specialty care
Project Identifier: 121785303.1.2

Provider: Gonzales Healthcare Systems (TPI 121785303) is the primary source of medical care for the residents of Gonzales County and is comprised of several entities including Memorial Hospital, a 34-bed acute care facility with the only emergency room in the county, a hospital-based Specialty Physician Clinic, and two rural health clinics. For the purposes of Medicaid billing, the TPI for Memorial Hospital is the same as that for Gonzales Healthcare Systems.

Intervention(s): This project will increase specialty care capacity by expanding hours and adding additional specialties not currently available at the Specialty Physician Clinic within the hospital.

Need for the project: Wait times for an appointment vary based on availability of a particular physician specialty. In a 2011 Community Needs Assessment, access to specialty care and community health were identified as issues. A third of the consumers surveyed were neutral or disagreed with the position that there was sufficient access to specialty care in the community. Primary care physicians have indicated Endocrinology would be an important addition due to a high rate of diabetes in the community. Increased access to current specialties such as Orthopedics or additional specialties, such as Rheumatology, have also been identified.

Target population: The target population is all patients living in the Gonzales Healthcare Systems service area who require specialty care services. Historically, 55-60% of all patients seen in the Memorial Hospital emergency room are Medicaid recipients or unfunded patients. By expanding specialty care capacity, this project will serve approximately 300 additional patients by DY5, a large percentage of whom will be Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits: This project seeks to increase the specialty clinic’s volume of visits by 150 visits in DY4 and 300 visits in DY5.

Category 3 outcomes: IT-6.1 Improve patient satisfaction scores. Our goal is to increase patient satisfaction scores 5% over baseline in DY4 and 10% over baseline in DY5.
Category 1: Infrastructure Development
Expand Specialty Care Capacity
1.9.2 Improve access to specialty care

Identifying Project and Provider Information:
PROJECT TITLE – Expand Specialty Care Capacity
RHP IDENTIFICATION NUMBER – 121785303.1.2
PERFORMING PROVIDER – Gonzales Healthcare Systems/121785303 (Memorial Hospital)

Project Description:
This project will increase specialty care capacity by expanding the days and/or hours that current specialist providers are available and adding additional specialties not currently available.

Goals and relationship to regional goals:
Project goals:
- Increase specialty clinic volume of visits
- Reduce wait times for patients requiring visits with specialty providers
- Add specialties not currently available thereby reducing the distance patients must travel to access these services

This project meets the following Region 4 goal:
- Expand access to specialty care providers and services

Challenges:
There are some challenges in the ability to recruit specialists to come to the community due to the distance from major medical facilities and limitations on current space and personnel available to facilitate an increased number of physicians or hours. To address these challenges, we will evaluate our current recruitment strategies and those of other regional providers to identify those that have been most successful. These strategies will be employed to actively recruit and retain specialty providers and clinic staff.

Five year expected outcome: The five-year expected outcome for patients is greater access to specialty providers in the areas of Endocrinology, Rheumatology, Orthopedics and an increase in specialty clinic volume of visits of 10% over baseline.

Starting Point/Baseline:
Specialties currently available at or through Gonzales Healthcare Systems include Cardiology, Dermatology, Gynecology, Nephrology, Neurology, Neurosurgery, Oncology, Ophthalmology, Orthopedics, Otorhinolaryngology, Podiatry, Pulmonology and Urology. Availability varies from half a day once a month (Neurology) to daily (Cardiology). Recruitment of an endocrinologist is planned for DY2 with the addition of hours occurring as soon as he/she is available.

Rationale:
Wait times for an appointment vary based on availability of a particular physician specialty. In a 2011 Community Needs Assessment, access to specialty care and community health were identified as issues. A third of the consumers surveyed were neutral or disagreed with the position that there was sufficient access to specialty care in the community. Primary care physicians have indicated
Endocrinology would be an important addition. This is reasonable in light of reports such as the 2010 Chronic Disease Burden Report from the Texas Department of State Health Services as well as the Texas Behavioral Risk Factor Surveillance System report for 2010 showing the prevalence of diabetes in Texas. The Chronic Disease Burden Report indicated Gonzales County has a higher rate of mortality due to diabetes that the state average (although not statistically significantly higher than the state rate). Increased access to current specialties such as Orthopedics or additional specialties, such as Rheumatology, have also been identified.

Project Components:

• *Increase service availability with extended hours.* This project will add additional service hours in the areas of Endocrinology, Rheumatology, and Orthopedics.

• *Increase number of specialty clinic locations.* This project is an expansion of an existing hospital-based specialty clinic which is centrally located for patients in our service area. Therefore, additional locations are not being added at this time.

• *Implement transparent, standardized referrals across the system.* We plan to evaluate our current referral system with regard to average process time, time to appointment, and current referral and work-up guidelines. We will coordinate with referring physicians to develop and implement standardized referral processes that improve transparency and efficiency.

• *Conduct quality improvement for project using methods such as rapid cycle improvement.* Using patient survey results, physician surveys, and staff experiences, frequent evaluations will be performed to ensure project goals are being met.

Milestones & Metrics:

• Process Milestones: P-11(P-11.1)

• Improvement Milestones: I-23(I-23.1)

Unique community need identification numbers the project addresses:

CN.2 – Inadequate access to specialty services
CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
CN.9 – Shortage of specialty care physicians
CN.14 – High rates of diabetes, including gestational diabetes

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

This project enhances the region’s existing delivery system by expanding capacity of an existing specialty care clinic. This project does not include another federal funding source.

Related Category 3 Outcome Measure(s):

OD-6 – Patient Satisfaction, IT-6.1 – Improve patient satisfaction/experience scores.

Reason for selecting the outcome measure:

Implementation of this project is intended to improve patient satisfaction by providing specialties either not available at all in the community or expanding the availability of existing specialties to make it easier to access those physicians.
Relationship to Other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support a number of other projects within the region, including the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FQHC providers.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center, Driscoll Children’s Hospital, Yoakum Community Hospital and Christus Spohn.

Project Valuation:
Physician payment guarantees may be necessary to ensure the addition of some specialties. According to the Merritt Hawkins and Associates salary survey, the salary of an endocrinologist would cost the hospital roughly $9,230 a year for one half-day a month. The services of a rheumatologist would cost approximately $8,076 for one half-day a month. Additional nursing personnel to assist specialty clinic physicians would cost an additional $2,800. Supplies and utilities would likely be negligible in the beginning of the project. Salary guarantees and staff salaries would increase as the project progressed. The administration of a patient survey is estimated to cost $5,000 per year. These projections result in costs of $17,110 in DY2, $34,416 in DY 3 and $51,722 in DY 4. Due to a building of their respective practices and increased revenue from patients with funding, it is anticipated that costs in DY 5 would not be significantly different from those in DY 4 so $51,722 is being estimated for that year. The total valuation would then be $154,970. If these goals are achieved, the expected allotment for DY2 would be $15,399. In DY3 this would increase to $30,974. DY4 would be $43,963 and DY5 would be $34,653. The total for the four years would be $124,989.
**121785303.1.2** | **1.9.2** | **1.9.2.A** | **EXPAND SPECIALTY CARE CAPACITY**
---|---|---|---
Gonzales Healthcare Systems (Memorial Hospital) | | | 121785303

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

| 121785303.2 | IT-6.1 | Improve patient satisfaction/experience scores |
---|---|---|

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1** – P-11. Launch/expand a specialty care clinic.

**Metric 1** – P-11.1. Establish/expand specialty care clinics

Baseline/Goal: No endocrinology services available / Add Endocrinology at least one half-day per month (6-12 patients per month).

Data Source: Clinic documentation.

**Milestone 1 Estimated Incentive Payment:** $15,399

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**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 2** – P-11. Launch/expand a specialty care clinic.

**Metric 1** – P-11.1. Establish/expand specialty care clinics

Baseline/Goal: DY 2, no services/Increase Endocrinology presence to one full day per month (12-20 patients per month). Add Rheumatology at least one half-day per month (6-12 patients per month). Consider increasing Orthopedics to 1.5 days per week (140-200 patients seen per month).

Data Source: Clinic documentation.

**Milestone 2 Estimated Incentive Payment:** $30,974

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**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 3** – P-11. Launch/expand a specialty care clinic.

**Metric 1** – P-11.1. Establish/expand specialty care clinics

Baseline/Goal: Increase Endocrinology to 1.5 days per month (18-24 patients). Increase Rheumatology to one full day per month (12-20 patients). Increase Orthopedics to two full days per week (200-220 patients per month).

Data Source: Clinic documentation.

**Milestone 3 Estimated Incentive Payment:** $21,982

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**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 4** – I-23. Increase specialty care clinic volume of visits and evidence of improved access of patients seeking service.

**Metric 1** – I-23.1 Documentation of increased number of visits.

Demonstrate improvement over prior reporting period.

Additional 150 specialty visits over DY3 baseline Data Source: Clinic documentation.

**Milestone 4 Estimated Incentive Payment:** $17,326

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**Milestone 5** – P-11. Launch/expand a specialty care clinic.

**Metric 1** – P-11.1. Establish/expand specialty care clinics

Baseline/Goal: Increase Endocrinology and Rheumatology to at least one half day per week each (36-40 patients each).

Data Source: Clinic documentation.

**Milestone 5 Estimated Incentive Payment:** $17,327

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**Milestone 6** – I-23. Increase specialty care clinic volume of visits and evidence of improved access of patients seeking service.

**Metric 1** – I-23.1 Documentation of increased number of visits.

Demonstrate improvement over prior reporting period.

Baseline/Goal: Additional 300 specialty visits over DY3 baseline

**Milestone 6 Estimated Incentive Payment:** $17,326
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<td>Year 5 Estimated Milestone Bundle Amount: $34,653</td>
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TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $124,989
Performing Provider: Gonzales Healthcare Systems (Memorial Hospital Home Health Agency)
Project Name: 1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care
Project Identifier: 121785303.1.3

Provider: Gonzales Healthcare Systems (TPI 121785303) is the primary source of medical care for the residents of Gonzales County and is comprised of several entities including Memorial Hospital (a 34-bed acute care facility) and two rural health clinics. In addition, Gonzales Healthcare Systems provides home care services to patients residing in its service area through the Memorial Hospital Home Health Agency (TPI 023701801).

Intervention(s): This project will initiate a telemonitoring program for patients with chronic disease using multiple biometric devices to monitor weight, blood pressure, blood glucose, oxygen saturation and/or peak flow. An experienced RN will provide essential data to the patient’s physician to make treatment adjustments and provide direct coaching to meet treatment goals.

Need for the project: In the first six months of 2012, 22% of patients receiving home health services through the agency required one or more emergency room visits while on service. Telemonitoring will improve care for the population of patients with one or more chronic diseases by early identification of symptoms related to the disease state. Early detection of such symptoms will lead to earlier intervention and adjustments and prevent avoidable hospitalizations or re-hospitalizations of patients with chronic diseases.

Target population: The target population is chronically ill patients in the Gonzales Healthcare Systems service area. Early identification of symptoms related to the chronic disease state via telemonitoring will allow for earlier intervention and prevent avoidable hospitalizations. Historically, 55-60% of all patients seen in the Memorial Hospital emergency room are Medicaid recipients or unfunded patients. This project will serve approximately 10-15 patients by DY5, some of whom will be Medicaid eligible and/or indigent.

Category 1 or 2 expected patient benefits: The number of patients accessing nursing care management via the telemonitoring program is expected to increase to 4 patients in DY3, 8 patients in DY4, and 12 patients in DY5.

Category 3 outcomes: IT-9.2 ED appropriate utilization. Our goal is to reduce emergency department visits for target conditions among patients receiving home health services for heart failure, COPD, diabetes, or hypertension by 10% in DY4 and 15% in DY5.
Category 1: Infrastructure Development
Introduce, Expand, or Enhance Telemedicine/Telehealth

1.7.2 Implement remote patient monitoring programs for diagnosis and/or management of care.

Identifying Project and Provider Information:
PROJECT TITLE – Initiate telemonitoring program for Home Health
RHP IDENTIFICATION NUMBER – 121785303.1.3
PERFORMING PROVIDER – Gonzales Healthcare Systems/121785303 (Memorial Hospital Home Health Agency/023701801)

Project Description:
Initiate a telemonitoring program for patients with chronic disease using multiple biometric devices to monitor weight, blood pressure, blood glucose, oxygen saturation and/or peak flow. Clinical management of the patient will be integral to the success of the program. An experienced RN will provide essential data to the patient’s physician to make treatment adjustments and provide direct coaching to meet treatment goals.

Goals and Relationship to Regional Goals:
- Improve continuity of care, early diagnosis of chronic disease complications, and patient health outcomes.
- Reduce emergency department utilization and potentially preventable hospitalizations for patients with chronic disease conditions.

This project meets the following Region 4 goals:
- Expand access to primary care providers and services
- Improve provision and coordination of healthcare services for persons with chronic conditions

Challenges:
Inadequate monitoring of patients with chronic disease conditions following hospital discharge often results in re-hospitalizations that could have been avoided. However, there are currently no programs in Gonzales County that provide access to care on a daily basis. Telemonitoring will allow for daily monitoring of high-risk patients resulting in earlier intervention and improved health outcomes. Program success will be dependent on care coordination between the monitoring nurse and the patient’s physician. Provider and staff trainings will address this need prior to program implementation.

Five Year Expected Outcome:
Over five years, this project is expected to result in significant improvements in early detection and treatment of disease complications for patients with chronic conditions. As a result, there will be a reduction in potentially preventable hospitalizations and patients will experience improved health outcomes.

Starting Point/Baseline:
There are currently no telehealth capabilities within the community. The agency provides intermittent, part-time nursing care to homebound patients that includes monitoring of chronic
RHP Plan for Region 4

Program Components:
The only required core component for this project is to conduct quality improvement. Using patient survey results, physician surveys, and staff experiences, frequent evaluations will be performed to ensure project goals are being met.

Milestones and Metrics:
- Process Milestones and Metrics: P-5(P-5.1), P-10(P-10.1)
- Improvement Milestones and Metrics: I-17(I-17.1)

Unique community need identification number the project addresses:
CN.3 – Inadequate provision and coordination of health care services for persons with chronic conditions
CN.7 – High rates of preventable hospital admissions

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative as telemonitoring is not currently available in Gonzales County. This project does not include another federal funding source.

Related Category 3 Outcome Measure(s):
OD-9 – Right Care, Right Setting, IT-9.2 – ED appropriate utilization

Reason for selecting outcome measure:
Use of telemonitoring in the home health setting is anticipated to reduce emergency room visits for patients admitted to the home health setting, particularly for target conditions such as congestive heart failure, diabetes, end stage renal disease, cardiovascular disease/hypertension, chronic obstructive pulmonary disease and asthma.

Relationship to Other Projects:
This project’s focus on improving access to care and care management of individuals with chronic conditions is related to and will support many projects throughout the region. Primary projects with
direct ties to this initiative include: 020811801.2.4 – Expand Care Transitions Program; 121775403.1.3: Implement a chronic disease registry to support and sustain management of patients in care transitions program; and 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We are pleased to be able to participate in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. Other providers with whom we will collaborate who have similar projects include Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, and Christus Spohn.

**Project Valuation:**
The costs of implementing the project would be $87,000 in DY2. This would cover the cost of establishing a relationship with a monitoring company, acquiring the necessary equipment, training personnel in the use of the equipment, and getting at least one patient started in the process. A 10% increase in the number of patients using telemonitoring per year is anticipated and total costs would be $425,550 for the four years. Meeting our Category 1 objectives in this project should be valued at $78,300 in DY2, $86,760 in DY3, $93,925 in DY4 and $88,205 in DY5 for a total of $347,190.
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### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1** – P-5. Implement remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context.  
**Metric 1** – P-5.1. Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.  
Baseline/Goal: Establish program, train staff and begin monitoring at least one patient.  
Data Source: Agency documentation, HR records, vendor agreement.

**Milestone 2** – P-10. Review project data and respond to it every week with tests of new ideas, practices, tools or solutions.  
**Metric 1** – P-10.1. New ideas or practices introduced each week program is in use.  
Baseline/Goal: No previous program / At least one new idea or practice introduced each week.  
Data Source: Agency records, vendor reports.

**Milestone 2 Estimated Incentive Payment:** $43,380

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3** – I-17. Improved access to specialists care or other needed services, e.g., community-based nursing care management, patient education, counseling, etc.  
**Metric 1** – I-17.1. Number of patients participating in program for the first time.  
Baseline/Goal: No previous program / 4 patients accessing nursing care management.  
Data Source: Agency records, vendor reports.

**Milestone 4 Estimated Incentive Payment:** $93,925

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 4** – I-17. Improved access to specialists care or other needed services, e.g., community-based nursing care management, patient education, counseling, etc.  
**Metric 1** – I-17.1. Number of patients participating in program for the first time.  
Baseline/Goal: 8 patients accessing nursing care management.  
Data Source: Agency records, vendor reports.

**Milestone 4 Estimated Incentive Payment:** $88,205

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 5** – I-17. Improved access to specialists care or other needed services, e.g., community-based nursing care management, patient education, counseling, etc.  
**Metric 1** – I-17.1. Number of patients participating in program for the first time.  
Baseline/Goal: 12 patients accessing nursing care management.  
Data Source: Agency records, vendor reports.

**Milestone 5 Estimated Incentive Payment:** $88,205
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<th>121785303.1.3</th>
<th>1.7.2</th>
<th>1.7.2</th>
<th><strong>INTRODUCE, EXPAND OR ENHANCE TELEMEDICINE/TELEHEALTH</strong></th>
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<td><strong>Gonzales Healthcare Systems (Memorial Hospital Home Health Agency)</strong></td>
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<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
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<td><strong>IT-9.2</strong></td>
<td><strong>ED appropriate utilization</strong></td>
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<td>Year 2 Estimated Milestone Bundle Amount: $78,300</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $93,925</td>
<td>Year 5 Estimated Milestone Bundle Amount: $88,205</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $347,190
Jackson County Hospital District / 1218083-05
Expand Specialty Care Capacity – Pulmonary Rehabilitation Clinic
121808305.1.1

- **Provider**: Jackson County Hospital is a 25-bed critical access hospital serving an 800 square mile district and a population of about 15,000.

- **Intervention**: This project will expand specialty care capacity by establishing an outpatient pulmonary rehabilitation clinic, thereby reducing unnecessary emergency room visits and improving patient quality of life in a region with high COPD.

- **Need for the project**: Patients with pulmonary disorders currently must drive 50 to 100 miles for treatment, at great inconvenience and cost.

- **Target population**: The target population for the project is older adult and geriatric patients in the hospital district, including: (a) an estimated 760 patients with COPD in the market area; (b) Many patients are Medicaid eligible and the hospital district is responsible by law for healthcare “for the needy inhabitants of the district”. JCHD efforts will focus on education and outreach with several RHP 4 agencies that serve Medicaid eligible and indigent patients. Based on rural trends, we expect that the Medicaid eligible/indigent patients served will increase each year with our minimum target for DY1 at 12%. It is important to note that the baseline conversion rates as well as compliance to treatment percentages have not been established to date and that our projections may need to be adjusted based on annual outcomes. And, for this reason, these projections are conservative with the understanding that the OPR will treat Medicaid eligible or indigent patients that are referred for treatment that meet criteria for treatment and that are willing to be treated.

- **Category 1 or 2 expected patient benefits**: Establish an outpatient pulmonary specialty clinic in DY2. Train staff and establish baseline referral numbers in DY3. Increase referral numbers to 80 patients in DY4. Increase referral numbers to 100 patients in DY5.

- **Category 3 outcomes**: IT 9.2 Our goal is to reduce COPD related visits to the Emergency Department by 3% in DY3, 6% in DY4, and 9% below the baseline by DY5.
Project Title: 1.9.2 Expand Specialty Care Capacity – Pulmonary Rehabilitation Clinic

Performing Provider: Jackson County Hospital District/1218083-05

RHP Project Number: 121808305.1.1

Project Description:
This project will expand specialty care capacity in the Region by establishing a hospital-based outpatient pulmonary rehabilitation (OPR) clinic. The purpose of OPR is to enhance the ability of older adults with chronic obstructive pulmonary disease (COPD) to perform activities of daily living (ADL) and improve quality of life. Jackson County Hospital District will partner with the Diamond Healthcare Corporation to provide OPR services that are patient-centered, physician-directed, multi-disciplinary (e.g. occupational therapy, respiratory therapy, social work, pharmacological review, nutrition, and nursing), and outcome oriented. Each patient who visits the clinic will receive an individualized treatment plan with short and long-term goals based on a comprehensive initial assessment. Typically, a course of OPR lasts six weeks with patients seen at the clinic two to three days per week. The OPR program will provide a combination of endurance training, rehabilitation, education, behavioral health and psychosocial support to patients with the ultimate goal of reducing disability and improving control over COPD symptoms.

Currently the Region faces challenges in providing specialty care services to the community. Like most counties in the Region, Jackson County is a designated Medically Underserved Area and Health Professional Shortage Area. The low provider to patient ratio in the region results in many patients with COPD not having access to a necessary level of pulmonary care to adequately manage symptoms and reduce disability. A market analysis conducted by the Diamond Healthcare Corporation found that between 65 and 140 potential OPR patients in the areas served by Jackson County Hospital District are not receiving treatment. Consequently, these patients are at risk for acute exacerbations of their COPD which often necessitates emergency department utilization and hospitalization. Patient participation in OPR programs can significantly reduce acute care utilization and associated costs for rural hospital systems.

Project goals:
- Improve access to pulmonary rehabilitation for patients with COPD
- Increase the number of referrals of targeted patients to the OPR program
- Reduce emergency department utilization and hospitalization due to acute exacerbations of COPD
- Reduce patient disability and improve quality of life

This project addresses the following regional goals:
- Improve specialty care capacity so that patients have timely access to necessary healthcare services provided in the most appropriate and cost-efficient setting
- Improve the provision and coordination of healthcare services for persons with chronic disease

Five year expected outcome:
Jackson County Hospital District anticipates that referrals of patients with COPD to the outpatient pulmonary rehabilitation clinic will increase by 8% over baseline by DY5.

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22 U.S. Department of Health & Human Services, Health Resources and Services Administration

23 Diamond Healthcare Corporation, Jackson Healthcare Center Summary Market Analysis: Outpatient Pulmonary Rehabilitation Services, 2011.

**Starting Point/Baseline:**
Currently, Jackson County Hospital District does not have an OPR program. Therefore, the baseline for the number of patient referrals to the clinic is zero in DY2.

**Rationale:**
The OPR clinic will be located adjacent to Jackson County Hospital in Edna, Texas. Jackson County Hospital (JCH) is a 25-bed critical access hospital with a service area covering Jackson, Calhoun, Lavaca, Matagorda, Victoria, and Wharton counties. JCH is the sole hospital located in Jackson County which has a population of nearly 15,000. The median household income for the county is $38,137 with 16% of residents living at or below the poverty level. Medicaid enrollment is 12% with 25% of enrollees qualifying as aged, blind, or disabled, the populations most likely to benefit from an expansion of pulmonary care services.

The defined market for the OPR clinic is comprised of Jackson, Victoria, and Wharton counties. From 2005 to 2010, potentially preventable hospitalizations due to COPD in these counties totaled 1,379 at a cost of over $29 million. As previously noted, participation in OPR programs by patients with COPD can reduce hospitalizations due to acute exacerbations of the disease. Because emphysema and chronic bronchitis become more prevalent with age, a majority of the clinic’s patients are expected to come from the community’s older adult and geriatric populations. According to the market analysis conducted by the Diamond Healthcare Corporation, approximately 27% of residents in the clinic’s defined market area are 55 years of age or older. Furthermore, the portion of the population within this age range is expected to increase by 13% by 2014. Based on national prevalence rates for emphysema and chronic bronchitis, the estimated number of COPD cases in the defined market is approximately 760 with an estimated 265 to 340 of these patients being candidates for OPR. Currently, there are four OPR programs located in, or adjacent to, the proposed OPR clinic service area, each with a maximum capacity of 50 patients. This suggests there are at least 65 to 140 individuals who would benefit from OPR and may currently be untreated. Therefore, JCH’s OPR clinic will fill a critical need to provide medically necessary care to individuals who currently lack access to these services.

**Project components:**
We propose to meet all of the required project components as follows:

a) **Increase service availability with extended hours.** The clinic will operate during regular business hours Monday through Friday. Although evening and weekend hours will not be available initially, service availability is being substantially increased as previously there was no clinic. In the future, extended hours will be considered if it better meets the needs of our patients.

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27 Texas Health and Human Services Commission
28 Texas Department of State Health Services, Potentially Preventable Hospitalizations County Profiles, 2012.
29 Diamond Healthcare Corporation, Jackson Healthcare Center Summary Market Analysis: Outpatient Pulmonary Rehabilitation Services, 2011.
30 Ibid.
31 Diamond Healthcare Corporation, Jackson Healthcare Center Summary Market Analysis: Outpatient Pulmonary Rehabilitation Services, 2011.
b) *Increase number of specialty clinic locations.* As previously discussed, we will establish a new OPR clinic located adjacent to Jackson County Hospital. This will increase the number of OPR clinics in our three-county service area from four to five.

c) *Implement transparent, standardized referrals across the system.* All providers and staff will be trained on the processes, guidelines, and technology for the referral of patients to the OPR clinic.

d) *Conduct quality improvement for project.* This will be accomplished through the assessment of project impacts. Data will be collected on the number of referrals of patients to the clinic, number of patient encounters, and emergency department utilization due to COPD. This information will provide a measure of our success and identify areas in which we need to improve.

**Milestones and Metrics:**

- **P-11** Launch a specialty care clinic for pulmonary rehabilitation
  - **P-11.1** Establish specialty care clinic
- **P-2** Train care providers and staff on processes, guidelines, and technology for referrals and consultations into selected medical specialties
  - **P-2.1** Training of staff and providers on referral guidelines, process and technology
- **I-29** Increase number of referrals of targeted patients to the specialty care clinic
  - **I-29.1** Targeted referral rate

**Unique community need identification numbers:**

- **CN.1** Improve access to care for primary care and specialty services
- **CN.2** Improve the provision and coordination of health care services for persons with chronic conditions

**Related Category 3 Outcome Measure:**
The selected Category 3 Outcome Measure for this project is IT-9.2 *ED appropriate utilization* for the targeted condition of COPD. In FY 2012, 520 patients with COPD accessed acute care services at Jackson County Hospital District. Many of these encounters may have been preventable with an appropriate level of outpatient care. Recent research has indicated that participation in a pulmonary rehabilitation program can reduce emergency department utilization by patients with COPD.  

**Relationship to other Projects:**
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support a number of other projects within the region, including the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FZHC providers.

Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

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Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center and Christus Spohn.

Project Valuation:
When determining a value for expanding access to specialty care through an OPR clinic in Jackson County, we first determined the priority of this initiative to our community. As a critical access hospital in a Medically Underserved Community and Health Professional Shortage Area, the hospital is forced to use limited resources to serve a wide variety health conditions. When scarce medical resources are used it must be for the greater good of the most residents. And as in most rural communities, the demographic in Jackson County is older – with nearly 30% of the population 55 years old or older. Utilizing the Office of Extramural Research, National Institute of Health model, we identified the impact of this project as a high level. The insufficient access to these services in our area, results in patients’ delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. By providing access to pulmonary care locally, many older residents in need of treatment will be spared the expense and hardship of traveling 60 to 100 miles for pulmonary care. Finally, we calculated the tangible expenses of space, utilities, technology, supplies, equipment, physician recruitment and staffing to determine the total project value. Living in rural Texas, we are painfully aware of the challenges to attract physicians to our area. Therefore, recruitment and salary packages must be competitive and access to health care resources plentiful to grow programs and patient satisfaction.

The building for the OPR program will be renovated, the service area informed, and staff recruited and trained in DY2. Operational guidelines and baseline referral numbers will be established in DY3. Patient referrals are projected to increase to 80 patients in DY4 and to 100 patients by DY5.

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<tr>
<th>UNIQUE IDENTIFIER:</th>
<th>PROJECT COMPONENTS:</th>
<th>EXPAND SPECIALTY CARE CAPACITY – PULMONARY REHABILITATION CLINIC</th>
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**Jackson County Hospital District**  

**TPI – 121808305**

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

| 121808305.3.1 | IT-9.2 | ED appropriate utilization |

**Metric 1**  

**Baseline/Goal:** Open Clinic  

**Data Source:** Documentation of new specialty care clinic

**Milestone 1 Estimated Incentive Payment (maximum amount):** $400,000

**Milestone 1 [P-11]:** Launch a specialty care clinic for pulmonary rehabilitation  
**Metric 1 : [P-11.1] Establish specialty care clinic**  
**Baseline/Goal:** Open Clinic  
**Data Source:** Documentation of new specialty care clinic

**Milestone 1 Estimated Incentive Payment:** $400,000

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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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**Milestone 2[P-2]:** Train care providers and staff on processes, guidelines, and technology for referrals and consultations into selected medical specialties.  
**Metric 1: [P-2.1] Training of staff and providers on referral guidelines, process and technology**  
**Baseline/Goal:** 90% of expected goal/10 hospital staff  
**Data Source:** Log of specialty care personnel trained and curriculum for training

**Milestone 2 Estimated Incentive Payment:** $200,000

**Milestone 2 Estimated Milestone Bundle Amount:** $200,000

**Goal:** Launch a specialty care clinic for pulmonary rehabilitation

**Baseline/Goal:** Open Clinic  

**Data Source:** Documentation of new specialty care clinic

**Milestone 2 Estimated Incentive Payment:** $400,000

**Milestone 3 [I-29]:** Increase number of referrals of targeted patients to the specialty care clinic  
**Metric 1 [I-29.1]:** Targeted referral rate  
**Baseline/Goal:** Increase referrals to at least 80 for the calendar year.  
**Data Source:** Registry and/or paper documentation as designated by Performing Provider

**Milestone 3 Estimated Incentive Payment:** $300,000

**Milestone 3 Estimated Milestone Bundle Amount:** $300,000

**Goal:** Increase number of referrals of targeted patients to the specialty care clinic

**Baseline/Goal:** Increase referrals to at least 100 for the calendar year.  
**Data Source:** Registry and/or paper documentation as designated by Performing Provider

**Milestone 3 Estimated Incentive Payment:** $400,000

**Milestone 4 Estimated Milestone Bundle Amount:** $400,000

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1.3 million
RHP4-Pass 2
Camino Real Community Services
Infrastructure Development: 1.12.3 Enhance Service Availability
121990904.1.1 (Pass 2)

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

Intervention(s): This project will implement a Mobile Crisis Outreach Team to provide behavioral health crisis intervention services to patients in the Karnes County service area 24/7.

Need for the project: Clients residing within the targeted service area currently have limited access to behavioral health crisis services, which are provided by mental health workers an hour away in a neighboring county. There are no local psychiatric hospitals or crisis stabilization facilities in the service area. Karnes County is designated as a health care professional shortage area and mental health professional shortage area, which has resulted in limited accessibility to needed services and requires patients to be placed in inpatient hospitals in San Antonio, Texas, which is approximately a 1 ½ hour drive. As a result, patients frequently turn to the local emergency department to access behavioral health crisis services due to a lack of other options. There is currently no federal funding supporting this project.

Target population: The target population includes individuals of all ages experiencing a psychiatric crisis in the Karnes county area. The center’s current behavioral health population is comprised of individuals who are either indigent or Medicaid/Medicare eligible. Based on historical data related to persons served in crisis, approximately 70% of patients were Medicaid eligible, so we expect they will represent the majority of clients benefiting from these mobile crisis intervention services.

Category 1 or 2 expected patient benefits: These services intend to benefit patients by providing crisis services to individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. Inherent to the program design will be the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance patient skills. It is the performing provider’s expectation that this model will improve access to the appropriate level of care for patients. The other benefits include decreasing use of Emergency Department services and decreasing travel for patients needing crisis stabilization services. The project expects to provide crisis services in the local community to at least 30 unique individuals in DY4 and 36 in DY5.

Category 3 outcomes: IT-9.2 ED appropriate Utilization. Our goal is to reduce ED Visits by 5% in DY4 and by 10% DY5.
Project Option 1.12.3 Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care: mobile clinics

**Unique RHP Project Identification Number:** #: 121990904.1.1 (Pass 2)

**Performing Provider:** Camino Real Community Services

**Performing Provider TPI:** 121990904

**Project Description:**
_Camino Real proposes to enhance service availability (i.e., hours, locations, transportation, and mobile clinics) of appropriate levels of behavioral health care: Mobile Clinics._
The project is to increase the capacity of its crisis services by establishing a Mobile Crisis Outreach Team (MCOT) in the service area. The goal of this project is to enhance access to crisis services, while reducing the need for local Emergency Departments (ED) in Camino Real’s catchment area and reducing the number of individuals sent to more expensive mental health inpatient beds for crisis resolution services that could be provided to these individuals in a less restrictive environment.

Through this project, Camino Real Community Services (CRCS) will implement clinically staffed mobile treatment teams that provide prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community. These services intend to reach individuals at their place of residence, school and/or other community-based safe locations, 24 hours per day, 365 days per year. It is the performing provider’s expectation that this model will improve access to the appropriate level of care for patients in the provider’s service area, reduce the need for utilization of local EDs, and provide an alternate and more expedient option for law enforcement when encountering individuals in the community suffering from psychiatric disorders or experiencing a crisis. The program will also be designed to interface with CRCS’s outpatient mental health clinics to ensure that all behavioral health issues are treated in the most therapeutic manner possible.

**Goals and Relationship to Regional Goals:**
The target goal is to decrease use of higher cost services in Emergency Rooms and/or Inpatient Facilities and get people timely access to needed services. Additional goals would be to decrease travel for patients needing crisis stabilization services. Inherent to the program design will be the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance consumer skills. This project is responsive to RHP Community Need #4, #6, #19.

**Project Goals:**
- Increase the number of persons in psychiatric crisis served by Mobile Crisis Outreach Team
- Decrease number of persons inappropriately utilizing the Emergency Room or inpatient psychiatric facilities
- This project meets the following Region 4 goals:
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of
appropriate care, including behavioral health services, particularly in our rural communities.

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a growing, yet historically underserved region.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or ability to pay.

The Mobile Crisis Outreach Team (MCOT) uses a community based approach addressing emerging crisis situations by providing intensive interventions or referrals to resolve the crisis promptly and thus potentially diverting from the Emergency room or inpatient hospitalization. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. This service will expand and improve upon the existing crisis “on-call” system provided by the local mental health authority by expanding hours and days of operation.

**Challenges:**

Currently, local data for Karnes County, illustrates that in FY 12 there were 182 calls to the Crisis Hotline that required 51 face to face assessments with 10 resulting inpatient hospitalizations. The Camino Real Community Services area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible crisis interventions. The designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. The lack of robust social agencies or organizations geared towards addressing behavioral health crisis shifts the burden to the public community mental health system that has not been funded to develop dedicated Mobile Crisis Outreach teams in this area. The lack of high volume of activity challenges the justification of dedicated MCOT in the region when compared to an urban setting, but the lack of options in the rural community offsets the perceived inefficiency.

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

By the end of the 5 year period and the establishment of Mobile Crisis Outreach Teams, consumers in need will be able to access these services in their community. Response times to consumers will be immediate and lead to significantly reduced wait times in emergency rooms and/or long transport times to State Hospitals and other private psychiatric facilities. The efficacy of treatment will be significantly improved and overall costs to the total care system (not just hospitals) would be significantly reduced.

**Starting Point/Baseline:**

Currently, no local 24 hour Mobile Crisis Outreach Teams exist in the community for persons who are in psychiatric crisis; persons either stay in hospital emergency rooms or are transported long distances to more restrictive inpatient service environments. Therefore, the baseline will be set at 0 for DY1-2.
Rationale:
Camino Real has selected Project Option #1.12.3, Develop and staff a mobile crisis outreach team that can provide access to care in very remote, inaccessible, or impoverished areas of Texas. This selection is based on the fact that there are no local Mobile Crisis Outreach Teams, no local psychiatric hospitals nor local crisis stabilization services available to persons in psychiatric crisis in the Camino Real service area. The population has a significant need as evidenced by the number of calls made to the local crisis hotline and the requests made for crisis assessment at local hospitals. Development of Mobile Crisis Outreach Teams/Services offers an alternative to costly hospitalization that may occur if crisis situations escalate due to lack of immediate intervention.

Milestones & Metrics:
The following milestones and metrics have been chosen based on the needs of the target population:
- Process Milestones and Metrics: (P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.1);
- Improvement Milestones and Metrics: I-11 (I-11.1)
- Unique community need identification number the project addresses:
  - CN.4- Inadequate access to behavioral health services
  - CN.6- High rates of inappropriate emergency department utilization and dissatisfaction of emergency department services
  - CN.19- Negative mental health outcomes, such as suicide or mental health admissions in jail/prisons

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a significantly enhanced initiative for the Performing Provider since there are no local mobile crisis outreach teams; although, there is a 24-Hour crisis hotline available to persons in psychiatric crisis and a limited response system in place for purposes of determining recommendations for placement of persons in a more restrictive environment.

Related Category 3 Outcome Measure(s):
OD-9 Right Care Right Setting
IT-9.2 ED appropriate utilization: Reduce Emergency Department visits
  - Behavioral Health/Substance Abuse

Reasons/rationale for selecting the outcome measures:
The reason for selecting this measure is that it captures the impact of having a local, cost effective alternative to higher costs systems such as jail, emergency room, or inpatient hospitalization when addressing crisis situations that can be quickly resolved. The project will track the number of persons served by the Mobile Crisis Outreach Teams and compare to historical data kept by the Center regarding the number of admissions to public and private inpatient psychiatric institutions to calculate cost avoidance. As the community becomes familiar with the MCOT services and these teams divert persons in psychiatric crisis from the jails, Emergency Room, and inpatient hospitals, data will be tracked and calculation of cost
avoidance to the ER and jails will be maintained to substantiate the cost effectiveness of this alternative.

**Relationship to other Projects:**
This project is related to and complements our other project, 121990904.3.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. This project is also related to all initiatives designed to expand access to behavioral health care including: 135254407.3.1, 121775403.1.5 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system; 09422902.2.6, 080368601.2.1, 138305109.2.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services; 020973601.1.4, 094118902.1.1 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Gulf Bend Center, Christus Spohn Hospital - Alice, Christus Spohn Hospital – Corpus Christi, DeTar Hospital, Corpus Christi Medical Center, Coastal Plains Community Center, and MHMR of Nueces County.

**Project Valuation:**
This project valuation has taken into consideration 1) Costs for both State operated Psychiatric Hospitals, 2) Costs of Local Emergency Department Visits, 3) Cost of local Judicial systems, 4) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.
The implementation of local service options will result in significant costs savings to various entities locally and at the state and federal level through basic cost avoidance. This project will provide services much more responsive to consumer needs and a more efficient use of limited resources will produce the outcomes desired in a transformation initiative!
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Camino Real Community Services

**Related Category 3**

Outcome Measure(s): 121990904.3.2 IT-9.2

**ED appropriate utilization (stand-alone measure)** Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse

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**Milestone 1:** (P-3) Develop administrative protocols and clinical guidelines for project selected

**Metric 1:** (P-3.1) Manual of operations for the project detailing administrative protocols and clinical guidelines

- **Baseline:** Baseline is zero.
- **Goal:** Project protocols in place by end of DY2
- **Data Source:** Project Manual, Administrative protocols; clinical guidelines

**Milestone 1 Estimated Incentive Payment:** $ 28,820

**Milestone 2:** (P-4) Hire and train staff to operate and manage project selected

**Metric 1:** (P-4.1) Number of staff secured and trained

- **Baseline:** Establish baseline.
- **Goal:** The goal is to have staff hired by beginning of DY3
- **Data Source:** Project records

**Milestone 2 Estimated Incentive Payment:** $ 15,549

**Milestone 3:** (P-5) Establish extended hours, transportation and/or mobile clinic options

**Metric 1:** P-5.1. Number of areas prioritized for intervention with options in operation

- **a.** Number of patients served in these options
- **Baseline/Goal:** Baseline is zero. The goal is to have enhanced mobile crisis services at designated site.
- **Data Source:** Client Data records

**Milestone 3 Estimated Incentive Payment:** $15,550

**Milestone 4:** (I-11) Increased utilization of community behavioral healthcare

**Metric 1:** I-11.1 Increase utilization of community behavioral healthcare services

- **Baseline:** Established in DY3
- **Goal:** Increase number of persons served by innovative program to 30
- **Data Source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs

**Milestone 4 Estimated Incentive Payment:** $31,351

**Milestone 5:** (I-11) Increased utilization of community behavioral healthcare

**Metric 1:** I-11.1 - Increase over DY4 utilization of community behavioral healthcare services

- **Baseline:** Established in DY3
- **Goal:** Increase number of persons served by innovative program to 36
- **Data Source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs

**Milestone 5 Estimated Incentive Payment:** $ 34,188 34,069

RHP Plan for Region 4
| 121990904.1.1 | 1.12.3 | N/A | 1.12.3 **ENHANCE SERVICE AVAILABILITY (i.e. HOURS, LOCATIONS, TRANSPORTATION, MOBILE CLINICS) OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: MOBILE CLINICS**
| --- | --- | --- | ---
| Camino Real Community Services | 121990904

Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>121990904.3.2</td>
<td>IT-9.2</td>
<td><strong>ED appropriate utilization (stand-alone measure) Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse</strong></td>
<td></td>
</tr>
</tbody>
</table>

Year 2 Estimated Milestone Bundle Amount: $28,820

Year 3 Estimated Milestone Bundle Amount: $31,099

Year 4 Estimated Milestone Bundle Amount: $31,351

Year 5 Estimated Milestone Bundle Amount: $34,069

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $125,339**
**Project Title:** 1.1 Expand Primary Care Capacity, 1.1.4 Other project option

**Unique RHP Project Identification Number:** 130958505.1.1

**Performing Provider/TPI:** Corpus Christi-Nueces County Public Health Department/130958505

- **Provider:** The Corpus Christi-Nueces County Public Health District has oversight of public health initiatives, prevention and intervention for the City of Corpus Christi and surrounding communities within the borders of Nueces County (Population 343,281).

- **Intervention:** This project will implement the hiring, training, and placement of a Community Health Worker (CHW) as a Care Coordinator at each of seven Community Health Centers and/or Public Health Clinics. The CHW’s role will be to refer the target population to community based support programs for chronic disease management and prevention and to refer to patient-centered medical homes when indicated. With this coordination of care patients will be more empowered through education and resources to better adhere to, preventative self-care behaviors and clinical practice recommendations.

- **Need for the project:** There is currently no mechanism to coordinate care among the Community Health Centers, Public Health Clinics, and community support programs and/or chronic disease management and prevention programs resulting in poor coordination of services for patients in a population with the greatest barriers to medical care and preventive services and a high risk for and prevalence of chronic disease. Although locally, Community Health Workers currently serve as Patient Navigators and Care Coordinators in the hospital based setting, community and public based health centers have not yet utilized the Community Health Worker for care coordination. Furthermore, no federally funded program exists in this community to support this continuum of care.

- **Target population:** The target population is approximately 3,000 patients referred in the Medicaid eligible population who receive their health care from the Community Health Centers, Public Health Clinics, and hospital emergency departments. These patients will receive enhanced coordination of preventative care and access to medical and support services.

- **Category 1 or 2 expected patient benefits:** The project seeks to train/hire additional primary care providers/staff by hiring one CHW Care Coordinator for each of seven community healthcare settings in Nueces County (four independent, non-hospital-based community health centers and three public health clinics) who will increase access to primary care capacity, specifically increasing the access to community support services and chronic disease management and prevention programs and patient-centered medical homes. The goal of this project is to increase access for approximately 3,000 patients by the end of DY5.

- **Category 3 outcomes:** It is our goal to have 80% of patients in the target population referred to the appropriate USPSTF-endorsed screening outcome for ①tobacco cessation; ②multicomponent behavior intervention for obesity; and ③referral to patient-centered medical home when indicated.
Project Title: 1.1 Expand Primary Care Capacity, 1.1.4 Other project option
Unique RHP Project Identification Number: 130958505.1.1
Performing Provider/TPI: Corpus Christi - Nueces County Public Health Department/130958505

Project Description:
This project under the oversight of the Corpus Christi-Nueces County Public Health District (CC-NCPHD) supports enhanced staffing primary and preventative health care environments to provide care coordination for patient education and support by implementing the hiring, training, and placement of a State certified Community Health Worker (CHW) as a Care Coordinator at each of seven Community Health Centers and/or Public Health Clinics as an effective means to improved access and coordination of medical services and community resources. With the utilization of trained CHW’s, the community and public health clinics will create a safety net for this target Medicaid population whose socioeconomic and psychosocial needs often are barrier to what is recommended by their licensed health care provider. The Care Coordinator will be available to clinic patients in finding resources in the community to support their needs including but not limited to patient-centered medical homes, prescription medication assistance programs, food pantries, chronic disease management programs, medical specialty care, and mental health support services. Additionally, the Care Coordinator will be instrumental in guiding this population toward proactive and preventative care in a medical home and away from the common and reactive practice of using the emergency room for non-emergencies. The implementation of this project involves only the expansion of clinic staffing and not of clinic space or hours.

Goals and Relationship to Regional Goals:
The project goal is to increase capacity for this targeted population including coordination of patient referrals to patient centered medical homes, community resources, education and support for chronic disease self-management and prevention.

Challenges and how addressed:
Patients seek services at seven (7) non-hospital based health clinics within Nueces County including three (3) clinics operated by the CC-NCPHD. The patients served at these facilities experience several barriers to accessing health care services and adhering to treatment plans, including but not limited to: high rates of poverty, lack of health insurance, low educational levels, and cultural and linguistic barriers to care. These factors when unaddressed can lead to patients not having regular access to primary health care services and specialists, using the emergency room for chronic care management, and poor health outcomes as a result of untreated medical conditions and/or chronic diseases. This project will provide greater care coordination, communication between health care providers, and resources to decrease these barriers.

5-Year Expected Outcome for Provider and Patients:
Through increased access to primary care and expanding our staff we expect to serve approximately 3,000 individuals who represent the underinsured and Medicaid population.
through the coordination of services and referrals to medical homes, community resources, chronic disease management and prevention services.

**Starting Point/Baseline:**
The baseline for this project is zero (0) representing the total lack of Community Health Workers serving in Community Health Centers and/or Public Health Clinics as Care Coordinators. Also, there is a baseline of zero patients connected from their independent non-hospital-based health center to medical homes, community resources, and chronic disease management and prevention services.

**Rationale:**
Nueces County has a population of 343,281 with 15% enrolled in Medicaid (53,056)\(^{33}\) 26% uninsured (89,253), and 21% ranking of poor to fair health that is higher than the State (19%) and national benchmark (10%)\(^{34}\). Adding to the disparity of the County’s health is an adult obesity rate of 30% that contributes to the prevalence of chronic disease and disabilities that plague this area of South Texas. The high rates of underinsured patients, lack of access to patient centered medical homes and poor coordination between the health care systems and community based service providers contribute to poor health outcomes. In addition to the aforementioned primary care health centers, these public health clinics, faith-based nonprofits and federally qualified healthcare centers attempt to provide comprehensive preventive health care at the lowest possible cost. The Amistad Community Health Center serves an adult population of 5,000 patients. This population alone will provide a strong cohort for this project. This requires extensive coordination of care among licensed health care professionals, public health programs, pharmaceutical suppliers, laboratory providers, x-ray services, and educational programs, e.g. DSME and DSMS.

The addition of a care coordinator at each primary care clinic would help achieve the reality of a medical home for each patient, providing consistent services to each individual and allowing the patient a strong support network between services in and out of the clinical setting. To further strengthen the community safety net for patients with or at risk for chronic diseases, a care coordinator would be added to each of the CC-NCPHD clinics. These critical access points to health and wellness representing the appropriate setting for primary and preventative care will provide a network of support to keep patients adherent to treatment and educational action plans resulting in better health outcomes.

**Project Components:**
This project supports enhanced staffing for primary and preventative health care environments to provide care coordination for patient education and support as an effective means to chronic disease self-management and prevention and referring to medical homes.

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For the start-up we plan to expand primary care clinic staffing and until further review and evaluation we will not include expansion of clinic space or increased clinic hours as we do not feel this is required at this time. After the initial implementation we will re-evaluate the overall expansion and if necessary make adjustments accordingly. There are no required core components for this project.

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the Expand Primary Care Capacity project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-X (P-X.1); P-5 (P-5.1)
Improvement Milestones and Metrics: I-15 (I-15.1)

**Unique community need identification number the project addresses:**
- CN.1 - Improve access to care for primary care and specialty services
- CN.2 - Improve the provision and coordination of health care services for persons with chronic conditions.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project represents a new initiative as we will hire Community Health Workers to serve in Community Health Centers and/or Public Health Clinics as Care Coordinators. We will also connect patients from their independent non-hospital-based health center to medical homes, community resources, and chronic disease management and prevention services.

**Related Category 3 Outcome Measure(s):**
It is our goal to have 80% of patients in the target population referred to the appropriate USPSTF-endorsed screening outcome for ①tobacco cessation; ②multicomponent behavior intervention for obesity; and ③referral to patient-centered medical home when indicated. Use of these measures will demonstrate whether the initiative is contributing in part to the access to preventative services for the target population and increasing connection to patient-centered medical homes.

**Relationship to other Projects:**
This project enables the other projects (specifically the expansion of evidence-based health promotion – Project 2.6.3) by contributing to the manpower needed to accomplish them and by connecting the patients to the resources of the primary care system. This complements Corpus Christi Medical Center’s proposal to expand primary care capacity by expanding primary care clinic staffing via addition of a primary care physician at the FQHC Amistad Federally Qualified Health Center. This will result in decreased emergency department (ED) and hospital visits plus improved clinical outcomes. For example, patients with diabetes who are educated regarding self-management and are adherent to their medical regimen and able to access resources would have decreased hospitalizations for infections and poor glucose control (hypoglycemia and hyperglycemia). In addition, resultant improved glucose control (A1C’s at goal) decrease
morbidity and mortality if hospitalization is needed for illness or surgery. The work of the CHW care coordinator will be greatly enhanced by implementation of EMR and HIE (Project 1.3.1). This project also will support and enhance other projects within the region, particularly those designed to expand access to care, reduce costs, and assist patients in accessing care from the most suitable setting. Projects that this initiative is related to include project 121775403.12, project 137907508.1.1, and project 020973601.1.1 – Expand Primary Care Capacity; and 121775403.1.4 – Introduce expand or Enhance Telemedicine/Telehealth; and 130958505.2.1 – Implement an innovative and evidence-based health promotion program.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with whom we will collaborate include Christus Spohn, Memorial Hospital, Corpus Christi Medical Center, Yoakum Community Hospital, Jackson County Hospital District, and Lavaca Medical Center.

Project Valuation:
Nueces County has a population of 343,281 with 15% enrolled in Medicaid (53,056), 26% uninsured (89,253). These patients along with the underinsured receive their health care in community-based health centers and hospital emergency departments (ED). This patient population often seeks medical care at the Amistad Community Health Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces County operated by the CC-NCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, has approximately 5,000 adult patients.

This project aims to engage these patients in community support programs that provide chronic disease management and prevention services by identification and referral at the clinic and health center level by a CHW trained in care coordination, addressing RHP 4 Priority Community Needs CN.1 Improve access to care for primary care and specialty services and CN.2 Improve the provision and coordination of health care services for persons with chronic conditions. A medical home model with chronic disease management has been demonstrated to improve clinical outcomes, decrease ED visits, and decrease cost of care in Amarillo, Texas. Implementation of a similar model in Nueces County via this project plus Project 2.6.2 and Project 1.3.1 could potentially avoid $2,500 in medical costs per patient per year as occurred at the J.O. Wyatt Clinic in Amarillo by 2011. Individuals and the community benefit from healthier people in improved quality of life and productivity.

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<table>
<thead>
<tr>
<th>130958505.1.1</th>
<th>1.1.4</th>
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<tbody>
<tr>
<td><strong>“OTHER” project option: Implement other evidence-based project to expand primary care capacity in an innovative manner not described in the project options above.</strong></td>
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</tr>
<tr>
<td><strong>Nueces County Public Health Department</strong></td>
<td></td>
<td>130958505</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>130958505.3.1</td>
<td>IT12.5</td>
</tr>
<tr>
<td><strong>Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention)</strong></td>
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**Milestone 1: P-X: Develop a plan for training/hiring CHW Care Coordinators**

**Metric 1: P-X.1 Engage stakeholders, develop hiring qualifications, job description, and policies and procedures for the new CHW care coordinator position**

**Baseline/Goal:** Complete planning and finalize report with implementation plans, policies and procedures

**Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider report, policy, contract or other documentation

**Milestone 1 Estimated Incentive Payment (maximum amount):** $400,000

**Milestone 2: P-5: Train/hire additional primary care providers/staff – Hire one CHW Care Coordinator for each of seven community healthcare settings in Nueces County (four independent, non-hospital-based community health centers and three public health clinics)**

**Metric 1 P-5.1 Documentation of increased number of providers - one CHW Care Coordinator for each of seven community healthcare settings in Nueces County (four independent, non-hospital-based community health centers and three public health clinics)**

**Baseline/Goal:** 0/7 CHW Care Coordinators

**Data Source:** Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider report, policy, contract or other documentation

**Milestone 2 Estimated Incentive Payment:** $477,229

**Year 2 Estimated Milestone Bundle Amount:** $400,000

**Year 3 Estimated Milestone Bundle Amount:** $477,229

**Year 4 Estimated Milestone Bundle Amount:** $522,720

**Year 5 Estimated Milestone Bundle Amount:** $351,720

**Milestone 3: I-15: Increase access to primary care capacity**

**Metric 1: I-15.1 Increase percentage of target population reached.**

**Baseline/Goal:** Baseline will equal zero patients as there is not an existing program for care coordination. Goal equals 1500 patients in the target population served by the project.

**Data Source:** Documentation of target population reached, as designated in the project plan

**Milestone 3 Estimated Incentive Payment:** $522,720

**Milestone 4: I-15 Increase access to primary care capacity**

**Metric 1: I-15.1 Increase percentage of target population reached by the coordination of services.**

**Baseline/Goal:** Baseline equals 1500 patients. Goal equals 3000 patients in the target population served by the project.

**Data Source:** Documentation of target population reached, as designated in the project plan

**Milestone 4 Estimated Incentive Payment:** $351,720
“Other” project option: Implement other evidence-based project to expand primary care capacity in an innovative manner not described in the project options above.

<table>
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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>130958505.3.1</th>
<th>IT12.5</th>
<th>Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention)</th>
</tr>
</thead>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $1,751,669
Project Title: 1.3.1 Implement a Chronic Disease Management Registry; Implement/enhance and use chronic disease management registry functionalities

Unique RHP Project Identification Number: 130958505.1.2
Performing Provider/TPI: Nueces County Public Health Department/130958505

Project Summary Information:

- Provider: An existing public-private partnership between the Corpus Christi-Nueces County Public Health District (CC-NCPHD) and the Diabetes Community Coalition of the Coastal Bend (DCC) that currently focuses on diabetes prevention and control.
  - The CC-NCPHD has oversight of public health initiatives, prevention and intervention for the City of Corpus Christi and surrounding communities within the borders of Nueces County (Population 343,281).
  - The DCC is an umbrella organization of the more than 22 hospitals, clinics, churches, educational organizations and community based organizations who through partnerships seek to improve the health and wellness of the at-risk and identified diabetic community of Nueces and surrounding Counties.

- Intervention(s): This project seeks to implement a comprehensive system to include electronic medical records (EMR), a health information exchange (HIE) and coordinated care record (CCR) in key community based health clinics and diabetes self-management education (DSME) and diabetes self-management support (DSMS) programs creating a disease management registry for Nueces County.

- Need for the project: With a 13.6% diabetes rate in a county population of 343,281 there is a critical need for better coordination of patient care. Furthermore, community based providers are often overlooked when considering points in which people seek medical intervention. As health systems move into the world of electronic health information, it is critical that all providers active in the care of the patient have access to the patient’s health records.

- Target population: The target population is the underinsured and uninsured patient population accessing services within the community and public health clinics and diabetes self-management programs in Nueces County.

- Category 1 expected patient benefits: This project seeks to:
  - Implement the electronic records system in 80% of target sites by DY2.
  - Enroll approximately 2000 patients representative of the cohort into the disease management registry by DY5.

- Category 3 outcomes: It is our goal to decrease the number of patients in the target population who have poor glucose control (HbA1c > 9.0%) by 10% over baseline by end of DY5.
**Project Title:** 1.3.1 Implement a Chronic Disease Management Registry; Implement/enhance and use chronic disease management registry functionalities

**Unique RHP Project Identification Number:** 130958505.1.2

**Performing Provider/TPI:** Corpus Christi Nueces County Public Health Department/130958505

**Project Description:**
This project will allow for the creation and oversight of a diabetes management registry via the implementation of an electronic medical record (EMR) system in community diabetes self-management education (DSME), diabetes self-management support (DSMS) programs, independent non-hospital-based community health centers, and public health clinics and implementation of a health information exchange (HIE) system. The EMR is an electronic version of a patient’s medical history that is maintained, over time, by the provider and may include all of the key administrative clinical data relevant to that person’s care under a particular provider, including demographics, diagnoses, progress notes, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. Additionally, EMR has the ability to support other care-related activities directly or indirectly through HIE, including evidence-based decision support, quality management, and outcomes reporting. For the patient, this translates into the sharing of pertinent information and coordination of services between every provider that is involved in his or her care. Data relating to diabetes bio-markers and standards of care can then be extracted and assessed, hence, creating a diabetes registry. This centralized data will provide invaluable support to designing customized treatment plans, setting self-management goals, and improving quality of care (QI).

**Goals and Relationship to Regional Goals:**
The goals for this project include sharing of critical medical information and coordination of services between providers involved with a patient’s care via the implementation of an electronic medical record system. Accomplishing our goals will support the regional goals of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

**Challenges:**
Patients served at the non-hospital based community health centers and CC-NCHPD sites experience several barriers to accessing health care services and adhering to treatment plans, including but not limited to: high rates of poverty, lack of health insurance, low educational levels, and cultural and linguistic barriers to care. These factors when unaddressed often result in patients not having regular access to primary health care services and specialists, the use of emergency room services for chronic care management, and poor health outcomes as a result of untreated or uncontrolled diabetes. The need for greater care coordination, communication between health care providers, and resources to decrease these barriers is clear.

**5-Year Expected Outcome for Provider and Patients:**
We expect to see 2000 diabetes patients enrolled in the registry relative to the baseline.
Starting Point/Baseline:
The current status of zero functionality will serve as the project baseline.

Rationale:
Diabetes is a major health problem in the Coastal Bend. The prevalence of diabetes in Nueces County is 13.6%, higher than both the state of Texas (9.1%) and the nation (8.7%)\(^{37}\). Worse yet, the mortality rate from diabetes in Nueces County is 52 deaths per 100,000 population compared to only 28 deaths per 100,000 population for the state overall\(^{38}\). This large disparity in diabetes mortality between the county and the state is likely caused by several factors, such as high rates of uninsured and underinsured patients, lack of access to health care services, and poor coordination among health care providers.

While EMR and HIE systems are being implemented in providers offices and hospital systems, there are a vast number of community and public health providers who collect valuable patient data that should be considered. The CC-NCPHD recognizes the gap in the clinical versus public/community based health settings and would take the lead in this project to ensure that all health providers are vested in the process. The community health clinics and diabetes education program sites serve a primarily low-income, uninsured, and medically underserved population within Nueces County. Moreover, the CCNCPHD in partnership with the Diabetes Community Coalition of the Coastal Bend (DCC) will take the project a step further in creating a registry to collect and analyze data related to diabetes.

Data would be entered at every point of care, and the patient would have the ability to authorize who would be permitted access to the information. Ultimately, every provider designated on the patient’s care team would be able to share notes, coordinate treatments, consider diagnostics and medication regimens refer to inpatient and emergency department records, and review adjunct protocols and action plans from services such as diabetes self-management education and support.

EMRs, HIE and collaborative care records are the next steps in the continued progress of healthcare that can strengthen the relationship between patients and care providers and to improve outcomes and efficiency. The data and its timeliness and availability, will enable providers to make better decisions based on a more comprehensive patient record, provide better care, avoid duplication of diagnostics, and at the same time empower the patient to be an adherent participant in the process.

Implementation of the HIE would also position the CC-NCPHD for future enhancement of collection and reporting of other diseases such as infectious diseases.


Project Components:
Through the Chronic Disease Management Registry project we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) Enter patient data into unique chronic disease registry
b) Use registry data to proactively contact, educate and track patients by disease status, risk status, self-management status, community and family need
c) Use registry reports to develop and implement targeted QI plan
d) Conduct quality improvement for project using methods such as rapid cycle improvement

Milestones & Metrics:
The following milestones and metrics have been chosen for the Chronic Disease Management Registry project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-1 (P-1.1); P-4 (P-4.1)
Improvement Milestones and Metrics: I-15 (I-15.1); I-16 (I-16.1)

Unique community need identification number the project addresses:
- CN.3 - Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.14 - High rates of diabetes, including gestational diabetes

Related Category 3 Outcome Measure(s): The related Category 3 outcome measure is IT-1.10, Diabetes care: HbA1c poor control (>9.0%). The availability of each patient’s accurate and timely medical record information to the care team should allow for the early identification of emerging medical problems, leading to the treatment of those problems in a preventive care setting, where feasible.

Relationship to other Projects:
The HIE system is directly related to an ongoing effort by the Health Information Network of South Texas (HINSTX). HINSTX has been working toward implementation for the Coastal Bend area of South Texas, including Nueces and surrounding counties. Additionally, the implementation of an HIE system will be a catalyst for improved outcomes and coordination amongst health care providers, educators and outreach workers, strengthening the projects related to medical homes and chronic care management. This project also will support and enhance other projects within the region, particularly those designed to expand access to care, reduce costs, and assist patients in accessing care from the most suitable setting. Projects that this initiative is related to include project 121775403.12, project 137907508.1.1, and project 020973601.1.1 – Expand Primary Care Capacity; and 121775403.1.4 – Introduce expand or Enhance Telemedicine/Telehealth; and 130958505.2.1 – Implement an innovative and evidence-based health promotion program; and 121775403.1.3 – Implement a chronic disease registry. EMR and HIE will allow tracking of diabetes care recommendations individually and collectively, assisting the Diabetes Care Team in ensuring patients receive the medical care and services required. These tools will also enhance coordination of care by the CHW Care Coordinator.
Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with whom we will collaborate include Christus Spohn, Memorial Hospital, Corpus Christi Medical Center, Yoakum Community Hospital, Jackson County Hospital District, and Lavaca Medical Center.

Project Valuation:
Nueces County has a population of 343,281 with 26% uninsured (89,253)\(^{39}\), with 13.6% of the population having diabetes, this calculates to 12,138 people who have diabetes but no health insurance, many who do not qualify for Nueces Aid (county indigent health care). These patients along with the underinsured receive their health care in community-based health centers and hospital emergency departments (ED). This patient population often seeks medical care at the Amistad Federally Qualified Health Center, Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces County operated by the CC-NCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, and has ~2,000 diabetes patients in its system. While the Nueces County Hospital District has a contract in place for those patients qualifying for the indigent care program to receive care at the CHRISTUS Spohn Memorial Hospital and the CHRISTUS Spohn hospital-based family health centers, this patient population must meet both residency and household income requirements. Often, patient populations such as the working poor, undocumented immigrants and those people living in areas outlining Nueces County borders seek medical care within the non-hospital based community health centers, public health centers and support programs located in Nueces County. Amistad Community Health Center is the only Federally Qualified Health Center in Nueces County and is a key partner in this project. Amistad serves as a safety net for the Medicaid/CHIP patient population as they offer adult medicine, women services and pediatric care. Currently, with the exception of Amistad Community Health Center, community based providers within the scope of this project do not have access to patient records electronically; hence, as a person seeks treatment and services at whichever site that is most immediately affordable there is no continuity to treatment records. This is reciprocal for the local hospital systems when the aforementioned patient population presents as a hospital or emergency room admission.

This project seeks to implement an EMR in each of the community based sites and interface each site with a Health Information Exchange (HIE). The HIE system is directly related to an ongoing effort by the Health Information Network of South Texas (HINSTX) that recently received approval from the Texas Department of State Health Services. The timing of this proposed community based project is a natural fit to the ongoing efforts to connect individual

health providers, hospital systems, diagnostic facilities and ancillary clinics with the HIE. As the HIE uses an automated process to gather information from a variety of sources, it also requires limited manual intervention. Workflows are scalable and accommodate the increasing number of chronically ill patients.\(^{40}\) The EMR and HIE together offer the capacity to create a patient registry specific to chronic and communicable diseases so that as a patient moves from one point of care to the next, each provider has access to critical information. What ensues is a level of preventative care that can reduce complications and the need for hospital and/or emergency room admissions. Furthermore, in relation to public health issues, the HIE would allow for identification of disease outbreaks in the community more quickly, potentially saving 100’s or 1000’s of lives as treatment such as point of dispensing (POD) sites could be set up earlier and medication could be delivered to the whole community within the three (3) day emergency preparedness requirement as outlined by the Center for Disease Control (CDC).\(^{41}\) One analysis conducted with the North Carolina Medicaid system found that significant cost savings may be derived if these interventions are associated with even modest improvements in the appropriateness of care. With only 10% of non-urgent, emergency department encounters redirected to the more appropriate care setting, there will be an estimated $12,523 monthly cost savings to the State’s Medicaid system. This conservative projection would provide an annual cost savings of $150,276.\(^{42}\)

Using HIE’s to improve care, enhance coordination among members of the care team, enable regular and frequent interventions can help to lower overall health care costs and produce a substantial ROI for a community or organization.\(^4\) Appropriate to Nueces County and in consideration of a single chronic disease and related complication, the County had 150 hospital admissions in 2010 for lower-extremity amputation with a risk-adjusted admission rate of 58.70 per 100,000 population, which was significantly higher than the state average rate based on 95 percent confidence interval.\(^{43}\) Delaying complications in 2,000 or just 16% of the uninsured diabetes patients by just one year would save $56,986,400. Delaying complications in 2,000 diabetes patients by five years would save $284,932,000. Bringing together clinical, community and public health records under one comprehensive health information system will be a catalyst for improved planning, treatment, and education; hence, better outcomes for the patient and community.

Estimated local funding for this project is $4,030,000.


\(^{43}\) Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File, 2010.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1:</td>
<td>Milestone 2:</td>
<td>Milestone 3:</td>
<td>Milestone 4:</td>
</tr>
<tr>
<td>P-1: Identify one or more target populations diagnosed with selected chronic diseases (diabetes)</td>
<td>P-4: Implement/expand a functional disease management registry</td>
<td>I-15: Increase the number of patients enrolled in the registry</td>
<td>I-15: Increase the number of patient contacts in the registry</td>
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<tr>
<td>Metric 1 P-1.1 Documentation of patients to be entered into the registry</td>
<td>Metric 1 P-4.1 Registry functionality is available in 80% of project related provider sites and includes an expanded number of targeted diseases or clinical conditions</td>
<td>Metric 1 I-15.1 Number of patients in the registry</td>
<td>Metric 1 I-15.1 Number of patients in the registry</td>
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<tr>
<td>Baseline/Goal: 0 documented patients</td>
<td>Baseline/Goal: 0 project sites/80% of project sites having disease management registry implemented.</td>
<td>Baseline/Goal: 0 patients enrolled/approximately 1000 patients enrolled in the registry</td>
<td>Baseline/Goal: Approximately 1000 patients/approximately 2000 patients enrolled in the registry.</td>
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<tr>
<td>Data Source: Provider records/documentation</td>
<td>Data Source: Documentation of adoption, installation, upgrade, interface, or similar documentation</td>
<td>Data Source: Registry or EHR</td>
<td>Data Source: Registry or EHR</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $1,388,021</td>
<td>Milestone 2 Estimated Incentive Payment: $610,118</td>
<td>Milestone 3 Estimated Incentive Payment: $610,118</td>
<td>Milestone 4 Estimated Incentive Payment: $510,118</td>
</tr>
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**Year 2 Estimated Milestone Bundle Amount:** $1,388,021

**Year 3 Estimated Milestone Bundle Amount:** $610,118

**Year 4 Estimated Milestone Bundle Amount:** $610,118

**Year 5 Estimated Milestone Bundle Amount:** $510,118

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** ($3,118,375)
Driscoll Children’s Hospital
1.1.2 (B & C) - Expand Primary Care Capacity
132812205.1.1

- **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** This project will expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll’s Urgent Care Center and selected clinics.

- **Need for the project:** When a patient’s pediatrician’s office is closed, Driscoll’s non-emergent care clinics are a low-cost, reliable source of care and an appropriate alternative to the emergency room for patients seeking treatment(s) for a minor illness or injury.

- **Target population:** Medicaid patients account for more than 70 percent of Driscoll’s patient base. The project will help improve access to primary care services during after-hours and reduce the number of preventable emergency department visit. Patients will also experience greater convenience and less expensive care compared to what they would experience at the Emergency Room.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, the project expects to accomplish the following:
  - Increase access to After Hour facilities by increasing clinic hours by 2% over baseline in DY3, 4% over baseline in DY4 and 6 percent over baseline in DY5;
  - Improve access to care by Increasing the number of patient visits during After-Hours at Driscoll non-emergent care clinics by an additional 200 visits in DY3, 400 visits in DY 4, and 600 visits in DY5;

- **Category 3 outcomes:** IT-9.4 Our goal is to reduce the number of non-emergency pediatric Emergency Department visits that would have occurred absent the project.
Project Option: 1.1.2 (B & C) - Expand Primary Care Capacity
Unique Project ID: 132812205.1.1
Performing Provider name/TPI: Driscoll Children’s Hospital/ 132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties, including non-emergent care currently located at our out-patient clinics in Corpus Christi, Victoria and McAllen. Since 1953, the mission of Driscoll Children’s Hospital has impacted the lives of children all over South Texas. Driscoll is the only free-standing children’s hospital with specialized medical and surgical services in the South Texas region. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United State: Medicaid patients account for more than 70 percent of Driscoll’s patient base. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care.

This project will expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll’s Urgent Care Center and selected clinics. When a patient’s pediatrician’s office is closed, Driscoll’s non-emergent care clinics are a low-cost, reliable source of care and an appropriate alternative to the emergency room for patients seeking treatment(s) for a minor illness or injury. In Year 2, Driscoll will develop a plan to expand clinic after-hours care based on community need and appoint an interdisciplinary Task Force to oversee the plan development and implementation during the project period. The Task Force will meet twice per year and be charged with activities such as, identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Primary Care Expansion Project. Also in DY 2, Driscoll will begin a media campaign to inform our target population about the planned service expansion. In Years 3-5, Driscoll will expand After Hour clinic hours and increase the number of primary care patient visits during the new expansion hours.

Driscoll expects that the service expansion will translate into prevented emergency department visits. For this project’s Category 3 outcome measure, we will develop and administer a patient survey that will be used to identify those patients who would have otherwise visited the emergency department if they did not have access to the after-hours clinic. For this improvement target, only those individuals who report they would have otherwise visited the ED based on the severity of the patient’s condition will be included in the Category 3 IT 9.4 improvement target measurement.

Driscoll Health System’s Urgent Care Center is the only center of its kind in the region. The Urgent Care Center provides treatment for minor emergencies and illnesses and offers more convenience to patients by offering shorter wait times than an emergency room. Additionally, if a patient needs more comprehensive care than can be provided at the Urgent Care Center, they can be transported by Driscoll ambulance to the main hospital campus for further evaluation or extended care. Also, Driscoll will have two other facilities in our geographic service delivery area: McAllen Quick Care Clinic and Victoria After Hours Clinic. Driscoll’s Children’s Quick Care offers quality care in a hometown atmosphere with a staff of doctors and nurse from the community. The doctors are independent practitioners who work in partnership with the clinic. They deliver healthcare with pride.
and strive to make a difference in the lives of children who need outpatient services. Both the McAllen Quick Care Clinic and the Victoria After Hours Clinic, offer timely treatment to a wide range of common problems like coughs, colds, asthma, allergies, minor lacerations, fractures and sprains. They are both good alternatives to hospital emergency rooms by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. In FY 2012, Driscoll’s non-emergent care clinics recorded approximately 27,000 patient visits during after-hours compared to approximately 35,000 patient visits in Driscoll Children’s Hospital Emergency Room.

**Project Goals & Challenges:**
Expanding pediatric primary care access and services is essential to improving overall health care delivery and health outcomes in the region. The project will help achieve this goal by improving access to primary care services during after-hours and reducing the number of preventable emergency department visit. Patients will also experience greater convenience and less expensive care compared to what they would experience at the Emergency Room.

**By the end of Year 5, the project expects to accomplish the following:**
- Increase access to After Hour facilities by 2 percent over baseline in DY3, 4% over baseline in DY4, and 6 percent over baseline in DY5;
- Increase access to care as measured by the total number of patient visits during After-Hours at Driscoll non-emergent care clinics by 200 visits in DY 3, 400 visits in DY4 and 600 visits in DY 5;
- Increase the number of prevented Emergency Department visits that would have occurred absent the project. Results will be determined through a survey of after hour patients. Numerator will be those patients who report in the survey that, without access to the after-hours clinic, they would have otherwise taken the patient to the emergency department (i.e., prevented pediatric ED visits). The denominator will be after-hours surveyed patients. The goal will be to increase the number of prevented ED visits over baseline in DY4 and in DY5. Baseline will be established in DY3.

The project will help advance several health care goals in Region 4 related to expanding primary care services and reducing inappropriate utilization of Emergency Department services. As described in the RHP plan and the community needs assessment, Region 4 is a medically underserved area with a shortage of primary care physicians and services. The region also experiences high rates of inappropriate emergency department utilization and dissatisfaction of emergency department services. This project will help will help address these issues by expanding primary care services at Driscoll’s non-emergent care clinics during after-hours, providing residents an appropriate and convenient alternative source of care to the Emergency Room.

Some of the challenges that Driscoll expects to face with this project include changing the behavior of clients who are accustomed to receiving routine or non-emergency care in Driscoll’s emergency department rather than seeking such care in one of our After-Hours Clinics. Educating clients about our planned clinic after-hours expansion and greater patient convenience at our non-emergent care clinics will help to address these challenges.
Starting Point/Baseline:
The FY 2012 baseline measurement for Urgent Care, After Hours, and Quick Care facilities in Driscoll’s service area will begin at approximately 5,800 hours. The baseline number for patient visits during expanded after-hours is zero visits since the plan for expansion will not be implemented until DY3.

Rationale:
The Emergency Department (ED) is often the first contact many patients have with our hospital. Data suggest there is a high utilization of emergency room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expanding pediatric primary care access and services in our non-emergent care clinics during After Hours is essential to improving overall health care delivery and health outcomes in the region and will help reduce unnecessary ED utilization. An After Hours Clinic(s) setting provide a convenient and more appropriate setting for treating minor illnesses and injuries to the Emergency Department. This project includes project components: Expand primary care clinic space and Expand primary care clinic hours. Driscoll Children’s Hospital does not include any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services. This project addresses CN.1 (Inadequate Access to Primary Care Services) and CN.5 (High Rates of Emergency Department utilization).

Project Components:
Through the expansion of primary care capacity project, we propose to meet the required project components:

a) **Expand primary care clinic hours** – We will develop a plan within different committees and management teams to access the highest need for expanding After Hours facility hours. These teams and/or committees will review the current emergency room patient flow by focusing on past trending patient volumes during the week and time of day. Based on this data, expanded hours will be assigned accordingly. This information along with trending data will be assessed and use on a yearly basis for the need of additional improvement to the existing expansion plan.

b) **Expand primary care clinic staffing** – We will develop a plan within different committees and management teams to access the highest need for training and hiring additional clinical staff for After Hours facilities. These teams and/or committees will review the current staff labor trending for these facilities in relation to current patient flow (hourly volumes). With this information and execution of Project Component (a), we will forecast patient flow patterns and volumes which will be used to assign additional clinical staff. This information along with labor trending data will be assessed and use on a yearly basis for the need of additional improvement to the existing expansion plan.

We, however, will not be able to meet the require project component of:

a) **Expand primary care clinic space**. – We will not increase the current space available for our primary care clinics due to our current underutilization. We are not currently utilizing the total available space within these facilities though we will plan to consider utilizing this space if any future need develops.
**Related Category 3 Outcome Measure(s):** The related Category Outcome Measure selected for this project is OD-9 Right Care, Right Setting - IT-9.4 ED Prevention: Increase the number of prevented pediatric ED visits. This outcome will be measured by a survey of patients using the after-hours services, to identify patients who would have otherwise sought services at the Emergency Department if they did not have access to the After Hours clinic.

**Relationship to other Projects:**
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. Specific projects that will be enhanced and supported include the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FZHC providers. Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
Driscoll Children’s Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. While no other providers have submitted projects related to expansion of oral health services, almost all providers are participating in projects that expand access to care, including Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, Lavaca Medical Center, and Jackson County Hospital District. We will be collaborating with each of these as well as other region participants.

**Project Valuation:**
The quantitative value is based in part on a determination that emergency room use is a high cost service line. For certain levels of care, an After Hours clinic or pediatric primary care office is a more appropriate and efficient use of resources. Increasing the hours and use of an After Hour Clinic versus utilizing the ED creates significant savings and value. The extended hours will also support improved continuity of care for patients needing follow-up treatment. Whereas patients visiting the ED must obtain follow-up care from a provider who does not have access to their ED records, which may result in duplication of tests and services provided in the ED, patients visiting the clinic will be able to receive follow-up services from a clinic-based physician who has full access to the patient’s records.

The net payment for an After Hours clinic Managed Medicaid patient visit differs significantly from Emergency Room visit by location and level. An Emergency Room cost to Medicaid is consistently higher than an Urgent Care, Quick Care, or After Hours clinic visit. A payment difference exists between a visit at Driscoll’s Urgent Care vs. a Driscoll Children’s Hospital Emergency Room visit for a Level 1, a Level 2, and Level 3. Based on the most recent 12 months, we calculated the difference in potential savings by these levels for a Medicaid patient visit in an After Hours clinic versus an emergency department. The historical data and savings potential included Corpus Christi, Victoria, and McAllen. These payments include all ancillary services and the performing provider’s payment.
If improved patient access were not provided in an After Hours clinic setting in Driscoll’s service area, patients would over utilize the emergency room, a more costly and less convenient source of care. In addition to providing a more appropriate setting for non-emergency services, patients who are able to access the After Hours clinic instead of the emergency room will also benefit from reduced waiting times and increased satisfaction with their health care experience. Enabling these patients to avoid unnecessary ED visits will also reduce wait times for other patients visiting the ED and allow providers to more quickly treat patients with more serious conditions.

Based on the Calendar 2011 patient population and the estimated savings from diversion of patients from the ED to the After Hours clinic, we estimate a total savings and value to the state of approximately $8.8 million per year for this proposed project, or more than $25 million for DY 3-5. Based on these savings and the additional benefits to patients and the community as a whole, the requested DRSIP funding to be allocated to this project is $15,376,388 (inclusive of Categories 3 and 4).
### Unique Identifier: 132812205.1.1
### Project Components: 1.1.2. (B & C)
### Project Title: Expand Primary Care Capacity

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-X]: Develop a plan to expand access to primary care services in the Driscoll Service Area  
**Metric 1** [P-X.1]: Documentation of plan  
**Data Source:** Hospital records  
**Milestone 1:** Estimated Incentive Payment (maximum amount): $690,625 |  |  |  |  |
| **Milestone 2** [P-X.1]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing after hours primary care services for children in the Driscoll service area  
**Metric 2** [P-X.1]: Documentation of Task Force establishment  
**Data Source:** Hospital record  
**Milestone 2:** Estimated Incentive Payment (maximum amount): $690,625 |  |  |  |  |
| **Milestone 3** [P-X.2]: Begin media campaign to inform target patient population about Driscoll’s planned After Hours Clinic Expansion  
**Metric 3** [P-X.2]: Evidence of marketing (e.g., billboards, radio announcements, etc.)  
**Data Source:** Hospital/Clinic documentation  
**Milestone 3:** Estimated Incentive Payment (maximum amount): $690,625 |  |  |  |  |
| **Milestone 4** [P-X.3]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area  
**Metric 5a** [P-X.3.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 5b** [P-X.3.2]: Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area  
**Data Source:** Hospital record  
**Milestone 4:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 5** [P-X.4]: Expand After Hours Clinic hours  
**Metric 6** [P-X.4.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 2% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Metric 6a** [P-X.4.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 4% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Milestone 5:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 6** [P-X.5]: Expand After Hours Clinic hours  
**Metric 7** [P-X.5.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 2% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Metric 7a** [P-X.5.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 4% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Milestone 6:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 7** [P-X.6]: Expand After Hours Clinic hours  
**Metric 8** [P-X.6.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 2% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Metric 8a** [P-X.6.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 4% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Milestone 7:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 8** [P-X.7]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area  
**Metric 9a** [P-X.7.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 9b** [P-X.7.2]: Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area  
**Data Source:** Hospital record  
**Milestone 8:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 9** [P-X.8]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area  
**Metric 10a** [P-X.8.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 10b** [P-X.8.2]: Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area  
**Data Source:** Hospital record  
**Milestone 9:** Estimated Incentive Payment (maximum amount): $1,000,000 |  |  |  |  |
| **Milestone 10** [P-X.9]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area  
**Metric 11a** [P-X.9.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 11b** [P-X.9.2]: Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area  
**Data Source:** Hospital record  
**Milestone 10:** Estimated Incentive Payment (maximum amount): $826,500 |  |  |  |  |
| **Milestone 11** [P-X.10]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area  
**Metric 12a** [P-X.10.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 12b** [P-X.10.2]: Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area  
**Data Source:** Hospital record  
**Milestone 11:** Estimated Incentive Payment (maximum amount): $826,500 |  |  |  |  |
| **Milestone 12** [P-X.11]: Expand After Hours Clinic hours  
**Metric 12a** [P-X.11.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 6% above the FY 2012 baseline  
**Data Source:** Clinic Documentation  
**Milestone 12:** Estimated Incentive Payment (maximum amount): $826,500 |  |  |  |  |

**Outcome Measure(s):**

- **Increase the number of prevented pediatric emergency department visits**
- **Increase After Hours clinic hours**
- **Increase After Hours clinic hours of availability in Driscoll Service delivery area by 6% above the FY 2012 baseline**
- **Increase After Hours clinic hours of availability in Driscoll Service delivery area by 4% above the FY 2012 baseline**

**TPI:** 132812205

**RHP Plan for Region 4**
**RHP Plan for Region 4**

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<th><strong>RHP PP Reference Number:</strong></th>
<th><strong>Project Components:</strong></th>
<th><strong>Project Title:</strong> Expand Primary Care Capacity</th>
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<td>1.1.2</td>
<td>1.1.2. (B &amp; C)</td>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>Increase the number of prevented pediatric emergency department visits</td>
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**Payment (maximum amount):**  
$690,625

**Milestone 4:** [P-5] Train/hire additional primary care providers (i.e. nursing and etc.) and staff and/or increase the number of primary care clinics for existing providers (i.e. nursing and etc.)

**Metric 4 [P-5.1]:** Documentation of increased number of providers and staff and/or clinic sites.

**Data Source:** Documentation of HR records

**Milestone 4:** Estimated Incentive Payment (maximum amount): $690,625

**Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):**  
$2,762,500

**Year 3 Estimated Milestone Bundle Amount:** $3,000,000

**Year 4 Estimated Milestone Bundle Amount:** $3,000,000

**Year 4 Estimated Milestone Bundle Amount:** $2,479,500

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

**Metric 7 [I-12.1]:** Increase number of primary care clinic visits by 200 visits above the FY 2012 cumulative baseline.

**Data Source:** Clinic Documentation

**Milestone 7:** Estimated Incentive Payment (maximum amount): $1,000,000

**Year 3 Estimated Milestone Bundle Amount:** $3,000,000

**Year 4 Estimated Milestone Bundle Amount:** $3,000,000

**Year 4 Estimated Milestone Bundle Amount:** $2,479,500

**Milestone 10:** Estimated Incentive Payment (maximum amount): $1,000,000

**Metric 10 [I-12.1]:** Increase number of primary care clinic visits by 400 visits above the FY 2012 cumulative baseline.

**Data Source:** Clinic Documentation

**Milestone 13:** Estimated Incentive Payment (maximum amount): $826,000

**Metric 13 [I-12.1]:** Increase number of primary care clinic visits by 600 above the FY 2012 cumulative baseline.

**Data Source:** Clinic Documentation

**Milestone 13:** Estimated Incentive Payment (maximum amount): $826,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $11,242,000
Driscoll Children’s Hospital
1.8.12 – Increase, Expand, and Enhance Oral Health Services
132812205.1.2

- **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** This project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s (PCP’s) office. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery.

- **Need for the project:** In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%.

- **Target population:** Medicaid patients account for more than 70 percent of Driscoll’s patient base. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

- **Category 1 or 2 expected patient benefits:** By the end of year 5, the oral health project will accomplish the following:
  - Increase, expand, and enhance oral health services performed by PCPs in the Driscoll’s delivery service area by 20 percent over the baseline (State Fiscal Year 2012). The project is estimated to serve 350 additional patients in DY 2 (5% increase); 700 additional patients in DY 3 (10% increase); 1,050 additional patients in DY 4 (15% increase); and 1,400 additional patients in DY 5 (20% increase).
  - Train 30 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (SFY12), which represents an increase of more than 30 percent.

- **Category 3 outcomes:** Driscoll Children’s Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 10%.
Project Option: 1.8.12 – Increase, Expand, and Enhance Oral Health Services

Unique Project ID: 132812205.1.2
Performing Provider Name/TPI: Driscoll Children’s Hospital / 132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital -- the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

The DSRIP project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s (PCP’s) office. In the U.S., millions of children are predisposed to dental disease because of dietary, behavioral, and socio-environmental factors that overwhelm preventive interventions available to them. For children with extreme dental disease, dental caries frequently contribute to distracted behavior and associated poor educational performance. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Today, Driscoll Children’s Hospital collaborates with Driscoll Children’s Health Plan and Primary Care Provider (PCP) to offer dental fluoride varnish treatments to Medicaid-enrolled children in the office of their PCP. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

To further enhance the Oral Health Program, Driscoll Health System will form an Oral Health Services Task Force that will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Oral Health services milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges
identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Oral Health Services Project.

**Project Goals and Challenges:**
Expanding access to education and preventive dental care to children in a PCP’s office will improve and promote better oral health care for low-income children and help to prevent severe dental caries that often result in loss of teeth and surgical interventions.

**By the end of year 5, the Oral Health project will accomplish the following:**
- Increase, expand, and enhance oral health services performed by PCPs in the Driscoll’s delivery service area by 20 percent over the baseline (Calendar Year 11)
- Train 30 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (CY 11), which represents an increase of more than 30 percent.
- Prevent number of children requiring surgical intervention to treat severe dental caries.

This project advances Region 4 goals identified in the RHP Plan and in the Community Needs Assessment of expanding access to oral health services and reducing preventable health care complications that result from poor oral health, such as severe dental caries that often must be treated with surgery. The project also promotes care coordination between PCPs and traditional oral health care providers.

Driscoll faces several challenges and barriers to implement the fluoride varnish program; including the high rate of early childhood dental caries in our target population, a need to reach underserved populations to deliver preventative services; the need to educate PCPs in appropriate evaluation and preventive oral health.

**Starting Point/Baseline:**
For Project option 1.8.12, Driscoll provided 7,000 dental education and fluoride varnish treatments for Calendar Year 2011 baseline metric. Today, one hundred thirty five trained medical providers who represent approximately 60 percent of our target provider population in the Driscoll service area are qualified to perform Driscoll oral health services today.

**Rationale:**
The United States Surgeon General identified tooth decay as the most common chronic childhood disease in a 2000 report, “Oral Health in America.” Tooth decay is five times more common than asthma. In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%. Many parents and even physicians do not understand the importance of healthy primary teeth. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Data suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The project goal is to increase access to dental fluoride varnish treatments in our service delivery area. Driscoll Children’s Hospital does not include any
project components and does not receive any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

RHP 4 Plan and Community Needs Assessment expressed a strong need for additional dental care and recommends increasing the number of residents’ access to dental care. Consistent with this assessment this project addresses CN.5 (Inadequate Access to Dental Care) and CN.8 (High Rates of Poor Dental Health and associated Medical Issues).

Related Category 3 Outcome Measure(s): OD-7 Oral Health – IT-7.10 Other Outcome Improvement Target – Reduce incidence of severe dental caries that result in operative interventions

Driscoll Children’s Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 5% in DY 4 and 10% in DY 5

The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in preventing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30% of all cases performed in the operating room for Calendar Year 2011. Application of dental education and fluoride varnish treatments will prevent dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

Relationship to other Projects:
This project, Expand Access to Oral Health Services, complements and enhances other projects that expand access to services for children, including projects 137907508.1.1 and 1309585095.1.1, and 020973601.1.1 – expansion of primary care capacity; and 121775403.2.3 – Redesign of primary care to improve continuity of care, decrease average length of stay, and increase patient satisfaction. The only related category 4 measures is RD-4 patient Satisfaction.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
Driscoll Children’s Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. While no other providers have submitted projects related to expansion of oral health services, almost all providers are participating in projects that expand access to care, including Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, Lavaca Medical Center, and Jackson County Hospital District. We will be collaborating with each of these as well as other region participants.

Project Valuation:
We believe the Oral Health project is a highly valuable initiative in the RHP 4 Region in terms of cost avoidance, population served, and community benefit and need. In 2011, Medicaid spent $4.6 million at Driscoll Hospital on operating room (OR) and related follow up services to treat children with severe dental caries. Dental cases account for 30 percent of all OR cases at Driscoll hospital. A large share of these surgical procedures and costs could have been avoided if the patients had access to appropriate preventive dental care. Over the demonstration period, the proposed DSRIP project will expand Driscoll’s oral health program by 20 percent, serve more children, and reduce even further surgical interventions and cost to treat severe dental caries. In addition, the project will
significantly expand qualified providers in the Driscoll area to perform dental education and fluoride varnish treatments in a PCP’s office by more than 30 percent. These improvements will have a significant impact on improving health status of under-served, low-income children in our region. Based on these reasons, the value of the Oral Health project is $15,424,370 (inclusive of Categories 3 and 4).
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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| **Milestone 1** [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing pediatric oral health services performed by a primary care provider  
**Metric 1** [P-X.1]: Documentation of Task Force establishment  
Goal: Appointment and activation of Task Force  
**Data Source**: Hospital/health plan record  
**Milestone 1**: Estimated Incentive Payment *(maximum amount)*: $ 724,680 | **Milestone 5** [P-X1]: Task Force leads quality improvement initiative for oral health care project  
**Metric 5a** [P-X1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 5b**: [P-X1.2] Documentation of Task Force report, findings and/or action plan to further enhance oral health project.  
Goal: successful completion of task force report and quality improvement meetings  
**Data Source**: Hospital/health plan record  
**Milestone 5**: Estimated Incentive Payment *(maximum amount)*: $ 976,267 | **Milestone 8** [P-X1]: Task Force leads quality improvement initiative for oral health care project  
**Metric 8a** [P-X1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 8.b**: [P-X1.2] Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project  
Goal: Successful completion of task force report and quality improvement meetings  
**Data Source**: Hospital/health plan record  
**Milestone 8**: Estimated Incentive Payment *(maximum amount)*: $ 987,500 | **Milestone 11** [P-X1]: Task Force leads quality improvement initiative for oral health care project  
**Metric 11a** [P-X1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 11b** [P-X1.2]: Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project  
Goal: Successful completion of task force report and quality improvement meetings  
**Data Source**: Hospital/health plan record  
**Milestone 11**: Estimated Incentive Payment *(maximum amount)*: $ 827,475 |
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 3 Outcome Measure(s):**  
132812205.3.2  
it-7.10  
Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area

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- **Year 2 Estimated Milestone Bundle Amount:** $ 2,898,719  
- **Year 3 Estimated Milestone Bundle Amount:** $ 2,928,800  
- **Year 4 Estimated Milestone Bundle Amount:** $ 2,962,500  
- **Year 5 Estimated Milestone Bundle Amount:** $ 2,482,424

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $ 11,272,443
Driscoll Children’s Hospital
1.9.3 – Expand Specialty Care Capacity
132812205.1.3

- **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** This project will expand access to specialized pediatric health care services for children in South Texas, specifically endocrinology services.

- **Need for the project:** Nueces County has more than 9% of the population diagnosed with diabetes and other Coastal Bend counties have 8.3% to 8.9% of their populations diagnosed with diabetes. Expansion and access of sub-specialty services is key to improving overall health care delivery and health outcomes in the region.

- **Target population:** Low-income residents have difficulty accessing timely care for endocrinology services. Medicaid patients account for more than 70 percent of Driscoll’s patient base.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, this project proposes to:
  - Increase number of patient visits at selected specialty clinics for endocrinology services with an additional 100 patient visits in DY 3 (5% increase over baseline); 201 additional patient visits in DY 4 (10% increase over baseline); and 300 additional patient visits in DY 5 (15% increase over baseline)
  - Increase the number of endocrinology pediatric specialists serving South Texas by the addition of 0.5 FTEs in DY 3, 1.0 FTE in DY 4, and 1.5 FTEs in DY 5 over a 2013 baseline of 9 FTEs.
  - Increase patient satisfaction in patient’s rating of doctor access to specialty care

- **Category 3 outcomes:** IT-1.1, IT-I Our goal is to reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment and increase patient satisfaction in patient’s rating of doctor access to specialty care.
Project Option: 1.9.3 – Expand Specialty Care Capacity
Unique Project ID: 132812205.1.3
Performing Provider Name/TPI: Driscoll Children’s Hospital / 132812205

Project Description:

Expand Specialty Care Capacity
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. Since 1953, the mission of Driscoll Children’s Hospital has impacted the lives of children all over South Texas. Driscoll is the only free-standing children’s hospital with specialized medical and surgical services in the South Texas region. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing “safety net” children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care.

This project will expand access to specialized endocrinology pediatric health care services for children in South Texas. Today, Driscoll offers complex and comprehensive medical and surgical services to the pediatric population (0-21 years old) in 31 counties of South Texas. The geographic area covers 33,000 square miles and extends from rural South Texas, to Corpus Christi, and throughout the Rio Grande Valley. Driscoll’s main facility is located in Corpus Christi and satellite clinics are located in McAllen, Brownsville, Harlingen, Laredo, Victoria and other locations. Driscoll’s clinics are the only ones in the Valley entirely comprised of pediatric, board certified medical staff that are trained to care exclusively for children. The subspecialty services, provided by Driscoll, range from Behavior/Child Psychiatry, Neurology, Sports Medicine, Pulmonology, Cardiology, Surgery, GI, Orthopedic, Child Abuse, Endocrinology, Dermatology, Rheumatology, Bariatric, Hematology/Oncology and several others. These specialty services provide a variety of care to children with suspected developmental and/or learning problems, obesity, diabetes, growth disorders, metabolic bone disease, cardiac diseases, skin disorders, gastrointestinal and liver disorders, chronic illnesses that affect respiratory functionality and more.

In Year 3, the project will focus on expanding access to endocrinology services in the Corpus Christi service area. The expansion will include but is not limited to increasing providers and patient visits. Endocrinology is concerned with the study of the biosynthesis, storage, chemistry, biochemical and physiological function of hormones and with the cells of the endocrine glands and tissues that secrete them. The endocrinology service specializes in treating disorders of the endocrine system, such as diabetes, obesity, hyperthyroidism, puberty and sexual development disorders, growth disorders, pituitary disorder and long term management of disorder of deficiency or excess of one or more hormones. These services provide assistance to children as they advance through childhood and into adulthood. Endocrinology services are currently underserviced in the Corpus Christi and Driscoll Service area.

To further enhance the project, Driscoll will form an internal Task Force that will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the endocrinology project services milestones and metrics. The task force meetings will serve as a structure for activity such as: identifying project impacts and “lessons
learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the project.

**Project Goals and Challenges:**
Driscoll has one of the highest percentages of Medicaid patients (over 70 percent) of any free standing children’s facility in the nation. To ensure that children throughout the region have access to pediatric specialists, Driscoll provides multiple points of access to sub-specialty clinics in the Driscoll Service Area. Driscoll physicians and staff travel every day by plane and car from Corpus Christi to Driscoll’s specialty clinics in outlying service areas. This minimizes travel and time that patients and families must spend in order to access high-quality, pediatric care. Driscoll Children’s Hospital is dedicated to giving every child access to the same high quality care regardless of economic status, in an environment of hope and healing. The goal of this project is to improve access to specialty care services for children in South Texas. Improving access to sub-specialty services is key to improving overall health care delivery and health outcomes in the region.

**By the end of Year 5, this project proposes to:**
- Increase number of patient visits for endocrinology services at selected specialty clinics by an estimated additional 100 patient visits in DY3 (5% increase), 200 patient visits in DY4 (10% increase), and 300 patient visits in DY 5 (15% increase)
- (specifically Endocrinology services in Corpus Christi) serving South Texas by an increase of one 0.5 FTE over baseline in DY 3; 1 FTE over baseline in DY 4; and 1.5 FTE over baseline in DY5. Increase patient satisfaction in patient’s rating of doctor access to specialty care
- Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment

The challenges associated with this project are access to specialty care, particularly for patients with multiple disorders or complications and patient compliance to provider care instructions. Diabetes is one of the most common chronic diseases among children in the United States. Multiple issues arise with endocrine patients; approximately 80% of visits are for endocrine disorders other than diabetes. The demand for consultation with a DCH Endocrinologist far exceeds the ability to deliver this care to the children of South Texas with the current availability of specialists.

This project advances RHP 4 goals of expanding access to specialty care services in rural areas. As described in the RHP plan and the community needs assessment, Region 4 is a medically underserved area with a shortage of specialty care physicians and services. This shortage is most acutely felt in rural areas of the region. This project will help to address this community need by increasing the number of pediatric specialists and patient visits in the region.

**Starting Point/Baseline:**
For Project Option 1.9.3. – The starting point / baseline for the number of providers in Endocrinology for Federal Calendar Year 2012 was a total of 9 providers which included medical doctor (MD), registered nurse (RN), medical assistant (MA), RN/Certified Dietary Educator (CDE) and Dietician/CDE. The starting point/baseline for the increase in patient visits will be determined in DY 2 but is estimated at approximately 2000 patient visits for endocrinology services.
Rationale:
Low-income residents have difficulty accessing timely sub-specialty services. Patients that are especially vulnerable include those with asthma, diabetes, thyroid issues and epilepsy. According to the Centers for Disease Control, a total of 23.6 million people or 7.8% of the population have diabetes. Nueces County has more than 9% of the population diagnosed with diabetes and other Coastal Bend counties have 8.3% to 8.9% of their populations diagnosed with diabetes. Expansion and access of sub-specialty services is key to improving overall health care delivery and health outcomes in the region. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

RHP 4 plan and the Community Needs Assessment identifies a need for additional pediatric specialists, especially in rural areas of the region. Consistent with the community needs assessment, this project supports CN.2 (Inadequate access to specialty Services) and CN.9 (Shortage of specialty care physicians) and CN.15 (Inadequate health care access in rural areas).

Related Category 3 Outcome Measure(s):
The related Category 3 Outcome measures are:
- OD-6, IT-1 Percent improvement over baseline of patient satisfaction scores –(2) how well their doctors communicate
- OD-1, IT-1.1 Third next available appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Relationship to other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. Specific projects that will be enhanced and supported include the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FZHC providers. Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center and Christus Spohn.

Project Valuation:
Our method of valuation is based on expanding availability of pediatric endocrinology specialty care and access to Medicaid members in more than 30 counties, estimated savings of providing preventive sub-specialty care, and investment of providing these services for a geographic location the size of South Carolina.
Endocrinology services to children living in these aforementioned regions, many of whom would not be served without Driscoll Children’s providing pediatric sub-specialty access to Medicaid members for over 30 counties. In determining the value of this project, we considered the estimated savings that will accrue as a result of children receiving preventive services that will prevent the need for more complicated and costly medical care, the benefits of providing more timely access to services for children with chronic conditions and who might otherwise be forced to delay necessary care or obtain more costly care from an emergency room, as well as the savings from preventable admissions that result from improved access to care. We also included the value of patient satisfaction, particularly for those patients who would otherwise be forced to travel long distances for services without these improvements. Finally, we considered the costs associated with providing these additional services. Based on these factors, the investment of providing these services for our geographic location is valued at more than $18 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DRSIP funding to be allocated to this project is $14,358,720 (inclusive of Categories 3 and 4).
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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**Performing Provider Name:** Driscoll Children's Hospital  
**TPI:** 132812205  
**Related Category:** 3  
**Outcome Measure(s):**  
- 132812205.3.4  
- 132812205.3.3  

| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
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**Milestone 3** [P-X2]: Establish baseline(s) to measure improvements in patient visits to endocrinology specialists at targeted Driscoll specialty clinics.  
**Metric 3**: [P-X2.1]: Documentation of baseline development.  
Goal: Development of baseline information.  
**Data Source**: Clinic records.  
**Milestone 3**: Estimated Incentive Payment (maximum amount): $850,000

| **Year 2 Estimated Milestone Bundle Amount:**  
(add incentive payments amounts from each milestone): | **Year 3 Estimated Milestone Bundle Amount:** | **Year 4 Estimated Milestone Bundle Amount:** | **Year 5 Estimated Milestone Bundle Amount:** |
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $10,474,040

**Milestone 12** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties identified by Task Force in Year 3.  
**Metric 12**: [I-22.1]: Increase number of endocrinology specialist providers by 1.5 FTE over baseline.  
Goal: Increase number of providers by 1.5 FTE.  
**Data Source**: HR documents or other documentation demonstrating employed/contracted specialists

**Milestone 12**: Estimated Incentive Payment (maximum amount): $807,500
Driscoll Children’s Hospital
1.7.7 – Expand and Enhance Tele-psychiatry services in the Driscoll Service Area
132812205.1.4 – Pass 2

- **Provider**: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s)**: Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care. Driscoll entered into a contractual relationship with the University of Texas Medical Branch at Galveston (UTMB) to provide child and adolescent tele-psychiatric services through the Nueces County Mental Health and Mental Retardation Center.

- **Need for the project**: Driscoll Children’s Health System serves children in 24 counties of South Texas. In this 24 county region, there are only 7 child psychiatrists for a population of 713,667 children for a ratio of less than 1 child psychiatrist per 100,000 children. In the 24 county region of South Texas, there are 20 counties without a child psychiatrist. These shortages in South Texas are worse than Alaska (3.1/100,000) which is considered the worst in the US. With the significant shortage of child psychiatrists, many primary care physicians have taken on the temporary burden of providing care to these children until patients can be seen by a psychiatrist, which even for crisis care can take up to six weeks.

- **Target population**: The goal of this project is to provide telehealth/telemedicine services to Driscoll Healthplan children in the Driscoll Service area. Telemedicine/Telehealth project will help and support patients by improving patient care satisfaction, increasing access to care and distributing care specialists across underserved areas.

- **Category 1 or 2 expected patient benefits**: By the end of Year 5, the project will accomplish the following goals: Increase the number of patients who received diagnostic and treatment services via a specific telemedicine delivered service by 69 additional telemed visits (25% above baseline) in DY 3; 138 additional telemed visits (50% above baseline) in DY 4; and 207 additional telemed visits (75% above baseline) in DY 5; Increase the number of telemedicine clinics by one location; Increase the number of telemedicine/telehealth sessions provided via video-conferencing for remote health care providers by increasing the number of hours by 25% in DY 3 (an additional 48 hours); by 50% in DY 4 for an additional 96 hours; and by 75% in DY 5 for an additional 144 hours.

- **Category 3 outcomes**: IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236. Our goal is to provide follow-up visits following hospitalization at 7 days after discharge and 30 days after discharge. We will establish our Improvement Targets no later than DY 3. The increased availability of follow-up visits will improve health care outcomes and will reduce the likelihood of hospital readmissions.
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital – the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

Driscoll Children’s Health System serves children in 24 counties of South Texas. These counties have a critical shortage of child psychiatrists. The US average is 8.7 child psychiatrists per 100,000 children (Thomas and Holzer, 2006). In this 24 county region, there are only 7 child psychiatrists for a population of 713,667 children for a ratio of less than 1 child psychiatrist per 100,000 children. In the 24 county region of South Texas, there are 20 counties without a child psychiatrist. These shortages in South Texas are worse than Alaska (3.1/100,000) which is considered the worst in the US. With the significant shortage of child psychiatrists, many primary care physicians have taken on the temporary burden of providing care to these children until patients can be seen by a psychiatrist, which even for crisis care can take up to six weeks.

In DY 2, Driscoll entered into a contractual relationship with the University of Texas Medical Branch at Galveston (UTMB) to provide child and adolescent telepsychiatric services through the Nueces County Mental Health and Mental Retardation Center due to the increased need and the mal-distribution of psychiatrists in Texas. This program started in October 2012 with one half day of these services. New patients are allocated one hour per visit and follow-up patients have 30 minutes per visit. Driscoll is working with UTMB to increase the number of days in the Driscoll Service area.

**Goals and Relationship to Regional Goals:**
The goal of this project is to provide telehealth/telemedicine services to Driscoll Health plan members in the Driscoll Service area. These psychiatric services will be provided to Driscoll Health plan members by a health care child psychiatrist professional. Telemedicine/Telehealth project will help and support patients by improving patient care satisfaction, increasing access to care and distributing care specialists across underserved areas.

**Project Goals:**
- Increase the number of telemedicine visits per year by 25% in DY 3 for an additional 69 visits; by 50% in DY 4 for an additional 138 visits; by 75% in DY5 for an additional 207 visits.
- Increase the hours of availability for telemedicine services by 25% in DY 3 for an additional 48 hours; by 50% in DY4 for an additional 96 hours; by 75% in DY5 for an additional 144 hours.

**This project meets the following regional goals:**
- Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care.

**Challenges:**
Because the time of a child psychiatrist is so valuable, the primary challenge is ensuring that the Medicaid patients arrive for their appointments and arrive on time. Many of these families have difficulties maintaining their appointments because of transportation, being able to leave work, or other issues. Other challenges include ramping up this program through the grossly underserved large geographic area previously described (about the size of South Carolina). To address these challenges, we will increase patient awareness of transportation service opportunities offered to Medicaid and CHIP patients. We also plan to track and address patient No-Show ratings in collaboration with MHMR.

RHP 4 plans and the Community Needs Assessment identify an inadequate access to behavioral health care services. In 2009, Coastal Bend hospitals reported that schizoaffective disorder and manic depressive disorder were the third and fourth most common principal admission diagnosis for patients aged 18 to 49 years. About 23% of those responding to a telephone survey of Coastal Bend residents stated they had depression, and 12.5% reported that one of their children needed mental health services. Of that group, 33% said they did not receive the mental health services they needed.

**5-Year Expected Outcome for Provider and Patients:**
Driscoll Children’s Health System expects to see expansions in the number of half days contracted with UTMB to 3 days a week in the Nueces MHMR as well as starting this program in the Laredo MHMR within the Driscoll Service Area. The provider expects to expand and enhance telemedicine visits within the Driscoll service area for targeted population. Expected outcomes will relate to the project goals described above.
**Starting Point/Baseline:**
Telepsychiatry services provided to Driscoll Children Health Plan patients began in DY2 in the Driscoll Service area. The number of visits and number of available hours is 0 at the beginning of DY2. Driscoll plans to establish baselines during DY2 but increase in services are estimated to be approximately 276 patient visits and 192 available patient access hours.

**Rationale:**
Telepsychiatry services will help patients and their families to access child psychiatrists in a timelier manner. Services provided will include:
- Diagnostic evaluation
- Medication management
- Psychotherapy

The RHP 4 providers, stakeholders and other partners comprise a wide assortment of public and private institutions coming together to address the region’s heavy burden of behavioral health care services and treatment. The telehealth/telemedicine project will:
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

About 20 percent of U.S. children and adolescents (15 million), ages 9 to 17, have diagnosable psychiatric disorders (MECA, 1996, the Surgeon General, 1999). The Center for Mental Health Services (1998), a federal agency, estimated that 9 to 13 percent of U.S. children and adolescents, ages 9 to 17, meet the definition of “serious emotional disturbance” and 5 to 9 percent of U.S. children and adolescents, “extreme functional impairment.” Only about 20 percent of emotionally disturbed children and adolescents receive some kind of mental health services (the Surgeon General, 1999), and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists. The demand for the services of child and adolescent psychiatry is projected to increase by 100 percent between 1995 and 2020, and for general psychiatry, by 19 percent (U.S. Bureau of Health Professions, DHHS, 2000). The population of children and adolescents under age 18 is projected to grow by more than 40 percent in the next 50 years from the current 70 million to more than 100 million by 2050 (U.S. Bureau of the Census, 2000).

In Texas, communities are struggling to care for an increasing number of underserved, disadvantaged, and at-risk populations. Nowhere is this more evident than for children in Texas. Statistics from HHSC estimated that 13.8% of children lived in one of the state’s 177 rural counties, but only five percent of general pediatricians practiced in these counties. The shortage of pediatric subspecialists such as psychiatry is even more pronounced in these same geographic regions since most of the subspecialists are located in metropolitan areas, most often associated with major medical centers. At the time of this project, there are 178 out of 254 counties with no psychiatrists. According to the Texas Department of Health Services, there

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44 Texas Workforce Commission, *Coastal Bend Workforce Development Area* (June 2012)
were only 333 child psychiatrists in Texas and only 7 in the 24 county South Texas regions in 2012 and that the supply gap in mental health providers is likely to become even larger as we see fewer people entering the mental health profession and as the aging workforce retire.  

**Project Components:**
This project has no required core components.

**Unique community need identification numbers the project addresses:**
- CN.4 - Inadequate access to behavioral health services
- CN.16 - Lack of integration of physical and behavioral health services

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is a new initiative for this region to expand child psychiatry in particular. With the acute shortage of child psychiatrists in South Texas, this telemedicine project will be used to provide these services bringing the child psychiatrists who live in the major metropolitan areas of Texas to the children of South Texas.

**Related Category 3 Outcome Measures:**
OD-1- Primary Care and Chronic Disease Management  
IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236
- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

**Reasons/rationale for selecting the outcome measures:**
Currently, it is difficult for patients discharged from inpatient behavioral health to get an appointment with a child psychiatrist, essentially impossible within 7 days. This project will improve the ability of patients to get an appointment with a child psychiatrist in a timelier manner.

**Relationship to other Projects:**
This project’s focus is on Introduce, Expand, or Enhance Telemedicine/Telehealth services in the region. Specific projects that will be enhanced and supported include the following: 020973601.1.4 Enhance Service Availability of Appropriate Levels of Behavioral Health Care. Related Category 4 measures include RD-2 Thirty day readmissions – (3) Behavioral Health and Substance Abuse: 30-day Readmissions.

http://www.tmb.state.tx.us/agency/statistics/demo/docs/d2012/0912/m-n.php
Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center, Nueces County Mental Health Mental Retardation and Christus Spohn.

Project Valuation:
In most communities, especially in rural areas, care is not organized to promote prevention and early intervention, coordinate services, or monitor access to and quality of care. Moreover, public and private funding to subsidize care remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own.\(^{46}\) The quantitative value is based on a determination that inpatient and Emergency Room use is a high cost setting for providing behavioral care services. Decreasing the number of behavioral inpatient and emergency encounters is a more cost efficient use of resources. Expanding accessibility to behavioral telemedicine services will create significant savings and value.

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\(^{46}\) [http://telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf](http://telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf)
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<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

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

**Metric 1 [P-3.2]**: Documentation of the number of consults delivered by each specialty

**Baseline**: At the beginning of DY2, the telehealth/telemedicine services were starting to be implemented; therefore, baseline will be established within the first six months of DY2.

**Goal**: To provide telehealth/telemedicine services to Driscoll Health plan patients in the service area.

**Data source**: clinic log of health services by telemedicine service;

**Milestone 1 Estimated Incentive Payment (maximum amount)**: $510,000

**Milestone 2 [P-X]**: Implement or expand telemedicine program accessibility to targeted patients within the Driscoll Service area.

**Metric 1 [P-X]**: Documentation of operational hours/contracted hours

**Metric 1 [P-X.1]**: Increase the number of telemedicine/telehealth hours of operation.

**Goal**: Increase the number of patient access hours of in the Driscoll service area by 25% from the baseline for an additional 48 hours.

**Data source**: Documentation of operational hours/contracted hours

**Milestone 3 [P-X.1.1]**: Increase the number of telemedicine visits for each specialty identified as high need

**Metric 1 [P-X.1.1]**: Number of telemedicine visits

**Goal**: Increase the number of patient visits in the Driscoll service area by 25% from the baseline to provide 69 additional visits.

**Data source**: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 3**: Estimated Incentive Payment (maximum amount): $595,620

**Milestone 4 [P-X.1]**: Increase accessibility for telemedicine services

**Metric 1 [P-X.1]**: Increase accessibility for telemedicine services

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

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

**Goal**: Increase the number of patient visits in the Driscoll service area by 50% from the baseline to provide 138 additional visits.

**Data source**: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 5**: Estimated Incentive Payment (maximum amount): $590,149

**Milestone 6 [P-X.1]**: Increase accessibility for telemedicine services

**Metric 1 [P-X.1]**: Increase accessibility for telemedicine services

**Milestone 7 [P-12]**: Increase number of telemedicine visits for each specialty identified as high need

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

**Goal**: Increase the number of patient visits in the Driscoll service area by 75% from the baseline to provide 207 additional visits.

**Data source**: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 7**: Estimated Incentive Payment (maximum amount): $466,650

**Milestone 8 [P-X]**: Increase accessibility for telemedicine services

**Metric 1 [P-X]**: Increase the number of telemedicine/telehealth hours of operation.

**Goal**: Increase the number of patient access hours in the Driscoll service area by 75% from the baseline for an additional 144 hours.

**Data source**: Documentation of operational hours/contracted hours

**Milestone 6**: Estimated Incentive Payment (maximum amount): $466,650

**Milestone 7**: Estimated Incentive Payment (maximum amount): $466,650

**Milestone 8**: Estimated Incentive Payment (maximum amount): $466,650
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<th><strong>PROJECT COMPONENTS:</strong></th>
<th><strong>Introduce, Expand, or Enhance Telemedicine/Telehealth</strong></th>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>Baseline: At the beginning of DY2, the telehealth/telemedicine services were being implemented; therefore, baseline hours will be established within the first six months of DY2.</td>
<td>Goal: To provide access to telehealth/telemedicine services to Driscoll Health plan patients in the service area.</td>
<td>Data source: Documentation of operational hours/contracted hours</td>
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<td></td>
<td>Payment <em>(maximum amount)</em>: $590,149</td>
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**Year 2 Estimated Milestone Bundle Amount:** $1,020,000  
**Year 3 Estimated Milestone Bundle Amount:** $1,191,241  
**Year 4 Estimated Milestone Bundle Amount:** $1,180,298  
**Year 5 Estimated Milestone Bundle Amount:** $933,300

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $4,324,839
**Lavaca Medical Center**  
*Expand existing primary care capacity*  
135233809.1.1

**Provider:** Lavaca Medical Center is located in the town of Hallettsville, located in Lavaca County, a rural area in south central Texas. We are a 25 bed Critical Access Hospital and a designated level IV Trauma Center, also operating an outpatient Rural Health Clinic. We provide care for residents of Lavaca County and the surrounding areas with a primary service area population of 13,100 and a secondary service area of 27,000.

**Intervention(s):** This project will provide greater access to primary care services in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care.

**Need for the project:** Our clinic currently has one full time and one half time Primary Care Physicians. There is one other half time Primary Care Physician in private practice that is in her 60’s and looking towards retirement. With our Primary and Secondary service areas of close to 40,000, we need additional Primary Care Physicians in order to continue providing quality, timely, primary care health services.

**Target population:** The target population for the project includes the numbers in our service area as specified above; approximately 40,000 individuals. According to the U.S Census and Applied Geographic Solutions data, we have both a higher percentage of older adults (21%) than the averages within Texas (10%) or the U.S. averages (13%) and more low-income residents with the per capita income and the median income lagging behind both the Texas and U.S. averages. As found in other geographic locations with high percentages of low-income or high percentages of the elderly, our patients have high rates of chronic but potentially preventable diseases such as diabetes, hypertension, and heart disease. Medicaid and/or indigent patients will benefit from the project by having greater access and more timely care offered to them.

**Category 1 or 2 expected patient benefits:** Our project is designed to provide at least 8,200 additional Primary Care visits by the conclusion of Year 5. We seek to provide at least 2,200 additional clinic visits in DY 3, 2,800 additional clinic visits in DY 4, and 3,200 additional clinic visits in DY 5. Additionally the project will expand the hours of accessibility to Primary Care in DY4 and in DY5.

**Category 3 outcomes:** OD- 9 Right Care, Right Setting, T-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions. Our goal is to reduce Emergency Department visits with the target conditions of diabetes, cardiovascular disease, and hypertension by 3% in DY4 and an additional 10% in DY5.
Project Option 1.1.2 – Expand existing primary care capacity

Unique RHP Project Identification Number: 135233809.1.1
Performing Provider Name/TPI: Lavaca Medical Center/135233809

Project Description:

Lavaca Medical Center proposes to provide greater access to primary care services by expanding primary care clinic staffing and hours.

Lavaca Medical Center proposes to provide greater access to primary care services in order to keep individuals and families healthy and therefore avoid more costly ER and inpatient care. This project will provide more preventive, primary and chronic care in our community by expanding existing capacity in the primary care setting. We propose to recruit and hire additional Primary Care Providers and expand clinic hours, having already met the need and requirement of increasing clinic space.

Lavaca Medical Center is located in Lavaca County, a small rural area in south central Texas. We are a 25 bed Critical Access Hospital and a designated level IV Trauma Center, also operating an outpatient Rural Health Clinic, and a program of ‘Visiting Specialists’. We provide care for residents of Lavaca County and the surrounding areas with a primary service area population of 13,100 and a secondary service area of 27,000.

According to the U.S Census and Applied Geographic Solutions data, within our service population of just over 40,000, we have both a higher percentage of older adults (21%) than the averages within Texas (10%) or the U.S. averages (13%) and more low-income residents with the per capita income and the median income lagging both the Texas and U.S. averages. As found in other geographic locations with high percentages of low-income or high percentages of the elderly, our patients have high rates of chronic, but potentially preventable diseases such as diabetes, hypertension, and heart disease.

A hurdle we faced, and one of the core components of this project, was a lack of clinic space. We found that one of the difficulties in recruiting additional primary care physicians was a lack of space as well as the efficient use of the space we had. Our clinic consisted of three separate older private practice areas that we had cobbled together through the years as physicians retired or moved to another location outside of Lavaca County. This challenge has been addressed with the recent completion of a renovation/expansion project that added both additional exam rooms and efficiencies in patient care.

Lavaca Medical Center’s project will improve access to primary care services and increase the volume of primary care visits that may otherwise have been treated episodically in an Emergency Department or other higher cost setting.

Goals and Relationship to Regional Goals:

Through our project, the primary care needs of patients will be better met, allowing them to receive the right care at the right time in the right setting. Achieving our project goals will improve access across the continuum of preventive, primary and chronic care and further increase efficiencies to maximize our current capacity.
Project Goals:
- Increase primary care capacity by hiring additional primary care providers and expanding clinic hours
- Increase volume of primary care clinic visits
- Reduce wait times for primary care appointments
- Reduce inappropriate utilization of the emergency department
- Reduce unnecessary health care expenses

This project supports the Region’s goal of providing patients with timely access to primary health care services in the most appropriate and cost-efficient settings, thereby improving patient outcomes and reducing acute care utilization.

Challenges:
A key challenge in implementing this project will be attracting physicians to our clinic. Primary care physicians in rural areas are asked to meet a multitude of patient needs, not just in the outpatient clinic setting, but also caring for inpatients and nursing home patients as part of their routine practice. In larger, urban areas there has been a move to ‘clinic physicians’, physician hospitalists, and even physician groups that focus solely on nursing home residents. Due to both a cultural expectation as well as a financial reality, the physicians we seek must be willing to take on all three aspects of a practice. Our experience has shown that this concept of delivering care in all three settings (clinic, hospital, and nursing home) is at odds with what primary care physicians are being taught in their medical schools and in their experience in the more urban areas. Our project addresses this challenge of physician recruitment in a highly competitive market by including a recruitment strategy in the overall intervention plan to be developed in DY2. This will ensure we are using the most appropriate strategies and resources in the recruitment/hiring of a provider.

5-Year Expected Outcome for Provider and Patients:
Lavaca Medical Center plans to add two additional primary care providers and to expand clinic hours to better meet the needs of our patient population. In turn, we expect to better serve our target population with an additional 8,200 clinic appointments in order to see a primary care physician.

Starting Point/Baseline:
Data collection conducted in DY2 will be used to establish a baseline for the number of clinic visits.

Rationale:
Like other counties in our Region, Lavaca County is a designated Medically Underserved Area due to a shortage of primary care providers, high infant mortality, high poverty, and/or high elderly population. The median household income in Lavaca County is $39,468 with approximately 14% of residents at or below the poverty level. In addition, Lavaca County has

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47 U.S. Department of Health & Human Services, Health Resources and Services Administration
a high proportion of elderly residents at 21.3% of the population compared to 10% for all of Texas.\textsuperscript{49} Low-income and elderly populations often lack resources for seeking medical care, are more likely to suffer from chronic disease conditions, and have been found to be more likely to use the emergency department for non-emergent care. These populations are also the most likely to benefit from an expansion of primary care capacity.

By increasing the overall primary care capacity there are beneficial results like better health outcomes, improved patient satisfaction, more appropriate utilization of resources and reduced cost of services. Adding providers to increase access to primary care will play a key role in improved disease management and will better address the chronic care needs of many of our patients rather than episodic care. With enough providers in place we can focus on more data driven care, using technology to assist us with models of care for diabetes, hypertension, and heart disease.

**Project Components:**
Lavaca Medical Center’s project of expanding existing primary care capacity will meet each of the required core project components:

a) *Expand primary care clinic space.* As addressed above, we have already expanded the space with a significant addition/renovation project completed in September 2012.

b) *Expand primary care clinic hours.* We will expand clinic hours after successfully completing the component of expanding the staffing. The determination of the appropriate time frame and additional hours to expand is taken into account with the overall implementation plan that will be completed in DY2.

c) *Expand primary care clinic staffing.* The recruitment and hiring of additional providers is the key component of this project. Within the overall intervention plan will be strategies to ensure we are using the most appropriate strategies and resources in the recruitment/hiring of primary care providers.

**Milestones & Metrics:**
The following milestones and metrics have been chosen for our project based on the core components

- P-5 Hire additional primary care providers
  - P-5.1 Documentation of increased number of providers
- P-4 Expand hours of the primary care clinic, including evening and/or weekend hours
  - P-4.1 Increased number of hours and primary care clinic over baseline
- I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
  - I-12.1 Documentation of increased number of visits

The following customizable process milestones are necessary in order to do appropriate planning to implement project components and for us to determine if we have met our goals for increased clinic volume of visits in DY3-5:

- P-X Complete a planning process to expand the number of primary care clinic staff and hours in the primary care clinic

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\textsuperscript{49} U.S. Census Bureaus, Lavaca County, Texas, 2011
P-X.1 Documentation of completed plan that includes: effective recruitment strategies; identification of resources and potential partnerships; implementation timeframe to expand the number of staff; implementation timeframe of clinic hour’s expansion

- P-X1 Collect baseline data on primary care clinic volume of visits
- P-X1.1 Establish baseline data for number of visit

**Community need identification number addressed:**
CN.1 Inadequate access to primary care
CN.6 High rates of inappropriate emergency department utilization
CN.10 Shortage of primary care physicians

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently, our community has insufficient access to primary care services placing a significant strain on our health care delivery system. By increasing the number of primary care providers and expanding primary care clinic hours, this project will enhance our existing delivery system and provide much needed increased primary care capacity.

**Related Category 3 Outcome Measure(s):**
IT-9.2 ED appropriate utilization
- Reduce Emergency Department visits for target conditions

**Reasons/rationale for selecting the outcome measure:**
Reduced access to primary care physicians often leads to patients seeking medical care in urgent and emergent care settings for conditions that can be addressed in a more coordinated and cost-effective manner in the primary care setting. Expanding primary care capacity will result in patients being able to secure appointments with primary care physicians at times that are convenient for them and with minimal waiting periods. As a result, emergency department visits for non-urgent care will be reduced resulting in significant cost-savings and more coordinated patient care.

**Relationship to other projects:**
Many of the projects in this region are related to expansion of care and improving access to care. This project’s focus on expanding care will support and enhance these Category 1 and 2 projects in our RHP: 0208811801.1.1 – Expand Primary Care Capacity; 121775403.2.3 – Primary Care Redesign; and 0942220902.2.4, Expand Care Transitions program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of
challenges and testing of new ideas and solutions to promote continuous improvement in our 
Region’s healthcare system. Other providers with similar projects with whom we will 
participate in the learning collaborative include Christus Spohn, Memorial Hospital, Lavaca 
medical Center, Yoakum Community Hospital, and Corpus Christi-Nueces County Public Health.

**Project Valuation:**
The Community Needs Assessment identified a shortage of primary care providers as a 
significant problem for our Region. At our current capacity, patients in our service area are 
often unable to secure appointments at convenient times and without significant waiting 
periods. This result in patients seeking care in emergency departments for non-urgent 
conditions or waiting to seek medical care until their conditions have reached a critical state. 
Expanding primary care capacity will yield substantial savings due to patients being able to seek 
timely care in a primary care clinic setting rather than visiting the emergency department. 
Other factors considered in valuing this project include expected improvements in patient 
outcomes and care coordination as well as in patient satisfaction.
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<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
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<th>1.1.2</th>
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<th>Expand Existing Primary Care Capacity</th>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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</table>

**Milestone 1 [P-X]:** Complete a planning process to expand the number of primary care clinic staff and hours in the primary care clinic.

**Metric 1 [P-X.1]:** Documentation of completed plan that includes: Effective recruitment strategies; Identification of resources and potential partnerships; Implementation timeframe to expand the number of staff; Implementation timeframe of clinic hour’s expansion

Baseline: There is no comprehensive plan at beginning of DY2; baseline is 0.
Goal: Completed plan
Data Source: Contracts, agreements, reports

*Milestone 1 Estimated Incentive Payment: $24,255*

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

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

Baseline: There are no new providers at beginning of DY 2; baseline is 0.
Goal: to successfully recruit and hire one new primary care physician
Data Source: Documentation of

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

**Metric 1 [I-12.1]:** Documentation of increased number of visits.

Baseline/Goal: increase visits by 2,200
Data Source: Census reports, EHR, claims data
Milestone 3 Estimated Incentive Payment: $39,807

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

**Metric 1 [I-12.1]:** Documentation of increased number of visits.

Baseline/Goal: increase visits by 2,200
Data Source: Census reports, EHR, claims data
Milestone 4 Estimated Incentive Payment: $39,807

**Milestone 5 [P-4]:** Expand hours of the primary care clinic, including evening and/or weekend hours

**Metric 1 [P-4.1]:** Increased number of hours at primary care clinic over baseline
Baseline/Goal: Increase in primary care clinic hours over DY2 baseline
Data Source: Clinic records
Milestone 5 Estimated Incentive Payment: $39,807

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

**Metric 1 [I-12.1]:** Documentation of increased number of visits.

Baseline/Goal: increase visits by 2,200
Data Source: Census reports, EHR, claims data
Milestone 6 Estimated Incentive Payment: $39,807

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

**Metric 1 [I-12.1]:** Documentation of increased number of visits.

Baseline/Goal: increase visits by 3,200
Data Source: Census reports, EHR, claims data
Milestone 7 Estimated Incentive Payment: $32,884

**Milestone 8 [P-5]:** Hire additional primary care providers

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

Baseline/Goal: 1 additional physician (2 total over baseline)
Data Source: Documentation of completion of agreements, contracts, or other documentation.

Milestone 8 Estimated Incentive Payment: $32,884
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<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
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- completion of agreements, contracts or other documentation
- Milestone 2 Estimated Incentive Payment: $24,255

**Milestone 3 [P-X1]:** Collect baseline data on primary care clinic volume of visits.

**Metric 1:** [P-X1.1] Establish baseline for number of visits
- Baseline/Goal: TBD
- Data Source: Registry, EHR, claims data
- Milestone 2 Estimated Incentive Payment: $24,256

Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone): $72,766*  
Year 3 Estimated Milestone Bundle Amount: $79,384  
Year 4 Estimated Milestone Bundle Amount: $79,614  
Year 5 Estimated Milestone Bundle Amount: $65,768

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $297,532*
**RHP Project Identification Number:** 135254407.1.1  
**Performing Provider/TPI:** Gulf Bend Center/135254407  
**Title of Project:** 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospitalization (Crisis Assessment Center with Medical Clearance)

- **Provider** - Gulf Bend Center is the Community Mental Health Center located in Victoria, Texas. Gulf Bend Center provides services to individuals in the following seven county area: DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging.

- **Intervention:** This project will expand and enhance Gulf Bends behavioral crisis services by implementing a Crisis Assessment Center with Medical clearance to provide crisis stabilization services. The services that will be included in this project are crisis residential services and crisis respite services that offer varying degrees of support based upon the needs of the client.

- **Need for project:** In 2011, Detar Hospital and Citizens Medical Center had a total of 1,200 patients present to the emergency department with a primary or secondary behavioral health emergency diagnosis. Gulf Bend found that 610 behavioral health crisis assessments were performed in the Gulf Bend service region. Of the 610 behavioral health crisis assessments, only 108 were performed at Gulf Bend. The remaining crisis assessments were performed at local emergency departments (456), local jails (29), and other locations (17).

- **Target population:** The target population is the patients affected by a mental/behavioral health crisis who seek treatment in the local emergency department or are arrested while having the crisis. The goal of this project is to reach and help the 10,000 residents in the Gulf Bend service area that are affected by mental and or behavioral illness and currently have Medicaid as their primary insurance. Gulf Bend hopes to perform 100 Assessments in DY4 and 125 assessments in DY 5.

- **Category 1 expected benefits:** The project seeks to decrease crisis assessments in the ED and criminal justice setting, reducing costs and inappropriate care setting. This will also allow the patient quicker access to the correct treatment.

- **Category 3 outcomes:** The Category 3 Outcome Measure chosen by Gulf Bend for this project is OD-9 Right Care, Right Setting.  
  - IT-9.1 Decrease in mental health admission and readmissions to the criminal justice setting by 15% by DY 5.  
  - IT-9.2 Appropriate use of the emergency department for behavioral health by decreasing emergency department visits due to behavioral health crisis by 15% by DY 5.
Category 1: Infrastructure Development

Title of Project: 1.13.1 Development of behavioral health crisis stabilization services as alternatives to hospitalization (Crisis Assessment Center with Medical Clearance)

RHP Project Identification Number: 135254407.1.1
Performing Provider/TPI: Gulf Bend Center/135254407

Project Description:
The purpose of this project is to expand and enhance Gulf Bend’s ability to offer 24 hour Crisis Stabilization Services and Medical Clearance to those affected by behavioral or mental health illnesses in times of crisis. The services that will be included in this project are crisis residential services and crisis respite services that offer varying degrees of support based upon the needs of the client. The project will include communicating and training community stakeholders (first responders) on the purpose of the Crisis Assessment Center, performing behavioral health assessments, offering counseling or behavioral health services, and performing medical screenings. A medical clearance is an assessment or screening performed by a physician to diagnose a physical health issue. The goal of performing a medical clearance assessment is to diagnose and prepare for the treatment of an underlying physical health illness so that the appropriate treatment may be administered. Per Texas state law, before admission to an inpatient psychiatric unit, a patient must receive medical clearance. Currently, Gulf Bend's service area has a population of 200,000. There are currently 19,213 Medicaid enrollees within the Gulf Bend Service region. Based upon national statistics, roughly 10,000 are affected by mental and behavioral illness. Through this project, Gulf Bend hopes to improve the lives of the 10,000 residents who are affected by mental/behavioral illness and have Medicaid as their primary insurance. By the end of DY 5, Gulf Bend will try to have performed 125 crisis assessments. We will start performing the assessments in DY 4 with a goal of 100.

Goal(s) and Relationship to Regional Goal(s):
The goal of the project is to help decrease unnecessary use of the emergency department, the county jail, and inpatient psychiatry units by those affected by mental illness and undergoing a mental health crisis. Too often, those in the midst of a behavioral health crisis are transported to the nearest emergency department by first responders because there is not a facility that offers crisis stabilization services. The patient then spends unnecessary time in the emergency department waiting for the medical screening, which is required by Texas state law. After the medical screening the patient is either booked into the local jail or is admitted into a state inpatient psychiatric unit. Through this project the Gulf Bend Center will offer crisis stabilization services and decrease unnecessary use of the emergency department, jail, and inpatient psychiatric units in this community. Not only will the patient get the needed and necessary behavioral health services, but emergency department and jail usage will also be decreased. It is the goal of this project to reach and help the 10,000 residents in the Gulf Bend service area that are affected by mental and or behavioral illness and currently have Medicaid as their primary insurance. In DY 4, Gulf Bend will strive to perform 100 assessments at the newly established Crisis Assessment Center. We hope to increase the number of assessments to 125 by the end of DY 5.

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50 Texas State Department of Health Services, 2010 Census data
Challenges and how addressed:
There will be several challenges facing Gulf Bend in the development and implementation of the Crisis Assessment Center. One challenge will be communicating to community stakeholders what are crisis stabilization services and what are the types of clients served by crisis stabilization services. However, Gulf Bend feels that this challenge can be overcome with proper communication and training among the community members and stakeholders.

Another challenge will be developing and implementing the project plan for the assessment center. One particular aspect will be the development and implementation of medical procedure policies and guidelines. To meet this challenge, Gulf Bend will reach out to and collaborate with medical staff personnel at local hospitals for guidance on the development and implementation of the needed physical health policies, procedures, and treatment plans.

The last challenge will be the recruiting, hiring, and training of staff required for the Crisis Assessment center. The selection and hiring of primary care staff specifically will present the greatest challenge. However, Gulf Bend will seek guidance using professional associations and the local primary care providers and organizations skilled in this level of service.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcome through the enhancement and expansion of the Gulf Bend crisis stabilization services project is to have a significant impact of 25% or more reduction in emergency department usage and in the criminal justice system due to behavioral health crisis. This will lead to an overall reduction in costs, but more importantly an increase in the efficacy in the treatment of those suffering from a behavioral health or mental health crisis.

Starting Point/Baseline:
Gulf Bend will use the total number of emergency department visits due to behavioral health crisis from their 2011 data as the baseline, or starting point, to demonstrate the effectiveness of its expanded and enhanced crisis stabilization services. Current data is from Citizens Medical Center and Detar Hospital in Victoria, Texas. In 2011, DeTar Hospital and Citizens Medical Center had a total of 1,200 patients present to the emergency department with a primary or secondary behavioral health emergency diagnosis.

Rationale:
Gulf Bend is the local mental health authority and has a strong history of providing behavioral health crisis assistance. Gulf Bend selected this project because current crisis stabilization services within its service area are limited. Currently, if a patient in the area is suffering from a behavioral health or mental illness crisis, first responders in the area transport the client to the emergency department or to the local jail. This occurs because there is a lack of understanding on behavioral health crisis' and crisis stabilization services in the area.

This project was chosen by Gulf Bend because there is a demonstrated community need for Crisis Stabilization services in the area. Gulf Bend was aware of this need in 2006 after reviewing collected data. The data shows that over 55% of the crisis assessments and stabilization services were performed at the emergency department. Gulf Bend found that 610 behavioral health crisis assessments were performed in the Gulf Bend service region. Of the 610 behavioral health crisis assessments, only 108 were performed at Gulf Bend. The remaining crisis assessments were performed at local emergency
departments (456), local jails (29), and other locations (17). In 2011 and 2012 YTD, there has been an increase in the number of individuals seen by Gulf Bend staff in the local emergency departments due to a behavioral health crisis. In 2011, Gulf Bend crisis staff saw 271 individuals having a behavioral health crisis. As of October 2012, Gulf Bend crisis staff has seen 286 individuals that presented to the emergency departments in the Gulf Bend service area for crisis stabilization services. This number is considerably larger than the 271 that Gulf Bend provided crisis stabilization services for the entire year in 2011. The data from DeTar proves that many undergoing a behavioral health crisis are seeking care in an inappropriate setting, the emergency department, and would be better served by the Gulf Bend Crisis Stabilization Center.

Data from the criminal justice system also shows alarmingly high rates of admissions. In 2011, there were 1,199 individuals arrested that were diagnosed with a mental illness. Of the 1,199, almost all were transported to the emergency department for a mental health assessment and then incarcerated. None of the individuals were assessed or treated by Gulf Bend crisis staff. This number will show improvement if Gulf Bend increases its capacity to deliver these services. Gulf Bend is confident that by using the 1115 funding to expand and enhance crisis stabilization services, that we will be able to offer a decrease in emergency department visits due to behavioral health crisis.

Project Components:
We propose to meet all of the required project components as follows:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (e.g. for example, one community with high rates of incarceration and/or ED visits for intoxicated patients may need a sobering unit while another community with high rates of hospitalizations for mild exacerbations mental illness that could be treated in community setting may need crisis residential programs).

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

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)

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

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
Milestones and Metrics: The following milestones and metrics were chosen for the Crisis Assessment Center with Medical Clearance project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.1); P-9 (P-9.1)

Improvement Milestones and Metrics: I-10 (I-10.1); I-11 (I-11.1); I-12 (I-12.1)

Unique community needs identification numbers:
- CN1 – Access to primary care
- CN.2 - Improve the provision and coordination of health care services for persons with chronic conditions.

Related Category 3 Outcome Measure(s):
The Category 3 Outcome Measure chosen by Gulf Bend for this project is OD-9 Right Care, Right Setting.
- IT-9.1 Decrease in mental health admission and readmissions to the criminal justice setting by 15%
- IT-9.2 Appropriate use of the emergency department for behavioral health by decreasing emergency department visits due to behavioral health crisis by 15%

The reason for choosing this outcome measure is that the data has shown that the emergency department utilization rate for those with a mental health crisis is high in the Gulf Bend service region. In 2006, 456 patients presented to local emergency departments. This rate is high because first responders do not have a location to transport someone having a mental illness crisis. The only location that they know of, or has the capacity to deal with someone having a mental illness crisis, is the emergency department. Not only does this put the patient at risk, because they are not receiving the appropriate and needed behavioral health services, it also causes problems at the emergency department because the patient has to undergo a medical clearance exam. These additional and potentially avoidable services also increase the cost to the health care delivery system.

If there were expanded crisis stabilization services that offered medical clearance, the first responder could transport the patient to the Crisis Assessment Center directly. Having these needed services available would not only lead to better behavioral and physical health outcomes, it would also lead to decreased recidivism of emergency departments and jail systems and lower the costs of providing care to those with a mental health crisis. Studies have shown that crisis stabilization services, which would be provided in Gulf Bends Crisis Assessment Center, are more effective at treatment at a hospital. The same study also showed that a patient undergoing a hospital or jail based intervention was 51% more likely to be readmitted than a patient that had received services from a crisis intervention site that offered crisis stabilization services. One particular study showed the efficacy of a site that offered crisis stabilization services. The study showed that a jail diversion program that included the transportation of the patient to a crisis stabilization site resulted in a lowering of the arrest rate among individuals having a mental illness crisis by over 30%.

Relationship to other Projects:
Gulf Bend is also proposing to integrate primary care into its existing behavioral health services in its Category 2 project 138305109.2.4. The site for this integration will assist in the continuity of care by providing short term and long term crisis stabilization and respite care.
This project is an important component of the region’s vision for redesigning Primary and Behavioral Health Services. It’s focus and emphasis on improving patient experience and outcomes, ensuring patients receive the right care in the right setting, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to behavioral health care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
Gulf Bend will hold regularly scheduled learning collaborative meetings at its facility. The collaborative will include city and county officials, law enforcement officials, hospital administrators, behavioral health specialist, and EMS personnel within the RHP. The purpose of this collaborative is to promote the sharing of information among the members, but also to promote a constant cycle of learning and improvement. This collaborative will foster the dissemination of knowledge and data so that Gulf Bend will have the tools to improve the enhanced crisis stabilization services that are needed in the area. The goal of this learning collaborative is to improve upon the expanded and enhanced crisis stabilization services using the data and knowledge shared among the RHP partners.

We also will participate in a region-wide learning collaborative offered by the Anchor entity for Region 4, Nueces County Hospital District. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The approach used to value this project was based upon the community need for enhanced and expanded crisis stabilization services. To determine the value of this project, Gulf Bend based its valuation on current and future community need for crisis stabilization services. Currently, the Gulf Bend service region is undergoing a surge in population size. This is due to the economic growth in the area. The biggest economic growth is due to the discovery of oil within the Eagle ford shale. Another increase in growth is due to the development of new industries. Caterpillar, a leading manufacturer of construction equipment, built a new plant in Victoria. Invista and Dow chemical corporations will also be expanding their production capabilities. This economic growth means that there will be new jobs in the area. As people move to the area for these jobs, which means that Gulf Bends service population will continue to grow. The more people that move into and live in the area; the greater the prevalence of mental and behavioral health illness, and the greater chance of behavioral health crisis.

Part of expanding and enhancing this future need is the hiring of staff to have crisis stabilization services available 24 hours a day and open seven days a week. Gulf Bend understands that behavioral health crisis can occur at any time of day and on any day of the week. Therefore, our enhanced services must be available every day and all day.
Another component to the project valuation was the site for crisis stabilization services. To meet the current and expected future need, Gulf Bend will need to enhance its existing service location. This will include ordering new equipment (desks, chairs and computers) and supplies. The supply component factored in the need for not only enhanced behavioral health crisis stabilization services, but also to provide the needed medical clearance services that Gulf Bend will incorporate into its crisis stabilization services.

This project also presents value to the community and to the health care system within the Gulf Bend service area. The average cost for an emergency department visit is $2,400\textsuperscript{51}. Given that there were 1,200 visits to local emergency departments for behavioral health crisis that equates to a total cost of $2,880,000. If Gulf Bend were able to divert 25% of those visits, that would equate to a cost savings of $720,000. This is just cost savings on the hospital side. There will also be savings to the criminal justice system as well, which in turn result in less usage and decrease in costs for emergency departments.

If first responders would bring the patient to the crisis assessment center first, instead of the emergency department or jail, the costs savings and decrease in emergency department visits would continue to increase. In 2011, Gulf Bend authorized a study to determine the financial impact of mental illness on the criminal justice system in the Gulf Bend service region. The study found that the average costs for a patient undergoing a behavioral health crisis and being admitted into the criminal justice system is $130 per day with an average stay of 80 days\textsuperscript{52}. This equated to a total cost of $10,400 for each patient. In 2011, there were 1,199 individuals arrested with mental illness. Assuming an 80 day stay, that equates to a total cost of $12,469,600. If Gulf Bend were to decrease the number of arrests and jail time by 20%, that would lead to an overall savings of $1,870,440. The total savings by implementing the crisis assessment center with medical clearance is $2,590,440.

The other factor used in this valuation was the benefit to the community. When the crisis assessment center is fully operational, first responders will be able to transport the patient to the assessment center. From there, Gulf Bend staff will be able to meet all the needs of the patient. That means that the first responder can then return to their normal duty. In the case of a police officer, he or she will be able to release the patient into our care and then return to their normal duty to help protect the citizens of the area.

\textsuperscript{51} National Alliance on Mental Illness, 2011
\textsuperscript{52}Gulf Bend Center, Mental Health at the Crossroads, 2011
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>135254407.3.1</th>
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<th>IT-9.1</th>
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<td>Gulf Bend Center</td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<tr>
<td><strong>Milestone 1</strong></td>
<td><strong>Milestone 5</strong></td>
<td><strong>Milestone 7</strong></td>
<td><strong>Milestone 8</strong></td>
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<tr>
<td><strong>P-1 Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers.</strong></td>
<td><strong>P-9 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.</strong></td>
<td><strong>I-12 Utilization of appropriate crisis alternatives</strong></td>
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<td><strong>Metric 1</strong></td>
<td><strong>Metric 1</strong></td>
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<td><strong>P-1.1 Number of meetings and participants</strong></td>
<td><strong>P-9.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP</strong></td>
<td><strong>I-12.1 Increase in utilization of appropriate crisis alternatives</strong></td>
<td><strong>I-12.1 Increase in utilization of appropriate crisis alternatives</strong></td>
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<tr>
<td><strong>Goal: Conduct 4 stakeholder meetings</strong></td>
<td><strong>Goal: Participate in semi-annual face-to-face meetings or seminars organized by the RHP</strong></td>
<td><strong>Goal:</strong> Perform 100 crisis assessments at the new Crisis Stabilization Center</td>
<td><strong>Goal:</strong> Perform 125 crisis assessments at the new Crisis Stabilization Center</td>
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<td><strong>Data Source:</strong> Attendance lists</td>
<td><strong>Data Source:</strong> Written plan</td>
<td><strong>Data Source:</strong> Criminal justice system records, and data from local crisis stabilization sites</td>
<td><strong>Data Source:</strong> Claims, encounter, and clinical record data</td>
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<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $73,625</td>
<td><strong>Milestone 5 Estimated Incentive Payment (maximum amount):</strong> $275,288</td>
<td><strong>Milestone 7 Estimated Incentive Payment (maximum amount):</strong> $738,000</td>
<td><strong>Milestone 8 Estimated Incentive Payment (maximum amount):</strong> $307,661</td>
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<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 6</strong></td>
<td><strong>Milestone 9</strong></td>
<td><strong>Milestone 8</strong></td>
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<tr>
<td><strong>P-2 Conduct mapping and gap analysis of current crisis system.</strong></td>
<td><strong>P-6.1 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.</strong></td>
<td><strong>I-11 Costs avoided by using lower cost crisis alternative settings</strong></td>
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<td><strong>Metric 1</strong></td>
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<tr>
<td><strong>P-2.1 Produce a written analysis of community needs for crisis services.</strong></td>
<td><strong>P-6.1 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.</strong></td>
<td><strong>I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization.</strong></td>
<td><strong>I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings such as ER, jail, hospitalization.</strong></td>
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<tr>
<td><strong>Goal: Produce a written analysis of community needs for crisis services.</strong></td>
<td><strong>Goal:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP</td>
<td><strong>Goal:</strong> Reduce costs by 20%</td>
<td><strong>Goal:</strong> Reduce costs by 20%</td>
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<tr>
<td><strong>Data Source:</strong> Written plan</td>
<td><strong>Data Source:</strong> Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Claims, encounters and service event data from ER, forensic records, communality</td>
<td><strong>Data Source:</strong> Claims, encounters and service event data from ER, forensic records, communality</td>
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<td><strong>Milestone 2 Estimated Incentive Payment (maximum amount):</strong> $73,625</td>
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<td>135254407.1.1</td>
<td>1.13.1</td>
<td>1.13.1A-E</td>
<td>DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION - CRISIS ASSESSMENT CENTER WITH MEDICAL CLEARANCE</td>
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<td>Gulf Bend Center</td>
<td>135254407.1</td>
<td>IT-9.1</td>
<td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons IT-9.2 ED appropriate utilization</td>
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<td>Related Category 3 Outcome Measure(s):</td>
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<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 3</strong> P-3 Develop implementation plans for needed crisis services <strong>Metric 1</strong> P-3.1 Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. <strong>Goal:</strong> Produce Data driving written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs <strong>Data Source:</strong> Written plan</td>
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<td><strong>Milestone 6</strong> P-4 Hire and train staff to implement identified crisis stabilization services <strong>Metric 1</strong> P-4.1 Number of staff hired and trained <strong>Goal:</strong> Hire and train staff <strong>Data Source:</strong> Staff rosters, training records and training curricula</td>
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<td><strong>Milestone 9 Estimated Incentive Payment (maximum amount):</strong> $307,661</td>
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<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount):</strong> $73,625</td>
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<td><strong>Milestone 4</strong> P-5 Develop administration of operational protocols and clinical guidelines for crisis services <strong>Metric 1</strong> P-5.1 Completion of policies and procedures. <strong>Goal:</strong> Completion of policies and</td>
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<td>Milestone 6 Estimated Incentive Payment: $275,289</td>
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### Year 2 Outcome Data

- **Year 2 (10/1/2012 – 9/30/2013)**
  - Instrument/Methodology: Procedures
  - Data Source: Internal policy and procedures documents and operations manual

### Milestone 4 Estimated Incentive Payment (maximum amount):

- $73,625

### Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):

- $294,500

### Year 3 Estimated Milestone Bundle Amount: $550,577

### Year 4 Estimated Milestone Bundle Amount: $738,000

### Year 5 Estimated Milestone Bundle Amount: $615,322

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):

- $2,198,399
Performing Provider Name/TPI: Gulf Bend Center/1352544-07
Unique RHP Project Identification Number: 135254407.1.2 (Pass 2)

Project Option 1.7.3-Use telehealth to deliver specialty, psychosocial, and community-based nursing services

- **Provider**: Gulf Bend Center is the Community Mental Health Center located in Victoria, Texas. Gulf Bend Center provides services to individuals in the following seven county area: DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging.

- **Intervention**: Expand and enhance the psychiatric and behavioral health telemedicine services already provided by Gulf Bend in its service area in an effort to enhance and improve treatment for individuals with behavioral health conditions. Gulf Bend will place the needed telemedicine equipment within school districts, primary care provider offices, and other community based settings to improve access to behavioral health within its seven county service region.

- **Need for project**: Gulf Bend's service region is located in a Mental Health Professional Shortage Area (MHPSA). There are not enough mental health professionals to meet the needs of the residents in Gulf Bends service area. To meet these needs, Gulf Bend has already implemented telemedicine with several local hospitals. However, there are still patients with unmet behavioral health needs. Currently, Gulf Bend is limited in its telemedicine services to four of the seven counties that we serve. The current telemedicine services are for pharmacologic management and not behavioral health due to the limited services provided.

- **Target population**: The target population are the at risk populations who lack access to behavioral health services due geographical and socioeconomic barriers. Gulf Bend will be targeting the 10,000 service area residents that are affected by mental illness and have Medicaid as their primary insurance. In DY 4, Gulf Bend will offer these services to 150 patients and increase that number to 300 patients by the end of DY 5.

- **Category 1 expected benefits**: The project seeks to decrease inpatient and ED admissions for mental illness lower the costs of providing care, and providing greater access to behavioral health services for those living in isolated, rural areas within the Gulf Bend service region.

- **Category 3 outcomes**: The Category 3 Outcome Measure chosen by Gulf Bend for this project is IT- 6.1 patient satisfaction with receiving timely care, appointments, and information
  - a 15% increase over baseline in patient satisfaction with receiving timely care, appointments, and information
Performing Provider Name/TPI: Gulf Bend Center/1352544-07
Unique RHP Project Identification Number:135254407.1.2 (Pass 2)
Project Option 1.7.3-Use telehealth to deliver specialty, psychosocial, and community-based nursing services

Project Description:
Gulf Bend proposes a project to enhance and expand its telehealth services to provide greater access to behavioral health services.

This project is to expand and enhance the psychiatric and behavioral health telemedicine services already provided by Gulf Bend in its service area in an effort to enhance and improve treatment for individuals with behavioral health conditions. Currently, Gulf Bend is limited in its telemedicine services to four of the seven counties that we serve. The current telemedicine services are for pharmacologic management and not behavioral health due to the limited services provided. Gulf Bend will increase its telemedicine presence in primary care providers offices, hospitals, schools, and other community based settings with a demonstrated community need for such services. Gulf Bend will accomplish this by placing the necessary telemedicine equipment in the primary care provider's office, or other patient convenient location, so that the patient can receive the appropriate mental/behavioral health treatment. Primary care providers, hospitals, school districts, and other community organizations will be able to allow their patients/residents with mental illness or behavioral health problems access to Gulf Bend's mental health providers via telemedicine in an effort to provide collaborative care to the patient. By using primary care providers, school counselors/nurses, and hospital nursing staff/providers as a gateway to Gulf Bend's services, this will increase the opportunity for an integrated collaborative care between primary care providers, school counselors, hospital staff and an increased chance of greater overall health outcomes for the residents of all ages within the Gulf Bend service area. Per state census and records, there are 200,000 residents within Gulf Bend's service area. Of the 200,000, 19,213 have Medicaid as their primary insurance. National statistics show that roughly 45% will have a behavioral or mental illness. Gulf Bend hopes to improve access to the 10,000 residents that have Medicaid as their primary insurance and are affected by behavioral and mental illness but lack access to the needed care and services. Due to the needed time to create and implement the needed technology infrastructure and education of service area providers and community partners, Gulf Bend will reach 150 patients with Medicaid as their primary insurance by the end of DY 4. Gulf Bend will increase the number of patients served by the tele-health project to 300 by then end of DY 5.

Goals and Relationship to Regional Goals:
The goal of this project is to utilize Gulf Bends existing telehealth equipment to enhance and expand behavioral health services to the 10,000 patients who face barriers to access, due to socioeconomic factors or geographical barriers.

Project Goals:
- Increased access to psychiatric care to residents of the Gulf Bend service area
- Improved communication between primary care providers and mental health care providers
- Improved behavioral health outcomes
- Improved physical health outcomes
- Increased access to behavioral health care providers
- Increased patient satisfaction with care
- Cost savings
This project meets the following Region 4 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
There will be challenges in the development and implementation of this project. The first challenge will be garnering the support and the cooperation of the primary care providers, schools, and hospitals in the regional area. To meet this challenge, Gulf Bend will reach out to these various community partners through stakeholder meetings. Gulf Bend will identify through these meetings what makes the providers hesitant to seek and use Gulf Bend’s telemedicine services for the treatment of behavioral health illnesses. After these meetings, Gulf Bend will research and implement an evidence-model for delivering care through telemedicine in physician offices, hospitals, schools and other community locations that all providers, staff, and community stakeholders agree to.

The second challenge will be implementing the needed technologies within primary care providers office. Gulf Bend’s service region is in a largely predominant rural area. Therefore, there could be some difficulties with putting the needed technologies in place. However, Gulf Bend will work closely with IT or HIS teams within the local hospitals to determine what the best way to implement the needed technologies is.

The third challenge will be the sharing of patient health information. Gulf Bend must find a way to ensure that during the telemedicine visits that the patients privacy is kept confidential. However, Gulf Bend currently provides telemedicine behavioral health services. Therefore, Gulf Bend already has the necessary privacy policies and procedures in place to ensure patients privacy. Gulf Bend will arrange training sessions with primary care providers, school nurses, hospitals and their staff to educate them on these policies and procedures to maintain the patients privacy during the telemedicine visits.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcome through the development and implementation of the project to expand and enhance Gulf Bends ability to provide behavioral and mental health with the main focus being those patients that face geographical and economic barriers. Gulf Bend expects that the number of patients seeking behavioral health services increases by 25 to 40%, which will then lead to an overall improvement in overall health outcomes, reduction in ED visits, and greater communication. Gulf Bend also expects that there will be an increase in the collaborative care between primary care providers and Gulf Bend's behavioral/mental health providers. There is also the expectation that patient satisfaction of Gulf Bend's and the primary care providers services will increase due to the removal of geographical barriers.

Starting Point/Baseline:
Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Using national statistics we can conclude approximately 50,000 individuals have some form of mental illness. Gulf
Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year. In 2011, Gulf Bend performed 594 telemedicine visits. Of the 594 telemedicine visits, 244 visits were performed with the client being located in a different locale within the Gulf Bend service area and 24 visits were performed with the patient being located within the criminal justice setting.

Rationale:
In the 2011-2016 Statewide Healthplan, the Texas Statewide Health Council found that “Texas faces particular challenges with respect to physician and other healthcare workforces not primarily because of an overall shortage, but because of sharp disparities in the allocation of healthcare resources to different parts of the state”\textsuperscript{53}. Per the National Alliance on Mental Illness, 1.1 million Texas residents suffer from mental illness. Of these 1.1 million residents, 275,000 do not seek or receive treatment for their mental illness due to access, geographical, and socioeconomic barriers. This is evident to Gulf Bend and the residents of its service area. Gulf Bend's service region is located in a Mental Health Professions Shortage (MHPSA). There are not enough mental health professionals to meet the needs of the residents in Gulf Bends service area. To meet these needs, Gulf Bend has already implemented telemedicine with several local hospitals. However, there are still patients with unmet behavioral health needs. These patients often seek behavioral health treatment at the local emergency room of primary care providers offices due to the lack of behavioral health providers in their immediate area, socioeconomic barriers, and geographical barriers. Expanding and enhancing Gulf Bend’s telemedicine capability will allow those with unmet behavioral health needs to receive the treatment they need and a chance to increase the behavioral health of its residents.

Research has shown that using telemedicine for behavioral health has been shown to help increase behavioral health outcomes. The first way is that it removes the access barrier. Patients have the ability to seek behavioral health treatment without traveling a far distance. They can seek effective behavioral health treatment for their home or primary care providers office. In 2009, a review of 148 peer-reviewed journals found that the use of telemedicine for behavioral health treatment showed positive clinical outcomes\textsuperscript{54}. Gulf Bend expects similar results by removing the access barrier by expanding and enhancing its telemedicine capabilities in an area that is located within a MHPSA.

The second way that telemedicine improves behavioral health outcomes is that it removes the stigma of seeking behavioral health treatment. In 2009, a Substance Abuse and Mental Health Services Administration survey found that less than 25% of the 45 million Americans with mental illness sought treatment due to the stigma associated with making contact with a behavioral health care provider. Gulf Bends expansion of its telemedicine operations will allow the patient to seek the needed care by allowing them access to our behavioral health staff from their primary care providers office, local hospital, community center, or even their own home. By increasing a patients access to behavioral health in an environment that they are comfortable in, there will be a reduction in the amount of patients with untreated mental/behavioral illness since the stigma of seeking treatment is removed with telemedicine.

School aged children within the Gulf Bend service region lack access to critical behavioral health services. Data and research by the American Academy of Pediatrics shows that untreated


\textsuperscript{54}Clinical Psychology: Science and Practice, Vol. 16, No. 3
mental and behavioral health disorders lead to higher rates of youth in the criminal justice setting, drug and alcohol abuse, low school performance, and school dropout. Research has also concluded that the use of telemedicine in schools has a positive impact for the treatment of behavioral health illnesses among school aged children. In a study conducted by the University of Texas Medical Branch, the use of telemedicine for behavioral health treatment in schools lead to a statistically significant reduction in symptom levels between the Child's initial visit and the third month visit. The study also showed that 72% of the children's parents agreed that the child was "getting along better with family members" and 69% agreed that the child was performing better in school. Gulf Bend feels that these results can be duplicated if we expand and enhance our telemedicine capabilities into the school districts.

**Project Components:** N/A

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the telemedicine/telehealth expansion project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-3 (P-3.1); P-4 (P-4.2); P-6 (P-6.1); P-7 (P-7.1); P-8 (P-8.1); P-11 (P-11.1)
- Improvement Milestones and Metrics: I-13; I-16; I-17; I-17.3; I-18.2

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

- CN.4 - Inadequate access to behavioral health services
- CN.6 - High rates of inappropriate emergency department utilization and dissatisfaction of emergency department services
- CN.15 - Inadequate health care access in rural areas CN.23 - Lack of patient navigation, patient and family education and information programs
- CN.16 - Lack of integration of physical and behavioral health services

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently, Gulf Bend provides pharmacologic management via telemedicine in four of the seven counties. At this time, behavioral health services (crisis assessments, counseling, psychosocial therapy) are not provided due to the limited equipment and personnel needed to provide these services. There are residents of the Gulf Bend service region that are in need of behavioral health services that rely on their primary care providers or the local emergency department for treatment. This creates a bottleneck and limits those patients who are in true need of ED services. By expanding our existing telemedicine services to behavioral health, Gulf Bend will be able to implement a project that will offer a significant change in the delivery of behavioral health services.

**Related Category 3 Outcome Measure(s):**
OD-6 Patient Satisfaction:
IT-6.1 Percent Improvement over baseline of patient satisfaction scores
- Improvement over baseline with access to Gulf Bend's services via the use of telemedicine

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55 University of Texas Medical Branch at Galveston. Telehealth for school-based mental health. 2004.
**Reasons/rationale for selecting the outcome measures:**
Using national statistics, of the 200,000 residents in Gulf Bends service area, 50,000 residents have a mental/behavioral illness and are not seeking the appropriate treatment. Research has shown that the integration of behavioral health via telemedicine not only increases overall health outcomes, but increase patient satisfaction and use of the appropriate setting for behavioral health care. In a study conducted by the University of Texas Medical Branch, the results showed that there was a 50.5 percent reduction in Emergency Department usage for psychiatric needs. Gulf Bend selected this Category 3 outcome measure because we feel that if a patient is satisfied with our telemedicine services, they will be more likely to seek behavioral health services from Gulf Bend and lower the likelihood of seeking behavioral health services in an emergency department. This will have an overall effect of less cost to the health care system within RHP 4 as well as providing an overall increase to health outcomes within RHP 4.

**Relationship to Other Projects:**
This project is related to and complements our other projects addressing access to behavioral health care: 135254407.1.1, 135254407.2.1. This project is also related to the following initiatives by other Performing Providers: 135254407.3.1, 121775403.1.5 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system; 094222902.2.6, 080368601.2.1, 138305109.2.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services; 020973601.1.4, 094118902.1.1 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Camino Real Community Services, Christus Spohn Hospital - Alice, Christus Spohn Hospital – Corpus Christi, DeTar Hospital, Corpus Christi Medical Center, Coastal Plains Community Center, and MHMR of Nueces County.

**Project Valuation:** Through the waiver, Gulf Bend is able to implement projects that will transform the delivery of healthcare in our region. Gulf Bend valued its projects based upon four criteria of achieving the waivers goals, addressing community needs, the population served, and the project investment.

1. **Achieves Waiver Goals** - The expansion and enhancement of our existing telemedicine services into primary care providers offices, schools, hospitals, and other community organizations will address the waiver goals of delivering an overall change in the delivery of behavioral health services. There has always been a need for these services, but not a method or means in which to do so. Through this project and the 1115 Waiver, Gulf Bend will

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56Vo, A.; Brooks, G.B.  Benefits of Telemedicine in Remote Communities and Use of Mobile and Wireless Platforms in Health Care. University of Texas Medical Branch, Galveston, Texas. 2010
be able to implement a positive change in the delivery of behavioral health services within a MHPSA

2. **Addresses Community Need(s) -** There is a defined community need for behavioral health services and behavioral health professionals. Gulf Bend is located in a MHPSA and a rural area where access to the few behavioral health professionals is limited. This project will address the stated community needs by providing access to behavioral health professionals.

3. **Population Served -** Gulf Bend will target those patients population that have limited or no access to behavioral health services due to geographic location and/or socioeconomic status.

4. **Project Investment -** This project will require Gulf Bend to make a significant investment in both equipment and personnel. To meet the demand, Gulf Bend will need to hire numerous staff to provide behavioral health services, as well as staff for the operation, maintenance, and training on the telemedicine equipment.
USE TELEHEALTH TO DELIVER SPECIALTY, PSYCHOSOCIAL, AND COMMUNITY-BASED NURSING SERVICES

Gulf Bend Center

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<tr>
<th>Related Category 3 Outcome Measure(s)</th>
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Milestone 1 [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need
Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.
Goal: Submission of implementation documentation
Data Source: Program materials
Milestone 1 Estimated Incentive Payment (maximum amount): $116,876

Milestone 2 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need
Metric 1 [P-4.1]: Documentation of the quantity of actual telehealth services delivered after implementation
Goal: Submit the number of telemedicine/telehealth sessions provided via video-conferencing for remote health care providers along with the educational materials from
Milestone 2 Estimated Incentive Payment (maximum amount): $116,876

Milestone 3 [P-6]: Implement or expand medical education and specialized training programs via telehealth program
Metric 1 [P-6.1]: Submission and number of distinct curriculums delivered
Goal: Submission of documentation for all offered curriculums
Data Source: Program materials
Milestone 4 Estimated Incentive Payment (maximum amount): $88,672

Milestone 4 [P-7]: Create plan to monitor and enhance technical properties, bandwidth, of telemedicine/telehealth program.
Metric 1 [P-7.1]: Documentation of bandwidth capacity in relationship to program needs
Goal: Submission of bandwidth capacity assessment and anticipated bandwidth needs for optimal program functioning/expansion.
Data source: Bandwidth assessment and program plan
Milestone 4 Estimated Incentive Payment (maximum amount): $88,672

Milestone 6 [P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
Goal: Participate in semi-annual face to face meetings or seminars organized by the RHP
Data Source: EHR
Milestone 6 Estimated Incentive Payment: $70,937

Milestone 7 [I-13]: Increase number of electronic “curbside consults” provided by specialists to
Milestone 10 [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc.
Metric 1 [I-17.1]: Percentage of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time.
Baseline/Goal: 150/300 patients seeing a specialist or using the services for the first time.
Data source: EHR or other program records
Milestone 9 Estimated Incentive Payment: $146,154

Milestone 11 [I-18]: Implement interventions to achieve improvements in access to care of
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<th>135254407.1.2</th>
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**Related Category 3 Outcome Measure(s):**

| 135254407.3.4 | IT-6.1 | Patient Satisfaction |

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<td>the session; Data source: log of tele-services by type of health care professionals and type of service; Milestone 2 Estimated Incentive Payment (maximum amount): $116,876</td>
<td>$88,672</td>
<td>primary care physicians through an electronic consults or electronic referral processing system. Milestone 5 [P-8]: Create plan to monitor and enhance internet use for telemedicine/telehealth program. Metric 1 [P-8.1]: Documentation of expansion of services utilizing the internet as a medium. Goal: Submission of plan identifying which services can be made available through internet applications as well as steps to implement these services. Data source: Program plan</td>
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<td>primary care physicians through an electronic consults or electronic referral processing system. Milestone 5 [P-8]: Create plan to monitor and enhance internet use for telemedicine/telehealth program. Metric 1 [P-8.1]: Documentation of expansion of services utilizing the internet as a medium. Goal: Submission of plan identifying which services can be made available through internet applications as well as steps to implement these services. Data source: Program plan</td>
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<td>Milestone 8 Estimated Incentive Payment: $88,672</td>
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<td>Milestone 8 [I-16]: Expand telemedicine program to additional clinics. Metric 1 [I-16.1]: New telemedicine-enhanced clinics. Goal: 4 clinics providing at least ten telemedicine visits per month. Data Source: Appointment scheduling software records</td>
<td>Milestone 8 Estimated Incentive Payment: $88,672</td>
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**Outcome Measure(s):**

| 135254407.3.4 | IT-6.1 | Patient Satisfaction |

**Year 2**

- **Outcome Measure(s):**
  - 135254407.3.4
  - IT-6.1

- **Patient Satisfaction**

**Year 3**

- **Outcome Measure(s):**
  - 135254407.3.4
  - IT-6.1

- **Patient Satisfaction**

**Year 4**

- **Outcome Measure(s):**
  - 135254407.3.4
  - IT-6.1

- **Patient Satisfaction**

**Year 5**

- **Outcome Measure(s):**
  - 135254407.3.4
  - IT-6.1

- **Patient Satisfaction**
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**Year 2** (10/1/2012 – 9/30/2013)  
**Year 3** (10/1/2013 – 9/30/2014)  
**Year 4** (10/1/2014 – 9/30/2015)  
**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 9 [I-17]:** Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc.

**Metric 1 [I-17.1]:** Number of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time.

- **Baseline/Goal:** 0/150 patients seeing a specialist or using the services for the first time.
- **Data source:** EHR or other program records

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $233,753

**Year 3 Estimated Milestone Bundle Amount:** 265,878

**Year 4 Estimated Milestone Bundle Amount:** 283,748

**Year 5 Estimated Milestone Bundle Amount:** 291,031

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add milestone bundle amounts over DYs 2-5): $1,074,410
Otto Kaiser Memorial Hospital
Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region
136412710.1.1

Provider: OKMH is a 25 bed critical access hospital in Kenedy, TX. The hospital serves a population of over 10,000 locally as well as a large number of oil field employees.

Intervention(s): This project will implement neuro telemedicine in the ED to provide patient access to neurologists to provide better care and improved outcomes for stroke patients.

Need for the project: In 2011, the OKMH emergency department treated 53 stroke patients, but had no access to a neurologist. Lack of neurological specialty care creates risks for patients at a time when immediate care is critical to the patient’s outcome.

Target population: The target population includes residents of Karnes County and surrounding areas seeking treatment at OKMH for stroke symptoms or other neurological conditions. We anticipate the project will serve over 50 patients annually OKMH has 1.5% Medicaid patients and 3.9% Indigent Care patients. When the hospital is able to provide better care for stroke patients, it is anticipated the number of patients seeking care at the hospital will increase.

Category 1 or 2 expected patient benefits: The project seeks to provide neurology consults to over 25 patients in DY3, over 30 patients in DY4, and over 35 patients in DY5.

Category 3 outcomes: Our Category 3 Improvement Outcome goal is to improve patient satisfaction through the provision of more comprehensive and more timely care, which should improve long term health outcomes and enable patients to receive treatment in a local setting. Using telecommunications for patient consultations will enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that will improve the patient’s experience and provide significant healthcare outcomes.
Category 1: Infrastructure Development
Project Option 1.7.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region

Unique RHP Project ID Number: 136412710.1.1
Performing Provider/TPI: Otto Kaiser Memorial Hospital/136412710

Project Description:
To increase the ability of Otto Kaiser Memorial Hospital (OKMH) to provide specialty care, this project will expand neurology consultations through the establishment of a telemedicine program. This initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. To ensure patients have access to neurology services closer to home with more accurate and timely diagnosis, the telemedicine program will offer access to neurology services.

Currently the Region faces challenges providing both primary care and specialty care services to the community population. Every county in the region, including Karnes County (the home of OKMH) faces shortages of primary care, behavioral health care, and other specialty care providers, causing delays in care until medical care becomes an urgent need. Patients requiring specialty care must often drive long distances to see a provider, and may not receive services until the condition becomes critical. Through the creation and operation of a telemedicine program, this project will enable OKMH to better meet the community and Region needs for neurology services.

Goals and Relationship to Regional Goals:
This project supports the Region’s goals of ensuring residents have timely access to necessary health care services from an appropriate setting, within a reasonable distance, and receive the most cost-effective and appropriate treatment that enhances their ability to live healthy, productive lives.

Project Goals:
- Use telemedicine to provide better care for patients with acute stroke and other neurology conditions in the emergency department
- Provide specialty and quality care close to patients’ home, and improve outcomes by reducing the length of time for access to a neurologist.

The project will begin with developing a plan to implement neurology telemedicine in the Emergency Room, including evaluation of companies, training for staff, estimation of cost, assessment of safety needs, and more. Once a company is chosen, the equipment will be installed, staff trained, and program initiated. The five year expected outcome of the project is to increase neurology encounters by 25% by providing prompt diagnosis and treatment of neurological disorders.

Challenges:
Several challenges exist for this project especially related to the administration of recombinant tissue plasminogen activator (t-PA). Currently the hospital pharmacy does not stock t-PA. The administration of t-PA when given very early improves the outcome for a patient after a stroke. Early treatment can be beneficial for persons with a wide spectrum of neurological deficits. Necessary equipment will need purchased to support the telemedicine consultations. Hospital staff will need additional training to care for acute neurology patients since most patients are transferred to larger hospitals. These challenges will be addressed by training the staff to be competent caregivers.
specifically related to neurological conditions, ensure t-PA is in stock in the pharmacy and available in a timely manner, appropriate contract agreements are finalized, and purchase of equipment is installed prior to implementation.

5-Year Expected Outcome for Provider and Patients:
Otto Kaiser Memorial Hospital expects to see improvements in the treatment of neurological conditions that will improve health outcomes, improve access to local treatment options, and achieve cost efficiencies.

Starting Point/Baseline:
The baseline is zero for DY 2 as OKMH currently does not have access to neurologists, other than occasional phone discussions physician to physician. No neurologist comes to the hospital for consults, and the hospital does not have telemedicine capability for any specialty at this time. The timeline for the baseline will be assessed in DY 2 for implementation in DY 3.

Rationale:
Otto Kaiser Memorial Hospital is a 25 bed public critical access hospital located in a rural area in South Texas with limited access to healthcare. As the county seat of Karnes County, Texas, OKMH strives to offer compassionate patient and family centered care to every person who enters our doors. In this proposal we identify opportunities to improve and transform our system of delivering quality healthcare to our community of Karnes and surrounding counties specifically for neurological conditions. This project addresses the need for patients in Karnes County to have access to neurology consults in the Emergency Department. Evidence confirms neurology patients in rural areas often do not have as good of outcomes as patients in urban areas. According to Demaerschalk, neuro-telemedicine is a method to decrease the disparity between urban and rural care. In 2011, all stroke and major neurology cases at OKMH, a total of 55 patients, were transferred to other hospitals since there is no available neurology consultations in the county. Transferring patients results in long drives for family members, longer response time for care, and could result in poorer health outcomes. During a recent root cause analysis (RCA) involving an ED neurology patient, access to neurologists and the medication, TNKase, were identified as major factors to improve care for neurology patients at OKMH. An ED physician stated the hospital could give better care if we kept TNKase in our pharmacy and provided access for neurology consults. Recently Medical Memorial Center in Port Lavaca, TX, a critical access hospital with a similar patient population and census, reported they had implemented neuro-telemedicine with good outcomes. OKMH chose to implement neuro-telemedicine based on current evidence, the positive reviews of Memorial Medical Center, outcome of a recent RCA, and to promote better access for our patients as well as improved health outcomes for the community.

Milestones & Metrics:
Process Milestones:
- DY 2: P-4; P-4.1
- DY 3: P-11; P-11.1; P-3; P-3.2

Improvement Milestones:
- DY 4: I-17; I-17.1; I.17-2
- DY 5: I-17; I17.1; I-17.2

Unique community need identification number the project addresses: CN. 2; CN.9; CN-15

6.1: Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction:

IT-6.1 Percent Improvement over baseline of patient satisfaction scores
Using telecommunications for patient consults to exchange medical data, between a patient and a health professional for use in rendering a diagnosis and treatment plan is a viable way to make medical care more accessible. The development and installation of high-speed wireless telecommunications system will allow for real-time monitoring and interactions with patients and specialty care providers. This real/near-time monitoring and interacting will allow our healthcare team to diagnose and address patient problems in a more timely manner to ensure patients receive the most appropriate care as quickly as possible. Given the long term consequences of neurologic conditions, including stroke, timely care is critical to ensuring optimal outcomes. Because this intervention will improve the quality of care, enable quicker access to specialty services, and improve patient outcomes, tracking patient satisfaction is an effective method of monitoring the success and improvements associated with this project.

Relationship to other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of health care options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support a number of other projects within the region, including the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FQHC providers.

Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center and Christus Spohn.

Project Valuation:
OKMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.
In valuing this project, OKMC took into account the extent to which the implementation of telemedicine for neurological specialty care capacity would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

The expansion of specialty care capacity will promote and encourage patients to access care which will lead to better health outcomes for the community. OKMC took these potential effects into account when considering the appropriate incentive payment value for this project.
| Milestone 1 [P-4] | Milestone 2 [P-11]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings organized by the RHP. Baseline/Goal: 2 meetings/year Data Source: Documentation of meetings Milestone 2 Estimated Incentive Payment *(maximum amount):* $107,608 | Milestone 3 P-3: Implement telemedicine program for neurological consults Metric 1 [P-3.2]: Documentation of the number of consults delivered by neurologists Baseline/Goal: 25 consults/year Data Source: clinic log of health services by telemedicine services | Milestone 4 [I-17]: Improved access to specialists care Metric 1 [I-17.1]: Number of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time. Baseline/Goal: 35 consults/year Data Source: clinic log of health services by telemedicine services Milestone 4 Estimated Incentive Payment *(maximum amount):* $107,921 | Milestone 5 P-11: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings organized by the RHP. Baseline/Goal: 2 meetings/year Data Source: Documentation of meetings Milestone 5 Estimated Incentive Payment *(maximum amount):* $89,152 | Milestone 6 I-17: Improved access to specialists care Metric 1 I-17.1: Number of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time. Baseline/Goal: 35 consults/year Data Source: clinic log of health services by telemedicine services Milestone 5 Estimated Incentive Payment *(maximum amount):* $89,152 |
| Milestone 1 Estimated Incentive Payment *(maximum amount):* $197,275 | Milestone 2 Estimated Incentive Payment *(maximum amount):* $107,608 | Milestone 3 Estimated Incentive Payment *(maximum amount):* $107,608 | Milestone 4 Estimated Incentive Payment *(maximum amount):* $107,921 | Milestone 7 P-11: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-11.1]: Participate in semi-annual face-to-face meetings organized by the RHP. Baseline/Goal: 2 meetings/year Data Source: Documentation of meetings |
### IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION

**Otto Kaiser Memorial Hospital**

**Related Category 3 Outcome Measure(s):** 136412710.3.1

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 3 Estimated Incentive Payment <em>(maximum amount):</em> $107,608</td>
<td>meetings</td>
<td>Milestone 5 Estimated Incentive Payment <em>(maximum amount):</em> $107,921</td>
<td>Milestone 6 Estimated Incentive Payment <em>(maximum amount):</em> $89,152</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):** $197,275

| Year 3 Estimated Milestone Bundle Amount: $215,216 | Year 4 Estimated Milestone Bundle Amount: $215,842 | Year 5 Estimated Milestone Bundle Amount: $178,304 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $806,637
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Kleberg/136436606
Unique Identifier - 136436606.1.1

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s):** Spohn will implement a Chronic Disease registry to assist Spohn in tracking and managing patients with conditions, which will initially focus on patients with CHF and diabetes. The chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients.

- **Need for the project:** Current documentation by the Care Transitions/Care Partners teams is handwritten paper format and Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. The registry will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams that is untenable under the current documentation system. The registry and repository will link to the EMR and provide the ability to track, trend and alert both inpatient and outpatient care providers to multiple hospitalizations and ED visits regardless of facility or location within the Spohn hospital system. Automated acquisition, storage and access to this data will enhance identification of individual patient needs to analyze and report trends in resource utilization.

- **Target population:** The target population of this project includes charity, Medicaid and self-pay patients with CHF and/or diabetes who are not currently enrolled in our Care Transitions or Care Partners programs (“target population”). Patients are identified by case managers in the acute care setting and referrals submitted to the Community Outreach department for program enrollment. Based on implementation of the original program at CHRISTUS Spohn Hospital Corpus Christi – Memorial campus and current discharge data for CHF and Diabetes at CHRISTUS Spohn Hospital Kleberg, the projected target population will be 262 patients. Each of those patients receives 5 encounters as part of the program, after which an estimated 80% of those patients will be referred into the Care Partners program. Referral rates are estimated based on current referrals at CSHCC – Memorial. For those patients referred and enrolled in Care Partners, an average of 90 additional visits per patient will occur over an additional 18 months (a total of 18,900 patient encounters). This project seeks to enroll the target population into these programs, which Spohn estimates will impact 131 additional enrollees who will receive a total of approximately 10,105 encounters (based on current trends).

- **Category 1 or 2 expected patient benefits:** Spohn expects to have the registry implemented by the end of DY4, which Spohn expects to result in at least 50% of targeted patients receiving educational, disease-appropriate information after visits with the Care Transition team by the end of DY5 (an estimated 131 enrollees). These interventions should improve patient self-management skills, short- and long-term health outcomes, and patient satisfaction with the healthcare delivery system.

- **Category 3 outcomes:** IT- 3.2: Our goal is for the use of the registry to result in an 8% reduction from DY2’s CHF patient all-cause 30-day readmission rates for Spohn’s Kleberg campuses by the end of DY5.
Implement Chronic Disease Registry

Category 1: Infrastructure Development

Identifying Project and Provider Information:
Implement a Chronic Disease Registry, 1.3.1
CHRISTUS Spohn Hospital Kleberg/136436606
Unique Identifier - 136436606.1.1

Project Description:
CHRISTUS Spohn Hospital Kleberg (“Spohn”) will implement a Chronic Disease registry to assist Spohn in tracking and managing patients’ with chronic disease. The project will initially focus on CHF and diabetes. By entering patient data into the registry, Spohn will manage the conditions of patients with CHF and diabetes. This includes engaging these patients in education, community outreach, regular status checks with their primary care providers, maintaining an active support system, and engaging patients to exercise self-management of their conditions. Upon implementing the registry and using it proactively, Spohn will use the reports generated by the registry to develop and implement a plan for quality improvement in the medical care provided to patients with these chronic conditions. The implementation of this plan will likely include identifying best practices and training staff to expand their use of those practices, discovering why certain patients are “frequent-flyers” and taking steps to provide additional support to those patients, and to determine how many, if any, of the chronic conditions could be better managed with additional input or support from other providers within Spohn’s network.

More specifically, a chronic disease database/repository will be created for Spohn by heartbase™ to support and sustain management of patients in our Care Transitions/Care Partners program, which focuses on using RN Coaches to coordinate the care for chronically ill patients. heartbase™ is our current vendor for national registries cardiovascular benchmark reporting of AMI, CHF and Open Heart Surgery with expansion to stroke and core measure data to The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS). heartbase™ is a certified vendor by TJC, CMS, American College of Cardiology (ACC) and Society of Thoracic Surgery (STS) with representation on international cardiovascular Health Information Exchange (“HIE”) teams.

This database will combine registry and longitudinal tracking of patients with chronic disease by automating patient documentation currently used by the Care Transitions and Care Partners (CHW) programs. Initial focus will be patients with CHF and diabetes but capability will incorporate all chronic disease and potential co-existing behavioral health diagnoses. The database will utilize a combined set of elements. Data points will not be duplicated but rather shared if they are the same data point, like ICD9 (Future ICD-10) and patient name.

The registry will interface with Meditech, our current inpatient EMR, and Athena, the future EMR for our Family Health Centers (“FHC”). Automation of the named documents and proposed interfaces will provide a provider and patient portal to a chronic disease repository that is used by all six Spohn facilities, related clinics and doctor offices. The database vision is one where the community stores all related chronic disease information on a server that is shared by hospital, clinics, physicians, and patients that participate in this program at CHRISTUS Spohn Health System. Access will be via a web-based front end with secured areas for both patients and staff and will also have the ability to interface with the developing health information network of South Texas, HINSTX.
The proposed registry will also have the ability to interface and house future proposed telehealth/telemedicine devices used to remotely access and monitor patients in their homes by the Care Transition and Care Partners teams as well as regional primary care providers.

**Project Goals/5 Year Expected Outcome:**
- Registry implemented at Kleberg Care Transitions and Care Partners Program.
- At least 50% of targeted patients receiving educational, disease-appropriate information after visits. Engage in quality improvement by collecting and disseminating best practices from Spohn’s Region 4 FHC.

**Project Challenges:**
- Creating and implementing the actual registry (which will include provider training and assistance from third parties).
- Collecting accurate and current data regarding the health status of FHC patients.
- Training providers to engage in effective outreach, support, and management for patients with these chronic diseases.
- Maintaining the registry consistently.
- Sharing information across FHCs in an organized and effective manner.

Spohn will address these challenges by taking deliberate steps towards implementing the registry in an organized and thoughtful manner. The registry will not be useful if providers cannot use it properly or do not understand the value of increased patient outreach and education. Thus, creating the registry and training our providers are the most important steps in DYs 2-3. In DYs 4-5, the FHCs can begin taking steps to improve on current practices using the registry for guidance and to stay organized. The registry itself will allow the FHCs to share more information than they may currently be able to do on a day-to-day basis.

**Relationship to Regional Goals:** Region 4 wants to transform care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improve patient satisfaction and outcomes while reducing the systemic costs of treating unmanaged chronic care conditions. This project addresses these goals head on.

**Starting Point/Baseline:**
Current documentation by the Care Transitions/Care Partners teams is handwritten paper format. Care Transitions nurses call the inpatient case managers (CM) daily to identify patients for potential discharge. They are often contacted by individual unit staff when patients not identified by CM receive discharge orders. Program expansion is to be implemented under the waiver plan for projected impact on approximately 177 (60%) of CHF and Diabetes patients by the end of the waiver.

**Rationale:**
On a macro level, Region 4 has a high incidence of chronic disease, as noted in the Region’s Community Needs Assessment: “Regional hospital admissions and related data indicate that there is a prevalence of chronic conditions that lead to preventable hospitalizations, and which require a coordinated care management team approach to maximize patient outcomes.” RHP Plan, p. 29. Additionally, chronic diseases including CHF, COPD, Diabetes, and asthma are linked with Nueces...
County having a higher rate of Potentially Preventable Admissions than the statewide average. Avoidable hospitalization has a twofold negative impact on the delivery system: (1) patient health outcomes and satisfaction are reduced in the long- and short-term, and (2) the cost of delivering care is immediately and going forward more expensive when patients’ conditions deteriorate to an acute level.

This project will provide a substantial infrastructure to identification, tracking and monitoring Medicaid/uninsured/Self-pay patients regardless of entry point into the CHRISTUS Spohn Health System. This capability will link patients throughout the region and provide a future avenue for global integration to external HIEs. In addition to access and exchange of information, the registry/repository will allow streamlined documentation and increased efficiency for the Care Transitions and Care Partners teams. This flow of communication does not currently exist. A frequently occurring example of the breakdown in the current system identified by the Care Transitions/Care Partners staff is patients missing their scheduled clinic appointments because they are inpatients at the hospital. Our planned registry will provide patient and hospital alerts to maximize the efficiency of communication and disease management.

Milestones and Metrics: Spohn chose its DY 2-3 milestones in metrics in order to develop, test, and implement the registry, as well as train staff to populate it and use it successfully. Spohn chose its DY 4-5 milestones and metrics in order to effectuate improved care for patients with the targeted chronic conditions and to engage in quality improvement by the end of DY5.

Community Needs Identification Number Addressed by this Project: CN.3, CN.7, CN.12

**Related Category 3 Outcome Measure(s): OD 3: Potentially Preventable Readmissions; Improvement Target 3.2: CHF 30 Day Readmissions**

Automation and integration of Care Transitions and Care Partners programs with interfaces to hospital and clinic EMRs will streamline communication and provide longitudinal tracking and monitoring of chronically ill patients upon discharge from the inpatient setting. Spohn selected this outcome measure because one goal behind developing the registry is to longitudinally track patients with CHF and develop alerts for those who experience frequent readmissions, regardless of cause. This project is intended to help Spohn to identify those patients that are at risk for readmission to the hospital (often multiple times) upon discharge and intervene to prevent the causes of their readmission (including the inability to self-manage CHF in the outpatient setting).

**Relationship to other Projects:**

This automated infrastructure will finally provide a link between inpatient and outpatient care provided to individual patients in an efficient and streamlined manner to facilitate integrated care coordination in multiple settings. It is related to the following projects also proposed in this waiver plan:

- **136436606.1.2- PADnet – telehealth/telemedicine** – This project also addresses streamlining care for chronic conditions and is a related cardiac condition.
- **121775403.2.1 Establish Medical Homes** – Part of the Medical Home model involves comprehensive management of patients’ conditions before they deteriorate, which is the specific purpose of the chronic disease registry.
• 121775403.2.3 Cost of Care Delivery – Primary Care Redesign – The hospitalist and resident teams assigned to patients will use the chronic disease registry to track their patients.
• 121775403.2.4. Diabetes Cellphone Application – Diabetes is another chronic condition that will be tracked in the registry, and the information will be used for outreach under this program.
• 136436606.2.4 Expand Care Transitions program – The chronic disease registry will assist the RN Coaches in managing chronically ill patients’ conditions.


This project provides integration of information with all 3 CHRISTUS Spohn Health System community facilities and CSHK. This is crucial to regional patient outcomes as patients transfer to Kleberg and Victoria from all remote areas of the RHP. This infrastructure and its ability to interface with future development of HINSTX will support the flow of communication beyond the CSHS boundaries and throughout the lifespan of the patients

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center and Driscoll Children’s hospital.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. Achieves Waiver Goals. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its application to the goals of the Waiver, in that it focuses on improving patient outcomes while reducing the systemic cost of providing care. The registry will allow Spohn to make proactive choices to maintain the health status of chronically ill patients, which will benefit their quality of life and satisfaction with their health care greatly. The high incidence of chronic disease in Nueces County means that the registry addresses known community needs and will serve a broad population of the County’s residents. Finally, creating, implementing, and proactively using the registry will require investment in technology, staff training, project planning, and community outreach.

59 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>1.3. IMPLEMENT A CHRONIC DISEASE REGISTRY</th>
<th>136436606</th>
</tr>
</thead>
<tbody>
<tr>
<td>136436606.3.1</td>
<td></td>
<td>CHF 30 Day Readmission rate</td>
<td>136436606</td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1** [P-1]: Identify 1 or more target patient populations diagnosed with selected diseases or multiple chronic conditions

**Metric 1** [P-1.1]: Documentation of personnel assigned to registry evaluations

**Baseline/Goal**: Registry Development for 2 major chronic diseases/conditions; CHF and diabetes

**Data Source**: Performing Provider documents

**Milestone 1 Estimated Incentive Payment** *(maximum amount)*: $116,514

**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 2** [P-2]: Review current registry capability and assess future needs

**Metric 1** [P-2.1]: Documentation of review of current registry capability and assessment of future needs

**Baseline/Goal**: Approval of comprehensive proposal to develop electronic infrastructure for longitudinal data registry

**Data Source**: Registry Project Management Plan/Proposal

**Milestone 2 Estimated Incentive Payment** *(maximum amount)*: $119,166

**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 3** [P-3]: Develop cross-functional team to evaluate registry program

**Metric 1** [P-3.1]: Documentation of personnel assigned to registry evaluations

**Baseline/Goal**: Spohn multidisciplinary team development of chronic disease registry

**Numerator**: number of personnel assigned to enter the registry

**Denominator**: total number of personnel

**Data Source**: Registry Project Management Plan/Proposal

**Milestone 3 Estimated Incentive Payment** *(maximum amount)*: $119,166

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 4** [P-4]: Implement/expand a functional disease management registry

**Metric 1** [P-4.1]: Registry functionality is available in X% of Performing Provider’s sites and includes an expanded number of targeted diseases or clinical conditions.

**Baseline/goal**: The registry measuring CHF and diabetes will be

**Milestone 5** [P-8]: Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases.

**Metric 1** [P-8.1]: Submitted protocols for the specified conditions and health indicators

**Baseline/Goal**: Spohn will create protocols for using the information stored in the registry to address diabetes and CHF in its Spohn Kleberg hospital facility

**Data Source**: Protocols

**Milestone 5 Estimated Incentive Payment** *(maximum amount)*: $118,981.50

**Year 6** (10/1/2016 – 9/30/2017)

**Milestone 6** [I-15]: Increase the percentage of patients enrolled in the registry.

**Metric 1** [I-15.1]: Percentage of patients in the registry with targeted chronic conditions

**Baseline/Goal**: Increase the percentage of the FHCs’ diabetic and CHF patients entered into the registry by 10% over the percentage in the registry in DY3 (if DY3 reflects 100% of these

**Data Source**: Disease registry or EHR
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
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<th>CHF 30 Day Readmission rate</th>
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<td><strong>136436606.3.1</strong></td>
<td><strong>CHF 30 Day Readmission rate</strong></td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)
- **Numerator:** number of CHF and diabetic patients in the registry
- **Denominator:** number of diabetic and CHF patients assigned to this clinic for routine care
- **Data Source:** Registry and/or EHR

### Milestone 4 Estimated Incentive Payment (maximum amount):
$119,166

### Milestone 8 [Additional Process Milestones in Planning Protocol Instructions] Redesign the processes in order to be more effective, incorporating learnings (Quality Improvement)
- **Metric:** documentation of redesign assessment and steps taken to make the process more effective
- **Baseline/goal:** Identify one best practice from any of Spohn’s sister facilities in Region 4 regarding (1) diabetes management, and (2) CHF management, and implement the best practices at each FHC or expand upon the concept
- **Data source:** Documentation of assessment of best practices and steps taken to implement the best practices at each FHC

### Milestone 8 Estimated Incentive Payment: $96,072

### Year 3 (10/1/2013 – 9/30/2014)
- **Numerator:** number of CHF and diabetic patients in the registry
- **Denominator:** number of diabetic and CHF patients assigned to this clinic for routine care
- **Data Source:** Registry and/or EHR

### Milestone 6 Estimated Incentive Payment (maximum amount):
$118,981.50

### Milestone 7 Estimated Incentive Payment: $96,072

### Year 4 (10/1/2014 – 9/30/2015)
- **Numerator:** number of CHF and diabetic patients in the registry
- **Denominator:** number of diabetic and CHF patients assigned to this clinic for routine care
- **Data Source:** Registry and/or EHR

### Milestone 7 Estimated Incentive Payment: $96,072

### Year 5 (10/1/2015 – 9/30/2016)
- **Numerator:** number of CHF and diabetic patients in the registry
- **Denominator:** number of diabetic and CHF patients assigned to this clinic for routine care
- **Data Source:** Registry and/or EHR

### Milestone 8 Estimated Incentive Payment: $96,072

### Year 2 Estimated Milestone Bundle Amount: $233,028
### Year 3 Estimated Milestone Bundle Amount: $238,332
### Year 4 Estimated Milestone Bundle Amount: $237,963
### Year 5 Estimated Milestone Bundle Amount: $192,144

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $901,467
Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth

CHRISTUS Spohn Hospital Kleberg / TPI 136436606

Unique project ID number: 136436606.1.2

- **Provider**: CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s)**: Spohn plans to implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and treatment plans. The PADnet™ Disease Management System provides patients that present at the local FQHC and PCP offices with access to specialists to address issues with PAD.

- **Need for the project**: As a screening tool, PADnet is recommended for early detection and intervention in people with symptoms or at risk for peripheral arterial disease (PAD). Currently, diagnostics are performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a specialist for follow-up, diagnostics and treatment plan with or without requisite interventions. Current wait times for indigent patients to see a specialist can exceed 30 days. PAD is very painful and as it progresses undetected or untreated it can result in skin ulcers, gangrene and amputation. The ability to be screened in PCP office or FHC expedites diagnosis and treatment without delays to specialists visit.

- **Target population**: The target population of this project includes Kleberg and surrounding county’s residents at risk for PAD, who seek treatment in the local FQHC and require cardiovascular services. Major risk factors contributing to PAD include smoking, diabetes and/or hypertension in persons 50 or older with a family history of coronary artery disease. Pad that is asymptomatic has been reported to exist in 80% of the population. Spohn intends to screen its high risk clinic patients with diabetes who are not currently symptomatic for PAD. Spohn’s Primary Care and neighboring clinics treat approximately 10,000 patients per year, approximately 13.4% of which are diabetic and many of whom are high risk because of their family history, ethnicity and/or age. Spohn will identify those patients based on ethnicity, diabetes, hypertension and history of smoking and screen them for PAD.

- **Category 1 or 2 expected patient benefits**: Through implementing the use of PADnet™ in the FQHC by the end of DY3, Spohn expects the benefits to patients to include 54 PADnet screenings in DY3, 109 PADnet screenings in DY4, and 163 PADnet screenings in DY5, as well as a 5% reduction in the wait time experienced by indigent patients for a cardiology consult by the end of DY3, and a 5% increase in telemedicine cardiology consults for patients residing in geographically underserved areas served by Spohn’s clinics from the first year of operation by the end of DY5.

- **Category 3 outcomes**: IT-1.11: Our goal is a 10% increase in the number of diabetic patients with controlled blood pressure, which should decrease those patients’ risk of developing PAD
Introduce PADnet for Peripheral Arterial Disease Screening and Treatment

Category 1: Infrastructure Development

Identifying Project and Provider Information:

Project 1.7: Introduce, Expand, or Enhance Telemedicine/Telehealth

Project Option 1.7.6: Implement an electronic consult processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

CHRISTUS Spohn Hospital Kleberg/ TPI 136436606

Unique project ID number: 136436606.1.2

Project Description:

CHRISTUS Spohn Hospital Kleberg (“Spohn”) plans to implement a system for early detection and to mitigate the adverse effects of chronic disease rampant in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider (PCP) offices for both diagnostics and interventions. The PADnet™ Disease Management System provides patients who present at PCP offices with access to specialists to address issues with peripheral arterial disease (PAD). Spohn expects this to result in fewer unnecessary referrals to specialists for treatment the PCP is able to provide personally, earlier detection for patients who need immediate intervention, and greater care coordination between PCPs and cardiac specialists. No federal funds have been received or are being used for this project.

Project Goals/5-Year Expected Outcome:

The remote diagnostic devices will be implemented in the local FQHC, and can be located in PCP offices and will allow for increased communications through telemedicine with cardiologists or cardiovascular surgeons to interpret, diagnose and prescribe treatment or work in collaboration with the PCP to determine an appropriate follow-up/prevention plan when no interventions are needed. Finally, through quality improvement initiatives, the project will assess the project’s impact, lessons learned and opportunities to scale the project to a broader population.

Implementation of PADnet will help demonstrate the benefits of early detection and intervention for PAD, both for patient quality of life, satisfaction and long-term health outcomes and for the systemic cost of providing care to the chronically ill.

Specific goals include:

- 5% increase in PADnet™ screenings in DY3, over baseline set in DY2; 10% increase over DY2 baseline in DY4; 15% increase over DY2 baseline in DY5
- 5% reduction in wait time to cardiovascular consult for PAD in DY3 (using records from DY2 to measure improvement)
- Implement the use of PADnet™ in the Kleberg FQHC by the end of DY4

This project is related to Region 4 goals in that it seeks to prevent diabetes related complications by allowing rural and indigent patients to access real-time diagnostics and reads by a specialist. These complications are costly to Region 4 communities in that they increase the cost of delivering care (often because they lead to ED visits), reduce productivity in the work-force, and cause ripple-effects for affected families. Any and all providers in the Region can access this network through purchasing the diagnostic equipment, which is fairly low cost.
**Project Challenges:**
- Identifying cardiac specialists willing to provide electronic consults for patients in Kleberg County
- Implementing new technology in the local FQHC
- Training providers in the FQHCs to use the PADnet technology
- Educating patients about the benefits of using electronic consults

Spohn will address these challenges by coordinating with stakeholders to identify appropriate partners for the project (i.e. specialists to provide the consults) and by using DY2 to train providers and create processes that are consistent across participating providers. Finally, Spohn will train providers on how to present the PADnet telemedicine option to patients in a manner that alerts them to the benefits of using this technology.

**Starting Point/Baseline:**
Diagnostics are currently performed manually using a blood pressure cuff to calculate a ratio (ankle and brachial pressures) indicative of PAD. This current method provides only a numeric value reflective of the differences in the two pressures and does not produce graphic representation of flow. Patients are then sent to a cardiologist or cardiovascular (CV) surgeon for follow-up, diagnostics or planned interventions. Depending on the severity of the disease, peripheral artery angioplasty, stenting, surgical revascularization and amputation are all possible interventions. For less severe disease or those with high risk factors, minor disease can benefit from medical treatment. In the past year, 14 surgical treatments have been performed on patients for PAD at Spohn Kleberg; of those, 3 patients were Medicaid-eligible or self-pay. Data analysis by zip code of patients treated at CSHCC – Memorial and Shoreline show that the majority of Kleberg residents are transferred to Corpus Christi for interventional procedures as CSHK cannot provide an interventional service. With a 68% Hispanic population, 49% MCD/UI rate and a 13.4% diabetes rate in Kleberg County Spohn estimates a target screening population of 1087 patients.

**Rationale:**
Like many diagnostic modalities designed for early detection of potentially life altering diseases, PADnet provides a solution that decreases the cost and burden of diagnostic on the patient and healthcare system. For the Medicaid, charity and self-pay patients in RHP 4, patients suspected of having or at risk for PAD have historically been referred to a Cardiology/CV Surgeon for evaluation. PAD in its moderate to advanced stages is associated with high pain levels especially with weight-bearing patients. Severe circulatory compromise results in swelling of the lower extremities and often open ulcers or wounds. Uninsured/underinsured patients often skip specialist appointments due to expense of the visit, time missed at work for a doctor visit or because they think they can tolerate it a little longer. They are often unaware that the PAD does not go away on its own but can be treated successfully if identified during the early stages. Another identified barrier in our region is the delay obtaining an appointment with these specialties. Current wait times for indigent patients to see a cardiologist ranges from 40-60 days.

One key to determine the precedence for screening in RHP 4 as well as other areas of the state is to analyze current statistics:
- Approximately 5 million Americans in the US are affected by PAD
- Predominant populations include Hispanic blacks, diabetics and elderly (> age 70) with the elderly being the highest at 14.5%
- 66,000 people with diabetes had non-trauma related lower extremity amputations in 2006 (Briggs, 2006)
  - Mean hospital charge was $56,400 accounting for $3.7 billion for amputations alone
- Additional risk factors should also be considered; obesity, age, gender, smoking, cholesterol, blood pressure to name a few
- South Texas also sees a predominant culture of complacency regarding amputations in familial lines. This often lends to delay in seeking treatment early for onset of symptoms associated with the disease

The evidence statement on Peripheral Arterial Disease (PAD) posted by the USPSTF (2005) addresses two patient populations; asymptomatic/low risk and symptomatic/at-risk. Despite the USPSTF statement, numerous studies since 2005 indicate a more rigid investigation of screening in asymptomatic people using the Ankle-Brachial Index (ABI) and may support project expansion to the asymptomatic, low-risk patient population in the future. One study (McDermott et al, 2010) shows a relationship between PAD and walking endurance measured by ABI with or without claudication. Although the USPSTF-endorsed screening statement is outdated, the American College of Preventive Medicine (ACPM) supports their 2005 stance in asymptomatic patients in an ACPM 2011 guideline (Lim et.al, 2011). A Draft Research Plan (Wilt, 2011) has also been posted to the USPSTF site that proposes a more rigid investigation of ABI and asymptomatic patient populations. Despite the views on routine screening in asymptomatic patients, the American Heart Association (AHA) and the American Diabetes Association (ADA) both support screening and early intervention in symptomatic and at-risk patients specifically those with diabetes.

The high prevalence of diabetes in our region and the remote locations with limited accessibility to specialists lend credibility to an early screening routine for the Hispanic, diabetic and high-risk populations. The PADnet diagnostic device located in Primary Care Centers and Medical Homes will provide direct communication to a remote specialist, eliminating the need for delayed appointments and unnecessary visits while still affording the patient and PCP access to the clinical specialist for diagnosis and treatment/prevention options. Patients are more likely to seek screening when done in their primary care setting instead of traveling to a specialist’s office.

The PADnet project will also allow storage of diagnostic information that can be used for longitudinal comparison and eventual incorporation in the patients EHR and regional HIE.

**Community Needs Assessment:** CN.2 (Inadequate access to specialty services); CN. 3 (Inadequate provision and coordination of healthcare services for persons with chronic conditions); CN.6 (high rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions)

**Milestones and Metrics:** Spohn chose Milestones 1 and 3 in order to assure that Spohn successfully implements the use of PADnet Milestones 2-6, are intended to measure the increased use of telemedicine consults for patients at risk for PAD over the life of the Waiver.

**Related Category 3 Outcome Measure(s):**
Associated Outcome Measures selected for this project include:
OD-1: Primary Care and Chronic Disease Management
IT-1.11 –
Diabetes Care – Blood Pressure Control

Spohn developed this outcome measure consistent with studies that demonstrate that early detection of PAD in symptomatic and at-risk populations allows early interventions that can reduce the need for amputations. By increasing the coordination of primary care and specialist physicians through the PADnet technology, Spohn intends that the target population will receive more preventative care at the early stages of this chronic disease.

**Relationship to other Projects:**
This project’s focus on treating chronic disease and increasing access to specialty care and provider training is related to and will enhance the following projects:

- 136436606.1.1 - Establish Chronic Disease Management Registry (Spohn intends to expand its tracking and primary care treatment of chronic diseases, including PAD, through comprehensive reform)
- 136436606.2.4 Care Transitions (patients who may be hospitalized with a diagnosis of PAD will benefit from Care Transitions to assist in management of their condition upon discharge)
- 130958505.2.1 – Implement an innovative and evidence-based health promotion program


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing a telemedicine training program, other similar projects will focus on improving access to care, including projects submitted by Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:
1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) prescribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its relationship to Waiver goals. Specifically, this project is patient-centered because it aims to increase and improve access to specialists for patients at risk for PAD, and will also reduce the systemic cost of treating patients with PAD. This project addresses community needs for patients at risk of PAD (including elderly patients, smokers, diabetics, obese patients, and patients with high blood pressure and/or cholesterol) by enabling quicker diagnosis and treatment if they are determined to have PAD. The investment in this project will be substantial, in that equipment/software will need to be purchased, providers trained, and the community educated.

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60 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #93049
<table>
<thead>
<tr>
<th>Milestone 1</th>
<th>Milestone 2</th>
<th>Milestone 3</th>
<th>Milestone 4</th>
<th>Milestone 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-3]: Implement telemedicine program for PAD</td>
<td>[P-X]: Establish a baseline in order to measure improvement over self</td>
<td>[I-14]: Reduce wait times to cardiovascular specialist for PAD screening/diagnostics</td>
<td>[I-13]: Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult</td>
<td>[I-13]: Increase number of electronic “curbside consults” provided by specialists to PCPs through an electronic consult</td>
</tr>
<tr>
<td>Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and training logs</td>
<td>Metric 1: The number of PAD screenings performed subsequent to implementation during DY2</td>
<td>Metric 1 [I-14.1]: Number of days until first available time for review and consultation for patient referred telemedicine consults</td>
<td>Metric 1 [P-3.2]: Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient Denominator: Number of patients referred to all medical specialties using referral processing system</td>
<td>Metric 1 [P-3.2]: Numerator: # of electronic referrals through which specialists can provide direct advice to the PCP on diagnosis and treatment without needing to actually have an encounter with the patient Denominator: Number of patients referred to all medical specialties using referral processing system</td>
</tr>
<tr>
<td>Baseline/Goal: Initiate PADnet program/infrastructure for remote screening and access to cardiovascular specialists in the Kleberg FQHC</td>
<td>Baseline/Goal: Spohn expects to screen at least 54 patients through PADnet in DY3</td>
<td>Goal: 5% reduction in wait time to cardiovascular consult for PAD</td>
<td>Baseline/Goal: Increase PAD screenings in the Kleberg FQHC with access to cardiovascular specialists by 109 (163 total estimated)</td>
<td>Baseline/Goal: Increase PAD screenings in the Kleberg FQHC with access to cardiovascular specialists by 163 (326 total estimated)</td>
</tr>
<tr>
<td>Data Source: Program materials and documents</td>
<td>Milestone 2 Estimated Incentive Payment (maximum amount): $144,701.50</td>
<td>Data Source: Referral documentation and PADnet reports.</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $288,955</td>
<td>Milestone 5 Estimated Incentive Payment (maximum amount): $116,659</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $282,963</td>
<td>Milestone 3 Estimated Incentive Payment (maximum amount): $144,701.50</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $288,955</td>
<td>Milestone 5 Estimated Incentive Payment (maximum amount): $116,659</td>
<td>Milestone 6 [I-17]: Improved access to cardiovascular care for PAD</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td>Impact</td>
<td><strong>IT-1.11</strong></td>
<td><strong>IT – Diabetes Care – Blood Pressure Control</strong></td>
<td><strong>IT – Diabetes Care – Blood Pressure Control</strong></td>
<td><strong>IT – Diabetes Care – Blood Pressure Control</strong></td>
</tr>
</tbody>
</table>

**RHP Plan for Region 4**
**Goal**: 5% increase in telemedicine consults from geographically underserved areas of Kleberg County and the surrounding area – 78363, 78343, 78332, 78375, 78355, 78379, 78389, 78022

**Data Source**: PADnet reports

Milestone 6 Estimated Incentive Payment *(maximum amount)*: $116,659

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Milestone Bundle Amount: <em>(add incentive payments amounts from each milestone)</em></th>
<th>Goal</th>
<th>Milestone 6 Estimated Incentive Payment</th>
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<tbody>
<tr>
<td>Year 2</td>
<td>$282,963</td>
<td></td>
<td>$116,659</td>
</tr>
<tr>
<td>Year 3</td>
<td>$289,403</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>$288,955</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>$233,318</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: *(add milestone bundle amounts over Years 2-5)*: $1,094,638
Performing Provider: Citizens Medical Center / 137907508
Project Name: 1.1.2 – Expand primary care capacity
Project Identifier: 137907508.1.1

- **Provider**: Citizens Medical Center is a not-for-profit County facility in Victoria, TX comprised of a 344 bed (licensed) acute care hospital with a Lead III Trauma Center, a certified Stroke Program, a certified Cancer Center, a certified Chest Pain Center, a home health agency, two (2) hospital-based healthcare clinics, a health and wellness facility, and an outpatient imaging center. The Medical Center is the largest acute care facility in the region, providing a full range of healthcare services to citizens in Victoria and Victoria County (882.14 sq. miles and population of 86,793) and the Coastal Bend Crossroads area which includes six (6) counties (5,447 sq. miles and population of 89,409). Medicare comprises 58% of the Citizens Medical Center’s clients; 8.4% are Medicaid, and 12.8% are self-pay.

- **Intervention(s)**: This project will expand primary care capacity in the Victoria area of Region 4 to better accommodate the healthcare needs of the regional patient population and community. The Medical Center’s association with a recently established Federally Qualified Health Clinic (FQHC) which opened on 10/01/12 in Victoria will serve to expand overall primary and preventive medical care capacity, thereby reducing non-urgent emergency room visits, admissions, readmissions, and complications.

- **Need for the project**: In our current system, more often than not, patients receive services for non-urgent needs in emergency care settings which usually result in more costly, less coordinated care and lack of appropriate follow-up care which can lead to potentially preventable complications, admissions, and readmissions.

- **Target population**: The target population for this project primarily includes the uninsured, the indigent, and those enrolled in Medicaid in Victoria and surrounding counties. In Victoria County, 24% of patients are uninsured, 18% are indigent, and 14.9% are Medicaid. The other counties in the hospital’s service area have higher numbers of Medicaid and uninsured patients than Victoria County. This project should be beneficial to the majority of these individuals in a preventive care setting.

**Category 1 or 2 expected patient benefits**: This project will expand primary care capacity to allow for an additional 10 patient visits per day in DY3, 35 additional visits per day in DY4, and 75 additional visits per day in DY5 (baseline is 65 patient visits per day). In addition, patient education on targeted diagnoses will be provided to those patients referred to the FQHC and patients who present to the emergency department with targeted diagnoses will receive mental health screenings with subsequent referrals to the FQHC or LMHA.

**Category 3 outcomes**:
~ IT-2.5 - Reduce potentially preventable admissions (specifically COPD) in DY4 from baseline (TBD DY3)
~ IT-9.2 – Reduce potentially avoidable emergency department visits in DY5 from baseline (TBD DY3)
Project Option 1.1.2– Expand Primary Care Capacity
Unique RHP Identification r: 137907508.1.1
Performing Provider Name/TPI: Citizens Medical Center/137907508

Project Description:
Citizens Medical Center intends to expand primary care capacity through a close working relationship with a recently established Federally Qualified Health Clinic (FQHC) in the facility’s service area. This project will not result in a duplication of federal funds.

This project will promote the expansion of primary care capacity in the Victoria area of the region to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment. Through this expansion of primary care services for all payor types, patients will have enhanced access to services that allows them to receive the right care at the right time in the right setting. By supporting the recently established FQHC (owned and operated by Community Health Centers of South Central Texas) in the provision of primary care services, Citizens Medical Center will serve to expand overall primary and preventive medical care capacity within the region.

The expansion of primary care services in Victoria through the FQHC is the direct result of efforts on behalf of Citizens Medical Center’s Chief Executive Officer. The CEO recognized the potential benefit to citizens of the county and region and was able to communicate the need to the County Judge, whose approval was needed for the project. In addition, a clinic owned and operated by Citizens Medical Center for low income residents has recently been turned over to the FQHC, including equipment, supplies, and patient base. By providing additional space and staffing to the FQHC, this project will extend available appointment times beyond general business hours and, possibly, include weekends and allow for the provision of additional primary care services. Due to this expansion of primary care services, patients and their families will be able to align themselves with the primary care system instead of depending on the emergency department for primary care services, resulting in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services over the five years of the project. With appropriate primary care services, patients and their families will have access to preventive care, which will also serve to reduce non-emergent visits to the emergency department and the avoidance of unnecessary hospitalizations.

In addition to expanding primary care capacity, this project aims to provide enhanced patient education for targeted diagnoses and to implement mental health screenings for patients with targeted diagnoses who present to the emergency department. Patients identified via the screening program will be subsequently referred to the FQHC or LMHA. Providing diagnosis-specific education will empower patients to take control of their health, improve their self-management of their disease conditions, and will result in fewer disease complications and reduced emergency department utilization. Identifying patients with possibly mental health conditions in the emergency department and referring them for appropriate care will result in better health outcomes, more appropriate utilization of resources, and reduced health care costs.

This project is directly linked to the regional goals of expanding primary care services, reducing inappropriate emergency department utilization, and reducing high rates of preventable hospital admissions.
Project Components:
It is the intent of Citizens Medical Center to work closely with the newly established FHQC in Victoria to expand primary care service capacity for the target population of Medicare, Medicaid, and indigent patients in the service area which covers an area of 7,561.97 square miles. The following core project components will be addressed:

- Citizens has already provided space for the FQHC in space previously utilized by the hospital; it is anticipated that additional space will be required and acquired to meet the extended patient care services that will be added in the future;
- Appointment times will be extended as detailed earlier in the project description;
- Citizens will provide a licensed nurse (RN), nurse practitioner (APN), or a physician’s assistant (PA) to the FHQC for staff extension to provide additional services to the target population, including disease specific educational programs for the patients.

Goals and Relationship to Regional Goals:
Citizens Medical Center proposes to address potentially preventable admissions (PPAs), potentially avoidable Emergency Department (PAED) visits, potentially preventable complications (PPCs), and potentially preventable readmissions (PPRs) by screening patients who present to the Emergency Department for non-urgent complaints in regard to the presence of chronic conditions, the level of these patients’ understanding about their disease(s), and the potentiality of secondary mental illness / substance abuse issues which increase the possibility for PPAs, PAEDs, PPCs, and PPRs.

Unique community need(s) this project addresses:
CN.1 – Inadequate access to primary care
CN.6 – High rates of inappropriate ED utilization and dissatisfaction of ED services
CN.8 – High rates of preventable hospital admissions

Starting Point/Baseline
Currently, the FQHC averages 65 primary care visits per day. The baseline number of patient visits for hospital-provided staff is 0. The mental health screening program is a new service and therefore the baseline is 0.

Rationale
In our current system, more often than not, patients receive services in urgent and emergency care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of an assigned provider, physical disability, inability to receive appointments in a timely manner, and a lack of knowledge about what types of services are provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services, and overall primary care capacity (including clinic space, hours of operation, and staffing), patients and their families will align themselves with
the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services. This project goal, increased access to health services, is also consistent with Healthy People 2020 high-priority issues that represent significant threats to the public’s health. In addition, increased access to health services has been identified as a need by the RHP needs assessment. The milestones and metrics selected for this project are designed to track performance associated with Citizens’ working relationship with the new FQHC in Victoria and will measure the impact of planned expanded services.

Victoria County has a population of 86,793 with 62,592 people living in the City of Victoria. The area has a 24% uninsured rate. The 24% uninsured rate for Victoria County represents 20,830 residents with an additional 24,825 uninsured residents in the other six (6) counties served by Citizens.

Description of the Population to be Served
In addition to the Victoria County uninsured, the county is surrounded by six (6) counties. All six (6) Counties are significantly medically underserved areas as related in the Regional Needs Assessment in Section III of the RHP 4 Plan. The populations, percent uninsured, and number of uninsured of the six (6) counties served are outlined in the following chart by county.

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Percent Uninsured</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>86,793</td>
<td>24%</td>
<td>20,830</td>
</tr>
<tr>
<td>DeWitt</td>
<td>20,097</td>
<td>27%</td>
<td>5,426</td>
</tr>
<tr>
<td>Jackson</td>
<td>14,075</td>
<td>28%</td>
<td>3,841</td>
</tr>
<tr>
<td></td>
<td>5,201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calhoun</td>
<td>21,381</td>
<td>29%</td>
<td>6,200</td>
</tr>
<tr>
<td>Goliad</td>
<td>7,210</td>
<td>29%</td>
<td>2,090</td>
</tr>
<tr>
<td>Refugio</td>
<td>7,383</td>
<td>28%</td>
<td>2,067</td>
</tr>
</tbody>
</table>

The projected payer mix for the Victoria Community Health Center is as follows:

<table>
<thead>
<tr>
<th>Payer Mix</th>
<th>Medical</th>
<th>Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>59.4%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>24.4%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Medicare</td>
<td>5.5%</td>
<td>5.8%</td>
</tr>
<tr>
<td>CHIP</td>
<td>.72%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Private Ins.</td>
<td>9.8%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

The percentages are based on UDS trends for 2011. Not included in the payer mix are the State grants such as Family Planning, Primary Health Care, Breast and Cervical Cancer Services, Maternal Child Health and Dental. Projected Revenues from the payers listed above for medical and dental is $1,154,873.

Lack of access to primary care services can lead to high utilization of emergency departments, and increased inpatient hospital costs for conditions which might otherwise have been treated in a preventive care setting. Some of these circumstances are described below.
Potentially Avoidable Emergency Department Visits
Preliminary data from the Citizens Medical Center database regarding the most common potentially avoidable emergency department visits from January 1, 2012 through September 30, 2012 indicates the following diagnoses: 1) Urinary Tract Infections – 892; 2) Headache – 447; and 3) Otitis Media – 432 (ICD-9 codes used from Medi-Cal resource).

Potentially Preventable Admissions (PPAs)
In Texas, potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse in these medical conditions:
- COPD – 44.4% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- Asthma – 37.0% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- UTI – 36.1% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- Bacterial Pneumonia – 32.5% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse (Texas Health and Human Services Commission, 2012).

Statistics for Victoria County (2009) for chronic lower respiratory disease indicates 31 deaths and a County rate of 36.3 vs. a State rate of 43.4. The report also reveals 21 deaths for pneumonia with a County rate of 24.9 vs. a State rate of 16.7 (Texas Department of State Health Services, 2009).

Potentially Preventable Readmissions (PPRs)
Another important link to mental illness/substance abuse is hospital readmissions: for adults, a readmission becomes 15% more likely; for pediatrics, 35% more likely (Texas Health & Human Services Commission, 2011).

Related Category 3 Outcome Measures
IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5 (Standalone measure)
IT-9.2 ED Appropriate Utilization

These measures were selected because the region experiences a high incidence of COPD and ED utilization as identified in the Community Needs Assessment.

Relationship to Other Projects and Measures
This project is related to Category 2.8 – Apply Process Improvement Methodology to Improve Quality/Efficiency.

Relationship to other projects:
Many of the projects in this region are related to expansion of care and improving access to care. This project’s focus on expanding care will support and enhance these Category 1 and 2 projects in our RHP: 0208811801.1.1 – Expand Primary Care Capacity; 121775403.2.3 – Primary Care Redesign; and 0942220902.2.4, Expand Care Transitions program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

Plan for Learning Collaborative
Citizens Medical Center will support the development of Regional Collaborative learning through group meetings, website portals, web-ex sessions, and/or audio-conferences. In addition, Citizens Medical Center will participate in the Premier Quality Advisor Comparative Database to evaluate hospital performance compared to peers. Also, the hospital will access and contribute lessons learned with identified challenges and solutions through the premier Connect Portal, which is a portal for sharing best practices. Finally, Citizens Medical Center will access learning opportunities provided by Premier, Texas Medical Foundation, Institute for Healthcare Improvement, National Quality Forum, Agency for Healthcare Research & Quality, American Heart Association’s Get With the Guidelines, and local and national quality management conferences. Other stakeholders with similar projects with whom we will collaborate include Christus Spohn, Driscoll Children’s Hospital, Corpus Christi Medical Center and Corpus Christi-Nueces County Public Health District.

Project Valuation
The expansion of primary care capacity with enhanced services such as mental health screening and disease specific educational programs will better accommodate the needs of the regional patient population and allow them to receive the right care at the right time in the right setting. Baseline data reveals the rate of people 0-64 without health insurance in Victoria County in 2009 was 18,289, or 24.5% of the population. More specifically, the age group of 1-17 had 3,883 individuals without health insurance, which was 16.3% of the population. Residents in Victoria County living below the poverty level in 2009 in all age groups were 12,041, or 14% of the population. The provision of diagnosis specific education on potentially avoidable emergency department visits will likely realign patients to the most appropriate primary care setting. This realignment will result in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services.

Another consideration when applying valuation to this project is the potentially preventable admissions that have been linked to secondary diagnoses of mental illness/substance abuse in the following medical conditions (Texas Health and Human Services Commission, 2012):

- Chronic obstructive pulmonary disease (44.4%)
- Asthma (37.0%)
- Urinary tract infection (36.1%)
- Bacterial pneumonia (32.5%)

Through the commitment of resources, these patients can be screened and directed to appropriate mental health resources in an effort to prevent the potential admission to the
hospital setting, which is the most expensive care setting. As previously noted, the expansion of primary care services in Victoria through the FQHC is the direct result of efforts on behalf of Citizens Medical Center’s Chief Executive Officer. The CEO recognized the potential benefit to citizens of the county and region and was able to communicate the need to the County Judge, whose approval was needed for the project. In addition, a clinic owned and operated by Citizens Medical Center for low income residents has recently been turned over to the FQHC, including equipment, supplies, and patient base.

Another component of this program is the prevention of potentially preventable readmissions of adults and pediatric patients suffering from mental illness/substance abuse. Data reveals adults are 15% more likely to be readmitted if they have a secondary diagnosis as mentioned above. Pediatric patients, however, are 35% more likely to be readmitted (Texas Health and Human Services Commission, 2011).

References


### Related Category 3

<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-4.</strong> Through coordination with FQHC leaders, expand the hours of the primary care clinic, including evening and/or weekend hours.</td>
<td><strong>Baseline/Goal:</strong> 44 hours per week / ≥ 48 hours per week</td>
<td><strong>Baseline/Goal:</strong> 44 hours per week / ≥ 64 hours per week</td>
<td><strong>Baseline/Goal:</strong> 44 hours per week / ≥ 64 hours per week</td>
<td><strong>Baseline/Goal:</strong> 44 hours per week / ≥ 64 hours per week</td>
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<tr>
<td><strong>Metric 1: P-4.1.</strong> Increase number of hours at primary care clinic over baseline</td>
<td><strong>Data Source:</strong> FQHC data on number of hours open per week at primary care clinic.</td>
<td><strong>Data Source:</strong> FQHC data on number of hours open per week at primary care clinic.</td>
<td><strong>Data Source:</strong> FQHC data on number of hours open per week at primary care clinic.</td>
<td><strong>Data Source:</strong> FQHC data on number of hours open per week at primary care clinic.</td>
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$ 394,636</td>
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<tr>
<td><strong>Milestone 2: P-X1.</strong> Confirm hospital baseline data for the three (3) most common potentially avoidable emergency department visits.</td>
<td><strong>Metric 2: P-X1.1.</strong> Confirmation of hospital preliminary data for the three (3) most common potentially avoidable emergency department visits, namely, Urinary Tract Infections, Headache, and Otitis Media.</td>
<td><strong>Baseline/Goal:</strong> Preliminary data quoted in narrative / Confirm accuracy of preliminary data and establish baseline number of patients.</td>
<td><strong>Baseline/Goal:</strong> Preliminary data quoted in narrative / Confirm accuracy of preliminary data and establish baseline number of patients.</td>
<td><strong>Baseline/Goal:</strong> Preliminary data quoted in narrative / Confirm accuracy of preliminary data and establish baseline number of patients.</td>
</tr>
<tr>
<td><strong>Milestone 4: I-15.</strong> Work with the local Federal Qualified Health Clinic (FQHC) leaders to increase access to primary care capacity</td>
<td><strong>Metric 4: I-15.2.</strong> Increase number of primary care visits at local FQHC</td>
<td><strong>Baseline/Goal:</strong> Average of 65 visits per day / Increase to 75 visits per day</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY3 (Metric 4: P-X2.1) / 30 patients seen by hospital staff member per week</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY4 (Metric 7: P-X5.1) / 30 patients seen by hospital staff member per week</td>
</tr>
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<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$ 403,619</td>
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<tr>
<td><strong>Milestone 5: P-X3.</strong> Provide a licensed nurse, nurse practitioner, and / or physician’s assistant to the FQHC for at least eight (8) hours per week to assist in the provision of primary care services in conjunction with educational programs for the aforementioned established potentially preventable emergency department referrals to the FQHC clinic.</td>
<td><strong>Metric 5: P-X3.1.</strong> Number of patients assessed / treated / educated by staff member provided by the hospital</td>
<td><strong>Baseline/Goal:</strong> 0 / 20 patients seen by hospital staff member per week</td>
<td><strong>Baseline/Goal:</strong> Average of 65 visits per day / Increase to 100</td>
<td><strong>Baseline/Goal:</strong> Average of 65 visits per day / Increase to 100</td>
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<tr>
<td><strong>Data Source:</strong> Time records of hospital staff member</td>
<td></td>
<td><strong>Data Source:</strong> Time records of hospital staff member; FQHC data regarding number of patients seen by hospital staff member.</td>
<td></td>
<td><strong>Data Source:</strong> Time records of hospital staff member; FQHC data regarding number of patients seen by hospital staff member.</td>
</tr>
<tr>
<td><strong>Milestone 7: P-X5.</strong> Provide a licensed staff member to the FQHC for at least twelve (12) hours per week to assist in the provision of primary care services in conjunction with educational programs for the aforementioned emergency department referrals to the FQHC clinic.</td>
<td><strong>Metric 7: P-X5.1.</strong> Increase number of patients assessed / treated / educated by staff member provided by the hospital</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY3 (Metric 4: P-X2.1) / 30 patients seen by hospital staff member per week</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY4 (Metric 7: P-X5.1) / 30 patients seen by hospital staff member per week</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY4 (Metric 7: P-X5.1) / 30 patients seen by hospital staff member per week</td>
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<td><strong>Milestone 7 Estimated Incentive Payment (maximum amount):</strong></td>
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<td><strong>Milestone 8: I-15.</strong> Continue to work with the local FQHC leaders to increase access to primary care capacity</td>
<td><strong>Metric 8: I-15.2.</strong> Increase number of primary care visits at local FQHC</td>
<td><strong>Baseline/Goal:</strong> Average of 65 visits per day / Increase to 100</td>
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<td></td>
</tr>
<tr>
<td><strong>Milestone 10 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$ 244,048</td>
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<tr>
<td><strong>Milestone 10: P-4.</strong> Through coordination with FQHC leaders, expand the hours of the primary care clinic, including evening and/or weekend hours.</td>
<td><strong>Metric 10: P-4.1.</strong> Increase the number of hours at primary care clinic over baseline</td>
<td><strong>Baseline/Goal:</strong> 44 hours per week / ≥ 64 hours per week</td>
<td></td>
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</tr>
<tr>
<td><strong>Milestone 11: P-X7.</strong> Provide a licensed staff member to the FQHC for at least sixteen (16) hours per week to assist in the provision of primary care services in conjunction with educational programs for the aforementioned emergency department referrals to the FQHC clinic.</td>
<td><strong>Metric 11: P-X7.1.</strong> Increase number of patients assessed / treated / educated by staff member provided by the hospital</td>
<td><strong>Baseline/Goal:</strong> Number of patients reported in DY4 (Metric 7: P-X5.1) / 30 patients seen by hospital staff member per week</td>
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</tbody>
</table>
### Related Category 3 Outcome Measure(s):

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

**Data Source:** Hospital Meditech and Premier databases

**Milestone 2 Estimated Incentive Payment (maximum amount):** $394,636

**Milestone 3: P-X2.** Establish a baseline for the number of patients utilizing the emergency department with one of the following diagnoses:

- Chronic Pulmonary Obstructive Disease (COPD);
- Asthma;
- Urinary Tract Infection (UTI); and
- Bacterial pneumonia

**Metric 3P-X2.1** Baseline data for patients presenting to the emergency department with one of the following primary diagnoses:

- Chronic Pulmonary Obstructive Disease (COPD);
- Asthma;
- Urinary Tract Infection (UTI); and
- Bacterial pneumonia

**Baseline/Goal:** Document baseline number of patients presenting to the emergency department with one of the above diagnoses.

**Data Source:** Citizens Medical Center database; Meditech and hospital staff member; FQHC data regarding number of patients seen by hospital staff member.

**Milestone 5 Estimated Incentive Payment (maximum amount):** $403,619

**Milestone 6: P-X4.** Develop a screening tool derived from evidence based data to identify patients presenting to the emergency department with underlying mental health illness for referral to FQHC or LMHA, specific to the following diagnoses:

- Chronic obstructive pulmonary disease (COPD);
- Asthma;
- Urinary Tract Infection (UTI); and
- Bacterial pneumonia

**Metric 6P-X4.1** Develop a screen to be performed in the emergency department to make appropriate referrals to FQHC or LMHA specific to patients with one of the following diagnoses:

**Baseline/Goal:** Document the baseline number of patients screened out of the total number of patients presenting with one of the above diagnoses.

**Data Source:** FQHC data on number of patients seen per day.

**Milestone 8 Estimated Incentive Payment (maximum amount):** $402,993

**Milestone 9: P-X6.** Implement mental health screen developed in Year 3 to be performed in the emergency department to make appropriate referrals to FQHC or LMHA specific to patients with one of the following diagnoses:

- Chronic Pulmonary Obstructive Disease (COPD);
- Asthma;
- Urinary Tract Infection (UTI); and
- Bacterial pneumonia

**Metric 9P-X6.1** Screenings performed on patients with the aforementioned diagnoses

**Baseline/Goal:** Document the baseline number of patients screened out of the total number of patients presenting with one of the above diagnoses.

**Data Source:** Electronic screens in Citizens Medical Center database

**Milestone 11 Estimated Incentive Payment (maximum amount):** $244,048

**Milestone 12: P-X7.** Upgrade mental health screen to an electronic tool for screening patients for mental health illness presenting to the emergency department with one of the following diagnoses:

- Chronic Pulmonary Obstructive Disease (COPD);
- Asthma;
- Urinary Tract Infection (UTI); and
- Bacterial pneumonia

**Metric 12P-X7.1** Increase mental health screenings performed on patients with the above diagnoses

**Baseline/Goal:** Baseline number of patients screened in Year 4 / Number of patients screened out of the total number of patients presenting with one of the above diagnoses.

**Data Source:** Electronic screens in Citizens Medical Center database

**Milestone 12 Estimated Incentive Payment (maximum amount):** $244,048
### Related Category 3

**Outcome Measure(s):**
- 137907508.3.1
- 137907508.3.2

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier databases</td>
<td><strong>Baseline/Goal:</strong> No screen / Submit copy of mental health screen developed for determining appropriate FQHC and / LHMA referrals. <strong>Data Source:</strong> Hospital’s database and data from FQHC and LMHA on mental health screenings.</td>
<td><strong>Payment (maximum amount):</strong> $402,993</td>
<td><strong>Payment (maximum amount):</strong> $244,049</td>
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<tr>
<td><strong>Milestone 3 Estimated Payment Incentive (maximum amount):</strong> $394,636</td>
<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount):</strong> $403,618</td>
<td><strong>Milestone 8 Estimated Incentive Payment (maximum amount):</strong> $244,049</td>
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Year 2 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone):* $1,183,908

Year 3 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone):* $1,210,856

Year 4 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone):* $1,208,979

Year 5 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone):* $976,194

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $4,579,937
1.9.1 Expansion of Specialty Care Capacity

**Provider:** Cuero Community Hospital (CCH) is a 49-bed general medical and surgical hospital located in Cuero, Texas. It is the only hospital in DeWitt County, which has a population of 20,173. CCH’s Outpatient Specialty Clinic serves as the primary provider for outpatient specialty services for area residents.

**Intervention(s):** This project will increase access to specialty care services by expanding the capacity of CCH’s Outpatient Specialty Clinic. To ensure patients have the ability to secure appointments with appropriate providers and with minimal wait periods, the clinic will increase its staffing of specialty care providers.

**Need for the project:** Like other counties the region, DeWitt County is a designated Medically Underserved Area. Currently, CCH contracts with 24 physicians to provide services through its Outpatient Specialty Clinic. However, most of these providers have very limited clinic hours amounting to one or two half days per month. In addition, no emergency or after hours surgeries are performed resulting in patients postponing procedures or traveling 30 miles to Victoria, TX. Improved access to specialty care providers will prevent delays in patients receiving appropriate outpatient care, thereby reducing disease complications and preventable hospitalizations.

**Target population:** The target population for this project is adult patients in CCH’s service area who require specialty care services. Medicaid enrollment in DeWitt County is 15% with 29% of enrollees qualifying as Aged or Blind & Disabled. Additionally, 18.3% of county residents are age 65 years or older compared to 10% of all Texas residents. The elderly and disabled are more likely to suffer from multiple chronic conditions, more likely to require specialty care services, and thus most likely to benefit from an expansion in specialty care capacity. Approximately 2500 patient visits for specialty services will occur by DY5 with a high percentage of patients being Medicaid eligible and/or indigent.

**Category 1 or 2 expected patient benefits:** The project is expected to increase specialty care clinic volume of visits by 2% over baseline in DY3, 4% over baseline in DY4, and 6% over baseline in DY5.

**Category 3 outcomes:** IT-6.1 Percent improvement of over baseline of patient satisfaction scores. Our goal is to improve patient satisfaction in the areas of getting timely care, appointments, and information.
Category 1: Infrastructure Development

Project Title: 1.9.1 Expansion of Specialty Care Capacity
Performing Provider/TPI: Cuero Community Hospital/138911609
RHP Identification Number: 138911609.1.1

Project Description:
This project will increase access to specialty care services by expanding the capacity of an existing hospital-based clinic located at Cuero Community Hospital (CCH). This initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. To ensure patients have the ability to secure appointments with appropriate providers and with minimal wait periods, the clinic will increase its staffing of specialty care providers.

Currently, the region faces challenges in providing specialty care services to the community population. Every county in the region, including DeWitt County (the home of CCH), faces shortages of primary care, behavioral health care, and other specialty care providers. As a result, patients have difficulty securing timely appointments and must often drive long distances to see a provider. These barriers lead to delays in care, which in turn lead to higher rates of disease complications and increased acute care utilization. This creates unnecessary costs and burdens on the existing health care system and may contribute to poorer patient outcomes. By increasing the number of providers in the specialty areas of greatest need, CCH will be better able to meet community and Regional needs for specialty care services.

Goals and Relationship to Regional Goals:
The goals of this project are:
- Improve access to specialty care providers and services
- Reduce the need for clients to travel excessive distances for health care services
- Increase the number of health care providers and services available to community residents
- Improve patient outcomes by enabling patients to obtain more timely care and preventing medical conditions from reaching a critical state
- Improve patient satisfaction by reducing the wait time for appointments with specialty providers

This project supports the Region’s goal of providing residents with timely access to necessary health care services in an appropriate setting located within a reasonable distance from their homes.

Challenges and how addressed:
A key challenge in implementing this project will be attracting physicians to our clinic. Continued and new efforts for recruitment will be as follows:
1. Based on the specialty care gap assessment, specialty physicians will be invited to join the CCH Ambulatory Department through personal invitations from the Medical Staff.
2. Targeted specialty physicians will be encouraged to visit our facility through personal phone calls from the CEO, CFO and COO of CCH.
3. Targeted outpatient specialty physicians will be asked to increase their current clinic hours. For example, diseases of the nervous system and sensory organs have been identified as one of the leading ICD 9 codes in our ER patients. Our current neurologist comes to our specialty clinics twice a month for 2 hours each time. He will be asked to increase the time span of his clinic thus increasing improved access to these services.

4. Educational symposiums offered through the DeWitt Medical Foundation will encompass identified high impact/most impacted medical specialties as calculated by our ER visits. Individualized presentations by specialty physicians will educate the community as well as the surrounding area physicians on these topics thus promoting wellness and care of the identified medical specialties.

5. We will form stronger alliances with our Victoria, Seguin and San Antonio Health Science Center Physicians.

6. Through our networking with our DISRIP Project, greater access to specialty physicians will be achieved.

7. Encouragement from a fellow physician could be a very effective tool for recruiting. We will encourage Outpatient specialty physicians to collaborate with their colleagues in the same or related specialty areas to assist with recruiting them to our clinic. For example, an Urologist may know a Nephrologist to whom he would like to refer patients, or a General Surgeon may be familiar with a Vascular Surgeon who could provide services here.

8. Newspaper articles, ads and bill boards will be utilized to promote the specialty physicians.

5-Year Expected Outcome for Providers and Patients:
Cuero Community Hospital plans to contract with additional specialty providers to improve and increase access for their targeted population. Increasing the number of health care providers and services available to the community residents will ultimately improve patient outcomes by enabling patients to obtain more timely care and preventing medical conditions from reaching a critical state. The contracting with specialty providers will occur at a rate of one provider per Demonstration Year (DY) beginning in DY3. The number of specialty care encounters will grow accordingly with the addition of each provider so that the total number of encounters will increase by 6% by the end of DY5.

Starting Point/Baseline:
Currently, CCH contracts with 24 specialty physicians to provide services at our outpatient specialty clinic who provide services 4 hours/month/specialist. Data collection conducted in DY2 will be used to establish a baseline for the number of specialty care encounters.

Rationale:
Cuero Community Hospital (CCH) is located in Cuero, Texas, which is the county seat of DeWitt County. Cuero’s population is approximately 6,800 and includes 34% of the county’s 20,173 residents. CCH is a 49-bed general medical and surgical hospital and is the only hospital

61 Texas State Data Center, Texas Population 2010
located in DeWitt County. CCH’s hospital-based Outpatient Specialty Clinic serves as the primary provider for outpatient specialty services for area residents. Like other counties in our Region, DeWitt County is a designated Medically Underserved Area due to a shortage of primary care providers, high infant mortality, high poverty and/or high elderly population.\textsuperscript{62} Currently, CCH contracts with 24 physicians to provide services through its Outpatient Specialty Clinic. However, as shown in the following table, most of these providers have very limited clinic hours amounting to one or two half days per month. In addition, no emergency or after hours surgeries are performed resulting in patients postponing procedures or traveling 30 miles to Victoria, TX. Total outpatient visits for 2010, the most recent year for which data is available, was approximately 140,000.\textsuperscript{63}

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Current Number</th>
<th>Clinic Hours</th>
<th>Specialty</th>
<th>Current Number</th>
<th>Clinic Hours</th>
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</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>7</td>
<td>2-4 half days per week</td>
<td>Oncology/Hematology</td>
<td>1</td>
<td>2 half days per month</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1</td>
<td>1 half day per month</td>
<td>Orthopedic</td>
<td>3</td>
<td>1 full day per week</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2</td>
<td>3 days per week</td>
<td>Otolaryngology</td>
<td>1</td>
<td>2 half days per month</td>
</tr>
<tr>
<td>Gynecology</td>
<td>1</td>
<td>1 half day per month</td>
<td>Pain Management</td>
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<td>1 full day per week</td>
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<tr>
<td>Neonatology</td>
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<td>1 half day per month</td>
<td>Podiatry</td>
<td>1</td>
<td>2 days per week</td>
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<tr>
<td>Nephrology</td>
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<td>2 half days per month</td>
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<td>Neurology</td>
<td>1</td>
<td>2 half days per month</td>
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The median household income in DeWitt County is $36,611 with approximately 1 in 5 residents living at or below the poverty level.\textsuperscript{64} Medicaid enrollment is 15% with 29% of enrollees qualifying as Aged or Blind & Disabled. Furthermore, 18.3% of county residents are age 65 years or older compared to 10% of all Texas residents.\textsuperscript{65} The elderly and disabled are more likely to suffer from multiple chronic conditions, more likely to require specialty care services, and thus most likely to benefit from an expansion in specialty care capacity. Without adequate access to these services, patients’ disease conditions may become critical leading to emergency department utilization and hospitalizations that could have been prevented. National hospitalization rates show that individuals who are 65 years or older account for 39% of

\textsuperscript{62} U.S. Department of Health & Human Services, Health Resources and Services Administration  
\textsuperscript{63} Texas Department of State Health Services, American Hospital Association, Texas Hospital Association, 2009 & 2010 Annual Survey of Hospitals and Hospital Database  
\textsuperscript{64} U.S. Census Bureau, Small Area Income and Poverty Estimates – 2010 County Level Estimations; U.S. Census Bureau, American Community Survey, 2009-2010.  
\textsuperscript{65} U.S. Census Bureau, DeWitt County, Texas, 2011
hospital discharges and 45% of hospital days despite comprising just 13% of the population.\textsuperscript{66} From 2005-2010, DeWitt County residents experienced nearly 1,300 potentially preventable hospitalizations at a cost of $21 million.\textsuperscript{67} Improved access to specialty care providers will prevent delays in patients receiving appropriate outpatient care, thereby reducing chronic disease complications and preventable hospitalizations.

**Project Components:**

Our plan to increase staffing of specialty care physicians significantly enhances our existing delivery system by allowing us to address the Region’s critical need for additional providers and improving our ability to provide patients with timely care in the most appropriate setting. Project components include:

a) *Identify high impact/most impacted specialty services and gaps in care and coordination.* A gap assessment will be conducted in DY2 to identify the most impacted specialty services and gaps in care. The results of this assessment will guide our hiring of specialty providers.

b) *Increase the number of residents/trainees choosing targeted shortage specialties.* Cuero Community Hospital is a non-teaching hospital. Therefore, this core project component (1.9.1.b) is not applicable.

c) *Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention).* As discussed above, a number of activities will be conducted to recruit and retain specialty physicians including personal invitations to targeted physicians to tour our facility, educational symposiums, media utilization, and greater collaboration with our Victoria, Sequin and San Antonio Health Science Center physicians.

d) *Conduct quality improvement for project.* This component is not being pursued at this time and will be reconsidered in DY6 after we have contracted with three additional specialty providers.

**Milestones and Metrics**

- P-1 Conduct a specialty care gap assessment based on community need
  
  P-1.1 Documentation of gap assessment

- I-22 Increase the number of specialist providers and clinic hours for the high impact/most impacted medical specialties
  
  I-22.1 Increase number of specialist providers and clinic hours in targeted specialties

- I-23 Increase specialty clinic volume of visits and evidence of improved access for patients seeking services
  
  I-23.1 Documentation of increased number of visits

The following customizable process milestone is necessary for us to be able to determine if we’ve met our goals for increased specialty care clinic volume of visits in DY3-5:

- P-22 Collect baseline data on specialty care clinic volume of visits
  
  P-22.1 Establish baseline for number of visits

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\textsuperscript{66} Texas Hospital Association, Fast Facts on Texas Hospitals 2012-2013

\textsuperscript{67} Texas Department of State Health Services, DeWitt County Potentially Preventable Hospitalizations
Community needs identification numbers the project addresses:
CN.2 Inadequate access to specialty services
CN.9 Shortage of specialty care physicians
CN.15 Inadequate healthcare access in rural areas

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
Currently the Cuero community has limited access to specialty care providers placing a significant strain on our health care delivery system. By increasing the number of physicians providing services through the Outpatient Specialty Care Clinic, this project will enhance our existing delivery system and provide much needed increased capacity to best serve the community’s specialty care needs.

Related Category 3 Outcome Measure:
The selected Category 3 Outcome Measure for this project is IT-6.1 Percent improvement over baseline of patient satisfaction scores in domain OD-6 Patient Satisfaction. Our goals in expanding specialty care capacity are to improve access to specialty care providers, enable patients to obtain timely and convenient care, and to improve patients’ health outcomes. As each of these objectives is patient-focused, we believe that patient satisfaction will be an accurate gauge of success in meeting our objectives. We intend to use the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to improve performance as measured by whether patients are (1) getting timely care, appointments, and information. This data will provide us with meaningful information regarding our ability to meet patient expectations for access to care and will identify areas where we need to improve. Ensuring that patients receive the care they need without significant delays will result in improved health outcomes and greater patient satisfaction. The HCAHPS survey is an effective tool for measuring our performance and the data it provides will enable us make adjustments as necessary to continually improve.

Relationship to other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support a number of other projects within the region, including the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FQHC providers.

Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.
**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center, Driscoll Children’s Hospital, and Christus Spohn.

**Project Valuation:**
The Community Needs Assessment identified a shortage of specialty care providers as a significant problem for the Cuero community. At our current specialty care capacity, many of the 20,000+ individuals living within our service area must travel long distances to receive the care they need. Many of these patients are low income, elderly and on some form of state or federal insurance. In addition, many of our residents lack reliable transportation which makes travelling to see a specialist difficult. For these reasons, patients tend to put off seeking treatment until their medical conditions become critical, at which point they visit the local emergency department. Increasing specialty care capacity will yield substantial savings due to patients being able to seek timely care from local providers in an outpatient setting rather than visiting the emergency department. We also expect to see a reduction in hospitalization costs due to patients receiving specialty care before their medical conditions reach a critical state. Other factors considered in valuing this project include savings in transportation expenses and decreased absenteeism from work due to specialty care services being available locally and patients no longer needing to travel great distances for care. Finally, our valuation takes into consideration subjectively valued quality of life associated with the convenience of local healthcare services for our patients.
**Cuero Community Hospital**

### Expansion of Specialty Care Capacity

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>138911609.3.1</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
</table>

1. **Milestone 1** [P-1]: Conduct specialty care gap assessment based on community need
   - **Metric 1** [P-1.1]: Documentation of gap assessment.
     - Baseline/Goal: TBD
     - Data Source: Needs Assessment
   - **Milestone 1 Estimated Incentive Payment (maximum amount):** $316,296

2. **Milestone 2** [P-22]: Collect baseline data on specialty care clinic volume of visits.
   - Metric 1: [P-22.1] Establish baseline for number of visits
     - Baseline/Goal: TBD
     - Data Source: Registry, EHR, claims, or other performing provider source
   - **Milestone 2 Estimated Incentive Payment (maximum amount):** $316,296

3. **Milestone 3** [I-22]: Increase the number of specialist providers and clinic hours for the high impact/most impacted medical specialties.
   - **Metric 1** [I-22.1]: Increase number of specialist providers and clinic hours in targeted specialties.
     - Baseline/Goal: Currently 24 specialists (as listed in chart above). Goal is 1 specialist over baseline.
     - Data Source: documentation demonstrating contract with specialists
   - **Milestone 3 Estimated Incentive Payment:** $345,063

4. **Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
   - **Metric 1** [I-23.1]: Documentation of increased number of visits.
     - Demonstrate improvement over prior reporting period.
     - Goal: Increase in total number of visits of 2% over baseline established in DY2
     - Data Source: Registry, EHR, claims or other Performing Provider source
   - **Milestone 4 Estimated Incentive Payment:** $345,063

5. **Milestone 5** [I-22]: Increase the number of specialist providers and clinic hours for the high impact/most impacted medical specialties.
   - **Metric 1** [I-22.1]: Increase number of specialist providers and clinic hours in targeted specialties.
     - Baseline/Goal: 2 specialist providers over the baseline of 24.
     - Data Source: documentation demonstrating contract with specialists
   - **Milestone 5 Estimated Incentive Payment:** $346,065

6. **Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
   - **Metric 1** [I-23.1]: Documentation of increased number of visits.
     - Demonstrate improvement over prior reporting period.
     - Goal: Increase in total number of visits of 4% over baseline
     - Data Source: Registry, EHR, claims or other Performing Provider source
   - **Milestone 6 Estimated Incentive Payment:** $346,065

7. **Milestone 7** [I-22]: Increase the number of specialist providers and clinic hours for the high impact/most impacted medical specialties.
   - **Metric 1** [I-22.1]: Increase number of specialist providers and clinic hours in targeted specialties.
     - Baseline/Goal: 3 specialist providers over the baseline of 24.
     - Data Source: documentation demonstrating contract with specialists
   - **Milestone 7 Estimated Incentive Payment:** $285,880

8. **Milestone 8** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
   - **Metric 1** [I-23.1]: Documentation of increased number of visits.
     - Demonstrate improvement over prior reporting period.
     - Goal: Increase in total number of visits of 6% over baseline
     - Data Source: Registry, EHR, claims or other Performing Provider source
   - **Milestone 8 Estimated Incentive Payment:** $285,880
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>138911609.3.1</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount:</td>
<td>$632,592</td>
<td>Year 3 Estimated Milestone Bundle Amount:</td>
<td>$690,126</td>
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<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>Year 4 Estimated Milestone Bundle Amount:</td>
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<tr>
<td>Year 4 Estimated Milestone Bundle Amount:</td>
<td>$692,130</td>
<td>Year 5 Estimated Milestone Bundle Amount:</td>
<td>$571,760</td>
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<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>
D. Category 2: Program Innovation and Redesign
Improvement in Quality and Safety for patients with Sepsis; 2.8.11
CHRISTUS Spohn Hospital Beeville/ 020811801
Unique Identifier - 020811801.2.1

- CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital serving a 2,666 square mile area and a population of approximately 108,346. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

- Intervention(s): This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) within Spohn’s Beeville provider facilities.

  Need for the project: In FY 2012, Spohn completed approximately 3000 MEWS tools (sepsis screening) and identified 81 cases of sepsis. Of the cases identified, 16% were Medicaid/uninsured (28 cases). The average length of stay for a septic patient was 3 days and the average charge per patient was $119,000 totaling $ 9.7 million in charges. Spohn collected $617,856 of those charges, meaning the remaining $9 million went uncompensated. The sepsis mortality rate in FY 2012 was 13.6% of all cases (3 deaths). Each of these numbers can be improved through implementing this project.

- Target population: The target population includes all patients in Spohn’s hospital campuses who are at risk for sepsis, including elderly and surgical patients. Spohn discharges approximately 1,975 inpatients annually, 38% of which are Medicaid/uninsured (approximately 755 inpatients).

  Category 1 or 2 expected patient benefits: By DY5, Spohn expects to achieve 95% of patients with a suggestion of severe sepsis or septic shock have their lactate level drawn. In addition, Spohn expects a 10% increase in the number of patients screened with the MEWS tool. Category 3 outcomes: IT-4.8 – By DY5, Spohn expects this project to result in a 2% reduction in septicemia mortality rates in Spohn’s Beeville facilities from the baseline established in DY2.
Category 2: Program Innovation and Redesign
Sepsis

Identifying Project and Provider Information:
Project 2.8.11: Improvement in Quality and Safety for patients with Sepsis
CHRISTUS Spohn Hospital Beeville (“Spohn”)/ 020811801
Unique Identifier – 020811801.2.1

Project Description:
This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) in Spohn’s provider facility. Spohn will gauge resultant improvements in care through the assessment and monitoring of process and outcome measures across the lifespan of the project. Initially, measurements will constitute a baseline from which improvements at subsequent intervals will be gauged. Providers needed for this concept include nurse practitioners, nurses and physicians within hospital settings.

Project Goals/Five Year Expected Outcome: By using nurse practitioners, nurses and physicians to implement both Sepsis Resuscitation and Sepsis Management Bundles, this project’s goals are:

- Implement a 90-day rapid cycle improvement plan for sepsis.
- 10% increase in cases with resuscitation initiated within 6 hours-order set initiation.
- 15% increase in use of electronic MEWS by nursing staff on patients admitted to medical/surgical units.

Project Challenges: The top challenge of this initiative will be automating the MEWS screening tool and provider compliance with bundles. Implementation will consist of staff education, provider training, point of entry protocol development, sepsis bundle and sepsis management bundle implementation set forth as a 90-day rapid cycle improvement.

Starting Point/Baseline:
In FY 2012, Spohn completed 3,000 MEWS tools (sepsis screening) and identified 81 cases of sepsis. Of the cases identified, 16% were Medicaid/uninsured (28 cases). The average length of stay for a septic patient was 3 days and the average charge per patient was $119,000 totaling in $ 9.7 million in charges. Spohn collected $617,856 of those charges, meaning the remaining $ 9 million went uncompensated. The sepsis mortality rate in FY 2012 was 13.6% of all cases (3 deaths). In 2012, approximately zero % of patients had lactate drawn upon a suggestion of sepsis or severe septic shock; the target should be at 100% because the lactate level confirms the presence of sepsis.

Rationale:
Severe sepsis is a major healthcare problem that affects millions of people around the world each year with an extremely high mortality rate of 30 to 60 percent. Mortality from sepsis is greater than breast cancer, lung cancer and colon cancer combined and is the number one cause of death in the non-coronary ICU. The incidence of severe sepsis is expected to double over the next 25 to 30 years. Thus, it is imperative for the health and safety of Nueces County residents who may be hospitalized...
and exposed to this infection at some point during their lives, Spohn takes steps to detect sepsis early and have a tried and true protocol for responding effectively.

Our goal at Spohn is to reduce septicemia mortality. In order to impact this mortality rate, early recognition for signs and symptoms of sepsis and immediate initiation of treatment is required. Time is of the essence making this a high priority initiative with a substantial amount of work to accomplish over a short period of time. This full scale quality improvement initiative requires a structured and defined process to ensure all phases of improvement are completed; Plan-Do-Study-Act. This system-wide initiative will be accomplished using a 90-day rapid cycle improvement process specific to early recognition and treatment of sepsis.

**Milestones and Metrics:** Spohn chose the DY2 milestones in order to put in place the infrastructure to improve its capability to quickly detect sepsis and respond effectively. In the subsequent years, Spohn chose milestones that would allow it to measure and improve its processes for responding to cases of sepsis within the hospital at a consistent rate.

**Ties to Community Needs Identification Number:** CN.18 (high rate of sepsis in Region 4)

**Project Components:**
- Baseline assessment (see baseline data)
- Review of evidence for early warning system tool and tool selection – will be part of completing Milestone 1 in DY2
- Identify team to champion initiative – include all stakeholders, must commit time to implement 90-day rapid cycle improvement and continuous improvement – will be part of completing Milestone 3 in DY3
- Plan – workflow, implementation, training, dissemination of information, metrics for short, intermediate and long term outcomes (will be part of Milestones 1 and 3).
  - Short term – recognition and treatment initiation
  - Intermediate – hardwire processes evidenced by consistent use of tools
  - Long term – reduce sepsis mortality rates, decrease cost associated with PPC
- Do – implement Modified Early Warning Score (MEWS) and Lactate Levels Draw upon Suggestion of Severe Sepsis or Septic shock – to be completed through Milestones 2 and 4
- Study – Analyze and interpret the results – to be completed through Milestones 5-9 in DYs 3-5.
- Act – Identify areas for change and implement rapid process to resolve – to be completed as part of Milestones 5-9 in DYs 3-5.

**Related Category 3 Outcome Measure(s):** OD 4 (Potentially Preventable Complications and Healthcare Acquired Conditions); IT 4.8 (Sepsis Mortality)

Spohn selected this outcome because the goal of creating the sepsis early warning system and corresponding protocols is intended to result in early recognition and treatment of sepsis in the medical/surgical patient population, which is in turn expected to result in a lower rate for sepsis mortality in Spohn’s inpatient population.
Relationship to other Projects:
This project relates to and supports the following projects because it requires the vigilance and cooperation of all hospital providers (including physicians):

121775403.1.5 – Expand high impact specialty scare capacity through development of a structured critical service model focusing on providing intensivists driven services;
121775403.2.2 – Establishment of Hospitalist Program model that provides continuity of care through clinical integration of services in non-ICU patients
020973601.2.2 – Apply process Improvement methodology to improve sepsis mortality and length of stay.
Related Category 4 measures include potentially preventable complications in RD-3 and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers who have submitted similar projects with whom we will collaborate include Corpus Christi Medical Center.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Beeville (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects; to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 68

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

The value of this particular project is based on the prevalence of sepsis mortality across Texas hospitals, including in Nueces County. Sepsis can affect any at-risk patients in the hospital, thus the project is necessary to protect a myriad of different types of patients. The investment required for this project ties into implementing the early warning system, rapid-cycle improvement, and provider training. Ultimately, this project meets Waiver goals by focusing on improving patient health outcomes while also reducing the systemic cost of providing inpatient hospital care associated with sepsis.

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68 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### RHP Plan for Region 4

#### CHRISTUS Spohn Hospital Beeville

<table>
<thead>
<tr>
<th>Milestone 1 [P-7]: Implement a rapid improvement project using Rapid Cycle improvement methodology</th>
<th>Milestone 3 [P-8]: Train providers/staff on process improvement</th>
<th>Milestone 6 [I-14]: Measure efficiency – initiate CPOM for Sepsis</th>
<th>Milestone 8 [I-14]: Measure efficiency – initiate CPOM for Sepsis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Rapid Improvement Cycle for Sepsis; Standardize process, Set the measure, Validate the measure, Innovate implementation, Standardize new process, Continue cycle</td>
<td><strong>Metric 1</strong> [P-8.1]: Number of providers/staff trained</td>
<td><strong>Metric 1</strong> [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock</td>
<td><strong>Metric 1</strong> [I-14.1]: Increase use of electronic MEWS by nursing staff</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Implement a 90-day rapid cycle improvement plan for Sepsis.</td>
<td><strong>Baseline/goal</strong>: Implement a 90-day rapid cycle improvement plan for Sepsis.</td>
<td><strong>Goal</strong>: 75% (estimate 60) of patients with suggestion of severe sepsis will have lactate level drawn</td>
<td><strong>Goal</strong>: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 450 additional screenings)</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Documentation of all steps included in rapid cycle methods were performed</td>
<td><strong>Data Source</strong>: Documentation of training materials</td>
<td><strong>Data Source</strong>: EMR</td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $87,423</td>
<td>Milestone 4 Estimated Incentive Payment: $89,608.66</td>
<td>Milestone 6 Estimated Incentive Payment: $89,274.50</td>
<td>Milestone 8 Estimated Incentive Payment: $72,085</td>
</tr>
</tbody>
</table>

#### Year 2 (10/1/2012 – 9/30/2013)

<table>
<thead>
<tr>
<th>Milestone 2 [P-1]: Target workflow, processes and clinical areas to improve: Implement early warning system (MEWS) for sepsis on medical/surgical inpatient units. <strong>Metric 1</strong> [P-1.1]: Identify and prioritize processes to improve</th>
<th>Milestone 4 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR</th>
<th>Milestone 7 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline/Goal</strong>: Implement an early warning system (MEWS) for sepsis on medical/surgical inpatient units in order to streamline the process for responding to sepsis and to improve patient outcomes. <strong>Data Source</strong>: Hospital quality</td>
<td><strong>Metric 1</strong> [I-14.1]: Increase use of electronic MEWS by nursing staff</td>
<td><strong>Metric 1</strong> [I-14.1]: Increase use of electronic MEWS by nursing staff</td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $89,274.50</td>
<td>Goal: 10% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 300 additional screenings)</td>
<td><strong>Goal</strong>: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 450 additional screenings)</td>
</tr>
<tr>
<td><strong>Data Source</strong>: hospital EMR reports</td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
</tr>
</tbody>
</table>

#### Year 3 (10/1/2013 – 9/30/2014)

| Milestone 3 Estimated Incentive Payment: $87,423 | Milestone 7 Estimated Incentive Payment: $89,608.66 | Milestone 8 Estimated Incentive Payment: $72,085 |

#### Year 4 (10/1/2014 – 9/30/2015)

| Milestone 6 Estimated Incentive Payment: $89,274.50 | Milestone 8 Estimated Incentive Payment: $72,085 |

#### Year 5 (10/1/2015 – 9/30/2016)

| Milestone 7 Estimated Incentive Payment: $89,274.50 | Milestone 9 Estimated Incentive Payment: $72,085 |

#### Milestone 8 [I-14]: Measure efficiency – initiate CPOM for Sepsis

**Metric 1** [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock

**Goal**: 95% (estimate 81) of patients with suggestion of severe sepsis will have lactate level drawn

**Data Source**: EMR

**Milestone 8 Estimated Incentive Payment**: $72,085

#### Milestone 9 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR

**Metric 1** [I-14.1]: Increase use of electronic MEWS by nursing staff

**Goal**: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 450 additional screenings)

**Data Source**: hospital EMR reports

**Milestone 9 Estimated Incentive Payment**: $72,085
<table>
<thead>
<tr>
<th>020811801.2.1</th>
<th><strong>2.8.11</strong></th>
<th><strong>2.8.11</strong></th>
<th><strong>SEPSIS</strong></th>
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<tbody>
<tr>
<td></td>
<td>CHRISTUS Spohn Hospital Beeville</td>
<td></td>
<td>020811801</td>
</tr>
</tbody>
</table>

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

- **020811801.3.3**
- **IT-4.8**
- **Sepsis Mortality**

**Year 2 (10/1/2012 – 9/30/2013):**
- Documentation, sepsis dashboards
- Milestone 2 Estimated Incentive Payment (**maximum amount**): $87,423

**Year 3 (10/1/2013 – 9/30/2014):**
- Over DY2 baseline (approximately 150 additional screenings)
- Data Source: hospital EMR reports
- Milestone 5 Estimated Incentive Payment: $59,608.67

**Year 4 (10/1/2014 – 9/30/2015):**

**Year 5 (10/1/2015 – 9/30/2016):**

**Year 2 Estimated Milestone Bundle Amount:**
- (Add incentive payments amounts from each milestone): $174,846

**Year 3 Estimated Milestone Bundle Amount:**
- $178,826

**Year 4 Estimated Milestone Bundle Amount:**
- $178,549

**Year 5 Estimated Milestone Bundle Amount:**
- $144,170

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**  
(Add milestone bundle amounts over DYs 2-5): $676,390
Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Beeville/ TPI 020811801

Unique Identifier - 020811801.2.2

- CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

- Intervention(s): This is a large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors, and will require integration between Pharmacy, Information Technology (IT) and Nursing. The project will result in all doses of medications given to patients in Spohn’s Beeville locations having viable barcodes that are read into the Meditech informatics system.

- Need for the project: Spohn’s present medication management system entails a completely manual system from order to medication administration. Medication reconciliation is a cumbersome process upon admission and discharge, as well as during transfers between levels of care. An improvement in the coordination between departments, availability and use of technology, and training on best practices will reduce the risk of hospitalized patients receiving improper dosages, duplicative medication administration, and/or overdoses. Spohn’s annual medication errors totaled 225 for errors reported in 2011. Medication administration specific errors accounted for 53% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. Additionally, audits can be run through the automated system to provide a better picture of opportunities for improvement and continuous quality improvement. Additionally, the barcoding will enable more efficient medication reconciliation upon discharge, and will be coupled with an initiative to provide more patient consultations by clinical pharmacists prior to discharge.

- Target population: The target population of this project is all inpatients and outpatients treated in Spohn’s Beeville facility, which amount to approximately 17,889 patients in FY2012 (1,613 inpatients; 11,849 ED patients), 50.6% of which are uninsured or Medicaid-eligible (combined). There are approximately 57 RNs and 2 pharmacists in the facility who will be trained in the BMV process. Those providers administer approximately 200,000 doses of medication to patients annually. Currently, only 10% of inpatients receive consultations by clinical pharmacists prior to discharge (approximately 161 patients).

- Category 1 or 2 expected patient benefits: Spohn expects to achieve 90% adherence to the barcoding system by the end of DY3, for 70% of inpatients to receive medication reconciliation upon discharge (expected to impact 1,129 patients), and for 30% of inpatients to receive in-person counseling from the clinical pharmacists prior to discharge; approximately 484 inpatients annually by DY5. This improvement will benefit the hospital-wide health outcomes for patients who receive medication as inpatients in Spohn’s Beeville facility.

- Category 3 outcomes: IT 4.10 - Medication Errors. By DY5, Spohn expects a 15% reduction in bedside medication administration errors in its Beeville facility, due to the implementation of the barcode system for medication management. IT4.10 – Average Length of Stay. By DY5 Spohn expects a 10% increase in RN/Clinical Pharmacist utilization review for high risk patients and those patients receiving medications identified as high risk for medication errors. IT4.10 – Cost Savings. By DY5 Spohn expects to implement a Cost Minimization Analysis (CMA) to
demonstrate cost savings in care delivery associated with medication management utilization review in high risk patients, specifically long-term treatment patients eligible for Intravenous (IV) home infusion therapy.
Implementation of Bedside Medication Verification (BMV) Process

*Project 2.11: Conduct Medication Management*

*Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.*

CHRISTUS Spohn Hospital Beeville/ TPI 020811801
Unique Identifier - 020811801.2.2

**Project Description:**
This is a large scale project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. The project requires integration between Pharmacy, Information Technology (IT) and Nursing. All doses of medications must have a viable barcode that is to be read into the Meditech informatics system. It should be noted that many medications arrive in a pharmacy in the form of bulk bottles (approximately 30% of inventory). These bulk bottles must then be repackaged into individual units of use which contains the barcode that is used to verify the correct medication. The repackaging of this medication requires high reliability standards. Given this requirement, Spohn determined that the majority of these medications should come from one site in order to reduce variability. Establishment and implementation of a central site of distribution from which most drugs will be administered is a key requirement of the process that must precede the successful transition to a bedside verification system. Another challenge is the fact that this process requires all nurses to have a computer available to them at all times in order to scan the patients’ arm band and the medication being administered, as well as documenting the administration into an electronic medication administration record (eMAR). Spohn conducted a feasibility study to calculate the number of personal computers necessary, and determined that additional safety features are needed to ensure scanning of patient ID bracelets versus patient labels or stickers generated on the care delivery units. These labels are known shortcuts reported in the nursing and pharmacy literature due the increased difficulty with scanning the patient’s ID bracelet. Unique printers with the ability to generate a 2D barcode, similar to those barcodes now seen in advertising and various industries, provides the additional security against medication errors by ensuring the scan occurs at the point of care. These 2D barcodes contain additional patient-specific information not available in current barcoding.

Spohn will develop guidelines to incorporate the 2D barcoding into practice to ensure the most efficient location of 2D barcode printers and protection of private health information. The barcoding process will streamline the administration of medication, and will implemented in tandem with all facilities targeting an improvement in the number of patients receiving in-person consultations from clinical pharmacists regarding their medications prior to discharge. Additionally, whether or not patients receive an pharmaceutical consultation, patients’ medications that need to be continued, discontinued, and/or changed upon discharge will be reconciled by the providers upon discharge from the inpatient setting.

The fact that this project represents a dramatic paradigm shift for Spohn means that, adequate training of both nursing staff and nursing staff is major priority. For this requirement, Spohn will designate super user groups to provide much of the hands on training of all staff.

Medication errors are associated with a significant number of deaths. The literature estimates that 70% of fatal medication errors were preventable and the cost of $4,000 - $8,000 associated with
medication errors that reach the patient (IHI; *To Err is Human*). The right medication must be given to the right patient, at the right time, in the right dosage and via the right route. Errors in any of these stages can lead to serious consequences. By requiring a barcoded step to verify right patient, right medication and implementing an electronic medication administration record (eMAR) that confirms the right time, many of these errors can be avoided.

Implementation of an intra-disciplinary case management/utilization review program at point-of-entry coupled with the barcoding process and increase in the number of patient consultations with clinical pharmacists, Spohn can assure that patients’ medications are safely administered in the hospital and safely managed by patients upon leaving the hospital. Spohn will evaluate reductions in average length of stay and cost savings in care delivery using Cost Minimization Analysis (CMA) for BMV, clinical pharmacist consultation and utilization review.

**Goals and Relationship to Regional Goals:**
The goal of this project is to implement the use of a barcoding system that clinicians can use to identify and document the administration of medications for all hospitalized patients. The expansion of this program will include the documentation not only at the bedside but at the point of entry into the system. When Pharmaceuticals arrive for use into the hospital region they will documented for tracing purposes so that any safety recalls can be monitored and further provide a save mechanism for our pharmacy professionals. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Regional opportunities for providers include the decrease in preventable complications and further the reduction in cost of care for the community we jointly serve. Medication Management is crucial in the decrease in cost of care, reductions in length of stay and in the compilation of data that physicians can use to assure that electronic data is reliable and safe.

**Challenges:**
The primary challenge will be to engage the physician provider groups with adhering to the use of the new BMV system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success. The success of BMV is directly in support of the CPOM system. The reduction in transcription errors will provide for a more reliable use of medication administration. With the implementation of the Meditech “Unity” standardization project, the BMV project will leverage both standards and advanced clinical technology to enhance patient safety, reduce medication administration errors, and reduce the overall cost of providing services.

**Starting Point/Baseline:** Prior to implementing the BMV program, Spohn providers administered medications from handwritten orders. Those handwritten orders were scanned to the Pharmacy department, which then manually transcribed the orders into a pharmacy-specific computer.
application. Simultaneously, the RN on duty manually entered the medication ordered onto the patient’s Medication Administration Record (MAR). The RN then used the MAR to withdraw the meds entered by the pharmacy from the electronic dispenser and administer that medication to the patient. This process allowed for administrative errors because RNs would often pull several patients’ medications at a time and then mis-administer the medications by failing to verify the patient identifiers. At midnight each night, a new MAR was printed for each patient, and the RN had to reconcile the new MAR with the previous day’s MAR and verify any changes order in the last 24 hours. The BMV process will allow the pharmacy to use the Medi-tech module that is connected with the patients’ EMR. Additionally, the pharmacy will not do any manual transcription of orders into the system. The BMV program also allows RNs to access eMAR instead of individual paper-versions of patients’ prescriptions and the bar-coding technology provides a safety feature to assure that the patient receives the correct medication and dosage. Clinical Pharmacists consulted on approximately 161 (10%) inpatient discharges during FY12. The intra-disciplinary Utilization Review Program will be initiated as a result of the reduction in average length of stay and cost savings in care delivery identified with Bee County charity care.

Rationale:
Spohn chose this project with the goal of reducing the possibility for errors in delivering medication at its facilities, improving its system for medication reconciliation upon discharge, and enabling patients to safely manage the medications they must continue upon discharge. At the hospital level, many medications are purchased and/or delivered in bulk, creating opportunities for either mislabeling or dispensing errors, which could result in unintended health complications. To reduce the possibility of such inadvertent errors, and to improve the management of delivery of medication, Spohn will implement a new medication management system to improve the delivery of medication and instructions to patients. By matching barcodes on medications with patients, the BMV system will allow multiple healthcare professionals to understand and deliver the proper medication to patients, reducing the risk of errors and improving the overall health of the patient population, consistent with the goals of the Waiver.

When patients are discharged, it is important to reconcile their medications to the amount/type required when transitioning from an inpatient to an outpatient. Part of this process can be done electronically, but Spohn also believes that more patients need in-person consultations from clinical pharmacists so they can effectively administer and manage their medications at home, and can avoid contraindicated medications that may be prescribed by another physician or purchased over the counter.

Milestones and Metrics: Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project and incentivize reductions in medication error rates, which will achieve the goals of the Waiver.
**Community Needs Addressed by the Project:** Spohn’s annual medication errors totaled 225 for errors reported in 2011. Medication administration specific errors accounted for 53% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. The target population of this project is all inpatients in Spohn’s Beeville facilities, 28% of which are uninsured or Medicaid-eligible.

**Community Needs Addressed by Identification Number:**
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

**Project core components:**
a. Spohn will develop a system to ensure this project is implemented first to acute care patients at its hospital facilities, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented in DY 2 through Milestone 1.
b. The system will include tools to provide education and support to patients in acute settings to reduce risk of medication errors, and will be implemented in DY2 through Milestone 1.
c. In the first year of the Waiver (DY1) Spohn performed an analysis of the root cause of potential medication errors and identified repackaging as one area of concern. To that end, the project plan will include the processes Spohn has identified to address the repackaging steps to reduce error rates.
d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 4 specifically).

**Related Category 3 Outcome Measure(s):**
OD – 4 Potentially Preventable Complication and Healthcare Acquired conditions.
IT-4.10 Other Outcome Improvement Target:
• Decrease in errors in Bedside Medication Administration
IT-4.10 Other Improvement Target:
• Average length of stay for high risk patient and patients receiving medications identified as high risk for medication errors
IT-4.10 Other Improvement Target:
• Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review using Cost Minimization Analysis.

Spohn chose this outcome because this project to implement electronic medication management and involve the clinical pharmacists in medication management is expected to reduce the patient fall rate by allowing the pharmacists and providers to take proactive steps to avoid falls caused by a medication-induced altered state (by either changing the medication or monitoring patients at risk more closely).

**Relationship to Other Performing Providers’ Projects in the RHP:**
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project
is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7. - Medication Management to reduce medication administration errors.


Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

1. Achieves Waiver Goals. This project directly relates to assuring quality of care, improving the health of patients and reducing costs of care by removing opportunities for medication management errors for all patients, including the low-income and underserved patients. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. Addresses Community Need(s). Although medication mismanagement was not an identified community need, improvements that reduce opportunities for errors help to reduce the community’s need for costly procedures following medication errors and can help to reduce the high level of chronic disease in the community.

3. Population Served. Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve and found that improvements in medication management will serve most patients receiving care at Spohn’s facilities.
4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects. 69

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn ensured that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

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69 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1** [P-1]: Implement a medication management system; bedside medication verification with barcoding (BMV)

**Metric 1** [P-1.1]: Program documentation for people, processes and technology

**Baseline/Goal**: Implementation of BMV at CSHB

**Data Source**: Written medication management plan including workflow for providers

Milestone 1 Estimated Incentive Payment: $55,633

**Milestone 2** [P-X]: Identify shortcuts and work-arounds to improve efficiencies w BMV processes

**Metric 1** [P-X.1]: Evaluate, modify BMV processes to eliminate identified work-arounds.

**Baseline/Goal**: Review BMV processes 6 months post-implementation to identify work-arounds.

**Data Source**: Staff input, variance reports, medication error investigations

Milestone 2 Estimated Incentive Payment: $55,633

**Milestone 3** [I-13]: Implement electronic medication reconciliation at the point of care

**Metric 1** [I-13.1]: Increase the number of patients that receive electronic medication reconciliation at the point of care

**Goal**: 25% use of electronic medication reconciliation for inpatients of the facility

**Data Source**: EMR

Milestone 3 Estimated Incentive Payment: $56,899

**Milestone 4** [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions

**Metric 1** [P-9.1]: Number of new ideas, practices, tools or solutions tested.

**Baseline/Goal**: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement

**Data Source**: FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions

Milestone 4 Estimated Incentive Payment: $113,622

**Milestone 5** [I-14]: Provide reconciliation of medications at discharge **Metric 1** [I-14.1]: Increase the percent of identified patients that have medications reconciled as a standard part of the discharge process

**Goal**: 90% compliance with medication reconciliation upon discharge (expected to impact 1,129 patient annually)

**Data Source**: EMR

Milestone 5 Estimated Incentive Payment: $91,744

**Milestone 6** [I-15]: Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting.

**Metric 1**: % of patients receiving consultation by clinical pharmacists

**Baseline/Goal**: Currently, an estimated 10% (or 161 in 1,613) of inpatients in the facility receive consultation from the clinical pharmacists upon discharge. Spohn will increase that percentage by 20% to achieve a 30% total number of inpatients receiving consultations (or 484 in 1,613) from clinical pharmacists upon discharge by the end of DY5.

**Data Source**: Patient EMR

Milestone 6 Estimated Incentive Payment: $91,744

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Errors in Bedside Medication Administration; Average length of stay for high risk patients and patients receiving meds at high risk for error; Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.
<table>
<thead>
<tr>
<th>020811801.2.2</th>
<th>2.11.1</th>
<th>2.11.1.A,B,C,D</th>
<th>Implementation of Bedside Medication Verification (BMV) Process</th>
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<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Beeville</td>
<td>020811801</td>
<td></td>
<td></td>
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</table>

**Related Category 3 Outcome Measure(s):**
- 020811801.3.4
- 020811801.3.5
- 020811801.3.6
- 3.IT-4.10
- 3.IT-4.10
- 3.IT-4.10

**Errors in Bedside Medication Administration; Average length of stay for high risk patients and patients receiving meds at high risk for error; Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment: $56,899</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $111,266</td>
<td>Year 3 Estimated Milestone Bundle Amount: $113,798</td>
<td>Year 4 Estimated Milestone Bundle Amount: $113,622</td>
<td>Year 5 Estimated Milestone Bundle Amount: $91,744</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $430,430*
Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.

CHRISTUS Spohn Hospital Beeville/ TPI 020811801
Unique Identifier - 020811801.2.3

- CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.
- **Intervention(s):** CHRISTUS Spohn Hospital Beeville (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech.
- **Need for the project:** By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges. Spohn typically has 10,000-20,000 encounters in its hospital facilities per year, and approximately 8-10 orders are entered per encounter per day. With such a high volume of orders for a large number of patients, the need for a faster, safer, and more efficient system is great.
- **Target population:** According to our most recent data (Nov 2012), Spohn is supported by over 40 providers, 80% of which will use this advanced clinical technology. The target population of this project is all inpatients and outpatients treated at Spohn, which amount to approximately 17,889 patients in FY2012 (1,613 inpatient, 11,849 ED patients), 50.6% of which are uninsured or Medicaid-eligible (combined). **Category 1 or 2 expected patient benefits:** By DY5, Spohn expects 75% of orders placed by providers for inpatients in acute care settings to be ordered electronically; 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter to be generated electronically; and 60% of prescriptions written to ED patients upon discharge will be generated electronically.
- **Category 3 outcomes:** IT-4.10 – By DY5, Spohn expects 85% compliance for VTE Prophylaxis Core Measure Indicators in its Beeville facility.
Computerized Physician Order Management (CPOM)  
**Category 2: Program Innovation and Redesign**  
**Project 2.11: Conduct Medication Management**  
**Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.**  
CHRISTUS Spohn Hospital Beeville/ TPI 020811801  
**Unique Identifier – 020811801.2.3**

**Project Description:**
CHRISTUS Spohn Hospital Beeville (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech. By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) Increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.

**5 Year Expected Outcome**
Through implementing the CPOM system, Spohn expects the following outcomes:

1) 75% electronic system adherence by providers placing orders/prescriptions for inpatients in the acute care setting by the end of the Waiver
2) 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter generated electronically by the end of the Waiver
60% of prescriptions written for ED patients upon discharge generated electronically by the end of the Waiver

**Goals and Relationship to Regional Goals**
This project is intended to internally upgrade the hospital’s management of information in a manner which upholds strategic safety initiatives and technological changes in healthcare. The use of electronic order entry communication and standards of practice by prescribing providers will allow for a safer order entry methodology and fewer medication transcription errors. Spohn will accomplish patient safety through order entry as the provider becomes integrated into the reliability process of care management. The extension and continued process improvement of order entry will formulate the basis for a comprehensive patient medical record that in the end help with data sharing between provider through an HIE network, allowing accountability in the care management between regional healthcare providers in the Region.

The project is related to Regional goals in that it is completely patient centered. The use of an electronic order system provides additional assurance that patients are provided treatment tailored to their individual health needs and adds safeguards against human error. Additionally, the expected reduction in medication transcription errors will reduce the cost of such mistakes, and improve patient satisfaction and quality of life.
**Challenges:**
The primary challenge will be to engage the physician provider groups to adhere to the use of this new CPOM system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success.

**Starting Point/Baseline:**
The U.S. Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) has mandated that US healthcare providers make efforts towards achieving participation in electronic health initiatives. To that end, healthcare provider organizations are encouraged to meet several measurement criteria over the course of time. The ultimate goal of meeting these criteria is to (1) Improve access to healthcare nation-wide, (2) Improve clinical outcomes and the patient experience, and (3) Decrease the cost of healthcare. By implementing CPOM, Spohn will meet HHS/CMS goals and improve the overall health of the 1.5 million inhabitants of South Texas we serve.

According to our most recent data (Nov 2012), Spohn Beeville is supported by over 40 providers, 80% of which will make use of this advanced clinical technology. Spohn’s annual medication errors totaled 225 for errors reported in 2011. Medication transcription specific errors accounted for 6% of the total reported, which is a statistic that can be minimized by CPOM. Based on the nearly 10,000 – 20,000 typical annual encounters (based on FY-12 statistics w approximately 14% being Medicaid and uninsured) within the region, the impact will be realized extensively throughout our Spohn Beeville service area. Based on the project implementation timeline, FY-12 data will be used as the initial baseline data. Currently, orders and prescriptions are written on paper and entered into the hospital system manually by nurses, which can lead to transcription errors, is inefficient, and allows some orders/medications that could be automatically entered to be missed.

**Rationale:**
Spohn has chosen Meditech as its primary health information system. As the leading nation-wide, fully integrated system, Meditech offers the ability to directly interface multiple aspects and processes from the patient care continuum. As such, when moving to CPOM, Spohn will facilitate quick recall of consistent information from not only orders, but also lab results, diagnostic images, medication management and reconciliation, and numerous other clinical areas. Additionally, through our Novo interface engine, Spohn offers local, secure access to providers’ patient data, further streamlining the patient care process. While Meditech is a solid, cost effective solution, preparation for the deployment of CPOM, an advanced clinical process supported by technology, does not come without a significant financial investment (discussed below in “enabling projects”).

Project components and phases – As in most any major technology enabled project, CPOM consists of several phases. While some of these phases are executed concurrently by function and/or location, each is key to the successful completion of the project. In summary, the project phases include System Design and Set-up, System Build, Testing – including unit and integrated testing, Super User and End-user Training, System “Go-Live”, and post “Go-Live” support.
Unity – The Meditech “Unity” project was completed in February 2012 in preparation for the CPOM project. The Unity project required the upgrade and standardization of the Meditech application to version 5.6.4 throughout the entire CHRISTUS Health System. Achieving this standard enabled enterprise wide maintenance and support, faster turnaround on system issues, and streamlined process changes.

Network upgrade – In conjunction with the Unity project, CHRISTUS Health conducted network upgrade and server standardization. Consolidating the physical and virtual server environments to the CHRISTUS Health Information Technology Center (ITC) in San Antonio, Texas enabled several of the support improvement mentioned about. Additionally, by elimination much of the regional and local data center support operations (nine regions and numerous locally supported file servers), CHRISTUS Health was able to husband the financial resources necessary to fund this multi-million dollar enabling project.

Wireless Infrastructure Upgrade – Prior to October 2011, the CHRISTUS Spohn Health System maintained approximately 100 Wireless Access Points (WAPs) in six hospitals. These devices enabled secure wireless access to the CHRISTUS Spohn computer network and associated applications. However, while access was sufficient for most unit based systems and devices, it was insufficient to handle the additional capacity and mobile nature of the devices and systems required for an advanced clinical program such as CPOM. Accordingly, in October of 2011, CHRISTUS Health completed a comprehensive analysis and upgrade of its wireless infrastructure. The number of WAPs were increased to over 200 and existing WAPs were upgraded or replaced with newer models capable of handling the increased mobile device requirements of CPOM.

Equipment technical refresh (New Clinical Workstations) – In order to ensure adequate PC resources by each unit’s support staff, CHRISTUS Health has recently upgraded over 500 PC’s throughout the SPOHN Health System. Priority of technical device refresh has been to clinical areas and supporting ancillary areas.

CPOM Specific Equipment Deployment – While support staff (nurses, unit clerks, techs in the OR, Post-op, lab, pharmacy, radiology, and other key areas) have received new PCs, the providers are getting additional PC resources specifically supporting individual order entry, medical record recall, and test results access. Using a combination of CHRISTUS Health standards and national best practice PC configuration analysis, CHRISTUS Spohn is deploying 325 additional devices for providers. These devices consist of a combination of 200 advanced desktop PCs for static, unit based clinical documentation and 125 mobile PCs of “PDOCs” (Provider Documentation Stations) that may be used during provider rounding on multiple units. In addition to PCs and mobile stations deployed for provider documentation, CHRISTUS Spohn Health System is also providing instruction and configuration assistance for individual provider personal devices (e.g. iPads, iPhones – iOS supported devices and HTC Flyer, Android Phones and other Android OS support devices) to access the CHRISTUS network.

PC Operating System Upgrade (Windows XP SP3 to Windows 7 SP1) – In order to take full advantage of Meditech’s CPOM capability as well as other interfaced systems (PACS, Pharmacy, Health Information Management, etc.), CHRISTUS Health is upgrading the standard PC operating system from Microsoft Windows XP (Service Pack 3) to Windows 7 (Service Pack 1). This upgrade will be complete prior to the completion of the CPOM project.

Milestones and Metrics: Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize
the extension and implementation of the project through its physician network and incentivize use of the CPOM system, which will achieve the goals of the Waiver.

**Community Needs Addressed by this Project:** According to Spohn’s most recent data (Nov 2012), Spohn is supported by over 40 providers, 80% of whom will make use of this advanced clinical technology. Based on Spohn’s 10,000-20,000 typical annual encounters (based on FY-12 statistics, with approximately 14% being Medicaid and uninsured) within the region, the impact will be realized extensively throughout our Spohn Beeville service area.

**Community Needs Addressed by Identification Number:**
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

**Project Core Components:**
a. Spohn will develop a system to ensure this CPOM project is implemented first to acute care patients at its facility, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented in DY 2.
b. The system developed in DY2 will include tools to provide education and support to patients in acute settings to reduce delays in implementing orders and possible errors in interpreting or transcribing orders, and will be implemented in DY2.
c. Spohn has already undertaken in the first year of the Waiver (DY1) an analysis of physician order implementation and identified transcription errors and delays as one area for improvement. To that end, the project plan will include the processes Spohn has identified to remedy the transcription errors and delays by having the physician enter the orders directly.
d. Throughout the performance of the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 3 specifically).

**Related Category 3 Outcome Measure(s):**
OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 Compliance with VTE Prophylaxis Core Measures

**Reasons for selecting the outcome measures:**
Spohn is continuously improving its CPOM services with the goal of reducing variations in the delivery of services based on delayed or misinterpreted physician orders. Spohn has low compliance in CMS VTE Prophylaxis Core Measure indicators placing patients at risk for VTE during hospitalization, a potentially preventable complication. The use of CPOM is expected to improve Spohn’s percentage of compliance and reduce potentially preventable complications for VTE in Spohn’s facility.

**Relationship to Other Performing Providers’ Projects in the RHP:**
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the
process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7. Medication Management to reduce medication administration errors.

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We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

1. **Achieves Waiver Goals.** This project directly relates to assuring quality of care, improving the health of patients and reducing costs of care by removing opportunities for physician order delays or errors for all patients, including the low-income and underserved patients. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Although physician order entry implementation was not an identified community need, improvements that reduce opportunities for delays and errors in receiving proper care help to reduce the community’s need for inconsistent care and can help to reduce the high level of chronic disease in the community.

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve, and found that improvements in physician order implementation will serve most patients receiving care at Spohn’s facilities.
4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects.\(^\text{70}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project was valued, Spohn ensured that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

\(^{70}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Implement a medication management system</td>
<td><strong>Milestone 3</strong> [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions</td>
<td><strong>Milestone 5</strong> [I-18]: CPOE utilization measure</td>
<td><strong>Milestone 7</strong> [I-12]: Implement electronic prescription writing at the point of care</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-1.1]: Program elements to include document of program, people and technologies required to implement system</td>
<td><strong>Metric 1</strong> [P-9.1]: Number of new ideas, practices, tools or solutions tested.</td>
<td><strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient</td>
<td><strong>Metric 1</strong> [I-12]: Increase number of new and refill prescription written and generated electronically</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Implementation team and Infrastructure in place for CPOM/Med Mgmt. Go-Live</td>
<td><strong>Baseline/Goal</strong>: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement</td>
<td><strong>Goal</strong>: 75% of orders in the acute care setting are entered electronically</td>
<td>Numerator: number of new and refill prescriptions written and generated electronically</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Implementation plan with team, infrastructure and processes documentation</td>
<td><strong>Data Source</strong>: FAQs, Up-To-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions</td>
<td><strong>Data Source</strong>: EMR reports, hospital informatics reports and audits documentation</td>
<td>Denominator: number of new and refill prescriptions written in a specific time period</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $55,633</td>
<td>Milestone 3 Estimated Incentive Payment: $56,899</td>
<td>Milestone 5 Estimated Incentive Payment: $ 56,811</td>
<td><strong>Baseline/goal</strong>: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-7]: Implement CPOM to allow providers to enter medical orders directly via computer, replacing the more traditional paper, verbal, telephone and fax methods</td>
<td><strong>Milestone 4</strong> [I-18]: CPOE utilization measure</td>
<td>Milestone 6 Estimated Incentive Payment: $56,811</td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong>: $45,872</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Create a system to implement CPOM</td>
<td><strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient</td>
<td></td>
<td><strong>Milestone 8</strong> [I-17]: Increase the number of patient visits for which a medication is prescribed that have medication reconciliation and prescription generation performed electronically</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Transition at least 50% of physician orders to electronic order entry</td>
<td><strong>Goal</strong>: 60% of orders in the acute care setting are entered electronically</td>
<td></td>
<td><strong>Metric 1</strong>: Percent of patient visits at which a medication was prescribed that had medication reconciliation and prescription generation performed electronically.</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Patient medical records and EMRs, Hospital informatics utilization reports</td>
<td><strong>Data Source</strong>: EMR reports, hospital informatics reports and audits documentation</td>
<td></td>
<td>Numerator: number of ED visits where medication is prescribed electronically to patient’s pharmacy</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $55,633</td>
<td>Milestone 4 Estimated Incentive Payment: $56,899</td>
<td>Milestone 6 Estimated Incentive Payment: $56,811</td>
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</tr>
<tr>
<td>020811801.2.3</td>
<td>2.11.2</td>
<td>2.11.2.B</td>
<td>COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)</td>
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<td></td>
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<td>CHRISTUS Spohn Hospital Beeville</td>
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<tr>
<td></td>
<td>020811801.3.7</td>
<td>3.IT-4.10</td>
<td>Compliance with VTE Prophylaxis Core Measure Indicators</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: number of ED visits where medication is prescribed</td>
<td></td>
<td></td>
<td>Denominator: number of ED visits where medication is prescribed</td>
</tr>
<tr>
<td><strong>Baseline/goal:</strong> 60% of prescriptions written in ED are submitted electronically</td>
<td></td>
<td></td>
<td><strong>Baseline/goal:</strong> 60% of prescriptions written in ED are submitted electronically</td>
</tr>
<tr>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $45,872</td>
<td></td>
<td></td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $45,872</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $111,266

**Year 3 Estimated Milestone Bundle Amount:** $113,798

**Year 4 Estimated Milestone Bundle Amount:** $113,622

**Year 5 Estimated Milestone Bundle Amount:** $91,744

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $430,430*
Expand Care Transitions Program; 2.12.2
CHRISTUS Spohn Hospital Beeville/020811801
Unique project ID number: 020811801.2.4

- CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital serving a 2,666 square mile area and a population of approximately 108,346. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

**Intervention(s):** This project will expand Spohn’s Care Transitions program to focus on preventing readmissions for CHF and diabetes patients at Spohn’s Beeville campus. Under the expansion, the RN Coach is the centerpiece of the program, and will function as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The RN Coach will facilitate the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit, the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge.

- **Need for the project:** Spohn’s Memorial campus launched the Care Transitions program in 2011 to target chronically ill charity patients for transition to self-management; however the scope for the first year was limited to 237 patients with a myriad of conditions. Chronic Heart Failure (CHF)-targeted Care Transitions is needed at Spohn Beeville because CHF is the second most prevalent primary diagnosis in Region 4 and the most costly for potentially preventable readmissions (PPR). Spohn Beeville has a 19.3% PPR rate for CHF; higher than the statewide average of 12.7%.

- **Target population:** The target population includes CHF and diabetes patients treated as inpatients at Spohn’s Beeville campus who are Medicaid/self-pay/charity eligible. In FY2012, Spohn treated approximately 67 patients with CHF or diabetes, of which 20 (30%) were Medicaid/uninsured (the majority of the 67 (49%) were Medicare patients).

**Category 1 or 2 expected patient benefits:** By the end of DY3, Spohn expects to have fully implemented the CHF and diabetes-targeted Care Transitions program for Beeville for all Medicaid/self-pay/uninsured patients by the end of DY5. **Category 3 outcomes:** IT-3.2 – As a result of implementing the CHF-targeted Care Transitions at Beeville, Spohn expects an 8% reduction in CHF 30-day readmission rates in the Beeville facilities.
Identifying Project and Provider Information:
Expand Care Transitions Program: 2.12.2
CHRISTUS Spohn Hospital Beeville/020811801
Unique project ID number: 020811801.2.4

Project Description:
The Care Transitions program addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program. Frequently healthcare delivery is fragmented, lacks communication among providers and hospitals, and patients do not know how to access care or navigate the healthcare system. A reoccurring theme identified during the course of the program involved clients who did not understand how to manage their disease and discharged unprepared for the transition to the home setting. They are overwhelmed by their healthcare needs. This program is designed to empower patients and their families to become active shareholders and to promote quality healthcare in the community for the chronically ill. This expansion is in keeping with CHRISTUS Health’s commitment to creating healthier communities while reducing costs to the health care system.

The RN Coach is the centerpiece of this program, and functions as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The patient and caregiver are coached to play a central and active role in the formation and execution of the plan of care. The RN facilitates the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge. The four conceptual domains are introduced to the patient, by the RN Transitions Coach, commonly referred to as the 4 Domains or Pillars of care:

1. Medication self-management and medication reconciliation
2. Use of a dynamic patient-centered record, the Personal Health Record [PHR]
3. Timely primary care / specialty care follow-up
4. Knowledge of red flags that indicate a worsening in condition and how to respond

The target population includes patients with high risk discharge conditions, multiple medications, and the chronically ill. Program goal is to improve patient outcomes, maintain quality, and assist the patient and caregivers with the transition from hospital to home. Care Transitions provides patients with the tools and support to promote self-management, improve communication between patient and the primary Care Physician; reducing preventable hospital readmissions.

At discharge the patient has a support team, comprising of an RN Transition Coach, a Community Health Worker, and caregiver with the patient as an active participant in recovery. This is a uniquely designed program which has demonstrated great success.

As patients successfully transition from hospital to home care with the assistance of the Care Transitions model, they will also receive an additional 18 months of support and self-management training from a certified community health worker. The Care Management/Care Partner program is a self-management support program, facilitated by a specially trained community health worker working under the direct supervision of a registered nurse. This is the systematic provision of
education and supportive interventions to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress, goal setting, and problem solving support.

**Project Goals:**

- Implement the Care Transitions program for all Medicaid/uninsured/self-pay patients by DY5
- Reduction in avoidable CHF 30-day readmissions by 8% by DY5.
- Begin case management and discharge planning early; targeting high-risk patients and coordinate care.
- Improved care transitions from hospital to home; avoiding deterioration in health status, which often occurs upon discharge.
- Integrate hospital and outpatient care.

**Project Challenges:**

- Communication between inpatient and outpatient/community providers.
- Technology to support communication and electronic referrals.
- Potential enrollee’s may opt out of participating with Care Transitions Program.
- Barriers to care such as; financial, socioeconomic, and availability to providers.

Spohn will address these challenges by thoughtfully creating a plan to effectively communicate with patients and their caregivers about next steps and to establish a trusting, cooperative relationship. Providers will be trained to use the technology associated with the program. Finally, patients will be educated and encourage participating in the program, and the providers will work with clients to address financial and other barriers to participation.

**5 Year Expected Outcome**

The Care Transition Program has been in place on a small scale throughout the CHRISTUS Health System for over a year. Large amounts of research are now being published on the benefits and results of Care Transition Programs in Chronic Disease Management. Our 5-yr plan is to expand current Care Transition program coverage across diagnoses and payors. Despite our specific target for Medicaid, charity patients, and the uninsured, we have a responsibility to our community to provide the services for commercial payors that do not cover such programs or hold those that do to the same level of expectations.

Our plan is identified on the project timeline (2.12.1 Table) and consists of expansion beginning with CHF Key to program success is continuous evaluation and targeted on-going improvement that will minimize inefficiencies and promote effective patient outcomes.

**Starting Point/Baseline:**

The CHRISTUS Spohn Community Outreach Program launched the Care Transitions Program in 2011 to assist charity care recipients with chronic diseases to transition from in-patient care to home self-management. Quarterly metrics demonstrate the effectiveness of the Care Transition and Care Partners program collaboration.

The thirty-three day RN intervention allows patients with complex needs to receive one on one instructions and coaching. In the reporting period, the provider averaged 948 encounters and served
237 patients from program implementation, which began in March of 2011 to the end of reporting period of June 30, 2012. Data is cumulative.

**Rationale:**
Bee County, where Spohn’s Beeville campus provides care, has a high rate of potentially preventable hospitalizations for the following conditions: bacterial pneumonia, congestive heart failure, COPD, and long-term complications related to diabetes (RHP Plan, Section 3, Table 10). Many of these patients have been hospitalized previously, and likely could have avoided subsequent hospitalizations if provided with the requisite support to transition to self-management of their conditions outside of the hospital setting. Additionally, Bee County is designated as a Medically Underserved Shortage Area, which means that patients are not receiving the primary care interventions they need to avoid repeat hospitalizations for manageable conditions (RHP Plan, Section 3, Table 11). The Care Transitions program can assist patients in finding and obtaining the medical support they need when resources are often limited.

The proposed plan is CHRISTUS Spohn Health System’s answer to reducing readmissions for chronically ill patients admitted to the six CHRISTUS Spohn facilities, by implementing the Care Transition and Care Partner Programs already in place at CHRISTUS Spohn Corpus Christi-Memorial. The Care Transitions model is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across health care settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention. The use of specialized teaching tools and red flag rules, allows the patient to learn self-management skills and become an active partner of their healthcare team. Engaging the patient and family to become active partners in their healthcare, has directly impacted re-admission rates in the initial targeted population group at CHRISTUS Spohn Hospital-Memorial. This has resulted in a significant reduction in hospital utilization within the targeted group.

The program can be easily implemented within the CHRISTUS Spohn Region to target disease specific diagnoses within the uninsured, managed care, or Medicare populations. The Care Transitions program has been successfully implemented at various facilities throughout the CHRISTUS Health System, to include St. Michael, St. Frances Cabrini, St. John, and Schumpert St. Mary, Spohn Memorial, and Spohn Shoreline. The average cost of care per client for the CHRISTUS programs regionally ending Q2 FY12 are such successes as pre-enrollment costs at $16,273 with a significant reduction in costs to the post-90 day enrollment cost of $3,425. Results from the current Care Transition program limited to the charity care population at CSHCC-Memorial have had the following impact:

- Cost per case reduction 50%-75% based on site and target diagnoses
- Decreased ED utilization for inappropriate visits stabilized per covered lives volumes
- Average inpatient admission reduction >50% per patient
- ALOS reductions by as much as 1 patient day

**Milestones and Metrics:**
Spohn chose Milestones 1,2, and 3 in order to implement the expansion of the Care Transitions program by first putting processes in place at the new participating facilities, and to share best
practices with other providers taking similar action in Region 4. It is imperative to the success of the program that the expansion plan and implementation includes provider training, consistent policies, and sharing of information. Spohn chose Milestones 4, 5, and 6 in order to put the plans and processes into action, which will include full integration of the Care Transitions program into the standard discharge processes performed by the providers at Spohn’s South and Memorial campuses, and will include increasing participating for patients with targeted dual diagnoses by DY5.

**Ties to Community Needs:** CN.3, CN.4, CN.7, CN.12, CN.16

**Related Category 3 Outcome Measure(s): OD 3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates; Improvement Target 3.3.2 – Congestive heart Failure 30 Day Readmission Rate**

The Care Transition model will target patients admitted to the CHRISTUS Spohn Health System with a diagnosis of CHF. Care Transition nurses along with the medical team will enroll high risk CHF patients meeting program criteria, through admission census reports and daily rounding processes. The RN Transition Coaches and Community Health Workers will form community collaborations to promote healthcare and positively impact preventable hospitalizations for released CHF patients.

**Relationship to Other Projects:** This project’s focus on patient empowerment and education to improve care management of chronically ill patients is related to and will support many projects throughout the region. Primary projects with direct ties to this initiative include: 020811801.2.4 – Expand Care Transitions Program; 121775403.1.3: Implement a chronic disease registry to support and sustain management of patients in care transitions program; and 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care.

Related Category 4 Measures include Potentially Preventable Admissions in RD – 1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**

This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges with lessons learned and obstacles to delivery will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**

The Waiver provides the opportunity for CHRISTUS Spohn Beeville (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:
1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects; to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with regard to its relevance to the goals of the Waiver; specifically, that the Care Transitions program is patient-centered, designed to improve patient outcomes and satisfaction, and should result in a reduction in the constantly growing cost of providing healthcare to the indigent and uninsured residents in Region 4. The project addresses community needs by targeting patients who have recently been released from the hospital and need assistance in order to avoid readmission – this is especially relevant for elderly patients, patients with chronic diseases, or patients who for other reasons have difficulty self-managing their conditions. The investment necessary to expand this program is great, including provider training, creating infrastructure at newly participating facilities, and creatively engaging in patient and community outreach to garner participation and changes in behavior.

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71 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### Related Category 3

**Outcome Measure(s):**
- E, XPAND C, ARE TRANSITIONS PROGRAM
- COVERAGE AREA & DIAGNOSES

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<thead>
<tr>
<th>Milestone 1</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-2]: Implement standardized care transition processes <strong>Metric 1</strong> [P-2.1]: Care transitions policies and procedures <strong>Baseline/Goal</strong>: Implement Care Transition standardization in Spohn's Beeville Facility, meaning consistent standards for eligibility, processes for patient coordination, and provider training— with a focus on CHF and diabetes patients <strong>Data Source</strong>: Care Transitions Policies, Procedures, Protocols Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $238,426</td>
<td><strong>Milestone 2</strong> [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects <strong>Metric 1</strong> [P-10.1]: Number of bi-weekly meetings <strong>Baseline/Goal</strong>: Establish open lines of communications to share learning experiences during 1st year after expansion with other RHP 4 providers – schedule interactions on a regular basis <strong>Data Source</strong>: Meeting minutes/agenda, lessons learned, documented challenges Milestone 2 Estimated Incentive Payment: $243,853</td>
<td><strong>Milestone 3</strong> [[I-14]: Implement standardized care transition program for the CHF and diabetes population <strong>Metric 1</strong> [P-9.1]: Measure adherence to processes <strong>Goal</strong>: Full implementation of CHF and diabetes care transitions program at facility for all (approximately 20) Medicaid, self-pay and charity patients. <strong>Data Source</strong>: Care Transitions documentation, community outreach documentation Milestone 3 Estimated Incentive Payment: $243,475</td>
<td><strong>Milestone 4</strong> [[I-14]: Implement standardized care transition program for the CHF and diabetes population at facility <strong>Metric 1</strong> [P-9.1]: Measure adherence to processes <strong>Goal</strong>: Full implementation of CHF and diabetes care transitions program at campus for all (approximately 25) Medicaid, self-pay and charity patients. <strong>Data Source</strong>: Care Transitions documentation, community outreach documentation Milestone 4 Estimated Incentive Payment: $196,595</td>
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**Year 2 Estimated Milestone Bundle Amount**: $238,426 **Year 3 Estimated Milestone Bundle Amount**: $243,853 **Year 4 Estimated Milestone Bundle Amount**: $243,475 **Year 5 Estimated Milestone Bundle Amount**: $196,595

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add milestone bundle amounts over DYs 2-5*): $922,350
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Beeville / 020811801
Project Unique ID: 020811801.2.5

- CHRISTUS Spohn Hospital – Beeville is a 49-bed hospital in Beeville serving a 460 square mile area and a population of approximately 460,000. It is the only acute care hospital for Bee and neighboring Live Oak and San Patricio counties averaging 7,600 patient days and 2,000 discharges annually.

- Intervention(s): Spohn will implement a screening and treatment protocol in its hospital EDs and Family Health Centers (FHCs) to identify patients with dual diagnoses (medical and behavioral health (BH)) and assign a case manager to coordinate their care. Two medical diagnoses, CHF and Diabetes, will be targeted for screening and identification of co-existing BH illness.

- Need for the project: Currently, Spohn patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 years earlier than those with mental health illness alone mainly due to unmanaged physical health. National studies show that approximately 58% of the adult population suffer from a medical condition and of those, 29% also have unaddressed behavioral health needs. Additionally, people with schizophrenia and bi-polar disorders are up to 3 times more likely to have three or more chronic conditions than people without those disorders.

- Target population: The target population includes all patients presenting to Spohn’s Beeville hospital facilities and all of Spohn’s clinics with a CHF or diabetes diagnosis. A recent 9-month data review of Spohn ED visits with dual diagnoses shows that 97 patients presented with a CHF or diabetes diagnosis, Diabetes, and secondary diagnosis of BH (28% of which were Medicaid eligible/uninsured). The approximate number of patients who presented in the ED with a diagnosis of CHF or diabetes is 247 (39% of which were Medicaid/uninsured, which is approximately 96 patients), and of those 247 patients, 107 presented with Behavioral Health, indicating that only those with a clear presentation of BH were identified. Of the 247 CHF and diabetes patients, 140 were neither screened nor diagnosed for BH.

- Category 1 or 2 expected patient benefits: This project seeks to screen all CHF and diabetes patients for BH issues, and expects to refer 28 (20%) of those previously unscreened/undiagnosed patients to behavioral health specialists by the end of DY4, and expects a 40% of the target population referred to a BH specialist by the end of DY5 (56 patients anticipated).

- Category 3 outcomes: IT-1.9.2 - Spohn aims to reduce the volume of ED visits from CHF and diabetic patients 10% by DY5 due to this project because patients will be screened in the EDs and other treatment settings for BH referrals and will subsequently receive the treatment they need (which Spohn hopes will lead to reduced misuse of the ED).
Identifying Project and Provider Information:
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Beeville / 020811801
Project Unique ID: 020811801.2.5

Project Description:
This project focuses on identification and screening of target populations for co-existing physical and behavioral health diagnoses. Spohn will implement a screening and treatment protocol in its hospital campuses and FHCs to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Spohn believes that identification and screening of these target populations will guide treatment plans for dual diagnoses, which will improve patient outcomes. In addition, identification of dual diagnoses in the acute care setting should improve the initiation of care management, which Spohn projects will impact in-patient outcomes and reduce LOS. Two medical diagnoses, CHF and Diabetes, will be targeted by this project for screening of co-existing BH illness. This screening will be initiated in Spohn’s ED and FHCs to facilitate early referral to a LMHP for further assessment or intervention. Concurrently, Spohn will perform medical screenings in the BH population in outpatient BH settings such as MHMR clinics. This project will be collaboration between Spohn’s Beeville facility, LMHA, and Spohn’s Family Medicine and Emergency Medicine GME programs (wherein residents will be trained and participate in the screening processes).

Project Goals/Five Year Expected Outcome:
The goal of this project is to identify patients with dual diagnoses for behavioral and physical health conditions, and to intervene earlier and more effectively in their treatment and disease management. Spohn aims to reduce the use of the ED by patients with co-diagnoses for treatment and to reduce the amount and duration of preventable inpatient stays for these patients, which should result from proactive screening and earlier treatment intervention organized by case managers/care coordinators. Specifically:

- Spohn intends to implement screening protocols in its FHCs and hospital campuses to identify patients with a dual diagnosis of BH/depression and diabetes or CHF
- Spohn intends to assign these patients to Spohn staff who will act as care coordinators for this population
- Spohn expects a 10% reduction in ED visits for patients with dual diagnoses by the end of DY5
- Spohn expects a 5% reduction in preventable hospital stays for patients with dual diagnoses by the end of DY5

Project Challenges:
- Garnering participation in screening and treatment for chronically ill patients with behavioral health issues
- Educating physician and mid-level providers on effective methods for identifying, screening, and treating patients at risk for dual diagnoses (specifically, BH and CHF or diabetes)
- Hiring/training care coordinators to effectively manage the care of patients with these dual diagnoses

Spohn will address these challenges by engaging in thoughtful planning in DYs 2-3, seeking patient and community input into best practices and patient needs, and will refer to clinical best practices when training care coordinators.
Starting Point/Baseline:
Currently, patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. A 9-month data review of ED visits with dual diagnoses shows:
- 97 with a primary medical diagnoses and 2\textsuperscript{nd} BH;
  - 25\% of those patients were over age 35 and 75\% were admitted to inpatient status
- 247 patients presented with the target diagnoses of CHF or Diabetes
  - 107 also presented with a BH diagnosis
  - 289 were not screened for BH
  - 39\% were Medicaid pending or uninsured

Rationale:
Spohn chose this project because Bee County is designated as a partial Health Provider Shortage Area in the mental health domain and the primary care domain, indicating the patients needing both mental health treatment and chronic disease management are likely slipping through the cracks in the system (RHP Plan, Section 3, Table 11). The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 yrs. earlier than those with mental health illness alone mainly due to unmanaged physical health. National Comorbidity Survey Replication data (2001-2003) shows that approximately 30\% of patients with a chronic medical disorder also have a mental health disorder. While those with BH illness and a secondary medical illness die earlier, those with chronic medical diseases such as CHF, Diabetes or COPD and a co-existing BH illness have more frequent admissions with longer lengths of stay for seemingly unknown reasons. It is purported to be a result of undiagnosed or untreated mental health such as depression. Thus, this project should have a positive outcome on the long-term health outcomes for these patients, and should result in a reduction in the systemic cost of providing health care to this population.

Core Components: This project has 8 core components, which Spohn will address individually below:

a. Conduct data matching to identify individuals with co-occurring disorders who do not receive routine and/or needed primary and specialty care, over-utilize ED and crisis response services, and are becoming involved with the criminal justice system due to unmanaged symptoms. Spohn will perform this component through Milestone 1 in DY2 by undertaking review and analysis of medical data for Spohn’s FHC and hospital patients.

b. Review chronic care management best practices such as Wagner’s Chronic Care Model and select practices compatible with organization readiness for adoption and implementation. Spohn will incorporate this component into Milestone 3 in DY3 when it prepares its protocol for implementing screening and care coordination to identify and effective treat patients with a dual diagnosis of BH/depression and diabetes or CHF. Spohn will directly reference the best practices it identifies from this review in the protocol it creates.

c. Identification of BH case managers and disease care managers to receive assignment of these individuals. Spohn will address this core component through Milestone 2 in DY2. Spohn will identify existing or new staff to provide care coordination for patients identify with dual diagnoses, assigning the equivalent of at least 3 full-time care coordinators in DY2.

d. Develop protocols for coordinating care; identify community resources and services available for supporting this population. Spohn will address this component with Milestone 3 in DY3.
The protocol will address community needs, best practices, internal processes, key challenges, and an implementation plan.

e. **Identify and implement specific disease management guidelines for high prevalence disorders.** Spohn will address this requirement through Milestone 4 in DY3. Care coordinators and medical providers will be trained in the screening, diagnosis, care coordination and treatment of patients with CHF or diabetes and BH/depression, and will implement the guidelines accordingly.

f. **Train staff in protocols and guidelines.** This requirement will also be addressed through Milestone 4 in DY3, as staff will be trained in both the guidelines for screening and treatment, and Spohn’s hospital/FHC specific protocol for addressing this community need.

g. **Develop registries to track client outcomes.** Spohn will address this component through performing Milestones 5 and 6 in DYs 4-5. Spohn is creating a Chronic Disease Registry for its campuses and FHCs, which it will use to track patients identified with the targeted dual diagnoses and their use of the ED and rate of potentially preventable hospitalization.

h. **Review the intervention’s impact on quality of care and integration of care and identify lessons learned, opportunities to expand the program, and key challenges with expanding.** In DY 4, Spohn will draft a report identifying aspects of the protocol that have yielded positive results, identify areas for improvement, and targets for expanding the scope of the project to additional chronic diseases and/or other mental health issues (i.e. substance abuse).

Ties to Community Needs Assessment: CN.2 (Inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (Negative mental health outcomes)

**Related Category 3 Outcome Measure(s):**
Outcome Domain 9: Right Care, Right Setting
Improvement Target 9.2 – ED Appropriate Utilization

Spohn chose this outcome measure because it directly correlates with the purpose of this project – Spohn seeks to identify and treat more of these patients in the community so they will be less likely to misuse the ED and/or deteriorate into an acute condition where they need emergency care.

**Relationship to other Projects:**
This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following:
020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.
Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Beeville (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

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72 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project complies with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its impact on the goals of the Waiver: the project is patient-centered because it offers needed screening and targeted care management for patients coping with both physical and mental conditions; the project also reduces the systemic cost of providing care to this population by using prevention and care management to reduce the use of the ED and/or preventable hospital admissions for patients with co-diagnoses. The project addresses community needs, as this community is lacking mental health providers and services, and will serve a population of chronically ill patients. The investment necessary to implement this project is great: protocols must be created, providers identified and trained; patients educated; and transformation of the delivery system accomplished through actual reductions in ED and hospital admissions.
**2.19.1**  
**CARE MANAGEMENT TO INTEGRATE PRIMARY AND BEHAVIORAL HEALTH NEEDS**

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<thead>
<tr>
<th>020811801.2.5</th>
<th>2.19.1</th>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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| **Milestone 1** [P-4]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis to identify over/under utilization  
**Metric 1** [P-4.1]: Data analysis  
**Baseline/Goal**: Spohn will develop a system to identify patients with co-diagnoses of CHF &/or Diabetes with BH/Depression using its available medical data and will produce written analysis of the available data  
**Data Source**: Written analysis  
**Milestone 1 Estimated Incentive Payment**: $119,213 | **Milestone 3** [P-6]: Care coordination protocols are developed  
**Metric 1** [P-6.1]: Written protocols available to staff  
**Baseline/Goal**: Spohn will identify and define practice guidelines and processes for coordination of care between services in a written manual for providers  
**Data Source**: Written protocols, standards, policies and procedures  
**Milestone 3 Estimated Incentive Payment**: $121,926.50 | **Milestone 5** [I-22] Increase use of specialty care in line with professionally accepted practice guidelines  
**Metric 1**: X% increase/decrease use of specialty care according to practice guidelines  
**Baseline/goal**: 20% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment (Spohn)  
**Data source**: Care transitions registry  
**Milestone 5 Estimated Incentive Payment**: $121,737.50 | **Milestone 7** [I-22] Increase use of specialty care in line with professionally accepted practice guidelines  
**Metric 1**: X% increase/decrease use of specialty care according to practice guidelines  
**Baseline/goal**: 40% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment  
**Data source**: Care Transitions registry  
**Milestone 7 Estimated Incentive Payment**: $196,595 |
| **Milestone 2** [P-5]: BH case manager and disease care manager identified  
**Metric 1** [P-5.1]: Number of staff identified with the capacity to support the target population  
**Baseline/Goal**: Identify and engage the equivalent of three (3) care coordinators to manage targeted patients  
**Data Source**: Staff rosters and documents of caseloads | | | |
| **Milestone 4** [P-8]: Staff member training in care coordination protocols and practice guidelines for CHF, Diabetes and Depression/BH  
**Metric 1** [8.1]: Percent of staff trained  
**Goal**: 80% off FHC and hospital staff identified in target areas will receive training in screening/care coordination for patients with targeted dual diagnoses  
**Data Source**: Training materials and attendance records  
**Milestone 4 Estimated Incentive Payment**: $121,926.50 | | | |
| **Milestone 6**: P-X Assess efficacy of process in place and recommend process improvements to implement if any  
**Metric X-1**: Identify opportunities to improve on the redesign methodology, as documented in the assessment document  
Baseline/goal: analyze the effectiveness and quality improvement resulting from this project  
**Data source**: documentation of assessment | | | |

**CHRISTUS Spohn Hospital Beeville**

**Related Category 3 Outcome Measure(s):**  
020811801.3.9  
IT-9.2  
- ED Appropriate Utilization (BH/SA patients)
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<td>Payment: $119,213</td>
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<td>Milestone 6 Estimated Incentive Payment: $121,737.50</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $238,426</td>
<td>Year 3 Estimated Milestone Bundle Amount: $243,853</td>
<td>Year 4 Estimated Milestone Bundle Amount: $243,475</td>
<td>Year 5 Estimated Milestone Bundle Amount: $196,595</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $922,350
Corpus Christi Medical Center
Implement/Expand Care Transition Programs
020973601.2.1

- **Provider**: The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

- **Intervention**: This project will develop evidence based standardized protocols centered around improving the transition of care from an inpatient hospital setting to an ambulatory setting. The protocols will address 1) effective communication with patient and family, 2) discharge instructions and education, 3) barriers to chronic disease management, and 4) proper identification and placement with a primary care physician.

- **Need for the project**: Care coordination in our community is fragmented and inadequate, leading to increased costs, conflicting care protocols, and sub-optimal patient outcomes and satisfaction. Re-admission rates are high for patients living with chronic diseases such as; diabetes, congestive heart failure, and congestive obstructive pulmonary disease. In order to make a difference in our patient outcomes we must start working together as a healthcare community which will require us to establish effective communication mechanisms with providers and community resources.

- **Target population**: The target population will be our patients at the greatest risk for re-admission to the hospital within 30 days. Approximately 31% of our patients with a chronic disease are Medicaid eligible or uninsured. We expect the use of the developed protocols will benefit a similar percentage of Medicaid eligible or uninsured patients.

- **Category 1 expected patient benefits**: The project expects to implement the developed care transition protocols on 40% of the target population by DY5 and that 40% of the target population also receives the recommended education and other informational material developed with the protocols.

- **Category 3 outcomes**: IT-3.1 – All cause 30 day readmission rate. Reduction in the 30 day readmission rate is a key indicator that will demonstrate the success of our care transition protocols. Keeping our patients out of the hospital and managing their chronic illness will improve the overall health of our community.
Category 2: Program Innovation and Redesign
Implement/Expand Care Transition Programs
Project Option 2.12.1 – Implement/Expand Care Transitions Programs
Project ID – 020973601.2.1
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Project Description:
Health care spending in the United States is highly disproportionate, with half of health care dollars spent on approximately five percent of the population. Individuals with chronic conditions consume a high proportion of health care services. These patients struggle with multiple illnesses as well as mental health and substance abuse needs, medical frailty, social isolation and homelessness. Unfortunately, these individuals are the least poised to navigate our complex and fragmented health care system.

This project will develop a Care Transition program for discharged patients who are at high risk of readmission and most in need of care coordination. The project development will draw upon best practices from a range of models – RED, BRIDGE, INTERACT, etc. In addition, a detail analysis will be performed on the key drivers of CCMC’s 30 day readmission rates using a chart review tool embedded in our case management software and patient interviews. The project will also develop a system to identify those patients being discharged that are at higher risk for needing acute care services within the next 30 – 60 days and include enhanced discharge planning programs and post discharge support programs. In developing the program, various interventions will be tested and piloted to determine what works best for our patient population. Anticipated interventions to be tested include: identification of key learners, teach back techniques, barrier rounds, medication reconciliation, MD Navigate for patient callbacks, hand off communications, online patient education, and home follow up visits. These interventions will be integrated, to the extent possible, within our existing information systems. The project team will be comprised of clinical and administrative representatives from all care continuums and will utilize quality improvement methodologies and lessons learned to continually refine the processes and the program. Project components will include the following:

1. Review best practices from a range of models
2. Conduct an analysis of the key drivers of 300-day hospital readmissions using a chart review tool and patient interviews
3. Integrate information systems so that continuity of care for patients is enabled
4. Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
5. Implement discharge planning program and post discharge support program
6. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers and home care providers
7. Conduct quality improvement for project using methods such as rapid cycle improvement.
**Project Goals/Challenges:**
The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. The project will develop a comprehensive care transition program with policies and procedures, written protocols, and quality improvement activities to reduce readmissions. We anticipate a minimum of 500 patients from the target populations receiving standardized care according to the approved clinical protocols and care transition policies for both chronic conditions by DY4 and a minimum of 1,000 patients by DY5.

This project contributes to the regional goals of better health outcomes and reduced health cost by focusing on safe, effective care transitions to avoid gaps/failures in care delivered to patients. Reducing readmissions prevents morbidity declines, stabilizes health and prevents hospitalization costs.

All chronic conditions present with a common set of challenges to the sufferers and their families; dealing with symptoms, disability, emotional impacts, complex medication regimens, difficult lifestyle adjustments, and obtaining coordinated medical care. Our Care Transition program will focus on coordinating care between providers, patient and family education, barriers to effective discharge, and medication reconciliation.

**Starting Point/Baseline:**
Currently, CCMC has a staff of case managers and social workers who have the primary responsibility for coordinating the healthcare and social needs of the patients post discharge from the hospital. Their workload is approximately 20 patients per case manager and 60 patients per social worker. The goal is to place the patient in the most appropriate post discharge setting based on physician order, family preference, and community availability. Minimal follow up is completed by CCMC once the patient has been discharged and placed in their post-acute setting.

CCMC has an overall 7.4% readmission rate within 30 days. Readmissions are over 1,400 annually. The conditions with the highest readmission rates are; Acute Myocardial Infarction (AMI), Heart Failure (HF), Chronic Obstructive Pulmonary Disease (COPD), Behavioral Health (BH), and Pneumonia (PN). This project should primarily benefit those patients with chronic conditions – Heart Failure and COPD.

**Rationale:**
The number of persons with chronic illnesses is growing at an astonishing rate because of the rapid aging of the population and the greater longevity of persons with many chronic conditions. CCMC is just one part of the community healthcare system. Effective chronic illness management requires an appropriately organized delivery system that is linked with complementary community resources available outside of the organization. Recent evidence suggests that a patient’s confidence and skills in managing their condition will have a greater impact than just focusing on disease knowledge and treatment alone. Self-management support and links to patient-oriented community resources help to activate and inform patients and families to better cope with the challenges of living with and treating chronic illness. Our community does not have an unlimited supply of healthcare resources and we must find a way to more effectively and efficiently manage these resources. Improvements in care
transitions are a key measure that will provide lasting benefits to the community through improved patient outcomes and satisfaction and overall cost reductions.

**Unique Community Need Identification Numbers the Project Addresses:**
- CN.3 – Inadequate provision and coordination for health care services for persons with chronic conditions
- CN.7 – High rates of preventable hospital admissions
- CN.17 – High incidence, mortality, and cost associated with Chronic Obstructive Pulmonary Disease

**Related Category 3 Outcome Measure(s):**
The key outcome measure that will be used to measure the effectiveness of this project will be: IT-3.1 All cause 30 day readmission rate. Standalone measure.

Appropriate Care Transitions will positively impact chronic conditions (HF and COPD) as well as other conditions such as AMI, PN, and BH. Since the program will benefit a wide range of patients the All cause 30 day readmission rate is the most appropriate to measure the effectiveness of the project.

**Relationship to other Projects:**
Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, CPOD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols, and sub optimal patient outcomes and satisfaction. Corpus Christi is usually not the first destination (or even the top ten) when graduating residents are making the determination of where to establish their practice. National data and our local experience have shown that we have a good chance of retaining graduating residents who train in our community. Increasing the number of residents training in primary care and specialty care areas in our community is critical to reducing these local provider deficits. Projects 020973601.1.1, 020973601.1.2, and 020973601.1.3 address the access to primary care and the resulting impact on chronic conditions. Increasing the number of primary care providers in the community is only the first step in achieving the overall goals of:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Additional work is needed with care coordination and the management of chronic diseases. This project along with project 020973601.2.1 address chronic disease management, readmission rates, and care transitions.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Christus Spohn.

Project Valuation:
One of the single greatest needs for our community is the coordination of care between healthcare providers. Chronic disease rates are only expected to increase over the coming years and improving the care coordination will take tremendous time, resources, and commitment to effect a substantive change. The community will look to the acute care providers to be the leaders in this initiative given our access to data, personnel, and information technology resources. Average reimbursement for the targeted readmission population is approximately $5,600/admission. This reduction in cost to the payors does not even take into account the health benefits from improved management of chronic diseases. The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
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<tr>
<td>Priority Community Need</td>
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<td>Significant readmission rates for chronic diseases</td>
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<td>Populations Served</td>
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<td>Delivery Transformation</td>
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<td>Metric 1 [P-1.1]: Care transition protocols</td>
<td>Milestone 1 [P-1] Develop or implement best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions. Baseline: No protocols currently in place Goal: Submission of protocols Data Source: Approved protocols Milestone 1 Estimated Incentive Payment $382,171</td>
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<td>Metric 1 [P-1.1]: Care transition protocols</td>
<td>Milestone 4 [I-10] Identify the top chronic conditions and other patient characteristics that are common causes of avoidable readmissions Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of readmissions. Baseline: No comprehensive report currently is available Goal: List by frequency of most prevalent chronic conditions, patient factor or other socioeconomic factors in patient panel resulting in highest readmission rates. Data Source: EHR data Milestone 4 Estimated Incentive Payment $562,251.50</td>
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<td>Milestone 2 [P-3]: Establish a process for hospital-based case managers (or other qualified personnel) to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms, and where appropriate, additional patient education and/or coaching as identified during discharge.</td>
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<td>Metric 2 [I-2.1]: Implement care transition protocols - communication Baseline: No protocols currently in place Goal: Implementation of protocols on all nursing units</td>
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<td>Milestone 5 [P-2]: Implement standardized care transition protocols. Metric 1 [P-2.1]: Implement care transition protocols - communication Baseline: No protocols currently in place Goal: Implementation of protocols on all nursing units</td>
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RHP Plan for Region 4
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<th>020973601.2.1</th>
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<td>Data Source: Education/training program, roll out schedule, post go-live reviews</td>
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<td>Goal: Minimum of 100 patients from the target population that have received all the recommended education, care and services as outlined in the approved protocol</td>
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<tr>
<td>Baseline: No protocols currently in place</td>
<td>Goal: Submission of protocols</td>
<td>Data Source: Registry or EHR reports</td>
<td></td>
</tr>
<tr>
<td>Goal: Development of stratification system</td>
<td>Data Source: Approved protocols</td>
<td>Milestone 2 Estimated Incentive Payment $382,171</td>
<td></td>
</tr>
<tr>
<td>Baseline: No stratification system in place</td>
<td>Goal: Implementation of protocols on all nursing units</td>
<td>Data Source: Education/training program, roll out schedule, post go-live reviews</td>
<td></td>
</tr>
<tr>
<td>Goal: Development of stratification system</td>
<td>Data Source: Stratification system</td>
<td>Milestone 5 Estimated Incentive Payment: $562,251.50</td>
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<tr>
<td>Milestone 1 Estimated Incentive Payment $382,170</td>
<td></td>
<td>Goal: Minimum of 200 patients from the target population that have received all the recommended education, care and services as outlined in the approved protocol</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Data Source: Registry or EHR reports</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,146,512</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,124,503</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,202,956</td>
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<td></td>
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<td>Year 5 Estimated Milestone Bundle Amount: $1,188,692</td>
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<td></td>
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<td>Milestone 7 Estimated Incentive Payment: $1,188,692</td>
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<tr>
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<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD <em>(add milestone bundle amounts over DYS 2-5)</em>: $4,662,663</td>
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</tr>
</tbody>
</table>

RHP Plan for Region 4
Provider: The Corpus Christi Medical Center (CCMC) is a 631 bed multi campus facility serving Nueces and the surrounding eleven counties. CCMC is considered a major safety net hospital. The total population of the primary and secondary service areas is approximately 559,000 with 56% White-Hispanic and 37% White-Non Hispanic. CCMC provides comprehensive inpatient, outpatient, surgical, and emergency services. Inpatient services include 106 behavioral health beds in two locations, 15 bed inpatient rehab, and women’s services with a Level III NICU and over 3,800 deliveries annually. A FP/IM residency program supports the primary care and hospitalist physicians practicing at the facilities. Other key statistics include; 10,000 annual surgical procedures, 75,000 annual emergency room visits, and 5,000 annual cardiac catheterization procedures.

Intervention: This project will implement standardized evidence based identification and care management protocols for sepsis patients. We expect to use the developed protocols on 50% of our sepsis patients by DY5 with a 15% improvement in mortality and average length of stay.

Need for the project: Our incidence of sepsis is above national averages and is partly reflective of our high rates of chronic illnesses – diabetes and kidney and liver disease. Patients with weakened immune systems are also at higher risk for developing sepsis. Employing evidence based protocols (similar to AMI and Stroke protocols) that focus on the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to positively impact the outcome.

Target population: The target population is any patient of CCMC that is identified with sepsis (or has the potential to develop sepsis). Approximately 32% of our patients with sepsis are either Medicaid eligible or indigent so we expect that same percentage to benefit from the use of the developed protocol(s).

Category 1 expected patient benefits: The project expects to utilize the evidence based protocols on approximately 190 patients in DY4 and 270 patients in DY5. Actual numbers may vary depending on the actual volumes of Sepsis cases seen at CCMC in those demonstration years. The use of these protocols should enable earlier identification of patients progressing to severe sepsis, shorten the length of stay, and provide for improved patient outcomes. The mortality rate for severe sepsis or septic shock is very high (between 30 – 50%). We intend to improve the current mortality rates with these protocols.

Category 3 outcomes: IT-4.8 and IT-4.9 Sepsis Mortality and Average length of stay. The goal is to reduce sepsis mortality and average length of stay 15% from the baseline by DY5.
Category 2: Program Innovation and Redesign
Apply Process Improvement Methodology to Improve Quality/Efficiency
Project Option 2.8.11 - Sepsis
Project ID – 020973601.2.2
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Project Description:
Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight an infection trigger inflammation throughout the body. This inflammation creates microscopic blood clots that can block nutrients and oxygen from reaching organs, causing them to fail. Some physicians view sepsis as a three-stage syndrome, starting with sepsis and progressing through severe sepsis to septic shock. Most people recover from mild sepsis, but the mortality rate for severe sepsis or septic shock is between 30 – 50%. The incidence of sepsis in the United States is growing faster than the overall population due to an aging population, drug-resistant bacteria, and more patients with weakened immune systems. Individuals with long-term chronic disease, such as diabetes, are also at increased risk for developing sepsis. CCMC is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We will implement a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions will be based upon evidence-based care models, which include an evidence based sepsis resuscitation bundle for patients initially diagnosed with sepsis and an evidence based sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED goals for improvement in sepsis identification and treatment includes, revised nurse sepsis screenings, staff education, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This project contributes to the regional goals of better health outcomes and reduced health cost by hardwiring evidence-based sepsis resuscitation and management bundles to decrease mortality and morbidity. The project goal by the end of DY5 is to have 50% of the targeted sepsis cases follow the evidence based resuscitation and management bundles with the quality goal of reducing mortality and average LOS by 15% from the baseline.

Challenges:
Diagnosing sepsis can be difficult because its signs and symptoms can be caused by other disorders. Similar to trauma, AMI, or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence the outcomes. Given all the factors noted above, the appropriate identification, care, and treatment of sepsis is a top clinical priority for our community. Evidence based resuscitation and management bundles are a key component in the quick and effective treatment of severe sepsis or septic shock.

Starting Point/Baseline:
Anyone can get sepsis, but people with weakened immune systems, children, infants and the elderly are most vulnerable. People with chronic illnesses, such as diabetes, AIDS, cancer and kidney or liver disease are also at increased risk. Common symptoms of sepsis are fever, chills, rapid breathing and heart rate, rash, confusion and disorientation. Many of these symptoms, such as fever and difficulty
breathing, mimic other conditions, making sepsis hard to diagnose in its early stages. CCMC’s mortality and average length of stay for severe sepsis patients are consistent with national averages. The goal is to develop evidence based protocols for the early detection and aggressive treatment of patients that develop sepsis and severe sepsis. The protocols will be developed in conjunction with key medical staff leaders and provide the nursing staff with specific screenings and tests that will enable earlier detection of patients progressing towards severe sepsis.

For the 12 months ended 09/30/2012 approximately 550 patients were seen at CCMC for a diagnosis of sepsis with a mortality rate that exceeded 18%. CCMC will develop a true baseline for the project in DY2.

Rationale:
Many people who survive severe sepsis recover completely and their lives return to normal. But some people, especially those who had pre-existing chronic diseases, may experience permanent organ damage. For example, in someone who already has kidney impairment, sepsis can lead to kidney failure that requires lifelong dialysis. There is also some evidence that an episode of severe sepsis disrupts a person's immune system, making him or her more vulnerable to future infections. Studies have shown that people who have experienced sepsis have an increased risk of dying, even several years after the episode. Treatment for sepsis often involves a prolonged stay in the intensive care unit and complex therapies, which incur high costs. It has been estimated that $17 billion is spent annually in the United States to treat sepsis. Our community has a very high rate of diabetes and chronic illnesses which puts our residents at a higher risk for developing severe sepsis. Early detection and aggressive treatment protocols are critical to ensuring better health outcomes for our community.

Unique Community Need Identification Numbers the Project Addresses:
- CN.18 – High incidence and mortality of sepsis and severe sepsis

Related Category 3 Outcome Measure(s):
The key outcome measures that will be used to measure the effectiveness of this project will be:
IT-4.8 Sepsis mortality. Standalone measure.
IT-4.9 Average length of stay (severe sepsis and septic shock). Non-standalone measure
The outcomes selected reflect the effectiveness of implementing evidence-based care such as the resuscitation and management bundles.

Relationship to other Projects:
Chronic disease management and care coordination are the key quality improvement measures for several projects aimed at addressing physician shortages and access to care. One of the risk factors for developing sepsis is a weakened immune system due to chronic illness. While, this project addresses the early detection and aggressive treatment once sepsis has developed, the other projects listed address some of risk factors for developing sepsis. Appropriate access to primary care and specialty providers is the main underlying issue in our community. This lack of access, whether due to lack of healthcare coverage, inadequate number of providers, or inaccessible provider locations leads to frequent use of hospital emergency departments and increased risk for complications and readmissions for the chronic conditions prevalent with our patient population (CHF, CPOD, Diabetes). Care coordination is fragmented and inadequate leading to increased costs, conflicting care protocols,
and sub optimal patient outcomes and satisfaction. Projects 020973601.1.1, 020973601.1.2, and 020973601.1.3 address the access to primary care and the resulting impact on chronic conditions. Additional work is needed with care coordination and the management of chronic diseases. Project 020973601.2.2 address chronic disease management, readmission rates, and care transitions. Other projects that will are supported or enables by this project include 020811801.2.5 – Improvement in Quality and Safety for patients with Sepsis, and 121775403.2.2, Redesign of primary care through the development of a clinically integrated hospitalist service model.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Christus Spohn.

**Project Valuation:**
The project is valued by scoring each of the areas in the table below from 1 to 5 and then using the total score as a percent of all category 1 and 2 project scores to allocate the DSRIP dollars.

<table>
<thead>
<tr>
<th>Determinate</th>
<th>Score</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Community Need</td>
<td>4</td>
<td>Significant opportunity for rapid process improvement</td>
</tr>
<tr>
<td>Populations Served</td>
<td>3</td>
<td>Primarily the elderly/dual eligible patients</td>
</tr>
<tr>
<td>Delivery Transformation</td>
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<td></td>
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<tr>
<td>Outcomes/Cost</td>
<td>5</td>
<td>Improve Sepsis mortality/ALOS</td>
</tr>
<tr>
<td>Project Investment</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>020973601.3.11</td>
<td>IT-4.8</td>
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<tr>
<td><strong>Milestone 1 [P-1]</strong> Target specific workflows, processes and/or clinical areas to improve - sepsis</td>
<td>2.8.11</td>
<td>2.8.11</td>
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<tr>
<td></td>
<td><strong>Metric 1 [P-1.1]:</strong> Performing Provider review and prioritization of areas or processes to improve upon.</td>
<td><strong>Baseline:</strong> N/A</td>
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<td></td>
<td><strong>Milestone 1 Estimated Incentive Payment</strong> $360,939</td>
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<tr>
<td></td>
<td><strong>Milestone 2 [P-2]</strong> Identify /target metric to measure impact of process improvement methodology and establish baseline - sepsis</td>
<td></td>
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<tr>
<td></td>
<td><strong>Metric 1 [P-2.1]:</strong> Performing Provider identification of impact metrics and baseline</td>
<td><strong>Baseline:</strong> N/A</td>
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<td><strong>Milestone 2 Estimated Incentive</strong></td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Milestone 4 [P-4]</strong> Define operational procedures needed to improve overall efficiencies in care management - sepsis</td>
<td><strong>Metric 1 [P-4.1]:</strong> Report on at least two new operational procedures needed to improve overall efficiencies in care management</td>
<td><strong>Baseline:</strong> N/A</td>
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<td><strong>Milestone 4 Estimated Incentive Payment</strong> $354,010</td>
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<tr>
<td><strong>Milestone 5 [P-6]</strong> Implement a program to improve efficiencies and/or reduce program variation</td>
<td><strong>Metric 1 [P-6.1]:</strong> Performance improvement events</td>
<td><strong>Baseline:</strong> N/A</td>
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<td></td>
<td></td>
<td><strong>Baseline:</strong> N/A</td>
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<tr>
<td></td>
<td><strong>Milestone 5 Estimated Incentive Payment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 [I-13]</strong> Progress toward goal</td>
<td><strong>Metric 1 [I-13.1]</strong> Number or percent of all clinical cases that meet target/goal</td>
<td><strong>Goal:</strong> Based on current volumes estimate, the patient impact to be approximately 190 cases (35 %) follow PI recommended process changes. 10% improvement from baseline in mortality and LOS</td>
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<td><strong>Milestone 7 Estimated Incentive Payment</strong> $568,062</td>
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<tr>
<td><strong>Milestone 8 [P-12]</strong> Report finds and learning – sepsis interim report</td>
<td><strong>Metric 1 [P-12.1]</strong> Submission of report that outlines preliminary findings and learning from sepsis PI program</td>
<td><strong>Baseline:</strong> N/A</td>
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<td><strong>Milestone 8 Estimated Incentive</strong></td>
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<tr>
<td><strong>Milestone 9 [I-13]</strong> Progress toward goal</td>
<td><strong>Metric 1 [I-13.1]</strong> Number or percent of all clinical cases that meet target/goal</td>
<td><strong>Goal:</strong> Based on current volumes estimate, the patient impact to be approximately 270 cases (50 %) follow PI recommended process changes. 15% improvement from baseline in mortality and LOS</td>
</tr>
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<td><strong>Milestone 9 Estimated Incentive Payment</strong> $561,327</td>
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</tr>
<tr>
<td><strong>Milestone 10 [P-12]</strong> Report finds and learning – sepsis interim report</td>
<td><strong>Metric 1 [P-12.1]</strong> Submission of report that outlines preliminary findings and learning from sepsis PI program</td>
<td><strong>Baseline:</strong> N/A</td>
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<td><strong>Milestone 10 Estimated Incentive</strong></td>
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<td>Outcome Measure(s):</td>
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<tr>
<td>020973601.3.11</td>
<td>IT-4.8, IT-4.9</td>
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<tr>
<td>Sepsis Mortality</td>
<td>Average length to stay (severe sepsis and septic shock)</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
<td>Payment $360,939</td>
<td>go-live reviews</td>
<td>Payment $568,063</td>
<td>Payment $561,327</td>
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<td><strong>Milestone 3</strong> [P-3] Identify / target metric to measure impact of process improvement methodology and establish baseline - sepsis</td>
<td><strong>Milestone 3</strong> [P-3] Identify / target metric to measure impact of process improvement methodology and establish baseline - sepsis</td>
<td><strong>Milestone 5</strong> Estimated Incentive Payment $354,010</td>
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<td><strong>Metric 1</strong> [P-3.1] Compare and analyze clinical / quality data, and identify at least one area for improvement</td>
<td><strong>Metric 1</strong> [P-3.1] Compare and analyze clinical / quality data, and identify at least one area for improvement</td>
<td><strong>Milestone 6</strong> [I-13] Progress toward goal - sepsis</td>
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<tr>
<td>Baseline: N/A Goalt: Analysis and identification of target area Data Source: Analysis / committee reports</td>
<td>Baseline: N/A Goalt: Analysis and identification of target area Data Source: Analysis / committee reports</td>
<td>Baseline: N/A Goal: 20 % of cases follow PI recommended process changes Data Source: TBD</td>
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<td>Milestone 3 Estimated Incentive Payment $360,939</td>
<td>Milestone 3 Estimated Incentive Payment $360,939</td>
<td>Milestone 6 Estimated Incentive Payment $354,010</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $1,082,817</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,062,030</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,136,125</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,122,654</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $4,403,626*
Performing Provider/TPI: Coastal Plains Community Center/080368601
Project Title: 2.15.1 Design, implement and evaluate projects that provide integrated primary and behavioral health care services
Unique RHP project identification number: 080368601.2.1

Provider: Coastal Plains Community Center (CPCC) is a Mental Health Intellectual and Developmental Disability (MHIDD) Community Center located in South Texas that serves a large, sparsely populated rural area (239,761 people) that includes the following nine counties: Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, and San Patricio. Coastal Plains provides services to people who have serious mental illness. The Center currently serves 2100 adults per month.

Intervention(s): The goals of this project are to integrate primary healthcare and substance abuse services within the walls of five (5) Behavioral/Mental Health Clinics using the 4-Quadrant Model. Two traditional non-profit organizations, the Federally Qualified Health Center (FQHC) operated by Community Action Corporation of South Texas (CACOST) and the Council on Alcohol and Drug Abuse of the Coastal Bend dba Prevention and Addiction Council (PAC), are partnering with the Center to provide these services.

Need for the project: The vast majority of the people we serve either do not utilize, or significantly underutilize, the services of primary care providers due to lack of payor source and/or issues related to their mental illness. Substance abuse outpatient treatment services are not available in seven of the nine counties we serve. The people we serve have to drive to Corpus Christi or Alice, Texas to receive substance abuse counseling.

Target population: The target population is our mental health patients who need routine and ongoing medical care and substance abuse treatment to prevent the use of more costly services. By Demonstration Year 5 (2016), all five Primary Healthcare and Substance Abuse Services integration programs will be operational with 1700 adults being served by integrated primary care providers (500 in DY2, 1000 in DY3, 1350 in DY4) and 345 adults served by integrated substance abuse providers (60 in DY2, 195 in DY3, 275 in DY4). Currently 32% of the population served is Medicaid, 19% is Medicare or other commercial insurance, and 49% are indigent.

Category 1 or 2 expected patient benefits: This project seeks to provide primary care related medication to the indigent (up to 1000 people per year), twice-annual preventive dental services, ongoing health education classes, and care management/health navigators in addition to integrated primary care and substance abuse services.

Category 3 outcomes: The following Category 3 Outcome measures apply to this project All goals are to be achieved by the end of year 5:

- IT-1.10 Diabetes Care HbA1c poor control - goal of 20% improvement over baseline
- IT-1.11 Diabetes Care: BP control (140/80mm Hg) goal of 20% improvement over baseline
- IT- 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons - goal of 15% decrease in admissions to criminal justice settings such as jails or prisons
- IT-10.7 Other Outcome Improvement Target: 70% of admissions to SA Services successfully complete treatment services
**Project Title:** 2.15 Integrate Primary and Behavioral Health Care - South Texas Whole Health and Substance Abuse Integration; 2.15.1 Design, implement and evaluate projects that provide integrated primary and behavioral health care services

**Unique RHP project identification number:** 080368601.2.1

**Performing Provider/TPI:** Coastal Plains Community Center/080368601

**Project Description:**
Coastal Plains Community Center (CPCC) is a Mental Health Intellectual and Developmental Disability (MHIDD) Community Center located in the coastal bend region of South Texas that spans 8,817 square miles of land along the southern part of the Gulf of Mexico. This is a large, sparsely populated rural area that includes the following nine counties: Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, and San Patricio. The area has a lower income level than the statewide average and, in some areas, the term that best describes the towns or Colonias is impoverished. The total population is 239,761 for the nine counties served with 64% Hispanic ethnicity. The U.S. Census Bureau 2010 data shows that in eight of the nine counties “per capita money income” was $18,241, which was lower than the statewide average of $24,870. CPCC provides services to people who have serious mental illness and/or have difficulty with daily functioning due to mental illness. CPCC provides adult and children’s mental health services and services for people with intellectual and developmental disabilities (IDD).

The South Texas Whole Health and Substance Abuse Integration Project integrates primary care and behavioral health (mental health and substance abuse) services into community behavioral health center settings to provide comprehensive, high quality health care to adults with serious mental illness (SMI). The target population will receive primary care services, including diabetes care and primary dental services, in addition to the treatment for mental illness and substance abuse services.

**Goals and Relationship to Regional Goals:**
The goals of this project are to integrate primary healthcare and substance abuse services within the five (5) Behavioral/Mental Health Clinics using the 4-Quadrant Model. Primary Healthcare (PH) clinics will be integrated into Behavioral/Mental Health clinics over the following timeline: three PH clinics in 2013; one PH clinics integrated in 2014; and one in 2015. Likewise, Substance Abuse (SA) services will be integrated into the Behavioral/Mental Health clinics according to the following timeline: one SA services clinic will be integrated into a Behavioral/Mental Health Clinic in 2013; two clinics will be integrated in 2014; and two in 2015. By Demonstration Year 5 (2016), all five Primary Healthcare and Substance Abuse Services integration programs will be operational.

**Challenges and how addressed:**
There are many challenges to ensuring adequate primary care for people with serious mental illness. Foremost among them are stigma, fragmentation between the behavioral and primary care providers, inadequate diagnosis and treatment of co-occurring mental and substance use disorders and financial considerations. People with serious mental illness (SMI) sometimes have greater difficulty following through with treatment, which puts them at risk for destabilization and potentially a need for a higher intensity of care, if there is not adequate care management and care coordination. Also, people with mental illness sometimes self-medicate with alcohol or drugs that are not prescribed and which negatively impact both their physical and mental health. Resistance among individuals with SMI to quit illegal substance use is a challenge for providers in helping patients...
maintains physical as well as mental well-being. In addition, local self-help groups in our area (e.g. Alcoholics Anonymous, Narcotics Anonymous) do not offer the greater level of support that is needed by individuals with SMI. This places an even greater strain on an already over-stretched community mental health system.

Unhealthy dietary habits of many South Texans—eating traditional foods they grew up with, which are often high in fat, calories and carbohydrates, but low in cost—can impact physical and mental health but are challenging to change because they are rooted in local and cultural traditions and customs. Better integration of primary and behavioral health care services will help people living with mental illness develop and maintain better eating habits.

The South Texas Whole Health and Recovery Integration Project seeks to counteract negative health factors by integrating primary and behavioral health care in our community mental health settings throughout the Coastal Bend. We will create a health care home that provides a continuum of services, including regular follow-up, as well as education and community support to empower consumers. Periodic health fairs and educational programs on healthy eating and food preparation will further support healthy lifestyles.

According to the National Council for Community and Behavioral Healthcare, a health care home gives each patient an ongoing relationship with a personal physician and a team of practice-level providers who are accountable for providing ongoing, coordinated, and integrated care marked by quality and safety. The presence of both highly trained primary care providers and psychiatrists offers an opportunity for care consultation and collaboration which greatly enhances continuity of care and maximizes utilization of resources. Another essential hallmark of the health care home is that it supports and empowers clients to set and reach self-management goals. Both of these important features are built into our plans and goals for the South Texas Whole Health and Recovery Project. Through the use of the Four-Quadrant Clinical Integration Model, physical and behavioral health care is integrated and provides supports for individuals who are in any quadrant of this model developed by the National Council for Community Behavioral Health Care. The model is based upon complexity and risk of both behavioral health needs and primary health care needs. The FQHC will address patients in quadrant one (1) and three (3); CMHC will address persons in quadrant two (2) and four (4) with persons in quadrant four (4) being served in the FQHC when needed.

5 Year expected outcome:
Expected outcomes for this project are a decrease in emergency department visits at area hospitals and better health outcomes, as a result of adopting a holistic approach to care and thereby reducing fragmentation between physical and behavioral health care services. Over the course of the project we expect to see diabetic patients with better control of their blood pressure as well as their HbA1c levels. We also expect to see an increase in the percentage of admissions to substance abuse services where individuals successfully complete treatment services.

Starting Point/Baseline: In regards to substance abuse services, there are 102 adult behavioral health consumers in the seven counties to be served who have been diagnosed with co-occurring disorders (substance abuse diagnosis and serious mental illness) and who are open to receiving services. These individuals have self-reported that they have had moderate to significant adverse

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RHP Plan for Region 4
effects due to their substance use. Another 218 individuals served by CPCC have indicated on their current assessments that they have used substances within the last 90 days and had some consequences due to this use, though they felt that it was “minimal.”

Rationale:
The Coastal Bend area suffers from a serious dearth of qualified medical professionals. According to the U.S. Department of Health and Human Services, eight of the nine counties in the proposed area to be served are designated as Health Professional Shortage Areas (HPSA’s). Of these eight counties, seven have shortages in primary healthcare, mental health care and dental care; the eighth county is designated as an HPSA in mental health care. Coastal Plains is the HPSA provider of mental health services in the Coastal Bend area. In 2009, the Agency for Healthcare Research and Quality (AHRQ) released a publication recommending integrated mental and physical health services for people with depression. 74 The AHRQ found evidence that people with depression who receive coordinated services for mental health and physical health have fewer symptoms than those who only receive a single service. It was also found that this integrated health system reduces overall healthcare costs as mental health symptoms can increase the physical health symptoms associated with a chronic illness. With treatment of the mental health symptoms, the chronic health symptoms are decreased. It stands to reason that this would be similar for people with SMI other than depression.

Individuals with mental health conditions often have co-occurring substance use conditions and vice versa. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 8.9 million adults have both a mental and substance use disorder and only 7.4% of these individuals receive treatment for both conditions. Another 55.8% receive no treatment at all. 75 SAMHSA also notes, “There are many consequences of undiagnosed, untreated, or undertreated co-occurring disorders including higher likelihood of experiencing: Homelessness; Incarceration; Medical illnesses; Suicide; and Early Mortality. The integration of mental health and substance abuse treatment and services is associated with lower costs and better outcomes such as: Reduced substance use; Improved psychiatric symptoms and functioning; Decreased hospitalization; Increased housing stability; Fewer arrests; and Improved quality of life.” 76

Project Components:
Through the South Texas Whole Health and Substance Abuse Integration Program we propose to meet all required project components of 2.15.1 as listed below and believe that the selected milestones and metrics relate to the project components:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health provider could be facilitated

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral health and physical health providers

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75 Substance Abuse and Mental Health Services Administration. Co-occurring disorders. Available at http://www.samhsa.gov/co-occurring/
76 Substance Abuse and Mental Health Services Administration. Co-occurring disorders. Available at http://www.samhsa.gov/co-occurring/
d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations.
e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   • Regular consultative meetings between physical health and behavioral health practitioners
   • Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners
   • Shared treatment plans co-developed by both physical health and behavioral health practitioners
f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.
g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
h) Arrange for utilities and building services for these settings.
i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include but are not limited to identifying project impacts, identifying “lessons learned”, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Milestones and Metrics:** The following milestones and metrics have been chosen for the South Texas Whole Health and Substance Abuse Integration Program based on the core components and the needs of the target population:
Process Milestones and Metrics: P-5 (P-5.1, P-5.2); P-6 (P-6.1); P-7 (P-7.1);
Improvement Milestones and Metrics: I-8 (I-8.1); I-9 (I-9.1); I-10 (I-10.1); I-11 (I-11.1); I-12 (I-12.1); I-X2 (I-X2.1); I-X (I-X.1)

**Unique community need identification number(s):**
The project addresses the following unique community needs as identified in the community needs assessment:
   • CN 2 – Inadequate access to specialty care
   • CN 4 – Inadequate access to behavioral health services
   • CN 15 – Inadequate health care access in rural areas
   • CN 19 – Negative mental health outcomes, such as suicide or mental admissions in jails/prisons

**Related Category 3 Outcome Measure(s):**
The following Category 3 Outcome measures apply to this project:
   • IT-1.10 Diabetes Care HbA1c poor control (>9.0%) - NQF 0059 (standalone measure)
• **IT-1.11 Diabetes Care: BP control (<140/80mm Hg) - NQF 0061 (standalone measure)**

The data and literature demonstrate a greater risk for obesity, diabetes and high cholesterol among the SMI population. Lack of access to primary care physicians results in poor disease management and preventable health conditions which, in turn, leads to high rates of ED utilization, preventable hospitalizations, and elevated healthcare costs. By integrating primary and behavioral healthcare in our community, we will provide a continuum of services with an emphasis on prevention and wellness, leading to overall improved health.

• **IT- 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (standalone measure)**

Admission and readmission to criminal justice settings is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

• **IT-10.7 Other Outcome Improvement Target: 70% of admissions to SA Services successfully complete treatment services (non-standalone measure)**

Patients with co-occurring disorders often exhibit more severe symptoms than those caused by either disorder alone, underscoring the need for integrated treatment. Careful diagnosis and monitoring will help ensure that symptoms related to drug abuse (e.g., intoxication, withdrawal) are not mistaken for a discrete mental disorder. Even in people whose co-morbidities do not occur simultaneously, research shows that mental disorders can increase vulnerability to subsequent drug abuse and that drug abuse constitutes a risk factor for subsequent mental disorders. Therefore, diagnosis and treatment of one disorder will likely reduce risk for the other, or at least improve its prognosis.

**Relationship to other Projects:**

This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following:

- 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas;
- 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization;
- 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care,
- 121990904.2.1 – Integrate primary and behavioral health care services.


**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**

Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share...
information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**
We propose to use an annual cost savings of $2,040 per patient served by our primary care / behavioral health integration. This cost savings comes from the Colorado Study\textsuperscript{77} of 1,000 Medicaid patients in primary care that were provided depression management services. We believe that this is a conservative figure for this project for the following reasons:

- We project that 1,000 of the 1,700 persons to be served by our project will be uninsured. Their uninsured status should mean that their historical health services are far more meager than the Medicaid recipients in Colorado, and therefore present a greater possibility of improvement.
- We propose to provide twice annual preventive dental services to our 1,700 patients. Although we cannot cite specific cost savings from this service, it is well documented that good oral hygiene is integral to good physical health.
- We propose to provide ongoing health education, disease management, weight control and smoking cessation classes for all our patients.
- We propose to employ care management / health navigators at all of our clinics to foster compliance with medical appointments and health recommendations for the patients.

In estimating total cost savings for the 4-year project, we have multiplied the total number of patients to be served each year by the expected savings of $2,040 which equals $9,282,000.

In addition to the above medical cost savings, we project that we will transfer 500 stable patients from the care of our psychiatrists to our primary care provider. Currently we have a large number of patients in psychiatric care who have been stable on their medications for a year or longer and could be appropriately served in a primary care setting. They have not been moved to this less expensive setting because they are either uninsured or we have been unable to secure a primary care physician for them. Our FQHC partner has agreed to accept these patients because of the availability of psychiatric consultation and readmission. Our State developed Cost Accounting Methodology gives us an average annual cost of $582 for these psychiatric services. In estimating our cost savings for this 4-year project, we have multiplied the number of stable patients transferred to primary care by our cost savings of $582, for a total cost savings of $727,500.

The cost savings in regards to substance abuse services could be significant. Not only do studies show financial savings, just saving one person from driving drunk could save a life. The Haymarket Study\textsuperscript{78} found that over four years, intensive out-patient treatment produced a cumulative savings of $14,589 per person. This cumulative savings results in an average savings of $4,608.25 per person per year. We have taken this average savings and multiplied it by the projected number of persons our service partner will treat each year, for a total savings over the four years of $4,032,086.

\textsuperscript{77} Thomas, M. Colorado Access. Presentation at Robert Wood Johnson Foundation Depression in Primary Care Annual Meeting, February 2006 as quoted in “The Business Case for Bidirectional Integrated Care: Mental Health and Substance Abuse Services in Primary Care Settings and Primary Care Services in Specialty Mental Health and Substance Use Settings” from The California Integration Policy Initiative. June 2010.

\textsuperscript{78} Dennis, M., Scott, C., Godley, M., Lustig, D., Chestnut Health Systems, Feb. 22, 2011 Presentation: “Substance Abuse Treatment Reduces Costs to Society: Eliminating Substance Abuse Treatment Increases Costs”
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<tr>
<th>TPI #: 080368601</th>
<th>Integrate Primary and Behavioral Health Care Services</th>
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<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
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<td>080368601.3.1</td>
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<th>Year 2</th>
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<tr>
<td><strong>First 6 Months:</strong></td>
<td><strong>Milestone 8 P-5:</strong> Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 1 P-5.1: Number of agreements signed for the provision of integrated services. <strong>Baseline:</strong> No service agreements <strong>Goal:</strong> 2 Service agreements - 1 w/FQHC and 1 w/COADA-CB <strong>Data Source:</strong> Project Data Metric 2 P-5.2 (a): Number of primary care providers newly located in behavioral health settings. <strong>Baseline:</strong> No primary care or substance abuse providers located in behavioral health clinics <strong>Goal:</strong> (a) FQHC will provide primary health care staffing sufficient for 3 BH clinics as per agreement. This will include at least 0.2 FTE per clinic of the following: Primary Care (PA/APN)</td>
<td><strong>Milestone 18 P-5:</strong> Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 2 P-5.2: Number of primary care providers newly located in behavioral health settings. <strong>Baseline:</strong> No service agreements for primary health care staffing sufficient for 3 BH clinics as per agreement. <strong>Goal:</strong> (a) FQHC will provide primary health care staffing sufficient for 1 additional BH clinic as per agreement. This will include at least 0.2 FTE per clinic of the following: primary care provider, LVN and clerk. A total of 4 clinics will be integrated by FY 3 end with patient access to CACOST health clinics in each county 5 days a week. (b) SA Provider (COADA-CB) or other DSHS approved SA provider(s) will provide sufficient staffing with at least 0.75 FTE LCDC per clinic into 2 BH clinics as per agreement (total 3 clinics).</td>
<td><strong>Milestone 28 P-5:</strong> Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 2 P-5.2: Number of primary care providers newly located in behavioral health settings. <strong>Baseline:</strong> No service agreements for primary health care staffing sufficient for 3 BH clinics as per agreement. <strong>Goal:</strong> (a) FQHC will continue to provide Primary Health care staffing sufficient for the 5 BH clinics as per agreement. Through this agreement there will be at least 0.2 FTE per clinic, A primary care provider (PA/APN), LVN and Clerk with access to CACOST health clinic 5 days a week. (b) SA Provider (COADA-CB) or other DSHS approved SA provider(s) will provide sufficient staffing (at least 0.75 FTE LCDC per clinic) into 1 additional BH clinic as per agreement. (total = 5 clinics).</td>
</tr>
<tr>
<td>Milestone 2 P-7: Evaluate and continuously improve integration of primary and behavioral health services</td>
<td>Coastal Plains Community Center</td>
<td>TPI #: 080368601</td>
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| Metric 1 P-7.1: Project planning and implementation documentation demonstrates "plan, do, study, act" quality improvement cycles | Baseline: no quality improvement plan in place. 
Goal: Quality Improvement Plan developed with preliminary outcome measures. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or state and federal guidelines). | Baseline/Goal: ERS system utilized by all three service providers w/in state and federal guidelines. 
Data Source: Project data |
| Coastal Plains will provide 1 FTE navigator per clinic | Data Source: Project Data | Data Source: Project Data |
| Milestone 9 Estimated Incentive Payment (maximum amount): $324,000 | Milestone 19 Estimated Incentive Payment (maximum amount): $324,000 | Milestone 29 Estimated Incentive Payment (maximum amount): $295,520 |
| Milestone 10 P-7: Evaluate and continuously improve integration of primary and behavioral health services | Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 20 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Metric 1 P-7.1: Project planning and implementation documentation demonstrates "plan, do, study, act" quality improvement cycles | Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 30 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 21 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 31 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 32 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 33 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 34 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 35 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 36 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 37 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 38 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 39 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
| Baseline/Goal: Quality Improvement Plan reviewed quarterly. 
Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous | Milestone 40 P-7: Evaluate and continuously improve integration of primary and behavioral health services |
Coastal Plains Community Center

**Milestone 2** Estimated Incentive Payment *(maximum amount)*: $449,642

**Second 6 Months:**

**Milestone 3** I-8: Integrated Services

**Metric 1** I-8.1

(a) BH/PC Services: Number of Individuals receiving both physical and behavioral health care at the established locations.
(b) BH/SA Services: Number of individuals receiving substance abuse and BH services at the established location.

Baseline: 0 people receiving BH/PC services; 0 people receiving BH/SA services
Goal: (a) 500 people served in both BH and Primary Care services (b) 60 people served in both BH and SA services.

Data Source: Project data; claims and encounter data; medical records

**Milestone 4** I-9: Coordination of Care

**Metric 1** I-9.1 Number of Individuals with a treatment plan developed and implemented with primary care and BH expertise

Baseline/Goal: 250 people will

Milestone 2 Estimated Incentive Payment *(maximum amount)*: $449,642

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Coastal Plains Community Center

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<tr>
<th>Milestone 12</th>
<th>Estimated Incentive Payment (maximum amount): $324,000</th>
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<tbody>
<tr>
<td><strong>Milestone 13 I-10: No-Show Appointments</strong> Metric 1 I-10.1: % decrease the “no shows” for behavioral and physical health appointments (doctor appointments). Baseline/Goal: 2 % decrease over DY2 through navigation and case management (total of 2.5% decrease) Data Source: Project Data; Clinic Registry Data; Claims and Encounter data Milestone 13 Estimated Incentive Payment (maximum amount): $324,000</td>
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<tr>
<td><strong>Milestone 14 I-11: Health Metrics</strong> Metric 1 I-11.1: % Increase in Positive Results of Standardized Health Metrics Baseline/Goal: <em>10</em>% increase in positive results of a health metrics over DY2 baseline</td>
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<td><strong>Milestone 22</strong></td>
<td>Estimated Incentive Payment (maximum amount): $324,000</td>
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<td><strong>Milestone 23 I-10 No-Show Appointments (doctor appointments)</strong> Metric 1 I-10.1: % decrease the “no shows” for behavioral and physical health appointments. Baseline/Goal: 2 % decrease from DY3 through navigation and case management (total of 4.5% decrease) Data Source: Project Data; Clinic Registry Data; Claims and Encounter data Milestone 23 Estimated Incentive Payment (maximum amount): $324,000</td>
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<td><strong>Milestone 32</strong></td>
<td>Estimated Incentive Payment (maximum amount): $295,520</td>
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<td><strong>Milestone 33 I-10 No-Show Appointments (doctor appointments)</strong> Metric 1 I-10.1: % decrease the “no shows” for behavioral and physical health appointments. Baseline/Goal: 2 % decrease from DY4 through navigation and case management (total of 6.5% decrease) Data Source: Project Data; Clinic Registry Data; Claims and Encounter data Milestone 33 Estimated Incentive Payment (maximum amount): $295,520</td>
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<tr>
<td><strong>Milestone 34 I-11: Health Metrics</strong> Metric 1 I-11.1: % Increase in Positive Results of Standardized Health Metrics Baseline/Goal: 20 % increase in positive results of a standardized health metrics from DY3</td>
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<td>TPI #: 080368601</td>
<td>Integrate Primary and Behavioral Health Care Services</td>
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<td><strong>Milestone 6 P-X:</strong> Establish a baseline for measuring increase in positive results of standardized health metrics. <strong>Metric 1 P-X.1:</strong> Positive Results of Standardized Health Metrics Baseline: at least 50% of the people served in mental health services either have high blood pressure, high cholesterol, BMI over 30 and/or diabetes (high A1C) Goal: To provide testing, education and medications as appropriate to 625 (80%) of people served in collaborative care regarding their A1C, cholesterol, and blood pressure to establish baseline. Data Source: Project Data; Medical Records; Claims and Encounter Data</td>
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<td><strong>Milestone 14 Estimated Incentive Payment (maximum amount): $324,000</strong></td>
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<td><strong>Milestone 15 I-X:</strong> Preventable Admissions and Readmissions <strong>Metric 1 I-X.1:</strong> 0.5% Decrease in preventable admissions and readmissions to psychiatric and other inpatient facilities; Baseline/Goal: Through navigation and education services 250/1000 served will report using outpatient primary care/psychiatric services instead of Emergency Room to address non-emergency health needs. Data Source: Admission, quarterly and exit questionnaire completed by patient with navigator. Project Data; Claims/encounter and clinical record data and other hospitals</td>
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<td><strong>Milestone 15 Estimated Incentive Payment (maximum amount): $324,000</strong></td>
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<td><strong>Milestone 25 I-X:</strong> Preventable Admissions and Readmissions <strong>Metric 1 I-X.1:</strong> 0.75% Decrease in preventable admissions and readmissions to psychiatric inpatient facilities; Baseline/Goal: Through navigation and education services 338/1350 served will report using outpatient primary care/psychiatric services instead of Emergency Room to address non-emergency health needs Data Source: Admission, quarterly and exit questionnaire completed by patient with navigator. Project Data; Claims/encounter and clinical record data and other hospitals</td>
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<td><strong>Milestone 25 Estimated Incentive Payment (maximum amount): $324,000</strong></td>
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<td><strong>Milestone 34 Estimated Incentive Payment (maximum amount): $295,520</strong></td>
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<td><strong>Milestone 35 I-X:</strong> Preventable Admissions and Readmissions <strong>Metric 1 I-X.1:</strong> 1% Decrease in preventable admissions and readmissions to psychiatric inpatient facilities; Baseline/Goal: Through navigation and education services 425/1700 served will report using outpatient primary care/psychiatric services instead of Emergency Room to address non-emergency health needs Data Source: Admission, quarterly and exit questionnaire completed by patient with navigator. Project Data; Claims/encounter and clinical record data and other hospitals</td>
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<td><strong>Milestone 35 Estimated Incentive Payment (maximum amount): $295,520</strong></td>
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<td></td>
<td><strong>Milestone 36 I-X.2 Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventative and ongoing care.</strong></td>
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<tr>
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<td><strong>Milestone 26 I-17 Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventative and ongoing care.</strong></td>
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<tr>
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<td><strong>Milestone 36 I-17 Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventative and ongoing care.</strong></td>
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<tr>
<td>Baseline/Goal: Through navigation and education services 125/500 served will report using outpatient primary care/psychiatric services instead of Emergency Room to address non-emergency health needs. Data Source: Admission, quarterly and exit questionnaire completed by patient with navigator. Project Data; Claims/ encounter and clinical record data other hospitals.</td>
<td>Coastal Plains Community Center</td>
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<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,147,490</td>
<td>Milestone 17 I-12: Improved Consumer satisfaction with Integrated Services Metric 1 I-12.1: 75% of People report satisfaction with integrated services Baseline/Goal: 75% of patients with integrated services Data Source: from completed consumer satisfaction surveys Milestone 17 Estimated Incentive Payment (maximum amount): $324,000</td>
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<td>Year 3 Estimated Milestone Bundle Amount: $3,240,000</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,240,000</td>
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<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD; $12,582,690</td>
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<td>Milestone 36 Estimated Incentive Payment (maximum amount): $295,520</td>
<td>Milestone 37 Estimated Incentive Payment (maximum amount): $295,520</td>
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**DeTar Healthcare System/ 094118902**

### 2.2.1 Redesign outpatient delivery system to coordinate care for patients with chronic diseases

*094118902.2.1*

**Provider:** DeTar Healthcare System is a 308-bed two-hospital system in Victoria, Texas that serves Victoria and surrounding counties. We serve a 5,200 square mile area and a population of approximately 164,467.

**Intervention(s):** This project will provide clinics in five counties that are Medicaid underserved and/or HPSA/MUAs to increase access to care. Part of the mission is to target patients with chronic illnesses to help them self-manage their diseases to prevent potentially unnecessary hospital admissions/readmissions.

**Need for the project:** The targeted counties have approximately 720 readmissions per year by patients with chronic conditions. Access to care is limited in these rural locations. These clinics will utilize multidisciplinary involvement in patient care and provide an accountability system that will help each patient remain responsible for their disease maintenance. They will be located in the community where the patient resides to avoid transportation barriers and assure coordination with community resources needed by the patient.

**Target population:** The target populations are persons with chronic diseases, with attention to those discharged from hospitals that are at risk for potentially preventable readmissions. This population will be able to benefit from treatment and support systems/resources that allow them to maintain optimal health through self-management of their illnesses. The patients affected will be from all financial classes. Because of the difficulty of finding practices that accept unfunded and Medicaid patients, it is anticipated a significant portion of the clients will fall into these categories.

**Category 2 expected patient benefits:** Access to care will be increased in underserved areas, and there will be consistent follow-up and accountability. Patients will be educated and supported in self-management of their diseases, monitored for compliance, provided group support, and receive assistance in navigating their care throughout the various services/professionals needed for their condition. Potentially unnecessary hospitalizations or re-hospitalizations will be avoided. This project will result in two clinics being opened in DY2 that are new points of access and an additional three clinics opened in DY3. All clinics will be open four hours per day per clinic Monday through Friday. This project will serve 245 patients who are followed in DY2, 320 in DY3, 330 in DY4 and 340 in DY5.

**Category 3 outcomes:**

**IT-3.2** Our goal is to decrease those with congestive heart failure from having potentially avoidable readmissions to hospital within 30 days By the end of DY5, seventy-two (72) readmissions related to poor control of CHF will be prevented. This will be achieved by the percentage of readmissions going from the established rate of 25% to 20% in DY2, 15% in DY3, 12% in DY4, and 10% in DY5.

**IT-3.3** Our goal is to decrease those with diabetes from having potentially avoidable readmissions to hospital within 30 days By the end of DY5 twenty-four (24) readmissions related to poor control of diabetes will be prevented. This will be achieved by the percentage of readmissions going from the established rate of 25% to **20%** in DY2, 15% in DY3, 12% in DY4, and 10% in DY5.

**IT-3.5** Our goal is to decrease those who have had acute myocardial infarction from having potentially avoidable readmissions to hospital within 30 days. By the end of DY5 twenty-four (24) readmissions related to inadequate self-management of cardiac disease will be prevented. This will be achieved by the percentage of readmissions going from the established rate of 25% to 20% in DY2, 15% in DY3, 12% in DY4, and 10% in DY5. **IT-3.7** Our goal is to decrease those who have had stroke from having potentially avoidable readmissions to hospital within 30 days...
By the end of DY5 twenty-seven (27) readmissions related to inadequate self-management of stroke will be avoided. This will be achieved by the percentage of readmissions going from the established rate of 25% to 20% in DY2, 15% in DY3, 12% in DY4, and 10% in DY5.
Category II-Program Innovation and Redesign

Project Option: 2.2.1 Redesign outpatient delivery system to coordinate care for patients with chronic diseases

Unique RHP Project Identification number: 094118902.2.1

Performing Provider/TPI: DeTar Healthcare System/094118902

Project Description: DeTar Healthcare System will establish multiple outpatient clinics with a focus on chronic disease management in the counties we serve.

The purpose of this project is to provide an outpatient delivery system that coordinates care for patients and allows them optimal quality of life while living with a chronic illness. Health records show that certain chronic conditions result in a high rate of admissions/readmissions to inpatient care. Without proper management by the health care provider, as well as self-management by the patient and caregivers, hospitalizations are likely. Texas Medicaid estimates it could save more than $10 Million a year if these avoidable hospitalizations were reduced by only 10%. A readmission is one that would have a plausible clinical connection to the first stay. In 2010, 3.7% of Texas Medicaid stays were followed by a potentially preventable readmission. These readmissions cost Medicaid $106 Million. It is estimated a minimum of 11% of re-hospitalizations could be avoided.

DeTar Healthcare System is a 308-bed acute care hospital located in Victoria, Texas. Care is provided to patients of all ages. We pride ourselves on provision of evidence-based care and excellent performance. Achievements that lend toward managing chronic conditions to the level that will promote optimal lifestyle and health, and prevent hospitalizations, include: Chest Pain Center accreditation from the Society of Chest Pain Centers; Platinum Award from the National Cardiovascular Data Registry—ACTION Registry 2012; Silver Award from American Heart Association for Chest Pain management; Bronze Award for Heart Failure and MISSION: Lifeline as well as the Gold Plus Award for Stroke from American Heart Association Get With the Guidelines; and Stroke certification both from the Joint Commission and designation from the State of Texas as a primary stroke center. We were recognized by Joint Commission for our high scores with core measures, consistently scoring over 99.5% on these evidence based protocols. We employ both certified diabetic educators and wound management specialists.

This project will increase service options in the rural outpatient setting where access to intensely focused programs in chronic disease management may not be prevalent. DeTar will partner with community-based health care infrastructure leaders in DeWitt, Jackson, Lavaca, Refugio, and Victoria Counties to establish clinics in each of these areas so resources exist where the client resides. These clinics will be opened in a location agreed upon by the community leaders. They will be staffed with mid-level practitioners who report to a medical director. Other members of the care team available to each clinic will include: Respiratory Therapist, Nutritionist, Pharmacist/Tech, and Disease Educators for Stroke, Heart, and Diabetic conditions, and case management as indicated for navigation of care. We will partner with trained Community Health Workers for those who may need attention in their home setting.

The clinics will provide a resource for patients with chronic conditions. Their care team will coach the patient in self-management of their condition, provide professional monitoring, assume oversight for medication reconciliation and compliance, and help them when

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79 hhsc.state.tx.us, March-April 2012
navigation of the various care settings they use is required. All known patients who have been discharged from hospitals that fall into those categories known for potential admissions (Pneumonia, Dehydration, UTI, Angina, CHF, Hypertension, Asthma, COPD, Diabetes) will be targeted for intense follow-up care and redesigned program. We will provide team based care for patients enrolled in this program. Optimally, the area hospitals will notify us to see patients who agree to enrollment while they are still in the hospital setting. If the patient does not have an appointment with the primary care doctor within four days of discharge, they will be seen in a clinic as an interim measure for transitional support and to initiate the redesigned process. In addition to patients who have been hospitalized, the program will also serve anyone with a chronic condition who presents to the clinic either independently or is referred.

The processes for enrollment and follow-up include:

1. Standardized screening to assess patient understanding of his condition and level of compliance.
2. Assessment for risk of hospitalization based on health history, social issues, family support, level of independence, and health risks.
3. Risk stratification based on initial assessments to prepare treatment and maintenance plans. Considerations will intensify on those with multiple chronic conditions, recently hospitalized, those that have multiple ED visits in a short time, clients without a PCP, and those on a large number of medications.
4. Medications will be reviewed by pharmacy staff to assure medications are reconciled to the current orders. Patient understanding of the medicines will be assessed and education/coaching/teach-back will be used if patient is not clear. Assessment will be made whether all prescriptions were filled. If they have not been filled, the care team will facilitate correction. The pharmacy will send any recommendations for medication changes/improvements to the PCP.
5. If recently hospitalized, evaluation will be done on lab work to assure the results were acted upon when appropriate.
6. History and physical assessments will be completed and a schedule made for patients for on-going care, education, and life improvement programs.
7. Education will be ongoing with teach-back or demonstration used by client/care giver to assure correct understanding of activities needed for optimal self-management. A self-management notebook will be provided as indicated.
8. All patients with chronic conditions will have information on the red flags that should precipitate communication with the care team provider.
9. Ongoing visits will be tracked and patients contacted if there is failure to comply with the schedule. The community health worker will be dispatched to the home as needed if there is mobility, transportation, or other issues that may prohibit the patient from compliance. Community resources will be used and information provided to the patient to facilitate use of these programs.
10. If patients need other services, the case management team will assist in navigation to appropriate providers.
11. Every patient will be given the names and contacts for the members of his/her care team and be informed how to reach them by phone, email, or personal contact.
12. Every hospitalization and/or ED visit will be reviewed to determine if there was a failure in the program.

Other program requirements will involve:

1. A computerized program that tracks patients and quality outcomes. It includes health information that can be shared with other clinical providers.
2. Each clinic will be provided with automatic updates from DynaMed so evidence based practices remain updated and current at all times.
3. Continuity of care will include sending a report of every visit, intervention, and patient’s involvement in this program to the PCP if there is one. Families or other support persons will be included in all aspects of the program.
4. There will be one person dedicated to call-backs to patients who have just been discharged from a hospital, have had medication changes by their PCP, fail to come to appointments or classes, or when other follow-up is needed.

Each client, along with his/her support persons, will be engaged in regular education to increase the client’s engagement in self-management. This is done individually on each visit with the midlevel or support persons on the care team such as a nutritionist, but our experience is that group support is effective in helping patients learn and better manage their condition. Currently DeTar hosts such groups for chronic disease conditions only in Victoria County. As an example, we have a “Lunch Bunch” program for diabetics and their support person who attend lunch every month. Over lunch, education is provided on how they can better manage their condition, new breakthroughs or evidence that may have emerged about their condition, and resources they can use. We will have similar groups in each of the clinics being established. The community resources from each clinic where care is provided will be given to the patients and we will help them access these as indicated.

To address quality improvement the team will discuss client’s progress, preferably with client/family present, on a scheduled basis to assure the approach for them is efficacious. Changes will be made if they are not and new treatment approaches used. We will study the most successful interventions and extrapolate them out to future clients as their baseline treatment approach, so that quality continues to improve. Lessons learned will not only be taken to our own clinics, but to our medical partners in this project. We will share successes and lessons learned with hospitals and medical leaders in each market. The outcomes will be shared with those treating chronic diseases such as physicians, local support groups, mid-level practitioners and others who can expand what we have learned to their own population.

Project Goals and Relationship to Regional Goals:

- Establish outpatient clinics in rural counties that provide an outpatient care team approach to patients with chronic conditions.
- Provide evidence-based care to enrollees that will enrich their self-management of their condition.
- Prevent potentially unnecessary admissions/readmissions. Provide access to multidisciplinary care team that can be reached for assistance and education/group support that empowers patient to better manage his/her condition.
- Establish tracking system that facilitates compliance with appointments, classes, and other interventions recommended for the chronic care conditions.

Our project goals support the regional goals of addressing the region’s heavy burden of chronic disease and health disparities by providing additional clinics focused on chronic disease management. The clinics will provide a resource for patients with chronic conditions. Their care team will coach the patient in self-management of their condition, provide professional monitoring, assume oversight for medication reconciliation and compliance, and help them when navigation of the various care settings they use is required.

**Challenges:**
- Alignment with community partners in the designated counties for clinic establishment and operations.
- Training/Education of care team, community health workers, and support staff.
- Resources for social problems such as inability to afford medications, get transportation, or make modifications to residences that have fall risks.
- Costs.

As the Performing Provider we will overcome these challenges by partnering with the community medical leaders who will share knowledge and provide advice on locations, hours, operations, and best forms of communication.

**5 year expected outcome:**
The expected outcome is to establish two clinics with this program by the end of DY2 and the additional three completed DY3. The improvement measures will include admission/readmission rates for Congestive Heart Failure, Diabetes, Stroke, and AMI. Literature reveals that the readmission rate for the targeted chronic conditions is 25%. The outcome will reduce this from 25% to 20% in DY2, 15% DY3, 12% in DY4, and 10% in DY5. From the baseline year of DY1 there will be a cumulative increase in the success of avoiding unnecessary readmissions. To illustrate, for every 100 patients in DY1 at a 25% readmission rate, or 25 patients, would be readmitted. This will diminish to 20 patients in DY2, 15 in DY3, 12 in DY 4, and 10 in DY 5. Based on readmissions in this geographical area and the number of patients anticipated to use the clinics described in this project, the 5-year expected outcome will be 72 avoided readmissions for Congestive Heart Failure; 24 prevented re-admissions for diabetes issues; 24 prevented readmissions for myocardial infarction and 27 preventable readmissions for stroke.

**Starting Point/Baseline:**
- In DY1 there are no clinics to provide chronic care disease management in any of the involved counties.
- In DY 1 there are no care team models that work with post-hospitalized patients in the targeted counties.
- In 2010 Victoria County had 476 readmissions for CHF, Hypertension, and diabetes complications; Lavaca County had 149, Goliad, 22; Refugio, 18, and DeWitt, 40.
Rationale:
This project was selected because of the increasing problem with readmissions to the hospital. Research shows that there are diagnoses that lend toward re-hospitalizations and risk factors—such as having two chronic diseases—that make potentially unnecessary hospitalizations even more likely. In our facility we do call backs to our patients. Despite careful explanations and teaching, these calls reveal some patients did not understand exactly what to do. Especially in the area of medication, there is misunderstanding of schedules, what medications were to be stopped, and dosages. Our experience also tells us that follow-up appointments have either not been made or are too far in the future. This is especially true for patients who do not have a regular PCP and who may not have the funds to be aligned with a regular physician. Research shows early interventions, patient’s knowledge of his or her disease, and effective management of the chronic conditions can reduce hospital episodes.

Project Components:
These clinics will be the foundation for meeting the conditions a-e of this project option.

a) Design and implement care teams that are tailored to the patient’s health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system

b) Ensure that patients can access their care teams in person or by phone or email

c) Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions

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

Milestones & Metrics:
The following milestones and metrics have been chosen for the redesign outpatient delivery system to coordinate care for patients with chronic diseases project based on the core components and the needs of the target population:

- **Process Milestones and Metrics:** P-1 (P-1.1); P-3 (P-3.2)
- **Improvement Milestones and Metrics:** I-17 (I-17.1)

Unique community need identification number the project addresses:
- CN.3 - Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.7 - High rates of preventable hospital admissions
- CN.9 - Shortage of specialty care physicians
How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will increase service options in the rural outpatient setting where access to intensely focused programs in chronic disease management may not be prevalent. The additional clinics will provide additional access to needed care for this population.

Related Category 3 Outcome Measures:
IT-3.2 Congestive heart Failure 30-day readmission rate (Stand-alone).
IT-3.3 Diabetes Failure 30-day readmission rate (Standalone).
IT-3.5 Acute Myocardial Infarction (AMI) readmission rate (Standalone).
IT-3.7 Stroke 30-day readmission rate (Standalone).

Reasons/rationale for selecting the outcome measures:
These outcome measurements were selected because patients with these conditions are at high risk for readmission if not properly managed. All have the potential for severe disability and death, and the quality of life is diminished if not properly managed. We will implement a program that provides management for chronic disease that involves collaboration from a multidisciplinary team. By educating, involving the patient/support in disease management, scheduling evidence based follow-up practices, and facilitating compliance, unnecessary admissions to a hospital will be avoided for those patients with this chronic disease enrolled in our program. The clinics will be in rural areas where this type of approach and ongoing case management is not always available. Research shows diabetes is one of the chronic illnesses that often require readmission, and this is a prevalent disease in these areas.

Relationship to Other Projects:
All of our projects complement each other in providing enhanced and increased access to services for our targeted population. Increasing the number of clinics supports our community needs across projects to include additional capacity for providing prenatal/postnatal, chronic disease management and behavioral health outpatient care for our community. Other related projects that will be enhanced include: 094222902.1.2 – Implement a chronic disease registry, and 121775403.2.8 – Expand Care Transitions Program. Related Category 4 measures include RD-1 – Potentially Preventable Admissions, and RD-2: 30 day readmissions, and RD-3 – Potentially Preventable Complications.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects who will participate in the collaborative include CHRISTUS Spohn.
**Project Valuation:**
This project will provide a change in outpatient management of chronic diseases with the goals of improving compliance, providing education and skills, and avoiding inpatient hospitalization. There were 2,171 potentially preventable hospitalizations in the targeted counties identified in this project in 2010, and the average hospital cost per case was $10,388.70 (DSHS). For the patients we serve, by having their self-management improved, close oversight for compliance, and ongoing monitoring of their condition, unnecessary hospitalizations will be avoided. Our improvement goal will be to have no more than 20% of the clients using our clinics to have a potentially unnecessary admission/readmission for the first year services are open; 15% in DY3, 12% in DY4, and 10% DY 5. Based on our predicted volume by DY5 147 inpatient hospitalizations/re-hospitalizations will be avoided because of these clinics.

The current estimated cost of a readmission is $10,388.70 and valuation increases this amount by 3% per year as an inflation factor. By DY5 there will be 147 readmissions saved as a result of the programs offered in these clinics.
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<th>094118902.2.1</th>
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<th>EXPAND CHRONIC CARE MANAGEMENT MODELS</th>
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<td>VICTORIA, TEXAS</td>
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**Related Category 3 Outcome Measure(s):**
- 094118902.3.3
- 094118902.3.4
- 094118902.3.5
- 094118902.3.6

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<th>EXPAND CHRONIC CARE MANAGEMENT MODELS</th>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>Milestone 1 P-1 Expand the chronic care model to primary clinics in rural counties that will provide chronic care model for management of chronic diseases. <strong>Metric 1</strong> P-1.1: Increase number of primary care clinics using the Chronic Care model - Preparation complete by determining regulations, building program plan, securing location and developing physical plant. <strong>Baseline/Goal:</strong> Baseline 0 clinics in targeted areas. Goal Two of the planned 5 clinics open by end of year and will institute interdisciplinary chronic care approach for 245 patients. <strong>Data Source:</strong> Performing Provider evidence of innovational plan. <strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $523,069</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Milestone 2 P-1 Expand the chronic care model to primary care clinics - Establish 3 additional clinics by end of 2nd Q DY 3. <strong>Metric 1</strong> P-1.1: Increase number of primary care clinics using the chronic care model. <strong>Baseline/Goal:</strong> Two clinics opened &amp; model in place; Goal 5 clinics open and chronic care model in place. Patients served 320. <strong>Data Source:</strong> Documentation of practice management, Provider records. <strong>Process Milestone 2 Estimated Incentive Payment:</strong> $718,994</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Milestone 3 I-17 Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally. <strong>Metric 1</strong> I-17.1 Increase the number of patients receiving care under the chronic care model. <strong>Baseline/Goal:</strong> Baseline is 320 patients and this will increase to 330 in DY4. <strong>Data Source:</strong> Registry, Provider Records, program enrollment records. <strong>Milestone 3 Estimated Incentive Payment:</strong> $740,564</td>
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<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Milestone 4 I-17 Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally. <strong>Metric 1</strong> I-17.1 Increase the number of patients in a care under the chronic care model. <strong>Baseline/Goal:</strong> Data Baseline is 330 patients and this will increase to 340 patients in DY5. <strong>Data Source:</strong> Registry, Provider Records, program enrollment records. <strong>Milestone 4 Estimated Incentive Payment:</strong> $755,125</td>
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**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $523,069

| Year 3 Estimated Milestone Bundle Amount: | $718,994 |
| Year 4 Estimated Milestone Bundle Amount: | $740,564 |
| Year 5 Estimated Milestone Bundle Amount: | $755,125 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $2,737,752
DeTar Healthcare System/ 094118902

2.7.4 Implement Evidence-based Strategies to Reduce Low Birth Weight and Preterm Birth
094118902.2.2

Provider: DeTar Healthcare System is a 308-bed two-hospital system in Victoria, Texas that serves Victoria and surrounding counties. We serve a 5,200 square mile area and a population of approximately 164,467.

Intervention(s): This project will provide prenatal clinics in five counties that are Medicaid and/or MUAs. Women will be able to receive prenatal care without the barriers of waiting for Medicaid eligibility. They will continue to receive care throughout pregnancy and have postpartum follow-up. These clinics will be located in their own rural communities to negate transportation barriers.

Need for the project: There are no prenatal clinics for impoverished women in four of the targeted counties. Thirteen percent of the babies born in the counties where the clinics will be offered are preterm (<37 weeks) and/or have low birth weights. This includes Goliad County at 8.3%, Jackson County 14.6%, Lavaca County 15.8%, Refugio County 12.2% and Victoria County 14.4%.

Target population: The target population is pregnant women who need prenatal care. This will be provided in early pregnancy, within the first trimester when possible, and continue through post-partum examination regardless of the patient’s funding. It is estimated 100% of these women will be indigent or receiving Medicaid benefits. It also targets those pregnant women with wellness improvement opportunities surrounding diet, smoking cessation, immunization provision, and education to the benefits of exclusive breast-feeding. The estimated number of patients is 150 DY2, 180 DY3, 210 DY4, and 240 DY5.

Category 2 expected patient benefits: Patients will have access to care in their own communities and will not need to travel. Care will be offered in the first trimester to all participants and extend through post-delivery. Evidence shows early prenatal care with interventions for improved health measures (current immunizations, smoking cessation, nutrition counseling) are less likely to have pre-term babies. The cost to care for premature infants can be avoided. The cost for a pre-term baby in the first year of their life averages about $41,681 compared to $4,331 for full term infants.

Category 3 outcomes:

- IT-8.1 Our goal is to provide timely prenatal and postpartum care to women in five counties located in their own location. This will allow 50% of the women in these areas to access care in first trimester in DY3 up to 75% in DY5.
- IT-8.2 Our goal is to decrease low birth weight babies by the women who have used these clinics for prenatal care. Currently the low birth weight rate in these counties is 13%. By DY5 this will be reduced to 9% for these participants in the clinics.
**Project Option:** 2.7.4 Implement Evidence-based Disease Prevention Programs: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth

**Unique RHP Project Identification number:** 094118902.2.2

**Performing Provider/TPI:** DeTar Healthcare System/094118902

**Project Description:**

*This project will provide enhanced prenatal clinics that will also incorporate healthy lifestyle measures that evidence shows lends toward a non-complicated pregnancy and full term births.*

Because underinsured women in rural communities have few resources for early prenatal care without some type of funding, a conveniently located clinic that does not require a patient to wait for Medicaid eligibility encourages early prenatal care. According to *CDC Reproductive Health of Women*, low income is one of the most important predictors of insufficient prenatal care. Residing in isolated rural areas also poses a barrier as the distance from care is a challenge. The Institutes of Medicine (IOM) reported that mothers under 18 years of age and unmarried mothers were less likely to seek care. They also identified Hispanics as one of the cultural groups who fail to get early prenatal care.80

DeTar Healthcare System is licensed for 308 beds and has stand-alone hospitals in two separate locations in Victoria, Texas. One of these hospitals is a Women’s and Children’s facility. Women’s Services have been included in our core business for nearly 100 years, and we deliver more babies than any other facility in our service area which encompasses Victoria, Lavaca, DeWitt, Jackson, Refugio, Goliad and Calhoun Counties. Our medical staff that addresses women’s issues includes eight OB physicians, six Family Practice physicians who deliver infants, four Neonatologists, and 14 Pediatricians. We have an additional 15 Family Practitioners who provide infant and child care. Our scope of women’s and children’s services includes prenatal, ante-partum, and post-partum care, GYN and general surgery (open, laparoscopic and robotic), pediatric surgery, mammography and ultrasound services, a dedicated 26-bed pediatric unit with ICU capability, a 9-bed NICU, 15-bed intermediate infant care unit, 13-delivery suites, 32 post-partum and GYN beds and a well-baby nursery. We have significant experience in maternal care in the rural community. We deliver 1,200-1,400 babies annually and have 24-hour per day, 7-day per week neonatology coverage for our Level III nursery. Our obstetric volume has grown 28% in the past year, and we are planning an expansion in 2013. We have a neonatal transport program where infants can be secured and moved quickly from the small rural hospital to a higher level of care.

DeTar Healthcare System aggressively led this community in offering early prenatal care by establishing a clinic for low-income mothers who were unable to afford medical care. We have provided the resources for a free-standing, low-income prenatal clinic that we continue to support today. Less than 2% of mothers giving birth have not had prenatal care compared with 20% previously. This DSRIP project will bring this same success to rural areas in Goliad, Jackson, Jackson, Refugio, Goliad and Calhoun Counties.

80 cdc.gov/reproductivehealth/ProductsPubs/DatatoAction/pdf/rhow8.pdf
Lavaca, and Refugio counties. Victoria’s second low-income prenatal clinic operated by UTMB closed in August 2012; therefore, these clinics will also expand resources in Victoria County to assure no woman is denied care for lack of money.

This project targets woman like those described in the IOM study that are at risk for not receiving early prenatal care. The targeted counties are rural areas. The proposed clients are often low income. There is a significant Hispanic population. By providing low cost prenatal care in their residential location more women will have access to care. This project was chosen because it affects a high number of people, and quality of life improvements and cost savings will be meaningful. This will be an enhanced prenatal clinic that will also incorporate healthy lifestyle measures that evidence shows lends toward a non-complicated pregnancy and full term births including:

1. Work with rural hospital partners to provide a mid-level OB practitioner to provide prenatal services without waiting for patients to qualify for Medicaid.
2. Establish low-income obstetric clinics in rural areas of Goliad, Jackson, Lavaca, and Refugio counties—expand availability in Victoria County.
3. Provide professional staffing for obstetrical clinics including medical director, mid-level practitioners, respiratory therapist, nutritionist, and lactation specialist.
4. Include health and wellness education and interventions such as smoking cessation provided by respiratory therapist, influenza and other vaccines needed for health promotion, nutritional counseling, and education on infant care including breast-feeding.
5. Institute a scheduling system for ongoing prenatal care with a timely call program for any patient who misses an appointment. Maintain computerized program to operate initiative, maintain data, and provide a resource for following patients.
6. Do domestic violence screening on all women and provide with interventions and resources as indicated.
7. Provide a neonatal transport service to the rural hospitals that moves infants to a higher level of care.
8. Provide education on breast feeding during prenatal period. Provide lactation specialist for breast feeding mothers with hotline support 24-hours a day for questions. Follow post-delivery to assure successful breast feeding experience for mom/baby.
9. Collaborate with community partners on in-home pre-delivery education for the very young mother who has no experience in child rearing to teach infant care, feeding, and health maintenance.

This project will also include providing infrastructure for five clinics that are located near the homes of low-income mothers. We will partner with the hospitals in each of these communities for appropriate space and locations. We will provide the medical and office equipment that is required. Currently there are no mid-level practitioners or medical directors to use in the clinics; these will be recruited and placed in each area. There is no computer tracking system for outcomes program, and this would be developed by DY3. It will include a tracking mechanism with notification if appointments are not met as scheduled. We will maintain data on the women who choose not to smoke after interventions are complete, the number who breast-feed, those current on immunizations, and those choosing a healthy diet. Our goal will
be to continually improve the services and quality offered and to have effective outcomes resulting in a healthy mother, a healthy newborn, and an educated mother who can provide good care for her infant. We will monitor project impacts to identify areas needing improvement and modify the project as needed.

**Project Goals and Relationship to Regional Goals:**

- Increase number of prenatal clinics available for low-income patients in their small communities to allow early prenatal care with reduced risk for pre-term delivery.
- Increase the number and availability of prenatal providers and educational opportunities in the home community of the mother.
- Include education and programs in the prenatal care that evidence shows to result in a healthier delivery of baby and for the mother.
- Early introduction and encouragement of exclusive breastfeeding.

Our project goals support the regional goals of leveraging and improving on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of our growing community. This increased clinic availability will decrease the wait time and encourage early and appropriate levels of care.

**Challenges**

- Alignment with community partners in small, under-served areas on locations and operational hours for outreach prenatal care clinics.
- Developing baseline data collection systems and analysis. Determining appropriate medical records system.

As the Performing Provider we will overcome these challenges by partnering with healthcare leaders in the surrounding counties to establish prenatal clinics in their communities. Collaboration would occur regarding locations, hours of operation, and appropriate staff and equipment in each county location. The healthcare members of these communities are the most knowledgeable about their population and will provide direction and advice.

**5 Year Expected Outcome:**

The expected outcome is to have clinics available in at least five locations by September 30, 2013. As census builds and more women are enrolled in the enhanced program, performance improvement measures of birth weight over 2500 grams and reduction in neonatal deaths related to women being compliant with their schedules will occur. There will also be improvements in women choosing healthy lifestyles by quitting smoking, choosing to be immunized, meeting appointments, and considering exclusive breast feeding of their infants.

**Starting Point/Baseline:**

- In DY1 there were no low-income maternity clinics in Goliad, Jackson, Lavaca, or Refugio counties. There is one located in Victoria County and services will be expanded. The baseline for this area is 0 and the goal is 5.
• In the targeted counties current low birth weight/pre-term rate is 13%.
• Infant death per county due to complications will be measured as women enroll in the newly established clinics. The goal is to have no more than one death in all the counties combined.

Rationale:
This project was selected because 13% of the babies born in the targeted counties are preterm (<37 weeks) and/or have low birth weights. Healthy Babies Expert Panel in July 2012 disclosed preterm birth weights in Goliad County at 8.3%, Jackson County 14.6%, Lavaca County 15.8%, Refugio County 12.2% and Victoria County 14.4.

Pre-term births typically require prolonged specialty neonatal hospitalizations which are costly, interfere with parent/child bonding since tubes, ventilators, and other equipment discourages spontaneous cuddling, swaddling, and breast feeding, and is a hardship on the parents who must travel back and forth to the NICU from their rural homes. The infant often continues to have developmental delays even after discharge. According to HHS, in the U.S. the number of infants born prematurely—before 39 weeks gestation—has increased 36% over the past two decades to more than 500,000 pre-term births annually. Officials note that a 10% reduction in pre-term births could save Medicaid more than $75 million annually. HHS also estimates that medical costs for babies delivered pre-term in their first year of life averages about $41,681, compared with $4,331 for full-term infants (Center for Healthcare Research & Transformation).

Milestones & Metrics:
The following milestones and metrics have been chosen for this project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1)
Improvement Milestones and Metrics: I-5 (I-5.1)

Unique community need identification number the project addresses:
• CN.10 High rates of poor birth outcomes and low birth-weight babies
• CN.12 Insufficient access to services for pregnant women, particularly low income women

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will provide enhanced services to this targeted population and increase the number of prenatal clinics available for low-income patients in their small communities to allow early prenatal care with reduced risk for pre-term delivery.

Related Category 3 Outcome Measure(s):
IT-8.2 Milestone: Percentage of low birth weight infants will decrease. Babies born of mothers who were enrolled with the project prenatal clinic will exceed 2500 grams at least 87% of the time. This will progressively improve year over year to 91% by DY 5.
IT-8.2 a) Numerator: Number of babies born weighing <2,500 grams at birth
b) Denominator: All births.
c) Data Source: Birth records, claims.
d) Rationale: To validate early and sustained prenatal care will result in better health improved care and lower costs. Low birth weight infants experience severe health and developmental difficulties that can impose substantial costs on society. The expected costs of delivery and initial care of a baby weighing 1000 grams at birth can exceed $100,000 and the risk of death within one year of birth is over 1:5.

IT-8.1 Milestone: Deliveries of live births for women receiving the following facets of prenatal and postpartum care:

a) Numerator: Deliveries of live births for which women receive the following:
   Rate 1: Received prenatal care visit in clinic within the first trimester or within 42 days of enrollment
   Rate 2: Had postpartum visit for pelvic exam or postpartum care between 21 and 56 days post delivery

b) Denominator: Deliveries of live births in same time period.
c) Data Source: Medical records, claims
d) Rationale: Rate 1: Timeliness of prenatal care. The percentage of deliveries that received a prenatal visit in the first trimester or 42 days of enrollment.
   Rate 2: Postpartum Care. Percentage of deliveries that had post-partum visits between day 21-56 post-delivery.

Reasons/rationale for selecting the outcome measures:
This outcome measurement was selected because studies show as many as half of all deaths from pregnancy complications could be prevented if there was better access to prenatal care, better quality of care, and changes in health and lifestyle habits (CDC 2002). It affects large numbers of people, is a frequently occurring condition, has high resource use, and complications in pregnancy are common. This project will reduce costs related to neonatal and maternal hospital care. It is known that age and financial means are issues in seeking prenatal care. In our experience at DeTar in 2011 and 2012 we had 2514 OB hospitalizations and 249 (9.9%) of these patients were under 18-years of age. These adolescents are often unmarried and, of those 18 years or younger, only two were insured by a non-public payer. The other 249 were either unfunded or had Medicaid benefits. There were an additional 249 patients ages 19 and 20 and of those one had commercial insurance; the rest were unfunded or receiving Medicaid benefits. Because so many of the pregnant population in this area are unable to afford prenatal care, this is often delayed and, unfortunately, occasionally never received. Upon enrollment in these clinics the clients will be assessed for the effectiveness of their social support systems, immunization status, nutritional knowledge needed to carry a healthy baby, and barriers to complying with a prenatal program. This program will offer education and preparation for child rearing that will fill in the gap of the younger client related to her youth and inexperience. The client will be expected to teach back, receive information on how to balance their own schooling with pregnancy and newborn care, and be provided basic skills of managing the baby including things like how to take a temperature and schedules for well-baby checkups. Literature shows that some women delay receiving pre-natal care because they are
not insured. These clinics will not require the woman wait for Medicaid eligibility so that early prenatal care is encouraged. Because a healthy newborn is often related to early prenatal care and regular OB visits, this program will contact those who miss an appointment or have difficulty complying with a prenatal program that promotes health for mom and baby. In 2011 and 2012 DeTar had 305 NICU admissions and only 15% of these infants were covered by commercial insurance. The other 85% had no payer source or were qualified for Medicaid coverage. Not all of these were related to an ineffective prenatal program, but those that were could have been avoided. By providing a program that offers wellness interventions such as smoking cessation and nutritional counseling and removing the barriers of distance/transportation from a clinic for those who live in rural areas it will be easier to access care and reduce NICU admissions.

**Relationship to Other Projects:**
All of our projects complement each other in providing enhanced and increased access to services for our targeted population. Increasing the number of clinics supports our community needs across projects to include additional capacity for providing prenatal/postnatal care, chronic disease management and behavioral health outpatient care for our targeted population. This project shares common goals with and will enhance and compliment the following specific project: 1328122051.2.1 – Implement Evidence based Health Promotion Programs. Related Category 4 measures include RD-3, Potentially Preventable Complications and RD-4 Patient Centered Healthcare.

**Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other performing providers with similar projects who will participate in the learning collaborative include Driscoll Children’s Hospital.

**Project Valuation:**
This project will enhance maternal and infant care in multiple communities. The Center for Healthcare Research & Transformation reports premature babies use $41,681 per year in medical costs vs. $4,331 per year for the full term infant. Our enrollment goal for year one will be 150, and we will reduce pre-term deliveries amongst enrollees by 1% in DY 2, an additional 1% in DY3, DY4, and DY5. Reductions in pre-term deliveries will bring savings of $37,350 per additional full-term delivery. Lifestyle risks for premature labor include little or no prenatal care, smoking, drinking alcohol, illegal drug use, domestic violence, lack of social support, stress, low income and long working hours. All of these will be addressed when the client uses one of the maternity clinics. The clinics will attempt to provide the support and resources to remove these barriers to a full term birth with a healthy infant. The enrollment will increase every year. In DY 2 there will be 150 clients, DY3 180, DY 4 210, and DY5 245 in all clinics.
combined and numbers of avoided preterm births will increase as more women receive complete prenatal care with the other supportive aspects of this prenatal program.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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| **Milestone 1** [P-1] Development of innovative evidence-based project for target population (pregnant, low income women). Includes placement of clinics in their own rural community for increased access.  
**Metric 1** [P-1.1] Document strategy and plan.  
**Baseline/Goal:** DY 2 clinics/ Four additional clinics will be established in Goliad, Jackson, Lavaca, and Refugio Counties as well as expansion Victoria County.  
**Data Source:** Performing Provider evidence of innovational plan.  
**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $387,769 | **Milestone 2** [I-5] Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model  
**Metric 1** [I-5.1] Increase number of patients who will receive early prenatal care in maternity clinics by 30 in all clinics combined.  
**Baseline/Goal:** 150/180.  
**Data Source:** Target population reached, Clinic Records  
**Milestone 2 Estimated Incentive Payment:** $343,369 | **Milestone 3** [I-5] Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model  
**Metric 1** [I-5.1] Increase enrollment by 30 additional women to 210 clients of the target population all clinics combined.  
**Baseline/Goal:** DY 3 goal 180/ Increase number of patients receiving care to 210  
**Data Source:** Target population reached, Claims, Medical Records  
**Milestone 3 Estimated Incentive Payment (maximum amount):** $353,670 | **Milestone 4** [I-5] Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model  
**Metric 1** [I-5.1] Increase enrollment to 240 clients all clinics combined.  
**Baseline/Goal:** DY 4 goal 210/ Increase number of patients receiving care to 240  
**Data Source:** Target population reached, Claims, Medical Records  
**Milestone 4 Estimated Incentive Payment (maximum amount):** $360,441 |

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $387,769  
**Year 3 Estimated Milestone Bundle Amount:** $343,369  
**Year 4 Estimated Milestone Bundle Amount:** $353,670  
**Year 5 Estimated Milestone Bundle Amount:** $360,441

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $1,445,249
Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Alice/ TPI 094222902

Unique Identifier - 094222902.2.1

- **Provider:** CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s):** This is a large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors, and will require integration between Pharmacy, Information Technology (IT) and Nursing. The project will result in all doses of medications given to patients in Spohn’s Alice locations having viable barcodes that are read into the Meditech informatics system.

- **Need for the project:** Spohn’s present medication management system entails a completely manual system from order to medication administration. Medication reconciliation is a cumbersome process upon admission and discharge, as well as during transfers between levels of care. An improvement in the coordination between departments, availability and use of technology, and training on best practices will reduce the risk of hospitalized patients receiving improper dosages, duplicative medication administration, and/or overdoses. Spohn’s annual medication errors totaled 176 for errors reported in 2011. Medication administration specific errors accounted for 23% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. Additionally, audits can be run through the automated system to provide a better picture of opportunities for improvement and continuous quality improvement. Additionally, the barcoding will enable more efficient medication reconciliation upon discharge, and will be coupled with an initiative to provide more patient consultations by clinical pharmacists prior to discharge.

- **Target population:** The target population of this project is all inpatients and outpatients treated in Spohn’s Alice facility, which amount to approximately 20,662 patients in FY2012 (2,977 inpatients; 17,685 ED patients), 30% of which are uninsured or Medicaid-eligible (6,100 patients). There are approximately 96 RNs and 2 pharmacists in the facility who will be trained in the BMV process. Those providers administer approximately 301,056 doses of medication to patients annually. Currently, 70% of inpatients receive consultations by clinical pharmacists prior to discharge (approximately 2,080 inpatients).

- **Category 1 or 2 expected patient benefits:** Spohn expects to achieve 90% adherence to the barcoding system by the end of DY3, for 70% of inpatients to receive medication reconciliation upon discharge (expected to impact 2,080 patients), and for 80% of inpatients (2,380) to receive in-person counseling from the clinical pharmacists prior to discharge (which Spohn intends to impact primarily Medicaid/uninsured patients, who constitute approximately 30% of inpatients; 893 patients annually). This improvement will benefit the hospital-wide health outcomes for patients who receive medication as inpatients in Spohn’s Corpus facilities.

- **Category 3 outcomes:** IT 4.10 – Medication Errors. By DY5, Spohn expects a 15% reduction in bedside medication administration errors in its Alice facility, due to the implementation of the barcode system for medication management. IT4.10 – Average Length of Stay. By DY5 Spohn expects a 10% increase in RN/Clinical Pharmacist utilization review for high risk patients and those patients receiving medications identified as high risk for medication errors. IT4.10 – Cost
Savings. By DY5 Spohn expects to implement a Cost Minimization Analysis (CMA) to demonstrate cost savings in care delivery associated with medication management utilization review in high risk patients, specifically long-term treatment patients eligible for Intravenous (IV) home infusion therapy.
Implementation of Bedside Medication Verification (BMV) Process

Project 2.11: Conduct Medication Management

Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Alice/ TPI 094222902
Unique Identifier - 094222902.2.1

Project Description:
This is a large scale project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. The project requires integration between Pharmacy, Information Technology (IT) and Nursing. All doses of medications must have a viable barcode that is to be read into the Meditech informatics system. It should be noted that many medications arrive in a pharmacy in the form of bulk bottles (approximately 30% of inventory). These bulk bottles must then be repackaged into individual units of use which contains the barcode that is used to verify the correct medication. The repackaging of this medication requires high reliability standards. Given this requirement, Spohn determined that the majority of these medications should come from one site in order to reduce variability. Establishment and implementation of a central site of distribution from which most drugs will be administered is a key requirement of the process that must precede the successful transition to a bedside verification system. Another challenge is the fact that this process requires all nurses to have a computer available to them at all times in order to scan the patients’ arm band and the medication being administered, as well as documenting the administration into an electronic medication administration record (eMAR). Spohn conducted a feasibility study to calculate the number of personal computers necessary, and determined that additional safety features are needed to ensure scanning of patient ID bracelets versus patient labels or stickers generated on the care delivery units. These labels are known shortcuts reported in the nursing and pharmacy literature due the increased difficulty with scanning the patient’s ID bracelet. Unique printers with the ability to generate a 2D barcode, similar to those barcodes now seen in advertising and various industries, provides the additional security against medication errors by ensuring the scan occurs at the point of care. These 2D barcodes contain additional patient-specific information not available in current barcoding. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Spohn will develop guidelines to incorporate the 2D barcoding into practice to ensure the most efficient location of 2D barcode printers and protection of private health information. The barcoding process will streamline the administration of medication, and will implemented in tandem with all facilities targeting an improvement in the number of patients receiving in-person consultations from clinical pharmacists regarding their medications prior to discharge. Additionally, whether or not patients receive a pharmaceutical consultation, patients’ medications that need to be continued, discontinued, and/or changed upon discharge will be reconciled by the providers upon discharge from the inpatient setting.
The fact that this project represents a dramatic paradigm shift for Spohn means that, adequate training of both nursing staff and nursing staff is major priority. For this requirement, Spohn will designate super user groups to provide much of the hands on training of all staff.

Medication errors are associated with a significant number of deaths. The literature estimates that 70% of fatal medication errors were preventable and the cost of $4,000 - $8,000 associated with medication errors that reach the patient (IHI; To Err is Human). The right medication must be given to the right patient, at the right time, in the right dosage and via the right route. Errors in any of these stages can lead to serious consequences. By requiring a barcoded step to verify right patient, right medication and implementing an electronic medication administration record (eMAR) that confirms the right time, many of these errors can be avoided.

5 Year Anticipated Outcome:
Implementation of an intra-disciplinary case management/utilization review program at point-of-entry coupled with the barcoding process and increase in the number of patient consultations with clinical pharmacists, will allow Spohn to ensure that patients’ medications are safely administered in the hospital and safely managed by patients upon leaving the hospital. Spohn will evaluate reductions in average length of stay and cost savings in care delivery using Cost Minimization Analysis (CMA) for BMV, clinical pharmacist consultation and utilization review.

Goals and Relationship to Regional Goals:
The goal of this project is to implement the use of a barcoding system that clinicians can use to identify and document the administration of medications for all hospitalized patients. The expansion of this program will include the documentation not only at the bedside but at the point of entry into the system. When Pharmaceuticals arrive for use into the hospital region they will documented for tracing purposes so that any safety recalls can be monitored and further provide a save mechanism for our pharmacy professionals. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Regional opportunities for providers include the decrease in preventable complications and further the reduction in cost of care for the community we jointly serve. Medication Management is crucial in the decrease in cost of care, reductions in length of stay and in the compilation of data that physicians can use to assure that electronic data is reliable and safe.

Challenges:
The primary challenge will be to engage the physician provider groups with adhering to the use of the new BMV system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success. The success of BMV is directly in support of the CPOM system. The reduction in transcription errors will provide for a more reliable use of medication administration. With the implementation of the Meditech “Unity”
standardization project, the BMV project will leverage both standards and advanced clinical technology to enhance patient safety, reduce medication administration errors, and reduce the overall cost of providing services.

**Starting Point/Baseline:** Prior to implementing the BMV program, Spohn providers administered medications from handwritten orders. Those handwritten orders were scanned to the Pharmacy department, which then manually transcribed the orders into a pharmacy-specific computer application. Simultaneously, the RN on duty manually entered the medication ordered onto the patient’s Medication Administration Record (MAR). The RN then used the MAR to withdraw the meds entered by the pharmacy from the electronic dispenser and administer that medication to the patient. This process allowed for administrative errors because RNs would often pull several patients’ medications at a time and then mis-administer the medications by failing to verify the patient identifiers. At midnight each night, a new MAR was printed for each patient, and the RN had to reconcile the new MAR with the previous day’s MAR and verify any changes order in the last 24 hours. The BMV process will allow the pharmacy to use the Medi-tech module that is connected with the patients’ EMR. Additionally, the pharmacy will not do any manual transcription of orders into the system. The BMV program also allows RNs to access eMAR instead of individual paper-versions of patients’ prescriptions and the bar-coding technology provides a safety feature to assure that the patient receives the correct medication and dosage. Clinical Pharmacists consulted on approximately 2080 (70%) inpatient discharges during FY12. The intra-disciplinary Utilization Review Program will be initiated as a result of the reduction in average length of stay and cost savings in care delivery identified with Nueces County charity care.

**Rationale:**
Spohn chose this project with the goal of reducing the possibility for errors in delivering medication at its facilities, improving its system for medication reconciliation upon discharge, and enabling patients to safely manage the medications they must continue upon discharge. At the hospital level, many medications are purchased and/or delivered in bulk, creating opportunities for either mislabeling or dispensing errors, which could result in unintended health complications. To reduce the possibility of such inadvertent errors, and to improve the management of delivery of medication, Spohn will implement a new medication management system to improve the delivery of medication and instructions to patients. By matching barcodes on medications with patients, the BMV system will allow multiple healthcare professionals to understand and deliver the proper medication to patients, reducing the risk of errors and improving the overall health of the patient population, consistent with the goals of the Waiver.

When patients are discharged, it is important to reconcile their medications to the amount/type required when transitioning from an inpatient to an outpatient. Part of this process can be done electronically, but Spohn also believes that more patients need in-person consultations from clinical pharmacists so they can effectively administer and manage their medications at home, and can avoid contraindicated medications that may be prescribed by another physician or purchased over the counter.

**Community Needs Addressed by Identification Number:**
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

**Milestones and Metrics:** Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project and incentivize reductions in medication error rates, which will achieve the goals of the Waiver.

**Project core components:**
- Spohn will develop a system to ensure this project is implemented first to acute care patients at its hospital facilities, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented DY 2.
- The system will include tools to provide education and support to patients in acute settings to reduce risk of medication errors, and will be implemented in DY2 through Milestone 1.
- In the first year of the Waiver (DY1) Spohn performed an analysis of the root cause of potential medication errors and identified repackaging as one area of concern. To that end, the project plan will include the processes Spohn has identified to address the repackaging steps to reduce error rates.
- Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 4 specifically).

**Related Category 3 Outcome Measure(s):**
- OD – 4 Potentially Preventable Complication and Healthcare Acquired conditions.
- IT-4.10 Other Outcome Improvement Target:
  - *Decrease in errors in Bedside Medication Administration*

**IT-4.10 Other Improvement Target:**
- *Average length of stay for high risk patient and patients receiving medications identified as high risk for medication errors*

**IT-4.10 Other Improvement Target:**
- *Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review using Cost Minimization Analysis.*

Spohn chose these outcomes because this project to implement electronic medication management and involve the clinical pharmacists in medication management is expected to reduce the patient fall rate by allowing the pharmacists and providers to take proactive steps to avoid falls caused by a medication-induced altered state (by either changing the medication or monitoring patients at risk more closely).

**Relationship to Other Performing Providers’ Projects in the RHP:**
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support
include 121775403.2.6, and 121775403.2.7. - Medication Management to reduce medication administration errors.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

1. **Achieves Waiver Goals.** This project directly relates to assuring quality of care, improving the health of patients and reducing costs of care by removing opportunities for medication management errors for all patients, including the low-income and underserved patients. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Although medication mismanagement was not an identified community need, improvements that reduce opportunities for errors help to reduce the community’s need for costly procedures following medication errors and can help to reduce the high level of chronic disease in the community.
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve and found that improvements in medication management will serve most patients receiving care at Spohn’s facilities.
4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects.\(^\text{81}\)

\(^\text{81}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn ensured that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rate because it leads to improvements in the overall health of patients but does not expand the availability of care.
<table>
<thead>
<tr>
<th>Related Category 3</th>
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<td></td>
<td>094222902.3.6</td>
<td>Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.</td>
</tr>
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</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1** [P-1]: Implement a medication management system; bedside medication verification with barcoding (BMV)

**Metric 1** [P-1.1]: Program documentation for people, processes and technology

**Baseline/Goal**: Implementation of BMV at CSHA

**Data Source**: Written medication management plan including workflow for providers

**Milestone 1 Estimated Incentive Payment**: $67,199

**Milestone 2** [P-X]: Identify shortcuts and work-arounds to improve efficiencies w BMV processes

**Metric 1** [P-X.1]: Evaluate, modify BMV processes to eliminate identified work-arounds.

**Baseline/Goal**: Review BMV processes 6 months post-implementation to identify work-arounds.

**Data Source**: Staff input, variance reports, medication error investigations

**Milestone 2 Estimated Incentive Payment**: $67,199

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3** [I-13]: Implement electronic medication reconciliation at the point of care

**Metric 1** [I-13.1]: Increase the number of patients that receive electronic medication reconciliation at the point of care

**Goal**: 10% (298) use of electronic medication reconciliation for inpatients of the facility

**Data Source**: EMR

**Milestone 3 Estimated Incentive Payment**: $68,729

**Milestone 4** [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions

**Metric 1** [P-9.1]: Number of new ideas, practices, tools or solutions tested.

**Baseline/Goal**: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement

**Data Source**: FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions

**Milestone 4 Estimated Incentive Payment**: $137,244

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5** [I-14]: Provide reconciliation of medications at discharge

**Metric 1** [I-14.1]: Increase the percent of identified patients that have medications reconciled as a standard part of the discharge process

**Goal**: 50% compliance with medication reconciliation upon discharge (expected to impact 1,250 MCD/UI patients annually)

**Data Source**: EMR

**Milestone 5 Estimated Incentive Payment**: $110,819

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 6** [I-15]: Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting.

**Metric 1**: X% of patients receiving consultation by clinical pharmacists

**Baseline/Goal**: Currently, an estimated 70% (2080 discharges) of discharges in the facility receive consultation from the clinical pharmacists upon discharge. Spohn will increase that percentage by 10% to achieve an 80% total number of inpatients receiving consultations (or 2380 discharges; 300 additional discharges) from clinical pharmacists upon discharge by the end of DYS.

**Data Source**: Patient EMR

**Milestone 6 Estimated Incentive Payment**: $110,819
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> <em>(add milestone bundle amounts over DYs 2-5)</em>: <strong>$519,919</strong></td>
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</table>
Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.

CHRISTUS Spohn Hospital Alice/ TPI 094222902
Unique Identifier - 094222902.2.2

- **Provider**: CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s)**: CHRISTUS Spohn Hospital Alice (‘Spohn’) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech.

- **Need for the project**: By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges. Spohn Alice averages 14,000 – 15,000 patient days annually and approximately 8-10 orders are entered per patient per day. With such a high volume of orders for a large number of patients, the need for a faster, safer, and more efficient system is great. Spohn’s annual medication errors totaled 176 for errors reported in 2011. Medication transcription specific errors accounted for 14% of the total reported, which is a statistic that can be minimized by CPOM.

- **Target population**: According to our most recent data (Nov 2012), Spohn is supported by over 25 physician providers, 80% of which will make use of this advanced clinical technology. The target population of this project is all inpatients and outpatients treated at Spohn, which amount to approximately 20,662 patients in FY2012, 2,977 inpatient, 17,685 ED patients, 30% of which are uninsured or Medicaid-eligible (6,100). **Category 1 or 2 expected patient benefits**: By DY5, Spohn expects 75% of orders placed by providers for inpatients in acute care settings to be ordered electronically; 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter to be generated electronically; and 60% of prescriptions written to ED patients upon discharge will be generated electronically.

- **Category 3 outcomes**: IT-4.10 – By DY5, Spohn expects 85% compliance for VTE Prophylaxis Core Measure Indicators in its Alice facility.
Computerized Physician Order Management (CPOM)

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:
Project 2.11: Conduct Medication Management
Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.

CHRISTUS Spohn Hospital Alice/ TPI 094222902
Unique Identifier - 094222902.2.2

Project Description:
CHRISTUS Spohn Hospital Alice (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech. By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) Increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.

5 Year Expected Outcome:
Through implementing the CPOM system, Spohn expects the following outcomes:
1) 75% electronic system adherence by providers placing orders/prescriptions for inpatients in the acute care setting by the end of the Waiver
2) 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter generated electronically by the end of the Waiver
3) 60% of prescriptions written for ED patients upon discharge generated electronically by the end of the Waiver

Goals and Relationship to Regional Goals
This project is intended to internally upgrade the hospital’s management of information in a manner which upholds strategic safety initiatives and technological changes in healthcare. The use of electronic order entry communication and standards of practice by prescribing providers will allow for a safer order entry methodology and fewer medication transcription errors. Spohn will accomplish patient safety through order entry as the provider becomes integrated into the reliability process of care management. The extension and continued process improvement of order entry will formulate the basis for a comprehensive patient medical record that in the end help with data sharing between provider through an HIE network, allowing accountability in the care management between regional healthcare providers in the Region.

The project is related to Regional goals in that it is completely patient centered. The use of an electronic order system provides additional assurance that patients are provided treatment tailored to their individual health needs and adds safeguards against human error. Additionally, the expected reduction in medication transcription errors will reduce the cost of such mistakes, and improve patient satisfaction and quality of life.
Challenges:
The primary challenge will be to engage the physician provider groups to adhere to the use of this new CPOM system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success.

Starting Point/Baseline:
The U.S. Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) has mandated that US healthcare providers make efforts towards achieving participation in electronic health initiatives. To that end, healthcare provider organizations are encouraged to meet several measurement criteria over the course of time. The ultimate goal of meeting these criteria is to (1) Improve access to healthcare nation-wide, (2) Improve clinical outcomes and the patient experience, and (3) Decrease the cost of healthcare. By implementing CPOM, Spohn will meet HHS/CMS goals and improve the overall health of the 1.5 million inhabitants of South Texas we serve.

According to our most recent data (Nov 2012), Spohn is supported by over 25 providers, 80% of which will make use of this advanced clinical technology. Based on the nearly 140,000 typical annual encounters (based on FY-12 statistics) within the region, the impact will be realized extensively throughout our 15 country service area. Based on the project implementation timeline, FY-12 data will be used as the initial baseline data. Currently, orders and prescriptions are written on paper and entered into the hospital system manually by nurses, which can lead to transcription errors, is inefficient, and allows some orders/medications that could be automatically entered to be missed.

Rationale:
Spohn is regionally deploying Meditech as its primary health information system. As the leading nation-wide, fully integrated system, Meditech offers the ability to directly interface multiple aspects and processes from the patient care continuum. As such, when moving to CPOM, Spohn will facilitate quick recall of consistent information from not only orders, but also lab results, diagnostic images, medication management and reconciliation, and numerous other clinical areas. Additionally, through our Novo interface engine, Spohn offers local, secure access to providers’ patient data, further streamlining the patient care process. While Meditech is a solid, cost effective solution, preparation for the deployment of CPOM, an advanced clinical process supported by technology, does not come without a significant financial investment (discussed below in “enabling projects”).

Project components and phases – As in most any major technology enabled project, CPOM consists of several phases. While some of these phases are executed concurrently by function and/or location, each is key to the successful completion of the project. In summary, the project phases include System Design and Set-up, System Build, Testing – including unit and integrated testing, Super User and End-user Training, System “Go-Live”, and post “Go-Live” support.

Enabling projects –
Unity – The Meditech “Unity” project was completed in February 2012 in preparation for the CPOM project. The Unity project required the upgrade and standardization of the Meditech application to version 5.6.4 throughout the entire CHRISTUS Health System. Achieving this standard
enabled enterprise wide maintenance and support, faster turnaround on system issues, and streamlined process changes.

Network upgrade – In conjunction with the Unity project, CHRISTUS Health conducted network upgrade and server standardization. Consolidating the physical and virtual server environments to the CHRISTUS Health Information Technology Center (ITC) in San Antonio, Texas enabled several of the support improvement mentioned about. Additionally, by elimination much of the regional and local data center support operations (nine regions and numerous locally supported file servers), CHRISTUS Health was able to husband the financial resources necessary to fund this multi-million dollar enabling project.

Wireless Infrastructure Upgrade – Prior to October 2011, the CHRISTUS Spohn Health System maintained approximately 100 Wireless Access Points (WAPs) in six hospitals. These devices enabled secure wireless access to the CHRISTUS Spohn computer network and associated applications. However, while access was sufficient for most unit based systems and devices, it was insufficient to handle the additional capacity and mobile nature of the devices and systems required for an advanced clinical program such as CPOM. Accordingly, in October of 2011, CHRISTUS Health completed a comprehensive analysis and upgrade of its wireless infrastructure. The number of WAPs were increased to over 200 and existing WAPs were upgraded or replaced with newer models capable of handling the increased mobile device requirements of CPOM.

Equipment technical refresh (New Clinical Workstations) – In order to ensure adequate PC resources by each unit’s support staff, CHRISTUS Health has recently upgraded over 500 PC’s throughout the SPOHN Health System. Priority of technical device refresh has been to clinical areas and supporting ancillary areas.

CPOM Specific Equipment Deployment – While support staff (nurses, unit clerks, techs in the OR, Post-op, lab, pharmacy, radiology, and other key areas) have received new PCs, the providers are getting additional PC resources specifically supporting individual order entry, medical record recall, and test results access. Using a combination of CHRISTUS Health standards and national best practice PC configuration analysis, CHRISTUS Spohn is deploying 325 additional devices for providers. These devices consist of a combination of 200 advanced desktop PCs for static, unit based clinical documentation and 125 mobile PCs of “PDOCs” (Provider Documentation Stations) that may be used during provider rounding on multiple units. In addition to PCs and mobile stations deployed for provider documentation, CHRISTUS Spohn Health System is also providing instruction and configuration assistance for individual provider personal devices (e.g. iPads, iPhones – iOS supported devices and HTC Flyer, Android Phones and other Android OS support devices) to access the CHRISTUS network.

PC Operating System Upgrade (Windows XP SP3 to Windows 7 SP1) – In order to take full advantage of Meditech’s CPOM capability as well as other interfaced systems (PACS, Pharmacy, Health Information Management, etc.), CHRISTUS Health is upgrading the standard PC operating system from Microsoft Windows XP (Service Pack 3) to Windows 7 (Service Pack 1). This upgrade will be complete prior to the completion of the CPOM project.
**Milestones and Metrics:** Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project through its physician network and incentivize use of the CPOM system, which will achieve the goals of the Waiver.

Community Needs Addressed by Project: According to our most recent data (Nov 2012), Spohn is supported by over 25 physician providers, 80% of which will make use of this advanced clinical technology. Based on the over 20,000-30,000 typical annual encounters (FY-12 statistics) within the region, the impact will be realized extensively throughout Spohn Alice service area. Of those 20,000-30,000 typical encounters, 28% are Medicaid and uninsured.

**Community Needs Addressed by Identification Number:**
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

**Project Core Components:**
a. Spohn will develop a system to ensure this CPOM project is implemented first to acute care patients at its facility, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented in DY 2.
b. The system will include tools to provide education and support to patients in acute settings to reduce delays in implementing orders and possible errors in interpreting or transcribing orders, and will be implemented in DY2.
c. Spohn has already undertaken in the first year of the Waiver (DY1) an analysis of physician order implementation and identified transcription errors and delays as one area for improvement. To that end, the project plan will include the processes Spohn has identified to remedy the transcription errors and delays by having the physician enter the orders directly.
d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 3 specifically).

**Related Category 3 Outcome Measure(s):**
OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4. 10 Compliance with VTE Prophylaxis Core Measures

**Reasons for selecting the outcome measures:**
Spohn is continuously improving its CPOM services with the goal of reducing variations in the delivery of services based on delayed or misinterpreted physician orders. Spohn has a low compliance with CMS VTE Prophylaxis Core Measure Indicators placing patients at risk for VTE during hospitalization, a potentially preventable complication. The use of CPOM is expected to improve Spohn’s VTE percentage of compliance and reduce potentially preventable complications for VTE in Spohn’s facilities.
Relationship to Other Performing Providers’ Projects in the RHP:
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7. - Medication Management to reduce medication administration errors.


Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

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   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Although physician order entry implementation was not an identified community need, improvements that reduce opportunities for delays and errors in receiving proper care help to reduce the community’s need for inconsistent care and can help to reduce the high level of chronic disease in the community.

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve, and found that
improvements in physician order implementation will serve most patients receiving care at Spohn’s facilities.

4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects. 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project was valued, Spohn ensured that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rate because it leads to improvements in the overall health of patients but does not expand the availability of care.

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82 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### Milestone 1 [P-1]: Implement a medication management system
**Metric 1** [P-1.1]: Program elements to include document of program, people and technologies required to implement system
**Baseline/Goal**: Implementation team and Infrastructure in place for CPOM/Med Mgmt. Go-Live
**Data Source**: Implementation plan with team, infrastructure and processes documentation

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### Milestone 2 [P-7]: Implement CPOM to allow providers to enter medical orders directly via computer, replacing the more traditional paper, verbal, telephone and fax methods
**Metric 1** [P-7.1]: Create a system to implement CPOM
**Baseline/Goal**: Transition 50% of physician orders to electronic order entry
**Data Source**: Patient medical records and EMRs, Hospital informatics utilization reports

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### Milestone 3 [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions
**Metric 1** [P-9.1]: Number of new ideas, practices, tools or solutions tested.
**Baseline/Goal**: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement
**Data Source**: FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions

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### Milestone 4 [I-18]: CPO utilization measure
**Metric 1** [I-18.1]: Increase number of electronic entry orders per patient
**Goal**: 75% of orders in the acute care setting are entered electronically
**Data Source**: EMR reports, hospital informatics reports and audits documentation

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### Milestone 5 [I-19]: CPO utilization measure
**Metric 1** [I-19.1]: Increase number of new and refill prescription written and generated electronically
**Baseline/goal**: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically

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### Milestone 6 [I-12]: Implement electronic prescription writing at the point of care
**Metric 1**: Increase number of new and refill prescription written and generated electronically
Numerator: number of new and refill prescriptions written and generated electronically
Denominator: number of new and refill prescriptions written in a specific time period
**Baseline/goal**: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically

<table>
<thead>
<tr>
<th>Year 5</th>
<th>(10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 7 Estimated Incentive Payment:</td>
<td>$55,409.50</td>
</tr>
</tbody>
</table>

### Compliance with VTE Prophylaxis Core Measure Indicators
**Year 4**
**9/30/2015**

- **Denominator**: Number of new and refill prescriptions written and generated electronically
- **Numerator**: Number of new and refill prescriptions written and generated electronically
- **Baseline/goal**: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically

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**RHP Plan for Region 4**

475
<table>
<thead>
<tr>
<th>09422902.2</th>
<th><strong>2.11.2</strong></th>
<th><strong>2.11.2.B</strong></th>
<th><strong>COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOM)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Alice</td>
<td></td>
<td>09422902</td>
<td></td>
</tr>
</tbody>
</table>

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

- **09422902.3.7**  
  - 3. IT-4.10
  - Compliance with VTE Prophylaxis Core Measure Indicators

**Year 2**  
(10/1/2012 – 9/30/2013)

**Year 3**  
(10/1/2013 – 9/30/2014)

**Year 4**  
(10/1/2014 – 9/30/2015)

**Year 5**  
(10/1/2015 – 9/30/2016)

**Denominator:** number of ED visits where medication is prescribed

**Baseline/goal:** 60% of prescriptions written in ED are submitted electronically

**Milestone 8 Estimated Incentive Payment:** $55,409.50

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone):
$134,398

**Year 3 Estimated Milestone Bundle Amount:** $137,458

**Year 4 Estimated Milestone Bundle Amount:** $137,244

**Year 5 Estimated Milestone Bundle Amount:** $110,819

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**  
(add milestone bundle amounts over DYs 2-5): $519,919
Improvement in Quality and Safety for patients with Sepsis; 2.8.11
CHRISTUS Spohn Hospital Alice/ 094222902
Unique Identifier - 094222902.2.3

- **Provider:** CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s):** This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) within Spohn’s Alice provider facilities.

- **Need for the project:** In FY 2012, Spohn completed approximately 6200 MEWS tools (sepsis screening) and identified 151 cases of sepsis. Of the cases identified, 22% was Medicaid/uninsured (33 cases). The average length of stay for a septic patient was 3 days (1-10 day range) and the average charge per patient was $36,561 totaling $5.5 million in charges. Spohn collected $1 million of those charges, meaning the remaining $20.1 million went uncompensated. The sepsis mortality rate in FY 2012 was 7.7% of all cases (4 deaths).

- **Target population:** The target population includes all patients in Spohn’s hospital campuses who are at risk for sepsis, including elderly and surgical patients. Spohn discharges approximately 3,900 inpatients annually, 37% of which are Medicaid/uninsured (approximately 1,426 inpatients).

- **Category 1 or 2 expected patient benefits:** By DY5, Spohn expects to achieve 95% (estimate 143) of patients with a suggestion of severe sepsis or septic shock will have their lactate level drawn. In addition, Spohn expects a 10% increase in the number of patients screened with the MEWS tool by DY5.

- **Category 3 outcomes:** IT-4.8 – By DY5, Spohn expects this project to result in a 2% reduction in septicemia mortality rates in Spohn’s Alice facilities from the baseline established in DY2.
Identifying Project and Provider Information:
Improvement in Quality and Safety for patients with Sepsis at CSHSA; 2.8.11
CHRISTUS Spohn Hospital Alice (“Spohn”)/ 094222902
Unique Identifier - 094222902.2.3

Project Description:
This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) in Spohn’s provider facility. Spohn will gauge resultant improvements in care through the assessment and monitoring of process and outcome measures across the lifespan of the project. Initially, measurements will constitute a baseline from which improvements at subsequent intervals will be gauged. Providers needed for this concept include nurse practitioners, nurses and physicians within hospital settings.

Project Goals/Five Year Expected Outcome: Our goal at Spohn is to reduce septicemia mortality. In order to impact this mortality rate, early recognition for signs and symptoms of sepsis and immediate initiation of treatment is required. By using nurse practitioners, nurses and physicians to implement both Sepsis Resuscitation and Sepsis Management Bundles, this project’s goals are:

- Implement a 90-day rapid cycle improvement plan for sepsis.
- 15% increase in Patients having Lactate levels drawn when evidence to suggest severe sepsis and/or septic shock exists
- 15% increase in use of electronic MEWS by nursing staff on patients admitted to medical/surgical units.

This project meets the following regional goals:
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Project Challenges: The top challenge of this initiative will be automating the MEWS screening tool and provider compliance with bundles. Implementation will consist of staff education, provider training, point of entry protocol development, sepsis bundle and sepsis management bundle implementation set forth as a 90-day rapid cycle improvement.

Starting Point/Baseline:
In FY 2012, Spohn completed approximately 6200 MEWS tools (sepsis screening) and identified 151 cases of sepsis. Of the cases identified, 22% were Medicaid/uninsured (33 cases). The average length of stay for a septic patient was 3 days and the average cost per patient was $36,000, totaling in $5.5 million in charges. Spohn collected $1 million of those charges, meaning the remaining $20.1 million went uncompensated. The sepsis mortality rate in FY 2012 was 7.7% of all cases (4 deaths). In 2012, approximately 10% of patients had lactate drawn upon a suggestion of sepsis or severe septic shock; the goal should be at 95% because the lactate level confirms the presence of sepsis.

Rationale:
Severe sepsis is a major healthcare problem that affects millions of people around the world each year with an extremely high mortality rate of 30 to 60 percent. Mortality from sepsis is greater than
breast cancer, lung cancer and colon cancer combined and is the number one cause of death in the non-coronary ICU. The incidence of severe sepsis is expected to double over the next 25 to 30 years. Thus, it is imperative for the health and safety of Nueces County residents who may be hospitalized and exposed to this infection at some point during their lives that CHRISTUS Spohn Hospital Alice (“Spohn”) take steps to detect sepsis early and have a tried and true protocol for responding effectively.

Our goal at Spohn is to reduce septicemia mortality. In order to impact this mortality rate, early recognition for signs and symptoms of sepsis and immediate initiation of treatment is required. Time is of the essence making this a high priority initiative with a substantial amount of work to accomplish over a short period of time. This full scale quality improvement initiative requires a structured and defined process to ensure all phases of improvement are completed; Plan-Do-Study-Act. This system-wide initiative will be accomplished using a 90-day rapid cycle improvement process specific to early recognition and treatment of sepsis.

Milestones and Metrics: Spohn chose the DY2 milestones in order to put in place the infrastructure to improve its capability to quickly detect sepsis and respond effectively. In the subsequent years, Spohn chose milestones that would allow it to measure and improve its processes for responding to cases of sepsis within the hospital at a consistent rate.

Ties to Community Needs Identification Number: CN.18 (high rate of sepsis in Region 4)

Project Components:
- Baseline assessment (see baseline data)
- Review of evidence for early warning system tool and tool selection – will be part of completing Milestone 1 in DY2
- Identify team to champion initiative – include all stakeholders, must commit time to implement 90-day rapid cycle improvement and continuous improvement – will be part of completing Milestone 3 in DY3
- Plan – workflow, implementation, training, dissemination of information, metrics for short, intermediate and long term outcomes (will be part of Milestones 1 and 3).
  - Short term – recognition and treatment initiation
  - Intermediate – hardwire processes evidenced by consistent use of tools
  - Long term – reduce sepsis mortality rates, decrease cost associated with PPC
- Do – implement Modified Early Warning Score (MEWS) and Lactate Levels Draw upon suggestion of Severe Sepsis or Septic shock – to be completed through Milestones 2 and 4
- Study – Analyze and interpret the results – to be completed through Milestones 5-9 in DYs 3-5.
- Act – Identify areas for change and implement rapid process to resolve – to be completed as part of Milestones 5-9 in DYs 3-5.

Related Category 3 Outcome Measure(s): OD 4 (Potentially Preventable Complications and Healthcare Acquired Conditions); IT 4.8 (Sepsis Mortality)

Spohn selected this outcome because the goal of creating the sepsis early warning system and corresponding protocols is intended to result in early recognition and treatment of sepsis in the
medical/surgical patient population, which is in turn expected to result in a lower rate for sepsis mortality in Spohn’s inpatient population.

**Relationship to other Projects:**
This project relates to and supports the following projects because it requires the vigilance and cooperation of all hospital providers (including physicians):

121775403.1.5 – Expand high impact specialty scare capacity through development of a structured critical service model focusing on providing intensivists driven services;
121775403.2.2 – Establishment of Hospitalist Program model that provides continuity of care through clinical integration of services in non-ICU patients
020973601.2.2 – Apply process Improvement methodology to improve sepsis mortality and length of stay.
Related Category 4 measures include potentially preventable complications in RD-3 and patient satisfaction in RD-4.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers who have submitted similar projects with whom we will collaborate include Corpus Christi Medical Center.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
a. Will the project address one or more community needs identified:
   i. In the region’s workgroup initiatives; and/or
   ii. In the region’s community needs assessment?

b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

The value of this particular project is based on the prevalence of sepsis mortality across Texas hospitals, including in Nueces County. Sepsis can affect any at-risk patients in the hospital, thus the project is necessary to protect a myriad of different types of patients. The investment required for this project ties into implementing the early warning system, rapid-cycle improvement, and provider training. Ultimately, this project meets Waiver goals by focusing on improving patient health outcomes while also reducing the systemic cost of providing inpatient hospital care associated with sepsis.

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83 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Milestone 1 [P-7]: Implement a rapid improvement project using Rapid Cycle Improvement methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Metric 1 [P-7.1]: Rapid Improvement Cycle for Sepsis; Standardize process, Set the measure, Validate the measure, Innovate implementation, Standardize new process, Continue cycle</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Baseline/Goal</strong>: Implement a 90-day rapid cycle improvement plan for Sepsis.</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source</strong>: Documentation of all steps included in rapid cycle methods were performed</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 1 Estimated Incentive Payment</strong>: $105,598.50</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 2 [P-1]: Target workflow, processes and clinical areas to improve: Implement early warning system (MEWS) for sepsis on medical/surgical inpatient units.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Metric 1 [P-1.1]: Identify and prioritize processes to improve</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Baseline/Goal</strong>: Implement an early warning system (MEWS) for sepsis on medical/surgical inpatient units in order to streamline the process for</td>
</tr>
<tr>
<td>Year 3</td>
<td>Milestone 3 [P-8]: Train providers/staff on process improvement</td>
</tr>
<tr>
<td></td>
<td><strong>Metric 1 [P-8.1]: Number of providers/staff trained</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Baseline/goal</strong>: train all hospital mid-level staff in using the MEWS system and the processes that flow from identifying a case of sepsis</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source</strong>: Documentation of training materials</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong>: $72,001.66</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 4 [I-14]: Measure efficiency – initiate CPOM for Sepsis</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Metric 1 [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Goal</strong>: 75% (estimate 113) of patients with suggestion of severe sepsis will have lactate level drawn</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source</strong>: EMR</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 4 Estimated Incentive Payment</strong>: $107,835</td>
</tr>
<tr>
<td>Year 4</td>
<td>Milestone 5 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR</td>
</tr>
<tr>
<td></td>
<td><strong>Metric 1 [I-14.1]: Increase use of electronic MEWS by nursing staff</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Goal</strong>: 10% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 390 additional screenings)</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 5 Estimated Incentive Payment</strong>: $107,835</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric 1 [P-8.1]: Number of providers/staff trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 3 [P-8]: Train providers/staff on process improvement</td>
<td><strong>Baseline/goal</strong>: train all hospital mid-level staff in using the MEWS system and the processes that flow from identifying a case of sepsis</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Documentation of training materials</td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong>: $72,001.66</td>
</tr>
<tr>
<td><strong>Milestone 4 [I-14]: Measure efficiency – initiate CPOM for Sepsis</strong></td>
<td><strong>Metric 1 [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock</strong></td>
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<td><strong>Data Source</strong>: EMR</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment</strong>: $107,835</td>
<td><strong>Milestone 5 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [I-14.1]: Increase use of electronic MEWS by nursing staff</strong></td>
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<tr>
<td><strong>Data Source</strong>: hospital EMR reports</td>
<td><strong>Milestone 5 Estimated Incentive Payment</strong>: $107,835</td>
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</table>

**Milestone 6 [I-14]: Measure efficiency – initiate CPOM for Sepsis**

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric 1 [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock</th>
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<tbody>
<tr>
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<td><strong>Goal</strong>: 75% (estimate 113) of patients with suggestion of severe sepsis will have lactate level drawn</td>
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<tr>
<td></td>
<td><strong>Data Source</strong>: EMR</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 6 Estimated Incentive Payment</strong>: $107,835</td>
</tr>
</tbody>
</table>

**Milestone 7 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR**

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric 1 [I-14.1]: Increase use of electronic MEWS by nursing staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Goal</strong>: 10% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 390 additional screenings)</td>
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<tr>
<td></td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong>: $107,835</td>
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</tbody>
</table>

**Milestone 8 [I-14]: Measure efficiency – initiate CPOM for Sepsis**

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric 1 [I-14.1]: Percentage of patients who had lactate drawn upon evidence that suggests severe sepsis and/or septic shock</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Goal</strong>: 95% (estimate 143) of patients with suggestion of severe sepsis will have lactate level drawn</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source</strong>: EMR</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 8 Estimated Incentive Payment</strong>: $87,071.50</td>
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</table>

**Milestone 9 [I-14]: Measure efficiency – electronic documentation of MEWS in EMR**

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric 1 [I-14.1]: Increase use of electronic MEWS by nursing staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Goal</strong>: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 585 additional screenings)</td>
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<tr>
<td></td>
<td><strong>Data Source</strong>: hospital EMR reports</td>
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<tr>
<td></td>
<td><strong>Milestone 9 Estimated Incentive Payment</strong>: $87,071.50</td>
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</table>
## RHP Plan for Region 4

### CHRISTUS Spohn Hospital Alice

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

| 09422902.3.8 | IT-4.8 | Sepsis Mortality |

#### Yearly Data:

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>responding to sepsis and to improve patient outcomes.</td>
<td>over DY2 baseline</td>
<td>Milestone 5 Estimated Incentive Payment: $72,001.66</td>
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<td><strong>Data Source:</strong> Hospital quality documentation, sepsis dashboards</td>
<td>Data Source: hospital EMR reports</td>
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<tr>
<td><strong>Milestone 2 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$105,598.50</td>
<td></td>
<td></td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):</td>
<td>$211,197</td>
<td>Year 3 Estimated Milestone Bundle Amount: $216,005</td>
<td>Year 4 Estimated Milestone Bundle Amount: $215,670</td>
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</table>

#### Total Estimated Incentive Payments for 4-Year Period:

(add milestone bundle amounts over DYs 2-5): $817,016

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RHP Plan for Region 4
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Alice / 094222902
Project Unique ID: 094222902.2.4

- Provider: CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- Intervention(s): Spohn Alice will implement a screening and treatment protocol in its hospital ED and FHC to identify patients with dual diagnoses (medical and behavioral health (BH) and assign a case manager to coordinate their care. Two medical diagnoses, CHF and Diabetes, will be targeted for screening and identification of co-existing BH illness.

- Need for the project: Currently, Spohn Alice patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 years earlier than those with mental health illness alone mainly due to unmanaged physical health. National studies show that approximately 58% of the adult population suffer from a medical condition and of those, 29% also have unaddressed behavioral health needs. Additionally, people with schizophrenia and bi-polar disorders are up to 3 times more likely to have three or more chronic conditions than people without those disorders.

- Target population: The target population includes all patients presenting to Spohn Alice hospital and all of Spohn’s clinics with a CHF or diabetes diagnosis. A recent 9-month data review of Spohn Alice ED visits with dual diagnoses shows that 127 patients presented with a CHF or diabetes diagnosis and secondary diagnosis of BH (21% of which were Medicaid eligible/uninsured). The total number of patients who presented in the ED with a diagnosis of CHF or diabetes is 519, and of those patients, 230 presented with Behavioral Health, indicating that only those with a clear presentation of BH were identified.

- Category 1 or 2 expected patient benefits: This project seeks to screen all CHF and diabetes patients for BH issues, and expects to refer 25% of that target population to behavioral health specialists by the end of DY4 (Spohn estimates this number to be 58 patients), and 40% of the target population by the end of DY5 (Spohn estimates this number to 92 patients).

- Category 3 outcomes: IT-9.2 – Spohn aims to reduce the volume of ED visits from diabetic patients 10% by DY5 due to this project because patients will be screened in the EDs and other treatment settings for BH referrals and will subsequently receive the treatment they need (which Spohn hopes will lead to reduced misuse of the ED)
Identifying Project and Provider Information:
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Alice / 094222902
Project Unique ID: 094222902.2.4

Project Description:
This project focuses on identification and screening of target populations for co-existing physical and behavioral health diagnoses. CHRISTUS Spohn Hospital Alice (“Spohn”) will implement a screening and treatment protocol in its hospital campuses and FHCs to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Spohn believes that identification and screening of these target populations will guide treatment plans for dual diagnoses, which will improve patient outcomes. In addition, identification of dual diagnoses in the acute care setting should improve the initiation of care management, which Spohn projects will impact in-patient outcomes and reduce LOS. Two medical diagnoses, CHF and Diabetes, will be targeted by this project for screening of co-existing BH illness. This screening will be initiated in Spohn’s ED and FHCs to facilitate early referral to a LMHP for further assessment or intervention. Concurrently, Spohn will perform medical screenings in the BH population in outpatient BH settings such as MHMR clinics. This project will be collaboration between Spohn’s Alice facility, LMHA, and Spohn’s Family Medicine and Emergency Medicine GME programs (wherein residents will be trained and participate in the screening processes).

Project Goals/Five Year Expected Outcome:
The goal of this project is to identify patients with dual diagnoses for behavioral and physical health conditions, and to intervene earlier and more effectively in their treatment and disease management. Spohn aims to reduce the use of the ED by patients with co-diagnoses for treatment and to reduce the amount and duration of preventable inpatient stays for these patients, which should result from proactive screening and earlier treatment intervention organized by case managers/care coordinators. Specifically:

- Spohn intends to implement screening protocols in its FHCs and hospital campuses to identify patients with a dual diagnosis of BH/depression and diabetes or CHF
- Spohn intends to assign these patients to Spohn staff who will act as care coordinators for this population

Project Challenges:
- Garnering participation in screening and treatment for chronically ill patients with behavioral health issues
- Educating physician and mid-level providers on effective methods for identifying, screening, and treating patients at risk for dual diagnoses (specifically, BH and CHF or diabetes)
- Hiring/training care coordinators to effectively manage the care of patients with these dual diagnoses

Spohn will address these challenges by engaging in thoughtful planning in DYs 2-3, seeking patient and community input into best practices and patient needs, and will refer to clinical best practices when training care coordinators.

Starting Point/Baseline:
Currently, patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. A 9-month data review of ED visits with dual diagnoses shows:

- 519 patients presented with the target diagnoses of CHF or Diabetes
  - 230 of those also presented with a BH diagnosis
  - 289 visits for CHF or Diabetes were not screened for BH
  - 35% were Medicaid pending or uninsured

**Rationale:**
Spohn chose this project because Jim Wells County is designated as a partial Health Provider Shortage Area in the mental health domain and the primary care domain, indicating the patients needing both mental health treatment and chronic disease management are likely slipping through the cracks in the system (RHP Plan, Section 3, Table 11). The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 yrs. earlier than those with mental health illness alone mainly due to unmanaged physical health. National Comorbidity Survey Replication data (2001-2003) shows that approximately 30% of patients with a chronic medical disorder also have a mental health disorder. While those with BH illness and a secondary medical illness die earlier, those with chronic medical diseases such as CHF, Diabetes or COPD and a co-existing BH illness have more frequent admissions with longer lengths of stay for seemingly unknown reasons. It is purported to be a result of undiagnosed or untreated mental health such as depression. Thus, this project should have a positive outcome on the long-term health outcomes for these patients, and should result in a reduction in the systemic cost of providing health care to this population.

**Core Components:** This project has 8 core components, which Spohn will address individually below:

a. **Conduct data matching to identify individuals with co-occurring disorders who do not receive routine and/or needed primary and specialty care, over-utilize ED and crisis response services, and are becoming involved with the criminal justice system due to unmanaged symptoms.** Spohn will perform this component through Milestone 1 in DY2 by undertaking review and analysis of medical data for Spohn’s FHC and hospital patients.

b. **Review chronic care management best practices such as Wagner’s Chronic Care Model and select practices compatible with organization readiness for adoption and implementation.** Spohn will incorporate this component into Milestone 3 in DY3 when it prepares its protocol for implementing screening and care coordination to identify and effective treat patients with a dual diagnosis of BH/depression and diabetes or CHF. Spohn will directly reference the best practices it identifies from this review in the protocol it creates.

c. **Identification of BH case managers and disease care managers to receive assignment of these individuals.** Spohn will address this core component through Milestone 2 in DY2. Spohn will identify existing or new staff to provide care coordination for patients identify with dual diagnoses, assigning the equivalent of at least 3 full-time care coordinators in DY2.

d. **Develop protocols for coordinating care; identify community resources and services available for supporting this population.** Spohn will address this component with Milestone 3 in DY3. The protocol will address community needs, best practices, internal processes, key challenges, and an implementation plan.
e. **Identify and implement specific disease management guidelines for high prevalence disorders.** Spohn will address this requirement through Milestone 4 in DY3. Care coordinators and medical providers will be trained in the screening, diagnosis, care coordination and treatment of patients with CHF or diabetes and BH/depression, and will implement the guidelines accordingly.

f. **Train staff in protocols and guidelines.** This requirement will also be addressed through Milestone 4 in DY3, as staff will be trained in both the guidelines for screening and treatment, and Spohn’s hospital/FHC specific protocol for addressing this community need.

g. **Develop registries to track client outcomes.** Spohn will address this component through performing Milestones 5 and 6 in DYs 4-5. Spohn is creating a Chronic Disease Registry for its campuses and FHCs, which it will use to track patients identified with the targeted dual diagnoses and their use of the ED and rate of potentially preventable hospitalization.

h. **Review the intervention’s impact on quality of care and integration of care and identify lessons learned, opportunities to expand the program, and key challenges with expanding.** In DY 4, Spohn will draft a report identifying aspects of the protocol that have yielded positive results, identify areas for improvement, and targets for expanding the scope of the project to additional chronic diseases and/or other mental health issues (i.e. substance abuse).

Ties to Community Needs Assessment: CN.2 (Inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (Negative mental health outcomes)

**Related Category 3 Outcome Measure(s):**
Outcome Domain 9: Right Care, Right Setting
Improvement Target 9.2 – ED Appropriate Utilization

Spohn chose this outcome measure because it directly correlates with the purpose of this project – Spohn seeks to identify and treat more of these patients in the community so they will be less likely to misuse the ED and/or deteriorate into an acute condition where they need emergency care.

**Relationship to other Projects:**
This project focuses on improving care coordination for physical and behavioral health care services and will enhance or support other projects designed to improve health care outcomes and care coordination. Specific projects that will be enhance or supported included: 020973601.1.4 – Enhance Service Availability of Appropriate Levels of Behavioral Health care; 121775403.1.1 – Expand high impact specialty care capacity; 121775403.2.9 – Integrate Primary Care and Behavioral health care.

Related Category 4 measures include preventable admissions measures in RD-1 and patient Satisfaction in RD-4.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s
healthcare system. Other providers who have submitted similar projects with whom we will share
information through the learning collaborative include MHMR of Nueces County and Coastal Plains
Community Center.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform
Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region.
Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas
Health and Human Services Commission, we understand that the RHP Plan must contain a narrative
that describes the overall regional and individual project approach for valuing each project.
Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP
projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does
   the project achieve the waiver goals of enhancing access, assuring quality of care, and
   improving the health of patients? Spohn considered how the project proposes to address the
   following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured
      residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent
   does the project address community needs? Spohn considered the following attributes when
   scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in
   total volume of patients or the type of population the project will serve (for example,
   predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the
   expected investment to successfully implement this project and achieve the milestones and
   metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value
Weight of Project. The valuation template then calculates initial project values for the projects based
on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of
Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports
with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any

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84 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or
investment and 5 having the largest impact or investment.

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category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its impact on the goals of the Waiver: the project is patient-centered because it offers needed screening and targeted care management for patients coping with both physical and mental conditions; the project also reduces the systemic cost of providing care to this population by using prevention and care management to reduce the use of the ED and/or preventable hospital admissions for patients with co-diagnoses. The project addresses community needs, as this community is lacking mental health providers and services, and will serve a population of chronically ill patients. The investment necessary to implement this project is great: protocols must be created, providers identified and trained; patients educated; and transformation of the delivery system accomplished through actual reductions in ED and hospital admissions.
**Related Category 3**  
Outcome Measure(s): 09422902.3.9  
IT-9.2 - ED Appropriate Utilization (BH/SA patients)

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**Milestone 1 [P-4]:** Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis to identify over/under utilization  
**Metric 1 [P-4.1]:** Data analysis  
**Baseline/Goal:** Spohn will develop a system to identify patients with co-diagnoses of CHF &/or Diabetes with BH/Depression using its available medical data and will produce written analysis of the available data  
**Data Source:** Written analysis

Milestone 1 Estimated Incentive Payment: $153,598

**Milestone 2 [P-5]:** BH case manager and disease care manager identified  
**Metric 1 [P-5.1]:** Number of staff identified with the capacity to support the target population  
**Baseline/Goal:** Identify and engage the equivalent of three (3) care coordinators to manage targeted patients  
**Data Source:** Staff rosters and documents of caseloads

Milestone 2 Estimated Incentive Payment: $153,598

**Milestone 3 [P-6]:** Care coordination protocols are developed  
**Metric 1 [P-6.1]:** Written protocols available to staff  
**Baseline/Goal:** Spohn will identify and define practice guidelines and processes for coordination of care between services in a written manual for providers  
**Data Source:** Written protocols, standards, policies and procedures

Milestone 3 Estimated Incentive Payment: $157,094.50

**Milestone 4 [P-8]:** Staff member training in care coordination protocols and practice guidelines for CHF, Diabetes and Depression/BH  
**Metric 1 [P-8.1]:** Percent of staff trained  
**Goal:** 80% off FHC and hospital staff identified in target areas will receive training in screening/care coordination for patients with targeted dual diagnoses  
**Data Source:** Training materials and attendance records

Milestone 4 Estimated Incentive Payment: $157,094.50

**Milestone 5 [I-22]:** Increase use of specialty care in line with professionally accepted practice guidelines  
**Metric 1:** X% increase/decrease use of specialty care according to practice guidelines  
**Baseline/goal:** 20% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment (Spohn)  
**Data source:** Care transitions registry

Milestone 5 Estimated Incentive Payment: $156,851

**Milestone 6 P-X:** Assess efficacy of process in place and recommend process improvements to implement if any  
**Metric X-1:** Identify opportunities to improve on the redesign methodology, as documented in the assessment document  
**Baseline/goal:** analyze the effectiveness and quality improvement resulting from this project  
**Data source:** documentation of assessment

Milestone 6 Estimated Incentive Payment: $156,851

**Milestone 7 [I-22]:** Increase use of specialty care in line with professionally accepted practice guidelines  
**Metric 1:** X% increase/decrease use of specialty care according to practice guidelines  
**Baseline/goal:** 40% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment  
**Data source:** Care Transitions registry

Milestone 7 Estimated Incentive Payment: $253,299
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<td>Year 2 Estimated Milestone Bundle Amount: $307,196</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $313,702</td>
<td>Year 5 Estimated Milestone Bundle Amount: $253,299</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $1,188,386

**Related Category 3 Outcome Measure(s):**
- 09422902.3.9
- IT-9.2
- ED Appropriate Utilization (BH/SA patients)
Expand Care Transitions Program; 2.12.2
CHRISTUS Spohn Hospital Alice/094222902
Unique project ID number: 094222902.2.5

- **Provider**: CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s)**: This project will expand Spohn’s Care Transitions program to focus on preventing readmissions for CHF and diabetes patients at Spohn’s Alice campus. Under the expansion, the RN Coach is the centerpiece of the program, and will function as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The RN Coach will facilitate the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit, the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge.

- **Need for the project**: Spohn’s Memorial campus launched the Care Transitions program in 2011 to target chronically ill charity patients for transition to self-management; however, the scope of the program during the first year was limited to 237 patients with a myriad of conditions. CHF-targeted Care Transitions is needed because CHF is the second most prevalent primary diagnosis in Region 4 and one of the most costly for preventable readmissions. Spohn Alice has a 16% PPR rate for CHF, which is higher than the statewide average of 12.7%.

- **Target population**: The target population includes CHF and diabetes patients treated as inpatients at Spohn’s Alice campus who are Medicaid/self-pay/charity eligible. In FY2012, Spohn treated approximately 207 visits with CHF or diabetes, of which 50 (24%) were Medicaid/uninsured (the majority of the 207 were Medicare patients).

- **Category 1 or 2 expected patient benefits**: By the end of DY3, Spohn expects to have fully implemented the CHF and diabetes-targeted Care Transitions program at its Alice facility for all (estimate 50) Medicaid/self-pay/uninsured patients by the end of DY5.

- **Category 3 outcomes**: IT- 3.2 – As a result of implementing the CHF-targeted Care Transitions at Alice, Spohn expects an 8% reduction in CHF 30-day readmission rates at its Alice facility.
Identifying Project and Provider Information:
Expand Care Transitions Program; 2.12.2, CHRISTUS Spohn Hospital Alice/094222902
Unique project ID number: 094222902.2.5

Project Description:
The Care Transitions program addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program. Frequently healthcare delivery is fragmented, lacks communication among providers and hospitals, and patients do not know how to access care or navigate the healthcare system. A reoccurring theme identified during the course of the program involved clients who did not understand how to manage their disease and discharged unprepared for the transition to the home setting. They are overwhelmed by their healthcare needs. This program is designed to empower patients and their families to become active shareholders and to promote quality healthcare in the community for the chronically ill. This expansion is in keeping with CHRISTUS Health’s commitment to creating healthier communities while reducing costs to the health care system.

The RN Coach is the centerpiece of this program, and functions as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The patient and caregiver are coached to play a central and active role in the formation and execution of the plan of care. The RN facilitates the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge. The four conceptual domains are introduced to the patient, by the RN Transitions Coach, commonly referred to as the 4 Domains or Pillars of care:

1. Medication self-management and medication reconciliation
2. Use of a dynamic patient-centered record, the Personal Health Record [PHR]
3. Timely primary care / specialty care follow-up
4. Knowledge of red flags that indicate a worsening in condition and how to respond

The target population includes patients with high risk discharge conditions, multiple medications, and the chronically ill. Program goal is to improve patient outcomes, maintain quality, and assist the patient and caregivers with the transition from hospital to home. Care Transitions provides patients with the tools and support to promote self-management, improve communication between patient and the primary Care Physician; reducing preventable hospital readmissions.

At discharge the patient has a support team, comprising of an RN Transition Coach, a Community Health Worker, and caregiver with the patient as an active participant in recovery. This is a uniquely designed program which has demonstrated great success.

As patients successfully transition from hospital to home care with the assistance of the Care Transitions model, they will also receive an additional 18 months of support and self-management training from a certified community health worker. The Care Management/Care Partner program is a self-management support program, facilitated by a specially trained community health worker working under the direct supervision of a registered nurse. This is the systematic provision of
education and supportive interventions to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress, goal setting, and problem solving support.

**Project Goals:**
The proposed plan is CHRISTUS Spohn Health System’s answer to reducing readmissions for chronically ill patients admitted to the six CHRISTUS Spohn facilities, by implementing the Care Transition and Care Partner Programs. The Care Transitions model is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across health care settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions.

- Implement the Care Transitions program for all Medicaid/uninsured/self-pay patients by DY5
- Reduction in avoidable CHF 30-day readmissions by 8% by DY5.
- Begin case management and discharge planning early; targeting high-risk patients and coordinate care.
- Improved care transitions from hospital to home; avoiding deterioration in health status, which often occurs upon discharge.
- Integrate hospital and outpatient care.

**Project Challenges:**
- Communication between inpatient and outpatient/community providers.
- Technology to support communication and electronic referrals.
- Potential enrollee’s may opt out of participating with Care Transitions Program.
- Barriers to care such as; financial, socioeconomic, and availability to providers.

This project meets the following regional goals:
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

CHRISTUS Spohn Hospital Alice (“Spohn”) will address these challenges by thoughtfully creating a plan to effectively communicate with patients and their caregivers about next steps and to establish a trusting, cooperative relationship. Providers will be trained to use the technology associated with the program. Finally, patients will be educated and encourage participating in the program, and the providers will work with clients to address financial and other barriers to participation.

**5 Year Expected Outcome**
The Care Transition Program has been in place on a small scale throughout the CHRISTUS Health System for over a year. Large amounts of research are now being published on the benefits and results of Care Transition Programs in Chronic Disease Management. Our 5-yr plan is to expand current Care Transition program coverage across diagnoses and payors. Despite our specific target for Medicaid, charity patients, and the uninsured, we have a responsibility to our community to provide the services for commercial payors that do not cover such programs or hold those that do to the same level of expectations.
Our plan is identified on the project timeline (2.12.1 Table) and consists of expansion beginning with CHF patients. The key to program success is continuous evaluation and targeted on-going improvement that will minimize inefficiencies and promote effective patient outcomes.

**Starting Point/Baseline:**
The CHRISTUS Spohn Community Outreach Program launched the Care Transitions Program in 2011 to assist charity care recipients with chronic diseases to transition from in-patient care to home self-management. Quarterly metrics demonstrate the effectiveness of the Care Transition and Care Partners program collaboration.

The thirty-three day RN intervention allows patients with complex needs to receive one on one instructions and coaching. In the reporting period, the provider averaged 948 encounters and served 237 patients from program implementation, which began in March of 2011 to the end of reporting period of June 30, 2012. Data is cumulative.

**Rationale:**
Jim Wells County, where Spohn Alice provides care, has a high rate of potentially preventable hospitalizations for the following conditions: bacterial pneumonia, congestive heart failure, COPD, and long-term complications related to diabetes (RHP Plan, Section 3, Table 10). Many of these patients have been hospitalized previously, and likely could have avoided subsequent hospitalizations if provided with the requisite support to transition to self-management of their conditions outside of the hospital setting. Additionally, Jim Wells County is designated as a Medically Underserved Shortage Area, which means that patients are not receiving the primary care interventions they need to avoid repeat hospitalizations for manageable conditions (RHP Plan, Section 3, Table 11). The Care Transitions program can assist patients in finding and obtaining the medical support they need when resources are often limited.

The proposed plan is CHRISTUS Spohn Health System’s answer to reducing readmissions for chronically ill patients admitted to the six CHRISTUS Spohn facilities, by implementing the Care Transition and Care Partner Programs already in place at CHRISTUS Spohn Corpus Christi-Memorial. The Care Transitions model is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across health care settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention. The use of specialized teaching tools and red flag rules, allows the patient to learn self-management skills and become an active partner of their healthcare team. Engaging the patient and family to become active partners in their healthcare, has directly impacted re-admission rates in the initial targeted population group at CHRISTUS Spohn Hospital-Memorial. This has resulted in a significant reduction in hospital utilization within the targeted group.

The program can be easily implemented within the CHRISTUS Spohn Region to target disease specific diagnoses within the uninsured, managed care, or Medicare populations. The Care Transitions program has been successfully implemented at various facilities throughout the CHRISTUS Health System, to include St. Michael, St. Frances Cabrini, St. John, and Schumpert St. Mary, Spohn Memorial, and Spohn Shoreline. The average cost of care per client for the CHRISTUS programs
regionally ending Q2 FY12 are such successes as pre-enrollment costs at $16,273 with a significant reduction in costs to the post-90 day enrollment cost of $3,425.

Results from the current Care Transition program limited to the charity care population at CSHCC-Memorial have had the following impact:

- Cost per case reduction 50%-75% based on site and target diagnoses
- Decreased ED utilization for inappropriate visits stabilized per covered lives volumes
- Average inpatient admission reduction >50% per patient
- ALOS reductions by as much as 1 patient day

**Milestones and Metrics:**
Spohn chose Milestones 1, 2, and 3 in order to implement the expansion of the Care Transitions program by first putting processes in place at the new participating facilities, and to share best practices with other providers taking similar action in Region 4. It is imperative to the success of the program that the expansion plan and implementation includes provider training, consistent policies, and sharing of information. Spohn chose Milestone 4 to show expansion of the new program.

**Ties to Community Needs:** CN.3, CN.4, CN.7, CN.12, CN.16

**Related Category 3 Outcome Measure(s): OD 3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates; Improvement Target 3.3.2 – Congestive heart Failure 30 Day Readmission Rate**
The Care Transition model will target patients admitted to the CHRISTUS Spohn Health System with a diagnosis of CHF. Care Transition nurses along with the medical team will enroll high risk CHF patients meeting program criteria, through admission census reports and daily rounding processes. The RN Transition Coaches and Community Health Workers will form community collaborations to promote healthcare and positively impact preventable hospitalizations for released CHF patients.

**Relationship to Other Projects:** This project’s focus on patient empowerment and education to improve care management of chronically ill patients is related to and will support many projects throughout the region. Primary projects with direct ties to this initiative include: 020811801.2.4 – Expand Care Transitions Program; 121775403.1.3: Implement a chronic disease registry to support and sustain management of patients in care transitions program; and 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care.

Related Category 4 Measures include Potentially Preventable Admissions in RD – 1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges with lessons learned and obstacles to delivery will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.
Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment ("DSRIP") projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 projects to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

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85 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

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RHP Plan for Region 4 497
Spohn valued this particular project with regard to its relevance to the goals of the Waiver; specifically, that the Care Transitions program is patient-centered, designed to improve patient outcomes and satisfaction, and should result in a reduction in the constantly growing cost of providing healthcare to the indigent and uninsured residents in Region 4. The project addresses community needs by targeting patients who have recently been released from the hospital and need assistance in order to avoid readmission – this is especially relevant for elderly patients, patients with chronic diseases, or patients who for other reasons have difficulty self-managing their conditions. The investment necessary to expand this program is great, including provider training, creating infrastructure at newly participating facilities, and creatively engaging in patient and community outreach to garner participation and changes in behavior.
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| **Milestone 1** [P-2]: Implement standardized care transition processes | **Milestone 2** [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects | **Milestone 3** [[I-14]: Implement standardized care transition program for the CHF and diabetes population | **Milestone 4** [[I-14]: Implement standardized care transition program for the CHF and diabetes population at facility
| **Metric 1** [P-2.1]: Implement Care transitions policies and procedures | **Metric 1** [P-10.1]: Number of bi-weekly meetings | **Metric 1** [P-9.1]: Measure adherence to processes | **Metric 1** [P-9.1]: Measure adherence to processes
| **Baseline/Goal:** Care Transition standardization in Spohn’s Alice Facility, meaning consistent standards for eligibility, processes for patient coordination, and provider training – with a focus on CHF and diabetes patients | **Baseline/Goal:** Establish open lines of communications to share learning experiences during 1st year after expansion with other RHP 4 providers – schedule interactions on a regular basis | **Goal:** Full implementation of CHF and diabetes care transitions program at facility for all (estimate 50) Medicaid, self-pay and charity patients. | **Goal:** Full implementation of CHF and diabetes care transitions program at campus for all Medicaid, self-pay and charity patients.
| **Data Source:** Care Transitions Policies, Procedures, Protocols | **Data Source:** Meeting minutes/agenda, lessons learned, documented challenges | **Data Source:** Care Transitions documentation, community outreach documentation | **Data Source:** Care Transitions documentation, community outreach documentation

**Milestone 1 Estimated Incentive Payment (maximum amount):**
$287,997

**Milestone 2 Estimated Incentive Payment:** $294,552

**Milestone 3 Estimated Incentive Payment:** $294,095

**Milestone 4 Estimated Incentive Payment:** $237,468

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $287,997

**Year 3 Estimated Milestone Bundle Amount:** $294,552

**Year 4 Estimated Milestone Bundle Amount:** $294,095

**Year 5 Estimated Milestone Bundle Amount:** $237,468

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $1,114,112
Care Management to Integrate Primary and Behavioral Health Needs; 2.15.1
CHRISTUS Spohn Hospital Alice / 094222902
Project Unique ID: 094222902.2.6

- **Provider:** CHRISTUS Spohn Hospital – Alice is a 135-bed hospital in Alice serving a 432 square mile area and a population of approximately 20,000. It is the only acute care hospital for Jim Wells and neighboring Duval, Brooks, McMullen and Live Oak counties averaging 15,000 patient days and 3,600 discharges annually.

- **Intervention(s):** Spohn plans to provide a Licensed Mental Health Provider (LMHP) in its Freer clinic in order to integrate the treatment of physical and behavioral conditions into one location.

- **Need for the project:** Service integration does not exist in Spohn’s clinics or the Freer clinic currently. The existing process requires referrals to other providers and additional appointments with inherent delays in time to appointment, which is a known contributor to “no-show” rates and increased ED visits. The Freer clinic averages approximately 4,362 encounters per year for approximately 1,250 patients, but does not currently track how many are referred for BH/SA services.

- **Target population:** The target population includes residents of Duval, Brooks, Live Oak and McMullen County who are uninsured and require behavioral health services, in addition to primary care. The uninsured rates for these counties are as follows; Duval = 26%; Brooks = 27% (33% below poverty level); Live Oak = 29% (21% below poverty level) and McMullen = 27% (13% below poverty level). The Freer clinic averages 4500 visits per year and Spohn expects that 30% of those patients have unaddressed behavioral health issues based on the Community Needs Assessment. Those approximately 375 patients could be referred to the LMHP onsite for a full assessment. Additionally, the LMHP can travel to other clinic sites to provide integrated care to a broader population base.

- **Category 1 or 2 expected patient benefits:** Spohn’s goal for this project is to provide integrated care/screening to 30% of its Freer clinic patients in DY4 (approximately 113/375 patients), and to provide integrated care/screenings to 40% of its Freer patients in DY 5 (approximately 150/ 375 patients) by DY 5. This will benefit targeted patients by allowing streamlined care that is quicker and easier to access, which is expected to improve patient satisfaction, quality of life, and short- and long-term health outcomes.

- **Category 3 outcomes:** IT-9.2 – The expected outcome of this project is a reduction in ED visits from service area zip codes for behavioral health/SA, including a 20% reduction where BH/SA is a primary diagnosis by the end of waiver, and a 15% reduction where BH/SA is a secondary diagnosis by end of waiver.
**Identifying Project and Provider Information:**

*Integrate Primary Care and Behavioral Health Care Services*; 2.15.1  
*CHRISTUS Spohn Hospital Alice/094222902*

*Project Unique ID Number:* 094222902.2.6

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**Project Description:**

CHRISTUS Spohn Hospital Alice (Spohn), working with Nueces MHMR, plans to provide integrated physical and behavioral health services for at least one of its Family Health Clinics (“FHC”) to integrate the treatment of physical and behavioral conditions into one location. Spohn has already performed some initial data analysis and identified three potential sites for initial integration and intends to do further analysis about where to place an appropriate number and mix of Licensed Mental Health Providers (LMHPs) in order to have the highest impact on low-income patients in need of integrated care.

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**Project and Regional Goals:**

The purpose of this project is to facilitate integration of physical care and behavioral health for patients with dual diagnoses, by combining and integrating services in a primary care setting, in order to reduce utilization of ED services for this population. By DY 5 an additional 150 patients will receive integrated services.

Spohn hopes that by providing integrated services in the community, patients will seek and receive earlier intervention into BH/SA conditions, and maintain a consistent course of treatment and medication management (where appropriate) that is difficult to maintain through a hospital setting. Additionally, LMHPs can assist the primary care provider staff at the FHCs to screen and identify potential MH/SA patients, and consult with the patients directly.

This project meets the following regional goals:

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

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**Project Challenges:**

- Recruiting and retaining a qualified LMHP to provide services in Spohn’s FHCs.
- Coordinating care between medical and behavioral providers.
- Patient education about the availability of integrated services.
- Determining the most appropriate location in which to place the LMHP.

Spohn will address these challenges by thoughtfully creating a comprehensive plan for this integration, and will engage in aggressive recruiting strategies in order to identify a qualified candidate to provide these services in a primary care setting. Finally, Spohn will train its providers to communicate with clients regarding care integration services.

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**Starting Point/Baseline:**

Service integration does not exist in Spohn’s FHCs currently. The existing process requires referrals to other providers and additional appointments with inherent delays in time to appointment, which is a

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66 There may be other LMHPs placed at a Spohn FHC as part of a related project.
known contributor to “no-show” rates and increased ED visits. The local LMHA also states there is no provision of physical medicine assessments in their behavioral health clinics.

**Rationale:**
The purpose of this project is to facilitate integration of physical care and behavioral health for patients with dual diagnoses, by combining and integrating services in a primary care setting, in order to reduce utilization of ED services for this population. Spohn has initially identified its Robstown FHC as needing LMHPs after a review of ED admission data for behavioral health diagnoses shows that 113 visits to Spohn EDs in a 9 month period were residents of zip codes from Robstown and the I-35 corridor between Corpus Christi and Beeville. The top 4 diagnoses of these presentations were Anxiety (10), Depression (43), Psychosis (4) and Suicidal ideation (18). 84% of these patients presented to Spohn-Memorial in Corpus Christi. This data led to the selection of this project for the addition of LMHPs to facilitate a shift in care delivery to the right setting to reduce inappropriate ED visits and PPA. Collaborative discussions with Nueces County MHMR have identified a need for physical medicine assessments in behavioral health settings also. Process measures in DY2 and DY3 will provide structure to an integrated plan that will expand the coverage area and increase access to integrated care.

The Coastal Bend’s Community Health Needs Assessment (2010) supports the high correlation between mental illness and chronic medical disease. Heart Failure is the 2nd highest principle diagnosis with Manic Depressive Disorder and Schizoaffective Disorder, also making the top DRG list. The top secondary diagnosis list includes Diabetes among the chronic diseases listed. Additional analysis of hospital data will provide direction for dual diagnoses presenting to our facilities. This analysis in the process phase of the waiver will be used to further define additional locations and target populations for screening and evaluation.

**Core Components:** Spohn will address the ten (10) core components for this project as follows:

- **a)** Identify sites for integrated care projects with potential benefit for significant number of people: This component is addressed in Milestone 1 in DY1.
- **b)** Develop provider agreements whereby co-scheduling and information sharing occurs between physical and behavioral health providers can be facilitated: This component is addressed in Milestone 3 in DY3.
- **c)** Establish protocols and process for communication, data-sharing and referrals between providers: This component will also be addressed through Milestone 3 in DY3.
- **d)** Recruit a number of specialty providers to provide services in specific locations: This component will be addressed through Milestone 2, whereby Spohn will hire/contract with at least one or more LMHPs to treat Spohn’s FHC patients.
- **e)** Train physical and behavioral health providers in protocols and build a shared culture: This component will be addressed through the implementation portion of Milestone 3 in DY3.
- **f)** Acquire data reporting, communication and collection tools to be used in the integrated setting (i.e. electronic health record system): Spohn and its FHC’s already possess EHR capabilities for use in an integrated setting and will make them available to the additional providers, and therefore do not need to include this component as a milestone during the Waiver.
g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice: Spohn will address this component through its performance of Milestone 3 in DY3.

h) Arrange for utilities and building services at these sites: Spohn’s Freer clinic and other sites where the LMHP will practice, are already fully functional and therefore Spohn will not include this component in its Milestones.

i) Develop and implement data collection and reporting mechanisms and standards to track utilization of integrated services: In order to perform Milestones 5-6, Spohn will address this component by creating and implementing a system to track the increased use of on-site referrals over the life of the Waiver of the integrated services.

Conduct quality improvement: Spohn will accomplish this component by performing Milestone 4 in DY4.

Ties to Community Needs Assessment: CN.2 (Inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (negative mental health outcomes)

**Related Category 3 Outcome Measure(s):**
OD 9: Right Care, Right Setting; IT-9.2 ED appropriate utilization – Reduce ED visits for behavioral health/SA

Spohn chose this outcome measure because one of the purposes behind offering behavioral health/SA and physical care in an integrated primary care setting is to give Medicaid patients and uninsured patients options for treatment outside of the ED. If patients receive earlier intervention and care in the community, they will be less likely to seek treatment for non-emergent conditions in the ED, which will reduce the systemic cost to provide care in Nueces County.

**Relationship to other Projects:**
This project is closely related to the global vision to redesign Primary and Behavioral Health Service. It’s focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**
This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal
learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any

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87 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

#95298
category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

This project was valued in consideration of the fact it addresses a clear community need (as evidenced by the ED admissions for behavioral health diagnoses from the Robstown area), the fact that the LMHP will be an extension of primary care, which is scarce in Region 4 and Nueces County, and because the cost savings of preventing acute episodes or misuse of ED by behavioral health/SA patients because they receive earlier intervention/prevention makes this project very valuable. Finally, this project is patient-centered in that it seeks to improve the quality of primary care for patients, which will increase affected patients’ satisfaction and quality of life.
### Related Category 3 Outcome Measure(s):

**094222902.3.11**  
**3. IT-9.2**  
**ED appropriate utilization – Reduce ED visits for behavioral health/SA**

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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1 [P-2]:** Identify existing clinics or other community-based settings where integration could be supported.  
**Metric 1 [P-2.1]:** Discussion/Interviews with community healthcare providers  
**Baseline/Goal:** Identify a site for physical/behavioral care integration, which may be the Robstown FHC or another location in the Alice community  
**Data Source:** Needs assessment, ED admission data by zip codes  

**Milestone 1 Estimated Incentive Payment:** $143,998.50

**Milestone 2 [Additional Process Milestones allowed in the Planning Protocol] Hire personnel to support the project.**  
**Metric 1 [P-3.3]:** Number of personnel hired  
**Baseline/Goal:** Recruit and retain at least one LMHP to provide care on a full-time basis through one or more of Spohn’s FHCs  
**Data Source:** Documentation of hire/contract  

**Milestone 3 Estimated Incentive Payment:** $294,552

**Milestone 3 [P-3]:** Develop and implement a set of standards to be used for integrated services to ensure effective information sharing and referrals between physical and behavioral health providers  
**Metric 1 [P-3.3]:** Number of referrals which follow established standards  
**Baseline/Goal:** Establish guidelines for screening and referrals between services and effect at least 25 referrals to the LMHP in the FHC – also address practical requirements for implementing the integration program, such as legal agreements  
**Data Source:** Referral system documentation and documentation of Spohn’s established protocol and standards for behavioral health integration  

**Milestone 3 Estimated Incentive Payment:** $294,552

**Milestone 4 [P-7]:** Evaluate and continuously improve integration of primary and behavioral health services  
**Metric 1 [P-7.1]:** PDSA and PIP for service integration  
**Goal:** Identification and resolution of shortcuts/work-arounds due to inefficient referral system  
**Data Source:** Referral system documentation, quality and PI documentation  

**Milestone 4 Estimated Incentive Payment:** $147,047.50

**Milestone 5 [I-8]:** Integrated services  
**Metric 1 [P-8.1]:** % of individuals receiving both physical and behavioral health care at established location  
**Numerator:** Number of individuals receiving both physical and behavioral health care at Freer clinic.  
**Denominator:** Number of individuals receiving services in Freer clinic  
**Baseline/Goal:** Spohn seeks to provide integrated screenings/care to 40% of its Freer patients (approximately 150/ 375 patients)  
**Data Source:** Referral system documentation  

**Milestone 6 Estimated Incentive Payment:** $237,468
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### Year 2
(10/1/2012 – 9/30/2013)
- Milestone 2 Estimated Incentive Payment: $143,998.50

### Year 3
(10/1/2013 – 9/30/2014)
- Year 3 Estimated Milestone Bundle Amount: $294,552

### Year 4
(10/1/2014 – 9/30/2015)
- Data Source: Referral system documentation
- Milestone 5 Estimated Incentive Payment: $147,047.50
- Year 4 Estimated Milestone Bundle Amount: $294,095

### Year 5
(10/1/2015 – 9/30/2016)
- Year 5 Estimated Milestone Bundle Amount: $237,468

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYS 2-5): $1,114,112
• **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

• **Intervention(s)**: Spohn proposes to adapt and disseminate AT&T’s mobile application that offers instant feedback via text messaging, coaching, and patient/provider web portals as a patient self-management tool to reduce HA1c in patients with Type 2 diabetes. Patients using the application will receive quarterly biometric screenings at the clinics (their medical home) as part of the program.

• **Need for the project**: Nueces County has a higher percentage of preventable hospital admissions than the statewide average for diabetes long-term complications. Spohn Corpus Christi treats between 10,000-15,000 inpatients per year with a primary or secondary diagnosis of diabetes and/or related complications, which is often a result of patients mismanaging their conditions due to a lack of access to provider support and education. This project seeks to assist patients with self-management of their conditions in order to avoid unnecessary ED visits and hospitalizations.

• **Target population**: The target population of this project is patients seen at the Spohn’s family health clinic sites and the Hector P Garcia clinic (where Spohn physician-residents provide care), who are managing Type I or Type 2 diabetes. Of the approximately 19,500 patients the participating clinics treat each year, approximately 40% are diabetic (7800 patients). Approximately 83% of these clinical patients are uninsured or Medicaid eligible (approximately 6500 of the 7800 diabetic patients). This project will specifically target those patients, in an effort to give them access to provider support that is often difficult to access for non-commercial patients.

• **Category 1 or 2 expected patient benefits**: By the end of DY 4, Spohn expects to enroll 20% of targeted clinic patients into the AT&T Diabetes Cellphone Application (approximately 1560 diabetic patients). By DY 5, Spohn seeks to enroll 40% of its eligible (i.e. diabetic) patients to participate in the mobile application (approximately 3100 diabetic patients). Of those patients, each will receive quarterly biometric screenings as part of the program (12,400 estimated annual encounters by end of DY5).

• **Category 3 outcomes**: IT-1.10 – Spohn expects a 5% increase in the number of patients with controlled HbA1c levels (less than 9%) at its FHCs in DY4, and an 8% increase in DY5.
Diabetes Cell phone Application

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:
AT&T Diabetes Cellphone Application, 2.6.1
CHRISTUS Spohn Hospital Corpus Christi/121775403
Unique Identifier – 121775403.2.1

Project Description:
Spohn proposes to adapt and disseminate AT&T’s mobile application that offers instant feedback via text messaging, coaching, and patient/provider web portals as a patient self-management tool to reduce HA1c in patients with Type 2 diabetes.

The project would improve monitoring of patient’s glycated hemoglobin (HA1c), in comparison to patients utilizing standard diabetes care, by offering mobile diabetes-coaching interventions. The mobile coaching will be personalized according to individually analyzed data, which will include blood glucose levels, lifestyle behaviors, and patient self-management. After analyzing the patient’s inputs, the AT&T Diabetes Cell phone Application (Diabetes Manager) will provide real-time feedback in response to their blood glucose levels, diabetes medication management, and diet. The first year of this application will entail developing a collaboration with AT&T. Together, these entities will provide a team of clinical and technical support to enhance patient self-management.

Diabetes Manager is a unique self-management tool that affords easy access and instant feedback from evidence-based practice and their own Primary Care Physician (PCP) and wellness counselors. This project will require identification of a PCP for enrollment routing new and existing patients with uncontrolled diabetes (HA1c > 9.0%) into a primary care setting. Identifying patients that can benefit from this innovative intervention will address self-management to controlled glucose levels through instant, individualized feedback, easily accessible education, and support for their self-management. Patient access to primary care and establishment of a medical home in the treatment of chronic disease, such as diabetes, has also shown to contribute to a reduction in inappropriate ED visits among this population. The ability to self-manage diabetes and receive immediate feedback on text submitted blood sugar readings has been shown to play a role in reducing ED visits by individualizing patient interventions.

Project Goals/5 Year Expected Outcome:
The goal of this project is to lower HA1c levels in patients with Type 2 diabetes by offering them a mobile application that provides self-management through instant glucose level feedback, coaching and patient/provider web portals for access to educational resources, communication and self-management trending. For the initial pilot phase, we propose to target patients with a HA1c ≥ 9.0% and an established Primary Care Physician (PCP). Wellness Counselors and PCPs will help and support these patients as they improve their management of their diabetes. Evaluation of self-management data and trends at the end of the one year pilot will determine the likelihood of expanding the Diabetes Manager to the Medicaid and indigent populations served by Spohn and our Region. Previous randomized clinical trials (RCTs) with this mobile application prior to instant text messaging feedback capabilities showed a 2% reduction in HA1c over the 1-yr study (Quinn et.al, 2008). A
second RCT was conducted comparing 3 group’s outcomes with diabetes self-management (Quinn et. al, 2011) also so showing a significant improvement in the self-management of HA1c. Additional research is currently underway in indigent populations and has reported substantial improvements in adherence to self-management regimes that will also lend support to expansion in this specific population.

Specific project goal:
- 20% of eligible Spohn FHC patients (Type 2 Diabetes + Medicaid/uninsured) participate in the mobile diabetes application by end of DY4 (approximately 1560 patients) and 40% by end of DY5 (approximately 3100 patients).
- All patients participating in the mobile diabetes application will receive quarterly biometric appointments

Project Challenges:
The primary challenge for this project will be patient understanding and competency of the Diabetes Manager software. The application provides coaching in English only, and a significant number of residents in the Texas Coastal Bend area are Spanish-speaking. While the vendor is working to add education in Spanish, our primary experience is indigent residents who are Spanish-speaking only cannot read Spanish however many have adapted to cell phone use. Additionally, to take full use of Diabetes Manager and receive feedback on their dietary intake, patients will need to understand and be able to calculate carbohydrate intake. Another concern will be attrition rates for patients using Diabetes Manager. Once beginning the program, the challenge will be with encouragement to continue and participate in the quarterly biometric screenings.

Relationship to Regional Goals:
The Region intends to increase health care outcomes and reduce the Region’s high chronic disease rate. This project will fulfill these two goals through communication with patients diagnosed with diabetes, providing instant communication and feedback regarding treatment. This patient interaction will have a direct result on improving patient’s health care outcomes.

Starting Point/Baseline:
The project will begin with a 1-year pilot of Diabetes Manager among Spohn associates with uncontrolled Type 2 Diabetes. Once the pilot is completed, analysis of data and trends will be evaluated for ongoing improvements to operationalize this self-management tool and expand its use to the Medicaid, indigent and uninsured populations of our Region. Provider portals will also be expanded to clinics, medical homes and FQHCs in the region wanting to participate in this innovative self-management solution.

Rationale:
According to the Region’s Community Needs Assessment, Nueces County has a higher percentage of preventable hospital admissions than the statewide average for diabetes long-term complications. These statistics highlight the need for innovate tools to reduce preventable hospital admissions, and thus to reduce health care costs. By instituting this project, Spohn will use low cost technology to meet both of these goals.
In the United States, diabetes is the leading cause of kidney failure, lower limb amputations, and new cases of blindness among adults. It is also a major cause of heart disease and stroke, and is the seventh leading cause of death in the United States. The Center for Disease Control and Prevention’s 2011 estimates indicate that diabetes affects 25.8 million people, or 8.3% of the U.S. population. In the thirteen counties of the Texas Coastal Bend area, the prevalence is substantially higher at 47% of the population. Diabetes Manager will ensure proper care 24 hours per day, seven days per week individualized to the patients established care regime. (Texas Department of State Health Services, Center for Health Statistics; [http://www.dshs.state.tx.us/diabetes/tdcdata.shtm]) Preliminary research conducted prior to the addition of text messaging capability and instantaneous treatment feedback has already been shown to result in an average of 2% decrease in HA1c levels.

This project was chosen based on evidence from several RCTs and provided by the American Diabetes Association on the impact of self-management in the maintenance of chronic Diabetes. Diabetes Manager provides patients a mobile phone–based treatment/behavioral coaching intervention. Services provided by Diabetes Manager include:

- Real-time feedback based on inputted blood glucose levels, lifestyle behaviors, and patient self-management.
- Reminders to take medications, check blood glucose levels or to eat.
- A learning library with educational information on diabetes and wellness healthcare.
- Clinical support and decision-making from case managers and the patient’s physician.

**Milestones and Metrics:** Spohn chose the milestones for DY4 and DY5 in order to effectively implement this project at the facility. The milestones in DY 2 and DY 3 are imperative to lay the groundwork for Diabetes Manager through the appropriate planning and training of personnel. Spohn chose its metrics in DY 4 and DY 5 to assess the effectiveness of the project—specifically, the percentage of the target population that has been reached by Diabetes Manager.

**Ties to Community Needs Assessment Unique IDs:** CN.17, CN.14

**Related Category 3 Outcome Measure(s):**
OD-1 Diabetes Care Outcomes:
- IT-1.10 HbA1c poor control (> 9.0%)
  - Increase access to health promotion and activities using Diabetes Manager for patients with HbA1c ≥ 9.0%.

**Relationship to other Projects:**
This project focuses on processes that support and enable patients to take charge of their own health, resulting in better patient outcomes and chronic disease management. The project will enhance and support several other related projects within the region, including the following project options: 121775403.2.8 and 020973601.2.1 – Implementation/expansion of care transition programs; and 094222902.1.2 – Chronic Disease Registry.

Related Category 4 measures include potentially preventable admissions measures in RD-1 and patient Satisfaction in RD-4.
Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. While no other provider has an identical project, providers with similar projects with whom we will collaborate and share information include MHMR of Nueces County, Corpus Christi-Nueces County Public Health District, and Driscoll Children’s Hospital.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?[^88]

[^88]: For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Using this methodology, Spohn weighted this project highly given the potential benefit from real-time monitoring for diabetes patients using Diabetes Manager and its ability to allow interactions with physicians sooner than other norms of treatment. Patients will be empowered to manage their disease from their homes and workplaces, and will receive individualized feedback. This is expected to increase patient quality of life and satisfaction with the healthcare delivery system, which is imperative to achieving the goals of the Waiver. This project is expected to lead to cost savings in PPAs, PPRs, and ED misuse. The impact of the project is great, in that it is expected to touch at least 2000 patients by DY5, and has the potential to affect many more.
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<td><strong>IT-1.10 Diabetes Care: HbA1c poor control (&gt;9.0%)</strong></td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 1</strong> [P-2]: Development of Diabetes cellphone application pilot. <strong>Metric 1</strong> [P-2.1]: Document Diabetes Manager strategy and plan <strong>Baseline/Goal</strong>: Baseline of 100 eligible clients with diabetes Type 2 and an established relationship with a PCP. <strong>Data Source</strong>: Project Plan documentation</td>
<td>Milestone 3 [P-5]: Execution of evaluation process for Diabetes Manager <strong>Metric 1</strong> [P-5.1]: Document evaluation process, tools and analytics. <strong>Goal</strong>: Evaluate the success of the pilot program, the value and quantity of data obtained and disseminated, and what conclusions result from analysis of the relevant data <strong>Data Source</strong>: Evaluation report Milestone 3 Estimated Incentive Payment: $1,881,054</td>
<td>Milestone 4 [I-6]: Percent of diabetic clients receiving Diabetes cellphone application <strong>Metric 1</strong> [I-6.1]: Percent of eligible indigent, Medicaid and self-pay patients participating in Diabetes Manager <strong>Goal</strong>: 25% of eligible clinic patients (diabetes Type 2) will participate in the Diabetes Manager application (approximately 1000 enrollees, 4000 biometric screenings) <strong>Data Source</strong>: Provider, hospital and clinic records Milestone 4 Estimated Incentive Payment: $1,878,137</td>
<td>Milestone 5 [I-6]: Percent of diabetic clients receiving Diabetes cellphone application <strong>Metric 1</strong> [I-6.1]: Percent of eligible indigent, Medicaid and self-pay patients participating in Diabetes Manager <strong>Goal</strong>: 50% of eligible patients (diabetes Type 2 will participate in the Diabetes Manager application (approximately 2000 enrollees, 8000 biometric screenings) <strong>Data Source</strong>: Provider, hospital and clinic records Milestone 5 Estimated Incentive Payment: $1,516,508</td>
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<td>Milestone 1 Estimated Incentive Payment (maximum amount): $919,595</td>
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<td>Milestone 2 [P-3]: Implement, document and test Diabetes Manager pilot <strong>Metric 1</strong> [P-3.1]: Document implementation strategy and testing outcomes <strong>Baseline/Goal</strong>: Baseline of 100 eligible clients <strong>Data Source</strong>: Application reports and project results. Milestone 2 Estimated Incentive Payment: $919,595</td>
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RHP Plan for Region 4
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $7,114,889*
CHRISTUS Spohn Hospital Corpus Christi
Redesign primary care access through development of a hospitalist service model, 2.5.4
Project Identifier: 121775403.2.2

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s)**: CHRISTUS Spohn Hospital Corpus Christi (“Spohn”) proposes to redesign the delivery of inpatient care by establishing a clinically integrated Hospitalist model. The Hospitalist program design will implement patient assignment to a multidisciplinary team headed by a hospitalist who will remain the assigned provider for the patient throughout hospitalization and post-discharge. The hospitalists will be responsible for inpatient admits, patient care until discharge, and post-discharge follow-up. Spohn expects this to reduce the number of days Medicaid/charity/uninsured patients remain hospitalized over the DRG-average days (called “opportunity days”), to increase the availability of beds in Spohn’s facilities, to improve provider/patient communication, to reduce PPCs and hospital acquired conditions, and to improve patient satisfaction and quality of life. **Need for the project**: Currently, patients at the hospital are treated by a multitude of providers, including resident physicians on duty or physician providers on call at given times during the day/week. This means that a patient who is hospitalized for three days may see up to 6 physicians, each of whom is unfamiliar with this patient and are less likely to recommend timely discharge than a physician who is familiar with the patient. This leads to longer than necessary inpatient hospital stays. Post-discharge, uninsured/Medicaid patients are randomly assigned to providers within Spohn’s family health clinics at each visit, meaning they are again unlikely to have a provider who is familiar with the particular patients or their conditions.

- **Target population**: The target population is Spohn’s non-ICU patients requiring hospitalization who have no established relationship with a primary care provider. With 60 percent of Spohn’s patients entering the unassigned Category, the necessity for Hospitalists to furnish care is enormous. Spohn’s Corpus facilities discharge approximately 26,000 inpatients annually, of which approximately 15,600 are unassigned, and the average length of stay is 5.6 days (for a total of 117,600 patient days). Of the approximately 15,600 unassigned inpatients, approximately 32% are Medicaid/uninsured, which equates to approximately 5000 inpatients in that population benefiting from this project. Spohn roughly estimates that its current cost per inpatient is $8400, but will determine an accurate cost-accounting methodology and baseline number by the end of DY2.

- **Category 1 or 2 expected patient benefits**: The project seeks to decrease the cost of treating Medicaid, uninsured, and charity patients as non-ICU inpatients by reducing the cost per inpatient stay for the Medicaid/uninsured population by 2% from baseline (estimated $168 per admission) in DY3, by 3% from baseline (estimated $252 per admission) by DY4, and by 4% from baseline (estimated $336 per admission) by DY5.

- **Category 3 outcomes**: IT-4.2 – By DY 5, Spohn expects this project to result in a reduction in the baseline rate of CLABSI for non-ICU patients by 55%.
Identifying Project and Provider Information:
Redesign primary care access through development of a hospitalist service model, 2.5.4
CHRISTUS Spohn Hospital Corpus Christi/121775403

Project Description:
CHRISTUS Spohn Hospital Corpus Christi ("Spohn") proposes to redesign the delivery of inpatient care by establishing a clinically integrated Hospitalist model. Currently, patients at the hospital are treated by a multitude of providers, including resident physicians on duty or physician providers on call at given times during the day/week. This means that a patient who is hospitalized for three days may see up to 6 physicians, each of whom is unfamiliar with this patient and are less likely to recommend timely discharge than a physician who is familiar with the patient. This leads to longer than necessary inpatient hospital stays and higher costs of providing care to all patients, including Medicaid, uninsured and charity care patients. Once patients are discharged from the hospital, they often receive their follow-up and subsequent primary care at one of Spohn’s local Family Health Clinics ("FHCs"), the Hector P Garcia clinic (where Spohn’s physician-residents provide care), and sometimes there are attempts to integrate them into a medical home. Patients who qualify for access to FHC’s or are not integrated into a medical home are randomly assigned to doctors when they present for an appointment and may see a different doctor each time they visit. This system means that patients often lack the consistent support they need to self-manage their conditions and are more likely to require readmission to an inpatient setting. The current structure does not provide adequate transition of care processes nor does it allow for a true clinical integration to occur.

Spohn intends to develop an entirely different system of care going forward, which will entail the following steps/components: (1)Spohn will redesign its protocol for treating inpatients to require assignment of individual patients to hospitalist staff members (the number of which will be increased by this project) and residents who operate in teams to treat particular patients; (2) the hospitalist will remain the primary physician for his/her patients while they are admitted as inpatients; (3) the hospitalist will provide clinical integration with the PCP provider so that follow-up care becomes part of their discharge transitional responsibility; and (4) in addition to patients’ assigned physicians, Spohn will designate multidisciplinary teams to inpatients who will provide quality medical care and prompt attention to patient care needs in a holistic manner; the teams will include Clinical nurses, Case Managers, Clinical Pharmacist, and Social Services associates who will connect inpatients to a transitional care model that will tie patient to a primary care physician (PCP) and medical home. The Hospitalist and residents must serve as a key component of the healthcare continuum.

The Hospitalist program design and implementation will provide a structured mechanism and processes to provide efficient effective care of non-ICU patients that do not have relationships with primary care providers and require hospital care. With 60 percent of hospital admissions entering the unassigned, unfunded Category, the necessity for hospitalist providers to furnish
care is enormous. The current hospital care provider becomes the patient’s admitting physician by the luck of the draw dependent on which provider is on the on-call coverage schedule. The goal is to provide a Hospitalist program which provides 24 hour access and delivery of comprehensive medical care to hospitalized patients, thereby improving their short- and long-term health outcomes and reducing the system-wide cost of providing their care.

**Project Goals/5 Year Expected Outcome:**
The overarching goal of this project is to redesign the delivery system to reduce costs while improving patients’ experiences. Spohn hopes that by improving its processes to be more efficient (including the expanding its use of hospitalist providers, which will take initial cost investment) and providing patients with higher quality care, the benefits will include a lower overall cost of providing care. Specific goals include:

- Implementing the hospitalist model to include multi-disciplinary teams assigned to individual patients
- Educate providers how to effectively operate as hospitalist teams
- Determine a cost-accounting methodology to measure cost-containment caused by hospitalist model
- Reduce the cost per inpatient stay for the Medicaid/uninsured population by 2% from baseline (estimated $168 per admission) in DY3, by 3% from baseline (estimated $252 per admission) by DY4, and by 4% from baseline (estimated $336 per admission) by DY5.
- Reduce the rate of risk-adjusted PPCs for non-ICU inpatients

**Project Challenges:**
- Provider cooperation in training regarding referrals and consultations to Hospitalists.
- Developing a specialty care access plan for the project.
- Selecting training materials about the hospitalist care model delivery in order to train staff regarding program.

Organizing and maintaining care teams for patients to extend beyond discharge, coordinating with the FHCs to maintain the stability of patients’ conditions after discharge from the inpatient setting. Spohn will address these challenges through organized training sessions, appointing leadership staff to oversee the program, and engaging provider enthusiasm for reforming Spohn’s provision of care.

**Relationship to Regional Goals:**
Region 4 intends to improve health care outcomes through quality of care improvements. This project furthers this goal by creating a hospitalist program that provides 24/7 care to hospitalized patients. By focusing on team integration, patients will receive care more effective and appropriate treatment.

**Starting Point/Baseline:**
Currently, Spohn does not have an integrated hospitalists model to provide care to all unassigned inpatients. Approximately 21,000 inpatients per year are in the unassigned category, and therefore would benefit from a hospitalist model of care (of those, at least 7000 are expected to be Medicaid/uninsured).
**Rationale:**
Spohn chose this project because Region 4 faces higher poverty rates than statewide averages, and all of the counties in the Region have been designated as either partially or medically underserved and have a shortage of primary care providers (RHP Plan, Section 3, Table 11). According to the Community Needs Assessment, the rural nature of the Region also results in many residents having decreased access to primary health care services. Twenty-two percent of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover healthcare bills, creating large uncompensated costs for Spohn when patients in this population require hospitalization. Nueces County has a higher percentage of Preventable Hospital Admissions than the statewide average for the following conditions that can be managed upon discharge through regular access to a primary care provider: Asthma, COPD, CHF, bacterial pneumonia, and diabetes long-term complications.

The American Journal of Managed Care reported that in a review of 502 abstracts and 17 studies of 137,561 patients, LOS was significantly shorter when an organized Hospitalist group existed. Hospitalists are able to provide hospital oversight without the distractions of private practice. An organized hospitalist program will add quality and value with a new model of care and dramatically reduce costs in the long-term. Currently, there are a multitude of independent physicians providing hospital coverage and care to the hospitalized patient providing care at Memorial. CHRISTUS Spohn will assist in identifying a hospitalist section of the organized medical staff, identify preferred provider model(s) and fully align the hospitalist program in order to impact patient care and care outcomes.

The target population is Spohn’s non-ICU patients requiring hospitalization who have no established relationship with a primary care provider. With 60 percent of hospital admissions for Spohn’s patients entering the unassigned, unfunded Category (which includes uninsured and/or Medicaid patients), the necessity for Hospitalist to furnish care is enormous.

**Project components:**
Through the Hospitalist Program model redesign we propose to meet the 2.5.2 project components through the following steps:
1) Process milestones – In DY2, Spohn will use P-1 to develop a cost-accounting methodology to measure the progress of the hospitalist project, and will use P-2 to establish a baseline by which to measure progress.
2) Improvement Milestone I-11: Spohn will use Milestone I-11, Metrics 1 and 2 in DYs 4-5.
Milestones and Metrics: Spohn chose the milestones for DY4 and DY5 because the goal of the project is to reduce the cost of providing inpatient hospital services to Medicaid, uninsured and charity care patients through the use of the new hospitalist model and the resulting shorter average LOS and decreased readmission rate. The milestones in DY 2 and DY 3 are imperative to lay the groundwork for measuring the cost containment effected by this redesign.

Ties to Community Needs Assessment Unique IDs: CN.1 (hospitalists will remain assigned to patients through Spohn’s FHCs after the patients are discharged into the community), CN.3 (hospitalists will spearhead better care provision and coordination for non-ICU, chronically ill patients), CN.18 (hospitalists can participate in reducing the rate of sepsis and improving the reaction time and mortality rate within Spohn), CN.7 (the hospitalist model within the hospital and post-discharge should have a positive impact on the number of PPRs by providing patients will improved, organized, continuous care)

Related Category 3 Outcome Measure(s):
OD 4 Potentially Preventable Complications; Improvement Target 4.2 : CLABSI

Spohn chose this outcome because the hospital intends to cause a reduction in central line associated bloodstream infections through redesigning the provision of care at Spohn to include consistent treatment from a dedicated team during hospitalization. Spohn believes that using this hospitalist team model will result in fewer central line infections as patients receive an improved level of care (based on review of the literature).

Relationship to other Projects:
This project’s focus is to develop practice focus initiatives for non-ICU patients through innovation that transition the hospitalized patient to the Primary Care Medical Home setting. Spohn’s Intensivist project(121775403-1.9.1), Expansion of Primary Care Hours-staffing project(121775403 – 1.1.2), Chronic Disease Management Registry project(121775403 – 1.3.1), Establishment of Medical Homes projects(121775403.2.3 – 2.1.1), Cost of Care delivery-Primary Increase Primary Care Training (121775403-1.2.1), Expand Care Transitions Program (121775403- 2.12.2) and Integration of BH to Primary Care project(121775403– 2.15.1) are all interrelated and will be crucial in the redesigning of the Healthcare delivery system. This project is closely related to the Increase Primary Care Training project in that both seek to redesign the provision of care to indigent and unassigned patients who visit and are discharged from the hospital. This Hospitalist project seeks to assign patients to multi-disciplinary teams while receiving treatment in the hospital (which will be spearheaded by the hospitalists, and include at least one Family Practice Resident each), while the Increase Primary Care Training project seeks to allow discharged patients to continue being managed by the hospitalist assigned to their case in the hospital and to be treated by the residents who were on the inpatient teams assigned to each patient in the HP Garcia clinic. This continuity of care and individual provider responsibility for patients should increase patient satisfaction and quality of life, improve Spohn’s ability to assist patients in managing their chronic diseases, and reduce systemic costs of providing care to chronically ill indigent patients in the Region.

Through the implementation of this project, related category 4 measures that will be impacted are RD-3 Potentially Preventable Complications and RD-4 Patient satisfaction.
Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing an identical program, other similar projects will focus on improving health care outcomes and reducing the cost of care, including projects proposed by Corpus Christi Medical Center, Citizens Medical Center, and Driscoll Children’s Hospital.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

The value of this project is based upon the population served, which will include the majority of inpatients admitted from treatment in Spohn’s facilities. The need for this project is exhibited by the rate of patients who are admitted without a physician (60%), who currently receive care from multiple providers during their stay. Those multiple providers may not have a chance to communicate to each other and will not become acquainted with each patient’s individual situation when they only see them sporadically. The hospitalist model will change the way these unassigned patients are treated, and is expected to increase patient satisfaction, outcomes, and quality of life. The required investments in implementing this project will include recruiting and retaining hospitalist providers to work at Spohn, training staff of procedures for using the hospitalist model, creating a coordination system with the local clinics and other PCPs, and putting system in place to measure the cost impact of the project. Finally, the stated goal of this project is to contain costs associated with inpatient hospital stays that are often longer than they need to be for patients who may not have required admission in the first place. The hospitalist model should allow Spohn to reduce patient “opportunity days” and to reduce repetitive ordering of tests, just to name a few ways the project is expected to meet its stated goal of reducing the cost of treating the target population.

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89 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

#95300
### Related Category 3 Outcome Measure(s):

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#### Milestone 1 [P-1]

Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions.  
**Metric 1 [P-12.1]:** Cost account methodology  
**Baseline/Goal:** Spohn will develop a methodology for comparing the current cost of treating Medicaid, uninsured and charity care non-ICU inpatients at its Corpus Christi locations under the current system where multiple providers treat inpatients and develop a methodology for comparing this accurately to the cost of assigning hospitalists to inpatients who remain under the hospitalists’ care (which is expected to reduce length of stay)  
**Data Source:** cost accounting system  
**Milestone 1 Estimated Incentive Payment (maximum amount):** $689,696

#### Milestone 2 [P-2]

Establish a baseline for cost  
**Metric 1 [P-2.1]:** Establish a baseline for cost

#### Milestone 3 [I-11]: [I-11]

Improvements in cost containment using innovative project option.  
**Metric [1.11.1.]:** Total cost per member of the population per month  
**Metric [I-11.2]:** Hospital and ED utilization rates  
**Baseline/Goal:** 2% decrease in the monthly cost of treating Medicaid, uninsured, and charity patients as non-ICU inpatients at Spohn’s Corpus facilities as compared to the baseline established in DY2 and using the designated cost-accounting methodology  
**Numerator:** DY4 inpatient cost for treating this population  
**Denominator:** DY3 monthly inpatient cost for treating this population  
**Data Source:** Hospital reports, EMRs

**Milestone 3 Estimated Incentive Payment: $705,395**

#### Milestone 4 [P-9]

Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around

**Milestone 4 Estimated Incentive Payment: $1,408,603**

#### Milestone 5 [I-11]: [I-11]

Improvements in cost containment using innovative project option.  
**Metric [1.11.1.]:** Total cost per member of the population per month  
**Metric [I-11.2]:** Hospital and ED utilization rates  
**Baseline/Goal:** 3% decrease in the monthly cost of treating Medicaid, uninsured, and charity patients as non-ICU inpatients at Spohn’s Corpus facilities as compared to the baseline established in DY2 using the designated cost-accounting methodology  
**Numerator:** DY5 inpatient cost for treating this population  
**Denominator:** DY3 monthly inpatient cost for treating this population  
**Data Source:** Hospital reports, EMRs

**Milestone 5 Estimated Incentive Payment: $1,137,381**

#### Milestone 6 [I-11]

Improvements in cost containment using innovative project option.  
**Metric [1.11.1.]:** Total cost per member of the population per month  
**Baseline/Goal:** % decrease in the monthly cost of treating Medicaid, uninsured, and charity patients as non-ICU inpatients in Spohn’s Corpus facilities as compared to the baseline established in DY2 using the designated cost-accounting methodology  
**Numerator:** DY5 inpatient cost for treating this population  
**Denominator:** DY3 monthly inpatient cost for treating this population  
**Data Source:** Hospital reports, EMRs

**Milestone 6 Estimated Incentive Payment: $1,137,381**
## Related Category 3 Outcome Measure(s):

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<td>Baseline/Goal: Establish the current cost of treating inpatient Medicaid, uninsured, and charity care non-ICU inpatients under the current model of care (the doctor/resident working treats all patients), so Spohn can measure cost containment going forward when patients are assigned to particular hospitalists and residents who remain their providers throughout their stay and afterwards through the clinic. A basic review of Spohn’s FY 2012 numbers indicate that the average cost per Medicaid/uninsured inpatient stay was $8400, although Spohn intends to undertake a comprehensive review of the relevant data in developing its cost accounting methodology and establishing an accurate baseline upon which to measure improvement going forward. Data Source: Financial data set for target population</td>
<td>shared or similar projects. Metric 1 [P-9.1] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: to meet twice per year with other providers in the Region to discuss cost containment best practices, key challenges, and related issues. Data source: meeting notes, slides, or agenda</td>
<td>Milestone 4 Estimated Incentive Payment: $705,395</td>
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**Milestone 2 Estimated Incentive Payment:** $689,696

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $1,379,392

**Year 3 Estimated Milestone Bundle Amount:** $1,410,790

**Year 4 Estimated Milestone Bundle Amount:** $1,408,603

**Year 5 Estimated Milestone Bundle Amount:** $1,137,381
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TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $5,336,167
CHRISTUS Spohn Hospital Corpus Christi/ 121775403
Cost of Care Delivery: Primary Care Delivery Method Redesign; 2.5.2
Unique Identifier - 121775403.2.3

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** This project will focus on expanding the training program for residents to provide care in the Hector P Garcia clinic. The current Family Practice Residency Program focuses on hospitalist training. Under the expanded training program, residents will receive training and provide expanded primary care service to patients.

- **Need for the project:** The current care delivery model used by the Family Practice Residency Program promotes hospitalist training more than primary care, and the use of assigned patient panels by providers is not in place. This method of care delivery has resulted in episodic care by providers that are not established with the patients they see, which in turn results in an increased average length of stay (ALOS) in the hospital setting and fragmented follow-up care. Currently, the family practice residents are each available for only 200 days (or 40 weeks) per year at the clinic (80% of the average full-time provider), meaning that the patients assigned to those residents are often unable to schedule appointments for up to a month at a time while their assigned resident is on another rotation or providing care in the hospital setting.

- **Target population:** The target population of this project includes Spohn’s 36 Family Practice residents who can obtain better training relevant to their chosen specialty by treating the same patients regularly in a clinic setting, while filling a pronounced community need for patients without a medical home or PCP (which is the direct target population of this project). There are currently 36 residents in the Family Practice Graduate Medical Program providing care at the Hector P Garcia clinic, and the Hector P. Garcia clinic provides approximately 29,000 patient encounters per year to approximately 9000 patients, 72% of whom are Medicaid, uninsured, or charity patients (approximately 6700 patients). This project will target these patients (specifically those with chronic conditions and/or a history of preventable admissions/ED visits) and assign them a Family Practice resident as their PCP of record.

**Category 1 or 2 expected patient benefits:** Spohn intends to increase the number of clinic days each resident providers per year by 5 days in DY4 (for a total of 180 additional days of appointment availability, which Spohn estimates will allow 2880 additional appointments), and by an additional 3 days in DY5 (for a total of 8 additional days per year, totaling 288 additional days of appointment availability, which Spohn estimates will allow 4600 additional clinic appointments per year).

**Category 3 outcomes:** IT-2.7 – Spohn expects to reduce the rate of PPAs related to short-term diabetes complications by 15% from baseline by the end of DY5. Spohn expects this to result from fewer patients resorting to the ED for primary care, where they previously would have been admitted based on having no access to a primary care physician. Additionally, increased access to the residents for the clinic’s patients should result in improved outcomes, reducing the rate of hospitalization.
Cost of Care Delivery  
*Category 2: Program Innovation and Redesign*

**Identifying Project and Provider Information:**
Cost of Care Delivery: Primary Care Delivery Method Redesign; 2.5.2  
CHRISTUS Spohn Hospital Corpus Christi/ 121775403

*Unique Identifier - 121775403.2.3*

**Project Description:**
A Primary Care Delivery redesign is necessary to improve patient outcomes for uninsured/underinsured patients in Nueces County. The project will focus on redesigning the Family Practice Residency Program to focus less on hospitalist training on an episodic basis and instead assign the residents to panels of patients and provider teams and make those residents available to those patients on a more regular basis. Spohn expects the transformation from hospitalist episodic care to patient-assigned care at the clinics with regularly available residents will increase the continuity of care for patients, decrease their ALOS and increase satisfaction by establishing patient/provider relationship. Physician patient panels are supported by evidence in the medical home literature and reported to increase patient satisfaction and reduce no-show rates in primary care centers as well as impact PPA/PPR in associated acute inpatient settings.

The target population of this project includes Family Practice residents who can obtain better training relevant to their chosen specialty by treating the same patients regularly in a clinic setting, while filling a pronounced community need for patients without a medical home or PCP (which is the direct target population of this project). There are currently 36 residents in the Family Practice Graduate Medical Program, and the Hector P Garcia clinic currently provides 29,000 patient encounters per year to approximately 9000 patients, the majority of whom are Medicaid, uninsured, or charity patients. The residents provide some of the care in this clinic already, but are often away on other rotations (sometimes not returning for over a month) and unable to consistently provide appointments and/or increase their primary care capacity. This project will target the indigent patients (specifically those with chronic conditions and/or a history of preventable admissions/ED visits) by assigning them to a Family Practice resident as their PCP of record who will be regularly available to those patients.

The current care delivery model used by the Family Practice Residency Program promotes hospitalist training instead of primary care. This method of care delivery has resulted in episodic care by providers that are not established with the patients they see, which in turn results in an increased average length of stay (ALOS) in the hospital setting and fragmented follow-up care which results in worse long- and short-term patient health outcomes. Redesigning Primary Care Delivery will dramatically improve the cost-effectiveness of care delivery for the Coastal Bend Medicaid and indigent population. Changes in the delivery system have been initiated but the need for total redesign remains in light of continued shortcomings in patient outcomes.

Spohn will focus on the following methods as a means of improving care:
- Patient family centered care
- Team Rounding (Doc, nurse, case management)
- Continuity of care – Nursing, Docs, and ER to ICU to Floor to DC and Follow up
• Efficient and Relevant Consulting
• Efficient Lab and X-Ray Utilization
• Improve GME and student learning
• Decrease crossover and pass-offs
• Decrease “July – New Year Effect”
• Improve supervision of patient care

Project Goals/5 Year Expected Outcome:
• 8 additional days of full-time clinic service for each of the 36 residents per year
• 4600 additional clinic encounters available to patients per year

Project Challenges:
• Changing residents’ schedules to include more clinic hours and fewer hospital hours
• Providing space for the additional resident hours within the clinic
• Efficiently assigning patients to teams of residents so patients are not left without a provider for weeks or a month at a time
• Redesigning the way residents are trained and scheduled
• Updating training materials

Relationship to Regional Goals:
RHP 4 intends to increase patients’ quality and access to primary care through this project. Spohn recognizes the need to train future primary care providers as much as possible in the setting of their future profession while ultimately increasing care for indigent patients now. This project is 100% patient focused, and will also reduce the institutional cost of providing care.

Starting Point/Baseline:
The current care delivery model used by the Family Practice Residency Program promotes hospitalist training instead of primary care. This method of care delivery has resulted in episodic care by providers that are not established with the patients they see. This has led to an increased average length of stay (ALOS) and fragmented follow-up care. The vast majority of residents’ time spent in the hospital providing hospitalist care delivery. A redesign will shift residents’ time to establishing a primary care practice by assigning a panel of patients to each provider or group of providers/attending, and require residents to be available to their patients on a regular basis. Currently, residents only work 40/52 weeks per year in the clinic.

Rationale:
Spohn chose this project because 20% of Nueces County residents, and 31% of Nueces County children, live in poverty and therefore traditionally suffer from limited access to primary care. Additionally, 21% of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover healthcare bills. Nueces County has a higher percentage of preventable hospital admissions than the statewide average for the following conditions that can be managed through regular access to primary care providers: asthma, COPD, CHF, bacterial pneumonia, and diabetes long-term complications. These statistics highlight the need for expanded primary care capacity in the existing clinics in Nueces County which will only be possible long-term if providers are trained to treat this population and opt to provide care in South Texas. In the short term, needy
patients will benefit from having increased access to physicians while they are training in the clinic. By redesigning the delivery of primary care services to assign patients to residents and physicians rather than address care episodically, Spohn intends to provide a meaningful benefit and continuity of care to patients, many of whom are Medicaid-eligible or uninsured.

Milestones and Metrics:
Spohn wrote its own milestones for DYs 4-5 to allow for the existing residency program to expand its provision of services in the Hector P Garcia clinic, allowing more patients to access primary care and enabling residents to receive additional primary care training.

Ties to Community Needs Assessment Unique IDs:
CN.1 – Inadequate access to primary care
CN.6 – High rates of inappropriate ED use
CN.7 – High rates of preventable hospital admissions
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services
CN.17 – High incidence and mortality of sepsis and severe sepsis

Related Category 3 Outcome Measure(s):
Outcome Domain 2: Potentially Preventable Admissions
Improvement Target 2.7: Diabetes short term complication admission rate

Spohn is targeting this outcome because it expects the increased involvement and availability of the residents in the Hector P Garcia medical home to result in fewer indigent residents suffering from complications and from fewer patients misusing the ED for primary care (where they previously would have been admitted based on having no access to a physician outside of the hospital).

Relationship to Other Projects in the RHP:
Many of the projects in this region are related to redesigning and improving access to care through various initiatives. This project’s focus on expanding care will support and enhance these Category 1 and 2 projects in our RHP: 094222902.1.3, Introduce Expand or Enhance Telemedicine/Telehealth; 0208811801.1.1 – Expand Primary Care Capacity; 0942220902.2.4 - Expand Care Transitions program; 121775403.2.2; and 020973601.2.2 - Redesign of primary care through the development of a clinically integrated hospitalist service model. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

This project is specifically related to Spohn’s project to implement the Hospitalist model of inpatient care to indigent and unassigned patients in order to improve patient outcomes, which is in turn projected to reduce the systemic cost of providing hospital care to those patients (which can be redirected towards qualitative improvements and/or investment in primary care in the community). While in the hospital, unassigned patients will be assigned to multi-disciplinary teams of providers that are spear-headed by the hospitalist. Each team will include at least one of Spohn’s Family Practice Residents, who remain assigned to the individual patients and provide their outpatient care in the HP Garcia clinic after discharge (under the continued supervision of the hospitalists.)
continuity of care is expected to yield great benefits for chronically ill patients and to reduce systemic costs of providing care to this population.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Memorial Hospital, Jackson County Hospital District, Yoakum Community Hospital, Corpus Christi Medical Center, and Driscoll Children’s hospital.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?⁹⁰

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⁹⁰ For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

In valuing this project, Spohn considered the affect the project has on achieving the Waiver’s goals of improving and increasing the delivery of patient centered care. Increasing the primary care training of residents will allow them to provide care effectively to this population in the future, and will allow them to provide much needed care to indigent patients through their training. This should reduce the systemic cost of providing care in the Region by reducing misuse of EDs, PPAs, and PPRs for indigent and chronically ill patients.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td>IT-2.7</td>
<td><strong>Milestone 1 [P-2]</strong>: Expand primary care training for primary care providers, including physicians <strong>Metric 1 [P-2.1]</strong>: Expand primary care residency training program and/or rotations <strong>Baseline/Goal</strong>: Develop an agreement with Hector P Garcia to expand the rotations/hours that the residents spend providing primary care in the clinic, with a focus on assigning patient panels and maintaining regular appointment hours <strong>Data Source</strong>: Documentation of agreement to expand training program</td>
<td><strong>Milestone 2 [P-3]</strong>: Expand positive primary care exposure for residents/trainees <strong>Metric 1</strong>: Train trainees in the medical home model, chronic care model and/or disease registry use <strong>Baseline/goal</strong>: Presently, Spohn’s residents are assigned to patients in the Hector P Garcia clinic (approximately 9000 patients), but are not regularly available to those patients. The goal of this project is to incorporate the residents into the Medical Home Model that is being implemented at the clinic through another DSRIP project. Residents will be regularly available for their assigned patient panel, and will be trained in using the chronic disease registry being implemented through another DSRIP project as part of their provision of care</td>
<td><strong>Milestone 3 [I-X]</strong>: Increase clinic days by existing residents. <strong>Metric 1 [I-X.1]</strong>: Documentation of increase in clinic days by 36 Family Practice Residents <strong>Baseline/Goal</strong>: The 36 Family Practice Residents currently provide 200 days (40 weeks) of full-time care in the clinics per year. Spohn’s goal is to increase this by 5 days in DY4 for each resident (which Spohn estimates will result in 2880 additional patient encounters per year). <strong>Data source</strong>: documentation of clinic/resident schedules</td>
<td><strong>Milestone 4 [I-X]</strong>: Increase clinic days by existing residents. <strong>Metric 1 [I-X.1]</strong>: Documentation of increase in clinic days by 36 Family Practice Residents <strong>Baseline/Goal</strong>: The 36 Family Practice Residents currently provide 200 days (40 weeks) of full-time care in the clinics per year. Spohn’s goal is to increase this by 8 days (for 208 days total) in DY4 for each resident (which Spohn estimates will result in 4600 additional patient encounters per year). <strong>Data source</strong>: documentation of clinic/resident schedules</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Develop an agreement with Hector P Garcia to expand the rotations/hours that the residents spend providing primary care in the clinic, with a focus on assigning patient panels and maintaining regular appointment hours <strong>Data Source</strong>: Documentation of agreement to expand training program</td>
<td><strong>Milestone 1 Estimated Incentive Payment</strong>: $1,379,392</td>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>: $1,410,790</td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong>: $1,408,603</td>
<td><strong>Milestone 4 Estimated Incentive Payment</strong>: $1,137,381</td>
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</table>

**Year 2 Estimated Milestone Bundle Amount**: (add incentive payments amounts from each milestone): $1,379,392 **Year 3 Estimated Milestone Bundle Amount**: $1,410,790 **Year 4 Estimated Milestone Bundle Amount**: $1,408,603 **Year 5 Estimated Milestone Bundle Amount**: $1,137,381

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $5,336,167
CHRISTUS Spohn Hospital Corpus Christi/121775403
Integrate Primary Care and Behavioral Health Care Services; 2.15.1
Project Unique ID Number: 121775403.2.4

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** CHRISTUS Spohn Hospital Corpus Christi (Spohn), working with Nueces MHMR, plans to provide a Licensed Mental Health Provider (LMHP) for at least one of its Family Health Clinics (FHC) in order to integrate the treatment of physical and behavioral conditions into one location.

- **Need for the project:** Service integration does not exist in Spohn’s clinics or the Hector P Garcia clinic currently. The existing process requires referrals to other providers and additional appointments with inherent delays in time to appointment, which is a known contributor to “no-show” rates and increased ED visits. The local LMHA also states there is no provision of physical medicine assessments in their behavioral health clinics. The clinics provide approximately 67,000 patient encounters per year for approximately 18,500 patients, but does not currently track how many are referred for BH/SA services.

- **Target population:** After a review of ED admission data for behavioral health diagnoses indicated that 113 patient visits to Spohn EDs in a 9 month period were by residents of zip codes from Robstown and the I-35 corridor between Corpus Christi and Beeville, Spohn will likely place the LMHP in the Robstown clinic to facilitate a shift in care delivery to the right setting to reduce inappropriate ED visits and PPAs. The Robstown clinic sees approximately 2100 patients per year, and Spohn expects that 33% of those patients have unaddressed behavioral health issues based on the Community Needs Assessment (at page 36). Those approximately 700 patients could be referred to the LMHP onsite for a full assessment. Additionally, the LMHP can travel to other clinic sites to provide integrated care to a broader population base.

- **Category 1 or 2 expected patient benefits:** Spohn’s goal for this project is to provide integrated care/screening to 15% of its Robstown clinic patients in DY4 (approximately 315/2100 patients), and to provide integrated care/screenings to 25% of its Robstown patients in DY 5 (approximately 525/2100 patients). by DY5 (approximately 350 patients). This will benefit targeted patients by allowing streamlined care that is quicker and easier to access, which is expected to improve patient satisfaction, quality of life, and short- and long-term health outcomes.

- **Category 3 outcomes:** IT-9.2 – The expected outcome of this project is a reduction in ED visits from service area zip codes for behavioral health/SA, including a 20% reduction where BH/SA is a primary diagnosis by the end of waiver, and a 15% reduction where BH/SA is a secondary diagnosis by end of waiver.
Integrate Primary and Behavioral Health Care Services

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Integrate Primary Care and Behavioral Health Care Services; 2.15.1
CHRISTUS Spohn Hospital Corpus Christi/121775403
Project Unique ID Number: 121775403.2.4

Project Description:
CHRISTUS Spohn Hospital Corpus Christi (Spohn), working with Nueces MHMR, plans to provide integrated physical and behavioral health services at least one or more of its Family Health Clinics (FHC”) to integrate the treatment of physical and behavioral conditions into one location. Spohn has already performed some initial data analysis and identified three potential sites for initial integration and intends to do further analysis about where to place an appropriate number and mix of Licensed Mental Health Providers (LMHPs) in order to have the highest impact on low-income patients in need of integrated care.

Project Goals: Spohn hopes that by providing integrated services in the community, patients will seek and receive earlier intervention into BH/SA conditions, and maintain a consistent course of treatment and medication management (where appropriate) that is difficult to maintain through a hospital setting. Additionally, LMHPs can assist the primary care provider staff at the FHCs to screen and identify potential MH/SA patients, and consult with the patients directly.

Project challenges:
- Recruiting and retaining a qualified LMHPs to provide services in Spohn’s FHCs
- Coordinating care between medical and behavioral providers
- Patient education about the availability of integrated services
- Determining the most appropriate location in which to place the LMHP

Spohn will address these challenges by thoughtfully creating a comprehensive plan for this integration, and will engage in aggressive recruiting strategies in order to identify a qualified candidate to provide these services in a primary care setting. Finally, Spohn will train its providers to communicate with clients regarding care integration services.

Starting Point/Baseline:
Service integration does not exist in Spohn’s FHCs currently. The existing process requires referrals to other providers and additional appointments with inherent delays in time to appointment, which is a known contributor to “no-show” rates and increased ED visits. The local LMHA also states there is no provision of physical medicine assessments in their behavioral health clinics.

Rationale:
The purpose of this project is to facilitate integration of physical care and behavioral health for patients with dual diagnoses, by combining and integrating services in a primary care setting, in order to reduce utilization of ED services for this population. Spohn has initially identified its Robstown FHC as needing LMHPs after a review of ED admission data for behavioral health diagnoses shows that 113 visits to Spohn EDs in a 9 month period were residents of zip codes from Robstown and the I-35

91 There may be other LMHPs placed at a Spohn FHC as part of a related project.
The corridor between Corpus Christi and Beeville. The top 4 diagnoses of these presentations were Anxiety (10), Depression (43), Psychosis (4) and Suicidal ideation (18). 84% of these patients presented to Spohn-Memorial in Corpus Christi. This data led to the selection of this project for the addition of LMHPs to facilitate a shift in care delivery to the right setting to reduce inappropriate ED visits and PPA. Collaborative discussions with Nueces County MHMR have identified a need for physical medicine assessments in behavioral health settings also. Process measures in DY2 and DY3 will provide structure to an integrated plan that will expand the coverage area and increase access to integrated care.

The Coastal Bend’s Community Health Needs Assessment (2010) supports the high correlation between mental illness and chronic medical disease. Heart Failure is the 2nd highest principle diagnosis with Manic Depressive Disorder and Schizoaffective Disorder, also making the top DRG list. The top secondary diagnosis list includes Diabetes among the chronic diseases listed. Additional analysis of hospital data will provide direction for dual diagnoses presenting to our facilities. This analysis in the process phase of the waiver will be used to further define additional locations and target populations for screening and evaluation.

Core Components: Spohn will address the ten (10) core components for this project as follows:

a) Identify sites for integrated care projects with potential benefit for significant number of people: This component is addressed in Milestone 1 in DY1.

b) Develop provider agreements whereby co-scheduling and information sharing occurs between physical and behavioral health providers can be facilitated: This component is addressed in Milestone 3 in DY3.

c) Establish protocols and process for communication, data-sharing and referrals between providers: This component will also be addressed through Milestone 3 in DY3.

d) Recruit a number of specialty providers to provide services in specific locations: This component will be addressed through Milestone 2, whereby Spohn will hire/contract with at least one or more LMHPs to treat Spohn’s FHC patients.

e) Train physical and behavioral health providers in protocols and build a shared culture: This component will be addressed through the implementation portion of Milestone 3 in DY3.

f) Acquire data reporting, communication and collection tools to be used in the integrated setting (i.e. electronic health record system): Spohn and its FHCs already possess EHR capabilities for use in an integrated setting and will make them available to the additional providers, and therefore do not need to include this component as a milestone during the Waiver.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice: Spohn will address this component through its performance of Milestone 3 in DY3.

h) Arrange for utilities and building services at these sites: Spohn’s Robstown clinic and other sites currently have space, where the LMHPs will practice, are already fully functional and therefore Spohn will not include this component in its Milestones.

i) Develop and implement data collection and reporting mechanisms and standards to track utilization of integrated services: In order to perform Milestones 5-6, Spohn will address this component by creating and implementing a system to track the increased use of on-site referrals over the life of the Waiver of the integrated services.
j) Conduct quality improvement: Spohn will accomplish this component by performing Milestone 4 in DY4.

Ties to Community Needs Assessment: CN.2 (inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (negative mental health outcomes)

Related Category 3 Outcome Measure(s):
OD 9: Right Care, Right Setting; IT-9.2 ED appropriate utilization – Reduce ED visits for behavioral health/SA

Spohn chose this outcome measure because one of the purposes behind offering behavioral health/SA and physical care in an integrated primary care setting is to give Medicaid eligible and uninsured patients options for treatment outside of the ED. If patients receive earlier intervention and care in the community, they will be less likely to seek treatment for non-emergent conditions in the ED, which will reduce the systemic cost to provide care in Nueces County.

Relationship to other Projects:
This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. It’s focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following:
020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project.
Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

This project was valued in consideration of the fact it addresses a clear community need (as evidenced by the ED admissions for behavioral health diagnoses from the Robstown area), the fact that the LMHPs will be an extension of primary care, which is scarce in Region 4 and Nueces County, and because the cost savings of preventing acute episodes or misuse of ED by behavioral health/SA patients because they receive earlier intervention/prevention makes this project very valuable. Finally, this project is patient-centered in that it seeks to improve the quality of primary care for patients, which will increase affected patients’ satisfaction and quality of life.

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92 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### Physical and Behavioral Health Integration

**CHRISTUS Spohn Hospital Corpus Christi**

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

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Milestone 1 [P-2]:</strong> Identify existing clinics or other community-based settings where integration could be supported. <strong>Metric 1 [P-2.1]:</strong> Discussion/Interviews with community healthcare providers <strong>Baseline/Goal:</strong> Identify a site for physical/behavioral care integration, which may be the Robstown FHC or another location in the Corpus Christi community <strong>Data Source:</strong> Needs assessment, ED admission data by zip codes</td>
<td><strong>Milestone 3 [P-3]:</strong> Develop and implement a set of standards to be used for integrated services to ensure effective information sharing and referrals between physical and behavioral health providers <strong>Metric 1 [P-3.3]:</strong> Number of referrals which follow established standards <strong>Baseline/Goal:</strong> Establish guidelines for screening and referrals between services and effect at least 25 referrals to the LMHP in the FHC – also address practical requirements for implementing the integration program, such as legal agreements <strong>Data Source:</strong> Referral system documentation and documentation of Spohn’s established protocol and standards for behavioral health integration</td>
<td><strong>Milestone 4 [P-7]:</strong> Evaluate and continuously improve integration of primary and behavioral health services <strong>Metric 1 [P-7.1]:</strong> PDSA and PIP for service integration <strong>Goal:</strong> Identification and resolution of shortcuts/work-arounds due to inefficient referral system <strong>Data Source:</strong> Referral system documentation, quality and PI documentation</td>
<td><strong>Milestone 6 [I-8]:</strong> Integrated services <strong>Metric 1 [I-8.1]:</strong> % of individuals receiving both physical and behavioral health care at established location <strong>Baseline/Goal:</strong> Spohn seeks to provide integrated care to 25% of its Robstown patients (approximately 525/2100 patients) <strong>Data Source:</strong> Referral system documentation</td>
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $919,595</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $1,881,054</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $939,068</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $1,516,508</td>
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- **Outcome Measure(s):** 121775403.3.10 IT-9.2
  - **Goal:** ED appropriate utilization – REDUCE ED visits for behavioral health/SA
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<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
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<td>Outcome Measure(s):</td>
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<td>IT-9.2</td>
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<td>ED appropriate utilization – Reduce ED visits for behavioral health/SA</td>
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<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $939,068</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,839,190</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,881,054</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,878,137</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,516,508</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $7,114,889*
Provider: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

Intervention(s): Spohn will implement a screening and treatment protocol in its hospital EDs and Family Health Centers (FHCs) to identify patients with dual diagnoses (medical and behavioral health (BH)) and assign a case manager to coordinate their care. Two medical diagnoses, CHF and Diabetes, will be targeted for screening and identification of co-existing BH illness.

Need for the project: Currently, Spohn patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 years earlier than those with mental health illness alone mainly due to unmanaged physical health. National studies show that approximately 58% of the adult population suffer from a medical condition and of those, 29% also have unaddressed behavioral health needs. Additionally, people with schizophrenia and bi-polar disorders are up to 3 times more likely to have three or more chronic conditions than people without those disorders.

Target population: The target population includes all patients presenting to Spohn’s Corpus Christi hospital facilities and all of Spohn’s clinics with a CHF or diabetes diagnosis. 409 patients presented with a CHF or diabetes diagnosis and secondary diagnosis of BH (44% of which were Medicaid eligible/uninsured). The approximate number of patients who presented in the ED with a diagnosis of CHF or diabetes is 1684 (41% of which were Medicaid/uninsured, which is approximately 690 patients), and of those patients, 0 were screened for Behavioral Health, meaning that only those with a clear presentation of BH were identified. Of the 1684 CHF and diabetes patients, 1275 were neither screened nor diagnosed for BH.

Category 1 or 2 expected patient benefits: This project seeks to screen all CHF and diabetes patients for BH issues, and expects to refer 120 of those previously unscreened/undiagnosed patients to behavioral health specialists by the end of DY4, and expects a 100% increase from DY4 to DY5 of the target population referred to a BH specialist (240 patients anticipated).

Category 3 outcomes: IT- 9.2 – Spohn aims to reduce the volume of ED visits from diabetic patients of 15% by DY5 due to this project because patients will be screened in the EDs and other treatment settings for BH referrals and will subsequently receive the treatment they need (which Spohn hopes will lead to reduced misuse of the ED).
Category 2: Program Innovation and Redesign
Identifying Project and Provider Information:
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Corpus Christi / 121775403
Project Unique ID: 121775403.2.5

Project Description:
This project focuses on identification and screening of target populations for co-existing physical and behavioral health diagnoses. Spohn will implement a screening and treatment protocol in its hospital campuses and FHCs to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Spohn believes that identification and screening of these target populations will guide treatment plans for dual diagnoses, which will improve patient outcomes. In addition, identification of dual diagnoses in the acute care setting should improve the initiation of care management, which Spohn projects will impact in-patient outcomes and reduce LOS. Two medical diagnoses, CHF and Diabetes, will be targeted by this project for screening of co-existing BH illness. This screening will be initiated in Spohn’s ED and FHCs to facilitate early referral to a LMHP for further assessment or intervention. Concurrently, Spohn will perform medical screenings in the BH population in outpatient BH settings such as MHMR clinics. This project will be collaboration between Spohn’s Corpus Christi facilities (including the hospital campuses and FHCs), LMHA, and Spohn’s Family Medicine and Emergency Medicine GME programs (wherein residents will be trained and participate in the screening processes).

Project Goals/Five Year Expected Outcome:
The goal of this project is to identify patients with dual diagnoses for behavioral and physical health conditions, and to intervene earlier and more effectively in their treatment and disease management. Spohn aims to reduce the use of the ED by patients with co-diagnoses for treatment and to reduce the amount and duration of preventable inpatient stays for these patients, which should result from proactive screening and earlier treatment intervention organized by case managers/care coordinators. Specifically:
- Spohn intends to implement screening protocols in its FHCs and hospital campuses to identify patients with a dual diagnosis of BH/depression and diabetes or CHF
- Spohn intends to assign these patients to Spohn staff who will act as care coordinators for this population
- Spohn expects a 15% reduction in ED visits for patients with dual diagnoses by the end of DY5
- Spohn expects a 5% reduction in preventable hospital stays for patients with dual diagnoses by the end of DY5

Project Challenges:
- Garnering participation in screening and treatment for chronically ill patients with behavioral health issues
- Educating physician and mid-level providers on effective methods for identifying, screening, and treating patients at risk for dual diagnoses (specifically, BH and CHF or diabetes)
- Hiring/training care coordinators to effectively manage the care of patients with these dual diagnoses
Spohn will address these challenges by engaging in thoughtful planning in DYs 2-3, seeking patient and community input into best practices and patient needs, and will refer to clinical best practices when training care coordinators.

**Starting Point/Baseline:**
Currently, patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. A 9-month data review of ED visits with dual diagnoses shows:
- 409 with a primary medical diagnoses and 2nd BH;
  - 75% of those patients were over age 35 and 75% were admitted to inpatient status
- 1684 ED visits from diabetic/CHF patients

**Rationale:**
Spohn chose this project because Nueces County is designated as a partial Health Provider Shortage Area in the mental health domain and the primary care domain, indicating the patients needing both mental health treatment and chronic disease management are likely slipping through the cracks in the system (RHP Plan, Section 3, Table 11). The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 yrs. earlier than those with mental health illness alone mainly due to unmanaged physical health. National Comorbidity Survey Replication data (2001-2003) shows that approximately 30% of patients with a chronic medical disorder also have a mental health disorder. While those with BH illness and a secondary medical illness die earlier, those with chronic medical diseases such as CHF, Diabetes or COPD and a co-existing BH illness have more frequent admissions with longer lengths of stay for seemingly unknown reasons. It is purported to be a result of undiagnosed or untreated mental health such as depression. Thus, this project should have a positive outcome on the long-term health outcomes for these patients, and should result in a reduction in the systemic cost of providing health care to this population.

**Core Components:** This project has 8 core components, which Spohn will address individually below:
- **Conduct data matching to identify individuals with co-occurring disorders who do not receive routine and/or needed primary and specialty care, over-utilize ED and crisis response services, and are becoming involved with the criminal justice system due to unmanaged symptoms.** Spohn will perform this component through Milestone 1 in DY2 by undertaking review and analysis of medical data for Spohn’s FHC and hospital patients.
- **Review chronic care management best practices such as Wagner’s Chronic Care Model and select practices compatible with organization readiness for adoption and implementation.** Spohn will incorporate this component into Milestone 3 in DY3 when it prepares its protocol for implementing screening and care coordination to identify and effective treat patients with a dual diagnosis of BH/depression and diabetes or CHF. Spohn will directly reference the best practices it identifies from this review in the protocol it creates.
- **Identification of BH case managers and disease care managers to receive assignment of these individuals.** Spohn will address this core component through Milestone 2 in DY2. Spohn will identify existing or new staff to provide care coordination for patients identify with dual diagnoses, assigning the equivalent of at least 3 full-time care coordinators in DY2.
d. **Develop protocols for coordinating care; identify community resources and services available for supporting this population.** Spohn will address this component with Milestone 3 in DY3. The protocol will address community needs, best practices, internal processes, key challenges, and an implementation plan.

e. **Identify and implement specific disease management guidelines for high prevalence disorders.** Spohn will address this requirement through Milestone 4 in DY3. Care coordinators and medical providers will be trained in the screening, diagnosis, care coordination and treatment of patients with CHF or diabetes and BH/depression, and will implement the guidelines accordingly.

f. **Train staff in protocols and guidelines.** This requirement will also be addressed through Milestone 4 in DY3, as staff will be trained in both the guidelines for screening and treatment, and Spohn’s hospital/FHC specific protocol for addressing this community need.

g. **Develop registries to track client outcomes.** Spohn will address this component through performing Milestones 5 and 6 in DYs 4-5. Spohn is creating a Chronic Disease Registry for its campuses and FHCs, which it will use to track patients identified with the targeted dual diagnoses and their use of the ED and rate of potentially preventable hospitalization.

h. **Review the intervention’s impact on quality of care and integration of care and identify lessons learned, opportunities to expand the program, and key challenges with expanding.** In DY 4, Spohn will draft a report identifying aspects of the protocol that have yielded positive results, identify areas for improvement, and targets for expanding the scope of the project to additional chronic diseases and/or other mental health issues (i.e. substance abuse).

Ties to Community Needs Assessment: CN.2 (Inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (Negative mental health outcomes)

**Related Category 3 Outcome Measure(s):**
Outcome Domain 9: Right Care, Right Setting
Improvement Target 9.2 – ED Appropriate Utilization

Spohn chose this outcome measure because it directly correlates with the purpose of this project – Spohn seeks to identify and treat more of these patients in the community so they will be less likely to misuse the ED and/or deteriorate into an acute condition where they need emergency care.

**Relationship to other Projects:**
This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. It’s focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following:

- 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas;
- 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization;
- 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care,
- 121990904.2.1 – Integrate primary and behavioral health care services. Related

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**

This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**

The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system.
   c. Improve outcomes while containing cost growth.

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?93

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93 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its impact on the goals of the Waiver: the project is patient-centered because it offers needed screening and targeted care management for patients coping with both physical and mental conditions; the project also reduces the systemic cost of providing care to this population by using prevention and care management to reduce the use of the ED and/or preventable hospital admissions for patients with co-diagnoses. The project addresses community needs, as this community is lacking mental health providers and services, and will serve a population of chronically ill patients. The investment necessary to implement this project is great: protocols must be created, providers identified and trained; patients educated; and transformation of the delivery system accomplished through actual reductions in ED and hospital admissions.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>121775403.3.11</th>
<th>IT-9.2</th>
<th>• ED Appropriate Utilization (BH/SA patients)</th>
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<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-4]:</strong> Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis to identify over/under utilization</td>
<td><strong>Metric 1 [P-4.1]:</strong> Data analysis</td>
<td><strong>Baseline/Goal:</strong> Spohn will develop a system to identify patients with co-diagnoses of CHF &amp;/or Diabetes with BH/Depression using its available medical data and will produce written analysis of the available data</td>
<td><strong>Data Source:</strong> Written analysis</td>
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<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $747,171</td>
<td><strong>Milestone 3 [P-6]:</strong> Care coordination protocols are developed</td>
<td><strong>Metric 1 [P-6.1]:</strong> Written protocols available to staff</td>
<td><strong>Baseline/Goal:</strong> Spohn will develop and define practice guidelines and processes for coordination of care between services in a written manual for providers</td>
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<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $764,178</td>
<td><strong>Milestone 4 [P-8]:</strong> Staff member training in care coordination protocols and practice guidelines for CHF, Diabetes and Depression/BH</td>
<td><strong>Metric 1 [P-8.1]:</strong> Percent of staff trained</td>
<td><strong>Goal:</strong> 80% off FHC and hospital staff identified in target areas will receive training in screening/care coordination for patients with targeted dual diagnoses</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $764,178</td>
<td><strong>Milestone 5 [I-22]:</strong> Increase use of specialty care in line with professionally accepted practice guidelines</td>
<td><strong>Metric 1:</strong> X% increase/decrease use of specialty care according to practice guidelines</td>
<td><strong>Baseline/goal:</strong> 10% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment (Spohn)</td>
</tr>
<tr>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $762,993</td>
<td><strong>Milestone 6 P-X:</strong> Assess efficacy of process in place and recommend process improvements to implement if any</td>
<td><strong>Metric X-1:</strong> Identify opportunities to improve on the redesign methodology, as documented in the assessment document</td>
<td><strong>Baseline/goal:</strong> analyze the effectiveness and quality improvement resulting from this project</td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $1,232,163</td>
<td><strong>Milestone 7 [I-22]:</strong> Increase use of specialty care in line with professionally accepted practice guidelines</td>
<td><strong>Metric 1:</strong> X% increase/decrease use of specialty care according to practice guidelines</td>
<td><strong>Baseline/goal:</strong> 15% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment</td>
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<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $1,232,163</td>
<td><strong>Data Source:</strong> Care transitions registry</td>
<td><strong>Data source:</strong> Care Transitions registry</td>
<td><strong>Data source:</strong> documentation of assessment</td>
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**Related Category 3 Outcome Measure(s):** 121775403.3.11

**Milestone 1 [P-4]:** Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis to identify over/under utilization

**Metric 1 [P-4.1]:** Data analysis

**Baseline/Goal:** Spohn will develop a system to identify patients with co-diagnoses of CHF &/or Diabetes with BH/Depression using its available medical data and will produce written analysis of the available data

**Data Source:** Written analysis

**Milestone 1 Estimated Incentive Payment:** $747,171

**Milestone 2 [P-5]:** BH case manager and disease care manager identified

**Metric 1 [P-5.1]:** Number of staff identified with the capacity to support the target population

**Baseline/Goal:** Identify and engage the equivalent of three (3) care coordinators to manage targeted patients

**Data Source:** Staff rosters and documents of caseloads

**Milestone 2 Estimated Incentive Payment:** $747,171

**Milestone 3 [P-6]:** Care coordination protocols are developed

**Metric 1 [P-6.1]:** Written protocols available to staff

**Baseline/Goal:** Spohn will identify and define practice guidelines and processes for coordination of care between services in a written manual for providers

**Data Source:** Written protocols, standards, policies and procedures

**Milestone 3 Estimated Incentive Payment:** $764,178

**Milestone 4 [P-8]:** Staff member training in care coordination protocols and practice guidelines for CHF, Diabetes and Depression/BH

**Metric 1 [P-8.1]:** Percent of staff trained

**Goal:** 80% off FHC and hospital staff identified in target areas will receive training in screening/care coordination for patients with targeted dual diagnoses

**Data Source:** Training materials and attendance records

**Milestone 4 Estimated Incentive Payment:** $764,178

**Milestone 5 [I-22]:** Increase use of specialty care in line with professionally accepted practice guidelines

**Metric 1:** X% increase/decrease use of specialty care according to practice guidelines

**Baseline/goal:** 10% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment (Spohn)

**Data source:** Care transitions registry

**Milestone 5 Estimated Incentive Payment:** $762,993

**Milestone 6 P-X:** Assess efficacy of process in place and recommend process improvements to implement if any

**Metric X-1:** Identify opportunities to improve on the redesign methodology, as documented in the assessment document

**Baseline/goal:** analyze the effectiveness and quality improvement resulting from this project

**Data source:** documentation of assessment

**Milestone 6 Estimated Incentive Payment:** $1,232,163

**Milestone 7 [I-22]:** Increase use of specialty care in line with professionally accepted practice guidelines

**Metric 1:** X% increase/decrease use of specialty care according to practice guidelines

**Baseline/goal:** 15% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment

**Data source:** Care Transitions registry

**Milestone 7 Estimated Incentive Payment:** $1,232,163
| 121775403.2.5 | 2.19.1 | 2.19.1.A-H | **CARE MANAGEMENT TO INTEGRATE PRIMARY AND BEHAVIORAL HEALTH NEEDS**  
**CHRISTUS Spohn Hospital Corpus Christi** | 121775403 |
|---|---|---|---|---|
| **Related Category 3**  
**Outcome Measure(s):** | 121775403.3.11 | **IT-9.2** | • ED Appropriate Utilization (BH/SA patients) |  

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|---|---|---|---|
| Milestone 6 Estimated Incentive  
Payment: $762,993 |  
| Year 2 Estimated Milestone Bundle  
Amount: $1,494,342 | Year 3 Estimated Milestone Bundle  
Amount: $1,528,356 | Year 4 Estimated Milestone Bundle  
Amount: $1,525,986 | Year 5 Estimated Milestone Bundle  
Amount: $1,232,163 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add milestone bundle amounts over DYs 2-5*): $5,780,847
CHRISTUS Spohn Hospital Corpus Christi / 121775403
Project Option 2.1. Establish Medical Homes
Unique Identifier - 121775403.2.6

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 463,577. The Hospital is comprised of 3 facilities on 3 campuses

- **Intervention(s)**: The Medical Home Model of care delivery provides a PCP-led team approach to primary care services with emphasis on care coordination, patient-centered care delivery and communication between providers and patients. This project will implement the Medical Home Model of care delivery in community clinics to improve accessibility to primary care and reducing the appointment wait time to impact the percentage of potentially preventable admissions (PPAs), which is currently higher than the statewide average for asthma, COPD, CHF, bacterial pneumonia, and diabetes long-term complications manageable through regular follow up with primary care providers.

- **Need for the project**: The Hector P Garcia clinic (where Spohn’s physician-residents provide care) is located in proximity to zip codes with patients identified for higher incidence of ED usage for primary care diagnoses. In FY 2012, Spohn’s Corpus Christi EDs received almost 44,000 non-emergent visits from approximately 27,000 patients. Of those patients, almost 67% were Medicaid/uninsured. This is a major contributor to ED overcrowding and extended wait times. Currently, delays to follow-up for patients discharged from the hospital are 30-36 days, contributing to patients returning to the ED and impacting PPR rates. At the Hector P Garcia clinic, the current time to third next available appointment is 20 days. **Target population**: Spohn will implement the Medical Home Model in the local community clinic called Hector P. Garcia, where Spohn’s physician-residents provide care. This facility treats an estimated 8000+ patients annually and provides approximately 29,000 encounters, and 83% of those patients are Medicaid/uninsured on average (approximately 6,640 patients).

- **Category 1 or 2 expected patient benefits**: Spohn expects patients to experience a 10% decrease in the number of days to the 3rd next-available appointment at the Hector P Garcia clinic by the end of Waiver (approximately 2 days), and a 15% increase in the number of patients newly assigned to a Medical Home within that clinic who are contacted within 60-90 days for their first patient visit.

- **Category 3 outcomes**: IT-9.2 – One goal is to enable patients with chronic diseases to receive consistent and ongoing support, education, and management from a single panel of providers. Spohn expects a 15% decrease in the number of ED visits related to CHF and diabetes short-term complications for patients enrolled in the Medical Home Model through Spohn’s FHCs, by DY5.
Establish Medical Homes

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Project 2.1: Enhance/Expand Medical Homes
Project Option 2.1.1: Develop, implement and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

CHRISTUS Spohn Hospital Corpus Christi / 121775403

Unique Identifier - 121775403.2.6

Project Description:

Spohn will implement the Medical Home Model of care delivery in the Hector P Garcia community clinic, which will provide a PCP-led team approach to primary care services. The 2011 Medical Home standards include assisting patients with self-management, assistance with access to community resources, improved communication between medical facilities and patient-centered services. The model emphasizes care coordination and communication between providers and patients. It facilitates the development of physician-patient relationships through the establishment of patient panels. This project will redesign the current system in the Hector P Garcia clinic, in which Spohn’s 36 physician-residents provide care to the community, to a care delivery system more closely aligned to independent primary care practices; i.e. practice with established patients and physician partners practicing in an “office” setting. Spohn chose the Hector P Garcia clinic because it is largest clinic provider in Corpus Christi and Spohn’s residents provide care there. Spohn’s residents and the community physicians working in the clinic provide approximately 29,000 encounters per year to approximately 8000 patients, and therefore the impact of this project is huge.

Project Goals/5 Year Expected Outcome:

- Implementation of Medical Home transition using P-D-S-A methodology for quality improvement (QI) in the Hector P Garcia clinic.
- 10% decrease in number of days to 3rd next-available appointment at FHCs by end of Waiver.
- 15% Increase in number of new patients contacted within 60-90 for first patient visit.

Project Challenges:

- Cooperation of medical home personnel on PCMH change concept.
- Educating patients regarding the medical home model.
- Provider cooperation in bi-weekly interactions discussing successes and challenges of model.
- Selecting evidence-based curriculum to train stakeholders

Spohn will address these challenges by educating providers about the benefits of participating in the medical home model. Spohn will carefully select the educational/training material from the broad base of literature and training materials available on the subject in order to effectuate a smooth transition into the medical home model. Providers may be resistant to the bi-weekly meetings, but Spohn will work to ensure that the meetings are productive and organized, which Spohn hopes will reduce provider resistance to participating.
**Relationship to Regional Goals:**
Region 4 is focused on improving health care outcomes and increase access to primary care in the community. Medical homes have been shown to increase coordinate patient care and maximize health outcomes for patients. This project furthers the regional goal by implementing a new delivery model to improve access and quality of care.

**Starting Point/Baseline:**
The Hector P Garcia clinic is a currently set up in a clinic format with inconsistent patient panels and assigned PCPs. Patients currently identify with the clinic but not the physician due to current scheduling and coverage practices. Family Practice Residents provide in-house coverage for “no-doc” patients admitted to the facility, limiting their training in the office/clinic setting. Physicians and Residents do not consistently carry an established caseload or patient panel, and instead are randomly assigned patients as they present for treatment.

Time to primary care follow-up visits for patients discharged from the hospital is currently 30-36 days. The number of days to 3rd next available appointment is 20 days. Spohn expects patients to experience a 10% decrease in the number of days to the 3rd next-available appointment at the Hector P Garcia clinic by the end of Waiver (approximately 2 days), and a 15% increase in the number of patients newly assigned to a Medical Home within that clinic who are contacted within 60-90 days for their first patient visit.

**Rationale:**
Region 4 faces higher poverty rates than statewide averages, and all of the counties in the Region have been designated as either partially or medically underserved and have a shortage of primary care providers. According to the Community Needs Assessment, the rural nature of the Region also results in many residents having decreased access to primary health care services. Additionally, 21% of Nueces County residents are completely uninsured, meaning they have no source of 3rd party payment to cover healthcare bills. Nueces County has a higher percentage of Preventable Hospital Admissions than the statewide average for the following conditions that can be managed through regular access to primary care providers: Asthma, COPD, CHF, bacterial pneumonia, and diabetes long-term complications. The cost (financial and to patient quality of life) of preventable hospital admissions and misuse of the ED have a deep impact on the long-term health outcomes for patients, which Spohn seeks to improve through this project.

The Hector P Garcia clinic is located in proximity to zip codes with patients identified for higher incidence of ED usage for primary care diagnoses. In FY 2012, Spohn’s Corpus Christi EDs received almost 44,000 non-emergent visits from approximately 27,000 patients. Of those patients, almost 67% were Medicaid/uninsured. Those 27,000 patients constitute approximately 36% of all ED patients Spohn’s Corpus facilities treat. Those non-emergent patient visits lead to ED overcrowding and extended wait times, and do not result in a long-term solution to those patients’ health issues.

In addition to primary care visits occurring in the ED setting, delays to primary care follow-up visits for patients discharged from the hospital is currently 30-36 days. This also contributes to patients returning to the ED and impacts PPR rates. CHF, Diabetes-short term, 2 of our target DRGs for population/chronic disease management are in the top 10 PPA and PPR rates for Nueces County. CHF accounts for one of the highest PPR rates by volume, which amounts to 17.8% across the Spohn
system of facilities, with a financial impact of $220 Million in charges from Nueces County alone (June 2012). While Diabetes-short term complications are not the cause of Spohn’s highest volume PPA/PPR rates, they do constitute one of the most concerning trends with the following percentages of Medicaid/Self-pay patients by county:

- 58% Nueces County and
- 42% San Patricio County

**Milestones and Metrics:** Spohn chose the milestones for DY4, and DY5 in order to effectively implement the medical home model at the facility. The milestones in DY 2 and DY 3 are imperative to lay the groundwork for a successful medical home transition through the appropriate planning and training of personnel. Spohn chose its metrics in DY 4 and DY 5 to assess the effectiveness of the project—specifically, the number of clinics using the model, number of patients accessing services, and the time until the third next available appointment. This project thus evaluates the progress of the project on a multifaceted level in order to broadly gauge the impact the project has on alleviating a community need.

**Core project components:**

a. Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs’ NCQA PCMH readiness – Spohn will address this requirement through Milestone 1, during DY2.

b. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status – Spohn will address this requirement through Milestone 1, during DY2.

c. Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision – Spohn will address this requirement through Milestone 3, in DY3.

d. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations – Spohn will address this requirement through Milestone 5, in DY4.

**Ties to Community Needs Assessment Unique IDs:** CN.1, CN.7, CN.12

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

Outcome Measure OD-9 (right care, right setting) and IT-9.2 (ED appropriate utilization)

Spohn chose this outcome because one of the key goals behind implementing the Medical Home model in the Hector P. Garcia clinic is to reduce the inappropriate use of the ED by indigent patients seeking primary care services. In FY 2012, Spohn’s Corpus Christi EDs received almost 44,000 non-emergent visits from approximately 27,000 patients. Of those patients, almost 67% were Medicaid/uninsured. Those 27,000 patients constitute approximately 36% of all ED patients Spohn’s Corpus facilities treat. Those non-emergent patient visits lead to ED overcrowding and extended wait times, and do not result in a long-term solution to those patients’ health issues.
Spohn believes that by assigning patients to Medical Homes and improving the access to appointments and post-discharge follow-up, patients will be less likely to present in the ED for non-emergent care, and their chronic conditions will be less likely to deteriorate into an acute condition requiring use of the hospital ED/inpatient setting. Hector P Garcia currently treats approximately 8000 patients per year, meaning that improving its provision of care to its existing clients and those released from the hospital should have a large impact on the ED misuse at the neighboring Spohn hospitals.

**Relationship to other Projects:**
This project’s focus is to facilitate access to primary care and enhance the delivery of care through the medical home model. Because of its relationship to primary care expansion projects, this project will support enhance many of the projects within the region, including the following: the Intensivist project (121775403.1.9), Expansion of Primary Care (Projects 137907508.1.1, and 1309585-05.1.1 and 121775403.1.1), Chronic Disease Management Registry project (121775403.1.3), Establishment of Medical Homes project (121775403.2.3), and Expand Care Transitions Program (121775403.2.12).

Through the implementation of this project, related category 4 measures that will be impacted are RD-3 Potentially Preventable Complications and RD-4 Patient satisfaction.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
This will be a CHRISTUS Spohn Health System initiative directly impacting our 13 county service area but having indirect impact on other providers throughout the region. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no other provider is proposing an identical program, other similar projects will focus on expanding primary care, improving health care outcomes and reducing the cost of care, including projects proposed by Corpus Christi Medical Center, Citizens Medical Center, and Driscoll Children’s Hospital.

**Relationship to other Projects:**
This project has a substantial relationship to the following projects:
- 1.1.2. Expand PC Capacity – hours and staffing
- 1.3.1. Develop Chronic Disease Management Registry
- 1.7.1. PADnet
- 2.5.2. Cost of Care – Primary Care Redesign
- 2.6.1. Diabetes Manager Cellphone Application
- 2.12.1. Care Transitions
- 2.15.1. Integration of PC and BH
- 2.19.1. Care Management for PC and BH – dual diagnoses

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative
that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

This project furthers the Waiver goals by implementing a model that will improve access to primary care services, directly benefiting Medicaid and uninsured residents in the Region while also coordinating care (resulting in improved health outcomes) and diverting patients from the Emergency Department (resulting in reduced health care costs). Additionally, this project directly alleviates the community need of improved primary care access to the entire Region. By investing in future primary care, this project will have long term results of decreased costs and improved patient outcomes.

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94 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #95305
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Utilize gap analysis methodology to measure readiness and feasible steps to achieve NCQA PCMH status in the Hector P Garcia clinic. <strong>Metric 1</strong> [P-X.1]: Documentation of gaps in Hector P Garcia readiness and steps required to achieve PCMH status <strong>Baseline/Goal</strong>: [Core Component 2.1.1.a] Baseline Gap Analysis and [Core Component 2.1.b.] Feasibility Study completed for Hector P Garcia clinic <strong>Data Source</strong>: Gap Analysis/Feasibility documents Milestone 1 Estimated Incentive Payment (maximum amount): $1,839,190</td>
<td><strong>Milestone 2</strong> [P-8]: Develop or utilize evidence-based training material for medical homes based on model change concepts <strong>Metric 1</strong> [P-8.1]: Documentation of staff training materials <strong>Baseline/Goal</strong>: Spohn will select evidence-based curriculum to train stakeholders and develop plan for completing training with necessary stakeholders <strong>Data Source</strong>: Training materials Milestone 2 Estimated Incentive Payment: $940,527</td>
<td><strong>Milestone 4</strong> [P-1]: Implement the Medical Home Model in primary care clinics <strong>Metric 1</strong> [P-1.1]: Increase number of primary care clinics using medical home model <strong>Baseline/Goal</strong>: [Core Component 2.1.1.d.] Implement Medical Home transition using P-D-S-A method for quality improvement (QI) in the Hector P Garcia community clinic (where Spohn physician-residents provide care) <strong>Data Source</strong>: Implementation plan documentation Milestone 4 Estimated Incentive Payment (maximum amount): $626,045</td>
<td><strong>Milestone 7</strong> [I-14]: Patient access to Medical Home <strong>Metric 1</strong> [P-14.1]: Third next available appointment <strong>Baseline/Goal</strong>: Achieve 10% average decrease in number of days to 3rd next-available appointment in the Hector P Garcia community clinic, from DY4 when the medical home model was initially implemented <strong>Data Source</strong>: Central scheduling Milestone 7 Estimated Incentive Payment: $758,254</td>
<td><strong>Milestone 3</strong> [P-9]: Train medical home personnel on PCMH change concept <strong>Metric 1</strong> [P-9.1]: Number of personnel trained <strong>Baseline/Goal</strong>: [Core Component 2.1.1.c] Medical Home education to 85% of Hector P Garcia clinic staff. <strong>Data Source</strong>: Training schedules, attendance logs Milestone 3 Estimated Incentive Payment: $940,527</td>
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<td>Related Category 3</td>
<td>Outcome Measure(s)</td>
<td>ED appropriate utilization (Standalone measure)</td>
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<td>121775403.3.12</td>
<td>IT-9.2</td>
<td>Reduce all ED visits (including ACSC)</td>
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### Year 2

- **Milestone 6** ([I-14]: Patient access to Medical Home
  **Metric 1** ([P-14.1]: Third next available appointment

  **Baseline/Goal**: Achieve 10% average decrease in number of days to 3rd next-available appointment in the Hector P Garcia community clinic, from baseline (estimated to be 20 days)

  **Data Source**: Central scheduling.

  Milestone 6 Estimated Incentive Payment: $626,046

**Year 2 Estimated Milestone Bundle Amount**: (add incentive payments amounts from each milestone): $1,839,190

**Year 3 Estimated Milestone Bundle Amount**: $1,881,054

**Year 4 Estimated Milestone Bundle Amount**: $1,878,137

**Year 5 Estimated Milestone Bundle Amount**: $1,516,508

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $7,114,889
CHRISTUS Spohn Hospital Corpus Christi/ TPI 121775403
Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.
Unique Identifier - 121775403.2.7

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s)**: This is a large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors, and will require integration between Pharmacy, Information Technology (IT) and Nursing. The project will result in all doses of medications given to patients in Spohn’s Corpus Christi locations having viable barcodes that are read into the Meditech informatics system.

- **Need for the project**: Spohn’s present medication management system entails a completely manual system from order to medication administration. Medication reconciliation is a cumbersome process upon admission and discharge, as well as during transfers between levels of care. An improvement in the coordination between departments, availability and use of technology, and training on best practices will reduce the risk of hospitalized patients receiving improper dosages, duplicative medication administration, and/or overdoses. Spohn’s annual medication errors totaled 1059 for errors reported in 2011. Medication administration specific errors accounted for 88% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. Additionally, audits can be run through the automated system to provide a better picture of opportunities for improvement and continuous quality improvement. Additionally, the barcoding will enable more efficient medication reconciliation upon discharge, and will be coupled with an initiative to provide more patient consultations by clinical pharmacists prior to discharge.

- **Target population**: The target population of this project is all inpatients and outpatients treated in Spohn’s Corpus Christi facilities, which amount to approximately 117,000 patients in FY2012 (26,000 inpatients; 91,000 ED patients), % of which are uninsured or Medicaid-eligible (combined). There are approximately 1800 RNs and 50 pharmacists in Spohn’s Corpus facilities who will be trained in the BMV process. Those providers administer approximately 4 million doses of medication to patients annually. Currently, only 30% of inpatients receive consultations by clinical pharmacists prior to discharge (approximately 7800 patients).

- **Category 1 or 2 expected patient benefits**: Spohn expects to achieve 100% adherence to the barcoding system by the end of DY3, for 75% of inpatients to receive medication reconciliation upon discharge (expected to impact 26,250 patients), and for 45% of inpatients to receive in-person counseling from the clinical pharmacists prior to discharge (which Spohn intends to impact primarily Medicaid/uninsured patients, who constitute approximately 32% of inpatients). This improvement will benefit the hospital-wide health outcomes for patients who receive medication as inpatients in Spohn’s Corpus facilities.

- **Category 3 outcomes**: IT 4.10 - By DY5, Spohn expects a 10% reduction in bedside medication administration errors in its Corpus facilities, due to the implementation of the barcode system for medication management. IT 4.10 - We also will reduce the average length of stay for patients at high risk or taking medications at high risk for medication errors. IT 4.10 – By implementing a multi-disciplinary case management review process for patients at high risk of...
medication errors, Spohn will reduce the cost of care and identify cost savings using a cost minimization analysis.
Implementation of Bedside Medication Verification (BMV) Process

Project 2.11: Conduct Medication Management

Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Corpus Christi/ TPI 121775403

Unique Identifier - 121775403.2.7

Project Description:
This is a large scale project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. The project requires integration between Pharmacy, Information Technology (IT) and Nursing. All doses of medications must have a viable barcode that is to be read into the Meditech informatics system. It should be noted that many medications arrive in a pharmacy in the form of bulk bottles (approximately 30% of inventory). These bulk bottles must then be repackaged into individual units of use which contains the barcode that is used to verify the correct medication. The repackaging of this medication requires high reliability standards. Given this requirement, Spohn determined that the majority of these medications should come from one site in order to reduce variability. Establishment and implementation of a central site of distribution from which most drugs will be administered is a key requirement of the process that must precede the successful transition to a bedside verification system. Another challenge is the fact that this process requires all nurses to have a computer available to them at all times in order to scan the patients’ arm band and the medication being administered, as well as documenting the administration into an electronic medication administration record (eMAR). Spohn conducted a feasibility study to calculate the number of personal computers necessary, and determined that additional safety features are needed to ensure scanning of patient ID bracelets and patient labels or stickers generated on the care delivery units. These labels are known shortcuts reported in the nursing and pharmacy literature due the increased difficulty with scanning the patient’s ID bracelet. Unique printers with the ability to generate a 2D barcode on the patient’s ID bracelet, similar to those barcodes now seen in advertising and various industries, provides the additional security against medication errors by ensuring the scan occurs at the point of care. These 2D barcodes contain additional patient-specific information not available in current barcoding. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Spohn will develop guidelines to incorporate the 2D barcoding into practice to ensure the most efficient location of 2D barcode printers and protection of private health information. The barcoding process will streamline the administration of medication, and will implemented in tandem with all facilities targeting an improvement in the number of patients receiving in-person consultations from clinical pharmacists regarding their medications prior to discharge. Additionally, whether or not patients receive an pharmaceutical consultation, patients’ medications that need to be continued, discontinued, and/or changed upon discharge will be reconciled by the providers upon discharge from the inpatient setting.
The fact that this project represents a dramatic paradigm shift for Spohn means that adequate training of both nursing staff and nursing staff is major priority. For this requirement, Spohn will designate super user groups to provide much of the hands on training of all staff.

Medication errors are associated with a significant number of deaths. The literature estimates that 70% of fatal medication errors were preventable, and the costs estimated at $4000-$8000 associated with medication errors that reach the patient. The right medication must be given to the right patient, at the right time, in the right dosage and via the right route. Errors in any of these stages can lead to serious consequences. By requiring a barcoded step to verify right patient, right medication and implementing an electronic medication administration record (eMAR) that confirms the right time, many of these errors can be avoided. Implementation of an intra-disciplinary case management/utilization review program at point-of-entry coupled with the barcoding process and increase in the number of patient consultations with clinical pharmacists, Spohn can assure that patients’ medication are safely administered in the hospital and sagely managed by patients upon leaving the hospital. Spohn will evaluate reductions in average length of stay and cost savings in care delivery using Cost Minimization Analysis (CMA) for BMV, clinical pharmacist consultation and utilization review.

Goals and Relationship to Regional Goals:
The goal of this project is to implement the use of a barcoding system that clinicians can use to identify and document the administration of medications for all hospitalized patients. The expansion of this program will include the documentation not only at the bedside but at the point of entry into the system. When Pharmaceuticals arrive for use into the hospital region they will documented for tracing purposes so that any safety recalls can be monitored and further provide a safe mechanism for our pharmacy professionals. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Regional opportunities for providers include the decrease in preventable complications and further the reduction in cost of care for the community we jointly serve. Medication Management is crucial in the decrease in cost of care, reductions in length of stay and in the compilation of data that physicians can use to assure that electronic data is reliable and safe.

Challenges:
The primary challenge will be to engage the physician provider groups with adhering to the use of the new BMV system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success. The success of BMV is directly in support of the CPOM system. The reduction in transcription errors will provide for a more reliable use of medication administration. With the implementation of the Meditech “Unity” standardization project, the BMV project will leverage both standards and advanced clinical
technology to enhance patient safety, reduce medication administration errors, and reduce the overall cost of providing services.

**Starting Point/Baseline:**
Prior to implementing the BMV program, Spohn providers administered medications from handwritten orders. Those handwritten orders were scanned to the Pharmacy department, which then manually transcribed the orders into a pharmacy-specific computer application. Simultaneously, the RN on duty manually entered the medication ordered onto the patient’s Medication Administration Record (MAR). The RN then used the MAR to withdraw the meds entered by the pharmacy from the electronic dispenser and administer that medication to the patient. This process allowed for administrative errors because RNs would often pull several patients’ medications at a time and then mis-administer the medications by failing to verify the patient identifiers. At midnight each night, a new MAR was printed for each patient, and the RN had to reconcile the new MAR with the previous day’s MAR and verify any changes order in the last 24 hours. The BMV process will allow the pharmacy to use the Medi-tech module that is connected with the patients’ EMR. Additionally, the pharmacy will not do any manual transcription of orders into the system. The BMV program also allows RNs to access eMAR instead of individual paper-versions of patients’ prescriptions and the bar-coding technology provides a safety feature to assure that the patient receives the correct medication and dosage. Clinical pharmacists consulted on approximately 3,680 (70%) inpatient discharges at the memorial facility during FY12. The intra-disciplinary Utilization Review Program will be expanded to all of Spohn’s Corpus Christi facilities as a result of the reduction in average length of stay and cost savings in care delivery for Nueces County charity care.

**Rationale:**
Spohn chose this project with the goal of reducing the possibility for errors in delivering medication at its facilities, improving its system for medication reconciliation upon discharge, and enabling patients to safely manage the medications they must continue upon discharge. At the hospital level, many medications are purchased and/or delivered in bulk, creating opportunities for either mislabeling or dispensing errors, which could result in unintended health complications. To reduce the possibility of such inadvertent errors, and to improve the management of delivery of medication, Spohn will implement a new medication management system to improve the delivery of medication and instructions to patients. By matching barcodes on medications with patients, the BMV system will allow multiple healthcare professionals to understand and deliver the proper medication to patients, reducing the risk of errors and improving the overall health of the patient population, consistent with the goals of the Waiver.

When patients are discharged, it is important to reconcile their medications to the amount/type required when transitioning from an inpatient to an outpatient. Part of this process can be done electronically, but Spohn also believes that more patients need in-person consultations from clinical pharmacists so they can effectively administer and manage their medications at home, and can avoid contraindicated medications that may be prescribed by another physician or purchased over the counter.
**Milestones and Metrics:** Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project and incentivize reductions in medication error rates, which will achieve the goals of the Waiver.

**Project core components:**

a. Spohn will develop a system to ensure this project is implemented first to acute care patients at its hospital facilities, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented in DY 2.

b. The system will include tools to provide education and support to patients in acute settings to reduce risk of medication errors, and will be implemented in DY through Milestone 1.

c. In the first year of the Waiver (DY2) Spohn performed an analysis of the root cause of potential medication errors and identified repackaging as one area of concern. To that end, the project plan will include the processes Spohn has identified to address the repackaging steps to reduce error rates.

d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 4 specifically).

**Ties to Community Needs Assessment Unique IDs:** CN.3, CN.12, CN.13

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

- OD – 4 Potentially Preventable Complication and Healthcare Acquired conditions.

  - **IT-4.10 Other Outcome Improvement Target:**
    - Decrease in errors in Bedside Medication Administration

  - **IT-4.10 Other Outcome Improvement Target:**
    - Average length of stay for high risk patients and patients receiving medications identified as high risk for medication errors

  - **IT-4.10 Other Outcome Improvement Target:**
    - Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review using Cost Minimization Analysis

Spohn chose these outcomes because the main purpose behind implementing the BMV process is to reduce the number of errors in bedside medication administration. By reducing errors, the average length of stay will decrease due to a reduction in complications that would have otherwise occurred. This outcome will benefit patient health outcomes and satisfaction, and will reduce the cost of providing inpatient hospital care, thus increasing the cost savings associated with this project.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support
include 121775403.2.6, and 121775403.2.7. - Medication Management to reduce medication administration errors.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs, including Corpus Christi Medical Center, Corpus Christi-Nueces County Public Health District, and DeTar Healthcare System.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment ("DSRIP") projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

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   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
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      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?
3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rate because it leads to improvements in the overall health of patients but does not expand the availability of care.

---

95 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
### Implementation of Bedside Medication Verification (BMV) Process

**CHRISTUS Spohn Hospital Corpus Christi**

**Errors in Bedside Medication Administration; Average length of stay for high risk patients and patients receiving meds at high risk for error; Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>2.11.1</th>
<th>2.11.1.A,B,C,D</th>
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<tr>
<td></td>
<td>121775403.3.15</td>
<td>IT4.10</td>
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**Milestone 1 [P-1]: Implement a medication management system; bedside medication verification with barcoding (BMV)**

**Metric 1 [P-1.1]: Program documentation for people, processes and technology**

**Baseline/Goal:** Implementation of BMV at all three Corpus Christi facilities

**Data Source:** Written medication management plan including workflow for providers

**Milestone 1 Estimated Incentive Payment:** $402,322.50

**Milestone 2 [P-X]: Identify shortcuts and work-arounds to improve efficiencies w BMV processes**

**Metric 1 [P-X.1]: Evaluate, modify BMV processes to eliminate identified work-arounds.**

**Baseline/Goal:** Review BMV processes 6 months post-implementation to identify work-arounds.

**Data Source:** Staff input, variance reports, medication error investigations

**Milestone 2 Estimated Incentive Payment:** $402,322.50

**Milestone 3 [I-13]: Implement electronic medication reconciliation at the point of care**

**Metric 1 [I-13.1]: Increase the number of patients that receive electronic medication reconciliation at the point of care**

**Goal:** 100% use of electronic medication reconciliation for inpatients in Spohn’s 3 Corpus facilities

**Data Source:** EMR

**Milestone 3 Estimated Incentive Payment:** $411,481

**Milestone 4 [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions**

**Metric 1 [P-9.1]: Number of new ideas, practices, tools or solutions tested.**

**Baseline/Goal:** Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement

**Data Source:** FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and

**Milestone 4 Estimated Incentive Payment:** $821,685

**Milestone 5 [I-14]: Provide reconciliation of medications at discharge**

**Metric 1 [I-14.1]: Increase the percent of identified patients that have medications reconciled as a standard part of the discharge process**

**Goal:** 75% compliance with medication reconciliation upon discharge (expected to impact 26,250 patient annually)

**Data Source:** EMR

**Milestone 5 Estimated Incentive Payment:** $663,472

**Milestone 6 [I-15]: Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting.**

**Metric 1:** X% of patients receiving consultation by clinical pharmacists

**Baseline/Goal:** Currently, an estimated 22% (or 1 in 5) of inpatients in Spohn’s Corpus facilities receive consultation from the clinical pharmacists upon discharge. Spohn will increase that percentage by 11% to achieve a 33% total number of inpatients receiving consultations (or 1 in 3) from clinical pharmacists upon discharge by the end of DY5.

**Data source:** Patient EMR

**Milestone 6 Estimated Incentive Payment:** $663,472
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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>2.11.1</th>
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<td>IT4.10</td>
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</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)
- Payment: $402,322.50
- Milestone 4 Estimated Incentive Payment: $411,480
- Year 2 Estimated Milestone Bundle Amount: $804,645

### Year 3 (10/1/2013 – 9/30/2014)
- Payment: solutions
- Year 3 Estimated Milestone Bundle Amount: $822,961

### Year 4 (10/1/2014 – 9/30/2015)
- Year 4 Estimated Milestone Bundle Amount: $821,685

### Year 5 (10/1/2015 – 9/30/2016)
- Year 5 Estimated Milestone Bundle Amount: $663,472

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $3,112,764*
CHRISTUS Spohn Hospital Corpus Christi/ TPI 121775403
Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.
Unique Identifier - 121775403.2.8

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.
- **Intervention(s):** CHRISTUS Spohn Hospital Corpus Christi (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech.
- **Need for the project:** By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges. Spohn typically has 200,000-300,000 encounters in its hospital facilities per year, and approximately 8-10 orders are entered per encounter per day. With such a high volume of orders for a large number of patients, the need for a faster, safer, and more efficient system is great.
- **Target population:** According to our most recent data (Nov 2012), Spohn is supported by over 800 providers, 80% of which (over 640 providers) will make use of this advanced clinical technology. The target population of this project is all inpatients and outpatients treated in Spohn’s Corpus Christi facilities, which amount to approximately 117,000 patients in FY2012 (26,000 inpatient, 91,000 patients), 52% of which are uninsured or Medicaid-eligible (combined).
- **Category 1 or 2 expected patient benefits:** By DY5, Spohn expects 75% of orders placed by providers for inpatients in acute care settings to be ordered electronically; 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter to be generated electronically; and 60% of prescriptions written to ED patients upon discharge will be generated electronically.
- **Category 3 outcomes:** IT-4.6 – By DY5, Spohn expects a 15% reduction in the rate of hospital acquired VTE in its Corpus hospital facilities.
Computerized Physician Order Management (CPOM)

Category 2: Program Innovation and Redesign

Project 2.11: Conduct Medication Management

Project Option 2.11.2 Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.

CHRISTUS Spohn Hospital Corpus Christi/ TPI 121775403

Unique Identifier - 121775403.2.8

Project Description:
CHRISTUS Spohn Hospital Corpus Christi (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech. By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) Increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.

5 Year Expected Outcome

Through implementing the CPOM system, Spohn expects the following outcomes:

1) 75% electronic system adherence by providers placing orders/prescriptions for inpatients in the acute care setting by the end of the Waiver
2) 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter generated electronically by the end of the Waiver
3) 60% of prescriptions written for ED patients upon discharge generated electronically by the end of the Waiver

Goals and Relationship to Regional Goals

This project is intended to internally upgrade the hospitals’ management of information in a manner which upholds strategic safety initiatives and technological changes in healthcare. The use of electronic order entry communication and standards of practice by prescribing providers will allow for a safer order entry methodology and fewer medication transcription errors. Spohn will accomplish patient safety through order entry as the provider becomes integrated into the reliability process of care management. The extension and continued process improvement of order entry will formulate the basis for a comprehensive patient medical record that in the end help with data sharing between provider through an HIE network, allowing accountability in the care management between regional healthcare providers in the Region.

The project is related to Regional goals in that it is completely patient centered. The use of an electronic order system provides additional assurance that patients are provided treatment tailored to their individual health needs and adds safeguards against human error. Additionally, the expected reduction in medication transcription errors will reduce the cost of such mistakes, and improve patient satisfaction and quality of life.
**Challenges:**
The primary challenge will be to engage the physician provider groups to adhere to the use of this new CPOM system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success.

**Starting Point/Baseline:**
The U.S. Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) has mandated that US healthcare providers make efforts towards achieving participation in electronic health initiatives. To that end, healthcare provider organizations are encouraged to meet several measurement criteria over the course of time. The ultimate goal of meeting these criteria is to (1) Improve access to healthcare nation-wide, (2) Improve clinical outcomes and the patient experience, and (3) Decrease the cost of healthcare. By implementing CPOM, Spohn will meet HHS/CMS goals and improve the overall health of the 1.5 million inhabitants of South Texas we serve.

According to our most recent data (Nov 2012), Spohn is supported by over 800 providers, 80% of which (over 640 providers) will make use of this advanced clinical technology. Based on the nearly 400,000 typical annual encounters (based on FY-12 statistics) within the region, the impact will be realized extensively throughout our 15 country service area. Based on the project implementation timeline, FY-12 data will be used as the initial baseline data. Currently, orders and prescriptions are written on paper and entered into the hospital system manually by nurses, which can lead to transcription errors, is inefficient, and allows some orders/medications that could be automatically entered to be missed.

**Rationale:**
Spohn is regionally deploying Meditech as its primary health information system. As the leading nation-wide, fully integrated system, Meditech offers the ability to directly interface multiple aspects and processes from the patient care continuum. As such, when moving to CPOM, Spohn will facilitate quick recall of consistent information from not only orders, but also lab results, diagnostic images, medication management and reconciliation, and numerous other clinical areas. Additionally, through our Novo interface engine, Spohn offers local, secure access to providers’ patient data, further streamlining the patient care process. While Meditech is a solid, cost effective solution, preparation for the deployment of CPOM, an advanced clinical process supported by technology, does not come without a significant financial investment (discussed below in “enabling projects”).

Project components and phases – As in most any major technology enabled project, CPOM consists of several phases. While some of these phases are executed concurrently by function and/or location, each is key to the successful completion of the project. In summary, the project phases include System Design and Set-up, System Build, Testing – including unit and integrated testing, Super User and End-user Training, System “Go-Live”, and post “Go-Live” support.

Enabling projects –
Unity – The Meditech “Unity” project was completed in February 2012 in preparation for the CPOM project. The Unity project required the upgrade and standardization of the Meditech
application to version 5.6.4 throughout the entire CHRISTUS Health System. Achieving this standard enabled enterprise wide maintenance and support, faster turnaround on system issues, and streamlined process changes.

Network upgrade – In conjunction with the Unity project, CHRISTUS Health conducted network upgrade and server standardization. Consolidating the physical and virtual server environments to the CHRISTUS Health Information Technology Center (ITC) in San Antonio, Texas enabled several of the support improvement mentioned about. Additionally, by elimination of much of the regional and local data center support operations (nine regions and numerous locally supported file servers), CHRISTUS Health was able to husband the financial resources necessary to fund this multi-million dollar enabling project.

Wireless Infrastructure Upgrade – Prior to October 2011, the CHRISTUS Spohn Health System maintained approximately 100 Wireless Access Points (WAPs) in six hospitals. These devices enabled secure wireless access to the CHRISTUS Spohn computer network and associated applications. However, while access was sufficient for most unit based systems and devices, it was insufficient to handle the additional capacity and mobile nature of the devices and systems required for an advanced clinical program such as CPOM. Accordingly, in October of 2011, CHRISTUS Health completed a comprehensive analysis and upgrade of its wireless infrastructure. The number of WAPs were increased to over 200 and existing WAPs were upgraded or replaced with newer models capable of handling the increased mobile device requirements of CPOM.

Equipment technical refresh (New Clinical Workstations) – In order to ensure adequate PC resources by each unit’s support staff, CHRISTUS Health has recently upgraded over 500 PC’s throughout the SPOHN Health System. Priority of technical device refresh has been to clinical areas and supporting ancillary areas.

CPOM Specific Equipment Deployment – While support staff (nurses, unit clerks, techs in the OR, Post-op, lab, pharmacy, radiology, and other key areas) have received new PCs, the providers are getting additional PC resources specifically supporting individual order entry, medical record recall, and test results access. Using a combination of CHRISTUS Health standards and national best practice PC configuration analysis, CHRISTUS Spohn is deploying 325 additional devices for providers. These devices consist of a combination of 200 advanced desktop PCs for static, unit based clinical documentation and 125 mobile PCs of “PDOCs” (Provider Documentation Stations) that may be used during provider rounding on multiple units. In addition to PCs and mobile stations deployed for provider documentation, CHRISTUS Spohn Health System is also providing instruction and configuration assistance for individual provider personal devices (e.g. iPads, iPhones – iOS supported devices and HTC Flyer, Android Phones and other Android OS support devices) to access the CHRISTUS network.

PC Operating System Upgrade (Windows XP SP3 to Windows 7 SP1) – In order to take full advantage of Meditech’s CPOM capability as well as other interfaced systems (PACS, Pharmacy, Health Information Management, etc.), CHRISTUS Health is upgrading the standard PC operating system from Microsoft Windows XP (Service Pack 3) to Windows 7 (Service Pack 1). This upgrade will be complete prior to the completion of the CPOM project.
Milestones and Metrics: Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project through its physician network and incentivize use of the CPOM system, which will achieve the goals of the Waiver.

Project Core Components:
a. Spohn will develop a system to ensure this CPOM project is implemented first to acute care patients at its hospital facilities, with the rollout to additional areas of the hospital thereafter. The system will be developed and implemented in DY 2.
b. The plan will include tools to provide education and support to patients in acute settings to reduce delays in implementing orders and possible errors in interpreting or transcribing orders, and will be implemented in DY2.
c. Spohn has already undertaken in the first year of the Waiver (DY1) an analysis of physician order implementation and identified transcription errors and delays as one area for improvement. To that end, the project plan will include the processes Spohn has identified to remedy the transcription errors and delays by having the physician enter the orders directly.
d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 3 specifically).

Ties to Community Needs Assessment Unique IDs:
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

Related Category 3 Outcome Measure(s):
OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.6 Hospital Acquired Venous Thromboembolism

Reasons for selecting the outcome measures:
Spohn is continuously improving its CPOM services with the goal of reducing variations in the delivery of services based on delayed or misinterpreted physician orders. Spohn has a high rate of potentially preventable cases of hospital acquired VTE (50% - 9 of 18), and has low scores in several of the CMS VTE indicators. The use of CPOM is expected to improve Spohn’s scores and reduce the incidence of hospital acquired VTE in Spohn’s facilities.

Relationship to Other Performing Providers’ Projects in the RHP:
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7 - Medication Management to reduce medication administration errors.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs, including Corpus Christi Medical Center, Corpus Christi-Nueces County Public Health District, and DeTar Healthcare System.

**Project Valuation:**
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).
4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rating because it leads to improvements in the overall health of patients but does not expand the availability of care.

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96 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #93049
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<td>CHRISTUS Spohn Hospital Corpus Christi</td>
<td>IT-4.6</td>
<td>Hospital Acquired VTE</td>
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<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Milestone 1 [P-1]: Implement a medication management system <strong>Metric 1</strong> [P-1.1]: Program elements to include documentation of program, people and technologies required to implement system <strong>Baseline/Goal</strong>: Implementation team and infrastructure in place for CPOM/Med Mgmt. Go-Live <strong>Data Source</strong>: Implementation plan with team, infrastructure and processes documentation Milestone 1 Estimated Incentive Payment: $402,322.50</td>
<td>Milestone 3 [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions <strong>Metric 1</strong> [P-9.1]: Number of new ideas, practices, tools or solutions tested. <strong>Baseline/Goal</strong>: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement <strong>Data Source</strong>: FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions</td>
<td>Milestone 5 [I-18]: CPOE utilization measure <strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient <strong>Goal</strong>: 75% of orders in the acute care setting are entered electronically <strong>Data Source</strong>: EMR reports, hospital informatics reports and audits documentation Milestone 5 Estimated Incentive Payment: $410,842</td>
<td>Milestone 7 [I-12]: Implement electronic prescription writing at the point of care <strong>Metric 1</strong>: Increase number of new and refill prescription written and generated electronically <strong>Baseline/goal</strong>: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically Milestone 7 Estimated Incentive Payment: $331,736</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Milestone 2 [P-7]: Implement CPOM to allow providers to enter medical orders directly via computer, replacing the more traditional paper, verbal, telephone and fax methods <strong>Metric 1</strong> [P-7.1]: Create a system to implement CPOM <strong>Baseline/Goal</strong>: Transition at least 50% of physician orders to electronic order entry (expected to impact nearly 200,000 patient encounters) <strong>Data Source</strong>: Patient medical records and EMRs, Hospital informatics utilization reports Milestone 2 Estimated Incentive Payment: $402,322.50</td>
<td>Milestone 4 [I-18]: CPOE utilization measure <strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient <strong>Goal</strong>: 60% of orders in the acute care setting are entered electronically <strong>Data Source</strong>: EMR reports, hospital informatics reports and audits documentation Milestone 4 Estimated Incentive Payment: $411,480.50</td>
<td>Milestone 6 [I-12]: Implement electronic prescription writing at the point of care <strong>Metric 1</strong>: Increase number of new and refill prescription written and generated electronically <strong>Baseline/goal</strong>: 50% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically Milestone 6 Estimated Incentive Payment: $410,842</td>
<td>Milestone 8 [I-17]: Increase the number of patient visits for which a medication is prescribed that have medication reconciliation and prescription generation performed electronically <strong>Metric 1</strong>: Percent of patient visits at which a medication was prescribed that had medication reconciliation and prescription generation performed electronically <strong>Baseline/goal</strong>: 50% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically Milestone 8 Estimated Incentive Payment: $331,736</td>
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<td><strong>Denominator</strong>: number of ED visits where medication is prescribed</td>
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<td><strong>Year 2 Estimated Milestone Bundle Amount</strong>: (add incentive payments amounts from each milestone): $804,645</td>
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CHRISTUS Spohn Hospital Corpus Christi/ 121775403
Improvement in Quality and Safety for patients with Sepsis at CSHSCC; 2.8.11
Unique Identifier - 121775403.2.9

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s)**: This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) within Spohn’s Corpus Christi provider facilities.

- **Need for the project**: In FY 2012, Spohn’s Corpus facilities screened completed 56,921 MEWS tools (sepsis screening) and identified 2180 cases of sepsis. Of the cases identified, 21% were Medicaid/uninsured (458 cases). The average length of stay for a septic patient was 11 days and the average cost per patient was $104,390, totaling in $227 million in charges. Spohn collected $37 million of those charges, meaning the remaining $90 million went uncompensated. The sepsis mortality rate in FY 2012 was 16% of all cases (88 deaths). Approximately X% of patient received the sepsis resuscitation bundle within 6 hours of onset.

- **Target population**: The target population includes all patients in Spohn’s hospital campuses who are at risk for sepsis, including elderly and surgical patients. Spohn discharges approximately 35,000 inpatients annually, 31% of which are Medicaid/uninsured (approximately 11,000 inpatients).

- **Category 1 or 2 expected patient benefits**: By DY5, Spohn expects to achieve 95% of patients with a suggestion of severe sepsis or septic shock have their lactate level drawn by DY5. In addition, Spohn expects a 15% increase in the number of patients screened with the MEWS tool by DY5

- **Category 3 outcomes**: IT-4.8 – By DY5, Spohn expects this project to result in a 3% reduction in septicemia mortality rates in Spohn’s Corpus Christi facilities from the baseline established in DY2.
Sepsis

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Improvement in Quality and Safety for patients with Sepsis; 2.8.11
CHRISTUS Spohn Hospital Corpus Christi (“Spohn”)/ 121775403
Unique Identifier - 121775403.2.9

Project Description:
This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) in Spohn’s provider facilities. Spohn will gauge resultant improvements in care through the assessment and monitoring of process and outcome measures across the lifespan of the project. Initially, measurements will constitute a baseline from which improvements at subsequent intervals will be gauged. Providers needed for this concept include nurse practitioners, nurses and physicians within hospital settings.

Project Goals/Five Year Expected Outcome: By using nurse practitioners, nurses and physicians to implement both Sepsis Resuscitation and Sepsis Management Bundles, this project’s goals are:

- Implement a 90-day rapid cycle improvement plan for sepsis.
- 15% increase in cases with resuscitation initiated within 6 hours- order set initiation.
- 15% increase in use of electronic MEWS by nursing staff on patients admitted to medical/surgical units.

Project Challenges: The top challenges of this initiative will be automating the MEWS screening tool and provider compliance with bundles. Implementation will consist of staff education, provider training, point of entry protocol development, sepsis bundle and sepsis management bundle implementation set forth as a 90-day rapid cycle improvement.

Starting Point/Baseline:
In FY 2012, Spohn’s Corpus facilities screened completed 56,921 MEWS tools (sepsis screening) and identified 2180 cases of sepsis. Of the cases identified, 21% were Medicaid/uninsured (458 cases). The average length of stay for a septic patient was 11 days and the average cost per patient was $104,390, totaling in $227 million in charges. Spohn collected $37 million of those charges, meaning the remaining $90 million went uncompensated. The sepsis mortality rate in FY 2012 was 16% of all cases (88 deaths). In 2012, approximately 60% of patients had lactate drawn upon a suggestion of sepsis or severe septic shock; this number should be at 100% because the lactate level confirms the presence of sepsis.

Rationale:
Severe sepsis is a major healthcare problem that affects millions of people around the world each year with an extremely high mortality rate of 30 to 60 percent. Mortality from sepsis is greater than breast cancer, lung cancer and colon cancer combined and is the number one cause of death in the non-coronary ICU. The incidence of severe sepsis is expected to double over the next 25 to 30 years. Thus, it is imperative for the health and safety of Nueces County residents who may be hospitalized
and exposed to this infection at some point during their lives that Spohn take steps to detect sepsis early and have a tried and true protocol for responding effectively.

Our goal at Spohn is to reduce septicemia mortality. In order to impact this mortality rate, early recognition for signs and symptoms of sepsis and immediate initiation of treatment is required. Time is of the essence making this a high priority initiative with a substantial amount of work to accomplish over a short period of time. This full scale quality improvement initiative requires a structured and defined process to ensure all phases of improvement are completed; Plan-Do-Study-Act. This system-wide initiative will be accomplished using a 90-day rapid cycle improvement process specific to early recognition and treatment of sepsis.

**Milestones and Metrics:** Spohn chose the DY2 milestones in order to put in place the infrastructure to improve its capability to quickly detect sepsis and respond effectively. In the subsequent years, Spohn chose milestones that would allow it to measure and improve its processes for responding to cases of sepsis within the hospital at a consistent rate.

**Ties to Community Needs Identification Number:** CN.18 (high rate of sepsis in Region 4)

**Project Components:**
- Baseline assessment (see baseline data)
- Review of evidence for early warning system tool and tool selection – will be part of completing Milestone 1 in DY2
- Identify team to champion initiative – include all stakeholders, must commit time to implement 90-day rapid cycle improvement and continuous improvement – will be part of completing Milestone 3 in DY3
- Plan – workflow, implementation, training, dissemination of information, metrics for short, intermediate and long term outcomes (will be part of Milestones 1 and 3)
  - Short term – recognition and treatment initiation
  - Intermediate – hardwire processes evidenced by consistent use of tools
  - Long term – reduce sepsis mortality rates, decrease cost associated with PPC
- Do – implement Modified Early Warning Score (MEWS) and Lactate Levels Draw upon Suggestion of Severe Sepsis or Septic shock – to be completed through Milestones 2 and 4
- Study – Analyze and interpret the results – to be completed as part of Milestones 5-9 in DYs 3-5.
- Act – Identify areas for change and implement rapid process to resolve - to be completed as part of Milestones 5-9 in DYs 3-5.

**Related Category 3 Outcome Measure(s):** OD 4 (Potentially Preventable Complications and Healthcare Acquired Conditions); IT 4.8 (Sepsis Mortality)

Spohn selected this outcome because the goal of creating the sepsis early warning system and corresponding protocols is intended to result in early recognition and treatment of sepsis in the medical/surgical patient population, which is in turn expected to result in a lower rate for sepsis mortality in Spohn’s inpatient population.
Relationship to other Projects:
This project relates to and supports the following projects because it requires the vigilance and cooperation of all hospital providers (including physicians):

121775403.1.5 – Expand high impact specialty scare capacity through development of a structured critical service model focusing on providing intensivists driven services;
121775403.2.2 – Establishment of Hospitalist Program model that provides continuity of care through clinical integration of services in non-ICU patients
020973601.2.2 – Apply process Improvement methodology to improve sepsis mortality and length of stay.
Related Category 4 measures include potentially preventable complications in RD-3 and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers who have submitted similar projects with whom we will collaborate include Corpus Christi Medical Center.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

The value of this particular project is based on the prevalence of sepsis mortality across Texas hospitals, including in Nueces County. Sepsis can affect any at-risk patients in the hospital, thus the project is necessary to protect a myriad of different types of patients. The investment required for this project ties into implementing the early warning system, rapid-cycle improvement, and provider training. Ultimately, this project meets Waiver goals by focusing on improving patient health outcomes while also reducing the systemic cost of providing inpatient hospital care associated with sepsis.

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97 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-7]: Implement a rapid improvement project using Rapid Cycle Improvement methodology  
**Metric 1** [P-7.1]: Rapid Improvement Cycle for Sepsis: Standardize process, Set the measure, Validate the measure, Innovate implementation, Standardize new process, Continue cycle  
**Baseline/Goal**: Implement a 90-day rapid cycle improvement plan for Sepsis.  
**Data Source**: Documentation of all steps included in rapid cycle methods were performed |  
| **Milestone 3** [P-8]: Train providers/staff on process improvement  
**Metric 1** [P-8.1]: Number of providers/staff trained  
Baseline/goal: train all hospital mid-level staff in using the MEWS system and the processes that flow from identifying a case of sepsis  
**Data Source**: Documentation of training materials |  
| **Milestone 3 Estimated Incentive Payment**: $431,074 |  
| **Milestone 4** [I-14]: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1** [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock  
**Goal**: 85% of patients with suggestion of severe sepsis will have lactate level drawn  
**Data Source**: EMR |  
| **Milestone 4 Estimated Incentive Payment**: $645,609 |  
| **Milestone 5** [I-14]: Measure efficiency – electronic documentation of MEWS in EMR  
**Metric 1** [I-14.1]: Increase use of electronic MEWS by nursing staff  
**Goal**: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 8400 additional screenings)  
**Data Source**: hospital EMR reports |  
| **Milestone 5 Estimated Incentive Payment**: $521,300 |  
| **Milestone 6** [I-14]: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1** [I-14.1]: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock  
**Goal**: 85% of patients with suggestion of severe sepsis will have lactate level drawn  
**Data Source**: EMR |  
| **Milestone 6 Estimated Incentive Payment**: $645,610 |  
| **Milestone 7** [I-14]: Measure efficiency – electronic documentation of MEWS in EMR  
**Metric 1** [I-14.1]: Increase use of electronic MEWS by nursing staff  
**Goal**: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 8400 additional screenings)  
**Data Source**: hospital EMR reports |  
| **Milestone 7 Estimated Incentive Payment**: $521,300 |  
| **Milestone 8** [I-14]: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1** [I-14.1]: Percentage of patients who had lactate drawn upon evidence that suggests severe sepsis and/or septic shock  
**Goal**: 95% of patients with suggestion of severe sepsis will have lactate level drawn  
**Data Source**: EMR |  
| **Milestone 8 Estimated Incentive Payment**: $521,299 |  
| **Milestone 9** [I-14]: Measure efficiency – electronic documentation of MEWS in EMR  
**Metric 1** [I-14.1]: Increase use of electronic MEWS by nursing staff  
**Goal**: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 8400 additional screenings)  
**Data Source**: hospital EMR reports |  
<p>| <strong>Milestone 9 Estimated Incentive Payment</strong>: $521,300 |</p>
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>121775403.3.17</th>
<th>IT-4.8</th>
<th>Sepsis Mortality</th>
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<tbody>
<tr>
<td><strong>Data Source</strong>: Hospital quality documentation, sepsis dashboards</td>
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<tr>
<td>Milestone 2 Estimated Incentive Payment (<em>maximum amount</em>): $632,222</td>
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<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payment amounts from each milestone): $1,264,443</td>
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<td>Year 3 Estimated Milestone Bundle Amount: $1,293,224</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $1,291,219</td>
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<td>Year 5 Estimated Milestone Bundle Amount: $1,042,599</td>
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<tr>
<td><strong>Data Source</strong>: over DY2 baseline, hospital EMR reports</td>
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<tr>
<td>Milestone 5 Estimated Incentive Payment: $431,075</td>
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</tbody>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5)*: $4,891,486
CHRISTUS Spohn Hospital Corpus Christi/121775403
Expand Care Transitions Program; 2.12.2
Unique project ID number: 121775403.2.10

- **Provider:** CHRISTUS Spohn Hospital – Corpus Christi is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s):** This project will expand Spohn’s Care Transitions program to focus on preventing readmissions for CHF and diabetes patients at Spohn’s South, Memorial and Shoreline campuses. Under the expansion, the RN Coach is the centerpiece of the program, and will function as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The RN Coach will facilitate the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit, the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge.

- **Need for the project:** Spohn’s Memorial campus launched the Care Transitions program in 2011 to target chronically ill charity patients for transition to self-management; however the scope for the first year was limited to 237 patients with a myriad of conditions. CHF-targeted Care Transitions is needed because CHF is the second most prevalent primary diagnosis in Region 4 and Nueces County has a much higher prevalence of potentially preventable hospitalizations related to CHF than the statewide average. Patients with CHF and a BH diagnosis have not been identified or actively managed when presenting to the ED or admitted to inpatient services. Data shows these patients once admitted have a longer length of stay and comparable readmissions to CHF alone. Research also shows patients with both BH and chronic medical conditions tend to die approximately 25 years younger than their single diagnosis counterparts.

- **Target population:** The target population includes CHF and diabetes patients treated as inpatients at Spohn’s Memorial, South and Shoreline campuses who are Medicaid/self-pay/charity eligible. In FY2012, Spohn Corpus treated approximately 13,000 patients with CHF or diabetes, of which 2300 were Medicaid/uninsured (the majority of the 13,000 were Medicare patients). **Category 1 or 2 expected patient benefits:** By the end of DY3, Spohn expects to have fully implemented the CHF and diabetes-targeted Care Transitions program at its Memorial facility for all Medicaid/self-pay/uninsured patients; at its Shoreline facility for the same population by the end of DY4; and at South for the same population by the end of DY5.

- **Category 3 outcomes:** IT- 3.2 – As a result of implementing the CHF-targeted Care Transitions at Spohn’s Corpus facilities, Spohn expects an 10% reduction in CHF 30-day readmission rates among its three Corpus Christi facilities (South, Shoreline, and Memorial).
**Identifying Project and Provider Information:**
Expand Care Transitions Program; 2.12.2, CHRISTUS Spohn Hospital Corpus Christi/121775403
Unique project ID number: 121775403.2.10

**Project Description:**
The Care Transitions program addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program. Frequently, healthcare delivery is fragmented, lacks communication among providers and hospitals, and patients do not know how to access care or navigate the healthcare system. A reoccurring theme identified during the course of the program involved clients who did not understand how to manage their disease and discharged unprepared for the transition to the home setting. They are overwhelmed by their healthcare needs. This program is designed to empower patients and their families to become active shareholders and to promote quality healthcare in the community for the chronically ill. This expansion is in keeping with CHRISTUS Health’s commitment to creating healthier communities while reducing costs to the health care system.

The RN Coach is the centerpiece of this program, and functions as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The patient and caregiver are coached to play a central and active role in the formation and execution of the plan of care. The RN facilitates the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge. The four conceptual domains are introduced to the patient, by the RN Transitions Coach, commonly referred to as the 4 Domains or Pillars of care:

1. Medication self-management and medication reconciliation
2. Use of a dynamic patient-centered record, the Personal Health Record [PHR]
3. Timely primary care / specialty care follow-up
4. Knowledge of red flags that indicate a worsening in condition and how to respond

The target population includes patients with high risk discharge conditions, multiple medications, and the chronically ill. Program goal is to improve patient outcomes, maintain quality, and assist the patient and caregivers with the transition from hospital to home. Care Transitions provides patients with the tools and support to promote self-management, improve communication between patient and the primary Care Physician; reducing preventable hospital readmissions.

At discharge the patient has a support team, comprising of an RN Transition Coach, a Community Health Worker, and caregiver with the patient as an active participant in recovery. This is a uniquely designed program which has demonstrated great success.

As patients successfully transition from hospital to home care with the assistance of the Care Transitions model, they will also receive an additional 18 months of support and self-management training from a certified community health worker. The Care Management/Care Partner program is a self-management support program, facilitated by a specially trained community health worker working under the direct supervision of a registered nurse. This is the systematic provision of
education and supportive interventions to increase patients' skills and confidence in managing their health problems, including regular assessment of progress, goal setting, and problem solving support.

**Project Goals:**
- Implement the Care Transitions program at all three Corpus Christi facilities for all Medicaid/uninsured/self-pay patients by DY5
- Reduction in avoidable CHF 30-day readmissions by 8% by DY5.
- Begin case management and discharge planning early; targeting high-risk patients and coordinate care.
- Improved care transitions from hospital to home; avoiding deterioration in health status, which often occurs upon discharge.
- Integrate hospital and outpatient care.

**Project Challenges:**
- Communication between inpatient and outpatient/community providers.
- Technology to support communication and electronic referrals.
- Potential enrollee’s may opt out of participating with Care Transitions Program.
- Barriers to care such as; financial, socioeconomic, and availability to providers.

Spohn will address these challenges by thoughtfully creating a plan to effectively communicate with patients and their caregivers about next steps and to establish a trusting, cooperative relationship. Providers will be trained to use the technology associated with the program. Finally, patients will be educated and encourage to participate in the program, and the providers will work with clients to address financial and other barriers to participation.

**5 Year Expected Outcome**
The Care Transition Program has been in place on a small scale throughout the CHRISTUS Health System for over a year. Large amounts of research are now being published on the benefits and results of Care Transition Programs in Chronic Disease Management. Our 5-yr plan is to expand current Care Transition program coverage across diagnoses and payors. Despite our specific target for Medicaid, charity patients, and the uninsured, we have a responsibility to our community to provide the services for commercial payors that do not cover such programs or hold those that do to the same level of expectations.

Our plan is identified on the project timeline (2.12.1 Table) and consists of expansion by priority diagnoses; CHF, Diabetes and Behavioral Health. Key to program success is continuous evaluation and targeted on-going improvement that will minimize inefficiencies and promote effective patient outcomes.

**Starting Point/Baseline:**
The CHRISTUS Spohn Community Outreach Program launched the Care Transitions Program in 2011 to assist charity care recipients with chronic diseases to transition from in-patient care to home self-management. Quarterly metrics demonstrate the effectiveness of the Care Transition and Care Partners program collaboration.
The thirty-three day RN intervention allows patients with complex needs to receive one-on-one instructions and coaching. In the reporting period, the provider averaged 948 encounters and served 237 patients from program implementation, which began in March of 2011 to the end of reporting period of June 30, 2012. Data is cumulative.

**Rationale:**
Nueces County, where Spohn's Corpus Christi campuses provide care, has a high rate of potentially preventable hospitalizations for the following conditions: bacterial pneumonia, congestive heart failure, COPD, and long-term complications related to diabetes (RHP Plan, Section 3, Table 10). Many of these patients have been hospitalized previously, and likely could have avoided subsequent hospitalizations if provided with the requisite support to transition to self-management of their conditions outside of the hospital setting. Additionally, Nueces County is designated as a Partial Medically Underserved Shortage Area, which means that patients are not receiving the primary care interventions they need to avoid repeat hospitalizations for manageable conditions (RHP Plan, Section 3, Table 11). The Care Transitions program can assist patients in finding and obtaining the medical support they need when resources are often limited.

The proposed plan is CHRISTUS Spohn Health System’s answer to reducing readmissions for chronically ill patients admitted to the six CHRISTUS Spohn facilities, by implementing the Care Transition and Care Partner Programs already in place at CHRISTUS Spohn Corpus Christi-Memorial. The Care Transitions model is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across health care settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention. The use of specialized teaching tools and red flag rules, allows the patient to learn self-management skills and become an active partner of their healthcare team. Engaging the patient and family to become active partners in their healthcare, has directly impacted readmission rates in the initial targeted population group at CHRISTUS Spohn Hospital-Memorial. This has resulted in a significant reduction in hospital utilization within the targeted group.

The program can be easily implemented within the CHRISTUS Spohn Region to target disease specific diagnoses within the uninsured, managed care, or Medicare populations. The Care Transitions program has been successfully implemented at various facilities throughout the CHRISTUS Health System, to include St. Michael, St. Frances Cabrini, St. John, and Schumpert St. Mary, Spohn Memorial, and Spohn Shoreline. The average cost of care per client for the CHRISTUS programs regionally ending Q2 FY12 are such successes as pre-enrollment costs at $16,273 with a significant reduction in costs to the post-90 day enrollment cost of $3,425.

Results from the current Care Transition program limited to the charity care population at CSHCC-Memorial have had the following impact:
- Cost per case reduction 50%-75% based on site and target diagnoses
- Decreased ED utilization for inappropriate visits stabilized per covered lives volumes
- Average inpatient admission reduction >50% per patient
- ALOS reductions by as much as 1 pt day
Milestones and Metrics:
Spohn chose Milestones 1, 2, and 3 in order to implement the expansion of the Care Transitions program by first putting processes in place at the new participating facilities, and to share best practices with other providers taking similar action in Region 4. It is imperative to the success of the program that the expansion plan and implementation includes provider training, consistent policies, and sharing of information. Spohn chose Milestones 4, 5, and 6 in order to put the plans and processes into action, which will include full integration of the Care Transitions program into the standard discharge processes performed by the providers at Spohn’s South and Memorial campuses, and will include increasing participating for patients with targeted dual diagnoses by DY5.

Ties to Community Needs: CN.3, CN.4, CN.7, CN.12, CN.16

Related Category 3 Outcome Measure(s): OD 3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates; Improvement Target 3.3.2 – Congestive heart Failure 30 Day Readmission Rate
The Care Transition model will target patients admitted to the CHRISTUS Spohn Health System with a diagnosis of CHF. Care Transition nurses along with the medical team will enroll high risk CHF patients meeting program criteria, through admission census reports and daily rounding processes. The RN Transition Coaches and Community Health Workers will form community collaborations to promote healthcare and positively impact preventable hospitalizations for released CHF patients.

Relationship to Other Projects: This project’s focus on patient empowerment and education to improve care management of chronically ill patients is related to and will support many projects throughout the region. Primary projects with direct ties to this initiative include: 020811801.2.4 – Expand Care Transitions Program; 121775403.1.3: Implement a chronic disease registry to support and sustain management of patients in care transitions program; and 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care.

Related Category 4 Measures include Potentially Preventable Admissions in RD – 1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:
Through the learning collaborative, we will work with other community entities to discuss challenges with lessons learned and obstacles to delivery will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach
for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

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1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 98

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with regard to its relevance to the goals of the Waiver; specifically, that the Care Transitions program is patient-centered, designed to improve patient outcomes and satisfaction, and should result in a reduction in the constantly growing cost of providing healthcare to the indigent and uninsured residents in Region 4. The project addresses community needs by targeting patients who have recently been released from the hospital and need assistance in order to avoid readmission – this is especially relevant for elderly patients, patients with chronic diseases, or patients who for other reasons have difficulty self-managing their conditions. The investment necessary to expand this program is great, including provider training, creating

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98 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
infrastructure at newly participating facilities, and creatively engaging in patient and community outreach to garner participation and changes in behavior.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-2]:</strong> Implement standardized care transition processes</td>
<td><strong>Milestone 3 [P-10]:</strong> Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td><strong>Milestone 5 [I-14]:</strong> Implement standardized care transition program for the CHF and diabetes population at Shoreline campus</td>
<td><strong>Milestone 6 [I-14]:</strong> Implement standardized care transition program for the CHF and diabetes population at Shoreline campus</td>
</tr>
<tr>
<td><strong>Metric 1 [P-2.1]:</strong> Care transitions policies and procedures</td>
<td><strong>Metric 1 [P-10.1]:</strong> Number of bi-weekly meetings</td>
<td><strong>Metric 1 [P-9.1]:</strong> Measure adherence to processes</td>
<td><strong>Metric 1 [P-9.1]:</strong> Measure adherence to processes</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Implement Care Transition standardization in Spohn’s Corpus Christi Facilities, meaning consistent standards for eligibility, processes for patient coordination, and provider training — with a focus on CHF and diabetes patients</td>
<td><strong>Baseline/Goal:</strong> Establish open lines of communications to share learning experiences during 1st year after expansion with other RHP 4 providers — schedule interactions on a regular basis</td>
<td><strong>Goal:</strong> Full implementation of CHF and diabetes care transitions program at the Shoreline campus or all Medicaid, self-pay and charity patients.</td>
<td><strong>Goal:</strong> Full implementation of CHF and diabetes care transitions program at the Shoreline campus for all Medicaid, self-pay and charity patients.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Care Transitions Policies, Procedures, Protocols</td>
<td><strong>Data Source:</strong> Meeting minutes/agenda, lessons learned, documented challenges</td>
<td><strong>Data Source:</strong> Care Transitions documentation, community outreach documentation</td>
<td><strong>Data Source:</strong> Care Transitions documentation, community outreach documentation</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $862,120</td>
<td>Milestone 3 Estimated Incentive Payment: $881,744</td>
<td>Milestone 5 Estimated Incentive Payment: $1,760,754</td>
<td>Milestone 6 Estimated Incentive Payment: $1,421,727</td>
</tr>
</tbody>
</table>

**Milestone 2 [P-7]:** Develop a staffing and implementation plan to accomplish goals/objectives of the program

**Metric 1 [P-7.1]:** Documentation of staffing and implementation plan

**Baseline/Goal:** Complete staffing and implementation plan for expansion by diagnosis and by site which addresses the additional staffing and resources necessary for successful implementation, necessary training, and other institutional changes required:

**Goal:** Currently, only Nueces Charity chronically ill patients served at Memorial are targeted by the Care Transitions program. The goal for this year is full implementation of care transitions at Memorial for patients with CHF and diabetes across all Medicaid, self-pay and
<table>
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<th>121775403.2.10</th>
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<th>EXPAND CARE TRANSITIONS PROGRAM; COVERAGE AREA &amp; DIAGNOSES</th>
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<td>CHRISTUS Spohn Hospital Corpus Christi</td>
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<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>121775403.3.18</td>
<td>IT 3.2</td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)
- CHF and Diabetes Care Transitions at all three Corpus facilities
  Data Source: Staffing and operational plan for Care Transition expansion
  Milestone 2 Estimated Incentive Payment: $862,120

**Year 3** (10/1/2013 – 9/30/2014)
- Charity eligible patients
  Data Source: Care Transitions documentation, community outreach documentation, LMHA documentation
  Milestone 54 Estimated Incentive Payment: $881,744

**Year 4** (10/1/2014 – 9/30/2015)

**Year 5** (10/1/2015 – 9/30/2016)

Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,724,240
Year 3 Estimated Milestone Bundle Amount: $1,763,488
Year 4 Estimated Milestone Bundle Amount: $1,760,754
Year 5 Estimated Milestone Bundle Amount: $1,421,727

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $6,670,208
Performing Provider: CHRISTUS Spohn Hospital Corpus Christi/121775403
Project Name: 2.8.1: Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency
Project Identifier - 121775403.2.11 – Pass 2

- **Provider**: CHRISTUS Spohn Hospital – Corpus Christi (“CSHCC”) is a 730-bed hospital in Corpus Christi serving a 460 square mile area and a population of approximately 460,000. The Hospital is comprised of 3 facilities on 3 campuses.

- **Intervention(s)**: CSHCC will spearhead the transformation of the CHRISTUS Spohn Health System’s (“CSHS”) culture of safety and efficiency within its three CSHCC facilities and its three community facilities (Spohn Beeville, Spohn Alice, and Spohn Kleberg). Specifically, CSHS will work with Hospital Performance Innovation, LLC (“HPI”) to develop and implement standardized safety and efficiency protocols, and to develop education materials and methods to train CSHS providers in the protocols.

- **Need for the project**: An initial analysis shows that CSHS’ current rate of serious safety events (SSEs) is equal to 7.1 per 10,000 patient days, which works out to X patients per month. SSEs are defined as events that reach the patient and result in moderate to severe harm or death.

- **Target population**: The target population of this project includes all patients treated within CSHS hospitals (including all six Spohn facilities in Nueces, Kleberg, Jim Wells, and Bee Counties). CSHS experiences over 391,000 patient encounters per year. Of those encounters, approximately 45,000 are inpatient encounters and approximately 346,000 are outpatient. Medicaid, self-pay and charity encounters comprise approximately 57% of the total encounters. (total of approximately 223,000 encounters). With CSHS’s high volume of Medicaid and uninsured patients, improvements in safety awareness and prevention will certainly benefit this population.

- **Category 1 or 2 expected patient benefits**: The project seeks to develop improved safety and efficiency protocols that will reduce safety errors and costs associated with providing care. Specifically, the project seeks to reduce CSHS’ rate of SSEs per 10,000 patient days by 15% in DY3 (reduced to approximately 6.035), by 30% in DY4 (approximately 4.97) and by 35% in DY5 (approximately 4.615).

- **Category 3 outcome**: Through increasing safety in the hospital system, Spohn expects to reduce the Patient Fall Rate by 20% in DY3, 30% in DY4, and 42% in DY5. CHRISTUS Spohn Hospital Beeville ("Spohn Beeville") entered into Collaboration Agreements with CHRISTUS Spohn Hospital Alice ("Spohn Alice") and CHRISTUS Spohn Hospital Kleberg ("Spohn Kleberg") in order to allow Spohn Beeville, as the Performing Provider, to undertake a transformative project that will improve access to health care for indigent patients in Region 4 by opening a primary care clinic to operate five days per week in Bee County. Spohn Beeville, Spohn Kleberg and Spohn Alice are each hospitals operating under the same corporate entity and entered into the Collaboration Agreement voluntarily. This project is transformative for Region 4 because it will improve health outcomes and access to care for indigent patients (which is the very heart of the Waiver) and reduce the cost of providing care to these patients, who are often treated in inappropriate care.
settings. Each of the collaborating hospitals provide care to rural residents of Region 4 and are dedicated to reducing inappropriate use of local emergency departments, assisting patients in managing chronic diseases, and strengthening the network of primary care providers in the Region. The FQHC that historically treated the indigent residents in Bee County has recently closed, meaning that the need for this project is urgent. Spohn Beeville will be responsible for carrying out the full scope of the project, and Spohn Beeville believes that its collaborations are fully consistent with the terms of Section 25(c)(iv) of the Funding and Mechanics Protocol. Spohn Beeville notes that nothing in Section 25(c)(iv) requires both parties to participate in the implementation of the DSRIP projects undertaken pursuant to a collaboration agreement.
Project Option 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.

**Unique RHP Project Identification Number:** 121775403.2.11 – Pass 2  
**Performing Provider Name/TPI:** CHRISTUS Spohn Hospital Corpus Christi 121775403

**Project Description: Hospital “Culture of Safety and Efficiency” Transformation**

Spohn Corpus Christi (“CSHCC”) will spearhead the transformation of the CHRISTUS Spohn Health System’s (“CSHS”) culture of safety and efficiency within its three CSHCC facilities and its three community facilities (Spohn Beeville, Spohn Alice, and Spohn Kleberg) by investing in provider training, developing high reliability leadership, implementing safety tools, defining behavioral expectations, and a system of accountability for all Spohn providers.

CSHS obtained a diagnostic assessment from Healthcare Performance Improvement, LLC (“HPI”) that showed the most pressing systemic weakness is the organization’s level of safety and reliability. In partnership with HPI, CSHS will develop a plan for educating its hospital providers, leadership, and employees in proven safety and reliability tools, such as communication protocols, self-checking, cross monitoring, peer coaching, and collegial interactive teamwork. In addition to learning these safety protocols, providers will be trained in methods for improving care in an efficient manner, communicating with the patient with courtesy, and clarity and tools for recovering from service failures. These are designed to improve patient satisfaction and to provide an environment in which safe, reliable, compassionate care can be delivered. The trainings will be conducted on-site at the six CSHS hospital sites.

The protocols CSHS implements will also include leadership methodologies (such as, “rounding to influence” or “leadership safety walk-arounds”) and processes for staff to be accountable for patient safety (such as using “behavior based expectation” methods to prevent staff errors). CSHS will also work with HPI to develop standard methods for measuring its own performance (for example, implementing HPI’s “Safety Event Classification” and “Serious Safety Event Rates” methodologies) and determining key challenges and best practices. For example, the plan protocols may include such standard practices as SBAR communication protocol (Situation; Background; Assessment; Recommendations), STAR self-check protocol (Stop, Think, Act, Review) methodology for stopping unsafe behaviors ARCC (Ask a question, Make a request, Voice a concern, Use chain of command.)

Finally, after training staff, leadership, and providers, CSHS will officially implement the Apparent Cause Analysis and Rapid Chain of Command in its facilities. Apparent Cause Analysis (ACA) relies on asking what caused the problem at the most recognizable level, not going into the depth and breadth of formal root cause analysis. The goal of the ACA is to determine the most probable cause(s) of events and other hospital errors, with the cause being the organizational or programmatic action or condition that brought about the problem. The Root Cause Analysis (RCA) is the methodology used to investigate serious safety events (SSEs). Chain of Command in healthcare is the line of responsibility to both the delivery of appropriate patient care, and feedback about perceived appropriateness and the impact of that care.
An effective chain of command in healthcare organizations facilitates, rather than impedes, communication, teamwork, and collaboration between the decision maker and the frontline clinician. Rapid Chain of Command builds upon this idea and creates a leadership structure whereby safety concerns can be addressed in an immediate fashion.

Goals and Relationship to Regional Goals:
The goal of this project is to increase the protections in place within the CSHS directed towards patients and staff, thereby improving patient health outcomes, patient/provider satisfaction, and reducing the systemic cost of providing care. The intended outcome is a reduction in variation across the system, and an improved ability to prevent and address safety events in the hospital facilities.

Specific Project Goals:
- Train hospital leadership in proven strategies for creating and sustaining a high reliability organization in DY1 and DY2
- Train physician/midlevel providers and hospital staff in safety/efficiency protocols and implement protocols in DY3
- Implement system-wide quality dashboard and measure progress in DY3
- Implement Rapid Chain of Command and Apparent Cause Analysis in DY4
- Achieve at least one safety champion in at least 80% of CSHS units in DY5
- In DYs 3-5 accomplish a reduction in the rate of serious safety events ("SSEs"), defined as events that reach the patient and result in moderate to severe harm or death, due to the training and implementation of safety and efficiency protocols throughout the Waiver
  - Baseline: 7.1 SSEs per 10,000 patient days
  - 15% rate reduction in DY3
  - 30% rate reduction in DY4
  - 35% rate reduction in DY5

This project meets the following Region 4 goals:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
- Inconsistent commitment on the part of leaders, staff and medical staff leaders to improve patient care
- A culture which is significantly resistant to change. Disruptive power distance (Authority Gradient) exists in most practice areas.
• A lack of regional standardization and care processes.

Transformation of the hospital’s culture in the arena of safety presents an uphill battle, but is absolutely crucial to effecting healthcare delivery reform in Region 4. CSHS will address these challenges by explaining to staff the benefits of operating a safer and more efficient facility, and by building upon intuitions and experience that providers already possess to address resistance to change.

5-Year Expected Outcome for Provider and Patients:
Spohn expects the provision of care to patients in its Corpus Christi and community facilities to improve upon the safety transformation. When providers are better trained, more safety-conscious, and operating under standard and specific protocols, their work will be more efficient and methodical, leading to fewer events of serious patient harm and reduced systemic costs. CSHS expects provider job satisfaction to improve upon receiving increased support and training from the CSHS, and receiving cohesive instructions across the hospital systems.

Starting Point/Baseline:
In the past Spohn had no adherence to definable safety protocols and no robust process for tracking, trending and sharing lessons from serious safety events. Spohn’s safety protocols were not based on any definable model. Training for provider-staff addressed safety issues only tangentially. Spohn’s current rate of SSEs is 7.1 per 10,000 patient days. To date, Spohn has:

• Initiated a contract with HPI
• Obtained an HPI Reliability System Diagnostic Assessment
• Initiated Leadership Training
• Begun working to establish a standardized taxonomy of serious safety events
• Begun working to define serious safety event rate metric

Rationale:
Between CSHS‘s three community facilities, the total number of staffed beds in 2010 was 266, and the total number of inpatient days equaled 42,327, 23% of which were Medicaid inpatient days. At CSHCC, there were 1459 staffed beds and 329,581 inpatient days in 2010, of which 23% were Medicaid inpatient days (RHP Plan, CNA, Table 8). With such high volumes of patients to staffed beds, it is imperative that CSHS staff are trained in standardized safety protocols to prevent errors that can occur when staff are overworked, overwhelmed, or receive limited supervision due to shortages of higher-level providers. This innovative project targets the severity of safety events across all categories of PPCs to identify practices and/or processes that contribute to the most serious of patient safety events.

CSHS‘ primary rationale for transforming the culture into high reliability was to reduce the number of patients who are harmed in the delivery of healthcare services. In order to achieve this primary goal we found it necessary to develop our leadership, improve our analysis of serious safety events in an effort to identify and correct system failures, improve transparency
and incorporate proven safety behaviors and tools. Creating an environment in which patients always receive exactly the care they need and the care is provided in the system that has no inefficiencies or waste.

**Core Requirements:** Spohn will meet the core requirements in the following ways:

a) Provide training/education to clinical/administrative staff on process improvement strategies, methodologies, and culture – CSHS will address this requirement through Milestones 2 and 5.

b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction – CSHS will address this requirement through Milestone 4, by making this part of the dashboard.

c) Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis and dissemination of performance on these measures – CSHS will address this requirement through Milestones 1, 4, and 7.

d) Develop standard workflow process maps, staffing and care coordination models, protocols and documentation to support continuous process improvement – CSHS will address this requirement through a combination of Milestones 1, 2, 4, 7, 8 and 9.

e) Implement software to integrate workflows and provide real-time performance feedback – Spohn will address this requirement through Milestone 4.

f) Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators – CSHS will address this requirement through Milestone 9.

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

- CN.1-Inadequate provision and coordination of health care services for persons with chronic conditions
- CN.12- Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services
- CN.18- High incidence and mortality of sepsis and severe sepsis

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
The hospital “culture of safety” transformation is a new, and much needed, initiative for the Spohn hospital system.

**Related Category 3 Outcome Measure(s):**
OD-4 Potentially Preventable Complications
IT- 4.5 – Patient Fall Rate

Increasing safety in the hospital protocols is expected to result in a comprehensive improvement in potentially preventable complications and hospital acquired conditions. Patient falls can be prevented through improved monitoring, medication management, and coordinated efforts to improve patient safety and work as a team.
**Reasons/rationale for selecting the outcome measures:**
CSHCC chose this outcome because a stated goal behind implementing this project is to improve the safety measures in place within the CSHS, which is intended to have a measurable impact on the rate of potentially preventable complications experienced by hospital patients. PPCs have a negative impact on patient short- and long-term health outcomes, patient satisfaction, and increase the systemic cost of providing care, and therefore are an important area to target for improvement.

**Relationship to Other Projects:**
This project is intended to compliment and correlate with Spohn – Corpus Christi’s other following projects: 121775403.1.4 (Intensivist Program); 121775403.2.10 (Care Transitions Program). This project is also related to initiatives by other Performing Providers in our region to improve care delivery including: 137907508.2.1 – Design, develop, and implement a program of continuous rapid process improvement that will address issues of safety, quality, and efficiency; 094222902.2.3, 020811801.2.1, 136436606.2.3 – Apply process improvement methodology to improve quality/efficiency; 094222902.2.5, 0208118012.4, 136436606.2.4 – Implement one or more pilot interventions in care transitions; 020973601.2.1 – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Christus Spohn – Alice, Christus Spohn – Beeville, Christus Spohn – Kleberg, Corpus Christi Medical Center, Citizens Medical Center, and Driscoll Children’s Hospital. In addition, Spohn-Corpus Christi Nursing Leaders will form partnerships with the Nursing Leadership at the other three Christus Spohn Hospitals (Alice, Beeville, and Kleberg), Texas A&M Corpus Christi, CHRISTUS Health Nursing Leadership, and the American Organization of Nurse Executives (AONE).

**Project Valuation:**
The Waiver provides the opportunity for CHRISTUS Spohn Corpus Christi (“Spohn”) to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.
The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this project based on its systemic scope (all four Spohn facilities will participate), its expected impact on Spohn’s delivery of care to all hospital patients, and its expected impact on the cost of providing care to the indigent and Medicaid patients in the community. The hospital culture of safety project will enable Spohn to create consistent protocols for ensuring that the care provided at its hospital facilities keeps patients safe and maximizes efficiency. This project is imperative to creating a consistent and efficient hospital environment, which will have health, satisfaction, and cost benefits for patients and providers. The investment in the

99 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
project will come in the form of provider education and training to change the hospital staff’s mindset and habits going forward, developing and implementing the best methods for promoting safety, and monitoring the best practices and addressing challenges in accomplishing the use of the interdisciplinary teams.
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<td>121775403.3.19</td>
<td>IT-4.5</td>
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</tbody>
</table>
| **Milestone 1** [P-2] Identify/target metric to measure impact of process methodology and establish timeline (core requirement (d))<br>**Metric 1** [P-2.1]: Performing Provider identification of impact metric and baseline<br>**Baseline/Goal**: CSHS will work with HPI to identify a measure indicative of improved efficiency and safety in care provided to patients, and develop specific protocols to obtain and track this measure in each of Spohn’s six hospital facilities<br>**Data Source**: Performing provider report identifying measure of improvement, and comprehensive plan to address safety/inefficiency issues<br><br>Milestone 1 Estimated Incentive Payment: $1,232,633.66 | Patient Fall Rate<br><br>Milestone 2 [P-8] Train providers/staff in Transformation to HRO [Core requirements (a), (c), (d)]<br>**Metric 1** [P-8.1] Number of providers/staff trained<br>**Baseline/Goal**: 20% of active mid-level/physician providers on staff and 50% of associates at CSHS | Year 2<br>(10/1/2012 – 9/30/2013)<br><br>Milestone 3 [P-9] Develop a quality dashboard that will quantify/trend SSE and its impact on care provided in the organization (Core requirements (b), (c), (e))<br>**Metric 1** [P-10.1] Submission of quality dashboard development, utilization and results<br>**Goal**: Develop and implement an integrated system for measuring adherence to and effectiveness of safety and efficiency protocols<br>**Data Source**: documentation system, reports generated<br><br>Milestone 4 Estimated Incentive Payment: $1,306,547 | Year 3<br>(10/1/2013 – 9/30/2014)<br><br>Milestone 4 [P-10] Develop a quality dashboard that will quantify/trend SSE and its impact on care provided in the organization (Core requirements (b), (c), (e))<br>**Metric 1** [P-10.1] Submission of quality dashboard development, utilization and results<br>**Goal**: Develop and implement an integrated system for measuring adherence to and effectiveness of safety and efficiency protocols<br>**Data Source**: documentation system, reports generated<br><br>Milestone 5 [P-8] Train providers/staff in Culture of Safety Transformation (Core requirement (a))<br>**Metric 1** [P-8.1] Number of providers/staff trained<br>**Baseline/Goal**: Currently, only hospital staff in leadership positions have received training. Spohn’s goal is for 40% of active mid-level/physician providers on staff and 95% of associates at CSHS to be trained in safety/efficiency protocols | Year 4<br>(10/1/2014 – 9/30/2015)<br><br>Milestone 5 Estimated Incentive Payment: $1,303,700 | Year 5<br>(10/1/2015 – 9/30/2016)<br><br>Milestone 6 [P-9] Implement a program to improve efficiencies and/or reduce program variation. (Core requirements (c), (d))<br>**Metric 1** [P-9.1] Number of performance improvement events<br>**Baseline/Goal**: CSHS will implement the following two protocols across the six facilities to promote safety and efficiency: Apparent Cause Analysis (ACA)/Root Cause Analysis (RCA) and Rapid Chain of Command<br>**Data Source**: Documentation of implemented protocols and reports of progress<br><br>Milestone 7 Estimated Incentive Payment: $1,679,256.50 | Year 6<br>(10/1/2016 – 9/30/2017)<br><br>Milestone 7 [P-6] Implement a program to improve efficiencies and/or reduce program variation. (Core requirements (c), (d))<br>**Metric 1** [P-6.1] Number of performance improvement events<br>**Baseline/Goal**: CSHS will implement the following two protocols across the six facilities to promote safety and efficiency: Apparent Cause Analysis (ACA)/Root Cause Analysis (RCA) and Rapid Chain of Command<br>**Data Source**: Documentation of implemented protocols and reports of progress<br><br>Milestone 8 Estimated Incentive Payment: $1,679,256.50 | Year 7<br>(10/1/2017 – 9/30/2018)<br><br>Milestone 8 [I-14] Measure efficiency and/or cost (core requirement (d))<br>**Metric 1** [I-14.1] Measure efficiency and cost savings tied to safety protocols implemented during DY4<br>**Goal**: Currently, Spohn experiences 7.1 Serious Safety Events per 10,000 patient days. Spohn’s goal is to measure improvement in this domain in order to determine the success of the protocols in improving the efficiency, cost, and safety of providing inpatient hospital care. Spohn expects a 35% improvement from baseline by the end of DY5 (4.615/10,000).<br>**Data Source**: EMR, financial reports, risk variance reports, patient safety committee documentation and summary of lessons learned<br><br>Milestone 9 Estimated Incentive Payment: $1,679,256.50 | Year 8<br>(10/1/2018 – 9/30/2019)<br><br>Milestone 9 [I-15] Increase number of process improvement champions<br>**Metric 1** [I-15.1] Number of designated process improvement champions<br>**Goal**: 1 champion in at least 80% of
### 121775403.2.11

**Design, Develop, and Implement a Program of Continuous, Rapid Process Improvement That Will Address Issues of Safety, Quality, and Efficiency: Hospital “Culture of Safety” Transformation**

**CHRISTUS Spohn Hospital Corpus Christi**

**Related Category 3 Outcome Measure(s):** 121775403.3.19

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<tr>
<th>Outcome Measure(s):</th>
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<th>Milestone 2 Estimated Incentive Payment: $1,232,633.66</th>
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<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Patient Fall Rate</td>
<td>trained in safety/efficiency protocols</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Curriculum and/or training schedules and documentation of provider participation</td>
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**Milestone 3** [P-11] Number of trainings conducted by process improvement champions

**Metric 1** [P-11.1]: Trained by the champion trainings

**Baseline/Goal:** CSHS champions will provide 85% of the training sessions

**Data Source:** Training class schedules, instructor assignments, session attendance logs

**Milestone 3 Estimated Incentive Payment:** $1,232,633.66

| Year 3 (10/1/2013 – 9/30/2014) | Patient Fall Rate | improving the efficiency, cost, and safety of providing inpatient hospital care. Spohn expects an improvement of 30% from baseline by the end of DY4 (4.97/10,000).

**Data Source:** EMR, financial reports, risk variance reports, patient safety committee documentation and summary of lessons learned

**Milestone 6 Estimated Incentive Payment:** $1,306,547

| Year 4 (10/1/2014 – 9/30/2015) | Patient Fall Rate | the units among all 6 facilities of the CSHS.

**Data Source:** Training logs, list of champions.

**Milestone 11 Estimated Incentive Payment:** $1,679,256.50

| Year 5 (10/1/2015 – 9/30/2016) | Patient Fall Rate | currently, Spohn experiences 7.1 Serious Safety Event per 10,000 patient days. Spohn’s goal is to measure improvement in this domain in order to determine the success of the protocols in improving the efficiency, cost, and safety of providing inpatient hospital care. Spohn expects a 15% improvement from baseline by the end of DY4 (6.035/10,000).

**Data Source:** EMR, financial reports, risk variance reports, patient safety committee documentation and summary of lessons learned

**Milestone 8 Estimated Incentive Payment:** $1,303,700

| Milestone 9 [P-12] Report findings and learnings (core requirements (d), (f)) |
|----------------------|--------|------------------------------------------------------|
| **Metric 1** [P-12.1] Final report/summary |
| **Goal:** Analyze data concerning the results of the new safety and efficiency protocols, and determine best practices and key challenges, and areas for continued improvement |

**Data Source:** final report

**Milestone 9 Estimated Incentive Payment:** $1,303,700

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**RHP Plan for Region 4**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-4.5</th>
<th>Patient Fall Rate</th>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5):* $14,887,155
Performing Provider: Gonzales Healthcare Systems (Memorial Hospital Home Health Agency)
Project Name: 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs.
Project Identifier: 121785303.2.1

Provider: Gonzales Healthcare Systems (TPI 121785303) is the primary source of medical care for the residents of Gonzales County and is comprised of several entities including Memorial Hospital (a 34-bed acute care facility) and two rural health clinics. In addition, Gonzales Healthcare Systems provides home care services to patients residing in its service area through the Memorial Hospital Home Health Agency (TPI 023701801).

Intervention(s): The purpose of this project is to develop, implement and evaluate a palliative care program that offers supportive care to improve the quality of life of patients living with chronic conditions.

Need for the project: Currently, palliative care is not available for patients in an active disease state. Local primary care physicians manage the symptoms of the disease state but have no additional resources to offer the patient for supportive care. Analysis of hospital and home health agency records of patients who died while in the hospital or on service demonstrated there were 23 patients during the period from July 2011 through December 2012 who could possibly have benefited from palliative care. There are a number of other patients who have experienced one or more admissions in the same time period that are still living that may benefit from this type of care. The goal is for patients with chronic conditions to receive dignified and culturally appropriate supportive care that prioritizes pain control, social and spiritual care, and patient or family preferences. The initiation of a palliative care program will ensure that patients with chronic illnesses who are in pain will receive appropriate clinical assessments, will be able to make their preferences for life-sustaining treatments known, and will be encouraged to discuss their spiritual or religious concerns.

Target population: The target population is chronically ill patients in the Gonzales Healthcare Systems service area. Historically, 55-60% of all patients seen in the Memorial Hospital emergency room are Medicaid recipients or unfunded patients. Therefore a substantial percentage of patients served by this project are expected to be Medicaid eligible or indigent. By DY5, this project is expected to serve approximately 60 patients per year.

Category 1 or 2 expected patient benefits: The number of patients receiving palliative care consults is expected to increase to 10 patients in DY3, 20 patients in DY4, and 30 patients in DY5.

Category 3 outcomes:
- IT-13.1 Our goal is for 80% of palliative care patients who screen positive for pain to receive a clinical assessment within 24 hours by DY5.
- IT-13.2 80% of palliative care patients will have documentation of preferences for life-sustaining treatments by DY5
- IT-13.5 80% of palliative care patients will have a documented discussion of spiritual/religious concerns by DY5
Category 2: Program Innovation and Redesign
2.10 Use of Palliative Care Programs
2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs.

Identifying Project and Provider Information:
PROJECT TITLE – Implement a Palliative Care Program through Memorial Hospital Home Health Agency
RHP UNIQUE IDENTIFICATION NUMBER – 121785303.2.1
PERFORMING PROVIDER – Gonzales Healthcare Systems/121785303 (Memorial Hospital Home Health Agency/023701801)

Project Description:
Develop, implement and evaluate a palliative care program that offers supportive care to improve the quality of life of patients living with chronic conditions.

Project Goal(s): The goal of this project is to establish a palliative care program based in Gonzales County, not just to provide end-of-life care, but to provide assistance to patients suffering from chronic conditions.

Relationship to Regional Goals: RHP4 has set as one of its goals the improvement of access to primary and specialty care, with a focus on individuals with chronic conditions and seeing they receive the most appropriate care for those conditions. We believe palliative care can be the most appropriate care for some patients.

Challenges or Issues: Patients are often unwilling to participate in this type of program because of a lack of understanding and a belief that participation is a sign of “giving up”. This represents a significant challenge from a patient education standpoint. Education efforts will be aimed at gaining understanding that palliative care includes not only end-of-life care, but also pain management, assistance in making decisions regarding treatment, and, if necessary, assistance with making end-of-life decisions.

Five-Year Expected Outcome: Within five years, it is expected the program will be established, personnel hired and policies and procedures developed. Beginning in DY3, palliative care consultations will be conducted for hospitalized patients and at least one patient accepted into the program. The number of consultations is expected to increase by 10% in DY4 and 10% in DY5.

Starting Point/Baseline:
There are currently no programs based in the county that provide palliative care to patients in active treatment.

Rationale:
Reason for Selection: Palliative care has not been accessed for patients in an active disease state within the county. Patients with active treatable diseases are referred out of county to specialists. Local primary care physicians manage the symptoms of the disease state, with no additional resources to offer the patient for supportive care. The goal is for patients with chronic conditions to
receive dignified and culturally appropriate supportive care that prioritizes pain control, social and spiritual care, and patient or family preferences.

**Project Components:** The required core components for this project are as follows:

- Developing a business case for palliative care and conducting planning activities necessary as a precursor to implementing a palliative care program. Terminal care is being addressed somewhat in the community, but we believe care for the chronically ill patient has not been sufficiently addressed. The evaluation to be conducted will include surveys of patients and local physicians. Policies and procedures will be developed and personnel hired to administer the program. Training for existing and new home health care staff will be conducted.

- Transitioning palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility. There are hospice and skilled nursing facility agencies offering some terminal care services in the community. Our plan is to screen inpatients with chronic conditions that may be appropriate for palliative care services and transition them as necessary to a home care-based program.

- Implementing a patient/family experience survey regarding the quality of care, pain and symptom management, an degree of patient/family centeredness in care and improve scores over time. All patients and their families who participate in the palliative care program will be surveyed regarding their experience.

- Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned”, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. Using patient survey results, physician surveys and staff experiences, frequent evaluations will be performed during the initiation phases of this project to ensure project goals are being met.

**Milestones and Metrics:**

- **DY2 –**
  Process Milestone 1: P-5 – Implement/expand a palliative care program
  Metric: P-5.1 – Implement comprehensive palliative care program

- **DY3 –**
  Process Milestone 2: P-6 – Increase the number of palliative care consults
  Metric: P-6.1 – Palliative care consults meet targets established by the program (10 patient consults)

  Improvement Milestone 3: I-10 – Among patients who died in the hospital, increase the proportion of those who received a palliative care consult.
  Metric: I-10.1 – Percent of total in-hospital deaths who had a palliative care consult (5%)

- **DY4 –**
  Process Milestone 4: P-6 – Increase the number of palliative care consults
  Metric: P-6.1 – Palliative care consults meet targets established by the program (20 patient consults)

  Process Milestone 5: I-10 – Among patients who died in the hospital, increase the proportion of those who received a palliative care consult
  Metric: I-10.1 – Percent of total in-hospital deaths who had a palliative care consult (5% increase over DY3)
• **DY5**
  
  Process Milestone 6: **P-6** – Increase the number of palliative care consults
  
  **Metric:** P-6.1 – Palliative care consults meet targets established by the program (30 patient consults)
  
  Process Milestone 7: **I-10** – Among patients who died in the hospital, increase the proportion of those who received a palliative care consult
  
  **Metric:** I-10.1 – Percent of total in-hospital deaths who had a palliative care consult (10% increase over DY4)

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

• **CN.3** – Inadequate provision and coordination of health care services for persons with chronic conditions.

**How the Project Represents a New Initiative or Significantly Enhances and Existing Delivery System Reform Initiative:** There is not a palliative care program available locally. Hospice services for patients with terminal conditions have been available from agencies based outside the county, but not true palliative care.

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

OD-13 Palliative Care, IT-13.1 - Pain assessment, IT-13.2 – Treatment preferences, IT-13.5 – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

**Reasons and Rationale for Selecting the Outcome Measures:** Research has shown that 40-70% of patients with serious incurable illness and who are nearing end of life experience high rates of pain. Research has also shown significant reductions in pharmacy, laboratory and intensive care costs with palliative care that prioritizes pain control, social and spiritual care, and patient/family preferences. The initiation of a palliative care program will ensure that patients with chronic illnesses who are in pain will receive appropriate clinical assessments, will be able to make their preferences for life-sustaining treatments known, and will be encouraged to discuss their spiritual or religious concerns. Monitoring of these outcome measures will ensure this occurs.

**Relationship to other Projects:**

This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. This project will enhance and support other projects within the region dealing with care of patients with chronic conditions including 130958505.1.2, 121775403.1.2, and 094118902.2.1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s
healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center and Christus Spohn.

**Project Valuation:**
In the first year, the services of a partial RN FTE plus administrative costs related to the development of policies and procedures and a business plan are estimated at $60,000. In DY 3, the services of an RN would increase to at least 75 of an FTE. Additional administrative costs and supplies to serve a minimum of 15 patients would result in costs estimated at $70,000. DY4 costs related to the care of an average of 17 patients would place the total at roughly $80,000. In DY5, a transition to at least 20 patients would increase costs to approximately $100,000. The total for the four years would be $310,000. The values for achieving Category 2 goals should be $54,000 in DY2, $63,000 in DY3, $68,000 in DY4 and $67,000 in DY5 for a total of $252,000.
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<tr>
<th>Related Category 3</th>
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<th>Use of Palliative Care Programs</th>
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<td>2.10.1</td>
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Use of Palliative Care Programs

**Related Category 3**

**Outcome Measure(s):**
- 121785303.2.1
- 121785303.3.4
- 121785303.3.5
- 121785303.3.6

**Gonzales Healthcare Systems (Memorial Hospital Home Health Agency)**

**Related Category 3**

**Outcome Measure(s):**
- 121785303.4
- 121785303.5
- 121785303.6

**Pain assessment, treatment preferences, discussion of spiritual/religious concerns**

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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1** – P-5. Implement/expand a palliative care program.

**Metric 1** – P-5.1. Implement comprehensive palliative care program.

- **Baseline/Goal:** Form a multidisciplinary care team with an operational plan.
- **Data Source:** Agency records, HR records.

**Milestone 1** Estimated Incentive Payment: $54,000

**Milestone 2** – P-6. Increase the number of palliative care consults.

**Metric 1** – P-6.1. Palliative care consults meet targets established by the program.

- **Baseline/Goal:** 10 consults.
- **Data Source:** Agency records.

**Milestone 2** Estimated Incentive Payment: $31,500

**Milestone 3** – I-10. Among patients who died in the hospital, increase the proportion who received a palliative care consult.

**Metric 1** – I-10.1 Percent of total in-hospital deaths who had a palliative care consult

- **Baseline/Goal:** To be determined / 5% increase over DY 2 experience.
- **Data Source:** Agency records

**Milestone 3** Estimated Incentive Payment: $31,500

| Year 2 Estimated Milestone Bundle Amount: $54,000 |
| Year 3 Estimated Milestone Bundle Amount: $63,000 |
| Year 4 Estimated Milestone Bundle Amount: $68,000 |
| Year 5 Estimated Milestone Bundle Amount: $67,000 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $252,000
Gonzales Healthcare Systems (Memorial Hospital)

2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents – “Get Healthy Gonzales” program

121785303.2.2 (Pass 2)

**Provider:** Gonzales Healthcare Systems (TPI 121785303) is the primary source of medical care for the residents of Gonzales County and is comprised of several entities including Memorial Hospital (a 34-bed acute care facility), and two rural health clinics.

**Intervention(s):** Working with local entities such as public and private schools, after-school programs, head-start programs, grocery stores, restaurants, and local employers, we will create and implement a program aimed at developing healthy habits, particularly among adolescents, to reduce and prevent obesity.

**Need for the project:** The 2007 National Survey of Children’s Health found that 20.4% of Texas children aged 10 to 17 were obese, compared to 16.4% for all U.S. children. Additionally, focus groups participating in a 2011 Gonzales County Needs Assessment identified high obesity rates as a cause for community concern, saying partnerships to address chronic diseases and related risk factors had not been developed at a significant level in the County. In Gonzales County, the adult obesity rate (BMI >30) is 28.0% and the low-income preschool obesity rate is 18.7%. Currently, there are no other programs of this nature in the community.

**Target population:** The program will target students exiting the sixth grade and entering junior high whose BMI exceeds a certain level which is to be determined. According to representatives of the local public school system, current enrollment is approximately 200 students per grade. If, based on current data, the obesity rate is approximately 15-20%, an estimated 30-40 students per grade could be eligible for the program each year. According to the Center for Public Policy Priorities, approximately 40% of children living in Gonzales County are enrolled in Medicaid. A similar percentage of students enrolled in the obesity prevention program are expected to be Medicaid eligible.

**Category 1 or 2 expected patient benefits:** At least 15 students in DY4 and 25 students in DY5 are expected to be enrolled in the obesity prevention program.

**Category 3 outcomes:** IT-10.1 Quality of Life. Our goal is for quality of life survey scores to increase by 10% in DY4 (over baseline) and 10% in DY5 (over DY4).
Project Title: Create “Get Healthy Gonzales” Program
RHP Identification Number:  121785303.2.2 (Pass 2)
Project Option:  2.7.5 – Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.
Performing Provider:  Gonzales Healthcare Systems (Memorial Hospital) – 121785303

Project Description:
This project represents the goals of a program as outlined in a meeting of stakeholders on November 20, 2012. Working with local entities such as public and private schools, after-school programs, head-start programs, grocery stores, restaurants, and local employers, we would create and implement a program aimed at developing healthy habits, particularly among adolescents, to reduce and prevent obesity (2.7.5). As there is currently no program of this nature in the community, the initial efforts will be aimed at developing an evidence based program.

With assistance from the local school system and the data they have gathered through the state’s Fitnessgram testing, the program would be aimed at students exiting the sixth grade and entering junior high whose BMI exceeds a certain level. The program would include an initial determination of current “quality of life” and then annual re-evaluation to determine how obesity impacts their lives and the anticipated positive impact the program has had on their lives.

Securing survey materials, leaders and trainers, educational materials, and suitable locations as well as developing the structure of the program would likely consume most of the first year. Once the program has been developed, it will be implemented and tested using a core group of students and will be evaluated on a regular basis so that changes in the curriculum and learning materials can be made before implementing the program on a wide-scale basis. At the end of the testing period, the program will be opened to all at-risk students in this age group and continued with those in the initial test group. The intent is to follow students through junior high and high school or until they have reached a healthy weight and exercise level.

Each year the students in the program will participate in a quality of life survey to evaluate baseline levels and whether they have exhibited any improvement. Subsequent years would require reassessment of participants and an increase in participation. According to representatives of the local public school system, current enrollment is approximately 200 students per grade. If, based on current data, the obesity rate is approximately 15-20%, an estimated 30-40 students per grade could be eligible for the program each year.

Project Goal(s): With the initiation of this program, we hope to reduce obesity rates among local children, introduce families to better food and exercise options, and improve the overall health of the community.

Relationship to Regional Goals: The goal of this project is to improve the overall health of the community, reducing the development of chronic conditions, and reducing the need for use of healthcare facilities because of those chronic conditions.

Challenges or Issues: The number of children living in poverty, language and knowledge barriers, cultural preferences, and possible limited parental involvement are all challenges that would need to be addressed. We plan to make the program available through the local school district to try and make it easier for children to be involved. We also intend to use bilingual instructors as much as feasible. In addition, a lack of local facilities and resources may adversely impact success. The
Gonzales Independent School District may have facilities available that can be used. In addition, a local youth program and one or more churches in the community may have facilities that we can use. The program also needs to be geared toward addressing the entire family dynamic—not just the individual child’s involvement. To address this challenge, we plan to hold introductory meetings for entire families and periodic group activities including family members.

**Five-year Expected Outcome:** We expect to see improvements in quality of life outcomes, specifically related to obesity, for students completing the program within the Gonzales Healthcare Systems. Expected outcomes will relate to the project goals described above.

**Starting Point/Baseline:**
There are currently no programs of this nature in the community. The plan is to initiate program development during DY2 and identification of subjects for the target group.

**Rationale:**
Reason for Selection: According to the U.S. Centers for Disease Control and Prevention (CDC), 63.2% of adults in the United States were obese or overweight in 2009. In Texas, this description applies to two-thirds of adults. The 2007 National Survey of children’s Health found that 20.4% of Texas children aged 10 to 17 were obese, compared to 16.4% for all U.S. Children. Focus groups participating in a 2011 Gonzales County Needs Assessment identified high obesity rates as a cause for community concern, saying partnerships to address chronic diseases and related risk factors had not been developed at a significant level in the County. In Gonzales County, the adult obesity rate (BMI >30) is 28.0% and the low-income preschool obesity rate is 18.7%. It is well known that obesity puts children at risk for the development of a number of chronic illnesses, including diabetes, hypertension, joint and muscle conditions, not to mention low self-esteem and depression. While the schools make efforts to provide healthy meal choices and physical education, children spend more of their time outside of school and family influences can have a profound effect on their choices. Helping adolescents and their families with nutrition and exercise education will eventually result in a healthier community.

We propose developing and implementing a program for at-risk children and their families that would address issues including, but not limited to:

- Good nutrition on a budget
- Making healthy choices when not eating at home
- Alternatives to eating to deal with boredom or loneliness
- Fun, inexpensive exercise options
- Preventing eating disorders

**Project Components:** There are no required core components for this project option.

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100 “Gaining Costs, Losing Time – 2011 Special Report: The Obesity Crisis in Texas”, Publication #96-1360, February 2011, Texas Comptroller’s Office

101 2007 National Survey of Children’s Health, National Center for Health Statistics

102 Draft Gonzales Community Needs Assessment.

103 City-Data.com, reviewed November 19, 2012
Milestones and Metrics:

- **DY2**

- **DY3**

- **DY4**
  - Improvement Milestone 4: I-5 – Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric: I-5.1 – At least 15 students enrolled in program and baseline surveys performed.

- **DY5**
  - Improvement Milestone 5: I-5 – Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric: I-5.1 – At least 25 students enrolled in program and baseline surveys performed.

Unique Community Need Identification Number the Project Addresses:

- CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.
- CN.14 – High rates of diabetes, including gestational diabetes.

How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative: Currently, there are no obesity prevention programs targeting children or adolescents and their families in our community. This project represents a new initiative and will provide targeted families with education and resources for reducing obesity and lead to improved quality of life and health outcomes.

Related Category 3 Outcome Measure(s):

- IT-10.1 Quality of Life – Demonstrate improvement in Quality of Life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population.

Reasons and rationale for selecting the outcome measures: The measures chosen represent a way for us to determine if we have been successful with implementation of this program. In the first year we will be developing the project. The goal for the second year is to form a test group and obtain baseline data for participants as well as sharing information on program implementation with all those involved in order to learn from process. In the subsequent years, success will be measured by improvement in the quality of life scores obtained from participants.

Relationship to Other Projects:

Preventing and reducing obesity in children and adolescents will contribute to a reduction in chronic disease and improved long-term health outcomes. This project is related to and will coordinate with projects: 130958505.2.2 - Implement innovative evidence-based strategies to prevent and reduce obesity in children and adolescents; 130958505.2.1 – Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies. Related Category 4
outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi-Nueces County Health District.

Project Valuation:
In DY2, the program development is estimated to cost $41,300 and we have valued meeting our objectives at $39,465. These funds would be used for surveys to determine community interest and baseline quality of life, research and materials for project implementation. In addition, a part-time program coordinator would be necessary to arrange meetings between stakeholders, perform research and write policies and procedures. The costs for DY3 would increase to $49,700 and the valuation for meeting our objectives would be $47,295. In this initial implementation phase, the program coordinator salary would continue. Materials for education of the initial group of participants would be purchased and other supplies such as food for cooking demonstrations, the services of a physical trainer, and meeting space rental would be necessary. In DY4, the first year of full implementation, the costs incurred in DY3 would continue and would increase due to an increase in the number of participants beyond the initial test group. This is expected to cost $53,150 and the estimated valuation for meeting our objectives would be $47,685. DY5 expenditures are expected to be $61,450 and the valuation would be $43,215. The ongoing costs are expected to be at least the same. If the program has been successful, a higher participation rate and subsequent higher costs for materials and supplies is expected. The total costs for the four years would be $205,600 and the total valuation would be $177,660.
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<th><strong>IT-10.1</strong></th>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>Milestone 1 – P-1: Development of innovative evidence-based project for targeted population. Metric 1 – P-1.1: Document innovational strategy and plan.</td>
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<td><strong>Baseline/Goal</strong>: Hiring of program coordinator, development of plan, writing of policies and procedures, identification of initial target group.</td>
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<td><strong>Baseline/Goal</strong>: Introduction of program to community, enrollment and survey of test group of students in program, and initiation of weekly meetings.</td>
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<td><strong>Milestone 3</strong> – P-2: Implement evidence-based innovational project for targeted population. Metric 1 – P-2.1: Document implementation strategy and testing outcomes. Goal: At least 10% improvement over baseline scores in DY3 test group, survey and enrollment of additional students in program. Data Source: Survey results, program records.</td>
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<td><strong>Goal</strong>: At least 15 students enrolled and participating in program.</td>
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<td><strong>Milestone 4</strong> – I-5: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 – I-5.1: Program enrollment Goal: At least 15 students enrolled and participating in program. Data Source: Program records.</td>
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<tr>
<td><strong>Goal</strong>: At least 25 students enrolled and participating in program.</td>
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<td><strong>Data Source</strong>: Program records</td>
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<tr>
<td><strong>Milestone 5 Estimated Incentive Payment</strong>: $43,215</td>
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<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount: $47,685</td>
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td>Year 5 Estimated Milestone Bundle Amount: $43,215</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5)</strong>: $177,660</td>
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Camino Real Community Services
Program Innovation and Redesign: Integrate Primary and Behavioral Health Care Services
121990904.2.1

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

Intervention(s): This project will implement integrated behavioral health and physical health services for clients served in Karnes County.

Need for the project: The service area currently has limited access to behavioral health and physical health care practitioners. Karnes County is designated as a health care professional shortage area and mental health professional shortage area, which has resulted in limited accessibility to needed medical services and requires patients to travel long distances for health care in San Antonio, Texas or to use the local Emergency Department to access behavioral health and medical services when ill. There are no other federal funds that will be utilized for this project.

Target population: The target population includes individuals with behavioral health and co-occurring medical conditions. Approximately 48% of the current behavioral health population is Medicaid eligible and 52% are indigent. Based on historical data, approximately 70% of patients served have behavioral health conditions with co-existing medical conditions such as diabetes.

Category 1 or 2 expected patient benefits: These services are designed to benefit patients by integrating behavioral health services into the physical health setting and integrating physical health care services into the behavioral health setting. Access to the most appropriate integrated, community-based services will enable patients to receive more timely care in the most appropriate setting, will improve access to community-based care and reduce reliance on emergency departments for non-emergency care, alleviate the need to travel long distances for care, and will empower persons to better manage their chronic health conditions and wellness. This project is particularly beneficial for the low-income population we serve due to transportation issues many of them face. We estimate the project will provide integrated services in the local community to at least 25 unique individuals in DY4 and 30 in DY5.

Category 3 outcomes: The Category 3 Outcome Measure selected for the Camino Real Community Services Integrating Primary and Behavioral Health Care Services Project is OD-6 Patient Satisfaction. By providing integrated services locally we expect patients to have increased access to care in a more timely manner and in a more convenient location, which should significantly improve patient satisfaction.
**Project Title:** 2.15.1 Integrate Primary and Behavioral Health Care Services, Design, implement and evaluate projects that provide integrated primary and behavioral health care services

**Unique RHP Project Identification Number:** 121990904.2.1

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

**Project Description:**

This project proposes to integrate psychiatric services into the primary care setting as well as integrate primary care services into the behavioral health setting. Providing adequate health care to people with behavioral health and medical conditions requires a comprehensive, person-centered approach within an integrated, “no wrong door” access and delivery system. Access to the most appropriate integrated and community-based services will empower persons to better manage their health and wellness. The volume this project seeks to serve is 25 adults and youth in DY4 and an additional 30 in DY5 in an integrated Behavioral Health/Primary Care setting in the local home community of the patients.

A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems or high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems. Cardiovascular diseases are also very prevalent among people with mental illness. Psychiatric medications exacerbate the problem because they are associated with obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive timely and appropriate treatment. Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.\(^{104}\)

Medical homes and similar collaborative care approaches have been determined to be beneficial in the treatment of mental illness in a variety of controlled studies.\(^{105}\) Behavioral health problems are often cyclical in nature meaning they over a course of months or years a person may experience periods of time when symptoms are well controlled (or in remission) while at other times symptoms can range from moderate to severe. The concept of an integrated medical home provides supports for individuals who are in any quadrant of the National Council for Community Behavioral Health (NCCBH) Four Quadrant Clinical Integration Model at a given time.

**Goals and Relationship to Regional Goals:**

The goal for this project is to co-locate primary care and behavioral health care services in order to improve integration of care and improve access to needed services. The concept of a medical home that can address the needs of the whole person is increasingly recognized as a key in improving both

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104 Bazelon Center for Mental Health Law (2004), GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders

access to care, continuity of care and improved outcomes. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades.

Challenges and how addressed:
Some of the challenges and issues to overcome in the implementation of this project include the following:

- Cross-training of staff in the primary and behavioral settings
- Electronic Health Records - how to integrate two separate systems
- Physical plant modifications
- Recruitment and retention of health care professionals
- Establishment of protocols to screen for project participants

We will coordinate and provide cross-training on an ongoing basis for our staff in these settings and evaluate the best approach for integrating our systems soliciting staff input and guidance. We will seek guidance from professional associations, stakeholders and human resources to recruit and develop a retention plan for increasing our health care professionals for this area.

5 Year expected outcome:
The first year of the project will focus on assessment of the need/gap analysis, which will lead to planning and implementation of the services in the 2nd and 3rd years. The outcome improvement target expected for the 4th year includes an improvement over the baseline of patient satisfaction for patients getting timely care, appointments, information and integrated services. The outcome improvement target expected for the 5th year includes an improvement over the baseline of patient satisfaction as stated above and improvement for the patient’s rating of the doctor’s access to a specialist. We expect to see at least 20% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise by DY5.

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

Rationale:
According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with Behavioral Health Conditions (24% of the adult population) receive adequate treatment. Patients with Behavioral Health issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses. Behavioral health conditions, also account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs. Camino Real Community Services seeks to improve overall wellness for persons with mental illness by mutually integrating primary care and behavioral health care access for those individuals requiring this level of care. National statistics indicate persons with mental illness die an average of 25 years
earlier than the general population due to poor or inadequate access to primary health care. The counties identified for this project are designated as medically underserved and as healthcare professional shortage areas. There is a high incidence of obesity, diabetes, and chronic health conditions that are exacerbated by the mental illness conditions that challenge compliance with prescribed interventions.

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

**Project Components:**
We propose to meet all of the required project components as follows:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   - Regular consultative meetings between physical health and behavioral health practitioners;
   - Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
   - Shared treatment plans co-developed by both physical health and behavioral health practitioners.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

h) Arrange for utilities and building services for these settings

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

j) Conduct quality improvement for project using methods such as rapid cycle improvement.
Milestones & Metrics:
The following milestones and metrics have been chosen for the Camino Real integrated primary and behavioral health care project based on the core components and the needs of the target population:
- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-4 (P-4.1); P-6 (P-6.1)
- Improvement Milestones and Metrics: I-8 (I-8.1); I-9 (I-9.1); I-12 (I-12.1)

Unique community need identification number the project addresses:
- CN.1 - Inadequate access to primary care
- CN.4 - Inadequate access to behavioral health services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently no integrated medical and behavioral health care models exist in the targeted area that address services for the serious and persistent mental illness (SPMI) population and those requiring primary medical care services, so providing this integrated physical and behavioral health care services model will be a new initiative and provide critical services to this targeted population.

Related Category 3 Outcome Measure(s):
The Category 3 Outcome Measure selected for the Camino Real Community Services Integrating Primary and Behavioral Health Care Services Project is OD-6 Patient Satisfaction. We intend to use the CG-CAHPS survey to measure improvement over the baseline of patient satisfaction scores in the following two areas. Patient surveys will include patient satisfaction for getting timely care, appointments, and information, and patient satisfaction for the patient’s rating of the doctor’s access to a specialist. Obtaining patient feedback on our ability to provide timely care, appointments and information is critical to the success of this project. Patients having access and receiving the appropriate behavioral and primary health care in one integrated setting provides the opportunity for overall patient health and wellness as well as patient satisfaction. We expect the number of individuals receiving and reporting satisfaction in Years 4 and 5, with both physical and behavioral health care at the established locations will show improvement over the baseline and provide us with meaningful and objective information that will be used to determine opportunities for improvement. People living with serious mental illnesses are dying on average 25 years earlier than the rest of the population, in large part due to unmanaged physical health conditions. Many people with both physical and behavioral health illnesses can benefit from immediate attention to conditions as well as prevention efforts, screening tests, routine check-ups, and treatment through an integrated approach.

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

Relationship to other Projects:
Our plans to integrate primary and behavioral health care services will support the region’s goals to improve access to care - including behavioral health care, provide better care coordination, and provide better treatment of chronic conditions. This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and
access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation**

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

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

Addressing physical health and behavioral health conditions in an integrated community setting will greatly decrease utilization of higher cost service environments. Provision of comprehensive psychiatric and primary care services in the local community is not only cost effective but more user friendly and convenient for the person with co-morbid conditions.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td><strong>Milestone 1</strong> P- 1. Conduct needs assessment to determine areas of the state where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs.</td>
<td><strong>Milestone 4</strong> P-6 Develop integrated behavioral health and primary care services within co-located sites. Metric 1 P-6.1 Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). <strong>Baseline/Goal:</strong> To be determined <strong>Data Source:</strong> Project data</td>
<td><strong>Improvement Milestone 5</strong> I-8 Integrated Services Metric 1 I-8.1 individuals receiving both physical and behavioral health care at the established locations. <strong>Goal:</strong> 25 individuals receive both physical and behavioral health care at the established locations <strong>Data Source:</strong> Project data; claims and encounter data; medical records</td>
<td><strong>Improvement Milestone 7</strong> I-9 Coordination of Care Metric 1 I-9.1 20% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise <strong>Goal:</strong> 20% above baseline <strong>Data Source:</strong> Project data; claims and encounter data; medical records</td>
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<tr>
<td><strong>Milestone 2</strong> P- 2 Identify existing clinics or other community-based settings where the co-location of services could be supported. It is expected that physical health practitioners will share space in existing behavioral</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $ 219,258</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $ 110,762</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $ 75,541</td>
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<tr>
<td><strong>Data Source:</strong> Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data</td>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount):</strong> $ 70,058</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $ 110,762</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $ 75,541</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $ 70,058</td>
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<tr>
<td><strong>Milestone 2</strong></td>
<td><strong>Milestone 4</strong> P-6 Develop integrated behavioral health and primary care services within co-located sites. Metric 1 P-6.1 Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). <strong>Baseline/Goal:</strong> To be determined <strong>Data Source:</strong> Project data</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $ 219,258</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $ 75,541</td>
</tr>
<tr>
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<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $ 75,541</td>
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### 121990904.2.1

**2.15.1**

**2.15.1.A-J**

Integrate Primary and Behavioral Health Care Services

**Camino Real Community Services**

<table>
<thead>
<tr>
<th>Related Category 3 Measures:</th>
<th>121990904.3.1</th>
<th>IT-6-1</th>
<th>Patient Satisfaction</th>
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<td><strong>Year 2</strong></td>
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<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
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<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
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<td>Improved Consumer satisfaction with Integrated Services</td>
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Health settings, but it may also be possible to include both in new settings and for physicians to share their office space with behavioral health practitioners.

**Metric 1 P-2.1**

Discussions/interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations

**Baseline/Goal:** To be determined

**Data Source:** Information from persons interviewed.

**Milestone 2 Estimated Incentive Payment (maximum amount):**

$ 70,058

**Milestone 3** P-4 Assess ease of access to potential locations for project implementation

**Metric 1 P-4.1** Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services

**Baseline/Goal:** To be determined

**Data Source:** City/County data,
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<th>Measure Code</th>
<th>Measure Name</th>
<th>Measure Details</th>
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<td>121990904.2.1</td>
<td>Integrate Primary and Behavioral Health Care Services</td>
<td>Camino Real Community Services</td>
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<tr>
<td>121990904.3.1</td>
<td>IT-6-1</td>
<td>Patient Satisfaction</td>
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Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services
Establish/Expand a Patient Care Navigation Program; Patient Navigator for Persons with Chronic Illnesses
Project Identifier: 126844305.2.1

- **Provider:** Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority for Gonzales County in Region 4 as well as for seven other Counties in three other RHP’s located east of and parallel to IH 35 extending north of Austin, Texas. We are responsible for an array of public services and for behavioral health planning and coordination throughout our local service area. We operate a clinic co-located with the local Federally Qualified Health Center (FQHC) and provide the only public behavioral health services in the County.

- **Intervention(s):** BTCS, in collaboration with Gonzales Memorial Hospital and the local FQHC will implement a patient navigation project for frequent users of the ED due to chronic health conditions including behavioral health disorders. 2 RN’s will be located at the Hospital and provide assessment, triage, diversion and referral. Those without PCP’s will be referred to establish ongoing care and a medical home.

- **Need for the project:** Leadership at the Hospital and the Mental Health Task Force for Gonzales County have identified a group of about 50 patients who are frequent users of the ED, defined as more than 5 visits a year. These patients account for a disproportionate cost to the Hospital and the ED. Navigation will reduce the cost and improve overall health and well-being for this group of patients. This project addresses all three of the needs in the RHP 4 Community Needs Assessment plan. It supports: CN.1 “Improve access to care for primary care and specialty services;” CN.2 “Improve the provision and coordination of health care services for persons with chronic conditions;” and CN.3 “Expand access to behavioral health services.”

- **Target population:** The target population is patients who have visited the Gonzales Memorial Hospital ED more than 5 times in a year. BTCS served 770 persons in Gonzales County in FY 2012; 565 persons with mental illnesses. An average of 43% of the adults and 76% of the children with mental illnesses were eligible for Medicaid or CHIP and approximately 25 % of non-Medicaid adults were indigent. We expect about 75 % of the persons benefitting from these services to be Medicaid or CHIP eligible or uninsured.

- **Category 1 or 2 expected patient benefits:** The starting point/baseline for this service in DY 2 is 0 since no such service currently exists in this County. The project seeks to serve 30 people in DY 4 and 50 people in DY 5. Those served will be high utilizers of the ED with multiple visits per year. We plan to intervene at the point of the visit and to assist the individuals in connecting for ongoing care through a medical home, thereby reducing future ED utilization.

- **Category 3 outcomes:** IT-3.1 Our goal is to reduce all cause 30 day readmission rate for these high utilizers by a percentage TBD after baseline is established in DY 3.
Category 2 DSRIP Project Narrative Template

Category: Category 2 – Innovation and Redesign
Project Area and Option: Project Area 9 - Establish/Expand a Patient Care Navigation Program; Project Option 1 – Provide navigation services to targeted patients who are at high risk of disconnect from institutional health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others.)

Title of Project: Patient Navigator for Persons with Chronic Illnesses
RHP Project Identification Number: 126844305.2.1

Performing Provider Name Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Project Description: Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Gonzales County in Region 4 as well as for seven other Counties located east of and parallel to IH 35 extending north of Austin, Texas in Travis County. In that capacity we are responsible for an array of public services as well as for behavioral health planning and coordination throughout our local service area. We operate a clinic co-located with the local FQHC and provide behavioral health services in Gonzales County and we have responsibility to identify gaps in service or barriers to access for persons diagnosed with behavioral health disorders residing in the area.

BTCS proposes to work in collaboration with the Gonzales Health Care System, and specifically with Gonzales Memorial Hospital and local Federally Qualified Health Center (FQHC), Community Health Centers of South Central Texas, within that System, to implement a patient navigation project for persons who are frequent users of the Emergency Department (ED) due to chronic health conditions including behavioral health disorders. We have a good relationship with the hospital, the FQHC and with other health care providers in Gonzales County. BTCS staff frequently assists the hospital with assessment, discharge and continuity of care issues for BTCS patients and therefore are familiar with key staff, facilities and resources. We held planning discussions with the leadership of Gonzales Memorial Hospital and are in agreement that we will locate the navigation program staff within the hospital itself. BTCS is in a long term partnership with the FQHC, Community Health Centers of South Central Texas, which will further enhance this project to ensure accessibility to a medical home. Plans for the project are to hire two RN’s to deliver the navigation services. The RNs will provide patient education, assessment and guidance on follow up care and they will identify community resources and directly link and advocate for the patients.

The goals will be for the patient navigators to provide enhanced social support and culturally competent care to this high risk population. They will help and support the patients as they seek access throughout the continuum of health care. In addition they will ensure timely,
coordinated and site appropriate health care and if needed behavioral health care. The patient navigators will work closely with hospital and emergency department staff to divert non urgent patients to other more appropriate levels of care. This includes connecting patients to primary care providers who can offer a medical home where the patient can benefit from education and disease self-management opportunities. If needed, the navigators will connect patients to mental health and substance abuse services offered in the community.

The challenges BTCS and patients face in this county are documented in the RHP 4 Community Needs Assessment. Also, BTCS has participated as a member of the Gonzales County Mental Health Task Force to identify behavioral health gaps and needs. Health disparity is often driven by income disparity. The data finds 19.8% of adults and 31.8% of children under 18 in Gonzales County below the poverty level. Additionally, 29.3 % of the adults in the County are without insurance or any third party coverage. The entire county has been designated a health care provider shortage area for behavioral health and for primary care according to US Department of HHS, HRSA. Additionally, the RHP 4 needs data shows there are no specialists other than one Ob/Gyn and an Occupational Medicine physician practicing in Gonzales County. An area of concern that the hospital leadership, task force members and BTCS have identified is the repeated ED visits by a group of patients some of whom are BTCS patients and some of whom are not. Anecdotal evidence indicates reasons for the multiple ED visits by this group of patients, ranges from chronic behavioral health issues, mental illnesses and substance use disorders to chronic physical health issues such as asthma, chronic pain, cardiopulmonary disease, etc., but frequently triggered by behavioral health conditions. A large number of visits to the EDs throughout the US are related to anxiety, symptoms of mental illness and/or substance abuse. Poverty and provider shortages coupled with cognitive deficits that are symptoms of mental illnesses, makes finding and accessing care difficult for many in Gonzales County. We believe a special intervention provided by people who are trained in behavioral health assessment and in chronic illness assessment and management is required. The target population is composed of patients identified as having multiple emergency department/hospitalizations over the last year. Most of the patients have chronic health problems often exacerbated by substance abuse and mental illness. They tend to have poor compliance with treatment recommendations, often lack a medical home and have few natural community supports such as friends and family.

This project will address this problem by providing the opportunity for a person-centered intervention to connect the individuals to services at the point that they need them the most, i.e., at the point they are seeking emergency care. We expect to use community resources to fill unmet social needs such as housing, transportation, income, food and medication. For those who are in need of behavioral health services either as a short term stabilization strategy or for long-term, we will connect patients to BTCS or to primary care practitioners who can support behavioral health treatment. We plan to provide transportation to make access to healthcare as smooth as possible. This approach is aimed at resolving the multiple issues that lead to repeated visits to the ED. Our goal is to do all we can to ensure connection to aftercare and follow up rather than quick treatment and release from the ED with instructions for aftercare but no community support.
This project advances the regional goal of integrating primary and behavioral health care. It also addresses the triple aim of CMS with respect to improved patient care including access and health outcomes. It also advances CMS aim of cost reduction by addressing ED use by these high utilizers. It addresses the Regional goal to improve access to comprehensive behavioral health services and access for all.

Over the next five years we expect the outcomes of this project to be the continued development robust alternatives to ED care and improve the performing provider and the healthcare system in the region. We expect the patients who receive navigation services to reduce utilization of EDs and reduce preventable readmissions as a result. These outcomes are directly achievable due to the goals and interventions described above.

Starting Point/Baseline: Since this program has not been established, we will use the remainder of DY 2 to identify the target population and establish the baseline. Our plan is that the baseline will be calculated on three months of emergency department admissions at Gonzales Memorial Hospital. We do not have current data to identify those from Gonzales County who are accessing ED services and at what frequency, but an important first step in this project will be to explore some other means of gathering and tracking that data. Since BTCS has not provided this service we expect to spend most of DY 2 in planning and gathering data.

Rationale: In Category 2 – Innovation and Redesign; we selected Project Area 9 “Establish/Expand a Patient Care Navigation Program”; Project Option 1 – “Provide navigation services to targeted patients who are at high risk of disconnect from institutional health care(for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others.)” We selected this Project Area and Option because it describes the goal and intent of our project, which is to establish a patient navigation program for persons with multiple chronic conditions including cognitive impairments and who are frequent visitors to the ED. Since this is a wholly new program for Gonzales County we expect to follow and carry out each of the required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

c) Connect patients to primary and preventive care.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
As described earlier we will spend most of DY 2 identifying frequent ED users. We plan to use RN’s who can address the needs of this population. We are in partnership with the FQHC and co-locate behavioral health services with primary care services at a single site in Gonzales. Finally, our QM department is charged with responsibility for managing a rapid cycle improvement process for this project, similar to that we are using currently with other projects at BTCS.

The Process Milestones we selected for DY2 and DY3 support these core components and are:
P-1. Milestone: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program;
P-2. Milestone: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education; and
P-3. Milestone: Provide care management/navigation services to targeted patients.
The Metrics we are using include: development of program policies and procedures, hiring staff and medical record evidence that we are providing care to this population.

We selected Implementation Milestones for DYs 4 and 5:

The project seeks to serve 30 people in DY 4 and 50 people in DY 5. Those served will be high utilizers of the ED with multiple visits per year. We plan to intervene at the point of the visit and to assist the individuals in connecting for ongoing care through a medical home, thereby reducing future ED utilization. We selected Improvement Milestones ‘Number of patient interventions’ and Metric, ‘Number served in the target population’ in order to demonstrate quantifiable patient impact. The number of high utilizers served who receive navigation services will reduce potentially preventable readmissions and improve lives by linkage to primary care.

This project addresses all three of the needs in the RHP 4 Community Needs Assessment plan. It supports: CN.1 “Improve access of care for primary care and specialty services;” CN.2 “Improve the provision and coordination of health care services for persons with chronic conditions;” and CN.3 “Expand access to behavioral health services.”

BTCS has been engaged in planning for a number of years with the local FQHC, Community Health Centers of South Central Texas, to build and establish a clinic site that integrates behavioral health care and primary care in Gonzales County. This navigation project is enhanced by that delivery system reform. During 2012, BTCS and our partner FQHC planned for and were awarded a federal grant through the Health Resources and Services Administration (HRSA) Division of the US Department of HHS to develop a primary care/behavioral health care clinic site in a county adjacent to Gonzales County, in Seguin. These federal funds will not be used to support the patient navigation program in Gonzales County. The needed integration is already in place in Gonzales County where we do plan to provide options for care and a medical home.
Related Category 3 Outcome Measure(s): The Category 3 Outcome Measure that we selected is “OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs IT-3.1 All cause 30 day readmission rate- NQF 1789.” This is a stand-alone measure. We selected this measure because the goal of this project is to help people who have multiple visits to EDs and we believe in many cases that have resulted in admission and readmission to hospital. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the program. Over the four years of the project we expect to dramatically reduce the number of ED visits for the target population and the associated inpatient admissions. These reductions will occur by improved chronic disease management, linkage to a primary care provider and medical home. The RN will be hired and trained to deliver culturally and linguistically appropriate services to the target population. Patients will be diverted from EDs/hospitals and linked with primary care providers who can offer a medical home. Navigators will also link patients to social support programs and behavioral health programs where a need is identified. It is expected that utilization of programs such as self-management support, patient education, improved patient provider communication and coordination with community resources will lead to increased patient engagement in maintaining their health. This outcome supports RHP 4 goals to improve health for low-income populations and link to a medical home.

Relationship to other Projects: In RHP 4 BTCS has one project but also a complementary project in an adjacent county in RHP 6 to establish a new treatment site for outpatient substance abuse care. The navigation project will be able to refer to services offered through the substance abuse clinic and thereby initiate much needed treatment and reduce returns to the ED. This is project fills a gap in services that the patient navigators will need for referral and care. This projects focus on improving patient access to care, educating and assisting patients in the use of appropriate health care settings and will enhance the following regional projects: 1309585-05.1.1 – Expand Primary care capacity using community health workers; and 138305109.2.1 – Dual Diagnosis Crisis stabilization project. Related Category 4 measures include potentially preventable admissions measures in RD-1, and patient satisfaction in RD-4.

Learning Collaboratives: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers that we will collaborate with who have similar projects include Gonzales Health Care System and Gulf Bend Center. We believe it is important to improving and adjusting the care provided.

Project Valuation: The project seeks to serve 30 people in DY 4 and 50 people in DY 5. Those served will be high utilizers of the ED with multiple visits per year. We plan to intervene at the point of the visit and to assist the individuals in connecting for ongoing care through a medical home, thereby reducing future ED utilization. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both
of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled ‘Valuing Transformation Projects,’ has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.
126844305.2.1  2.9.1  2.9.1 a-e)  PATIENT NAVIGATOR FOR PERSONS WITH CHRONIC ILLNESSES

Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services  126844305

**Related Category 3**

**Outcome Measure(s):**

| IT – 3.1 | 126844305.3.1 | Potentially Preventable Re-Admissions -30 day Readmission Rates (PPRs) All cause 30 day readmission rate- NQF 1789 |

### Year 2

![Date: 10/1/2012 – 9/30/2013]

**Milestone 1 P-1:** Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.

**Metric 1 P1.1:** Provide report identifying the following:
- Patient characteristics; Service gaps;
- Triage and referral; Number of patients; Number of staff; Program location.

**Baseline/Goal:** N/A/Produce a comprehensive report documenting all points above.

**Data Source:** Program documentation, EHR, claims, needs assessment Survey

**Milestone 1 Estimated Incentive Payment (maximum amount):** $272,935

### Year 3

![Date: 10/1/2013 – 9/30/2014]

**Milestone 2 P-2:** Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

**Metric 1 P2.1:** Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.

**Baseline/Goal:** At the beginning of DY 2 patient navigators did not exist therefore, baseline for all is 0.

**Goals:** Develop the training program with procedures and continuing education. Deploy 2 navigators, RN’s.

**Data Source:** Workforce development plan for patient navigator recruitment, training and education

**Milestone 2 Estimated Incentive Payment:** $149,859

### Year 4

![Date: 10/1/2014 – 9/30/2015]

**Milestone 3 P-3:** Provide navigation services to targeted patients.

**Milestone 4 [I-X]:** Number of patient interventions.

**Metric 1 [I-X.1]:** Number of patient in target population served by this patient navigation service.

**Baseline/Goal:** Baseline – Baseline 0 for DY 2 since no such service currently exists in the RHP; Goal - Serve 30 people in DY4 who are high utilizers of ED services.

**Data Source:** EHR and ED records

**Milestone 4 Estimated Incentive Payment:** $320,627

### Year 5

![Date: 10/1/2015 – 9/30/2016]

**Milestone 5 [I-X]:** Number of patient interventions.

**Metric 1 [I-X.1]:** Number of patient in target population served by this patient navigation service.

**Baseline/Goal:** Baseline – Baseline 0 for DY 2 since no such service currently exists in the RHP; Goal - Serve 50 people in DY5 who are high utilizers of ED services.

**Data Source:** EHR and ED records

**Milestone 5 Estimated Incentive Payment:** $309,785
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**Related Category 3 Outcome Measure(s):**

IT – 3.1 126844305.3.1 Potentially Preventable Re-Admissions -30 day Readmission Rates (PPRs) All cause 30 day readmission rate- NQF 1789

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<th>Metric 1 P3.1: Increase in the number or percent of targeted patients enrolled in the program</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>Baseline/Goal: TBD Data Source: Enrollment reports</td>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $272,935</td>
<td>Year 3 Estimated Milestone Bundle Amount: $299,717</td>
<td>Year 4 Estimated Milestone Bundle Amount: $320,627</td>
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<tr>
<td>Milestone 3 Estimated Incentive Payment: $149,858</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:**

(add milestone bundle amounts over Years 2-5): $1,203,064
**Project Title:** 2.6.3 Implement an innovative and evidence-based health promotion program; Engage community health workers in an evidenced-based program to increase health literacy of a targeted population

**Unique RHP Project Identification Number:** 130958505.2.1

**Performing Provider/TPI:** Nueces County Public Health District /130958505

**Summary Information:**

- **Provider:** The Corpus Christi-Nueces County Public Health District (CCNCPHD) has oversight of public health initiatives, prevention and intervention for the City of Corpus Christi and surrounding communities within the borders of Nueces County (Population 343,281).

- **Intervention:** Create Diabetes Care Teams consisting of both Certified Diabetes Educators (CDEs) and Community Health Workers (CHWs) working through community Diabetes Self-Management Education/Support (DSME/S) programs to improve health outcomes via high quality DSME/S and care coordination in a high risk population.

- **Need for the project:** Over 12,000 high risk diabetes patients in Nueces County face barriers to preventive medical care and care coordination which can best be addressed by combining the knowledge and skills of CDEs and CHWs providing education and coordination of care. There are no DSME/S programs in Nueces County that have a Diabetes Care Team consisting of both a CDE and CHW. Existing programs have either a CDE, CHW, or neither. There is no other federal funding being received for this project.

- **Target population:** The target population is ~2,000 diabetes patients who are uninsured or underinsured and not covered by the Nueces County indigent health plan (Nueces Aid) who receive their health care from the Community Health Centers, Public Health Clinics, and hospital emergency departments. These patients will receive enhanced diabetes self-management education and coordination of care and access to medical care and support services.

- **Category 1 or 2 expected patient benefits:** This project seeks to implement and test the innovative Diabetes Care Team model (CDE plus CHW) with 15% of the target population of 2000 patients with diabetes receiving care from a Diabetes Care Team in DY4. There will be an increase of 20% over DY4 by end of DY5 resulting in improved DSME/S and coordination of care leading to better patient care and improved clinical outcomes for approximately 660 patients with diabetes.

- **Category 3 outcomes:** It is our goal to decrease the number of patients in the target population who have poor glucose control (HbA1c > 9.0%) by 10% over baseline by end of DY5.
**Project Title:** 2.6.3 Implement an innovative and evidence-based health promotion program; Engage community health workers in an evidenced-based program to increase health literacy of a targeted population

**Unique RHP Project Identification Number:** 130958505.2.1

**Performing Provider/TPI:** Corpus Christi-Nueces County Public Health District/130958505

**Project Description:**
There is a gap between healthcare in the clinical setting with that which exists in the community and public health environments. Although services have long existed in both sectors, there has been a disconnect between actions taken in the physician’s office or hospital setting and the reality for patients adhering to what has been suggested and/or prescribed due to social and economic barriers. A seamless continuum of care between clinical, public and community health translates into better patient care and improved clinical outcomes. The Corpus Christi-Nueces County Public Health District (CCNCPHD) will take the lead for community/public health and create an infrastructure for diabetes prevention and care that will allow for better access to services and a safety net for vulnerable people who have or are at risk for diabetes.

The CCNCPHD will join the strengths of a Certified Diabetes Educator (CDE) with that of a Community Health Worker (CHW), hence, creating a Diabetes Care Team. When considering the seven (7) self-care behaviors essential for diabetes management as stated by the American Association of Diabetes Educators (AADE) that include healthy eating, being active, monitoring, taking medications, problem solving, healthy coping and reducing risks, a team approach better ensures that education, treatment recommendations and action plans to change behavior will be delivered in a way that respects the culture, literacy level and economic status of the patient. This project seeks to bridge current gaps by strategically pairing a CDE with a CHW at each point of access to these community based diabetes prevention and control programs.

**Goals and Relationship to Regional Goals:**
Our goal is to create Diabetes Care Teams (CDEs and CHWs) to inform and educate patients about disease prevention and treatment to promote improved health outcomes with a reduction in diabetes related complications. Individualized interventions and coordinated care plans will further support our region’s goals to improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions.

**Challenges and how addressed:**
Patients seek services at the Nueces County clinics operated by the CCNCPHD. The patients served at these facilities experience several barriers to accessing health care services and adhering to treatment plans, including but not limited to: high rates of poverty, lack of health insurance, low educational levels, and cultural and linguistic barriers to care. These factors when unaddressed can lead to patients not having regular access to primary health care services and specialists, using the emergency room for chronic care management, and poor health outcomes as a result of untreated or uncontrolled diabetes. This project will provide...
greater care coordination, communication between health care providers, and resources to decrease these barriers.

**5 Year Expected Outcome:**
Through the successful implementation of this program, we anticipate patients will receive more timely care, improved care coordination for diabetes related services, and better education in how to control and manage the condition. We anticipate an improvement in the number of people with high glycohemoglobin A1c levels, as measured by our category 3 outcome measure.

**Starting Point/Baseline:** The baseline for this project will be the number of CDE’s and CHW’s existing within community based Diabetes Care Team DSME and DSMS programs. Baseline data will be collected from the newly implemented EMRs and HIE (Project 1.3.1). Baseline 2011 data from the Federally Qualified Health Center in Corpus Christi indicates 45% of diabetes patients have an A1C ≥ two times a year (67.5% for Texas), 29% of diabetes patients have an A1C > 9.0 (17% for J.O. Wyatt Clinic, Clinic for Amarillo Hospital District Patients that implemented Diabetes Management Team in 2002), 40% of diabetes patients have an A1C < 7.0% (56% for J.O. Wyatt Clinic).

**Rationale:**
The prevalence of diabetes in Nueces County is 13.6%, higher than both the state of Texas (9.1%) and the nation (8.7%). Worse yet, the mortality rate from diabetes in Nueces County is 52 deaths per 100,000 population compared to only 28 deaths per 100,000 population for the state overall. This large disparity in diabetes mortality between the county and the state is likely caused by several factors, such as: high rates of uninsured and underinsured patients, lack of access to health care services, and poor coordination among health care providers. The diabetes education program sites serve a primarily low-income, uninsured, and medically underserved population within Nueces County. Patients served at these sites experience several barriers to accessing health care services and adhering to treatment plans, including but not limited to: high rates of poverty, lack of health insurance, low educational levels, and cultural and linguistic barriers to care. These factors when unaddressed can lead to patients not having regular access to primary health care services and specialists, using the emergency room for chronic care management, and poor health outcomes as a result of untreated or

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108 Responding to the Epidemic: Strategies for Improving Diabetes Care in Texas. Texas Health Institute November 2010
uncontrolled diabetes. The need for greater care coordination, communication between health care providers, and resources to decrease these barriers is clear.

Expert consensus supports the need for specialized diabetes and educational training beyond academic preparation for the primary instructors on the diabetes team. Certification as a diabetes educator by the National Certification Board for Diabetes Educators (NCBDE) is one way a health professional can demonstrate mastery of a specific body of knowledge, and this certification has become an accepted credential in the diabetes community. CDE’s are traditionally trained as registered nurses and dietitians; however, it is becoming more common to see other licensed health care professionals take on the role as a CDE.

A Community Health Worker is a member of a community who serves as a liaison between health-care providers and patients who have traditionally lacked access to good health care. Community health workers are also sometimes referred to as community health-care advocates, lay health educators, community health outreach workers and, in Spanish, promotores de salud. CHW’s assist patients in overcoming barriers to managing health concerns by offering education, psychosocial support and navigation to community resources to improve the patient’s circumstances in and out of the medical setting. In Texas, CHW’s can achieve a State certification based on completion of a credentialed training program or consideration of prior work. CHW’s have been recognized as being effective educators and advocates in diabetes self-management with measurable clinical outcomes in lowering HbA1c’s when promoting blood glucose control, healthy eating and increased physical activity111.

By combining the efforts of these two (2) disciplines, a patient-centered, holistic model of care is created. This approach serves as a risk-reduction program to ensure at-risk diabetes patients will receive proactive, ongoing care that keeps them healthy and empowers them to self-manage their conditions in order to avoid worsening health and needing emergency or inpatient care. Studies have shown that the more patients and their families are informed and educated about disease prevention and treatment, the more adherent they are with their treatment plan resulting in improved health outcomes with a reduction in diabetes related complications112113.

This Diabetes Care Team will offer education and services to support the diverse cultures, learning and literacy levels, and social barriers that are represented in the diabetes patient community. The tools and mechanisms for this patient support will be innovative in the sense that it is not a one size fits all but unique and creative individualized intervention for each patient.

Milestones & Metrics:
The following milestones and metrics have been chosen for the innovative and evidence-based health promotion program based project component and the needs of the target population:
Process Milestones and Metrics: P-2 (P-2.1); P-3 (P-3.1)
Improvement Milestones and Metrics: I-6 (I-6.1)

Unique community need identification number the project addresses:
- CN.1 - Improve access to care for primary care and specialty services
- CN.2 - Improve the provision and coordination of health care services for persons with chronic conditions.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project enhances our diabetes education and treatment programs by providing a team with complementary skills which currently does not exist in any of our programs and provides the best opportunity for our patients to receive the care they require in a more effective and cost efficient way.

Related Category 3 Outcome Measure(s): The related Category 3 outcome measure is IT-1.10, Diabetes care: HbA1c poor control (>9.0%). The introduction of a comprehensive, coordinated approach to managing patients with diabetes should contribute to improvement in glucose control and thereby a reduction in HbA1c values indicating improving care and self-management for patients with the chronic condition of diabetes.

Relationship to other Projects: This project is supported and related to other CCNCPHD projects, including 1309585-05.1.1 Enhancement of primary care capacity, and 130958505.2.2, Implementation of the MEND Community Based Obesity Prevention program to reduce and prevent obesity in children and adolescents. The CDE/CHW Diabetes Care Team complements the expansion of primary care services by adding to the network of support in the clinical setting. The project also facilitates a smooth transition for patients moving from one healthcare setting to another ensuring that existing barriers are resolved. Integral to the success of the CHWs and CDEs in contributing to chronic disease management as part of the primary care team and medical home is the project regarding implementing and utilizing disease management registry functionality. These project elements will benefit and support other projects in our region, including 121775403.2.3 – Cost of Care Delivery: Primary Care Redesign; 1217775403.2.4 – Implement evidence-based health promotion program for diabetes; and 0208811801.1.3 – Implementation of a chronic disease registry.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our
Region’s healthcare system. Other providers with similar projects include Christus Spohn and DeTar Healthcare System.

**Project Valuation:**
Nueces County has a population of 343,281 with 26% uninsured (89,253)\(^8\), with 13.6% of the population having diabetes, this calculates to 12,138 people who have diabetes but no health insurance, many who do not qualify for Nueces Aid (county indigent health care). These patients along with the underinsured receive their health care in community-based health centers and hospital emergency departments (ED). This patient population often seeks medical care at the Amistad Federally Qualified Health Center, Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces County operated by the CCNCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, and has ~2,000 diabetes patients in its system.

This project aims to engage these diabetes patients in a Diabetes Care Team consisting of a CDE and CHW engaging the patients in standard of care DSME and DSMS and coordinating care to meet clinical practice recommendations, addressing RHP 4 Priority Community Needs. CN.1 Improve access to care for primary care and specialty services and CN.2 Improve the provision and coordination of health care services for persons with chronic conditions. A Diabetes Care Team in a medical home model with chronic disease management has been demonstrated to improve clinical outcomes, decrease ED visits, and decrease cost of care in Amarillo, Texas.\(^{114}\)

Implementation of a similar model in Nueces County via this project plus Project 2.6.2 and Project 1.3.1 could potentially avoid $2,500 in medical costs per patient per year for ~2,000 patients as occurred at the J.O. Wyatt Clinic in Amarillo by 2011. This would translate to $5,000,000 in cost avoidance per year via decreased ED visits, decreased hospitalizations, and decreased hospital costs for those admitted, as demonstrated in the medical literature\(^{115}116117118119120121122123124\). Long term health care costs would be greatly decreased.

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\(^{114}\) J.O. Wyatt Clinic. Report to Texas Diabetes Council Outcomes Subcommittee, Austin, Texas, August 9, 2012.
Improved clinical outcomes, specifically A1C levels, decrease complications such as retinopathy, nephropathy, and neuropathy by ~40%. Considering the cost of End Stage Renal Disease is $71,233 per year, $356,165 would be saved by delaying ESRD five years in a single diabetes patient. The lifetime medical cost of this complication for one individual typically exceeds $1.5 million. Nueces County had 150 hospital admissions in 2010 for lower-extremity amputation with a risk-adjusted admission rate of 58.70 per 100,000 population; which was significantly higher than the state average rate based on 95 percent confidence interval. Delaying complications in 2,000 diabetes patients just one year would save $56,986,400. Delaying complications in 2,000 diabetes patients five years would save $284,932,000. At this same rate and in consideration of this project, delaying complications in 660 diabetes patients one year would save $18,805,512. Delaying complications in this target population five years would save $94,027,560.

Individuals and the community benefit from healthier people in improved quality of life and productivity. Lost productivity due to diabetes in Nueces County was estimated to be $154,300,000 in 2006. On average, people with diabetes miss 1.9 more workdays per year than people without diabetes. Decreased absenteeism for 2,000 people with diabetes would save employers $304,000 per year.

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127 Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File, 2010.
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<td><strong>P-2:</strong> Development of evidence-based project for targeted population based on distilling the needs assessment and determining priority of interventions for the community</td>
<td><strong>P-3:</strong> Implement, document and test an evidence-based innovative project for targeted population</td>
<td><strong>I-6:</strong> Identify 300 of patients in defined population receiving innovative intervention consistent with evidence-based model</td>
<td><strong>I-6:</strong> Identify 360 of patients in defined population receiving innovative intervention consistent with evidence-based model</td>
</tr>
<tr>
<td><strong>Metric 1[P-2.1]:</strong> Document innovative strategy and plan</td>
<td><strong>Metric 1[P-3.1]:</strong> Document implementation strategy and testing outcomes</td>
<td><strong>Metric 1[I-6.1]</strong> Enroll 300 individuals representative of the target population in the innovative intervention. Baseline/Goal: Zero patients/300 patients</td>
<td><strong>Metric 1[I-6.1]</strong> Enroll 360 individuals representative of the target population in the innovative intervention. Baseline/Goal: 300 patients/660 patients</td>
</tr>
<tr>
<td>Goal: Complete project planning and needs assessment</td>
<td>Goal: Complete implementation strategy and testing of project</td>
<td>Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider</td>
<td>Milestone 4 Estimated Incentive Payment: $646,162</td>
</tr>
<tr>
<td>Data Source: Performing Provider evidence of innovative plan</td>
<td>Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider</td>
<td>Milestone 3 Estimated Incentive Payment: $746,162</td>
<td>Milestone 4 Estimated Incentive Payment: $646,162</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $579,389</td>
<td>Milestone 2 Estimated Incentive Payment: $629,653</td>
<td>Milestone 3 Estimated Incentive Payment: $746,162</td>
<td>Milestone 4 Estimated Incentive Payment: $646,162</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $579,389</td>
<td>Year 3 Estimated Milestone Bundle Amount: $629,653</td>
<td>Year 4 Estimated Milestone Bundle Amount: $746,162</td>
<td>Year 5 Estimated Milestone Bundle Amount: $646,162</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $2,601,366
**Project Title:** 2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.

**Unique RHP Project Identification Number:** 130958505.2.2

**Performing Provider/TPI:** Corpus Christi - Nueces County Public Health District/130958505

Program Summary Information:

- **Provider:** The Corpus Christi-Nueces County Public Health District has oversight of public health initiatives, prevention and intervention for the City of Corpus Christi and surrounding communities within the borders of Nueces County (Population 343,281).

- **Intervention(s):** This project will address the obesity epidemic among children in our county by applying an internationally recognized and scientifically sound method for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits.

- **Need for the project:** Texas Department of State Health Services estimates that approximately 70 percent of adults in Public Health Region 11 are overweight and 35 percent are obese. In addition to being tied to diabetes, obesity also increases the risk for certain types of cancer, heart disease, stroke, arthritis and other diseases. Nueces County has a 13.6% diabetes rate in a population of 343,281. While there are many causes for diabetes, it has been established that 90 percent of obesity can be prevented. Rather than developing a program that addresses adult obesity, we have chosen to aggressively prevent and reduce childhood obesity.

- **Target population:** The target population is medically eligible Medicaid/CHIP recipients ages 2-5, ages 7-13 and their caregivers. As of 2010, notably, in Nueces County, 37.4% of children were enrolled in Medicaid and 36.2% of Nueces County children received benefits through the Supplemental Nutrition Assistance Program (SNAP). Both of these rates are higher than that of the State of Texas.\(^\text{130}\)

- **Category 1 or 2 expected patient benefits:**
  - Improve the effectiveness of obesity prevention and care among Nueces County residents who are medically underserved,
  - Increase program participants’ knowledge of healthy eating and lifestyle habits, and
  - Improve patient and community health.

  By DY4, 3,064 children in the Medicaid eligible population will complete the 10 week Mend program. In DY5 that number will increase by 676 to a total of 3,755 of the eligible population, who will complete the program.

- **Category 3 outcomes:** Have 40% of the program participants in DY 5 achieve a reduction in the zBMI score at the completion of the program by DY 5.

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**Project Title:** 2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.

**Unique RHP Project Identification Number:** 130958505.2.2

**Performing Provider/TPI:** Corpus Christi - Nueces County Public Health District/130958505

**Project Description:**
The MEND Community Based Obesity Prevention Program will address the obesity epidemic by applying a nationally recognized and scientifically sound method for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits.

For the intervention in Nueces County, we will use one of the most thoroughly researched and proven obesity prevention programs in the world: MEND (Mind, Exercise, Nutrition ... Do It!). MEND was developed in the United Kingdom in 2001 and has since then been delivered and evaluated in Europe, Australia, Canada and the United States. In Texas, MEND is currently being delivered in Austin, Dallas and Houston, where it is the focus of a large randomized control trial (RCT) study funded by a US Childhood Obesity Research Demonstration Project (CORD) grant from the U.S. Centers for Disease Control and Prevention (CDC). The Texas research team includes senior faculty from the University of Texas Health Science Center at Austin, and the U.S. Department of Agriculture/Agricultural Research Service and the Children’s Nutrition Research Center at Baylor College of Medicine in the Texas Medical Center.

MEND’s evidence base, clinical rigor and academic links are significant differentiators in a healthcare marketplace that demands measurable outcomes and clinical effectiveness. In the area of community-based child weight management, MEND is the only organization with a completed successful RCT showing efficacy on a wide range of health and psychosocial outcomes. Evaluation of over 10,000 children in the UK and 1,660 in the US has demonstrated similar effectiveness when the program was delivered at scale by leaders from diverse backgrounds and varied settings. This replicability is highly unusual.

The RCT results demonstrated that children who attended the MEND 7-13 program, compared to controls, had a statistically significantly reduced waist circumference, zBMI score and increased their cardiovascular fitness, physical activity levels and self-esteem at 3 and 6 months. Half the children were then followed up at 12 months where the majority of outcomes were either improved or sustained.

The evaluation of the US children concluded that:
- Physical activity increased by 5 hours per week
- Screen time and sedentary activity decreased by 3.5 hours per week
- Cardiovascular fitness was improved (recovery heart rate after a step test: -5.1 beats per minute)
- Body image and self-esteem improved (measured using validated questionnaires)
- Dietary behaviors and nutritional intake improved
- All results are highly statistically significant

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132 Ibid.
133 Ibid.
Evaluated against the U.S. Preventive Services Task Force’s recommendations for healthy lifestyles for children, MEND proved to be highly successful:

Criteria Before MEND / After MEND
Participation in the recommended 60 minutes of physical activity per day: 53% / 83%
Sedentary for more than 2 hours per day: 24% / 10%
Children were having sugar sweetened beverages a few times per day: 13% / 2%
Children rarely consumed sugar sweetened beverages: 26% / 47%
Children were eating 4-5 fruits and vegetables per day: 9% / 24%
Children were eating less than two fruits and vegetables per day: 33% / 12%

Implementation in Nueces County
The Corpus Christi - Nueces County Public Health District (CCNCPHD) will implement the MEND program in close collaboration with the Coastal Bend Diabetes Community Coalition which has a long track record for promoting and nurturing diabetes prevention and self-management programs in the community. Another partner will be a statewide non-profit, Population Health Institute of Texas that will assist with the launch and evaluation.

The program will focus on two age groups: ages 2-5 and ages 7-13 and their parents.
MEND 2-5 is a healthy lifestyle program for children aged 2 to 5 and their parents.
It involves a 90-minute session once a week for ten weeks. MEND 2-5 is adapted for use in the US and is being launched in select communities in the US in 2012. MEND 2-4 is currently running in Alberta, Canada.

MEND 7-13 is a healthy lifestyle program for 7 to 13 year olds who are above a healthy weight and their parents. Meetings are held twice a week for ten weeks and involve nutrition education for the family, parenting support strategies and fun, group exercise for kids to support and promote an active, healthy lifestyle. It is available currently in seven US states and in Alberta, Canada.

Goals and Relationship to Regional Goals:
The project goals include increased patient self-esteem and motivation, increased physical activity and healthy eating and decrease in weight and overall body mass index all in support of a healthier lifestyle avoiding medical complications and/or the onset of chronic conditions. This project also supports the overall regional goals of providing preventative care and education as well as increased awareness and access to appropriate levels of care in the right settings.

Challenges and how addressed:
Some of the challenges will include community education and consistent participation with both children and their parents required to be involved with the program.
The programs will focus on the communities in Nueces County with the highest need: with consideration of the neighborhoods around Roy Miller High School in Corpus Christi. In the planning, the program team will visit with all the potential partners for the delivery of the program, including, but not limited to Driscoll Children’s Hospital, daycare centers, elementary
schools, middle schools, places of worship, YMCA and the community based organizations who are already participating in the diabetes self-management programs.

The participants will be referred to the program by their health care providers, school professionals or self-referred via community promotions. Medical matters that arise in the course of the program will be referred to the appropriate primary care team. If patients and providers mutually consent blood pressure, cholesterol and blood sugar control measures will be tracked.

After Year 1 being spent on planning, the project will launch in Q3 of 2013 with training of the health educators followed the roll out in Q4 with 110 children and 110 parents. These numbers will gradually increase to 405 children and 405 parents in the last quarter of the funding period.

The total impact:
Total MEND 7-13 programs: 180
Total MEND 2-5 programs: 180
Families served by MEND programs: 3,755
Direct beneficiaries (1 caregiver per child): 7,510
Total family beneficiaries: 15,020

5 year expected outcomes:
By implementing this internationally recognized and evidence based program in Nueces County, we expect to:

- Improve the effectiveness of obesity prevention and care among Nueces County residents who are medically underserved
- Increase program participants’ knowledge of healthy eating and lifestyle habits
- Improve patient and community health

Starting Point / Baseline:
Participants will be evaluated at baseline, at 10 weeks program completion, 3 months, 6 months and 12 months against three domains:

- Patient-centered: Self-Esteem Score
- Behaviors: physical activity, healthy eating
- Biometrics: abdominal circumference, Zone Body Mass Index (zBMI)\(^{134}\), Recovery Heart Rate

Rationale:
Texas Department of State Health Services estimates\(^{135}\) that approximately 70 percent of adults in Public Health Region 11 are overweight and 35 percent are obese. In addition to being tied to diabetes, obesity also increases the risk for certain types of cancer, heart disease, stroke, arthritis and other diseases.

\(^{134}\) zBMI = Age- and sex-standardized BMI
\(^{135}\) Texas Department of State Health Services. Behavioral Risk Factor Surveillance Survey. 2011
Nueces County has a 13.6% diabetes rate in a population of 343,281\textsuperscript{136}. While there are many causes for diabetes, it has been established that 90 percent of obesity can be prevented. Rather than developing a program that addresses adult obesity, we have chosen to aggressively prevent and reduce childhood obesity.

Addressing obesity among participants in the Medicaid program is particularly relevant. A 2006 study by Thompson Medstat reviewed Medicaid claims data from 2004 and found that\textsuperscript{137}:

- Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
- Children treated for obesity are roughly three times more expensive for the health system than the average insured child.
- Annual healthcare costs are about $6,700 for children treated for obesity covered by Medicaid and about $3,700 for obese children with private insurance.
- The national cost of childhood obesity is estimated at approximately $11 billion for children with private insurance and $3 billion for those with Medicaid.
- Children diagnosed with obesity are two to three times more likely to be hospitalized.
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
- Children treated for obesity are far more likely to be diagnosed with mental health disorders or bone and joint disorders than non-obese children.

**Project Components:** This project has no required core components.

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the MEND Community Based Obesity Prevention Program based on the core components and the needs of the target population:

- Process Milestones and Metrics: \textit{P-X} (P-X.1); \textit{P-2} (P-2.1)
- Improvement Milestones and Metrics: \textit{I-5} (I-5.1)

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

- CN.3 - Inadequate provision and coordination of health care services for persons with chronic conditions.
  - CN. 12 - Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services


How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative for this region as currently in Texas, MEND is only being delivered in Austin, Dallas and Houston.

Related Category 3 Outcome Measure(s) and Rationale for selecting:
The related Category 3 outcome measure is IT-1.20 Other Outcome Improvement Target: Zone Body Mass Index (zBMI), the most appropriate metric for investigating impact of obesity intervention programs targeting children according to The Cochrane Collaboration\textsuperscript{138}.

Relationship to other Projects:
This project is supported by the other projects, in particular the diabetes related projects: 130958505.1.1 - Expand Primary Care Capacity which will provide care coordination for patient education and support as an effective means to chronic disease self-management emphasizing diabetes self-management education (DSME) and diabetes self-management support (DSMS) in a Diabetes Care Team model. 130958505.2.1 - Implement an innovative and evidence-based health promotion program; Engage community health workers in an evidenced-based program to increase health literacy of a targeted population which will create an infrastructure for diabetes prevention and care that will allow for better access to services and a safety net for vulnerable people who have or are at risk for diabetes.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects include Christus Spohn and Driscoll Children’s Hospital.

Project Valuation:
Nueces County has a population of 37,060 individuals under the age of 19 enrolled in Medicaid\textsuperscript{139}. If we conservatively estimate that approximately 45 percent of these children and adolescents are overweight and 25 percent are obese, then we end up with large target population of 16,677 and 9,265 respectively.

The program will enroll 4,694 children and it is expected that 80 percent or 3,755 of them will complete the 10 week program of two classes per week.


If 50 percent of this group keep their zBMI below 30 or reduce it below 30, then the potential annual savings in costs in medical care and drugs would amount to $4,284\textsuperscript{140} per child or $8,043,638 potential annual savings.

Excluded from this valuation are the lifetime savings from a MEND program participant avoiding or postponing the onset of obesity in adulthood. Furthermore, there would also be potential benefits from the 6,834 parents or caregivers who will join their children or adolescents at the training classes. While many of them will change their lifestyles towards improved eating habits and increased exercise, we do not have data to estimate the “spill-over effect” to parents and other family members (another parent, siblings) who do not participate in the program.

Estimated local funding for this project is $7,401,720

Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Other Outcome Improvement Target: Zone Body Mass Index (zBMI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nueces County Public Health District</td>
<td>130958505.2.2</td>
<td>IT-1.20</td>
</tr>
</tbody>
</table>

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

**Milestone 1:** P-X Project planning - complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign

**Metric 1 P-X.1** Engage stakeholders, identify resources and potential partnership and develop intervention plan – Document innovative strategy and plan

**Baseline/Goal:** Engage stakeholders, identify resources and potential partnership and develop intervention plan – Document innovative strategy and plan

**Data Source:** Performing Provider evidence of innovative plan

**Milestone 2:** P-2 Implement, document and test an evidence-based innovative project for targeted population

**Metric 1 P-2.1** Document implementation strategy and testing outcomes

**Baseline/Goal:** 5 sites will run MEND programs

**Data Source:** Performing Provider contract or other documentation of implementation TBD by Performing Provider

**Milestone 2 Estimated Incentive Payment:** $2,000,000

**Milestone 3:** I-5: Identify 3,064 eligible patients in defined population receiving innovative intervention consistent with evidence-based model. **Metric 1 I-5.1** TBD by Performing Provider based on metric described above

**Baseline/Goal:** 0 children in the program/3,064 children in the Medicaid eligible population complete the 10 week MEND program.

**Data Source:** Participant records

**Milestone 3 Estimated Incentive Payment:** $2,000,000

**Milestone 4:** I-5 Identify 3,755 of eligible patients in defined population receiving innovative intervention consistent with evidence-based model. **Metric 1 I-5.1** TBD by Performing Provider based on metric described above

**Goal:** 3,755 children in the Medicaid eligible population complete the 10 week MEND program.

**Data Source:** Participant records

**Milestone 4 Estimated Incentive Payment:** $901,720

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $2,500,000

**Year 3 Estimated Milestone Bundle Amount:** $2,000,000

**Year 4 Estimated Milestone Bundle Amount:** $2,000,000

**Year 5 Estimated Milestone Bundle Amount:** $901,720

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $7,401,720
Driscoll Children’s Hospital  
TPI: 132812205  
2.7.1– Implement Evidence-based Disease Prevention Programs  
Unique ID: 132812205.2.1

- **Provider**: Driscoll Children’s Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s)**: A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby’s heart.

- **Need for the project**: A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5%-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States.

- **Target population**: MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. This project does not overlap with RHP5 project ID 132812205.2.2 or RHP 20 132812205.2.1 because each of these projects serves a distinct and unique patient population that is specific to that region.

- **Category 1 or 2 expected patient benefits**: By the end of Year 5, the project will accomplish the following goals:
  - Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an additional 850 patient procedures; 7 percent in DY4 for an additional 1190 patient procedures; 10 percent in DY5 for an additional 1700 procedures
  - Expand MFM clinics and outreach program facility hours by 2 percent in DY 3 for an additional 98 hours; by 4 percent in DY4 for an additional 196 hours; and 6 percent in DY5 for an additional 294 hours

- **Category 3 outcomes**: IT-8.9 Our goal is to Increase the number of detected related fetal anomalies in high-risk pregnant patients.
**Project Option 2.7.1 – Implement Evidence-based Disease Prevention Programs**

**Unique Project ID:** 132812205.2.1  
**Performing Provider Name/TPI:** Driscoll Children’s Hospital/132812205

**Project Description:**  
**Implement Evidence-based Disease Prevention Programs**

Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. All of these expectant mothers can benefit from the care of a maternal-fetal medicine specialist. MFM specialists receive two to three years of additional training after an OB/GYN residency that focuses on high-risk pregnancies, ultrasound techniques and fetal anomalies.

A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pregestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects result in the most costly hospital admissions for birth defects in the United States. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby’s heart.

This team approach in prenatal diagnosis allows for better pregnancy counseling and improved neonatal outcomes. Driscoll Health System will coordinate this initiative with local Maternal-Fetal Medicine specialists, Pediatric Cardiologists, managed care organizations, and community collaborators. Driscoll Health System will form a Disease Prevention Task Force and will hold quality
improvement meetings twice a year to review. The task force will be multidisciplinary in composition and will assess progress on Maternal Fetal Medicine project milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Disease Prevention Project.

**Project Goals and Challenges:**
Since it was established, the MFM outreach program has proven highly successful in the early detection of fetal anomalies in patients with high risk pregnancies. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region. The challenges with this project are the patient compliance of provider care instructions and the availability of timely access to care.

**By the end of Year 5, the project will accomplish the following goals:**

- Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an increase of 850 procedures; 7 percent in DY4 for an increase of 1190 procedures; and 10 percent in DY5 for an additional 1700 procedures.
- Expand MFM clinics and outreach program facility hours by 2 percent in DY3 for an additional 98 hours; 4 percent in DY4 for 196 additional hours; and 6 percent in DY5 for an additional 294 hours.
- Increase the number of detected related fetal anomalies in high-risk pregnant patients

This project advances RHP 4 goals and community needs assessment by expanding access to early detection program for fetal anomalies in patients with high-risk pregnancies. The 2010 Coastal Bend community needs assessment indicated preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. The preterm birth rate for Texas is 13.3%, which is slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

<table>
<thead>
<tr>
<th>Metropolitan Statistical Area</th>
<th>% Preterm</th>
<th>State Average</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownsville- Harlingen</td>
<td>15.4</td>
<td>13.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Corpus Christi</td>
<td>14.9</td>
<td>13.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Laredo</td>
<td>13.8</td>
<td>13.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Victoria</td>
<td>14.0</td>
<td>13.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**
The MFM clinics and outreach program facilities in Driscoll’s service area for baseline measurement will begin at approximately 4,900 hours of operation in CY 2011. The MFM echocardiogram program
in Driscoll’s service area for baseline measurement will begin at approximately 17,000 completed procedures in CY 2011.

**Rationale:**
Low-income pregnant women are at higher risk for pre-term births for a variety of known as well as unknown reasons. Expectant mothers and their unborn babies who are at high risk for certain health problems such as heart disease, high blood pressure, diabetes or other endocrine disorders, kidney or gastrointestinal disease, infectious diseases and maternal immune disorders should seek maternal-fetal medicine specialists. Healthy women whose pregnancy is at high risk for complications includes abnormal maternal serum screening, twins, triplets or more, advanced maternal age, recurrent pregnancy loss and more. Every year, Driscoll’s Transport Team transfers more than 840 neonatal and pediatric patients to or from Driscoll’s Children’s Hospital to receive the highest standard of care in the region. Maternal-fetal medicine specialists offer a wide range of care including a variety of therapies and programs that make sure that any high-risk baby in South Texas will have the best chances of living a healthy, normal life. This initiative will improve access to Maternal and Fetal Medicine care programs for Medicaid recipients. We are not currently able to provide all types of services to the entire diabetic population, which are considered high risk patients. This shortfall in services has created a demand for services that we are currently unable to meet. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

This project does not overlap with RHP5 project ID 132812205.2.2 or RHP 20 132812205.2.1 because each of these projects serves a distinct and unique patient population that is specific to that region.

**Unique community need identification numbers the project addresses:**
Consistent with RHP 4’s community need assessment, this project addresses CN.11 (High rates of poor birth outcomes and low birth-weight babies), CN.12 (Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services), and CN.13 (Insufficient access to services for pregnant women, particularly low income women).

**Related Category 3 Outcome Measure(s):** OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies

**Reasons/rationale for selecting the outcome measures:**
The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. Increased access to MFM clinics/outreach programs will provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Fetal anomalies are defined as any conditions that are not normal anatomical structure or function. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as
well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

**Relationship to other Projects:**
Implement Evidence-based Disease Promotion Programs supports 2.6-Implement Evidence-based Health Prevention Programs through early intervention with high-risk pregnant patients. This project is related to and will support other regional projects including but not limited to Expanding Primary Care Capacity Projects 020973601.1.1, and 020973601.1.2; and 130958505.2.1, Implement an innovative and evidence-based health promotion program using community health workers and certified diabetes educators. Unique Project 132812205.2.1-Implement Evidence-based Disease Promotion Programs supports RHP5 Unique Project 132812205.2.2-Implement Evidence-based Disease Promotion Programs though does not create any overlap within the financial valuation. Related Category 4 outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate include Christus Spohn, Corpus Christi Medical Center, and Corpus Christi-Nueces County Public Health District.

**Project Valuation:**
The quantitative value is based in part on a determination that the NICU is a high cost service. By expanding the number of patients served by the MFM echocardiogram, we will decrease the number of patients who need NICU services, and will reduce the average length of stay (ALOS) for a NICU patient. Through expanding the availability of these services, our project will improve both the short and long-term health outcomes of the patients served, reducing future health care costs. Increasing the hours and use of a MFM clinic/outreach program and increasing the number of Maternal Fetal echocardiogram procedures will create significant savings and value and will support a more efficient use of resources as future costs savings attributed to this program may be used to fund other critical health care services.

Driscoll provides MFM services to the community for multiple reasons, one of which is to help reduce ALOS for NICU patients. Since the beginning of the MFM program, ALOS for a NICU patient has decreased significantly, resulting in reductions of NICU payment dollars between FY2010 and FY2012.

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Pediatric Cardiologists working in
collaboration with the Maternal Fetal Medicine program give Perinatalists adjunctive support in diagnosing congenital heart disease, aiding in management of arrhythmias and congestive heart failure from various causes. Additionally, it allows for detailed counseling using the expertise of a Pediatric Cardiologist.

Maternal fetal echocardiogram programs provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. In addition, having an established prenatal diagnosis allows for plans to be set for delivery in facility with a level three neonatal service. Based on the change in NICU ALOS between Calendar 2010 and 2012 plus the Calendar 2012 NICU admissions, we estimate a total saving and value to the state of approximately $7.5 million per year for this proposed project. Based on these reasons and value of project to the region, the maximum DSRIP funding to be allocated to this project is $18,250,000 (inclusive of Categories 3 and 4).
**Unique Identifier:** 132812205.2.1  
**RHP PP Reference Number:** 2.7.1  
**Project Components:** N/A  
**Implement Evidence-based Disease Prevention Programs**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 3 Outcome Measure(s):**  
132812205.3.5  
IT-8.9  

- **Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1 [P-X]:** Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing Driscoll’s Maternal Fetal Medicine (MFM) Program.  
**Metric 1 [P-X.1]:** Documentation of Task Force establishment  
**Data Source:** Hospital/health plan record  
**Milestone 2: Estimated Incentive Payment (maximum amount):** $1,700,000

**Milestone 2 [P-1]:** Develop plan/strategy to expand the Maternal Fetal Medicine Program in Driscoll service area  
**Metric 2 [P-1.1]:** Document innovative strategy and plan  
**Data Source:** Hospital health plan record  
**Milestone 2: Hospital health plan record**  
**Milestone 2: Estimated Incentive Payment (maximum amount):** $1,700,000

**Milestone 3 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 3a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 3b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record  
**Milestone 3: Estimated Incentive Payment (maximum amount):** $1,200,000

**Milestone 4 [I-7]:** Increase access to MFM program  
**Metric 4 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 5 percent above CY 2011 baseline for an additional 850 procedures above baseline.  
**Data Source:** Hospital/health plan record  
**Milestone 4: Estimated Incentive Payment (maximum amount):** $1,200,000

**Milestone 5 [I-7]:** Increase access to MFM program  
**Metric 5 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 7 percent above CY 2011 baseline for an additional 1190 procedures above baseline.  
**Data Source:** Hospital/health plan record  
**Milestone 5: Estimated Incentive Payment (maximum amount):** $1,187,500

**Milestone 6 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 6a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 6b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record  
**Milestone 6: Estimated Incentive Payment (maximum amount):** $1,187,500

**Milestone 7 [I-7]:** Increase access to MFM program  
**Metric 7 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 10 percent above the CY 2011 baseline for an additional 1700 procedures above baseline.  
**Data Source:** Hospital/health plan record  
**Milestone 7: Estimated Incentive Payment (maximum amount):** $1,187,500

**Milestone 8 [P-X1]:** Increase hours

**Milestone 9 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 9a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 9b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record  
**Milestone 9: Estimated Incentive Payment (maximum amount):** $950,000

**Milestone 10 [I-7]:** Increase access to MFM program  
**Metric 10 [I-7.2]:** Increase number of MFM echocardiogram procedures by 10 percent above the CY 2011 baseline for an additional 1700 procedures above baseline.  
**Data Source:** Hospital/health plan record  
**Milestone 10: Estimated Incentive Payment (maximum amount):** $950,000

**Milestone 11 [P-X1]:** Increase hours
**Unique Identifier:** 132812205.2.1  
**RHP PP Reference Number:** 2.7.1  
**Project Components:** N/A  
**Implement Evidence-based Disease Prevention Programs**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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

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<th>Year 4</th>
<th>Year 5</th>
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- **Milestone 5 [P-X1]:** Increase hours of accessibility of MFM clinics/outreach program
- **Metric 5 [P-X1.1]:** Increase MFM clinic/outreach program hours by 2% above baseline for an additional 98 hours  
**Data Source:** Hospital/health plan record

- **Milestone 5:** Estimated Incentive Payment *(maximum amount):*$1,200,000

- **Metric 8 [P-X1.1]:** Increase of MFM clinics/outreach program hours by 4% above baseline for an additional 196 hours  
**Data Source:** Hospital/health plan record

- **Milestone 8 Estimated Incentive Payment *(maximum amount):*$1,187,500

- **Metric 11 [P-X1.1]:** Increase of MFM clinics/outreach program hours by 6% above baseline for an additional 294 hours  
**Data Source:** Hospital/health plan record

- **Milestone 11:** Estimated Incentive Payment *(maximum amount):*$950,000

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $3,400,000

**Year 3 Estimated Milestone Bundle Amount:** $3,600,000

**Year 4 Estimated Milestone Bundle Amount:** $3,562,500

**Year 5 Estimated Milestone Bundle Amount:** $2,850,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $13,412,500
Driscoll Children’s Hospital  
TPI: 132812205  
2.6.2 – Implement Evidence-based Health Promotion Programs  
132812205.2.2

- **Provider**: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s)**: The goal of this project is to educate and provide support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery.

- **Need for the project**: Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU). Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care.

- **Target population**: This project will increase community participation and education through these services targeted to serve low-income populations.

- **Category 1 or 2 expected patient benefits**: By the end of Year 5, Driscoll plans to:
  - Expand prenatal educational sessions by 5% in DY 2, serving an additional 20 patients; by 10% in DY3, serving an additional 40 patients; by 15% in DY 4, serving an additional 60 patients; by 20 percent in DY 5, serving an additional 80 patients.
  - Expand consultation visits by 5% in DY2 for an additional 100 patient consults; by 10% in DY3 for an additional 200 patient consults; by 15% in DY4 for an additional 300 patient consults; by 20 percent in DY5 for an additional 400 patient consults
  - Expand Cadena Health plan participants by 5% in DY3 for an additional 65 participants; by 8% in DY3 for an additional 104 participants; by10% in DY4 for an additional 130 participants; by 12% in DY5 for an additional 156 patients

- **Category 3 outcomes**: Our goal is to reduce the Neonatal ICU Average Length of Stay for the targeted population, TPI 2.6– Implement Evidence-based Health Promotion Programs.
Project Option: 2.6.2 – Implement Evidence-based Health Promotion Programs

Unique Project ID: 132812205.2.2
Performing Provider Name/TPI: Driscoll Children’s Hospital/132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital -- the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

In collaboration with Driscoll Health Plan, Driscoll Hospital plans to expand a highly successful prenatal program that promotes healthy behavior and provides supports to low-income women with high-risk pregnancies. The program, called Cadena de Madres Project (Mother’s network), seeks to reduce low birth weight and premature deliveries in targeted Texas counties by providing enhanced educational and social support for indigent, predominately Hispanic, women considered to be high risk for adverse birth outcomes. The Project focuses on improving maternity social and healthcare supports available to indigent women during pregnancy. The overall goal of the program is to reduce prematurity and thereby reduce admissions and days in the neonatal intensive care unit (NICU).

The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery. The baby showers focus on encouraging prenatal care, improving nutrition, promoting breast feeding, avoiding dangerous behaviors, and recognizing the signs and symptoms of premature labor. Pregnant women enrolled in Driscoll Children’s Health Plan are mailed an invitation each month of their pregnancy. After attending our baby shower sessions the participant will be educated on how to distinguish healthy choices during their pregnancy and recognize the negative impact of smoking, alcohol, and drugs can have on their health and comprehend the advantages of prenatal care and understand the complications that may occur during their pregnancy. Educational baby showers also recognize signs of preterm labor, and pre labor signs, and understand when medical intervention is needed.
Nutritional advice can be reinforced or further advice can be sought from the dietitian, particularly for those with diabetes or gestational diabetes which comprise 13 percent of the population.

The consultation visits encourage postpartum care of the mother, timely infant care, successful breastfeeding, and good nutrition for the mother and the infant, consideration of family planning to gain appropriate birth spacing, and re-enrollment for continuing medical insurance coverage. The consult visitor can also teach important infant safety points like “back to sleep”, the importance of proper car seat use, the appropriate use of the medical office and the emergency room for medical issues. Convincing a mother to breast feed promotes further bonding to the new infant. This can be aided by having consultations with a certified lactation consultant. Breast fed infants have less visits to the physician for medical illness than those that bottle feed. Most mothers will consider delaying the next pregnancy until they wean the current infant.

This team approach in prenatal and postnatal care allows for better pregnancy counseling and improved neonatal outcomes. Driscoll will coordinate this initiative with local maternal-fetal medicine specialists, managed care organizations, and community collaborators. To further enhance the project, Driscoll Health System will form a Health Promotion Task Force and will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Health Promotion milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Health Promotion Task Force.

**Project Goals and Challenges:**
The goal of this project is to reduce preterm births by educating and providing support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The increased consults, Cadena participants and educational sessions may include one or all of the different program locations.

**By the end of Year 5, Driscoll plans to:**
- Expand prenatal educational sessions by 5% in DY 2, serving an additional 20 patients; by 10% in DY3, serving an additional 40 patients; by 15% in DY 4, serving an additional 60 patients; by 20 percent in DY 5, serving an additional 80 patients.
- Expand consultation visits by 5% in DY2 for an additional 100 patient consults; by 10% in DY3 for an additional 200 patient consults; by 15% in DY4 for an additional 300 patient consults; by 20 percent in DY5 for an additional 400 patient consults Reduce NICU days per delivery
- Expand Cadena Healthplan participants by 5% in DY3 for an additional 65 participants; by 8% in DY3 for an additional 104 participants; by 10% in DY4 for an additional 130 participants; by 12% in DY5 for an additional 156 patients

This project advances RHP 4 goals and community needs assessment by expanding access to prenatal education and consultations to support low-income pregnant women deliver healthy babies and reduced need for neonatal intensive care services. The 2010 Coastal Bend community needs
assessment indicated Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. For the U.S. in 2008, 12.3% of all births were preterm. Preterm births declined from 2006 to 2008 for mothers of all age groups under age 40, for the largest race and Hispanic origin groups and for most U.S. states including Texas. The preterm birth rate for Texas, however, is 13.3%, slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

%Preterm (<37 weeks gestation) - Texas 2012

<table>
<thead>
<tr>
<th>Metropolitan Statistical Area</th>
<th>% Preterm</th>
<th>State Average</th>
<th>Percent Higher</th>
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</thead>
<tbody>
<tr>
<td>Brownsville- Harlingen</td>
<td>15.4</td>
<td>13.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Corpus Christi</td>
<td>14.9</td>
<td>13.2</td>
<td>1.7</td>
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<tr>
<td>Laredo</td>
<td>13.8</td>
<td>13.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Victoria</td>
<td>14.0</td>
<td>13.2</td>
<td>0.8</td>
</tr>
</tbody>
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Starting Point/Baseline:
During calendar year 2011, Driscoll provided over 400 prenatal educational sessions, 1,300 Cadena Healthplan participants and over 2,000 educational consult visits to high risk pregnant women.

Rationale:
Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This initiative will expand health education to high risk pregnant Medicaid patients as well as provide counseling and education on tobacco and alcohol use for pregnant women. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

Consistent with RHP 4’s community need assessment, this project addresses CN.11 (High rates of poor birth outcomes and low birth-weight babies), CN.12 (Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services), and CN.13 (Insufficient access to services for pregnant women, particularly low income women).

Related Category 3 Outcome Measure(s): OD-8 Perinatal Outcome: IT-8.9
Reduce the Neonatal ICU days per delivery for the targeted population, TPI 2.6—Implement Evidence-based Health Promotion Programs.

Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in pre-term births with a resultant decrease in NICU days are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy
pregnancies, deliveries, and infant care. This project will increase community participation and education through these services targeted to serve low-income populations.

**Relationship to other Projects:**
Implement Evidence-based Health Promotion Programs supports TPI 2.7-Implement Evidence-based Disease Prevention Programs through early intervention with high-risk pregnant patients. This project is related to and will support other regional projects including but not limited to Expanding Primary Care Capacity Projects 020973601.1.1, and 020973601.1.2; and 130958505.2.1, Implement an innovative and evidence based health promotion program using community health workers and certified diabetes educators. Related Category 4 outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Although no providers have projects that duplicate our plan, other providers with projects with similar components whom we will collaborate include Christus Spohn, Corpus Christi Medical Center, and Corpus Christi-Nueces County Public Health District.

**Project Valuation:**
The quantitative value is based on a determination that Neonatal ICU (NICU) use is a high cost service. Decreasing the number of premature infant admissions less than 37 weeks with a resultant decrease in NICU days per delivery is a more efficient use of resources. Expanding health education to high risk pregnant patients as well as increasing the number of provided counseling sessions on tobacco and alcohol use for pregnant women will create significant savings and value.

Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients.

Based on the decreasing number of premature infant admissions less than 37 weeks and the decrease in NICU days per delivery, we estimated a total saving and value to the state of approximately $5.5 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DSRIP funding to be allocated to this project is $15,740,479 (inclusive of Categories 3 and 4).
**Unique Identifier:**  132812205.2.2  
**RHP PP Reference Number:**  2.6.2  
**Project Components:**  N/A  
**Implement evidenced-based health promotion program: Expand Cadena de Madres program**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:**  132812205

**Related Category 3 Outcome Measure(s):**  
- 132812205.3.6  
- IT-8.9  
Reduce the Neonatal ICU Average Length of Stay for the targeted population

<table>
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<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1 [P-X]:** Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing the Cadena de Madres Program. **Metric 1 [P-X.1]:** Documentation of Task Force establishment  
**Data Source:** Hospital/health plan record  
**Goal:** Appoint Task Force  
**Milestone 1:** Estimated Incentive Payment (maximum amount): $510,000 | **Milestone 6 [P-X2]:** Task Force leads quality improvement initiative for Cadena de Madres program  
**Metric 6a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 6b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program  
**Data Source:** Hospital/health plan record  
**Goal:** Complete report on QI findings  
**Milestone 6:** Estimated Incentive Payment (maximum amount): $800,075 | **Milestone 10 [P-X2]:** Task Force leads quality improvement initiative for Cadena de Madres program  
**Metric 10a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 10b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program  
**Data Source:** Hospital/health plan record  
**Goal:** Complete report on QI findings  
**Milestone 10:** Estimated Incentive Payment (maximum amount): $796,875 | **Milestone 14 [P-X2]:** Task Force leads quality improvement initiative for Cadena de Madres program  
**Metric 14a [P-X2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 14b [P-X2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program  
**Data Source:** Hospital/health plan record  
**Milestone 14:** Estimated Incentive Payment (maximum amount): $641,250 |
| **Milestone 2 [P-X1]:** Develop plan to expand Cadena de Madres program to women with high risk pregnancies  
**Metric 2 [P-X1.1]:** Evidence of plan  
**Goal:** Complete development of plan  
**Data Source:** Hospital/health plan record  
**Milestone 2:** Estimated Incentive Payment (maximum amount): $510,000 | **Milestone 7 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 7 [I.X.1]:** Increase number of prenatal education sessions for target population  
**Goal:** Increase number of sessions by | **Milestone 11 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 11 [I.X.1]:** Increase number of prenatal education sessions for target population by 20 percent above CY 11 baseline for an additional 80 sessions.  
**Goal:** Increase number of sessions by | **Milestone 15 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 15 [I.X.1]:** Increase number of prenatal education sessions for target population by 20 percent above CY 11 baseline for an additional 80 sessions.  
**Data Source:** Hospital/health plan record |
| **Milestone 3 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 3 [I.X.1]:** Increase number of prenatal education sessions for target population  
**Goal:** Increase number of sessions by | **Milestone 6 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 6 [I.X.1]:** Increase number of prenatal education sessions for target population by 10 percent above CY 11 baseline for an additional 40 sessions.  
**Goal:** Increase number of sessions by | **Milestone 10 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 10 [I.X.1]:** Increase number of prenatal education sessions for target population by 15 percent above CY 11 baseline for an additional 60 sessions.  
**Goal:** Increase number of sessions by | **Milestone 14 [I.X]:** Increase access to prenatal education sessions for target population  
**Metric 14 [I.X.1]:** Increase number of prenatal education sessions for target population by 20 percent above CY 11 baseline for an additional 80 sessions.  
**Data Source:** Hospital/health plan record |
**Related Category 3**

**Outcome Measure(s):**

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<th>Year 5</th>
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- **Prenatal education sessions for target population by 5 percent above CY 11 baseline for an additional 20 patient sessions.**
  - **Goal:** Increase number of sessions provided
  - **Data Source:** Hospital/health plan record
  - **Milestone 3:** Increase access to prenatal education consults for target population
  - **Metric 4:** Increase number of prenatal education consults above baseline for target population by 5 percent above CY 11 baseline for an additional 100 consultations
  - **Goal:** Increase number of consultations by 5%
  - **Data Source:** Hospital/health plan record

- **Milestone 4:** Increase number of Cadena Healthplan participants by 15% for an additional 100 participants
  - **Data Source:** Hospital/health plan record
  - **Metric 5:** Increase number of Cadena Healthplan participants for target population by 8% for an additional 104 participants
  - **Milestone 5:** Increase number of Cadena Healthplan participants for target population by 10 percent for an additional 130 participants

**Implement Evidence-Based Health Promotion Program: Expand Cadena de Madres Program**

**Performing Provider Name:** Driscoll Children’s Hospital

**TPI:** 132812205

**Reduce the Neonatal ICU Average Length of Stay for the targeted population**

**Goal:** Increase number of consultations by 10%

**Data Source:** Hospital/health plan record

**Milestone 6:** Increase access to prenatal education consults for target population

**Metric 6:** Increase number of prenatal education consults above baseline for target population by 10 percent above CY 11 baseline for an additional 300 consultations

**Goal:** Increase number of consultations by 15%

**Data Source:** Hospital/health plan record

**Milestone 7:** Increase access to prenatal education consults for target population

**Metric 7:** Increase number of prenatal education consults above baseline for target population by 5 percent above CY 11 baseline for an additional 200 consultations

**Goal:** Increase number of consultations by 10%

**Data Source:** Hospital/health plan record

**Milestone 8:** Increase number of Cadena Healthplan participants for target population by 5% for an additional 104 participants

**Data Source:** Hospital/health plan record

**Milestone 9:** Increase number of Cadena Healthplan participants for target population by 8% for an additional 104 participants

**Data Source:** Hospital/health plan record

**Milestone 10:** Increase number of Cadena Healthplan participants for target population by 10 percent for an additional 130 participants

**Data Source:** Hospital/health plan record

**Milestone 11:** Increase access to prenatal education consults for target population

**Metric 11:** Increase number of prenatal education consults above baseline for target population by 15 percent above CY 11 baseline for an additional 300 consultations

**Goal:** Increase number of consultations by 20%

**Data Source:** Hospital/health plan record

**Milestone 12:** Increase access to prenatal education consults for target population

**Metric 12:** Increase number of prenatal education consults above baseline for target population by 10 percent above CY 11 baseline for an additional 200 consultations

**Goal:** Increase number of consultations by 25%

**Data Source:** Hospital/health plan record

**Milestone 13:** Increase number of Cadena Healthplan participants for target population by 10% for an additional 104 participants

**Data Source:** Hospital/health plan record

**Milestone 14:** Increase number of Cadena Healthplan participants for target population by 15% for an additional 130 participants

**Data Source:** Hospital/health plan record

**Milestone 15:** Increase access to prenatal education consults for target population

**Metric 15:** Increase number of prenatal education consults above baseline for target population by 20 percent above CY 11 baseline for an additional 400 consultations

**Goal:** Increase number of consultations by 25%

**Data Source:** Hospital/health plan record

**Milestone 16:** Increase access to prenatal education consults for target population

**Metric 16:** Increase number of prenatal education consults above baseline for target population by 15 percent above CY 11 baseline for an additional 300 consultations

**Goal:** Increase number of consultations by 20%

**Data Source:** Hospital/health plan record

**Milestone 17:** Increase number of Cadena Healthplan participants

**Metric 17:** Increase number of Cadena Healthplan participants for target population by 12% for an additional 156 participants

**Goal:** Increase number of participants
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performing Provider Name:</strong> Driscoll Children’s Hospital</td>
<td><strong>TPI:</strong> 132812205</td>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>Reduce the Neonatal ICU Average Length of Stay for the targeted population</strong></td>
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<tr>
<td><strong>Unique Identifier:</strong> 132812205.2.2</td>
<td><strong>RHP PP Reference Number:</strong> 2.6.2</td>
<td><strong>Project Components:</strong> N/A</td>
<td><strong>Implement Evidenced- Based Health Promotion Program:</strong> Expand Cadena de Madres program</td>
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<td><strong>Participants</strong></td>
<td><strong>Goal:</strong> increase number of participants by 8%</td>
<td><strong>Goal:</strong> increase number of participants by 10%</td>
<td><strong>Goal:</strong> increase number of participants by 12%</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Hospital/health plan record</td>
<td><strong>Data Source:</strong> Hospital/health plan record</td>
<td><strong>Data Source:</strong> Hospital/health plan record</td>
<td><strong>Data Source:</strong> Hospital/health plan record</td>
</tr>
<tr>
<td><strong>Milestone 5:</strong> Estimated Incentive Payment (maximum amount): $510,000</td>
<td><strong>Milestone 9:</strong> Estimated Incentive Payment (maximum amount): $800,075</td>
<td><strong>Milestone 13:</strong> Estimated Incentive Payment (maximum amount): $796,875</td>
<td><strong>Milestone 17:</strong> Estimated Incentive Payment (maximum amount): $641,250</td>
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<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> (add incentive payments amounts from each milestone): $2,550,000</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $3,200,330</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $3,187,500</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $2,565,000</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $11,502,830</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $11,502,830</td>
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</tr>
</tbody>
</table>
Driscoll Children’s Hospital

2.12.3 – Develop, Implement and evaluate a specialize follow-up clinic program for High Risk infants and young children in the Driscoll Service Area

132812205.2.3 – Pass 2

- **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** The High Risk Infant Follow-up Program is designed to assist pediatricians and families in follow-up care for infants and young children who are at high risk for developmental and neurological problems following discharge from an intensive care unit (ICU) at Driscoll Children’s Hospital or other local Neonatal ICU’s.

- **Need for the project:** This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Babies who are born experiencing unusual or difficult birth circumstances are at major risk for death or a lifetime of health problems unless they receive intense care immediately and for months and years after birth.

- **Target population:** Medicaid patients account for more than 70 percent of Driscoll’s patient base. The type of patients seen in the High Risk Follow-up Clinic setting are infants and young children from birth to three years of age who are at risk for developmental problems due to prematurity, low birth weight or other complications at birth.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, the project will accomplish the following goals:
  - Implement the Bayley Scales of Infant and Toddler Development 3rd Ed. developmental exam performed in the high risk follow-up program, serving an estimated baseline of 10 patients in DY 2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY 4 for an additional 1 patient; and 15% in DY5 for an additional 2 patients.
  - Implement the high risk follow-up program to serve an estimated baseline of 25 patients in DY 2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY4 for an additional 3 patients; 15% in DY5 for an additional 4 patients.
  - Increase the number of clinic hours by 5% over baseline for an additional 10 hours in DY3; by 10% above baseline in DY4 for an additional 19 hours; by 15% over baseline for an additional 29 hours.

- **Category 3 outcomes:** IT-6.1, Our goal is to demonstrate a percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making. The Target Improvement will be established no later than DY 3.
Project Option 2.12.3 – Develop, Implement and evaluate a specialize follow-up clinic program for High Risk infants and young children in the Driscoll Service Area

**Unique Project ID:** 132812205.2.3 (Pass 2)

**Performing Provider Name/TPI:** Driscoll Children’s Hospital / 132812205

**Project Description:**

*Implement/Expand Care Transition Programs*

Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first—and today still remains the only—free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital—the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)'s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

The High Risk Follow-Up Program is a service that we propose to offer to families of children cared for in a Neonatal/ Pediatric Intensive care and other care type units who meet the eligible criteria. This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Babies who are born experiencing unusual or difficult birth circumstances are at major risk for death or a lifetime of health problems unless they receive intense care immediately and for months and years after birth. The High Risk Infant Follow-up Program is designed to assist pediatricians and families in follow-up care for infants and young children who are at high risk for developmental and neurological problems following discharge from an intensive care unit (ICU) at Driscoll Children’s Hospital or other local Neonatal ICU’s. The type of patients seen in the High Risk Follow-up Clinic setting are infants and young children from birth to three years of age who are at risk for developmental problems due to prematurity, low birth weight or other complications at birth. Children, who have had typical neonatal courses, can also be seen if their Pediatrician has concern for developmental delay.

During a patient’s visit, the child and family are seen by a licensed provider (neonatal nurse practitioner and/or registered nurse). They will gather information about the child's
health history since discharge from the NICU or last visit. Next, they will evaluate the patient using a developmental exam called The Bayley Scales of Infant and Toddler Development 3rd Ed. Assessment followed by a physical exam, specifically looking for neurological findings. Parents will be asked to report early language milestones. At the end of the exam, the patient’s weight, height and head circumference will be measured. Finally, testing results and recommendations will be discussed and a copy of the findings will be forwarded to the child’s PCP. These visits can take several hours to perform on a patient.

To further enhance the project, Driscoll Health System will form an Outreach Council and will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Care transition milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Care Transition Program.

Goals and Relationship to Regional Goals:
The goal of this project is to have a specialized program for babies born with birth complications and other criteria, identified by a neonatologist, available through referral by the primary care physicians. The project would also provide developmental age-appropriate testing and enhance development as well as enable the family to become knowledgeable about their baby’s developmental needs, help the infant to achieve maximum potential and to empower families with information to access healthcare.

Project Goals:
- Implement the Bayley Scales of Infant and Toddler Development 3rd Ed. developmental exam performed in the high risk follow-up program, serving an estimated baseline of 10 patients in DY2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY 4 for an additional 1 patient; and 15% in DY 5 for an additional 2 patients.
- Implement the high risk follow-up program, serving an estimated baseline of 25 patients in DY2 with a target increase in subsequent years of 5% in DY 3 for an additional 1 patient; 10% in DY 4 for an additional 3 patients; and 15% in DY 4 for an additional 4 patients.
- Increase accessibility to High Risk patients in targeted population

This project meets the following regional goals:
- Transform health care delivery to a patient–centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
Challenges:
Driscoll faces several challenges and barriers to implement the high risk infant follow-up program; including the high rate of patient no-shows to appointments and to provide timely access to patients and their families.

The High Risk Infant Follow-up Program will work to overcome No Show Rate challenges by performing positive initiatives, such as:
- Providing a blanket to patients at the three month visit
- Developing a patient of the month bulletin
- Establishing a Reach Out and Read Program
- Providing a Monthly Newsletter to patients and families
- Enhancing services accessibility to patients

5-Year Expected Outcome for Provider and Patients:
Driscoll Children’s Hospital expects to see improvements in care transition program for patients. The provider expects to improve accessibility to the High Risk Infant Follow-up program across the Driscoll Service area. This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Currently the High Risk Infant Follow-up clinic does not exist within the Driscoll Children’s Hospital. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2. Driscoll plans to establish baselines during DY2 but the increase in services are estimated to be approximately 25 patient visits and 10 Bayley exams.

Rationale:
Developmental delays and conditions are common in early childhood, affecting at least 10 percent of children. Early developmental delays are markers for later developmental conditions such as autism, intellectual disability, hearing or vision impairment, cerebral palsy, speech and language disorders, and learning disabilities. Risk factors such as family poverty, parents’ mental illness, and child neglect and abuse increase the likelihood of developmental delays. Recent studies emphasize the importance of the interaction of brain development and environment on children’s developmental and behavioral outcomes. The tremendous adaptability of the brain in the first three years of life means that early treatment of delays leads to improved outcomes, whereas later intervention is less effective. To improve children’s outcomes through provided treatment, early identification of delays and sensory impairments (i.e., vision and hearing problems) is critical. Pediatricians and other primary care medical providers who see children for regularly scheduled preventive care visits during their first three

years of life, and who are trained in child development, could play a key role in the early identification of developmental delays.

In response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region, Driscoll Children’s Hospital care transition program is designed to:

- Increase the capacity of safety net providers in the region to provide patient-centered care and care management, particularly for patients with chronic conditions, to improve health literacy, self-care management skills, and more effectively access or navigate the health care system appropriately.

Project Components:
This project has no required core components.

Unique community need identification numbers the project addresses:
- CN.2 – Inadequate access to specialty services.
- CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently, a High Risk Follow-up program does not exist for NICU patients in the Driscoll Children’s Service Area. Our hospital will offer developmental evaluation services through a multidisciplinary team which include neonatal nurse practitioner, registered dietician, speech therapist, occupational therapist, and physical therapist. The initiative will improve access to specialized services for targeted patients while helping the hospital reach capacity for treating high-risk patients.

Related Category 3 Outcome Measures:
OD-6 – Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

Reasons/rationale for selecting the outcome measures:
Most studies of developmental screening in practice have reported positive results in terms of increased rates of detection/referral and/or parental satisfaction. Parents who reported that their children had received a developmental assessment were more likely to be satisfied with their child’s medical care; these visits were also associated with higher quality ratings. These results suggest that providers and practices who take a structured approach to developmental assessment are providing a higher level of care overall, thereby potentially contributing to improved child health outcomes.  

**Relationship to other Projects:**
This project’s focus is on enhancing a care transition program which ties to these Category 1 and 2 projects in our RHP: 020973601.2.1 Implement/Expand Care Transitions Programs, 0942220902.2.5 Expand Care Transitions Program and 121775403.2.10 Expand Care Transitions Program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center, Early Childhood Intervention program and Christus Spohn.

**Project Valuation:**
According to the article: *Developmental Screening in Primary Care: The Effectiveness of Current Practice and Recommendations for Improvement*, early developmental delays are often not identified in a timely way. Many children are not identified until kindergarten entry or later—well beyond the period in which early intervention is most effective. Therefore, in many cases, opportunities to intervene early to improve children’s developmental outcomes are missed. Validated developmental screening tools that could increase identification of developmental delays exist, but most physicians do not use them systematically to screen all patients. Recently revised guidelines from the American Academy of Pediatrics recommend routine screening at three specific ages in early childhood, and may lead to the increased use of screening tools.

We are using an estimated program patient volume and conservative Quality Adjusted Life Year ("QALY") per year valuation to demonstrate a one-time improvement in the quality of life. Although our estimates are based on a one-time improvement, the project’s value and community benefit is realized throughout many years.

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<table>
<thead>
<tr>
<th>TPI: 132812205</th>
<th>Implement/Expand Care Transition Programs</th>
</tr>
</thead>
</table>

**Performing Provider Name: Driscoll Children’s Hospital**

### Outcome Measure(s):

| Related Category 3 | 132812205.3.8 | IT-6.1
|---------------------|----------------|--------------------------|
| **Year 2**<br>(10/1/2012 – 9/30/2013) | **Year 3**<br>(10/1/2013 – 9/30/2014) | **Year 4**<br>(10/1/2014 – 9/30/2015) | **Year 5**<br>(10/1/2015 – 9/30/2016)

**Milestone 1** [P-2]: Implement standardized care transition processes

- **Metric 1** [P-2.1]: Care transitions policies and procedures
- **Goal**: Submission of protocols
- **Data Source**: Policies and procedures of care transitions program materials

**Milestone 1**: Estimated Incentive Payment *(maximum amount):* $153,638

**Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program.

- **Metric 1** [P-7.1]: Documentation of the staffing plan.
- **Goal**: Create staffing and implementation plan.
- **Data Source**: Completed Staffing and implementation plan.

**Milestone 2**: Estimated Incentive Payment *(maximum amount):* $153,638

**Milestone 3** [P-X]: Plan and Establish baseline clinic hours for...
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk Follow-up clinic</strong></td>
<td><strong>High Risk Follow-up clinic</strong></td>
<td><strong>High Risk Follow-up clinic</strong></td>
<td><strong>High Risk Follow-up clinic</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
</tr>
<tr>
<td>Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for hours is zero. Goal: Develop the operational hours for the program. Data Source: Outreach council implementation plan.</td>
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<td><strong>Milestone 3</strong>: Estimated Incentive Payment (maximum amount): $153,638</td>
<td><strong>Milestone 4 [P-X1]: Plan and Establish baseline for the number of Bayley Infant Neurodevelopmental assessment exams.</strong></td>
<td><strong>Milestone 5</strong>: Estimated Incentive Payment (maximum amount): $225,000</td>
<td><strong>Milestone 6</strong>: Estimated Incentive Payment (maximum amount): $225,000</td>
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<tr>
<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
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<td><strong>Metric 1 [P-X.1]: Documentation of operational hours.</strong></td>
</tr>
<tr>
<td>Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for hours is zero. Goal: Develop the High Risk Infant Follow-up Program with assessment exams to be performed data and the patient medical record.</td>
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<tr>
<td><strong>Milestone 8</strong>: Estimated Incentive Payment (maximum amount): $225,000</td>
<td><strong>Milestone 9 [I-X.1.1]: Provide Bayley Infant Neurodevelopment assessment exams to targeted patients.</strong></td>
<td><strong>Milestone 10</strong>: Estimated Incentive Payment (maximum amount): $225,000</td>
<td><strong>Milestone 11</strong>: Estimated Incentive Payment (maximum amount): $225,000</td>
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<tr>
<td><strong>Metric 1 [I-X.1.1]: Increase Bayley Infant Neurodevelopment assessment exams in the Driscoll Service area.</strong></td>
<td><strong>Metric 1 [I-X.1.1]: Increase Bayley Infant Neurodevelopment assessment exams in the Driscoll Service area.</strong></td>
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</tr>
<tr>
<td>Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 5% above the baseline estimate of 10 exams, for one additional exam. Data Source: Claims data</td>
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<td><strong>Milestone 12</strong>: Estimated Incentive Payment (maximum amount): $253,125</td>
<td><strong>Milestone 13 [I-X.1.1]: Provide Bayley Infant Neurodevelopment assessment exams to targeted patients.</strong></td>
<td><strong>Milestone 14</strong>: Estimated Incentive Payment (maximum amount): $253,125</td>
<td><strong>Milestone 15</strong>: Estimated Incentive Payment (maximum amount): $253,125</td>
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<td><strong>Metric 1 [I-X.1.1]: Increase Bayley Infant Neurodevelopment assessment exams in the Driscoll Service area.</strong></td>
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<tr>
<td>Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 10% above the baseline for one additional exam. Data Source: Claims data</td>
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<td><strong>Milestone 16</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
<td><strong>Milestone 17 [I-X.1.1]: Increase the number of Bayley Infant Neurodevelopment assessment exams by 15% over baseline in the Driscoll Service area.</strong></td>
<td><strong>Milestone 18</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
<td><strong>Milestone 19</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
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<td><strong>Metric 1 [I-X.1.1]: Increase the number of Bayley Infant Neurodevelopment assessment exams by 15% over baseline in the Driscoll Service area.</strong></td>
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<td>Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 15% over baseline for 2 additional exams. Data Source: Claims data</td>
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<td><strong>Milestone 17</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
<td><strong>Milestone 18 [P-X2]: Task Force continues to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program.</strong></td>
<td><strong>Milestone 19</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
<td><strong>Milestone 20</strong>: Estimated Incentive Payment (maximum amount): $247,716</td>
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<td><strong>Metric 1 [P-X.2.1]: Documentation of Quality Improvement meetings.</strong></td>
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**Driscoll Children’s Hospital**
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<th>Related Category 3</th>
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<td>IT-6.1</td>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205  

**IT-6.1:** Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

**Milestone 4:** Estimated Incentive Payment (maximum amount): $153,638

**Milestone 5** [P-X2]: Appoint an interdisciplinary Task Force to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program.

**Metric 1** [P-X2.1]: Documentation of Task Force establishment.  
Goal: Participate in all semi-annual Quality Improvement meetings.  
Data Source: Hospital/health plan record

**Milestone 10:** Estimated Incentive Payment (maximum amount): $225,000

**Milestone 14:** Estimated Incentive Payment (maximum amount): $253,125

**Milestone 18:** Estimated Incentive Payment (maximum amount): $247,717

**Data Source:** Claims data

**Year 2 durante a patient’s visit. Estimate establishing a baseline of 10 Bayley assessment exams**

**Year 3** Quality Improvement meetings held twice per year.  
Goal: Participate in all semi-annual Quality Improvement meetings.  
Data Source: Hospital/health plan record

**Milestone 6** [P-X3]: Plan and Establish baseline for the number of patient visits.

**Metric 1** [P-X3.1]: Documentation of Quality Improvement meetings held twice per year.  
Goal: Participate in all semi-annual Quality Improvement meetings.  
Data Source: Hospital/health plan record

**Goal:** Participate in all semi-annual Quality Improvement meetings.  
**Data Source:** Hospital/health plan record

**Milestone 10:** Estimated Incentive Payment (maximum amount): $225,000

**Milestone 14:** Estimated Incentive Payment (maximum amount): $253,125

**Milestone 18:** Estimated Incentive Payment (maximum amount): $247,717

**Data Source:** Hospital/health plan record
<table>
<thead>
<tr>
<th>132812205.2.3</th>
<th>2.12.3</th>
<th>N/A</th>
<th>Implement/Expand Care Transition Programs</th>
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<tr>
<td>Performing Provider Name: Driscoll Children’s Hospital</td>
<td>TPI: 132812205</td>
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<td>Related Category 3 Outcome Measure(s):</td>
<td>132812205.3.8</td>
<td>IT-6.1</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.</td>
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<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
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<td>the estimated assessment exams to be performed during DY2. Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for patient visits is zero. Goal: Develop an estimated number of the patient visits in the High Risk Infant Follow-up Program. Data Source: Claims data</td>
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<td>Milestone 6: Estimated Incentive Payment <em>(maximum amount)</em>: $153,638</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $921,828</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,000,000</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,012,500</td>
<td>Year 5 Estimated Milestone Bundle Amount: $990,865</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):</strong> $3,925,193</td>
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</table>
RHP Project Identification Number: 135254407.2.1;  
Performing Provider/TPI: Gulf Bend Center/1352544-07  
Project Option: 2.15.1 Integrate Primary and Behavioral Health Care Services  
Provider - Gulf Bend Center is the Community Mental Health Center located in Victoria, Texas. Gulf Bend Center provides services to individuals in the following seven county area: DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging. 
Intervention: Develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails. The person-centered behavioral health medical home will offer the following services in the same location: Behavioral Health Services; Primary care services; Health behavior education and training programs; Long and short term care for those with mental illness and co-occurring chronic disease; Case Management services to help patient navigate the services provided in the community. 
Need for project: The need for this project was based upon data for Victoria County from the Texas Department of State Health Services for preventable hospitalizations from diabetes, asthma, and COPD with a coexisting behavioral/mental health disorder. The data showed the following:  
- Between 2005 and 2010, 1,021 patients in Victoria County were hospitalized due to complications from diabetes. Using national research, we can conclude that of those 1,021 patients hospitalized for diabetes, 296 were patients receiving behavioral health services from Gulf Bend. The average cost of providing inpatient care to Gulf Bend patients suffering from diabetes totaled $7,382,972.  
- Between 2005 and 2010, there were 657 hospitalizations for asthma. This equates to a total cost of $12,347,639 for asthma hospitalizations. Of the 657 hospitalizations for asthma, there was a high association of that asthma with the co-occurring mental illness of anxiety and depression.  
- Between 2005 and 2010, there 843 hospitalizations for COPD. The total costs of $18,935,618 for inpatient care. Of the 843 hospitalizations for COPD, the prevalence of depression within those patients was 37% to 71%\(^{145}\). This shows that of the 843 hospitalizations, between 311 and 598 patients were suffering from depression.  
Target population: The target population are the at risk populations with co-morbid diseases of mental illness and chronic disease. State figures and national data shows that Gulf Bend has the potential to reach 10,000 residents in its service area that suffer from co-occurring mental illness and chronic disease with Medicaid as their primary insurance. In DY3, Gulf Bend estimates that it will serve 150 patients with co-occurring chronic disease and mental illness. In DY 4, we expect to serve 350 patients and 450 patients by the end of DY 5.  
Category 1 expected benefits: The project seeks to decrease inpatient and ED admissions for co-occurring mental illness and chronic diseases, lower the costs of providing care, and providing greater access to primary care for those with co-occurring mental illness and chronic diseases.  
Category 3 outcomes: The Category 3 Outcome Measure chosen by Gulf Bend for this project is OD-2 Potentially Preventable Admissions - IT-2.4 Behavioral Health/Substance Abuse Admission Rate  
- One for BH/SA as the principal diagnosis

A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.)

Gulf Bend will attempt to decrease admissions due to asthma, depression, and asthma with an underlying or co-existing mental health disorder by 20% by the end of DY 5.
Category 2: Program Innovation and Redesign

Title of Project: 2.15.1 Integrate Primary and Behavioral Health Care Services - Person-Centered Behavioral Health Medical Home; RHP Project Identification Number: 135254407.2.1; Performing Provider/TPI: Gulf Bend Center/1352544-07

Project Description:
The goal of this project is to develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails. Gulf Bend has a service area with a population of 200,000 patients. Of the 200,000 patients, roughly 19,000 will have Medicaid as their primary insurance. Using national research statistics, of the 19,000, 68% will have co-occurring chronic disease and mental illness. Gulf Bend is hoping to provide the integrated services to the 10,000 patients suffering from co-occurring mental illness and chronic disease in its service region with Medicaid as their primary insurance. In DY 3, Gulf Bend fully expects to serve 150 patients in the integrated care site and increase the number of patients served to 350 by the end of DY 4. In DY 5, Gulf Bend will provide services to 450 patients in the integrated care site.

This project proposes a solution by offering a site that will integrate primary care into the behavioral health services that Gulf Bend already provides in its service region. The person-centered behavioral health medical home will offer the following services in the same location:

1. Behavioral Health Services
2. Primary care services
3. Health behavior education and training programs
4. Long and short term care for those with mental illness and co-occurring chronic disease
5. Case Management services to help patient navigate the services provided in the community.

The goals for this project include the following:
- Increase in access to primary care
- Increase in access to behavioral health care services
- Reduction in inpatient psychiatric hospitalizations
- Implement the IMPACT model of integrated collaborative care
- Increase in patient satisfaction
- Reduction in Emergency Department visits
- Chance to develop and change health behaviors
- Reduction in preventable behavioral health and chronic disease hospitalizations

Challenges and how addressed: There will be challenges in the development and implementation of this project. The first challenge will be developing and implementing the needed primary care services policies, procedures, and treatment plans. To meet this challenge, Gulf Bend will reach out to local and regional primary care providers and seek input and advice on how to develop and implement the needed policies and treatment plans. Gulf Bend will also reach out and seek advice from other community mental health centers that have integrated primary care services with mental and behavioral health services. Gulf Bend will also research and seek out evidence based practice approaches that have shown a high degree of success in the outcomes of integrating primary care and behavioral health.

Another challenge for Gulf Bend will be in the recruiting, selection, and hiring of primary care staff. This is a unique challenge for Gulf Bend. It is unique in one way in that Gulf Bend does not have any experience in the recruiting and selection of primary care providers and needed support staff. It is also unique in that Gulf Bend must recruit and select primary care staff that has experience...
in working in an integrated primary care-behavioral health model of care. To make an effective impact for our patients and other members of the community, Gulf Bend will place importance in selecting primary care providers who have experience in delivering care in a team based integrated primary and behavioral health care model.

**5-Year Expected Outcome:** The five year expected outcome through the development and implementation of the Person-Centered Behavioral Health Medical Home project is to provide critical services to the targeted population with co-morbid diseases of mental illness and chronic disease that currently go untreated or under treated. Through the delivery of integrated medical and behavioral health care we expect to see individuals with a treatment plan developed and implemented with delivery provided by those with primary care and behavioral health expertise. We also expect to see an overall reduction in costs and an increase in the overall satisfaction and health and well-being of this population.

**Starting Point/Baseline:** Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Using national statistics we can conclude approximately 50,000 individuals have some form of mental illness of which 34,000 likely have a medical and/or chronic disease. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging.

**Rationale:** Gulf Bend selected this project because of the critical need for these services, which was based upon national and local data. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders. Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population\(^\text{146}\).

There is a demonstrated community need in Victoria County for this project. Texas Department of State Health Services data showed alarming rates of chronic disease and preventable hospitalizations based upon data from 2005 to 2010. Between 2005 and 2010, 1,021 patients in Victoria County were hospitalized due to complications from diabetes. Using national research, we can conclude that of those 1,021 patients hospitalized for diabetes, 296 were patients receiving behavioral health services from Gulf Bend. The total cost of providing care to the 1,021 individuals diagnosed with diabetes was $28,022,632. That means that the average cost of providing care to Gulf Bend patients suffering from diabetes totaled $7,382,972. The integration of primary care services could help Gulf Bend not only improve the quality of life for its patients suffering from a chronic disease and a mental health illness, but also helps reduce the cost of providing care for a preventable hospital admission.

Diabetes is not the only co-occurring chronic disease that Gulf Bend will target in its integration of primary care services. Using state health records for Victoria, there is a demonstrated

\(^{146}\text{Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group, May 2006.}\)
community need for the treatment of both asthma and Chronic Obstructive Pulmonary Disease (COPD). Between 2005 and 2010, there were 657 hospitalizations for asthma and 843 for COPD. This equates to a total cost of $12,347,639 (asthma) and $18,935,618 (COPD) for each chronic disease over five years. Using the national research data, we can conclude that of the 657 hospitalizations for asthma, there was a high association of that asthma with the co-occurring mental illness of anxiety and depression. \(^{147,148}\) We can also further conclude that of the 843 hospitalizations for COPD, the prevalence of depression within those patients was 37% to 71%.\(^{149}\) This shows that of the 843 hospitalizations, between 311 and 598 patients were suffering from depression.

The integration of primary care into Gulf Bends existing behavioral health services will help control the preventable hospitalizations and costs due to diabetes, asthma and COPD. Research has shown that integrated primary care and behavioral health services, which Gulf Bend will accomplish as part of this project, can decrease admissions due to diabetes, asthma, and COPD among those affected by mental illness or behavioral health needs. Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have led to improved outcomes in physical health, benefited various populations and have provided a lower cost of long term health care services.\(^{150}\) Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had a significantly greater improvement in their health.\(^{151}\) Research has shown that the integration of primary care and behavioral health services in the same service location has increased outcomes for those suffering from mental illness and co-occurring chronic disease. A reason for these improved outcomes is due to the fact that integrated care offers "one-stop shopping" for its patients. Data from the Bureau of Primary Care shows that only 1 in 4 patients referred for mental health or chronic disease management make the first appointment. The same research further showed that co-location of integrated primary care services and behavioral health services resulted in improved behavioral health and chronic disease outcomes and proved to provide cost savings.

Project Components: We propose to meet all of the required project components as follows:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

b) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.

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\(^{148}\) Goodwin RD, Jacobi F, Thefeld W. Mental disorders and asthma in the community. *Archives of General Psychiatry*, Vol 60, November 2003


\(^{150}\) http://www.impact-uw.org/about/research.html

c) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations.

d) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   • Regular consultative meetings between physical health and behavioral health practitioners;
   • Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
   • Shared treatment plans co-developed by both physical health and behavioral health practitioners.

e) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

f) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

g) Arrange for utilities and building services for these settings

h) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

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

**Milestones and Metrics:** Project milestones and measures were carefully chosen by Gulf Bend based upon their importance to developing and integrating primary care into its existing behavioral health operations. For example, one process milestone chosen was to identify the exact location for the integrated care site. This is because Gulf Bend wants to make sure that the location for the integrated delivery of care is easy to access for its patients. For example, possible needs will be access or proximity to bus stops so those patients without transportation services can have the same amount of access as those with vehicles. Another milestone chosen was to develop and implement standards and guidelines that ensure effective collaboration and communication among providers of both behavioral and primary care.

Another milestone selected was that of determining which model of collaborative and integrated care model to select. Gulf Bend wants to ensure that it not only meets its project goals but also to provide efficient integrated care to meet the needs of its existing patients and the community.

Specifically the following milestones and metrics have been chosen for the Person-Centered Behavioral Health Medical Home project based on the core components and the needs of the target population:
   • Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.2); P-6 (P-6.1); P-7 (P-7.1); P-X (P-X.1); P-X (P-X.2)
   • Improvement Milestones and Metrics: I-8 (I-8.1); I-9 (I-9.1); I-10 (I-10.1); I-11 (I-11.1); I-12 (I-12.1)

**Unique community need identification numbers:**
   CN1 – Access to primary care; CN2 – CN3 –
Related Category 3 Outcome Measure(s): The related Category 3 outcome measure chosen for this project is OD-2 Potentially Preventable Admissions - IT-2.4 Behavioral Health/Substance Abuse Admission Rate

1. One for BH/SA as the principal diagnosis
2. A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.)

Gulf Bend will attempt to decrease admissions due to asthma, depression, and COPD with an underlying or co-existing mental health disorder by 20% by the end of DY 5.

Reasons/Rationale for selecting the outcome measure(s): Using the above statistics from national, state, and local data sources, there is a community need to prevent admissions in hospitals in Gulf Bends service area for co-occurring co-morbid diseases. The integrated delivery of care will help prevent these admissions and help reduce the overall cost of providing health care to these patients. Several studies have shown the effectiveness of integrated patient centered homes for those suffering from co-occurring co-morbid diseases. On study performed in Texas showed that using an integrated collaborative care site using the IMPACT model of care enhanced access to mental health services, improved quality of life, reduced the occurrence of depression and anxiety, decrease in the utilization of unnecessary emergency department services, and a reduction in overall health care costs. In the study, researchers found that anxiety scores fell by 50%, emergency department use decreased by 50%, and the average health care cost per enrolled decreased by 17% in the second year and 56% in the third year of the program. This data is significant because the targeted patient population size is similar in the Gulf Bend area.

There is another benefit to an integrated collaborative care site. The other benefit of an integrated approach that will help reduce the number of admissions is long-term compliance. In 2000, researchers found that patients that receive care in an integrated care site show a higher level of adherence and retention in treatment. This translates into an overall decrease in hospital admissions. This is because the patient only has to travel to one location for their behavioral and physical health services and has increased access to those services.

The research and data shown above provides evidence that Gulf Bends Category 2 project will have a significant impact and help achieve its selected Category 3 outcome measure. Gulf Bend will be integrating primary care into its existing behavioral health services and will therefore be able to reduce admissions of those affected with co-occurring co-morbid disease.

Relationship to other Projects:
This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care

center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative**

This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:** This project is valued based upon the resources needed to meet its goal, but also the value to the community. The biggest cost will be the needed staff. Gulf Bend will be hiring a mid-level practitioner and necessary nursing staff to meet the needed integrated primary care services. Gulf Bend will also need to hire community health workers and even more licensed professional counselors to meet the needs of the community. There will also be the needed support staff to help deliver the integrated care. Another consideration in the cost of hiring the staff is offering health, dental, and retirement benefits.

The other factor used to determine the cost was the purchasing of the needed equipment to offer primary care. Gulf Bend will need to purchase the necessary durable medical equipment and appropriate medical supplies to help deliver the primary care services. The valuation also took into account the benefit to the community for providing the integrated primary care and behavioral health services. Using data and statistics from above, if Gulf Bend were to reduce admissions due to diabetes by 10%, this would represent an overall cost savings of $738,283. If the integrated services were to decrease admissions due to COPD by 10%, then the overall savings would be $1,893,546. If admissions due to asthma were to decrease by 10%, then the overall savings would be $617,350. This would lead to an overall savings of $3,249,179. This number is based upon conservative estimates of the impact that Gulf Bend will have on admissions for chronic disease with secondary diagnosis of a mood/affective disorders. If Gulf Bend were to double the percentages, then it could lead to an overall cost savings of $6,498,358.

These numbers only take into account the affect the project will have on admissions. To this point, readmissions for co-occurring chronic disease and mental illness have not been determined. National data shows that the re-admission rate for chronic disease is 24%\(^{153}\). That means that of the 2,521 admissions for chronic disease, 605 patients were readmitted for the same chronic disease. Using national research data further, of the 605 readmissions, 175 of those had a co-occurring mental illness such as depression or anxiety. Gulf Bend could prevent those readmissions and help save in excess of $2.5 million dollars in preventable readmission costs. This leads to an overall cost savings of nine million dollars.

The decrease in costs due to a decrease in hospital admissions is not the only cost determining factor used in this valuation. One valuation was the effect on the patient themselves. Due to these services, Gulf Bend feels that healthier individuals will have a longer and more

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\(^{153}\)Hospital Readmission Rates Higher for Chronic Conditions. AHRQ News and Numbers, March 7, 2012. Agency for Healthcare Research and Quality, Rockville, MD
productive life span. Those persons with mental illness and co-occurring chronic disease have a lifespan of 25 years less than those who do not have a co-occurring mental illness. Since patients will receive the needed primary care services and studies have shown that compliance is increased, Gulf Bend expects these patients to be able to be more productive and help contribute to the overall benefit of society. Studies have shown that depression is the leading cause of a decrease in productivity in the work place. If the integration of services were to help increase the productivity of patients suffering from a mood disorder and co-occurring chronic disease then the community will benefit as a whole.
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<td>IT-2.4</td>
<td></td>
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<td>Potentially Preventable Admissions</td>
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**Year 2**
(10/1/2012 – 9/30/2013)

**Milestone 1** [P-1]: Conduct needs assessment to determine areas of the state where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs.

**Metric 1** [P-1.1]: Numbers of patients in various areas who might benefit from integrated services.

Demographics, location, & diagnoses

**Baseline**: 0

**Data Source**: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data

Milestone 1 Estimated Incentive Payment (maximum amount): $261,375

**Milestone 2** [P-2]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share.

**Data Source**: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data

Milestone 2 Estimated Incentive Payment (maximum amount): $261,375

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<td>(10/1/2013 – 9/30/2014)</td>
<td>[P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.</td>
<td>[P-4]: Develop agreements to share information to continuously improve integration of primary and behavioral health services.</td>
<td>[P-5]: Evaluate and continuously improve integration of primary and behavioral health services.</td>
<td>[P-6]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.</td>
<td>[P-7]: Develop agreements to share information to continuously improve integration of primary and behavioral health services.</td>
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**Data Source**: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data

Milestone 3 Estimated Incentive Payment (maximum amount): $348,018

**Milestone 4** [P-X.2]: Recruit and hire needed primary and behavioral health staff based upon needs assessment

**Metric 1** [P-X.1.2]: Needed employees hired by start date

Baseline/Goal: 0/5

**Data Source**: Employee roster

Milestone 4 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 5** [P-X.3]: Recruit and hire needed primary and behavioral health staff based upon needs assessment

**Metric 1** [P-X.2.1]: Needed employees hired by start date

Baseline/Goal: 0/5

**Data Source**: Employee roster

Milestone 5 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 6** [P-X.4]: Recruit and hire needed primary and behavioral health staff based upon needs assessment

**Metric 1** [P-X.3.1]: Needed employees hired by start date

Baseline/Goal: 0/5

**Data Source**: Employee roster

Milestone 6 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 7** [P-7]: Develop agreements to share information to continuously improve integration of primary and behavioral health services.

**Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

Baseline/Goal: 0/3

**Data Source**: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

Milestone 7 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 8** [P-8]: Recruit and hire needed primary and behavioral health staff based upon needs assessment

**Metric 1** [P-8.1]: Needed employees hired by start date

Baseline/Goal: 0/5

**Data Source**: Employee roster

Milestone 8 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 9** [P-9]: Coordination of Care

**Metric 1** [P-9.1]: 350 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise

Baseline/Goal: 150/350

**Data Source**: Survey of primary care providers and vice versa.

Milestone 9 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 10** [P-10]: Coordination of Care

**Metric 1** [P-10.1]: 350 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise

Baseline/Goal: 150/350

**Data Source**: Survey of primary care providers and vice versa.

Milestone 10 Estimated Incentive Payment (maximum amount): $431,700

**Milestone 11** [P-11]: Health Metrics

**Metric 1** [P-11.1]: 20% Increase in positive results of standardized health metrics which may include objective health indicators such as body mass index, glycated hemoglobin (A1c), blood pressure; behavioral health instruments such as Quality of Life (QOL) Questionnaire, Adult Needs and Strengths Assessment (ANSA)

Baseline/Goal: 0/20% increase

**Data Source**: Project data; Medical Records; Claims and Encounter Data

Milestone 11 Estimated Incentive Payment: $260,645

**Milestone 12** [P-12]: Improved consumer satisfaction with integrated services

**Metric 1** [P-12.1]: number of people report satisfaction with integrated services

Baseline/Goal: 0/125

**Data Source**: Completed consumer satisfaction surveys

Milestone 12 Estimated Incentive Payment: $260,645

**Milestone 13** [P-13]: Improved consumer satisfaction with integrated services

**Metric 1** [P-13.1]: number of people report satisfaction with integrated services

Baseline/Goal: 0/125

**Data Source**: Completed consumer satisfaction surveys

Milestone 13 Estimated Incentive Payment: $260,645
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
<tbody>
<tr>
<td>their office space with behavioral health practitioners</td>
<td></td>
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<tr>
<td><strong>Metric 1 [P-2.1]</strong>: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.</td>
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<tr>
<td><strong>Baseline/Goal</strong>: 0/10</td>
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<tr>
<td><strong>Data Source</strong>: Information from persons interviewed</td>
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<tr>
<td>Milestone 2 Estimated Incentive Payment (maximum amount): $261,375</td>
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<tr>
<td>Milestone 3 [P-4]: Assess ease of access to potential locations for project implementation</td>
<td></td>
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<tr>
<td><strong>Metric 1 [P-4.1]</strong>: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services.</td>
<td></td>
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<tr>
<td><strong>Baseline/Goal</strong>: Assess ease of access to potential locations for project implementation</td>
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<tr>
<td><strong>Data Source</strong>: City/County data, maps, demographic data relating to prevalence of health conditions</td>
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<tr>
<td>Milestone 3 Estimated Incentive Payment (maximum amount): $348,018</td>
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<tr>
<td>Milestone 7 [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project</td>
<td></td>
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<tr>
<td><strong>Metric 1 [P-5.2]</strong>: Number of primary care providers newly located in behavioral health settings.</td>
<td></td>
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<tr>
<td><strong>Baseline/Goal</strong>: 0/1 primary care providers newly located in behavioral health settings.</td>
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<tr>
<td><strong>Data Source</strong>: Project data</td>
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<tr>
<td>Milestone 7 Estimated Incentive Payment (maximum amount): $348,018</td>
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<tr>
<td>Milestone 10 Estimated Incentive Payment: $431,700</td>
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<tr>
<td>Milestone 11 [I-10]: No-Show Appointments</td>
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<tr>
<td><strong>Metric 1 [I-10.1]</strong>: 10% decrease the “no shows” for behavioral and physical health appointments</td>
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<tr>
<td><strong>Goal</strong>: 10% decrease in the “no shows” for behavioral and physical health appointments over DY3 baseline of 0</td>
<td></td>
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<tr>
<td><strong>Data Source</strong>: Project Data; Clinic Registry Data; Claims and Encounter Data</td>
<td></td>
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<tr>
<td>Milestone 11 Estimated Incentive Payment: $431,700</td>
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<tr>
<td>Milestone 12 [I-12]: Coordination of care</td>
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<tr>
<td><strong>Metric 1 [I-12.1]</strong>: 450 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
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<tr>
<td><strong>Goal</strong>: 450 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
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<tr>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
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<tr>
<td>Milestone 12 Estimated Incentive Payment: $260,645</td>
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<tr>
<td>Milestone 14 [I-8]: Integrated Services</td>
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<tr>
<td><strong>Metric 1 [I-8.1]</strong>: Number of Individuals receiving both physical and behavioral health care at the established locations</td>
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<tr>
<td><strong>Baseline/Goal</strong>: 350/450 Individuals receiving both physical and behavioral health care at the established locations</td>
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<tr>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
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<tr>
<td>Milestone 14 Estimated Incentive Payment: $260,645</td>
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<tr>
<td>Milestone 15 [I-9]: Coordination of Care</td>
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<tr>
<td><strong>Metric 1 [I-9.1]</strong>: 450 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
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<tr>
<td><strong>Goal</strong>: 450 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
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<tr>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
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<td>Milestone 15 Estimated Incentive Payment: $260,645</td>
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<td>Outcome Measure(s):</td>
<td>1352544-07.3.3</td>
<td>IT-2.4</td>
<td>Potentially Preventable Admissions</td>
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<tr>
<td>---------------------</td>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>348,018</td>
<td></td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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**Milestone 4** P-X Develop and create policies, procedures, and treatment plans for the delivery of integrated care

**Metric 1** [P-X.1]: Policy and procedure manual

**Goal:** Develop policy and procedure manual

**Data Source:** Gulf Bend Procedure Manual

**Milestone 4 Estimated Incentive Payment (maximum amount):** $261,375

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $1,045,500

**Year 3 Estimated Milestone Bundle Amount:** $1,392,075

**Year 4 Estimated Milestone Bundle Amount:** $1,295,100

**Year 5 Estimated Milestone Bundle Amount:** $1,303,225

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYS 2-5):** $5,035,400
Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Kleberg/ TPI 136436606
Unique Identifier - 136436606.2.1

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s):** This is a large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors, and will require integration between Pharmacy, Information Technology (IT) and Nursing. The project will result in all doses of medications given to patients in Spohn’s Kleberg locations having viable barcodes that are read into the Meditech informatics system.

- **Need for the project:** Spohn’s present medication management system entails a completely manual system from order to medication administration. Medication reconciliation is a cumbersome process upon admission and discharge, as well as during transfers between levels of care. An improvement in the coordination between departments, availability and use of technology, and training on best practices will reduce the risk of hospitalized patients receiving improper dosages, duplicative medication administration, and/or overdoses. Spohn Kleberg’s 6 month medication errors totaled 124 for errors reported in 2011. Medication administration specific errors accounted for 23% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. Additionally, audits can be run through the automated system to provide a better picture of opportunities for improvement and continuous quality improvement. Additionally, the barcoding will enable more efficient medication reconciliation upon discharge, and will be coupled with an initiative to provide more patient consultations by clinical pharmacists prior to discharge.

- **Target population:** The target population of this project is all inpatients and outpatients treated in Spohn’s Kleberg facility, which amount to approximately 19,559 patients in FY2012 (3,059 inpatients; 13,135 ED patients), 38.7% of which are uninsured or Medicaid-eligible (combined). There are approximately 89 RNs and 5 pharmacists in the facility who will be trained in the BMV process. Those providers administer approximately 319,000 doses of medication to patients annually. Currently, only 10% of inpatients receive consultations by clinical pharmacists prior to discharge (approximately 306 patients).

- **Category 1 or 2 expected patient benefits:** Spohn expects to achieve 90% adherence to the barcoding system by the end of DY3, for 70% of inpatients to receive medication reconciliation upon discharge (expected to impact 2,141 patients), and for 30% of inpatients to receive in-person counseling from the clinical pharmacists prior to discharge; approximately 918 (30%) inpatients. This improvement will benefit the hospital-wide health outcomes for patients who receive medication as inpatients in Spohn’s Kleberg facility.

- **Category 3 outcomes:** IT 4.10 – Medication Errors. By DY5, Spohn expects a 15% reduction in bedside medication administration errors in its Kleberg facilities, due to the implementation of the barcode system for medication management. IT4.10 – Average Length of Stay. By DY5 Spohn expects a 10% increase in RN/Clinical Pharmacist utilization review for high risk patients and those patients receiving medications identified as high risk for medication errors. IT4.10 – Cost Savings. By DY5 Spohn expects to implement a Cost Minimization Analysis (CMA) to
demonstrate cost savings in care delivery associated with medication management utilization review in high risk patients, specifically long-term treatment patients eligible for Intravenous (IV) home infusion therapy.
Implementation of Bedside Medication Verification (BMV) Process

Project 2.11: Conduct Medication Management
Project Option 2.11.1: Implement interventions that put in place the teams, technology, and processes to avoid medication errors.

CHRISTUS Spohn Hospital Kleberg/ TPI 136436606
Unique Identifier - 136436606.2.1

Project Description:
This is a large scale project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. The project requires integration between Pharmacy, Information Technology (IT) and Nursing. All doses of medications must have a viable barcode that is to be read into the Meditech informatics system. It should be noted that many medications arrive in a pharmacy in the form of bulk bottles (approximately 30% of inventory). These bulk bottles must then be repackaged into individual units of use which contains the barcode that is used to verify the correct medication. The repackaging of this medication requires high reliability standards. Given this requirement, Spohn determined that the majority of these medications should come from one site in order to reduce variability. Establishment and implementation of a central site of distribution from which most drugs will be administered is a key requirement of the process that must precede the successful transition to a bedside verification system. Another challenge is the fact that this process requires all nurses to have a computer available to them at all times in order to scan the patients’ arm band and the medication being administered, as well as documenting the administration into an electronic medication administration record (eMAR). Spohn conducted a feasibility study to calculate the number of personal computers necessary, and determined that additional safety features are needed to ensure scanning of patient ID bracelets versus patient labels or stickers generated on the care delivery units. These labels are known shortcuts reported in the nursing and pharmacy literature due the increased difficulty with scanning the patient’s ID bracelet. Unique printers with the ability to generate a 2D barcode, similar to those barcodes now seen in advertising and various industries, provides the additional security against medication errors by ensuring the scan occurs at the point of care. These 2D barcodes contain additional patient-specific information not available in current barcoding.

Spohn will develop guidelines to incorporate the 2D barcoding into practice to ensure the most efficient location of 2D barcode printers and protection of private health information. The barcoding process will streamline the administration of medication, and will implemented in tandem with all facilities targeting an improvement in the number of patients receiving in-person consultations from clinical pharmacists regarding their medications prior to discharge. Additionally, whether or not patients receive an pharmaceutical consultation, patients’ medications that need to be continued, discontinued, and/or changed upon discharge will be reconciled by the providers upon discharge from the inpatient setting.

The fact that this project represents a dramatic paradigm shift for Spohn means that, adequate training of both nursing staff and nursing staff is major priority. For this requirement, Spohn will designate super user groups to provide much of the hands on training of all staff.

Medication errors are associated with a significant number of deaths. The literature estimates that 70% of fatal medication errors were preventable and the cost of $4,000 - $8,000 associated with
medication errors that reach the patient (IHI; To Err is Human). The right medication must be given to the right patient, at the right time, in the right dosage and via the right route. Errors in any of these stages can lead to serious consequences. By requiring a barcoded step to verify right patient, right medication and implementing an electronic medication administration record (eMAR) that confirms the right time, many of these errors can be avoided.

Implementation of an intra-disciplinary case management/utilization review program at point-of-entry coupled with the barcoding process and increase in the number of patient consultations with clinical pharmacists, Spohn can assure that patients’ medications are safely administered in the hospital and safely managed by patients upon leaving the hospital. Spohn will evaluate reductions in average length of stay and cost savings in care delivery using Cost Minimization Analysis (CMA) for BMV, clinical pharmacist consultation and utilization review.

**Goals and Relationship to Regional Goals:**
The goal of this project is to implement the use of a barcoding system that clinicians can use to identify and document the administration of medications for all hospitalized patients. The expansion of this program will include the documentation not only at the bedside but at the point of entry into the system. When Pharmaceuticals arrive for use into the hospital region they will documented for tracing purposes so that any safety recalls can be monitored and further provide a save mechanism for our pharmacy professionals. Pharmacy consults and multidisciplinary utilization review to facilitate medication management will not only assist to prevent medication errors but also identify opportunities to optimize medication selection, identify patients receiving medications known to be high risk for errors and opportunities to reduce average length of stay for patients through utilization review and medication management.

Regional opportunities for providers include the decrease in preventable complications and further the reduction in cost of care for the community we jointly serve. Medication Management is crucial in the decrease in cost of care, reductions in length of stay and in the compilation of data that physicians can use to assure that electronic data is reliable and safe.

**Challenges:**
The primary challenge will be to engage the physician provider groups with adhering to the use of the new BMV system and assuring that network and regional communication occurs and continues so that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success. The success of BMV is directly in support of the CPOM system. The reduction in transcription errors will provide for a more reliable use of medication administration. With the implementation of the Meditech “Unity” standardization project, the BMV project will leverage both standards and advanced clinical technology to enhance patient safety, reduce medication administration errors, and reduce the overall cost of providing services.

**Starting Point/Baseline:** Prior to implementing the BMV program, Spohn providers administered medications from handwritten orders. Those handwritten orders were scanned to the Pharmacy department, which then manually transcribed the orders into a pharmacy-specific computer application. Simultaneously, the RN on duty manually entered the medication ordered onto the
patient’s Medication Administration Record (MAR). The RN then used the MAR to withdraw the meds entered by the pharmacy from the electronic dispenser and administer that medication to the patient. This process allowed for administrative errors because RNs would often pull several patients’ medications at a time and then mis-administer the medications by failing to verify the patient identifiers. At midnight each night, a new MAR was printed for each patient, and the RN had to reconcile the new MAR with the previous day’s MAR and verify any changes order in the last 24 hours. The BMV process will allow the pharmacy to use the Medi-tech module that is connected with the patients’ EMR. Additionally, the pharmacy will not do any manual transcription of orders into the system. The BMV program also allows RNs to access eMAR instead of individual paper-versions of patients’ prescriptions and the bar-coding technology provides a safety feature to assure that the patient receives the correct medication and dosage. Clinical Pharmacists consulted on approximately 161 (10%) inpatient discharges during FY12. The intra-disciplinary Utilization Review Program will be initiated as a result of the reduction in average length of stay and cost savings in care delivery identified with Bee County charity care.

**Rationale:** Spohn chose this project with the goal of reducing the possibility for errors in delivering medication at its facilities, improving its system for medication reconciliation upon discharge, and enabling patients to safely manage the medications they must continue upon discharge. At the hospital level, many medications are purchased and/or delivered in bulk, creating opportunities for either mislabeling or dispensing errors, which could result in unintended health complications. To reduce the possibility of such inadvertent errors, and to improve the management of delivery of medication, Spohn will implement a new medication management system to improve the delivery of medication and instructions to patients. By matching barcodes on medications with patients, the BMV system will allow multiple healthcare professionals to understand and deliver the proper medication to patients, reducing the risk of errors and improving the overall health of the patient population, consistent with the goals of the Waiver.

When patients are discharged, it is important to reconcile their medications to the amount/type required when transitioning from an inpatient to an outpatient. Part of this process can be done electronically, but Spohn also believes that more patients need in-person consultations from clinical pharmacists so they can effectively administer and manage their medications at home, and can avoid contraindicated medications that may be prescribed by another physician or purchased over the counter.

**Milestones and Metrics:** Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project and incentivize reductions in medication error rates, which will achieve the goals of the Waiver.

**Community Needs Addressed:** Spohn Kleberg’s 6 month medication errors totaled 124 for errors reported in 2011. Medication administration specific errors accounted for 23% of the total reported, which is a statistic that can be minimized or even eliminated by bedside barcode scanning and automated electronic medication administration record (eMAR) documentation. The target population of this project is all inpatients in Spohn’s Kleberg facilities, 14% of which are uninsured or Medicaid-eligible.
**Community Needs Addressed by Identification Number:**
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

**Project core components:**
a. Spohn will develop a system to ensure this project is implemented first to acute care patients at its Kleberg hospital facility. The system will be developed and implemented in DY 2 as part of accomplishing Milestone 1.
b. The system will include tools to provide education and support to patients in acute settings to reduce risk of medication errors, which will be implemented in DY2 as part of Milestone 1.
c. In the first year of the Waiver (DY1) Spohn performed an analysis of the root cause of potential medication errors and identified repackaging as one area of concern. To that end, the project plan will include the processes Spohn has identified to address the repackaging steps to reduce error rates.
d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 4 specifically).

**Related Category 3 Outcome Measure(s):**
OD – 4 Potentially Preventable Complication and Healthcare Acquired conditions.

**IT-4.10 Other Outcome Improvement Target:**
- *Decrease in errors in Bedside Medication Administration*

**IT-4.10 Other Improvement Target:**
- *Average length of stay for high risk patient and patients receiving medications identified as high risk for medication errors*

**IT-4.10 Other Improvement Target:**
- *Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review using Cost Minimization Analysis.*

Spohn chose this outcome because this project to implement electronic medication management and involve the clinical pharmacists in medication management is expected to reduce the patient fall rate by allowing the pharmacists and providers to take proactive steps to avoid falls caused by a medication-induced altered state (by either changing the medication or monitoring patients at risk more closely).

**Relationship to Other Performing Providers’ Projects in the RHP:**
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7. - *Medication Management to reduce medication administration errors, 136436606.2.2 (CPOM) and 136436606.2.3 (Sepsis).*
Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

1. **Achieves Waiver Goals.** This project directly relates to assuring quality of care, improving the health of patients and reducing costs of care by removing opportunities for medication management errors for all patients, including the low-income and underserved patients. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Although medication mismanagement was not an identified community need, improvements that reduce opportunities for errors help to reduce the community’s need for costly procedures following medication errors and can help to reduce the high level of chronic disease in the community.

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve and found that improvements in medication management will serve most patients receiving care at Spohn’s facilities.

4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects.¹⁵⁴

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn ensured that each project comports with the final

¹⁵⁴ For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #95302
Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rate because it leads to improvements in the overall health of patients but does not expand the availability of care.
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<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
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<tbody>
<tr>
<td></td>
<td>136436606.3.3, 136436606.3.4, 136436606.3.5</td>
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<tr>
<td></td>
<td>3.IT-4.10, 3.IT-4.10, 3.IT-4.10</td>
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**CHRISTUS Spohn Hospital Kleberg**

**Med Management – Bedside Medication Verification**

**Errors in Bedside Medication Administration; Average length of stay for high risk patients and patients receiving meds at high risk for error; Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Milestone 1 [P-1]:</strong> Implement a medication management system; bedside medication verification with barcoding (BMV) <strong>Metric 1 [P-1.1]:</strong> Program documentation for people, processes and technology  <strong>Baseline/Goal:</strong> Implementation of BMV at CSHK  <strong>Data Source:</strong> Written medication management plan including workflow for providers</td>
<td><strong>Milestone 3 [I-13]:</strong> Implement electronic medication reconciliation at the point of care  <strong>Metric 1 [I-13.1]:</strong> Increase the number of patients that receive electronic medication reconciliation at the point of care  <strong>Goal:</strong> 25% use of electronic medication reconciliation for inpatients of the facility  <strong>Data Source:</strong> EMR</td>
<td><strong>Milestone 5 [I-14]:</strong> Provide reconciliation of medications at discharge <strong>Metric 1 [I-14.1]:</strong> Increase the percent of identified patients that have medications reconciled as a standard part of the discharge process  <strong>Goal:</strong> 90% compliance with medication reconciliation upon discharge  <strong>Data Source:</strong> EMR</td>
<td><strong>Milestone 6 [I-15]:</strong> Increase number or percent of patients that receive consultation by clinical pharmacists, prior to discharge in the in-patient setting and upon refilling a new prescription in the outpatient setting.  <strong>Metric 1:</strong> X% of patients receiving consultation by clinical pharmacists  <strong>Baseline/Goal:</strong> Currently, an estimated 10% (or 306 in 3,059) of inpatients in the facility receive consultation from the clinical pharmacists upon discharge. Spohn will increase that percentage by 20% to achieve a 30% total number of inpatients receiving consultations (or 918 in 3,059) from clinical pharmacists upon discharge by the end of DY5.  <strong>Data source:</strong> Patient EMR</td>
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<td>Milestone 1 Estimated Incentive Payment: $58,257</td>
<td>Milestone 3 Estimated Incentive Payment: $59,583</td>
<td>Milestone 5 Estimated Incentive Payment: $118,981</td>
<td>Milestone 6 Estimated Incentive Payment: $96,072</td>
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<p>| Milestone 2 [P-X]: Identify shortcuts and work-arounds to improve efficiencies w BMV processes <strong>Metric 1 [P-X.1]:</strong> Evaluate, modify BMV processes to eliminate identified work-arounds.  <strong>Baseline/Goal:</strong> Review BMV processes 6 months post-implementation to identify work-arounds.  <strong>Data Source:</strong> Staff input, variance reports, medication error investigations  | Milestone 4 [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions  <strong>Metric 1 [P-9.1]:</strong> Number of new ideas, practices, tools or solutions tested.  <strong>Baseline/Goal:</strong> Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement  <strong>Data Source:</strong> FAQs, Up-to-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions  | Milestone 6 Estimated Incentive Payment: $96,072 |
| Milestone 2 Estimated Incentive Payment: $58,257 | Milestone 4 Estimated Incentive Payment: $59,583 | |</p>
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>MED MANAGEMENT – BEDSIDE MEDICATION VERIFICATION</th>
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<tr>
<td>Outcome Measure(s):</td>
<td>136436606.3.3</td>
<td>Errors in Bedside Medication Administration; Average length of stay for high risk patients and patients receiving meds at high risk for error; Cost savings in care delivery for implementation of BMV and intra-disciplinary point of care review.</td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $116,514</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $118,981</td>
<td>Year 5 Estimated Milestone Bundle Amount: $96,072</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYS 2-5): $450,733*
Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.

CHRISTUS Spohn Hospital Kleberg/ TPI 136436606
Unique Identifier - 136436606.2.2

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s):** CHRISTUS Spohn Hospital Kleberg (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech.

- **Need for the project:** By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges. Spohn typically has 10,000-20,000 encounters in its hospital facilities per year, and approximately 8-10 orders are entered per encounter per day. With such a high volume of orders for a large number of patients, the need for a faster, safer, and more efficient system is great.

- **Target population:** According to our most recent data (Nov 2012), Spohn Kleberg is supported by over 46 providers, 80% of which will make use of this advanced clinical technology. The target population of this project is all inpatients and outpatients treated at Spohn, which amount to approximately 19,559 patients in FY2012 (3,059 inpatient, 13,135 ED patients), 39% of which are uninsured or Medicaid-eligible (combined).

- **Category 1 or 2 expected patient benefits:** By DY5, Spohn expects 75% of orders placed by providers for inpatients in acute care settings to be ordered electronically; 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter to be generated electronically; and 60% of prescriptions written to ED patients upon discharge will be generated electronically.

- **Category 3 outcomes:** IT-4. 10 – By DY5, Spohn expects 85% compliance for VTE Prophylaxis Core Measure Indicators in its Kleberg facility.
**Identifying Project and Provider Information:**

*Project 2.11: Conduct Medication Management*

*Project Option 2.11.2: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.*

**CHRISTUS Spohn Hospital Kleberg/ TPI 136436606**

**Unique Identifier -** 136436606.2.2

**Project Description:**

CHRISTUS Spohn Hospital Kleberg (“Spohn”) will implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into our primary Health Information System (HIS), Meditech. By moving order entry from a paper-based system where orders are entered by nurses and ward clerks directly to the providers, the project will help realize 1) Increased speed and reduced process times, 2) greater accuracy, 3) reduced validation/verification calls to units, 4) improved outcomes through faster process through clinical pathways, and 5) an overall reduction in costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.

**5 Year Expected Outcome**

Through implementing the CPOM system, Spohn expects the following outcomes:

1) 75% electronic system adherence by providers placing orders/prescriptions for inpatients in the acute care setting by the end of the Waiver

2) 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter generated electronically by the end of the Waiver

3) 60% of prescriptions written for ED patients upon discharge generated electronically by the end of the Waiver.

**Goals and Relationship to Regional Goals**

This project is intended to internally upgrade the hospital’s management of information in a manner which upholds strategic safety initiatives and technological changes in healthcare. The use of electronic order entry communication and standards of practice by prescribing providers will allow for a safer order entry methodology and fewer medication transcription errors. Spohn will accomplish patient safety through order entry as the provider becomes integrated into the reliability process of care management. The extension and continued process improvement of order entry will formulate the basis for a comprehensive patient medical record that in the end help with data sharing between provider through an HIE network, allowing accountability in the care management between regional healthcare providers in the Region.

The project is related to Regional goals in that it is completely patient centered. The use of an electronic order system provides additional assurance that patients are provided treatment tailored to their individual health needs and adds safeguards against human error. Additionally, the expected reduction in medication transcription errors will reduce the cost of such mistakes, and improve patient satisfaction and quality of life.

**Challenges:**

The primary challenge will be to engage the physician provider groups to adhere to the use of this new CPOM system and assuring that network and regional communication occurs and continues so
that a truly computerized system exists. Education and change in culture of providers will be a continuous platform for improvement. The wide range of providers not only in age, experience and desire to progress to the use of an electronic medical record will be a challenge. Educational champions and support from technology will prove to be the basis for success.

Starting Point/Baseline:
The U.S. Department of Health and Human Services (HHS) Center for Medicare and Medicaid Services (CMS) has mandated that US healthcare providers make efforts towards achieving participation in electronic health initiatives. To that end, healthcare provider organizations are encouraged to meet several measurement criteria over the course of time. The ultimate goal of meeting these criteria is to (1) Improve access to healthcare nation-wide, (2) Improve clinical outcomes and the patient experience, and (3) Decrease the cost of healthcare. By implementing CPOM, Spohn will meet HHS/CMS goals and improve the overall health of the 1.5 million inhabitants of South Texas we serve.

According to our most recent data (Nov 2012), Spohn Kleberg is supported by over 46 providers, 80% of which will make use of this advanced clinical technology. Spohn Kleberg’s annual medication errors totaled 124 for errors reported in 2011. Medication transcription specific errors accounted for 40% of the total reported, which is a statistic that can be minimized by CPOM. Based on the nearly 10,000 – 20,000 typical annual encounters (based on FY-12 statistics, with approximately 26% being Medicaid and uninsured) within the region, the impact will be realized extensively throughout our Spohn Kleberg service area. Based on the project implementation timeline, FY-12 data will be used as the initial baseline data. Currently, orders and prescriptions are written on paper and entered into the hospital system manually by nurses, which can lead to transcription errors, is inefficient, and allows some orders/medications that could be automatically entered to be missed.

Rationale:
Spohn has chosen Meditech as its primary health information system. As the leading nation-wide, fully integrated system, Meditech offers the ability to directly interface multiple aspects and processes from the patient care continuum. As such, when moving to CPOM, Spohn will facilitate quick recall of consistent information from not only orders, but also lab results, diagnostic images, medication management and reconciliation, and numerous other clinical areas. Additionally, through our Novo interface engine, Spohn offers local, secure access to providers’ patient data, further streamlining the patient care process. While Meditech is a solid, cost effective solution, preparation for the deployment of CPOM, an advanced clinical process supported by technology, does not come without a significant financial investment (discussed below in “enabling projects”).

Project components and phases – As in most any major technology enabled project, CPOM consists of several phases. While some of these phases are executed concurrently by function and/or location, each is key to the successful completion of the project. In summary, the project phases include System Design and Set-up, System Build, Testing – including unit and integrated testing, Super User and End-user Training, System “Go-Live”, and post “Go-Live” support.

Enabling projects –
Unity – The Meditech “Unity” project was completed in February 2012 in preparation for the CPOM project. The Unity project required the upgrade and standardization of the Meditech application to version 5.6.4 throughout the entire CHRISTUS Health System. Achieving this standard
enabled enterprise wide maintenance and support, faster turnaround on system issues, and streamlined process changes.

Network upgrade – In conjunction with the Unity project, CHRISTUS Health conducted network upgrade and server standardization. Consolidating the physical and virtual server environments to the CHRISTUS Health Information Technology Center (ITC) in San Antonio, Texas enabled several of the support improvement mentioned about. Additionally, by elimination much of the regional and local data center support operations (nine regions and numerous locally supported file servers), CHRISTUS Health was able to husband the financial resources necessary to fund this multi-million dollar enabling project.

Wireless Infrastructure Upgrade – Prior to October 2011, the CHRISTUS Spohn Health System maintained approximately 100 Wireless Access Points (WAPs) in six hospitals. These devices enabled secure wireless access to the CHRISTUS Spohn computer network and associated applications. However, while access was sufficient for most unit based systems and devices, it was insufficient to handle the additional capacity and mobile nature of the devices and systems required for an advanced clinical program such as CPOM. Accordingly, in October of 2011, CHRISTUS Health completed a comprehensive analysis and upgrade of its wireless infrastructure. The number of WAPs were increased to over 200 and existing WAPs were upgraded or replaced with newer models capable of handling the increased mobile device requirements of CPOM.

Equipment technical refresh (New Clinical Workstations) – In order to ensure adequate PC resources by each unit’s support staff, CHRISTUS Health has recently upgraded over 500 PC’s throughout the SPOHN Health System. Priority of technical device refresh has been to clinical areas and supporting ancillary areas.

CPOM Specific Equipment Deployment – While support staff (nurses, unit clerks, techs in the OR, Post-op, lab, pharmacy, radiology, and other key areas) have received new PCs, the providers are getting additional PC resources specifically supporting individual order entry, medical record recall, and test results access. Using a combination of CHRISTUS Health standards and national best practice PC configuration analysis, CHRISTUS Spohn is deploying 325 additional devices for providers. These devices consist of a combination of 200 advanced desktop PCs for static, unit based clinical documentation and 125 mobile PCs of “PDOCs” (Provider Documentation Stations) that may be used during provider rounding on multiple units. In addition to PCs and mobile stations deployed for provider documentation, CHRISTUS Spohn Health System is also providing instruction and configuration assistance for individual provider personal devices (e.g. iPads, iPhones – iOS supported devices and HTC Flyer, Android Phones and other Android OS support devices) to access the CHRISTUS network.

PC Operating System Upgrade (Windows XP SP3 to Windows 7 SP1) – In order to take full advantage of Meditech’s CPOM capability as well as other interfaced systems (PACS, Pharmacy, Health Information Management, etc.), CHRISTUS Health is upgrading the standard PC operating system from Microsoft Windows XP (Service Pack 3) to Windows 7 (Service Pack 1). This upgrade will be complete prior to the completion of the CPOM project.
Milestones and Metrics: Spohn chose the Milestones for the first year to ensure that the project is developed and implemented properly, including a quality improvement assessment to identify and resolve any shortcomings in the program. For years 3 to 5, Spohn chose the Milestones to incentivize the extension and implementation of the project through its physician network and incentivize use of the CPOM system, which will achieve the goals of the Waiver.

Community Needs Addressed through the Project: Spohn Kleberg’s annual medication errors totaled 124 for errors reported in 2011. Medication transcription specific errors accounted for 40% of the total reported, which is a statistic that can be minimized by CPOM. Based on Spohn’s 10,000-20,000 typical annual encounters (based on FY 2012 statistics, with approximately 26% being Medicaid and uninsured) within the region, the impact will be realized extensively throughout our Spohn Kleberg service area.

Community Needs Addressed by Identification Number:
CN.3 – Inadequate Provision and coordination of health care services for persons with chronic conditions.
CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services.

Project Core Components:
ar. Spohn will develop a system to ensure this CPOM project is implemented first to acute care patients at its facility, with the rollout to additional areas of the hospital thereafter. The system will be implemented in DY 2.
b. The system will include tools to provide education and support to patients in acute settings to reduce delays in implementing orders and possible errors in interpreting or transcribing orders, which Spohn will implement in DY2 through Milestone 1.
c. Spohn has already undertaken in the first year of the Waiver (DY1) an analysis of physician order implementation and identified transcription errors and delays as one area for improvement. To that end, the project plan will include the processes Spohn has identified to remedy the transcription errors and delays by having the physician enter the orders directly.
d. Throughout the project, Spohn will evaluate best practices and its implementation process to identify lessons learned, remedies for unanticipated procedural issues and other improvements designed to reduce medication errors (see Milestone 3 specifically).

Related Category 3 Outcome Measure(s):
OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 Compliance with VTE Prophylaxis Core Measures

Reasons for selecting the outcome measures:
Spohn is continuously improving its CPOM services with the goal of reducing variations in the delivery of services based on delayed or misinterpreted physician orders. Spohn has a low compliance for CMS VTE Prophylaxis Core Measure indicators. The use of CPOM is expected to improve Spohn’s percentage of compliance and reduce potentially preventable complications for VTE in Spohn’s facility.
Relationship to Other Performing Providers’ Projects in the RHP:
The need for full implementation of safe and reliable medication administration is paramount for all providers within RH4. EMR’s are being used throughout the region and the new CMS requirement for Health Information Exchange will be dependent on the use of electronic documentation. This project is of great importance to not only Spohn providers but also those providers that have or are in the process of implementing such a process. Other projects which this activity will enhance or support include 121775403.2.6, and 121775403.2.7. - Medication Management to reduce medication administration errors.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. While no providers other than Christus Spohn facilities have proposed projects for medication management, we will collaborate with providers who have a variety of initiatives designed to improve patient outcomes, reduce complications and reduce health care costs.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, and in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn valued this project upon consideration of the following four criteria:

1. **Achieves Waiver Goals.** This project directly relates to assuring quality of care, improving the health of patients and reducing costs of care by removing opportunities for physician order delays or errors for all patients, including the low-income and underserved patients. Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Although physician order entry implementation was not an identified community need, improvements that reduce opportunities for delays and errors in receiving proper care help to reduce the community’s need for inconsistent care and can help to reduce the high level of chronic disease in the community.

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve, and found that
improvements in physician order implementation will serve most patients receiving care at Spohn’s facilities.

4. **Project Investment.** Relative to the Spohn’s other proposed projects, the expected investment to successfully implement this project and achieve the milestones and metrics is less than other projects.\(^{155}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of the project. Spohn calculated the initial project values for this project based on Spohn’s allocation of funding and the Value Weight of this project, relative to the Value Weights of Spohn’s other projects. After each project was valued, Spohn ensured that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project, and (2) prescribes the maximum funding distribution allocation to categories 1 and 2.

Spohn estimates that this project will be less costly to implement and rated it modestly in meeting the aims of the Waiver. Relative to other Spohn projects, this project has the lowest overall rate because it leads to improvements in the overall health of patients but does not expand the availability of care..

\(^{155}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.
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<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Implement a medication management system</td>
<td><strong>Milestone 3</strong> [P-9]: Review project data and respond to it every week with tests of new ideas, practices, tools or solutions</td>
<td><strong>Milestone 5</strong> [I-18]: CPOE utilization measure</td>
<td><strong>Milestone 7</strong> [I-12]: Implement electronic prescription writing at the point of care</td>
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<tr>
<td><strong>Metric 1</strong> [P-1.1]: Program elements to include document of program, people and technologies required to implement system Baseline/Goal: Implementation team and Infrastructure in place for CPOM/Med Mgmt. Go-Live Data Source: Implementation plan with team, infrastructure and processes documentation</td>
<td><strong>Baseline/Goal: Provide open, continuous communication among implementation team and end users/direct providers to facilitate continuous improvement</strong> Data Source: FAQs, Up-To-Date posting of issues with resolutions, cataloguing of ideas, tools and solutions</td>
<td><strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient Goal: 75% of orders in the acute care setting are entered electronically Data Source: EMR reports, hospital informatics reports and audits documentation</td>
<td><strong>Metric 1</strong>: Increase number of new and refill prescription written and generated electronically Numerator: number of new and refill prescriptions written and generated electronically Denominator: number of new and refill prescriptions written in a specific time period Baseline/goal: 60% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically</td>
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<td>Milestone 5 Estimated Incentive Payment: $59,490.50</td>
<td>Milestone 7 Estimated Incentive Payment: $48,036</td>
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<td><strong>Milestone 2</strong> [P-7]: Implement CPOM to allow providers to enter medical orders directly via computer, replacing the more traditional paper, verbal, telephone and fax methods <strong>Metric 1</strong> [P-7.1]: Create a system to implement CPOM Baseline/Goal: Transition at least 50% of physician orders to electronic order entry Data Source: Patient medical records and EMRs, Hospital informatics utilization reports</td>
<td><strong>Milestone 4</strong> [I-18]: CPOE utilization measure <strong>Metric 1</strong> [I-18.1]: Increase number of electronic entry orders per patient Goal: 60% of orders in the acute care setting are entered electronically Data Source: EMR reports, hospital informatics reports and audits documentation</td>
<td><strong>Metric 1</strong>: Increase number of new and refill prescription written and generated electronically Numerator: number of new and refill prescriptions written and generated electronically Denominator: number of new and refill prescriptions written in a specific time period Baseline/goal: 30% of prescriptions written for inpatients upon discharge and/or refilled thereafter are generated electronically</td>
<td><strong>Milestone 8</strong> [I-17]: Increase the number of patient visits for which a medication is prescribed that have medication reconciliation and prescription generation performed electronically. <strong>Metric 1</strong>: Percent of patient visits at which a medication was prescribed that had medication reconciliation and prescription generation performed electronically. Numerator: number of ED visits where medication is prescribed electronically to patient’s pharmacy</td>
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<td>Milestone 2 Estimated Incentive Payment: $58,257</td>
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**Related Category 3 Outcome Measure(s):**

- 136436606.3.6
- 3.IT-4.10

**Computerized Physician Order Entry (CPOE)**

**CHRISTUS Spohn Hospital Corpus Christi**

**Compliance with VTE Prophylaxis Core Measure Indicators**
### Related Category 3 Outcome Measure(s):

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**Outcome Measure Details**

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**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $116,514

**Year 3 Estimated Milestone Bundle Amount:** $119,166

**Year 4 Estimated Milestone Bundle Amount:** $118,981

**Year 5 Estimated Milestone Bundle Amount:** $96,072

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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5):* $450,733
Improvement in Quality and Safety for patients with Sepsis; 2.8.11
CHRISTUS Spohn Hospital Kleberg/ 136436606
Unique Identifier - 136436606.2.3

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Well counties averaging 17,101 patient days and 3,879 discharges annually.
- **Intervention(s):** This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) within Spohn’s Kleberg provider facilities.
- **Need for the project:** In FY 2012, Spohn completed 4900 MEWS tools (sepsis screening) and identified 178 cases of sepsis. Of the cases identified, 16% were Medicaid/uninsured (28 cases). The average length of stay for a septic patient was 4 days and the average charge per patient was $96,000 totaling in $6.6 million in charges. Spohn collected $1.7 million of those charges, meaning the remaining $4.9 million went uncompensated. The sepsis mortality rate in FY 2012 was 5% of all cases (3 deaths). **Target population:** The target population includes all patients in Spohn’s hospital campuses who are at risk for sepsis, including elderly and surgical patients. Spohn discharges approximately 4,113 inpatients annually, 29% of which are Medicaid/uninsured (approximately 1,173 inpatients). **Category 1 or 2 expected patient benefits:** By DY5, Spohn expects to achieve 95% (estimate 169) of patients with a suggestion of severe sepsis or septic their lactate level drawn by DY5. In addition, Spohn expects a 10% increase in the number of patients screened with the MEWS tool by DY5.
- **Category 3 outcomes:** IT-4.8 – By DY5, Spohn expects this project to result in a 2% reduction in septicemia mortality rates in Spohn’s Kleberg facilities from the baseline established in DY2.
DSRIP Projects – CSHK: Sepsis

Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:
Improvement in Quality and Safety for patients with Sepsis; 2.8.11
CHRISTUS Spohn Hospital Kleberg (“Spohn”)/ 136436606
Unique Identifier - 136436606.2.3

Project Description:
This intervention consists of implementing both the Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl) in Spohn’s provider facility. Spohn will gauge resultant improvements in care through the assessment and monitoring of process and outcome measures across the lifespan of the project. Initially, measurements will constitute a baseline from which improvements at subsequent intervals will be gauged. Providers needed for this concept include nurse practitioners, nurses and physicians within hospital settings.

Project Goals/Five Year Expected Outcome: By using nurse practitioners, nurses and physicians to implement both Sepsis Resuscitation and Sepsis Management Bundles, this project’s goals are:

- Implement a 90-day rapid cycle improvement plan for sepsis.
- 15% increase in cases with resuscitation initiated within 6 hours- orderset initiation.
- 15% increase in use of electronic MEWS by nursing staff on patients admitted to medical/surgical units.

Project Challenges: The top challenge of this initiative will be automating the MEWS screening tool and provider compliance with bundles. Implementation will consist of staff education, provider training, point of entry protocol development, sepsis bundle and sepsis management bundle implementation set forth as a 90-day rapid cycle improvement.

Starting Point/Baseline:
In FY 2012, Spohn completed 4,900 MEWS tools (sepsis screening) and identified 178 cases of sepsis. Of the cases identified, 16% were Medicaid/uninsured (28 cases). The average length of stay for a septic patient was 4 days and the average charge per patient was $96,000, totaling in $6.6 million in charges. Spohn collected $1.7 million of those charges, meaning the remaining $4.9 million went uncompensated. The sepsis mortality rate in FY 2012 was 5% of all cases (3 deaths). In 2012, approximately zero % of patients had lactate drawn upon a suggestion of sepsis or severe septic shock; the target should be 100% because the lactate level confirms the presence of sepsis.

Rationale:
Severe sepsis is a major healthcare problem that affects millions of people around the world each year with an extremely high mortality rate of 30 to 60 percent. Mortality from sepsis is greater than breast cancer, lung cancer and colon cancer combined and is the number one cause of death in the non-coronary ICU. The incidence of severe sepsis is expected to double over the next 25 to 30 years. Thus, it is imperative for the health and safety of Nueces County residents who may be hospitalized and exposed to this infection at some point during their lives that CHRISTUS Spohn Hospital Kleberg
(“Spohn”) take steps to detect sepsis early and have a tried and true protocol for responding effectively.

Our goal at Spohn is to reduce septicemia mortality. In order to impact this mortality rate, early recognition for signs and symptoms of sepsis and immediate initiation of treatment is required. Time is of the essence making this a high priority initiative with a substantial amount of work to accomplish over a short period of time. This full scale quality improvement initiative requires a structured and defined process to ensure all phases of improvement are completed; Plan-Do-Study-Act. This system-wide initiative will be accomplished using a 90-day rapid cycle improvement process specific to early recognition and treatment of sepsis.

**Milestones and Metrics:** Spohn chose the DY2 milestones in order to put in place the infrastructure to improve its capability to quickly detect sepsis and respond effectively. In the subsequent years, Spohn chose milestones that would allow it to measure and improve its processes for responding to cases of sepsis within the hospital at a consistent rate.

**Ties to Community Needs Identification Number:** CN.18 (high rate of sepsis in Region 4)

**Project Components:**
- Baseline assessment (see baseline data)
- Review of evidence for early warning system tool and tool selection – will be part of completing Milestone 1 in DY2
- Identify team to champion initiative – include all stakeholders, must commit time to implement 90-day rapid cycle improvement and continuous improvement – will be part of completing Milestone 3 in DY3
- Plan – workflow, implementation, training, dissemination of information, metrics for short, intermediate and long term outcomes (will be part of Milestones 1 and 3).
  - Short term – recognition and treatment initiation
  - Intermediate – hardwire processes evidenced by consistent use of tools
  - Long term – reduce sepsis mortality rates, decrease cost associated with PPC
- Do – implement Modified Early Warning Score (MEWS) and Lactate Levels Draw upon Suggestion of Severe Sepsis or Septic shock – to be completed through Milestones 2 and 4
- Study – Analyze and interpret the results – to be completed through Milestones 5-9 in DYs 3-5.
- Act – Identify areas for change and implement rapid process to resolve – to be completed as part of Milestones 5-9 in DYs 3-5.

**Related Category 3 Outcome Measure(s):** OD 4 (Potentially Preventable Complications and Healthcare Acquired Conditions); IT 4.8 (Sepsis Mortality)

Spohn selected this outcome because the goal of creating the sepsis early warning system and corresponding protocols is intended to result in early recognition and treatment of sepsis in the medical/surgical patient population, which is in turn expected to result in a lower rate for sepsis mortality in Spohn’s inpatient population.
Relationship to other Projects:
This project relates to and supports the following projects because it requires the vigilance and cooperation of all hospital providers (including physicians):

121775403.1.5 – Expand high impact specialty scare capacity through development of a structured critical service model focusing on providing intensivists driven services;
121775403.2.2 – Establishment of Hospitalist Program model that provides continuity of care through clinical integration of services in non-ICU patients
020973601.2.2 – Apply process Improvement methodology to improve sepsis mortality and length of stay.
Related Category 4 measures include potentially preventable complications in RD-3 and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers who have submitted similar projects with whom we will collaborate include Corpus Christi Medical Center.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects; to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth
2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? \(^{156}\)

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

The value of this particular project is based on the prevalence of sepsis mortality across Texas hospitals, including in Nueces County. Sepsis can affect any at-risk patients in the hospital, thus the project is necessary to protect a myriad of different types of patients. The investment required for this project ties into implementing the early warning system, rapid-cycle improvement, and provider training. Ultimately, this project meets Waiver goals by focusing on improving patient health outcomes while also reducing the systemic cost of providing inpatient hospital care associated with sepsis.

\(^{156}\) For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #95314
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1 [P-7]**: Implement a rapid improvement project using Rapid Cycle improvement methodology  
**Metric 1 [P-7.1]**: Rapid Improvement Cycle for Sepsis; Standardize process, Set the measure, Validate the measure, Innovate implementation, Standardize new process, Continue cycle  
**Baseline/Goal**: Implement a 90-day rapid cycle improvement plan for Sepsis.  
**Data Source**: Documentation of all steps included in rapid cycle methods were performed.  
Milestone 1 Estimated Incentive Payment: $91,546.50 | **Milestone 3 [P-8]**: Train providers/staff on process improvement  
**Metric 1 [P-8.1]**: Number of providers/staff trained  
Baseline/goal: train all hospital mid-level staff in using the MEWS system and the processes that flow from identifying a case of sepsis  
**Data Source**: Documentation of training materials  
Milestone 3 Estimated Incentive Payment: $62,420.33 | **Milestone 6 [I-14]**: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1 [I-14.1]**: Percentage of patients who had lactate drawn with evidence that suggests severe sepsis and/or septic shock  
**Goal**: 75% (estimate 133) of patients with suggestion of severe sepsis will have lactate level drawn  
**Data Source**: EMR  
Milestone 6 Estimated Incentive Payment: $93,485.50 | **Milestone 8 [I-14]**: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1 [I-14.1]**: Percentage of patients who had lactate drawn upon evidence that suggests severe sepsis and/or septic shock  
**Goal**: 95% (estimate 169) of patients with suggestion of severe sepsis will have lactate level drawn  
**Data Source**: EMR  
Milestone 8 Estimated Incentive Payment: $75,485 |
| **Milestone 2 [P-1]**: Target workflow, processes and clinical areas to improve: Implement early warning system (MEWS) for sepsis on medical/surgical inpatient units.  
**Metric 1 [P-1.1]**: Identify and prioritize processes to improve  
**Baseline/Goal**: Implement an early warning system (MEWS) for sepsis on medical/surgical inpatient units in order to streamline the process for responding to sepsis and to improve patient outcomes.  
Milestone 2 Estimated Incentive Payment: $56,830.30 | **Milestone 4 [I-14]**: Measure efficiency – initiate CPOM for Sepsis  
**Metric 1 [I-14.1]**: Percentage of patients who had lactate drawn with evidence that suggests sepsis and/or septic shock  
Goal: 55% (estimate 97) of patients with suggestion of sepsis will have a lactate level drawn  
**Data Source**: EMR  
Milestone 4 Estimated Incentive Payment: $62,420.33 | **Milestone 7 [I-14]**: Measure efficiency – electronic documentation of MEWS in EMR  
**Metric 1 [I-14.1]**: Increase use of electronic MEWS by nursing staff  
**Goal**: 10% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 490 additional screenings)  
**Data Source**: hospital EMR reports  
Milestone 7 Estimated Incentive Payment: $93,485.50 | **Milestone 9 [I-14]**: Measure efficiency – electronic documentation of MEWS in EMR  
**Metric 1 [I-14.1]**: Increase use of electronic MEWS by nursing staff  
**Goal**: 15% increase in use on patients admitted to medical/surgical units over DY2 baseline (approximately 735 additional screenings)  
**Data Source**: hospital EMR reports  
Milestone 9 Estimated Incentive Payment: $75,485 |
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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>136436606.3.7</th>
<th>IT-4.8</th>
<th>Sepsis Mortality</th>
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<td>Data Source: Hospital quality documentation, sepsis dashboards</td>
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<td>Milestone 2 Estimated Incentive Payment (maximum amount):</td>
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<td>over DY2 baseline</td>
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<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):</td>
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<tr>
<td>Year 5 Estimated Milestone Bundle Amount:</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $708,295
Expand Care Transitions Program; 2.12.2
CHRISTUS Spohn Hospital Kleberg/136436606
Unique project ID number: 136436606.2.4

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s):** This project will expand Spohn’s Care Transitions program to focus on preventing readmissions for CHF and diabetes patients at Spohn’s Kleberg campus. Under the expansion, the RN Coach is the centerpiece of the program, and will function as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The RN Coach will facilitate the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit, the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge.

- **Need for the project:** Spohn’s Memorial campus launched the Care Transitions program in 2011 to target chronically ill charity patients for transition to self-management; however the scope for the first year was limited to 237 patients with a myriad of conditions. CHF-targeted Care Transitions is needed because CHF is the second most prevalent primary diagnosis in Region 4 and the most costly for preventable admissions. Spohn Kleberg has a 21% PPR rate for CHF; higher than the statewide average of 12.7%.

- **Target population:** The target population includes CHF and diabetes patients treated as inpatients at Spohn’s Kleberg campus who are Medicaid/self-pay/charity eligible. In FY2012, Spohn treated approximately 115 patients with CHF or diabetes, of which 31% were Medicaid/uninsured (the majority of the 115 (48%) were Medicare patients).

- **Category 1 or 2 expected patient benefits:** By the end of DY3, Spohn expects to have fully implemented the CHF and diabetes-targeted Care Transitions program at its Kleberg facility for all (estimate 35) Medicaid/self-pay/uninsured patients by the end of DY5.

- **Category 3 outcomes:** IT-3.2 – As a result of implementing the CHF-targeted Care Transitions at Kleberg, Spohn expects an 8% reduction in CHF 30-day readmission rates among its Kleberg facility.
**Expand Care Transitions Program**

**Category 2: Program Innovation and Redesign**

**Identifying Project and Provider Information:**
Expand Care Transitions Program; 2.12.2, CHRISTUS Spohn Hospital Kleberg/136436606
Unique project ID number: 136436606.2.4

**Project Description:**

The Care Transitions program addresses the priority of readmissions for chronically ill patients in our community through the Care Transitions Intervention Program. Frequently healthcare delivery is fragmented, lacks communication among providers and hospitals, and patients do not know how to access care or navigate the healthcare system. A reoccurring theme identified during the course of the program involved clients who did not understand how to manage their disease and discharged unprepared for the transition to the home setting. They are overwhelmed by their healthcare needs. This program is designed to empower patients and their families to become active shareholders and to promote quality healthcare in the community for the chronically ill. This expansion is in keeping with CHRISTUS Health’s commitment to creating healthier communities while reducing costs to the health care system.

The RN Coach is the centerpiece of this program, and functions as a facilitator of an interdisciplinary collaboration to transition patients from hospital to home self-care. The patient and caregiver are coached to play a central and active role in the formation and execution of the plan of care. The RN facilitates the intervention over a 33 day period by identifying and meeting with the patient at bedside, and conducting a home visit within 48-72 hours post discharge. In addition to the home visit the RN Coach will conduct 3 follow-up calls at intervals of 7, 14 and 31 days post discharge. The four conceptual domains are introduced to the patient, by the RN Transitions Coach, commonly referred to as the 4 Domains or Pillars of care:

1. Medication self-management and medication reconciliation
2. Use of a dynamic patient-centered record, the Personal Health Record [PHR]
3. Timely primary care / specialty care follow-up
4. Knowledge of red flags that indicate a worsening in condition and how to respond

The target population includes patients with high risk discharge conditions, multiple medications, and the chronically ill. Program goal is to improve patient outcomes, maintain quality, and assist the patient and caregivers with the transition from hospital to home. Care Transitions provides patients with the tools and support to promote self-management, improve communication between patient and the primary Care Physician; reducing preventable hospital readmissions.

At discharge the patient has a support team, comprising of an RN Transition Coach, a Community Health Worker, and caregiver with the patient as an active participant in recovery. This is a uniquely designed program which has demonstrated great success.

As patients successfully transition from hospital to home care with the assistance of the Care Transitions model, they will also receive an additional 18 months of support and self-management training from a certified community health worker. The Care Management/Care Partner program is a self-management support program, facilitated by a specially trained community health worker.
working under the direct supervision of a registered nurse. This is the systematic provision of education and supportive interventions to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress, goal setting, and problem solving support.

**Project Goals:**
- Implement the Care Transitions program for all Medicaid/uninsured/self-pay patients by DY5
- Reduction in avoidable CHF 30-day readmissions by 8% by DY5.
- Begin case management and discharge planning early; targeting high-risk patients and coordinate care.
- Improved care transitions from hospital to home; avoiding deterioration in health status, which often occurs upon discharge.
- Integrate hospital and outpatient care.

**Project Challenges:**
- Communication between inpatient and outpatient/community providers.
- Technology to support communication and electronic referrals.
- Potential enrollee’s may opt out of participating with Care Transitions Program.
- Barriers to care such as; financial, socioeconomic, and availability to providers.

CHRISTUS Spohn Hospital Kleberg (“Spohn”) will address these challenges by thoughtfully creating a plan to effectively communicate with patients and their caregivers about next steps and to establish a trusting, cooperative relationship. Providers will be trained to use the technology associated with the program. Finally, patients will be educated and encourage participating in the program, and the providers will work with clients to address financial and other barriers to participation.

**5 Year Expected Outcome**
The Care Transition Program has been in place on a small scale throughout the CHRISTUS Health System for over a year. Large amounts of research are now being published on the benefits and results of Care Transition Programs in Chronic Disease Management. Our 5-yr plan is to expand current Care Transition program coverage across diagnoses and payors. Despite our specific target for Medicaid, charity patients, and the uninsured, we have a responsibility to our community to provide the services for commercial payors that do not cover such programs or hold those that do to the same level of expectations.

Our plan is identified on the project timeline (2.12.1 Table) and consists of expansion beginning with CHF. Key to program success is continuous evaluation and targeted on-going improvement that will minimize inefficiencies and promote effective patient outcomes.

**Starting Point/Baseline:**
The CHRISTUS Spohn Community Outreach Program launched the Care Transitions Program in 2011 to assist charity care recipients with chronic diseases to transition from in-patient care to home self-management. Quarterly metrics demonstrate the effectiveness of the Care Transition and Care Partners program collaboration.

The thirty-three day RN intervention allows patients with complex needs to receive one on one instructions and coaching. In the reporting period, the provider averaged 948 encounters and served
237 patients from program implementation, which began in March of 2011 to the end of reporting period of June 30, 2012. Data is cumulative.

CHF-targeted Care Transitions is needed at Spohn Kleberg because CHF is the second most prevalent primary diagnosis in Region 4 and the most costly for preventable readmissions. Spohn Kleberg has a 21% PPR rate for CHF; higher than the statewide average of 12.7%.

Rationale:
Kleberg County, where Spohn’s Kleberg campus provides care, has a high rate of potentially preventable hospitalizations for the following conditions: bacterial pneumonia, congestive heart failure, COPD, and long-term complications related to diabetes (RHP Plan, Section 3, Table 10). Many of these patients have been hospitalized previously, and likely could have avoided subsequent hospitalizations if provided with the requisite support to transition to self-management of their conditions outside of the hospital setting. Additionally, Kleberg County is designated as a Medically Underserved Shortage Area, which means that patients are not receiving the primary care interventions they need to avoid repeat hospitalizations for manageable conditions (RHP Plan, Section 3, Table 11). The Care Transitions program can assist patients in finding and obtaining the medical support they need when resources are often limited.

The proposed plan is CHRISTUS Spohn Health System’s answer to reducing readmissions for chronically ill patients admitted to the six CHRISTUS Spohn facilities, by implementing the Care Transition and Care Partner Programs already in place at CHRISTUS Spohn Corpus Christi-Memorial. The Care Transitions model is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across health care settings. During an episode of illness, patients may receive care in multiple settings, often resulting in fragmented and poorly executed transitions. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention. The use of specialized teaching tools and red flag rules, allows the patient to learn self-management skills and become an active partner of their healthcare team. Engaging the patient and family to become active partners in their healthcare, has directly impacted re-admission rates in the initial targeted population group at CHRISTUS Spohn Hospital-Memorial. This has resulted in a significant reduction in hospital utilization within the targeted group.

The program can be easily implemented within the CHRISTUS Spohn Region to target disease specific diagnoses within the uninsured, managed care, or Medicare populations. The Care Transitions program has been successfully implemented at various facilities throughout the CHRISTUS Health System, to include St. Michael, St. Frances Cabrini, St. John, and Schumpert St. Mary, Spohn Memorial, and Spohn Shoreline. The average cost of care per client for the CHRISTUS programs regionally ending Q2 FY12 are such successes as pre-enrollment costs at $16,273 with a significant reduction in costs to the post-90 day enrollment cost of $3,425. Results from the current Care Transition program limited to the charity care population at CSHCC-Memorial have had the following impact:
  • Cost per case reduction 50%-75% based on site and target diagnoses
  • Decreased ED utilization for inappropriate visits stabilized per covered lives volumes
  • Average inpatient admission reduction >50% per patient
  • ALOS reductions by as much as 1 patient day
Milestones and Metrics:
Spohn chose Milestones 1, 2, and 3 in order to implement the expansion of the Care Transitions program by first putting processes in place at the new participating facilities, and to share best practices with other providers taking similar action in Region 4. It is imperative to the success of the program that the expansion plan and implementation includes provider training, consistent policies, and sharing of information. Spohn chose Milestones 4 to achieve full integration of the Care Transitions program for all Medicaid, self-pay, and charity patients by DY5.

Ties to Community Needs: CN.3, CN.4, CN.7, CN.12, CN.16

Related Category 3 Outcome Measure(s): OD 3 – Potentially Preventable Re-Admissions – 30 Day Readmission Rates; Improvement Target 3.3.2 – Congestive heart Failure 30 Day Readmission Rate

The Care Transition model will target patients admitted to the CHRISTUS Spohn Health System with a diagnosis of CHF. Care Transition nurses along with the medical team will enroll high risk CHF patients meeting program criteria, through admission census reports and daily rounding processes. The RN Transition Coaches and Community Health Workers will form community collaborations to promote healthcare and positively impact preventable hospitalizations for released CHF patients.

Relationship to Other Projects: This project’s focus on patient empowerment and education to improve care management of chronically ill patients is related to and will support many projects throughout the region. Primary projects with direct ties to this initiative include: 020811801.2.4 – Expand Care Transitions Program; 121775403.1.3: Implement a chronic disease registry to support and sustain management of patients in care transitions program; and 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care.

Related Category 4 Measures include Potentially Preventable Admissions in RD – 1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:
This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges with lessons learned and obstacles to delivery will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:
The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project.
Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects; to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics? 157

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with regard to its relevance to the goals of the Waiver; specifically, that the Care Transitions program is patient-centered, designed to improve patient outcomes and satisfaction, and should result in a reduction in the constantly growing cost of providing healthcare to the indigent and uninsured residents in Region 4. The project addresses community needs by targeting patients who have recently been released from the hospital and need assistance in order to avoid readmission – this is especially relevant for elderly patients, patients with chronic diseases, or patients who for other reasons have difficulty self-managing their conditions. The

157 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment.

#95312

RHP Plan for Region 4
investment necessary to expand this program is great, including provider training, creating infrastructure at newly participating facilities, and creatively engaging in patient and community outreach to garner participation and changes in behavior.
## CHRISTUS Spohn Hospital Kleberg

**Related Category 3 Outcome Measure(s):**
- **136436606.2.4**
- **136436606.3.8**
- **IT 3.2**
- **PPR – 30-day: CHF**

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<thead>
<tr>
<th>Milestone 1 [P-2]: Implement standardized care transition processes</th>
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<tr>
<td><strong>Metric 1 [P-2.1]: Implement Care transitions policies and procedures</strong></td>
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<tr>
<td><strong>Baseline/Goal:</strong> Care Transition standardization in Spohn’s Kleberg Facility, meaning consistent standards for eligibility, processes for patient coordination, and provider training— with a focus on CHF and diabetes patients</td>
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<td><strong>Data Source:</strong> Care Transitions Policies, Procedures, Protocols</td>
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<td>Milestone 1 Estimated Incentive Payment (maximum amount): $249,673</td>
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### Year 2 (10/1/2012 – 9/30/2013)

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<th>Milestone 2 [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects</th>
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<td><strong>Metric 1 [P-10.1]: Number of bi-weekly meetings</strong></td>
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<td><strong>Baseline/Goal:</strong> Establish open lines of communications to share learning experiences during 1st year after expansion with other RHP 4 providers – schedule interactions on a regular basis</td>
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<td><strong>Data Source:</strong> Meeting minutes/agenda, lessons learned, documented challenges</td>
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### Year 3 (10/1/2013 – 9/30/2014)

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<th>Milestone 3 [[I-14]: Implement standardized care transition program for the CHF and diabetes population</th>
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<tr>
<td><strong>Metric 1 [P-9.1]: Measure adherence to processes</strong></td>
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<td><strong>Goal:</strong> Full implementation of CHF and diabetes care transitions program at facility for all (estimate 35) Medicaid, self-pay and charity patients. <strong>Data Source:</strong> Care Transitions documentation, community outreach documentation</td>
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<td>Milestone 3 Estimated Incentive Payment: $254,960</td>
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### Year 4 (10/1/2014 – 9/30/2015)

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<th>Milestone 4 [[I-14]: Implement standardized care transition program for the CHF and diabetes population at facility</th>
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<td><strong>Metric 1 [P-9.1]: Measure adherence to processes</strong></td>
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<tr>
<td><strong>Goal:</strong> Full implementation of CHF and diabetes care transitions program at campus for all Medicaid, self-pay and charity patients. <strong>Data Source:</strong> Care Transitions documentation, community outreach documentation</td>
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<td>Milestone 4 Estimated Incentive Payment: $205,868</td>
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### Year 5 (10/1/2015 – 9/30/2016)

| Milestone 4 Estimated Incentive Payment: $205,868 |

### Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $249,673

### Year 3 Estimated Milestone Bundle Amount: $255,356

### Year 4 Estimated Milestone Bundle Amount: $254,960

### Year 5 Estimated Milestone Bundle Amount: $205,868

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $965,857
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Kleberg / 136436606
Project Unique ID: 136436606.2.5

- **Provider:** CHRISTUS Spohn Hospital – Kleberg is a 100-bed hospital in Kleberg serving a 900 square mile area and a population of approximately 31,000. It is the only acute care hospital for Kleberg and neighboring Kennedy, Brooks and lower Jim Wells counties averaging 17,101 patient days and 3,879 discharges annually.

- **Intervention(s):** Spohn will implement a screening and treatment protocol in its hospital EDs and Family Health Centers (FHCs) to identify patients with dual diagnoses (medical and behavioral health (BH)) and assign a case manager to coordinate their care. Two medical diagnoses, CHF and Diabetes, will be targeted for screening and identification of co-existing BH illness.

- **Need for the project:** Currently, Spohn patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 years earlier than those with mental health illness alone mainly due to unmanaged physical health. National studies show that approximately 58% of the adult population suffer from a medical condition and of those, 29% also have unaddressed behavioral health needs. Additionally, people with schizophrenia and bi-polar disorders are up to 3 times more likely to have three or more chronic conditions than people without those disorders.

- **Target population:** The target population includes all patients presenting to Spohn’s Kleberg hospital facilities and all of Spohn’s clinics with a CHF or diabetes diagnosis. A recent 9-month data review of Spohn ED visits with dual diagnoses shows that 38 patients presented with a CHF or diabetes diagnosis and secondary diagnosis of BH (20% of which were Medicaid eligible/uninsured). The approximate number of patients who presented in the ED with a diagnosis of CHF or diabetes is 233 (28% of which were Medicaid/uninsured, which is approximately 66 patients), and of those patients, 91 presented with Behavioral Health, indicating that only those with a clear presentation of BH were identified. Of the 233 CHF and diabetes patients, 142 were neither screened nor diagnosed for BH.

- **Category 1 or 2 expected patient benefits:** This project seeks to screen all CHF and diabetes patients for BH issues, and expects to refer 28 (20%) of those previously unscreened/undiagnosed patients to behavioral health specialists by the end of DY4, and expects a 40% of the target population referred to a BH specialist by the end of DY5; approximately 57 patients.

- **Category 3 outcomes:** IT-1. 9.2 - Spohn aims to reduce the volume of ED visits from CHF and diabetic patients 10% by DY5 due to this project because patients will be screened in the EDs and other treatment settings for BH referrals and will subsequently receive the treatment they need (which Spohn hopes will lead to reduced misuse of the ED).
Care Management to Integrate Primary and Behavioral Health Needs
Identifying Project and Provider Information:
Care Management to Integrate Primary and Behavioral Health Needs; 2.19.1
CHRISTUS Spohn Hospital Kleberg / 136436606
Project Unique ID: 136436606.2.5

Project Description:
This project focuses on identification and screening of target populations for co-existing physical and behavioral health diagnoses. CHRISTUS Spohn Hospital Kleberg (“Spohn”) will implement a screening and treatment protocol in its hospital campuses and FHCs to identify patients with dual diagnoses and assign case manager to these patients to coordinate their care. Spohn believes that identification and screening of these target populations will guide treatment plans for dual diagnoses, which will improve patient outcomes. In addition, identification of dual diagnoses in the acute care setting should improve the initiation of care management, which Spohn projects will impact in-patient outcomes and reduce LOS. Two medical diagnoses, CHF and Diabetes, will be targeted by this project for screening of co-existing BH illness. This screening will be initiated in Spohn’s ED and FHCs to facilitate early referral to a LMHP for further assessment or intervention. Concurrently, Spohn will perform medical screenings in the BH population in outpatient BH settings such as MHMR clinics. This project will be collaboration between Spohn’s Kleberg facility, LMHA, and Spohn’s Family Medicine and Emergency Medicine GME programs (wherein residents will be trained and participate in the screening processes).

Project Goals/Five Year Expected Outcome:
The goal of this project is to identify patients with dual diagnoses for behavioral and physical health conditions, and to intervene earlier and more effectively in their treatment and disease management. Spohn aims to reduce the use of the ED by patients with co-diagnoses for treatment and to reduce the amount and duration of preventable inpatient stays for these patients, which should result from proactive screening and earlier treatment intervention organized by case managers/care coordinators. Specifically:
• Spohn intends to implement screening protocols in its FHCs and hospital campuses to identify patients with a dual diagnosis of BH/depression and diabetes or CHF
• Spohn intends to assign these patients to Spohn staff who will act as care coordinators for this population

Project Challenges:
• Garnering participation in screening and treatment for chronically ill patients with behavioral health issues
• Educating physician and mid-level providers on effective methods for identifying, screening, and treating patients at risk for dual diagnoses (specifically, BH and CHF or diabetes)
• Hiring/training care coordinators to effectively manage the care of patients with these dual diagnoses

Spohn will address these challenges by engaging in thoughtful planning in DYs 2-3, seeking patient and community input into best practices and patient needs, and will refer to clinical best practices when training care coordinators.
Starting Point/Baseline:
Currently, patients with chronic illness do not undergo routine screening for co-existing BH diagnosis in the ED or acute inpatient setting. Likewise, BH patients are not routinely screened or managed by medical professionals to identify chronic medical disease concerns. A 9-month data review of ED visits with dual diagnoses shows:

- 233 patients presented with the target diagnoses of CHF or Diabetes
  - 91 also presented with a BH diagnosis
  - 142 were not screened for BH
  - 28% were Medicaid pending or uninsured

Rationale:
Spohn chose this project because Kleberg County is designated as a partial Health Provider Shortage Area in the mental health domain and the primary care domain, indicating the patients needing both mental health treatment and chronic disease management are likely slipping through the cracks in the system (RHP Plan, Section 3, Table 11). The American Council for Community Behavioral Health (2009) reported that patients with serious mental health diagnosis and a chronic medical diagnosis die an estimated 25 yrs. earlier than those with mental health illness alone mainly due to unmanaged physical health. National Comorbidity Survey Replication data (2001-2003) shows that approximately 30% of patients with a chronic medical disorder also have a mental health disorder. While those with BH illness and a secondary medical illness die earlier, those with chronic medical diseases such as CHF, Diabetes or COPD and a co-existing BH illness have more frequent admissions with longer lengths of stay for seemingly unknown reasons. It is purported to be a result of undiagnosed or untreated mental health such as depression. Thus, this project should have a positive outcome on the long-term health outcomes for these patients, and should result in a reduction in the systemic cost of providing health care to this population.

Core Components: This project has 8 core components, which Spohn will address individually below:

a. **Conduct data matching to identify individuals with co-occurring disorders who do not receive routine and/or needed primary and specialty care, over-utilize ED and crisis response services, and are becoming involved with the criminal justice system due to unmanaged symptoms.** Spohn will perform this component through Milestone 1 in DY2 by undertaking review and analysis of medical data for Spohn’s FHC and hospital patients.

b. **Review chronic care management best practices such as Wagner’s Chronic Care Model and select practices compatible with organization readiness for adoption and implementation.** Spohn will incorporate this component into Milestone 3 in DY3 when it prepares its protocol for implementing screening and care coordination to identify and effective treat patients with a dual diagnosis of BH/depression and diabetes or CHF. Spohn will directly reference the best practices it identifies from this review in the protocol it creates.

c. **Identification of BH case managers and disease care managers to receive assignment of these individuals.** Spohn will address this core component through Milestone 2 in DY2. Spohn will identify existing or new staff to provide care coordination for patients identify with dual diagnoses, assigning the equivalent of at least 3 full-time care coordinators in DY2.

d. **Develop protocols for coordinating care; identify community resources and services available for supporting this population.** Spohn will address this component with Milestone 3 in DY3. The protocol will address community needs, best practices, internal processes, key challenges, and an implementation plan.
e. **Identify and implement specific disease management guidelines for high prevalence disorders.** Spohn will address this requirement through Milestone 4 in DY3. Care coordinators and medical providers will be trained in the screening, diagnosis, care coordination and treatment of patients with CHF or diabetes and BH/depression, and will implement the guidelines accordingly.

f. **Train staff in protocols and guidelines.** This requirement will also be addressed through Milestone 4 in DY3, as staff will be trained in both the guidelines for screening and treatment, and Spohn’s hospital/FHC specific protocol for addressing this community need.

g. **Develop registries to track client outcomes.** Spohn will address this component through performing Milestones 5 and 6 in DYs 4-5. Spohn is creating a Chronic Disease Registry for its campuses and FHCs, which it will use to track patients identified with the targeted dual diagnoses and their use of the ED and rate of potentially preventable hospitalization.

h. **Review the intervention’s impact on quality of care and integration of care and identify lessons learned, opportunities to expand the program, and key challenges with expanding.** In DY 4, Spohn will draft a report identifying aspects of the protocol that have yielded positive results, identify areas for improvement, and targets for expanding the scope of the project to additional chronic diseases and/or other mental health issues (i.e. substance abuse).

**Ties to Community Needs Assessment:** CN.2 (Inadequate access to specialty services); CN.4 (inadequate access to behavioral health services); CN.6 (High rates of inappropriate ED utilization); CN.7 (high rates of preventable hospital admissions); CN.12 (lack of patient navigation); CN.16 (Lack of integration of physical and behavioral health services); CN.19 (Negative mental health outcomes)

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

Outcome Domain 9: Right Care, Right Setting
Improvement Target 9.2 – ED Appropriate Utilization

Spohn chose this outcome measure because it directly correlates with the purpose of this project – Spohn seeks to identify and treat more of these patients in the community so they will be less likely to misuse the ED and/or deteriorate into an acute condition where they need emergency care.

**Relationship to other Projects:**

This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience and outcomes, and improving coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.
Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative

This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

Project Valuation:

The Waiver provides the opportunity for Spohn to support and implement Delivery System Reform Incentive Payment (“DSRIP”) projects that will transform the delivery of healthcare in our region. Based on the final Program and Funding Mechanics Protocol and current guidance from the Texas Health and Human Services Commission, we understand that the RHP Plan must contain a narrative that describes the overall regional and individual project approach for valuing each project. Therefore, in order to implement an objective, reasonable, and equitable method for valuing DSRIP projects, Spohn prepared a valuation template to value each of its projects.

The valuation template considers four criteria for each project:

1. **Achieves Waiver Goals.** Relative to Spohn’s other proposed projects, to what extent does the project achieve the waiver goals of enhancing access, assuring quality of care, and improving the health of patients? Spohn considered how the project proposes to address the following:
   a. Improve the health care infrastructure to better serve the Medicaid and uninsured residents of Region 4.
   b. Further develop and maintain a coordinated care delivery system
   c. Improve outcomes while containing cost growth

2. **Addresses Community Need(s).** Relative to Spohn’s other proposed projects, to what extent does the project address community needs? Spohn considered the following attributes when scoring projects on this domain:
   a. Will the project address one or more community needs identified:
      i. In the region’s workgroup initiatives; and/or
      ii. In the region’s community needs assessment?
   b. How significant is the expected impact?

3. **Population Served.** Spohn considered how many patients the project will impact, either in total volume of patients or the type of population the project will serve (for example, predominately Medicaid and uninsured).

4. **Project Investment.** Relative to the Spohn’s other proposed projects, how large is the expected investment to successfully implement this project and achieve the milestones and metrics?  

The scores across each of the criteria are then summed to produce a total score, called the Value Weight of Project. The valuation template then calculates initial project values for the projects based on Spohn’s allocation of funding and each project’s Value Weight, relative to the Value Weights of

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158 For each proposed project, SPOHN scores the projects on a scale of 1-5 for each criteria, with a 1 having a minimal impact or investment and 5 having the largest impact or investment. #95308
Spohn’s other projects. After each project is valued, Spohn will ensure that each project comports with the final Program and Funding Mechanics Protocol, which (1) limits the amount allocated to any category 1 or 2 project to 10% of Spohn’s total Pass 1 allocation, and (2) proscribes the maximum funding distribution allocation to categories 1 and 2.

Spohn valued this particular project with reference to its impact on the goals of the Waiver: the project is patient-centered because it offers needed screening and targeted care management for patients coping with both physical and mental conditions; the project also reduces the systemic cost of providing care to this population by using prevention and care management to reduce the use of the ED and/or preventable hospital admissions for patients with co-diagnoses. The project addresses community needs, as this community is lacking mental health providers and services, and will serve a population of chronically ill patients. The investment necessary to implement this project is great: protocols must be created, providers identified and trained; patients educated; and transformation of the delivery system accomplished through actual reductions in ED and hospital admissions.
**CARE MANAGEMENT TO INTEGRATE PRIMARY AND BEHAVIORAL HEALTH NEEDS**

**CHRISTUS Spohn Hospital Kleberg**

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

136436606.3.9  IT-9.2

- ED Appropriate Utilization (BH/SA patients)

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<thead>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1 [P-4]:** Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis to identify over/under utilization

**Metric 1** [P-4.1]: Data analysis

- **Baseline/Goal:** Spohn will develop a system to identify patients with co-diagnoses of CHF &/or Diabetes with BH/Depression using its available medical data and will produce written analysis of the available data

- **Data Source:** Written analysis

**Milestone 1 Estimated Incentive Payment:** $124,836.50

**Milestone 2 [P-5]:** BH case manager and disease care manager identified

**Metric 1** [P-5.1]: Number of staff identified with the capacity to support the target population

- **Baseline/Goal:** Identify and engage the equivalent of three (3) care coordinators to manage targeted patients

- **Data Source:** Staff rosters and documents of caseloads

**Milestone 2 Estimated Incentive Payment:** $127,678

**Milestone 3 [P-6]:** Care coordination protocols are developed

**Metric 1** [P-6.1]: Written protocols available to staff

- **Baseline/Goal:** Spohn will identify and define practice guidelines and processes for coordination of care between services in a written manual for providers

- **Data Source:** Written protocols, standards, policies and procedures

**Milestone 3 Estimated Incentive Payment:** $127,678

**Milestone 4 [P-8]:** Staff member training in care coordination protocols and practice guidelines for CHF, Diabetes and Depression/BH

**Metric 1** [P-8.1]: Percent of staff trained

- **Goal:** 80% off FHC and hospital staff identified in target areas will receive training in screening/care coordination for patients with targeted dual diagnoses

- **Data Source:** Training materials and attendance records

**Milestone 4 Estimated Incentive Payment:** $127,678

**Milestone 5 [I-22]:** Increase use of specialty care in line with professionally accepted practice guidelines

**Metric 1:** X% increase/decrease use of specialty care according to practice guidelines

- **Baseline/goal:** 20% of CHF or diabetes patients treated at Spohn facilities are referred to a behavioral health provider for assessment and/or treatment (Spohn)

- **Data Source:** Care transitions registry

**Milestone 5 Estimated Incentive Payment:** $127,480

**Milestone 6 P-X:** Assess efficacy of process in place and recommend process improvements to implement if any

**Metric X-1:** Identify opportunities to improve on the redesign methodology, as documented in the assessment document

- **Baseline/goal:** analyze the effectiveness and quality improvement resulting from this project

- **Data source:** documentation of assessment

**Milestone 6 Estimated Incentive Payment:** $205,868
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<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>136436606.3.9</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization (BH/SA patients)</th>
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<td>Year 2 Estimated Milestone Bundle Amount: $249,673</td>
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<td>Year 3 Estimated Milestone Bundle Amount: $254,960</td>
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<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $205,868</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $965,857
Performing Provider: Citizens Medical Center / 137907508
Project Name 2.8.1 – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Project Identifier: 137907508.2.1

- **Provider**: Citizens Medical Center is a not-for-profit County facility in Victoria, TX comprised of a 344 bed (licensed) acute care hospital with a Lead III Trauma Center, a certified Stroke Program, a certified Cancer Center, a certified Chest Pain Center, a home health agency, two (2) hospital-based healthcare clinics, a health and wellness facility, and an outpatient imaging center. The Medical Center is the largest acute care facility in the region, providing a full range of healthcare services to citizens in Victoria and Victoria County (882.14 sq. miles) and the Coastal Bend Crossroads area which includes an additional six (6) counties for a total of 7561.97 sq. miles of service area. Also, Citizens Medical Center is one of the largest employers in the area providing employment to approximately 1200 personnel.

- **Intervention(s)**: This project will deploy the *Lean Methodology* hospital-wide to achieve the following goals: improve patient safety, quality of care, patient experience, as well efficiency, and optimize patient flow and eliminate waste and redundancies at the facility. Hospital leaders, physicians, and staff will be targeted to receive training regarding the Lean methodology whereby they will become active participants in performance and process improvements.

- **Need for the project**: Quality problems are manifested in a wide variation in the use of healthcare services, underuse of some services, overuse of other services, and misuse of specific services, including an unacceptable level of errors. Planned implementation of the *Lean Methodology* by Citizens Medical Center will promote the identification of opportunities for improvement specific to processes that affect patient outcomes and patient satisfaction. The project is related to the underlying regional goal of transforming health care delivery.

- **Target population**: *All patients treated within our facility will benefit from activities formulated utilizing the Lean Methodology.* Citizens Medical Center had a total of 8,209 adults and children admitted and 817 newborns during calendar year 2012. It is estimated that 58.7% or approximately 4,800 were Medicare recipients, 8.4% were Medicaid recipients (690 adults and children and 69 newborns), and 12.8% were self-pay patients.

- **Category 2 expected patient benefits**: The project seeks to increase patient satisfaction and improve patient outcomes by making improvements in patient care processes while decreasing costs to the hospital and to the patient. All patients admitted to our facility, approximately 9,000 adults, children, and newborns per DY, will benefit from the improved patient care processes and decreased costs resulting from the project.

- **Category 3 outcomes**: 
  ~ IT-4.8 – Reduce Sepsis mortality in DY4 and DY 5 from baseline established in DY3
  ~ IT-5.1 – Improve Cost Savings in DY4 and DY5 from baseline established in DY3
Category 2: Program Innovation and Redesign

Unique RHP Identification: 137907508.2.1
Project Reference Number: 2.8.1
Performing Provider Name/TPI: Citizens Medical Center/137907508

Project Description
This project will deploy the Lean methodology in order to achieve the following goals:

- Improve safety;
- Improve quality;
- Improve patient experience;
- Improve efficiency;
- Optimize patient flow; and
- Eliminate waste and redundancies.

The Lean methodology, as applied to medicine, evaluates the use of resources, measures the value to the patient, considers the use of resources in terms of their value to the patient, and eliminates those that are wasteful. Using methodologies such as Lean have been proven to eliminate waste and redundancies and optimize patient flow; hospitals may customize a project that will develop and implement a program of continuous improvement to increase communication, integrate system workflows, provide actionable data to providers and patients, and identify and improve models of patient-centered care that address issues of safety, quality, and efficiency. A representative sample of projects provided by the consultant may include:

- Cost management;
- Increasing capacity and throughput;
- Improving supply chain management;
- Reducing diagnostic testing turnaround times;
- Reducing wait time in emergency departments and ambulatory clinics;
- Reducing inpatient length of stays;
- Optimizing work flow;
- Reducing surgical cycle time;
- Redesigning work flow in support of the use of information technology; and
- Technology assessment and facilitation of technology adoption.

The Lean methodology is a quality improvement tool which will be the instrument utilized by the facility, whereby a program of continuous, rapid process improvement will address issues of safety, quality, and efficiency. The Lean consultants will work with the Citizens Medical Center Project Anchor and Senior Leadership staff to:

a. Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture,
b. Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care, and satisfaction, efficiency and other issues aligned with continuous process improvement,
c. Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures,
d. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement,
e. Implement software to integrate workflows and provide real-time performance feedback, and
f. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.

Project Goals:
This project will deploy the Lean methodology in order to achieve the following goals:
• Improve safety;
• Improve quality;
• Improve patient experience;
• Improve efficiency;
• Optimize patient flow; and
• Eliminate waste and redundancies.

The project seeks to increase patient satisfaction and improve patient outcomes by making improvements in patient care processes while decreasing costs to the hospital and to the patient. The rate of improvement will be determined when the baseline data is collected and analyzed. In addition, the hospital personnel and physicians will be targeted to receive instructions regarding the Lean methodology whereby they will become active participants in performance and process improvements.

Challenges: Project implementation frequently requires a new “operational mindset” using tools such as Lean to identify and progressively eliminate inefficiencies while at the same time linking human performance, process performance and system performance into transformational performance in the delivery system, a central aim of the region and of the 1115 Medicaid waiver. It will be critical for leaders of the organization over the next five years to become early adopters in an effort to change the culture to one of continuous quality improvement through the use of the Lean methodology.

Starting Point/Baseline
During DY 2 a special opportunity analysis/needs assessment will be conducted by the Lean consultant to determine a baseline for the organization, which will identify opportunities to improve safety, quality, patient experience, efficiency, and patient flow. Opportunities to eliminate waste and redundancies will also be identified.

It is anticipated that at least one specific medical diagnosis (i.e. severe sepsis) will be verified as needing the support of the Lean methodology to acquire success in improving patient outcomes by implementing new and/or revised patient care standards. Likewise, the hospital
expects hospital costs to be identified by the opportunity analysis/needs assessment as another priority item that the Lean methodology can address and improve. By including staff and physicians in Lean methodology education programs, they will become prepared to assist in the redesign and/or implementation of new processes and to improve their patient care services.

**Rationale**

Every day, millions of Americans receive high-quality healthcare that helps to maintain or restore their health and ability to function. However, far too many do not. Quality problems are reflected in a wide variation in the use of healthcare services, underuse of some services, overuse of other services, and misuse of other services, including an unacceptable level of errors. A central goal of healthcare quality improvement is to maintain what is good about the existing healthcare system while focusing on the areas that need improvement. Implementation of the Lean methodology at Citizens Medical Center will promote identification of opportunities for improvement specific to processes that affect patient outcomes and patient satisfaction.

Several types of quality problems in healthcare have been documented through peer-reviewed research as identified by the Agency for Healthcare Research and Quality. Nursing sensitive indicators such as patient falls, hospital acquired pressure ulcers, and hospital acquired infections are currently being reported to the National Database for Nursing Quality Indicator for benchmarking purposes. Implementation of the Lean methodology will facilitate improvement processes thereby improving patient outcomes related to these nursing sensitive indicators.

In addition, there continues to be a pattern of wide variation in healthcare practice, including regional variations and small-area variations. This is a clear indicator that healthcare practice has not kept pace with the evolving science of healthcare to ensure evidence-based practice in the United States (i.e. treatment for severe sepsis). Implementation of the Lean methodology will identify areas in which evidence-based physician orders are recommended but not being used, such as treatment for severe sepsis.

**Description of the Population to be Served**

In addition to the Victoria County uninsured, the county is surrounded by six (6) counties all of which are significantly medically underserved areas as related in the Regional Needs Assessment in Section III of the RHP 4 Plan. The populations, percent uninsured, and number of uninsured of the six (6) counties served are outlined in the following chart by county.

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Percent Uninsured</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>86,793</td>
<td>24%</td>
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<td>DeWitt</td>
<td>20,097</td>
<td>27%</td>
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<td>Jackson</td>
<td>14,075</td>
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<td>Lavaca</td>
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<td>Calhoun</td>
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<tr>
<td>Goliad</td>
<td>7,210</td>
<td>29%</td>
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</tr>
</tbody>
</table>
Citizens Medical Center had a total of 8,209 adults and children admitted and 817 newborns during calendar year 2012. It is estimated that 58.7% or approximately 4,800 were Medicare recipients and 8.4% were Medicaid recipients (690 adults and children and 69 newborns). All of these patients will benefit by this project. Also, by including staff members and physicians in Lean methodology education programs, they will become prepared to assist in the redesign and/or implementation of new processes and to improve their own patient care services resulting in positive patient outcomes and patient satisfaction.

**Milestones and Metrics:** The milestones and metrics include analysis and planning related to implementation of the Lean methodology, and markers to track performance over time.

**Ties to Community Needs:** The project is related to the underlying regional goal of transforming health care delivery. The Citizens Medical Center service area includes seven (7) counties encompassing a total of 7,561.97 square miles. Victoria County (where Citizens is based) is a medically underserved area as are at least five (5) other counties in the hospital’s service area. It should be noted that the percentages of Medicare, Medicaid, and self-pay (indigent) patients that Citizens serves are 58.7%, 8.4%, and 12.8%, respectively. Utilizing the Lean methodology to focus on opportunities for patient care improvement will contribute to upgraded care for all patients, but it must be recognized that 79.9% of the patients who present themselves to Citizens in a calendar year for care are a part of the categories previously listed. Even though we are a medically underserved area, this facility has the capability to provide a wide assortment of services at a high level of care for all those in need, but the facility is consistently involved with improvement processes as they present themselves.

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

IT-4.8  Sepsis mortality (Standalone measure)
Citizens Medical Center’s efforts have been ongoing since 2008 to reduce its severe sepsis mortality rate but to date have not yet substantially improved this patient outcome even though the national standards and processes promulgated as the “Surviving Sepsis Campaign” were introduced at the facility. As previously related in the Starting Point/Baseline section, it is anticipated that this medical diagnosis will be verified as needing the support of the Lean methodology to acquire success in improving patient outcomes through the implementation of new and/or revised patient care standards. The *Surviving Sepsis Campaign Care Bundles* are the core of the sepsis improvement efforts.* The consistent use of these evidence based order sets will likely reduce sepsis mortality and at the same time will potentially decrease the length of stay, thereby reducing costs for this patient population. It should also be noted that the high incidence and mortality of sepsis and severe sepsis is listed as Community Need (CN) 18 of Region 4.
IT-5.1 Improved Cost Savings (Standalone measure)
In recent years, it has become more difficult for all healthcare facilities to receive adequate compensation for the services and care rendered to patients who receive Medicare and Medicaid, therefore reducing the amount of facility funds on hand to disburse for healthcare supplies and equipment. In addition, the current national economy status has made those businesses that manufacture healthcare items increase their charges which in turn can force facilities to buy “bargain” items versus high quality items. One of the specialties of the Lean methodology is cost reduction with resultant revenue growth; therefore, it is anticipated that a Lean Consultant will merge cost saving activities with patient outcome improvement measures while retained. As noted above, a focus on sepsis mortality and the implementation of evidence based sepsis order sets will both decrease the mortality rate as well as improve cost savings. This in turn will benefit both the patient and the facility.

Relationship to Other Projects
This project is related to Citizens Medical Center’s other project – 137907508.1.1 - Expand primary care capacity. Other projects within the region that will be supported or enhanced by the implementation of this project include: 0208811801.1.1 – Expand Primary Care Capacity; 121775403.2.3 – Primary Care Redesign; and 0942220902.2.4 - Expand Care Transitions program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1

Plan for Learning Collaborative
Citizens Medical Center will support the development of Regional Collaborative learning through group meetings, website portals, web-ex sessions, and/or audio-conferences. In addition, Citizens Medical Center will participate in the Premier Quality Advisor Comparative Database to evaluate hospital performance compared to peers. Also, the hospital will access and contribute lessons learned with identified challenges and solutions through the Premier Connect Portal, which is a portal for sharing best practices. The final findings from this project and lessons learned can be replicated throughout the region for improved quality/efficiency in other organizations.

Project Valuation
Use of the Lean methodology in healthcare has resulted in the following results (Graban, 2012), which may be replicated at Citizens Medical Center:

- Reduced turnaround time for clinical laboratory results by 60% in 2004 without adding personnel or new instruments; further reduced times by another 33% from 2008 to 2010 an Alegent Health, Nebraska;
- Reduced instrument decontamination and sterilization cycle time by 54% while improving productivity by 16% at Kingston General Hospital, Ontario;
- Reduced central-line-associated bloodstream infections by 76% thereby reducing patient deaths from infections by 95% and saving $1 million at Allegheny Hospital, Pennsylvania;
- Reduced readmission rates for chronic obstructive pulmonary disease patients by 48% at UPMC St. Margaret Hospital, Pennsylvania;
• Reduced patient waiting time for orthopedic surgery from 14 weeks to 31 hours (from first call to surgery); improved inpatient satisfaction scores from 68% “very satisfied” to 90% at ThedaCare, Wisconsin;
• Increased employee engagement scores by 15% at St. Bonifact Hospital, Manitoba;
• Reduced patient length of stay by 29% and avoided $1.25 million in new emergency department construction at Avera McKennan, South Dakota;
• Bottom-line benefit of $54 million, through cost reduction and revenue growth, helping an urban safety net hospital avoid layoffs at Denver Health, Colorado; and
• Avoidance of $180 million in capital spending through Lean improvements at Seattle Children’s Hospital, Washington.

Graban (2012) also suggests that an estimated 13% of a hospital’s costs are due to inefficient practices within control of the hospital, while other estimates were closer to 20%. Implementation of the Lean methodology will identify opportunities to improve processes, eliminate waste, and eliminate redundancies, which will thereby reduce costs.

Recognizing these examples of success in the utilization of Lean methodology by other healthcare organizations boosts the prospect of similar accomplishments at Citizens Medical Center.

References


* www.survivingsepsiscampaign.org/guidelines
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<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Milestone 1: P-6.</strong> Implement a program to improve efficiencies and/or reduce program variation. Metric 1: P-6.1. Performance improvement events identified by opportunity analysis/needs assessment. Baseline/Goal: No current opportunity analysis/needs assessment available / Identify opportunities for improvement cited by completion of an opportunity analysis/needs assessment. Data Source: Lean Consultant; Opportunity analysis/needs assessment. <strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $355,172</td>
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<td><strong>Milestone 2: P-2.</strong> Identify/Target metric to measure impact of process improvement methodology and establish baseline. Metric 2: P-2.1. Complete opportunity analysis/needs assessment and prioritize areas or processes to improve upon. <strong>Milestone 2 Estimated Incentive Payment (maximum amount):</strong> $355,172</td>
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<td><strong>Milestone 6: P-4.</strong> Define operational procedures needed to improve overall efficiencies in care management. Metric 6: P-4.1. Report on at least two operational procedures needed to improve overall efficiencies in care management. Baseline/Goal: 0 / Report on 2 operational procedures needed Data Source: Lean Consultant; Opportunity analysis/needs assessment. <strong>Milestone 6 Estimated Incentive Payment (maximum amount):</strong> $259,469</td>
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<td><strong>Milestone 7: P-9.</strong> Complete a value stream map, which is a detailed, real-time sequence of steps in a given process to identify value-added and non-value added steps for the patient and staff. Metric 7: P-9.1. Value stream mapping: submission of completed value stream map. Baseline/Goal: 0 / Completion of first value stream map. Data Source: Lean consultant’s <strong>Milestone 7 Estimated Incentive Payment (maximum amount):</strong> $259,469</td>
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<td><strong>Milestone 13: P-5.</strong> Complete a Kaizen assessment. Metric 13: P-5.1. Implement at least two (2) patient centered process improvement projects. Baseline/Goal: 0 / 2 patient care process improvement projects Data Source: Team meeting minutes; Opportunity analysis/needs assessment. <strong>Milestone 13 Estimated Incentive Payment (maximum amount):</strong> $362,693</td>
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<td><strong>Milestone 14: P-3.</strong> Compare and analyze clinical/quality data, and identify at least one area for improvement. Apply the Lean methodology in this area. Metric 14: P-3.1. Analysis and identification of target area. Baseline/Goal: 2 / 1 additional PI project Data Source: Team meeting minutes; Opportunity analysis/needs assessment. <strong>Milestone 14 Estimated Incentive Payment (maximum amount):</strong></td>
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<tr>
<td><strong>Milestone 18: P-6.</strong> Continue to work on implementation of Lean throughout the organization by comparing and analyzing clinical/quality data, and identify at least two (2) areas for improvement. Apply the Lean methodology in these areas. Metric 18: P-6.1. Baseline/Goal: 3 / 2 additional PI projects Data Source: CMC records and reports; Lean consultant’s reports; Opportunity analysis/needs assessment. <strong>Milestone 18 Estimated Incentive Payment (maximum amount):</strong> $244,048</td>
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<td><strong>Milestone 19: P-15.</strong> Train staff in the target areas identified in Process Milestone 18: P-6. Metric 19: P-15.1. 95% of the staff in the target areas identified in Process Milestone 19: P-6 will successfully complete a Lean training session. Baseline/Goal: 0 / 95% of staff in target areas trained in Lean methodology Data Source: Opportunity <strong>Milestone 19 Estimated Incentive Payment (maximum amount):</strong></td>
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**RHP Plan for Region 4**

### DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT

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- **Baseline/Goal:** 0 / Prioritize areas or processes to improve upon
- **Data Source:** Lean Consultant and team members; Opportunity analysis/needs assessment.

**Milestone 2 Estimated Incentive Payment (maximum amount):**

$355,172

**Milestone 3:** P-7. Implement a rapid improvement project using the Lean methodology for an identified priority in workflow, process or clinical area.

**Metric 3:** P-7.1. Documentation that all steps included in the cycle methodology were performed: e.g. (1) Standardized an operation; (2) Measured the standardized operation (cycle time and amount of in process inventory); (3) Gauged measurements against requirements; (4) Innovated to meet requirements and increase productivity; (5) Standardized the new, improved operations; and (6) Continue the cycle.

**Baseline/Goal:** 0 / Specific team organized to implement one rapid improvement project using Lean report; Team meeting minutes; Opportunity analysis/needs assessment.

- **Milestone 7 Estimated Incentive Payment (maximum amount):** $259,469

**Milestone 8:** P-3. Compare and analyze clinical/quality data, and identify at least one area for improvement. Apply the Lean methodology in this area.

**Metric 8:** P-3.1. Analysis and identification of target area.

**Baseline/Goal:** 1 / 1 additional PI project

- **Data Source:** Lean consultant’s report; team meeting minutes; opportunity analysis/needs assessment

**Milestone 8 Estimated Incentive Payment (maximum amount):** $362,693

**Milestone 15:** P-8. Train staff in process improvement utilizing the Lean methodology.

**Metric 15:** P-8.1. 95% of the staff in the target areas identified in Process Milestone 13: P-5 and Process Milestone 14: P-3 and will successfully complete a Lean training session.

**Baseline/Goal:** 0 / 95% of staff in target areas trained in Lean methodology

- **Data Source:** Leadership meeting minutes; training attendance records

**Milestone 15 Estimated Incentive Payment (maximum amount):** $362,693

**Milestone 20:** P-3. Compare and analyze clinical/quality data, and identify at least one area for improvement. Apply the Lean methodology in this area.

**Metric 20:** P-3.1. Analysis and identification of target area.

**Baseline/Goal:** 5 / 1 additional PI project

- **Data Source:** CMC records and reports; Lean consultant’s reports; Opportunity analysis/needs assessment

**Milestone 20 Estimated Incentive Payment (maximum amount):** $244,048

**Milestone 21:** P-12. Report findings and lessons learned.

**Metric 21:** P-12.1. Documentation of report findings and lessons learned.

**Baseline/Goal:** The opportunity analysis/needs assessment.
RHP Plan for Region 4

Citizens Medical Center

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**Milestone 3 Estimated Incentive Payment (maximum amount):**
$355,172

**Milestone 4: P-8.** Train leaders in process improvement utilizing the Lean methodology.

**Metric 4: P-8.1.** Documentation that all (100%) Leaders in the organization have successfully completed a Lean training session.

Baseline/Goal: 0 / 100% of the Leaders determined by Administration to attend a Lean training session.

Data Source: Leadership meeting minutes / attendance record.

**Milestone 3 Estimated Incentive Payment (maximum amount):**
$355,172

**Milestone 5: I-X1.** Establish a minimal number of process improvement champions to attend the target area(s) identified in Process Milestone 5: I-X1 will successfully complete a Lean training session.

Baseline/Goal: 0 / 95% of group selected for training completed training

Data Source: Leadership meeting minutes; training attendance record

**Milestone 9 Estimated Incentive Payment (maximum amount):**
$259,469

**Milestone 10: P-10.** Develop a quality dashboard.

**Metric 10: P-10.1.** Documentation of a quality dashboard.

Baseline/Goal: 0 / Completed quality dashboard

Data Source: Consultant’s report; Opportunity analysis/needs assessment

**Milestone 10 Estimated Incentive Payment (maximum amount):**
$362,693

**Milestone 17: I-X3.** Increase the percent of staff who have participated in a process improvement project utilizing the Lean methodology to at least 6% of total staff.

**Metric 17: I-X3.1.** The percent of staff that have participated in a process improvement project utilizing the Lean methodology.

Baseline/Goal: Number of leaders and staff members trained and involved in Lean improvement

**Milestone 11: I-13.** Progress toward analysis/needs assessment conducted in DY 2 will be used as the baseline / Report will contain a summary of findings and lessons learned pertaining to PI through the utilization of Lean methodology.

Data Source: CMC records and reports; Opportunity analysis/needs assessment.

**Milestone 21 Estimated Incentive Payment (maximum amount):**
$244,048


**Metric 22: I-13.1.** Measure efficiency and/or cost or process improvement projects, and/or cost savings through implementation of the Lean methodology as defined in DY 2

Process Milestone 2: P-7.

Baseline/Goal: The opportunity analysis/needs assessment conducted in DY 2 will be used as the baseline / Data collected will relate to efficiency, cost, and/or process improvements

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methodology

Data Source: Consultant’s reports, Team meeting minutes, Citizens database.

**Milestone 3 Estimated Incentive Payment (maximum amount):**
$355,172

**Milestone 4: P-8.** Train leaders in process improvement utilizing the Lean methodology.

**Metric 4: P-8.1.** Documentation that all (100%) Leaders in the organization have successfully completed a Lean training session.

Baseline/Goal: 0 / 100% of the Leaders determined by Administration to attend a Lean training session.

Data Source: Leadership meeting minutes / attendance record.

**Milestone 3 Estimated Incentive Payment (maximum amount):**
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**Milestone 5: I-X1.** Establish a minimal number of process improvement champions to attend the target area(s) identified in Process Milestone 5: I-X1 will successfully complete a Lean training session.

Baseline/Goal: 0 / 95% of group selected for training completed training

Data Source: Leadership meeting minutes; training attendance record

**Milestone 9 Estimated Incentive Payment (maximum amount):**
$259,469

**Milestone 10: P-10.** Develop a quality dashboard.

**Metric 10: P-10.1.** Documentation of a quality dashboard.

Baseline/Goal: 0 / Completed quality dashboard

Data Source: Consultant’s report; Opportunity analysis/needs assessment

**Milestone 10 Estimated Incentive Payment (maximum amount):**
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**Milestone 17: I-X3.** Increase the percent of staff who have participated in a process improvement project utilizing the Lean methodology to at least 6% of total staff.

**Metric 17: I-X3.1.** The percent of staff that have participated in a process improvement project utilizing the Lean methodology.

Baseline/Goal: Number of leaders and staff members trained and involved in Lean improvement

**Milestone 11: I-13.** Progress toward analysis/needs assessment conducted in DY 2 will be used as the baseline / Report will contain a summary of findings and lessons learned pertaining to PI through the utilization of Lean methodology.

Data Source: CMC records and reports; Opportunity analysis/needs assessment.

**Milestone 21 Estimated Incentive Payment (maximum amount):**
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**Metric 22: I-13.1.** Measure efficiency and/or cost or process improvement projects, and/or cost savings through implementation of the Lean methodology as defined in DY 2

Process Milestone 2: P-7.

Baseline/Goal: The opportunity analysis/needs assessment conducted in DY 2 will be used as the baseline / Data collected will relate to efficiency, cost, and/or process improvements
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**Milestone 5 Estimated Incentive Payment (maximum amount):** $355,172

**Milestone 12: I-X2.** Increase the percent of staff who have participated in a process improvement project utilizing the Lean methodology to at least 3% of total staff.

- **Metric 12: I-X2.1.** The percent of staff that have participated in a process improvement project utilizing the Lean methodology.
  - **Baseline/Goal:** Number of leaders who have participated in Lean projects in DY3 / Number of staff currently employed
  - **Data Source:** CMC records and reports; Opportunity analysis/needs assessment.

**Milestone 17 Estimated Incentive Payment (maximum amount):** $362,693

**Milestone 22 Estimated Incentive Payment (maximum amount):** $244,048

**Milestone 23: I-X4.** Increase the percent of staff who have participated in a process improvement project utilizing the Lean methodology to at least 9% of total staff.

- **Metric 23: X-4.1.** The percent of staff that have participated in a process improvement project utilizing the Lean methodology.
  - **Baseline/Goal:** Number of leaders and staff members trained and involved in Lean improvement projects in DY3 / Number of staff currently employed
  - **Data Source:** CMC records and reports; Opportunity analysis/needs assessment.
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<td>and staff members trained and involved in Lean improvement projects in DY2 / Number increased to include at least 3% of staff currently employed in area of focus</td>
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<td>Milestone 23 Estimated Incentive Payment (maximum amount): $244,048</td>
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<td>Milestone 12 Estimated Incentive Payment (maximum amount): $259,469</td>
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<td>Year 2 Estimated Milestone Bundle Amount: $1,775,862</td>
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<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $6,869,906</td>
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MHMR of Nueces County
Integrated Care Program
138305109.2.1

- **Provider**: MHMR of Nueces County is a community mental health center which functions as the Local Mental Health Authority for Nueces County. The center employs approximately 240 individuals and provides mental and behavioral healthcare services to residents of Nueces County. MHMR-NC serves a population of approximately 1500 adults and 400 children and adolescents. The population of the center’s service area is approximately 350,000 persons.

- **Intervention(s)**: This project aims to incorporate primary preventive care into the existing behavioral healthcare service delivery system. As the population served has much higher rates of preventable medical conditions, e.g., diabetes mellitus, hypertension etc. this project will provide these preventive medical services to a population which is grossly underserved in primary care. The purpose is to reduce the number of potentially preventable hospitalizations while increasing the effectiveness of holistic treatment by focusing on not only the recovery and rehabilitation of a person’s mind but their body as well.

- **Need for the project**: Individuals with severe and persistent mental illness are at a much greater risk for development of serious medical conditions. A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive or seek the appropriate treatment for both their physical and behavioral health issues.

- **Target population**: This project will serve individuals who are underserved or not receiving services for primary healthcare. As the majority of our population is indigent we expect the majority of our population to benefit from integrated services in this project.

- **Category 1 or 2 expected patient benefits**: The project aims to provide primary preventive care in a medical home model to 450 individuals by DY5.

- **Category 3 outcomes**: IT-2.12 our goal is to prevent the rate of potentially admissible hospitalizations by eliminating 75 preventable admissions in DY3 150 in DY4 and 225 in DY5.
  - o IT-6.1, an additional goal for the ICP program outcome measures is to increase patient satisfaction and provision of timely care to 75 individuals in DY3, 150 individuals in DY4, and 225 individuals in DY5.
Category 2: Program Innovation and Redesign
Project Option 2.15.1 – Design, implement and evaluate projects that provide integrated primary and behavioral health care services.

Unique RHP Project Identification Number: 138305109.2.1
Performing Provider/TPI: MHMR NUECES COUNTY/ 138305109

Project Description:
MHMR of Nueces County (MHMR-NC) will implement an Integrative Care Program (ICP) to improve access to integrated care for persons with behavioral, physical, and substance use needs through the co-location and integration of these services within its existing framework of behavioral healthcare. At present MHMR-NC serves a priority population within Nueces County. This population consists of individuals diagnosed with severe persistent mental illnesses including Major Depressive Disorder, Bipolar Disorder, Schizophrenia, and Schizoaffective disorder. Implementation of the ICP program will not only improve coordination of care between primary health services and behavioral health services and substance use treatment, it will provide primary healthcare to a population that is currently indigent at a rate of roughly 50%. The ICP program will in addition develop a smoking cessation services program to be provided ancillary to behavioral healthcare and primary physical healthcare in an outpatient community services setting. The ICP project aims to establish a “medical home” for its current population. The concept of a medical home that can address the needs of the whole person is increasingly recognized as a key medium for improving both access to care, continuity of care, and improved health outcomes. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades as medical homes and similar collaborative care approaches have been determined to be beneficial in the treatment of mental illness in a variety of controlled studies.

Goals and Relationship to Regional Goals:
The goal of this project is to integrate the physical, behavioral health, and substance abuse services into one co-location so that individuals with mental illness can easily access services all needed services. The project will improve access to care, improve health outcomes, and achieve cost efficiencies.
The project meets the following Region 4 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of the existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges
Challenges to the implementation of this program include, data sharing, capital resource development, specialty providers, limited availability of psychiatric providers, provider
capacity/workforce recruitment and retention, and coordinating services amongst providers. This program will address the above challenges through creative solutions in utilization of existing information systems, providers, and recruitment from within existing frameworks.

5-Year Expected Outcome for Provider and Patients:
MHMR of Nueces County expects to improve the integration of primary and behavioral health care for the target population. Patients with behavioral health issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical diseases. Providing access and addressing both physical and behavioral health care needs in one integrated setting provides the best opportunity for overall patient health and wellness as well as patient satisfaction. Behavioral health conditions also account for increased health care expenditures such as high rates of potentially preventable inpatient admissions therefore the MHMR-NC ICP also expects to see a decrease in hospital admissions for patients with a primary or secondary diagnosis of significant behavioral health or substance abuse conditions.

Starting Point/Baseline:
The starting point/baseline for this project is presently at zero. However, by the end of year 3 this program we expect will serve a minimum of 75 individuals through the ICP program.

Rationale:
A recent study of adults discharged from psychiatric hospitals found 20% with chronic and serious conditions such as HIV infection, brain trauma, cerebral palsy and heart disease. As many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure. High rates were also seen for vision (93%), hearing (78%), and dental (60%) problems. The effects of atypical antipsychotic medications, which exacerbate this predisposition impacts individuals with schizophrenia who also have high rates of diabetes mellitus. Cardiovascular diseases are also very prevalent among people with mental illnesses. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive or seek the appropriate treatment for both their physical and behavioral health issues.

Through the integration of behavioral and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Additionally, access to care is enhanced because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs.
Individuals receiving services through MHMR-NC’s ICP will experience close collaboration in a fully integrated system. A multi-disciplinary approach will create a cohesive environment and system of care so that the patient will experience primary care as part of their mental health treatment and vice versa.

**Project Components:**
Through the Nueces County ICP we will design, implement and evaluate projects that provide integrated primary and behavioral health care services and propose to meet all project core components as listed below:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health provider could be facilitated

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral health and physical health providers

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   - Regular consultative meetings between physical health and behavioral health practitioners
   - Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners
   - Shared treatment plans co-developed by both physical health and behavioral health practitioners

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice

h) Arrange for utilities and building services for these settings

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings

j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include but are not limited to identifying project impacts, identifying “lessons learned”, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations
Milestones and Metrics:
The following milestones and metrics have been chosen for the ICP project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1(P-1.1); P-5(P-5.1, P-5.2, P-5.3)
- Improvement Milestones and Metrics: I-8 (I-8.1); I-9 (I-9.1); I-10 (I-10.1); I-11 (I-11.1)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:

- CN-1 Inadequate access to primary care
- CN-4 Inadequate access to behavioral health services
- CN-7 High rates of preventable hospital admissions
- CN 14 High rates of diabetes, including gestational diabetes
- CN-15 Inadequate health care access in rural areas
- CN-16 Lack of integration of physical and behavioral health services.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
Currently integrated primary and behavioral health care services are not provided in the Nueces County community. The current ICP target population receives primary health care outside of the MHMR-NC. This project will be new and provide individuals the opportunity to receive both physical and behavioral health care in one integrated setting through a coordinated patient-centered approach.

Related Category 3 Outcome Measure(s):

**OD-6 Patient Satisfaction**

**IT-6.1** Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to answered to be a standalone measure) Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

1. are getting timely care, appointments, and information; (Standalone measure)
2. how well their doctors communicate; (Standalone measure)
3. patient’s rating of doctor access to specialist; (Standalone measure)
4. patient’s involvement in shared decision making (Standalone measure)
5. patient’s overall health status/functional status. (Standalone measure)

**OD-2 Potentially Preventable Admissions**

**IT-2.12** Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions247 (Standalone measure)

Overall Composite – PQI 90
Acute Composite- PQI 91
Chronic Composite- PQI 92
Reasons/rationale for selecting the outcome measure(s):
The ICP will aid in the achievement of the outcome measures listed above as a result of increased continuity in primary care for the current BHC target population. As previously mentioned roughly 50% of the population is presently indigent and has limited access to primary and preventive healthcare. The resulting increase in communication, data sharing, and continuity through integration and co-location of services will positively impact the overall health of the target population and thus help avoid unnecessary hospitalizations. Data on specific local hospitalization rates for the outcomes listed above are forthcoming pending the implementation of the ICP program.

Patient satisfaction is also a priority for the ICP program. Through integration and co-location of primary care and behavioral healthcare MHMR-NC aims to significantly impact satisfaction within the targeted population. This outcome is a direct measure of successful person centered integrative care and is reflective of the transformational impacts of the project.

Relationship to other Projects:
MHMR of Nueces County’s four projects will complement the delivery of behavioral health services to an underserved area in rural Texas. Projects include peer to peer support, integration of physical and behavioral health, social media and outreach programs, and dual diagnosis crisis stabilization services. This project is also related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.
**Project Valuation:**
The percentage of the ICP program’s target population who receive primary health care outside of MHMR-NC is at present 100%. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000.
Implementation of the integrative care program could reduce this cost to the community by $6,138,900 between DY3 – DY5.
Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.
The rationale for the valuation of the integrated care program centers on cost savings to the program is the summative cost savings to the community through the elimination of potentially preventable hospitalizations. Values were calculated by multiplying the total projected number of hospitalizations to be prevented by the mean cost of preventable hospitalization for individuals with an MH diagnosis.
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 P-1</td>
<td>Conduct needs assessment to determine areas of the state where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs. Baseline/Goal: Baseline for persons served is zero. Identify Demographics, location &amp; diagnoses. Data Source: Inpatient, discharge &amp; ED records survey of primary care providers; survey of behavioral health providers, etc. Milestone Estimated Incentive Payment: $311,333.33</td>
</tr>
<tr>
<td>Milestone 2 P-5</td>
<td>Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 1 P-5.1 Number of agreements signed for the provision of integrated services Baseline/Goal: Baseline is Zero. Goal is to have at minimum one integrated provider for DY3.</td>
</tr>
<tr>
<td>Milestone 4 P-6</td>
<td>Milestone: Develop integrated behavioral health and primary care services within collocated sites. Metric 1 P-6.2: Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system) Baseline/Goal: Baseline is zero. Goals is at minimum one provider will achieve level 5 interaction. Data Source: Project data Milestone 4 Estimated Incentive Payment 254,945</td>
</tr>
<tr>
<td>Milestone 5 I-8</td>
<td>Integrated Services. Metric 1 I-8.1 75 Individuals receiving both physical and behavioral health care at the established locations. Data Source: Project data; claims and encounter data; medical records Baseline/Goal: Baseline is zero. Goal is at minimum 75 individuals receiving ICP services. Milestone 5 Estimated Incentive Payment: $254,945</td>
</tr>
<tr>
<td>Milestone 6 I-10</td>
<td>No-Show Appointments Metric 1 I-10.1 5% decrease in “no shows” for behavioral and physical health appointments. Baseline/Goal: Baseline is zero. Baseline will be established by mid-year. Reduction in no show rate of 4 persons by end of DY3.</td>
</tr>
<tr>
<td>Milestone 8 I-8</td>
<td>Integrated Services. Metric 1 I-8.1 150 individuals receiving both physical and behavioral health care at the established locations. Data Source: Project data; claims and encounter data; medical records Baseline/Goal: Baseline is 75 individuals served in DY3. Goal is 150 individuals served in DY4. Milestone Estimated Incentive Payment: $383,210</td>
</tr>
<tr>
<td>Milestone 9 I-9</td>
<td>Coordination of Care Metric 1 I-9.1 Number of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Baseline/Goal: A minimum of 120 out of 150 individuals will have a treatment plan developed and implemented with primary care and behavioral health services. Data Source: Project data; claims and encounter data; medical records Milestone Estimated Incentive Payment: $383,210</td>
</tr>
<tr>
<td>Milestone 10 I-10</td>
<td>No-Show Appointments Metric 1 I-10.1 10% decrease in “no shows” for behavioral and physical health appointments. Baseline/Goal: Baseline established at</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
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<td>-------</td>
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<tr>
<td>Data Source: Project data</td>
<td>Data Source: Project Data</td>
</tr>
<tr>
<td>Metric 2 P-5.2 Number of primary care providers newly located in behavioral health settings.</td>
<td><strong>Baseline/Goal:</strong> Baseline is zero. Goal is to have at least 1 integrated provider for DY3.</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Baseline is zero. Goal is to have at least 1 integrated provider for DY3.</td>
<td><strong>Data Source:</strong> Project Data</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project Data</td>
<td><strong>Milestone 2 Estimated Incentive Payment (maximum amount):</strong> 311,333.33</td>
</tr>
<tr>
<td><strong>Milestone 3 P-3</strong> Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. <strong>Metric 1 P-3.1</strong> Number and types of referrals that are made between providers at the location.</td>
<td><strong>Baseline/Goal:</strong> Baseline is zero. Goal is 10% increase in Positive Results of Standardized Health Metrics, which may include: Objective health indicators such as Body Mass Index, glycated hemoglobin (A1c), blood pressure, and other specific blood assays, etc. Behavioral health instruments such as the Child Behavior Checklist (CBCL) the Quality of Life (QOL) Questionnaire, the Child Needs and Strengths Assessment (CANS), the Adult Needs and Strengths Assessment (ANSA).</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project Data; Medical Records; Claims and Encounter Data.</td>
<td><strong>Data Source:</strong> Project Data; Medical Records; Claims and Encounter Data.</td>
</tr>
<tr>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $254,945</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $383,209</td>
</tr>
</tbody>
</table>

**Related Category 3 Measures:**
- 138305109.3.1
- 138305109.3.2
- IT-2.12
- IT-6.1

**Potential Preventable Admissions**

**Patient Satisfaction**
<table>
<thead>
<tr>
<th>Metric 2 P-3.2</th>
<th>Metric 3 P-3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Baseline is zero referrals. Goal is at least 10 persons referred from external sources. <strong>Data Sources:</strong> Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results.</td>
<td><strong>Baseline/Goal:</strong> Baseline is zero referrals following established standards. Goal is to establish referral standards and receive at minimum 10 referrals. <strong>Data Source:</strong> Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results.</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Data.</strong> This would be measured at baseline and at specified time intervals throughout the project. <strong>Milestone 16 estimated Incentive Payment:</strong> $497,935.00</td>
<td><strong>Data.</strong> This would be measured at baseline and at specified time intervals throughout the project. <strong>Milestone 16 estimated Incentive Payment:</strong> $497,935.00</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $934,000

**Year 3 Estimated Milestone Bundle Amount:** $1,019,780

**Year 4 Estimated Milestone Bundle Amount:** $1,532,838

**Year 5 Estimated Milestone Bundle Amount:** $1,991,740

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $5,478,358
**Provider:** MHMR of Nueces County is a community mental health center which functions as the Local Mental Health Authority for Nueces County. The center employs approximately 240 individuals and provides mental and behavioral healthcare services to residents of Nueces County. MHMR-NC serves a population of approximately 1500 adults and 400 children and adolescents. The population of the center’s service area is approximately 350,000 persons.

**Intervention(s):** MHMR of Nueces County’s Peer to Peer Day Center Program aims to increase access to peer provided behavioral healthcare services through establishment of a “Drop-in” center for individuals receiving outpatient mental health services. This “Drop In” center will incorporate trained peer specialists in the provision of community based supports. We anticipate the project will result in a reduction of crisis and potentially preventable hospitalizations.

**Need for the project:** At present many recipients of community based services have little or no support within the community. The Peer to Peer center will provide open access to supports and resources on a daily basis from 8am – 5pm, Monday through Friday. Active engagement and support is a key predictor of positive outcomes in mental health services and is a need of our population.

**Target population:** The target population for this project includes all persons receiving outpatient services, with a primary focus on persons with severe persistent mental illness at high risk for hospitalization. Most of these individuals are indigent/Medicaid or Medicare eligible and do not have additional supports within the community. Approximately 95% of our patient population is enrolled in Medicaid or medically indigent.

**Category 1 or 2 expected patient benefits:** The project seeks to provide peer to peer support services to 5% of the target population in DY4, and 10% of the population in DY5, or 75 and 150 patients respectively. Through the implementation of this project, peer providers will be recruited and trained, a health risk assessment will be developed and implemented, and health risks for potential participants will be identified. The program will conduct a plan, do, study, act quality improvement cycle beginning in DY4 through DY5.

**Category 3 outcomes:** Our category 3 outcome is IT-9.1. Our goal is to reduce the number of mental health admissions and readmissions to criminal justice settings by 5% in DY-3, 10% in DY4, and 15% in DY5. This will be done by providing enhanced community based supports and resource access through the peer to peer program.
**Category 2: Program Innovation and Redesign**

**Project Option 2.18.1 -** Recruit, train, and support consumers of mental health services to provide peer support services – Peer to Peer Day Center Program

**Unique RHP Project ID Number:** 138305109.2.2

**Performing Provider Name/TPI:** MHMR of Nueces County/138305109

**Project Description:**
MHMR of Nueces County’s Peer to Peer Day Center Program aims to increase access to peer provided behavioral healthcare services through establishment of a “Drop-in” center for individuals receiving outpatient mental health services. The goal for this project is to facilitate a reduction in the recidivism of potentially preventable hospitalizations, incarcerations, and psychiatric emergency services. We expect to see increased efficacy in behavioral health services in a peer to peer run service coordination model. The model which will be utilized in program implementation is the Georgia Real Choice Systems Change Model.

The goal of this project is to use consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services. These services are supportive and not necessarily clinical in nature. Building on a project originally established under the State’s Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training is provided to certified peers specialists in “whole health”. With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes and COPD. While such training currently exists, very limited numbers of peers are trained due to resource limitations. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness213. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population214 ), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase215.

**Goals and Relationship to Regional Goals:**
The goal of this project is to use consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services. These services are supportive and not necessarily clinical in nature. This project will support the regional goal of promote the decrease in utilization of preventable hospital admissions and complement other regional projects associated with the behavioral health delivery system.

**Project Goals:**
- Decrease the high rates of preventable hospital admissions
- Improve negative mental health outcomes such as suicide or mental admissions in jails/prisons
- Train additional mental health consumers to provide peer support services
This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, and builds on the accomplishments of the existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
Capital resource development, Recruiting peer providers, Provider capacity/workforce recruitment and retention, coordinating services amongst providers, Engagement of target population and development of program curricula and material. This program will address these challenges through recruitment from within existing provider frameworks, establishment of new providers through recruitment from within the region, modeling program curricula and materials after evidenced based programs being implemented throughout the state and nation, and recruitment of peer providers currently engaged in BHC services.

Starting Point/Baseline:
At present there are no peer to peer run day centers providing behavioral health services to the target population. For FY 2011 there were a total of 670 individuals who were incarcerated in Nueces County Jail that had a diagnosis of mental illness. The cost of incarceration is calculated to be $180 per day. Implementation of this program will seek to reduce this rate by 67 individuals in DY3, 101 individuals in DY4, and 134 individuals in DY5.

Rationale:
Building on a project originally established under the State’s Mental Health Transformation grant, consumers are being trained to serve as peer support specialists. In addition to the basic peer specialist training and certification, an additional training is provided to certified peers specialists in “whole health”. With the whole health training peer specialists learn to work with other consumers to set achievable goals to prevent or self-manage chronic diseases such as diabetes and COPD. While such training currently exists, very limited numbers of peers are trained due to resource limitations. Evidence exists that such an approach can work with particularly vulnerable populations with serious mental illness. The need for strategies to improve the health outcomes for people with behavioral health disorders is evidenced by their disparate life expectancy (dying 29 years younger than the general population), increased risk of mortality and poor health outcomes as severity of behavioral health disorders increase.

In proposing this project MHMR of Nueces County plans to positively impact existing behavioral healthcare services through the integration of peer provided support in a day center setting. This project aims to increase access to peer provided behavioral healthcare services through establishment of a “Drop-in” center for individuals receiving outpatient mental health services.

Project Components:
Through the Peer-to-Peer Day Center Program, we propose to meet all required project components listed below and have selected milestones and metrics that relate to these components.
a) Train administrations and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system
b) Conduct readiness assessments of organization that will integrate peer specialists into their network
c) Identify peer specialists interested in this type of work
d) Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks e.g. obesity, tobacco use, physical inactivity)
e) Implement health risk assessments to identify existing and potential health risks for behavioral health consumers
f) Identify patients with serious mental illness who have health risk factors that can be modified
g) Implement whole health peer support
h) Connect patients to primary care and preventive services
i) Track patient outcomes. Review the interventions, impact on participants and identify “lessons learned”, opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

Milestones and Metrics:
The following milestones and metrics have been chosen for the Peer-to-Peer Day Center Program project based on the core components and the needs of the target population:

Process Milestones and Metrics: P1 (P-1.1, P-1.2); P-2 (P-2.1); P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.1); P-6 (P-6.1, P6.2); P-7 (P-7.1)
Improvement Milestones and Metrics: I-17 (I 17.1); I-18 (I 18.1)

Unique community need identification number the project addresses:
- CN 4 – Inadequate access to behavioral health services
- CN 7 - High rates of preventable hospital admissions
- CN 15 – Inadequate health care access in rural areas
- CN 16 – Lack of integration of physical and behavioral health services
- CN 19 – Negative mental health outcomes, such as suicide or mental health admissions in jail/prisons

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
Currently the Peer-to-Peer Day Center program is not provided in the Nueces County community. This project will be new and through training and support we will use consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide peer support services to the targeted population.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure) Percent improvement over baseline of patient
satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
(1) are getting timely care, appointments, and information; (Standalone measure)
(4) patient’s involvement in shared decision making, (Standalone measure)
(5) patient’s overall health status/functional status. (Standalone measure)

**OD- 9 Right Care, Right Setting**

**IT-9.1** Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure)

**Reasons/Rationale for selecting the outcome measure(s):**
The Peer-to-Peer specialist project will aid in the achievement of the outcome measures listed above as a result of increased focus on behavioral health care illness in the community and providing trained resources to support those individuals in need of behavioral health services. Through peer support specialists, trained in the “whole health” approach, individuals will have greater opportunity for achieving their goals and preventing or self-managing their chronic diseases thus reducing the recidivism of potentially preventable hospitalizations, incarcerations, and psychiatric emergency services. Overall achieving these outcomes will positively impact individuals receiving behavioral health care services through the integration of peer provided support in a day center setting and will increase patient satisfaction.

**Relationship to other Projects:**
MHMR of Nueces County’s four projects will complement the delivery of behavioral health services to an underserved area in rural Texas. Projects include peer to peer support, integration of physical and behavioral health, social media and outreach programs, and dual diagnosis crisis stabilization services. This project is also related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share
information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**
The percentage of target population who receive peer to peer services in a day center setting is currently 0%. Establishment of a “Drop-In” center for peer led services will provide an environment of care which reduces recidivism in hospitalizations and incarcerations by engaging the target population in an evidenced based peer to peer program. For FY 2011 the number of hospitalizations in the target population for those who receive outpatient mental health services through MHMR-NC was the number of individuals in the target population who were incarcerated was 670. The average cost of inpatient MH services per hospitalization is $13,642 and the average cost for incarceration in Nueces County Jail is $180 per day with an assumed average length of stay of 30 days. Successful implementation of this program will result in a minimum community cost savings of $823,870.99. The valuation of this program was calculated by multiplying the number of individuals which will be re-directed from hospitalization by the mean cost of a mental health hospitalization. The total program value is the summative cost savings to the community. Cost averages were drawn from 2008 (most recent available) cost data for MH hospitalizations as cited in the 2008 DSHS statistical brief. The cost savings to the community for reduction in incarcerations is factored into the valuation. For FY 2011 there were a total of 670 individuals who were incarcerated in Nueces County Jail that had a diagnosis of mental illness. The cost of incarceration is calculated to be $180 per day. Implementation of this program will seek to reduce this rate by 5% in DY3, 10% in DY4, and 15% in DY5.
### RHP Plan for Region 3

#### Payment Milestone 1 Estimated Incentive

**Metric 1 P-1.1** Number of staff trained
- Baseline is 0 administrators trained. Goal is to train at minimum one administrator and one clinician on recovery/wellness and integration of peer support services.

**Data Source:** Training records and training evaluation records

**Milestone 1 Estimated Incentive Payment:** $217,007

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#### Payment Milestone 2 Estimated Incentive

**Metric 2 P-3** Identify and train peer specialists to conduct whole health classes.

**Metric 1 P-3.1** Number of peers trained in whole health planning.

**Baseline/Goal:** Baseline is zero. Goal is to have each individual complete an HRA.

**Data Source:** Internal database

**Milestone 2 Estimated Incentive Payment:** $47,169

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#### Payment Milestone 3 Estimated Incentive

**Metric 3 P-4** Select and implement a health risk assessment (HRA) tool.

**Metric 1 P-4.1** Number of HRAs completed by consumers.

**Baseline/Goal:** Baseline is zero. Goal is to have each individual complete an HRA.

**Data Source:** Internal database

**Milestone 3 Estimated Incentive Payment:** $47,169

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#### Payment Milestone 4 Estimated Incentive

**Metric 4 P-5** Identify health risks of consumers with serious mental illness.

**Metric 1 P-5.1** Number of consumers identified with modifiable health risks.

**Baseline/Goal:** Baseline is zero. At

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#### Payment Milestone 5 Estimated Incentive

**Metric 5 P-7** Evaluate and continuously improve peer support services.

**Metric 1 P-7.1** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles.

**Baseline/Goal:** Baseline is no quality improvement plan for DY-3. Goals is to implement a quality improvement plan utilizing a “plan, do, study, act quality improvement plan”.

**Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvement to guide

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#### Payment Milestone 6 Estimated Incentive

**Metric 6 P-8** Preventative Services Task Force.

**Baseline/Goal:** Baseline of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force.

**Data Source:** Clinical Records

**Milestone 6 Estimated Incentive Payment:** $101,125

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#### Payment Milestone 7 Estimated Incentive

**Metric 7 P-17** Receipt of Recommended Preventative Services

**Metric 1 I-17.1** The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force.

**Baseline/Goal:** Baseline is zero. Goal: 75 persons will receive recommended peer provided services resulting in redirection from inpatient hospitalization or incarceration.

**Data Source:** Clinical Records

**Milestone 7 Estimated Incentive Payment:** $102,930

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#### Payment Milestone 8 Estimated Incentive

**Metric 8 P-7** Evaluate and continuously improve peer support services.

**Metric 1 P-7.1** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles.

**Baseline/Goal:** Baseline is no quality improvement plan for DY-3. Goals is to implement a quality improvement plan utilizing a “plan, do, study, act quality improvement plan”.

**Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvement to guide

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#### Payment Milestone 9 Estimated Incentive

**Metric 9 I-17.1** The percentage of individuals 18 years and older who receive peer support services and who also receive services as recommended by the US Preventative Services Task Force.

**Baseline/Goal:** Baseline for DY4 is 75 persons. Goal for DY5 is 150 persons recommended peer provided services resulting in redirection from inpatient hospitalization or incarceration.

**Data Source:** Clinical Records

**Milestone 9 Estimated Incentive Payment:** $102,930

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#### Payment Milestone 10 Estimated Incentive

**Metric 10 P-7** Evaluate and continuously improve peer support services.

**Metric 1 P-7.1** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles.

**Baseline/Goal:** Baseline is an established quality improvement plan in DY3 utilizing plan, do, study, act improvement plan. Goals is to expand and continue implementation of a quality
<table>
<thead>
<tr>
<th><strong>138305109.2.2</strong></th>
<th>2.18.1</th>
<th>2.18.1 A-i</th>
<th><strong>RECRUIT, TRAIN AND SUPPORT CONSUMERS OF MENTAL HEALTH SERVICES TO PROVIDE PEER SUPPORT SERVICES</strong></th>
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<td><strong>MHMR OF NUECES COUNTY</strong></td>
<td><strong>138305109</strong></td>
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</table>
| **Related Category 3 Measures:** | | | **Percent improvement over baseline of patient satisfaction scores**  
| | | | **Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons** |
| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
| minimum identify 35 consumers with modifiable health risks.  
**Data Source:** Internal data base.  
**Milestone 4 Estimated Incentive Payment:** $47,169 | | | |
| **Milestone 5 P-6:** Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors.  
**Metric 1 P-6.1:** Number of participants receiving peer services.  
**Baseline/Goal:** Baseline is at present zero. Goal will be to provide peer services to 35 individuals  
**Data Source:** Internal records and clinical records. | | | |
| continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, monthly dashboards with data on readmissions, and feedback from consumers to drive improvement)  
**Milestone 8 Estimated Incentive Payment:** 101,125 | | | |
| **Milestone 6 P-7:** Evaluate and continuously improve peer support | | | |
| improvement plan utilizing a “plan, do, study, act quality improvement cycle”.  
**Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, monthly dashboards with data on readmissions, and feedback from consumers to drive improvement).  
**Milestone 10 Estimated Incentive Payment:** $102,930 | | | |
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<tr>
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<th>2.18.1 A-i</th>
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<td><strong>Related Category 3 Measures:</strong></td>
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<td>3 IT 9.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
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<td>138305109.3.4</td>
<td>3 IT-6.1</td>
<td>Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td>services</td>
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<tr>
<td><strong>Metric 1 P-7.1</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles.</td>
<td><strong>Baseline/Goal:</strong> Baseline is no quality improvement plan for DY-2. The Goal for DY-3 is to develop or identify a quality improvement plan, utilizing a plan, do, study, act quality improvement cycle.</td>
<td><strong>Data Source:</strong> Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, monthly dashboards with data on readmissions, and feedback from consumers to drive improvement).</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $47,169</td>
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<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $217,007</td>
<td>Year 3 Estimated Milestone Bundle Amount: <strong>$235,845</strong></td>
<td>Year 4 Estimated Milestone Bundle Amount: <strong>$202,250</strong></td>
<td>Year 5 Estimated Milestone Bundle Amount: <strong>$205,860</strong></td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5): <strong>$860,962</strong></td>
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</table>
**MHMR of Nueces County**  
**Social and New Media Outreach and Education**  
138305109.2.3

- **Provider:** MHMR of Nueces County is a community mental health center which functions as the Local Mental Health Authority for Nueces County. The center employs approximately 240 individuals and provides mental and behavioral healthcare services to residents of Nueces County. MHMR-NC serves a population of approximately 1500 adults and 400 children and adolescents. The population of the center’s service area is approximately 350,000 persons.

- **Intervention(s):** This project will implement an innovative system for community outreach and education which will include a website and mobile applications incorporating social and electronic media. This project will increase the scope of education services and outreach for behavioral health care and provide psycho-educational curricula with the goal of increased preventive mental health and behavioral health care education, recruitment of those in need into existing service delivery systems, and increased service delivery through new media.

- **Need for the project:** Given the limited access to services and opportunities for patient outreach and education, this project will vastly increase the ease of access and availability of basic preventive, psychoeducational, and other behavioral healthcare information. This is a particularly effective delivery model given the large rural population we serve, and challenges in reaching individuals with limited transportation options.

- **Target population:** The target population for this project includes all persons within Nueces County. It will benefit the persons accessing the service through increased availability of information related to mental and behavioral health including pathways for access to care. We expect to see an increase in participation in available services and an expansion into online intervention and prevention. Approximately 95% of our clients are enrolled in Medicaid or indigent.

- **Category 1 or 2 expected patient benefits:** The project seeks to engage at minimum 5% of the target population receiving new media services over baseline of zero by the end of DY3. The program will expand access to health promotion programs and engage a minimum of 100 persons in new media intervention with at least 75 persons recruited into direct care services as a result of the programs outreach in DY4. Persons receiving new media services and innovative intervention will also expand by 10%. In DY5 this program will expand by 15% those engaged in new media services and engage at minimum 125 persons in innovative new media intervention with a minimum of 100 engaged in direct care services as a result.

- **Category 3 outcomes:** IT-2.4. Our goal through the expansion of service delivery using new media will be to reduce the hospitalizations of persons with behavioral health and substance abuse by 10% from baseline in DY3. In DY4 the program will expand its impact to reduce this hospitalization rate by 15%, and 20% in DY5. Reduction in hospitalization will be the result of increased service access, delivery, and recruitment to those who would otherwise have not accessed care.
Category 2: Program Innovation and Redesign

Project Option 2.6.1 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

**Unique RHP Project ID Number:** 138305109.2.3  
**Performing Provider/TPI:** MHMR of Nueces County/138305109

**Project Description:**
MHMR of Nueces County is seeking to develop a program to provide outreach and education for Region 4 target populations within the coastal bend community which incorporates the internet and social media; e.g. Facebook, MySpace, Twitter etc. in the administration of outreach and education services. We will collaborate with other agencies and community education programs such as Texas A&M Health Sciences Center and others to expand the scope of mental health and behavioral health services to communities and schools within Region 4. The goal for this project is to increase the scope of education and outreach for behavioral health care in Region 4 and provide psycho-educational curricula through the use of social media and the internet with the aim of increased preventive mental health and behavioral health care, and increased service delivery through new media.

**Goals and Relationship to Regional Goals:**
The goal for this project is to increase the scope of education and outreach for behavioral health care in Region 4 and provide psycho-educational curricula through the use of social media and the internet with the aim of increased preventive mental health and behavioral health care, and increased service delivery through new media.

This project meets the following Region 4 goals:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of the existing health care delivery system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

**Challenges:**
The challenges for this project will be the development of the outreach and education plan development, identification of the targeted population that would benefit and utilize the social media as a learning tool, capturing and reporting data. MHMR of Nueces County will meet these challenges by collaborating with other regional and state partners that have a similar interest, identify best practices, and share processes and techniques that benefit the targeted population.

**5-Year Expected Outcome for Provider and Patients:**
We expect to reach 15% of the targeted population by DY 5 and utilize the innovative interventions of social media for outreach and education for behavioral health delivery services.
**Starting Point/Baseline:**
At present in Region 4 there are no outreach and education programs for mental and behavioral health which are utilizing new social media.

**Rationale:**
The program’s rationale centers on increased engagement of the target populations by providing increased access to care and facilitation of appropriate use of health resources through outreach and cultural linkages between communities and delivery systems. Through the MHMR of Nueces County social media connection we will implement innovative evidence based health promotion strategies including innovation in social media, community education and messaging for the targeted population. We will also engage in population based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging for our identified population. The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Delivery mechanisms include community health workers which can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Information sharing, program support, program evaluation, and continuing education are needed to expand the use of community health workers and better integrate them into the health care delivery system.

Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for some chronic conditions i.e. arthritis and asthma in adults; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

**Milestones and Metrics:**
The following milestones and metrics have been chosen for the MHMR of Nueces County social media project based on the overall project goals and expected results for the target population:

- Process Milestones and Metrics: P-1(P-1.1); P-2(P-2.1); P-3 (P-3.1); P-5 (P-5.1); P-7 (P.7.1)
- Improvement Milestones and Metrics: I-6 (I-6.1); I-8 (I-8.1)

**Unique community need identification number the project addresses:**
- CN 4 – Inadequate access to behavioral health care
• CN 12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services
• CN 15 – Inadequate health care access in rural areas
• CN 16 – Lack of integration of physical and behavioral health services

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
Currently there are no outreach and education programs for mental and behavioral health which are utilizing new media in the Nueces County community. This outreach strategy is new and will increase the scope of education and outreach for the targeted population in Region 4 and provide psycho-educational curricula through the use of social media and the internet with the aim of increased preventive mental health and behavioral health care and increased service delivery knowledge of behavioral health care.

Related Category 3 Outcome Measure(s):
We propose to meet the following outcome measures with the implementation of the MHMR Nueces County social media project:

OD-2 Potentially Preventable Admissions
IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate
Performing provider will report on both categories below:
  1. One for BH/SA as the principal diagnosis
  2. A second category in which a significant BH/SA secondary diagnosis is present (e.g. admission for an accident or diabetes with a secondary diagnosis of psychosis.

OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:
(1) are getting timely care, appointments, and information;
(2) how well their doctors communicate;
(3) patient’s involvement in shared decision making, and
(4) patient’s overall health status/functional status.

Reasons/Rationale for selecting the outcome measure(s):
The Nueces County social media project described above will aid in the achievement of the outcome measures as a result of increased awareness and education for the current behavioral health target population. Connecting and providing individuals with the appropriate resources/information and education assists them in making informed decisions regarding their health care, reduces cost, improves detection of problems, improves quality by contributing to patient-provider communication, promotes continuity of care and consumer protection and satisfaction. As mentioned previously this population is not receiving outreach and education programs for mental
and behavioral health using new media; this new more far-reaching approach can positively impact the overall health of the target population and thus help avoid unnecessary hospitalizations, decrease emergency room use and avoid mental health crisis. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalizations in Nueces County is $38,130,000.

**Relationship to other Projects:**
MHMR of Nueces County’s four projects will complement the delivery of behavioral health services to an underserved area in rural Texas. Projects include peer to peer support, integration of physical and behavioral health, social media and outreach programs, and dual diagnosis crisis stabilization services. This project is also related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:**
The program’s value centers on the outreach and engagement of persons through electronic and social media in addition to traditional methods of outreach. The program seeks to divert potentially preventable hospitalizations through engaging persons in preventive behavioral and primary care. Values were calculated through tracking the number of persons engaged in outpatient care as a preventative pathway to reducing hospitalizations; and subsequently, the cost to the community. Implementation of this program seeks to reduce the cost of potentially preventable hospitalizations to the community by a minimum of $494,522.50. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalizations in Nueces County is $38,130,000.
hospitalization to Nueces County is $38,130,000. Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.
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<tr>
<th>138305109.2.3</th>
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<td><strong>Related Category 3 Measures</strong></td>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tr>
<td><strong>Milestone 1 P-1</strong> Conduct an assessment of health promotion programs that involve community health workers at local and regional level. <strong>Metric 1 P-1.1</strong> Document regional assessment. <strong>Baseline/Goal:</strong> At present there are no outreach and education programs for mental and behavioral health provided in region 4. Goal is to assess any existing outreach and education programs at the local and regional level. <strong>Data Source:</strong> Performing Provider assessment and summary of findings. <strong>Milestone 1 Estimated Incentive Payment:</strong> $53,040</td>
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<td><strong>Milestone 2 P-2</strong> Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. <strong>Metric 1 P-2.1</strong> Document innovative strategy and plan. <strong>Baseline/Goal:</strong> At present there are no outreach and education programs for mental and behavioral health provided in region 4. Goal: Begin developing an outreach and education program strategy for the targeted population. <strong>Milestone 3 Estimated Incentive Payment:</strong> $54,765.66</td>
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<td><strong>Milestone 3 P-3</strong> Implement, document and test an evidence-based innovative project for targeted population. <strong>Metric 1 P-3.1</strong> Document implementation strategy and testing outcomes. <strong>Baseline/Goal:</strong> Baseline is zero documentation for implementation strategy’s and outcome testing. Goal is to develop and implement a tool for program strategy and outcome testing. <strong>Data Source:</strong> Performing Provider contract or other documentation of implementation established. <strong>Milestone 4 Estimated Incentive Payment:</strong> $54,765.67</td>
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<td><strong>Milestone 6 I-6</strong> 150 patients in defined population receiving innovative intervention consistent with evidence-based model. <strong>Metric 1 I-6.1</strong> TBD by Performing Provider based on measure described above. <strong>BASELINE/GOAL:</strong> Persons receiving innovative interventions will increase to 150 persons. <strong>Data Source:</strong> Patient records. <strong>Milestone 6 Estimated Incentive Payment:</strong> $64,826</td>
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<td><strong>Milestone 7 I-8</strong> Increase access to health promotion programs and activities using innovative project option. <strong>Metric 1 I-8.1</strong> Increase percentage of target population reached. <strong>Data Source:</strong> Documentation of target population reached, as designated in the project plan. <strong>BASELINE/Goal:</strong> Baseline is 125 persons receiving innovative intervention in DY4. Goal is to increase persons receiving innovative interventions to a minimum of 175 persons with another 50 who are engaged in outpatient care as a result of innovative intervention. <strong>Milestone 8 I-6</strong> 225 patients in defined population receiving innovative intervention consistent with evidence-based model. <strong>Metric 1 I-6.1</strong> TBD by Performing Provider based on measure described above. <strong>BASELINE/GOAL:</strong> Persons receiving innovative interventions will increase to a minimum of 225. <strong>Data Source:</strong> Patient records. <strong>Milestone 8 Estimated Incentive Payment:</strong> $58,963</td>
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**RHP Plan for Region 3**
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<td><strong>Program.</strong></td>
<td><strong>Milestone 5 I-6 75 person’s patients in defined population receiving innovative intervention consistent with evidence-based model.</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $64,826</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $58,963</td>
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<tr>
<td><strong>Data Source:</strong> Performing Provider evidence of innovational plan</td>
<td><strong>Metric 1 I-6.1 Provider based on measure described above.</strong></td>
<td><strong>Baseline/GOAL:</strong> 75 Persons receiving innovative interventions through new media.</td>
<td><strong>Data Source:</strong> Patient records.</td>
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<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $53,040</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $54,765.67</td>
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<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> (add incentive payments amounts from each milestone): $106,080</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $164,297.00</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $129,652</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $117,927</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5): $517,956</td>
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MHMR of Nueces County/138305109
Dual Diagnosis Crisis Stabilization Clinic Project
138305109.2.4

2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of service in a specified setting - Dual Diagnosis Crisis Stabilization Clinic Project

- **Provider:** MHMR of Nueces County is a community mental health center which functions as the Local Mental Health Authority for Nueces County. The center employs approximately 240 individuals and provides mental and behavioral healthcare services to residents of Nueces County. MHMR-NC serves a population of approximately 1500 adults and 400 children and adolescents. The population of the center’s service area is approximately 350,000 persons. MRMR of Nueces County will not receive federal funds for this project.

- **Intervention(s):** This project will provide a dual diagnosis clinic to provide outpatient crisis prevention and support staff development using National Association of Dual Diagnosis (NADD) direct support certification and clinical competency standards for individuals with a dual diagnosis of intellectual or developmental disability (IDD) and mental health (MH).

- **Need for the project:** We currently have no clinic serving individuals with dual diagnosis through supportive therapies and behavioral health interventions by clinicians competent in both Mental Health and IDD. Most hospitalizations and SSLC commitments for individuals with IDD occur in individuals with a dual diagnosis.

- **Target population:** It is estimated that up to 35% of the 800 individuals in services with IDD in Nueces County also have a co-occurring Mental Illness. Currently 95% of the individuals we serve have Medicaid or are indigent.

- **Category 1 or 2 expected patient benefits:** This program proposes to serve 20 individuals in year 3, 25 in year 4 and 30 individuals in DY5. Services will increase the use of appropriate community based interventions and decrease emergency department and facility based interventions.

- **Category 3 outcomes:**
  - It is our goal to reduce emergency department visits for the target population by 10% in year 4 and 15% in year 5.
  - It is our goal to reduce admissions to ICF-ID facilities including state supported living centers for the target population by 5% in year 4 and 10% in year 5.
Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Project Title: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of service in a specified setting - Dual Diagnosis Crisis Stabilization Clinic Project

RHP Project Identification Number: 138305109.2.4

Performing Provider/TPI: MHMR of Nueces County/138305109

Project Description:

MHMR of Nueces County will establish an outpatient psychiatric clinic that offers medication and supportive therapies to individuals with a dual diagnosis of intellectual or developmental disability (IDD) and mental health (MH).

The clinic team will receive and then provide training to deliver community based interventions for individuals with dual diagnosis. The team will be comprised of an LPC or LPA therapist with experience in applied behavior therapy, Cognitive Adaptive Therapy training, and trauma informed care training. There will also be direct care staff that is trained to meet the requirements for the National Association of Dual Diagnosis (NADD) direct support certification. The team will have contracted support of a Psychiatrist, and an RN. The clinic will provide additional mental health training to expand crisis prevention knowledge and wellness education for patients, educators, and caregivers for the IDD population to include training and certification in crisis stabilization through the NADD Competence Based Direct Support Professional Certification Program to caregivers who support people with a dual diagnosis, and will obtain certification within 2 years of implementation. Clinicians within the program will use NADD clinical competency standards and within two years will obtain NADD certification.

Initially, the clinic will be a resource to individuals currently receiving services, during regular operating hours. Over the course of the project, the clinic will expand to provide crisis support during the times identified as peak crisis times in our community. MRMR of Nueces County will not receive federal funds for this project.

Goals and Relationship to Regional Goals:

The goals for this project are to expand psychiatric, psychological, service coordination, para-professional, peer to peer and volunteer training programs to include education about IDD and dual MH diagnosis, to develop a holistic and comprehensive treatment clinic where individuals with dual diagnosis receive treatment and support services from trained and competent providers that address the bio-psycho-social needs of the individual using person directed processes and NADD recommended interventions.

Challenges and how addressed:

Some of the challenges we face in implementing a dual diagnosis Crisis Stabilization Clinic include the following:

- DADS and DSHS contracts contradict and do not currently allow for serving a person with IDD in the community mental health services
- Training and recognition of dual diagnosis is currently limited
- Peak crisis times need to be identified
- Psychiatric and Behavioral Health Care Analyst staff are difficult to locate within our community
We will communicate and collaborate as necessary with the state agencies to manage any contract issues and work closely with the community for training and understanding of those individuals with a dual diagnosis. We will coordinate closely with our community hospitals, police departments, criminal justice system and other providers to identify the peak crisis times and implement procedures to address these as appropriate. Knowing psychiatric and behavioral health care professionals are difficult to recruit and hire we will seek guidance using professional associations and local providers and organizations skilled in behavioral health care to assist with identification of eligible candidates for hire.

5-Year Expected Outcome for Provider and Patients:
By DY5, the IDD dual diagnosis clinic will serve 30 individuals with dual diagnosis in our community, and reduce the use of hospital emergency room, inpatient hospital admissions, police department services and institutional care for this population. Individuals with IDD and dual diagnosis of autism or mental illness will receive appropriate intervention in their homes and community instead of relying on more costly hospital and institutional care resulting in a significant decrease in the number of behavioral crisis that lead to hospitalization, jail, or institutional care for individuals with IDD. Individuals with IDD and dual diagnosis of mental illness will remain in their community and experience a higher quality of life while reducing the cost of hospitalizations and long term institutionalization.

Starting Point/Baseline:
The starting point/baseline for this project is presently at zero. However, by the end of year 5 this program will have served a minimum of 30 individuals.

Rationale:
The percentage of target population who receive behavioral health interventions by clinicians competent in both Mental Health and IDD is estimated to be zero, as there is no clinic currently in Nueces County treating dually diagnosed individuals. Most hospitalizations and SSLC commitments for individuals with IDD occur in individuals with a dual diagnosis. This program proposes to serve 20 individuals in year 3 and 30 individuals in years 4 and 5. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000. Implementation of the dual diagnosis clinic program could reduce this cost to the community by preventing one hospitalization for each person in service per year; potential savings is $1,091,361 between DY3 – DY5.

Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief. The cost of admission or re-admission to a state supported living center is $547 a day, or $199,827 a year per person. Preventing 2 SSLC admissions per year will save the state of Texas $599,481 between DY3 - DY 5. Total potential savings $1,690,842. Additional savings that do not have a dollar cost will be realized through improved integration and quality of life for those participating in the dual diagnosis clinic.

**Project Components:**
Through the Dual Diagnosis Crisis Stabilization Clinic Project we propose to meet all of the required project components:

a) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.

b) Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

d) Design models which include an appropriate range of community-based services and residential supports.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

**Milestones and Metrics:**
The following milestones and metrics were chosen for the Dual Diagnosis Crisis Stabilization Clinic Project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-4 (P-4.1); P-5 (P-5.1)

Improvement Milestones and Metrics: I-5 (I-5.1)

**Unique community needs identification numbers:**
CN-4: Inadequate access to Behavioral Health services
CN 6: High rates of inappropriate emergency department utilization
CN 7: High rates of preventable hospital admissions

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently there is no clinic in the Nueces County community treating dually diagnosed individuals. This initiative will establish an outpatient psychiatric clinic that offers medication and supportive therapies to individuals with a dual diagnosis of intellectual or developmental disability (IDD) and mental health (MH). Expanding psychiatric, psychological, service coordination, para-professional, peer to peer and volunteer training programs including education about IDD and dual MH diagnosis, will provide the best opportunity to serve individuals in need of these services. Developing a holistic and comprehensive treatment clinic where individuals with dual diagnosis receive treatment and
support services from trained and competent providers that address the bio-psycho-social needs of the individual using person directed processes will also enhance the existing delivery systems.

**Related Category 3 Outcome Measure(s):**
The dual diagnosis clinic will increase appropriate use of community intervention services, and will reduce the use of emergency departments, criminal justice, and institutional services. The following outcome measures will be used to determine effectiveness:

**OD-9 Right Care, Right Setting:**

**IT-9.2 ED appropriate utilization**
Reduce Emergency Department visits for target conditions of Behavioral Health/Substance Abuse in dual diagnosed population.
This measurement includes the percentage of patients with dual diagnosis who have greater than or equal to one visit to the emergency room for behavioral health during the measurement period. Emergency visits for behavioral health are an indicative of a breakdown in at home supports and interventions. Reducing emergency visits improves the stability of individuals with dual diagnosis. Providing behavioral interventions at home is less costly than hospitalization.

**IT-9.4 Other Outcome Improvement Target: Reduction in admissions to Small, Medium, or Large ICF-ID**

a. Numerator: Percentage of individuals served with IDD/MH dual diagnosis that have greater than or equal to one placement in a small, medium, or large ICF/IDD during the past three months.
b. Denominator: All individuals served with dual diagnosis in the past three months.
c. Data Source: Clinical record, ICF admission and encounter data

**Reasons/Rationale for selecting the outcome measures:**
Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the emergency department and/or the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.
Individuals with a dual diagnosis are at increased risk of admission to institutional care settings. Measuring % of the population served that are admitted to institutional care will provide baseline data, and will demonstrate program effectiveness if the % of admissions within the group served is decreased. Decreasing admissions to institutional settings is significant to the quality of life of persons served. It is also significant to our community, because there are cost savings when people are served at home instead of a state supported institution.

**Relationship to other Projects:**
MHMR of Nueces County’s four projects will complement the delivery of behavioral health services to an underserved area in rural Texas. Projects include peer to peer support, integration of physical and behavioral health, social media and outreach programs, and dual diagnosis crisis stabilization services. By establishing an outpatient psychiatric clinic that offers medication and supportive therapies to individuals with a dual diagnosis of intellectual or developmental disability (IDD) and
mental health (MH) conditions we support the overall goal of our region and our other projects to provide care in the right setting at the right time for the most efficient cost. This project is also related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services.


**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

**Project Valuation:** The percentage of target population who receive behavioral health interventions by clinicians competent in both Mental Health and IDD is estimated to be zero, as there is no clinic in Nueces County treating dually diagnosed individuals. Most hospitalizations and SSLC commitments for individuals with IDD occur in individuals with a dual diagnosis. This program proposes to serve 20 individuals in year 3 and 30 individuals in years 4 and 5. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000.

Implementation of the dual diagnosis clinic program could reduce this cost to the community by preventing one hospitalization for each person in service per year; potential savings is $1,091, 361 between DY3 – DY5.

Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief. The cost of admission or re admission to a state supported living center is $547 a day, or $199,827 a year per person. Preventing 2 SSLC admissions per year will save the state of Texas $599,481 between DY3 - DY 5. Total potential savings $1,690,842. Additional savings that do not have a dollar cost will be realized through improved integration and quality of life for those participating in the dual diagnosis clinic.

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<table>
<thead>
<tr>
<th>138305109.2.4</th>
<th>2.13.1</th>
<th>2.13.1 A-E</th>
<th>Dual Diagnosis Crisis Stabilization Clinic</th>
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<tr>
<td><strong>MHMR OF NUECES COUNTY</strong></td>
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<td>138305109</td>
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<tr>
<td>Related Category 3 Measures:</td>
<td>138305109.3.7</td>
<td>IT 9.2, 138305109.3.8</td>
<td>ED Appropriate Utilization Other Outcome Improvement Target</td>
</tr>
<tr>
<td><strong>Process Milestone 1 P-1</strong> Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources.</td>
<td><strong>Metric 1 P-1.1</strong> Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization</td>
<td><strong>Baseline/Goal:</strong> Determine baseline number of individuals with dual diagnosis in Nueces County.</td>
<td><strong>Data Source:</strong> Project documentation; Inpatient, discharge and ED records; State psychi atric facility records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review</td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount):</strong> $231,217.67</td>
<td><strong>Milestone 3 P-3</strong> Enroll and serve individuals with a diagnosis of severe mental illness with diagnosis of intellectual or developmental disability. <strong>Metric 1 P-3.1</strong> 20 targeted individuals enrolled and served in the dual diagnosis clinic <strong>Baseline/Goal:</strong> Currently zero individuals enrolled, goal is to enroll 20 individuals. <strong>Data Source:</strong> Project documentation</td>
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<td><strong>Milestone 4 P-4:</strong> Evaluate and continuously improve interventions <strong>Metric 1 P-4.1</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles <strong>Baseline/Goal:</strong> currently no quality improvement cycle, by DY 3 project planning and implementation documentation will reflect plan, do, study, act quality improvement cycle. <strong>Data Source:</strong> Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)</td>
<td><strong>Milestone 6 P-3:</strong> Enroll and serve individuals with a diagnosis of severe mental illness with diagnosis of intellectual or developmental disability. <strong>Metric 1 P-3.1:</strong> Number of targeted individuals enrolled/served in the project <strong>Baseline/Goal:</strong> 20 enrolled/enroll 5 additional individuals <strong>Data Source:</strong> Project Documentation</td>
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<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount):</strong> $387,195</td>
<td><strong>Milestone 7 I-5 Functional Status</strong> <strong>Metric 1 I-5.1</strong> The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g., ANSA, CANS, etc.) <strong>Baseline/Goal:</strong> Baseline is zero as functional status has not been measured. Goal is to measure an increase in functional status from entry into to services to 6 months after receiving services. <strong>Data Source:</strong> clinic program data, ANSA results</td>
<td><strong>Milestone 8 Estimated Incentive Payment (maximum amount):</strong> $341,643</td>
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<td><strong>Milestone 8 P-3:</strong> Enroll and serve individuals with a diagnosis of severe mental illness with diagnosis of intellectual or developmental disability. <strong>Metric 1 P-3.1:</strong> Number of targeted individuals enrolled/served in the project <strong>Baseline/Goal:</strong> 30 enrolled/enroll 10 additional individuals <strong>Data Source:</strong> Project Documentation</td>
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<td><strong>Milestone 9 I-5 Functional Status</strong> <strong>Metric 1 I-5.1</strong> The number of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g., ANSA, CANS, etc.) <strong>Baseline/Goal:</strong> Baseline is zero as functional status has not been measured. Goal is to measure an increase in functional status from entry into to services to 6 months after receiving services. <strong>Data Source:</strong> clinic program data, ANSA results</td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong></td>
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<tr>
<td>Interventions for target populations.</td>
<td>Metric 1 P-2.1 Project plans which are based on evidence/experience and which address the project goals. Baseline/Goal: Develop project plans which are based on evidence/experience. Data Source: Project documentation.</td>
<td>Milestone 5 P-5 Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 P-5.1 Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: currently no meetings held, by DY 3 documentation will reflect participation in bi-weekly phone meetings, conference calls, or webinars. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
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<td></td>
<td>(maximum amount): $231,217.67</td>
<td>Payment (maximum amount): $387,195</td>
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<tr>
<td></td>
<td>Year 2 Estimated Milestone Bundle Amount: $5221,336</td>
<td>Year 3 Estimated Milestone Bundle Amount: $693,653</td>
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<td>Year 4 Estimated Milestone Bundle Amount: $774,390</td>
<td>Year 5 Estimated Milestone Bundle Amount: $683,286</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $2,372,665</strong></td>
<td>entry into services to 6 months after receiving services. Data Source: clinic program data, ANSA results. Milestone 9 Estimated Incentive Payment (maximum amount): $341,643</td>
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E. Category 3: Quality Improvements
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

3.3. Potentially Preventable Re-admissions

- IT-3.2: Congestive Heart Failure 30 day readmission rate

CHRISTUS Spohn Hospital – Beeville/020811801
Project unique ID number: 020811801.3.1

**Outcome Measure Description**

Spohn will measure the rate of 30 day readmissions (for any reason) to its hospital facilities upon discharge from an inpatient stay for Congestive Heart Failure (“CHF”), and projects the outcome of its disease registry project to be a reduction in its overall potentially preventable readmission rate for this target population. Potentially Preventable Readmissions (PPRs) often result from the fact that patients lack support, information, and access to continued care in the outpatient setting upon discharge. These patients are at risk for their conditions deteriorating when they are no longer monitored and managed in the hospital, which can lead to relapses/additional acute episodes/complications requiring readmission to an inpatient setting. The systemic cost of readmissions and negative impact on patient quality of life, satisfaction, and long-term outcomes makes this achieving an improvement in this domain a high priority for Spohn.

**Process milestones:**

- DY2: Establish a baseline of CHF 30 day readmission rates

**Improvement milestones:**

- DY3: Reduce CHF PPRs by 3% from baseline
- DY4: Reduce CHF PPRs by 5% from baseline
- DY5: Reduce CHF PPRs by 8% from baseline

**Rationale:**

According to Region 4’s Community Needs Assessment, Bee County has a high incidence of hospitalization related to chronic diseases, including CHF (RHP Plan, Section 3, Table 10). Spohn chose this outcome measure to complement its disease registry project because one goal of the registry is to enable CHF patients to effectively manage their conditions and their overall health subsequent to discharge from an inpatient stay for CHF. Spohn expects to see evidence of a decrease in re-admission rates for this population as a result of (1) effective and efficient discharge planning while patients are in the hospital, (2) home visits within 48 hours of patients’ arrival home and (3) follow-up phone calls to ensure patients understand and have processed the education/information provided by Spohn.

Process milestones: During DYs 2-3, Spohn will establish a baseline rate of readmissions for its CHF patients in order to measure progress going forward, and will engage in project planning to create an effective approach to using the information in the registry to prevent readmissions.
for CHF patients within 30 days of discharge from an inpatient setting (including patient education, medication management, caregiver outreach, and timely follow up).

Improvement milestones: Spohn aims to reduce the percentage of 30 day readmissions for CHF patients by 5% under baseline in DY4, and by 8% under baseline in DY5. These targets were chosen to reflect reasonable but meaningful reforms in the CHF patient short-term outcomes and the cost of providing care to patients with this chronic disease.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to preventing unnecessary hospital readmissions for CHF patients. Hospital readmissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally they increase the systemic cost of providing care to indigent and uninsured patients in the community. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
| Process Milestone 1 [P-2]: Establish baseline rates – Spohn will determine the rate of 30 day readmissions for CHF patients at its Beeville campus for all causes | Outcome Improvement Target 1 [IT-3.1]: PPR  
**Improvement Target**: 3% reduction in all cause CHF patient 30-day readmission rates | Outcome Improvement Target 2 [IT-3.1]: PPR  
**Improvement Target**: 5% reduction in all cause CHF patient 30-day readmission rates for Spohn’s Beeville campus  
**Data Source**: Hospital admission records | Outcome Improvement Target 3 [IT-3.1]: PPR  
**Improvement Target**: 8% reduction in CHF patient all cause 30-day readmission rates for Spohn’s Beeville campus  
**Data Source**: Hospital admission records |
|---|---|---|---|
|  **Data Source**: Historical clinic/hospital/ED claims and financial data  
Process Milestone 1 Estimated Incentive Payment: $26,180 | Outcome Improvement Target 1 Estimated Incentive Payment: $30,346 | Outcome Improvement Target 2 Estimated Incentive Payment: $48,695 | Outcome Improvement Target 3 Estimated Incentive Payment: $116,445 |
| Year 2 Estimated Outcome Amount: $26,180 | Year 3 Estimated Outcome Amount: $30,346 | Year 4 Estimated Outcome Amount: $48,695 | Year 5 Estimated Outcome Amount: $116,445 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5)*: $221,666
Category 3: Quality Improvement

Identifying Outcome Measure and Provider Information:
1.7.6 - Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.
1.11 – Diabetes Care – Blood Pressure Control CHRISTUS Spohn Hospital Beeville / 020811801

Unique Identifier: 020811801.3.2

Outcome Measure Description
Diabetic patients are often at risk for Peripheral Arterial Disease (PAD) and Spohn is implementing a Category 1 project to provide more screenings by cardiovascular specialists for this at-risk population using telemedicine. As a result, Spohn expects more patients to receive cautionary information, medication management, and follow-up when they are identified as having high-blood pressure (which can increase the risk and symptoms of PAD). By identifying patients with the potential to develop or with early signs of PAD, Spohn can provide those patients with medication to reduce blood pressure and prevent/alleviate PAD in many cases. Project implementation is projected to have the following outcomes by end of waiver period:
- 10% increase in diabetic patients seen in Spohn clinics with controlled blood pressure (<140/80mm Hg)

Rationale:
Obesity, Diabetes-Type II, PAD, cardiovascular disease (CVD) and amputations have all been identified as prevalent in the Hispanic population in South Texas. This extremely at-risk population is in dire need of early screening, diagnostics and interventions to reduce the long-term complications of diabetes such as ulcerative or non-healing lesions, necrotic or gangrenous lower extremities and amputations. Diabetic patients with high-blood pressure will be at higher risk for developing PAD, as both conditions affect the patient’s blood flow to their extremities. In tandem with screening diabetes patients for PAD, Spohn clinics have a better chance of identifying and treating uncontrolled blood pressure, Spohn expects an increase in the number of diabetic patients with controlled blood pressure, which will reduce their risk of developing PAD.

Complacency, poor self-management and access to care are all shown to contribute to uncontrolled chronic disease. Implementation of a PAD screening program that extends screening to remote locations throughout the region using a telehealth screening solution would increase early detection for people at-risk and diagnostics and treatment during earlier stages of disease without the burden of appointment delays and multiple trips to specialists’ offices.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of controlling blood pressure in diabetic patients identified at high-risk for PAD and those currently experiencing symptoms such as pain and cramping to lower extremities. Controlling blood pressure will assist providers with
prevention and enable a reduction in PAD-related hospital admissions that impact a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Year 2</th>
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<tbody>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will develop an approach for identifying and treating diabetic patients with uncontrolled blood pressure, putting them at higher risk for PAD, in tandem with its project to use telemedicine to increase PAD screenings</td>
</tr>
</tbody>
</table>

**Data Source:** Project plan documentation

Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $15,895

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<tr>
<th>Year 3</th>
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<tbody>
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<td>(10/1/2013 – 9/30/2014)</td>
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<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems - Spohn will assess the volume of information collected through PADnet and blood pressure screenings to assure that the information is broadly disseminated through its system and functioning properly</td>
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</table>

**Data Source:** Chronic disease registry

Process Milestone 3 Estimated Incentive Payment: $18,424.50

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<tbody>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Outcome Improvement Target 1 [IT-1.11]: Diabetes care: BP control (&lt;140/80 mmHg)</td>
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</tbody>
</table>

**Improvement target:** 10% increase in diabetic patients with controlled blood pressure over DY2 baseline

Data Source: EHR, Claims

Outcome Improvement Target 1 Estimated Incentive Payment: $59,130

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<td>(10/1/2015 – 9/30/2016)</td>
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<tr>
<td>Outcome Improvement Target 2 [IT-1.11]: Diabetes care: BP control (&lt;140/80 mmHg)</td>
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**Improvement target:** 20% increase in diabetic patients with controlled blood pressure over DY2 baseline

Data Source: EHR, Claims

Outcome Improvement Target 2 Estimated Incentive Payment: $141,397

**Starting Point/Baseline:**

Approximately 16% of the patients treated in Spohn’s clinics and neighboring clinics are diabetic or pre-diabetic (approximately 1,500 patients), placing them at increased risk of PAD. Those diabetic patients with uncontrolled blood pressure (number not yet quantified) are at an even higher risk of PAD and associated amputations.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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<tbody>
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<td><strong>Starting Point/Baseline:</strong></td>
<td>Approximately 16% of the patients treated in Spohn’s clinics and neighboring clinics are diabetic or pre-diabetic (approximately 1,500 patients), placing them at increased risk of PAD. Those diabetic patients with uncontrolled blood pressure (number not yet quantified) are at an even high risk of PAD and associated amputations.</td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,790</td>
<td>Year 3 Estimated Outcome Amount: $36,849</td>
<td>Year 4 Estimated Outcome Amount: $59,130</td>
<td>Year 5 Estimated Outcome Amount: $141,397</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $269,166
**Title of Outcome Measure (Improvement Target):** Right Care, Right Setting- ED appropriate utilization

**Unique RHP outcome identification number(s):** 020811801.3.20 – Pass 2

**Outcome Measure Description:**
Spohn expects that establishing a primary care clinic in Beeville will shift the care of patients with primary care diagnoses (e.g. those who are often identified as non-urgent/emergent in the ED) to the right care setting by creating access to a medical home that does not currently exist on a consistent basis in the community. The opening of the clinic will also facilitate establishing a PC provider for patients not previously assigned. The shift in care to the appropriate setting will result in a reduction of ED visits for non-urgent/emergent diagnoses, which is an important goal to improve both patient outcomes and the institutional cost of providing care in the local community.

**Process Milestones:**
- DY2: P-1, P-3
- DY3: P-2, P-5

**Outcome Improvement Target(s) for each year:**
- DY4:
  - IT- 9.2
    - Reduce all ED visits to CSBH by 5% over baseline.
- DY5:
  - IT -9.2
    - Reduce all ED visits to CSBH by 10% over baseline.

**Rationale:**
Review of ED admissions data shows a high volume of non-urgent/non-emergent visits to the ED at CSBH are from the Beeville, Mathis, George West and Skidmore zip codes and include residents in Bee, San Patricio and Live Oak counties (although non-urgent/emergent diagnoses were identified from other zip codes in Bee, Goliad and Karnes counties, though not at as high a rate as the others). The primary diagnoses identified for primary care sought in the CSBH ED included nonspecific abdominal pain, fever, nonspecific chest pain, lower leg injuries and other diagnoses such as cough, headache and rash. Shifting this care to the primary care setting will substantially impact the volume of inappropriate ED visits. The availability of primary care services in the local community has been reduced in years past. As a result of establishing the new primary care clinic in Beeville, Spohn expects a shift of the burden of care from the CSBH ED to the FHC in Beeville.

**Outcome Measure Valuation:** The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to Primary Care access,
which is expected to reduce PPAs and inappropriate ED utilization. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.”
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020811801.3</th>
<th>020811801.1.3</th>
<th>020811801</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>16,374 total ED visits 3 quarters of FY 12 - 12,368 ED visits were from area zip codes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will plan for combining the increased primary care capacity in Beeville going forward with a reduction in inappropriate ED use. Plan will likely include community outreach and education, and provider outreach and education. Data Source: Project plan documentation</td>
<td>Process Milestone 2 [P-3]: Develop and test data systems – Spohn will develop a system for cross-referencing the patients accessing the Beeville clinic with the patients visiting the ED (and the frequency of each). Data source: evidence of the development of the data system and its output</td>
<td>Outcome Improvement Target 1 [IT-9.2]: Improvement Target: Reduced number of ED visits to CSBH by 5% over baseline Data Source: EHR, Claims</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $108,528</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>Year 5 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>$57,698</td>
<td>$68,167</td>
<td>$107,838</td>
<td>$271,402</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $505,104
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Outcome Domain 4: Potentially Preventable Complications and Healthcare Acquired Conditions;
Improvement Target 4.8: Sepsis Mortality (standalone)
CHRISTUS Spohn Hospital Beeville/ 020811801

Unique Identifier – 020811801.3.3

Outcome Measure Description
Hospitals nationwide and statewide have seen an increase in the rate of sepsis and the mortality rates associated with sepsis over the last twenty years. Spohn intends, through its use of an early detection warning system and a provider protocol for responding to cases of sepsis, to reduce the rate of mortality caused by sepsis in Spohn’s inpatient population.

Process milestones:
- Project planning: Spohn will create a plan to implement a 90-day rapid cycle improvement to address the sepsis mortality rate in Spohn’s Beeville facility
- Establish a baseline: Spohn will determine the mortality rate of all septic patients in Spohn’s Beeville facility during 2012
- Spohn will conduct Plan-Do-Study-Act cycles to test and improve upon its usage of the MEWS early detection system

Improvement targets:
- Reduction in Sepsis Mortality rates – 1% reduction by end of DY4
- Reduction in Sepsis Mortality rates - 2% reduction by end of DY5

Rationale:
Spohn’s goal is to decrease the number of deaths in septic patients who present in the early stages of sepsis or those that develop septicemia while in the hospital. The Region 4 Community Needs Assessment has identified a high incidence of sepsis and sepsis mortality for the Region (CN.18). Hospital inpatients are at risk for sepsis, especially if they have intravenous lines, bedsore, or surgical site wounds. Early recognition of the signs and symptoms of sepsis requires skilled assessment of specific indicators over an identified period of time and initiating immediate resuscitation effort upon identification. This rapid response to an identified increasing preventable complication is required to save lives in the acute inpatient setting.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable complications and hospital-acquired conditions/infections. Patient outcomes and satisfaction will absolutely be improved if the sepsis mortality rate is decreased, and the systemic cost of providing inpatient hospital care will be reduced for every septic infection and related death that can be prevented. Achieving this outcome will require considerable and concerted effort (i.e.
engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
**Potentially Preventable Complications and Healthcare-acquired Conditions:**
*Sepsis mortality and Average length of stay (ALOS)*

**CHRISTUS Spohn Hospital Beeville**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020811801.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>450 cases; 71% severe or shock; 6% received all applicable elements of resuscitation bundle</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</table>
| **Process Milestone 1 [P-1]:** Spohn will engage in project planning for 90-day rapid cycle improvement for Sepsis | **Process Milestone 3 [P-4]:** Conduct PDSA cycles to improve usage of electronic MEWS – Spohn will develop a plan to test the change, implement the plan, analyze the results, and determine what modifications are needed, if any | **Outcome Improvement Target 1 [IT-4.8]:** Sepsis mortality
**Improvement Target:** 1% reduction in septicemia mortality rates in Spohn’s Beeville facility from baseline established in DY2 | **Outcome Improvement Target 2 [IT-4.8]:** Sepsis mortality
**Improvement Target:** 2% reduction in septicemia mortality rates in Spohn’s Beeville facility from baseline established in DY2 |
| **Data Source:** Project plan | **Data Source:** EMR reports | **Data Source:** hospital quality reports, dashboards | **Data Source:** hospital quality reports, dashboards |

**Year 2 Estimated Outcome Amount:** $20,570

**Year 3 Estimated Outcome Amount:** $23,843

**Year 4 Estimated Outcome Amount:** $38,260

**Year 5 Estimated Outcome Amount:** $91,492

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $174,166
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Errors in Bedside Medication Administration
CHRISTUS Spohn Hospital Beeville / TPI: 020811801

Unique Identifier -020811801.3.4
As a result of Spohn’s ability to have electronic medication reconciliation at the point of care, Spohn expects to be able to have pharmacists as part of the medication reconciliation and utilization review process throughout the hospitalization and at discharge. Pharmacists will be specifically alerted to assess patient profiles for drug interactions and those receiving medications identified as being high risk for medication errors.

Outcome Measure Description
- DY2
  - P-2: Establish baseline rates for bedside medication administration errors. The baseline rate will be set based on the total number of medications administered during the year ending (the base period), with the numerator of the rate equaling the total number of medication errors for acute care patients during the base period and the denominator being set as the total medications administered to acute care patients at Spohn facilities during the base period. This medication error rate will serve as the basis for assessing the effectiveness of implementing the new BMV system.
    - Data Source: Quality reports, electronic medication administration record (eMAR) reports

Outcome Improvement Targets
- DY 3
  - IT-4.10: Other outcome improvement target
    Improvement Target: 5% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    Data Source: Quality reports
- DY4
  - IT-4.10: Other outcome improvement target
    Improvement Target: 10% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    Data Source: Quality reports
- DY 5
  - IT-4.10: Other outcome improvement target
    Improvement Target: 15% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    Data Source: Quality reports
**Rationale:**
Medication Management provides information that facilitates the appropriate use of medications in order to control illness and promote health according to *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*. Monitoring medication administration is key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications.

In a latest study out of the University of Pittsburgh Medical Center (Rack, Dudjak & Wolf, 2012) registered nurse (RN) workarounds were analyzed to determine the frequency and causes of workarounds while using bar code medication administration technology. Over half the nurses included in the study indicated that during their last shift worked, they administered medications without scanning the medication or the patient. Reasons for non-adherence to bar code scanning are identified as process related with an impact on patient safety outcomes. Process issues include step omission, steps out of sequence and unauthorized steps (Rack, 2012) that can be attributed to task, environment, patient, organization and technology related workarounds (Koppel, Wetterneck, Telles & Karsh, 2008).

While BMV does not eliminate medication errors, it has shown a large impact on errors of wrong dose and wrong time (Rack, 2012). Quasi-experimental studies have been conducted in both intensive care units (ICU) and non-ICU units. One ICU study showed an overall med error reduction of 56% ($p < 0.001$) with reduction in administration time errors (19.7% to 7.5%, $p < 0.001$) having the largest impact on overall reduction rates (DeYoung, Vanderkooi & Barletta, 2009). Another study with over 14,000 medication administrations and 3000 order transcriptions reported a 41.4% relative reduction rate in medication errors ($p <0.001$) for units using bar coding and eMAR versus units that did not.

Increasing control over the management and tracking of medication, particularly for acute care patients will help reduce the risk of medication errors and the resulting complications. The decrease in medication errors at the bedside will be a reliable indicator of the effectiveness of this project and in particular the goal of reducing preventable complications that arise with medication errors.

This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing errors from inadvertent mishandling of medications, which will also lead to a reduction in complications from errors in medication management. By targeting measures that reduce errors in the delivery of medication to patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care, in a manner consistent with recent studies.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of medication administration errors. Medication errors are a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to follow procedures designed to increase patient safety, reduce medications errors, identify process barriers that lead to work-arounds, proactive assessments of patients’ medications, communication between providers, and preemptive measures to protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020811801.2.2</th>
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</thead>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-2]:** Establish baseline rates for bedside medication administration errors, prior to implementation of new system | **Outcome Improvement Target 1 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 5% reduction in bedside medication administration errors from DY2 baseline | **Outcome Improvement Target 2 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 10% reduction in bedside medication administration errors from DY2 baseline | **Outcome Improvement Target 3 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 15% reduction in bedside medication administration errors from DY2 baseline |
| **Data Source:** Quality reports, electronic medication administration record (eMAR) reports | **Data Source:** Quality reports | **Data Source:** Quality reports | **Data Source:** Quality reports |

Process Milestone 1 Estimated Incentive Payment: $ 4,363

**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 5,057

**Outcome Improvement Target 1 Estimated Incentive Payment:** $ 5,057

**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 4,058

**Outcome Improvement Target 2 Estimated Incentive Payment:** $ 4,058

**Process Milestone 2 [P-5]:** Disseminate finding, lessons learned and best practices to stakeholders  
**Data Source:** Stakeholder meetings, minutes, attendance logs

Process Milestone 2 Estimated Incentive Payment: $ 4,058

Year 2 Estimated Outcome Amount: $ 4,363

Year 3 Estimated Outcome Amount: $ 5,057

Year 4 Estimated Outcome Amount: $ 8,116

Year 5 Estimated Outcome Amount: $ 19,407

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $ 36,944
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors

- Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
- IT4.10 - Other outcome improvement targets – Average length of stay

CHRISTUS Spohn Hospital Beeville / TPI: 020811801
Unique Identifier -020811801.3.5

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management.

Outcome Measure Description

- **DY2**
  - P-2: Establish baseline rates for patients for length of stay for high risk patients and patients receiving medications identified as high risk for medication errors. The baseline rate will be set based on the total number of high risk reviews performed. Program expansion is based on initial results at CSHCC-Memorial reporting an annualized reduction in average length of stay (ALOS) by 1 day reduction for IV home infusion transition alone during the year ending (the base period), with the numerator equaling the total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and the denominator being set as the total number of patients identified as high risk or receiving medications identified as high risk for medication errors at CHRISTUS Spohn Hospital Beeville (“Spohn”) facilities during the base period. This ratio will demonstrate the change ALOS for this target population (See rationale for criteria that define high risk)
  - **Data Source:** Quality reports, electronic medication administration record (eMAR) reports

- **DY3**
  - P-3 Develop and test data systems
  - **Data Source:** EMR and utilization review documents

- **DY4**
  - P-5 Disseminate finding, lessons learned and best practices to stakeholders
  - **Data Source:** Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:

- **DY 4**
  - IT-4.10: Other outcome improvement target
  - **Improvement Target:** Average Length of stay
  - **Data Source:** Medication Management and Utilization Review reports
- **DY 5**
  - IT-4.10: Other outcome improvement target
    - **Improvement Target**: Average Length of stay
    - **Data Source**: Medication Management and Utilization Review reports

**Rationale:**
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria include but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication management. Achieving this outcome will require considerable and concerted effort (i.e. assessment of each patient’s health literacy level, support in their post-discharge environment and ability to adhere to prescribed regimes and communication between providers to formulate the best possible treatment options) and investment in infrastructure; however, the outcome will justify the expense.
### Average Length of Stay for high risk patients and patients receiving drugs identified as high risk for medication errors and PPC

**CHRISTUS Spohn Hospital Beeville**

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish baseline rates for bedside medication administration errors, prior to implementation of new system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $4,363</td>
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<table>
<thead>
<tr>
<th>Process Milestone 2 [P-3]: Develop and test data systems</th>
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<tbody>
<tr>
<td><strong>Data Source:</strong> EMR and utilization review documents</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $5,057</td>
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</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-4.9]: Average length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Numerator: Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td>b. Denominator: Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Case Management and Utilization Review reports</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $4,058</td>
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</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 [IT-4.9]: Average length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Numerator: Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td>b. Denominator: Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Case Management and Utilization Review reports</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $19,407</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $4,363 |
| Year 3 Estimated Outcome Amount: $5,057 |
| Year 4 Estimated Outcome Amount: $8,116 |
| Year 5 Estimated Outcome Amount: $19,407 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5):* $36,944
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Cost savings in care delivery associated with medication management and utilization review in high risk patients
CHRISTUS Spohn Hospital Beeville / TPI: 020811801
Unique Identifier -020811801.3.6

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management.

Outcome Measure Description

- DY2
  - P-2: Establish baseline rates for cost savings in care delivery. The baseline rate will be determined using a Cost Minimization Analysis to quantify cost reduction resulting from concurrent case management/utilization review for patients identified as high risk or receiving medications identified at high risk for medication errors during the base period. This initial analysis for this project will be quantified from project implementation data at CSHCC-Memorial serving as the basis for project expansion and assessment of cost minimization.
    - Data Source: Case Management/Utilization review reports, financial reports

- DY 3
  - P-3: Develop and test data systems
    - Data Source: Quality reports

- DY 4
  - P-5: Disseminate finding, lessons learned and best practices to stakeholders
    - Data Source: Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:

- DY 4
  - IT-4.10: Other outcome improvement target
    - Improvement Target: Cost savings in care delivery
    - Data Source: Case Management/Utilization review reports, financial reports

- DY 5
  - IT-4.10: Other outcome improvement target
    - Improvement Target: Cost savings in care delivery
    - Data Source: Case Management/Utilization review reports, financial reports
Rationale:
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria included but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone with an associated cost minimization of $426,000 ($1.02 Million annualized).

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to cost savings in care delivery for patients identified as high risk or receiving medications at high risk for medication errors. Effective medication management reduces the risk of potentially preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to perform proactive assessment of patients’ medications, increase communication between providers, and identify preemptive measures to enhance treatment and protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong> Establish baseline rates for bedside medication administration errors, prior to implementation of new system</td>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems</td>
<td><strong>Outcome Improvement Target 1 [IT-4.9]:</strong> Average cost savings</td>
<td><strong>Outcome Improvement Target 2 [IT-4.10]:</strong> Average cost savings</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
<td><strong>Data Source:</strong> EMR and utilization review documents</td>
<td><strong>Improvement Target:</strong> Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis</td>
<td><strong>Improvement Target:</strong> Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $4,363</td>
<td>Process Milestone 2 Estimated Incentive Payment: $5,057</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: 4,058</td>
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<td>Year 4 Estimated Outcome Amount: $8,116</td>
<td>Year 5 Estimated Outcome Amount: $19,407</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $36,944*
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

CHRISTUS Spohn Hospital Beeville – 020811801
Project unique id number: 020811801.3.7

Outcome Measure Description

OD-4 Potentially Preventable complications and healthcare acquired Conditions.

IT-4.10: Other outcome Improvement Targets: Compliance with VTE Prophylaxis Core Measure Indicators

Outcome Description: Installation of a computerized patient order management (CPOM) system is expected to reduce the rate of VTE in Spohn’s Beeville facility by creating electronic order sets that include VTE prophylaxis. Spohn has a system-wide group that developed electronic evidence-based order sets. For example, if patient has surgery and the doctor wants the patient to get up and walking to prevent blood clots, there are different order sets that might be in place. For patients who cannot ambulate after surgery, they need anti-coagulants, but often the surgeons will not order these because they are concerned that the surgical sites might bleed. The CPOM system will create automatic order sets for particular surgeries and the medication order will then be in place (including treatment to prevent VTE). This prevents the physician from ordering contraindicated medications and makes sure that needed medications and therapeutic interventions are not missed due to human error.

VTE is a core CMS measure, and CMS has provided six indicators to be addressed in the prevention of hospital-acquired VTE. The six indicators measure the following (with Spohn’s first 6 months FY13 compliance in parentheses):
1. VTE1 prophylaxis (57.9%)
2. VTE2 intensive care unit VTE prophylaxis (69.2%)
3. VTE3 patients with anticoagulation overlap therapy (0%)
4. VTE4 patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol (not reported %)
5. VTE5 discharge instructions (100%), and
6. VTE6 incidence of potentially preventable VTE (not reported).

Clearly there is room for improvement, especially in light of the fact overall compliance is < 60%.

Process Milestones:
  •   DY 2
P-2: Establish baseline rates for compliance with VTE Prophylaxis Core Measure Indicators
P-5: Disseminate finding, lessons learned and best practices to stakeholders

Outcome Improvement Targets

- **DY3**
  - IT-4.10: Other outcome improvement target: compliance with VTE Prophylaxis Core Measure Indicators
    - **Improvement Target**: 5% increase in compliance with VTE Prophylaxis Core Measure Indicators

- **DY4**
  - [IT-4.10]: Other outcome improvement target: compliance with VTE Prophylaxis Core Measure Indicators
    - **Improvement Target**: 10% increase in compliance with VTE Prophylaxis Core Measure Indicators

- **DY5**
  - Outcome Improvement Target 3 [IT-4.10]: Other outcome improvement target: Compliance with VTE Prophylaxis Core Measure Indicators
    - **Improvement Target**: 15% increase in compliance with VTE Prophylaxis Core Measure Indicators

Rationale:

This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing potentially preventable complications like hospital-acquired VTE. By targeting measures that reduce hospital-acquired VTE in patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care, in a manner consistent with recent studies. According to a US Department of Health and Human Services website, “Pulmonary embolism resulting from deep vein thrombosis—collectively referred to as venous thromboembolism—is the most common preventable cause of hospital death. Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused.” (http://www.ahrq.gov/qual/vtguide/).

Milestones and Metrics: The first step in the process is gathering information to determine the magnitude of the baseline data needed to assure that an established baseline rate is set. Once CPOM is implemented, findings that have been determined to be pertinent to the implementation process will be disseminated, with dissemination of all lessons learned and use of best practices to all of those considered stakeholders. The use of Quality Reports, electronic medication administration record and EMR reports the reduction in transcription will in turn decrease the errors in medication administration.

Spohn selected the improvement targets to incentivize and reward utilization of the CPOM system, with the goal that its utilization will reduce medication transcription errors and also reduce the risks that inconsistent orders are misunderstood.
Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of hospital acquired VTE. VTE is a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. putting the order sets in place, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
Reduction in Hospital Acquired Venous Thromboembolism

CHRISTUS Spohn Hospital Beeville

**Starting Point/Baseline:**

Approximately 18 potentially preventable cases of VTE per year

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline rates for medication transcription errors in the Spohn facility Data Source: Quality reports, electronic medication administration record (eMAR) reports Process Milestone 1 Estimated Incentive Payment: $6,545</td>
<td>Outcome Improvement Target 1 [IT-4.6]: Hospital Acquired VTE Improvement Target: 10% increase in compliance with VTE Prophylaxis Core Measure indicators from baseline set in DY2 Data Source: Quality reports; EHR Claims</td>
<td>Outcome Improvement Target 2 [IT-4.6]: Hospital Acquired VTE Improvement Target: 15% increase in compliance with VTE Prophylaxis Core Measure Indicators from baseline set in DY2 Data Source: Quality reports; EHR Claims</td>
<td>Outcome Improvement Target 3 [IT-4.6]: Hospital Acquired VTE Improvement Target: 20% increase in compliance with VTE Prophylaxis Core Measure indicators from baseline set in DY2 Data Source: Quality reports; EHR Claims</td>
</tr>
<tr>
<td>Milestone 2 [P-1]Project Planning Goal: develop a plan for coordinating post-surgical order sets with the new CPOM system and training hospital staff on using the electronic system to more effectively prevent VTE Data source: documentation of plan Milestone 2 Estimated Incentive Payment: $6,545</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $15,173</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $24,348</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $58,222</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $13,090 Year 3 Estimated Outcome Amount: $15,173 Year 4 Estimated Outcome Amount: $24,348 Year 5 Estimated Outcome Amount: $58,222

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $110,833**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.12.2 - Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:

OD 3: Potentially Preventable Readmissions; Improvement Target 3.2 - CHF 30-day readmissions

Unique project ID number: 020811801.3.8
CHRISTUS Spohn Hospital – Beeville: 020811801

Outcome Measure Description

This outcome will measure the reduction in the number of Potentially Preventable Readmissions for CHF patients at Spohn’s Beeville facility due to the expanded implementation of the Care Transitions program. Spohn believes that patients who are at risk to be readmitted to the hospital within 30 days of discharge for congestive heart failure will benefit from increased care coordination upon discharge. This includes providers, patients and their caregivers education about medication, diet, and activity management, primary care resources that are available and need to be accessed, and community support available to recently discharged CHF patients.

Process milestones:

- **DY2:** Develop and test data systems + establish a baseline
  - Spohn will develop an integrated system for flagging CHF patients upon inpatient admission and readmission, in order to track progress in later years of the Waiver
  - Spohn will develop a baseline of CHF readmissions during DY2 in order to measure percentage improvement going forward

- **DY3:** Disseminate findings
  - Spohn will create and distribute its staff/stakeholders a plan for reducing CHF readmissions through the expansion of the Care Transitions program

Improvement milestones:

- **DY3:** Reduce CHF PPRs by 3% from baseline
- **DY4:** Reduce CHF PPRs by 6% from baseline
- **DY5:** Reduce CHF PPRs by 8% from baseline

Rationale:

Spohn chose this outcome using its evidence-based expectation of a decrease in re-admission rates as a result of the following processes in the Care Transitions program: 1) effective and efficient discharge planning while in the hospital, (2) home visit within 48 hours of patients arrival home and (3) follow-up phone calls to ensure education/information shared making this program a viable expansion option for chronic disease in populations across our region. Spohns’ review of its own needs and the Region 4 Community Needs Assessment identified CHF as an area requiring improvement. Specifically, Bee County’s highest incidence of potentially preventable hospitalizations occur due to CHF (RHP Plan, Section 3, Table 10) and Heart Failure was the second most common primary diagnosis for hospitalizations in Region 4 (RHP Plan,
Section 3, Table 9). Thus, CHF is a substantial problem that Spohn needs to address by reducing the number of potentially preventable readmissions for patients already hospitalized for and identified as patients with CHF.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication/diet/weight management for CHF patients to prevent unnecessary hospital admissions and readmission. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-3]:</th>
<th>Process Milestone 3 [P-5]:</th>
<th>Outcome Improvement Target 2 [IT-3.2]: PPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and test data systems – Spohn will put a system in place to identify and flag CHF patients at its Beeville facility upon initial admission and upon readmission</td>
<td>Disseminate finding and implementation plan to stakeholders – Spohn will develop and distribute a comprehensive plan for reducing CHF 30-day admissions (in conjunction with the Care Transitions program) to its Beeville facility</td>
<td>Improvement Target: 6% reduction in CHF, 30-day readmission rates from baseline established in DY2</td>
</tr>
<tr>
<td><strong>Data Source:</strong> referral logs documentation</td>
<td><strong>Data Source:</strong> Written integration plan</td>
<td><strong>Data Source:</strong> Care Transition caseload documentation; EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $14,025</td>
<td>Process Milestone 3 Estimated Incentive Payment: $16,257</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $52,173</td>
</tr>
</tbody>
</table>

**Process Milestone 2 [P-2]:** Establish baseline rates – Spohn will compile and evaluate the 30-day readmission data from 2012 for patients at its Beeville Facility discharged with a principal diagnosis of CHF

**Data Source:** Historical clinic/hospital/ED claims and financial data

Process Milestone 2 Estimated Incentive Payment: $14,025

**Outcome Improvement Target 1 [IT-3.2]: PPR**

**Improvement Target:** 3% reduction in CHF, 30-day readmission rates from baseline established in DY2

**Data Source:** Care Transition caseload documentation; EHR

Outcome Improvement Target 1 Estimated Incentive Payment: $16,257

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**Year 2 (10/1/2012 – 9/30/2013)**

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<thead>
<tr>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Year 2 Estimated Outcome Amount:** $28,050

**Year 3 Estimated Outcome Amount:** $32,514

**Year 4 Estimated Outcome Amount:** $52,173

**Year 5 Estimated Outcome Amount:** $124,762

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $237,499
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.19.1 Care Management to Integrate Primary and Behavioral Health Needs
   IT-9.2: ED Appropriate Utilization (reduce emergency department visits for diabetes)

CHRISTUS Spohn Hospital Beeville / 020811801
Project Unique ID: 020811801.3.9

Outcome Measure Description
Spohn expects the outcome of its project to identify patients with diabetes and CHF who have a co-diagnosis in BH/depression to result in a reduced volume of ED visits from diabetic patients. Spohn will screen patients who present in the ED initially for BH needs (and in its other treatment settings), and make referrals where necessary; this should result in fewer repeat ED visits by diabetic patients who possibly have a co-diagnosis from returning to the ED.

Process Milestones: In DY2, Spohn will create a plan for using its project to increase screening of CHF and diabetes patients for BH referrals to reduce the number of overall ED visits from diabetic patients. Spohn will also establish a baseline of the number of ED visits from diabetic patients in order to measure progress going forward.

Improvement Targets: In DY3, Spohn aims to reduce the volume of ED visits from patients with diabetes by 5% from the DY2 baseline. In DY4, Spohn aims for a decrease in ED visits from diabetic patients of 8% over DY2, and by the end of DY5 Spohn aims for a decrease in ED visits from diabetic patients of 10%.

Rationale:
Treatment management and patient outcomes such as PPR and mortality can only be impacted if patients with co-existing physical and behavioral illness can be identified and referred to the appropriate providers for a treatment plan inclusive of both domains. This is why we chose to focus on training providers in screening and recognition in target populations, communication between providers and increasing the number of patients screened in the EDs, Primary Care and BH settings.

Spohn expects that screening and identifying diabetic patients with potential BH needs will result in receive fewer subsequent visits to the ED from that population. This will indicate that more of those patients are receiving the right care in the right setting, and will reduce the high cost of treating Medicaid/uninsured patients in the ED. The reduced ED volume should also have a ripple effect for the inpatient setting – fewer of the targeted patients will be admitted from the ED and reduce inpatient costs, increase the availability of beds, and improve patient outcomes.
**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community of BH/SA screening/treatment for CHF patients and vice versa, in order to prevent unnecessary hospital admissions and readmissions. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Related Category 1 or 2 Projects:
- 020811801.3.9
- 020811801.2.5

### Starting Point/Baseline:
In FY 2012, Spohn’s ED experienced approximately 213 diabetes related visits

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

### Process Milestone 1 [P-1]: Project planning
- Goal: Spohn will create a protocol for ED providers in screening and referring diabetic patients for BH assessments where necessary and create a plan for tracking the repeat ED visits of those patients going forward
- Data Source: Project plan

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $14,025

### Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization
- **Improvement Target:** 5% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

**Outcome Improvement Target 1 Estimated Incentive Payment:** $32,514

### Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization
- **Improvement Target:** 8% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

**Outcome Improvement Target 2 Estimated Incentive Payment:** $52,173

### Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization
- **Improvement Target:** 10% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

**Outcome Improvement Target 3 Estimated Incentive Payment:** $124,762

### Year 2 Estimated Outcome Amount: $28,050
### Year 3 Estimated Outcome Amount: $32,514
### Year 4 Estimated Outcome Amount: $52,173
### Year 5 Estimated Outcome Amount: $124,762

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $237,499
**Category 3: Quality Improvements**

**Outcome Domain – Primary Care and Chronic Disease Management**

**Project Option IT-1.10 – Diabetes care: HbA1c poor control (>9.0%)**

Project ID - 020973601.3.1
Performing Provider/TPI: Corpus Christi Medical Center/020973601

**Outcome Measure Description**

DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Process milestone P-1 will address the project planning necessary for successful improvement in diabetes care: HbA1c levels below 9%. The planning will include all relevant stakeholders, identify the necessary resources, establish timelines, and document the implementation plan. Process milestone P-2 will take the next step and establish the baseline rate for HbA1c levels below 9% for Amistad’s patients. This is necessary to measure progress toward the quality improvement goal. Process milestone P-4 was selected so that we would have continuous Plan Do Study Act (PDSA) cycles in place that will enable us to understand our data and make any necessary process changes to achieve our goals.

For at least 20 years, diabetes rates in the United States have seen substantial increases. In 2010, nearly 26 million people have diabetes, of whom over one third remain undiagnosed. Another 57 million people are estimated to have prediabetes. An additional 57 million people have diabetes, of whom over one third remain undiagnosed. Another 57 million people have diabetes, of whom over one third remain undiagnosed. Another 57 million people have diabetes, of whom over one third remain undiagnosed. Another 57 million people have diabetes, of whom over one third remain undiagnosed.

**Rationale**

Diabetes is a leading cause of disability and death in the United States. Each year, nearly one million American adults are diagnosed with diabetes. The importance of glycemic control as part of the comprehensive management of diabetes is well documented. The National Committee for Quality Assurance (NCQA) data from 2007 reveals that between 13 and 22 percent of patients with diabetes do not get regular HbA1c testing. When testing is performed, significant numbers of patients are in poor control with HbA1c values of 9 percent or greater. For every 1 percent reduction in results of HbA1c blood tests, the risk of developing eye, kidney, and nerve disease is reduced by 40 percent while the risk of heart attack is reduced by 14 percent. Putting systems in place to track HbA1c testing frequency and values enables an organization to focus attention and services on those patients who are in poor control and at highest risk. Diabetes patients who maintain near-normal HbA1c values can gain an average extra five years of life, eight years of sight, and six years free from kidney disease.
disproportionately affects racial and ethnic minorities. Hispanics, African Americans, and Native Americans are more likely to be diagnosed with diabetes. Our community has a 56 percent Hispanic population which contributes to our higher diabetes prevalence rates. Additionally, Nueces County has a higher rate of potentially preventable hospitalizations due to long-term diabetes complications than the statewide average.

**Outcome Measure Valuation**

Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020973601.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong>: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan</td>
<td><strong>Process Milestone 3 [P-4]</strong>: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
</tr>
<tr>
<td>Data Source: Committee minutes, finalized plan</td>
<td>Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $149,929</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]</strong>: Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $325,345</td>
</tr>
<tr>
<td>Data Source: EHR, billing system</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-1.10]: Diabetes Care:HbA1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $149,928</td>
<td>Data Source: EHR, billing system</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $299,857</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $405,502</td>
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<td><strong>Year 3 Estimated Outcome Amount:</strong> $405,502</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $325,345</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $1,434,859</td>
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</tbody>
</table>

RHP Plan for Region 4
**Category 3: Quality Improvements**

**Outcome Domain – Primary Care and Chronic Disease Management**

**Project Option IT-1.7 – Controlling high blood pressure**  
**Project ID - 020973601.3.2**  
**Performing Provider/TPI: Corpus Christi Medical Center/020973601**

**Outcome Measure Description**  
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY 2: P-2 – Establish baseline rates.  
DY 3: P-4 – Develop and test data systems

Process milestone P-1 will address the project planning necessary for successful improvement in controlling high blood pressure. The planning will include all relevant stakeholders, identify the necessary resources, establish timelines, and document the implementation plan. Process milestone P-2 will take the next step and establish the baseline rate for high blood pressure for Amistad’s patients. This is necessary to measure progress toward the quality improvement goal. Process milestone P-4 was selected so that we would have continuous Plan Do Study Act (PDSA) cycles in place that will enable us to understand our data and make any necessary process changes to achieve our goals.

Hypertension is described as the most important modifiable risk factor for coronary heart disease (leading cause of death in the United States), stroke (third leading cause), congestive heart failure, and end-stage renal disease. Over 50 million Americans have high blood pressure warranting some form of treatment, and in 2009, there were 55 million physician office visits for hypertension. The prevalence of hypertension increases with age, from 7 percent among individuals aged 18 – 39 years to 67 percent in those 60 years of age or older. Adequately controlled blood pressure (normal to pre-hypertension) is considered to be a systolic blood pressure less than 140 and diastolic blood pressure less than 90 (140/90). Death from ischemic heart disease (IHD) and stroke increases linearly from blood pressure levels as low as 115/75. For every 20 mm Hg systolic or 10 mm Hg diastolic increase in blood pressure, mortality from both IHD and stroke doubles to increase the number of patients at Amistad Community Health Center with adequately controlled blood pressure (BP less than 140/90) by 5% in DY4 and 15% in DY5.

Milestones: In DY 2, Process Milestones P-1 and P-2 will be employed.  
In DY3, Process Milestone P-4 will be undertaken.

**Rationale**  
Having high blood pressure puts a person at risk for heart disease and stroke, the leading causes of death in the United States. About 1 in 3 U.S. adults has high blood pressure. Sixty nine percent of people who have a first heart attack and seventy seven percent of people who have a first stroke have high blood pressure. Costs directly attributable to high blood pressure for the nation total almost $131 billion annually in direct medical expenses and $25 billion in lost productivity. Less than one half of people with high blood pressure have their condition under control. High blood pressure can also accelerate the deleterious effects of diabetes which is prevalent in our community. Developing
protocols to identify and monitor at risk patients will improve the overall health and outcomes of Amistad’s patients.

**Outcome Measure Valuation**
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The percentage of annual DSRIP funding directed into Category 3 reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding by DYS takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th>020973601.3.2</th>
<th>IT-1.7</th>
<th>Controlling high blood pressure</th>
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</thead>
<tbody>
<tr>
<td>Corpus Christi Medical Center</td>
<td>TPI - 020973601</td>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan – Spohn will develop an approach for leveraging the expanded primary care capacity to</td>
<td>Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
<td>Outcome Improvement Target 1 [IT-1.7]: Controlling high blood pressure Improvement Target: 5% reduction from baseline Data Source: EHR, billing system</td>
<td>Outcome Improvement Target 2 [IT-1.7]: Controlling high blood pressure Improvement Target: 15% reduction from baseline Data Source: EHR, billing system</td>
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<tr>
<td>Data Source: Committee minutes, finalized plan</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
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<td>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: EHR, billing system</td>
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<td>Process Milestone 2 Estimated Incentive Payment: $149,928</td>
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<tr>
<td></td>
<td>Year 2 Estimated Outcome Amount: $299,857</td>
<td>Year 3 Estimated Outcome Amount: $405,502</td>
<td>Year 4 Estimated Outcome Amount: $325,345</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 5 Estimated Outcome Amount: $404,156</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $1,434,860*
Category 3: Quality Improvements

Outcome Domain – Potentially Preventable Re-Admissions – 30 day Readmission Rates

Project Option IT-3.2 - Congestive Heart Failure 30 day readmission rate
Project ID - 020973601.3.3
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Congestive heart failure was one of the two most common reasons for potentially preventable hospitalizations. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with congestive heart failure. The improvement milestone for this project is to reduce congestive heart failure 30 day readmissions by 20% by the end of the waiver.

Rationale:
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient and also have the opportunity to see congestive heart failure patients in the continuity of care clinics. Adding community health workers to work with the residents and Hospitalists will help to improve overall care coordination and reduce the re-admission rate. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 10% reduction each year (DY4 and DY5) in congestive heart failure re-admissions represents significant improvement and a reduction in overall healthcare expenditures. The healthcare delivery changes that are anticipated from this project will extend beyond the targeted patient population and establish best practices that should become standards of care in the community.

Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic
disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
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</thead>
<tbody>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
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<tr>
<td>Process Milestone 1 [P-1]:</td>
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</tr>
<tr>
<td>Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.</td>
<td></td>
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<tr>
<td>Data Source: Committee minutes, finalized plan</td>
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<td>Process Milestone 1 Estimated Incentive Payment:</td>
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<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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</tr>
<tr>
<td>Process Milestone 3 [P-4]:</td>
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<tr>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</td>
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</tr>
<tr>
<td>Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
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<td>Process Milestone 3 Estimated Incentive Payment:</td>
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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Outcome Improvement Target 1 [IT-3.2]: CHF 30 day readmission rate Improvement Target: 10% reduction from baseline</td>
<td></td>
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<tr>
<td>Data Source: EHR, billing system</td>
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<td>Outcome Improvement Target 1 Estimated Incentive Payment:</td>
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<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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<tr>
<td>Outcome Improvement Target 2 [IT-3.2]: CHF 30 day readmission rate Improvement Target: 20% reduction from baseline</td>
<td></td>
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<tr>
<td>Data Source: EHR, billing system</td>
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<td>Outcome Improvement Target 2 Estimated Incentive Payment:</td>
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<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$433,793</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$538,874</td>
</tr>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $1,678,026
Outcome Domain – Cost of Care

Project Option IT-5.2 – Per episode cost of care – Congestive Heart Failure patients
Project ID - 020973601.3.4
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Congestive heart failure is one of the top chronic diseases in our community as it relates to cost, readmissions, and ED utilization. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with congestive heart failure. The improvement milestone for this project is to reduce the per episode cost of care for CHF patients by 5% by the end of the waiver.

Rationale:
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient. The Hospitalists, working with the residents, are in the best position to develop and implement clinical protocols that will reduce the cost and improve outcomes for the congestive heart failure patients. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 2.5% reduction each year (DY4 and DY5) in congestive heart failure per episode cost of care represents significant improvement when considering historical annual healthcare inflation rates.

Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day readmissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting
point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th>020973601.3.4</th>
<th>IT-5.2</th>
<th>Per Episode Cost of Care – CHF patients</th>
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</table>

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

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

**Process Milestone 1 [P-1]:** Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.

- Data Source: Committee minutes, finalized plan

**Process Milestone 1 Estimated Incentive Payment:** $74,965

**Process Milestone 2 [P-2]:** Establish baseline rates.

- Data Source: EHR, billing system, cost accounting system

**Process Milestone 2 Estimated Incentive Payment:** $74,964

**Process Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

- Data Source: Committee minutes, action plans, revised processes (if applicable)

**Process Milestone 3 Estimated Incentive Payment:** $202,751

**Outcome Improvement Target 1 [IT-5.2]:** Per episode cost of care – CHF patients

- Improvement Target: 2.5% reduction from baseline
- Data Source: EHR, billing system, cost accounting system

**Outcome Improvement Target 1 Estimated Incentive Payment:** $433,793

**Outcome Improvement Target 2 [IT-5.2]:** Per episode cost of care – CHF patients

- Improvement Target: 5% reduction from baseline
- Data Source: EHR, billing system, cost accounting system

**Outcome Improvement Target 2 Estimated Incentive Payment:** $538,874

| Year 2 Estimated Outcome Amount: $149,929 | Year 3 Estimated Outcome Amount: $202,751 | Year 4 Estimated Outcome Amount: $433,793 | Year 5 Estimated Outcome Amount: $538,874 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,325,347
Outcome Domain – Right Care, Right Setting

Project Option IT-9.2 – ED Appropriate Utilization – Congestive Heart Failure patients
Project ID - 020973601.3.5
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Congestive heart failure is one of the top chronic diseases in our community as it relates to cost, readmissions, and ED utilization. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with congestive heart failure. The improvement milestone for this project is to reduce the ED visits for CHF patients by 10% by the end of the waiver.

Rationale:
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient. The Hospitalists, working with the residents, are in the best position to develop and implement clinical protocols that will reduce the cost and improve outcomes for the congestive heart failure patients. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 5.0% reduction each year (DY4 and DY5) in congestive heart failure ED visits represents significant improvement when considering historical ED utilization.

Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day readmissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting
point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
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<thead>
<tr>
<th>020973601.3.5</th>
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<td><strong>Starting Point/Baseline:</strong></td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1]:** Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.  
Data Source: Committee minutes, finalized plan | **Process Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  
Data Source: Committee minutes, action plans, revised processes (if applicable) | **Outcome Improvement Target 1 [IT-9.2]:** Per episode cost of care – CHF patients  
Improvement Target: 5.0% reduction from baseline  
Data Source: EHR, billing system | **Outcome Improvement Target 2 [IT-9.2]:** Per episode cost of care – CHF patients  
Improvement Target: 10.0% reduction from baseline  
Data Source: EHR, billing system |
| Process Milestone 1 Estimated Incentive Payment: $74,965 | Process Milestone 3 Estimated Incentive Payment: $202,751 | Outcome Improvement Target 1 Estimated Incentive Payment: $216,897 | Outcome Improvement Target 2 Estimated Incentive Payment: $269,437 |
| **Process Milestone 2 [P-2]:** Establish baseline rates.  
Data Source: EHR, billing system, | | | |
| Process Milestone 2 Estimated Incentive Payment: $74,964 | | | |
| Year 2 Estimated Outcome Amount: $149,929 | Year 3 Estimated Outcome Amount: $202,751 | Year 4 Estimated Outcome Amount: $216,897 | Year 5 Estimated Outcome Amount: $269,437 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $839,014

RHP Plan for Region 4  
823
**Category 3: Quality Improvements**

**Outcome Domain – Potentially Preventable Re-Admissions – 30 day Readmission Rates**

**Project Option IT-3.9 – Chronic Obstructive Pulmonary Disease 30 day readmission rate**  
**Project ID - 020973601.3.6**  
**Performing Provider/TPI: Corpus Christi Medical Center/020973601**

**Outcome Measure Description**

DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY 2: P-2 – Establish baseline rates.  
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Chronic Obstructive Pulmonary Disease (COPD) was one of the most common reasons for potentially preventable hospitalizations. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with COPD. The improvement milestone for this project is to reduce COPD 30 day re-admissions by 20% by the end of the waiver.

**Rationale:**
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient and also have the opportunity to see COPD in the continuity of care clinics. Adding community health workers to work with the residents and Hospitalists will help to improve overall care coordination and reduce the re-admission rate. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 10% reduction each year (DY4 and DY5) in COPD re-admissions represents significant improvement and a reduction in overall healthcare expenditures. The healthcare delivery changes that are anticipated from this project will extend beyond the targeted patient population and establish best practices that should become standards of care in the community.

**Outcome Measure Valuation:**
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic
disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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| **Year 2**
(10/1/2012 – 9/30/2013) | **Year 3**
(10/1/2013 – 9/30/2014) | **Year 4**
(10/1/2014 – 9/30/2015) | **Year 5**
(10/1/2015 – 9/30/2016) |
| **Process Milestone 1** [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan | **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable) | **Outcome Improvement Target 1** [IT-3.9]: COPD 30 day readmission rate Improvement Target: 10% reduction from baseline Data Source: EHR, billing system | **Outcome Improvement Target 2** [IT-3.9]: COPD 30 day readmission rate Improvement Target: 20% reduction from baseline Data Source: EHR, billing system |
| Process Milestone 1 Estimated Incentive Payment: $149,929 | Process Milestone 3 Estimated Incentive Payment: $405,502 | Outcome Improvement Target 1 Estimated Incentive Payment: $433,793 | Outcome Improvement Target 2 Estimated Incentive Payment: $538,874 |
| **Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR, billing system | | | |
| Process Milestone 2 Estimated Incentive Payment: $149,928 | | | |
| **Year 2 Estimated Outcome Amount:** $299,857 | **Year 3 Estimated Outcome Amount:** $405,502 | **Year 4 Estimated Outcome Amount:** $433,793 | **Year 5 Estimated Outcome Amount:** $538,874 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $1,678,026
Outcome Domain – Cost of Care

Project Option IT-5.2 – Per episode cost of care – Chronic Obstructive Pulmonary Disease patients
Project ID - 020973601.3.7
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Chronic Obstructive Pulmonary Disease (COPD) is one of the top chronic diseases in our community as it relates to cost, readmissions, and ED utilization. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with COPD. The improvement milestone for this project is to reduce the per episode cost of care for CHF patients by 5% by the end of the waiver.

Rationale:
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient. The Hospitalists, working with the residents, are in the best position to develop and implement clinical protocols that will reduce the cost and improve outcomes for the COPD patients. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 2.5% reduction each year (DY4 and DY5) in COPD per episode cost of care represents significant improvement when considering historical annual healthcare inflation rates.

Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting
point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
| Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan |
| Process Milestone 2 [P-2]: Establish baseline rates. Data Source: EHR, billing system, cost accounting system |

**Year 2 (10/1/2012 – 9/30/2013)**

- Process Milestone 1 Estimated Incentive Payment: $74,965
- Process Milestone 2 Estimated Incentive Payment: $74,964

**Year 2 Estimated Outcome Amount:** $149,929

**Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable)***

**Process Milestone 3 Estimated Incentive Payment:** $202,751

**Outcome Improvement Target 1 [IT-5.2]: Per episode cost of care – COPD patients**

- Improvement Target: 2.5% reduction from baseline
- Data Source: EHR, billing system, cost accounting system
- Outcome Improvement Target 1 Estimated Incentive Payment: $433,793

**Outcome Improvement Target 2 [IT-5.2]: Per episode cost of care – COPD patients**

- Improvement Target: 5% reduction from baseline
- Data Source: EHR, billing system, cost accounting system
- Outcome Improvement Target 2 Estimated Incentive Payment: $538,874

**Year 3 (10/1/2013 – 9/30/2014)**

- Year 3 Estimated Outcome Amount: $202,751
- Year 4 Estimated Outcome Amount: $433,793
- Year 5 Estimated Outcome Amount: $538,874

**Outcome Improvement Target 2 Estimated Incentive Payment:** $538,874

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $1,325,347
Outcome Domain – Right Care, Right Setting

Project Option IT-9.2 – ED Appropriate Utilization – Chronic Obstructive Pulmonary Disease patients
Project ID - 020973601.3.8
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Chronic Obstructive Pulmonary Disease (COPD) is one of the top chronic diseases in our community as it relates to cost, readmissions, and ED utilization. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with COPD. The improvement milestone for this project is to reduce the ED visits for COPD patients by 10% by the end of the waiver. In DY2, Process Milestones P-1 and P-2 will be employed. In DY3, Process Milestone P-4 will be undertaken.

Rationale:
Currently, the Hospitalist physicians practicing at CCMC are seeing between 65% - 70% of all Medicine, Cardiology, and Pulmonary admissions to our facilities. As outlined in previous sections, the family practice and internal medicine residents work closely with the Hospitalists to help manage these patients while an inpatient. The Hospitalists, working with the residents, are in the best position to develop and implement clinical protocols that will reduce the cost and improve outcomes for the COPD patients. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 5.0% reduction each year (DY4 and DY5) in COPD ED visits represents significant improvement when considering historical ED utilization.

Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day readmissions, and sepsis mortality and complications. The total value for category 3 measures starts
out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]:</th>
<th>Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</th>
<th>Outcome Improvement Target 1 [IT-9.2]: Per episode cost of care – COPD patients Improvement Target: 5.0% reduction from baseline Data Source: EHR, billing system</th>
<th>Outcome Improvement Target 2 [IT-9.2]: Per episode cost of care – COPD patients Improvement Target: 10.0% reduction from baseline Data Source: EHR, billing system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: EHR, billing system, Process Milestone 2 Estimated Incentive Payment: $74,964</td>
<td>Year 2 Estimated Outcome Amount: $149,929</td>
<td>Year 3 Estimated Outcome Amount: $202,751</td>
<td>Year 4 Estimated Outcome Amount: $216,897</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $149,929</td>
<td>Year 3 Estimated Outcome Amount: $202,751</td>
<td>Year 4 Estimated Outcome Amount: $216,897</td>
<td>Year 5 Estimated Outcome Amount: $269,437</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $839,014</td>
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</tbody>
</table>
**Category 3: Quality Improvements**

**Outcome Domain – Potentially Preventable Re-Admissions – 30 day Readmission Rates**

**Project Option IT-3.8 – Behavioral Health/Substance Abuse 30 day readmission rate**

**Project ID - 020973601.3.9**

**Performing Provider/TPI: Corpus Christi Medical Center/020973601**

**Outcome Measure Description**

- **DY 2: P-1** – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY 2: P-2** – Establish baseline rates.
- **DY 3: P-4** – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. Patients with behavioral health and/or substance abuse issues typically have limited access to primary care which results in overutilization of hospital emergency departments and frequent inpatient admissions. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients with behavioral health and/or substance abuse issues. The improvement milestone for this project is to reduce behavioral health/substance abuse 30 day re-admissions by 20% by the end of the waiver. In DY2, Process Milestones P-1 and P-2 will be employed. In DY3, Process Milestone P-4 will be undertaken.

**Rationale:**

The overall goal of this project is to provide expanded behavioral health/substance abuse services that help the patients “step down” from an acute inpatient stay using outpatient therapies and other techniques to effectively integrate them back to their appropriate home/life setting. Due primarily to the lack of physician providers and insufficient behavioral health services in our community, this patient population is at greater risk for fragmented care and readmissions. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 10% reduction each year (DY4 and DY5) in behavioral health/substance abuse re-admissions represents significant improvement and a reduction in overall healthcare expenditures. The healthcare delivery changes that are anticipated from this project will extend beyond the targeted patient population and establish best practices that should become standards of care in the community.
Outcome Measure Valuation:
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.</th>
<th>Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</th>
<th>Outcome Improvement Target 1 [IT-3.2]: Behavioral health/substance abuse 30 day readmission rate</th>
<th>Outcome Improvement Target 2 [IT-3.2]: Behavioral health/substance abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Committee minutes, finalized plan</td>
<td>Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
<td>Improvement Target: 10% reduction from baseline</td>
<td>Improvement Target: 20% reduction from baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $149,929</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
<td>Data Source: EHR, billing system</td>
<td>Data Source: EHR, billing system</td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates.</td>
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<td>Outcome Improvement Target 1 Estimated Incentive Payment: $433,793</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $538,874</td>
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<td>Data Source: EHR, billing system</td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $149,928</td>
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<td>Year 2 Estimated Outcome Amount: $299,857</td>
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<td>Year 4 Estimated Outcome Amount: $433,793</td>
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<td>Year 4 Estimated Outcome Amount: $433,793</td>
<td>Year 5 Estimated Outcome Amount: $538,874</td>
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</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,678,026
Category 3: Quality Improvements

Outcome Domain – Potentially Preventable Re-Admissions – 30 day Readmission Rates

Project Option IT-3.1 – All cause 30 day readmission rate
Project ID - 020973601.3.10
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Hospital care represents the largest component of overall health care expenditures. Some hospitalizations can be potentially prevented with timely and effective post discharge ambulatory care. In 2006, hospital costs for potentially preventable conditions totaled nearly $30.8 billion or one out of every ten dollars of total hospital expenditures. People with multiple health and social needs are high consumers of health care services and are thus drivers of high health care costs. Providing better care transitions from inpatient to outpatient care and/or to home will reduce the likelihood of expensive inpatient readmissions. The process milestones P-1, P-2, and P-4 were selected for inclusion in this project to ensure the appropriate time and resources were dedicated to the baseline assessment, development, and implementation of healthcare delivery changes that will positively impact the clinical outcomes and patient experience of CCMC’s patients. The improvement milestone for this project is to reduce all cause 30 day re-admissions by 20% by the end of the waiver. In DY2, Process Milestones P-1 and P-2 will be employed. In DY3, Process Milestone P-4 will be undertaken.

Rationale:
To effectively reduce costs from our current health care delivery system the approach must shift from providing health interventions to improving health outcomes through better self-management and appropriate access to health care resources and other community supports. Providing effective care transition plans, resources, and support will reduce the risk of readmissions and greatly improve patient satisfaction and outcomes. Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 10% reduction each year (DY4 and DY5) in all cause re-admissions represents significant improvement and a reduction in overall healthcare expenditures. The healthcare delivery changes that are anticipated from this project will extend beyond the targeted patient population and establish best practices that should become standards of care in the community.
**Outcome Measure Valuation:**
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.</td>
<td>Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td>Outcome Improvement Target 1 [IT-3.2]: All cause 30 day readmission rate Improvement Target: 10% reduction from baseline Data Source: EHR, billing system</td>
<td>Outcome Improvement Target 2 [IT-3.2]: All cause 30 day readmission rate Improvement Target: 20% reduction from baseline Data Source: EHR, billing system</td>
</tr>
<tr>
<td>Data Source: Committee minutes, finalized plan</td>
<td>Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $433,793</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $538,874</td>
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<td>Process Milestone 1 Estimated Incentive Payment: $149,929</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
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<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates.</td>
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<td>Outcome Improvement Target 1</td>
<td>Outcome Improvement Target 2</td>
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<tr>
<td>Data Source: EHR, billing system</td>
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<td>Estimated Incentive Payment: $433,793</td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $149,928</td>
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</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,678,026
**Category 3: Quality Improvements**

**Outcome Domain – Potentially Preventable Complications and Hospital Acquired Conditions**

**Project Option IT-4.8 – Sepsis Mortality**  
**Project ID: 020973601.3.11**  
**Performing Provider/TPI: Corpus Christi Medical Center/020973601**

**Outcome Measure Description**

DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY 2: P-2 – Establish baseline rates.  
DY 3: P-4 – Develop and test data systems

Severe sepsis and septic shock are major healthcare problems, affecting millions of individuals, killing one in four and increasing in incidence. Similar to acute myocardial infarction or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence the outcome. Through the implementation of evidence based protocols, the goal is to reduce sepsis mortality by 5% in DY4 and 15% by DY5.

**Rationale**

The 28-day mortality rate in sepsis patients is comparable to the 1960’s mortality rate for patients with acute myocardial infarction (AMI). The significant improvements in awareness and management for AMI since the 1960’s have resulted in declines in mortality. With efforts similar to AMI there should be substantial improvements that can be made in sepsis mortality rates. The number of severe sepsis cases is increasing, projecting to add an additional 1 million cases per year by the year 2020. This will increase the total mortality and increase the burden on healthcare resources. Changes have to be made in the early identification and management of this condition to moderate and/or reverse the current case trends.

**Outcome Measure Valuation**

Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
<table>
<thead>
<tr>
<th><strong>020973601.3.11</strong></th>
<th><strong>IT-4.8</strong></th>
<th><strong>Sepsis Mortality</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corpus Christi Medical Center</strong></td>
<td></td>
<td><strong>TPI - 020973601</strong></td>
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<table>
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<tr>
<th><strong>Related Category 1 or 2 Projects:</strong></th>
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<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
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<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan</td>
<td><strong>Process Milestone 3 [P-4]:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
<td><strong>Outcome Improvement Target 1 [IT-4.8]:</strong> Sepsis Mortality Improvement Target: 5% reduction from baseline Data Source: EHR, billing system</td>
<td><strong>Outcome Improvement Target 2 [IT-4.8]:</strong> Sepsis Mortality Improvement Target: 15% reduction from baseline Data Source: EHR, billing system</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $149,929</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $433,793</td>
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</table>

| **Year 2 Estimated Outcome Amount:** $299,857 | **Year 3 Estimated Outcome Amount:** $405,502 | **Year 4 Estimated Outcome Amount:** $433,793 | **Year 5 Estimated Outcome Amount:** $538,874 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,678,026
Category 3: Quality Improvements

Outcome Domain – Potentially Preventable Complications and Hospital Acquired Conditions

Project Option IT-4.9 – Average Length of Stay - Sepsis
Project ID - 020973601.3.12
Performing Provider/TPI: Corpus Christi Medical Center/020973601

Outcome Measure Description
DY 2: P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY 2: P-2 – Establish baseline rates.
DY 3: P-4 – Develop and test data systems

Severe sepsis and septic shock are major healthcare problems, affecting millions of individuals, killing one in four and increasing in incidence. Similar to acute myocardial infarction or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence the outcome. Through the implementation of evidence based protocols, the goal is to reduce sepsis average length of stay by 5% in DY4 and 15% by DY5.

Rationale
The 28-day mortality rate in sepsis patients is comparable to the 1960’s mortality rate for patients with acute myocardial infarction (AMI). The significant improvements in awareness and management for AMI since the 1960’s have resulted in declines in mortality. With efforts similar to AMI there should be substantial improvements that can be made in sepsis mortality rates and the resulting cost of care and length of stay. The number of severe sepsis cases is increasing, projecting to add an additional 1 million cases per year by the year 2020. This will increase the burden on healthcare resources. Changes have to be made in the early identification and management of this condition to moderate and/or reverse the current case trends and to reduce the overall length of stay and cost of care.

Outcome Measure Valuation
Each outcome measure selected for the four category 1 projects and two category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on
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<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020973601.2.2</th>
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<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD</strong></td>
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<td><strong>Process Milestone 3 [P-4]:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
<td><strong>Outcome Improvement Target 1 [IT-4.9]:</strong> Average Length of Stay – Severe Sepsis and Septic Shock Improvement Target: 5% reduction from baseline Data Source: EHR, billing system</td>
<td><strong>Outcome Improvement Target 2 [IT-4.9]:</strong> Average Length of Stay – Severe Sepsis and Septic Shock Improvement Target: 15% reduction from baseline Data Source: EHR, billing system</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $149,929</td>
<td>Process Milestone 3 Estimated Incentive Payment: $405,502</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $216,897</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $269,437</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates. Data Source: EHR, billing system</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $149,928</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5): $1.191,693*
Performing Provider/TPI: Corpus Christi Medical Center/020973601
Title of Outcome Measure (Improvement Target): IT- 2.12 Prevention Quality Indicators (PQI)
Composite Measures Potentially Preventable Hospitalizations
Unique RHP outcome identification number(s): 020973601.3.13 – Pass 2

Outcome Measure Description:
IT- 2.12 will use the chronic composite – PQI 92 score calculated for all patients seen at the Performing Provider’s locations. This overall composite rate links potentially preventable hospitalizations with individual PQI measures centered around chronic diseases – Diabetes, COPD, CHF, etc. Trending these rates over time should give us an indication of how well we are 1) improving access to primary care, 2) identifying and educating patients with chronic diseases, and 3) improving the health of the chronic disease patients. Though the composite measures rely on hospital inpatient discharge data, they are intended to reflect issues of access to, and quality of ambulatory care in a given geographic area. The PQI composites are intended to improve the statistical precision of the individual PQI. The PQI composites provide the following advantages:
- Provide assessment of quality and disparity
- Provide baselines to track progress
- Identify information gaps
- Emphasize interdependence of quality and disparities
- Promote awareness and change

Process Milestones:
- DY2: P-1; P-2;
- DY3: P-4

Outcome Improvement Target(s) for each year:
- DY4:
  - IT- 2.12 Chronic Composite – PQI 92
    - Decrease of 5% from baseline
- DY5:
  - IT- 2.12 Chronic Composite – PQI 92
    - Decrease of 15% from baseline

Rationale:
Process milestones P-1 and P-2, project planning and establish baseline rates, enable CCMC to appropriately engage all the stakeholders (physicians, case management, community), determine timelines, and develop solid baseline data in order to properly measure the progress against. Process milestone P-4 allows for the development of processes and data collection to ensure continual learning and internal feedback that will contribute to the attainment of the outcome goal. The improvement milestone goal of a 5% reduction for DY4 and 10% for DY 5 in the Chronic Composite – PQI 92 represents significant improvement and a reduction in overall healthcare expenditures.
**Outcome Measure Valuation:**
Each outcome measure selected for the category 1 projects and category 2 projects represent areas that address some of the more significant and costly health issues in our community; chronic disease management, fragmented care transitions, inappropriate ED utilization, 30 day re-admissions, and sepsis mortality and complications. The total value for category 3 measures starts out at 30% of the total DSRIP available funding for DY2 and increases to 40% by DY5. The starting point of 30% reflects the importance of these measures for the health of our community, the amount of effort involved in establishing and validating the health care delivery changes necessary, and the anticipated benefit when improvements are realized in the subsequent years of the waiver. Increasing the overall category 3 funding to 40% by DY5 takes into account the additional benefit of making transformative changes to health care delivery in our community and the impacts which will extend beyond the waiver period. The valuation of each individual category 3 measure was valued between 5 and 10 percent of the total category 3 funding. More weight was given to those measures with the greatest impact on improved health and patient satisfaction (chronic disease management, re-admissions, and sepsis mortality).
### Prevention Quality Indicators (PQI) – Chronic Composite PQI 92

**Corpus Christi Medical Center**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020973601.1.5</th>
</tr>
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<td><strong>Starting Point/Baseline:</strong></td>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $205,587</td>
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<tr>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baseline rates. Data Source: EHR, billing system</td>
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<td>Process Milestone 2 Estimated Incentive Payment: $205,586</td>
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<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Committee minutes, action plans, revised processes (if applicable)</td>
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<td>Process Milestone 3 Estimated Incentive Payment: $575,147</td>
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<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-2.12]: Chronic Composite PQI 92</td>
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<tr>
<td>Improvement Target: 5% reduction from baseline Data Source: EHR, billing system</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $613,926</td>
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<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
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<td><strong>Year 2 Estimated Outcome Amount:</strong> $411,173</td>
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<td><strong>Year 3 Estimated Outcome Amount:</strong> $575,147</td>
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<td><strong>Year 4 Estimated Outcome Amount:</strong> $613,926</td>
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<td><strong>Year 5 Estimated Outcome Amount:</strong> $810,099</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $2,410,345</td>
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</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
The outcome measures for Category 1 project: OD-9ED appropriate Utilization, IT-9.2 Reduce all ER visits
Refugio County Hospital District TPI 020991801.3.1

Outcome Measure Description
Refugio County Memorial Hospital intends to reduce the overall volume of the Emergency Department Visits by improving the access to primary care. The outcome measure is imperative to determine the level of success achieved by this project. With the expansion of primary care, and an aggressive public education campaign, we expect to see a 10% reduction in overall ER visits by DY 5.

Process Milestones:
The process milestones included for the expand primary care capacity project include the following:
- DY 2 – P-1; P-2
- DY 3 – P.3; P.4

Outcome Improvement Targets:
DY 4: IT 9.2 Improvement Target: Reduced number of all ED visits by 5% over DY2.
DY 5: IT 9.2 Improvement Target: Reduced number of all ED visits by 10% over DY2

With the improvement milestones identified above we expect to see an increase in overall clinic volume and thus a decrease in ED utilization. The goal by DY5 is to reduce overall ED visits by 10% over DY2.

Rationale:
In order for patients in a community to remain healthy, they must have timely and efficient access to primary care services. The most compliant patient cannot remain healthy if he or she cannot access primary care when they need it most. The limited access to primary care has caused well documented problems for our healthcare system nationwide. Patients will either delay or forgo treatment only to have their conditions worsen creating more serious or chronic problems. If RCMH can increase its patient’s access to primary care then better patient compliance could reasonably be expected. Better patient compliance through improved patient access will result in better delivery of primary care preventing unnecessary hospital admissions and emergency department visits; therefore, reducing the healthcare costs to the community and the overall healthcare system.

In DY 2, process milestone P-1 will include engaging stakeholders, identifying existing and needed resources, and developing implementation plans and timelines for the primary care expansion and public education campaign. Milestone P-2 is necessary for establishing baseline rates by which success can be measured in DY 4-5. In DY 3, process milestones P-3 and P-4 are
needed for establishing and testing data collection systems and for continuous quality improvement. In DY 4 and DY 5, improvement target values (5% and 10%, respectively) were selected based on current rates of non-emergent ED utilization and the level of primary care expansion this project is expected to achieve.

**Outcome Measure Valuation:**
The related Category 3 outcome measure chosen for this project is OD-9 ED appropriate utilization Refugio County Memorial Hospital will expand its primary care capacity at its rural health clinic in an effort to reduce Emergency room visits by 10% by DY 5.

In the year 2011 Refugio County Memorial Hospital District had 3871 Emergency Room Visits. Of these 198 were for diabetic related complications, 50 visits were for Congestive Heart Failure, and 46 visits were for bacterial pneumonia. Just these three specific diagnoses accounted for 294 potentially preventable conditions that have driven up the cost of healthcare in our region. If 50% of these E.R visits had been prevented, then the savings to the community and the healthcare system would have been $208,541.00 based upon our current financials.

According to State Data for the year 2010 there were:

- 11 patients admitted to RCMH for bacterial pneumonia with an average hospital bill of $31,186.
- 11 patients admitted to RCMH for Congestive Heart Failure with an average hospital bill of $26,002.
- 7 patients admitted to RCMH for Diabetic Related Long term complications with an average hospital bill of $41,330.

The combined costs of these three types of hospital admission for the 2010 year were $918,378. While it is expected that not all of these hospital admission could have been prevented, but even if only 25% of them had been prevented the savings to the community and the healthcare system could have been $229,594. The combined savings for emergency room visits and hospital admissions for these three diagnoses alone could have saved the community $438,135 in one year. Keeping patients out of the Emergency room and away from hospital admissions will have a drastic reduction on the cost of healthcare in the community.
<table>
<thead>
<tr>
<th>Process Milestone 1 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</th>
<th>Process Milestone 3 P-3: Develop and test data systems. <strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective system for the program.</th>
<th>Outcome Improvement Target 1 IT-9.2: Improvement Target: Reduced number of ED visits to RCMH by 5% over DY2. <strong>Data Source:</strong> EHR, Claims. Estimated Incentive Payment: $107,614</th>
<th>Outcome Improvement Target 2 IT-9.2: Improvement Target: Reduced number of ED visits to RCMH by 10% over DY2. <strong>Data Source:</strong> EHR, Claims. Estimated Incentive Payment: $201,190</th>
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</thead>
<tbody>
<tr>
<td>Process Milestone 2 P-2: Establish baseline rates. <strong>Data Source:</strong> Claims and encounters data, medical records.</td>
<td>Process Milestone 4 P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. <strong>Data Source:</strong> Program data.</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $107,614</td>
<td>Outcome Improvement Target 6 Estimated Incentive Payment: $201,190</td>
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<td>Process Milestone 3 Estimated Incentive Payment: $40,238</td>
<td>Year 2 Estimated Outcome Amount: $52,071</td>
<td>Year 5 Estimated Outcome Amount: $201,190</td>
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<td>Year 4 Estimated Outcome Amount: $107,614</td>
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<td>Year 5 Estimated Outcome Amount: $201,190</td>
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<td>Year 5 Estimated Outcome Amount: $201,190</td>
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<td>Year 5 Estimated Outcome Amount: $201,190</td>
<td>Year 5 Estimated Outcome Amount: $201,190</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $441,351
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease management, IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) - NQF 0059 (standalone measure)
Unique RHP outcome identification number: 080368601.3.1
Performing Provider/TPI: Coastal Plains Community Center/080368601

Outcome Measure Description:
IT-1.10 Diabetes Care HbA1c poor control (>9.0%) - NQF 0059 (standalone measure) Members 18-75 years of age as of December 31 of the measurement year will have their hemoglobin A1c (HbA1c) tested and Blood Pressure taken at admission to the program. They will be provided education and information regarding the prevention of diabetes; diabetes care; diabetes maintenance; blood pressure control and healthy eating, based upon testing results. Also, based upon test results, physician recommendations and standards of care, individual plans of care will be developed to provide on-going testing, education and support.

The goal will be to decrease the A1c levels and increase blood pressure control, by decreasing blood pressure readings for people with a diagnosis of diabetes (type 1 or type 2). A baseline will be determined during the first two years of the program, with an outcome measure to be determined (TBD).

Rationale:
Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half of these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

The data and literature demonstrates atypical antipsychotic use results in weight gain as compared to conventional antipsychotic medications and it was believed that the medications might interfere with the functions of the central nervous system and its role in metabolism. Patients taking atypicals or mood stabilizers reported increase weight gain, craving for "simple carbohydrates" and were found to have higher rates of obesity, diabetes mellitus, impaired glucose tolerance and high cholesterol. The SMI population is at a greater risk for obesity, diabetes and high cholesterol all of which can lead to heart disease and cardiovascular diseases and stroke. The cumulative result of these factors - rural setting with a disproportionately lower number of primary care physicians; low average economic status; a majority population of Hispanics at already elevated risk for preventable health conditions and chronic diseases; a high rate of emergency room visits and hospital admissions, extremely high health costs and poor community health levels.

The South Texas Whole Health and Recovery Integration Project seeks to counteract these negative health factors by integrating primary and behavioral health care in our community mental health settings throughout the Coastal Bend. We will create a health care home which provides a
continuum of services with regular follow-up and an emphasis on prevention and wellness to empower consumers through education and community support, leading to overall improved health.

**Outcome Measure Valuation:**

$90,000 per year for year’s 3 & 4 per Outcome Measure

$184,702 for year 5 per Outcome Measure

We propose to use an annual cost savings of $2,040 per patient served by our primary care / behavioral health integration. This cost savings comes from the Colorado Study\(^{161}\) of 1,000 Medicaid patients in primary care that were provided depression management services. We believe that this is a conservative figure for this project for the following reasons:

1. We project that 1,000 of the 1,700 persons to be served by our project will be uninsured. Their uninsured status should mean that their historical health services are far more meager than the Medicaid recipients in Colorado, and therefore present a greater possibility of improvement.
2. We propose to provide twice annual preventive dental services to our 1,700 patients. Although we cannot cite specific cost savings from this service, it is well documented that good oral hygiene is integral to good physical health.
3. We propose to provide ongoing health education, disease management, weight control and smoking cessation classes for all our patients.
4. We propose to employ care management / health navigators at all of our clinics to foster compliance with medical appointments and health recommendations for the patients.

In estimating total cost savings for the 4-year project, we have multiplied the total number of patients to be served each year by the expected savings of $2,040 which equals $9,282,000. In addition to the above medical cost savings, we project that we will transfer 500 stable patients from the care of our psychiatrists to our primary care provider. Currently we have a large number of patients in psychiatric care who have been stable on their medications for a year or longer and could be appropriately served in a primary care setting. They have not been moved to this less expensive setting because they are either uninsured or we have been unable to secure a primary care physician for them. Our FQHC partner has agreed to accept these patients because of the availability of psychiatric consultation and readmission. Our State developed Cost Accounting Methodology gives us an average annual cost of $582 for these psychiatric services. In estimating our cost savings for this 4-year project, we have multiplied the number of stable patients transferred to primary care by our cost savings of $582, for a total cost savings of $727,500.

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### 080368601.3.1
### IT-1.10
**Diabetes Care: HbA1c Poor Control (<9.0%)**  
Coastal Plains Community Center

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<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
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</table>
| **Process Milestone 1** P-2 Establish baseline rates | **Outcome Improvement Target 1**  
IT-1.10 Diabetes Care: HbA1c Poor control (>9.0%) - NQF 0059  
Increase in Positive Results of HbA1c Baseline/Goal: 10% of people will show a decrease in their HbA1c levels over their 1st year’s testing.  
Data Source: Project Data; Medical Records; Claims and Encounter Data  
Outcome Improvement Target 1 Estimated Incentive Payment: $90,000 | **Outcome Improvement Target 2**  
IT-1.10 Diabetes Care: HbA1c Poor control (>9.0%) - NQF 0059  
10% improvement noted over baseline  
Increase in Positive Results of HbA1c Baseline/Goal: 20% of people will show a decrease in their HbA1c levels over their 1st year’s testing.  
Data Source: Project Data; Medical Records; Claims and Encounter Data  
Outcome Improvement Target 2 Estimated Incentive Payment: $90,000 | **Outcome Improvement Target 3**  
IT-1.10 Diabetes Care: HbA1c Poor control (>9.0%) - NQF 0059  
20% improvement noted over baseline  
Increase in Positive Results of HbA1c Baseline/Goal: 30% of people will show a decrease in their HbA1c levels over their 1st year’s testing.  
Data Source: Project Data; Medical Records; Claims and Encounter Data  
Outcome Improvement Target 3 Estimated Incentive Payment: $184,702 |
| Baseline: at least 50% of the people served in mental health services either have high blood pressure, high cholesterol, BMI over 30 and/or diabetes (high A1C)  
Goal: To provide testing, education and medications as appropriate to (80%) of people served in collaborative care regarding their A1c, cholesterol, and blood pressure to establish baseline per person.  
Data Source: Project Data; Medical Records; Claims and Encounter Data | | | |
| | **Year 2 Estimated Outcome Amount** | **Year 3 Estimated Outcome Amount** | **Year 4 Estimated Outcome Amount** | **Year 5 Estimated Outcome Amount** |
| $0 | $90,000 | $90,000 | $184,702 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): | $364,702 | | |

**RHP Plan for Region 4**
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease management IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061

**Unique RHP outcome identification number:** 080368601.3.2

**Performing Provider/TPI:** Coastal Plains Community Center/080368601

**Outcome Measure Description:**

IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061. We will use automated data to identify the most recent blood pressure reading for our target population during the measurement year. The goal will be to increase blood pressure control, by decreasing blood pressure readings for people with a diagnosis of diabetes (type 1 or type 2) and maintain blood pressure at acceptable levels on going.

**Rationale:**

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half of these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

The data and literature demonstrates atypical antipsychotic use results in weight gain as compared to conventional antipsychotic medications and it was believed that the medications might interfere with the functions of the central nervous system and its role in metabolism. Patients taking atypicals or mood stabilizers reported increase weight gain, craving for "simple carbohydrates" and were found to have higher rates of obesity, diabetes mellitus, impaired glucose tolerance and high cholesterol. The SMI population is at a greater risk for obesity, diabetes and high cholesterol all of which can lead to heart disease and cardiovascular diseases and stroke. The cumulative result of these factors - rural setting with a disproportionately low number of primary care physicians; low average economic status; a majority population of Hispanics at already elevated risk for preventable health conditions and chronic diseases is a high rate of emergency room visits and hospital admissions, extremely high health costs and poor community health levels. *South Texas Whole Health and Recovery Integration Project* seek to counteract these negative health factors by integrating primary and behavioral health care in our community mental health settings throughout the Coastal Bend. We will create a health care home which provides a continuum of services with regular follow-up and an emphasis on prevention and wellness to empower consumers through education and community support, leading to overall improved health.

**Outcome Measure Valuation:**

$90,000 per year for year's 3 & 4 per Outcome Measure

$184,702 for year 5 per Outcome Measure
We propose to use an annual cost savings of $2,040 per patient served by our primary care/behavioral health integration. This cost savings comes from the Colorado Study\textsuperscript{162} of 1,000 Medicaid patients in primary care that were provided depression management services. We believe that this is a conservative figure for this project for the following reasons:

1. We project that 1,000 of the 1,700 persons to be served by our project will be uninsured. Their uninsured status should mean that their historical health services are far more meager than the Medicaid recipients in Colorado, and therefore present a greater possibility of improvement.
2. We propose to provide twice annual preventive dental services to our 1,700 patients. Although we cannot cite specific cost savings from this service, it is well documented that good oral hygiene is integral to good physical health.
3. We propose to provide ongoing health education, disease management, weight control and smoking cessation classes for all our patients.
4. We propose to employ care management/health navigators at all of our clinics to foster compliance with medical appointments and health recommendations for the patients.

In estimating total cost savings for the 4-year project, we have multiplied the total number of patients to be served each year by the expected savings of $2,040 which equals $9,282,000.

**RHP Plan for Region 4**

**Coastal Plains Community Center**

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<tr>
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<td>Baseline: at least 50% of the people served in mental health services either have high blood pressure, high cholesterol, BMI over 30 and/or diabetes (high A1C)</td>
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<tr>
<td></td>
<td>Goal: To provide testing, education and medications as appropriate to (80%) of people served in collaborative care regarding their A1c, cholesterol, and blood pressure to establish baseline per person.</td>
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<td>Data Source: Project Data; Medical Records; Claims and Encounter Data</td>
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<tr>
<td></td>
<td>IT-1.11 Diabetes Care: BP Control (&lt;140/80 mm hg) - NQF 0061</td>
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<tr>
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<td>Baseline line to be established after first 18 months of services.</td>
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<tr>
<td></td>
<td>Increase in Positive Results of Blood Pressure testing</td>
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<td>Baseline/Goal: 10% of people will show a decrease in their blood pressure over their 1st year’s testing.</td>
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<tr>
<td></td>
<td>Data Source: Project Data; Medical Records; Claims and Encounter Data</td>
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<td>Estimated Incentive Payment: $90,000</td>
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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<td>IT-1.11 Diabetes Care: BP Control (&lt;140/80 mm hg) - NQF 0061</td>
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<tr>
<td></td>
<td>10% improvement noted over baseline</td>
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<td>Increase in Positive Results of Blood Pressure testing</td>
</tr>
<tr>
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<td>Baseline/Goal: 20% of people will show a decrease in their Blood Pressure over their 1st year’s testing.</td>
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<td>20% improvement noted over baseline</td>
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<td>Increase in Positive Results of Blood Pressure testing</td>
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<td>Baseline/Goal: 30% of people will show a decrease in their Blood Pressure over their 1st year’s testing.</td>
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<tr>
<td></td>
<td>Data Source: Project Data; Medical Records; Claims and Encounter Data</td>
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<td></td>
<td>Estimated Incentive Payment: $184,702</td>
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<tr>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
<th><strong>Outcome Improvement Target 3</strong></th>
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<td>Year 5 Estimated Outcome Amount</td>
<td>$184,702</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $364,702
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right setting, IT-9.1 decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons

**Unique RHP outcome identification number:** 080368601.3.3

**Performing Provider/TPI:** Coastal Plains Community Center/080368601

**Outcome Measure Description:**

IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Current measure is "Adult SA Outpatient Providers must ensure that clients/patients/consumers will have no arrest since admission at 90%". The goal is to continue to reach this measure annually, though a baseline which will be determined the first year of service to determine if modifications to this measure may need to be made, due to increased needs of the SMI/Dual Diagnosis population. Data will be entered into the statewide system and reported to DSHS as per COADA contract.

**Rationale:**

Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

**Outcome Measure Valuation:**

The cost savings in regards to substance abuse services could significant. Not only do studies show financial savings, just saving one person from driving drunk could save a life. The Haymarket Study\(^\text{163}\) found that over four years intensive out-patient treatment produced a cumulative savings of $14,589 per person. This cumulative savings results in an average savings of $4,608.25 per person per year. We have taken this average savings and multiplied it by the projected number of persons our service partner will treat each year, for a total savings over the four years of $4,032,086. "A comparison group of 203 members received routine care in the form of separate outreach from substance abuse coordinators and care managers. Early results indicate that the intervention group reduced medical costs by $122 per member per month as compared to an increase in the comparison group. The intervention group's cost reductions were realized through a decrease of 288 admissions per 100 members as well as a decrease in 92 days admitted per 1,000 members. Moreover, the intervention group experienced increased enrollment in substance abuse treatment and case management, which appropriately offset some of the savings from hospital utilization."\(^\text{164}\) $90,000 per year per for year's 3 & 4 per Outcome Measure $184,704 for year 5 per Outcome Measure.

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\(^{163}\) Dennis, M., Scott, C., Godley, M., Lustig, D., Chestnut Health Systems, Feb. 22, 2011 Presentation: “Substance Abuse Treatment Reduces Costs to Society: Eliminating Substance Abuse Treatment Increases Costs”

\(^{164}\) Johns Hopkins Healthcare: Demonstrating a Return on Investment for Integrated Substance Abuse and Treatment.
<table>
<thead>
<tr>
<th>080368601.3.3</th>
<th>IT-9.1</th>
<th>Decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons</th>
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</thead>
<tbody>
<tr>
<td>Coastal Plains Community Center</td>
<td>080368601</td>
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**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1</td>
<td>Establish baseline rates</td>
<td>Outcome Improvement Target 1</td>
<td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
</tr>
<tr>
<td>Data source: Department of State Health Services (DSHS) CMBHS data system; Data Warehouse</td>
<td>5% decrease in admissions and re-admissions to criminal justice settings over baseline established after 1st 6 months of service for first integrated SA/BH clinic. Establish baseline for next 2 SA/BH clinics 1st 6 months and second six months, decrease admissions to criminal justice settings for those clinics by 5%. Data source: Department of State Health Services (DSHS) CMBHS data system; Data Warehouse</td>
<td>Outcome Improvement Target 2</td>
<td>IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons</td>
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<td>Process Milestone 1 Estimated Incentive Payment:</td>
<td>$90,000</td>
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<td>Year 3 Estimated Outcome Amount:</td>
<td>$90,000</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $364,702*
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): OD-10 Quality of Life/Functional Status IT-10.7
Other Outcome Improvement
Target - Increased percentage of individuals admitted to substance abuse services successfully complete treatment
Unique RHP outcome identification number: 080368601.3.4
Performing Provider/TPI: Coastal Plains Community Center/080368601

Outcome Measure Description:
IT-10.7 Other Outcome Improvement Target is 70% of admissions to SA Services successfully complete treatment services.
The goal is to continue to reach this measure annually, though a baseline which will be determined the first year of service to determine if modifications to this measure may need to be made, due to increased needs of the SMI/Dual Diagnosis population.

Rationale:
Current measure is "Adult SA Outpatient Providers must ensure that clients/patients/consumers successfully complete treatment at 70%". The high rate of co-morbid substance abuse and mental illness points to the need for a comprehensive approach that identifies, evaluates, and simultaneously treats both disorders. Patients with co-occurring disorders often exhibit more severe symptoms than those caused by either disorder alone, underscoring the need for integrated treatment. Careful diagnosis and monitoring will help ensure that symptoms related to drug abuse (e.g., intoxication, withdrawal) are not mistaken for a discrete mental disorder. Even in people whose co-morbidities do not occur simultaneously, research shows that mental disorders can increase vulnerability to subsequent drug abuse and that drug abuse constitutes a risk factor for subsequent mental disorders. Therefore, diagnosis and treatment of one disorder will likely reduce risk for the other, or at least improve its prognosis. The need to develop effective interventions to treat both conditions concurrently is strongly supported by research, but has been difficult to implement in practice because:
- The health care systems in place to treat substance abuse and mental illness are typically disconnected, hence inefficient. Physicians tend to treat patients with mental illnesses, where as a mix of providers with varying backgrounds deliver drug abuse treatment.
- Some substance abuse treatment centers are biased against using any medications, including those necessary to treat patients with severe mental disorders.

Still, behavioral treatment options customized for a given age group or gender have shown promise for treating drug abuse and mental disorder co-morbidities, and research is under way to identify medications targeting both disorders. Clinicians and researchers generally agree that broad-spectrum diagnosis and concurrent therapy (pharmacological and behavioral) will lead to better outcomes for patients with comorbid disorders. This training will provide Qualified Mental Health Professionals

(Case Managers) with the additional tools they need to ensure individual recovery plans incorporate whole health and substance abuse services, based upon needs and assessments.

**Outcome Measure Valuation:**

$90,000 per year for year’s 3 & 4 per Outcome Measure  
$184,704 for year 5 per Outcome Measure  

The cost savings in regards to substance abuse services could significant. Not only do studies show financial savings, just saving one person from driving drunk could save a life. The Haymarket Study\(^{166}\) found that over four years intensive out-patient treatment produced a cumulative savings of $14,589 per person. This cumulative savings results in an average savings of $4,608.25 per person per year. We have taken this average savings and multiplied it by the projected number of persons our service partner will treat each year, for a total savings over the four years of $4,032,086.

"A comparison group of 203 members received routine care in the form of separate outreach from substance abuse coordinators and care managers. Early results indicate that the intervention group reduced medical costs by $122 per member per month as compared to an increase in the comparison group. The intervention group's cost reductions were realized through a decrease of 288 admissions per 100 members as well as a decrease in 92 days admitted per 1,000 members. Moreover, the intervention group experienced increased enrollment in substance abuse treatment and case management, which appropriately offset some of the savings from hospital utilization." \(^{167}\)

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\(^{166}\) Dennis, M., Scott, C., Godley, M., Lustig, D., Chestnut Health Systems, Feb. 22, 2011 Presentation: "Substance Abuse Treatment Reduces Costs to Society: Eliminating Substance Abuse Treatment Increases Costs"

\(^{167}\) Johns Hopkins Healthcare: Demonstrating a Return on Investment for Integrated Substance Abuse and Treatment.
<table>
<thead>
<tr>
<th>Process Milestone 1 Estimated Incentive Payment: 0</th>
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<td>Year 2 Estimated Outcome Amount: $0</td>
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<td>Year 3 Estimated Outcome Amount: $90,000</td>
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<tr>
<td>Year 4 Estimated Outcome Amount: $90,000</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $184,702</td>
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<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $364,704</td>
</tr>
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</table>
Title of Outcome Measure (Improvement Target): IT-9.1 Decrease mental health admissions to criminal justice settings

Unique RHP outcome identification number(s): 094118902.3.1
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-9.1 Decrease mental health admissions to the criminal justice settings for those receiving intensive outpatient treatments in this program

Process Milestones:
- DY 2: P-1 Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 Establish baseline rates; P-4 Conduct PDSA

Outcome Improvement Target:
- DY4: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- DY5: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Rationale:
Victoria County has no intensive outpatient services for people with behavioral health disorders. Gulf Bend Mental Health Center in Victoria, Texas, has a multitude of vigorous programs for people of all ages with a wide variety of diagnoses, but none of these include intensive outpatient treatment that can support a person several hours a day, multiple days a week. Without this community resource, the behavioral patient uses inappropriate resources including emergency departments, inpatient hospitalization for psychiatric diagnoses and/or acute care episodes for conditions concomitant to the behavior disorder, and the Criminal Justice System. Hospitals are taxed with prolonged, expensive, labor-intensive responsibilities for the mentally ill patient who is boarded in ED until placement can be secured. This adversely affects the behavior disordered patient as well as the rest of the ED patients who are denied the time and full attention of the ED staff. The result is increased likelihood of mistakes and a decreased quality of care for all. The use of ED by the behavioral health patient has continued to rise over the past ten-years. Data reveals this type patient uses ED numerous times a year and has multiple hospitalizations compared to patients without psychiatric disorders. In Victoria a behavioral health client who leaves jail or an inpatient psychiatric setting has no intensive resource to help transition the patient back to a normal pattern. Suicide risk is greater on a psychiatric patient just released from jail and close monitoring is beneficial to prevent harm. An IOP is necessary in our county to keep this population of our community in a state of better health.

P-1 was chosen as a process milestone because of the need for a program with extended operating hours for this population. Without a program in this area, people needing this service are using inappropriate settings of jail or ED. This program will be operated during normal business hours as well as later in the day so that those who are employed will have access to this care. P-4 Milestone of having trained staff was chosen because of the difficulty obtaining trained personnel in this rural area, especially psychiatry, psychiatric trained mid-level nurse, and therapy staff. P-6 was chosen because
this community does not have a similar program. Conventional outpatient approaches after a patient is released from a psychiatric inpatient hospitalization does not meet the needs of people transitioning back into the community. Patients whose conditions become tenuous also have no intensive resources. This will fill the gap of them having no alternative to intensive attention that can maintain them outside of jail or a hospital.

**Outcome Measure Valuation:**
Research demonstrates the high costs of care for the behavioral health client. Nineteen percent of this population have a criminal background and will require incarceration at an average cost of $10,960. At least 50% of those with one jail stay will require re-entry at a later date and subsequent admissions are often due to inadequate treatment and rehabilitation resources in the community. For those 50% who are readmitted the cost in the criminal justice system is almost $22,000 per year. There are numerous entry points to jail and inappropriate use of ED and/or inpatient hospitalizations are two of these. According to AHRQ the number of patients with mental health and substance abuse conditions treated in EDs has been on the rise for more than a decade. Currently one of every eight ED visits involves people with a mental disorder (AHRQ). Of those who have ED encounters 37% will be hospitalized at a cost of $927 a day for an average of 12 days or $11,124 per hospitalization.

This IOP will open in the 2nd Quarter of 2013 with the purpose of reducing these ED, Jail, and inpatient episodes. In 2013 the IOP will serve 52 unique patients. This number will increase every year with 78 clients in DY3, 98 clients in DY4, 104 patients in DY5 for a total of 332 unique patients. Data reveals that 19% of the population with mental disorders has a criminal history, thus we would expect 64 of these clients to have one jail experience at a cost of $10,960 each and half of them, or 32, to return for a second incarceration at a similar cost. However, with enrollment in an IOP this rate is reduced to 87% saving 55 initial jail encounters that would occur without the program through DY2-DY5. Because there is an expected 37% admission rate it will also save 62 admissions through DY5.
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<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Process Milestone P-1**
Project planning – engage stakeholders, identify capacity and needed resources determine timeliness and document implementation plans.

**Baseline/Goal:** No project plan developed/Project plan completed

**Data Source:** Performing Provider evidence of innovative plan.

**Process Milestone 1 Estimated Incentive Payment:** $213,520

**Process Milestone P-2** Establish baseline rates

**Baseline/Goal:** 0/Baseline rate established for number of mental health admissions and readmissions to criminal justice settings in the target population

**Data Source:** Claims and related data

**Process Milestone 2 Estimated Incentive Payment:** $320,280

**Outcome Improvement Target 1**
**[IT-9.1]** Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

**Baseline/Goal:** DY3 baseline is 13% decrease and this will increase to a 16% decrease in admissions and readmissions to criminal justice settings

**Data Source:** Medical records, criminal justice records, EHR, claims

**Estimated Incentive Payment:** $408,677

**Outcome Improvement Target 3**

**Estimated Incentive Payment:** $436,542

**Outcome Improvement Target 2**
**[IT-9.1]** Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

**Baseline/Goal:** DY 4 baseline is 16% and this will increase to a 17% decrease in admissions and readmissions to criminal justice settings

**Data Source:** Medical records, criminal justice records, EHR, claims

**Estimated Incentive Payment:** $436,542

**Year 2 Estimated Outcome Amount:** $213,520

**Year 3 Estimated Outcome Amount:** $320,280

**Year 4 Estimated Outcome Amount:** $408,677

**Year 5 Estimated Outcome Amount:** $436,542

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,379,019
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 094118902.3.2
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-9.2 ED appropriate utilization – Reduce and/or avoid unnecessary emergency department use by providing intensive outpatient treatments in this program.

Process Milestones:
- DY 2: P-1 Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Outcome Improvement Targets:
- DY3: IT-9.2 ED appropriate utilization
- DY4: IT-9.2 ED appropriate utilization
- DY5: IT-9.2 ED appropriate utilization

Rationale:
Victoria County has no intensive outpatient services for people with behavioral health disorders. Gulf Bend Mental Health Center in Victoria, Texas, has a multitude of vigorous programs for people of all ages with a wide variety of diagnoses, but none of these include intensive outpatient treatment that can support a person several hours a day, multiple days a week. Without this community resource, the behavioral patient uses inappropriate resources including emergency departments, inpatient hospitalization for psychiatric diagnoses and/or acute care episodes for conditions concomitant to the behavior disorder, and the Criminal Justice System. Hospitals are taxed with prolonged, expensive, labor-intensive responsibilities for the mentally ill patient who is boarded in ED until placement can be secured. This adversely affects the behavior disordered patient as well as the rest of the ED patients who are denied the time and full attention of the ED staff. The result is increased likelihood of mistakes and a decreased quality of care for all. The use of ED by the behavioral health patient has continued to rise over the past ten-years. Data reveals this type patient uses ED numerous times a year and has multiple hospitalizations compared to patients without psychiatric disorders. In Victoria a behavioral health client who leaves jail or an inpatient psychiatric setting has no intensive resource to help transition the patient back to a normal pattern. Suicide risk is greater on a psychiatric patient just released from jail and close monitoring is beneficial to prevent harm. An IOP is necessary in our county to keep this population of our community in a state of better health.

P-1 was chosen as a process milestone because of the need for a program with extended operating hours for this population. Without a program in this area, people needing this service are using inappropriate settings of jail or ED. This program will be operated during normal business hours as well as later in the day so that those who are employed will have access to this care. P-4 Milestone of having trained staff was chosen because of the difficulty obtaining trained personnel in this rural area, especially psychiatry, psychiatric trained mid-level nurse, and therapy staff. P-6 was chosen because this community does not have a similar program. Conventional outpatient approaches after a patient
is released from a psychiatric inpatient hospitalization does not meet the needs of people transitioning back into the community. Patients whose conditions become tenuous also have no intensive resources. This will fill the gap of them having no alternative to intensive attention that can maintain them outside of jail or a hospital.

**Outcome Measure Valuation:**
In 2012 Victoria County had 315 ED visits clearly identified with the purpose of the visit to address behavioral health issues. Data shows 37% of the patients who come to ED for a behavioral disorder will be hospitalized – either for psychiatric hospitalization or acute care for a medical condition that often accompanies the mental health illness. The average cost of an ED visit for the psychiatric patient is $986. AHRQ notes that most behavioral patients will visit an ED multiple times a year and be hospitalized on multiple occasions. The cost of a hospitalization for a medical condition that is related to behavioral health is $6,280 to $15,000 per stay. AHRQ data shows one in eight ED visits relates to behavioral health. The burden is not just financial. Because of the intensity of this patient who often requires close monitoring and prolonged stays, the quality of care goes down for all ED patients.

This IOP will provide the support, treatment, and management needed by the behavioral health patient to reduce ED visits and the predicted 37% hospitalization rate. Twenty-five percent of the ED visits for patients in the IOP who would be expected to use this service will be eliminated. This equates to more than 160 avoided first time and subsequent ED visits by these patients. There will also be 62 fewer hospitalizations because these patients will not need to enter ER where they will be triaged to inpatient status.
<table>
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<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
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<td><strong>Baseline/Goal</strong>: No project plan developed/project plan completed</td>
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<td><strong>Data Source</strong>: Performing Provider evidence of innovative plan.</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)</strong>: $583,224</td>
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**Title of Outcome Measure (Improvement Target):** IT-3.3 Reduce potentially unnecessary diabetes readmissions

**Unique RHP outcome identification number(s):** 094118902.3.3

**Performing Provider/TPI:** DeTar Healthcare System/094118902

**Outcome Measure Description:**
IT-3.3 Diabetes 30 day readmission rate - Reduce the number of readmissions for patients 18-years or older for any cause, within 30 days of discharge, from the index diabetes admission. If an index admission has more than 1 readmission only the first is counted as a readmission.

**Process Milestones:**

**DY 2:**
- P-1 Complete planning, building program and location for five clinics in rural areas that will provide a chronic care like model for patients with chronic diseases. The goal is to have two of these clinics opened by the end of DY2. A modified chronic care model will be offered in these clinics.

**Outcome Improvement Target(s) for each year:**
- **DY 2 thru DY 5:** IT-3.3 Diabetes 30 day readmission rate

**Rationale:**
We will implement a program that provides management for chronic disease that involves collaboration from a multidisciplinary team. By educating, involving the patient/support in disease management, scheduling evidence based follow-up practices, and facilitating compliance, unnecessary admissions to a hospital will be avoided for those patients with this chronic disease enrolled in our program. The clinics will be in rural areas where this type of approach and ongoing case management is not always available. Research shows diabetes is one of the chronic illnesses that often require readmission, and this is a prevalent disease in these areas.

According to the State of Texas Comptroller Office there is a higher prevalence of obesity and diabetes in South Texas than in the rest of Texas or the nation. Obesity, which can lead to diabetes, is the most prevalent condition and diabetes ranks second. Hispanics have a higher prevalence of obesity and diabetes, and the long-term health complications include heart disease, stroke vascular disease, blindness, kidney disease, nerve damage and amputations. There are a large number of hospital admissions related to diabetes, and the incidence of end stage renal disease related to diabetes grow at 3% per year (Society of Nephrology). Management of this disease requires testing equipment, medications and supplies that are sometimes not affordable for the indigent patient. These clinics will assist the patient in obtaining needed resources. The program will focus teaching and providing support to the patient for self-management by providing education, referral networks, health care resources, and access to regular medical care. Because of our expertise in the area of diabetes care we have many resources we can take to the communities we will serve.
Improvement Measure 3.3 will allow us to bring a chronic disease management program to the community where the patient lives. We will track the effectiveness of the program, maintain data, and share successful interventions and outcomes with other clinics we establish as well as community partners in this project. DSHS data from 2010 shows in 2010 the cost of readmission was $10,389. Our goal is to reduce these readmissions from 25% (current rate) to 20% DY2 for the patients who use our clinics, to 15% DY3, 12% DY4 and 10% DY5.

Outcome Measure Valuation
The initial start-up costs of building out and implementing the programs will be $523,069 for the first year with the major expense being establishing the clinics. Adding locations and patients receiving the services would increase the cost of the service each year. The cost for implementing and growing this service over the four years has been estimated at $2,737,752.

There will be two clinics opened in DY2 and three additional clinics opened in DY3 – all in rural areas. The clinics will be open four hours/day Monday through Friday. The clinics will offer hands-on medical care, but also a program that develops patients and their supporters to be able to manage their care to maintain optimum health. This includes education on exercise, nutrition, medications, practices to keep diseases in check, and a way to reach someone promptly if there are questions or concerns about particular symptoms. By having a complete program it is estimated the current rate of readmissions, which is at 25%, will be reduced. Our goal is to reduce this to 20% in DY2, 15% in DY3; 12% in DY4; and 10% in DY5. From the baseline year of DY2 there will be a cumulative increase in the success of avoiding unnecessary readmissions. To illustrate, for every 100 patients in DY1 at a 25% readmission rate, 25 patients would be readmitted. This will diminish to 20 patients in DY2, 15 in DY3, 12 in DY4, and 10 in DY5. Based on readmissions in this geographical area and the number of patients anticipated to use the clinics described in this project the 5-year expected outcome will be 72 avoided readmissions for Congestive Heart Failure; 24 prevented re-admissions for diabetes issues; 24 prevented readmissions for myocardial infarction and 27 preventable readmissions for stroke. The valuation is based on $10,388.70 per readmission for DY2 and there is a 3% inflation factor added each subsequent year.

Related Improvement Categories:
3.2 Reduce potentially unnecessary CHF admissions
3.5 Reduce potentially unnecessary AMI admissions
3.7 Reduce potentially unnecessary Stroke admissions
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<th>IT-3.3</th>
<th>Reduce potentially unnecessary \textit{diabetes} readmissions</th>
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<tbody>
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**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:** Current rate of readmissions is 25%

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<th>Outcome Improvement Target 2 [IT-3.3]</th>
<th>Outcome Improvement Target 3 [IT-3.3]</th>
<th>Outcome Improvement Target 4 [IT-3.3]</th>
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<td>Year 2</td>
<td>Project planning – Engage stakeholders, identify current capacity and needed resources. Determine timelines and document implementation plans. <strong>Baseline/Goal:</strong> No project plan developed/Project plan completed. <strong>Data Source:</strong> Provider Plan</td>
<td><strong>Improvement Target:</strong> Reduce potentially unnecessary diabetes readmissions 5% for those patients with this chronic disease enrolled in our program <strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Improvement Target:</strong> Reduce potentially unnecessary diabetes readmissions 3% for those patients with this chronic disease enrolled in our program <strong>Baseline/Goal:</strong> Baseline is 15%. Goal is to reduce to 12%. This will save 5 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Improvement Target:</strong> Reduce potentially unnecessary diabetes readmissions 2% for those patients with this chronic disease enrolled in our program <strong>Baseline/Goal:</strong> Baseline is 12%. Goal is to reduce to 10%. This will save 3 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
</tr>
<tr>
<td>Year 3</td>
<td><strong>Baseline/Goal:</strong> Baseline is 25% readmission rate and goal is to reduce to 20%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Estimated Incentive Payment:</strong> $85,603</td>
<td><strong>Estimated Incentive Payment:</strong> $55,106</td>
<td><strong>Estimated Incentive Payment:</strong> $34,056</td>
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<td>Year 4</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 25% readmission rate and goal is to reduce to 20%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
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<tr>
<td>Year 5</td>
<td><strong>Baseline/Goal:</strong> Baseline is 25% readmission rate and goal is to reduce to 20%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
<td><strong>Baseline/Goal:</strong> Baseline is 20%. Goal is to reduce to 15%. This will save 8 readmissions for diabetes. <strong>Data Source:</strong> Claims, EHR</td>
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**Milestone 1 Estimated Incentive Payment (maximum amount):** $0

**Outcome Improvement Target 1 [IT-3.3]**

**Improvement Target:** Reduce potentially unnecessary diabetes readmissions 5% for those patients with this chronic disease enrolled in our program

**Baseline/Goal:** Baseline is 25% readmission rate and goal is to reduce to 20%. This will save 8 readmissions for diabetes.

**Data Source:** Claims, EHR

**Estimated Incentive Payment:** $83,110
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<td>Current rate of readmissions is 25%</td>
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<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
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<td>Year 2 Estimated Outcome Amount</td>
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</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td>Year 4 Estimated Outcome Amount: $55,106</td>
</tr>
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<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td>Year 5 Estimated Outcome Amount: $34,056</td>
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<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD <em>(add outcome amounts over DYS 2-5): $257,875</em></td>
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</tbody>
</table>

DeTar Healthcare System

RHP Plan for Region 4
Title of Outcome Measure (Improvement Target): IT-3.5 Reduce potentially unnecessary Myocardial Infarction readmissions

Unique RHP outcome identification number(s): 094118902.3.4

Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-3.5 Acute Myocardial infarction 30 day readmission rate - Reduce the number of readmissions for patients 18-years or older for any cause, within 30 days of discharge, from the index AMI admission. If an index admission has more than 1 readmission only the first is counted as a readmission.

Process Milestones:
DY 2:
- P-1 Complete planning, building program and location for five clinics in rural areas that will provide a chronic care like model for patients with chronic diseases. The goal is to have two of these clinics opened by the end of DY2. A modified chronic care model will be offered in these clinics.

Outcome Improvement Targets:
DY2 thru DYS:
- IT-3.5 Acute myocardial infarction 30 readmission rate

Rationale:
We will implement a program that provides management for chronic disease that involves collaboration from a multidisciplinary team. By educating, involving the patient/support in disease management, scheduling evidence based follow-up practices, and facilitating compliance, unnecessary admissions to a hospital will be avoided for those patients with this chronic disease enrolled in our program. The clinics will be in rural areas where this type of approach and ongoing case management is not always available. Research shows AMI is one of the chronic illnesses that often require readmission, and this is a prevalent disease in the areas where the clinics will be established. In a JAMA study it was learned that just under 14.5% of STEMI patients require readmission within the first 30 days. This has implications that reach beyond the heart since every hospitalization places a patient at risk for infections and other complications associated with inpatient care. DeTar is a Chest Pain accredited hospital and uses evidence based practices to assist patients in management of their disease. Our treatment record is demonstrated in the core measure reporting for AMI which always exceeds 99%. We have had an established cardiac rehabilitation program in place for over 25-years and have seen the success of patients avoiding future cardiac episodes once they have adopted exercise, nutrition, medication regimen, and checkup routines that are known to help maintain heart health. These clinics can bring this type of rehab, ongoing support and reinforcement, and improved heart health to the smaller communities where access is not currently available. Additionally DeTar is an accredited Chest Pain Center and involved with Mission Lifeline. We have intensified our processes over the past 4-years to reduce reperfusion time to as low as 24 minutes if the patient presents to our own E.D. and as low as 64 minutes if they come from
hospitals up to 25-miles away. By having our own clinics in these areas it is more opportunity to teach the Early Heart Attack Symptoms, have a presence in schools to teach young children the practices that will keep their heart healthy and present to women in each community the special considerations and health practices that are unique to women with cardiac disease.

Improvement Measure 3.5 will allow us to bring a chronic disease management program to the community where the patient lives, preventing travel and allowing care to be administered by local providers whom they know and trust. We will track the effectiveness of the program, maintain data, and share successful interventions and outcomes with other clinics we establish as well as community partners in this project. DSHS data from 2010 shows in 2010 the cost of readmission was $10,389. Our goal is to reduce these readmissions from 25% (current rate) to 20% DY2 for the patients who use our clinics, to 15% DY3, 12% DY4 and 10% DY5.

**Outcome Measure Valuation**
The initial start-up costs of building out and implementing the clinics will be $523,069 for the first year with the major expense being establishing the clinics. Adding locations and patients receiving the services would increase the cost of the service each year. The cost for implementing and growing this service over the four years has been estimated at $2,737,752. There will be two clinics opened four hours/day in DY2 for each clinic and three additional clinics opened in DY3 four hours/day for each clinic – all in rural areas. The clinics will offer hands-on medical care, but also a program that develops patients and their supporters to be able to manage their care to maintain optimum health. This includes education on exercise, nutrition, medications, practices to keep diseases in check, and a way to reach someone promptly if there are questions or concerns about particular symptoms. By having a complete program it is estimated the current rate of readmissions, which is at 25%, will be reduced. Our goal is to reduce this to 20% in DY2, 15% in DY3; 12% in DY4; and 10% in DY 5. From the baseline year of DY1 there will be a cumulative increase in the success of avoiding unnecessary readmissions. To illustrate, for every 100 patients in DY1 at a 25% readmission rate, 25 patients would be readmitted. This will diminish to 20 patients in DY2, 15 in DY3, 12 in DY 4, and 10 in DY 5. Based on readmissions in this geographical area and the number of patients anticipated to use the clinics described in this project the 5-year expected outcome will be 72 avoided readmissions for Congestive Heart Failure; 24 prevented re-admissions for diabetes issues; 24 prevented readmissions for myocardial infarction and 27 preventable readmissions for stroke. The valuation is based on $10,388.70 per readmission for DY2 and there is a 3% inflation factor added each subsequent year.

**Related Improvement Categories:**
3.2 Reduce potentially unnecessary CHF admissions
3.3 Reduce potentially unnecessary Diabetic admissions
3.7 Reduce potentially unnecessary stroke admissions
### Related Category 3 Outcome Measure(s):
**Process Milestone P-1**
Project planning – Engage stakeholders, identify current capacity and needed resources. Determine timelines and document implementation plans.
**Baseline/Goal:** No project plan developed/Project plan completed

**Data Source:** Provider Plan

#### Milestone 1 Estimated Incentive Payment (maximum amount): $0

#### Outcome Improvement Target 1 [IT-3.5]
Reduce potentially unnecessary AMI readmissions 5% for those AMI patients in our program. **Baseline/Goal:** Baseline is 25%. Goal is to reduce to 20%. This will save 8 readmissions for patients who have had a myocardial infarction.

**Data Source:** Claims, EHR
**Estimated Incentive Payment:** $85,603

#### Year 2
<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% readmission rate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Outcome Improvement Target 2 [IT-3.5]
Reduce potentially unnecessary AMI readmissions 5% for those AMI patients in our program. **Baseline/Goal:** Baseline is 20%. Goal is to reduce to 15%. This will save an additional 8 readmissions for patients who have had a myocardial infarction.

**Data Source:** Claims, EHR
**Estimated Incentive Payment:** $55,106

#### Outcome Improvement Target 3 [IT-3.5]
Reduce potentially unnecessary AMI readmissions 3%. **Baseline/Goal:** Baseline is 15%. Goal is to reduce to 12% for those patients with this chronic disease enrolled in our program. This will save an additional 5 readmissions for patients who have had myocardial infarction.

**Data Source:** Claims, EHR
**Estimated Incentive Payment:** $83,110

#### Outcome Improvement Target 4 [IT-3.5]
Reduce potentially unnecessary AMI readmissions 2% for those patients with this chronic disease enrolled in our program. **Baseline/Goal:** Baseline is 12%. Goal is to reduce to 10%. This will save an additional 3 readmissions for patients who have suffered myocardial infarction.

**Data Source:** Claims, EHR
**Estimated Incentive Payment:** $34,056
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<tr>
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<th>IT-3.5</th>
<th>AMI 30 day readmission rate</th>
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<th>ESTIMATED OUTCOME AMOUNT</th>
<th>YEAR 4</th>
<th>ESTIMATED OUTCOME AMOUNT</th>
<th>YEAR 5</th>
<th>ESTIMATED OUTCOME AMOUNT</th>
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<td>Year 3 Estimated Outcome Amount: $85,603</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): **$257,875**
Title of Outcome Measure (Improvement Target): IT-3.7 Reduce potentially unnecessary Stroke (CVA) readmissions

Unique RHP outcome identification number(s): 094118902.3.5
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-3.7 Stroke 30 day readmission rate - Reduce the number of readmissions for patients 18-years or older for any cause, within 30 days of discharge, from the index CVA admission. If an index admission has more than 1 readmission only the first is counted as a readmission.

Process Milestones:
DY 2:
  • P-1 Complete planning, building program and location for five clinics in rural areas that will provide a chronic care like model for patients with chronic diseases. The goal is to have two of these clinics opened by the end of DY2. A modified chronic care model will be offered in these clinics.

Outcome Improvement Targets:
DY2 through DY5:
  • IT-3.7 Stroke (CVA) 30 day readmission rate

Rationale:
We will implement a program that provides management for chronic disease that involves collaboration from a multidisciplinary team. By educating, involving the patient/support in disease management, scheduling evidence based follow-up practices, and facilitating compliance, unnecessary admissions to a hospital will be avoided for those patients with this chronic disease enrolled in our program. The clinics will be in rural areas where this type of approach and ongoing case management is not always available. Research shows stroke is one of the chronic illnesses that often require readmission, and this is a prevalent disease in these areas. DeTar is Stroke Certified and has expertise in management of this disease as demonstrated by core measure compliance over 99%. According to CDC mortality from stroke is the leading cause of death in the United States and a leading cause of long term severe disability. Because the permanent effects of a stroke can limit thought processes, mobility, strength, and ability to complete activities of daily living, one component of this program will be education not just for clients enrolled but to share with the entire community. There has been success in teaching children how to recognize symptoms and what to do if they observe these in the adults around them. The clinic will have stroke educators/presenters available for community presentations at organizations in the area. The Clinic will take each person who has had stroke or TIA and work with them on the health changes they need to make to prevent future occurrences. The detailed education required for those on blood thinners will be provided. Assistance with navigation of the services the stroke victim will need will be facilitated and case management/social services offered as indicated in the individual treatment plan. Improvement Measure 3.7 will allow us to bring a chronic disease management program to the community where the patient lives. We will track the effectiveness of the program, maintain data, and share successful interventions and outcomes with other clinics we establish as well as community partners in this project. DSHS data from 2010 shows in 2010 the cost of readmission was $10,389.
Our goal is to reduce these readmissions from 25% (current rate) to 20% DY2 for the patients who use our clinics, to 15% DY3, 12% DY4 and 10% DY5.

**Outcome Measure Valuation**
The initial start-up costs of building out and implementing the clinics will be $523,069 for the first year with the major expense being establishing the clinics. Adding locations and patients receiving the services would increase the cost of the service each year. The cost for implementing and growing this service over the four years has been estimated at $2,737,752. There will be two clinics opened in DY2 for four hours/day/clinic and three additional clinics opened in DY3 for four hours/day/clinic – all in rural areas. The clinics will offer hands-on medical care, but also a program that develops patients and their supporters to be able to manage their care to maintain optimum health. This includes education on exercise, nutrition, medications, practices to keep diseases in check, and a way to reach someone promptly if there are questions or concerns about particular symptoms. By having a complete program it is estimated the current rate of readmissions, which is at 25%, will be reduced. Our goal is to reduce this to 20% in DY2, 15% in DY3; 12% in DY4; and 10% in DY 5. From the baseline year of DY1 there will be a cumulative increase in the success of avoiding unnecessary readmissions. To illustrate, for every 100 patients in DY1 at a 25% readmission rate, 25 patients would be readmitted. This will diminish to 20 patients in DY2, 15 in DY3, 12 in DY 4, and 10 in DY 5. Based on readmissions in this geographical area and the number of patients anticipated to use the clinics described in this project the 5-year expected outcome will be 72 avoided readmissions for Congestive Heart Failure; 24 prevented re-admissions for diabetes issues; 24 prevented readmissions for myocardial infarction and 27 preventable readmissions for stroke. The valuation is based on $10,388.70 per readmission for DY2 and there is a 3% inflation factor added each subsequent year.

**Related Improvement Categories:**
3.2 Reduce potentially unnecessary CHF admissions
3.5 Reduce potentially unnecessary AMI admissions
3.3 Reduce potentially unnecessary diabetes admissions
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>094118902.2.1</th>
<th>094118902</th>
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<tbody>
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<td>25% readmission rate</td>
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<td><strong>Process Milestone P-1</strong></td>
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<td>Project planning – Engage</td>
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<td>Determine timelines and document</td>
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<tr>
<td><strong>Improvement Target:</strong></td>
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<td>Reduce potentially unnecessary CVA readmissions 5% for those patients with this chronic disease enrolled in our program.</td>
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<tr>
<td><strong>Baseline/Goal:</strong></td>
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<td>Baseline is 20%. Goal is to reduce to 15%. This will save nine readmissions for stroke from reoccurring in DY3.</td>
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<td><strong>Improvement Target:</strong></td>
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<td>Reduce potentially unnecessary CVA readmissions 3% for those patients with this chronic disease enrolled in our program.</td>
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<td><strong>Baseline/Goal:</strong></td>
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<td>Baseline is 15%. Goal is to reduce to 12%. This will save an additional 5 strokes from reoccurring in DY4.</td>
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<td><strong>Data Source:</strong></td>
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<td><strong>Baseline/Goal:</strong></td>
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<td>Baseline is 12%. Goal is to reduce to 10%. This will save an additional 4 readmissions from occurring in DY5.</td>
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<td><strong>Data Source:</strong></td>
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<td><strong>Baseline/Goal:</strong></td>
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<td>Baseline is 12%. Goal is to reduce to 10%. This will save an additional 4 readmissions from occurring in DY5.</td>
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<td>Year 4</td>
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<td>YEAR 2 ESTIMATED OUTCOME AMOUNT</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $290,316**
Title of Outcome Measure (Improvement Target): IT-3.2 Reduce potentially unnecessary CHF readmissions
Unique RHP outcome identification number(s): 094118902.3.6
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-3.2 Congestive Heart Failure 30 day readmission rate - Reduce the number of readmissions for patients 18-years or older for any cause, within 30 days of discharge, from the index CHF admission. If an index admission has more than 1 readmission only the first is counted as a readmission.

Process Milestones:
DY 2:
• P-1 Complete planning, building program and location for five clinics in rural areas that will provide a chronic care like model for patients with chronic diseases. The goal is to have two of these clinics opened by the end of DY2. A modified chronic care model will be offered in these clinics.

Outcome Improvement Targets:
DY2 through DY5:
• IT – 3.2 Congestive Heart Failure readmission rate

Rationale:
We will implement a program that provides management for chronic disease that involves collaboration from a multidisciplinary team. By educating, involving the patient/support in disease management, scheduling evidence based follow-up practices, and facilitating compliance, unnecessary admissions to a hospital will be avoided for those patients with this chronic disease enrolled in our program. The clinics will be in rural areas where this type of approach and ongoing case management is not always available. Research shows CHF is one of the chronic illnesses that often require readmission, and this is a prevalent disease in these areas. DeTar is a Bronze Award recipient from American Heart Association and has employed practices to best manage CHF. Core measure compliance is seldom less than 100%. In this area CHF is one of the most prevalent conditions seen in Victoria County hospitals. Post-hospital management must be precise to avoid re-admissions. The coordination of diet, weight management, exercise, proper medications, and knowing what symptoms to look for is critical to keep the CHF patient from requiring inpatient care. Quite often the symptoms become critical quickly and patients use both ED and inpatient services. The literature shows the most effective methods of preventing readmissions must include face-to-face patient contact at least once a month, care coordination to assure the CHF patient has access to all providers at the proper times, patient education about the disease, symptom recognition, and self-monitoring and medication management. All of these will be incorporated into the chronic care management clinics. There will be particular focus on the newly discharged patient to get a face-to-face encounter within a week to assure understanding of discharge instructions, that
there were no barriers to getting the medications and equipment recommended, and teach the monitoring activities the patient and/or his supporters need to implement.

Improvement Measure 3.2 will allow us to bring a chronic disease management program to the community where the patient lives. We will track the effectiveness of the program, maintain data, and share successful interventions and outcomes with other clinics we establish as well as community partners in this project. DSHS data from 2010 shows in 2010 the cost of readmission was $10,389. Our goal is to reduce these readmissions from 25% (current rate) to 20% DY2 for the patients who use our clinics, to 15% DY3, 12% DY4 and 10% DY5.

**Outcome Measure Valuation**
The initial start-up costs of building out and implementing the clinics will be $523,069 for the first year with the major expense being establishing the clinics. Adding locations and patients receiving the services would increase the cost of the service each year. The cost for implementing and growing this service over the four years has been estimated at $2,737,752. There will be two clinics opened in DY2 for four hours/day/clinic and three additional clinics opened in DY3 for four hours/day/clinic – all in rural areas. The clinics will offer hands-on medical care, but also a program that develops patients and their supporters to be able to manage their care to maintain optimum health. This includes education on exercise, nutrition, medications, practices to keep diseases in check, and a way to reach someone promptly if there are questions or concerns about particular symptoms. By having a complete program it is estimated the current rate of readmissions, which is at 25%, will be reduced. Our goal is to reduce this to 20% in DY2, 15% in DY3; 12% in DY4; and 10% in DY 5. From the baseline year of DY1 there will be a cumulative increase in the success of avoiding unnecessary readmissions. To illustrate, for every 100 patients in DY1 at a 25% readmission rate, 25 patients would be readmitted. This will diminish to 20 patients in DY2, 15 in DY3, 12 in DY 4, and 10 in DY 5. Based on readmissions in this geographical area and the number of patients anticipated to use the clinics described in this project the 5-year expected outcome will be 72 avoided readmissions for Congestive Heart Failure; 24 prevented re-admissions for diabetes issues; 24 prevented readmissions for myocardial infarction and 27 preventable readmissions for stroke. The valuation is based on $10,388.70 per readmission for DY2 and there is a 3% inflation factor added each subsequent year.

**Related Improvement Categories:**
3.3 Reduce potentially unnecessary Diabetes admissions
3.5 Reduce potentially unnecessary AMI admissions
3.7 Reduce potentially unnecessary Stroke admissions
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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| **Process Milestone P-1**      | **Outcome Improvement Target 2 [IT-3.2]** Reduce potentially unnecessary CHF readmissions 5% for those patients with this chronic disease enrolled in our program | **Outcome Improvement Target 3 [IT-3.2]** Reduce potentially unnecessary CHF readmissions 3% for those patients with this chronic disease enrolled in our program | **Outcome Improvement Target 4 [IT-3.2]** Reduce potentially unnecessary CHF readmissions 2%  
**Baseline/Goal:** Baseline is 12%. Goal is to reduce to 10% for those patients with this chronic disease enrolled in our program  
**Data Source:** Claims, EHR  
**Estimated Incentive Payment:** $113,520 |
| Project planning – Engage stakeholders, identify current capacity and needed resources. Determine timelines and document implementation plans.  
**Baseline/Goal** No project plan developed/Project plan completed  
**Data Source:** Provider Plan  
Milestone 1 Estimated Incentive Payment (maximum amount): $0 | **Baseline/Goal:** Baseline is 20%. Goal is to reduce to 15%. This will save 24 readmissions in DY3 related to CHF.  
**Data Source:** Claims, EHR  
**Estimated Incentive Payment:** $256,809 | **Baseline/Goal:** Baseline is 15%. Goal is to reduce to 12%. This will save 14 readmissions in DY4 related to CHF.  
**Data Source:** Claims, EHR  
**Estimated Incentive Payment:** $154,299 |
| **Outcome Improvement Target 1 [IT-3.2]** Improvement Target: Reduce potentially unnecessary CHF readmissions 5% for those patients with this chronic disease enrolled in our program.  
**Baseline/Goal:** Baseline is 25%. Goal is to reduce to 20%. This will be a savings of 24 readmissions for CHF.  
**Data Source:** Claims, EHR  
**Estimated Incentive Payment:** $249,329 | **Year 3 Estimated Outcome Amount:** $256,809 | **Year 4 Estimated Outcome Amount:** $154,299 | **Year 5 Estimated Outcome Amount:** $113,520 |
| **Year 2 Estimated Outcome Amount** $249,329 | | | |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5): $773,957** | | | |
Title of Outcome Measure (Improvement Target): IT-8.1 Timeliness of Prenatal/Postnatal Care
Unique RHP outcome identification number(s): 094118902.3.7
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-8.1 Timeliness of Prenatal/Postnatal Care - Deliveries of live births for women receiving the following facets of prenatal and postpartum care: Prenatal Rate 1: Received prenatal care visit in clinic within the first trimester or within 42 days of enrollment Rate 2: Had postpartum visit for pelvic exam or postpartum care between 21 and 56 days post-delivery.

Process Milestones:
- DY 2: P-1 Project planning, documentation, timelines and implementation will occur
- DY3: P-3 Establish baseline

Outcome Improvement Targets:
- DY 3 – DY 5: IT-8.1 Timeliness of prenatal/postnatal care
Women enrolled in the established maternity clinics with have timeliness of care with live-birth deliveries. By taking prenatal clinics to rural areas where care is convenient, insurance qualification is not a restriction, and a follow-up program is established timely care can be delivered. As a result there will be fewer pre-term infants born to this population.

Rationale:
We will move prenatal care to rural communities so that care is convenient to mothers in underserved areas. The program will encompass healthy lifestyle during pregnancy related to diet, not smoking, exercise, and immunizations. It will also encourage and teach benefits of exclusive breastfeeding to infants. There will be a monitoring program to assure women are compliant with appointments. Pre-term births can lead to non-viable or low-weight infants. The cost of neonatal intensive care is expensive and hard for the infant and parents. Evidence shows that women who receive pre-natal care are less likely to have a pre-term infant.

Improvement Measure IT-8.1 will allow us to serve women regardless of location, provide education, and reduce the number of low birth weight babies. The goal of DY 2 is to serve 150, women in these clinics, 180 DY3, 210 DY4 and 240 DY5. We will reduce pre-term deliveries amongst enrollees by 1% DY2, additional 1% in DY3, DY4, and DY5. Reductions in pre-term deliveries will bring savings of $37,350 per additional full-term delivery

Outcome Measure Valuation:
This project will enhance maternal and infant care in multiple communities. The Center for Healthcare Research and Transformation reports premature babies use $41,681 per year in medical costs vs. $4,331 per year for a full term newborn. The initial startup costs of building out and implementing these 5 clinics will be $387,769 for the first year. Adding patients receiving the services would increase the cost each year. The costs for implementing and growing this service over the four years are estimated at $1,445,249.
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<tbody>
<tr>
<td><strong>Process planning</strong></td>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: plan documentation. Baseline/Goal: N/A. Data Source: Plan documents.</td>
<td><strong>Process Milestone 2</strong> P-2 Establish baseline. Metric: Baseline Baseline/Goal: TBD Data Sources: Claims, EHR</td>
<td><strong>Outcome Improvement Target 1 [IT-8.1]</strong> Timeliness of Prenatal and postpartum care. Baseline/Goal: TBD/ 50% of women in target population will have visit in 1st trimester and 50% will have postpartum visit between 21 and 56 days of delivery Data Source: EHR, Claims Estimated Incentive Payment: $75,000</td>
<td><strong>Outcome Improvement Target 2: [IT-8.1]</strong> Timeliness of Prenatal and postpartum care. Baseline/Goal: DY 3 baseline/ 60% of women in clinics will have visit in 1st trimester and 60% will have postpartum visit between 21 and 56 days of delivery Data Source: EHR/Claims Estimated Incentive Payment: $112,500</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong> $37,500</td>
<td><strong>Outcome Improvement Target 1 [IT-8.1]</strong> Timeliness of Prenatal and postpartum care. Baseline/Goal: TBD/ 50% of women in target population will have visit in 1st trimester and 50% will have postpartum visit between 21 and 56 days of delivery Data Source: EHR, Claims Estimated Incentive Payment: $75,000</td>
<td><strong>Outcome Improvement Target 2: [IT-8.1]</strong> Timeliness of Prenatal and postpartum care. Baseline/Goal: DY 3 baseline/ 60% of women in clinics will have visit in 1st trimester and 60% will have postpartum visit between 21 and 56 days of delivery Data Source: EHR/Claims Estimated Incentive Payment: $112,500</td>
<td><strong>Outcome Improvement Target 3: [IT-8-1]</strong> Timeliness of Prenatal and postpartum care. Baseline/Goal: DY 3 baseline/ 75% of women in clinics will have visit in 1st trimester and 80% will have postpartum visit between 21 and 56 days of delivery Data Source: EHR/Claims Estimated Incentive Payment: $187,500</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $37,500</td>
<td>Year 3 Estimated Outcome Amount: $75,000</td>
<td>Year 4 Estimated Outcome Amount: $112,500</td>
<td>Year 5 Estimated Outcome Amount: $187,500</td>
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<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $412,500</td>
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</table>
Title of Outcome Measure (Improvement Target): IT-8.2 Percentage of low birth-weight births - Reduction in Low Birth Weight or pre-term infants

Unique RHP outcome identification number(s): 094118902.3.8
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description:
IT-8.2 Percentage of low birth-weight births - Reduction in Low Birth Weight or pre-term infants

Process Milestones:
DY2: P-1 Project planning, documentation and timelines
DY3: P-2 Establish baseline

Outcome Improvement Targets:
DY 3 – DY 5: IT-8.2 Percentage of low birth-weight births

Women enrolled in the established maternity clinics with have timeliness of care with live-birth deliveries. By taking prenatal clinics to rural areas where care is convenient, insurance qualification is not a restriction, and a follow-up program is established timely care can be delivered. As a result there will be fewer pre-term infants born to this population.

Rationale:
We will move prenatal care to rural communities so that care is convenient to mothers in underserved areas. The program will encompass healthy lifestyle during pregnancy related to diet, not smoking, exercise, and immunizations. It will also encourage and teach benefits of exclusive breastfeeding to infants. There will be a monitoring program to assure women are compliant with appointments. Pre-term births can lead to non-viable or low-weight infants. The cost of neonatal intensive care is expensive and hard for the infant and parents. Evidence shows that women who receive pre-natal care are less likely to have a pre-term infant.

Improvement Measure 8-2 will allow timely prenatal care in the rural area where women do not have to travel to get early monitoring and treatment. The goal of DY 2 is to serve 150 women in these Clinics, 180 DY3, 210 DY4 and 240 DY5. We will reduce pre-term deliveries amongst enrollees by 1% DY2, additional 1% in DY3, DY4, and DY5. Reductions in pre-term deliveries will bring savings of $37,350 per additional full-term delivery

The initial startup costs of building out and implementing these 5 clinics will be $387,769 for the first year. Adding patients receiving the services would increase the cost each year. The costs for implementing and growing this service over the four years are estimated at $1,445,249.
**Outcome Measure Valuation:**
This project will enhance maternal and infant care in multiple communities. The Center for Healthcare Research & Transformation reports premature babies use $41,681 per year in medical costs vs. $2,100 a year for the full term infant. Our enrollment goal for DY 2 is that 60 women will be served in these prenatal clinics. Currently the pre-term birth rate in the affected counties is 13%. Because the clinic openings are in the fourth quarter, there will be 15 babies affected. Each of these will have $37,350 less in medical costs in the first year plus no neonatal ICU experience.
<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 P-1</strong></td>
<td>Process Milestone 2 P-2 Establish baseline. Metric: Baseline Baseline/Goal: TBD Data Sources: Claims, EHR</td>
<td>Outcome Improvement Target 3 [IT-8.2] Reduction in Low Birth Weight or Pre-term Infants. Babies born of mothers who were enrolled with the project prenatal clinic will exceed 2500 grams. Baseline/Goal: DY 2 baseline/ &lt;89% of the time Data Source: EHR, Claims Estimated Incentive Payment $112,500</td>
<td>Outcome Improvement Target 4 [IT-8.2] Reduction in Low Birth Weight or Pre-term Infants. Babies born of mothers who were enrolled with the project prenatal clinic will exceed 2500 grams. Baseline/Goal: DY 2 baseline/ &lt;91% of the time Data Source: EHR, Claims Estimated Incentive Payment $187,500</td>
</tr>
<tr>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric: plan documentation. Baseline/Goal: N/A. Data Source: Plan documents.</td>
<td><strong>Outcome Improvement Target 2[IT-8.2]</strong> Babies born of mothers who were enrolled with the project prenatal clinic will exceed 2500 grams. <strong>Numerator</strong>: Number of babies born weighing &lt;2500 Grams at birth <strong>Denominator</strong>: All births from clinic in same time period. Baseline/Goal: DY 2 baseline/ &lt;87% of the time Data Source: EHR, Claims Estimated Incentive Payment $75,000</td>
<td><strong>Year 2 Estimated Outcome Amount</strong>: (add incentive payments amounts from each milestone/outcome improvement target): $ 37,500 <strong>Year 3 Estimated Outcome Amount</strong>: $75,000 <strong>Year 4 Estimated Outcome Amount</strong>: $112,500 <strong>Year 5 Estimated Outcome Amount</strong>: $187,500</td>
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<tr>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>: $37,500</td>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $412,500
CATEGORY 3: Quality Improvements

Title of Outcome Measure (Improvement Target):
IT-14.6 Percent of trainees who have spent at least 5 years living in a HPSA or MUA.

Unique RHP outcome identification number: 094118902.3.9 (Pass 2)
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description
IT-14.6 will be defined as the number of residents we are able to recruit into this new residency training program who have spent at least five-years in a Health Provider Shortage Area or Medically Underserved area.

Victoria County Texas, as well as all of its surrounding counties, has been designated by Health Resources and Services Administration (HRSA) as a Medicaid underserved population. Because of the limited access to care by impoverished patients in this area, their care is more costly due to preventable use of Emergency Departments (ED) and potentially preventable inpatient hospitalizations. Without continuity of care by a primary care provider, especially for those with chronic conditions, the patients are not monitored on an on-going basis and their health conditions worsen. To address this lack of access to care, DeTar Healthcare System will establish a Family Medicine Residency program affiliated with Texas A&M Health Science Center College of Medicine (TAMHSC) that will add 6 residents per year and an additional three faculty positions to this Medicaid underserved area. We will have clinics established and staffed by the residents and physicians that are easily accessed and can address this absence of resources.

For inpatient care our Hospitalists usually receive and treat these unaligned patients who use ED as their vehicle for fragmented primary medical care. Over 50% of them have chronic illnesses that need to be managed—primarily diabetes, heart failure, CAD, kidney failure and chronic respiratory illness such as COPD. Often on Medicaid or not insured, they cannot access primary care because of the shortage of doctors who accept these patients. In Victoria County, almost 17% of the population lives below the poverty level. Upon discharge, follow-up care—especially for those with limited resources—often cannot be found. Because there are few outpatient resources with limited appointment ability these chronic conditions are not being managed. This sets up a cycle of treatment in the hospital by hospitalists when the untreated chronic condition reaches the crisis stage to having no resources for follow-up care to re-hospitalization because the condition again re-intensified.

The long term goal is to retain some of these residents in our geographical area after they complete training. Because Victoria County is rural, physician recruitment is difficult to achieve. Research done by the American Academy of Family Practice (AAFP) determined that in order to attract a doctor to a rural area it is important to consider the resident’s background. If the resident lived in a rural area and/or an underserved area, he/she is more likely to locate in a like area. The AAFP supports rural medical school training programs that encourage the physician to choose a rural practice. Their data shows practitioners with this background are more likely to stay in rural practice for a longer period of time. The fact that the residents will
train in a rural area is also a factor in the physician choosing this type of practice. Studies show they feel better prepared, both medically and socially, for practice in a rural area than those unaware of the special characteristics of a rural practice. Those who felt prepared for small-town living were over twice as likely to remain in rural practice at least six years. Rural physicians have a broader scope of practice and will need special training in emergencies, obstetrical, and surgical care to feel confident in their abilities to practice in these areas. DeTar has the opportunity to provide the residents these experiences in our smaller community that offers a variety of services. The residency program will have the characteristics that are needed for a doctor to be successful in rural practice. We will focus on attracting applicants with the backgrounds known to encourage the physician to remain in an underserved area and accept Medicaid patients.

This residence program will have faculty on board in DY2 and Medicaid patients who currently use ED as a care provider will have the family practice residency clinic as an alternative. The number of faculty and residents will continue to grow each year, and the number of visits will increase to 4000 patient visits in DY4 to 14,000 visits in DY5. There is a $223 difference in the cost of an ED visit compared to a doctor’s office visit, and this amount will be saved on every patient who uses the residency clinic rather than ED. In addition, because the patient will have regular medical care and treatment, there will be avoided hospitalizations.

**Process Milestones:**

- **DY2:** P-1 Project planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans.
- **DY3:** P-3 Develop and test data systems.

**Outcome Improvement Target for each year:**

- **DY4**
  - IT-14.6 Percent of trainees who have spent at least 5 years living in HPSA/MUA
    - Of the six residents who were admitted there will be one who lived 5 years in an HPSA or MUA
- **DY5**
  - IT-14.6 Percent of trainees who have spent at least 5 years living in HPSA/MUA
    - Of the new group of six residents admitted in DY5, two will have lived 5 years in an HPSA or MUA.

**Rationale:**
Process Milestones P1 and P3 were chosen due to lack of accurate reports and resources currently available to identify resources. We will collaborate with our community and educational partners to obtain accurate data and establish timelines. In DY3 we will implement a system that is twofold: It will track resident requirements, information, and performance and there will be a system for an electronic health record of those patients they treat. The latter will be accessible at all times by the professional staff from any location.
Improvement targets were placed in DY4 and 5 based on the time frame required to develop this program and have it operational. The Improvement Outcome of choosing residents who have lived in HPSA/MUA will help direct the selection committee that reviews applicants. The culture of rural practice in an underserved area that is open to all payor mixes, including Medicaid can be introduced from the beginning.

**Outcome Measure Valuation**

By DY4 and DY5 both faculty physicians and residents will be treating patients for outpatient disease management. These doctors will treat patients of all ages with a variety of needs. CDC reported in 2012 that ED use is most common for those with public health insurance who live outside a metropolitan area. One of the main reasons cited is lack of care from a provider. This is the situation in our area where physicians who accept Medicaid patients is limited. Thus 4.5% of our ED admissions this past 12-months have been Medicaid patients. An ED visit is costs $383 while the national average doctor’s office visit is approximately $60. (Blue Cross 2012). In the past 12 months DeTar had 9,244 Medicaid funded patients in our ED and 412 of these had to be hospitalized. An average hospitalization charge is $10,388.70 (DHSH).

In this valuation the variance in an ED/office visit is $223 for DY4, which is the year residents will enter our program (starting in July). Care in DY4 will be provided predominantly by the Program Director and faculty staff (1 FTE combined). They will provide 4,000 patient visits, and 25% of these will be Medicaid funded. This will prevent 300 Medicaid-funded ED visits that will be seen in the clinics for a $223 savings each ($66,900). With monitoring by primary care doctors it will also save 15 admissions valued at $10,388.70 ($155,831). Costs will inflate 3% for an ED/Hospitalization visit in DYS. Another faculty will be added and, in addition, the six residents will have clinic rotations one-third of their time. This increases primary care providers to 3.5, and these faculty/residents will create 14,000 clinic visits. Using the same ratio, 1,400 ED encounters by Medicaid recipients will be eliminated ($322,100) and 62 admissions per year ($663,400) will be prevented. These numbers will continue to grow in subsequent years by increasing residents and faculty one more year and then retaining graduates who will practice in this area because they meet the outcome measurements of coming from a rural background, staying in an HPSA or MUA, and taking Medicaid patients. This will perpetuate greater access to care for patients of all payor types. By instituting this program over a two year period, it will save a total of 79 potentially unnecessary admissions and 1700 unnecessary ED encounters. These patients will have continuity of care, a better life-style, and be better able to manage their diseases with increased access to care.

**Related Improvement Categories:**

IT-14.7 Percent of trainees who plan to practice in HPSA or MUA.

IT 14-8 Percent of residents who plan to accept Medicaid patients.
### Percent of trainees who have spent at least 5 years living in a HPSA/MUA

<table>
<thead>
<tr>
<th>DETAR HEALTHCARE SYSTEM</th>
<th>094118902.3.9</th>
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</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>094118902.1.2 Increase the number of residency/training programs</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>No residency program at baseline – 0% trainees</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Process Milestone 2 [P-3] Develop and test data systems.</td>
<td>Outcome Improvement Target 1 (IT 14.6)  History of living in HPSA. Improvement Target: Of the potential 6 residents who are admitted, one will have lived 5 years in a HPSA or MUA. Numerator: Number of residents admitted who lived 5 years in a rural setting. Denominator: Total number of residents. Data Source: Resident Records Baseline/Goal: Baseline is 0 and Goal is to have one resident who was from a rural background.</td>
<td>Outcome Improvement Target 2 Metric 1 [IT 14.6] History of living in HPSA. Improvement Target: Of the potential 6 new residents admitted, at least 2 will have lived 5 years in a HPSA or MUA. Numerator: Number of residents admitted who lived 5 years in a rural setting. Denominator: Total number of residents. Data Source: Resident Records Baseline/Goal: Baseline is 0 and goal is 2 of the residents admitted this cycle.</td>
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<tr>
<td>Data source: Documentation of Implementation plans or other performing provider reports. Process Milestone 1 Estimated Incentive Payment: $50,000</td>
<td>Data Source: Implemented full I/S system for residency tracking and EHR function Process Milestone 2 Estimated Incentive Payment $40,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $74,283</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $328,500</td>
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<td>Year 2 Estimated Outcome Amount: $50,000</td>
<td>Year 3 Estimated Outcome Amount: $40,000</td>
<td>Year 4 Estimated Outcome Amount: $74,283</td>
<td>Year 5 Estimated Outcome Amount: $328,500</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $492,783
**CATEGORY 3: Quality Improvements**

**Title of Outcome Measure (Improvement Target):**
IT-14.7 Percent of residents who plan to practice in a HPSA or MUA.

**Unique RHP outcome identification number:** 094118902.3.10 (Pass 2)
**Performing Provider/TPI:** DeTar Healthcare System/094118902

**Outcome Measure Description**
IT-14.7 will be defined as the number of residents who respond to survey during their training program here that they will plan to practice in a Health Provider Shortage Area or Medically Underserved area.

Victoria County Texas, as well as all of its surrounding counties, has been designated by Health Resources and Services Administration (HRSA) as a Medicaid underserved population. Because of the limited access to care by impoverished patients in this area, their care is more costly due to preventable use of Emergency Departments (ED) and potentially preventable inpatient hospitalizations. Without continuity of care by a primary care provider, especially for those with chronic conditions, the patients are not monitored on an on-going basis and their health conditions worsen. To address this lack of access to care, DeTar Healthcare System will establish a Family Medicine Residency program affiliated with Texas A&M Health Science Center College of Medicine (TAMHSC) that will add 6 residents per year and an additional three faculty positions to this Medicaid underserved area. We will have clinics established and staffed by the residents and physicians that are easily accessed and can address this absence of resources.

For inpatient care our Hospitalists usually receive and treat these unaligned patients who use ED as their vehicle for fragmented primary medical care. Over 50% of them have chronic illnesses that need to be managed—primarily diabetes, heart failure, CAD, kidney failure and chronic respiratory illness such as COPD. Often on Medicaid or not insured, they cannot access primary care because of the shortage of doctors who accept these patients. In Victoria County, almost 17% of the population lives below the poverty level. Upon discharge, follow-up care—especially for those with limited resources—often cannot be found. Because there are few outpatient resources with limited appointment ability these chronic conditions are not being managed. This sets up a cycle of treatment in the hospital by hospitalists when the untreated chronic condition reaches the crisis stage to having no resources for follow-up care to re-hospitalization because the condition again re-intensified.

The long term goal is to retain some of these residents in our geographical area after they complete training. Because Victoria County is rural, physician recruitment is difficult to achieve. Research done by the American Academy of Family Practice (AAFP) determined that in order to attract a doctor to a rural area it is important to consider the resident’s background. If the resident lived in a rural area and/or an underserved area, he/she is more likely to locate in a like area. The AAFP supports rural medical school training programs that encourage the physician to choose a rural practice. Their data shows practitioners with this background are
more likely to stay in rural practice for a longer period of time. The fact that the residents will train in a rural area is also a factor in the physician choosing this type of practice. Studies show they feel better prepared, both medically and socially, for practice in a rural area than those unaware of the special characteristics of a rural practice. Those who felt prepared for small-town living were over twice as likely to remain in rural practice at least six years. Rural physicians have a broader scope of practice and will need special training in emergencies, obstetrical, and surgical care to feel confident in their abilities to practice in these areas. DeTar has the opportunity to provide the residents these experiences in our smaller community that offers a variety of services. The residency program will have the characteristics that are needed for a doctor to be successful in rural practice. We will focus on attracting applicants with the backgrounds known to encourage the physician to remain in an underserved area and accept Medicaid patients. There will be a systematic survey of the residents to determine intention to practice in HPSA/MUA and acceptance of Medicaid patients.

This residence program will have faculty on board in DY2 and Medicaid patients who currently use ED as a care provider will have the family practice residency clinic as an alternative. The number of faculty and residents will continue to grow each year, and the number of visits will increase to 4000 patient visits in DY4 to 14,000 visits in DY5. There is a $223 difference in the cost of an ED visit compared to a doctor’s office visit, and this amount will be saved on every patient who uses the residency clinic rather than ED. In addition, because the patient will have regular medical care and treatment, there will be avoided hospitalizations.

Process Milestones:

- **DY2:** P-1 Project planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans.
- **DY3:** P-3 Develop and test data systems.

Outcome Improvement Target for each year:

- **DY4**
  - IT-14.7 Percent of trainees who plan to practice in a HPSA/MUA
    - Of the six residents at least one will state the intention to practice in an HPSA or MUA
- **DY5**
  - IT-14.7 Percent of trainees who plan to practice in a HPSA/MUA
    - Of the new group of six residents admitted in DY5, two will express an intention to practice in an HPSA or MUA.

Rationale:

Process Milestones P1 and P3 were chosen due to lack of accurate reports and resources currently available to identify resources. We will collaborate with our community and educational partners to obtain accurate data and establish timelines. In DY3 we will implement a system that is twofold: It will track resident requirements, information, and performance and there will be a system for an electronic health record of those patients they treat. The latter will be accessible at all times by the professional staff from any location.
Improvement targets were placed in DY4 and 5 based on the time frame required to develop this program and have it operational. The Improvement Outcome of residents stating a plan to practice in an HPSA/MUA will help direct the selection committee that reviews applicants. The culture of rural practice in an underserved area that is open to all payor mixes, including Medicaid can be introduced from the beginning.

**Outcome Measure Valuation**

By DY4 and DY5 both faculty physicians and residents will be treating patients for outpatient disease management. These doctors will treat patients of all ages with a variety of needs. CDC reported in 2012 that ED use is most common for those with public health insurance who live outside a metropolitan area. One of the main reasons cited is lack of care from a provider. This is the situation in our area where physicians who accept Medicaid patients is limited. Thus 4.5% of our ED admissions this past 12-months have been Medicaid patients. An ED visit is costs $383 while the national average doctor’s office visit is approximately $60. (Blue Cross 2012). In the past 12 months DeTar had 9,244 Medicaid funded patients in our ED and 412 of these had to be hospitalized. An average hospitalization charge is $10,388.70 (DHSH).

In this valuation the variance in an ED/office visit is $223 for DY4, which is the year residents will enter our program (starting in July). Care in DY4 will be provided predominantly by the Program Director and faculty staff (1 FTE combined). They will provide 4,000 patient visits, and 25% of these will be Medicaid funded. This will prevent 300 Medicaid-funded ED visits that will be seen in the clinics for a $223 savings each ($66,900). With monitoring by primary care doctors it will also save 15 admissions valued at $10,388.70 ($155,831). Costs will inflate 3% for an ED/Hospitalization visit in DY5. Another faculty will be added and, in addition, the six residents will have clinic rotations one-third of their time. This increases primary care providers to 3.5, and these faculty/residents will create 14,000 clinic visits. Using the same ratio, 1,400 ED encounters by Medicaid recipients will be eliminated ($322,100) and 62 admissions per year ($663,400) will be prevented. These numbers will continue to grow in subsequent years by increasing residents and faculty one more year and then retaining graduates who will practice in this area because they meet the outcome measurements of coming from a rural background, staying in an HPSA or MUA, and taking Medicaid patients. This will perpetuate greater access to care for patients of all payor types. By instituting this program over a two year period, it will save a total of 79 potentially unnecessary admissions and 1700 unnecessary ED encounters. These patients will have continuity of care, a better life-style, and be better able to manage their diseases with increased access to care.

**Related Improvement Categories:**

IT-14.6 Percent of trainees who lived at least 5 years in an HPSA or MUA.

IT 14-8 Percent of residents who plan to accept Medicaid patients.
## Category 3 Milestones and Metrics

<table>
<thead>
<tr>
<th>094118902-3.10</th>
<th>3. IT 14-7</th>
<th>Percent of trainees who report they plan to practice in HPSAs or MUAs</th>
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<tr>
<td>DETAR HEALTHCARE SYSTEM VICTORIA, TEXAS</td>
<td>0941189-02</td>
<td></td>
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</table>

**Related Category 1 or 2 Projects:**

094118902.1.2 Increase the number of residency/training programs

**Starting Point/Baseline:**

No residency program at baseline – 0% trainees

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems.</td>
<td><strong>Outcome Improvement Target 1 Metric 1:</strong> [IT-14.7]: Percent of trainees who plan to practice in HPSA or MUA. Improvement Target: Of the potential 6 residents who are admitted, one will state intent of practicing in HPSA or MUA.</td>
<td><strong>Outcome Improvement Target 2 Metric 1:</strong> [IT-14.7] Percent of trainees who plan to practice in HPSA or MUA. Improvement Target: Of the potential 6 residents who are admitted, this cycle 2 will state intent of practicing in HPSA or MUA.</td>
</tr>
<tr>
<td>Data Source: Documentation of Implementation plans or other performing provider reports.</td>
<td>Data Source: Implemented full I/S system for residency tracking and EHR function</td>
<td>Numerator: Number of residents who plan to practice in targeted area. Denominator: All residents</td>
<td>Numerator: Number of residents who plan to practice in targeted area. Denominator: All residents</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $50,000</td>
<td>Process Milestone 2 Estimated Incentive Payment: $40,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: 74,283</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $328,500.</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $50,000 | Year 3 Estimated Outcome Amount: $40,000 | Year 4 Estimated Outcome: $74,283 | Year 5 Estimated Outcome Amount: $328,500. |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $492,783
CATEGORY 3: Quality Improvements

Title of Outcome Measure (Improvement Target):
IT-14.8 Percent of residents who plan to accept Medicaid patients.

Unique RHP outcome identification number: 094118902.3.11 (Pass 2)
Performing Provider/TPI: DeTar Healthcare System/094118902

Outcome Measure Description
IT-14.8 will be defined as the number of residents who respond to survey during their training program here that they will plan to serve Medicaid patients.

Victoria County Texas, as well as all of its surrounding counties, has been designated by Health Resources and Services Administration (HRSA) as a Medicaid underserved population. Because of the limited access to care by impoverished patients in this area, their care is more costly due to preventable use of Emergency Departments (ED) and potentially preventable inpatient hospitalizations. Without continuity of care by a primary care provider, especially for those with chronic conditions, the patients are not monitored on an on-going basis and their health conditions worsen. To address this lack of access to care, DeTar Healthcare System will establish a Family Medicine Residency program affiliated with Texas A&M Health Science Center College of Medicine (TAMHSC) that will add 6 residents per year and an additional three faculty positions to this Medicaid underserved area. We will have clinics established and staffed by the residents and physicians that are easily accessed and can address this absence of resources.

For inpatient care our Hospitalists usually receive and treat these unaligned patients who use ED as their vehicle for fragmented primary medical care. Over 50% of them have chronic illnesses that need to be managed—primarily diabetes, heart failure, CAD, kidney failure and chronic respiratory illness such as COPD. Often on Medicaid or not insured, they cannot access primary care because of the shortage of doctors who accept these patients. In Victoria County, almost 17% of the population lives below the poverty level. Upon discharge, follow-up care—especially for those with limited resources—often cannot be found. Because there are few outpatient resources with limited appointment ability these chronic conditions are not being managed. This sets up a cycle of treatment in the hospital by hospitalists when the untreated chronic condition reaches the crisis stage to having no resources for follow-up care to re-hospitalization because the condition again re-intensified.

The long term goal is to retain some of these residents in our geographical area after they complete training. Because Victoria County is rural, physician recruitment is difficult to achieve. Research done by the American Academy of Family Practice (AAFP) determined that in order to attract a doctor to a rural area it is important to consider the resident’s background. If the resident lived in a rural area and/or an underserved area, he/she is more likely to locate in a like area. The AAFP supports rural medical school training programs that encourage the physician to choose a rural practice. Their data shows practitioners with this background are more likely to stay in rural practice for a longer period of time. The fact that the residents will
train in a rural area is also a factor in the physician choosing this type of practice. Studies show they feel better prepared, both medically and socially, for practice in a rural area than those unaware of the special characteristics of a rural practice. Those who felt prepared for small-town living were over twice as likely to remain in rural practice at least six years. Rural physicians have a broader scope of practice and will need special training in emergencies, obstetrical, and surgical care to feel confident in their abilities to practice in these areas. DeTar has the opportunity to provide the residents these experiences in our smaller community that offers a variety of services. The residency program will have the characteristics that are needed for a doctor to be successful in rural practice. We will focus on attracting applicants with the backgrounds known to encourage the physician to remain in an underserved area and accept Medicaid patients.

This residence program will have faculty on board in DY2 and Medicaid patients who currently use ED as a care provider will have the family practice residency clinic as an alternative. The number of faculty and residents will continue to grow each year, and the number of visits will increase to 4000 patient visits in DY4 to 14,000 visits in DY5. There is a $223 difference in the cost of an ED visit compared to a doctor’s office visit, and this amount will be saved on every patient who uses the residency clinic rather than ED. In addition, because the patient will have regular medical care and treatment, there will be avoided hospitalizations.

Process Milestones:
- **DY2:** P-1 Project planning – engage stakeholders, identify capacity and needed resources, determine timelines and document implementation plans.
- **DY3:** P-3 Develop and test data systems.

Outcome Improvement Target for each year:
- **DY4**
  - IT-14.8 Percent of trainees who plan to accept Medicaid patients.
    - Of the six residents at least one will state the intention to accept Medicaid patients in their practice.
- **DY5**
  - IT-14.8 Percent of trainees who plan to accept Medicaid patients.
    - Of the new group of six residents admitted in DY5, two will express an intention to accept Medicaid patients.

Rationale:
Process Milestones P1 and P3 were chosen due to lack of accurate reports and resources currently available to identify resources. We will collaborate with our community and educational partners to obtain accurate data and establish timelines. In DY3 we will implement a system that is twofold: It will track resident requirements, information, and performance and there will be a system for an electronic health record of those patients they treat. The latter will be accessible at all times by the professional staff from any location.

Improvement targets were placed in DY4 and 5 based on the time frame required to develop this program and have it operational. The Improvement Outcome of residents stating a plan to
accept Medicaid patients will help direct the selection committee that reviews applicants. The culture of rural practice in an underserved area that is open to all payor mixes, including Medicaid can be introduced from the beginning.

**Outcome Measure Valuation**

By DY4 and DY5 both faculty physicians and residents will be treating patients for outpatient disease management. These doctors will treat patients of all ages with a variety of needs. CDC reported in 2012 that ED use is most common for those with public health insurance who live outside a metropolitan area. One of the main reasons cited is lack of care from a provider. This is the situation in our area where physicians who accept Medicaid patients is limited. Thus 4.5% of our ED admissions this past 12-months have been Medicaid patients. An ED visit is costs $383 while the national average doctor’s office visit is approximately $60. (Blue Cross 2012). In the past 12 months DeTar had 9,244 Medicaid funded patients in our ED and 412 of these had to be hospitalized. An average hospitalization charge is $10,388.70 (DHSH).

In this valuation the variance in an ED/office visit is $223 for DY4, which is the year residents will enter our program (starting in July). Care in DY4 will be provided predominantly by the Program Director and faculty staff (1 FTE combined). They will provide 4,000 patient visits, and 25% of these will be Medicaid funded. This will prevent 300 Medicaid-funded ED visits that will be seen in the clinics for a $223 savings each ($66,900). With monitoring by primary care doctors it will also save 15 admissions valued at $10,388.70 ($155,831). Costs will inflate 3% for an ED/Hospitalization visit in DY5. Another faculty will be added and, in addition, the six residents will have clinic rotations one-third of their time. This increases primary care providers to 3.5, and these faculty/residents will create 14,000 clinic visits. Using the same ratio, 1,400 ED encounters by Medicaid recipients will be eliminated ($322,100) and 62 admissions per year ($663,400) will be prevented. These numbers will continue to grow in subsequent years by increasing residents and faculty one more year and then retaining graduates who will practice in this area because they meet the outcome measurements of coming from a rural background, staying in an HPSA or MUA, and taking Medicaid patients. This will perpetuate greater access to care for patients of all payor types. By instituting this program over a two year period, it will save a total of 79 potentially unnecessary admissions and 1700 unnecessary ED encounters. These patients will have continuity of care, a better life-style, and be better able to manage their diseases with increased access to care.

**Related Improvement Categories:**

IT-14.6  Percent of trainees who lived at least 5 years in an HPSA or MUA.
IT 14-7  Percent of residents who plan to practice in an HPSA or MUA.
### Category 3 Milestones and Metrics

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects</th>
<th>094118902.1.2 Increase the number of residency/training programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline</td>
<td>No residency program at baseline – 0% trainees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<td><strong>Process Milestone 2 [p-3]: Develop and test data systems.</strong></td>
<td><strong>Outcome Improvement Target 1 Metric 1 [IT 14.8]: % of trainees who plan to treat Medicaid patients.</strong></td>
<td><strong>Outcome Improvement Target 2 Metric 1: [IT 14.8] % of trainees who plan to accept Medicaid patients.</strong></td>
</tr>
<tr>
<td>Data source: Documentation of Implementation plans or other performing provider reports.</td>
<td>Data Source: Implemented full I/S system for residency tracking and EHR function</td>
<td>Numerator: Number of residents planning to accept Medicaid. Denominator: All residents Data Source: Survey Results Baseline/Goal: Baseline is 0 and Goal is to have one resident who states intention of accepting Medicaid patients.</td>
<td>Numerator: Number of residents who plan accept Medicaid patients Denominator: All residents Data Source: Survey Results Baseline/Goal: Baseline is 0, goal is to increase to 2 from group being admitted this year.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $50,000</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $492,783**
DSRIP Projects – CSAH: Category 3: Quality Improvements

1.1.2 - Expand existing primary care capacity

Outcome Domain 9: Right Care, Right Setting; Improvement Target 9.2: ED Appropriate Utilization (All ED visits)
CHRISTUS Spohn Alice Hospital (“CSAH”)/TPI 094222902
Project Unique ID Number: 094222902.3.1

Outcome Measure Overview:
Spohn intends to reduce misuse of the ED through its project to increase the existing capacity of the Freer Clinic. This outcome is important to reforming the delivery-system to result in improved patient outcomes and reduced systemic costs of providing care. Many patients present to the ED because they are unable to pay for treatment and believe that the ED is their only option. The expanded capacity of the Freer clinic, along with Spohn’s intent to educate the community about the new capacity is expected to result in fewer patients resorting to seeking treatment in the Spohn-Alice ED.

Process milestones: Spohn chose the DY2 and DY3 process milestones in order to establish infrastructure and current data in order to set the stage for improvement and the ability to measure the improvement.

Improvement targets: Spohn chose its DY4 and DY5 targets as reasonable goals for improvement that are within the realm of possibility after expanding the small Freer clinic. Spohn expects a 15% reduction in all ED visits by the end of the Waiver.

Rationale:
Review of ED admissions data shows a high volume of non-urgent/non-emergent visits to the ED at CSAH are from the Freer, TX areas and Duval County. The current clinic services were reduced in years past and reassessment of current volumes/provider are insufficient to increase the volume at the clinic and reduce non-urgent ED visits. By expanding services, hours and staffing, an increase in capacity/access will shift the burden of care from the ED at CSAH to the expanded FHC in Freer.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to Primary Care access to avoid PPA and inappropriate ED utilization. Hospital and ER admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.”
### 094222902.3.1

**Right Care, Right Setting: ED appropriate utilization, all ED visits**

**CHRISTUS Spohn Alice Hospital**

**094222902.1.1**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>094222902</th>
<th>094222902.1.1</th>
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</table>

#### Starting Point/Baseline:

- **In FY 2012, Total ED visits:** 29,000 (16,100 MCD/UI; 56%), 13,472 non-emergent visits from approximately 8,600 patients. 8,658 MCD/UI visits from approximately 5,500 patients were non-emergent (46%).

<table>
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<th>Year 4</th>
<th>Year 5</th>
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**Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will work with the clinical staff to create a plan for community outreach and patient education about the benefits of seeking primary care outside of the ED**

**Data Source:** Project plan documentation

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $15,811.50

**Process Milestone 2 [P-2]: Establish baseline rates – Spohn will determine the number of ED visits during DY2 and the percentage of non-emergent visits to its Alice hospital during 2012**

**Data Source:** Hospital admission data

**Process Milestone 2 Estimated Incentive Payment: $15,811.50**

**Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization**

- **Improvement Target:** Reduce ED visits to Spohn Alice hospital by 5% (674 visits) over DY2 baseline

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $36,655

**Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization**

- **Improvement Target:** Reduce ED visits to Spohn Alice hospital by 10% (1,347 visits) over DY2 baseline

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $58,819

**Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization**

- **Improvement Target:** Reduce ED visits to Spohn Alice hospital by 15% (2,000) over DY2 baseline

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $140,654
Right Care, Right Setting - ED appropriate utilization, all ED visits

CHRISTUS Spohn Alice Hospital 094222902

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>094222902.1.1</th>
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<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,623</td>
<td>Year 3 Estimated Outcome Amount: $36,655</td>
<td>Year 4 Estimated Outcome Amount: $58,819</td>
<td>Year 5 Estimated Outcome Amount: $140,654</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $267,752
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
CHRISTUS Spohn Alice Hospital/TPI 094222902
IT-3.2: Congestive Heart Failure 30 day readmission rate
Project unique ID number: 094222902.3.2

Outcome Measure Description
CHRISTUS Spohn Hospital Alice (“Spohn”) will measure the rate of 30 day readmissions (for any reason) to its hospital facilities upon discharge from an inpatient stay for Congestive Heart Failure (“CHF”), and projects the outcome of its disease registry project to be a reduction in its overall potentially preventable readmission rate for this target population. Potentially Preventable Readmissions (PPRs) often result from the fact that patients lack support, information, and access to continued care in the outpatient setting upon discharge. These patients are at risk for their conditions deteriorating when they are no longer monitored and managed in the hospital, which can lead to relapses/additional acute episodes/complications requiring readmission to an inpatient setting. The systemic cost of readmissions and negative impact on patient quality of life, satisfaction, and long-term outcomes makes this achieving an improvement in this domain a high priority for Spohn.

Process milestones:
- DY2: P-2 Establish a baseline of CHF 30 day readmission rates

Improvement milestones:
- DY3: Reduce CHF PPRs by 3% from baseline
- DY4: Reduce CHF PPRs by 5% from baseline
- DY5: Reduce CHF PPRs by 8% from baseline

Rationale:
According to Region 4’s Community Needs Assessment, Jim Wells County has a high incidence of potentially preventable hospitalization related to chronic diseases, including CHF (RHP Plan, Section 3, Table 10). Spohn chose this outcome measure to complement its disease registry project because one goal of the registry is to enable CHF patients to effectively manage their conditions and their overall health subsequent to discharge from an inpatient stay for CHF. Spohn expects to see evidence of a decrease in re-admission rates for this population as a result of (1) effective and efficient discharge planning while patients are in the hospital, (2) home visits within 48 hours of patients’ arrival home and (3) follow-up phone calls to ensure patients understand and have processed the education/information provided by Spohn.

Process milestones: During DYs 2-3, Spohn will establish a baseline rate of readmissions for its CHF patients in order to measure progress going forward, and will engage in project planning to create an effective approach to using the information in the registry to prevent readmissions for CHF patients within 30 days of discharge from an inpatient setting (including patient education, medication management, caregiver outreach, and timely follow up).
Improvement milestones: Spohn aims to reduce the percentage of 30 day readmissions for CHF patients by 5% under baseline in DY4, and by 8% under baseline in DY5. These targets were chosen to reflect reasonable but meaningful reforms in the CHF patient short-term outcomes and the cost of providing care to patients with this chronic disease.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to preventing unnecessary hospital readmissions for CHF patients. Hospital readmissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally they increase the systemic cost of providing care to indigent and uninsured patients in the community. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### 094222902.3.2

**3.IT-3.2**

**PPR – 30-day: CHF**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td><strong>CHRISTUS Spohn Hospital Alice</strong></td>
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<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong> Establish baseline rates – Spohn will determine the rate of 30 day readmissions for CHF patients at its Alice campus for all causes</td>
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</tr>
<tr>
<td><strong>Data Source:</strong> Historical clinic/hospital/ED claims and financial data</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment:</td>
<td>$31,623</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$31,623</td>
</tr>
</tbody>
</table>

| Year 3 | (10/1/2013 – 9/30/2014) |
| Outcome Improvement Target 1 [IT-3.1]: PPR  |
| **Improvement Target:** 3% reduction in all cause CHF patient 30-day readmission rates  |
| **Data Source:** Hospital admission records  |
| Outcome Improvement Target 1 Estimated Incentive Payment: | $36,655 |
| Year 3 Estimated Outcome Amount: | $36,655 |

| Year 4 | (10/1/2014 – 9/30/2015) |
| Outcome Improvement Target 2 [IT-3.1]: PPR  |
| **Improvement Target:** 5% reduction in all cause CHF patient 30-day readmission rates for Spohn’s Alice campus  |
| **Data Source:** Hospital admission records  |
| Outcome Improvement Target 2 Estimated Incentive Payment: | $58,819 |
| Year 4 Estimated Outcome Amount: | $58,819 |

| Year 5 | (10/1/2015 – 9/30/2016) |
| Outcome Improvement Target 3 [IT-3.1]: PPR  |
| **Improvement Target:** 8% reduction in CHF patient all cause 30-day readmission rates for Spohn’s Alice campus  |
| **Data Source:** Hospital admission records  |
| Outcome Improvement Target 3 Estimated Incentive Payment: | $140,654 |
| Year 5 Estimated Outcome Amount: | $140,654 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $267,751*
Category 3: Quality Improvement

Identifying Outcome Measure and Provider Information:
1.7.6 - Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

IT-1.11: Diabetes Care – Blood Pressure Control
CHRISTUS Spohn Hospital Alice / 094222902
Unique Identifier: 094222902.3.3

Outcome Measure Description
This project will target people at-risk and those with symptomatic yet untreated signs of PAD. Connecting regional PCPs, FHCs, FQHCs and Medical Homes to cardiovascular/vascular specialists will identify patients earlier in the disease process allowing for varying levels of treatment prior to amputation. Diabetic patients are often at risk for Peripheral Arterial Disease (PAD) and Spohn is implementing a Category 1 project to provide more screenings by cardiovascular specialists for this at-risk population using telemedicine. As a result, Spohn expects more patients to receive cautionary information, medication management, and follow-up when they are identified as having high-blood pressure (which can increase the risk and symptoms of PAD). By identifying patients with the potential to develop or with early signs of PAD, Spohn can provide those patients with medication to reduce blood pressure and prevent/alleviate PAD in many cases. Project implementation is projected to have the following outcomes by end of waiver period:
- 10% increase in diabetic patients seen in the Freer Clinic with controlled blood pressure (<140/80mm Hg)

Rationale:
Obesity, Diabetes-Type II, PAD, cardiovascular disease (CVD) and amputations have all been identified as prevalent in the Hispanic population in South Texas. This extremely at-risk population is in dire need of early screening, diagnostics and interventions to reduce the long-term complications of diabetes such as ulcerative or non-healing lesions, necrotic or gangrenous lower extremities and amputations. Diabetic patients with high-blood pressure will be at higher risk for developing PAD, as both conditions affect the patient’s blood flow to their extremities. In tandem with screening diabetes patients for PAD, Spohn clinics have a better chance of identifying and treating uncontrolled blood pressure, Spohn expects an increase in the number of diabetic patients with controlled blood pressure, which will reduce their risk of developing PAD.

Complacency, poor self-management and access to care are all shown to contribute to uncontrolled chronic disease. Implementation of a PAD screening program that extends screening to remote locations throughout the region using a telehealth screening solution would increase early detection for people at-risk and diagnostics and treatment during earlier stages of disease without the burden of appointment delays and multiple trips to specialists’ offices.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn
determined the value of this outcome by assessing the potential impact of controlling blood pressure in diabetic patients identified at high-risk for PAD and those currently experiencing symptoms such as pain and cramping to lower extremities. Controlling blood pressure will assist providers with prevention and enable a reduction in PAD-related hospital admissions that impact a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
**Diabetic Care – Blood Pressure Control**

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will develop an approach for identifying and treating diabetic patients with uncontrolled blood pressure, putting them at higher risk for PAD, in tandem with its project to use telemedicine to increase PAD screenings. <strong>Data Source:</strong> Project plan documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates – Spohn will assess the number of patients with diabetes who also suffer from uncontrolled blood pressure. <strong>Data Source:</strong> Project Plan documentation</td>
</tr>
<tr>
<td><strong>Process Milestone 3 [P-3]:</strong> Develop and test data systems - Spohn will assess the volume of information collected through PADnet and blood pressure screenings to assure that the information is broadly disseminated through its system and functioning properly. <strong>Data Source:</strong> Chronic disease registry</td>
</tr>
<tr>
<td><strong>Process Milestone 4 [P-4]:</strong> Conduct PDSA to improve project activities – Spohn will implement its screening protocol for PAD and treat patients with uncontrolled blood pressure, and then analyze the results, determining best practices and key remaining challenges. <strong>Data Source:</strong> Project evaluation documentation, assessment of expanded target population</td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1 [IT-1.11]:</strong> Diabetes care: BP control (&lt; 140/80mmHg) <strong>Improvement target:</strong> 10% increase in diabetic patients with controlled blood pressure over DY2 baseline <strong>Data Source:</strong> EHR, Claims</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Outcome Improvement Target 2 [IT-1.11]:</strong> Diabetes care: BP control (&lt; 140/80mmHg) <strong>Improvement target:</strong> 20% increase in diabetic patients with controlled blood pressure over DY2 baseline <strong>Data Source:</strong> EHR, Claims</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Incentive Payment (maximum amount):</th>
<th>$19,200</th>
<th>Year 3 Estimated Incentive Payment:</th>
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<tbody>
<tr>
<td>Year 4 Estimated Incentive Payment:</td>
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<td>Year 5 Estimated Incentive Payment:</td>
<td>$170,794</td>
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<tr>
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<th>$44,510</th>
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<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$71,423</td>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$170,794</td>
</tr>
<tr>
<td>09422902.3.3</td>
<td>3.IT-1.11</td>
<td>Diabetic Care – Blood Pressure Control</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------</td>
<td>---------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHRISTUS Spohn Hospital Alice</td>
<td>09422902</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>09422902.1.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Approximately 16% of the patients treated in the Freer Clinic are diabetic or pre-diabetic (approximately 700 patients), placing them at increased risk of PAD. Those diabetic patients with uncontrolled blood pressure (number not yet quantified) are at an even high risk of PAD and associated amputations.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5): $325,127</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10- Other outcome improvement targets – Errors in Bedside Medication Administration
CHRISTUS Spohn Hospital Alice / TPI: 09422902
Unique Identifier -09422902.3.4

As a result of Spohn’s ability to have electronic medication reconciliation at the point of care, Spohn expects to be able to have pharmacists as part of the medication reconciliation and utilization review process throughout the hospitalization and at discharge. Pharmacists will be specifically alerted to assess patient profiles for drug interactions and those receiving medications identified as being high risk for medication errors.

Outcome Measure Description
• DY2
  o P-2: Establish baseline rates for bedside medication administration errors. The baseline rate will be set based on the total number of medications administered during the year ending (the base period), with the numerator of the rate equaling the total number of medication errors for acute care patients during the base period and the denominator being set as the total medications administered to acute care patients at CHRISTUS Spohn Hospital Alice (“Spohn”) facilities during the base period. This medication error rate will serve as the basis for assessing the effectiveness of implementing the new BMV system.
  o Data Source: Quality reports, electronic medication administration record (eMAR) reports

Outcome Improvement Targets:
• DY 3
  o IT-4.10: Other outcome improvement target
  Improvement Target: 5 % reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
  Data Source: Quality reports
• DY4
  o IT-4.10: Other outcome improvement target
  Improvement Target: 10 % reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
  Data Source: Quality reports
• DY 5
  o IT-4.10: Other outcome improvement target
  Improvement Target: 15 % reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
**Data Source:** Quality reports

**Rationale:**
Medication Management provides information that facilitates the appropriate use of medications in order to control illness and promote health according to *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* Monitoring medication administration is key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications.

In a latest study out of the University of Pittsburgh Medical Center (Rack, Dudjak & Wolf, 2012) registered nurse (RN) workarounds were analyzed to determine the frequency and causes of workarounds while using bar code medication administration technology. Over half the nurses included in the study indicated that during their last shift worked, they administered medications without scanning the medication or the patient. Reasons for non-adherence to bar code scanning are identified as process related with an impact on patient safety outcomes. Process issues include step omission, steps out of sequence and unauthorized steps (Rack, 2012) that can be attributed to task, environment, patient, organization and technology related workarounds (Koppel, Wetterneck, Telles & Karsh, 2008). While BMV does not eliminate medication errors, it has shown a large impact on errors of wrong dose and wrong time (Rack, 2012). Quasi-experimental studies have been conducted in both intensive care units (ICU) and non-ICU units. One ICU study showed an overall med error reduction of 56% ($p < 0.001$) with reduction in administration time errors (19.7% to 7.5%, $p < 0.001$) having the largest impact on overall reduction rates (DeYoung, Vanderkooi & Barletta, 2009). Another study with over 14,000 medication administrations and 3000 order transcriptions reported a 41.4% relative reduction rate in medication errors ($p < 0.001$) for units using bar coding and eMAR versus units that did not.

Increasing control over the management and tracking of medication, particularly for acute care patients will help reduce the risk of medication errors and the resulting complications. The decrease in medication errors at the bedside will be a reliable indicator of the effectiveness of this project and in particular the goal of reducing preventable complications that arise with medication errors.

This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing errors from inadvertent mishandling of medications, which will also lead to a reduction in complications from errors in medication management. By targeting measures that reduce errors in the delivery of medication to patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care, in a manner consistent with recent studies.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of medication administration errors. Medication errors are a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to follow procedures designed to increase patient safety, reduce medication errors, identify process barriers that lead to work-arounds, proactive assessments of
patients’ medications, communication between providers, and preemptive measures to protect patients) and investment in infrastructure; however, the outcome will justify the expense.
### CHRISTUS Spohn Hospital Alice

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>09422902.2.1</th>
</tr>
</thead>
</table>

#### Starting Point/Baseline:

**In FY 2012, Spohn experienced 176 medication errors of administration or omission**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-2]:** Establish baseline rates for bedside medication administration errors, prior to implementation of new system | **Outcome Improvement Target 1 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 5% reduction in bedside medication administration errors from DY2 baseline  
**Data Source:** Quality reports | **Outcome Improvement Target 2 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 10% reduction in bedside medication administration errors from DY2 baseline  
**Data Source:** Quality reports | **Outcome Improvement Target 3 [IT-4.10]:** Other outcome improvement target  
**Improvement Target:** 15% reduction in bedside medication administration errors from DY2 baseline  
**Data Source:** Quality reports |
| **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 5,270 | **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 6,109 | **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 4,901.50 | **Outcome Improvement Target 3 Estimated Incentive Payment:** $ 23,442 |
| **Process Milestone 2 [P-5]:** Disseminate finding, lessons learned and best practices to stakeholders  
**Data Source:** Stakeholder meetings, minutes, attendance logs | **Process Milestone 2 Estimated Incentive Payment:** $ 4,901.50 | **Year 2 Estimated Outcome Amount:** $ 5,270 | **Year 5 Estimated Outcome Amount:** $ 23,442 |
| **Year 3 Estimated Outcome Amount:** $ 6,109 | **Year 4 Estimated Outcome Amount:** $ 9,803 | **Year 4 Estimated Outcome Amount:** $ 9,803 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $ 44,624
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
   Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Average length of stay
CHRISTUS Spohn Hospital Alice / TPI: 094222902
Unique Identifier -094222902.3.5

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management.

Outcome Measure Description
- **DY2**
  - P-2: Establish baseline rates for patients for length of stay for high risk patients and patients receiving medications identified as high risk for medication errors. The baseline rate will be set based on the total number of high risk reviews performed. Program expansion is based on initial results at CSHCC-Memorial reporting an annualized reduction in average length of stay (ALOS) by 1 day reduction for IV home infusion transition alone during the year ending (the base period), with the numerator equaling the total number of **inpatient days** for patients identified as high risk or receiving medications identified as high risk for medication errors and the denominator being set as the total number of patients identified as high risk or receiving medications identified as high risk for medication errors at CHRISTUS Spohn Hospital Alice (“Spohn”) facilities during the base period. This ratio will demonstrate the change ALOS for this target population (See rationale for criteria that define high risk)
    - **Data Source**: Quality reports, electronic medication administration record (eMAR) reports
- **DY3**
  - P-3 Develop and test data systems
    **Data Source**: EMR and utilization review documents
- **DY4**
  - P-5 Disseminate finding, lessons learned and best practices to stakeholders
    **Data Source**: Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:
- **DY 4**
  - IT-4.10: Other outcome improvement target
    **Improvement Target**: Average Length of stay
    **Data Source**: Medication Management and Utilization Review reports
DY 5

- IT-4.10: Other outcome improvement target
  
  **Improvement Target:** Average Length of stay
  **Data Source:** Medication Management and Utilization Review reports

**Rationale:**
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria include but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication management. Achieving this outcome will require considerable and concerted effort (i.e. assessment of each patient’s health literacy level, support in their post-discharge environment and ability to adhere to prescribed regimes and communication between providers to formulate the best possible treatment options) and investment in infrastructure; however, the outcome will justify the expense.
**CHRISTUS Spohn Hospital Alice**

### Starting Point/Baseline:
In FY2012, Spohn’s Corpus Christi Memorial facility experienced an annualized reduction in patients requiring long-term IV therapy. 391 acute care patient days were eliminated by transitioning these patients to IV home infusion therapy. Patient days were determined by number of days required for treatment.

### Year 2 (10/1/2012 – 9/30/2013)

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish baseline rates for bedside medication administration errors, prior to implementation of new system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $5,270</td>
</tr>
</tbody>
</table>

### Year 3 (10/1/2013 – 9/30/2014)

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-3]: Develop and test data systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> EMR and utilization review documents</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $6,109</td>
</tr>
</tbody>
</table>

### Year 4 (10/1/2014 – 9/30/2015)

**Outcome Improvement Target 1** [IT-4.9]: Average length of stay

- **Numerator:** Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC
- **Denominator:** Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC

**Data Source:** Case Management and Utilization Review reports

Outcome Improvement Target 1 Estimated Incentive Payment: $4,901.50

### Year 5 (10/1/2015 – 9/30/2016)

**Outcome Improvement Target 2** [IT-4.9]: Average length of stay

- **Numerator:** Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC
- **Denominator:** Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC

**Data Source:** Case Management and Utilization Review reports

Outcome Improvement Target 2 Estimated Incentive Payment: $23,442

### Year 2 Estimated Outcome Amount: $5,270

### Year 3 Estimated Outcome Amount: $6,109

### Year 4 Estimated Outcome Amount: $9,803

### Year 5 Estimated Outcome Amount: $23,442

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $44,624
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors

Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions

IT4.10 - Other outcome improvement targets – Cost savings in care delivery associated with medication management and utilization review in high risk patients

CHRISTUS Spohn Hospital Alice / TPI: 094222902

Unique Identifier -094222902.3.6

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management.

Outcome Measure Description

- **DY2**
  - P-2: Establish baseline rates for cost savings in care delivery. The baseline rate will be determined using a Cost Minimization Analysis to quantify cost reduction resulting from concurrent case management/utilization review for patients identified as high risk or receiving medications identified at high risk for medication errors during the base period. This initial analysis for this project will be quantified from project implementation data at CSHCC-Memorial serving as the basis for project expansion and assessment of cost minimization.
    - **Data Source:** Case Management/Utilization review reports, financial reports

- **DY 3**
  - P-3: Develop and test data systems
    - **Data Source:** Quality reports

- **DY 4**
  - P-5: Disseminate finding, lessons learned and best practices to stakeholders
    - **Data Source:** Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:

- **DY 4**
  - IT-4.10: Other outcome improvement target
    - **Improvement Target:** Cost savings in care delivery
    - **Data Source:** Case Management/Utilization review reports, financial reports

- **DY 5**
  - IT-4.10: Other outcome improvement target
    - **Improvement Target:** Cost savings in care delivery
    - **Data Source:** Case Management/Utilization review reports, financial reports
Rationale:
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria included but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone with an associated cost minimization of $426,000 ($1.02 Million annualized).

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to cost savings in care delivery for patients identified as high risk or receiving medications at high risk for medication errors. Effective medication management reduces the risk of potentially preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to perform proactive assessment of patients’ medications, increase communication between providers, and identify preemptive measures to enhance treatment and protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong></td>
<td>Establish baseline rates for bedside medication administration errors, prior to implementation of new system <strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong></td>
<td>$5,270</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems <strong>Data Source:</strong> EMR and utilization review documents</td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong></td>
<td>$6,109</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Outcome Improvement Target 1 [IT-4.9]:</strong> Average cost savings <strong>Improvement Target:</strong> Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis <strong>Data Source:</strong> Case Management and Financial reports</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Outcome Improvement Target 2 [IT-4.10]:</strong> Average cost savings <strong>Improvement Target:</strong> Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis <strong>Data Source:</strong> Case Management and Financial reports</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td><strong>Process Milestone 2 [P-5]:</strong> Disseminate finding, lessons learned and best practices to stakeholders <strong>Data Source:</strong> Stakeholder meetings, minutes, attendance logs</td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong></td>
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</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
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<td><strong>Year 3 Estimated Outcome Amount:</strong></td>
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<tr>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td>$9,803</td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
<td>$23,442</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong></td>
<td>$44,624</td>
</tr>
</tbody>
</table>
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**
CHRISTUS Spohn Hospital Alice -094222902.3.7

**Outcome Measure Description**
OD-4 Potentially Preventable complications and healthcare acquired Conditions.

**IT-4.10: Other outcome Improvement Targets**
Compliance with VTE Prophylaxis Core Measure Indicators

**Outcome Description:** Installation of a computerized patient order management (CPOM) system is expected to reduce the rate of VTE in Spohn’s Alice facility by creating electronic order sets that include VTE prophylaxis. Spohn has a system-wide group that developed electronic evidence-based order sets. For example, if patient has surgery and the doctor wants the patient to get up and walking to prevent blood clots, there are different order sets that might be in place. For patients who cannot ambulate after surgery, they need anti-coagulants, but often the surgeons will not order these because they are concerned that the surgical sites might bleed. The CPOM system will create automatic order sets for particular surgeries and the medication order will then be in place (including treatment to prevent VTE). This prevents the physician from ordering contraindicated medications and makes sure that needed medications and therapeutic interventions are not missed due to human error.

VTE is a core CMS measure, and CMS has provided six indicators to be addressed in the prevention of hospital-acquired VTE. The six indicators measure the following (with Spohn’s first 6 months of FY13 compliance in parentheses):
- VTE1 prophylaxis (76.7%)
- VTE2 intensive care unit VTE prophylaxis (85%)
- VTE3 patients with anticoagulation overlap therapy (66.7%)
- VTE4 patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol (not reported%)
- VTE5 discharge instructions (0%), and
- VTE6 incidence of potentially preventable VTE (0%).

Clearly there is room for improvement, especially in light of the fact that Overall compliance is < 80%.

**Process Milestones:**
- **DY 2**
  - P-2: Establish baseline rates for compliance with VTE Prophylaxis Core Measure Indicators.
  - P-5: Disseminate finding, lessons learned and best practices to stakeholders

**Outcome Improvement Targets**
- **DY3**
  - IT-4.10: Other outcome improvement target
    Improvement Target: 10% increase in compliance for VTE Prophylaxis from baseline
- **DY4**
  - [IT-4.10]: Other outcome improvement target
    - Improvement Target: 15% reduction in compliance for VTE Prophylaxis from baseline

- **DY5**
  - Outcome Improvement Target 3 [IT-4.10]: Other outcome improvement target
    - Improvement Target: 20% reduction in compliance for VTE Prophylaxis from baseline

**Rationale:**
This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing potentially preventable complications like hospital-acquired VTE. By targeting measures that reduce hospital-acquired VTE in patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care in a manner consistent with recent studies. According to a US Department of Health and Human Services website, “Pulmonary embolism resulting from deep vein thrombosis—collectively referred to as venous thromboembolism—is the most common preventable cause of hospital death. Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused.” (http://www.ahrq.gov/qual/vtguide/).

**Milestones and Metrics:** The first step in the process is gathering information to determine the magnitude of the baseline data needed to assure that an established baseline rate is set. Once CPOM is implemented, findings that have been determined to be pertinent to the implementation process will be disseminated, with dissemination of all lessons learned and use of best practices to all of those considered stakeholders. The use of Quality Reports, electronic medication administration record and EMR reports the reduction in transcription will in turn decrease the errors in medication administration.

Spohn selected the improvement targets to incentivize and reward utilization of the CPOM system, with the goal that its utilization will reduce medication transcription errors and also reduce the risks that inconsistent orders are misunderstood.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of hospital acquired VTE. VTE is a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. putting the order sets in place, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline rates for medication transcription errors in the Spohn facility</td>
<td>Outcome Improvement Target 1 [IT-4.10]: Other outcome improvement target</td>
<td>Outcome Improvement Target 2 [IT-4.10]: Improvement Target: 15% increase in compliance with VTE Prophylaxis Core Measure Indicators from baseline set in DY2</td>
<td>Outcome Improvement Target 3 [IT-4.10]: Improvement Target: 20% increase in errors compliance with VTE Prophylaxis Core Measure indicators from baseline set in DY2</td>
</tr>
<tr>
<td>Data Source: Quality reports, electronic medication administration record (eMAR) reports</td>
<td>Compliance with VTE Prophylaxis Core Measure Indicators Improvement Target: 10% increase in compliance with VTE Prophylaxis Core Measure indicators from baseline set in DY2</td>
<td>Data Source: Quality reports; EHR Claims</td>
<td>Data Source: Quality reports; EHR Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $7,906</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $18,328</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $29,410</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $70,327</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-1]</strong> Project Planning Goal: develop a plan for coordinating post-surgical order sets with the new CPOM system and training hospital staff on using the electronic system to more effectively prevent VTE</td>
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<tr>
<td>Data source: documentation of plan</td>
<td><strong>Milestone 2 [P-1]</strong> Project Planning Goal: develop a plan for coordinating post-surgical order sets with the new CPOM system and training hospital staff on using the electronic system to more effectively prevent VTE</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $15,812</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $18,328</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $29,410</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $70,327</td>
</tr>
</tbody>
</table>
| TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $133,876 | **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $133,876** | **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $133,876** |}

**CHRISTUS Spohn Hospital Alice**

**Starting Point/Baseline:** **74% overall compliance with CMS VTE Indicators at Spohn**

**Related Category 1 or 2 Projects:** 094222902.2.2

**Compliance with VTE Prophylaxis Core Measure Indicators**

- Year 2 Estimated Outcome Amount: $15,812
- Year 3 Estimated Outcome Amount: $18,328
- Year 4 Estimated Outcome Amount: $29,410
- Year 5 Estimated Outcome Amount: $70,327

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $133,876**
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

*Outcome Domain 4: Potentially Preventable Complications and Healthcare Acquired Conditions;*

*Improvement Target 4.8: Sepsis Mortality (standalone)*

CHRISTUS Spohn Hospital Alice/09422902

Unique Identifier - 09422902.3.8

**Outcome Measure Description**

Hospitals nationwide and statewide have seen an increase in the rate of sepsis and the mortality rates associated with sepsis over the last twenty years. CHRISTUS Spohn Hospital Alice (“Spohn”) intends, through its use of an early detection warning system and a provider protocol for responding to cases of sepsis, to reduce the rate of mortality caused by sepsis in Spohn’s inpatient population.

**Process milestones:**

- Project planning: Spohn will create a plan to implement a 90-day rapid cycle improvement to address the sepsis mortality rate in Spohn’s Alice facility
- Establish a baseline: Spohn will determine the mortality rate of all septic patients in Spohn’s Alice facility during 2012
- Spohn will conduct Plan-Do-Study-Act cycles to test and improve upon its usage of the MEWS early detection system

**Improvement targets:**

- Reduction in Sepsis Mortality rates – 1% reduction by end of DY4
- Reduction in Sepsis Mortality rates – 2% reduction by end of DY5

**Rationale:**

Spohn’s goal is to decrease the number of deaths in septic patients who present in the early stages of sepsis or those that develop septicemia while in the hospital. The Region 4 Community Needs Assessment has identified a high incidence of sepsis and sepsis mortality for the Region (CN.18). Hospital inpatients are at risk for sepsis, especially if they have intravenous lines, bedsore, or surgical site wounds. Early recognition of the signs and symptoms of sepsis requires skilled assessment of specific indicators over an identified period of time and initiating immediate resuscitation effort upon identification. This rapid response to an identified increasing preventable complication is required to save lives in the acute inpatient setting.

**Outcome Measure Valuation:**

The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable complications and hospital-acquired conditions/infections. Patient outcomes and satisfaction will absolutely be improved if the sepsis mortality rate is decreased, and the systemic cost of providing inpatient hospital care will be reduced for every septic infection and related death that can be prevented. Achieving this outcome will require considerable and concerted effort (i.e.
engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Related Category 1 or 2 Projects:

** processo 09422902.3.8

** Starting Point/Baseline:** 09422902.2.3

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong></td>
<td><strong>Process Milestone 3 [P-4]:</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-4.8]:</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-4.8]:</strong></td>
</tr>
<tr>
<td>Spohn will engage in project planning for 90-day rapid cycle improvement for Sepsis</td>
<td>Conduct PDSA cycles to improve usage of electronic MEWS – Spohn will develop a plan to test the change, implement the plan, analyze the results, and determine what modifications are needed, if any</td>
<td>Sepsis mortality</td>
<td>Sepsis mortality</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project plan</td>
<td><strong>Data Source:</strong> EMR reports</td>
<td><strong>Improvement Target:</strong> 1% reduction in septicemia mortality rates in Spohn’s Alice facility from baseline established in DY2</td>
<td><strong>Improvement Target:</strong> 2% reduction in septicemia mortality rates in Spohn’s Alice facility from baseline established in DY2</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $12,423.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $28,801</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $46,215</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $110,514</td>
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<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates – Spohn will determine the mortality rate for septic patients in its Alice facility for 2012</td>
<td><strong>Data Source:</strong> hospital quality reports</td>
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<td><strong>Data Source:</strong> hospital quality reports, dashboards</td>
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<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $12,423.50</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $24,847</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $28,801</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $46,215</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $110,514</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $210,376
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

3.1. Primary Care and Chronic Disease Management – IT-. 9.2: ED Appropriate Utilization (reduce emergency department visits for diabetes)

CHRISTUS Spohn Hospital Alice / 094222902

Project Unique ID: 094222902.3.9

Outcome Measure Description

CHRISTUS Spohn Hospital Alice (“Spohn”) expects the outcome of its project to identify patients with diabetes and CHF who have a co-diagnosis in BH/depression to result in a reduced volume of ED visits from diabetic patients. Spohn will screen patients who present in the ED initially for BH needs (and in its other treatment settings), and make referrals where necessary; this should result in fewer repeat ED visits by diabetic patients who possibly have a co-diagnosis from returning to the ED.

Process Milestones: In DY2, Spohn will create a plan for using its project to increase screening of CHF and diabetes patients for BH referrals to reduce the number of overall ED visits from diabetic patients. Spohn will also establish a baseline of the number of ED visits from diabetic patients in order to measure progress going forward.

Improvement Targets: In DY3, Spohn aims to reduce the volume of ED visits from patients with diabetes by 5% from the DY2 baseline. In DY4, Spohn aims for a decrease in ED visits from diabetic patients of 8% over DY2, and by the end of DY5 Spohn aims for a decrease in the volume of ED visits from diabetic patients of 10%.

Rationale:

Treatment management and patient outcomes such as PPR and mortality can only be impacted if patients with co-existing physical and behavioral illness can be identified and referred to the appropriate providers for a treatment plan inclusive of both domains. This is why we chose to focus on training providers in screening and recognition in target populations, communication between providers and increasing the number of patients screened in the EDs, Primary Care and BH settings.

Spohn expects that screening and identifying diabetic patients with potential BH needs will result in fewer subsequent visits to the ED from that population. This will indicate that more of those patients are receiving the right care in the right setting, and will reduce the high cost of treating Medicaid/uninsured patients in the ED. The reduced ED volume should also have a ripple effect for the inpatient setting – fewer of the targeted patients will be admitted from the ED and reduce inpatient costs, increase the availability of beds, and improve patient outcomes.

Outcome Measure Valuation:

The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community of BH/SA screening/treatment for CHF patients and vice versa, in order to prevent unnecessary hospital visits.
admissions and readmissions. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Related Category 1 or 2 Projects:

- **CHRISTUS Spohn Hospital Alice**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>In FY 2012, Spohn’s ED experienced approximately 412 diabetes related visits</th>
</tr>
</thead>
</table>

#### Year 2 (10/1/2012 – 9/30/2013)

Process Milestone 1 [P-1]: Project planning – Spohn will create a protocol for ED providers in screening and referring diabetic patients for BH assessments where necessary and create a plan for tracking the repeat ED visits of those patients going forward

- **Data Source:** Project plan

  **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $16,941

Process Milestone 2 [P-S]: Establish baseline – Spohn will determine the number of ED visits from diabetic patients

- **Data Source:** FHC and hospital patient records

  **Process Milestone 2 Estimated Incentive Payment:** $16,941

#### Year 3 (10/1/2013 – 9/30/2014)

Outcome Improvement Target 1 [IT-9.2 ED appropriate utilization]

- **Improvement Target:** 5% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

  **Outcome Improvement Target 1 Estimated Incentive Payment:** $39,274

Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization

- **Improvement Target:** 8% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

  **Outcome Improvement Target 2 Estimated Incentive Payment:** $63,020

#### Year 4 (10/1/2014 – 9/30/2015)

Outcome Improvement Target 3 [IT-9.2 ED appropriate utilization]

- **Improvement Target:** 10% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

  **Outcome Improvement Target 3 Estimated Incentive Payment:** $150,701

#### Year 5 (10/1/2015 – 9/30/2016)

Outcome Improvement Target 3 [IT-9.2 ED appropriate utilization]

- **Improvement Target:** 10% reduction in the volume of ED visits from diabetic patients from baseline established in DY2
- **Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

  **Outcome Improvement Target 3 Estimated Incentive Payment:** $150,701

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $33,882

**Year 3 Estimated Outcome Amount:** $39,274

**Year 4 Estimated Outcome Amount:** $63,020

**Year 5 Estimated Outcome Amount:** $150,701

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $286,877
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
2.12.2 - Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of: OD 3: Potentially Preventable Readmissions; Improvement Target 3.3.2 - CHF 30-day readmissions
Unique project ID number: 094222902.3.10
CHRISTUS Spohn Hospital – Alice: 094222902

Outcome Measure Description
This outcome will measure the reduction in the number of Potentially Preventable Readmissions for CHF patients at Spohn’s Alice Facility due to the expanded implementation of the Care Transitions program. CHRISTUS Spohn Hospital Alice (“Spohn”) believes that patients who are at risk to be readmitted to the hospital within 30 days of discharge for congestive heart failure will benefit from increased care coordination upon discharge. This includes providers, patients and their caregivers’ education about medication, diet, and activity management, primary care resources that are available and need to be accessed, and community support available to recently discharged CHF patients.

Process milestones:
• DY2: Develop and test data systems + establish a baseline
  o Spohn will develop an integrated system for flagging CHF patients upon inpatient admission and readmission, in order to track progress in later years of the Waiver
  o Spohn will develop a baseline of CHF readmissions during DY2 in order to measure percentage improvement going forward
• DY3: Disseminate findings
  o Spohn will create and distribute its staff/stakeholders a plan for reducing CHF readmissions through the expansion of the Care Transitions program

Improvement milestones:
• DY3: Reduce CHF PPRs by 3% from baseline
• DY4: Reduce CHF PPRs by 6% from baseline
• DY5: Reduce CHF PPRs by 8% from baseline

Rationale:
Spohn chose this outcome using its evidence-based expectation of a decrease in re-admission rates as a result of the following processes in the Care Transitions program: 1) effective and efficient discharge planning while in the hospital, (2) home visit within 48 hours of patients arrival home and (3) follow-up phone calls to ensure education/information shared making this program a viable expansion option for chronic disease in populations across our region. Spohns’ review of its own needs and the Region 4 Community Needs Assessment identified CHF as an area requiring improvement. Specifically, Nueces County’s highest incidence of potentially preventable hospitalizations occur due to CHF (RHP Plan, Section 3, Table 10) and Heart Failure was the second most common primary diagnosis for hospitalizations in Region 4 (RHP Plan, Section 3, Table 9). Thus, CHF is a substantial problem that Spohn needs to address by reducing the number of potentially preventable readmissions for patients already hospitalized for and identified as patients with CHF.
**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication/diet/weight management for CHF patients to prevent unnecessary hospital admissions and readmission. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-3]**: Develop and test data systems – Spohn will put a system in place to identify and flag CHF patients at its Alice facility upon initial admission and upon readmission | **Process Milestone 3 [P-5]**: Disseminate finding and implementation plan to stakeholders – Spohn will develop and distribute a comprehensive plan for reducing CHF 30-day admissions (in conjunction with the Care Transitions program) to the Alice Facility | **Outcome Improvement Target 2 [IT-3.2 & IT-3.3, 3.8]**: PPR  
**Improvement Target**: 6% reduction in CHF, 30-day readmission rates from baseline established in DY2  
**Data Source**: EHR | **Outcome Improvement Target 3 [IT-3.2]**: PPR  
**Improvement Target**: 8% reduction in CHF, 30-day readmission rates from baseline established in DY2  
**Data Source**: EHR |
| Data Source: referral logs documentation | Data Source: Written integration plan | Outcome Improvement Target 2 Estimated Incentive Payment: $63,020 | Outcome Improvement Target 3 Estimated Incentive Payment: $150,701 |
| Process Milestone 1 Estimated Incentive Payment: $16,941 | Process Milestone 3 Estimated Incentive Payment: $19,637 | Year 2 Estimated Outcome Amount: $33,882 | Year 5 Estimated Outcome Amount: $150,701 |
| Year 2 Estimated Outcome Amount: $33,882 | Year 3 Estimated Outcome Amount: $39,274 | Year 4 Estimated Outcome Amount: $63,020 | Year 4 Estimated Outcome Amount: $63,020 |
| **Process Milestone 2 [P-2]**: Establish baseline rates – Spohn will compile and evaluate the 30-day readmission data from 2012 for patients at its Alice Facility discharged with a principal diagnosis of CHF  
**Data Source**: Historical clinic/hospital/ED claims and financial data | **Outcome Improvement Target 1 [IT-3.2]**: PPR  
**Improvement Target**: 3% reduction in CHF, 30-day readmission rates from baseline established in DY2  
**Data Source**: EHR | Outcome Improvement Target 1 Estimated Incentive Payment: $19,637 | |
| Process Milestone 2 Estimated Incentive Payment: $16,941 | Outcome Improvement Target 1 Estimated Incentive Payment: $19,637 | Year 3 Estimated Outcome Amount: $39,274 | |
| **Outcome Improvement Target 1 Estimated Incentive Payment**: $19,637 | Year 4 Estimated Outcome Amount: $63,020 | Year 4 Estimated Outcome Amount: $63,020 | |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $286,877
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

3. IT-9.2 ED appropriate utilization – Reduce ED visits for behavioral health/SA
CHRISTUS Spohn Hospital Alice / 094222902
Project Unique ID Number: 094222902.3.11

**Outcome Measure Description**
Spohn expects its integration of behavioral health/SA care into the primary medical care setting to result in a reduced misuse of the ED by behavioral health/SA for non-emergent treatment. This outcome measure is important because treatment in the ED is much more expensive to provide, and does not improve patient outcomes. Instead, early intervention provided in a comprehensive healthcare setting is expected to improve patient outcomes and satisfaction, and lead to fewer ED visits. Finally, the FHCs are set up to provide care to uninsured, so they may feel assured that the ED is not the only setting in which they can obtain behavioral health/SA care.

**Process Milestones:** In DY2, Spohn will develop a plan for leveraging the new LMHP in the community FHC to reduce misuse of the ED by behavioral health/SA patients, and will establish a baseline rate of non-emergent ED visits for behavioral health/SA.

**Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization**

**Improvement Target:** Reduce ED visits from service area zip codes for behavioral health/SA:
- DY 3: 5% reduction in ED visits from DY 2 baseline
- DY 4: 10% reduction in ED visits from DY 2 baseline
- DY 5: 15% reduction in ED visits from DY 2 baseline

**Rationale:**
These outcome measures and improvement targets were selected based on collaborative discussions with LMHAs and review of initial data for transformation of care delivery showing a high overuse of the ED by this patient population. In 2010, Jim Wells County hospitals provided $40,441,237 in uncompensated care, much of which was incurred through treatment provided in the ED that was non-emergent, including for behavioral health/SA patients (RHP Plan, Section 3, Table 8). Spohn, like many providers in Region 4 and Texas, has limited resources with which to provide services to the indigent and uninsured in the community; thus, reducing misuse of a very expensive care setting (the ED) is a reasonable outcome measure to target in conjunction with integrating behavioral and physical health care.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential health benefits to the community when resources can
be redirected from providing non-emergent care in the ED to improving primary care in the Region for patients with behavioral health and physical conditions requiring treatment.
### RHP Plan for Region 4

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>094222902.2.6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>CHRISTUS Spohn Hospital Alice</strong></td>
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<tr>
<td></td>
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</table>

<table>
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<tr>
<th>Year 2 <em>(10/1/2012 – 9/30/2013)</em></th>
<th>Year 3 <em>(10/1/2013 – 9/30/2014)</em></th>
<th>Year 4 <em>(10/1/2014 – 9/30/2015)</em></th>
<th>Year 5 <em>(10/1/2015 – 9/30/2016)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – Spohn will create a plan to use the behavioral health care integration to reduce the misuse of the ED, which will likely include strategies for community outreach and provider education</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]:</strong> ED appropriate utilization</td>
<td><strong>Outcome Improvement Target 2 [IT-9.2]:</strong> ED appropriate utilization</td>
<td><strong>Outcome Improvement Target 3 [IT-9.2]:</strong> ED appropriate utilization</td>
</tr>
<tr>
<td>Data Source: Project plan</td>
<td><strong>Improvement Target:</strong> Reduce ED visits to Spohn Alice from its service area zip codes for BH/SA (primary diagnosis) by 5%</td>
<td><strong>Improvement Target:</strong> Reduce ED visits to Spohn Alice from its service area zip codes for BH/SA (primary diagnosis) by 10% from baseline established in DY2</td>
<td><strong>Improvement Target:</strong> Reduce ED visits to Spohn Alice from service area zip codes for behavioral health/SA (primary diagnosis) by 15% from baseline established in DY2</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
<td><strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
<td><strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $18,070.50</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $41,892</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $67,222</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong> $160,748</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates – Spohn will determine the 2012 number of non-emergent ED visits for BH/SA from patients in its service area zip codes, so it can measure progress going forward</td>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $18,070.50</td>
<td></td>
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</tr>
<tr>
<td>Data Source: Historical clinic/hospital/ED claims and financial data</td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> <em>(add incentive payments amounts from each milestone/outcome improvement target)</em>: $36,141</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $41,892</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $67,222</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $160,748</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $306,003**

**In FY 2012, approximately 1,314 ED visits for BH/SA, 676 (51%) were Medicaid/uninsured**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
RHP Project Number: 112673204.3.1 (IT-1.11)
Performing Provider TPI: 112673204 / Yoakum Community Hospital

Outcome Measure Description: Diabetes care: BP control (<140/90 mm Hg)– NQF 0061 (Standalone measure)

Process Milestone 1 (DY2): DY2 will be used for Yoakum Community Hospital planning the diabetes program. An action plan will be developed that is used to guide the Yoakum Community Hospital program through its implementation.

Process Milestone 2 (DY3): DY3 will be used for Yoakum Community Hospital to develop a baseline target for our improvement measures and report on this target.

- **Numerator:** Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- **Denominator:** Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
- **Data Source:** Registry

Improvement Milestones (DY4 & DY5): The improvement target for DY4 and DY5 milestone will be dependent on the baseline year. Once the baseline is established, the improvement target will be discussed and reviewed for approval.

Rationale:
Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. Yoakum Community Hospital selected process milestones aimed at measuring and achieving improvements in the community’s heath through increasing primary care services. This project should provide a beneficial outcome by improving our capacity to provide increased care to diabetics and reduce overall blood pressure issues.

Outcome Measure Valuation:
The valuation of Yoakum Community Hospital’s Diabetes Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. YCH will focus on improving treatment access
for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver’s overriding goals. Diabetes is currently the sixth leading cause of death in Texas and caused numerous potentially preventable hospitalizations in RHP 4. As a result, this project will target a large segment of the region’s population and impact a substantial number of people, particularly the region’s uninsured and underinsured patients.
<table>
<thead>
<tr>
<th>112673204.3.1</th>
<th>3.IT-1.11</th>
<th>Diabetes care: BP control (&lt;140/90mm Hg) – NQF 0061 (Standalone measure)</th>
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<tbody>
<tr>
<td>Yoakum Community Hospital</td>
<td>112673204.1.1</td>
<td>112673204</td>
</tr>
</tbody>
</table>

### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
<table>
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</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1[P-1]</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2[P-2]</strong> Establish baseline rates for chosen improvement target IT-1.11.</td>
<td><strong>Outcome Improvement Target 2:</strong> [IT-1.11]: BP control (&lt;140/90mm Hg) <em>Improvement Target</em>: TBD</td>
<td><strong>Outcome Improvement Target 3:</strong> [IT-1.11]: BP control (&lt;140/90mm Hg) <em>Improvement Target</em>: TBD</td>
</tr>
<tr>
<td>Data Source: Action Plan</td>
<td>Data Source: Baseline from Registry</td>
<td>Data Source: Registry</td>
<td>Data Source: Registry</td>
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</tbody>
</table>

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $22,698 | Year 3 Estimated Outcome Amount: $26,310 | Year 4 Estimated Outcome Amount: $42,218 | Year 5 Estimated Outcome Amount: $100,957 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5):* $192,184
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

*RHP Project Number: 112673204.3.2 (IT-1.10): Diabetes Care: HbA1c Poor Control (>9.0%) / Yoakum Community Hospital TPI 112673204*

Outcome Measure Description

**Process Milestone 1**: Year one will be used for planning the diabetes program at Yoakum Community Hospital. An action plan will be developed that is used to guide the program through its implementation.

**Process Milestone 2-3**: Year two will be used to develop a baseline target for our improvement measures.

**Improvement Milestone**: The improvement target for DY4 and DY5 milestone will be dependent on the baseline year. Once the baseline is established, the improvement target will be discussed and reviewed for approval.

**Rationale**: Management of one’s glucose levels is key to managing diabetes and leading to better health outcomes. In 2009, the American Diabetes Association issued a statement stating, “Lowering A1C to below or around 7% has been shown to reduce micro vascular and neuropathic complications of type 1 and type 2 diabetes.” With monitoring this improvement measure, YCH will be able to better manage diabetes in patients. Because of the prevalence of diabetes related issues, Yoakum Community Hospital selected milestones and improvement targets we feel are attainable and will benefit the community. If we are successful in recruiting specialty care physicians, we believe we will be able to show demonstrable improvement in glucose management.

**Outcome Measure Valuation**: The valuation of this Diabetes Care project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. YCH will focus on improving treatment access for patients who might normally wait until manifestation of an emergent condition. This focus on improving access to care will also help improve quality of care, and the eventual outcomes related to follow-up treatment. These objectives are in line with the Waiver’s overriding goals. Diabetes is currently the sixth leading cause of death in Texas and causes numerous potentially preventable hospitalizations every year. As a result, this project will target a large segment of the region’s population and impact a substantial number of people, particularly the region’s uninsured and underinsured patients.
<table>
<thead>
<tr>
<th>112673204.3.2</th>
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<th>Diabetes Care: HbA1c Poor Control (&gt;9.0%)</th>
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<tr>
<td><strong>Related Category 1 or 2 Projects::</strong></td>
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<tr>
<td><strong>Starting Point/Baseline:</strong></td>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1: [P-1] Plan</strong></td>
<td>Establish baseline rates for chosen improvement target IT-1.10. <strong>Data Source:</strong> Baseline from Registry</td>
<td><strong>Outcome Improvement Target 1 [IT-1.10]:</strong> Diabetes care: HbA1c control (&gt;9.0%) <strong>Improvement Target:</strong> TBD <strong>Data Source:</strong> Registry</td>
<td><strong>Outcome Improvement Target 2 [IT-1.10]:</strong> Diabetes care: HbA1c control (&gt;9.0%) <strong>Improvement Target:</strong> TBD <strong>Data Source:</strong> Registry</td>
</tr>
<tr>
<td>development of comprehensive diabetes program, including necessary resources and time frames. <strong>Data Source:</strong> Action Plan</td>
<td>Milestone 2 Incentive Payment: $11,708</td>
<td>Improvement Target 1 Incentive Payment: $35,552</td>
<td>Improvement Target 2 Incentive Payment: $85,017</td>
</tr>
<tr>
<td>Milestone 1 Incentive Payment: $19,114</td>
<td>Process Milestone 3 [P-5] Disseminate baseline rates established in DY 1 and report on improvement target rates for DY 4 to YCH Board Meeting <strong>Data Source:</strong> Meeting Minutes</td>
<td></td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $19,114</td>
<td>Year 3 Estimated Outcome Amount: $22,156</td>
<td>Year 4 Estimated Outcome Amount: $35,552</td>
<td>Year 5 Estimated Outcome Amount: $85,017</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $161,839
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

1.1.2 - Expand existing primary care capacity
Right Care, Right Setting – ED Appropriate Utilization
CHRISTUS Spohn Hospital Corpus Christi/121775403
Unique Identifier - 121775403.3.1

Outcome Measure Description
Outcome Domain 9: Right Care in Right Setting
Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization – reduce all (non-urgent/non-emergent) ED visits

This outcome measure is targeted toward reducing the number of non-emergent visits to Spohn’s ED, in conjunction with Spohn’s initiative to expand primary care access to the Nueces County community. Spohn believes that by providing primary and preventative care in the community on an expanded basis, the number of uninsured and indigent patients seeking care in an inappropriate setting (i.e. the ED) will decrease.

Process Milestones 1-4
The process milestones Spohn chose are meant to enable Spohn to create a plan of action, establish a baseline for measuring success, test its systems for collecting and analyzing data, and putting an action plan into effect to cause a successful reduction in inappropriate use of the ED.

Improvement Targets:
- 5% reduction in all (non-urgent/non-emergent) ED visits by the end of DY4
- 10% reduction in all (non-urgent/non-emergent) ED visits by the end of DY5

Spohn chose these improvement targets with its current ratio of non-emergent ED visits to total visits in mind. As mentioned below in “Rationale,” Spohn currently has a 37% rate of non-emergent ED visits, which works about to approximately 44,000 non-emergent visits per year. A 5% reduction will result in approximately 2200 fewer unnecessary ED visits per year, and a 10% reduction will result in approximately 4400 fewer unnecessary ED visits per year. The cost savings for these numbers will have a meaningful impact on Spohn’s ability to provide quality care, and patients will see benefits to their satisfaction and health outcomes when they seek and receive care in the appropriate setting for their conditions.

Rationale:
Spohn selected this Category 3 Outcome for its project to Expand Primary Care Capacity because Spohn expects a direct correlation between improved access to primary and preventative care and misuse of the ED for non-emergent conditions. A review of Spohn’s ED admission data for FY12 showed 44,000 visits out of 119,000 (37%) were non-urgent/non-emergent visits that could be handled in the primary care setting. The total number of ED admissions for 2010 in Nueces County was 195,394 ER visits, meaning that Spohn sees the overwhelming majority of patients who present to the ED for primary care
services; thus, it is imperative that Spohn take steps to provide increased access to primary care, both to improve patient health outcomes and reduce the cost of providing care through its ED.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to Primary Care access to avoid PPA and inappropriate ED utilization. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Right Care Right Setting – ED appropriate utilization-all ((non-urgent/non-emergent) ED visits)

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<th>Year 2</th>
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**Process Milestone 1 [P-1]**
- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – specifically, Spohn will create a plan for increasing patient awareness of the increased availability of primary care and the value of seeking medical intervention outside of the ED.
- **Data Source:** Project plan documentation
- **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $114,949.50

**Process Milestone 2 [P-2]:**
- Establish baseline rates – specifically, Spohn will determine the number of ED visits during DY2 and the percentage of ED visits in 2012 that were deemed non-emergent, in order to measure progress going forward.
- **Data Source:** Project Plan documentation
- **Process Milestone 2 Estimated Incentive Payment:** $114,949.50

**Process Milestone 3 [P-3]:**
- Develop and test data systems – specifically, Spohn will develop systems for tracking patients who visit the ED with non-emergent conditions and cross-reference those with patients who access the clinics each year.
- **Data Source:** ED admission data and Patient appointment registry
- **Process Milestone 3 Estimated Incentive Payment:** $133,241.50

**Process Milestone 4 [P-4]:**
- Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities – specifically, Spohn will create and implement a plan to disseminate information to the community about the benefits using the clinics for primary care and the appropriate use of the ED.
- **Data Source:** Performance improvement plans (PIP)
- **Process Milestone 4 Estimated Incentive Payment:** $133,241.50

**Outcome Improvement Target 1 [IT-9.2]:**
- **Improvement Target:** Reduce all ED visits by 5% from baseline established in DY2.
- **Data Source:** EHR, Claims
- **Outcome Improvement Target 1 Estimated Incentive Payment:** $427,612

**Outcome Improvement Target 2 [IT-9.2]:**
- **Improvement Target:** Reduce all ED visits by 10% from baseline established in DY2.
- **Data Source:** EHR, Claims
- **Outcome Improvement Target 2 Estimated Incentive Payment:** $1,022,549

In FY 2012, Spohn’s Corpus Christi EDs received almost 44,000 non-emergent visits from approximately 27,239 patients. Of those patients, almost 60% were Medicaid/uninsured. The total number of ED visits was approximately 118,940, meaning that almost 37% were non-emergent.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>121775403.1.1</th>
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</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>In FY 2012, Spohn’s Corpus Christi EDs received almost 44,000 non-emergent visits from approximately 27,239 patients. Of those patients, almost 60% were Medicaid/uninsured. The total number of ED visits was approximately 118,940, meaning that almost 37% were non-emergent.</td>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tr>
<td>Year 2 Estimated Outcome Amount:$229,899</td>
<td>Year 3 Estimated Outcome Amount:$266,483</td>
<td>Year 4 Estimated Outcome Amount:$427,612</td>
<td>Year 5 Estimated Outcome Amount:$1,022,549</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,946,542
**Category 3: Quality Improvements**

Identifying Outcome Measure and Provider Information:

1.3.1 - Implement/enhance and use chronic disease management registry functionalities

3.3. Potentially Preventable Re-admissions
   - IT-3.2: Congestive Heart Failure 30 day readmission rate

*Project unique ID number: 121775403.3.2*

**Outcome Measure Description**

Spohn will measure the rate of 30 day readmissions (for any reason) to its hospital facilities upon discharge from an inpatient stay for Congestive Heart Failure (“CHF”), and projects the outcome of its disease registry project to be a reduction in its overall potentially preventable readmission rate for this target population. Potentially Preventable Readmissions (PPRs) often result from the fact that patients lack support, information, and access to continued care in the outpatient setting upon discharge. These patients are at risk for their conditions deteriorating when they are no longer monitored and managed in the hospital, which can lead to relapses/additional acute episodes/complications requiring readmission to an inpatient setting. The systemic cost of readmissions and negative impact on patient quality of life, satisfaction, and long-term outcomes makes this achieving an improvement in this domain a high priority for Spohn.

**Process milestones:**
- DY2: Establish a baseline of CHF 30 day readmission rates

**Improvement milestones:**
- DY3: Reduce CHF PPRs by 5% from baseline
- DY4: Reduce CHF PPRs by 10% from baseline
- DY5: Reduce CHF PPRs by 20% from baseline

**Rationale:**

According to Region 4’s Community Needs Assessment, Nueces County has a high incidence of potentially preventable hospitalization related to chronic diseases, including CHF (RHP Plan, Section 3, Table 10). Spohn chose this outcome measure to complement its disease registry project because one goal of the registry is to enable CHF patients to effectively manage their conditions and their overall health subsequent to discharge from an inpatient stay for CHF. Spohn expects to see evidence of a decrease in re-admission rates for this population as a result of (1) effective and efficient discharge planning while patients are in the hospital, (2) home visits within 48 hours of patients’ arrival home and (3) follow-up phone calls to ensure patients understand and have processed the education/information provided by Spohn.

Process milestones: During DYs 2-3, Spohn will establish a baseline rate of readmissions for its CHF patients in order to measure progress going forward, and will engage in project planning to create an effective approach to using the information in the registry to prevent readmissions for CHF patients within 30 days of discharge from an inpatient setting (including patient education, medication management, caregiver outreach, and timely follow up).
Improvement milestones: Spohn aims to reduce the percentage of 30 day readmissions for CHF patients by 5% under baseline in DY4, and by 8% under baseline in DY5. These targets were chosen to reflect reasonable but meaningful reforms in the CHF patient short-term outcomes and the cost of providing care to patients with this chronic disease.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to preventing unnecessary hospital readmissions for CHF patients. Hospital readmissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally they increase the systemic cost of providing care to indigent and uninsured patients in the community. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
CHRISTUS Spohn Hospital Corpus Christi

<table>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1217754032.1.2</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>The FY 2012 rate of PPRs for CHF was 18.23%.</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline rates – Spohn will determine the rate of 30 day readmissions for CHF patients at its three Corpus Christi campuses for all causes</td>
<td>Outcome Improvement Target 1 [IT-3.1]: PPR  Improvement Target: 5% reduction in all cause CHF patient 30-day readmission rates for Spohn’s Corpus Christi campuses  Data Source: Hospital admission records</td>
<td>Outcome Improvement Target 2 [IT-3.1]: PPR  Improvement Target: 10% reduction in all cause CHF patient 30-day readmission rates for Spohn’s Corpus Christi campuses  Data Source: Hospital admission records</td>
<td>Outcome Improvement Target 3 [IT-3.1]: PPR  Improvement Target: 20% reduction in CHF patient all cause 30-day readmission rates for Spohn’s Corpus Christi campuses  Data Source: Hospital admission records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $189,328</td>
<td>Process Milestone 2 Estimated Incentive Payment: $219,456</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $352,151</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $842,100</td>
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</table>

Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $189,328

Year 3 Estimated Outcome Amount: $219,456

Year 4 Estimated Outcome Amount: $352,151

Year 5 Estimated Outcome Amount: $842,100

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,603,035
**Category 3: Quality Improvement**

**Identifying Outcome Measure and Provider Information:**
Category 1 Project: 1.7.6 - Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.
Outcome Domain 1, Improvement Target 1.11: Diabetes Care, BP control; CHRISTUS Spohn Hospital Corpus Christi / 121775403

Unique Identifier: 121775403.3.3

**Outcome Measure Description**
Diabetic patients are often at risk for Peripheral Arterial Disease (PAD) and Spohn is implementing a Category 1 project to provide more screenings by cardiovascular specialists for this at-risk population using telemedicine. As a result, Spohn expects more patients to receive cautionary information, medication management, and follow-up when they are identified as having high-blood pressure (which can increase the risk and symptoms of PAD). By identifying patients with the potential to develop or with early signs of PAD, Spohn can provide those patients with medication to reduce blood pressure and prevent/alleviate PAD in many cases.

Project implementation is projected to have the following outcomes by end of waiver period:
- 10% increase in diabetic patients seen in Spohn clinics and Hector P Garcia clinic with controlled blood pressure (<140/80mm Hg)

**Rationale:**
Obesity, Diabetes-Type II, PAD, cardiovascular disease (CVD) and amputations have all been identified as prevalent in the Hispanic population in South Texas. This extremely at-risk population is in dire need of early screening, diagnostics and interventions to reduce the long-term complications of diabetes such as ulcerative or non-healing lesions, necrotic or gangrenous lower extremities and amputations. Diabetics with high-blood pressure will be at higher risk for developing PAD, as both conditions affect the patient’s blood flow to their extremities. In tandem with screening diabetes patients for PAD, Spohn clinics have a better chance of identifying and treating uncontrolled blood pressure, Spohn expects an increase in the number of diabetic patients with controlled blood pressure, which will reduce their risk of developing PAD.

Complacency, poor self-management and access to care are all shown to contribute to uncontrolled chronic disease. Implementation of a PAD screening program that extends screening to remote locations throughout the region using a telehealth screening solution would increase early detection for people at-risk and diagnostics and treatment during earlier stages of disease without the burden of appointment delays and multiple trips to specialists’ offices.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of controlling blood pressure in diabetic patients identified at high-risk for PAD and those currently experiencing symptoms such as pain and cramping to lower extremities. Controlling blood pressure will assist providers with
prevention and enable a reduction in PAD-related hospital admissions that impact a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
CHRISTUS Spohn Hospital Corpus Christi

### Related Category 1 or 2 Projects:

- **121775403.3**

### Starting Point/Baseline:

- Approximately 40% of the patients treated in Spohn’s clinics and the Hector P Garcia clinic are diabetic or pre-diabetic (approximately 7400 patients), placing them at increased risk of PAD. Those diabetic patients with uncontrolled blood pressure (number not yet quantified) are at an even higher risk of PAD and associated amputations.

### Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will develop an approach for identifying and treating diabetic patients with uncontrolled blood pressure, putting them at higher risk for PAD, in tandem with its project to use telemedicine to increase PAD screenings

**Data Source:** Project plan documentation

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $114,949.50

### Process Milestone 2 [P-2]: Establish baseline rates – Spohn will assess the number of patients with diabetes who also suffer from uncontrolled blood pressure symptoms and/or at high risk for PAD at its FHCs who are screened for PAD in DY2 and the number of cases where PAD is detected

**Data Source:** Project Plan documentation

**Process Milestone 2 Estimated Incentive Payment:** $133,241.50

### Process Milestone 3 [P-3]: Develop and test data systems - Spohn will assess the volume of information collected through PADnet and blood pressure screenings to assure that the information is broadly disseminated through its system and functioning properly

**Data Source:** Chronic disease registry

**Process Milestone 3 Estimated Incentive Payment:** $133,241.50

### Process Milestone 4 [P-4]: Conduct PDSA to improve project activities – Spohn will implement its screening protocol for PAD and treat patients with uncontrolled blood pressure, and then analyze the results, determining best practices and key remaining challenges

**Data Source:** Project evaluation documentation, assessment of expanded target population

**Process Milestone 4 Estimated Incentive Payment:** $133,241.50

### Outcome Improvement Target 1 [IT-1.11]: Diabetes care: BP control

**Improvement target:** 10% increase in diabetic patients with controlled blood pressure over DY2 baseline

**Data Source:** EHR, Claims

**Outcome Improvement Target 1 Estimated Incentive Payment:** $427,612

### Outcome Improvement Target 2 [IT-1.11]: Diabetes care: BP control

**Improvement target:** 10% increase in diabetic patients with controlled blood pressure over DY2 baseline

**Data Source:** EHR, Claims

**Outcome Improvement Target 2 Estimated Incentive Payment:** $1,022,549
<table>
<thead>
<tr>
<th>121775403.3.3</th>
<th>3.IT-1.11</th>
<th>Diabetes Care: BP Control</th>
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<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Corpus Christi</td>
<td>121775403</td>
<td>121775403.1.3</td>
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<td><strong>Related Category 1 or 2 Projects:</strong></td>
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<tr>
<td><strong>Starting Point/Baseline:</strong></td>
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<tbody>
<tr>
<td>Incentive Payment: $114,949.50</td>
<td>Year 2 Estimated Outcome Amount: <strong>$266,483</strong></td>
<td>Year 4 Estimated Outcome Amount: <strong>$427,612</strong></td>
<td>Year 5 Estimated Outcome Amount: <strong>$1,022,549</strong></td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $1,946,542
Identifying Outcome Measure and Provider Information:

1.9.3 - Implement other evidence based project to enhance specialty care capacity in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under improvement milestone I-X.
CHRIUSTUS Spohn Hospital Corpus Christi/ TPI 121775403

Outcome measure title admission rates:
IT 4.2 Central line-associated bloodstream infections (CLABSI)

Unique RHP outcome identification numbers: 121775403.3.4

Outcome Measure Description
IT 4.2 Spohn chose this outcome because one goal behind moving to the intensivist model of care is to reduce the rate of hospital-acquired and potentially preventable complications that often result from uncoordinated care and longer than necessary hospital visits. Evidence shows that when a hospitalist model is used, patients receiving non-specialized care experience improved outcomes. In review of Spohn’s PPCs for non-ICU patients, a higher than the national average rate was identified for CLABSI. These systemic infections increase the risk of mortality, increase the length of stay, and increase the cost per case to treat the hospital acquired infection.

Process Milestones:
- DY2:
  - PI – Project planning-engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plans
  - P2 – establish baseline rates
- DY3:
- DY4
  - 10% improvement in rate of CLABSI for ICU patients
- DY 5
  - 20% improvement in rate of CLABSI for ICU patients

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable complications. Patients who experience these infections are likely to experience worse short and long-term health outcomes, have a lower level of patient satisfaction, and cost more to the healthcare delivery system, each of which are issues that the Waiver is meant to address.
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will develop an approach for using the hospitalist model to directly address the rate of CLABSI for inpatients in the non-ICU setting</td>
<td><strong>Outcome Improvement Target 1</strong> [IT 4.2]: Spohn will reduce the rate of CLABSI for ICU patients by 22% from the baseline established in DY2 (for an estimated rate of 2.8) <strong>Data Source</strong>: EHR</td>
<td><strong>Outcome Improvement Target 2</strong> [IT 4.2]: Spohn will reduce the rate of CLABSI for ICU patients by 45% from the baseline established in DY2 (for an estimated rate of 2) <strong>Data Source</strong>: EHR</td>
<td><strong>Outcome Improvement Target 3</strong> [IT 4.2]: Spohn will reduce the rate of CLABSI for ICU patients by 58% from the baseline established in DY2 (for an estimated rate of 1.5) <strong>Data Source</strong>: EHR</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baseline rates – Spohn will establish the DY2 rate of Data Source: EHR</td>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $101,426</td>
<td><strong>Outcome Improvement Target 21</strong> Estimated Incentive Payment: $377,304</td>
<td><strong>Outcome Improvement Target 3</strong> Estimated Incentive Payment: $902,250</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> (add incentive payments amounts from each milestone/outcome improvement target): $202,852</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $235,132</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $377,304</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $902,250</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $1,717,537
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
ED appropriate utilization – reduce ED visits for BH/SA; 3.IT-9.2
CHRISTUS Spohn Hospital Corpus Christi/121775403

Unique Project ID Number: 121775403.3.5

Outcome Measure Description
The aim of this outcome measure is to reduce inappropriate use of the ED by patients seeking treatment for behavioral health or substance abuse conditions that are non-emergent. Spohn expects that by removing the PAS from Spohn’s ED that patients will present at the ED less frequently, and instead seek treatment at the FHC within the community as a first intervention.

Process milestones: Spohn will create a plan for reducing inappropriate use of the ED for targeted patients in DY2 (which is likely to include educating the community about the new clinic service availability). Spohn will establish a baseline of patients presenting in the ED for treatment related to behavioral health or substance abuse in DY2, allowing Spohn to measure progress going forward. Finally, Spohn will develop and test a tracking system for behavioral health patients utilizing the clinic and patients presenting at the ED, in order to look for overlap or a reduction in “frequent flyers.”

Improvement Targets: Spohn expects a ten percent reduction under the baseline set in DY2 of inappropriate use of the ED by patients seeking behavioral health or substance abuse treatment in DY4, and a fifteen percent reduction under the DY2 baseline by DY5.

Rationale:
Spohn chose this outcome measure based on its analysis of ED admission data by DRG for the past 2 fiscal years. This data revealed the highest number of ED visits for BH/SA occurred at Spohn’s Memorial location (where the PAS is located), with almost a fourth of those patients admitted and half of those admitted being discharged below the expected LOS indicative of potentially preventable admissions as described in previous sections.

Emergency room admissions are a much more expensive setting in which to provide non-emergent services than within a community clinic. Region 4 must reduce the systemic cost of providing care to the indigent and uninsured populations because high unnecessary high costs monopolize much needed funds to provide necessary services within the community. Additionally, Spohn believes that patients will benefit from receiving care in the clinic setting because they will receive more comprehensive treatment, will avoid the trauma and risks associated with hospital admission (where possible), and will create relationships with primary care providers who can help manage their conditions.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population
served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable admissions and the need for unnecessary ED visits. Excessive hospitalizations impact the patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – identify current capacity, resources and timeliness of treatment provided at Spohn’s existing PAS, and develop a plan to relocate the crisis stabilization unit and to improve patient outcomes, cost, and efficiency concurrently. <strong>Data Source:</strong> Written plan.</td>
<td><strong>Process Milestone 3 [P-3]:</strong> Develop and test data systems – create a system for tracking patients who present at the ED for BH/SA care with non-emergent conditions, the number of patients utilizing the new crisis stabilization center, and any overlap between the two. <strong>Data Source:</strong> Data acquisition procedures and reports.</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]:</strong> ED appropriate utilization Improvement Target: 10% reduction in ED visits at Spohn for BH/SA patients from baseline established in DY2. <strong>Data Source:</strong> ED hospital patient logs, financial reports on ED admissions by payor and diagnoses.</td>
<td><strong>Outcome Improvement Target 2 [IT-9.2]:</strong> ED appropriate utilization Improvement Target: 15% reduction in ED visits at Spohn for BH/SA patients from baseline established in DY2. <strong>Data Source:</strong> ED hospital patient logs, financial reports on ED admissions by payor and diagnoses.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $128,473</td>
<td>Process Milestone 3 Estimated Incentive Payment: $148,917</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $477,919</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,142,849</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates/cost for care in current settings – determine the number of ED visits at Spohn in DY2 for BH/SA patients and determine the percentage of patients presenting to Spohn’s ED for BH/SA treatment that are determined to have non-emergent or non-urgent conditions. <strong>Data Source:</strong> Spohn electronic health records.</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, lessons learned and best practices to stakeholders – draft a report addressing the success of reducing inappropriate ED utilization by the target population, key challenges identified to decreasing inappropriate utilization, and best practices identified, and meet with community stakeholders once during DY3. <strong>Data Source:</strong> Stakeholder reports, meeting minutes.</td>
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</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $256,946</td>
<td>Year 3 Estimated Outcome Amount: $297,833</td>
<td>Year 4 Estimated Outcome Amount: $477,919</td>
<td>Year 5 Estimated Outcome Amount: $1,142,849</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $2,175,547

RHP Plan for Region 4
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
12775403.1.9.1. Psychiatric Mental Health Nurse Practitioner – Expand Specialty Care Capacity
3.1. Primary Care and Chronic Disease Management – IT-1.18 CHRISTUS Spohn Hospital Corpus Christi / 121775403
Unique Identifier - 121775403.3.6

Outcome Measure Description
Outcome Improvement Target [IT-1.18]: Follow-Up After Hospitalization for Mental Illness

Improvement Target: Spohn intends to increase the number of mid-level psychiatric providers in Region 4, as a result of both students performing rotations in Spohn facilities and graduates from the MSA – NP program opting to remain in Region 4 and work in a practice with a high Medicaid share that reflect the distribution of Medicaid in the population. As a result, Spohn expects an increased rate of follow up to patients hospitalized for mental illness after discharge. The students on rotation and newly recruited providers will contact patients for follow up visits as soon as possible after discharge, with more acute patients receiving follow-up within 7 days and all others receiving follow up within 30 days of discharge.

Rationale:
Spohn chose this outcome because a natural consequence of adding student rotations and recruiting mental health providers into the community is that patients will have greater access to mental health providers, including after discharge. Follow-up after discharge is important because patients need to receive monitoring for signs of relapse, consistent medication management, integrated medical care, and support in order to remain in the community. The students on rotation at Spohn clinics should be able to identify and treat some patients prior to them requiring hospitalization, but for others can act as a safety net upon returning to the community from an inpatient stay.

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of increased availability of psychiatric nurse practitioners to provide follow-up contacts to recently discharged patients with mental illness. The potential patient impact for satisfaction with the healthcare delivery system and increased quality of life upon discharge are expected to increase with the timely provision of follow-up services. Additionally, Spohn expects that this will positively impact these patients’ access to integrated care and potentially reduce the rate of costly PPAs and PPRs for mental-health related issues.
| Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources for incorporating PMH-NPs into follow up care for inpatients with mental health diagnoses  
Data Source: Project plan documentation | Process Milestone 2 [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders regarding the use of PMH-NP rotations to expand Spohn’s follow up care in the community  
Data Source: Minutes, attendance logs, presentation documentation | Outcome Improvement Target 1 [IT-1.18]: Follow up after Hospitalization for Mental Illness  
Improvement Target:  
Numerator: Rate 1: outpatient visit within 30 days of discharge (outpatient visits on day of discharge can be counted).  
Rate 2: outpatient visit within 7 days of discharge (outpatient visits on day of discharge can be counted).  
Denominator: Patients 6 years or older on date of discharge from an acute care setting with a principal mental health diagnosis  
Goal: 15% of target population contacted within 30 days of discharge for an outpatient follow-up visit; 8% of target population contacted within 7 days for an outpatient follow-up visit  
Data Source: Loan documentation. | Outcome Improvement Target 3 [IT-1.18]: Follow up after Hospitalization for Mental Illness  
Improvement Target:  
Numerator: Rate 1: outpatient visit within 30 days of discharge (outpatient visits on day of discharge can be counted).  
Rate 2: outpatient visit within 7 days of discharge (outpatient visits on day of discharge can be counted).  
Denominator: Patients 6 years or older on date of discharge from an acute care setting with a principal mental health diagnosis  
Goal: 25% of target population contacted within 30 days of discharge for an outpatient follow-up visit; 10% of target population contacted within 7 days for an outpatient follow-up visit  
Data Source: Loan documentation. |
|---|---|---|---|
| Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $202,852 | Process Milestone 2 Estimated Incentive Payment: $117,566 | Outcome Improvement Target 2 [IT-1.18]: Follow up after Hospitalization for Mental Illness  
Improvement Target:  
Numerator: Rate 1: outpatient visit within 30 days of discharge (outpatient visits on day of discharge can be counted).  
Rate 2: outpatient visit within 7 days of discharge (outpatient visits on day of discharge can be counted).  
Denominator: Patients 6 years or older on date of discharge from an acute care setting with a principal mental health diagnosis  
Goal: 10% of target population contacted within 30 days of discharge for an outpatient follow-up visit; 5% of target population | Outcome Improvement Target 3 Estimated Incentive Payment: $902,254 |
<p>| Starting Point/Baseline: | Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) |</p>
<table>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>121775403.6</th>
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</thead>
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<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<tr>
<td>contacted within 7 days for an outpatient follow-up visit</td>
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<tr>
<td>Data Source: EHR, Claims</td>
<td>Outcome Improvement Target 1</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$117,566</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>(add incentive payments amounts from each milestone/outcome improvement target): $202,852</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$235,132</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$377,304</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$902,250</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $1,717,537
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.6.1 - Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population.

Primary Care and Chronic Disease Management – Diabetes Care: HA1c poor control (≥ 9%); 3.IT-1.10
CHRISTUS Spohn Hospital Corpus Christi/121775403
Unique Identifier – 121775403.3.7

Outcome Measure Description
Spohn expects the outcome of implementing and increasing participation in the diabetes mobile application program to be an increase in the number of diabetic patients in Spohn’s family health clinics ("FHCs") and the Hector P Garcia clinic with controlled glycemic rates.

Process milestones:
• DY2: Project planning
  o Spohn will plan for expanding the pilot program to include high-volume of diabetic patients seen in the clinics, and for assuring patient compliance with the program
• DY2: Establish a baseline
  o Spohn will determine the number patients treated in its clinics and the Hector P Garcia clinic (where Spohn’s physician-residents provide care) who have an uncontrolled glycemic rate (>9%)
• DY3: Test data systems
  o Spohn will measure patients’ compliance with the mobile application program and assure that the data retrieved and transmitted is received and interpreted accurately
• DY3: Disseminate findings
  o Spohn will take educate providers and patients and other stakeholders in the community about the potential impact of the mobile application, the success of the pilot program, and the purpose behind consistent monitoring

Improvement Targets:
• DY4: Increase in percentage of patients with controlled glycemic levels
  o Spohn estimates that 37% of patients have blood sugar above 9%, which would mean that approximately 7215 patients treated in Spohn’s clinics and the Hector P Garcia clinic could benefit from the mobile diabetes application
  o Spohn is targeting a 5% increase in the number of patients with controlled blood sugar over baseline (an estimated additional 361 patients)
• DY5: Increase in percentage of patients with controlled glycemic levels
  o Spohn is targeting a 8% increase in the number of patients with controlled blood sugar over baseline (an estimated additional 577 additional patients patients)

Rationale:
A 43% prevalence of Diabetes Type 2 in our region is enormous. As a major provider and employer in the region our goal is to establish an innovative solution using current technology to reduce the burden of self-management and expand accessibility to such solutions. Normalizing HbA1c levels will promote
wellness and reduce the impact of diabetes as a foundation for other chronic diseases such as heart, kidney and eye disease. Specifically, an increase in the volume of patients with controlled blood sugar should have a positive impact on the number of patients developing kidney disease, PAD, and blindness (to name a few) and the cost of treating those associated conditions. Spohn selected the specific outcome milestones and metrics to test and show the effectiveness of closer self-management of HA1c levels as part of its pilot and planning process, so that by year 5 of the Waiver Spohn can effect an 8% increase in the volume of clinic patients, including Medicaid, uninsured and indigent patients, who monitor and control their HbA1c levels and diabetes generally. Spohn roughly estimates that an 8% increase in the volume of patients with controlled blood sugar will affect 577 patients who are currently at risk for developing diabetes-related complications and needing potentially avoidable interventions.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to controlling blood sugar and preventing hospital admissions for diabetics with uncontrolled blood sugar. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Year 2 Baseline</th>
<th>Year 3 Baseline</th>
<th>Year 4 Baseline</th>
<th>Year 5 Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rate of diabetic patients in Spohn’s FHCs with controlled HbA1c levels (below 9%) as compared to the total number of diabetic patients</td>
<td></td>
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<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems – Spohn will develop a protocol for monitoring patients’ ongoing control of their blood sugar and test the system to assure stability and accuracy</td>
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</tr>
<tr>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders – Spohn will educate patients and providers about the benefits of controlling blood sugar, engaging in community outreach, and best practices for effecting lifestyle changes to better manage diabetes</td>
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</table>

**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)
- Improvement Target: 5% increase in patients with controlled HbA1c levels from baseline established in DY2
- Data Source: application reports, clinic and ED documentation
- Estimated Incentive Payment: $402,458

**Outcome Improvement Target 2** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)  
- Improvement Target: 8% increase in patients with controlled HbA1c levels from baseline established in DY2
- Data Source: application reports, clinic and ED documentation
- Estimated Incentive Payment: $962,399

**Total Estimated Incentive Payments for 4-Year Period** (add outcome amounts over DYs 2-5): $1,832,040
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.5.2 - Implement other evidence based project to redesign for cost containment in an innovative manner not described above. Note, providers opting to implement an innovative project under this option must propose relevant process metrics and report on the improvement metrics listed under milestone I-11.

Outcome Domain 4: Potentially Preventable Complications; IT 4.2 Central line-associated bloodstream infections (CLABSI) Rates CHRISTUS Spohn Hospital Corpus Christi/121775403
Unique Project ID: 121775403.3.8

Outcome Measure Description
Through its Category 2 project to move its Corpus facilities to the Hospitalist model of inpatient care, Spohn expects to reduce the rate of hospital acquired CLABSI. Spohn expects this result due to the team approach to care (the hospitalists will lead multi-disciplinary teams assigned to patients in the hospital), the individual attention given to patients by their assigned physician, and by the reduction in average length of stay expected as a result of having patients assigned to hospitalists.

Rationale:
Spohn chose this outcome because one goal behind moving to the hospitalist model of care is to reduce the rate of hospital-acquired and potentially preventable complications that often result from uncoordinated care and longer than necessary hospital visits. Evidence shows that when a hospitalist model is used, patients receiving non-specialized care experience improved outcomes. In review of Spohn’s PPCs for non-ICU patients, a higher than the national average rate was identified for CLABSI. These systemic infections increase the risk of mortality, increase the length of stay, and increase the cost per case to treat the hospital acquired infection.

Outcome Measure Valuation:
- The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients by reducing the rate of and risk for CLABSI. Patients who experience these infections are likely to experience worse short and long-term health outcomes, have a lower level of patient satisfaction, and cost more to the healthcare delivery system, each of which are issues that the Waiver is meant to address.
### Related Category 1 or 2 Projects:

121775403.2.2

**Starting Point/Baseline:**

For non-ICU patients in FY 2012, Spohn’s rate of CLASBI was 1.56, with a national benchmark target of 1.2. These rates are calculated based on infections per 1000 central line days. While this may not sound significant, the rate in the first six months of FY 2013, the rate has increased to 3.34.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – Spohn will create a comprehensive plan for using the hospitalist model to directly address the rate of CLBSI for inpatients in the non-ICU setting</td>
<td><strong>Outcome Improvement Target 1 [IT 4.2]:</strong> Spohn will reduce the rate of CLBSI for non-ICU patients by 16% from the baseline established in DY2 (for an estimated rate of 2.8) <strong>Data Source:</strong> EHR</td>
<td><strong>Outcome Improvement Target 2 [IT 4.2]:</strong> Spohn will reduce the rate of CLBSI for non-ICU patients by 40% from the baseline established in DY2 (for an estimated rate of 2) <strong>Data Source:</strong> EHR</td>
<td><strong>Outcome Improvement Target 3 [IT 4.2]:</strong> Spohn will reduce the rate of CLBSI for non-ICU patients by 55% from the baseline established in DY2 (for an estimated rate of 1.5) <strong>Data Source:</strong> EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <strong>(maximum amount):</strong> $81,141.</td>
<td>Process Milestone 3 Estimated Incentive Payment: $188,105</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $301,843</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $721,800</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates – Spohn will determine the current rate of CLASBI at its facilities for non-ICU patients <strong>Data Source:</strong> Charity, Medicaid, and uninsured hospital &amp; clinic financial data</td>
<td></td>
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</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $81,140</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $162,281</td>
<td>Year 3 Estimated Outcome Amount: $188,105</td>
<td>Year 4 Estimated Outcome Amount: $301,843</td>
<td>Year 5 Estimated Outcome Amount: $721,800</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):</strong> $1,374,030</td>
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**RHP Plan for Region 4**

CHRISTUS Spohn Hospital Corpus Christi
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
1.2.1 – Increase Training of Primary Care Workforce
CHRISTUS Spohn Hospital Corpus Christi/121775403
Diabetes Short Term Complication Admission Rate; OD 2, IT 2.7
Unique Identifier - 121775403.3.9

Outcome Measure Description
Diabetes hospital admissions often result from the fact that patients do not have regular access to care in the community, especially if they are indigent or rural patients. The Increase Primary Care Training project is expected to allow 4600 additional patient encounters per year, which Spohn hopes will result in fewer PPAs for patients in the HP Garcia clinic. Diabetes is a prevalent chronic disease in South Texas, and Spohn hopes that the increased resident presence in the clinic will reduce the number of patients who are admitted to the hospital for preventable diabetes complications.

Rationale:
A 43% prevalence of Diabetes Type 2 in our region is enormous. As a major provider and employer in the region our goal is to establish interventions to address the morbidity, complications, and deaths related to this chronic disease. One such intervention is providing more primary care and training more providers to give that care, in order to reduce the number of patients hospitalized for this manageable disease. A reduction in PPAs in this domain should indicate healthier patients in the community and lead to cost savings system wide.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of reducing hospital stays for chronically ill patients. Those PPAs are costly to the healthcare delivery system, they have a negative impact on patient health, and reduce patients’ quality of life and satisfaction with their access to healthcare.
<table>
<thead>
<tr>
<th>121775403.3.9</th>
<th>3.2.7</th>
<th>Diabetes Short Term Complication Admission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>121775403.2.3</td>
<td>CHRISTUS Spohn Hospital Corpus Christi</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>Spohn’s Corpus facilities experienced approximately 12,300 diabetes admissions in FY 2012.</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline rates of diabetes PPAs</td>
<td>Outcome Improvement Target 1 [IT-2.7]: Reduction in PPAs for short term diabetes complications</td>
<td>Outcome Improvement Target 2 [IT-3.2.7]: Reduction in PPAs for short term diabetes complications</td>
</tr>
<tr>
<td>Data Source: NCHD/Medicaid hospital &amp; clinic financial data</td>
<td>Improvement Target: 5% decrease in rate of targeted PPAs from baseline established in DY2</td>
<td>Improvement Target: 10% decrease in rate of targeted PPAs from baseline established in DY2</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $162,281</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $188,105</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $1,374,030*
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

3. IT-9.2 ED appropriate utilization – Reduce ED visits for behavioral health/SA

CHRISTUS Spohn Hospital Corpus Christi / 121775403
Project Unique ID Number: 121775403.3.10

**Outcome Measure Description**

Spohn expects its integration of behavioral health/SA care into the primary medical care setting to result in a reduced misuse of the ED by behavioral health/SA for non-emergent treatment. This outcome measure is important because treatment in the ED is much more expensive to provide than in other settings, and does not improve patient outcomes. Instead, early intervention provided in a comprehensive healthcare setting is expected to improve patient outcomes and satisfaction, and lead to fewer ED visits. Finally, the FHCs are set up to provide care to uninsured, so they may feel assured that the ED is not the only setting in which they can obtain behavioral health/SA care.

**Process Milestones:** In DY2, Spohn will develop a plan for leveraging the new LMHP in the community FHC to reduce misuse of the ED by behavioral health/SA patients, and will establish a baseline rate of non-emergent ED visits for behavioral health/SA.

**Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization**

**Improvement Target:** Reduce ED visits from service area zip codes for behavioral health/SA:

**Metric 1:** 15% reduction as a primary diagnosis by end of waiver

**Rationale:**

These outcome measures and improvement targets were selected based on collaborative discussions with LMHAs and review of initial data for transformation of care delivery showing a high overuse of the ED by this patient population. In 2010, Nueces County was charged for $307,282,274, much of which was incurred through treatment provided in the ED that was non-emergent, including for behavioral health/SA patients (RHP Plan, Section 3, Table 8). Spohn, like many providers in Region 4 and Texas, has limited resources with which to provide services to the indigent and uninsured in the community; thus, reducing misuse of a very expensive care setting (the ED) is a reasonable outcome measure to target in conjunction with integrating behavioral and physical health care.

**Outcome Measure Valuation:**

The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential health benefits to the community when resources can be redirected from providing non-emergent care in the ED to improving primary care in the Region for patients with behavioral health and physical conditions requiring treatment.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – Spohn will create a plan to use the behavioral health care integration to reduce the misuse of the ED, which will likely include strategies for community outreach and provider education. Data Source: Project plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates – Spohn will determine the 2012 number of ED visits for BH/SA patients, and of non-emergent ED visits for BH/SA from patients in its service area zip codes, so it can measure progress going forward. Data Source: Historical clinic/hospital/ED claims and financial data</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization \n<strong>Improvement Target:</strong> Reduce ED visits to Spohn’s Corpus Christi locations from its service area zip codes for BH/SA (primary diagnosis) by 5% \n<strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $250,807</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization \n<strong>Improvement Target:</strong> Reduce ED visits to Spohn’s Corpus Christi locations from its service area zip codes for BH/SA (primary diagnosis) by 10% \n<strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $402,458</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization \n<strong>Improvement Target:</strong> Reduce ED visits to Spohn’s Corpus Christi locations from service area zip codes for behavioral health/SA (primary diagnosis) by 15% \n<strong>Data Source:</strong> ED admissions data, clinic referral logs</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $962,399</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add in incentive payments amounts from each milestone/outcome improvement target): $216,375</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $250,807</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $402,458</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $962,399</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,832,040</td>
</tr>
</tbody>
</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
3.1. Primary Care and Chronic Disease Management –
   IT-9.2: ED Appropriate Utilization (reduce emergency department visits for diabetes)
CHRISTUS Spohn Hospital Corpus Christi / 121775403
Project Unique ID: 121775403.3.1

Outcome Measure Description
Spohn expects the outcome of its project to identify patients with diabetes and CHF who have a co-diagnosis in BH/depression to result in a reduced volume of ED visits from diabetic patients. Spohn will screen patients who present in the ED initially for BH needs (and in its other treatment settings), and make referrals where necessary; this should result in fewer repeat ED visits by diabetic patients who possibly have a co-diagnosis from returning to the ED.

Process Milestones: In DY2, Spohn will create a plan for using its project to increase screening of CHF and diabetes patients for BH referrals to reduce the number of overall ED visits from diabetic patients. Spohn will also establish a baseline of the number of ED visits from diabetic patients in order to measure progress going forward.

Improvement Targets: In DY3, Spohn aims to reduce the volume of ED visits from patients with diabetes by 5% from the DY2 baseline. In DY4, Spohn aims for a decrease in ED visits from diabetic patients of 10% over DY2, and by the end of DY5 Spohn aims for a decrease in the volume of ED visits from diabetic patients by 15%.

Rationale:
Treatment management and patient outcomes such as PPR and mortality can only be impacted if patients with co-existing physical and behavioral illness can be identified and referred to the appropriate providers for a treatment plan inclusive of both domains. This is why we chose to focus on training providers in screening and recognition in target populations, communication between providers and increasing the number of patients screened in the EDs, Primary Care and BH settings.

Spohn expects that screening and identifying diabetic patients with potential BH needs will result in receive fewer subsequent visits to the ED from that population. This will indicate that more of those patients are receiving the right care in the right setting, and will reduce the high cost of treating Medicaid/uninsured patients in the ED. The reduced ED volume should also have a ripple effect for the inpatient setting – fewer of the targeted patients will be admitted from the ED and reduce inpatient costs, increase the availability of beds, and improve patient outcomes.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community of BH/SA screening/treatment for CHF patients and vice versa, in order to prevent unnecessary hospital admissions and readmissions. Hospital admissions reduce a patient’s quality of life, functionality,
morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>CHRISTUS Spohn Hospital Corpus Christi</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – Spohn will create a protocol for ED providers in screening and referring diabetic patients for BH assessments where necessary and create a plan for tracking the repeat ED visits of those patients going forward</td>
<td><strong>121775403.2.5</strong></td>
</tr>
<tr>
<td><em>Data Source:</em> Project plan</td>
<td><strong>3. IT- 9.2. ED Appropriate Utilization</strong></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1 [IT-9.2]:</strong> ED appropriate utilization Improvement Target: 5% decrease in volume of ED visits from diabetic patients from baseline established in DY2</td>
<td><strong>ED Appropriate Utilization</strong></td>
</tr>
<tr>
<td><em>Data Source:</em> EMR, referral documentation, clinic and hospital financial/claims data</td>
<td>121775403</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-5]:</strong> Establish baseline – Spohn will determine the number of ED visits from diabetic patients</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,488,532</strong></td>
</tr>
<tr>
<td><em>Data Source:</em> FHC and hospital patient records</td>
<td><strong>RHP Plan for Region 4</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $87,902.50</td>
<td><strong>969</strong></td>
</tr>
</tbody>
</table>

**Year 2**

- **Year 2 Estimated Outcome Amount:** $175,805
- **Year 2 Estimated Incentive Payment:** $87,902.50

**Year 3**

- **Year 3 Estimated Outcome Amount:** $203,781
- **Year 3 Estimated Incentive Payment:** $87,902.50

**Year 4**

- **Year 4 Estimated Outcome Amount:** $326,997
- **Year 4 Estimated Incentive Payment:** $87,902.50

**Year 5**

- **Year 5 Estimated Outcome Amount:** $781,950
- **Year 5 Estimated Incentive Payment:** $87,902.50

In FY 2012, Spohn’s Corpus EDs experienced approximately 1300 diabetes related visits.
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

2.1.1 - Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Right Care in the Right Setting - ED appropriate utilization-reduce ED visits for enrolled patients with CHF and Diabetes; 3.9.IT-9.2

CHRISTUS Spohn Hospital Corpus Christi / 121775403
Unique Identifier - 121775403.3.12

**Outcome Measure Description**

**Outcome Improvement Target 3 [IT-9.2]:** Reduce ED visits for patients with Diabetes short-term complications

Improvement Target: 15% reduction in ED visits for CHF patients by end of waiver

**Rationale:**

This outcome measure and improvement target was selected based on initial analysis of ED visit data, PPA data and the evidence-based practice supporting the implementation of a Medical Home Model for care delivery. Spohn FHCs and the Hector P Garcia clinic are located in proximity to zip codes with patients identified for higher incidence of ED usage for primary care diagnoses. CHF is a prevalent chronic disease in South Texas, and with many patients having little to no access to primary care presently, many use the ED for their healthcare needs. While the number of ED visits for CHF patients may seem rather low at first blush (406 in FY 2012), the average cost of treating these patients in the ED (who are almost always thereafter admitted) is approximately 22% higher than other prevalent chronic diseases. The medical home model should allow primary care providers to furnish regular chronic care to the CHF population, and thereby reduce their use of the ED for non-emergent healthcare needs.

**Outcome Measure Valuation:**

The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable admissions and the need for unnecessary ED visits. Excessive hospitalizations impact the patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>121775403.3.12</th>
<th>3.IT-9.2</th>
<th>Right Care, Right Setting IT-9.2 ED appropriate utilization (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>121775403.2.6</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>In FY 2012, Spohn Corpus EDs received approximately 400 CHF-related visits and 350 patients; Diabetes: 1,278 visits/930 patients</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning w stakeholders to identify timelines, current capacity and implementation plan to enroll patients in the medical home and effect a reduction in misuse of the ED</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-9.2]: Reduce ED visits for patients with CHF by 5% from baseline in DY2 Improvement Target: 5% reduction in ED visits for CHF Data Source: chronic disease registry, hospital ED admission records</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-9.2]: Reduce ED visits for patients with CHF Improvement Target: 10% reduction in ED visits for CHF population from baseline in DY2 Data Source: chronic disease registry, hospital ED admission records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $108,188</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $250,807</td>
<td><strong>Outcome Improvement Target 2</strong> Estimated Incentive Payment: $402,458</td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline – number of ED visits related to CHF or Diabetes Data Source: Clinic financial reports, schedules, policies and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $108,187</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $216,375</td>
<td>Year 3 Estimated Outcome Amount: $250,807</td>
<td>Year 4 Estimated Outcome Amount: $402,458</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $1,832,040</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Errors in Bedside Medication Administration

Unique Identifier -121775403.3.13
As a result of Spohn’s ability to have electronic medication reconciliation at the point of care, Spohn expects to be able to have pharmacists as part of the medication reconciliation and utilization review process throughout the hospitalization and at discharge. Pharmacists will be specifically alerted to assess patient profiles for drug interactions and those receiving medications identified as being high risk for medication errors.

Outcome Measure Description
- DY2
  - P-2: Establish baseline rates for bedside medication administration errors. The baseline rate will be set based on the total number of medications administered during the year ending (the base period), with the numerator of the rate equaling the total number of medication errors for acute care patients during the base period and the denominator being set as the total medications administered to acute care patients at Spohn facilities during the base period. This medication error rate will serve as the basis for assessing the effectiveness of implementing the new BMV system.
  - **Data Source:** Quality reports, electronic medication administration record (eMAR) reports

Outcome Improvement Targets
- DY 3
  - IT-4.10: Other outcome improvement target
    - **Improvement Target:** 5% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    - **Data Source:** Quality reports
- DY 4
  - IT-4.10: Other outcome improvement target
    - **Improvement Target:** 10% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    - **Data Source:** Quality reports
- DY 5
  - IT-4.10: Other outcome improvement target
    - **Improvement Target:** 15% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
Data Source: Quality reports

Rationale:
Medication Management provides information that facilitates the appropriate use of medications in order to control illness and promote health according to The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. Monitoring medication is key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications.

In a latest study out of the University of Pittsburgh Medical Center (Rack, Dudjak & Wolf, 2012) registered nurse (RN) workarounds were analyzed to determine the frequency and causes of workarounds while using bar code medication administration technology. Over half the nurses included in the study indicated that during their last shift worked, they administered medications without scanning the medication or the patient. Reasons for non-adherence to bar code scanning are identified as process related with an impact on patient safety outcomes. Process issues include step omission, steps out of sequence and unauthorized steps (Rack, 2012) that can be attributed to task, environment, patient, organization and technology related workarounds (Koppel, Wetterneck, Telles & Karsh, 2008). While BMV does not eliminate medication errors, it has shown a large impact on errors of wrong dose and wrong time (Rack, 2012). Quasi-experimental studies have been conducted in both intensive care units (ICU) and non-ICU units. One ICU study showed an overall med error reduction of 56% ($p < 0.001$) with reduction in administration time errors (19.7% to 7.5%, $p < 0.001$) having the largest impact on overall reduction rates (DeYoung, Vanderkooi & Barletta, 2009). Another study with over 14,000 medication administrations and 3000 order transcriptions reported a 41.4% relative reduction rate in medication errors ($p < 0.001$) for units using bar coding and eMAR versus units that did not.

Increasing control over the management and tracking of medication, particularly for acute care patients will help reduce the risk of medication errors and the resulting complications. The decrease in medication errors at the bedside will be a reliable indicator of the effectiveness of this project and in particular the goal of reducing preventable complications that arise with medication errors.

Spohn selected this outcome because increasing control over the management and tracking of medication, particularly for acute care patients, will help reduce the risk of medication errors and the resulting complications. The decrease in medication errors at the bedside will be a reliable indicator of the effectiveness of this project and in particular the goal of reducing preventable complications that arise with medication errors.

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of medication administration errors. Medication errors are a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to follow procedures designed to increase patient safety, reduce medication errors, identify process barriers that lead to work-arounds, proactive assessments of...
patients’ medications, communication between providers, and preemptive measures to protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish baseline rates for bedside medication administration errors, prior to implementation of new system <strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</th>
<th>Outcome Improvement Target 1 [IT-4.10]: Other outcome improvement target  <strong>Improvement Target:</strong> 5% reduction in bedside medication administration errors from DY2 baseline  <strong>Data Source:</strong> Quality reports</th>
<th>Outcome Improvement Target 2 [IT-4.10]: Other outcome improvement target  <strong>Improvement Target:</strong> 10% reduction in bedside medication administration errors from DY2 baseline  <strong>Data Source:</strong> Quality reports</th>
<th>Outcome Improvement Target 3 [IT-4.10]: Other outcome improvement target  <strong>Improvement Target:</strong> 15% reduction in bedside medication administration errors from DY2 baseline  <strong>Data Source:</strong> Quality reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $31,555</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $36,576</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $29,346</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $421,050</td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)  
**Year 3** (10/1/2013 – 9/30/2014)  
**Year 4** (10/1/2014 – 9/30/2015)  
**Year 5** (10/1/2015 – 9/30/2016)

| Year 2 Estimated Outcome Amount: $31,555 | Year 3 Estimated Outcome Amount: $36,576 | Year 4 Estimated Outcome Amount: $58,692 | Year 5 Estimated Outcome Amount: $140,350 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $267,172*
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Average length of stay
CHRISTUS Spohn Hospital Corpus Christi / TPI: 121775403
Unique Identifier -121775403.3.14

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management

Outcome Measure Description
- DY2
  - P-2: Establish baseline rates for patients for length of stay for high risk patients and patients receiving medications identified as high risk for medication errors. The baseline rate will be set based on the total number of high risk reviews performed. Program expansion is based on initial results at CSHCC-Memorial reporting an annualized reduction in average length of stay (ALOS) by 1 day reduction for IV home infusion transition alone during the year ending (the base period), with the numerator equaling the total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and the denominator being set as the total number of patients identified as high risk or receiving medications identified as high risk for medication errors at CHRISTUS Spohn Hospital Corpus Christi (“Spohn”) facilities during the base period. This ratio will demonstrate the change ALOS for this target population (See rationale for criteria that define high risk)
  - Data Source: Quality reports, electronic medication administration record (eMAR) reports

- DY3
  - P-3 Develop and test data systems
  - Data Source: EMR and utilization review documents

Outcome Improvement Targets:
- DY 4
  - IT-4.10: Other outcome improvement target
    - Improvement Target: Average Length of stay
    - Data Source: Medication Management and Utilization Review reports

- DY 5
  - IT-4.10: Other outcome improvement target
    - Improvement Target: Average Length of stay
Data Source: Medication Management and Utilization Review reports

Rationale:
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria include but are not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone.

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication management. Achieving this outcome will require considerable and concerted effort (i.e. assessment of each patient’s health literacy level, support in their post-discharge environment and ability to adhere to prescribed regimes and communication between providers to formulate the best possible treatment options) and investment in infrastructure; however, the outcome will justify the expense.
**CHRISTUS Spohn Hospital Corpus Christi**

<table>
<thead>
<tr>
<th>121775403.14</th>
<th>3.4.IT-4.10</th>
<th>Average Length of Stay for high risk patients and patients receiving drugs identified as high risk for medication errors and PPC</th>
</tr>
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</table>

### Related Category 1 or 2 Projects:

Starting Point/Baseline:

In FY2012, Spohn’s Corpus Christi Memorial facility experienced an annualized reduction in patients requiring long-term IV therapy. 391 acute care patient days were eliminated by transitioning these patients to IV home infusion therapy. Patient days were determined by number of days required for treatment.

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

#### Process Milestone 1 [P-2]:
Establish baseline rates for bedside medication administration errors, prior to implementation of new system

- **Data Source:** Quality reports, electronic medication administration record (eMAR) reports

- **Process Milestone 1 Estimated Incentive Payment:** $31,555

#### Process Milestone 2 [P-3]:
Develop and test data systems

- **Data Source:** EMR and utilization review documents

- **Process Milestone 2 Estimated Incentive Payment:** $36,576

#### Outcome Improvement Target 1 [IT-4.9]:
Average length of stay

e. Numerator: Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC

f. Denominator: Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC

- **Data Source:** Case Management and Utilization Review reports

- **Estimated Incentive Payment:** $29,346

#### Process Milestone 2 [P-5]:
Disseminate finding, lessons learned and best practices to stakeholders

- **Data Source:** Stakeholder meetings, minutes, attendance logs

- **Process Milestone 2 Estimated Incentive Payment:** $29,346

### Year 2 Estimated Outcome Amount:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$31,555</td>
<td>$36,576</td>
<td>$58,692</td>
<td>$140,350</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $267,172
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Cost savings in care delivery associated with medication management and utilization review in high risk patients
CHRISTUS Spohn Hospital Corpus Christi / TPI: 121775403
Unique Identifier -121775403.3.15

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management

Outcome Measure Description
• DY2
  o P-2: Establish baseline rates for cost savings in care delivery. The baseline rate will be determined using a Cost Minimization Analysis to quantify cost reduction resulting from concurrent case management/utilization review for patients identified as high risk or receiving medications identified at high risk for medication errors during the base period. This initial analysis for this project will be quantified from project implementation data at CSHCC-Memorial serving as the basis for project expansion and assessment of cost minimization.
  o Data Source: Case Management/Utilization review reports, financial reports

• DY 3
  o P-3: Develop and test data systems
    Data Source: Quality reports

Outcome Improvement Targets:
• DY 4
  o IT-4.10: Other outcome improvement target
    Improvement Target: Cost savings in care delivery
    Data Source: Case Management/Utilization review reports, financial reports

• DY 5
  o IT-4.10: Other outcome improvement target
    Improvement Target: Cost savings in care delivery
    Data Source: Case Management/Utilization review reports, financial reports
**Rationale:**
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such as IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria included but were not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone with an associated cost minimization of $426,000 ($1.02 Million annualized).

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to cost savings in care delivery for patients identified as high risk or receiving medications at high risk for medication errors. Effective medication management reduces the risk of potentially preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to perform proactive assessment of patients’ medications, increase communication between providers, and identify preemptive measures to enhance treatment and protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>121775403.3.15</th>
<th>3.4.IT-4.10</th>
<th><strong>Cost savings as result of medication management/utilization review implementation using a Cost Minimization Analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHRISTUS Spohn Hospital Corpus Christi</strong></td>
<td></td>
<td><strong>121775403</strong></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td></td>
<td>121775403.2.7</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td>In FY2012, Spohn’s Corpus Christi Memorial facility experienced a cost minimization of $425,000 by transitioning patients requiring long-term IV therapy to IV home infusion therapy. Cost was determined by number of days required for treatment in each of the acute care and home settings.</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong> Establish baseline rates for bedside medication administration errors, prior to implementation of new system</td>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems</td>
<td><strong>Outcome Improvement Target 1 [IT-4.9]:</strong> Average cost savings</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
<td><strong>Data Source:</strong> EMR and utilization review documents</td>
<td><strong>Improvement Target:</strong> Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $31,555</td>
<td>Process Milestone 2 Estimated Incentive Payment: $36,576</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $29,346</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $31,555</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $36,576</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $58,692</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $267,172</td>
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</tr>
</tbody>
</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.11.2 - Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors.
CHRISTUS Spohn Hospital Corpus Christi - 121775403.3.16

Outcome Measure Description
OD-4 Potentially Preventable complications and healthcare acquired Conditions.

IT-4.6 : Other outcome Improvement Targets
Hospital Acquired Venous Thromboembolism (VTE)

Outcome Description: Installation of a computerized patient order management (CPOM) system is expected to reduce the rate of VTE in Spohn’s Corpus facilities by creating electronic order sets that include VTE prophylaxis. Spohn has a system-wide group that developed electronic evidence-based order sets. For example, if patient has surgery and the doctor wants the patient to get up and walking to prevent blood clots, there are different order sets that might be in place. For patients who cannot ambulate after surgery, they need anti-coagulants, but often the surgeons will not order these because they are concerned that the surgical sites might bleed. The CPOM system will create automatic order sets for particular surgeries and the medication order will then be in place (including treatment to prevent VTE). This prevents the physician from ordering contraindicated medications and makes sure that needed medications and therapeutic interventions are not missed due to human error.

VTE is a core CMS measure, and CMS has provided six indicators to be addressed in the prevention of hospital-acquired VTE. The six indicators measure the following (with Spohn’s historical compliance in parentheses):
(1) VTE prophylaxis (74.5%)
(2) intensive care unit VTE prophylaxis (83%)
(3) VTE patients with anticoagulation overlap therapy (70.5%)
(4) VTE patients receiving unfractionated heprin with dosages/platelet count monitoring by protocol (100%)
(5) VTE discharge instructions (86%), and
(6) incidence of potentially preventable VTE (44%).

Clearly there is room for improvement, especially in light of the fact that fewer than half of the potentially preventable incidences of hospital acquired VTE were successfully addressed.

Process Milestones:
• DY 2
  o P-2: Establish baseline rates for VTE
  o P-5: Disseminate finding, lessons learned and best practices to stakeholders

Outcome Improvement Targets
• DY3
  o IT-4.6: Hospital Acquired VTE
**Improvement Target:** 5% reduction in incidence of hospital acquired VTE from baseline

- **DY4**
  - IT-4.6: Hospital Acquired VTE

**Improvement Target:** 10% reduction in incidence of hospital acquired VTE from baseline

- **DY5**
  - IT-4.6: Hospital Acquired VTE

**Improvement Target:** 15% reduction in incidence of hospital acquired VTE from baseline

**Rationale:**
This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing potentially preventable complications like hospital-acquired VTE. By targeting measures that reduce hospital-acquired VTE in patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care in a manner consistent with recent studies. According to a US Department of Health and Human Services website, “Pulmonary embolism resulting from deep vein thrombosis—collectively referred to as venous thromboembolism—is the most common preventable cause of hospital death. Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused.” ([http://www.ahrq.gov/qual/vtguide/](http://www.ahrq.gov/qual/vtguide/)).

**Milestones and Metrics:** The first step in the process is gathering information to determine the magnitude of the baseline data needed to assure that an established baseline rate is set. Once CPOM is implemented, findings that have been determined to be pertinent to the implementation process will be disseminated, with dissemination of all lessons learned and use of best practices to all of those considered stakeholders. The use of Quality Reports, electronic medication administration record and EMR reports the reduction in transcription will in turn decrease the errors in medication administration.

Spohn selected the improvement targets to incentivize and reward utilization of the CPOM system, with the goal that its utilization will reduce medication transcription errors and also reduce the risks that inconsistent orders are misunderstood.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of hospital acquired VTE. VTE is a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. putting the order sets in place, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Reduction in Hospital Acquired Venous Thromboembolism

**CHRISTUS Spohn Hospital Corpus Christi**

**Starting Point/Baseline:** 75% compliance with CMS VTE Indicators in Corpus facilities; approximately 300 potentially preventable cases of VTE per year

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-2]: Establish baseline rates for medication transcription errors in Spohn’s facilities</td>
<td>Outcome Improvement Target 1 [IT-4.6] Hospital Acquired VTE Improvement Target: 5% reduction in incidence of hospital-acquired VTE from baseline set in DY2</td>
<td>Outcome Improvement Target 2 [IT-4.6] Hospital Acquired VTE Improvement Target: 10% reduction in incidence of hospital-acquired VTE from baseline set in DY2</td>
<td>Outcome Improvement Target 3 [IT-4.6] Hospital Acquired VTE Improvement Target: 15% reduction in incidence of hospital acquired VTE from baseline set in DY2</td>
</tr>
<tr>
<td>Data Source: Quality reports, electronic medication administration record (eMAR) reports</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, claims</td>
<td>Data Source: EHR, claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $47,332</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $109,728</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $176,075</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $421,050</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-1] Project Planning</strong></td>
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<tr>
<td>Goal: develop a plan for coordinating post-surgical order sets with the new CPOM system and training hospital staff on using the electronic system to more effectively prevent VTE</td>
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<tr>
<td>Data source: documentation of plan</td>
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</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $47,332</td>
<td></td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $94,664</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $109,728</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $176,075</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $421,050</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $801,517
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Outcome Domain 4: Potentially Preventable Complications and Healthcare Acquired Conditions;
Improvement Target 4.8: Sepsis Mortality (standalone)
CHRISTUS Spohn Hospital Corpus Christi/ 121775403
Unique Identifier - 121775403.3.17

Outcome Measure Description
Hospitals nationwide and statewide have seen an increase in the rate of sepsis and the mortality rates associated with sepsis over the last twenty years. Spohn intends, through its use of an early detection warning system and a provider protocol for responding to cases of sepsis, to reduce the rate of mortality caused by sepsis in Spohn’s inpatient population.

Process milestones:
- Project planning: Spohn will create a plan to implement a 90-day rapid cycle improvement to address the sepsis mortality rate in Spohn’s Corpus Christi facilities
- Establish a baseline: Spohn will determine the mortality rate of all septic patients in Spohn’s Corpus Christi facilities during 2012
- Spohn will conduct Plan-Do-Study-Act cycles to test and improve upon its usage of the MEWS early detection system

Improvement targets:
- Reduction in Sepsis Mortality rates – 2% reduction by end of DY4
- Reduction in Sepsis Mortality rates - 3% reduction by end of DY5

Rationale:
Spohn’s goal is to decrease the number of deaths in septic patients who present in the early stages of sepsis or those that develop septicemia while in the hospital. The Region 4 Community Needs Assessment has identified a high incidence of sepsis and sepsis mortality for the Region (CN.18). Nueces County alone sees 389,521 inpatient days per year, with an average length of stay just under 6 days. Hospital inpatients are at risk for sepsis, especially if they have intravenous lines, bedsore, or surgical site wounds. Early recognition of the signs and symptoms of sepsis requires skilled assessment of specific indicators over an identified period of time and initiating immediate resuscitation effort upon identification. This rapid response to an identified increasing preventable complication is required to save lives in the acute inpatient setting.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable complications and hospital-acquired conditions/infections. Patient outcomes and satisfaction will absolutely be improved if the sepsis mortality rate is decreased, and the systemic cost of providing inpatient hospital care will be reduced for every septic infection and related death that can be prevented. Achieving this outcome will require considerable and concerted effort (i.e.
engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Spohn will engage in project planning for 90-day rapid cycle improvement for Sepsis</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates – Spohn will determine the mortality rate for septic patients in its Corpus Christi facilities for 2012</th>
<th>Process Milestone 3 [P-4]: Conduct PDSA cycles to improve usage of electronic MEWS – Spohn will develop a plan to test the change, implement the plan, analyze the results, and determine what modifications are needed, if any</th>
<th>Process Milestone 4 [P-4]: Conduct PDSA cycles to improve usage of electronic MEWS – Spohn will develop a plan to test the change, implement the plan, analyze the results, and determine what modifications are needed, if any</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project plan</td>
<td>Data Source: hospital quality reports</td>
<td>Data Source: EMR reports</td>
<td>Data Source: EMR reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $74,379</td>
<td>Process Milestone 3 Estimated Incentive Payment: $172,430</td>
<td>Outcome Improvement Target 1 [IT-4.8]: Sepsis mortality Improvement Target: 2% reduction in septicemia mortality rates in Spohn’s Corpus Christi facilities from baseline established in DY2 Data Source: hospital quality reports, dashboards</td>
<td>Outcome Improvement Target 2 [IT-4.8]: Sepsis mortality Improvement Target: 3% reduction in septicemia mortality rates in Spohn’s Corpus Christi facilities from baseline established in DY2 Data Source: hospital quality reports, dashboards</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $74,379</td>
<td>Year 2 Estimated Outcome Amount: $148,758</td>
<td>Year 3 Estimated Outcome Amount: $172,430</td>
<td>Year 4 Estimated Outcome Amount: $276,690</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $172,430</td>
<td>Year 4 Estimated Outcome Amount: $276,690</td>
<td>Year 5 Estimated Outcome Amount: $661,650</td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,259,527</td>
</tr>
</tbody>
</table>
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:

2.12.2 - Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.

OD 3: Potentially Preventable Readmissions; Improvement Target 3.3.2 - CHF 30-day readmissions

Unique project ID number: 121775403.3.18
CHRISTUS Spohn Hospital – Corpus Christi: 121775403

Outcome Measure Description
This outcome will measure the reduction in the number of Potentially Preventable Readmissions for CHF patients at Spohn’s Corpus Christi facilities due to the expanded implementation of the Care Transitions program. Spohn believes that patients who are at risk to be readmitted to the hospital within 30 days of discharge for congestive heart failure will benefit from increased care coordination upon discharge. This includes providing patients and their caregivers education about medication, diet, and activity management, primary care resources that are available and need to be accessed, and community support available to recently discharged CHF patients.

Process milestones:

- DY2: Develop and test data systems + establish a baseline
  - Spohn will develop an integrated system for flagging CHF patients upon inpatient admission and readmission, in order to track progress in later years of the Waiver
  - Spohn will develop a baseline of CHF readmissions during DY2 in order to measure percentage improvement going forward
- DY3: Disseminate findings
  - Spohn will create and distribute its staff/stakeholders a plan for reducing CHF readmissions through the expansion of the Care Transitions program

Improvement milestones:

- DY3: Reduce CHF PPRs by 5% from baseline
- DY4: Reduce CHF PPRs by 10% from baseline
- DY5: Reduce CHF PPRs by 20% from baseline

Rationale:
Spohn chose this outcome using its evidence-based expectation of a decrease in re-admission rates as a result of the following processes in the Care Transitions program: 1) effective and efficient discharge planning while in the hospital, (2) home visit within 48 hours of patients arrival home and (3) follow-up phone calls to ensure education/information shared making this program a viable expansion option for chronic disease in populations across our region. Spohn’s review of its own needs and the Region 4 Community Needs Assessment identified CHF as an area requiring improvement. Specifically, Nueces County’s highest incidence of potentially preventable hospitalizations occur due to CHF (RHP Plan, Section 3, Table 10) and Heart Failure was the second most common primary diagnosis for hospitalizations in Region 4 (RHP Plan, Section 3, Table 9). Thus, CHF is a substantial problem that Spohn
needs to address by reducing the number of potentially preventable readmissions for patients already hospitalized for and identified as patients with CHF.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication/diet/weight management for CHF patients to prevent unnecessary hospital admissions and readmission. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>121775403.2.10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>The CHF readmission rate is 16%.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-3]:</strong> Development and test data systems – Spohn will put a system in place to identify and flag CHF patients at its Corpus Christi facilities upon initial admission and upon readmission. <strong>Data Source:</strong> referral logs documentation.</td>
<td><strong>Process Milestone 3 [P-5]:</strong> Disseminate finding and implementation plan to stakeholders – Spohn will develop and distribute a comprehensive plan for reducing CHF 30-day admissions (in conjunction with the Care Transitions program) to all of its Corpus Christi provider facilities. <strong>Data Source:</strong> Written integration plan.</td>
<td><strong>Outcome Improvement Target 2 [IT-3.2 &amp; IT-3.3, 3.8]:</strong> PPR Improvement Target: 10% reduction in CHF, 30-day readmission rates from baseline established in DY2. <strong>Data Source:</strong> EHR.</td>
<td><strong>Outcome Improvement Target 3 [IT-3.2]:</strong> PPR Improvement Target: 20% reduction in CHF, 30-day readmission rates from baseline established in DY2. <strong>Data Source:</strong> EHR.</td>
</tr>
</tbody>
</table>

| Process Milestone 2 [P-2]: Establish baseline rates – Spohn will compile and evaluate the 30-day readmission data from 2012 for patients at its Corpus Christi Facilities discharged with a principal diagnosis of CHF. **Data Source:** Historical clinic/hospital/ED claims and financial data. | | | |
| Process Milestone 2 Estimated Incentive Payment: $101,426 | | | |

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $202,852</th>
<th>Year 3 Estimated Outcome Amount: $235,132</th>
<th>Year 4 Estimated Outcome Amount: $377,304</th>
<th>Year 5 Estimated Outcome Amount: $902,250</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $1,717,537
**Title of Outcome Measure (Improvement Target):** Hospital “Culture of Safety” Transformation; OD 4: Potentially Preventable Complications and Healthcare Acquired Conditions Improvement Target 4.5: Patient Fall Rate

**Unique RHP outcome identification number(s):** 121775403.3.19 – Pass 2

**Outcome Measure Description:**
Transforming the culture of safety by adopting a new, evidence-based model of care delivery will reduce the number of PPCs in targeted domains where the CSHS facilities have room for improvement. Specifically, CSHS expects the training and implementation of safety and efficiency protocols to have a measurable effect on the rates of Patient Falls, in conjunction with the Medication Management DSRIP project.

**Process Milestones:**
P-2: Establish baseline rates for Spohn inpatient fall rates (in accordance with the criteria in the Protocol) in DY2

**Outcome Improvement Target(s) for each year:**
- DY3: 4.5 – 20% reduction in Patient Fall Rate across all facilities
- DY4: 4.5 – 30% reduction in Patient Fall Rate across all facilities
- DY5: 4.5 – 42% reduction in Patient Fall Rate across all facilities

**Rationale:**
Spohn’s primary rationale for transforming the culture into high reliability was to reduce the number of patients who are harmed in the delivery of healthcare services. Patient falls are costly to the healthcare delivery system, and negatively impact patient health outcomes, satisfaction, and quality of life. Patient falls must be addressed through comprehensive safety measures, which require a team approach to patient care, provider communication, and preventative measures that are performed as a matter of course with all at-risk patients. The Culture of Safety project is intended to create such a system.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to the ability to safe and efficient care in the hospital. Achievement of these targets has been shown to impact the cost of care delivery by reducing the expense associated with PPCs and to impact short- and long-term patient outcomes by reducing the rate of patient falls, improving patient satisfaction, and providing higher quality care to patients before they are discharged and left to self-manage their conditions.
### Patient Fall Rate

Related Category 1 or 2 Projects: 121775403.2.11

Starting Point/Baseline: In FY 2012, Spohn’s Corpus facilities experienced 516 patient falls, for a rate of 2.61 per 1000 patient days.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1] Establish baseline rates of patient falls across all Spohn facilities</strong></td>
<td><strong>Improvement Target 1: 4.5 Patient Fall Rate</strong></td>
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</tr>
<tr>
<td><strong>Improvement Target:</strong> 20% reduction in patient fall rate administration errors from DY2 baseline (for an estimated rate of 2.1)</td>
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<tr>
<td><strong>Data Source:</strong> Quality reports</td>
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<tr>
<td>Improvement Target 1 Estimated Incentive Payment: $435,047</td>
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<tr>
<td><strong>Outcome Improvement Target 2 [IT-4.5 Improvement Target]: 30% reduction in patient fall rate administration errors from DY2 baseline (for an estimated rate of 1.8)</strong></td>
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<tr>
<td><strong>Data Source:</strong> Quality reports</td>
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<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $522,619</td>
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<tr>
<td>Year 2 Estimated Outcome Amount: $435,047</td>
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</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $522,619</td>
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<tr>
<td>Year 4 Estimated Outcome Amount: $838,093</td>
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<tr>
<td>Year 5 Estimated Outcome Amount: $2,131,363</td>
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</table>

**Total Estimated Incentive Payments for 4-Year Period** (add outcome amounts over DYs 2-5): $3,927,120
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**
IT-9.2 – ED appropriate utilization  
Performing Provider ID: 121785303.3.1  
Performing Provider: Memorial Hospital

**Outcome Measure Description**
This outcome measure is related to project 121785303.1.1, which is an expansion of primary care capacity. This outcome will focus on reducing ED admissions for patients with targeted conditions. Following the assessment of capacity and establishment of baselines in DYs 2 and 3, the projected outcome is a reduction in Emergency Department visits by 5% in DY 4 and 10% in DY 5 versus the baseline.

**Process Milestones:**
- DY2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans  
- DY3: P-2 Establish baseline rates

**Outcome Improvement Targets:**
- DY4: IT-9.2: ED appropriate utilization: Decrease use of the emergency room for non-emergent care by patients with Waelder zip code by 5% from DY3  
- DY5: IT-9.2: ED appropriate utilization: Decrease use of the emergency room for non-emergent care by patients with Waelder zip code by 10% from DY3

**Rationale:**
Process milestones P-1 and P-2 were selected to enable Memorial Hospital to work with the community in assessing needs and capacity and develop a plan to address those issues. Memorial Hospital will also establish one or more baselines for ED visits during DY 3. Improvement measure IT-9.2 will allow us to track the effectiveness of the changes to the clinic schedule. A reduction of 5% per year in emergency department visits for non-emergent diagnoses by patients from the Waelder area is the goal for DY 4 and 10% for DY 5.

**Outcome Measure Valuation:**
The valuations for accomplishing Category 3 outcomes in this project cannot necessarily be measured financially. Improved access to primary care and reduction in the use of the county’s only emergency room for primary care will ultimately improve the quality of healthcare in the area. For measurement purposes, the amounts associated with achieving these goals are as follows: DY2 $15,690, DY3 $15,690, DY4 23,535, and DY5 $51,777.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>121785303.1.1</th>
<th>121785303</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
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<td>Starting Point/Baseline:</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td><strong>Process Milestone 1 – P-1.</strong> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans</td>
<td><strong>Process Milestone 2 – P-2.</strong> Establish baseline(s)</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-9.2]: ED appropriate utilization</strong></td>
</tr>
<tr>
<td>Baseline/Goal: TBD</td>
<td>Data Source: Clinic documentation</td>
<td>Improvement Target: Decrease use of the emergency room for non-emergent care by patients with Waelder zip code by 5% from DY3.</td>
<td>Improvement Target: Decrease use of the emergency room for non-emergent care by patients with Waelder zip code by 10% from DY3.</td>
</tr>
<tr>
<td>Data Source: Clinic documentation</td>
<td>Process Milestone 3 Estimated Incentive Payment: $15,690</td>
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<tr>
<td>Year 3 Estimated Outcome Amount: $15,690</td>
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<td>Outcome Improvement Target 1 Estimated Incentive Payment: $23,535</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $51,777</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $106,692*
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

IT-6.1 – Improve patient satisfaction/experience scores
Performing Provider ID: 121785303.3.2
Performing Provider: Memorial Hospital – 121785303

IT-6.1 (3) Percent improvement over baseline of patient satisfaction scores: (3) patient’s rating of doctor access to specialist; (Stand-alone measure)

Process Milestones:
- DY2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3: P-2 Establish baseline rates

Outcome Improvement Targets:
- DY4: IT-3.1: Percent improvement of patient satisfaction scores for a specific tool over baseline; Decrease neutral/dissatisfied scores regarding access to specialty care by 5% from DY2.
- DY5: IT-3.1: Percent improvement of patient satisfaction scores for a specific tool over baseline; Decrease neutral/dissatisfied scores regarding access to specialty care by 10% from DY2.

Rationale
A community needs assessment found 30% of patients were either neutral or dissatisfied with the level of specialty health care available in the community. As a result, we intend to expand access to endocrinology, rheumatology, and orthopedic services at our specialty care clinic. Improvement measure IT-6.1 was chosen as a way to measure the impact of the addition of these specialists to our physician roster as well as the expansion of access to some physicians already available. Based on our timeframe for hiring additional providers and increasing clinic hours, we anticipate conservative improvements in patient satisfaction scores of 5% over baseline in DY4 and 10% over baseline in DY5. In DY2, we will engage patients, providers, and staff in developing our plan for expanding specialty care capacity, identify current capacity and needed resources, and develop timelines (P-1). Baseline scores will be established in DY3 (P-2).

Outcome Measure Valuation:
The addition of specialties and/or hours to the current clinic schedule is expected to improve satisfaction scores on a community survey to be developed and administered beginning in DY 2. Accomplishing this goal has been anticipated to result in payment of $1,711 in DY2, $3,442 in DY3, $7,759 in DY4 and $17,069 in DY 5 for a total of $29,981.

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<th>IT-6.1(3)</th>
<th>Improve patient satisfaction/experience scores</th>
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<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
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<tr>
<td><strong>Process Milestone 1 – P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans</strong></td>
<td><strong>Baseline/Goal:</strong> Provider documentation</td>
<td><strong>Baseline/Goal: TBD</strong></td>
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<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $1,711</td>
<td><strong>Data Source:</strong> N/A</td>
<td><strong>Data Source: Selected survey tool</strong></td>
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<td><strong>Process Milestone 1 – P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans</strong></td>
<td><strong>Baseline/Goal:</strong> Provider documentation</td>
<td><strong>Baseline/Goal:</strong> DY 2 survey results</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Decrease neutral/dissatisfied scores regarding access to specialty care by 5% from DY3.</td>
<td><strong>Data Source:</strong> Community survey results</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $17,069</td>
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<tr>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $17,069</td>
<td><strong>Baseline/Goal:</strong> Decrease neutral/dissatisfied scores regarding access to specialty care by 10% from DY 2.</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $17,069</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $17,069</td>
<td><strong>Baseline/Goal:</strong> Decrease neutral/dissatisfied scores regarding access to specialty care by 10% from DY 2.</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $29,981
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
IT-9.2 – ED appropriate utilization
121785303.3.3
Memorial Hospital – 121785303

Outcome Measure Description
This outcome measure, IT-9.2, is related to project 121785303.1.3, which is an introduction of telemonitoring. This outcome will focus on reducing ED admissions for patients with targeted conditions. Following the assessment of capacity and establishment of baselines in DYs 2 and 3, the projected outcome is a reduction in Emergency Department visits by 10% in DY 4 and 15% in DY 5 versus the baseline.

Process Milestones:
- DY2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3: P-2 Establish baseline rates

Outcome Improvement Targets:
- DY4: IT-9.2: Reduce emergency department visits for target conditions; Reduce ER visits among patients receiving home health services for heart failure, COPD, diabetes or hypertension by 10% versus DY 3.
- DY5: IT-9.2: Reduce emergency department visits for target conditions; Reduce ER visits among patients receiving home health services for heart failure, COPD, diabetes or hypertension by 15% versus DY 3.

Rationale:
We wish to implement a program of home monitoring through our home health agency which would monitor vital signs, blood sugar, oxygenation and other symptoms to more readily identify patients who could benefit from early intervention. Process milestone P-1 in DY 2 is necessary to identify and assess community needs for services and select and contract with a vendor to supply those services, obtain the necessary monitoring equipment, train staff in the use of the equipment and interpretation of reports, and set up a trial of up to 15 patients to initiate the program. In DY 3, milestone P-2 is needed to establish baselines for the reduction of ED visits related to this project.

Improvement measure IT-9.2 will allow us to track the effectiveness of a home monitoring program. In the first half of 2012, 22% of patients receiving services through Memorial Hospital Home Health Agency went to the emergency room at least once while on service. Even modest reductions in this rate would control costs and improve the quality of life of those patients. Therefore, we aim to reduce emergency department visits among patients receiving home health services for heart failure, COPD, diabetes, or hypertension by 10% in DY4 and 15% in DY5.
Outcome Measure Valuation:
Initiating a home monitoring program is expected to reduce admissions and readmissions as well as use of the emergency department for home health patients. If these goals are accomplished, they should be valued at $8,700 in DY2, $9,640 in DY3, $16,575 in DY4 and $43,445 in DY5 for a total of $78,360.
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<tr>
<th>Related Category 1 or 2 Projects:</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<tr>
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<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans Baseline/Goal: TBD</td>
<td>P-2. Establish baselines. Data Source: Clinic documentation</td>
<td>IT-9.2: Reduce emergency department visits for target conditions. Baseline/Goal: DY 3 ED visits for target conditions/ Reduce ER visits among patients receiving home health services for heart failure, COPD, diabetes or hypertension by 10% versus DY 3. Data Source: Agency records, hospital records</td>
<td>IT-9.2: Reduce emergency department visits for target conditions. Baseline/Goal: DY 3 ED visits for target conditions/Reduce ER visits among patients receiving home health services for heart failure, COPD, diabetes or hypertension by 15% versus DY 3. Data Source: Agency records, hospital records</td>
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<tr>
<td>Data Source: Agency records Process Milestone 1 Estimated Incentive Payment (maximum amount): $8,700</td>
<td>Process Milestone 2 Estimated Incentive Payment: $9,640</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $16,575</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $43,445</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $8,700 | Year 3 Estimated Outcome Amount: $9,640 | Year 4 Estimated Outcome Amount: $16,575 | Year 5 Estimated Outcome Amount: $43,445 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $78,360**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
IT-13.1 Pain assessment (NQF-1637)
Unique RHP outcome identification number(s): 121785303.3.4
Performing Provider/TPI: Memorial Hospital/121785303

Outcome Measure Description
IT-13.1 – Pain assessment - Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. This outcome measure, IT-13.1, is related to project 121785303.2.1, which is an introduction of palliative care program. This outcome will focus on increasing the number of patients who receive a clinical assessment. Following the assessment of capacity and establishment of baselines in DYs 2 and 3, the projected outcome is an increase of patients receiving the assessment from 80% in DY 4 to 90% in DY 5 versus the baseline.

Process Milestones:
- DY2 P-1- Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation strategy
- DY3 P-2 – Establish baseline rates

Outcome Improvement Target:
- DY4 and DY5 IT-13.1 Pain assessment - Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening

Rationale:
There are a number of hospice programs providing true end-of-life services but not necessarily support for patients with chronic illnesses. The goal for the first year of the project would be analyze and assess community needs and begin to establish the palliative care program, by developing necessary policies and procedures and hire and train the staff necessary to administer the program. In DY 3, baselines will be established.

The goal of implementing the palliative care program is to reach an increasing number of patients each year. Beginning with DY 4, the number of patients will be expected to increase by at least 5% each year thereafter.

Improvement measure IT-13.1 will ensure the care provided to the patients in the palliative care program addresses their physical, social and cultural needs while ensuring their comfort. The goal will be for at least 80% of patients who experience pain will undergo a clinical assessment within 24 hours.

Outcome Measure Valuation:
The intent of this program is to improve quality of life for patients with chronic and/or terminal illnesses. Achieving success in meeting all of our improvement targets should be valued at a total of $6,000 in
DY2, a total of $7,000 in DY3, a total of $12,000 in DY4 and a total of $33,000 in DY5 for $58,000 over all four years.
<table>
<thead>
<tr>
<th>Process Milestone 1 P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans Baseline/Goal: TBD</th>
<th>Process Milestone 2 P-2. Establish baselines. Baseline/Goal: TBD  <strong>Data Source:</strong> Patient records, agency records.</th>
<th>Outcome Improvement Target 1 – IT-13.1: Percentage of patients who screen positive for pain receive a clinical assessment within 24 hours of screening. Baseline/Goal: DY 3 experience/80% of all patients admitted to program will be assessed.  <strong>Data Source:</strong> Agency records</th>
<th>Outcome Improvement Target 2 IT-13.1: Percentage of patients who screen positive for pain receive a clinical assessment within 24 hours of screening. Baseline/Goal: DY 3 experience/90% of all patients admitted to program will be assessed.  <strong>Data Source:</strong> Agency records</th>
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<tbody>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $2,000</td>
<td>Process Milestones 2 Estimated Incentive Payment: $2,334</td>
<td>Outcome Improvement Targets 1 Estimated Incentive Payment: $4,000</td>
<td>Outcome Improvement Targets 2 Estimated Incentive Payment: $11,000</td>
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<tr>
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<td>Year 3 Estimated Outcome Amount: $2,334</td>
<td>Year 4 Estimated Outcome Amount: $4,000</td>
<td>Year 5 Estimated Outcome Amount: $11,000</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $19,334**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
IT-13.2 – Treatment preferences (NQF 1641)

Unique RHP outcome identification number(s): 121785303.3.5
Performing Provider/TPI: Memorial Hospital/ 121785303

Outcome Measure Description
IT-13.2 – Treatment preferences - Percentage of patients with chart documentation of preferences for life-sustaining treatments. This outcome measure, IT-13.2, is related to project 121785303.2.1, which is an introduction of palliative care program. This outcome will focus on increasing the number of patients who have charted documentation for life sustaining preferences. Following the assessment of capacity and establishment of baselines in DYs 2 and 3, the projected outcome is an increase of the number of patients with charted preferences to 80% in DY 4 and 90% in DY 5 versus the baseline.

Process Milestones:
- DY2 P-1 - Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation strategy
- DY3 P-2 – Establish baseline rates

Outcome Improvement Target:
- DY4 and DY5 - IT-13.2 Treatment preferences - Percentage of patients with chart documentation of preferences for life-sustaining treatments

Rationale:
There are a number of hospice programs providing true end-of-life services but not necessarily support for patients with chronic illnesses. The goal for the first year of the project would be analyze and assess community needs and begin to establish the palliative care program, by developing necessary policies and procedures and hire and train the staff necessary to administer the program. In DY 3, baselines will be established.

The goal of implementing the palliative care program is to reach an increasing number of patients each year. Beginning with DY 4, the number of patients will be expected to increase by at least 5% each year thereafter.

Improvement measure IT-13.2 will ensure the care provided to the patients in the palliative care program addresses their physical, social and cultural needs while ensuring their comfort. The goal will be at least 80% of patients will be asked their choices regarding life-sustaining treatment and those choices documented.

Outcome Measure Valuation:
The intent of this program is to improve quality of life for patients with chronic and/or terminal illnesses. Achieving success in meeting all of our improvement targets should be valued at a total of $6,000 in DY2, a total of $7,000 in DY3, a total of $12,000 in DY4 and a total of $33,000 in DY5 for $58,000 over all four years.
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<th>IT-13.2</th>
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<td>Memorial Hospital</td>
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**Starting Point/Baseline:**
- **Year 2** (10/1/2012 – 9/30/2013)
  - **Process Milestone 1** P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
  - **Baseline/Goal:** TBD
  - **Data Source:** Agency records
  - Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,000

**Year 3** (10/1/2013 – 9/30/2014)
- **Process Milestone 2** P-2: Establish baselines.
  - **Baseline/Goal:** TBD
  - **Data Source:** Patient records, agency records.
  - Process Milestones 2 Estimated Incentive Payment: $2,333

**Year 4** (10/1/2014 – 9/30/2015)
- **Outcome Improvement Target 1** IT-13.2: Percentage of patients with documentation of preferences for life-sustaining treatments.
  - **Baseline/Goal:** DY 3 experience/80% of patients will have preferences documented.
  - **Data Source:** Agency records
  - Outcome Improvement Targets 1 Estimated Incentive Payment: $4,000

**Year 5** (10/1/2015 – 9/30/2016)
- **Outcome Improvement Target 2** IT-13.2: Percentage of patients with documentation of preferences for life-sustaining treatments.
  - **Baseline/Goal:** DY 3 experience/90% of patients will have preferences documented.
  - **Data Source:** Agency records
  - Outcome Improvement Targets 2 Estimated Incentive Payment: $11,000

**Year 2 Estimated Outcome Amount:** $2,000
**Year 3 Estimated Outcome Amount:** $2,333
**Year 4 Estimated Outcome Amount:** $4,000
**Year 5 Estimated Outcome Amount:** $11,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $19,333
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.
Unique RHP outcome identification number(s): 121785303.3.6
Performing Provider/TPI: Memorial Hospital/121785303

Outcome Measure Description
IT-13.5 – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. This outcome measure, IT-13.5, is related to project 121785303.2.1, which is an introduction of palliative care program. This outcome will focus on increasing the clinical documentation of patients who receive a discussion of spiritual/religious concerns, as well as documenting those who opted not to receive the conversation. Following the assessment of capacity and establishment of baselines in DYs 2 and 3, the projected outcome is an increase of 80% of the patients having the discussion documented in DY 4 and 90% in DY 5 versus the baseline.

Process Milestones:
- DY2 P-1 – Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation strategy
- DY3 P-2 – Establish baseline rates

Outcome Improvement Target:
- DY4 and DY5 – IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.

Rationale:
There are a number of hospice programs providing true end-of-life services but not necessarily support for patients with chronic illnesses. The goal for the first year of the project would be analyze and assess community needs and begin to establish the palliative care program, by developing necessary policies and procedures and hire and train the staff necessary to administer the program. In DY 3, baselines will be established.

The goal of implementing the palliative care program is to reach an increasing number of patients each year. Beginning with DY 4, the number of patients will be expected to increase by at least 5% each year thereafter.

Improvement measures IT-13.5 will ensure the care provided to the patients in the palliative care program addresses their physical, social and cultural needs while ensuring their comfort. The goal will be for at least 80% of patients will be asked about spiritual/religious preferences and those preferences documented or a refusal to discuss those preferences be documented.
Outcome Measure Valuation:
The intent of this program is to improve quality of life for patients with chronic and/or terminal illnesses. Achieving success in meeting all of our improvement targets should be valued at a total of $6,000 in DY2, a total of $7,000 in DY3, a total of $12,000 in DY4 and a total of $33,000 in DY5 for $58,000 over all four years.
<table>
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<tr>
<th>121785303.3.6</th>
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<th>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss</th>
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<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans</td>
<td><strong>Process Milestone 2</strong> P-2 Establish baselines. <strong>Baseline/Goal</strong>: TBD</td>
<td><strong>Outcome Improvement Target 1</strong> IT-13.5 Percentage of patients with documented discussion of spiritual/religious concerns or documentation they did not want to discuss. <strong>Baseline/Goal</strong>: DY 3 experience 80% of patients will have discussion documented. <strong>Baseline/Goal</strong>: EHR, claims, Agency records</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Agency records</td>
<td><strong>Process Milestones 2 and 3 Estimated Incentive Payment (maximum amount):</strong> $2,333</td>
<td><strong>Outcome Improvement Targets 1 Estimated Incentive Payment</strong>: $4,000</td>
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<td><strong>Year 4 Estimated Outcome Amount:</strong> $4,000</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $19,333**
Identifying Outcome Measure and Provider Information:
Project Title: Create “Get Healthy Gonzales” Program
RHP Identification Number: 121785303.2.2 (Pass 2)
Performing Provider: Gonzales Healthcare Systems (Memorial Hospital) – 121785303
Outcome Measure: OD-10: Quality of Life/Functional Status
Outcome Identification Number: 121785303.3.7

Outcome Measure Description
The Outcome Measure chosen is OD-10, Quality of Life/Functional Status. The 2007 National Survey of children’s Health found that 20.4% of Texas children aged 10 to 17 were obese, compared to 16.4% for all U.S. Children. IT-10.1 will measure improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for this program’s target population. The program will be opened to all identified at-risk students. An improvement in survey results among test group will be expected.

Process Milestones and Improvement Targets
- DY2 – Process Measure is P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. This will include hiring a program coordinator, developing the program curriculum, identifying necessary resources, and coordinating with local schools and other entities.
- DY3 – Process Measure is P-5: Disseminate findings, including lessons learned and best practices, to stakeholders. Program essentials will be shared with stakeholders and a core group of test subjects will be selected and baseline survey results obtained. Program will be implemented with test group and regularly evaluated to determine what is and is not working and results will be shared with stakeholders.
- DY4 – Improvement Target is IT-10.1: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. A 10% improvement in survey results among test group will be expected. The program will be opened to all identified at-risk students.
- DY5 – Improvement Target is IT-10.1: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. An additional 10% improvement among core group will be expected. In addition, a 10% improvement over baseline for additional students entered in the program is anticipated.

Rationale:
The process measures and improvement targets chosen represent the goals of the program as outlined in a meeting of stakeholders on November 20, 2012. Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor developing healthy habits to reduce and prevent obesity within the Gonzales Healthcare Systems. In order to report accurate data and establish baselines, P-1 must be approached in DY2. P-5 will be approached in DY3, after the initial gap analysis is completed. Lessons learned will be shared with the Region and stakeholders. Improvement targets were placed in DY4 and 5 based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The improvement target goal in DY4 will be to achieve a quality of life score 10% above the baseline percentage to be determined in in DY3. In DY5, the goal will be 10% improvement over the DY4 score.
Outcome Measure Valuation:
The outcome and improvement measures chosen for this project have no intrinsic or calculable value. There is currently no data available on the costs incurred locally related to obesity in children and adolescents. However, the intangible value of achieving these goals may be realized in the future with reduced use of emergency room services, decreased lost time at work, and improved productivity. This project addresses an identified need in the community and has the support of educators and others who work with children in the area. If the process and improvement measures are met, the following valuation has been assigned: DY2 is $4,385, DY3 is $5,255, DY4 is $8,415, DY5 is $21,285 and the four-year total would be $39,340.
<table>
<thead>
<tr>
<th>Process Milestone 1 – P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 – P-2: Establish baseline rates</th>
<th>Process Milestone 3 – P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</th>
<th>Outcome Improvement Target 1 – IT-10.1: Quality of Life Improvement Target: 10% improvement over baseline scores in test group</th>
<th>Outcome Improvement Target 2 – IT-10.1: Quality of Life Improvement Target: 10% improvement over DY4 results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Program records, human resources files</td>
<td>Data Source: Program records, school records</td>
<td>Data Source: Program records, survey results, school records</td>
<td>Data Source: Program records, survey results, school records</td>
<td>Data Source: Program records, survey results, school records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $4,385</td>
<td>Process Milestone 2 Estimated Incentive Payment: $2,628</td>
<td>Process Milestone 3 Estimated Incentive Payment: $2,627</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $8,415</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $21,285</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $4,385</td>
<td>Year 3 Estimated Outcome Amount: $5,255</td>
<td>Year 4 Estimated Outcome Amount: $8,415</td>
<td>Year 5 Estimated Outcome Amount: $21,285</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $39,340
Category 3: Quality Improvements

**Outcome Measure**: IT-9.2 ED appropriate utilization  
**Performing Provider**: Jackson County Hospital District  
**RHP Project Number**: 1218083-05.3.1  
**Performing Provider TPI**: 1218083-05

**Outcome Measure Description**:
IT-9.2 ED appropriate utilization  
- Reduce emergency department visits for target conditions: Chronic Obstructive Pulmonary Disease

**Process Milestones**:

**DY2**:
- P-2: Establish baseline rates

**Outcome Improvement Targets**:

**DY3**:
- IT-9.2: Reduce emergency department visits for COPD by 3% below baseline

**DY4**:
- IT-9.2: Reduce emergency department visits for COPD by 6% below baseline

**DY5**:
- IT-9.2: Reduce emergency department visits for COPD by 9% below baseline

**Rationale**:
Process milestone P-2 was selected due to the need to establish a baseline rate for emergency department visits due to chronic obstructive pulmonary disease. This will enable us to determine if we have successfully reduced emergency department visits and met our improvement targets in DY3-5. The improvement targets of reducing emergency department visits for COPD by 3% per year are based on the current rate of increase of COPD visits and the lack of specialty treatment for this condition in the county. The introduction of an outpatient pulmonary clinic within the proximity of the Emergency Department will result in a direct decrease in the number of patients with COPD related conditions in the Emergency Department.

**Outcome Measure Valuation**:
Jackson County Hospital District values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.
In valuing this project, Jackson County took into account the extent to which the expansion of specialty care capacity would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

The expansion of specialty care capacity for COPD patients will promote and encourage patients to access care which will lead to better clinical outcomes for the community. We took these potential effects into account when considering the appropriate incentive payment value for this project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Jackson County Hospital District</th>
<th>121808305.1.1</th>
<th>1218083-05</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 2</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
<th>Outcome Improvement Target 3</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>[P-2]: Establish baseline rates</td>
<td>[IT-9.2]: ED Appropriate Utilization</td>
<td>[IT-9.2]: ED Appropriate Utilization</td>
<td>[IT-9.2]: ED Appropriate Utilization</td>
</tr>
<tr>
<td></td>
<td>Metric 1: Baseline/Goal: TBD</td>
<td>Improvement Target: Reduce emergency department visits for COPD by 3% below baseline</td>
<td>Improvement Target: Reduce emergency department visits for COPD by 6% below baseline</td>
<td>Improvement Target: Reduce emergency department visits for COPD by 9% below baseline</td>
</tr>
<tr>
<td></td>
<td>Data Source: Performing Provider records</td>
<td>Data Source: Hospital records</td>
<td>Data Source: Hospital records</td>
<td>Data Source: Hospital records</td>
</tr>
<tr>
<td></td>
<td>Estimated Incentive Payment (maximum amount): $100,000</td>
<td>Estimated Incentive Payment: $125,000</td>
<td>Estimated Incentive Payment: $150,000</td>
<td>Estimated Incentive Payment: $200,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 Estimated Outcome Amount: $100,000</th>
<th>Year 3 Estimated Outcome Amount: $125,000</th>
<th>Year 4 Estimated Outcome Amount: $150,000</th>
<th>Year 5 Estimated Outcome Amount: $200,000</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $575,000**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 121990904.3.1

Performing Provider/TPI: Camino Real Community Services/121990904

Outcome Measure Description:
IT-6.1 Percent improvement over baseline of patient satisfaction scores

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

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

- DY 4 and DY 5 IT-6.1 Improvement over the baseline of patient satisfaction for patients getting timely care, appointments, and information and improvement over the baseline of patient satisfaction for the patient’s rating of the doctor’s access to a specialist

Rationale:
The process milestones for this project include project planning which will involve engagement of stakeholders, identifying current capacity of primary and behavioral health specialists and identifying where additional resources are required, establishing timelines and documenting implementation plans, as well as establishing baseline rates. Patient surveys will include patient satisfaction for getting timely care, appointments, and information, and patient satisfaction for the patient’s rating of the doctor’s access to a specialist. Obtaining patient feedback on our ability to provide timely care, appointments and information is critical to the success of this project. Patients having access and receiving the appropriate behavioral and primary health care in one integrated setting provides the opportunity for overall patient health and wellness as well as patient satisfaction. We expect the number of individuals receiving and reporting satisfaction in Years 4 and 5, with both physical and behavioral health care at the established locations will show improvement over the baseline and provide us with meaningful and objective information that will be used to determine opportunities for improvement.

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

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

Addressing physical health and behavioral health conditions in an integrated community setting will greatly decrease utilization of higher cost service environments. Provision of comprehensive psychiatric and primary care services in the local community is not only cost effective but more user friendly and convenient for the person with co-morbid conditions.
<table>
<thead>
<tr>
<th>Year</th>
<th>Related Category 1 or 2 Projects</th>
<th>Starting Point/Baseline</th>
<th>Patient Satisfaction Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>121990904.2.1</td>
<td>To Be Determined</td>
<td>Camino Real Community Services</td>
</tr>
</tbody>
</table>

### Process Milestone 1:
- **P-1** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **Data Source:** Information from discussions/interviews with community health care providers (physical and behavioral) and city and county governments, charities, faith based organizations and other community based helping organizations

- **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $0

### Process Milestone 2:
- **P-2** Establish baseline rates
  - **Data Source:** Claims and encounter data, medical records

- **Process Milestone 2 Estimated Incentive Payment:** $0

### Process Milestone 3:
- **P-3** Establish plan to develop and test data systems
  - **Data Source:** Information from discussions/interviews to understand current systems and then establish most effective systems for the programs

- **Process Milestone 3 Estimated Incentive Payment:** $12,181

### Process Milestone 4:
- **P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - **Data Source:** Claims and encounters data, medical records

- **Process Milestone 4 Estimated Incentive Payment:** $12,181

### Outcome Improvement Target 1:
- **IT 6.1 Patients are getting timely care, appointments, and information including 5% improvement over baseline**
  - **Data Source:** Patient survey

- **Outcome Improvement Target 1 Estimated Incentive Payment:** $19,547

### Outcome Improvement Target 2:
- **IT 6.1 Patient’s rating of doctor access to specialist improved over baseline**
  - **Data Source:** Patient Survey

- **Outcome Improvement Target 2 Estimated Incentive Payment:** $19,547

### Outcome Improvement Target 3:
- **IT 6.1 Improvement Target:** Patients are getting timely care, appointments, and information including 10% improvement over baseline
  - **Data Source:** Patient survey

- **Outcome Improvement Target 3 Estimated Incentive Payment:** $28,328

### Outcome Improvement Target 4:
- **IT 6.1 Patient’s rating of doctor access to specialist improved over DY4**
  - **Data Source:** Patient Survey

- **Outcome Improvement Target 4 Estimated Incentive Payment:** $28,328

### Yearly Estimated Outcome Amounts:
- **Year 2:** $0
- **Year 3:** $24,362
- **Year 4:** $39,093
- **Year 5:** $56,656

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $120,111
Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 121990904.3.2 – Pass 2

Performing Provider: Camino Real Community Services

Outcome Measure Description:
Camino Real Community Services has selected the following process and improvement measures for Category 3, OD-9 Right Care Right Setting:

Process Milestones:
DY 2: P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
DY 3: P-2 Establish Baseline rates.

Outcome Improvement Targets:
DY 4: IT-9.2 ED appropriate utilization
Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse
DY5: IT-9.2 ED appropriate utilization
Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse

Rationale:
The process milestones for this project include project planning, which will involve engagement of stakeholders, identifying current capacity, identifying where staff resources are required, establishing timelines and documenting implementation plans. Improvement targets were placed in DY4 and DY5 when the performing provider will establish baseline rates. Once resources are in place and services are rendered in the service area the provider will collect and track the number of individuals served by the Mobile Crisis Outreach Team in DY4, which will set the numbers for DY5. The improvement target goal is to decrease use of EDs by the behavioral health targeted population.

Outcome Measure Valuation:
The outcome measure valuation takes into consideration cost avoidance as related to the costs for state operated and private psychiatric hospitalizations, costs of local Emergency Department treatment, the costs of local judicial systems, and costs of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for individuals needing treatment.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Accurate Report Not Available</td>
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</table>

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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.&lt;br&gt;Data Source: Project Plan&lt;br&gt;Process Milestone 1 Estimated Incentive Payment: $0</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-2 Establish Baseline Rates&lt;br&gt;Data Source: Project Plan&lt;br&gt;Process Milestone 2 Estimated Incentive Payment: $3,455</td>
<td><strong>Outcome Improvement Target 1</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Data Sources: Claims encounter and clinical record data (criminal justice system records, local MH authority and state MH data system&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $5,533</td>
<td><strong>Outcome Improvement Target 2</strong>&lt;br&gt;IT-9.2 ED appropriate utilization&lt;br&gt;Data Sources: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $8,517</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $0</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $3,455</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $5,533</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $8,517</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $17,505
Category 3 DSRIP Project Narrative Template

**Outcome Domain:** OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

**Title of Category 1 or 2 Project:** Patient Navigator for Persons with Chronic Illnesses

**Title of Outcome Measure (Improvement Target):** IT-3.1 All cause 30 day readmission rate- NQF 1789

**Unique RHP Outcome Identification Number (e.g. [TPI].3.1):** 126844305.3.1

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

**Performing Provider TPI #:** 126844305

**Outcome Measure Description:**

Process Milestone for DY 2  
P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Process Milestones for DY 3  
P- 2 Establish baseline rates  
P- 3 Develop and test data systems

Improvement Target for DY 4 and 5 will be:  
IT-3.1 All cause 30 day readmission rate- NQF 1789 for patients 18 and older

Improvement Milestone for DY 4  
Reduce all cause 30 day readmission rate by 5% of baseline TBD in DY 3.

Improvement Milestone for DY 5  
Reduce all cause 30 day readmission rate by 10% of baseline TBD in DY 3.

**Rationale:**

**DY 2:** We must work with community providers and multiple health care systems to inventory capacity, determine when to initiate program, identify resource needs, complete agreements for data sharing and agreements for site utilization.

**DY 3:** This population of high frequent visitors to ED is not identified or characterized. We must develop sources of information across multiple health care systems; identify the group and establish a baseline.

The Improvement Target for DY 4 and 5, IT-3.1, is a stand-alone measure. We selected this measure because the goal of this project is to help people who have been frequent visitors to ED and even though a root cause might be the presence of behavioral health conditions, the admission cause will vary across a variety of physical and mental conditions. We believe that measuring the reduction in re-hospitalization will be a good indicator of success for the
program. Over the four years of the project we expect to dramatically reduce the number of ED visits for the target population and the associated inpatient admissions. These reductions will occur by improved chronic disease management, linkage to a primary care provider and medical home.

Project Valuation:
By targeting and serving 30 high utilizers of ED services in DY 4 and 50 in DY 5 we expect to improve lives and cost and effectiveness of the health care system. We are confident we will impact hospitalization use. The valuation calculated for this project used cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality-adjusted life-years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled ‘Valuing Transformation Projects,’ has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.
### Process Milestone 1

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

- **Baseline/Goal:** N/A
- **Data Source:** Program Documents

**Estimated Incentive Payment (maximum amount):** $14,365

### Starting Point/Baseline:

*No new outpatient substance abuse treatment site currently exists*

### Year 2 (10/1/2012 – 9/30/2013)

#### Process Milestone 1

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

#### Process Milestone 2

- **P-3** Develop and test data systems
  - **Baseline/Goal:** N/A
  - **Data Source:** EHR; Business Intelligence
  - **Process Milestone 2 Estimated Incentive Payment:** $16,651

#### Process Milestone 3

- **P-2** Establish baseline rates for all cause 30 day readmissions
  - **Baseline/Goal:** N/A
  - **Data Source:** EHR; Business Intelligence
  - **Process Milestone 2 Estimated Incentive Payment:** $16,651

### Year 3 (10/1/2013 – 9/30/2014)

#### Outcome Improvement Target 1

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 5% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $35,625

#### Outcome Improvement Target 2

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 10% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $77,446

### Year 4 (10/1/2014 – 9/30/2015)

#### Outcome Improvement Target 1

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 5% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $35,625

#### Outcome Improvement Target 2

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 10% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $77,446

### Year 5 (10/1/2015 – 9/30/2016)

#### Outcome Improvement Target 1

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 5% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $35,625

#### Outcome Improvement Target 2

- **3.1** All cause 30 day readmission rate - NQF 1789 for patients 18 and older
  - **Baseline:** DY 3 all cause 30-day readmissions
  - **Goal:** 10% reduction in DY 3 all cause 30-day readmissions.
  - **Data Source:** Hospital Records
  - **Estimated Incentive Payment:** $77,446

### Year 2 Estimated Outcome Amount:

(Add incentive payments amounts from each milestone/outcome improvement target): $14,365

### Year 3 Estimated Outcome Amount:

$33,302

### Year 4 Estimated Outcome Amount:

$35,625

### Year 5 Estimated Outcome Amount:

$77,446

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):

$160,738
Title of outcome measure: IT-12.5 Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention);

Unique RHP outcome identification number(s): 130958505.3.1

Performing Provider name/TPI: Nueces County Public Health Department/130958505

Outcome Measure Description:
IT-12.5 Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention)

Process milestones:
- DY 2 P-1 Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3 P-2 Establish baseline rates

Outcome Improvement Target:
- DY 4: IT 12.5 Increase 40% over baseline of zero for patient referrals made to tobacco cessation programs; obesity prevention and intervention programs
- DY 5 IT IT 12.5 - Increase 40% by the end of DY5 over DY 4 baseline for patient referrals made to tobacco cessation programs; obesity prevention and intervention programs and

Rationale:
The process milestones were selected because they permit planning and the assessment of current status with respect to increasing access to chronic disease management and prevention services and connection to patient-centered medical homes for the target patient population. The improvement target percentages were selected because they are reasonable and provide a suitable framework for judging health care improvements related to this particular measure in the target patient population.

Outcome Measure Valuation:
Nueces County has a population of 343,281 with 15% enrolled in Medicaid (53,056) 26% uninsured (89,253), and 21% ranking of poor to fair health that is higher than the State (19%) and national benchmark (10%). Adding to the disparity of the County’s health is an adult obesity rate of 30% that contributes to the prevalence of chronic disease and disabilities that plague this area of South Texas.170 The high rates of underinsured patients, lack of access to patient centered medical homes and poor coordination between the health care systems and community based service providers contribute to poor health outcomes.

Qualified Health Center, Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces

County operated by the CC-NCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, has and has approximately 5,000 adult patients in its system.

This project aims to engage this target population in community support programs that provide chronic disease management and prevention services by identification and referral at the clinic and health center level by a CHW trained in care coordination, addressing RHP 4 Priority Community Needs CN.1 Improve access to care for primary care and specialty services and CN.2 Improve the provision and coordination of health care services for persons with chronic conditions. A medical home model with chronic disease management has been demonstrated to improve clinical outcomes, decrease ED visits, and decrease cost of care in Amarillo, Texas. Implementation of a similar model in Nueces County via this project plus Project 2.6.2 and Project 1.3.1 could potentially avoid $2,500 in medical costs per patient per year as occurred at the J.O. Wyatt Clinic in Amarillo by 2011.\(^{171}\) This translates to a potential $7.5 million in cost avoidance by DY5 in meeting the target of 3,000 patients served.

Individuals and the community benefit from healthier people in improved quality of life and productivity.

<table>
<thead>
<tr>
<th>130958505.3.1</th>
<th>IT-12.5</th>
<th>Other USPSTF-endorsed screening outcome (Referral to community tobacco cessation programs and referral of obese patients to multicomponent behavioral intervention)</th>
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**Nueces County Public Health Department** 130958505

**Related Category 1 or 2 Projects:** 130958505.1.1

**Starting Point/Baseline:** 0

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1:** P-1: Project planning—engage stakeholders identify current capacity and needed resources  
Baseline/Goal: N/A  
Data Source: N/A | **Process Milestone 2:** P-2: Establish baseline rates  
Baseline/Goal: N/A  
**Data Source:** Available data from four non-hospital associated community health centers | **Outcome Improvement Target 1** IT-12.5 Referral to community tobacco cessation programs  
Baseline/Goal: Zero/40% of reported patients  
Data Source: Registry data | **Outcome Improvement Target 2** IT-12.5 Referral to community tobacco cessation programs  
Baseline/Goal: 40%/80% of reported patients  
Data Source: Registry data |
| Process Milestone 1 Estimated Incentive Payment (maximum amount): $0.00 | Process Milestone 2 Estimated Incentive Payment: $54,000 | Outcome Improvement Target 1 Estimated Incentive Payment: $60,000 | Outcome Improvement Target 2 Estimated Incentive Payment: $120,000 |

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $0.00  
Year 3 Estimated Outcome Amount: $54,000  
Year 4 Estimated Outcome Amount: $60,000  
Year 5 Estimated Outcome Amount: $120,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $234,000
Title of outcome measure: IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 130958505.3.2

Performing Provider name/TPI: Nueces County Public Health Department/1309585-05

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

Process Milestone:
- DY 2 - P-1, Project Planning
- DY 3 - P-2 Establish baseline rates.

Outcome Improvement Target:
- DY4 and DY5 IT-1.10 The goal is to achieve a 5% improvement over baseline in DY 4 and a 10% improvement over baseline in DY 5

Rationale:
The process milestones were selected because they permit planning and the assessment of current status with respect to blood glucose control for the target patient population. The improvement target percentages were selected because they are reasonable and provide a suitable framework for judging health care improvements related to this particular measure in the target patient population.

Outcome Measure Valuation:
Nueces County has a population of 343,281 with 26% uninsured (89,253), with 13.6% of the population having diabetes, this calculates to 12,138 people who have diabetes but no health insurance, many who do not qualify for Nueces Aid (county indigent health care). These patients along with the underinsured receive their health care in community-based health centers and hospital emergency departments (ED). This patient population often seeks medical care at the Amistad Federally Qualified Health Center, Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces County operated by the CC-NCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, and has ~2,000 diabetes patients in its system. While the Nueces County Hospital District has a contract in place for those patients qualifying for the indigent care program to receive care at the CHRISTUS Spohn Memorial Hospital and the CHRISTUS Spohn hospital-based family health centers, this patient population must meet both residency and household income requirements. Often, patient populations such as the working poor, undocumented immigrants and those people living in areas outlining Nueces County borders seek medical care within the non-hospital based community health centers, public health centers and support programs located in Nueces County. Currently, with the exception of Amistad Community Health Center, these community based providers do not have access to patient records electronically; hence, as a person seeks treatment and services at whichever site that is most immediately affordable there is no continuity to treatment records. This is reciprocal for the local hospital systems when the aforementioned patient population presents as a hospital or emergency room admission.

Using HIE’s to improve care, enhance coordination among members of the care team, enable regular and frequent interventions can help to lower overall health care costs and produce a substantial ROI.

for a community or organization\textsuperscript{4}. Appropriate to Nueces County and in consideration of a single chronic disease and related complication, the County had 150 hospital admissions in 2010 for lower-extremity amputation with a risk-adjusted admission rate of 58.70 per 100,000 population, which was significantly higher than the state average rate based on 95 percent confidence interval\textsuperscript{173}. Delaying complications in 2,000 or just 16\% of the uninsured diabetes patients by just one year would save $56,986,400. Delaying complications in 2,000 diabetes patients by five years would save $284,932,000. Bringing together clinical, community and public health records under one comprehensive health information system will be a catalyst for improved planning, treatment, and education; hence, better outcomes for the patient and community.

\textsuperscript{173} Texas Health Care Information Collection. Texas Hospital Inpatient Discharge Public Use Data File, 2010.
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<td><strong>Year 3</strong>&lt;br&gt; 10/1/2013 – 9/30/2014</td>
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<td><strong>Process Milestone 1</strong>&lt;br&gt;P-1: Project planning—engage stakeholders identify current capacity and needed resources&lt;br&gt;<strong>Baseline/Goal:</strong> N/A&lt;br&gt;<strong>Data Source:</strong> N/A</td>
<td><strong>Process Milestone 2</strong>&lt;br&gt;P-2: Establish baseline rates&lt;br&gt;<strong>Baseline/Goal:</strong> N/A&lt;br&gt;<strong>Data Source:</strong> Available data from three associated public health clinics</td>
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<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount):</em> $0</td>
<td>Process Milestone 2 Estimated Incentive Payment: $76,000</td>
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<td>Year 3 Estimated Outcome Amount: $76,000</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $304,000
Title of outcome measure: IT-1.10 Diabetes care: HbA1c poor control (>9.0%)  
Unique RHP outcome identification number(s): 130958505.3.3  
Performing Provider name/TPID: Nueces County Public Health Department/130958505

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

Process milestones:  
- DY 2 P-1 - Project Planning  
- DY 3 P-2 - Establish baseline rates

Outcome Improvement Targets:  
- DY 4 IT-1.10 Diabetes care: HbA1c poor control (>9.0%)  
- DY 5 IT-1.10 Diabetes care: HbA1c poor control (>9.0%)  

The goal is to achieve a 5% improvement over baseline in DY 4 and a 10% improvement over baseline in DY 5.

Rationale:  
The process milestones were selected because they permit planning and the assessment of current status with respect to ED visits for the target patient population. The improvement target percentages were selected because they are reasonable measure of the impact of a coordinated care approach to the treatment of diabetes, which is the focus of the related Category 2 project, 2.6.3, implementing an evidence-based health promotion program utilizing a Diabetes Care Team consisting of a Certified Diabetes Educator and a Community Health Worker.

Outcome Measure Valuation:  
Nueces County has a population of 343,281 with 26% uninsured (89,253), with 13.6% of the population having diabetes, this calculates to 12,138 people who have diabetes but no health insurance, many who do not qualify for Nueces Aid (county indigent health care). These patients along with the underinsured receive their health care in community-based health centers and hospital emergency departments (ED). This patient population often seeks medical care at the Amistad Federally Qualified Health Center, Mission of Mercy mobile clinic, Metro Ministries Gabbard Memorial Health Clinic, and Timon’s Ministries Health Clinic and three (3) health clinics within Nueces County operated by the CC-NCPHD. Amistad Federally Qualified Health Center is the largest community-based health center to address this population, and has ~2,000 diabetes patients in its system.

This project aims to engage these diabetes patients in a Diabetes Care Team consisting of a CDE and CHW engaging the patients in standard of care DSME and DSMS and coordinating care to meet clinical practice recommendations, addressing RHP 4 Priority Community Needs. A Diabetes Care Team in a medical home model with chronic disease management has been demonstrated to improve clinical outcomes, decrease ED visits, and decrease cost of care in Amarillo, Texas. Implementation of a similar model in Nueces County via this project plus Project 2.6.2 and Project 1.3.1 could potentially avoid $2,500 in medical costs per patient per year for ~2,000 patients as occurred at the J.O. Wyatt Clinic in Amarillo by 2011. This would translate to $5,000,000 in cost avoidance per year via decreased ED visits, decreased hospitalizations, and decreased hospital costs.
for those admitted, as demonstrated in the medical literature. Long term health care costs would be greatly decreased. Improved clinical outcomes, specifically A1C levels, decrease complications such as retinopathy, nephropathy, and neuropathy by ~40%. Considering the cost of End Stage Renal Disease is $71,233 per year, $356,165 would be saved by delaying ESRD five years in a single diabetes patient. The lifetime medical cost of this complication for one individual typically exceeds $1.5 million. Nueces County had 150 hospital admissions in 2010 for lower-extremity amputation with a risk-adjusted admission rate of 58.70 per 100,000 population, which was significantly higher than the state average rate based on 95 percent confidence interval. Delaying complications in 2,000 diabetes patients just one year would save $56,986,400. Delaying complications in 2,000 diabetes patients five years would save $284,932,000.

Individuals and the community benefit from healthier people in improved quality of life and productivity. Lost productivity due to diabetes in Nueces County was estimated to be $154,300,000 in 2006. On average, people with diabetes miss 1.9 more workdays per year than people without diabetes. Decreased absenteeism for 2,000 people with diabetes would save employers $304,000 per year.
**130958505.3.3**  
**IT-1.10**  
**Diabetes Care: HbA1c poor control (>9.0%)**  

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**Related Category 1 or 2 Projects:**  
130958505.2.1

**Starting Point/Baseline:** 0

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</table>
| **Process Milestone 1:** P-1: Project planning—engage stakeholders, identify current capacity and needed resources  
Baseline/Goal: N/A  
Data Source: N/A  
Process Milestone 1 Estimated Incentive Payment *(maximum amount): $0.00** | **Process Milestone 2:** P-2: Establish baseline rates  
Baseline/Goal: N/A  
**Data Source:** Available data from three associated public health clinics  
Process Milestone 2 Estimated Incentive Payment: $83,000 | **Outcome Improvement Target 1 IT-1.10 Diabetes care: HbA1c poor control**  
Baseline/Goal: DY 3 rates/5% improvement over DY 3 baseline  
**Data Source:** Registry data  
Outcome Improvement Target 1 Estimated Incentive Payment: $95,000 | **Outcome Improvement Target 2 IT-1.10 Diabetes care: HbA1c poor control**  
Baseline/Goal: DY 3 rates/10% improvement over DY 3 baseline  
**Data Source:** Registry data  
Outcome Improvement Target 2 Estimated Incentive Payment: $190,000 |

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0.00 | Year 3 Estimated Outcome Amount: $83,000 | Year 4 Estimated Outcome Amount: $95,000 | Year 5 Estimated Outcome Amount: $190,000 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $368,000**
**Title of outcome measure (Improvement Target):** IT-1.20 Other Outcome Improvement Target: Zone Body Mass Index (zBMI)

**Unique RHP outcome identification number(s):** 130958505.3.4

**Performing Provider name/TPI:** Corpus Christi - Nueces County Public Health District/130958505

**Outcome Measure Description:**
IT-1.20 Other Outcome Improvement Target: Zone Body Mass Index (zBMI)

**Process milestones:**
- DY 2 P-1 Project Planning
- DY 3 P-2 Establish baseline rates

**Outcome Improvement Target:**
- IT-1.20 Other Outcome Improvement Target: Zone Body Mass Index (zBMI). The goal is to have 33% of the program participants achieve a reduction in the zBMI score at the completion of the program by DY 4 and by DY 5, 40% of program participants in that year will achieve a reduction in the zBMI.

**Rationale:**
The process milestones were selected because they permit planning and the assessment of current status with respect to obesity prevention as measured by the zBMI for the target patient population. The improvement target percentages were selected because they are reasonable and provide a suitable framework for judging health care improvements related to this particular measure in the target patient population.

**Outcome Measure Valuation:**
Texas Department of State Health Services estimates that approximately 70 percent of adults in Public Health Region 11 are overweight and 35 percent are obese. In addition to being tied to diabetes, obesity also increases the risk for certain types of cancer, heart disease, stroke, arthritis and other diseases.

Nueces County has a 13.6% diabetes rate in a population of 343,281. While there are many causes for diabetes, it has been established that 90 percent of obesity can be prevented. Rather than developing a program that addresses adult obesity, we have chosen to aggressively prevent and reduce childhood obesity.

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175 Texas Department of State Health Services. Behavioral Risk Factor Surveillance Survey. 2011

Addressing obesity among participants in the Medicaid program is particularly relevant. A 2006 study by Thompson Medstat reviewed Medicaid claims data from 2004 and found that:\(^{177}\):

- Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance.
- Children treated for obesity are roughly three times more expensive for the health system than the average insured child.
- Annual healthcare costs are about $6,700 for children treated for obesity covered by Medicaid and about $3,700 for obese children with private insurance.
- The national cost of childhood obesity is estimated at approximately $11 billion for children with private insurance and $3 billion for those with Medicaid.
- Children diagnosed with obesity are two to three times more likely to be hospitalized.
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance.
- Children treated for obesity are far more likely to be diagnosed with mental health disorders or bone and joint disorders than non-obese children.

### 130958505.3.4

**IT-1.20**

Other Outcome Improvement Target: Zone Body Mass Index (zBMI)

<table>
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<tr>
<th>Corpus Christi - Nueces County Public Health District</th>
<th>130958505</th>
</tr>
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<td>Related Category 1 or 2 Projects:</td>
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<td>Starting Point/Baseline:</td>
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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 P-1:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Goal: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Program documentation/data.</td>
<td><strong>Process Milestone 2 P-2:</strong> Implement, document and test an evidence-based innovative project for targeted population. Goal: Implement, document and test an evidence-based innovative project for targeted population. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider.</td>
<td><strong>Outcome Improvement Target 1 IT-1.20 Other Outcome Improvement Target:</strong> Have 33% of the program participants achieve a reduction in the zBMI score at the completion of the program by DY 4. Goal: 33% of participants reduce zBMI. Data Source: Participant records. Outcome Improvement Target 1 Estimated Incentive Payment: $200,000</td>
<td><strong>Outcome Improvement Target 2 IT-1.20 Other Outcome Improvement Target:</strong> Have 40% of the program participants in DY 5 achieve a reduction in the zBMI score at the completion of the program by DY 5. Goal: 40% of participants reduce zBMI. Data Source: Participant records. Outcome Improvement Target 2 Estimated Incentive Payment: $340,000</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $0.00 | Year 3 Estimated Outcome Amount: $200,000 | Year 4 Estimated Outcome Amount: $200,000 | Year 5 Estimated Outcome Amount: $340,000 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $740,000**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
OD-9 Right Care, Right Setting, IT-9.4 ED Prevention: Increase the number of prevented pediatric emergency department visits, 132812205.1.1 Expand Primary Care Capacity –Driscoll Children’s Hospital [TPI: 132812205]
Unique Identifier: 132812205.3.1

Outcome Measure Description:
IT-9.4 ED Prevention: Increase the number of prevented pediatric emergency department visits

Process Milestone:
- **DY2:**
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-7: Develop a patient survey attending After Hours Clinic at Driscoll locations to measure outcome improvement target
- **DY3:**
  - P-2: Establish a baseline on the number of preventable and unnecessary pediatric emergency department visits

Outcome Improvement Targets for each year:
- **DY4:**
  - IT-9.4: Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline
- **DY5:**
  - IT-9.4: Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline

Pediatric primary care facilities like an Urgent Care, Quick Care or an After Hours, is a good alternative to a hospital emergency room by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. An ED visit is a higher cost than an Urgent Care, Quick Care, or After Hours clinic visit. If patients were seen in the Emergency Room setting rather than the After Hours clinic setting, the cost of providing care would increase. The outcome would be to increase the number of prevented pediatric ED visits by increasing access to pediatric primary care facilities. The outcome measure will be to increase the number of prevented pediatric emergency department visits XX% starting in DY4. The outcome targets will be established once the baseline is determined.

Rationale:
Low-income residents are disenfranchised from the medical system and have difficulty accessing pediatric primary care services. Pediatric primary care facilities like an Urgent Care, Quick Care or an After Hours, is a good alternative to a hospital emergency room by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. An ED visit is a higher cost than an
Urgent Care, Quick Care, or After Hours clinic visit. If patients were seen in the ED setting rather than the After Hours clinic setting, the cost of providing care would increase. The outcome would be to increase the number of prevented pediatric ED visits by increasing access to pediatric primary care facilities.

To measure the outcome, a patient survey will be developed in DY2 to collect information on the patient’s decision to utilize the after care facility. The patient’s parent/guardian will be surveyed to determine whether they would have sought services at the Emergency Department if they did not have access to the after-hours clinic. For measurement purposes, the numerator will include those patients who would have otherwise sought treatment in the ED; the denominator will be the total number of surveyed patients.

**Outcome Measure Valuation:**
An Emergency Room visit cost to Medicaid is consistently higher than an Urgent Care, Quick Care, or After Hours clinic visit. A payment difference exists between a visit at Driscoll’s Urgent Care vs. a Driscoll Children’s Hospital Emergency Room visit for a Level 1, a Level 2, and Level 3. Based on the most recent 12 months, we calculated the difference in potential savings by these levels for a Medicaid patient visit in an After Hours clinic versus an emergency department. If improved patient access is not provided in an After Hours clinic setting in Driscoll’s service area, patients will over utilize the emergency room. If patients were seen in the Emergency Room setting rather than the After Hours clinic setting, the cost of providing care would increase.
**RHP Plan for Region 4**

<table>
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<tr>
<th><strong>Unique Cat 3 ID:</strong> 132812205.3.1</th>
<th><strong>Reference Number from RHP PP:</strong> 3.IT-9.4</th>
<th><strong>Outcome Improvement Target:</strong> Increase the number of prevented pediatric emergency department visits</th>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 1 or 2 Projects:**  
**Unique Category 1 Identifier – 132812205.1.1**

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<th><strong>Starting Point/Baseline:</strong></th>
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(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
|---|---|---|---|

**Process Milestone [P-1]:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Data Source:** Documentation of meeting minutes.

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $162,500

**Process Milestone 2 [P-7]:** Develop a patient survey attending After Hours Clinic at Driscoll locations to measure outcome improvement target  
**Data Source:** Clinic Records

**Process Milestone 2:** Estimated Incentive Payment (maximum amount): $162,500

**Process Milestone 3: [P-2]:** Establish a baseline on the number of preventable and unnecessary pediatric emergency department visits  
**Numerator:** Total number of patients surveyed at Driscoll’s clinics during expanded after hours, who would have chosen the ED as their alternative source of care  
**Denominator:** Total number of patients surveyed during expanded hours  
**Data Source:** Clinic Records

**Process Milestone 3 Estimated Incentive Payment (maximum amount):** $375,000

**Outcome Improvement Target 1 [IT-9.4]:** Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline  
**Numerator:** Total number of patients surveyed at clinic during expanded after hours who indicate they would have chosen the ED as their alternative source of care  
**Denominator:** Total number of patients surveyed during expanded hours  
**Data Source:** Clinic Records

**Outcome Improvement Target 1 Estimated Incentive Payment:** $600,000

**Outcome Improvement Target 2 [IT-9.4]:** Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline  
**Numerator:** Total number of patients surveyed at clinic during expanded after hours who indicate they would have chosen the ED as their alternative source of care  
**Denominator:** Total number of patients surveyed during expanded hours  
**Data Source:** Clinic Records

**Outcome Improvement Target 2 Estimated Incentive Payment:** $1,435,500

| **Year 2 Estimated Outcome Amount:** $325,000 | **Year 3 Estimated Outcome Amount:** $375,000 | **Year 4 Estimated Outcome Amount:** $600,000 | **Year 5 Estimated Outcome Amount:** $1,435,500 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $2,735,500
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
OD-7 Oral Health – IT-7.10, Other Outcome Improvement Target, 132812205.1.2 – Increase, Expand, and Enhance Oral Health Services - Driscoll Children’s Hospital [TPI: 132812205]
Unique RHP outcome identification number: 132812205.3.2

Outcome Measure Description:
The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in reducing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011. Application of dental education and fluoride varnish treatments will reduce dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

IT-7.10 Other Outcome Improvement Target will be to decrease severe dental caries that result in operative interventions for targeted population in the Driscoll Service area by 5%.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area.

Outcome Improvement Targets for each year:
- DY4:
  - IT-7.10: Decrease by 5% severe dental caries from the baseline that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments
- DY5:
  - IT-7.10: Decrease by 10% severe dental caries from the baseline that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments

Rationale:
Studies have shown that application of fluoride varnish to erupting primary teeth can prevent the incidence of severe early childhood caries as shown in many studies and in our own pilot. By increasing the number of young children who have received the fluoride varnish, we expect a decrease in costly dental procedures under general anesthesia with the attendant risks.178 Data

suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The outcome improvement target is by increasing access to dental education and fluoride varnish treatments we would then decrease carries that would result in operative intervention in our service delivery area.

**Outcome Measure Valuation:**
Application of dental fluoride varnish treatments coupled with education will reduce dental operating room procedures. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011. The preventive treatment of dental education and fluoride varnish treatment versus dental operating room procedures creates significant value to our community.
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Performing Provider Name: Driscoll Children’s Hospital

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Starting Point/Baseline:

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Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: Hospital/Health plan records.

Process Milestone 1 Estimated Incentive Payment (maximum amount): $341,026

Process Milestone 2: [P-2] Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area.

**Numerator**: Total number of Driscoll’s Health plan children with severe dental caries requiring operative intervention during CY 2011.

**Denominator**: Total number of Driscoll’s Health plan participants who received dental education and fluoride varnish treatment for prevention of severe dental caries during CY 2011.

Data Source: Documentation of claims data.

Outcome Improvement Target 1 [IT-7.10]:

**Improvement Target**: Decrease by 5% below baseline severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments

Data Source: Documentation of claims data.

Outcome Improvement Target 2:

**Estimated Incentive Payment**: $366,100

Outcome Improvement Target 2:

**Estimated Incentive Payment**: $341,026

Outcome Improvement Target 2:

**Estimated Incentive Payment**: $366,100

Outcome Improvement Target 2:

**Estimated Incentive Payment**: $592,500

Outcome Improvement Target 2:

**Estimated Incentive Payment**: $1,437,193

Year 2 Estimated Outcome Amount: $341,026

Year 3 Estimated Outcome Amount: $366,100

Year 4 Estimated Outcome Amount: $592,500

Year 5 Estimated Outcome Amount: $1,437,193

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $2,736,819
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit, 132812205.1.9 – Expand Specialty Care Capacity- Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.3

Outcome Measure Description:
OD-1, IT-1.1 Third next available appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-7- Project Planning – select a targeted specialty clinic to measure Third Next Available appointment in proceeding demonstration year
- DY3:
  - P-2 -Establish baseline for reducing the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam at targeted specialty clinic(s) selected in DY2

Outcome Improvement Targets for each year:
- DY4:
  - IT-1.1: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam for specialty clinic(s)
- DY5:
  - IT-1.1: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam for specialty clinic(s)

Rationale:
The Third Next Available measurement demonstrates quality health care through:
- Improved access of children to pediatric specialty care,
- Decreased risk of health complications if timely care is accessible,
- Potential reduction in no-shows – patients who experience delays in accessing appointments are more likely to seek emergency care or other alternatives

Outcome Measure Valuation:
The Third Next Available measurement demonstrates an economic impact by:
- Increased number of patients able to be seen with improved access,
- Reduced organization threat to financial viability if patients cannot access appointments in a timely manner,
- Delays in care can result in patients needing more expensive level of care that results in higher costs for the healthcare organization.
### Outcome Improvement Target 1 [IT-1.1]:
**Improvement Target:**
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

- **Data Source:** Hospital records

### Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **Data Source:** Hospital records

### Process Milestone 3: [P-2] Establish baseline for reducing the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam at targeted specialty clinic(s) selected in DY2.

- **Numerator:** Average number of days to third next available appointment for an office visit for each clinic and/or department.
- **Denominator:** The measure applies to providers within a reported clinic and/or department.

- **Data Source:** Hospital records

### Process Milestone(s):
- **Estimated Incentive Payment:** $75,000

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3: [P-2]</strong> Establish baseline for reducing the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam at targeted specialty clinic(s) selected in DY2.</td>
<td><strong>Outcome Improvement Target 1 [IT-1.1]:</strong> Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.</td>
<td><strong>Outcome Improvement Target 2 [IT-1.1]:</strong> Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Hospital records</td>
<td><strong>Data Source:</strong> Hospital records</td>
<td><strong>Estimated Incentive Payment:</strong> $278,154</td>
<td><strong>Estimated Incentive Payment:</strong> $701,250</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $150,000 **Year 3 Estimated Outcome Amount:** $170,000 **Year 4 Estimated Outcome Amount:** $278,154 **Year 5 Estimated Outcome Amount:** $701,250

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5):* $1,299,404
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
OD-6 Patient Satisfaction, IT-6.1 – Percent improvement over baseline of patient satisfaction scores pertaining to the patient’s rate of doctor access to endocrinology specialist, 132812205.1.9 – Expand Specialty Care Capacity- Driscoll Children’s Hospital [TPI: 132812205]
Unique RHP outcome identification number(s): 132812205.3.4

Outcome Measure Description:
The outcome measure will be to increase the Patient satisfaction score percentage for targeted specialty care clinics by XX% starting in DY4.

OD-6 Patient Satisfaction
IT-6.1 – Percent improvement over baseline of patient satisfaction scores-(2)-how well their doctors communicate

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline for improvement of patient satisfaction scores through patient’s rating of how well their doctor communicate

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1: Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%
- DY5:
  - IT-6.1: Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%

Rationale:
Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction would help to increase patient compliance which in time would result in better continuum of care for the patient.

Outcome Measure Valuation:
Providing specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.
**Unique Category 3 ID:** 132812205.3.4  
**Ref Number from RHP PP:** 3.IT-6.1  
**Outcome Improvement Target:** Percent improvement over baseline of patient satisfaction scores-(2) How well their doctors communicate

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Hospital records  
Process Milestone 1 Estimated Incentive Payment (maximum amount): $150,000 | Process Milestone 2 : [P-2] Establish baseline for improvement of patient satisfaction scores through patient’s rating of how well their doctor communicate  
Numerator: Percent improvement in targeted patient satisfaction domain  
Denominator: Number of patients who were administered the survey  
Data Source: NRC Picker  
Process Milestone(s): | Improvement Target 1 [IT-6.1]  
Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%  
Data Source: NRC Picker  
Outcome Improvement Target 1: Estimated Incentive Payment: $278,164 | Outcome Improvement Target 2 [IT-6.1]:  
Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%  
Data Source: NRC Picker  
Outcome Improvement Target 3: Estimated Incentive Payment: $701,250 |

**Starting Point/Baseline:** To be determined in DY3

**Unique Category 1 Identifier** – 132812205.1.3

**Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**

**Data Source:** Hospital records

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $150,000

**Outcome Improvement Target 1:**

**Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**

**Data Source:** Hospital records

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $150,000

**Process Milestone 2 : [P-2] Establish baseline for improvement of patient satisfaction scores through patient’s rating of how well their doctor communicate**

**Numerator:** Percent improvement in targeted patient satisfaction domain

**Denominator:** Number of patients who were administered the survey

**Data Source:** NRC Picker

**Process Milestone(s):**

**Outcome Improvement Target 1:**

**Improvement Target 1 [IT-6.1] :**

Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%

**Data Source:** NRC Picker

**Outcome Improvement Target 1:**

**Estimated Incentive Payment:** $278,164

**Outcome Improvement Target 2 [IT-6.1]:**

Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%

**Data Source:** NRC Picker

**Outcome Improvement Target 3:**

**Estimated Incentive Payment:** $701,250

<table>
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<tr>
<th>Year 2 Estimated Outcome Amount: $150,000</th>
<th>Year 3 Estimated Outcome Amount: $170,000</th>
<th>Year 4 Estimated Outcome Amount: $278,154</th>
<th>Year 5 Estimated Outcome Amount: $701,250</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $1,299,404
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies: 132812205.27—Implement Evidence-based Disease Promotion Programs

Unique RHP outcome identification number(s): 132812205.3.5

Outcome Measure Description:

IT-8.9 Other Outcome Improvement Target will be to increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients

Outcome Improvement Targets for each year:
- DY4:
  - IT-8.9: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%
- DY5:
  - IT-8.9: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%

Rationale:
The early detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. This potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

Outcome Measure Valuation:
The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and
medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities.
**Unique Category 3 ID:** 13281225.3.5  
**3.IT-8.9**  
**Other Outcome Improvement Target: Early Detection of Maternal Fetal Anomalies**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 1 or 2 Projects:**

**Unique Category 2 Identifier:** 132812205.2.1

**Starting Point/Baseline:**

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

**Process Milestone 1 [P-1]:** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Data Source:** Documentation of meeting minutes.

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $400,000

**Process Milestone 2 [P-2]:** Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients.  
**Numerator:** Total number of early detected maternal fetal anomalies over a 12-month period less total number of early detected maternal fetal anomalies over the prior 12-month period.  
**Denominator:** Total number of early detected maternal fetal anomalies over the prior 12-month period.  
**Data Source:** Hospital Record

**Process Milestone 2 Estimated Incentive Payment:**$450,000

**Outcome Improvement Target 1 [IT-8.9]:** Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from prior demonstration year.

**Data Source:** Hospital records

**Outcome Improvement Target 1 Estimated Incentive Payment:** $712,500

**Outcome Improvement Target 2 [IT-8.9]:** Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from baseline year.

**Data Source:** Hospital records

**Outcome Improvement Target 2 Estimated Incentive Payment:** $1,650,000

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $400,000

**Year 3 Estimated Outcome Amount:** $450,000

**Year 4 Estimated Outcome Amount:** $712,500

**Year 5 Estimated Outcome Amount:** $1,650,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $3,212,500
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 NICU Average Days Per Delivery , 132812205.2.2—Implement Evidence-based Health Promotion Programs, Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.6

Outcome Measure Description:
The Project focuses on the current lack of informative and structured maternity social and healthcare supports available to indigent women during pregnancy as potential risk factors for these outcomes. Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term/low-weight births are keys to improving overall health care delivery and health outcomes in the region.

IT-8.9: Reduce the Neonatal ICU days per delivery for the targeted population by 5 percent for DY4-5. The targeted population is defined within Category 3 Outcome table.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Undertake steps and actions to establish baselines to Reduce Average NICU days per delivery for the targeted population

Outcome Improvement Targets for each year:
- DY4:
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 5% less than a Non-Cadena member (using CY2011 baseline information)
- DY5:
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 10% less than a Non-Cadena member (using CY2011 baseline information)

Rationale:
Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients. Reduction in pre-term births with a corresponding reduction in NICU utilization are keys to improving overall health care delivery and health
outcomes in the region. This outcome will be implemented in DY3 with improvement targets starting in DY4. Driscoll provides educational sessions and consulting visits to the public for multiple reasons, one of which is to help reduce ALOS for NICU patients.

**Outcome Measure Valuation:**
Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Neonatal ICU use is a high cost service line. Decreasing the number of premature infant admissions less than 37 weeks with a resulting decrease in the average NICU days per delivery is a more efficient use of resources as well as significantly decreasing complications for the infant. Expanding health education to high risk pregnant patients as well as increasing the number of women provided counseling sessions on tobacco and alcohol will create significant savings and value.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>132812205.2.2</th>
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</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be developed in DY3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</strong></td>
</tr>
<tr>
<td>Numerator:</td>
<td>Total Discharge Days for Non-Cadena members in the NICU during 2011</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of Non-Cadena member discharges in the NICU during CY2011</td>
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<tr>
<td>Data Source:</td>
<td>Claims data/Hospital documentation (utilizing Region 4 data)</td>
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<tr>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Undertake steps and actions to establish baselines for Reduce the Average NICU days per delivery for the targeted population</strong></td>
</tr>
<tr>
<td>Numerator:</td>
<td>Total Discharge Days for Cadena members in the NICU in DY4</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of Cadena member discharges in the NICU in DY4</td>
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<td>Data Source:</td>
<td>Hospital record</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Improvement Target for Cadena members: NICU days per delivery for a Cadena member will be at least 10% less than a Non-Cadena member (using CY2011 baseline information)</strong></td>
</tr>
<tr>
<td>Numerator:</td>
<td>Total Discharge Days for Cadena members in the NICU in DY4</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of Cadena member discharges in the NICU for DY5</td>
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<tr>
<td>Data Source:</td>
<td>Hospital record</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2</strong></td>
<td><strong>Improvement Target for Non-Cadena members: NICU days per delivery for a Non-Cadena member will be at least 10% less than a Non-Cadena member (using CY2011 baseline information)</strong></td>
</tr>
<tr>
<td>Numerator:</td>
<td>Total Discharge Days for Cadena members in the NICU in CY2011</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Total number of Cadena member discharges in the NICU for CY2011</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Hospital record</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $2,822,541
Title of Outcome Measure (Improvement Target): IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236

Driscoll Children’s Hospital [TPI: 132812205]
Unique RHP outcome identification number(s): 132812205.3.7 – Pass 2

Outcome Measure Description:
IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236
- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline of patients who receive a follow-up visit after hospitalization for a mental illness within 7 days and within 30 days of discharge.

Outcome Improvement Targets for each year:
- DY4:
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.
- DY5:
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.

**Rationale:**
Process milestones – P-1 through P-2 were chosen due to the recent development of telehealth and telemedicine services provided to Driscoll Children Health Plan patients within the Driscoll Children Health System. In order to report accurate data and establish baselines, P-1 and P-2 must be completed in DY2-DY3. In DY3 we will establish the baseline of our project outcome. Improvement targets will be chosen based on the timeframe in which the intervention will occur and expectations are established in DY3. The outcome being addressed for this project is based on the impact that telehealth/telemedicine services will have on providing earlier service interventions. By decreasing barriers of access to these specialty services, children are able to seek services early rather than later. If services are not provided to these patients, hospitalization or emergency care is likely to occur. Services provided in an emergency room or hospital cost more than those services provided in a telehealth/telemedicine setting.

**Outcome Measure Valuation:**
While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009. An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year. Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge. This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services. The quantitative value is based on a determination that inpatient and Emergency Room use is a high cost setting for providing behavioral care services. Decreasing the number of behavioral inpatient and emergency encounters is a more cost efficient use of resources. Expanding accessibility to behavioral telemedicine services will create significant savings and value.

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179 [http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf](http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf)
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project</td>
<td>Process Milestone 2: [P-2]</td>
<td>Outcome Improvement Target 1: [IT-1.18]: Improvement Target: Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge once baseline is established. IT-1.18 – Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.</td>
<td>Outcome Improvement Target 2: [IT-1.18]: Improvement Target: Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established. IT-1.18 – Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.</td>
</tr>
<tr>
<td>Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline of patients who receive a follow-up visit after hospitalization for a mental illness within 7 days and within 30 days of discharge.</td>
<td><strong>Outcome Improvement Target 2:</strong> Estimated Incentive Payment: $236,060</td>
<td><strong>Outcome Improvement Target 2:</strong> Estimated Incentive Payment: $540,331</td>
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<td>Data Source: Documentation of plan</td>
<td>Data Source: Documentation of claim data</td>
<td>Data Source: Documentation of claims data</td>
<td>Data Source: Documentation of claims data</td>
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<tr>
<td>Process Milestone(s): Estimated Incentive Payment (maximum amount): $120,000</td>
<td>Process Milestone(s): Estimated Incentive Payment: $148,905</td>
<td><strong>Outcome Improvement Target 2:</strong> Estimated Incentive Payment: $236,060</td>
<td><strong>Outcome Improvement Target 2:</strong> Estimated Incentive Payment: $540,331</td>
</tr>
</tbody>
</table>

Year 2 Estimated Outcome Amount: $120,000
Year 3 Estimated Outcome Amount: $148,905
Year 4 Estimated Outcome Amount: $236,060
Year 5 Estimated Outcome Amount: $540,331

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $1,045,296
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.8 – Pass 2

Outcome Measure Description:
OD-6 – Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 – Establish baseline for patient satisfaction rating (%) for targeted population

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1 - Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.
- DY5:
  - IT-6.1 - Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.

Rationale:
Process milestones – P-1 through P-2 were chosen for reporting accurate data and establish baselines, P-1 and P-2 must be approached in DY2-DY3. In DY3 we will establish baselines for the improvement target. Improvement targets were chosen during DY4 and DY5 based on the timeframe of patient interaction and early intervention services are provided.

Data suggests that parents who reported that their children had received a developmental assessment were more likely to be satisfied with their child’s medical care; these visits were also associated with higher quality ratings. These results suggest that providers and practices who take a structured approach to developmental assessment are providing a higher level of care overall, thereby potentially contributing to improved child health outcomes.

Outcome Measure Valuation:
Data suggest that early intervention to patients that qualify as a High Risk Infant Follow-up, have a direct impact on the quality and long-term benefits in a patient’s life. Early treatment of developmental delays leads to improved outcomes for children, and therefore reduced costs to society. Early intervention has been shown to be particularly effective at
improving outcomes for children who are at increased risk for developmental delays, or later academic underachievement, based on socioeconomic, medical, or other risk factors. A systematic review of early childhood development programs aimed at narrowing the achievement gap for children at risk because of poverty found that participation in such programs resulted in a mean 14 percent reduction in special education placement later in childhood, 13 percent reduction in not passing a grade in school, and an increase in IQ test scores of about 6.5 points. In addition, participation had significant long-term benefits in terms of reducing rates of teen pregnancy, increasing rates of high school graduation, and increasing rates of employment in early adulthood. The Infant Health and Development Program, a randomized, multi-site trial of a comprehensive early intervention effort aimed at premature children, from birth to 36 months, demonstrated sustained benefits, particularly for heavier infants in the cohort.\textsuperscript{180} We are using an estimated program patient volume and conservative Quality Adjusted Life Year (“QALY”) per year valuation to demonstrate a one-time improvement in the quality of life. \textsuperscript{181} Although our estimates are based on a one-time improvement, the project’s value and community benefit is realized throughout many years.

\textsuperscript{180} http://www.commonwealthfund.org/usr_doc/1082_Sices_developmental_screening_primary_care.pdf?section=4039
<table>
<thead>
<tr>
<th>132812205.3.8</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.</th>
</tr>
</thead>
</table>

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 1 or 2 Projects:**

| Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans |
| Process Milestone 1 Estimated Incentive Payment (maximum amount): $108,450 |

**Data Source:** Planning documentation and internal reports

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
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</tr>
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</table>

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Process Milestone 2: [P-2] Establish baseline for patient satisfaction rating (%) for targeted population  
**Data Source:** Patient survey  
**Process Milestone 2(s):**  
Estimated Incentive Payment: $ 125,000 |
| Outcome Improvement Target 1 [IT-6.1]:  
**Improvement Target:** Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.  
**Data Source:** Patient survey  
**Outcome Improvement Target 1:**  
Estimated Incentive Payment: $202,500 |
| Outcome Improvement Target 2 [IT-6.1]:  
**Improvement Target:** Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.  
**Data Source:** Patient survey  
**Outcome Improvement Target 2:**  
Estimated Incentive Payment: $573,658 |

| Year 2 Estimated Outcome Amount: $108,450 | Year 3 Estimated Outcome Amount: $125,000 | Year 4 Estimated Outcome Amount: $202,500 | Year 5 Estimated Outcome Amount: $573,658 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,009,608

RHP Plan for Region 4
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP Project Identification Number: 135233809.3.1
Performing Provider Name/TPI: Lavaca Medical Center/135233809

Outcome Measure Description:
IT-9.2 Reduce Emergency Department visits for target conditions
- Diabetes
- Cardiovascular Disease
- Hypertension

Process Milestones:
DY2:
- P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3: Develop and test data systems

DY3:
- P-2: Establish baseline rates of ED visits for target conditions of diabetes, cardiovascular disease, and hypertension
- P-3: Develop and test data systems

Outcome Improvement Targets for each year:
DY4:
- IT-9.2: Decrease percentage of ED visits for target conditions of diabetes, cardiovascular disease, and hypertension by 3% from baseline

DY5:
- IT-9.2: Decrease percentage of ED visits for target conditions of diabetes, cardiovascular disease, and hypertension by 10% from baseline.

Rationale:
Process milestones P-1 through P-3 were chosen due to the lack of a comprehensive implementation plan, accurate reports and resources currently available to measure ED visits for the targeted conditions. In order to determine proper interventions, report accurate data and establish baselines, P-1 and P-3 will be approached in DY2-DY3. In DY3 we will establish baselines and interventions for the targeted conditions with P-2.

The improvement targets were chosen based on the timeframe in which the intervention will occur and expectations of the challenges being addressed. The outcome measure being addressed may be affected by patient experiences with barriers in accessing primary care services such as transportation issues, cost, physical disability, and a lack of knowledge about what types of services can be provided in the primary care setting. With an effective intervention plan that includes educating patients and families, enhancing access points, greater patient awareness of available services and overall primary care capacity, our
goal is in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services.

**Outcome Measure Valuation:**
Factors considered in valuing this project include community benefit; population served, and cost avoidance. Lavaca Medical center has a service area of approximately 40,000 individuals, a high percentage of who are elderly and/or low-income. These populations have been traditionally underserved by the medical community and are more likely to utilize the emergency department for non-urgent care. Reducing inappropriate emergency department utilization through the expansion of primary care capacity will result in improved patient outcomes, better care coordination, and greater patient satisfaction for these populations, as well as the entire community. Furthermore, we anticipate significant cost savings due to the reduction in inappropriate emergency department utilization and improved capacity for providing the right care, in the right setting, at the right time.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><em>Data Source: EHR, performing provider reports</em></td>
<td>Process Milestone 3 [P-2]: Establish baseline rates of ED visits for target conditions of diabetes, cardiovascular disease, and hypertension</td>
<td><em>Data Source: EHR, Registry, claims data</em></td>
<td>Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization Improvement Target: Decrease percentage of ED visits for target conditions of diabetes, cardiovascular disease, and hypertension by 3% from baseline</td>
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<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
<td><em>Data Source: EHR, performing provider reports</em></td>
<td>Process Milestone 3 Estimated Incentive Payment: $9,923</td>
<td>Process Milestone 3 Estimated Incentive Payment: $9,924</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $26,540</td>
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<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $6,421</td>
<td>Process Milestone 2 Estimated Incentive Payment: $6,421</td>
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<td>Year 3 Estimated Outcome Amount: $19,847</td>
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<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong></td>
<td></td>
<td><strong>$108,844</strong></td>
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</tbody>
</table>
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
The outcome measure for the Crisis Assessment Center with Medical Clearance project includes: OD-9 Right Care, Right Setting -
IT-9.1 Decrease in mental health admissions and readmissions to the criminal justice settings
Unique RHP outcome identification number: 135254407.3.1
Performing provider/TPI: Gulf Bend Center 135254407

Process Milestones:
- DY2: P-1; P-2
- DY3: P-3

Outcome Improvement Targets:
- DY4: IT-9.2 Reduce criminal justice setting visits due to mental health by 5%
- DY5: IT-9.2 Reduce criminal justice setting visits due to mental health by 10%

Outcome Measure Description
The outcome measure for this project is OD-9 Right Care, Right Setting. IT-9.1 Decrease in mental health admissions and readmissions to the criminal justice settings such as jails or prisons. The goal is to decrease the number of admissions and readmissions to the criminal justice setting for those patients suffering from a behavioral health crisis. Gulf Bend will reduce the inappropriate use by expanding and enhancing the crisis stabilization services by developing and implementing a crisis assessment center that offers medical clearance. This is based upon community need within the Gulf Bend service region and supported by local data. Currently, first responders do not have many options when faced with a patient undergoing a behavioral health crisis. Their only option within the area is to transport the patient to the emergency department for a behavioral health assessment. The patient then waits creating a bottleneck of services before they are transported to the local jail or transferred to an inpatient psychiatric hospital.

If there were expanded crisis stabilization services that offered medical clearance, the first responder could transport the patient to the Crisis Assessment Center directly and potentially avoid admissions and readmissions to the criminal justice settings. At the crisis assessment center, the patient would undergo a behavioral and physical health assessment. If the patient were in need of respite care, counseling, or crisis residential services, then they would be offered those services at the same location that offered the assessment. If the patient were in need of primary care, then those services would be provided based upon the patients need since the crisis assessment center would offer medical clearance procedures as well. There would not be a need to transport the patient to the emergency department or local jail since there would be a facility to help assess and stabilize the patient.
**Rationale:**
Process milestones P-1 through P-3 were chosen so we can establish a detailed project plan including identifying current capacity and needed resources and baseline information in which to effectively manage and monitor the project. We included the improvement target of a decrease in mental health admissions and readmissions to criminal justice settings because we know that admissions and readmissions to criminal justice settings such as jails and prisons are disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions such as the Crisis Assessment Center which will prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

**Outcome Measure Valuation:**
This project also presents value to the community and to the health care system within the Gulf Bend service area. The average cost for an emergency department visit is $2,400\textsuperscript{182}. Given that there were 1,200 visits to local emergency departments for behavioral health crisis that equates to a total cost of $2,880,000. If Gulf Bend were able to divert 25% of those visits, that would equate to a cost savings of $720,000. The total costs savings for a decrease in criminal justice admissions is $1,870,440, which leads to an overall cost savings of $2,590,440.

\textsuperscript{182} National Alliance on Mental Illness, 2011
<table>
<thead>
<tr>
<th>135254407.3.1</th>
<th>3.IT.9.1</th>
<th>Reduction in mental health admissions to criminal justice setting</th>
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**Related Category 1 or 2 Projects:**

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

**Process Milestone 1P-1**

- Project planning- engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plans
- **Goal:** Project planning
- **Data Source:** Encounter data, claims, project data, criminal justice system records, ED records

**Process Milestone 1 Estimated Incentive Payment:** $3,875

**Process Milestone 2 P-2**

- Establish baseline rates
- **Goal:** Establish baseline rates
- **Data Source:** Jail records, emergency department records

**Process Milestone 2 Estimated Incentive Payment:** $3,875

**Outcome Improvement Target 1 IT-9.1**

- 5% decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- **Data Source:** Jail records, emergency department records

**Outcome Improvement Target 1 Estimated Incentive Payment:** $41,000

**Outcome Improvement Target 2 IT-9.1**

- 10% decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- **Data Source:** Jail records, emergency department records

**Outcome Improvement Target 2 Estimated Incentive Payment:** $95,000

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $7,750

**Year 3 Estimated Outcome Amount:** $37,500

**Year 4 Estimated Outcome Amount:** $41,000

**Year 5 Estimated Outcome Amount:** $95,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):$181,250*
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
The outcome measure for the Crisis Assessment Center with Medical Clearance project includes IT-9.2 Emergency Department appropriate utilization
Unique RHP outcome identification number: 135254407.3.2
Performing provider/TPI: Gulf Bend Center 135254407

Outcome Measure Description:
Process Milestones:
- DY2: P-1; P-2
- DY3: P-3

Outcome Improvement Targets:
- DY4: IT-9.2 Reduce emergency department visits due to mental health by 5%
- DY5: IT-9.2 Reduce emergency department visits due to mental health by 10%

This outcome measure is to reduce inappropriate use of the emergency department for those patients suffering from a behavioral health crisis. Gulf Bend will reduce the inappropriate use by expanding and enhancing their crisis stabilization services by developing and implementing a crisis assessment center that offers medical clearance. This is based upon community need within the Gulf Bend service region and supported by local data. First responders do not have many options when faced with a patient undergoing a behavioral health crisis. Their only option within the area is to transport the patient to the emergency department for a behavioral health assessment. The patient then waits creating a bottleneck of services before they are transported to the local jail or transferred to an inpatient psychiatric hospital.
If there were expanded crisis stabilization services that offered medical clearance, the first responder could transport the patient to the Crisis Assessment Center directly. At the crisis assessment center, the patient would then be able to undergo a behavioral and physical health assessment. If the patient were in need of respite care, counseling, or crisis residential services, then they would be offered those services at the same location that offered the assessment. If the patient were in need of primary care, then those services would be provided based upon the patients need since the crisis assessment center would offer medical clearance procedures as well. There would not be a need to transport the patient to the emergency department since there would be a facility to help assess and stabilize the patient.

Rationale:
Process milestones P-1 through P-3 were chosen so we can establish a detailed project plan including identifying current capacity and needed resources and baseline information in which to effectively manage and monitor the project. We included the improvement target of a reduction in emergency department visits for mental health conditions because by developing and implementing the Crisis Assessment Center with Medical Clearance we expect to have more individuals diverted from the emergency department because they will now be assessed
and stabilized in the appropriate setting and not have to be transported to the emergency room.

**Outcome Measure Valuation:**
This project also presents value to the community and to the health care system within the Gulf Bend service area. The average cost for an emergency department visit is $2,400. Given that there were 1,200 visits to local emergency departments for behavioral health crisis that equates to a total cost of $2,880,000. If Gulf Bend were able to divert 25% of those visits, that would equate to a cost savings of $720,000. The total costs savings for a decrease in criminal justice admissions is $1,870,440, which leads to an overall cost savings of $2,590,440.
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<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1** P-1 Project planning- engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plans  
*Goal:* Project planning  
*Data Source:* Encounter data, claims, project data, criminal justice system records, ED records | **Process Milestone 3** P-3 Develop and test data systems  
*Goal:* Develop and test data systems  
*Data Source:* Information from discussions/interviews to understand current systems and then establish most effective systems for the project | **Outcome Improvement Target 1** IT-9.2 Reduce emergency department visits due to mental health by 5%  
*Data Source:* Emergency department records | **Outcome Improvement Target 2** IT-9.2 Reduce emergency department visits due to mental health by 10%  
*Data Source:* Emergency department records |
| Process Milestone 1 Estimated Incentive Payment: $3,875 | Process Milestone 3 Estimated Incentive Payment: $37,500 | Outcome Improvement Target 1 Estimated Incentive Payment: $41,000 | Outcome Improvement Target 2 Estimated Incentive Payment: $95,000 |
| **Process Milestone 2** P-2 Establish baseline rates  
*Goal:* Establish baseline  
*Data Source:* Jail records, emergency department records |  |  |  |
| Process Milestone 2 Estimated Incentive Payment: $3,875 |  |  |  |

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<th>Year 2 Estimated Outcome Amount: $7,750</th>
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<th>Year 5 Estimated Outcome Amount: $95,000</th>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $181,250
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
The outcome measure for the Integrate Primary and Behavioral Health Care Services – Person-Centered Behavioral Health Medical Home Project includes: OD-2 Potentially Preventable Admissions, IT-2.4 Behavioral Health/Substance Abuse Admission Rate
RHP outcome identification number: 135254407.3.3
Performing provider/TPI: Gulf Bend Center/135254407

Outcome Measure Description:
The related Category 3 outcome improvement measure chosen for the Gulf Bend Person-Centered Behavioral Health Medical Home project is OD-2 Potentially Preventable Admissions, specifically IT-2.4 Behavioral Health/Substance Abuse Admission Rate including the following:

1. One for BH/SA as the principal diagnosis
2. A second category in which a significant BH/SA secondary diagnosis is present (e.g. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.

Through this project Gulf Bend expects to decrease admissions due to asthma, depression, and diabetes with an underlying or co-existing mental health disorder by 20% by the end of DY 5.

Rationale:
Process milestones P-1 through P-3 were chosen so we can establish a detailed project plan including identifying current capacity and needed resources and baseline information in which to effectively manage and monitor the project. Gulf Bend expects to see a decrease in the admission rates as described above by developing and implementing the Person-Centered Behavioral Health Medical Home. Targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments, inpatient hospitals or jails and through this outcome measure we expect to see the success of a reduction in hospital admissions with a primary diagnosis of chronic disease and a secondary diagnosis of behavioral health.

Outcome Measure Valuation:
Due to the high number of admissions to the local hospitals due to co-occurring mood/affective disorders and chronic co-morbid disease, Gulf Bend feels that an initial decrease for all three admissions by 20% by the end of DY 5 is a great starting point. This could lead to an overall savings of $3,249,179 in just one year. These numbers may seem low, but this is because the integration of primary care and behavioral health services is new to the area. It will take time for patients to take full advantage of the integrated services offered by Gulf Bend.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Process Milestone 2</th>
<th>Process Milestone 3</th>
<th>Outcome Improvement Target 1</th>
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</tr>
</thead>
<tbody>
<tr>
<td>P-1 Project planning, engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plans</td>
<td>P-2 Establish baseline rates</td>
<td>P-3 Develop and test data systems</td>
<td>IT-2.4 Reduction in hospital admissions with primary diagnosis of chronic disease and secondary diagnosis of behavioral health by 10%</td>
<td>IT-2.4 Reduction in hospital admissions with primary diagnosis of chronic disease and secondary diagnosis of behavioral health by 20%</td>
</tr>
<tr>
<td><strong>Goal:</strong> Project planning</td>
<td><strong>Goal:</strong> Establish baseline rates</td>
<td><strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective systems for the project</td>
<td><strong>Data Source:</strong> Hospital EHR records, discharge data</td>
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<td><strong>Data Source:</strong> Encounter data, claims, hospital records</td>
<td><strong>Data Source:</strong> Encounter data, claims, hospital records</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $27,500</td>
<td>Process Milestone 2 Estimated Incentive Payment: $27,500</td>
<td>Process Milestone 3 Estimated Incentive Payment: $230,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $143,900</td>
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<td>Year 2 Estimated Outcome Amount: $230,000</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5): $933,900*
Title of Outcome Measure (Improvement Target): IT- 6.1 Percent Improvement over baseline of patient satisfaction

Unique RHP outcome identification number(s): 135254407.3.4 – Pass 2

Performing provider/TPI: Gulf Bend Center/135254407

Outcome Measure Description:
IT- 6.1 will be defined as the percent increase over baseline of patient satisfaction with getting timely care, appointments, and information. In Gulf Bends service area, there are numerous barriers that prevent access to timely care for behavioral health and psychosocial services. Gulf Bend will distribute evidence based, qualitative surveys to patients that use the existing and enhanced telemedicine services. The survey will measure the patients satisfaction with the timeliness of receiving behavioral health care via telemedicine in a more patient convenient location, ease of access and overall quality of the telemedicine appointments, and the patients satisfaction of the information regarding their behavioral health condition and treatment from a Gulf Bend provider (psychiatrist, Licensed Clinical Social Worker, or Licensed Professional Counselor).

Process Milestones:
- DY2: P-1; P-2;
- DY3: P-3;

Outcome Improvement Target(s) for each year:
- DY4:
  - IT- 6.1 patient satisfaction with receiving timely care, appointments, and information
  - Of those patients who received behavioral health services from Gulf Bend via telemedicine, a 10% increase over baseline in patient satisfaction with receiving timely care, appointments, and information
- DY5:
  - IT- 6.1 patient satisfaction with receiving timely care, appointments, and information
  - Of those patients who received behavioral health services from Gulf Bend via telemedicine, a 15% increase over baseline in patient satisfaction with receiving timely care, appointments, and information

Rationale:
Process and improvement milestones were chosen based upon their ability create improvements in the health of the residents of Gulf Bend's service area. Process milestone P1 was chosen because Gulf Bend must identify and engage primary care providers, hospitals, school districts, and other community based organizations that would be willing to allow Gulf Bend to expand and provide telemedicine services in their buildings. This is critical to the success of the project because Gulf Bend will need to know who would be willing to work and
develop the project with Gulf Bend to increase the project's effectiveness. In order to report accurate data and establish baselines, process milestone P-2 was chosen in DY 2. Gulf Bend has not developed or implemented a survey to establish baseline data in regards to patient satisfaction with its existing telemedicine services. In order to meet the outcome milestones, it is important that Gulf Bend establish a baseline level of patient satisfaction. Process Milestone P-3 was chosen because Gulf Bend must test its current data system against the future need and demands of the data system with the expansion and enhancement of its telemedicine services. This process milestone will allow Gulf Bend to determine if the needed resources must be purchased or if improvements need to be made.

Improvement targets were placed in DY4 and 5 based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The improvement target goal will be to increase patient satisfaction with their appointment times, appointments, and information with Gulf Bend's telemedicine services by 10% over baseline. The improvement target for DY 5 is to show a 5% increase, with a total increase in patient satisfaction of 15% over baseline. DY 4 will be an important year for Gulf Bend because it will be the first measurement of its expanded telemedicine services.

**Outcome Measure Valuation:**
Each outcome measure selected for the category 1 represent areas that address some of the more significant and costly health issues in our community; lack of access to behavioral health services and providers, fragmented care transitions, inappropriate ED utilization, and inappropriate utilization of the criminal justice system. Our valuation of the outcome measure took into account the resources (human and capital) that will need to be purchased to achieve the outcome, but also the cost savings that the outcome measure will have on the health care system in the community. Of the counties in the Gulf Bend service region, all seven are designated by HRSA as Mental Health Profession Shortage Areas. Victoria County Hospitals currently have 315 visits to the ED for behavioral health. With the average cost of an ED visit being $986, the total cost of providing care for the 315 visits is $310,590. Increasing access via telemedicine has been proven in studies to decrease ED and criminal justice setting usage through patient satisfaction. If patient satisfaction increases 15% over baseline within DY 4 and DY 5, it could represent a cost savings of $46,588. This cost savings is only at Victoria county hospitals. If this number was extrapolated to include the other hospitals within the seven county service region, cost savings could be equivalent close to $250,000. This does not include the cost savings when including in appropriate use of the criminal justice setting in the seven county service region. The average cost for a mental/behavioral health patient in the jail is $10,960 (ALOS of 62 days and cost per day of $177). There were over 1,199 individuals arrested that were diagnosed with mental illness. If these patients had increased access to behavioral/mental health services and arrests were decreased by 15% due to patient satisfaction, there would be a cost savings of up to ~$2,000,000 in one year due to a decrease in criminal justice admission due to behavioral/mental illness.
### Related Category 1 or 2 Projects:

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### Starting Point/Baseline:

**Gulf Bend Center**

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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-3]:</strong> Develop and test data systems</td>
<td><strong>Outcome Improvement Target 1 [IT-6.1]:</strong> Patient satisfaction with receiving timely care, appointments, and information - Of those patients who received behavioral health services from Gulf Bend via telemedicine, a 10% increase over baseline in patient satisfaction with receiving timely care, appointments, and information</td>
<td><strong>Outcome Improvement Target 1 [IT-6.1]:</strong> Patient satisfaction with receiving timely care, appointments, and information - Of those patients who received behavioral health services from Gulf Bend via telemedicine, a 15% increase over baseline in patient satisfaction with receiving timely care, appointments, and information</td>
</tr>
<tr>
<td>Data Source: EHR reports</td>
<td>Data Source: EHR; Business Intelligence</td>
<td>Data Source: EHR; Patient surveys</td>
<td>Data Source: EHR; Patient surveys</td>
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<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $6,151.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $29,557</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $31,606</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $73,076</td>
</tr>
</tbody>
</table>

**Process Milestone 2 [P-2]:** Establish baseline rates of patients that will need to be surveyed for patient satisfaction survey

- Data Source: EHR; reports

  | Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,303 | Year 3 Estimated Outcome Amount: $29,557 | Year 4 Estimated Outcome Amount: $31,606 | Year 5 Estimated Outcome Amount: $73,076 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $146,542
Category 3: Quality Improvements
Title of Outcome Measure (Outcome Improvement Target): IT-6.1 – Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores
RHP Outcome Identification Number: 136412710.3.1

Performing Provider Name/TPI: Otto Kaiser Memorial Hospital/136412710

Outcome Measure Description:
This project provides care coordination, by more accurately assessing the patients’ needs, via telemedicine/telehealth consults and providing the patient more appropriate care in a timely manner. The performing provider and its partners expect to see better health outcomes by using telecommunications technologies and connectivity to provide access to underserved rural populations improved access to specialists, improved care and improved patient satisfaction. This project will create opportunities to improve health outcomes for stroke patients by implementing the telemedicine project that includes specialty consults, t-PA availability at the hospital ER, improved staff competence, and more efficient access to care. The improved access to care, availability of specialty services, and improved health care outcomes are expected to increase patient satisfaction.

Process Milestones:
- DY 2: P-1; P-7
- DY 3: P-2; P-4

Outcome Improvement Targets for each year:
- DY 4: IT 6.1 Percent improvement over baseline of patient satisfaction scores
- DY 5: IT 6.1 Percent improvement over baseline of patient satisfaction scores

Rationale:
Using telecommunications for patient consults to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan is a viable way to make medical care more accessible. The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients who would not otherwise have timely access to specialty care. This real/near-time monitoring and interacting will enable a healthcare team to address patient problems in a more timely manner, creating a patient-centered approach that will improve patient outcomes and patient satisfaction, and reduce readmissions for stroke victims as a result of the improved health care treatment.

Outcome Measure Valuation:
OKMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to affect each outcome.

In valuing this outcome measure, OKMC took into account the extent to which improvement in patient outcomes and improved access to care would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve
the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to improve health outcomes and patient satisfaction.
### RHP Plan for Region 4

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otto Kaiser Memorial Hospital</td>
<td>136412710.1.1</td>
</tr>
</tbody>
</table>

#### Starting Point/Baseline:

**136412710.3.1**

Year 2 (10/1/2012 – 9/30/2013)

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

- Data Source: Hospital Records and completed project implementation plan

- Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $17,406

**Process Milestone 2** P-7. Select survey instrument and finalize arrangements for survey implementation

- Data Source: Documentation of survey instrument selection

- Process Milestone 2 Estimated Incentive Payment: $17,406

<table>
<thead>
<tr>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 3 P-2 Establish Baseline Rates</td>
<td>Outcome Improvement Target 1 IT-6.1: Improvement over baseline of patient satisfaction scores</td>
<td>Outcome Improvement Target 2 IT-6.1: Improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Data Source: Hospital Documents</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $26,902</td>
<td>Data Source: Hospital Records; Survey Results</td>
<td>Data Source: Hospital Records; Survey Results</td>
</tr>
<tr>
<td>Process Milestone 4 P-4 Conduct Plan do Study Act cycles to improve data collection and intervention activities</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $71,947</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $106,509</td>
</tr>
<tr>
<td>Data Source: Hospital Documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $26,902</td>
<td></td>
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</tbody>
</table>

#### Year 2 Estimated Outcome Amount:

- (add incentive payments amounts from each milestone/outcome improvement target): $34,812

#### Year 3 Estimated Outcome Amount:

- $53,804

#### Year 4 Estimated Outcome Amount:

- $71,947

#### Year 5 Estimated Outcome Amount:

- $106,509

#### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (*add outcome amounts over DYs 2-5*)

- $267,072
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
136436606.1.3 Expand Care Transitions Program by location and diagnoses

3.3. Potentially Preventable Re-admissions
- IT-3.2: Congestive Heart Failure 30 day readmission rate

Project unique ID number: 136436606.3.1

Outcome Measure Description
CHRISTUS Spohn Hospital Kleberg (“Spohn”) will measure the rate of 30 day readmissions (for any reason) to its hospital facilities upon discharge from an inpatient stay for Congestive Heart Failure (“CHF”), and projects the outcome of its disease registry project to be a reduction in its overall potentially preventable readmission rate for this target population. Potentially Preventable Readmissions (PPRs) often result from the fact that patients lack support, information, and access to continued care in the outpatient setting upon discharge. These patients are at risk for their conditions deteriorating when they are no longer monitored and managed in the hospital, which can lead to relapses/additional acute episodes/complications requiring readmission to an inpatient setting. The systemic cost of readmissions and negative impact on patient quality of life, satisfaction, and long-term outcomes makes this achieving an improvement in this domain a high priority for Spohn.

Process milestones:
- DY2: Establish a baseline of CHF 30 day readmission rates

Improvement milestones:
- DY3: Reduce CHF PPRs by 3% from baseline
- DY4: Reduce CHF PPRs by 5% from baseline
- DY5: Reduce CHF PPRs by 8% from baseline

Rationale:
According to Region 4’s Community Needs Assessment, Kleberg County has a high incidence of hospitalization related to chronic diseases, including CHF (RHP Plan, Section 3, Table 10). Spohn chose this outcome measure to complement its disease registry project because one goal of the registry is to enable CHF patients to effectively manage their conditions and their overall health subsequent to discharge from an inpatient stay for CHF. Spohn expects to see evidence of a decrease in re-admission rates for this population as a result of (1) effective and efficient discharge planning while patients are in the hospital, (2) home visits within 48 hours of patients’ arrival home and (3) follow-up phone calls to ensure patients understand and have processed the education/information provided by Spohn.

Process milestones: During DYs 2-3, Spohn will establish a baseline rate of readmissions for its CHF patients in order to measure progress going forward, and will engage in project planning to create an effective approach to using the information in the registry to prevent readmissions for CHF patients within 30 days of discharge from an inpatient setting (including patient education, medication management, caregiver outreach, and timely follow up).
Improvement milestones: Spohn aims to reduce the percentage of 30 day readmissions for CHF patients by 5% under baseline in DY4, and by 8% under baseline in DY5. These targets were chosen to reflect reasonable but meaningful reforms in the CHF patient short-term outcomes and the cost of providing care to patients with this chronic disease.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to preventing unnecessary hospital readmissions for CHF patients. Hospital readmissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally they increase the systemic cost of providing care to indigent and uninsured patients in the community. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
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<th>136436606</th>
<th>136436606.3.1</th>
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</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>The FY 2012 rate of PPRs for CHF was 21%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-2]: Establish baseline rates – Spohn will determine the rate of 30 day readmissions for CHF patients at its Kleberg campus for all causes. &lt;br&gt;Data Source: Historical clinic/hospital/ED claims and financial data</td>
<td>Outcome Improvement Target 1 [IT-3.1]: PPR Improvement Target: 3% reduction in all cause CHF patient 30-day readmission rates&lt;br&gt;Data Source: Hospital admission records</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $27,415</td>
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<tr>
<td></td>
<td>Year 2 Estimated Outcome Amount: $27,415</td>
<td>Year 3 Estimated Outcome Amount: $31,778</td>
<td>Year 4 Estimated Outcome Amount: $50,992</td>
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<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td></td>
<td>Outcome Improvement Target 2 [IT-3.1]: PPR Improvement Target: 5% reduction in all cause CHF patient 30-day readmission rates for Spohn’s Kleberg campus&lt;br&gt;Data Source: Hospital admission records</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $50,992</td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $232,122
Category 3: Quality Improvement

Identifying Outcome Measure and Provider Information:
1.7.6 - Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.
IT -1.11 Diabetes Care – Blood Pressure Control;
CHRISTUS Spohn Hospital Kleberg / 136436606

Unique Identifier: 136436606.3.2

Outcome Measure Description
Diabetic patients are often at risk for Peripheral Arterial Disease (PAD) and Spohn is implementing a Category 1 project to provide more screenings by cardiovascular specialists for this at-risk population using telemedicine. As a result, Spohn expects more patients to receive cautionary information, medication management, and follow-up when they are identified as having high-blood pressure (which can increase the risk and symptoms of PAD). By identifying patients with the potential to develop or with early signs of PAD, Spohn can provide those patients with medication to reduce blood pressure and prevent/alleviate PAD in many cases. Project implementation is projected to have the following outcomes by end of waiver period:
- 10% increase in diabetic patients seen in Spohn clinics with controlled blood pressure (<140/80mm Hg)

Rationale:
Obesity, Diabetes-Type II, PAD, cardiovascular disease (CVD) and amputations have all been identified as prevalent in the Hispanic population in South Texas. This extremely at-risk population is in dire need of early screening, diagnostics and interventions to reduce the long-term complications of diabetes such as ulcerative or non-healing lesions, necrotic or gangrenous lower extremities and amputations. Diabetic patients with high-blood pressure will be at higher risk for developing PAD, as both conditions affect the patient’s blood flow to their extremities. In tandem with screening diabetes patients for PAD, Spohn clinics have a better chance of identifying and treating uncontrolled blood pressure, Spohn expects an increase in the number of diabetic patients with controlled blood pressure, which will reduce their risk of developing PAD.

Complacency, poor self-management and access to care are all shown to contribute to uncontrolled chronic disease. Implementation of a PAD screening program that extends screening to remote locations throughout the region using a telehealth screening solution would increase early detection for people at-risk and diagnostics and treatment during earlier stages of disease without the burden of appointment delays and multiple trips to specialists’ offices.

Outcome Measure Valuation:
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of controlling blood pressure in diabetic patients identified at high-risk for PAD and those currently experiencing symptoms such
as pain and cramping to lower extremities. Controlling blood pressure will assist providers with prevention and enable a reduction in PAD-related hospital admissions that impact a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Process Milestone 1 [P-1]
Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans – Spohn will develop an approach for identifying and treating diabetic patients with uncontrolled blood pressure, putting them at higher risk for PAD, in tandem with its project to use telemedicine to increase PAD screenings.

**Data Source:** Project plan documentation

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

**Process Milestone 2 [P-2]:** Establish baseline rates – Spohn will assess the number of patients with diabetes who also suffer from uncontrolled blood pressure.

**Data Source:** Project Plan documentation

**Process Milestone 3 [P-3]:** Develop and test data systems - Spohn will assess the volume of information collected through PADnet and blood pressure screenings to assure that the information is broadly disseminated through its system and functioning properly.

**Data Source:** Chronic disease registry

**Process Milestone 4 [P-4]:** Conduct PDSA to improve project activities – Spohn will implement its screening protocol for PAD and treat patients with uncontrolled blood pressure, and then analyze the results, determining best practices and key remaining challenges.

**Data Source:** Project evaluation documentation, assessment of expanded target population

### Outcome Improvement Target 1 [IT-1.11]: Diabetes care: BP control (<140/80mmHg)
**Improvement target:** 10% increase in diabetic patients with controlled blood pressure over DY2 baseline

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $61,919

### Outcome Improvement Target 2 [IT-1.11]: Diabetes care: BP control (<140/80mmHg)
**Improvement target:** 20% increase in diabetic patients with controlled blood pressure over DY2 baseline

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $148,067
<table>
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<th>Related Category 1 or 2 Projects:</th>
<th>136436606.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHRISTUS Spohn Hospital Kleberg</td>
<td>136436606</td>
</tr>
</tbody>
</table>

| **Starting Point/Baseline:** | Approximately 13% of the patients treated in Spohn and neighboring clinics are diabetic or pre-diabetic (approximately 585 patients), placing them at increased risk of PAD. Those diabetic patients with uncontrolled blood pressure (number not yet quantified) are at an even higher risk of PAD and associated amputations. |

<table>
<thead>
<tr>
<th><strong>Year 2 (10/1/2012 – 9/30/2013)</strong></th>
<th><strong>Year 3 (10/1/2013 – 9/30/2014)</strong></th>
<th><strong>Year 4 (10/1/2014 – 9/30/2015)</strong></th>
<th><strong>Year 5 (10/1/2015 – 9/30/2016)</strong></th>
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<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $33,290</td>
<td>Year 3 Estimated Outcome Amount: $38,587</td>
<td>Year 4 Estimated Outcome Amount: $61,919</td>
<td>Year 5 Estimated Outcome Amount: $148,067</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $281,863
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Errors in Bedside Medication Administration

CHRISTUS Spohn Hospital Kleberg / 136436606
Unique Identifier -136436606.3.3

As a result of Spohn’s ability to have electronic medication reconciliation at the point of care, Spohn expects to be able to have pharmacists as part of the medication reconciliation and utilization review process throughout the hospitalization and at discharge. Pharmacists will be specifically alerted to assess patient profiles for drug interactions and those receiving medications identified as being high risk for medication errors.

Outcome Measure Description
- **DY2**
  - P-2: Establish baseline rates for bedside medication administration errors. The baseline rate will be set based on the total number of medications administered during the year ending (the base period), with the numerator of the rate equaling the total number of medication errors for acute care patients during the base period and the denominator being set as the total medications administered to acute care patients at Spohn facilities during the base period. This medication error rate will serve as the basis for assessing the effectiveness of implementing the new BMV system.
  - **Data Source**: Quality reports, electronic medication administration record (eMAR) reports

Outcome Improvement Targets
- **DY 3**
  - IT-4.10: Other outcome improvement target
    - **Improvement Target**: 5% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    - **Data Source**: Quality reports

- **DY4**
  - IT-4.10: Other outcome improvement target
    - **Improvement Target**: 10% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.
    - **Data Source**: Quality reports

- **DY 5**
  - IT-4.10: Other outcome improvement target
**Improvement Target:** 15% reduction in bedside medication administration errors, in comparison to the baseline data, using the same metrics for calculating the medication error rate.

- **Data Source:** Quality reports

**Rationale:**
Medication Management provides information that facilitates the appropriate use of medications in order to control illness and promote health according to *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*. Monitoring medication administration is key. Medications usually need to be taken in specific doses at set intervals. Missing doses or timing doses incorrectly can cause complications.

In a latest study out of the University of Pittsburgh Medical Center (Rack, Dudjak & Wolf, 2012) registered nurse (RN) workarounds were analyzed to determine the frequency and causes of workarounds while using bar code medication administration technology. Over half the nurses included in the study indicated that during their last shift worked, they administered medications without scanning the medication or the patient. Reasons for non-adherence to bar code scanning are identified as process related with an impact on patient safety outcomes. Process issues include step omission, steps out of sequence and unauthorized steps (Rack, 2012) that can be attributed to task, environment, patient, organization and technology related workarounds (Koppel, Wetterneck, Telles & Karsh, 2008). While BMV does not eliminate medication errors, it has shown a large impact on errors of wrong dose and wrong time (Rack, 2012). Quasi-experimental studies have been conducted in both intensive care units (ICU) and non-ICU units. One ICU study showed an overall med error reduction of 56% (*p* < 0.001) with reduction in administration time errors (19.7% to 7.5%, *p* < 0.001) having the largest impact on overall reduction rates (DeYoung, Vanderkooi & Barletta, 2009). Another study with over 14,000 medication administrations and 3000 order transcriptions reported a 41.4% relative reduction rate in medication errors (*p* < 0.001) for units using bar coding and eMAR versus units that did not.

This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing errors from inadvertent mishandling of medications, which will also lead to a reduction in complications from errors in medication management. By targeting measures that reduce errors in the delivery of medication to patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care, in a manner consistent with recent studies.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of medication administration errors. Medication errors are a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers follow procedures designed to increase patient safety, reduce medication errors, identify process barriers that lead to work-arounds, proactive assessments of patients’ medications, communication between providers, and preemptive measures to protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish baseline rates for bedside medication administration errors, prior to implementation of new system</th>
<th>Outcome Improvement Target 1 [IT-4.10]: Other outcome improvement target</th>
<th>Outcome Improvement Target 2 [IT-4.10]: Other outcome improvement target</th>
<th>Outcome Improvement Target 3 [IT-4.10]: Other outcome improvement target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement Target: 5% reduction in bedside medication administration errors from DY2 baseline</td>
<td>Improvement Target: 10% reduction in bedside medication administration errors from DY2 baseline</td>
<td>Improvement Target: 15% reduction in bedside medication administration errors from DY2 baseline</td>
<td></td>
</tr>
<tr>
<td>Data Source: Quality reports, electronic medication administration record (eMAR) reports</td>
<td>Data Source: Quality reports</td>
<td>Data Source: Quality reports</td>
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</tr>
</tbody>
</table>

Process Milestone 1 Estimated Incentive Payment: $ 4,569

Outcome Improvement Target 1 Estimated Incentive Payment: $ 5,296

Outcome Improvement Target 2 Estimated Incentive Payment: $ 4,249

Outcome Improvement Target 3 Estimated Incentive Payment: $ 20,323

Year 2 Estimated Outcome Amount: $ 4,569

Year 3 Estimated Outcome Amount: $ 5,296

Year 4 Estimated Outcome Amount: $ 8,498

Year 5 Estimated Outcome Amount: $ 20,323

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $ 38,686
Identifying Outcome Measure and Provider Information:

2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors

Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions

IT4.10 - Other outcome improvement targets – Average length of stay

CHRISTUS Spohn Hospital Kleberg / TPI: 136436606
Unique Identifier 136436606.3.4

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management.

Outcome Measure Description

• DY2
  o P-2: Establish baseline rates for patients for length of stay for high risk patients and patients receiving medications identified as high risk for medication errors. The baseline rate will be set based on the total number of high risk reviews performed. Program expansion is based on initial results at CSHCC-Memorial reporting an annualized reduction in average length of stay (ALOS) by 1 day reduction for IV home infusion transition alone during the year ending (the base period), with the numerator equaling the total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and the denominator being set as the total number of patients identified as high risk or receiving medications identified as high risk for medication errors at CHRISTUS Spohn Hospital Kleberg (“Spohn”) facilities during the base period. This ratio will demonstrate the change ALOS for this target population (See rationale for criteria that define high risk)
  o Data Source: Quality reports, electronic medication administration record (eMAR) reports

• DY3
  o P-3 Develop and test data systems
    Data Source: EMR and utilization review documents

• DY4
  o P-5 Disseminate finding, lessons learned and best practices to stakeholders
    Data Source: Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:

• DY 4
  o IT-4.10: Other outcome improvement target
    Improvement Target: Average Length of stay
    Data Source: Medication Management and Utilization Review reports

• DY 5
  o IT-4.10: Other outcome improvement target
**Improvement Target:** Average Length of stay  
**Data Source:** Medication Management and Utilization Review reports

**Rationale:**
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria include but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication management. Achieving this outcome will require considerable and concerted effort (i.e. assessment of each patient’s health literacy level, support in their post-discharge environment and ability to adhere to prescribed regimes and communication between providers to formulate the best possible treatment options) and investment in infrastructure; however, the outcome will justify the expense.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish baseline rates for bedside medication administration errors, prior to implementation of new system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> Quality reports, electronic medication administration record (eMAR) reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $4,569</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-3]: Develop and test data systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> EMR and utilization review documents</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $5,296</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-4.9]: Average length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>g. Numerator:</strong> Total number of inpatient days for patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td><strong>h. Denominator:</strong> Total number of patients identified as high risk or receiving medications identified as high risk for medication errors and PPC</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Case Management and Utilization Review reports</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $4,249</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 3 [P-5]: Disseminate finding, lessons learned and best practices to stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> Stakeholder meetings, minutes, attendance logs</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $4,249</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

- Year 2 Estimated Outcome Amount: $4,569

### Year 3 (10/1/2013 – 9/30/2014)

- Year 3 Estimated Outcome Amount: $15,296

### Year 4 (10/1/2014 – 9/30/2015)

- Year 4 Estimated Outcome Amount: $8,498

### Year 5 (10/1/2015 – 9/30/2016)

- Year 5 Estimated Outcome Amount: $20,323

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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over FYs 2-5):** $38,686
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
2.11.1 - Implement interventions that put in place the teams, technology, and processes to avoid medication errors
Include: OD 4 Potentially Preventable complications and Healthcare Acquired Conditions
IT4.10 - Other outcome improvement targets – Cost savings in care delivery associated with medication management and utilization review in high risk patients
CHRISTUS Spohn Hospital Kleberg / TPI: 136436606
Unique Identifier 136436606.3.5

Spohn expects to implement a multi-disciplinary point of entry case management review that will target high risk patient and patients receiving medications known to be high risk for medication errors, falls, SSIs or other potentially preventable complications. High risk patients are identified as those receiving IV antibiotic therapy, Coumadin/anticoagulant therapy, or other obstacles identified by the care team as barriers to medication management

Outcome Measure Description
- DY2
  - P-2: Establish baseline rates for cost savings in care delivery. The baseline rate will be determined using a Cost Minimization Analysis to quantify cost reduction resulting from concurrent case management/utilization review for patients identified as high risk or receiving medications identified at high risk for medication errors during the base period. This initial analysis for this project will be quantified from project implementation data at CSHCC-Memorial serving as the basis for project expansion and assessment of cost minimization.
  - Data Source: Case Management/Utilization review reports, financial reports
- DY 3
  - P-3: Develop and test data systems
  Data Source: Quality reports
- DY 4
  - P-5: Disseminate finding, lessons learned and best practices to stakeholders
  Data Source: Stakeholder meetings, minutes, attendance logs

Outcome Improvement Targets:
- DY 4
  - IT-4.10: Other outcome improvement target
  Improvement Target: Cost savings in care delivery
  Data Source: Case Management/Utilization review reports, financial reports
- DY 5
  - IT-4.10: Other outcome improvement target
  Improvement Target: Cost savings in care delivery
  Data Source: Case Management/Utilization review reports, financial reports
Rationale:
Patients are most at risk during transition in care across settings, services, providers or levels of care. Development, reconciliation and communication of treatment plans throughout the continuum of care is an essential component in reducing transition-related adverse drug and treatment events. Ongoing review of patients at high risk patient for adverse drug and treatment events provides continuous review of medical necessity and promotes a reduction in length of stay (on average) by facilitating early discharge planning in identified cases of long-term treatment that can be provided on an outpatient basis such IV home infusion. Implementation of multi-disciplinary case management review at CSHCC-Memorial provided the initial results after 5 months of implementation. The program reported twice-weekly reviews with approximately 50 cases at each review. High risk criteria included but was not limited to 1) IV antibiotic therapy, 2) Coumadin/anticoagulant therapy, 3) negative pressure wound therapy (NPWT), 4) Home Health required, 5) Bi-Pap/C-Pap/Oxygen therapy and 6) those with immediate need for post-discharge follow up. The predominate actions from reviews include pharmacist to physician direct communication for medication treatment recommendations, improved clarification of medical necessity and identification of patients requiring long-term IV therapy eligible for home infusion. Five months of program implementation supported a decreased length of stay totaling 163 days (391 inpatient days annualized) for long-term IV infusion therapy alone with an associated cost minimization of $426,000 ($1.02 Million annualized).

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to cost savings in care delivery for patients identified as high risk or receiving medications at high risk for medication errors. Effective medication management reduces the risk of potentially preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. training providers to perform proactive assessment of patients’ medications, increase communication between providers, and identify preemptive measures to enhance treatment and protect patients) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>136436606.3.5.</th>
<th>3.4.IT-4.1</th>
<th>Cost savings as result of medication management/utilization review implementation using a Cost Minimization Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHRISTUS Spohn Hospital Kleberg</strong></td>
<td>136436606.2.1</td>
<td>136436606</td>
</tr>
</tbody>
</table>
| **Related Category 1 or 2 Projects::** | **Starting Point/Baseline:** | **Process Milestone 1 [P-2]:** Establish baseline rates for bedside medication administration errors, prior to implementation of new system  
**Data Source:** Quality reports, electronic medication administration record (eMAR) reports  
Process Milestone 1 Estimated Incentive Payment: $4,569  
In FY2012, Spohn’s Corpus Christi Memorial facility experienced a cost minimization of $425,000 by transitioning patients requiring long-term IV therapy to IV home infusion therapy. Cost were determined by number of days required for treatment in each of the acute care and home settings. |
| **Year 2** (10/1/2012 – 9/30/2013) | **Year 3** (10/1/2013 – 9/30/2014) | **Year 4** (10/1/2014 – 9/30/2015) | **Year 5** (10/1/2015 – 9/30/2016) |
| **Process Milestone 1 [P-2]:** Establish baseline rates for bedside medication administration errors, prior to implementation of new system  
**Data Source:** Quality reports, electronic medication administration record (eMAR) reports  
Process Milestone 1 Estimated Incentive Payment: $4,569 | **Process Milestone 2 [P-3]:** Develop and test data systems  
**Data Source:** EMR and utilization review documents  
Process Milestone 2 Estimated Incentive Payment: $5,296 | **Outcome Improvement Target 1 [IT-4.9]:** Average cost savings  
**Improvement Target:** Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis  
**Data Source:** Case Management and Financial reports  
Outcome Improvement Target 1 Estimated Incentive Payment: $4,249 | **Outcome Improvement Target 2 [IT-4.10]:** Average cost savings  
**Improvement Target:** Identify cost savings as a result of medication management/utilization review implementation using a Cost Minimization Analysis  
**Data Source:** Case Management and Financial reports  
Outcome Improvement Target 2 Estimated Incentive Payment: $20,323 |
| **Year 2 Estimated Outcome Amount:** $4,569 | **Year 3 Estimated Outcome Amount:** $5,296 | **Year 4 Estimated Outcome Amount:** $8,498 | **Year 5 Estimated Outcome Amount:** $20,323 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $38,686 |
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
CHRISTUS Spohn Hospital Kleberg -136436606.3. 6

Outcome Measure Description

OD-4 Potentially Preventable complications and healthcare acquired Conditions.

IT-4.10: Other outcome Improvement Targets – Compliance with VTE Prophylaxis Core Measure Indicators

Outcome Description: Installation of a computerized patient order management (CPOM) system is expected to reduce the rate of VTE in Spohn’s Kleberg facility by creating electronic order sets that include VTE prophylaxis. Spohn has a system-wide group that developed electronic evidence-based order sets. For example, if patient has surgery and the doctor wants the patient to get up and walking to prevent blood clots, there are different order sets that might be in place. For patients who cannot ambulate after surgery, they need anti-coagulants, but often the surgeons will not order these because they are concerned that the surgical sites might bleed. The CPOM system will create automatic order sets for particular surgeries and the medication order will then be in place (including treatment to prevent VTE). This prevents the physician from ordering contraindicated medications and makes sure that needed medications and therapeutic interventions are not missed due to human error.

VTE is a core CMS measure, and CMS has provided six indicators to be addressed in the prevention of hospital-acquired VTE. The six indicators measure the following (with Spohn’s historical compliance in parentheses):
(1) VTE1 prophylaxis (28%)
(2) VTE2 intensive care unit VTE prophylaxis (51.7%)
(3) VTE3 patients with anticoagulation overlap therapy (83.3%)
(4) VTE4 patients receiving unfractionated heprin with dosages/platelet count monitoring by protocol (100%)
(5) VTE5 discharge instructions (75%), and
(6) VTE6 incidence of potentially preventable VTE (0%).
Clearly there is room for improvement, especially in light of the fact that overall compliance is < 35.5%.

Process Milestones:
- DY 2
  - P-2: Establish baseline rates for compliance with VTE Prophylaxis Core Measure Indicators
  - P-5: Disseminate finding, lessons learned and best practices to stakeholders

Outcome Improvement Targets
- DY3
  - IT-4.10: Other outcome improvement target : Compliance with VTE Prophylaxis Core Measure Indicators
    Improvement Target: 10% increase in compliance with VTE Prophylaxis Core Measure Indicators
• **DY4**
  o [IT-4.10]: Other outcome improvement target: Compliance with VTE Prophylaxis Core Measure Indicators
• **DY5**
  o [IT-4.10]: Other outcome improvement target: Compliance with VTE Prophylaxis Core Measure Indicators
  Improvement Target: 20% increase in compliance with VTE Prophylaxis Core Measure Indicators

**Rationale:**
This project was selected to improve the delivery of medication to patients, with the resulting goal of reducing potentially preventable complications like hospital-acquired VTE. By targeting measures that reduce hospital-acquired VTE in patients, the outcome is tied directly to the effectiveness of the overall project in transforming the delivery of care in a manner consistent with recent studies. According to a US Department of Health and Human Services website, “Pulmonary embolism resulting from deep vein thrombosis—collectively referred to as venous thromboembolism—is the most common preventable cause of hospital death. Pharmacologic methods to prevent venous thromboembolism are safe, effective, cost-effective, and advocated by authoritative guidelines, yet large prospective studies continue to demonstrate that these preventive methods are significantly underused.” (http://www.ahrq.gov/qual/vtguide/).

**Milestones and Metrics:** The first step in the process is gathering information to determine the magnitude of the baseline data needed to assure that an established baseline rate is set. Once CPOM is implemented, findings that have been determined to be pertinent to the implementation process will be disseminated, with dissemination of all lessons learned and use of best practices to all of those considered stakeholders. The use of Quality Reports, electronic medication administration record and EMR reports the reduction in transcription will in turn decrease the errors in medication administration.

Spohn selected the improvement targets to incentivize and reward utilization of the CPOM system, with the goal that its utilization will reduce medication transcription errors and also reduce the risks that inconsistent orders are misunderstood.

**Outcome Measure Valuation:**
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to prevention of hospital acquired VTE. VTE is a major preventable complication affecting the safety of the hospitalized patient. Achieving this outcome will require considerable and concerted effort (i.e. putting the order sets in place, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-2]</strong>: Establish baseline rates for medication transcription errors in the Spohn facility</td>
<td><strong>Outcome Improvement Target 1 [IT-4.10: Hospital Acquired VTE</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-4.10: Compliance with VTE Prophylaxis Core Measure Indicators</strong></td>
<td><strong>Outcome Improvement Target 3 [4.10: Compliance with VTE Prophylaxis Core Measure Indicators</strong></td>
</tr>
<tr>
<td>Data Source: Quality reports, electronic medication administration record (eMAR) reports</td>
<td>Improvement Target: 10% increase in compliance with VTE Prophylaxis Core Measure indicators from baseline set in DY2</td>
<td>Improvement Target: 15% increase in compliance with VTE Prophylaxis Core Measure Indicators from baseline set in DY2</td>
<td>Improvement Target: 20% increase in compliance with VTE Prophylaxis Core Measure Indicators from baseline set in DY2</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $6,854</td>
<td>Data Source: Quality reports; EHR Claims</td>
<td>Data Source: Quality reports; EHR Claims</td>
<td>Data Source: Quality reports; EHR Claims</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-1]</strong> Project Planning</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment: $15,889</strong></td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment: $25,496</strong></td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment: $60,969</strong></td>
</tr>
<tr>
<td>Goal: develop a plan for coordinating post-surgical order sets with the new CPOM system and training hospital staff on using the electronic system to more effectively prevent VTE</td>
<td></td>
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<tr>
<td>Data source: documentation of plan</td>
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</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $6,854</td>
<td></td>
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<tr>
<td><strong>Year 2 Estimated Outcome Amount: $13,708</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $15,889</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $25,496</strong></td>
<td><strong>Year 5 Estimated Outcome Amount: $60,969</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $116,062**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Outcome Domain 4: Potentially Preventable Complications and Healthcare Acquired Conditions;
Improvement Target 4.8: Sepsis Mortality (standalone)
CHRISTUS Spohn Hospital Kleberg/136436606
Unique Identifier - 136436606.3.7

Outcome Measure Description
Hospitals nationwide and statewide have seen an increase in the rate of sepsis and the mortality rates associated with sepsis over the last twenty years. CHRISTUS Spohn Hospital Kleberg ("Spohn") intends, through its use of an early detection warning system and a provider protocol for responding to cases of sepsis, to reduce the rate of mortality caused by sepsis in Spohn’s inpatient population.

Process milestones:
- Project planning: Spohn will create a plan to implement a 90-day rapid cycle improvement to address the sepsis mortality rate in Spohn’s Kleberg facility
- Establish a baseline: Spohn will determine the mortality rate of all septic patients in Spohn’s Kleberg facility during 2012
- Spohn will conduct Plan-Do-Study-Act cycles to test and improve upon its usage of the MEWS early detection system

Improvement targets:
- Reduction in Sepsis Mortality rates – 1% reduction by end of DY4
- Reduction in Sepsis Mortality rates - 2% reduction by end of DY5

Rationale:
Spohn’s goal is to decrease the number of deaths in septic patients who present in the early stages of sepsis or those that develop septicemia while in the hospital. The Region 4 Community Needs Assessment has identified a high incidence of sepsis and sepsis mortality for the Region (CN.18). Hospital inpatients are at risk for sepsis, especially if they have intravenous lines, bed sore, or surgical site wounds. Early recognition of the signs and symptoms of sepsis requires skilled assessment of specific indicators over an identified period of time and initiating immediate resuscitation effort upon identification. This rapid response to an identified increasing preventable complication is required to save lives in the acute inpatient setting.

Outcome Measure Valuation:
The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to potentially preventable complications and hospital-acquired conditions/infections. Patient outcomes and satisfaction will absolutely be improved if the sepsis mortality rate is decreased, and the systemic cost of providing inpatient hospital care will be reduced for every septic infection and related death that can be prevented. Achieving this outcome will require considerable and concerted effort (i.e. engaging
in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
### Potential Preventable Complications and Healthcare-acquired Conditions: Sepsis mortality and Average length of stay (ALOS)

**CHRISTUS Spohn Hospital Kleberg**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>136436606.2.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>450 cases; 71% severe or shock; 6% received all applicable elements of resuscitation bundle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2  (10/1/2012 – 9/30/2013)</th>
<th>Year 3  (10/1/2013 – 9/30/2014)</th>
<th>Year 4  (10/1/2014 – 9/30/2015)</th>
<th>Year 5  (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Spohn will engage in project planning for 90-day rapid cycle improvement for Sepsis</td>
<td><strong>Process Milestone 3 [P-4]:</strong> Conduct PDSA cycles to improve usage of electronic MEWS – Spohn will develop a plan to test the change, implement the plan, analyze the results, and determine what modifications are needed, if any</td>
<td><strong>Outcome Improvement Target 1 [IT-4.8]:</strong> Sepsis mortality  <strong>Improvement Target:</strong> 1% reduction in septicemia mortality rates in Spohn’s Kleberg facility from baseline established in DY2</td>
<td><strong>Outcome Improvement Target 2 [IT-4.8]:</strong> Sepsis mortality  <strong>Improvement Target:</strong> 2% reduction in septicemia mortality rates in Spohn’s Kleberg facility from baseline established in DY2</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project plan</td>
<td><strong>Data Source:</strong> EMR reports</td>
<td><strong>Data Source:</strong> hospital quality reports, dashboards</td>
<td><strong>Data Source:</strong> hospital quality reports, dashboards</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $10,770</td>
<td>Process Milestone 3 Estimated Incentive Payment: $24,968</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $40,065</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $95,808</td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates – Spohn will determine the mortality rate for septic patients in its Kleberg facility for 2012</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Data Source:</strong> hospital quality reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $10,770</td>
<td>Year 2 Estimated Outcome Amount: $21,540</td>
<td>Year 3 Estimated Outcome Amount: $24,968</td>
<td>Year 4 Estimated Outcome Amount: $40,065</td>
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<tr>
<td></td>
<td>Year 5 Estimated Outcome Amount: $95,808</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $182,381
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

2.12.2 - Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. Examples of interventions include, but are not limited to, implementation of:

OD 3: Potentially Preventable Readmissions; Improvement Target 3.3.2 - CHF 30-day readmissions
Unique project ID number: 136436606.3.8
CHRISTUS Spohn Hospital – Kleberg: 136436606

Outcome Measure Description
This outcome will measure the reduction in the number of Potentially Preventable Readmissions for CHF patients at Spohn’s Kleberg facility due to the expanded implementation of the Care Transitions program. CHRISTUS Spohn Hospital Kleberg (“Spohn”) believes that patients who are at risk to be readmitted to the hospital within 30 days of discharge for congestive heart failure will benefit from increased care coordination upon discharge. This includes providers, patients and their caregivers education about medication, diet, and activity management, primary care resources that are available and need to be accessed, and community support available to recently discharged CHF patients.

Process milestones:
- DY2: Develop and test data systems + establish a baseline
  - Spohn will develop an integrated system for flagging CHF patients upon inpatient admission and readmission, in order to track progress in later years of the Waiver
  - Spohn will develop a baseline of CHF readmissions during DY2 in order to measure percentage improvement going forward
- DY3: Disseminate findings
  - Spohn will create and distribute its staff/stakeholders a plan for reducing CHF readmissions through the expansion of the Care Transitions program

Improvement milestones:
- DY3: Reduce CHF PPRs by 3% from baseline
- DY4: Reduce CHF PPRs by 6% from baseline
- DY5: Reduce CHF PPRs by 8% from baseline

Rationale:
Spohn chose this outcome using its evidence-based expectation of a decrease in re-admission rates as a result of the following processes in the Care Transitions program: 1) effective and efficient discharge planning while in the hospital, (2) home visit within 48 hours of patients arrival home and (3) follow-up phone calls to ensure education/information shared making this program a viable expansion option for chronic disease in populations across our region. Spohns’ review of its own needs and the Region 4 Community Needs Assessment identified CHF as an area requiring improvement. Specifically, Kleberg County’s highest incidence of potentially preventable hospitalizations occur due to CHF (RHP Plan, Section 3, Table 10) and Heart Failure was the second most common primary diagnosis for hospitalizations in Region 4 (RHP Plan, Section 3, Table 9). Thus, CHF is a substantial problem that Spohn
needs to address by reducing the number of potentially preventable readmissions for patients already hospitalized for and identified as patients with CHF.

**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community related to medication/diet/weight management for CHF patients to prevent unnecessary hospital admissions and readmission. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
## Related Category 1 or 2 Projects:

136436606.2.4

### Starting Point/Baseline:

The CHF readmission rate is 20%.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-3]:** Develop and test data systems – Spohn will put a system in place to identify and flag CHF patients at its Kleberg facility upon initial admission and upon readmission  
  **Data Source:** referral logs documentation  
  Process Milestone 1 Estimated Incentive Payment: $14,686.50 | **Process Milestone 3 [P-5]:** Disseminate finding and implementation plan to stakeholders – Spohn will develop and distribute a comprehensive plan for reducing CHF 30-day admissions (in conjunction with the Care Transitions program) to its Kleberg facility  
  **Data Source:** Written integration plan  
  Process Milestone 3 Estimated Incentive Payment: $17,023.50 | **Outcome Improvement Target 1 [IT-3.2]:** PPR  
  **Improvement Target:** 3% reduction in CHF, 30-day readmission rates from baseline established in DY2  
  **Data Source:** Care Transition caseload documentation; EHR  
  Outcome Improvement Target 1 Estimated Incentive Payment: $54,634 | **Outcome Improvement Target 3 [IT-3.2]:** PPR  
  **Improvement Target:** 8% reduction in CHF, 30-day readmission rates from baseline established in DY2  
  **Data Source:** Care Transition caseload documentation; EHR  
  Outcome Improvement Target 3 Estimated Incentive Payment: $130,647 |
| **Process Milestone 2 [P-2]:** Establish baseline rates – Spohn will compile and evaluate the 30-day readmission data from 2012 for patients at its Kleberg Facility discharged with a principal diagnosis of CHF  
  **Data Source:** Historical clinic/hospital/ED claims and financial data  
  Process Milestone 2 Estimated Incentive Payment: $14,686.50 |  | **Outcome Improvement Target 2 [IT-3.2 & IT-3.3, 3.8]:** PPR  
  **Improvement Target:** 6% reduction in CHF, 30-day readmission rates from baseline established in DY2  
  **Data Source:** Care Transition caseload documentation; EHR  
  Outcome Improvement Target 2 Estimated Incentive Payment: $54,634 |  |

### Year 2 Estimated Outcome Amount: $29,373  
### Year 3 Estimated Outcome Amount: $34,047  
### Year 4 Estimated Outcome Amount: $54,634  
### Year 5 Estimated Outcome Amount: $130,647

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $248,701*
**Category 3: Quality Improvements**

**Identifying Outcome Measure and Provider Information:**

2.19.1 Care Management to Integrate Primary and Behavioral Health Needs  
IT-9.2: ED Appropriate Utilization (reduce emergency department visits for diabetes)

CHRISTUS Spohn Hospital Kleberg/ 136436606

Project Unique ID: 136436606.3.9

**Outcome Measure Description**

CHRISTUS Spohn Hospital Kleberg (“Spohn”) expects the outcome of its project to identify patients with diabetes and CHF who have a co-diagnosis in BH/depression to result in a reduced volume of ED visits from diabetic patients. Spohn will screen patients who present in the ED initially for BH needs (and in its other treatment settings), and make referrals where necessary; this should result in fewer repeat ED visits by diabetic patients who possibly have a co-diagnosis from returning to the ED.

**Process Milestones:** In DY2, Spohn will create a plan for using its project to increase screening of CHF and diabetes patients for BH referrals to reduce the number of overall ED visits from diabetic patients. Spohn will also establish a baseline of the number of ED visits from diabetic patients in order to measure progress going forward.

**Improvement Targets:** In DY3, Spohn aims to reduce the volume of ED visits from patients with diabetes by 5% from the DY2 baseline. In DY4, Spohn aims for 8% over DY2, and by the end of DY5 Spohn aims for a decrease in the volume of ED visits from diabetic patients of 10%.

**Rationale:**

Treatment management and patient outcomes such as PPR and mortality can only be impacted if patients with co-existing physical and behavioral illness can be identified and referred to the appropriate providers for a treatment plan inclusive of both domains. This is why we chose to focus on training providers in screening and recognition in target populations, communication between providers and increasing the number of patients screened in the EDs, Primary Care and BH settings.

Spohn expects that screening and identifying diabetic patients with potential BH needs will result in receive fewer subsequent visits to the ED from that population. This will indicate that more of those patients are receiving the right care in the right setting, and will reduce the high cost of treating Medicaid/uninsured patients in the ED. The reduced ED volume should also have a ripple effect for the inpatient setting – fewer of the targeted patients will be admitted from the ED and reduce inpatient costs, increase the availability of beds, and improve patient outcomes.
**Outcome Measure Valuation:**
The valuation of each CHRISTUS Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact on individual patients and the community of BH/SA screening/treatment for CHF patients and vice versa, in order to prevent unnecessary hospital admissions and readmissions. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Achieving this outcome will require considerable and concerted effort (i.e. engaging in patient outreach and education, training providers to manage and support patients’ conditions, etc.) and investment in infrastructure; however, the outcome will justify the expense.
<table>
<thead>
<tr>
<th>136436606.3.9</th>
<th>3.IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>136436606.2.5</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>In FY 2012, Spohn’s ED experienced approximately 214 diabetes related visits.</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning – Spohn will create a protocol for ED providers in screening and referring diabetic patients for BH assessments where necessary and create a plan for tracking the repeat ED visits of those patients going forward.

Data Source: Project plan

Estimated Incentive Payment: $14,686.50

**Outcome Improvement Target 1** IT-9.2 ED appropriate utilization

**Improvement Target:** 5% reduction in the volume of ED visits from diabetic patients from baseline established in DY2

**Data Source:** EMR, referral documentation, clinic and hospital financial/claims data

Estimated Incentive Payment: $34,047

**Process Milestone 2 [P-5]:** Establish baseline – Spohn will determine the number of ED visits from diabetic patients.

Data Source: FHC and hospital patient records

Estimated Incentive Payment: $14,686.50

Estimated Outcome Amount: $29,373

| Year 2 Estimated Outcome Amount: $29,373 |
| Year 3 Estimated Outcome Amount: $34,047 |
| Year 4 Estimated Outcome Amount: $54,634 |
| Year 5 Estimated Outcome Amount: $130,647 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $248,701
Category 3: Quality Improvements

**Title of Outcome Measure (Improvement Target):** IT-2.5 Chronic Obstructive Pulmonary Disease Admission Rate

**Unique RHP outcome identification number(s):** 137907508.3.1

**Performing Provider Name/TPI:** Citizens Medical Center/137907508

**Outcome Measures Description:**
IT - 2.5 Chronic Obstructive Pulmonary Disease Admission Rate

**Process Milestones:**
- DY2 - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3 - P-2: Establish baseline data

**Outcome Improvement Target:**
- DY4 - IT-2.5 Chronic Obstructive Pulmonary Disease Admission Rate: Decrease COPD admission rate from DY3 baseline by X%. (TBD).
- DY5 - IT-2.5 Chronic Obstructive Pulmonary Disease Admission Rate: Decrease COPD admission rate from DY3 baseline by X%. (TBD)

**Starting Point/Baseline**
Baseline data will need to be obtained.

**Rationale**
In Texas, potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse in this medical condition. Approximately 44% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse. By addressing the secondary diagnosis of mental illness/substance abuse through referral to a Federally Qualified Health Clinic (FQHC) or the local mental health authority (LMHA), it may be possible to avoid potentially preventable admissions.

**Outcome Measure Valuation**
These potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse. Through the commitment of resources, these patients can be screened and directed to appropriate mental health resources in an effort to prevent the potential admission to the hospital setting, which is the most expensive care setting.
<table>
<thead>
<tr>
<th>137907508.3.1</th>
<th>IT-2.5</th>
<th>Chronic Obstructive Pulmonary Disease Admission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Citizens Medical Center</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137907508.1.1 Expand Primary Care Capacity</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1** P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.  
  **Baseline/Goal:** No Project Plan developed /Project Plan completed  
  **Data Source:** Citizens Medical Center’s reports, meeting minutes, and database; FQHC data | **Process Milestone 2** P-2: Establish baseline data regarding Chronic Obstructive Pulmonary Disease (COPD) admission rate.  
  **Baseline / Goal:** 0 / Number of COPD principle diagnosis admissions during Year 2  
  **Data Source:** Meditech database and Premier database. | **Outcome Improvement Target 1** IT-2.5: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate - Reduce potentially preventable admissions from baseline.  
  **Baseline/Goal:** Number of COPD principle diagnosis admissions determined in Year 3 /X% reduction from baseline in COPD admission rate  
  **Data Source:** Meditech database and Premier database. | **Outcome Improvement Target 2** IT-2.5: Chronic Obstructive Pulmonary Disease (COPD Admission Rate – Reduce potentially preventable admission from baseline.  
  **Baseline/Goal:** Number of COPD principle diagnosis admissions in Year 3 / X% reduction from baseline in COPD admission rate  
  **Data Source:** Meditech database and Premier database. |

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $87,052  
**Process Milestone 2 Estimated Incentive Payment (maximum amount):** $100,904  
**Outcome Improvement Target 1 Estimated Incentive Payment (maximum amount):** $150,200  
**Outcome Improvement Target 2 Estimated Incentive Payment (maximum amount):** $173,633

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $87,052  
**Year 3 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $100,904  
**Year 4 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $150,200  
**Year 5 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $173,633

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $511,789
Category 3: Quality Improvements

**Title of Outcome Measure (Improvement Target):** IT-9.2 Emergency Department Appropriate Utilization

**Unique RHP outcome identification number(s):** 137907508.3.2

**Performing Provider Name/TPI:** Citizens Medical Center/137907508

**Outcome Measures Description:**
IT-9.2 Emergency Department Appropriate Utilization

**Process Milestones:**
- DY2 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3 P-2: Establish baseline data

**Outcome Improvement Target:**
- DY4 IT-9.2 Emergency Department Appropriate Utilization: Reduce potentially avoidable Emergency Department visits for target conditions from DY3 baseline by 2%.
- DY5 IT-9.2 Emergency Department Appropriate Utilization: Reduce potentially avoidable Emergency Department visits for target conditions from DY3 baseline by 5%.

**Starting Point/Baseline**
Baseline data will need to be obtained.

**Rationale**
Hospital emergency departments are generally more costly to patients and third party payers than other ambulatory care settings. Providing patient education and the implementation of other strategies to redirect patients from the emergency care setting will likely reduce the number of potentially avoidable emergency department visits and reduce costs for key stakeholders.

**Outcome Measure Valuation**
Through the commitment of resources, certain patient populations can be screened and redirected to more appropriate care settings thereby reducing the expense of an emergency department visit for non-emergency care. The goal is to have the patient receive the right care at the right time in the right setting, which will reduce costs of healthcare.
<table>
<thead>
<tr>
<th>137907508.3.2</th>
<th>3.IT-9.2</th>
<th>Emergency Department Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizens Medical Center</td>
<td>137907508</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137907508.1.1 Expand Primary Care Capacity</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1** P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. | **Process Milestone 2** P-2: Establish baseline data regarding Emergency Department Appropriate Utilization.  
**Baseline/Goal:** 0 / Number of potentially avoidable emergency department visits.  
**Data Source:** Meditech database and Premier database. | **Outcome Improvement Target 1** IT-9.2: Emergency Department Appropriate Utilization: Reduce potentially avoidable emergency department visits  
**Baseline/Goal:** Number of potentially avoidable emergency department visits in Year 3 / Reduce by 2%  
**Data Source:** Meditech database and Premier database. | **Outcome Improvement Target 2** IT-9.2: Emergency Department Appropriate Utilization: Reduce potentially avoidable emergency department visits  
**Baseline/Goal:** Number of potentially avoidable emergency department visits in Year 3 / Reduce by 5%  
**Data Source:** Meditech database and Premier database. |
| Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $87,052 | Process Milestone 2 Estimated Incentive Payment *(maximum amount)*: $100,904 | Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount)*: $256,540 | Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount)*: $384,517,844 |
| **Year 2 Estimated Outcome Amount:**  
(add incentive payments amounts from each milestone/outcome improvement target): $87,052 | **Year 3 Estimated Outcome Amount**  
(add incentive payments amounts from each milestone/outcome improvement target): $100,904 | **Year 4 Estimated Outcome Amount**  
(add incentive payments amounts from each milestone/outcome improvement target): $256,540 | **Year 5 Estimated Outcome Amount**  
(add incentive payments amounts from each milestone/outcome improvement target): $517,844 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $962,340
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis Mortality
Unique RHP outcome identification number(s): 137907508.3.3
Performing Provider Name/TPI: Citizens Medical Center/137907508

Outcome Measure Description:
IT – 4.8 Sepsis Mortality

Process Milestones:
- DY2 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3 P-2: Establish baseline data

Outcome Improvement Target:
- DY4 IT-4.8 Sepsis Mortality: Reduce sepsis mortality from baseline established in DY3
- DY5 IT-4.8 Sepsis Mortality: Reduce sepsis mortality from rate determined in DY4

Starting Point/Baseline
Baseline data will need to be obtained.

Rationale
Mortality rates from severe sepsis are on a similar scale to lung, breast, and colon cancer, and it is one of the leading causes of death in the intensive care unit. Due to its aggressive, multifactorial nature, sepsis is a rapid killer. Death is common among sepsis patients, with around 30% of patients dying within the first month of diagnosis and 50% dying within 6 months. The 28-day mortality rate in sepsis patients in comparable to the 1960s hospital mortality rate for patients of acute myocardial infarction (AMI). Over recent years, there has been an improvement in the awareness and management of AMI, resulting in a decline in mortality, while sepsis remains an unacknowledged killer. Moreover, the number of severe sepsis cases is set to grow at a rate of 1.5% per annum, adding an additional 1 million cases per year in the USA alone by 2020. This will increase total mortality and increase the burden on healthcare resources. The increase is mainly due to the growing use of invasive procedures and increasing numbers of elderly and high-risk individuals, such as cancer and HIV patients. Older people are at an increased risk of sepsis as they are more vulnerable to infections due to aging, co-morbidities, use of invasive surgical techniques, and problems associated with institutionalization.

Outcome Measure Valuation
The average length of stay for sepsis patients at Citizens Medical Center is 8.4 days while the state average is 7.2 days. In addition, the average cost of treating a sepsis patient at Citizens Medical Center is $46,986 whereas the state average ranges from $22,292-$82,142. The use of evidence based order sets will likely reduce sepsis mortality and at the same time potentially decrease the length of stay, thereby reducing costs for this patient population. One of the specialties of the Lean methodology is cost reduction with resultant revenue growth; therefore,
it is anticipated that a Lean Consultant will merge cost saving activities with patient outcome improvement measures while retained. This is turn will benefit both the patient and the facility.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137907508.2.1 Apply Process Improvement Methodology to Improve Quality/Efficiency</th>
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<tbody>
<tr>
<td>Startting Point/Baseline:</td>
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</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. <strong>Baseline/Goal:</strong> No Project Plan developed / Project Plan completed <strong>Data Source:</strong> Citizens Medical Center’s reports, meeting minutes, and other planning documents.</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 87,052</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 P-2: Establish baseline data regarding the number of Sepsis deaths occurring at facility. <strong>Baseline/Goal:</strong> 0 / Number of deaths related to Sepsis diagnoses (sepsis, severe sepsis or septic shock and/or infection and organ dysfunction) during Year2. <strong>Data Source:</strong> Meditech database and Premier database.</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment (maximum amount): $ 100,904</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td></td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 IT-4.8: Sepsis Mortality: Reduce occurrences of Sepsis diagnosis related deaths occurring at facility. <strong>Baseline/Goal:</strong> Number of deaths related to Sepsis diagnoses (sepsis, severe sepsis or septic shock and/or infection and organ dysfunction) established as baseline Year 3 / X% reduction in sepsis related deaths <strong>Data Source:</strong> Meditech database and Premier database.</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment (maximum amount): $ 119,045</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 IT-4.8: Sepsis Mortality: Reduce occurrences of Sepsis diagnosis related deaths occurring at facility. <strong>Baseline/Goal:</strong> Number of deaths related to Sepsis diagnoses (sepsis, severe sepsis, or septic shock and/or infection and organ dysfunction) in Year 4 / X% reduction in sepsis related deaths <strong>Data Source:</strong> Meditech database and Premier database.</td>
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</tr>
<tr>
<td>Outcome Improvement 2 Estimated Incentive Payment (maximum amount): $ 204,788</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:: $87,052</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $100,904</td>
<td></td>
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<tr>
<td>Year 4 Estimated Outcome Amount: $119,045</td>
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</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $204,788</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $511,789
Category 3: Quality Improvements

**Title of Outcome Measure (Improvement Target):** IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery

**Unique RHP outcome identification number(s):** 137907508.3.4

**Performing Provider Name/TPI:** Citizens Medical Center/137907508

**Outcome Measure Description:** IT – 5.1 Improved Cost Savings; Demonstrate cost savings in care delivery

**Process Milestones:**
- DY2 P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3 P-2: Establish baseline data

**Outcome Improvement Target:**
- DY4 IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery as compared with baseline established in DY3.
- DY5 IT-5.1 Improved Cost Savings: Demonstrate cost savings in care delivery as compared with costs determined in DY4.

**Starting Point/Baseline**
Baseline data will need to be obtained.

**Rationale**
As healthcare costs rise – regulatory, policymakers, and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. Improving costs savings through implementation of the Lean methodology will improve safety, quality, patient experience, and efficiency while optimizing patient flow. In essence, the cost savings will help reduce the cost of care.

**Outcome Measure Valuation**
Citizens Medical Center’s goal is to realize similar financial results provided in the project valuation for the Category 2 project, Apply Process Improvement Methodology to Improve Quality/Efficiency.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137907508.3.4</th>
<th>Improved Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>1379075082.1</td>
<td>To be determined</td>
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</table>

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

**Process Milestone 1** P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.  
**Baseline/Goal:** No Project Plan developed / Project Plan completed  
**Data Source:** Citizens Medical Center’s reports, meeting minutes, and databases; Lean consultant’s reports.  
Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $87,052

**Process Milestone 2** P-2: Establish baseline data regarding costs in targeted patient care areas.  
**Baseline/Goal:** 0 / Collect monetary data/information regarding targeted high cost patient care areas  
**Data Source:** Meditech database and Premier database; Lean consultant’s reports;  
Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $100,904

**Outcome Improvement Target 1**  
**IT-5.1: Improved Cost Savings:** Demonstrate Cost Savings in Care Delivery  
**Baseline/Goal:** Cost of care data collected in Year 3 / X% improvement in cost savings  
**Data Source:** Meditech database and Premier database; Lean Consultant’s reports  
Outcome Improvement Target 1 Estimated Incentive Payment: $256,540

**Outcome Improvement Target 2**  
**IT-5.1: Improved Cost Savings:** Demonstrate Cost Savings in Care Delivery  
**Baseline/Goal:** Cost of care data collected in Year 4 / X% improvement in cost savings  
**Data Source:** Consultant for implementation of Lean methodology; Meditech database and Premier database  
Outcome Improvement Target 2 Estimated Incentive Payment: $517,844

**Year 2 Estimated Outcome Amount:**  
*(add incentive payments amounts from each milestone/outcome improvement target):* $87,052

**Year 3 Estimated Outcome Amount:**  
*(add incentive payments amounts from each milestone/outcome improvement target):* $100,904

**Year 4 Estimated Outcome Amount:**  
*(add incentive payments amounts from each milestone/outcome improvement target):* $256,540

**Year 5 Estimated Outcome Amount:**  
*(add incentive payments amounts from each milestone/outcome improvement target):* $517,844

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $962,340
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target): IT-2.12 Prevention Quality Indicators (PQI)

Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

Unique RHP Outcome ID Number: 138305109.3.1
Performing Provider/TPI: MHMR of Nueces County/ 138305109

Outcome Measure Description:
The outcome measure (2.12) and improvement targets for this project include full implementation of integrative care treatment modalities and establishment of primary care providers within existing behavioral healthcare services. Increase the number of persons receiving integrated care and smoking cessation treatment within target population to 5% over baseline of zero for fiscal year 2011. Total population served is approximately 1,500. A minimum 75 persons will receive integrated care services preventing hospitalization in DY3. Reduction in potentially preventable hospitalizations will consist of a 5% decrease for DY3 and will be decreased by 5% in consecutive years through implementation of improvement targets. Overall program goal is a 15% decrease in potentially preventable hospitalizations for DY5.

Process Milestones:
- DY 2: P-1; P-2; P-3

Outcome Improvement Targets for each year:
- DY 3: IT 2-12 Prevention Quality Indicators
  - 5% reduction in the rate of admission for potentially preventable hospitalizations.
- DY 4: IT 2-12 Prevention Quality Indicators
  - 10% reduction in the rate of admission for potentially preventable hospitalizations
- DY 5: IT 2-12 Prevention Quality indicators
  - 15% reduction in the rate of admission for potentially preventable hospitalizations

Rationale:
As previously mentioned roughly 50% of the population is presently indigent and has limited access to primary and preventive healthcare. The resulting increase in communication, data sharing, and continuity through integration and co-location of services will positively impact the overall health of the target population. Each milestone and outcome was chosen as an integral part of the transformation project due to their direct impacts on quality of care, continuity of care, integration and positive outcomes preventing hospitalizations, incarcerations, and MH crisis.

Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Additionally, access to care is enhanced because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs.
Finally, given the ever-increasing cost of transportation, a “one stop shopping” approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions. Co-location alone is not synonymous with integration. Levels of interaction between physical and behavioral health providers may range from traditional minimally collaborative models to fully integrated collaborative models. The expectation for this project will result in close collaboration in a fully integrated system where providers are part of the same team and system, and the patient experiences mental health treatment as part of their regular primary care or vice versa.

**Outcome Measure Valuation:**
The percentage of the ICP program’s target population who receive primary health care outside of MHMR-NC is at present 100%. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000.

Implementation of the integrative care program could reduce this cost to the community by $6,138,900 between DY3 – DY5.

Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.

The rationale for the valuation of the integrated care program centers is based on cost savings to the community through the elimination of potentially preventable hospitalizations, increased quality of care, and patient satisfaction. Values were calculated by multiplying the total projected number of hospitalizations to be prevented by the mean cost of preventable hospitalization for individuals with an MH diagnosis. The total value of the program is the summative cost savings to the community.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>MHMR OF NUECES COUNTY</th>
<th>138305109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<td>138305109.2.1</td>
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<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Process Milestone 1 P-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong></td>
<td>Baseline eligible population is 1,500 MH adult individuals. Program planning and development finalized. Acquisition of program resources, program materials, and capital. Program materials, operational and procedural guidelines are established and implemented. 100% of program staff has received training on primary care treatment modalities and integrative care. Establishment of MOU’s, contract agreements with providers, and continuing education for providers. Interview and hire 1 primary care provider and program supervisor.</td>
<td>Baseline/Goal: Baseline eligible population is 1,500 MH adult individuals. Program planning and development finalized. Acquisition of program resources, program materials, and capital. Program materials, operational and procedural guidelines are established and implemented. 100% of program staff has received training on primary care treatment modalities and integrative care. Establishment of MOU’s, contract agreements with providers, and continuing education for providers. Interview and hire 1 primary care provider and program supervisor.</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Information from stakeholder discussions and interviews including providers (physical and behavioral), and other community based organizations.</td>
<td>Information from stakeholder discussions and interviews including providers (physical and behavioral), and other community based organizations.</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Payment Incentive:</strong></td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Process Milestone 2 P-2</strong></td>
<td>Establish baseline rates</td>
<td>Establish baseline rates</td>
</tr>
<tr>
<td>Baseline/Goal: Establish baseline rates for</td>
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</table>

| **Outcome Improvement Target 1** | **IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions** | **Improvement Target:** | 5% reduction in the rate of admission for potentially preventable hospitalizations. | **Baseline/Goal:** Baseline is the rate of preventable admissions for DY2. Goal is a 5% reduction. | **Data Source:** EHR, claims, Program Data |
| **Estimated Incentive Payment:** | $407,912 |                          |                          |                          |                          |

| **Outcome Improvement Target 2** | **IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions** | **Improvement Target:** | 10% reduction in the rate of admission for potentially preventable hospitalizations. | **Baseline/Goal:** Baseline is the rate of preventable admissions for DY2. Goal is a 10% reduction. | **Data Source:** EHR, claims, Program Data |
| **Estimated Incentive Payment:** | $613,135 |                          |                          |                          |                          |

| **Outcome Improvement Target 3** | **IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions** | **Improvement Target:** | 15% reduction in the rate of admission for potentially preventable hospitalizations. | **Baseline/Goal:** Baseline is the rate of preventable admissions for DY2. Goal is a 15% reduction. | **Data Source:** EHR, claims, Program Data |
| **Estimated Incentive Payment:** | $796,696 |                          |                          |                          |                          |

RHP Plan for Region 4 1114
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>138305109.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>target population.</td>
<td></td>
<td></td>
<td></td>
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</table>

**Data Source:** Claims and encounter data, medical records

**Process Milestone 2 Estimated Payment Incentive:** $0

**Process Milestone 3 P-3** Develop and test data systems
Baseline/Goal: Baseline is zero data systems. Goal is to develop and test one data system.
**Data Source:** Information from discussions/interviews to understand current systems and then establish most effective systems for the program.

**Process Milestone 3 Estimated Payment Incentive:** $0

**Process Milestone 1, 2, 3, Estimated Incentive Payment (maximum amount):**
$0

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):</th>
<th>Year 3 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$407,912</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$613,135</td>
<td>$796,696</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,817,743
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores

Unique RHP Outcome ID Number: 138305109.3.2

Performing Provider/TPI: MHMR of Nueces County/ 138305109

Outcome Measure Description:
IT 6.1 will be defined as patients receiving timely care, appointments, and information. The integration of physical and behavioral health will allow patients with mental illness and substance abuse to receive services in a co-located office setting and will improve access to care, improve health outcomes, and improve patient satisfaction.

Process milestones
- DY2 P-1; P-2; P-3

Improvement milestones include the following:
- DY3 6.1(1-3) Percent improvement over baseline for patient satisfaction for getting timely care, appointments and information; how well their doctors communicate; patient’s rating of doctor access to specialist
  - 5% of the targeted population indicate improved patient satisfaction
- DY4 6.1 In addition to those improvements identified for DY3 we include percent improvement over baseline for patient’s involvement in shared decision making
  - 10% of the targeted population indicate improved patient satisfaction
- DY5 6.1 In addition to those improvements identified for DY4 we include percent improvement over baseline for patient’s overall health status/functional status
  - 15% of the targeted population indicate improved patient satisfaction

The outcome measures and improvement targets for this project include full implementation of integrative care treatment modalities and establishment of primary care providers within existing behavioral healthcare services.

Rationale:
As previously mentioned roughly 50% of the population is presently indigent and has limited access to primary and preventive healthcare. The resulting increase in communication, data sharing, and continuity through integration and co-location of services will positively impact the overall health of the target population. Each milestone and outcome was chosen as an integral part of the transformation project due to their direct impacts on quality of care, continuity of care, integration and positive outcomes.

Through the integration of behavioral health and physical health care services, opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Additionally, access to care is enhanced
because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs. Finally, given the ever-increasing cost of transportation, a “one stop shopping” approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions. Co-location alone is not synonymous with integration. Levels of interaction between physical and behavioral health providers may range from traditional minimally collaborative models to fully integrated collaborative models. The expectation for this project will result in close collaboration in a fully integrated system where providers are part of the same team and system, and the patient experiences mental health treatment as part of their regular primary care or vice versa, resulting in overall patient satisfaction.

**Outcome Measure Valuation:**
The percentage of the ICP program’s target population who receive primary health care outside of MHMR-NC is at present 100%. Implementation of the integrative care program could increase the efficacy of treatment in an integrated setting leading to higher outcomes in patient satisfaction at a value of 1,435,029. Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.

The rationale for the valuation of the integrated care program centers is based on cost savings to the community through the elimination of potentially preventable hospitalizations, increased quality of care, and patient satisfaction. Values were calculated by multiplying the total projected number of hospitalizations to be prevented by the mean cost of preventable hospitalization for individuals with an MH diagnosis. The total value of the program is the summative cost savings to the community.
### MHMR OF NUECES COUNTY

<table>
<thead>
<tr>
<th>138305109.3.2</th>
<th>3.IT- 6.1</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>138305109.2.1</td>
<td>138305109</td>
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<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>TBD</td>
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<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
</table>

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

**Baseline/Goal:** Baseline eligible population is 1,500 MH adult individuals. Program planning and development finalized. Acquisition of program resources, program materials, and capital. Program materials, operational and procedural guidelines are established and implemented. 100% of program staff has received training on primary care treatment modalities and integrative care. Establishment of MOU’s, contract agreements with providers, and continuing education for providers. Interview and hire 1 primary care provider and program supervisor

**Data Source:** Information from stakeholder discussions and interviews including providers (physical and behavioral), and other community based organizations

**Process Milestone 1 Estimated Payment Incentive:** $0

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 IT-6.1.1</th>
<th>Outcome Improvement Target 4 IT-6.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are getting timely care, appointments, and information including 5% improvement over baseline</td>
<td>Patients are getting timely care, appointments, and information including 10% improvement over baseline</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline is zero. Goal is the establishment of baseline rates for timely care.

**Data Source:** Patient survey

**Outcome Improvement Target 1 Estimated Incentive Payment:** $90,647

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 IT-6.1.2</th>
<th>Outcome Improvement Target 5 IT-6.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% improvement over baseline of patient satisfaction on how well their doctors communicate</td>
<td>10% improvement over baseline of patient satisfaction on how well their doctors communicate</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline established in DY3. Goal is a 5% improvement in patient report of satisfaction in communication with physicians.

**Data Source:** Patient Survey

**Outcome Improvement Target 2 Estimated Incentive Payment:** $102,189.25

<table>
<thead>
<tr>
<th>Outcome Improvement Target 3 IT-6.1.3</th>
<th>Outcome Improvement Target 8 IT-6.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients are getting timely care, appointments, and information including 15% improvement over baseline</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline established in DY3. Goal is a 10% improvement in timely care.

**Data Source:** Patient survey

**Outcome Improvement Target 3 Estimated Incentive Payment:** $102,189.25

<table>
<thead>
<tr>
<th>Outcome Improvement Target 4 IT-6.1.1</th>
<th>Outcome Improvement Target 8 IT-6.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients are getting timely care, appointments, and information including 15% improvement over baseline</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline is zero. Goal is the establishment of baseline rates for timely care.

**Data Source:** Patient survey

**Outcome Improvement Target 4 Estimated Incentive Payment:** $106,226.2

<table>
<thead>
<tr>
<th>Outcome Improvement Target 5 IT-6.1.2</th>
<th>Outcome Improvement Target 9 IT-6.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% improvement over baseline of patient satisfaction on how well their doctors communicate</td>
<td>15% improvement over baseline of patient satisfaction on how well their doctors communicate</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline established in DY3. Goal is a 15% improvement in patient satisfaction in communication with physicians.

**Data Source:** Patient Survey

**Outcome Improvement Target 5 Estimated Incentive Payment:** $106,226.2

<table>
<thead>
<tr>
<th>Outcome Improvement Target 8 IT-6.1.1</th>
<th>Outcome Improvement Target 9 IT-6.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients are getting timely care, appointments, and information including 15% improvement over baseline</td>
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</tbody>
</table>

**Baseline/Goal:** Baseline is zero. Goal is the establishment of baseline rates for timely care.

**Data Source:** Patient survey

**Outcome Improvement Target 8 Estimated Incentive Payment:** $106,226.2

**Outcome Improvement Target 9 Estimated Incentive Payment:** $106,226.2
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMR OF NUECES COUNTY</td>
<td>138305109.2.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline rates</strong></td>
<td>Baseline is zero baseline rates. Goal is to establish a baseline rate for target population. <strong>Data Source:</strong> Claims and encounter data, medical records.</td>
<td>5% improvement over baseline of patient’s rating of doctor access to specialist Baseline/Goal: Baseline established in DY3. Goal is a 5% improvement over baseline of patient’s rating of doctor access to specialist. <strong>Data Source:</strong> Patient Survey</td>
<td>Outcome Improvement Target 6 IT-6.1.3 10% improvement over baseline of patient’s rating of doctor access to specialist Baseline/Goal: Baseline established in DY3. Goal is a 10% improvement over. <strong>Data Source:</strong> Patient Survey</td>
<td>Outcome Improvement Target 10 IT-6.1.3 15% improvement over baseline of patient’s rating of doctor access to specialist Baseline/Goal: Baseline established in DY3. Goal is a 15% improvement over. <strong>Data Source:</strong> Patient Survey</td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Payment Incentive:</strong> $0</td>
<td></td>
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</tr>
<tr>
<td><strong>Process Milestone 3 P- 3 Develop and test data systems</strong> Baseline/Goal: Baseline is zero data systems. Goal is to develop and test one data system. <strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective systems for the program <strong>Process Milestone 3 Estimated Payment Incentive:</strong> $0</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment: $90,647</strong></td>
<td><strong>Outcome Improvement Target 6 Estimated Incentive Payment: $204,378.50</strong></td>
<td><strong>Outcome Improvement Target 10 Estimated Incentive Payment: $177,043.66</strong></td>
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</tr>
<tr>
<td><strong>Process Milestone 1, 2, 3, Estimated Incentive Payment (maximum amount):</strong> $0</td>
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<tr>
<td><strong>Process Milestone 3 Estimated Payment Incentive:</strong> $0</td>
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<tr>
<td><strong>Process Milestone 3 Estimated Payment Incentive:</strong> $0</td>
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</table>

**Outcome Improvement Target 7 IT-6.1.4** 5% improvement over baseline of patient involvement in shared decision making Baseline/Goal: Baseline is zero. Goal is a 5% increase in patient involvement in shared decision making. **Data Source:** Patient Survey | **Outcome Improvement Target 7 Estimated Incentive Payment: $5** | **Outcome Improvement Target 11 IT-6.1.4** 10% improvement over baseline of patient involvement in shared decision making Baseline/Goal: Baseline is zero. Goal is a 10% increase in patient involvement in shared decision making. **Data Source:** Patient Survey | **Outcome Improvement Target 15 IT-6.1.4** 15% improvement over baseline of patient involvement in shared decision making Baseline/Goal: Baseline is zero. Goal is a 15% increase in patient involvement in shared decision making. **Data Source:** Patient Survey | **Outcome Improvement Target 20 IT-6.1.4** 20% improvement over baseline of patient involvement in shared decision making Baseline/Goal: Baseline is zero. Goal is a 20% increase in patient involvement in shared decision making. **Data Source:** Patient Survey |
### Patient Satisfaction

**Related Category 1 or 2 Projects:**

- **Starting Point/Baseline:** TBD

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$204,378.50</td>
<td>$531,131</td>
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</tbody>
</table>

**11 Estimated Incentive Payment:** $177,043.66

**Outcome Improvement Target**

12 IT-6.1.5

Improvement over baseline in patient’s overall health status/functional status

Baseline/Goal: Baseline established in DY3. Goal is a 20% Improvement in patients’ health status.

**Data Source:** Patient Survey, medical record

**Estimated Incentive Payment:** $177,043.68

**Year 2 Estimated Outcome Amount:** $0

**Year 3 Estimated Outcome Amount:** $271,941

**Year 4 Estimated Outcome Amount:** $408,757

**Year 5 Estimated Outcome Amount:** $531,131

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,211,829
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target): IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Unique RHP outcome identification number: 138305109.3.3
Performing Provider/TPI: MHMR of Nueces County/138305109

Outcome Measure Description:
This outcome measure includes the number of individuals receiving project intervention who had a potentially preventable admission/readmission to a criminal justice setting within the measurement period. Implementation of this program expects to reduce the rate of admissions by 5% in DY3, 10% in DY4, and 15% in DY5.

Process Milestones:
- DY 2: P-1; P-2
- DY 3: P-3

Outcome Improvement Targets for each year:
- DY 4: IT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- DY 5: UT 9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons

Rationale:
Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning and patient satisfaction.

Outcome Measure Valuation:
The valuation of this program was calculated by multiplying the number of individuals which will be re-directed from hospitalization by the mean cost of a mental health hospitalization. The total program value is the summative cost savings to the community. Cost averages were drawn from 2008 (most recent available) cost data for MH hospitalizations as cited in the 2008 DSHS statistical brief.

The percentage of target population who receive peer to peer services in a day center setting is currently 0%. Establishment of a “Drop-In” center for peer led services will provide an environment of care which reduces recidivism in hospitalizations and incarcerations by engaging the target population in an evidenced based peer to peer program. For FY 2011 the number of hospitalizations
in the target population for those who receive outpatient mental health services through MHMR-NC was the number of individuals in the target population who were incarcerated was 670. The average cost of inpatient MH services per hospitalization is $13,642 and the average cost for incarceration in Nueces County Jail is $180 per day with an assumed average length of stay of 30 days. Successful implementation of this program will result in a minimum community cost savings of $823,870.99.

The cost savings to the community for reduction in incarcerations is factored into the valuation. For FY 2011 there were a total of 670 individuals who were incarcerated in Nueces County Jail that had a diagnosed mental illness. The cost of incarceration is calculated to be $180 per day. Implementation of this program will seek to reduce this rate by 5% in DY3, 10% in DY4, and 15% in DY5.
### Starting Point/Baseline:
**MHMR Nueces County**

#### Related Category 1 or 2 Projects:
- **13830510.2.2**

#### Year 2 (10/1/2012 – 9/30/2013)
- **Process Milestone 1** P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **Baseline/Goal:** Baseline eligible population is 1,500 MH adult individuals.
  - **Data Source:** Information from stakeholder discussions and interviews including providers (physical and behavioral), and other community based organizations
  - **Milestone 1 Estimated Incentive Payment (maximum amount):** $0

#### Year 3 (10/1/2013 – 9/30/2014)
- **Process Milestone 3** P-3 Develop and test data systems
  - **Baseline/Goal:** Baseline is zero data systems. Goal is to have a data system tested and implemented.
  - **Data Source:** Information from discussions/interviews to understand current systems and then establish most effective systems for the program
  - **Process Milestone 3 Estimated Incentive Payment:** $47,169

#### Year 4 (10/1/2014 – 9/30/2015)
- **Outcome Improvement Target 1** IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
  - **Baseline/Goal:** Baseline established in DY2. Decrease hospitalizations and incarcerations by 10%.
  - **Data Sources:** Claims/encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records
  - **Estimated Incentive Payment:** $80,900

#### Year 5 (10/1/2015 – 9/30/2016)
- **Outcome Improvement Target 3** IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
  - **Baseline/Goal:** Baseline established in DY2. Decrease hospitalizations and incarcerations by 15%.
  - **Data Sources:** Claims/encounter and clinical record data; anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records
  - **Estimated Incentive Payment:** $82,344

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**Process Milestone 2** P-2 Establish baseline rates
- **Baseline/Goal:** Baseline is zero. Goal is to establish a baseline rate for target population.
  - **Data Source:** Claims and encounter data, medical records
  - **Process Milestone 2 Estimated Incentive Payment:** $0
<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount:</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
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<tbody>
<tr>
<td>$0</td>
<td>$94,338</td>
<td>$80,900</td>
<td>$82,344</td>
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</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $257,582
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline for patient satisfaction for getting timely care, appointments and information

Unique RHP Outcome Identification Number: 138305109.3.4

Provider Name and TPI: MHMR of Nueces County 138305109

Outcome Measure Description:
Improvement milestones include the following:
IT 6.1.1(1) Percent improvement over baseline for patient satisfaction for getting timely care, appointments and information; 6.1. (4) Percent improvement over baseline for patient’s involvement in shared decision making

Process Milestones:
- DY 2: P-1; P-2

Outcome Improvement Targets for each year:
- DY 3 – IT 6.1
- DY 4 – IT 6.1
- DY 5 – IT 6.1

DY5 Include all improvements over baseline for patient satisfaction as listed for the prior years and expect an overall increase in the improvement percentage for each

Designing, implementing and providing the peer-to-peer day center program will result in positive outcomes and improved services for the target population. The outcome measures described above, as well as the ability to demonstrate improvements will allow for the best opportunity for patient satisfaction.

Rationale:
Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. Establishing this “Drop-In” center for peer led services will provide an environment of care which reduces hospital admissions/readmissions and incarcerations by engaging the target population in an evidenced based peer to peer program. Individuals will receive the right care at the right time in the right setting.

Outcome Measure Valuation:
The valuation of this program was calculated by multiplying the number of individuals which will be redirected from hospitalization by the mean cost of a mental health hospitalization. The total program
value is the summative cost savings to the community. Cost averages were drawn from 2008 (most recent available) cost data for MH hospitalizations as cited in the 2008 DSHS statistical brief.

The percentage of target population who receive peer to peer services in a day center setting is currently 0%. Establishment of a “Drop-In” center for peer led services will provide an environment of care which reduces recidivism in hospitalizations and incarcerations by engaging the target population in an evidenced based peer to peer program. For FY 2011 the number of hospitalizations in the target population for those who receive outpatient mental health services through MHMR-NC was the number of individuals in the target population who were incarcerated was 670. The average cost of inpatient MH services per hospitalization is $13,642 and the average cost for incarceration in Nueces County Jail is $180 per day with an assumed average length of stay of 30 days. Successful implementation of this program will result in a minimum community cost savings of $823,870.99.

The cost savings to the community for reduction in incarcerations is factored into the valuation. For FY 2011 there were a total of 670 individuals who were incarcerated in Nueces County Jail that had a diagnosed mental illness. The cost of incarceration is calculated to be $180 per day. Implementation of this program will seek to reduce this rate by 5% in DY3, 10% in DY4, and 15% in DY5.
### Process Milestone 1 P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Baseline/Goal:** Baseline eligible population is 1,500 MH adult individuals.

**Data Source:** Information from stakeholder discussions and interviews including providers (physical and behavioral), and other community-based organizations.

**Milestone 1 Estimated Incentive Payment (maximum amount):** $0

**Process Milestone 2 P-2 Establish baseline rates**

Baseline/Goal: Baseline is zero. Goal is to establish baseline rates for target population.

**Data Source:** Claims and encounter data, medical records

**Process Milestone 2 Estimated Incentive Payment: $0**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Outcome Improvement Target 1 IT-6.1.(1)** Patients are getting timely care, appointments, and information including 5% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 5% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $31,446 | **Outcome Improvement Target 2 IT-6.1.(4)** 5% improvement over baseline of patient involvement in shared decision making  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 5% improvement in patient involvement.  
  **Data Source:** Patient Survey  
  **Estimated Incentive Payment:** $31,446 | **Outcome Improvement Target 2 IT-6.1.(1)** Patients are getting timely care, appointments, and information including 10% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 10% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $26,966.50 | **Outcome Improvement Target 3 IT-6.1.(1)** Patients are getting timely care, appointments, and information including 15% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 15% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $27,448 |
| **Outcome Improvement Target 2 IT-6.1.(4)** 10% improvement over baseline of patient involvement in shared decision making  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 10% improvement in patient involvement.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $26,966.50 | **Outcome Improvement Target 4 IT-6.1.(4)** 15% improvement over baseline of patient involvement in shared decision making  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 15% improvement in patient involvement.  
  **Data Source:** Patient Survey  
  **Estimated Incentive Payment:** $27,448 | **Outcome Improvement Target 4 IT-6.1.(1)** Patients are getting timely care, appointments, and information including 10% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 10% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $26,966.50 | **Outcome Improvement Target 6 IT-6.1.(1) Patients are getting timely care, appointments, and information including 15% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 15% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $27,448 |
| **Outcome Improvement Target 2 IT-6.1.(4)** 10% improvement over baseline of patient involvement in shared decision making  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 10% improvement in patient involvement.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $26,966.50 | **Outcome Improvement Target 4 IT-6.1.(4)** 15% improvement over baseline of patient involvement in shared decision making  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 15% improvement in patient involvement.  
  **Data Source:** Patient Survey  
  **Estimated Incentive Payment:** $27,448 | **Outcome Improvement Target 4 IT-6.1.(1)** Patients are getting timely care, appointments, and information including 10% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 10% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $26,966.50 | **Outcome Improvement Target 6 IT-6.1.(1) Patients are getting timely care, appointments, and information including 15% improvement over baseline  
  **Baseline/Goal:** Baseline established in DY3. Goal is a 15% increase in patients receiving timely care.  
  **Data Source:** Patient survey  
  **Estimated Incentive Payment:** $27,448 |

**Related Category 1 or 2 Projects:**

- MHMR Nueces County  
  **138305109.2.2**

- **Starting Point/Baseline:** TBD

- **Year 2 (10/1/2012 – 9/30/2013):**

- **Year 3 (10/1/2013 – 9/30/2014):**

- **Year 4 (10/1/2014 – 9/30/2015):**

- **Year 5 (10/1/2015 – 9/30/2016):**
Year 2 Estimated Outcome Amount: $50  
Year 3 Estimated Outcome Amount: $62,892  
Year 4 Estimated Outcome Amount: $53,933  
Year 5 Estimated Outcome Amount: $54,896  

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $171,721
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target) - IT-2.4 Behavioral Health/Substance Abuse Admission Rate

Unique RHP Outcome ID Number: 138305109.3.5
Performing Provider/TPI: MHMR of Nueces County 138305109

Outcome Measure Description:
Process milestones for the MHMR new media outreach and education program include the following:
DY 2 P-1 Project planning – engage stakeholders identify current capacity and needed resources, determines timelines and document implementation plans; P-2 Establish baseline rates;
DY 3 P-3 Develop and test data systems;
DY 3, DY 4 and DY 5 IT-2.4 Behavioral Health/Substance Abuse admission rate (% reduction shown each year)

The goal for the potentially preventable admissions outcome measure is too progressively decrease the number of hospitalizations and incarcerations by 20% by DY5. Baseline for end of DY3 is a 10% reduction.

Process Milestones:
- DY 2 – P-1; P-2
- DY 3 – P-3

Outcome Improvement Targets for each year:
- DY 3:
  - IT 2.4 Behavioral Health/Substance Abuse Admission Rate
    - 10% reduction in discharges for patients with BH/SA as the principal diagnosis
- DY 4:
  - IT 2.4 Behavioral Health/Substance Abuse Admission Rate
    - 15% reduction in discharges for patients with BH/SA as the principal diagnosis
- DY 5:
  - IT 2.4 Behavioral Health/Substance Abuse Admission Rate
    - 20% reduction in discharges for patients with BH/SA as the principal diagnosis

Rationale:
The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Delivery mechanisms include community health workers that can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-
management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

Citing this rationale, the purpose of selecting the following outcomes and domains is their direct measure of the programs efficacy in service delivery. Patient satisfaction and a reduction in hospitalizations/incarcerations will provide evidence for the effectiveness of the outreach and education program. The use of new media in applied interventions is a new frontier in service delivery and its effectiveness will be evidenced by the outcomes as listed below.

**Outcome Measure Valuation:**
The rationale for the valuation of the innovative intervention for outreach and education via social network is based on cost savings to the community through the elimination of potentially preventable hospitalizations, increased quality of care, and patient satisfaction. Values were calculated by multiplying the total projected number of hospitalizations to be prevented by the mean cost of preventable hospitalization for individuals with an MH diagnosis. The total value of the program is the summative cost savings to the community.
<table>
<thead>
<tr>
<th>Process Milestone 1 P-1</th>
<th>Process Milestone 3 P-3</th>
<th>Process Milestone 2 Estimated Incentive Payment: $25,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Develop and test data systems</td>
<td>$32,859</td>
</tr>
<tr>
<td>Baseline/Goal: Baseline is zero for operational data systems. Goal is to have a comprehensive data system for claims and EHR in place.</td>
<td><strong>Data Source</strong>: Information from discussions/interviews to understand current systems and then establish most effective systems for the program</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Information from stakeholder discussions and interviews including providers (physical and behavioral), consumers and other community based organizations</td>
<td>Process Milestone 3 Estimated Incentive Payment: $32,859</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 P-2</strong></td>
<td><strong>Outcome Improvement Target 1 IT 2.4</strong></td>
<td><strong>Outcome Improvement Target 4 IT 2.4</strong></td>
</tr>
<tr>
<td>Establish baseline rates</td>
<td>10% reduction in discharges for patients with BH/SA as the principal diagnosis</td>
<td>15% reduction in discharges for patients with BH/SA as secondary diagnosis</td>
</tr>
<tr>
<td>Baseline/Goal: Baseline is zero. Goal is to identify providers and begin engaging stakeholders in the ICP program.</td>
<td><strong>Baseline/Goal</strong>: Baseline is the rate of preventable hospitalizations in DY2. Goal is a 10% reduction in preventable admissions by end of DY3.</td>
<td><strong>Baseline/Goal</strong>: Baseline is the number of discharges for patients with BH/SA as a secondary diagnosis in DY2. Goal is a 20% reduction.</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Claims and encounter data, medical records</td>
<td><strong>Data Source</strong>: EHR, claims</td>
<td><strong>Data Source</strong>: EHR, claims</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $25,000</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment</strong>: $32,860</td>
<td><strong>Outcome Improvement Target 4 Estimated Incentive Payment</strong>: $25,931</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount</strong>: $0</td>
<td><strong>Year 3 Estimated Outcome Amount</strong>: $65,719</td>
<td><strong>Year 4 Estimated Outcome Amount</strong>: $51,861</td>
</tr>
<tr>
<td><strong>Year 3 Estimated Outcome Amount</strong>: $65,719</td>
<td><strong>Year 4 Estimated Outcome Amount</strong>: $51,861</td>
<td><strong>Year 5 Estimated Outcome Amount</strong>: $47,171</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $164,751</td>
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</tr>
</tbody>
</table>
Category 3: Quality Improvements

Title of Outcome Measure (Improvement Target) – IT 6.1 Percent improvement over baseline of patient satisfaction scores

Unique RHP Outcome ID Number: 138305109.3.6
Performing Provider/TPI: MHMR of Nueces County/ 138305109

Outcome Measure Description
Process milestones for the MHMR new media outreach and education program include the following:
DY 2 P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans; P-2 Establish baseline rates;
DY 3 P-3 Develop and test data systems

Outcome Improvement Targets for each year:
DY 3 IT- 6.1 Percent improvement over baseline of patient satisfaction scores for the following: getting timely care, appointments and information; how well their doctors communicate;
DY 4 IT-6.1 Percent improvement over baseline of patient satisfaction scores for the following: getting timely care, appointments and information; how well their doctor’s communicate; patient’s involvement in shared decision making
DY 5 IT-6.1 Percent improvement over baseline of patient satisfaction scores for the following: getting timely care, appointments and information; how well their doctor’s communicate; patient’s involvement in shared decision making; patient’s overall health status/functional status
The goal for this outcome measure is too progressively increase the patient satisfaction for the target population by 5% in DY 3 to a total of 15% in DY 5.

Rationale:
The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Delivery mechanisms include community health workers that can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Information sharing, program support, program evaluation, and continuing education are needed to expand the overall communication and collaboration between providers and patients as well provide a better integrated behavioral health care delivery system.

Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to
reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

Citing this rationale, the purpose of selecting the following outcomes and domains is their direct measure of the programs efficacy in service delivery. Patient satisfaction and a reduction in hospitalizations/incarcerations will provide evidence for the effectiveness of the outreach and education program. The use of new media in applied interventions is a new frontier in service delivery and its effectiveness will be evidenced by the outcomes as listed below.

**Outcome Measure Valuation:**
The rationale for the valuation of the innovative intervention for outreach and education via social network is based on cost savings to the community through the elimination of potentially preventable hospitalizations, increased quality of care, and patient satisfaction. Values were calculated by multiplying the total projected number of hospitalizations to be prevented by the mean cost of preventable hospitalization for individuals with an MH diagnosis. The total value of the program is the summative cost savings to the community.
<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 P-1</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Baseline zero. Goal is to establish Baselines. <strong>Data Source:</strong> Information from stakeholder discussions and interviews including providers (physical and behavioral), consumers and other community based organizations</td>
<td><strong>Process Milestone 3 P-3</strong> Develop and test data systems Baseline/Goal: Baseline is no data system. Goal is to develop, test, and implement data systems. <strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective systems for the program</td>
<td><strong>Outcome Improvement Target 1 IT-6.1.1</strong> Patients are getting timely care, appointments, and information including 10% improvement over baseline Baseline/Goal: Baseline established in DY2. Goal is a 10% improvement in patients receiving timely care and information. <strong>Data Source:</strong> Patient survey</td>
<td><strong>Outcome Improvement Target 5 Estimated Incentive Payment:</strong> $11,524.67</td>
<td><strong>Outcome Improvement Target 6 IT-6.1.1</strong> Patients are getting timely care, appointments, and information including 15% improvement over baseline Baseline/Goal: Baseline established in DY2. Goal is a 15% improvement in patients receiving timely care and information. <strong>Data Source:</strong> Patient survey</td>
</tr>
<tr>
<td><strong>Process Milestone 2 P-2</strong> Establish baseline rates <strong>Data Source:</strong> Claims and encounter data, medical records Baseline/Goal: Baseline is zero. Goal is to establish baseline rates for target population.</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment:</strong> $14,604.33</td>
<td><strong>Outcome Improvement Target 4 IT-6.1.2</strong> 5% improvement over baseline of patient satisfaction on how well their doctors communicate <strong>Outcome Improvement Target 4 Estimated Incentive Payment:</strong> $11,524.67</td>
<td><strong>Outcome Improvement Target 7 IT-6.1.2</strong> 15% improvement over baseline of patient satisfaction on how well their doctors communicate <strong>Outcome Improvement Target 7 Estimated Incentive Payment:</strong> $7,861.75</td>
<td></td>
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<tr>
<td>Outcome Improvement Target 2</td>
<td>Outcome Improvement Target 5</td>
<td>Outcome Improvement Target 8</td>
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<tr>
<td>Baseline/Goal: Baseline established in DY3. Goal is a 5% improvement in patients rating of communication with physicians. <strong>Data Source:</strong> Patient Survey</td>
<td>Baseline/Goal: Baseline established in DY3. Goal is a 10% improvement in patient involvement in shared decision making. <strong>Data Source:</strong> Patient Survey</td>
<td>baseline of patient’s involvement in shared decision-making Baseline/Goal: Baseline established in DY3. Goal is a 10% improvement in patient involvement in shared decision making. <strong>Data Source:</strong> Patient Survey</td>
<td></td>
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</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $14,604.34</td>
<td><strong>Estimated Incentive Payment:</strong> $11,524.66</td>
<td>Outcome Improvement Target 8 <strong>Estimated Incentive Payment:</strong> $7,861.75</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IT-6.1.5</strong> 15% Improvement over baseline in patient’s overall health status/functional status Baseline/Goal: Baseline established in DY3 and DY4. Goal is to increase patient’s overall health status by 15%. <strong>Data Source:</strong> Patient Survey, medical record</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,861.75</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $0 | Year 3 Estimated Outcome Amount: $43,813 | Year 4 Estimated Outcome Amount: $34,574 | Year 5 Estimated Outcome Amount: $31,447 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $109,834
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): OD-9 - Right Care, Right Setting, IT 9.2 - ED appropriate utilization
Unique RHP outcome identification number: 138305109.3.7
Performing Provider/TPI: MHMR of Nueces County/138305109

Outcome Measure Description:
IT-9.2 ED appropriate utilization
This measurement includes the reduction of emergency department visits for target conditions of Behavioral Health/Substance Abuse in the dual diagnosed population. Measuring the percentage of patients with a dual diagnosis who have greater than or equal to one visit to the emergency room for behavioral health during the measurement period as a percentage of all patients will help assess the success of the DD Crisis Stabilization Clinic Project.

Process Milestones:
• DY2
  o P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  o P- 2 Establish baseline rates
• DY3
  o P- 3 Develop and test data systems

Outcome Improvement Targets:
• DY4
  o IT-9.2 ED appropriate utilization (showing reduction in usage each year)
• DY5
  o IT-9.2 ED appropriate utilization (showing increased reduction each year)

Rationale:
Emergency department visits for behavioral health conditions can be an indicator of a breakdown with at home supports and interventions. Reducing emergency department visits improves the stability of individuals with dual diagnoses. Providing behavioral interventions at home is less costly than hospitalization or other crisis management.

Outcome Measure Valuation:
Most hospitalizations and SSLC commitments for individuals with IDD occur in individuals with a dual diagnosis. This program proposes to serve 20 individuals in year 3 and 30 individuals in years 4 and 5. The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000.
Implementation of the dual diagnosis clinic program could reduce this cost to the community by preventing one hospitalization for each person in service per year; potential savings is $1,091,361 between DY3 – DY5.
Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.

The cost of admission or re-admission to a state supported living center is $547 a day, or $199,827 a year per person. Preventing 2 SSLC admissions per year will save the state of Texas $599,481 between DY3 - DY 5. Total potential savings $1,690,842. Additional savings that do not have a dollar cost will be realized through improved integration and quality of life for those participating in the dual diagnosis clinic.

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<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Baseline/Goal:</th>
<th>Data Source:</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Baseline eligible population is 280 dually diagnosed individuals. Goal for end of DY3 is engagement of 10% of eligible population into the Dual Diagnosis Crisis Stabilization program.</td>
<td>Encounter Data, Claims, Project Data</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Claims and encounter data, medical records</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2</td>
<td>Baseline/Goal:</td>
<td>Data Source:</td>
</tr>
<tr>
<td>P-2 Establish baseline rates</td>
<td>Baseline is no rate established, goal is to establish the baseline rates for target population.</td>
<td>Information from discussions/interviews to understand current systems and then establish most effective systems for the program</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Claims and encounter data, medical records</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1, 2 Estimated Incentive Payment (maximum amount):</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$0</td>
<td>$61,205</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$61,205</td>
<td>Year 4 Estimated Outcome Amount:</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $243,415**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting, IT 9.4 Other
Outcome Improvement Target
Unique RHP outcome identification number: 138305109.3.8
Performing Provider/TPI: MHMR of Nueces County/138305109

Outcome Measure Description:
IT-9.4 Outcome Improvement Target Reduction in admissions to Small, Medium, or Large ICF-ID
This measurement includes the percentage of individuals served with IDD and MH dual diagnosis who have greater than or equal to one placement in a small, medium, or large ICF/IDD during the past three months. Evaluating clinical records and ICF admission and encounter data will provide the data source for making the determination.

Process Milestones:
- **DY2**
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2 Establish baseline rates
- **DY3**
  - P-3 Develop and test data systems

Outcome Improvement Targets:
- **DY4**
  - IT-9.4 Other - Outcome Improvement Target Reduction in admissions to Small, Medium, or Large ICF-ID
- **DY5**
  - IT-9.4 Other – Outcome Improvement Target Reduction in admissions to Small, Medium or Large ICF-ID

Rationale:
Individuals with a dual diagnosis are at increased risk of admission to institutional care settings. Measuring % of the population served that are admitted to institutional care will provide baseline data, and will demonstrate program effectiveness if the % of admissions within the group served is decreased. Decreasing admissions to institutional settings is significant to the quality of life of persons served. It is also significant to our community, because there are cost savings when people are served at home instead of a state supported institution.

Outcome Measure Valuation:
Most hospitalizations and SSLC commitments for individuals with IDD occur in individuals with a dual diagnosis. This program proposes to serve 20 individuals in year 3 and 30 individuals in years 4 and 5.
The number of potentially preventable hospitalizations in 2010 (most recent data available) within Nueces County was approximately 4,100 at a mean cost of $13,642 per stay. The approximate yearly cost of potentially preventable hospitalization to Nueces County is $38,130,000.

Implementation of the dual diagnosis clinic program could reduce this cost to the community by preventing one hospitalization for each person in service per year; potential savings is $1,091,361 between DY3 – DY5. Cost averages were drawn from 2008 (most recent available) data on hospitalization as cited in the 2008 DSHS statistical brief.

The cost of admission or re-admission to a state supported living center is $547 a day, or $199,827 a year per person. Preventing 2 SSLC admissions per year will save the state of Texas $599,481 between DY3 - DY 5. Total potential savings $1,690,842. Additional savings that do not have a dollar cost will be realized through improved integration and quality of life for those participating in the dual diagnosis clinic.

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<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P-1</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Baseline/Goal:</strong> Baseline eligible population is 280 dually diagnosed individuals. <strong>Goal:</strong> Program planning and development finalized. Acquisition of program resources, program materials, and capital. Program materials, operational and procedural guidelines are established and implemented. 100% of program staff has received training on Dual Diagnosis using training provided through NADD. Establishment of MOU’s, contract agreements with providers, and continuing education providers. Interview and hire program supervisor. <strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective systems for the program</td>
<td><strong>Baseline:</strong> Baseline eligible population is 280 dually diagnosed individuals. <strong>Goal:</strong> Program planning and development finalized. Acquisition of program resources, program materials, and capital. Program materials, operational and procedural guidelines are established and implemented. 100% of program staff has received training on Dual Diagnosis using training provided through NADD. Establishment of MOU’s, contract agreements with providers, and continuing education providers. Interview and hire program supervisor. <strong>Data Source:</strong> Information from discussions/interviews to understand current systems and then establish most effective systems for the program</td>
<td><strong>Outcome Improvement Target 1</strong> IT-9.4 Other - Outcome Improvement Target Reduction in admissions to Small, Medium, or Large ICF-ID <strong>Baseline/Goal:</strong> Baseline is the number of ICF-ID admissions in DY2. Goal is reduction by 5%. <strong>Data Source:</strong> Clinical record, ICF admission and encounter data</td>
<td><strong>Outcome Improvement Target 2</strong> IT-9.4 Other - Outcome Improvement Target Reduction in admissions to Small, Medium, or Large ICF-ID <strong>Baseline/Goal:</strong> Baseline is the number of ICF-ID admissions in DY2. Goal is to reduce by 10%. <strong>Data Source:</strong> Clinical record, ICF admission and encounter data</td>
</tr>
<tr>
<td><strong>Process Milestone 2 P-2</strong> Establish baseline rates <strong>Baseline/Goal:</strong> Baseline is zero. Goal is to establish the baseline rates for target population. <strong>Data Source:</strong> Claims and encounter data, medical records</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1, 2, Estimated Incentive Payment (maximum amount):</strong> $0</td>
<td><strong>Process milestone 3 Incentive Payment:</strong> $61,205</td>
<td></td>
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</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $0</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $61,205</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $68,329</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $113,881</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $243,415</td>
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</tbody>
</table>
**Category 3: Quality Improvements**

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

**Performing Provider/TPI**: Cuero Community Hospital/138911609

**RHP Project Number**: 138911609.3.1

**Outcome Measure Description**

IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores

- Use HCAHPS survey to establish if patients: (1) are getting timely care, appointments, and information

**Process Milestones**

**DY2**:
- P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3: Develop and test data systems

**DY3**:
- P-2: Establish baseline rates

**Outcome Improvement Targets for each year**

**DY4**:
- IT-6.1: Improvement in patient satisfaction scores of X% over baseline (will be determined)

**DY5**:
- IT-6.1: Improvement in patient satisfaction scores of X% over baseline (will be determined)

**Rationale**:  
Process milestones P-1 through P-3 were selected due to the lack of accurate reports and resources currently available to measure and monitor patient satisfaction regarding timeliness of getting care, appointments, and information. In order to report accurate data and establish baseline rates, P-2 and P-3 must be addressed in DY2-DY3.

Outcome measure IT-6.1 was selected due to its close alignment with our project goals to improve patient access to specialty providers, enable patients to obtain timely and convenient care, and thereby improve patient satisfaction and health outcomes. Improvement targets over baseline will be established in DY3.

**Outcome Measure Valuation**:  
During DY2, CCH will work to engage stakeholders, identify needed resources, and develop an implementation plan to address and monitor patient satisfaction. In addition, CCH will assemble a team to review HCAHPS required data on patient experience. After the review, the team shall meet with a vendor to develop a customized survey tool to measure and monitor patient outcomes. Together, these process milestones are valued at $111,636 for staffing, design development, implementation, and monitoring.

In DY3, we will establish the baseline rates for HCAHPS focused areas including timely care, appointments, and information. Process milestone 3 includes collecting data from HCAHPS surveys and aligning our baseline of achievements or shortcomings to the national average, as well as, personal standards for CCH. We value this milestone at $172,532 for staffing, analysis, and monitoring.
CCH will incorporate milestone 3 to produce targeted improvement outcomes in demonstration years 4 and 5. Focus areas include timely care, appointments and information where goals in patient experiences fell below acceptable standards. Based on survey results, employee training shall be developed integrating patient experience into the curriculum. We value this improvement target at $230,712 in DY4 and $431,330 in DY5 for staffing, analyzing, curriculum development, training, and monitoring.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>138911609.1.1</th>
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<tbody>
<tr>
<td>Starting Point/Baseline:</td>
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<td>Cuero Community Hospital</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans&lt;br&gt;Data source: EHR, performing provider reports</td>
<td>Process Milestone 3 [P-2]: Establish baseline rates&lt;br&gt;Data Source: Patient survey</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $55,818</td>
<td>Process Milestone 3 Estimated Incentive Payment <em>(maximum amount)</em>: $172,532</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $230,712</td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $111,636</td>
<td>Year 3 Estimated Outcome Amount: $172,532</td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
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<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $946,210*
F. Category 4: Population-focused Improvements
Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: CHRISTUS Spohn Hospital – Beeville
Performing Provider TPI #: 020811801

Domain 1: Potentially Preventable Admissions (8 measures)
- **Description** – Spohn will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Several of Spohn’s Category 1 and Category 2 projects, including the Implementation of a Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs, are designed to provide education and support to hospital patients both during their hospital stay and for the coordination of care post hospitalization. Spohn anticipates that the increased education and support during hospital stays and post hospitalization will result in reduced admissions that can be prevented through either self-management or appropriate follow-up care outside of the hospital. As a result, Spohn anticipates a reduction in potentially preventable readmissions.

- **Valuation**
  - **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding which inpatient services which could have been avoided with better information or prevention is essential to addressing the long-term needs of the community. Further, understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving health outcomes and reducing costs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
- **Description** – Spohn will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with little follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Spohn anticipates that its Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs will result in improvements in management and coordination of post-hospitalization care, reducing the likelihood of unnecessary readmissions.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted toward prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates. Analyzing admissions to identify those instances where a breakdown in following-up care occurred is a critical starting point for tracking our improvement toward the goals of improving health outcomes and reducing costs.
Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Spohn will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment and protocols for preventing complications like the measures in this domain; and Spohn is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Several of Spohn’s category 1 and 2 projects are designed to improve the delivery of care within the hospital in order to reduce the likelihood of preventable complications, including the Chronic Disease Registry and Medication Management projects, as well as the nurse redesign project at CHRISTUS Spohn Hospital Corpus Christi. As a result, Spohn anticipates that it will see a demonstrable reduction in PPCs over the course of the Waiver.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and its operating costs. Self-evaluation of Spohn’s hospital services, coupled with understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving patient access and health outcomes while reducing costs of care.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Spohn will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management and honest interactions with practitioners. In turn, patients may experience negative health outcomes and be even more unsatisfied. Spohn is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Spohn is undertaking two separate projects designed to improve medication management to reduce errors in the delivery of medication. Spohn expects improved patient satisfaction in the hospital setting and effective medication management programs for inpatients to correlate with its projects to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). Finally, CHRISTUS Spohn Hospital Corpus Christi’s nurse redesign program will impact patient satisfaction at all Spohn facilities.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Spohn and how well Spohn performs its function of promoting medication management. Spohn is committed to improving patient outcomes, and therefore places a high value on these measures. Understanding our starting point requires diligent tracking of patient satisfaction and patient’s medication management techniques to improve patient access to quality care and reduce costs of care.

Domain 5: Emergency Department (1 measure)
• **Description** – Spohn will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Spohn plans to undertake several projects specifically designed to reduce inappropriate utilization of ED services, which should reduce ED overcrowding, including its primary care clinic and its telehealth project for early detection of peripheral arterial disease and other chronic diseases in primary care settings. Spohn is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold.

• **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. Understanding our starting point and tracking our improvement is essential to making progress.

**Domain 6: Optional Domain:** Initial Core Set of Health Care Quality Measures (13 measures)

• **Description** - Spohn will report on CMS’ Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Spohn is committed to providing quality care to all patients, regardless of ability to pay.

• **Valuation**
  - **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices.
### Category 4: Population-Focused Measures

**CHRISTUS Spohn Hospital – Beeville (020811801)**

| Capability to Report Category 4 | Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
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<thead>
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<tbody>
<tr>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
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<tr>
<td><strong>Estimated Maximum Incentive Amount</strong></td>
<td>$109,259</td>
<td>$63,644</td>
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</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $63,644

#### Domain 2: Potentially Preventable Rehospitalizations (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $63,644

#### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.

- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $67,828

#### Domain 4: Patient Centered Healthcare

- **Patient Satisfaction - HCAHPS**
  - Planned Reporting Period: 1 or 2
- **Medication Management**
  - Planned Reporting Period: 1 or 2
- **Domain 4 - Estimated Maximum Incentive Amount:** $63,644

#### Domain 5: Emergency Department

- Planned Reporting Period: 1 or 2
- **Domain 5 - Estimated Maximum Incentive Amount:** $63,644

**OPTIONAL Domain 6: Children and Adult Core Measures**

- **Initial Core Set of Health Care Quality Measures**

RHP Plan for Region 4
<table>
<thead>
<tr>
<th>for Children in Medicaid and CHIP (24 measures)</th>
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<tbody>
<tr>
<td>Measurement period for report</td>
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<td>October 1-September 30</td>
<td>October 1-September 30</td>
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<tr>
<td>Planned Reporting Period: 1 or 2</td>
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</tr>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
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<tr>
<td>Measurement period for report</td>
<td>October 1-September 30</td>
<td>October 1-September 30</td>
<td>October 1-September 30</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
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<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$63,644</td>
<td>$67,828</td>
<td>$74,751</td>
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<td>Grand Total Payments Across Category 4</td>
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<td>$381,864</td>
<td>$406,965</td>
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Category 4: Population-Focused Improvements
Corpus Christi Medical Center
TPI – 020973601

Domain 1: Potentially Preventable Admissions

Description:
Corpus Christi Medical Center (CCMC) will report on all 8 measures in this domain. The category 1 and 2 projects (and related category 3 projects) the Corpus Christi Medical Center (CCMC) is proposing relate primarily to access to care; primary care, specialty care, and behavioral health services and care transitions. The insufficient number of healthcare providers, lack of care coordination, and significant incidence of chronic diseases (CHF, COPD, Diabetes) in our community result in unnecessary hospital admissions and inappropriate utilization of hospital emergency departments. The projects noted below all address access to care and care transitions with a focus on reducing potentially preventable admissions.

<table>
<thead>
<tr>
<th>Category 1 Project ID</th>
<th>Category 2 Project ID</th>
<th>Category 3 Project ID</th>
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<td></td>
<td>020973601.2.1</td>
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</table>

Valuation:
CCMC’s valuation for this domain reflects in part the general value of the information that will be available as a result of this reporting process. The information on PPAs will be reviewed and shared with our staff to identify areas of potential improvement and to identify ways of improving health outcomes and providing care in a more cost-effective manner. The valuation was also determined based on DSRIP funding protocol requirements. All the domains are key indicators of the improving health of our local community and carry equal weight in our proposed valuation.

Domain 2: Potentially Preventable Readmissions

Description:
CCMC will report on all 7 measures within this domain. The same projects noted for Domain 1 above are also applicable for the Domain 2 outcome measures related to readmission rates. The category 1 projects listed below address the lack of primary care providers, insufficient specialty providers, and chronic disease registry. The related category 3 measures identify improvements in CHF, COPD, and Behavioral Health readmission rates. The category 2 project which addresses care transitions should enable CCMC to achieve improvements in the “all cause” readmission rate. Having improved access to primary and specialty care providers and better managing the transitions from inpatient to outpatient care settings will result in lower readmission rates for patients in our community.
Valuation:
CCMC’s valuation for this domain reflects in part the general value and benefits of understanding the occurrence of, causes and financial implications of readmissions. The collection and review of this data will be shared with our staff to identify areas of potential improvement and to identify ways of improving health outcomes, common factors that contribute to readmissions and steps we can take to ensure patients receive the most appropriate care for their condition, minimizing the risk of readmission. The valuation was also determined based on DSRIP funding protocol requirements and the availability of funds. All the domains are key indicators of the improving health of our local community and carry equal weight in our proposed valuation.

Domain 3: Potentially Preventable Complications

Description:
CCMS will report on all 64 measures. While the primary focus of our projects is on access to care and care transitions, there are also key metrics and performance measures related to potentially preventable complications. The expansion of the Amistad FQHC will allow for better management of diabetes and blood pressure. The performance improvement project will develop key identification and management protocols relating to severe sepsis and septic shock with the goal of reducing mortality and complications. The reporting of this information will provide important information that will assist in the monitoring and evaluation of the services we provide, the impact on patient outcomes, and areas where improvement or additional staff training is needed. Reducing the occurrence of preventable complications will improve patient health and patient satisfaction, and provides significant benefits to individual patients and their families. The table below identifies the specific projects relating to this domain.

<table>
<thead>
<tr>
<th>Category 1 Project ID</th>
<th>Category 2 Project ID</th>
<th>Category 3 Project ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>020973601.1.1</td>
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<td>020973601.3.1</td>
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<tr>
<td>020973601.1.3</td>
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<tr>
<td>020973601.1.4</td>
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<td>020973601.3.12</td>
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</tbody>
</table>

Valuation:
The ability to minimize complications among the patients we serve is an important priority at CCMC. The success of our efforts contributes to improved patient outcomes and patient satisfaction, shorter lengths of stay, and a reduction in the cost of care. The value of this domain is based in part on the
The importance of this measure as a reflection of the quality of care we provide, and the ability to further refine our internal processes and standards based on the information we collect through this reporting process. The valuation was also determined based on DSRIP funding protocol requirements and the availability of funds. All the domains are key indicators of the improving health of our local community and carry equal weight in our proposed valuation.

**Domain 4: Patient Centered Healthcare**

**Description:**

CCMC will report on both measures in this domain.
The measurement of patient satisfaction through the four HCAHPS themes of 1) Your care from doctors, 2) Your care from nurses, 3) The hospital environment, and 4) When you left the hospital has been measured and reported by CCMC for several years. Our medical facility has placed a high priority on patient satisfaction and ensuring the medical care they receive recognizes the individual and unique health needs of each patient. We have implemented ongoing hospital improvement activities around these measures and, therefore, we have not included any new projects relating to this domain measurement. However, the projects mentioned above related to improving access to care will likely impact a patient’s overall health status, which could result in an overall increase in patient satisfaction in all medical settings. While we do not expect a direct impact on our scores as a result of any specific project, we are hopeful patient satisfaction in general will be positively affected by our 1115 waiver participation.

The Domain 4 measurement of medication management through the medication reconciliation of discharge medications (taken and not to be taken by the patient) has been measured and reported by CCMC for several years. We have ongoing hospital improvement activities around this measure and therefore we have not included any new projects relating to this domain measurement and expect no direct impact on our scores from our 1115 waiver participation.

CCMC has established processes and benchmarks to measure each of these areas and continually reviews trends in order to maintain consistent improvement. Even though there are no specific projects related to these measures, CCMC will continue to focus and improve in these areas and has specific plans to implement electronic physician order management by the end of 2013.

**Valuation:**
The value of this reporting measure is based in part on the high value CCMC places on patient satisfaction, and also is determined based on DSRIP funding protocol requirements and the availability of funds. Because satisfaction is directly linked to high quality care and successful patient outcomes, these reporting measures are a reflection of how successful our staff and facilities are in meeting patient expectations. While we cannot control all factors related to patient’s satisfaction, we will use the information collected under these reporting requirements to ensure we are doing all that we can to ensure patients receive the best care possible. All the domains are key indicators of the improving health of our local community and carry equal weight in our proposed valuation.
Domain 5: Emergency Department

Description:
CCMC will report on the single measure related to this domain.

The Domain 5 measurement of Emergency Department throughput (admit decision time to ED departure) has been measured and reported by CCMC for several years. We have ongoing hospital improvement activities around this measure and therefore we have not included any new projects relating to this domain measurement. CCMC has established processes and benchmarks to measure our performance in this area and continually reviews trends in order to maintain consistent improvement. Even though there are no specific projects related to this reporting domain, CCMC will continue to focus and improve in these areas and has specific plans to implement electronic physician order management by the end of 2013.

Domain Valuation:
Because emergency care is often sought under stressful conditions, we recognize the importance and value of providing the most efficient care possible while ensuring patients also get the services they need when they need them. Our valuation of this reporting domain, along with all others, reflects our emphasis on maximizing patient outcomes while also focusing on patient satisfaction. Our valuation is also determined based on DSRIP funding protocol requirements and the availability of funds. All the domains are key indicators of the improving health of our local community and carry equal weight in our proposed valuation.

Domain 6: Optional Domain
CCMC will not report on Domain 6.
### Category 4: Population-Focused Measures

**Corpus Christi Medical Center - 020973801**

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<tr>
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<td>Domain 3: Potentially Preventable Complications (PPCs)</td>
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<tr>
<td>Includes a list of 64 measures identified in the RHP Planning Protocol.</td>
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<td>$309,941</td>
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<tr>
<td>Domain 4: Patient Centered Healthcare</td>
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<td><strong>Patient Satisfaction - HCAHPS</strong></td>
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<td>Domain 5: Emergency Department</td>
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<td>OPTIONAL Domain 6: Children and Adult Core Measures</td>
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<td><strong>Initial Core Set of Health Care Quality Measures</strong></td>
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<td>for Children in Medicaid and CHIP (24 measures)</td>
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<td>Measurement period for report</td>
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<td>Planned Reporting Period: 1 or 2</td>
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<td><strong>Initial Core Set of Health Care Quality Measures</strong></td>
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<td>for Medicaid-Eligible Adults (26 measures)</td>
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<td>$</td>
<td>$</td>
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<td>$1,414,821</td>
<td>$1,549,705</td>
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RD-1, RD-2, RD-3, RD-4, RD-5

Category 4 Reporting Measures by Domain
Perfoming Provider DeTar Healthcare System, TPI 094118902

DeTar Hospital is an acute care facility that admits an average of 730 patients per month. Our service area predominately includes patients from Victoria, Goliad, Refugio, Jackson, DeWitt, Lavaca, Calhoun, Bee, and Wharton counties. The manner in which the Category 4 measures relate to the project outcomes submitted by DeTar as the Performing Provider is that they address a population that has limited access to continuing care due to depressed income levels. The result is patient complications, potentially unnecessary admissions or readmissions, and diminished health levels for each individual involved.

The projects submitted by DeTar Healthcare System include: Establish a family practice residency program (1.2.); Expand the number of community based settings where behavioral health services are offered by establishing an intensive outpatient program (1.12); Redesign of outpatient delivery system through chronic care clinics (2.2); and Implement evidence-based strategies to prevent pre-term delivery (2.7). The second reporting period, from April through September for RD 1-5, has been selected.

Domain 1 - Potentially Preventable Admissions (8 measures)
Potentially Preventable Readmissions is addressed in all four of the projects submitted by this provider. The focus of each project is to make care accessible to a population that currently does not always have access—usually because of their geographical location, transportation problems, and financial limitations. Three of the four projects, a residency program, chronic care clinics, and intensive outpatient program for behavioral health, are focused on self-management skills so that the patient—along with his support group—knows what to do in order to maintain optimal health. These programs will focus on medical appointments, but also on nutrition, health habits, medication management, coping skills, and other initiatives that will enable the client to control his chronic conditions and thus reduce potentially preventable hospitalizations and re-hospitalizations. The prenatal clinics will be located where the patient lives so that care is convenient, child-care for other children is not an obstacle to meeting appointments, and keeping appointments is made easy. This program also will include health considerations known to result in healthy newborns including smoking cessation, screening for domestic violence or battering, nutritional education, assuring current immunizations, and education to care of the newborn including the benefits of breast-feeding for both mother and child. Every proposed project provides education with the expectation of client teach back and return demonstrations to assure clear understanding and adequate skills to critically think about the most effective actions to take in order to adequately manage his condition.

DeTar will report on all 8 measures.

Domain Valuation:
The patient population served by DeTar Healthcare System is significant and reporting will involve a large number of patients. The cost to develop and maintain tracking systems for the purpose of capturing the relevant, reportable data with respect to the patient population served in each domain...
will require significant resources, both in time and hard assets. DeTar expects to add staff to its Quality Management Department for the purpose of data collection and analysis of all the domains. Thus the value for each domain was estimated to be the same. We will also have to purchase and/or reprogram software for extraction and submission.

Domain 2 – Potentially Preventable Readmissions – 30 days (7 measures)
All four of the projects submitted will help prevent 30-day readmissions. A cornerstone for each of the programs except prenatal care is that hospitalized patients will be seen within 4-days of their discharge. The prenatal program will include post-partum follow-up within the first two weeks. The evidence shows that early intervention after hospitalization gives the provider the opportunity to assure patient understanding of discharge instructions, medication regimen, and validate the patient actually procured needed drugs and/or equipment prescribed at time of discharge. The medical provider can follow lab values and other results that were pending when the patient left the hospital. The IOP will serve as a transition program back into the community for the patient who was hospitalized for a mental health issue. Regarding readmissions we expect the greatest impact to come from Project 2.2.1 since an integral part of the chronic condition program is working with patients immediately upon discharge. We will collaborate with community partners in counties where the clinics are established and request the Clinics be considered as part of the patient’s discharge plan. Literature reveals the most effective method of preventing re-hospitalizations is early face-to-face contact and a methodology to assure late lab work is followed, the patients understand and have means to obtain medications, and that all discharge instructions are clear. These innovative clinics will be able to provide that as well as a program that will allow effective self-management by the patient.

DeTar Healthcare System has resources to bring experience and expertise to these communities. We have achieved accreditation status in chest pain, stroke care, and congestive heart failure. We have a diabetic educator, experience in prenatal care, and support staff for case management, health programs such as smoking cessation, nutrition, and medication management. The expected improvements in relation to RD-1 and RD 2 include saving preventable admissions and readmissions. There will be a savings of 61 Behavioral Health admissions through DY5, 147 Chronic Care hospitalizations (readmissions) as a result of outlying clinics, 7 prenatal or NICU hospitalizations and 77 preventable hospitalizations as a result of the residency program. By year these breakdown to 60 preventable hospitalizations or re-hospitalizations in DY2, 65 in DY3, 64 in DY 4 and 103 in DY5.

DeTar will report on all 7 measures.

Domain Valuation:
The patient population served by DeTar Healthcare System is significant and reporting will involve a large number of patients. The cost to develop and maintain tracking systems for the purpose of capturing the relevant, reportable data with respect to the patient population served in each domain will require significant resources, both in time and hard assets. DeTar expects to add staff to its Quality Management Department for the purpose of data collection and analysis of all the domains. Thus the value for each domain was estimated to be the same. We will also have to purchase and/or reprogram software for extraction and submission.
Domain 3 – Potentially Preventable Complications (64 measures)
All four of the projects submitted by DeTar Healthcare System will help prevent complications when patients do require hospitalization. By achieving better control of their condition, patients who participate in the four projects we have submitted will not present in such a severe level of acuity as they did when there was little access to care. The outcome goals for 1.12.1 include avoidance of jail and ED encounters, but there will still be over 50% of these patients who will require an inpatient stay. It is known that over 70% of the behavioral health patients have a concomitant physical chronic condition. Part of the IOP program will be monitoring the physical aspect of the patient as well as his emotional status. With controlled blood pressures, blood sugars, etc., there will be less likelihood of complications associated with the chronic diseases such as diabetic ketoacidosis, or MI. Project 2.7.4 will result in the woman having complete prenatal care as well as overall health improvements. Regular examinations can prepare the delivery team for potential concerns on pelvic size and larger infants in utero where complications such as lacerations can be avoided. The residency program (1.2.3) makes regular care available to patients who previously had limited access. The chronic care clinics (2.2.1) afford care to those in rural areas regardless of ability to pay. With improved self-management, regular examinations, monitoring of medications, and effective support systems, these patients should be in better condition when admission to a hospital is required thus reducing susceptibility to complications. As an example the elderly patient from a clinic where nutritional status was regularly assessed, corrections made, and blood sugars kept under control will be less likely to develop a decubitus ulcer when hospitalization and increased bed rest is indicated.

DeTar will report on all 64 measures.

Domain Valuation:
The patient population served by DeTar Healthcare System is significant and reporting will involve a large number of patients. The cost to develop and maintain tracking systems for the purpose of capturing the relevant, reportable data with respect to the patient population served in each domain will require significant resources, both in time and hard assets. DeTar expects to add staff to its Quality Management Department for the purpose of data collection and analysis of all the domains. Thus the value for each domain was estimated to be the same. We will also have to purchase and/or reprogram software for extraction and submission.

Domain 4 – Patient Centered Healthcare (2 measures)
Because staff from the hospital will be involved in the care of patients in all of the proposed programs, when hospitalization is required the patients will have already built a trust level that facilitates communication. They will have been exposed to nurse practitioners, staff nurses, nutritionists, pharmacy personnel, respiratory therapists if they suffered from a chronic respiratory illness, and case management. While all of the patients may not come to this provider’s inpatient facilities, they will be armed with information about their particular needs they learned in the IOP, prenatal clinics, residency clinic and chronic management programs. This will encourage them to ask questions, to have the knowledge needed to speak up if there is an incongruity, and to be open to teaching and coaching from professional staff. This should elicit a positive response to the HCAHPS questions of care from doctors, nurses, and discharge planning and information when they left the hospital.
A basic element of all programs is to have oversight of the patient’s medication regimen. The patients will be expected to maintain a list of their medications and carry it with them in case of emergencies. This is such an inherent part of all programs they will expect medication management in the hospital to include the indicators under RD-4 of a current medication list that has been reconciled for new medications, discontinued medications, and medications that caused an adverse or allergic reaction, if any, while the patient was hospitalized.

DeTar will report on both measures.

**Domain Valuation:**
The patient population served by DeTar Healthcare System is significant and reporting will involve a large number of patients. The cost to develop and maintain tracking systems for the purpose of capturing the relevant, reportable data with respect to the patient population served in each domain will require significant resources, both in time and hard assets. DeTar expects to add staff to its Quality Management Department for the purpose of data collection and analysis of all the domains. Thus the value for each domain was estimated to be the same. We will also have to purchase and/or reprogram software for extraction and submission.

**Domain 5 – Emergency Department (1 measures)**
The project DeTar Healthcare System submitted to start a residency program will be the most effective in admit decision time to ED departure time. Staffing in the ED will be increased because of the residents rotations. More professional staff are available to speak with doctors in receiving hospitals or treatment centers where patients transfer. They can provide reports that will give the receiving facility information on whether they can accept and effectively treat the patient. Our most frequent transfer out of our facilities is the psychiatric patient who requires inpatient hospitalization that we cannot provide. Because our IOP will be a receiving center from other areas, we will establish relationships with staff in other psychiatric facilities. They will have increased confidence in the decisions to transfer and will be more amenable to accepting as quickly as possible.

DeTar will report on the one measure in this domain.

**Domain Valuation:**
The patient population served by DeTar Healthcare System is significant and reporting will involve a large number of patients. The cost to develop and maintain tracking systems for the purpose of capturing the relevant, reportable data with respect to the patient population served in each domain will require significant resources, both in time and hard assets. DeTar expects to add staff to its Quality Management Department for the purpose of data collection and analysis of all the domains. Thus the value for each domain was estimated to be the same. We will also have to purchase and/or reprogram software for extraction and submission.

**Domain 6:**
We will not report on RD-6.
## Category 4: Population-Focused Measures

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<tbody>
<tr>
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<td>$97,640</td>
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### Domain 1: Potentially Preventable Admissions (PPAs)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 2</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
<tr>
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<td>$97,640</td>
<td>$101,240</td>
<td>$125,933</td>
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### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 2</th>
<th>Year 2</th>
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### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Planned Reporting Period: 2</th>
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<td>$101,240</td>
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### Domain 4: Patient Centered Healthcare

#### Patient Satisfaction - HCAHPS

<table>
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<tr>
<th>Measurement period for report</th>
<th>Year 2</th>
<th>Year 3</th>
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#### Medication Management

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<th>Measurement period for report</th>
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<td>2</td>
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<td>2</td>
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</tbody>
</table>

| Domain 4 - Estimated Maximum Incentive Amount | $97,640 | $101,240 | $125,933 |

### Domain 5: Emergency Department

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<tr>
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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
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<td>2</td>
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| Domain 5 - Estimated Maximum Incentive Amount | $97,640 | $101,240 | $125,933 |
### OPTIONAL Domain 6: Children and Adult Core Measures

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td><strong>Initial Core Set of Health Care Quality Measures</strong> for Children in Medicaid and CHIP (24 measures)</td>
<td></td>
</tr>
<tr>
<td>Measurement period for report</td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
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<tr>
<td><strong>Initial Core Set of Health Care Quality Measures</strong> for Medicaid-Eligible Adults (26 measures)</td>
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<tr>
<td><strong>Grand Total Payments Across Category 4</strong></td>
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Category 4 Population-Focused Improvements - Narrative Template (Hospitals only)

Performing Provider Name: CHRISTUS Spohn Hospital – Alice
Performing Provider TPI #: 094222902

Domain 1: Potentially Preventable Admissions (8 measures)
  • Description – Spohn will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Several of Spohn’s Category 1 and Category 2 projects, including the Implementation of a Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs, are designed to provide education and support to hospital patients both during their hospital stay and for the coordination of care post hospitalization. Spohn anticipates that the increased education and support during hospital stays and post hospitalization will result in reduced admissions that can be prevented through either self-management or appropriate follow-up care outside of the hospital. As a result, Spohn anticipates a reduction in potentially preventable readmissions.
  • Valuation
    o Rationale/Justification – The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding which inpatient services which could have been avoided with better information or prevention is essential to addressing the long-term needs of the community. Further, understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving health outcomes and reducing costs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
  • Description – Spohn will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with little follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Spohn anticipates that its Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs will result in improvements in management and coordination of post-hospitalization care, reducing the likelihood of unnecessary readmissions.
  • Valuation
    o Rationale/Justification - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted toward prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates. Analyzing admissions to identify those instances where a breakdown in following-up care occurred is a critical starting point for tracking our improvement toward the goals of improving health outcomes and reducing costs.
Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Spohn will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment and protocols for preventing complications like the measures in this domain; and Spohn is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Several of Spohn’s category 1 and 2 projects are designed to improve the delivery of care within the hospital in order to reduce the likelihood of preventable complications, including the Chronic Disease Registry and Medication Management projects, as well as the nurse redesign project at CHRISTUS Spohn Hospital Corpus Christi. As a result, Spohn anticipates that it will see a demonstrable reduction in PPCs over the course of the Waiver.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and its operating costs. Self-evaluation of Spohn’s hospital services, coupled with understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving patient access and health outcomes while reducing costs of care.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Spohn will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management and honest interactions with practitioners. In turn, patients may experience negative health outcomes and be even more unsatisfied. Spohn is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Spohn is undertaking two separate projects designed to improve medication management to reduce errors in the delivery of medication. Spohn expects improved patient satisfaction in the hospital setting and effective medication management programs for inpatients to correlate with its projects to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). Finally, CHRISTUS Spohn Hospital Corpus Christi’s nurse redesign program will impact patient satisfaction at all Spohn facilities.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Spohn and how well Spohn performs its function of promoting medication management. Spohn is committed to improving patient outcomes, and therefore places a high value on these measures. Understanding our starting point requires diligent tracking of patient satisfaction and patient’s medication management techniques to improve patient access to quality care and reduce costs of care.

Domain 5: Emergency Department (1 measure)
• **Description** – Spohn will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Spohn plans to undertake several projects specifically designed to reduce inappropriate utilization of ED services, which should reduce ED overcrowding, including its primary care clinic and its telehealth project for early detection of peripheral arterial disease and other chronic diseases in primary care settings. Spohn is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold.

• **Valuation**
  o **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. Understanding our starting point and tracking our improvement is essential to making progress.

**Domain 6: Optional Domain: Initial Core Set of Health Care Quality Measures (13 measures)**

• **Description** - Spohn will report on CMS’ Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Spohn is committed to providing quality care to all patients, regardless of ability to pay.

• **Valuation**
  o **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices.
**RHP Plan for Region 4**

<table>
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<th>Category 4: Population-Focused Measures</th>
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**Estimated Maximum Incentive Amount**

| 131,010 | 75,928 |  |

**Domain 1: Potentially Preventable Admissions (PPAs)**

- Planned Reporting Period: 1 or 2
- Domain 1 - Estimated Maximum Incentive Amount

| 75,928 | 81,226 | 88,289 |

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

- Planned Reporting Period: 1 or 2
- Domain 2 - Estimated Maximum Incentive Amount

| 75,928 | 81,226 | 88,289 |

**Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.**

- Planned Reporting Period: 1 or 2
- Domain 3 - Estimated Maximum Incentive Amount

| 81,226 | 88,289 |

**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

- Planned Reporting Period: 1 or 2

| 2 | 2 | 2 |

**Medication Management**

- Planned Reporting Period: 1 or 2

| 2 | 2 | 2 |

- Domain 4 - Estimated Maximum Incentive Amount

| 75,928 | 81,226 | 88,289 |

**Domain 5: Emergency Department**

- Planned Reporting Period: 1 or 2

| 2 | 2 | 2 |

- Domain 5 - Estimated Maximum Incentive Amount

| 75,928 | 81,226 | 88,289 |

**OPTIONAL Domain 6: Children and Adult Core Measures**
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<table>
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<tr>
<td></td>
<td>$75,928</td>
<td>$81,226</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Grand Total Payments Across Category 4</strong></th>
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<tbody>
<tr>
<td></td>
<td>$131,000</td>
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Category 4: Population-Focused Improvements (Hospitals only)
Performing Provider: Yoakum Community Hospital (“YCH”) – TPI 112673204

Domain 1: Potentially Preventable Admissions (PPAs) (8 measures)
- **Description** – YCH will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. YCH expects that its provision of expanded primary and specialty care services through its two Category 1 projects and related Category 3 outcomes will reduce the number of PPAs. Additionally, YCH hopes that its projects will allow for greater patient outreach regarding chronic diseases to enable patients to engage in self-management goals and activities of daily living that are essential to preventing PPAs.

- **Valuation Rationale/Justification** – The value YCH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
- **Description** – YCH will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. YCH expects that the provision of expanded primary and specialty care through its two Category 1 projects and related Category 3 outcomes will allow chronically ill patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. With specific regard to diabetic patients, YCH expects its projects to assist diabetic patients in addressing the short- and long-term complications that led to their hospitalizations, and prevent subsequent relapses. Finally, the expanded availability of clinics in the community will increase the resources available to patients upon discharge from an inpatient stay.

- **Valuation Rationale/Justification** - The value YCH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The
goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Many hospitalizations at YCH can be linked to manageable chronic diseases that YCH intends to address with its project to expand access to primary care.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – YCH will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and YCH is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. YCH expects its Category 1 projects to expand access to primary and specialty care and reducing the strain on hospital resources.

- **Valuation Rationale/Justification** – YCH valued this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and allow for valuable institutional change, both for the hospital’s patients and the operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – YCH will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. YCH is committed to preventing this from happening. Medication management will help YCH engage with patients to avoid readmissions, complications, and promote improved health outcomes. YCH expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with YCH’s Category 1 projects to expand primary and specialty care access because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge.

- **Valuation Rationale/Justification** – YCH valued this domain is based on the value the hospital attributes to understanding how patients perceive the care they receive from YCH and how well YCH performs its function of promoting medication management. YCH is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and
health outcomes. Understanding our starting point and tracking our improvement is essential to making progress in achieving healthy patient outcomes.

Domain 5: Emergency Department (1 measure)

- **Description** – YCH will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic awareness of the overall patient experience in the ED. Patients experience poor health outcomes when their treatment is delayed for any reason. By expanding access to primary and specialty care through Category 1 and 2 projects, YCH hopes to provide better patient outcomes, including in the ED. One cause of extended ED departure times is an overcrowded ED, so YCH’s focus on expanding access to primary care should also reduce the number of inappropriate ED visits, reducing the overall patient time in the ED and improving patient experiences.

- **Valuation Rationale/Justification** - The value YCH placed on this domain is based on the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress in achieving healthy patient outcomes.

Yoakum Community Hospital will not be participating in Domain 6 of Category 4 so funds allotted to this area are limited to 10% of the total DSRIP funds.
### Category 4: Population-Focused Measures

**Yoakum Community Hospital – TPI 112673204**

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<tr>
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<tbody>
<tr>
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<td>$9,693</td>
<td>$9,693</td>
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</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

**Planned Reporting Period:**

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<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

**Planned Reporting Period:**

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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$9,693</td>
<td>$10,369</td>
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</table>

#### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

**Planned Reporting Period:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
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#### Domain 4: Patient Centered Healthcare

**Patient Satisfaction – HCAHPS**

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**Medication Management**

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<td>$9,693</td>
<td>$10,369</td>
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#### Domain 5: Emergency Department

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**Grand Total Payments Across Category 4**

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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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#97922
Category 4 Population-Focused Improvements - Narrative Template (Hospitals only)

Performing Provider Name: CHRISTUS Spohn Hospital – Corpus Christi
Performing Provider TPI #: 121775403

Domain 1: Potentially Preventable Admissions (8 measures)
- **Description** – Spohn will report on 8 measures in this domain to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Spohn plans to implement a Category 1 project to expand access to primary care in the community, which will allow more patients to receive primary care services in a timely and convenient manner, reducing the need for inpatient services and thus reducing PPAs. Spohn plans to coordinate and integrate treatment of primary care and behavioral health in order to reduce the number of preventable admissions for the population with both physician and behavioral health issues. Spohn also plans to implement an early screening and intervention program for individuals in the community with peripheral arterial disease. Spohn believes that early intervention for these individuals will reduce the need for episodes of acute care, thereby also reducing PPAs.

- **Valuation**
  - **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. Understanding which inpatient services which could have been avoided with better information or prevention is essential to addressing the long-term needs of the community. Further, understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving health outcomes and reducing costs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
- **Description** – Spohn will report on the 7 measures in this domain to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with little follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Several of Spohn’s Category 1, 2, and 3 projects will specifically focus on improving follow-up care and/or reducing readmission rates for diabetes patients and mental health patients. Spohn expects that meaningful improvements in PPRs will result from the successful implementation of these projects.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted toward prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates. Analyzing admissions to identify those instances where a breakdown in following-up care occurred is a critical starting point for tracking our improvement toward the goals of improving health outcomes and reducing costs.
Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Spohn will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment and protocols for preventing complications like the measures in this domain; and Spohn is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. In particular, Spohn plans to implement a Category 2 project which will apply rapid-cycle quality improvement techniques to the problem of sepsis, which accounts for a large number of potentially preventable complications in the inpatient setting; Spohn expects that the PPC data to be reported under this reporting domain will be extremely useful in conducting this quality improvement and reducing the incidence of sepsis.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and its operating costs. Self-evaluation of Spohn’s hospital services, coupled with understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving patient access and health outcomes while reducing costs of care.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Spohn will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management and honest interactions with practitioners. In turn, patients may experience negative health outcomes and be even more unsatisfied. Spohn is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. In the inpatient setting, Spohn will be exploring a hospitalist model of care as a means to better coordinate inpatient care around the patient, which Spohn believes will result in greater patient satisfaction and correspondingly improved patient self-management.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Spohn and how well Spohn performs its function of promoting medication management. Spohn is committed to improving patient outcomes, and therefore places a high value on these measures. Understanding our starting point requires diligent tracking of patient satisfaction and patient’s medication management techniques to improve patient access to quality care and reduce costs of care.

Domain 5: Emergency Department (1 measure)

- **Description** – Spohn will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Spohn is committed to reducing its ED admit decision
time to ED departure if it is not within the recommended < 1 hour threshold. Spohn plans to implement a Psychiatric Assessment and Urgent Care Center project, which should improve wait times in the ED by offering a more appropriate and effective delivery model of care for urgent psychiatric patients who might otherwise seek care in an emergent setting.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care.

**Domain 6: Optional Domain:** Initial Core Set of Health Care Quality Measures (8 measures)

- **Description** - Spohn will report on CMS’ Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Spohn is committed to providing quality care to all patients, regardless of ability to pay.

- **Valuation**
  - **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices.
## Category 4: Population-Focused Measures

**CHRISTUS Spohn Hospital – Corpus Christi (121775403)**

<table>
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<tr>
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<td>$1,000,642</td>
<td>$1,070,366</td>
<td>$1,173,080</td>
</tr>
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</table>

### Domain 1: Potentially Preventable Admissions (PPAs)
- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** 2
  - Year 2: $1,000,642
  - Year 3: $1,070,366
  - Year 4: $1,173,080

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)
- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** 2
  - Year 2: $1,000,642
  - Year 3: $1,070,366
  - Year 4: $1,173,080

### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** 2
  - Year 2: $1,000,642
  - Year 3: $1,070,366
  - Year 4: $1,173,080

### Domain 4: Patient Centered Healthcare
#### Patient Satisfaction - HCAHPS
- **Measurement period for report:** Oct. 1-Sept 30
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

#### Medication Management
- **Measurement period for report:** Oct. 1-Sept 30
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

#### Domain 4 - Estimated Maximum Incentive Amount
- Year 2: $1,000,642
- Year 3: $1,070,366
- Year 4: $1,173,080

### Domain 5: Emergency Department
- **Measurement period for report:** Oct. 1-Sept 30
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

#### Domain 5 - Estimated Maximum Incentive Amount
- Year 2: $1,000,642
- Year 3: $1,070,366
- Year 4: $1,173,080

### OPTIONAL Domain 6: Children and Adult Core Measures

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RHP Plan for Region 4 1175
<table>
<thead>
<tr>
<th><strong>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</strong></th>
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<table>
<thead>
<tr>
<th><strong>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</strong></th>
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<tr>
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<td>Domain 6 - Estimated Maximum Incentive Amount</td>
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<td>$1,173,080</td>
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| **Grand Total Payments Across Category 4** | $1,718,627 | $6,003,852 | $6,422,196 | $7,038,480 |

95315
Category 4: Population-Focused Improvements: Driscoll Children’s Hospital [TPI: 132812205]

Domain 1: Potentially Preventable Admissions (8 measures)

Domain Description
Because Driscoll Children’s Hospital is a pediatric facility, reporting measure # 3 Behavioral Health and Substance Abuse Admission Rate and #6 Pediatric Asthma are the only Domain 1 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 1 because all other measures (1.1, 1.2, 1.4, 1.5 and 1.7) apply to populations age 18 and above. However, we will provide the reporting data as required. For reporting measure 6, we anticipate Project 1.1 – Expand primary care capacity will have an impact on PPAs for children with asthma and behavioral health and substance abuse admissions. By expanding services through increased hours and the number of patient visits, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospitalization is required. The increase in appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to hospitalization if left undetected. Additionally, the availability of after-hour appointments should reduce the number of children who seek care in an emergency room and who might require admittance due to delays in obtaining timely care.

Domain Valuation and Rationale:
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. As we increase our access to outpatient services for children throughout this region, we will provide services in a more timely and effective manner and will be able to treat patients before their condition becomes critical. By preventing hospital admissions through improved outpatient care, we will not only save money but will also improve the patient’s outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain Description:
Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 2.6 Pediatric Asthma is the only Domain 2 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 2 because all other
measures (RD 2.1, 2.2, 2.3, 2.4, 2.5, and 2.7) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospital readmission is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to a readmission if left undetected.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital readmissions through improved outpatient care, we will not only save money but will also improve the patient’s outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

**Domain 3: Potentially Preventable Complications (64 measures)**
**Domain Description:**
Although many of the measures included in domain 3 are specific to adult care, Driscoll Children’s Hospital is prepared to report on all measures found applicable by the state PPC data. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on many of the measures included in domain 3. However, we will provide the reporting data as required.

We do not anticipate any project impact at this time. However, Driscoll is prepared to report on all non-exempted measurements in an effort to understand the causes of PPCs and make changes to reduce complications within our organization.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. By tracking and reporting PPCs, Driscoll will be required to evaluate its own performance, and will drive organizational change to reduce the potential for complications associated with hospitalization. This will not only reduce cost but will also improve the patient’s outcome and quality of life. Avoiding PPCs also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.
**Domain 4: Patient-Centered Healthcare (2 measures)**

**Domain Description**
Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 4.2 Medication Management is the only Domain 4 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, RD 4.1 patient satisfaction is not applicable to the pediatric population due to HCAHPS requirements. However, we will provide the reporting data as required.

Although Driscoll is exempted from the patient satisfaction measure we are dedicated to improving patient satisfaction whenever possible and recognize the value of tracking and reporting such measures. Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction and medication management would help to increase patient compliance which in time would result in better continuum of care for the patient.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. The valuation is based on a determination that Providing pediatric specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.

**Domain 5: Emergency Department (1 measure)**

**Domain Description:**
Driscoll Children’s Hospital will measure the admit decision time to ED departure time for admitted patients. Driscoll supports a commitment to streamlining the patient transfer process and positively impacting the overall health and well-being of the children we serve. Although none of our projects directly impact the domain 5 measure, Driscoll is committed to improving the patient transfer process.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by streamlining the patient transfer process, and estimated availability of funding. Emergency room use is a high cost service line. The ED is the first contact that many patients have with our hospital. Driscoll Children Hospital ED cares for varying levels of acuity. It is imperative that the throughput is as efficient and effective as possible in order to treat these patients and improve patient flow throughout the system. Reducing the decision time to make the first call from arrival in transferring ED until call initiated the ED creates significant savings and value.
Optional Domain 6: Children and Adult Core Measures (8 measures)
Driscoll Children’s Hospital opts out of this domain
## Category 4: Population-Focused Measures

**Driscoll Children’s Hospital – TPI 132812205**

<table>
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<tr>
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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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<tr>
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<td>$441,009</td>
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### Domain 1: Potentially Preventable Admissions (PPAs)

**Planned Reporting Period:** 2

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<thead>
<tr>
<th><strong>Domain 1 - Estimated Maximum Incentive Amount</strong></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$441,009</td>
<td>$471,649</td>
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### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

**Planned Reporting Period:** 2

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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$441,009</td>
<td>$471,649</td>
<td>$516,617</td>
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### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

**Planned Reporting Period:** 2

<table>
<thead>
<tr>
<th><strong>Domain 3 - Estimated Maximum Incentive Amount</strong></th>
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<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$471,649</td>
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### Domain 4: Patient Centered Healthcare

**Patient Satisfaction - HCAHPS**

Measurement period for report 6 months prior to due date

**Planned Reporting Period:** 2

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<thead>
<tr>
<th><strong>Domain 4 - Estimated Maximum Incentive Amount</strong></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$471,649</td>
<td>$516,617</td>
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**Medication Management**

Measurement period for report 6 months prior to due date

**Planned Reporting Period:** 2

<table>
<thead>
<tr>
<th><strong>Domain 5: Emergency Department</strong></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
<tbody>
<tr>
<td>Measurement period for report</td>
<td>6 months prior to due date</td>
<td>6 months prior to due date</td>
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**Planned Reporting Period:** 2

<table>
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<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$441,009</td>
<td>$471,649</td>
<td>$516,617</td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 2</td>
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<td>2</td>
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<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$441,009</td>
<td>$471,650</td>
<td>$516,617</td>
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</tr>
<tr>
<td><strong>OPTIONAL Domain 6: Children and Adult Core Measures</strong></td>
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</tr>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
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<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
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Category 4 Population-Focused Improvements - Narrative Template (Hospitals only)

Performing Provider Name: CHRISTUS Spohn Hospital – Kleberg
Performing Provider TPI #: 136436606

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Spohn will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Several of Spohn’s Category 1 and Category 2 projects, including the Implementation of a Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs, are designed to provide education and support to hospital patients both during their hospital stay and for the coordination of care post hospitalization. Spohn anticipates that the increased education and support during hospital stays and post hospitalization will result in reduced admissions that can be prevented through either self-management or appropriate follow-up care outside of the hospital. As a result, Spohn anticipates a reduction in potentially preventable readmissions.

- **Valuation**
  - **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding which inpatient services which could have been avoided with better information or prevention is essential to addressing the long-term needs of the community. Further, understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving health outcomes and reducing costs.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Spohn will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with little follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Spohn anticipates that its Chronic Disease Management Registry, Conduct Medicaid Management and Implement/Expand Care Transition Programs will result in improvements in management and coordination of post-hospitalization care, reducing the likelihood of unnecessary readmissions.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted toward prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates. Analyzing admissions to identify those instances where a breakdown in following-up care occurred is a critical starting point for tracking our improvement toward the goals of improving health outcomes and reducing costs.
Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Spohn will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment and protocols for preventing complications like the measures in this domain; and Spohn is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Several of Spohn’s category 1 and 2 projects are designed to improve the delivery of care within the hospital in order to reduce the likelihood of preventable complications, including the Chronic Disease Registry and Medication Management projects, as well as the nurse redesign project at CHRISTUS Spohn Hospital Corpus Christi. As a result, Spohn anticipates that it will see a demonstrable reduction in PPCs over the course of the Waiver.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and its operating costs. Self-evaluation of Spohn’s hospital services, coupled with understanding our starting point and tracking our improvement is essential to making progress toward the goals of improving patient access and health outcomes while reducing costs of care.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Spohn will report on Patient Satisfaction and Medication Management for this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management and honest interactions with practitioners. In turn, patients may experience negative health outcomes and be even more unsatisfied. Spohn is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Spohn is undertaking two separate projects designed to improve medication management to reduce errors in the delivery of medication. Spohn expects improved patient satisfaction in the hospital setting and effective medication management programs for inpatients to correlate with its projects to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). Finally, CHRISTUS Spohn Hospital Corpus Christi’s nurse redesign program will impact patient satisfaction at all Spohn facilities.

- **Valuation**
  - **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Spohn and how well Spohn performs its function of promoting medication management. Spohn is committed to improving patient outcomes, and therefore places a high value on these measures. Understanding our starting point requires diligent tracking of patient satisfaction and patient’s medication management techniques to improve patient access to quality care and reduce costs of care.

Domain 5: Emergency Department (1 measure)
• **Description** – Spohn will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Spohn plans to undertake several projects specifically designed to reduce inappropriate utilization of ED services, which should reduce ED overcrowding, including its primary care clinic and its telehealth project for early detection of peripheral arterial disease and other chronic diseases in primary care settings. Spohn is committed to reducing its ED admit decision time to ED departure if it is not within the recommended < 1 hour threshold.

• **Valuation**
  o **Rationale/Justification** - The value Spohn placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. Understanding our starting point and tracking our improvement is essential to making progress.

**Domain 6: Optional Domain:** Initial Core Set of Health Care Quality Measures (13 measures)

• **Description** - Spohn will report on CMS’ Initial Core Set of Measures for Adults and Children in Medicaid/CHIP. These measures are important because the overarching goal of delivery system reform is to improve the quality of care provided to members of the community who are often underserved, including indigent children and adults. Spohn is committed to providing quality care to all patients, regardless of ability to pay.

• **Valuation**
  o **Rationale/Justification** – The value Spohn placed on this domain is based upon the value the hospital attributes to providing quality care to patients and maintaining a level of consistency in its provision of care. Medicaid and CHIP participants make up a large portion of the consumers of healthcare, and therefore the quality of care provided to this population is indicative of systemic practices.
## Category 4: Population-Focused Measures

**CHRISTUS Spohn Hospital – Kleberg**

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
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<tr>
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<td>$48,801</td>
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### Domain 1: Potentially Preventable Admissions (PPAs)

**Planned Reporting Period:** 1 or 2

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<th>Domain 1 - Estimated Maximum Incentive Amount</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tbody>
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<td></td>
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<td>$52,206</td>
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</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

**Planned Reporting Period:** 1 or 2

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<tbody>
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<td></td>
<td>$48,801</td>
<td>$52,206</td>
<td>$56,746</td>
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### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.

**Planned Reporting Period:** 1 or 2

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<th>Domain 3 - Estimated Maximum Incentive Amount</th>
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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$52,206</td>
<td>$56,746</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 4: Patient Centered Healthcare

#### Patient Satisfaction - HCAHPS

- **Measurement period for report:** Oct. 1 – Sept 30
- **Planned Reporting Period:** 1 or 2

<table>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tbody>
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#### Medication Management

- **Measurement period for report:** Oct. 1 – Sept 30
- **Planned Reporting Period:** 1 or 2

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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### Domain 4 - Estimated Maximum Incentive Amount

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tbody>
<tr>
<td>$48,801</td>
<td>$52,206</td>
<td>$56,746</td>
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</table>

### Domain 5: Emergency Department

- **Measurement period for report:** Oct. 1 – Sept 30
- **Planned Reporting Period:** 1 or 2

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### Domain 5 - Estimated Maximum Incentive Amount

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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
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<tr>
<td>Amount</td>
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<tr>
<td><strong>OPTIONAL Domain 6: Children and Adult Core Measures</strong></td>
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<tr>
<td><strong>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</strong></td>
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<tr>
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<tr>
<td><strong>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</strong></td>
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</tr>
<tr>
<td>Measurement period for report</td>
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D. Category 4: Population-Focused Improvements (Hospitals only)

Project Identification Number: 137907508.4

Domain 1 – Potential Preventable Admissions (PPAs)
Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
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<tr>
<td>1.1 – Expand Primary Care Capacity</td>
<td>2.8 – Apply Process Improvement Methodology to Improve Quality / Efficiency</td>
<td>IT – 2.5 COPD Admission Rate – PQI 5 (Standalone measure) IT – 2.6 Adult Asthma Admission – PQI 15 (Standalone measure)</td>
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Category 1 focuses on the expansion of primary care services, whereby patients and their families will have access to preventive care. This in turn will facilitate the reduction of unnecessary hospitalizations for those disease conditions which are prevalent in Victoria and the region.

In Texas, potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse in the following medical conditions:

- Chronic Obstructive Pulmonary Disease (COPD) – 44.4% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- Asthma – 37.0% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- Urinary Tract Infection (UTI) – 36.1% of patients admitted to a hospital had a secondary diagnosis of mental illness/substance abuse; and
- Bacterial Pneumonia – 32.5% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse (Texas Health and Human Services Commission, 2012).

NOTE: Citizens Medical Center will establish baseline data in Year 3 specific to our population. In reference to PPAs, Category 2 focuses on the implementation of the Process Improvement methodology Lean which will facilitate organizational activities to optimize safety, quality, patient experience, efficiency, and patient flow while eliminating waste and redundancies. By incorporating this methodology, it is anticipated that the diseases determined by the baseline data mining in Year 3 will have an overall decreased admission rate to the hospital.

Category 3 directly addresses PPA IT – 2.5 Chronic Obstructive Pulmonary. This diagnosis will be monitored to establish baseline admission data followed by continued measurement through Year 5 to observe for projected admission decreases.
Valuation:
It is the expectation that the expansion of primary care services through collaboration with a Federally Qualified Health Clinic owned by Community Health Centers of South Central Texas will facilitate at least a 5% improvement by Year 5 from baseline data for the aforementioned diagnoses. Calculations based on current data supports a projected savings of $2,425,737 over a four (4) year period ($21,736 per diagnosis x total case volume of 2,232 x 5.0%).

Project Identification Number: 137907508.4
Domain 2 – Potentially Preventable Readmissions (PPRs)
Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2.8 – Apply Process Improvement Methodology to Improve Quality / Efficiency</td>
<td>IT 5.1 – Improved cost savings</td>
<td>IT 9.2 – Emergency Department appropriate utilization</td>
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The Category 2 narrative section on Project Valuation provides evidence of reduced readmission rates for COPD “…disease patients by 48% at UPMC St. Margaret Hospital, Pennsylvania…” through the use of Lean methodology in healthcare. It is anticipated that the application of the Lean methodology at Citizens Medical Center will also be instrumental in decreasing the facility’s COPD readmission rate and costs. In addition, improved access to primary care services through FQHC will improve appropriate utilization of the ED.

Valuation:
It is foreseen that any reduction in readmissions in any population will result in cost savings and appropriate utilization of resources. The baseline goal will be determined by opportunity analysis / needs assessment results.

Project Identification Number: 137907508.4
Domain 3 – Potentially Preventable Complications (PPCs)
Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
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<tbody>
<tr>
<td></td>
<td>2.8 – Apply Process Improvement Methodology to Improve Quality / Efficiency</td>
<td>IT 4.8 Sepsis Mortality (Stand-alone measure)</td>
<td>IT 5.1 Improved Cost Savings</td>
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</table>
The implementation of *Lean* methodology described in *Category 2* will be instrumental in the improvement of patient care and safety, the reduction of hospital-acquired conditions, and increased staff efficiency through the promotion of evidence based medical and nursing practice at the facility.

*Category 3* focuses on multiple quality outcome measures and specifically on Sepsis Mortality (#35 on PPC list) as a potentially preventable condition / healthcare acquired condition. As noted in the *Category 3* narrative, research on sepsis reveals that there is a wide variation in healthcare practice in different geographical areas which have not kept in pace with the evolving science of healthcare to ensure evidence based practice. Treatment for sepsis is an example of how variation in healthcare can be reduced; this, in turn, will have an effect on mortality. Citizens Medical Center aspires to reduce the sepsis mortality rate by utilizing the nationally recommended “Bundle” concept included in the Surviving Sepsis Campaign which is a global initiative. It is anticipated that a Lean Consultant will merge cost saving activities with patient outcome improvement measures while retained. As noted above, a focus on sepsis mortality and the implementation of evidence based sepsis order sets will both decrease the mortality rate as well as improve cost savings. This is turn will benefit both the patient and the facility.

**Valuation:**
Based on HealthGrades data regarding the average cost of treating a sepsis patient and the average length of stay for a sepsis patient at Citizens Medical Center, it is projected that $1.8M can potentially be saved over a five (5) year period.

**Project Identification Number:** 137907508.4

**Domain 4 – Patient Centered Healthcare**
Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td>1.1 – Expand Primary Care</td>
</tr>
<tr>
<td>Capacity</td>
</tr>
</tbody>
</table>

Each of the three (3) *Categories (1, 2, and 3)* of this project has been designed to improve patient care and patient satisfaction through the provision of adequate services, adequate hours, adequate resources, and optimal healthcare services reflective of evidence based practice standards. These factors will also have a positive impact receiving the right care in the right setting. Through sustained utilization of the HCAHPS patient satisfaction tools and reports during this project’s subsequent years, Citizens Medical Center will monitor the results and continue to identify opportunities for improvement; appropriate corrective actions will be
developed for the provision of appropriate patient centered care, whereby patient satisfaction will be maintained. A secondary focus of this project is appropriate Medication Management. The Lean methodology will facilitate the redesign and implementation of an improved patient centered medication management program limited to the inpatient setting. This program will promote patient safety through the appropriate prescribing, dispensing, administering, and, in particular, using of prescribed medications upon discharge from the hospital.

Valuation:
Patient satisfaction is a major determinant of return “business” for a healthcare facility and is also a factor which influences reimbursement for services rendered. Applying the efficiency, effectiveness, and safety aspects of the Lean methodology to the medication management process will eliminate numerous non-value steps in the current process which in turn will promote cost savings.

Project Identification Number: 137907508.4
Domain 5 – Emergency Department (ED)
Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 – Expand Primary Care Capacity</td>
<td>2.8 – Apply Process Improvement Methodology to Improve Quality / Efficiency</td>
<td>IT 9.2 – Emergency Department appropriate utilization</td>
</tr>
<tr>
<td>I-X1. Reduce potentially avoidable emergency department visits by 2% through education for specific patient population as identified through primary diagnoses data confirmed in Y2</td>
<td>I-X2. Increase to 3% over baseline the number of patients screened for mental health illness in the following diagnoses: urinary tract infection (UTI), otitis media, and headache</td>
<td>IT 5.1 Improved Cost Savings</td>
</tr>
</tbody>
</table>

Category 1’s purpose in expanding primary care services includes the goal of reducing the number of potentially avoidable visits to the Citizens Medical Center’s emergency department by 2% of patients with a diagnosis of urinary tract infection, otitis media, or headache. Baseline data indicates that these diagnoses are the three (3) most frequently recorded non-emergent ED visits which can actually be cared for in the primary care system. When these same patients arrive in our ED, they will be screened for a secondary diagnosis of mental health illness and, if this diagnosis is potentially present, the patient will be given diagnosis-specific education and
then be directed to the most appropriate primary care setting (FQHC or LMHA) that provides mental health resources for follow-up. This realignment will result in better health outcomes, patient satisfaction, appropriate ED utilization, and reduced cost of services.

A section of the Category 2 project focuses on an annual review to be conducted on the number of ED visits related to the aforementioned three (3) most frequent non-emergent ED diagnoses, as well as COPD and bacterial pneumonia. It is projected that the number of patients screened for mental health illness in the ED will increase by 3% over the baseline number.

A primary goal of the Category 3 plan is to measure the results of strategies identified in Categories 1 and 2. It is anticipated that education of the frequent ED patients will assist them in identifying and accessing those healthcare provider services most appropriate for their care in the future; this, in turn, will promote cost savings and proper provider utilization. In addition, it will promote more timely treatment of those patients presenting to the ED with more serious medical conditions.

**Valuation** - Please see above narrative.

**Project Identification Number:** 137907508.4

**Domain 6 – Children and Adult Core Measures (Optional)**

Performing Provider Name / TPI: Citizens Medical Center / 137907508

<table>
<thead>
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<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
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<tbody>
<tr>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td>1.1 – Expand Primary Care Capacity</td>
</tr>
</tbody>
</table>

It is the intent of Citizens Medical Center to report on **RD-6. Optional Domain: Initial Core Set of Health Care Quality Measures** which will require the collection and submission of data on hospital services provided for children in the Medicaid and CHIP programs, as well as Medicaid eligible adults. In addition, data analysis will be performed with resultant recommendations communicated for corrective actions to be taken related to those measures which indicate opportunities for improvement.

**Valuation:**

The significant values of this reporting domain will be healthcare cost savings, appropriate healthcare utilization, improved patient outcomes, and improved patient satisfaction.
References

## Category 4: Population-Focused Measures

**Citizens Medical Center/137907508**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$174,104</td>
<td>$100,904</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

Planned Reporting Period: 1 or 2

<table>
<thead>
<tr>
<th>Domain 1 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
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<tr>
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<td></td>
<td>$100,904</td>
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### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

Planned Reporting Period: 1 or 2

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<thead>
<tr>
<th>Domain 2 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
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<th>Year 4</th>
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<td></td>
<td>$100,904</td>
<td>$107,945</td>
<td>$117,331</td>
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### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

Planned Reporting Period: 1 or 2

<table>
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<tr>
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<td>$107,944</td>
<td>$117,331</td>
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### Domain 4: Patient Centered Healthcare

#### Patient Satisfaction – HCAHPS

Measurement period for report

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<th>Year 2</th>
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#### Medication Management

Measurement period for report

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<th>Year 2</th>
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### Domain 5: Emergency Department

Measurement period for report

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<th>Year 4</th>
<th>Year 5</th>
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<td>2</td>
<td></td>
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<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
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### OPTIONAL Domain 6: Children and Adult Core Measures

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<th>Value 4</th>
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<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
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<tr>
<td>Measurement period for report</td>
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<tr>
<td>Planned Reporting Period: 1 or 2</td>
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<td></td>
<td></td>
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<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
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<tr>
<td>Measurement period for report</td>
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<td>Planned Reporting Period: 1 or 2</td>
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<td></td>
<td></td>
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<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$100,904</td>
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<tr>
<td>Grand Total Payments Across Category 4</td>
<td>$174,104</td>
<td>$605,424</td>
<td>$647,664</td>
<td>$703,986</td>
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</table>
Section VI. RHP Participation Certifications
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<tr>
<th>Signature</th>
<th>Name</th>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>Annette Rodriguez</td>
<td>Corpus Christi, Nueces County Health District</td>
<td></td>
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<tr>
<td></td>
<td>Andrea Richardson,</td>
<td>Bluebonnet Trails Community</td>
</tr>
<tr>
<td></td>
<td>Executive Director</td>
<td>MHMR Center d/b/a</td>
</tr>
<tr>
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<tr>
<td>Emma C. Garcia</td>
<td>Executive Director</td>
<td>Camino Real Community Services</td>
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</thead>
<tbody>
<tr>
<td>Pamela Robertson</td>
<td>Pamela Robertson</td>
<td>CHRISTUS Spohn Health System Corporation, DBA CHRISTUS Spohn Hospital Kleberg</td>
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<tr>
<td></td>
<td>Dr. Brown</td>
<td>Citizens</td>
</tr>
<tr>
<td></td>
<td>David P. Brown</td>
<td>Citizens Medical Center</td>
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<tr>
<td></td>
<td>Charles Sportsman</td>
<td>Coastal Plains Community Center</td>
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<tbody>
<tr>
<td>Jay Woodall</td>
<td>Jay Woodall</td>
<td>Corpus Christi Medical Center</td>
</tr>
<tr>
<td></td>
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<td>TPI 920973691</td>
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<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darryl Stefka</td>
<td>Cuero Community Hospital</td>
<td></td>
</tr>
</tbody>
</table>
November 7, 2012

Section VI. RHP Participation Certifications

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William R. Blanchard, Chief Executive Officer
DeTar Healthcare System
TPI 094118902
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<tbody>
<tr>
<td></td>
<td>Straub, T.</td>
<td>Driscoll Children's Hospital</td>
</tr>
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</table>
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<tr>
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<th>Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chuck Norris, CEO</td>
<td>Gonzales Healthcare Systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Memorial Hospital)</td>
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<tr>
<td></td>
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<tbody>
<tr>
<td>Bill Jones</td>
<td>Jackson County Hospital District</td>
<td></td>
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<tbody>
<tr>
<td>[Signature]</td>
<td>James E. Vanek</td>
<td>Lavaca Medical Center</td>
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<tbody>
<tr>
<td>Diane Lowrance</td>
<td>Diane Lowrance</td>
<td>MHMR of Nueces County</td>
</tr>
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<tr>
<td>Jonny F. Hipp</td>
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<td>Nueces County Hospital District</td>
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<tbody>
<tr>
<td>David Lee</td>
<td>David Lee</td>
<td>Otto Kaiser Memorial Hospital</td>
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Section VI. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.

By my signature below, I certify the following facts:
- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document;
- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Signature]</td>
<td>Louis R. Wilke</td>
<td>Refugio County Memorial Hospital</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Barber</td>
<td>Karen Barber</td>
<td>Yoakum Community Hospital</td>
</tr>
</tbody>
</table>
Section VII. Addendums
A. Certifications
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 094222902

CHRISTUS Spohn Health System Corporation

On behalf of DBA CHRISTUS Spohn Hospital Alice, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Pamela S. Robertson, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Jim Wells County ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. **Use of Supplemental Payments.**

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. **Agreements with Governmental Entity.**

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

   (1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

   (2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital’s rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Pamela S. Robertson, CEO

Name and Title (print or type)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 094222902

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1. Authorization.

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   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

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   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
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i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

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(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

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a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

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4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

**Signature**

Pamela S. Robertson, CEO

**Name and Title (print or type)**

10/31/12

**Date**
INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (the “Agreement”) is entered into as of the _______ day of ___________, 2012 (the “Effective Date”), by and among Citizens Medical Center (“Citizens”) and the affiliated hospitals listed on Exhibit A (hereafter the “Affiliated Hospitals”).

RECITALS:

WHEREAS, the State’s under-funding of, and reductions in eligibility for, Medicaid increases the volumes of indigent patients who rely on hospital emergency room services as the source of primary healthcare and shifts the burden for indigent care to the Affiliated Hospitals, Citizens, and the local community;

WHEREAS, Citizens and the Affiliated Hospitals desire to ensure that the indigent have access to and receive quality medical and hospital services;

WHEREAS, Citizens and the Affiliated Hospitals recognize that it is in their best interest to increase funding for the Medicaid population and to access federal funding for the indigent to which the Affiliated Hospitals are entitled under the State’s Medicaid program; and

WHEREAS, Citizens and the Affiliated Hospitals recognize that they need to collaborate to ensure their ability to deliver healthcare services to indigent patients in their community;

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 INDIGENT CARE COLLABORATION

1.1 Improving Access to Healthcare for Indigent. Citizens and the Affiliated Hospitals will assess the opportunities to improve access to healthcare for indigent persons residing in the community through participation in the Medicaid program.

2.0 REPRESENTATIONS AND WARRANTIES

2.1 Affiliated Hospitals Representations and Warranties. The Affiliated Hospitals represent and warrant that:

a. Each is a corporation or partnership, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;
b. There is no agreement to condition the amount transferred by Citizens nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospitals have provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospitals' indigent care obligation on the amount transferred by Citizens nor the amount of any Medicaid supplemental payment the Affiliated Hospitals might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospitals; and any escrow, trust, or other funding mechanism utilized in connection with an anticipated intergovernmental transfer ("IGT") from Citizens has been disclosed to the Texas Health and Human Services Commission ("HHSC") and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

e. Citizens has not received and will not receive refunds of payments Citizens made or makes to the Affiliated Hospitals for any purpose in consideration for an IGT by Citizens to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by the Affiliated Hospitals of this Agreement are within the Affiliated Hospitals' powers, are not in contravention of any other instruments governing the Affiliated Hospitals, and have been duly authorized and approved by the Affiliated Hospitals to the extent required by applicable law;

g. Neither the Affiliated Hospitals nor any of their representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of any of the Affiliated Hospitals, or any of their representatives, from participation in the Federal health care programs; and

h. This Agreement has been duly and validly executed by the Affiliated Hospitals.

2.2 **Citizens Representations and Warranties.** Citizens represents and warrants that:

a. It is a county hospital under the laws of the State of Texas, with all requisite power and authority to enter into this Agreement in all respects;
b. There is no agreement to condition the amount transferred by Citizens nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospitals have provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospitals’ indigent care obligation on the amount transferred by Citizens nor the amount of any Medicaid supplemental payment the Affiliated Hospitals might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospitals; and any escrow, trust, or other funding mechanism utilized in connection with an anticipated IGT from Citizens has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

e. Citizens has not received and will not receive refunds of payments Citizens made or makes to the Affiliated Hospitals for any purpose in consideration for an IGT by Citizens to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by Citizens of this Agreement are within Citizens’ powers, are not in contravention of any other instruments governing Citizens, and have been duly authorized and approved by the Board of Directors of Citizens as and to the extent required by applicable law;

g. Neither Citizens nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Citizens or any of its representatives from participation in Federal health care programs;

h. This Agreement has been duly and validly executed by Citizens; and

i. Citizens has public funds eligible to contribute to the non-federal share of Medicaid payments.

3.0 OBLIGATIONS OF THE AFFILIATED HOSPITALS

3.1 Agreement to Collaborate With Citizens. The Affiliated Hospitals agree to work collaboratively with Citizens to improve access to health care for indigent persons.
3.2 **Documentation.** The Affiliated Hospitals agree to provide Citizens documentation that demonstrates the amount and types of health care (including indigent health care and Medicaid services historically provided in the community) as requested by Citizens, but no more frequently than quarterly.

3.3 **Compliance With State and Federal Law.** The Affiliated Hospitals agree to retain qualified professionals to ensure health care is provided in compliance with state and federal charity care laws, anti-trust laws, any other applicable laws, and the Medicare and Medicaid programs.

3.4 **Indigent Care Program Participation.** At all times during the term of this Agreement, the Affiliated Hospitals shall use their best efforts to maintain their qualification for participation in the Medicaid and Medicare programs.

3.5 **Compliance With HIPAA and Access to Records.** To the extent applicable to this Agreement, the Affiliated Hospitals agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, et seq. ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as "HIPAA Requirements." The Affiliated Hospitals agree not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, the Affiliated Hospitals agree to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, the Affiliated Hospitals shall make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. The Affiliated Hospitals will also indemnify and hold Citizens harmless if any amount of reimbursement is denied or disallowed because of the Affiliated Hospitals’ failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties, and legal costs. If the Affiliated Hospitals carry out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospitals agree to include this requirement in any such subcontract.
This section is included pursuant to, and is governed by the requirements of, 42 U.S.C. § 1395x(v)(1) and the regulations thereeto.

4.0 OBLIGATIONS OF CITIZENS

4.1 Agreement to Collaborate With the Affiliated Hospitals. Citizens agrees to work collaboratively with the Affiliated Hospitals to improve access to health care for indigent persons.

4.2 No Condition on Medicaid Funding. Citizens agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective indigent care.

4.3 Retrospective Evaluation of Services. Citizens may retrospectively evaluate the amount and impact of the Affiliated Hospitals' indigent care delivery and can rely on such historical information in determining whether and to what degree it will provide an IGT in the future.

4.4 Documents Publicly Available. Citizens agrees to make publicly available any documentation utilized in connection with IGTs of funds.

4.5 Use of Public Funds. To the extent Citizens decides to provide funding for Medicaid supplemental payments, Citizens agrees to use public funds eligible for such funding.

4.6 Compliance With State and Federal Law. Citizens agrees to engage qualified professionals to ensure health care is provided in compliance with applicable laws and the Medicare and Medicaid programs.

4.7 Compliance With HIPAA and Access to Records. Citizens agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, et seq. (“HIPAA”), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as "HIPAA Requirements." Citizens agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Citizens agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, and security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General, or any of their duly
authorized representatives, Citizens shall make available those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services.

5.0 GENERAL PROVISIONS

5.1 Term and Termination. The term of this Agreement shall be one year from the Effective Date and shall automatically continue thereafter for additional terms of one year unless the parties agree otherwise; provided, however, that this Agreement shall terminate immediately upon written notice by either Citizens or the Affiliated Hospitals to the other party.

5.2 Notices. All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

Citizens: Citizens Medical Center 2701 Hospital Dr. Victoria, TX 77901 (361) 572-5113 Attention: David P. Brown Administrator dbrown@cmcvtx.org

Affiliated Hospitals: Memorial Hermann Hospital System 929 Gessner Road, Suite 2700 Houston, Texas 77024 (713) 242-2700 Attention: Daniel J. Wolterman President and Chief Executive Officer dan.wolterman@memorialhermann.org

With a Copy to: James E. Gjerset Gjerset & Lorenz, LLP 2801 Via Fortuna, Suite 500 Austin, Texas 78746 (512) 899-3995 gjerset@gl-law.com

5.3 Relationships Between the Parties. The relationship between Citizens and the Affiliated Hospitals is solely a contractual relationship between independent contractors. No party hereto is an agent or employee of any other party. Nothing in this Agreement shall prevent any affiliation or contracting by any party with any third party, with the exception that no party may contract or affiliate with
another party to gain entitlement to Medicaid supplemental payments pursuant to this Agreement.

5.4 **Governing Law.** This Agreement shall be governed by the laws of the State of Texas. The Affiliated Hospitals understand that Citizens is owned by a political subdivision of the State of Texas and governed by certain statutes applicable thereto.

5.5 **Assignment.** No party may assign any right, obligation, or responsibility under this Agreement except to a successor in interest.

5.6 **No Third-Party Beneficiary.** The parties to this Agreement do not intend to establish any third-party beneficiary relationships by virtue of this Agreement.

[Remainder of Page Intentionally Left Blank]
IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set forth above.

CITIZENS:  

CITIZENS MEDICAL CENTER

By: [Signature]
Name: [David P. Brown]
Title: CEO

AFFILIATED HOSPITALS: MEMORIAL HERMANN HOSPITAL SYSTEM

By: [Signature]
Daniel J. Wolterman
President and Chief Executive Officer
IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set forth above.

CITIZENS:  

CITIZENS MEDICAL CENTER

By:

Name: __________________________
Title: __________________________

AFFILIATED HOSPITALS: MEMORIAL HERMANN HOSPITAL SYSTEM

By: __________________________
Daniel J. Wolterman
President and Chief Executive Officer

95088
### EXHIBIT A

<table>
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<td><strong>MEMORIAL HERMANN MEMORIAL CITY HOSPITAL</strong></td>
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HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of ____________________________, a ____________________________ county hospital
organized under the laws of the State of Texas (hereinafter referred to as “the Governmental Entity”), I, ____________________________, affirm and certify the following:

1. Legal Authorization.

   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");

   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.

   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;

   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
a. Consistent with its constitutional, statutory, and fiduciary obligations, the
Governmental Entity may evaluate a private hospital’s historical experience in
providing indigent care in the community or performance under an Affiliation
Agreement including the impact and amount of indigent care provided by the
hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an
   Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will
    supply an IGT, provided such decision does not include consideration of
    matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited
    the community and whether its continued participation in the indigent
    care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the
   Governmental Entity’s mission and provide an appropriate and
   constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of
    this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above
statements; that the statements are true, correct, and complete; and that I am authorized to bind
the Governmental Entity and to certify to the above.

Signature

Date

Official Seal
(If applicable)

David Brown, Chief Executive Officer
Name and Title

95069
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM
CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 137805107

Memorial Hermann Hospital System d/b/a Memorial Hermann Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

   (1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

   (2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

c. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

   i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

   ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

   iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Signature
Daniel J. Wolterman, President
and Chief Executive Officer
Name and Title (print or type)

Date
11/17/2012
On behalf of Memorial Hermann Hospital System, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. Authorization.

a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. Assignment/Assumption of Governmental Entity Obligations.

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. Use of Financial Mechanisms. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital and to certify to the above.

[Signature]

Daniel J. Wolteman, President
and Chief Executive Officer

Name and Title (print or type)

[Date] 11-17-2012
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 146509801

Memorial Hermann Hospital System d/b/a Memorial Hermann Katy Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. **Authorization.**

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. **Assurances and Representations.**

   a. **Validity of Claims.** All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. Assignment/Assumption of Governmental Entity Obligations.

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. Use of Financial Mechanisms. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital’s rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

   On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital and to certify to the above.

   [Signature]

   [Name and Title (print or type)]

   Date: 11-17-2012

   Health & Human Services Commission
   Hospital Certification

1115 Demonstration Waiver Program
Version 2012-1 (09/05/2012)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 020934801

Memorial Hermann Hospital System d/b/a Memorial Hermann Medical City Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. *Use of Supplemental Payments.*

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. *Agreements with Governmental Entity.*

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. Assignment/Assumption of Governmental Entity Obligations.

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. Use of Financial Mechanisms. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital’s rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Signature: ___________________________ Date: ___________________________

Daniel J. Wolterman, President
and Chief Executive Officer

Name and Title (print or type):

95073
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 192751901

Memorial Hermann Hospital System d/b/a Memorial Hermann Northeast, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. **Authorization.**

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. **Assurances and Representations.**

   a. **Validity of Claims.** All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

   (1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

   (2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

   i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

   ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

   iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

   On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital and to certify to the above.

   [Signature]

   Daniel J. Wolterman, President
   and Chief Executive Officer

   Name and Title (print or type)

   [Date] 11-17-2012

   Health & Human Services Commission
   Hospital Certification

   1115 Demonstration Waiver Program
   Version 2012-1 (09/03/2012)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 146021401

Memorial Hermann Hospital System d/b/a Memorial Hermann Sugar Land Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Daniel J. Wolterman, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Citizens Medical Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

c. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Signed: Daniel J. Wollerman, President and Chief Executive Officer  
Name and Title (print or type)  

Date: 11-17-2012
NUECES COUNTY INDIGENT CARE AFFILIATION AGREEMENT

This Nueces County Indigent Care Affiliation Agreement (the "Agreement") is entered into as of the 1st day of October, 2012 ("Effective Date"), by and between Nueces County Hospital District ("District"), and Driscoll Children’s Hospital ("Hospital").

RECITALS:

WHEREAS, reductions in reimbursement under the Medicaid program and the growing uninsured population have created a gap between the costs Hospital incurs for treating Medicaid patients and the Indigent and the reimbursement Hospital actually receives;

WHEREAS, the District and Hospital recognize that the Indigent numbers in Nueces County and other counties in the Region will continue to increase, and that the burden of providing Health Care Services to the Indigent will continue to shift to the Hospital, District and local communities in Nueces County and other counties in the Region;

WHEREAS, the District is empowered by the Chapter 281 of the Texas Health and Safety Code and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code (as amended from time to time, the “Indigent Health Care Act”), to enter into contracts relating to or arranging for the provision of Health Care Services;

WHEREAS, District and Hospital desire to collaborate to ensure the Indigent have access to and receive quality Health Care Services;

WHEREAS, District and Hospital recognize that it is in the best interest of all to increase funding for the Medicaid population and to access federal funding for the Indigent to which the Hospital will be entitled under the current Texas Medicaid Section 1115 Waiver ("Waiver");

WHEREAS, the Waiver requires providers to work collectively and collaboratively to develop and submit a regional plan for health care delivery system reform through the formation of Regional Healthcare Partnerships ("RHPs");

WHEREAS, these RHPs are to be based on regions determined by the Texas Health and Human Services Commission ("HHSC");

WHEREAS, funds to finance the Waiver may be provided by public hospital Districts and other units of government through intergovernmental transfers ("IGTs");

WHEREAS, District and Hospital recognize that they need to collaborate to ensure their ability to deliver Health Care Services;
WHEREAS, Hospital desires to participate with the District and other entities to join in an affiliation with the District for purposes of forming an RHP; and

WHEREAS, the Waiver is intended to effect reform and improvement of healthcare delivery systems in four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) population-focused improvement and (4) clinical improvements in care.

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 PURPOSE

1.1 "Charity Care" means the provision of hospital services to the uninsured, as well as services defined by Texas Health and Safety Code §311.031(2).

1.2 "Health Care Services" means those services necessary to enhance the delivery of health care to the Indigent, as defined in Section 1.4 of this Agreement.

1.3 "HHSC" means the Texas Health and Human Services Commission.

1.4 "Indigent" means any person who meets (i) the income and other guidelines established for participation in the Texas Medicaid program, (ii) the income and other guidelines established for participation in the Children's Health Insurance Program ("CHIP"), (iii) the income and other guidelines established in the Nueces County Hospital Indigent Care Program Handbook for participation in the District's Indigent Health Care Program, (iv) the income and other guidelines established for participation in an indigent care program of a county or other hospital district in accordance with the Indigent Health Care Act, or (v) the income and other guidelines to qualify as "financially indigent" or "medically indigent" under Section 311.031 of the Texas Health and Safety Code.

1.5 "Indigent Care" means treatment, services and education concerning the inpatient and outpatient hospital and medical professional needs of the Indigent, including both the performance of services and the provision for services.

1.6 "IGT" means intergovernmental transfer.

1.7 "Waiver" means the Section 1115 Demonstration Waiver for the Texas Healthcare Transformation and Quality Improvement Program.

1.8 "Waiver Payments" means any Medicaid payments received by Hospital in accordance with the Waiver Program.
1.9 “Public Funds” means public revenue, generated by the District, which the District may transfer in part to HHSC through IGTs to serve as the non-federal share of Waiver Payments.

1.10 “Region” means the HHSC designated RHP Region 4 that includes the following counties: Aransas County, Bee County, Brooks County, DeWitt County, Duval County, Goliad County, Gonzales County, Jackson County, Jim Wells County, Karnes County, Kenedy County, Kleberg County, Lavaca County, Live Oak County, Nueces County, Refugio County, San Patricio County, and Victoria County.

2.0 PURPOSE

The purpose of this Agreement is to memorialize District’s and Hospital’s agreement to collaborate with the other and other RHP members to improve access of Indigents to quality Health Care Services, reduce health care costs, improve the health of populations, transform the health care delivery system, and facilitate Hospital’s participation in the Waiver pursuant to Title 1 of the Texas Administrative Code Section 355.8201(e)(1)(C).

3.0 REPRESENTATIONS AND WARRANTIES

3.1 Hospital’s Representations and Warranties. Hospital represents and warrants that:

a. Hospital is a Texas non-profit corporation, duly established and created pursuant to applicable laws with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the Public Funds transferred by District or the amount of Waiver Payments on the amount of Indigent Care Hospital has provided or will provide to the Indigent;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount of Public Funds transferred by District or the amount of any Waiver Payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District will be disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;

e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT that the District may make to fund Hospital’s Waiver Payments;
f. To the best of Hospital's knowledge, Hospital has complied and will continue to comply with all requirements of HHSC's Waiver Certification of Hospital Participation;

g. The execution, delivery, and performance by Hospital of this Agreement are within Hospital’s powers, are not in contravention of any other instruments governing Hospital, and have been duly authorized and approved by Hospital as and to the extent required by applicable law;

h. Neither Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Hospital, or any of its representatives from participation in Federal health care programs; and

i. This Agreement has been duly and validly executed by Hospital.

3.2 District Representations and Warranties. District represents and warrants that:

a. District is a unit of local government and more specifically a county hospital District, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by District or the amount of Medicaid Waiver payments on the amount of Indigent Care Hospital has provided or will provide;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount transferred by District or the amount of any Medicaid Waiver payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;
e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT District may make to fund Medicaid Waiver payments;

f. To the best of District’s knowledge, District has complied and will continue to comply with HHSC’s Waiver Certification of Government Entity Participation;

g. The execution, delivery, and performance by District of this Agreement are within District’s powers, are not in contravention of any other instruments governing District and have been duly authorized and approved by District as and to the extent required by applicable law;

h. Neither District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of District, or any of its representatives from participation in Federal health care programs; and

i. Notwithstanding anything in this Agreement to the contrary, any decision by District to provide funding for the Medicaid program for or on behalf of Hospital is at its sole discretion and subject to the appropriation of sufficient funds by District.

4.0 RESPONSIBILITIES AND OBLIGATIONS OF HOSPITAL

4.1 Agreement to Collaborate with District. Hospital agrees to work collaboratively with District and other RHP members to improve access to and the quality of healthcare, reduce health care costs, improve the health of populations and transform the healthcare delivery system.

4.2 Provision of Indigent Care. Hospital agrees to provide Health Care Services to the Indigent.

4.3 Documentation. Hospital agrees to provide District documentation at regular intervals, but not less often than quarterly, that demonstrates the amount and types of Health Care Services provided by the Hospital to the Indigent.

4.4 Compliance with State and Federal Law. Hospital will assure that health care is provided in compliance with state and federal Charity Care laws, anti-trust laws, any other applicable laws, and the requirements for participation in the Medicare and the Medicaid programs.
4.5 **Indigent Care Program Participation.** At all times during the term of this Agreement, Hospital shall use its best efforts to maintain its qualification for participation in the Medicaid and Medicare programs.

4.6 **Compliance with HIPAA and Access to Records.** To the extent applicable to this Agreement, Hospital agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d *et seq.* ("HIPAA") and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time and, all collectively referred to herein as "HIPAA Requirements." Hospital agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Hospital agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. § 1395x(v)(I) and the regulations thereto.

5.0 **RESPONSIBILITIES AND OBLIGATIONS OF THE District**

5.1 **Agreement to Collaborate with Hospital.** District agrees to work collaboratively with Hospital and other members of the RHP to improve access to and the quality of healthcare, reduce healthcare costs, improve the healthcare populations and transform the healthcare delivery system.

5.2 **No Condition on Medicaid Funding.** District agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective Indigent Care.
5.3 **Retrospective Evaluation of Services.** District may retrospectively evaluate the amount and impact of Hospital's Indigent Care delivery and can rely on such historical information in determining whether and to what degree it may provide an IGT in the future.

5.4 **Documents Publicly Available.** District agrees to make publicly available any documentation utilized in connection with any IGTs of funds.

### 6.0 GENERAL PROVISIONS

6.1 **Voluntary Termination.** Any party may terminate this Agreement without reason at any time during the term by providing written notice to all other parties at least thirty (30) days prior to the date of withdrawal.

6.2 **Term and Termination.** The term of this Agreement shall be from the Effective Date through the later of September 30, 2016, or the date the Waiver or any extension thereof is terminated; provided, however, that this Agreement shall terminate immediately in the event that District terminates this Agreement.

6.3 **Notices.** All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

**District:**
Nueces County Hospital District  
555 N. Carancahua St., Suite 950  
Corpus Christi, Texas 78401  
Attention: Administrator  
Telecopy No.: (361) 808-3274  
Telephone No.: (361) 808-3300
with a copy to: William DeWitt Alsup
Alsup and Alsup
555 N. Carancahua St., Suite 1560
Corpus Christi, Texas 78401
Telecopry No.: (361) 884-6000
Telephone No.: (361) 884-6321

and

Gary W. Eiland, Esq.
King & Spalding LLP
1100 Louisiana, Suite 4000
Houston, TX 77002
Telecopry No.: (713) 751-3290
Telephone No.: (713) 751 3207

Hospital: Driscoll Children's Hospital
3533 S. Alameda St.
Corpus Christi, TX 78411
Attention: President/Chief Executive Officer
Telecopry No.: (361) 694-5010
Telephone No.: (361) 694-5021

with a copy to:

6.5 Relationships Among the Parties. Each party to this Agreement is an independent contractor and not an agent, servant, joint enterprise, or employee as to the other parties to the Agreement and unless otherwise specified in this Agreement or another agreement, is responsible for its own acts, omissions, forbearance, negligence and deeds, and for those of its agents or employees in conjunction with the performance of services covered under this Agreement, and shall be specifically responsible for sufficient supervision and inspection to ensure compliance in every respect with the Agreement requirements. There shall be no contractual relationship between any subcontractor, agent, employee or supplier of Hospital and the District by virtue of this Agreement. The rights and obligations of each of the parties are individual, separate and independent.

6.6 Governing Law. This Agreement shall be governed by the laws of the State of Texas. This Agreement is performable and enforceable in Nueces County, Texas, where the principal office of the District is located, and the state or federal courts in the county shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding as between the parties that may be brought, or arisen out of, in connection with, or by reason of this Agreement. Hospital
understands that the District is a political subdivision of the State of Texas and governed by certain applicable statutes.

6.7 **Assignment or Subcontract.** No party may assign or subcontract any right, obligation, or responsibility under this Agreement except to a successor in interest without the prior written consent of the Anchor Facility.

6.8 **No Third Party Beneficiary.** This Agreement does not confer any right or benefit on any third party and may be enforced solely by the parties.

6.9 **Articles and Other Headings.** The division of this Agreement into articles and sections, and the use of captions and headings, are solely for convenience of reference, and shall have no legal effect in construing the provisions of this Agreement or in governing the rights, obligations, or liabilities of the parties.

6.10 **Multiple Originals.** This Agreement may be executed in one or more counterparts with multiple signature pages, each fully executed copy shall be deemed an original, and all of which together shall constitute one and the same instrument.

6.11 **Amendment or Modification.** This Agreement may only be amended or modified in writing by the mutual agreement of all parties hereto.

**IN WITNESS WHEREOF,** the parties have hereunto set their hand as of the date set forth above.

Nueces County Hospital District

By [Signature]

Jonny F. Hipp, Administrator/CEO

Driscoll Children's Hospital

By [Signature]

Steve Woerner, President and CEO
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION
FOR HOSPITAL AFFILIATES
Version 2012-1 (09/05/2012)
## DOCUMENT HISTORY LOG

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<tr>
<td>Baseline</td>
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<td>Initial version of the Certification of Governmental Entity Participation</td>
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<tr>
<td>Revision</td>
<td>1.1</td>
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<td>Added cover page.</td>
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<td>Added version number (Version 2012-1) and date of issuance to cover page and page footer.</td>
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<tr>
<td>Revision</td>
<td>1.5</td>
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<td>Deleted &quot;Texas&quot; from &quot;Health and Human Services Commission&quot; to reflect agency's statutory name.</td>
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<tr>
<td>Revision</td>
<td>1.6</td>
<td>09/05/2012</td>
<td>Revised paragraph 4.g. to replace &quot;and&quot; at the end of subparagraph ii following the semicolon with &quot;or.&quot;</td>
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1 "Baseline" indicates initial document issuances, "Revision" indicates changes to the Baseline version, and "Cancellation" indicates withdrawn versions.

2 Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., "1.2" refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of ____________, a ____________, organized under the laws of the State of Texas (hereinafter referred to as "the Governmental Entity"), I, ____________, affirm and certify the following:

1. Legal Authorization.
   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");
   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.
   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital’s historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

[Signature]
Jonny F. Hipp, Administrator/CEO
Name and Title

10-18-2012
Date
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 1328122-05

On behalf of Driscoll Children's Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Steve Woerner, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between Nueces County Hospital District ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital’s rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Signature

Steve Woerner, President & CEO

Name and Title (print or type)

______________________________
Signature

October 1, 2012

Date
The certifications enumerated below represent material facts upon which DSHS relies when reporting information to the federal government required under federal law. If the Department later determines that the Contractor knowingly rendered an erroneous certification, DSHS may pursue all available remedies in accordance with Texas and U.S. law. Signer further agrees that it will provide immediate written notice to DSHS if at any time Signor learns that any of the certifications provided for below were erroneous when submitted or have since become erroneous by reason of changed circumstances. **If the Signor cannot certify all of the statements contained in this section, Signor must provide written notice to DSHS detailing which of the below statements it cannot certify and why.**

Did your organization have a gross income, from all sources, of less than $300,000 in your previous tax year? □ Yes ☑ No

If your answer is "Yes", skip questions "A", "B", and "C" and finish the certification. If your answer is "No", answer questions "A" and "B".

---

**A. Certification Regarding % of Annual Gross from Federal Awards.**
Did your organization receive 80% or more of its annual gross revenue from federal awards during the preceding fiscal year? □ Yes ☑ No

If your answer is "Yes" to both question "A" and "B", you must answer question "C". If your answer is "No" to either question "A" or "B", skip question "C" and finish the certification.

---

**B. Certification Regarding Amount of Annual Gross from Federal Awards.**
Did your organization receive $25 million or more in annual gross revenues from federal awards in the preceding fiscal year? □ Yes ☑ No

---

**C. Certification Regarding Public Access to Compensation Information.**
Does the public have access to information about the compensation of the senior executives in your business or organization (including parent organization, all branches, and all affiliates worldwide) through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986? □ Yes □ No

If your answer is "Yes" to this question, where can this information be accessed?

---
If your answer is "No" to this question, you must provide the names and total compensation of the top five highly compensated officers below. For example:

John Blum: $500000; Mary Redd: $50000; Eric Gant: $400000; Todd Platt: $300000; Sally Tom: $300000

Provide compensation information here:

As the duly authorized representative (Signor) of the Contractor, I hereby certify that the statements made by me in this certification form are true, complete and correct to the best of my knowledge.

<table>
<thead>
<tr>
<th>Printed Name of Authorized Representative:</th>
<th>Signature of Authorized Representative:</th>
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<tr>
<td>Margaret L Hayes, CPA</td>
<td></td>
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<th>Title of Authorized Representative:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Nueces County Auditor</td>
<td>5-16-2012</td>
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<tr>
<th>Legal Name of Contractor:</th>
<th>FFATA Contact #1 Email Address:</th>
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<tbody>
<tr>
<td>Nueces County</td>
<td><a href="mailto:margaret.hayes@co.nueces.tx.us">margaret.hayes@co.nueces.tx.us</a></td>
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<th>Primary Address of Contractor:</th>
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<tr>
<td>901 Leopard Bm 304</td>
<td><a href="mailto:anna.velazquez@co.nueces.tx.us">anna.velazquez@co.nueces.tx.us</a></td>
</tr>
<tr>
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</table>

| ZIP: 9-digits Required www.usps.com      | State of Texas Comptroller Vendor       |
|------------------------------------------| Identification Number (VIN) (14-digits):|
| 78401 - 3600                             | 1M460005857016                         |
YOAKUM INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (this "Agreement") is entered into as of the 1st day of September, 2008 ("Effective Date"), by and among the Yoakum Hospital District (the "District") and Yoakum Community Hospital (the "Affiliated Hospital").

RECKITALS:

WHEREAS, the Affiliated Hospital and the District collectively provide a significant portion of the uncompensated care to the indigent residents of Lavaca, Dewitt and Gonzales Counties;

WHEREAS, the State’s under-funding of, and reductions in eligibility for, Medicaid increases the volumes of indigent patients who rely on hospital emergency room services as the source of primary healthcare and shifts the burden for indigent care to the District and the local community;

WHEREAS, the Affiliated Hospital and the District desire to ensure the indigent have access to and receive quality medical and hospital services;

WHEREAS, the Affiliated Hospital and the District recognize that it is in the Affiliated Hospital’s best interest to access federal funding for the indigent to which the Affiliated Hospital is entitled under Medicaid supplemental payment principles; and

WHEREAS, the Affiliated Hospital and the District recognize that they need to collaborate to ensure their ability to deliver healthcare services to indigent patients in Lavaca, Dewitt, and Gonzales counties;

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 DEFINITIONS

1.1 "Indigent Care Collaborative" means the collaborative formed by the Affiliated Hospital and the District to assess opportunities to improve indigent care in the community.

2.0 INDIGENT CARE COLLABORATION

2.1 Improving Access to Healthcare for Indigent. The Indigent Care Collaborative will assess the opportunities to improve access to healthcare for indigent persons residing in the community.

2.2 Unanimous Consent Required. The Indigent Care Collaborative may only act with the unanimous consent of its members.
3.0 REPRESENTATIONS AND WARRANTIES

3.1 Affiliated Hospital Representations and Warranties. The Affiliated Hospital represents and warrants:

a. It is a corporation, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. That there is no agreement to condition the amount transferred by the District nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospital has provided or will provide;

c. That there is no agreement to condition the amount of the Affiliated Hospital's indigent care obligation on the amount transferred by the District nor the amount of any Medicaid supplemental payment the Affiliated Hospital might receive;

d. That no escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital, and that any escrow, trust or other funding mechanism utilized in connection with an anticipated intergovernmental transfer ("IGT") from the District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. That the District has not received and will not receive refunds of payments the District made or makes to the Affiliated Hospital for any purpose in consideration for an IGT by the District to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by the Affiliated Hospital of this Agreement are within the Affiliated Hospital's powers, and are not in contravention of any other instruments governing the Affiliated Hospital and have been duly authorized and approved by the Affiliated Hospital to the extent required by applicable law;

g. Neither the Affiliated Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; or (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of the
Affiliated Hospital or any of its representatives from participation in the Federal health care programs; and

h. This Agreement has been duly and validly executed by the Affiliated Hospital.

3.2 **District Representations and Warranties.** The District represents and warrants:

a. It is a body politic and a political subdivision of the State of Texas, duly established and created pursuant to Article IX, Section 9 of the Texas Constitution and Chapter 317, Acts of the 59th Legislature, Regular Session, 1965 with all requisite power and authority to enter into this Agreement in all respects;

b. That there is no agreement to condition the amount transferred by the District nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospital has provided or will provide;

c. That there is no agreement to condition the amount of the Affiliated Hospital’s indigent care obligation on the amount transferred by the District nor the amount of any Medicaid supplemental payment the Affiliated Hospital might receive;

d. That no escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital, and that any escrow, trust or other funding mechanism utilized in connection with an anticipated IGT from the District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. That the District has not received and will not receive refunds of payments the District made or makes to the Affiliated Hospital for any purpose in consideration for an IGT by the District to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by the District of this Agreement are within the District’s powers, are not in contravention of any other instruments governing the District and have been duly authorized and approved by the District Board as and to the extent required by applicable law;

g. Neither the District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred,
or otherwise declared ineligible to participate in the Federal health care programs; or (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of the District, or any of its representatives from participation in Federal health care programs;

h. This Agreement has been duly and validly executed by the District; and

i. The District receives ad valorem tax revenues from property owners.

4.0 OBLIGATIONS OF THE AFFILIATED HOSPITAL

4.1 Agreement to Collaborate with the District. The Affiliated Hospital agrees to work collaboratively with the District to improve access to healthcare for indigent persons.

4.2 Documentation. The Affiliated Hospital agrees to provide the District documentation that demonstrates the amount and types of health care (including indigent health care and Medicaid services historically provided in the community) as requested by the District, but no more frequently than quarterly.

4.3 Compliance with State and Federal Law. The Affiliated Hospital agrees to retain qualified professionals to ensure health care is provided in compliance with state and federal charity care laws, anti-trust laws, any other applicable laws, and the Medicare and Medicaid programs.

4.4 Indigent Care Program Participation. At all times during the term of this Agreement, the Affiliated Hospital shall use its best efforts to maintain its qualification for participation in the Medicaid and Medicare programs.

4.5 Compliance with HIPAA and Access to Records. To the extent applicable to this Agreement, the Affiliated Hospital agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, et seq. (“HIPAA”), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the “Federal Privacy Regulations”), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the “Federal Security Regulations”), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the “Federal Electronic Transaction Regulations”), all as amended from time to time, and all collectively referred to herein as “HIPAA Requirements.” The Affiliated Hospital agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, the Affiliated Hospital agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.
As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the Affiliated Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. The Affiliated Hospital will also indemnify and hold the District harmless if any amount of reimbursement is denied or disallowed because of the Affiliated Hospital’s failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties and legal costs. If the Affiliated Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by the requirements of, 42 U.S.C. § 1395x(v)(1) and the regulations thereeto.

5.0 OBLIGATIONS OF THE DISTRICT

5.1 Agreement to Collaborate with the Affiliated Hospital. The District agrees to work collaboratively with the Affiliated Hospital to improve access to health care for indigent persons.

5.2 No Condition on Medicaid Funding. The District agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective indigent care.

5.3 Retrospective Evaluation of Services. The District may retrospectively evaluate the amount and impact of the Affiliated Hospital’s indigent care delivery and can rely on such historical information in determining whether and to what degree it will provide an IGT and/or set aside government funds in an escrow account in the future.

5.4 Documents Publicly Available. The District agrees to make publicly available any documentation utilized in connection with intergovernmental transfers of funds.

5.5 Use of Ad Valorem Tax Revenues. To the extent the District decides to provide funding for the Medicaid upper payment limit program, the District agrees to use its ad valorem tax revenues for such funding.

5.6 Compliance with State and Federal Law. The District agrees to engage qualified professionals to ensure health care is provided in compliance with applicable laws and the Medicare and Medicaid programs.

5.7 Compliance with HIPAA and Access to Records. The District agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as
codified at 42 U.S.C. Section 1320d, et seq. ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as “HIPAA Requirements.” The District agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, the District agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the District shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services.

6.0 GENERAL PROVISIONS

6.1 Term and Termination. The term of this Agreement shall be one year from the Effective Date and shall automatically continue thereafter for additional terms of one year unless the parties agree otherwise; provided, however, that this Agreement shall terminate immediately upon written notice by either the District or the Affiliated Hospital to the other party.

6.2 Notices. All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

District: 

YOAKUM HOSPITAL DISTRICT
P. O. Box 452
Yoakum, Texas 77995

With a Copy to:
Coneyetta Gaus Swaney
Gaus, Natho & Swaney, Attorneys
P. O. Box 50
Yoakum, Texas 77995

Affiliated Hospital:

YOAKUM COMMUNITY HOSPITAL
1200 Carl Ramert Drive
Yoakum, Texas 77995
ATTN: Chief Executive Officer
With a Copy to: James E. Gjerset  
GJERSET & LORENZ, LLP  
2801 Via Fortuna, Suite 500  
Austin, Texas  78746

And a Copy to: COMMUNITY HOSPITAL CORPORATION  
7160 Dallas Parkway, Suite 600  
Plano, Texas  75024  
ATTN: Chief Financial Officer

6.3 **Relationships between the Parties.** The relationship between the District and the Affiliated Hospital is solely a contractual relationship between independent contractors. No party hereto is an agent or employee of any other party. Nothing in this Agreement shall prevent any affiliation or contracting by any party with any third party, with the exception that no party may contract or affiliate with another party to gain entitlement to Medicaid supplemental payments pursuant to this Agreement.

6.4 **Governing Law.** This Agreement shall be governed by the laws of the State of Texas. The Affiliated Hospital understands that the District is a political subdivision of the State of Texas and governed by certain statutes applicable thereto.

6.5 **Assignment.** No party may assign any right, obligation, or responsibility under this Agreement except to a successor in interest.

6.6 **No Third Party Beneficiary.** The parties to this Agreement do not intend to establish any third party beneficiary relationships by virtue of this Agreement.

[remainder of page intentionally left blank]
IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set forth above.

DISTRICT:

YOAKUM HOSPITAL DISTRICT

By ____________________________

JIM WITTE, President

AFFILIATED HOSPITAL:

YOAKUM COMMUNITY HOSPITAL

By ____________________________

KAREN BARBER, CEO
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of the Yoakum Hospital District, a Hospital District organized under the laws of the State of Texas (hereinafter referred to as "the Governmental Entity"), I, Gery Maneth, affirm and certify the following:

1. Legal Authorization.
   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");
   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.
   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.

Health & Human Services Commission
Governmental Entity Certification for Hospital Payments

1115 Demonstration Waiver Program
Version 2012-1 (09/05/2012)
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

   i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

   ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

   iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

   i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

   ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital’s historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

Gery Maneth, President
Name and Title

18 Oct 2012
On behalf of Yoakum Community Hospital, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Karen Barber, affirm and certify the following:

1. **Authorization.**

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between the Yoakum Hospital District ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. **Assurances and Representations.**

   a. **Validity of Claims.** All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. *Use of Supplemental Payments.*

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. *Agreements with Governmental Entity.*

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. **Assignment/Assumption of Governmental Entity Obligations.**

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

   (1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

   (2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

   i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

   ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

   iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

Karen Barber, CEO  
Name and Title (print or type)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF
NUECES COUNTY HOSPITAL DISTRICT
AND
CHRISTUS SPOHN HEALTH SYSTEM CORPORATION
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF NUÑESES COUNTY HOSPITAL DISTRICT AND CHRISTUS SPOHN HEALTH SYSTEM CORPORATION

TPI Number: 121775403

On behalf of the Nueces County Hospital District ("District") and CHRISTUS Spohn Health System, a Texas nonprofit corporation, in good standing under the laws of the State of Texas ("Spohn"), we, Jonny F. Hipp, Administrator/CEO of the District, and Pamela S. Robertson, CEO of Spohn, respectively, to the best of our knowledge and belief and after consultation with the Health and Human Services Commission ("HHSC"), affirm and certify the following with respect to any period on or after October 1, 2012:

1. Authorization.

   a. Pursuant to that certain Spohn Membership Agreement ("Membership Agreement") entered into by and among the District, CHRISTUS Health, a Texas nonprofit corporation and Spohn effective as of October 1, 2012, the District and CHRISTUS Health are joint members in Spohn which serves as the public, safety-net hospital in and for Nueces County and surrounding communities.

   b. As a public hospital, Spohn is eligible to receive, and does receive, supplemental Medicaid payments ("Supplemental Payments") from HHSC pursuant to regulations at 1 Tex. Admin. Code§355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Public Adoption and Access.

   a. The governing body of the District approved and adopted the Membership Agreement by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
b. Copies of the Membership Agreement will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.

3. **Funding of Intergovernmental Transfers and Supplemental Payments.**

a. **District Source of Funds.** As a body politic and corporate and a political subdivision of the State of Texas, the District levies and collects ad valorem tax revenue and may generate other public revenue. Pursuant to the Membership Agreement, Spohn transfers a portion of its “net patient revenue” to the District, in the District’s capacity as a member of Spohn, on a weekly basis, where “net patient revenue” excludes any Medicare reimbursement, Medicaid reimbursement, or other federally funded reimbursement. The remaining net patient revenue is transferred by Spohn to CHRISTUS Health, in CHRISTUS Health’s capacity as a member of Spohn. Neither Spohn nor the terms of the Membership Agreement has imposed, nor will impose any limitations on the District’s use of the net patient revenue funds received from Spohn, nor is there any obligation for the District to contribute any specified amount for Supplemental Payments to Spohn or any other hospital.

b. The District may use its discretion to transfer public funds to HHSC via intergovernmental transfer (“IGT”) for use as the non-federal share of Supplemental Payments to Spohn and other hospitals in accordance with the Waiver Program.

4. **Assurances and Representations.**

a. **Use of Supplemental Payments.**

i. No funds derived from any Supplemental Payments received by Spohn have been or will be returned or reimbursed to the District.

ii. No other funds have been used to reimburse the District in consideration of any Supplemental Payments to Spohn.

iii. Neither the District nor Spohn has entered into any contingent fee arrangement regarding its participation in the Waiver Program, and Spohn will not use any of the Supplemental Payments it receives to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.
b. **Agreements with Governmental Entity.**

i. Spohn has not entered and will not enter into any agreement with the District to condition either the amount of the public funds transferred by the District or the amount of Supplemental Payments Spohn receives on the amount of indigent care Spohn has provided or will provide;

ii. Spohn has not entered and will not enter into any agreement with the District to condition the amount of Spohn’s indigent care obligation on either the amount of public funds transferred by the District to HHSC or the amount of Supplemental Payments Spohn may be eligible to receive;

iii. Aside from the various contributions of the District, CHRISTUS Health, and Spohn set forth in the Membership Agreement, including the contributions related to facilities, provision of health care services to the indigent, and sharing of net patient revenue, neither Spohn nor the District is aware of any affiliated hospital or other entity acting on behalf of an affiliated hospital or group of affiliated hospitals that has made or agreed to make cash or in-kind transfers to the District other than transfers and transactions that:

1. Are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the District to a hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Spohn and the District.

c. **Use of Financial Mechanisms.** With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that Spohn or an affiliated hospital provided or will provide;
ii. The District has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of Spohn or any affiliated hospitals.

5. Deferral or Disallowance of Federal Financial Participation.

a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Spohn to HHSC for Supplemental Payments, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Spohn's rights of administrative appeal.

b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.
On behalf of the District and Spohn, whereby certify that we have read and understood the above statements; that the statements are true, correct, and complete; and that we are authorized to bind the District and Spohn, respectively, and to certify to the above.

For the District:

Jonny F. Hipp
Administrator/CEO

[Signature]

Hospital District
Official Seal
(if applicable)

Date

For Spohn:

Pamela S. Robertson
President & CEO

[Signature]

Date

83370
INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (the “Agreement”) is entered into as of November 24, 2012, to be effective as of November 30, 2012 ("Effective Date"), by and between The Texas A&M University System Health Sciences Center, a member of The Texas A&M University System and an agency of the State of Texas ("the Governmental Entity") and Victoria of Texas, L.P. d/b/a DeTar Healthcare System ("Affiliated Hospital"), a Delaware limited partnership located at 506 East San Antonio Street, Victoria, Texas 77901.

RECITALS

WHEREAS, the Affiliated Hospital and the Governmental Entity collectively provide substantial uncompensated care to indigent persons annually;

WHEREAS, reduced funding and eligibility for Medicaid has increased the volumes of indigent patients who rely on hospital emergency room services as the source of primary healthcare and shifted the burden for indigent care to the Affiliated Hospital, the Governmental Entity, and the greater community;

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that there will be continued challenges in funding of the Texas Medicaid program due to future demographic changes and possible increases in the number of indigent patients;

WHEREAS, the Governmental Entity and the Affiliated Hospital desire to ensure that the indigent have access to and receive health care services;

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that it is in their best interest to increase funding for the Medicaid population and to access federal funding for the indigent to which the Affiliated Hospital will be entitled under the State’s Medicaid program; and

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that they need to cooperate to ensure their ability to deliver cost efficient healthcare services to indigent patients in their community;

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 INDIGENT CARE COLLABORATION

1.1 Improving Access to Healthcare for Indigent. The Governmental Entity and the Affiliated Hospital will assess the opportunities to improve access to healthcare for indigent persons residing in the community through participation in the Medicaid program including the Medicaid payments
authorized by the Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver (the “Section 1115 Waiver”).

1.2 Discretion of Governmental Entity to Provide Funding. Notwithstanding anything in this Agreement to the contrary, although the Governmental Entity may provide funding for the Medicaid program, any decision by the Governmental Entity to provide funding for the Medicaid program is at the sole discretion of the Governmental Entity.

2.0 REPRESENTATIONS AND WARRANTIES

2.1 Affiliated Hospital Representations and Warranties. The Affiliated Hospital represents and warrants that:

a. It is a Delaware limited partnership duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition any amounts transferred by the Governmental Entity nor the amount of Medicaid payments received on the amount of indigent care the Affiliated Hospital has provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospital’s indigent care obligation on the amount transferred by the Governmental Entity nor the amount of any Medicaid payment the Affiliated Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital; and that any escrow, trust or other funding mechanism utilized in connection with an anticipated intergovernmental transfer ("IGT") from the Governmental Entity has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. The Affiliated Hospital will not return or refund any Medicaid payments received to the Governmental Entity;

f. No part of any Medicaid payment received under the Section 1115 Waiver program will be used to pay a contingent fee, consulting fee, or legal fee associated with the Affiliated Hospital’s receipt of payments under the Section 1115 Waiver program;

g. The execution, delivery, and performance by the Affiliated Hospital of this Agreement are within the Affiliated Hospital’s powers, are not in contravention of any other instruments governing the Affiliated Hospital and have been duly authorized and approved by the Board of Directors of the Affiliated Hospital as and to the extent required by applicable law;
h. Neither the Affiliated Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) (the “federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the federal health care programs; or (iii) under investigation or otherwise aware of any circumstance which may result in the exclusion of the Affiliated Hospital or any of its representatives from participating in federal health care programs; and

i. This Agreement has been duly and validly executed and delivered by the Affiliated Hospital.

2.2 **Governmental Entity Representations and Warranties.** The Governmental Entity represents and warrants that:

a. It is a member of The Texas A&M University System and an agency of the State of Texas with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by the Governmental Entity nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospital have provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospital’s indigent care obligation on the amount transferred by the Governmental Entity nor the amount of any Medicaid supplemental payment the Affiliated Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital; and that any escrow, trust or other funding mechanism utilized in connection with an anticipated IGT from the Governmental Entity has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to the Affiliated Hospital for any purpose in consideration for an IGT by the Governmental Entity to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by the Governmental Entity of this Agreement are within the Governmental Entity’s powers, are not in contravention of any other instruments governing the Governmental Entity and have been duly authorized and approved by the Board of Directors of the Governmental Entity as and to the extent required by applicable law;
g. This Agreement has been duly and validly executed by the Governmental Entity;

h. The Governmental Entity has not received and has no agreement to receive any portion of any Medicaid payments made to Affiliated Hospital;

i. The Governmental Entity has not entered into a contingent fee arrangement related to its participation in the Section 1115 Waiver program; and

j. The Governmental Entity is authorized to participate in the Section 1115 Waiver program pursuant to a vote of its governing body in a public meeting preceded by public notice published in accordance with its usual and customary practices or the Texas Open Meetings Act, as applicable.

3.0 OBLIGATIONS OF THE AFFILIATED HOSPITAL

3.1 Agreement to Collaborate with the Governmental Entity. The Affiliated Hospital agrees to work cooperatively with the Governmental Entity to improve access to health care for indigent persons.

3.2 Documentation. The Affiliated Hospital agrees to provide the Governmental Entity documentation that demonstrates the amount and types of health care (including indigent health care and Medicaid services historically provided in its community) as requested by the Governmental Entity, but no more frequently than quarterly.

3.3 Compliance with State and Federal Law. The Affiliated Hospital agrees to retain qualified professionals to ensure health care is provided in compliance with state and federal charity care laws, anti-trust laws, and any other applicable laws, and the Medicare and Medicaid programs.

3.4 Indigent Care Program Participation. At all times during the term of this Agreement, the Affiliated Hospital shall use its best efforts to maintain its qualifications for participation in the Medicaid and Medicare programs.

3.5 Compliance with HIPAA. To the extent applicable to this Agreement, the Affiliated Hospital agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, et seq. ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as "HIPAA Requirements." The Affiliated
Hospital agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of the Agreement. In addition, the Affiliated Hospital agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the Affiliated Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after rendering of such services. The Affiliated Hospital will also indemnify and hold the Governmental Entity harmless if any amount of reimbursement is denied or disallowed because of the Affiliated Hospital’s failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties and legal costs. If the Affiliated Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by the requirements of, 42. U.S.C. § 1395x(v)(1) and the regulations thereto.

4.0. OBLIGATIONS OF THE GOVERNMENTAL ENTITY

4.1 Agreement to Cooperate with the Affiliated Hospital. The Governmental Entity agrees to work cooperatively with the Affiliated Hospital to improve access to health care for indigent persons.

4.2 No Condition on Medicaid Funding. The Governmental Entity agrees that it will not condition the amount to which it funds the non-federal share of Medicaid supplemental payments on a specified or required minimum amount of prospective indigent care.

4.3 Retrospective Evaluation of Services. The Governmental Entity may retrospectively evaluate the amount and impact of the Affiliated Hospital’s indigent care delivery and can rely on such historical information in determining whether and to what degree it will provide an IGT in the future.

4.4 Documents Publicly Available. The Governmental Entity agrees to make publicly available any documentation utilized in connection with intergovernmental transfers of funds and any documentation executed by the
Governmental Entity related to its participation in the Section 1115 Waiver, including this Agreement.

4.5 **Use of Public Funds.** To the extent the Governmental Entity decides to provide funding for Medicaid supplemental payments, the Governmental Entity agrees to use public funds for such funding.

4.6 **Compliance with HIPAA.** The Governmental Entity agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Sections 1320d, *et seq.* ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as "HIPAA Requirements." The Governmental Entity agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of the Agreement. In addition, the Governmental Entity agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the Governmental Entity shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after rendering of such services. To the extent allowed by the laws of the State of Texas, the Governmental Entity will also indemnify and hold the Affiliated Hospital harmless if any amount of reimbursement is denied or disallowed because of the Governmental Entity’s failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties and legal costs. If the Governmental Entity carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by the requirements of, 42 U.S.C. § 1395x(v)(1) and the regulations thereto.
5.0 GENERAL PROVISIONS

5.1 Term and Termination. The term of this Agreement shall be one year from Effective Date and shall automatically continue thereafter for additional terms of one year unless the parties agree otherwise; provided, however, that this Agreement shall terminate immediately upon written notice by either the Governmental Entity or the Affiliated Hospital to the other party.

5.2 Notices. All notices, requests, claims, demands and other communications required or permitted hereunder shall be in writing and shall be deemed to have been duly given (a) when received if delivered personally, (b) when transmitted by facsimile (with conformation of successful transmission), (c) upon receipt, if sent by registered or certified mail (postage prepaid, return receipt requested) and (d) the day after it is sent, if sent for next-day delivery to a domestic address by overnight mail or courier, to the parties as follows:

Governmental Entity: Texas A&M Health Science Center
Vice President for Finance & Administration
200 Technology Way, Suite 2079
College Station, TX 77845-3424
Facsimile: (979) 436-0075

With a Copy to: The A&M Health Science Center
Office of the President
8441 State Highway 47
Clinical Building I, Suite 3100
Bryan, Texas 77807
Facsimile: (979) 436-0072

Affiliated Hospital: DeTar Healthcare System
506 East San Antonio Street
Victoria, Texas 77901
Attn: William Blanchard, CEO, FACHE

With a Copies to: Legal Department
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attn: General Counsel

Eric J. Weatherford
Brown McCarroll, L.L.P.
2001 Ross Avenue, Suite 2000
Dallas, Texas 75201
5.3 **Relationship Between the Parties.** The relationship between the Governmental Entity and the Affiliated Hospital is solely a contractual relationship between independent contractors. No party hereto is an agent or employee of any other party. Nothing in this Agreement shall prevent any affiliation or contracting by any party with any third party, with the exception that no party may contract or affiliate with other party to gain entitlement to Medicaid supplemental payments pursuant to this Agreement.

5.4 **Governing Law.** This Agreement shall be governed by the laws of the State of Texas. The Affiliated Hospital understands that the Governmental Entity is an agency of the State of Texas and has certain Constitutional and statutory rights and privileges.

5.5 **Venue.** Pursuant to Section 85.18 of the Texas Education Code, venue for any suit filed against the Governmental Entity shall be in the County in which the primary office of the chief executive officer of the Governmental Entity is located. At the execution of this Agreement, such county is Brazos County, Texas.

5.6 **Assignment.** No party may assign any right, obligation, or responsibility under this Agreement except to a successor in interest.

5.7 **Third Party Beneficiaries.** The parties to this Agreement do not intend to establish any third party beneficiary relationship by virtue of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date(s) set forth below.

THE TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER

By: [Signature] Date: 12/13/12

VICTORIA OF TEXAS, L.P. D/B/A DETAR HEALTH SYSTEM, BY ITS GENERAL PARTNER, DETAR HOSPITAL, LLC

By: [Signature] Martin G. Schweinhart, President Date: 12-11-12
NUECES COUNTY INDIGENT CARE AFFILIATION AGREEMENT

This Nueces County Indigent Care Affiliation Agreement (the "Agreement") is entered into as of the 26th day of September, 2012 ("Effective Date"), by and between Nueces County Hospital District ("District"), and Bay Area Healthcare Group, Ltd. d/b/a Corpus Christi Medical Center ("Hospital").

RECITALS:

WHEREAS, reductions in reimbursement under the Medicaid program and the growing uninsured population have created a gap between the costs Hospital incurs for treating Medicaid patients and the Indigent and the reimbursement Hospital actually receives;

WHEREAS, the District and Hospital recognize that the Indigent numbers in Nueces County and other counties in the Region will continue to increase, and that the burden of providing Health Care Services to the Indigent will continue to shift to the Hospital, District and local communities in Nueces County and other counties in the Region;

WHEREAS, the District is empowered by the Chapter 281 of the Texas Health and Safety Code and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code, as amended from time to time (the "Indigent Health Care and Treatment Act"), to enter into contracts relating to or arranging for the provision of Health Care Services;

WHEREAS, District and Hospital desire to collaborate to ensure the Indigent have access to and receive quality Health Care Services;

WHEREAS, District and Hospital recognize that it is in the best interest of all to increase funding for the Medicaid population and to access federal funding for the Indigent to which the Hospital will be entitled under the current Texas Medicaid Section 1115 Waiver ("Waiver");

WHEREAS, the Waiver requires providers to work collectively and collaboratively to develop and submit a regional plan for health care delivery system reform through the formation of Regional Healthcare Partnerships ("RHPs");

WHEREAS, these RHPs are to be based on regions determined by the Texas Health and Human Services Commission ("HHSC");

WHEREAS, funds to finance the Waiver may be provided by public hospital districts and other units of government through intergovernmental transfers ("IGTs");

WHEREAS, District and Hospital recognize that they need to collaborate to ensure their ability to deliver Health Care Services;
WHEREAS, Hospital desires to participate with the District and other entities to join in an affiliation with the District for purposes of forming an RHP; and

WHEREAS, the Waiver is intended to effect reform and improvement of healthcare delivery systems in four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) population-focused improvement and (4) clinical improvements in care.

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 PURPOSE

1.1 “Charity Care” means the provision of hospital services to the uninsured, as well as services defined by Texas Health and Safety Code §311.031(2).

1.2 “Health Care Services” means those services necessary to enhance the delivery of health care to the Indigent, as defined in Section 1.4 of this Agreement.

1.3 “HHSC” means the Texas Health and Human Services Commission.

1.4 “Indigent” means any person who meets (i) the income and other guidelines established for participation in the Texas Medicaid program, (ii) the income and other guidelines established for participation in the Children’s Health Insurance Program (“CHIP”), (iii) the income and other guidelines established in the Nueces County Hospital Indigent Care Program Handbook for participation in the District’s Indigent Health Care Program, (iv) the income and other guidelines established for participation in an indigent care program of a county or other hospital district in accordance with the Indigent Health Care and Treatment Act, or (v) the income and other guidelines to qualify as “financially indigent” or “medically indigent” under Section 311.031 of the Texas Health and Safety Code.

1.5 “Indigent Care” means treatment, services and education concerning the inpatient and outpatient hospital and medical professional needs of the Indigent, including both the performance of services and the provision for services.

1.6 “IGT” means intergovernmental transfer.

1.7 “Waiver” means the Section 1115 Demonstration Waiver for the Texas Healthcare Transformation and Quality Improvement Program.

1.8 “Waiver Payments” means any Medicaid payments received by Hospital in accordance with the Waiver Program.
1.9 “Public Funds” means public revenue, generated by the District, which the District may transfer in part to HHSC through IGTs to serve as the non-federal share of Waiver Payments.

1.10 “Region” means the HHSC designated RHP Region 4 that includes the following counties: Aransas County, Bee County, Brooks County, DeWitt County, Duval County, Goliad County, Gonzales County, Jackson County, Jim Wells County, Karnes County, Kenedy County, Kleberg County, Lavaca County, Live Oak County, Nueces County, Refugio County, San Patricio County, and Victoria County.

2.0 PURPOSE

The purpose of this Agreement is to memorialize District’s and Hospital’s agreement to collaborate with each other and other RHP members to improve access of Indigents to quality Health Care Services, reduce health care costs, improve the health of populations, transform the health care delivery system, and facilitate Hospital’s participation in the Waiver pursuant to Title 1 of the Texas Administrative Code Section 355.8201(c)(1)(C).

3.0 REPRESENTATIONS AND WARRANTIES

3.1 Hospital’s Representations and Warranties. Hospital represents and warrants that:

a. Hospital is a Texas limited partnership, duly established and created pursuant to applicable laws with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the Public Funds transferred by District or the amount of Waiver Payments on the amount of Indigent Care Hospital has provided or will provide to the Indigent;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount of Public Funds transferred by District or the amount of any Waiver Payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District will be disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;

e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT that the District may make to fund Hospital’s Waiver Payments;
f. To the best of Hospital’s knowledge, Hospital has complied and will continue to comply with all requirements of HHSC’s Waiver Certification of Hospital Participation;

g. The execution, delivery, and performance by Hospital of this Agreement are within Hospital’s powers, are not in contravention of any other instruments governing Hospital, and have been duly authorized and approved by Hospital as and to the extent required by applicable law;

h. Neither Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Hospital, or any of its representatives from participation in Federal health care programs; and

i. This Agreement has been duly and validly executed by Hospital.

3.2 District Representations and Warranties. District represents and warrants that:

a. District is a unit of local government and more specifically a county hospital District, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by District or the amount of Medicaid Waiver payments on the amount of Indigent Care Hospital has provided or will provide;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount transferred by District or the amount of any Medicaid Waiver payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;
e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT District may make to fund Medicaid Waiver payments;

f. To the best of District's knowledge, District has complied and will continue to comply with HHSC's Waiver Certification of Government Entity Participation;

g. The execution, delivery, and performance by District of this Agreement are within District's powers, are not in contravention of any other instruments governing District and have been duly authorized and approved by District as and to the extent required by applicable law;

h. Neither District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of District, or any of its representatives from participation in Federal health care programs; and

i. Notwithstanding anything in this Agreement to the contrary, any decision by District to provide funding for the Medicaid program for or on behalf of Hospital is at its sole discretion and subject to the appropriation of sufficient funds by District.

4.0 RESPONSIBILITIES AND OBLIGATIONS OF HOSPITAL

4.1 Agreement to Collaborate with District. Hospital agrees to work collaboratively with District and other RHP members to improve access to and the quality of healthcare, reduce health care costs, improve the health of populations and transform the healthcare delivery system.

4.2 Provision of Indigent Care. Hospital agrees to provide Health Care Services to the Indigent.

4.3 Documentation. Hospital agrees to provide District documentation at regular intervals, but not less often than quarterly, that demonstrates the amount and types of Health Care Services provided by the Hospital to the Indigent.

4.4 Compliance with State and Federal Law. Hospital will assure that health care is provided in compliance with state and federal Charity Care laws, anti-trust laws, any other applicable laws, and the requirements for participation in the Medicare and the Medicaid programs.

DM$LIBRARY01-19630405.2
4.5 **Indigent Care Program Participation.** At all times during the term of this Agreement, Hospital shall use its best efforts to maintain its qualification for participation in the Medicaid and Medicare programs.

4.6 **Compliance with HIPAA and Access to Records.** To the extent applicable to this Agreement, Hospital agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d et seq. ("HIPAA") and any current and future regulations promulgated under the HITECH Act or HIPAA, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the “Federal Privacy Regulations”), the federal security standards contained in 45 C.F.R. Parts 160 and 164 (the “Federal Security Regulations”), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the “Federal Electronic Transactions Regulations”), all as amended from time to time and, all collectively referred to herein as “HIPAA Requirements.” Hospital agrees not to use or further disclose any Protected Health Information, including Electronic Protected Health Information (as those terms are defined in the HIPAA Requirements), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Hospital agrees to comply with any state laws and regulations that govern the confidentiality, privacy, security of, and electronic transactions pertaining to health care information.

As and to the extent required by law, upon the written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. § 1395x(v)(l) and the regulations thereto.

5.0 **RESPONSIBILITIES AND OBLIGATIONS OF THE DISTRICT**

5.1 **Agreement to Collaborate with Hospital.** District agrees to work collaboratively with Hospital and other members of the RHP to improve access to and the quality of healthcare, reduce healthcare costs, improve the healthcare populations and transform the healthcare delivery system.

5.2 **No Condition on Medicaid Funding.** District agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective Indigent Care.
5.3 **Retrospective Evaluation of Services.** District may retrospectively evaluate the amount and impact of Hospital’s Indigent Care delivery and can rely on such historical information in determining whether and to what degree it may provide an IGT in the future.

5.4 **Documents Publicly Available.** District agrees to make publicly available any documentation utilized in connection with any IGTs of funds.

6.0 **GENERAL PROVISIONS**

6.1 **Term and Termination.** The term of this Agreement shall be from the Effective Date through the later of September 30, 2016, or the date the Waiver or any extension thereof is terminated.

6.2 **Voluntary Termination.** Any party may terminate this Agreement without reason at any time during the term by providing written notice to all other parties at least thirty (30) days prior to the date of withdrawal.

6.3 **Notices.** All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

**District:** Nueces County Hospital District  
555 N. Carancahua St., Suite 950  
Corpus Christi, Texas 78401  
Attention: Administrator  
Telexcopy No.: (361) 808-3274  
Telephone No.: (361) 808-3300
with a copy to: William DeWitt Alsup
Alsup and Alsup
555 N. Carancahua St., Suite 1560
Corpus Christi, Texas 78401
Telecopy No.: (361) 884-6000
Telephone No.: (361) 884-6321

and

Gary W. Eiland, Esq.
King & Spalding LLP
1100 Louisiana, Suite 4000
Houston, TX 77002
Telecopy No.: (713) 751-3290
Telephone No.: (713) 751-3207

Hospital:
Corpus Christi Medical Center
3315 S. Alameda Street
Corpus Christi, Texas 78411
Attention: Chief Executive Officer
Telecopy No.: (361) 857-5960
Telephone No.: (361) 761-1501

with a copy to: V.P. & Chief Legal Officer
Corpus Christi Medical Center
7400 Fannin Street, Suite 650
Houston, Texas 77054
Telecopy No.: (713) 852-1799
Telephone No.: (713) 852-1500

6.5 Relationships Among the Parties. Each party to this Agreement is an independent contractor and not an agent, servant, joint enterprise, or employee as to the other parties to the Agreement and unless otherwise specified in this Agreement or another agreement, is responsible for its own acts, omissions, forbearance, negligence and deeds, and for those of its agents or employees in conjunction with the performance of services covered under this Agreement, and shall be specifically responsible for sufficient supervision and inspection to ensure compliance in every respect with the Agreement requirements. There shall be no contractual relationship between any subcontractor, agent, employee or supplier of Hospital and the District by virtue of this Agreement. The rights and obligations of each of the parties are individual, separate and independent.

6.6 Governing Law. This Agreement shall be governed by the laws of the State of Texas. This Agreement is performable and enforceable in Nueces County, Texas, where the principal office of the District is located, and the state or federal courts in the county shall be the sole and exclusive venue for any litigation, special
proceeding, or other proceeding as between the parties that may be brought, or
arisen out of, in connection with, or by reason of this Agreement. Hospital
understands that the District is a political subdivision of the State of Texas and
governed by certain applicable statutes.

6.7 Assignment or Subcontract. No party may assign or subcontract any right,
obligation, or responsibility under this Agreement except to a successor in interest
without the prior written consent of the Anchor Facility.

6.8 No Third Party Beneficiary. This Agreement does not confer any right or
benefit on any third party and may be enforced solely by the parties.

6.9 Articles and Other Headings. The division of this Agreement into articles and
sections, and the use of captions and headings, are solely for convenience of
reference, and shall have no legal effect in construing the provisions of this
Agreement or in governing the rights, obligations, or liabilities of the parties.

6.10 Multiple Originals. This Agreement may be executed in one or more
counterparts with multiple signature pages, each fully executed copy shall be
deemed an original, and all of which together shall constitute one and the same
instrument.

6.11 Amendment or Modification. This Agreement may only be amended or
modified in writing by the mutual agreement of all parties hereto.

IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set
forth above.

Nueces County Hospital District

By [Signature]
Jonny F. Hipp, Administrator/CEO

Bay Area Healthcare Group, Ltd. d/b/a Corpus Christi
Medical Center

By [Signature]
Maura Walsh, Senior Vice President
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION
FOR HOSPITAL AFFILIATES
Version 2012-1 (09/05/2012)
## DOCUMENT HISTORY LOG

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<tr>
<td>Baseline</td>
<td>n/a</td>
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<td>Initial version of the Certification of Governmental Entity Participation</td>
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<tr>
<td>Revision</td>
<td>1.1</td>
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<td>Added cover page.</td>
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<td>Revision</td>
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<tr>
<td>Revision</td>
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<tr>
<td>Revision</td>
<td>1.4</td>
<td>09/05/2012</td>
<td>Added version number (Version 2012-1) and date of issuance to cover page and page footer.</td>
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<tr>
<td>Revision</td>
<td>1.5</td>
<td>09/05/2012</td>
<td>Deleted “Texas” from “Health and Human Services Commission” to reflect agency’s statutory name.</td>
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<tr>
<td>Revision</td>
<td>1.6</td>
<td>09/05/2012</td>
<td>Revised paragraph 4.g. to replace “and” at the end of subparagraph ii following the semicolon with “or.”</td>
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1 "Baseline" indicates initial document issuances, “Revision” indicates changes to the Baseline version, and “Cancellation” indicates withdrawn versions.

2 Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of Nueces County Hospital District, a Hospital District organized under the laws of the State of Texas (hereinafter referred to as "the Governmental Entity"), I, Jonny F. Hipp, affirm and certify the following:

1. Legal Authorization.
   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");
   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.
   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.

Health & Human Services Commission
Governmental Entity Certification for Hospital Payments

1115 Demonstration Waiver Program
Version 2012-1 (09/05/2012)
RHP Plan for Region 4

1329
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity's participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.

Health & Human Services Commission
Governmental Entity Certification for Hospital Payments

1115 Demonstration Waiver Program
Version 2012-1 (09/05/2012)
a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital's historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital's participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

Jonny F. Hipp, Administrator/CEO
Name and Title

Signature

10-18-2012
Date
INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (the “Agreement”) is entered into as of the 1st day of October, 2012 (“Effective Date”), by and among Nueces County Hospital District, a body politic and corporate and a political subdivision of the State of Texas (“District”), and CHRISTUS SPOHN Health System Corporation, a Texas nonprofit corporation (“Spohn”), doing business as CHRISTUS Spohn Hospital Alice; CHRISTUS Spohn Hospital Kleberg; and CHRISTUS Spohn Hospital Beeville (each, “Affiliated Hospital” and collectively, “Affiliated Hospitals”).

RECITALS:

WHEREAS, reductions in reimbursement under the Medicaid program and the growing uninsured population have created a gap between the costs Affiliated Hospitals incur for treating Medicaid patients and the Indigent and the reimbursement Affiliated Hospitals actually receive;

WHEREAS, the District and Affiliated Hospitals recognize that the Indigent numbers in Nueces County and other counties in the Region will continue to increase, and that the burden of providing Health Care Services to the Indigent will continue to shift to the Affiliated Hospitals, District and local communities in Nueces County and other counties in the Region;

WHEREAS, the District is empowered by the Chapter 281 of the Texas Health and Safety Code and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code (as amended from time to time, the “Indigent Health Care Act”), to enter into contracts relating to or arranging for the provision of Health Care Services;

WHEREAS, District and Affiliated Hospitals desire to collaborate to ensure the Indigent have access to and receive quality Health Care Services;

WHEREAS, District and Affiliated Hospitals recognize that it is in the best interest of all to increase funding for the Medicaid population and to access federal funding for the Indigent to which the Affiliated Hospitals will be entitled under the current Texas Medicaid Section 1115 Waiver (“Waiver”);

WHEREAS, the Waiver requires providers to work collectively and collaboratively to develop and submit a regional plan for health care delivery system reform through the formation of Regional Healthcare Partnerships (“RHPs”);

WHEREAS, these RHPs are to be based on regions determined by the Texas Health and Human Services Commission (“HHSC”);

WHEREAS, funds to finance the Waiver may be provided by public hospital districts and other units of government through intergovernmental transfers (“IGTs”);
WHEREAS, District and Affiliated Hospitals recognize that they need to collaborate to ensure their ability to deliver Health Care Services;

WHEREAS, Affiliated Hospitals desire to participate with the District and other entities to join in an affiliation with the District for purposes of forming an RHP; and

WHEREAS, the Waiver is intended to effect reform and improvement of healthcare delivery systems in four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) population-focused improvement and (4) clinical improvements in care.

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 PURPOSE

1.1 "Charity Care" means the provision of hospital services to the uninsured, as well as services defined by Texas Health and Safety Code §311.031(2).

1.2 "Health Care Services" means those services necessary to enhance the delivery of health care to the Indigent, as defined in Section 1.4 of this Agreement.

1.3 "HHSC" means the Texas Health and Human Services Commission.

1.4 "Indigent" means any person who meets (i) the income and other guidelines established for participation in the Texas Medicaid program, (ii) the income and other guidelines established for participation in the Children’s Health Insurance Program (“CHIP”), (iii) the income and other guidelines established in the Nueces County Hospital Indigent Care Program Handbook for participation in the District’s Indigent Health-Care Program, (iv) the income and other guidelines established for participation in an indigent care program of a county or other hospital district in accordance with the Indigent Health Care Act, or (v) the income and other guidelines to qualify as “financially indigent” or “medically indigent” under Section 311.031 of the Texas Health and Safety Code.

1.5 "Indigent Care" means treatment, services and education concerning the inpatient and outpatient hospital and medical professional needs of the Indigent, including both the performance of services and the provision for services.

1.6 “IGT” means intergovernmental transfer.

1.7 “Waiver” means the Section 1115 Demonstration Waiver for the Texas Healthcare Transformation and Quality Improvement Program.

1.8 “Waiver Payments” means any Medicaid supplemental payments received by Affiliated Hospitals in accordance with the Waiver program.
1.9 "Public Funds" means public revenue, generated by the District, which the District may transfer in part to HHSC through IG Ts to serve as the non-federal share of Waiver Payments.

1.10 "Region" means the HHSC designated RHP Region 4 that includes the following counties: Aransas County, Bee County, Brooks County, DeWitt County, Duval County, Goliad County, Gonzales County, Jackson County, Jim Wells County, Karnes County, Kenedy County, Kleberg County, Lavaca County, Live Oak County, Nueces County, Refugio County, San Patricio County, and Victoria County.

2.0 PURPOSE

The purpose of this Agreement is to memorialize District's and Affiliated Hospitals' agreement to collaborate with the other and other RHP members to improve access of Indigents to quality Health Care Services, reduce health care costs, improve the health of populations, transform the health care delivery system, and facilitate Affiliated Hospitals' participation in the Waiver pursuant to Title 1 of the Texas Administrative Code Section 355.8201(c)(1)(C).

3.0 REPRESENTATIONS AND WARRANTIES

3.1 Affiliated Hospitals’ Representations and Warranties. Affiliated Hospitals represents and warrants that:

a. Affiliated Hospitals are a Texas non-profit corporation, duly established and created pursuant to applicable laws with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the Public Funds transferred by District or the amount of Waiver Payments on the amount of Indigent Care Affiliated Hospitals have provided or will provide to the Indigent;

c. There is no agreement to condition the amount of Affiliated Hospitals’ Indigent Care obligation on the amount of Public Funds transferred by District or the amount of any Waiver Payments Affiliated Hospitals might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Affiliated Hospitals; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District will be disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Affiliated Hospitals;
c. District has not received and will not receive refunds of payments from Affiliated Hospitals for any purpose in consideration for any IGT that the District may make to fund Affiliated Hospitals' Waiver Payments;

d. To the best of Affiliated Hospitals' knowledge, Affiliated Hospitals have complied and will continue to comply with all requirements of HHSC's Waiver Certification of Hospital Participation;

g. The execution, delivery, and performance by Affiliated Hospitals of this Agreement are within Affiliated Hospitals' powers, are not in contravention of any other instruments governing Affiliated Hospitals, and have been duly authorized and approved by Affiliated Hospitals as and to the extent required by applicable law;

h. Neither Affiliated Hospitals, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal health care programs"); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Affiliated Hospitals, or any of its representatives from participation in Federal health care programs; and

i. This Agreement has been duly and validly executed by and on behalf of Affiliated Hospitals.

3.2 District Representations and Warranties. District represents and warrants that:

a. District is a unit of local government and more specifically a county hospital District, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by District or the amount of Waiver Payments on the amount of Indigent Care Affiliated Hospitals have provided or will provide;

c. There is no agreement to condition the amount of Affiliated Hospitals' Indigent Care obligation on the amount transferred by District or the amount of any Waiver Payments Affiliated Hospitals might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services
provided or to be provided by Affiliated Hospitals; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Affiliated Hospitals;

e. District has not received and will not receive refunds of payments from Affiliated Hospitals for any purpose in consideration for any IGT District may make to fund Waiver Payments;

f. To the best of District’s knowledge, District has complied and will continue to comply with HHSC’s Waiver Certification of Government Entity Participation;

g. The execution, delivery, and performance by District of this Agreement are within District’ powers, are not in contravention of any other instruments governing District and have been duly authorized and approved by District as and to the extent required by applicable law;

h. Neither District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of District, or any of its representatives from participation in Federal health care programs; and

i. Notwithstanding anything in this Agreement to the contrary, any decision by District to provide funding for the Medicaid program for or on behalf of Affiliated Hospitals is at its sole discretion and subject to the appropriation of sufficient funds by District.

4.0 RESPONSIBILITIES AND OBLIGATIONS OF AFFILIATED HOSPITALS

4.1 Agreement to Collaborate with District. Affiliated Hospitals agree to work collaboratively with District and other RHP members to improve access to and the quality of healthcare, reduce health care costs, improve the health of populations and transform the healthcare delivery system.

4.2 Provision of Indigent Care. Consistent with their charitable missions, Affiliated Hospitals agree to provide Health Care Services to the Indigent including, without limitation, the availability to provide out-of-county Health Care Services to the Indigent residents of Nueces County, Texas.
4.3 **Documentation.** Affiliated Hospitals agree to provide District documentation at regular intervals, but not less often than quarterly, that demonstrates the amount and types of Health Care Services provided by the Affiliated Hospitals to the Indigent.

4.4 **Compliance with State and Federal Law.** Affiliated Hospitals will assure that health care is provided in compliance with state and federal Charity Care laws, anti-trust laws, any other applicable laws, and the requirements for participation in the Medicare and the Medicaid programs.

4.5 **Indigent Care Program Participation.** At all times during the term of this Agreement, Affiliated Hospitals shall use their best efforts to maintain their qualification for participation in the Medicaid and Medicare programs.

4.6 **Compliance with HIPAA and Access to Records.** To the extent applicable to this Agreement, Affiliated Hospitals agree to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”), the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d et seq. (“HIPAA”) and any current and future regulations promulgated under the HITECH Act or HIPAA, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the “Federal Privacy Regulations”), the federal security standards contained in 45 C.F.R. Parts 160 and 164 (the “Federal Security Regulations”), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the “Federal Electronic Transactions Regulations”), all as amended from time to time and, all collectively referred to herein as “HIPAA Requirements.” Affiliated Hospitals agree not to use or further disclose any Protected Health Information, including Electronic Protected Health Information (as those terms are defined in the HIPAA Requirements), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Affiliated Hospitals agree to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, Affiliated Hospitals shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Affiliated Hospitals carry out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, Affiliated Hospitals agree to include this requirement in any such subcontract. This section is included pursuant to and is
governed by the requirements of 42 U.S.C. § 1395x(v)(l) and the regulations thereto.

5.0 RESPONSIBILITIES AND OBLIGATIONS OF THE DISTRICT

5.1 Agreement to Collaborate with Affiliated Hospitals. District agrees to work collaboratively with Affiliated Hospitals and other members of the RHP to improve access to and the quality of healthcare, reduce healthcare costs, improve the healthcare populations and transform the healthcare delivery system.

5.2 No Condition on Medicaid Funding. District agrees that it will not condition the amount to which it funds the non-federal share of Waiver Payments on a specified or required minimum amount of prospective Indigent Care.

5.3 Retrospective Evaluation of Services. District may retrospectively evaluate the amount and impact of Affiliated Hospitals' Indigent Care delivery and can rely on such historical information in determining whether and to what degree it may provide an IGT in the future.

5.4 Documents Publicly Available. District agrees to make publicly available any documentation utilized in connection with any IGTS of funds.

6.0 GENERAL PROVISIONS

6.1 Term and Termination. The term of this Agreement shall be from the Effective Date through the later of September 30, 2016, or the date the Waiver or any extension thereof is terminated; provided, however, that this Agreement shall terminate immediately in the event that District terminates this Agreement.

6.2 Voluntary Termination. Any party may terminate this Agreement without reason at any time during the term by providing written notice to all other parties at least thirty (30) days prior to the date of withdrawal.

6.3 Notices. All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

District: Nueces County Hospital District
555 N. Carancahua St., Suite 950
Corpus Christi, Texas 78401
Attention: Administrator
Telecopy No.: (361) 808-3274
Telephone No.: (361) 808-3300
with a copy to: William DeWitt Alsup
Alsup and Alsup
555 N. Carancahua St., Suite 1560
Corpus Christi, Texas 78401
Telecopy No.: (361) 884-6000
Telephone No.: (361) 884-6321

and

Gary W. Eiland, Esq.
King & Spalding LLP
1100 Louisiana, Suite 4000
Houston, TX 77002
Telecopy No.: (713) 751-3290
Telephone No.: (713) 751 3207

Affiliated Hospitals
CHRISTUS Spohn Health System Corporation
1702 Santa Fe St.
Corpus Christi, Texas 78404
Attention: President/CEO
Telecopy No.: (361) 885-0566
Telephone No.: (361) 881-3405

with a copy to: Gjerset & Lorenz, LLP
2801 Via Fortuna, Suite 500
Austin, Texas 78746
Attention: Lance J. Ramsey
Telecopy No.: (512) 899-3939
Telephone No.: (512) 899-3995

6.5 Relationships Among the Parties. Each party to this Agreement is an
independent contractor and not an agent, servant, joint enterprise, or employee as
to the other parties to the Agreement and unless otherwise specified in this
Agreement or another agreement, is responsible for its own acts, omissions,
forbearance, negligence and deeds, and for those of its agents or employees in
conjunction with the performance of services covered under this Agreement, and
shall be specifically responsible for sufficient supervision and inspection to ensure
compliance in every respect with the Agreement requirements. There shall be no
contractual relationship between any subcontractor, agent, employee or supplier
of Affiliated Hospitals and the District by virtue of this Agreement. The rights
and obligations of each of the parties are individual, separate and independent.

6.6 Governing Law. This Agreement shall be governed by the laws of the State of
Texas. This Agreement is performable and enforceable in Nueces County, Texas,
where the principal office of the District is located, and the state or federal courts in the county shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding as between the parties that may be brought, or arisen out of, in connection with, or by reason of this Agreement. Affiliated Hospitals understand that the District is a political subdivision of the State of Texas and governed by certain applicable statutes.

6.7 **Assignment or Subcontract.** No party may assign or subcontract any right, obligation, or responsibility under this Agreement except to a successor in interest without the prior written consent of the District.

6.8 **No Third Party Beneficiary.** This Agreement does not confer any right or benefit on any third party and may be enforced solely by the parties.

6.9 **Articles and Other Headings.** The division of this Agreement into articles and sections, and the use of captions and headings, are solely for convenience of reference, and shall have no legal effect in construing the provisions of this Agreement or in governing the rights, obligations, or liabilities of the parties.

6.10 **Multiple Originals.** This Agreement may be executed in one or more counterparts with multiple signature pages, each fully executed copy shall be deemed an original, and all of which together shall constitute one and the same instrument.

6.11 **Amendment or Modification.** This Agreement may only be amended or modified in writing by the mutual agreement of all parties hereto.

[Signature Page Follows]
IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set forth above.

DISTRICT: Nueces County Hospital District

By Jonny F. Hipp
Administrator/CEO

AFFILIATED HOSPITALS: CHRISTUS Spohn Health System Corporation, DBA CHRISTUS Spohn Hospital Alice, CHRISTUS Spohn Hospital Kleberg and CHRISTUS Spohn Hospital Beeville

By Pamela S. Robertson
Printed Name: Pamela S. Robertson
Title: President and CEO
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION
FOR HOSPITAL AFFILIATES
Version 2012-1 (09/05/2012)
## DOCUMENT HISTORY LOG

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<td>Baseline</td>
<td>n/a</td>
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<td>Initial version of the Certification of Governmental Entity Participation</td>
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<tr>
<td>Revision</td>
<td>1.1</td>
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<tr>
<td>Revision</td>
<td>1.5</td>
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<td>Deleted &quot;Texas&quot; from &quot;Health and Human Services Commission&quot; to reflect agency's statutory name.</td>
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<tr>
<td>Revision</td>
<td>1.6</td>
<td>09/05/2012</td>
<td>Revised paragraph 4.g. to replace &quot;and&quot; at the end of subparagraph II following the semicolon with &quot;or.&quot;</td>
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1. "Baseline" indicates initial document issuances, "Revision" indicates changes to the Baseline version, and "Cancellation" indicates withdrawn versions.

2. Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., "1.2" refers to the first version of the document and the second revision.

3. Brief description of the changes to the document made in the revision.
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of Nueces County Hospital District, a Hospital District organized under the laws of the State of Texas (hereinafter referred to as "the Governmental Entity"), I, Jonny F. Hipp, affirm and certify the following:

1. Legal Authorization.

   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds ("Public Funds");

   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals ("the Affiliated Hospitals") for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.

   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;

   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. **Funding of Intergovernmental Transfers and Supplemental Payments.**

a. The Governmental Entity may agree or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. **Assurances and Representations.**

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
**Rider 4.g.**

Affiliated Hospital is part of CHRISTUS Spohn Health System Corporation, the same corporate entity in which Governmental Entity is a member and from which Governmental Entity receives a portion of the net patient revenue of CHRISTUS Spohn Hospital—Corpus Christi (but not the Affiliated Hospital) pursuant to the Spohn Membership Agreement effective as of October 1, 2012. Aside from any revenue received by Governmental Entity pursuant to such Membership Agreement, the

**Rider 4.b.ii.**

Following the date this Certification was executed, authorized
a. Consistent with its constitutional, statutory, and fiduciary obligations, the
Governmental Entity may evaluate a private hospital’s historical experience in
providing indigent care in the community or performance under an Affiliation
Agreement including the impact and amount of indigent care provided by the
hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an
Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will
supply an IGT, provided such decision does not include consideration of
matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited
the community and whether its continued participation in the indigent
care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the
Governmental Entity’s mission and provide an appropriate and
constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of
this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above
statements; that the statements are true, correct, and complete; and that I am authorized to bind
the Governmental Entity and to certify to the above.

[Signature] 10/24/2012

Jonny F. Hipp, Administrator/CEO
Name and Title
INDIGENT CARE AFFILIATION AGREEMENT

BETWEEN

NUECES COUNTY HOSPITAL DISTRICT

AND

CHRISTUS SPOHN HEALTH SYSTEM CORPORATION
NUECES COUNTY FACILITIES

For purposes of the Texas 1115 Waiver rules, the attached CHRISTUS Spohn Health System Corporation Membership Agreement serves as the Indigent Care Affiliation Agreement between the signatories of said Membership Agreement.
CHRISTUS SPOHN HEALTH SYSTEM CORPORATION
MEMBERSHIP AGREEMENT

This MEMBERSHIP AGREEMENT (the “Agreement”) is signed this 28th day of September 2012, effective as of October 1, 2012 (“Effective Date”) between CHRISTUS Spohn Health System Corporation (“Spohn”), a Texas nonprofit corporation, CHRISTUS Health (“CHRISTUS Health”), a Texas nonprofit corporation, and the Nueces County Hospital District (the “District”), a body politic and corporate and a political subdivision of the State of Texas, established and created pursuant to Article IX, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health and Safety Code, as amended (the “Act”). Spohn, CHRISTUS Health, and the District are sometimes referred to herein individually as “party” or collectively as “parties.” When referring to CHRISTUS Health or the District in their capacities as members of Spohn, CHRISTUS Health and the District are sometimes referred to herein individually as “Member” or collectively as “Members.”

RECITALS

WHEREAS, the District is obligated to furnish medical aid and hospital care to indigent and needy residents residing in Nueces County, Texas;

WHEREAS, the District is authorized under the Act and under Chapter 285.091 of the Texas Health and Safety Code to contract, collaborate, or enter into a joint venture with any public or private entity as necessary to carry out the functions of or provide services to the District;

WHEREAS, the District is empowered by the Act and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code (as amended from time to time, the “Indigent Health Care Act”), to enter into contracts relating to or arranging for the provision of health care services;

WHEREAS, in 1996 the parties entered into several agreements, including a Master Agreement as amended through September 28, 2012 (“Master Agreement”), a Lease Agreement as amended through September 28, 2012 (“Lease”), and an Indigent Care Agreement as revised and restated on November 18, 2005 and amended through September 28, 2012 (“ICA”) (together, the “1996 Transaction Agreements”) through which the District and Spohn shared an interest in the continued operation of a public hospital in Corpus Christi that would serve the needs of the indigent population in Nueces County, Texas and surrounding areas;

WHEREAS, Spohn serves as the public, safety-net hospital in Nueces County, Texas by providing care to the low-income and indigent population in Nueces County at the CHRISTUS Spohn Hospital Corpus Christi—Memorial, CHRISTUS Spohn Hospital Corpus Christi—Shoreline and CHRISTUS Spohn Hospital Corpus Christi—South hospital facilities (these Spohn hospital facilities along with the clinics, medical offices, and other health care facilities on the campuses of or affiliated with such Spohn hospital facilities that share common Medicare and Medicaid provider agreements are collectively referred to herein as the “Nueces County
CHRISTUS SPOHN HEALTH SYSTEM CORPORATION
MEMBERSHIP AGREEMENT

This MEMBERSHIP AGREEMENT (the "Agreement") is signed this ___ day of September ___ , 2012, effective as of October 1, 2012 ("Effective Date") between CHRISTUS Spohn Health System Corporation ("Spohn"), a Texas nonprofit corporation, CHRISTUS Health ("CHRISTUS Health"), a Texas nonprofit corporation, and the Nueces County Hospital District (the "District"), a body politic and corporate and a political subdivision of the State of Texas, established and created pursuant to Article IX, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health and Safety Code, as amended (the "Act"). Spohn, CHRISTUS Health, and the District are sometimes referred to herein individually as "party" or collectively as "parties." When referring to CHRISTUS Health or the District in their capacities as members of Spohn, CHRISTUS Health and the District are sometimes referred to herein individually as "Member" or collectively as "Members."

RECEITALS

WHEREAS, the District is obligated to furnish medical aid and hospital care to indigent and needy residents residing in Nueces County, Texas;

WHEREAS, the District is authorized under the Act and under Chapter 285.091 of the Texas Health and Safety Code to contract, collaborate, or enter into a joint-venture with any public or private entity as necessary to carry out the functions of or provide services to the District;

WHEREAS, the District is empowered by the Act and Section 61.036 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code (as amended from time to time, the "Indigent Health Care Act"), to enter into contracts relating to or arranging for the provision of health care services;

WHEREAS, in 1996 the parties entered into several agreements, including a Master Agreement as amended through September 28, 2012 ("Master Agreement"), a Lease Agreement as amended through September 28, 2012 ("Lease"), and an Indigent Care Agreement as revised and restated on November 18, 2005 and amended through September 28, 2012 ("ICA") (together, the "1996 Transaction Agreements") through which the District and Spohn shared an interest in the continued operation of a public hospital in Corpus Christi that would serve the needs of the indigent population in Nueces County, Texas and surrounding areas;

WHEREAS, Spohn serves as the public, safety-net hospital in Nueces County, Texas by providing care to the low-income and indigent population in Nueces County at the CHRISTUS Spohn Hospital Corpus Christi—Memorial, CHRISTUS Spohn Hospital Corpus Christi—Shoreline and CHRISTUS Spohn Hospital Corpus Christi—South hospital facilities (these Spohn hospital facilities along with the clinics, medical offices, and other health care facilities on the campuses of or affiliated with such Spohn hospital facilities that share common Medicare and Medicaid provider agreements are collectively referred to herein as the "Nueces County
Facilities") consistent with the provisions set forth in the Act, the Indigent Health Care Act, and in accordance with the ICA and the District's policies;

WHEREAS, as the Nueces County public safety-net hospital, Spohn relies on reimbursement from government programs and the District's support to sustain its operations;

WHEREAS, based on material changes in government program reimbursement resulting from the pending expansion of the use of Medicaid managed care in Texas and the implementation by the Texas Health and Human Services Commission ("HHSC") of a Medicaid Section 1115 Waiver, titled “The Texas Healthcare Transformation and Quality Improvement Program” ("Waiver"), Spohn issued notice to the District of the need to negotiate changes to the terms of the 1996 Transaction Agreements, in accordance with Section 11.24 of the Master Agreement, Section 10.23(b) of the Lease, and Section 9.6 of the ICA;

WHEREAS, Spohn is a Texas nonprofit corporation created under the Texas Nonprofit Corporations Act, codified at Chapter 22 of the Texas Business Organizations Code, with certain Member(s) designated in its organizational documents;

WHEREAS, through good faith negotiations, the parties determined that it is in their mutual interest to transition to a joint membership structure of Spohn by CHRISTUS Health and the District, such that CHRISTUS Health and the District will be Members of Spohn, consistent with the related amended organizational documents of Spohn and the continued operation of Spohn as the public, safety-net hospital in Nueces County, Texas;

WHEREAS, in connection with the Members' collaborative efforts to facilitate operation of a public, safety-net hospital in Nueces County, the parties have amended and terminated each of the 1996 Transaction Agreements effective not later than September 30, 2012;

WHEREAS, Spohn and CHRISTUS Health are parties to that certain Master Trust Indenture amended, restated and dated as of July 1, 2007 between CHRISTUS Health, the members of the Obligated Group (as defined under the Master Trust Indenture) and The Bank of New York Mellon Trust Company, N.A., together with various banking and insurance agreements relating to same (collectively, the “CHRISTUS Indenture”);

WHEREAS, the CHRISTUS Indenture secures certain outstanding debt of CHRISTUS and Spohn, and grants a security interest in their gross revenues, and imposes numerous financial and other covenants and requirements on CHRISTUS and Spohn and their properties and operations;

WHEREAS, the parties hereto acknowledge the CHRISTUS Indenture and agree that CHRISTUS Health may terminate this Agreement immediately to the extent (but only to the extent) that application or enforcement of this Agreement would cause a material violation, breach or default under the CHRISTUS Indenture; and

WHEREAS, the parties have mutually agreed to the Member contributions each shall make to Spohn as part of and for the duration of this Agreement as set forth in Article II below;

NOW, THEREFORE, in consideration of the premises, the mutual benefits to the
parties to be derived from the joint membership in Spohn and the obligations and responsibilities set forth in this Agreement, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree, with the intent to be legally bound, as follows:

ARTICLE I. SPOHN AS A PUBLIC HOSPITAL

Section 1.01. Public Hospital and Delivery of Indigent Care Services. Spohn has operated and will continue, during the term of this Agreement, to operate a safety-net hospital available for the provision of inpatient and outpatient hospital services to the indigent and needy residents in Nueces County, Texas at the Nueces County Facilities, in accordance with the District's obligations under the Texas Constitution and the Act and as more fully set forth in Section 8.03 and Schedule 2 of this Agreement.

ARTICLE II. MEMBERSHIP IN SPOHN.

Section 2.01. CHRISTUS Health. CHRISTUS Health and the District are Members of Spohn in accordance with the Amended and Restated Certificate of Formation of Spohn ("Certificate"), attached hereto as Exhibit A, and the Amended and Restated Bylaws of Spohn ("Bylaws"), attached hereto as Exhibit B. CHRISTUS Health and its members shall retain those reserved powers set forth in the Bylaws. CHRISTUS Health hereby agrees to abide by the terms set forth in the Bylaws and this Agreement.

Section 2.02. Nueces County Hospital District. Pursuant to this Agreement and the Bylaws, the District shall become a Member of Spohn, consistent with and in support of its interest in the continued operation of Spohn as the public safety-net hospital in Nueces County, Texas, the District's obligation to provide health care to the indigent and needy residents of Nueces County, Texas (as described in the Nueces County Hospital Indigent Care Program Handbook ("Handbook") and in accordance with the terms and conditions set forth in this Agreement), and with the District's legal obligation to provide healthcare services for the indigent residents of Nueces County under the Texas Constitution and the Act. The District hereby agrees to abide by the terms set forth in the Bylaws and this Agreement, to the extent not inconsistent with the Texas Constitution and the Act.

Section 2.03. Contributions of Members. Each Member shall provide to Spohn the managerial skills and expertise and available resources to permit Spohn to operate the public safety-net hospital in Nueces County, Texas. While CHRISTUS Health and the Spohn Board of Directors shall provide management personnel for the day-to-day operations of Spohn, both Members shall advise Spohn, through its Board of Directors, on steps that can be taken to improve the delivery of healthcare services to the indigent and low-income residents of Nueces County, Texas that present for hospital and certain medical services at the Nueces County Facilities.

(a) Contributions of CHRISTUS Health. During the term of this Agreement, and notwithstanding any reserved power set forth in Spohn's Bylaws, CHRISTUS Health shall permit Spohn to retain its title and ownership of, and the right to use

Spohn Membership Agreement
ARTICLE I. SPORN AS A PUBLIC HOSPITAL

Section 1.01. Public Hospital and Delivery of Indigent Care Services. Spohn has operated and will continue, during the term of this Agreement, to operate a safety-net hospital available for the provision of inpatient and outpatient hospital services to the indigent and needy residents in Nueces County, Texas at the Nueces County facilities, in accordance with the District’s obligations under the Texas Constitution and the Act and as more fully set forth in Section 8.03 and Schedule 2 of this Agreement.

ARTICLE II. MEMBERSHIP IN SPORN.

Section 2.01. CHRISTUS Health, CHRISTUS Health and the District are Members of Spohn In accordance with the Amended and Restated Certificate of Formation of Spohn ("Certificate"), attached hereto as Exhibit A, and the Amended and Restated Bylaws of Spohn ("Bylaws"), attached hereto as Exhibit B. CHRISTUS Health and its members shall retain those reserved powers set forth in the Bylaws. CHRISTUS Health hereby agrees to abide by the terms set forth in the Bylaws and this Agreement.

Section 2.02. Nueces County Hospital District. Pursuant to this Agreement and the Bylaws, the District shall become a Member of Spohn, consisting with and in support of its interest in the continued operation of Spohn as the public safety-net hospital in Nueces County, Texas, the District’s obligation to provide health care to the indigent and needy residents of Nueces County, Texas (as described in the Nueces County Hospital Indigent Care Program Handbook ("Handbook") and in accordance with the terms and conditions set forth in this Agreement), and with the District’s legal obligation to provide healthcare services for the indigent residents of Nueces County under the Texas Constitution and the Act. The District hereby agrees to abide by the terms set forth in the Bylaws and this Agreement, to the extent not inconsistent with the Texas Constitution and the Act.

Section 2.03. Contributions of Members. Each Member shall provide to Spohn the managerial skills and expertise and available resources to permit Spohn to operate the public safety-net hospital in Nueces County, Texas. While CHRISTUS Health and the Spohn Board of Directors shall provide management personnel for the day-to-day operations of Spohn, both Members shall advise Spohn, through its Board of Directors, on steps that can be taken to improve the delivery of healthcare services to the indigent and low-income residents of Nueces County, Texas that present for hospital and certain medical services at the Nueces County Facilities.

(a) Contributions of CHRISTUS Health. During the term of this Agreement, and notwithstanding any reserved power set forth in Spohn’s Bylaws, CHRISTUS Health shall permit Spohn to retain its title and ownership of, and the right to use
and operate the campuses known as CHRISTUS Spohn Hospital Corpus Christi—Shoreline and CHRISTUS Spohn Hospital Corpus Christi—South. Spohn shall continue to occupy and utilize the CHRISTUS Spohn Hospital Corpus Christi—Memorial facility contributed by the District and, shall comply with all of Spohn's obligations regarding the CHRISTUS Spohn Hospital Corpus Christi—Memorial facility set forth in Schedule 1. Further, to the extent that (i) Spohn acquires, owns, leases, or operates any additional hospital campuses or other facilities located within Nueces County, Texas during the term of this Agreement and (ii) such additional hospital campus(es), clinics, practices or other facility(ies) is (are) consolidated with the Nueces County Facilities for purposes of participation in the Medicare and Medicaid programs, then CHRISTUS Health and Spohn hereby agree that such additional campus(es) or other facility(ies) shall be treated as part of Spohn’s “Nueces County Facilities” for purposes of this Agreement. Any hospital campuses or other facilities owned or operated by CHRISTUS Health and/or Spohn that are not consolidated with the Nueces County Facilities for purposes of Spohn’s participation in the Medicare and Medicaid programs shall be excluded from the definition of “Nueces County Facilities,” regardless of where located.

(b) Contributions of the District. During the term of this Agreement, the District shall provide Spohn the right to occupy, use and operate the hospital facility and other property owned by the District at the location known as CHRISTUS Spohn Hospital Corpus Christi—Memorial along with the medical office buildings and clinics located at 2601 Hospital Boulevard, 2400 Morgan Avenue, 2500 Morgan Avenue, 1406 Martin L. King Drive, 14202 South Padre Island Dr., and 4617 Greenwood Drive, Corpus Christi, Texas and 1038 Texas Yes Boulevard, Robstown, Texas (together the “District Owned Facilities”).

Section 2.04. Additional Member Contributions.

(a) For any fiscal year in which Spohn incurs a “Net Operating Deficit,” as defined below, Spohn shall provide written notice of such deficit (“Notice of Net Operating Deficit”) to its Members after completing its final financial audit for such fiscal year, but in no event shall Spohn issue any such Notice of Net Operating Deficit later than one hundred and eighty (180) days after the close of such fiscal year. For purposes of this Agreement, for any fiscal year, a “Net Operating Deficit” shall mean the amount by which Spohn’s expenses from operating the Nueces County Facilities exceed its revenue from such operations, as determined after (i) excluding (1) expenses for interest, taxes, depreciation, amortization, judgments, settlements, or prior year cost report or other adjustments, (2) management fees paid or payable to CHRISTUS Health or any affiliates for that fiscal year, and (3) any inter-company transfers or extraordinary expenses; and (ii) offsetting proceeds from business interruption, flood, windstorm, or other similar insurance. Upon receipt of a Notice of Net Operating Deficit, each Member and its representatives will be entitled to access to and to receive copies of audited financial data and other certified supporting schedules and information substantiating the Net Operating Deficit.
(b) To help meet the needs of the indigent in Nueces County, Spohn may request that the Members contribute a pro rata share of the Net Operating Deficit, with such “pro rata share” computed on the same basis as the “Specified Annual Percentage” as determined under Section 7.03 below for the fiscal year in which the Net Operating Deficit occurred. Subject to Subsection 2.04 (c) below, upon such request, each Member shall contribute its pro rata share of the Net Operating Deficit to Spohn within one hundred and eighty (180) days of receipt of such a Notice of Net Operating Deficit.

(c) Either party may exercise its right to terminate this Agreement pursuant to Article IX of this Agreement prior to the expiration of the 180-day provision for contributions in Section 2.04(b) of this Agreement, and such termination shall excuse the Members’ obligations set forth in Section 2.04(b) of this Agreement.

(d) Nothing in this Section shall obligate any Member to incur any liability to any third party nor shall it confer any benefit on any third party that is not a party to this Agreement.

Section 2.05. Termination of 1996 Transaction Agreements. Spohn and the District shall enter into terminations of the 1996 Transaction Agreements, along with any related agreements, not later than the day prior to the Effective Date of this Agreement.

ARTICLE III. REPRESENTATIONS AND WARRANTIES

Section 3.01. District Representations and Warranties.

The District represents and warrants to CHRISTUS Health and Spohn as follows:

(a) The District is a validly existing county hospital district and political subdivision of the State of Texas established pursuant to Article 9, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health and Safety Code.

(b) To the District’s knowledge, the District has full power and authority to carry out and perform its undertakings and obligations as provided in this Agreement, including the execution, delivery and performance of this Agreement and related agreements and documents. This Agreement will constitute the legal valid and binding obligation of the District, enforceable against the District in accordance with its terms, except to the extent such enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium and other laws of general application relating to creditors' rights. The execution, delivery and performance by the District of this Agreement (i) have been duly and validly authorized by all proper and requisite action of the District's Board of Managers and the Nueces County Commissioners Court, (ii) will not conflict with, violate, constitute an event of default under or breach any provision of any binding order or resolution of the District's Board of Managers or the Nueces County Commissioners Court, or (iii) to the knowledge of the District, will not conflict with, violate, breach or
constitute any default under any contract, agreement or arrangement to which the District is a party or by which the District is bound.

Section 3.02. CHRISTUS Health Representations and Warranties. CHRISTUS Health represents and warrants to Spohn and the District as follows:

(a) CHRISTUS Health is a nonprofit corporation duly organized, validly existing and in good standing under the laws of the State of Texas. CHRISTUS Health has the corporate power and authority to carry on its business as now conducted.

(b) To CHRISTUS Health's knowledge, CHRISTUS Health has full power and authority to carry out and perform its undertakings and obligations as provided in this Agreement, including the execution, delivery and performance of this Agreement and related agreements and documents. This Agreement will constitute the legal valid and binding obligation of CHRISTUS Health, enforceable against CHRISTUS Health in accordance with its terms, except to the extent such enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium and other laws of general application relating to creditors' rights. The execution, delivery and performance by CHRISTUS Health of this Agreement (i) have been duly and validly authorized by all proper and requisite action of CHRISTUS Health's Board, (ii) will not conflict with, violate, constitute an event of default under or breach any provision of any binding order or resolution of CHRISTUS Health's Board, or (iii) to the knowledge of CHRISTUS Health, will not conflict with, violate, breach or constitute any default under any contract, agreement or arrangement to which CHRISTUS Health is a party or by which CHRISTUS Health is bound.

Section 3.03. Spohn Representations and Warranties. Spohn represents and warrants to CHRISTUS and the District as follows:

(a) Spohn is a nonprofit corporation duly organized, validly existing and in good standing under the laws of the State of Texas. -Spohn has the corporate power and authority to carry on its business as now conducted.

(b) To Spohn's knowledge, Spohn has full power and authority to carry out and perform its undertakings and obligations as provided in this Agreement, including the execution, delivery and performance of this Agreement and related agreements and documents. This Agreement will constitute the legal valid and binding obligation of Spohn, enforceable against Spohn in accordance with its terms, except to the extent such enforceability may be limited by bankruptcy, insolvency, reorganization, moratorium and other laws of general application relating to creditors' rights. The execution, delivery and performance by Spohn of this Agreement (i) have been duly and validly authorized by all proper and requisite action of Spohn's Board of Directors, (ii) will not conflict with, violate, constitute an event of default under or breach any provision of any binding order or resolution of Spohn's Board of Directors, or (iii) to the knowledge of Spohn,
will not conflict with, violate, breach or constitute any default under any contract, agreement or arrangement to which Spohn is a party or by which Spohn is bound.

(c) The execution, delivery, and performance of this Agreement by Spohn will not, (i) conflict with or violate the Certificate or Bylaws of Spohn, (ii) conflict with or violate any law applicable to Spohn or by which any property or asset of Spohn is bound or affected, or (iii) result in any material breach of or constitute a material default (or an event which with notice or lapse of time or both would become a material default) under, give to others any right of termination, amendment, acceleration or cancellation of, or result in the creation of a lien or other encumbrance on any material property or asset of such person pursuant to, any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise or other instrument or obligation to which Spohn is a party or by which Spohn is bound or affected, except in the case of clauses (ii) and (iii) for any such conflicts, violations, breaches, defaults or other occurrences which would not, individually or in the aggregate, prevent or materially delay the performance by Spohn of its obligations under this Agreement.

(d) Except as disclosed to CHRISTUS Health and the District in writing, there is no litigation action or claim pending or, to the knowledge of Spohn, threatened against or relating to Spohn, nor, to the knowledge of Spohn, is there any basis for any such action or claim, which, if determined adversely to the interest of Spohn, would prevent or delay the consummation of the transactions contemplated by this Agreement or would have a material adverse affect on the business operations or financial condition of Spohn. For purposes of this Section 3.03, materiality includes items involving amounts exceeding Ten Million Dollars ($10,000,000) individually or in the aggregate.

(e) Spohn has all licenses, permits and authorizations of applicable governmental entities materially necessary for the conduct of the business of the Nueces County Facilities. Spohn has possession of all licenses, permits and authorizations issued to it and in its name, and all such licenses, permits and authorizations are as of the date of this Agreement and shall be in full force and effect at the Effective Date. To Spohn's knowledge, no material violations are or have been recorded in respect of such licenses, permits and authorizations, and no proceeding is pending or, to the knowledge of Spohn, threatened seeking the revocation or limitation of any of such Spohn licenses, permits and authorizations.

(f) Spohn is a “Provider” under existing provider agreements for the Nueces County Facilities with the applicable Medicare and Medicaid authorities, and prior to the date hereof, CHRISTUS Health and the District have had the opportunity to review current and complete copies of such agreements, if any, and all notices of program reimbursement and notices of deficiencies relating to and materially affecting Spohn's participation in the Medicare and Medicaid programs for the last three (3) fiscal years of Spohn ending prior to the Effective Date.
(g) Spohn has timely filed all requisite cost reports and other material reports for the Nueces County Facilities required to be filed in connection with all state and federal Medicare and Medicaid programs due on or before the date hereof, which are to Spohn's knowledge complete and correct.

(h) To Spohn's knowledge, Spohn has in all material respects complied with, and is now in all material respects in compliance with, all applicable laws. Spohn shall provide CHRISTUS Health and the District copies of the public inspection copy of its Internal Revenue Service Form 990 ("Form 990") for each of the last three (3) fiscal years of Spohn ending prior to the Effective Date. Spohn represents that such Form 990s are in accordance with the books and records of Spohn, have been prepared in accordance with GAAP, consistently applied throughout the periods covered therein, and fairly present the financial condition and results of operation of Spohn.

(i) During the current fiscal year-to-date and last three (3) fiscal years of Spohn ending prior to the Effective Date, Spohn has actively maintained a compliance program consistent with CHRISTUS Health compliance program and that complies with the requirements of the Office of Inspector General for an effective compliance program.

ARTICLE IV. BOARD OF DIRECTORS AND VOTING RIGHTS OF MEMBERS.

Section 4.01. Appointment of Directors. All Directors on Spohn's Board of Directors serve staggered terms. It is the intention of the parties that the right to nominate and appoint Directors to the Spohn Board of Directors set forth in this Section shall be effected on a staggered basis. The Members shall have the right to nominate and appoint Directors to the Spohn Board of Directors as follows:

(a) CHRISTUS Health may nominate and appoint twelve Directors to the Spohn Board of Directors, or such other number of Directors as set forth in Spohn's Bylaws; and

(b) The District may nominate and appoint three Directors to the Spohn Board of Directors.

Any right to appoint Directors to Spohn's Board of Directors pursuant to this Agreement supersedes and replaces any similar right set forth in Section 10.5 of the Master Agreement during the term of this Agreement.

Section 4.02. Replacement of Current Directors. Not later than the Effective Date, the "Landlord Nominees" nominated by the Nueces County Commissioner's Court and appointed Directors on the Spohn Board of Directors in accordance with Section 10.5 of the Master Agreement shall be removed and replaced by Directors appointed by the District as set forth in Section 4.01(b) of this Agreement. All remaining Directors on the Spohn Board of Directors shall serve until replaced in accordance with Spohn's Bylaws and this Article IV. Consistent with the Bylaws, CHRISTUS Health and the District shall have the right to remove, with or without
cause, and replace any Directors of Spohn that each, respectively, nominated and/or appointed to Spohn's Board of Directors at any time during the term of this Agreement. CHRISTUS Health shall have the right to remove for cause any Spohn Board of Directors that do not meet the qualification criteria set forth in Spohn's Bylaws.

Section 4.03. Voting Rights. The District shall have the authority to approve or disapprove any amendments or revisions to the Bylaws of Spohn that alter or impair the District's reserved powers set forth in the Bylaws and this Agreement including, without limitation, the District's reserved power to receive transfers of assets of Spohn in accordance with Article VII of this Agreement.

ARTICLE V. ACCESS TO INFORMATION

Section 5.01. General Access to Information. On a quarterly basis, Spohn shall meet with the District's representatives to review and discuss Spohn's financial results, including its operating income or loss for the most recent quarter then ended and year to date. All Directors on Spohn's Board of Directors may have the right to review such information deemed reasonably necessary for the Directors to carry out their duties and responsibilities as Directors of Spohn; provided, however, that any information Spohn in its sole discretion deems to be confidential and/or privileged—whether due to privacy of patient medical records, attorney-client communication, trade secrets, peer review or any other privilege or right of confidentiality—may not be disclosed outside of the Spohn Board of Directors or staff.

Section 5.02. Notification. Spohn agrees, to the extent permitted by applicable law, to notify the District within ten (10) calendar days of (a) receipt of notice of the commencement of any investigation, audit, formal review or other regulatory action by or on behalf of a federal or state governmental authority involving Spohn or the Nueces County Facilities, (including but not limited to such action that involves an allegation of program fraud or abuse) which could be reasonably anticipated to prevent, delay, or substantially and negatively impact the continuing performance of Spohn's duties and obligations under this Agreement; (b) receipt of notice of any finding resulting from any such investigation, audit, formal review, or other regulatory action; (c) receipt of notice of proposed or actual termination, loss or lapse of the Medicare or Medicaid provider agreement of any of the Nueces County Facilities; and (d) the breach, lapse, or inaccuracy of any representation or warranty required under this Agreement. CHRISTUS Health agrees to notify the District in writing immediately upon determining that compliance with Section 7.02 or any other provision of this Agreement does or may potentially cause CHRISTUS Health to be in material breach, default, or violation of the terms of the CHRISTUS Indenture.
ARTICLE VI. LIABILITY AND INDEMNIFICATION OF MEMBERS

Section 6.01. Limitation on Members' Liability. Neither Member shall be held liable for the acts of Spohn as a result of serving as a Member in the corporation, nor shall any Member be held liable for the acts of Spohn because of its participation in this Agreement. Nothing in this Agreement is intended to create, nor does it create, any rights or benefits to third parties enforceable against any Member of Spohn. The Members do not by this Agreement assume any of the obligations, liabilities or debts of Spohn (including, without limitation, any bond indebtedness), and shall not, by virtue of their performance under this Agreement, assume or become liable for any of such obligations, debts or liabilities of Spohn.

Section 6.02. Indemnification.

(a) Indemnification of Members, Officers, and Directors of Spohn. To the fullest extent permitted by law, Spohn shall defend, indemnify and hold harmless the Members, their officers, agents and employees, and the Directors of Spohn ("Indemnified Parties") who were or are parties or are threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of Spohn or the Members) by reason of any acts, omissions or alleged acts or omissions arising out of an Indemnified Party's (i) activities as a Member, Director, officer, manager, or employee of Spohn, or as a partner, manager, officer, director, employee of a Member, on behalf of Spohn or in furtherance of the interest of Spohn, or (ii) performance of such Indemnified Party's obligations under this Agreement from and against any and all liabilities, losses, costs, damages, or expenses, unless any such damages arise from the bad faith or gross negligence of such Indemnified Party(ies). The termination of any action, suit, or proceeding by judgment, order, settlement, or upon a plea of nolo contendere or its equivalent, will not of itself create a presumption that an Indemnified Party acted in a manner constituting bad faith or gross negligence. A party's termination of this Agreement pursuant to Section 2.04(e) and Article IX will not constitute bad faith or gross negligence. The right of indemnification and payment of expenses under this Section 6.02(a) shall not be exclusive of any other right that any Indemnified Party may have or hereafter acquire under any statute, provision of the Certificate or Bylaws, provision of this Agreement, vote of the Members or otherwise. Spohn shall obtain director's and officer's insurance to insure against any claims that could be brought against the Members for their service as Members of Spohn or against the Directors for their service as Directors of the Board of Directors of Spohn.

(b) Indemnification of the District. Spohn agrees to indemnify the District, its officers, board of managers, employees and agents, against (a) any Damages (as defined below) which arise out of or in connection with any claims by or on behalf of in the name of a government entity or authority, State or federal, relating to Spohn's or the District's obligations under this Agreement, or related transactions, Spohn's receipt of payments under the Waiver, whether received before or after the Effective Date, and (b) Damages which arise out of or in
ARTICLE VI. LIABILITY AND INDEMNIFICATION OF MEMBERS

Section 6.01. Limitation on Members' Liability. Neither Member shall be held liable for the acts of Spohn as a result of serving as a Member in the corporation, nor shall any Member be held liable for the acts of Spohn because of its participation in this Agreement. Nothing in this Agreement is intended to create, nor does it create, any rights or benefits to third parties enforceable against any Member of Spohn. The Members do not by this Agreement assume any of the obligations, liabilities or debts of Spohn (including, without limitation, any bond indebtedness), and shall not, by virtue of their performance under this Agreement, assume or become liable for any of such obligations, debts or liabilities of Spohn.

Section 6.02. Indemnification.

(a) Indemnification of Members, Officers, and Directors of Spohn. To the fullest extent permitted by law, Spohn shall defend, indemnify and hold harmless the Members, their officers, agents and employees, and the Directors of Spohn ("Indemnified Parties") who were or are parties or are threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of Spohn or the Members) by reason of any acts, omissions or alleged acts or omissions arising out of an Indemnified Party's (i) activities as a Member, Director, officer, manager, or employee of Spohn, or as a partner, manager, officer, director, employee of a Member, on behalf of Spohn or in furtherance of the interest of Spohn, or (ii) performance of such Indemnified Party's obligations under this Agreement from and against any and all liabilities, losses, costs, damages, or expenses, unless any such damages arise from the bad faith or gross negligence of such Indemnified Party(ies). The termination of any action, suit, or proceeding by judgment, order, settlement, or upon a plea of nolo contendere or its equivalent, will not of itself create a presumption that an Indemnified Party acted in a manner constituting bad faith or gross negligence. A party's termination of this Agreement pursuant to Section 23.06 and Article IX will not constitute bad faith or gross negligence. The right of indemnification and payment of expenses under this Section 6.02(a) shall not be exclusive of any other right that any Indemnified Party may have or hereafter acquire under any statute, provision of the Certificate or Bylaws, provision of this Agreement, vote of the Members or otherwise. Spohn shall obtain director's and officer's insurance to insure against any claim that could be brought against the Members for their service as Members of Spohn or against the Directors for their service as Directors of the Board of Directors of Spohn.

(b) Indemnification of the District. Spohn agrees to indemnify the District, its officers, board of managers, employees and agents, against (a) any Damages (as defined below) which arise out of or in connection with any claims by or on behalf of or in the name of a government entity or authority, State or federal, relating to Spohn's or the District's obligations under this Agreement, or related transactions, Spohn's receipt of payments under the Waiver, whether received before or after the Effective Date, and (b) Damages which arise out of or in
connection with the negligence or malfeasance of any employee or agent of Spohn performing services under or in connection with this Agreement or Spohn's breach of any material requirement of this Agreement (the "Indemnity"). Subject to applicable law, Spohn shall have the right to select and engage defense counsel and manage the defense for any claim or action brought against the District by a third-party. The District shall cooperate with Spohn in Spohn's engagement of legal counsel to defend any such third-party claim or action. Notwithstanding anything in this Section 6.02(b) to the contrary, in the event that representation of Spohn and the District by the same counsel to defend any third-party claim or action subject to this Section 6.02(b) would be a conflict of interest for such counsel under the Texas Disciplinary Rules of Professional Conduct then in effect, the District may require Spohn to select another independent counsel, in consultation with the District, without relieving Spohn of its obligation to indemnify and defend the District under this Section 6.02(b). In the event the District or Spohn becomes aware of a third-party claim or action subject to this Section 6.02(b), such party shall provide the other party prompt written notice of the claim or action and shall use its best efforts to provide the other party sufficient information to identify the circumstances of the claim or action. Such notice shall be made as soon as practical from the date of actual notice of the claim or action to the party possessing such knowledge.

For purposes of this Section 6.02(b), "Damages" shall mean judgments, liabilities, fines, penalties, costs, and other amounts or assessments of responsibility, if any, required to be paid or refunded to, or recouped by, any person or entity, governmental authorities or entities or persons acting on behalf or in the name of such governmental entities or authorities, including statutory or other attorneys' fees and similar costs, incurred by the District related to any claim or action that entitles the District to the Indemnity pursuant to this Section 6.02(b).

(c) The provisions of this Section 6.02 shall survive the termination, expiration, or assignment of this Agreement.

ARTICLE VII. REVENUE SHARING

Section 7.01. Net Patient Revenue from Spohn's Nueces County Facilities. As used in this Agreement, the term "Net Patient Revenue" shall mean Spohn's direct cash collections received for the provision of inpatient and outpatient hospital services, including any ancillary and related services, at or through the Nueces County Facilities on or after the Effective Date, that are received from patients or third parties responsible for making payments on behalf of such patients. The term "Net Patient Revenue" shall not include any Medicare or CHAMPUS/TRICARE payments, the federal share of any Medicaid payments, or Medicaid Waiver or supplemental payments, nor any federal grant funding, paid to Spohn that is not specifically allocated to individual patients' services. Further, the term "Net Patient Revenue" shall not include any revenue generated from the operation or provision of services at any hospital, clinic or other facility that is not consolidated with the Nueces County Facilities for purposes of Spohn's participation in the Medicare and Medicaid programs.
connection with the negligence or malfeasance of any employee or agent of Spohn performing services under or in connection with this Agreement or Spohn’s breach of any material requirement of this Agreement (the “Indemnity”). Subject to applicable law, Spohn shall have the right to select and engage defense counsel and manage the defense for any claim or action brought against the District by a third-party. The District shall cooperate with Spohn in Spohn’s engagement of legal counsel to defend any such third-party claim or action. Notwithstanding anything in this Section 6.02(b) to the contrary, in the event that representation of Spohn and the District by the same counsel to defend any third-party claim or action subject to this Section 6.02(b) would be a conflict of interest for such counsel under the Texas Disciplinary Rules of Professional Conduct then in effect, the District may require Spohn to select another independent counsel, in consultation with the District, without relieving Spohn of its obligation to indemnify and defend the District under this Section 6.02(b). In the event the District or Spohn becomes aware of a third-party claim or action subject to this Section 6.02(b), such party shall provide the other party prompt written notice of the claim or action and shall use its best efforts to provide the other party sufficient information to identify the circumstances of the claim or action. Such notice shall be made as soon as practicable from the date of actual notice of the claim or action to the party possessing such knowledge.

For purposes of this Section 6.02(b), “Damages” shall mean judgments, liabilities, fines, penalties, costs, and other amounts or assessments of responsibility, if any, required to be paid or refunded to, or recouped by, any person or entity, governmental authorities or entities or persons acting on behalf or in the name of such governmental entities or authorities, including statutory or other attorneys’ fees and similar costs, incurred by the District related to any claim or action that entitles the District to the indemnity pursuant to this Section 6.02(b).

(c) The provisions of this Section 6.02 shall survive the termination, expiration, or assignment of this Agreement.

ARTICLE VII. REVENUE SHARING

Section 7.01. Net Patient Revenue from Spohn’s Nueces County Facilities. As used in this Agreement, the term “Net Patient Revenue” shall mean Spohn’s direct cash collections received for the provision of inpatient and outpatient hospital services, including any ancillary and related services, at or through the Nueces County Facilities on or after the Effective Date, that are received from patients or third parties responsible for making payments on behalf of such patients. The term “Net Patient Revenue” shall not include any Medicare or CHAMPS/TRICARE payments, the federal share of any Medicaid payments, or Medicaid Waiver or supplemental payments, nor any federal grant funding, paid to Spohn that is not specifically allocated to individual patients’ services. Further, the term “Net Patient Revenue” shall not include any revenue generated from the operation or provision of services at any hospital, clinic or other facility that is not consolidated with the Nueces County Facilities for purposes of Spohn’s participation in the Medicare and Medicaid programs.
Section 7.02. Establishment of Bank Deposit Accounts. Not later than thirty (30) days following execution of this Agreement, Spohn shall authorize Bank of America, N.A., or any successor financial institution ("Bank"), to establish or maintain one or more "Operating Bank Deposit Accounts" in the name of Spohn. Spohn shall deposit the Net Patient Revenue into the Operating Bank Deposit Account(s) at Bank. From the Operating Bank Deposit Account(s), Bank shall upon the direction of Spohn transfer all funds on a daily basis to a "Membership Bank Deposit Account" held at Bank in the name of Spohn. Bank shall transfer upon the direction of Spohn on a weekly basis all available funds deposited into the Membership Bank Deposit Account, by ACH or wire transfer, to accounts designated by CHRISTUS Health and the District, as follows: (i) the "Specified Annual Percentage," as defined below, shall be transferred to CHRISTUS Health's designated account, and (ii) the remaining percentage of such funds shall be transferred to the District's designated account. For each transfer of funds to the District in accordance with this Section 7.02, Spohn hereby affirms that such funds include only qualifying Net Patient Revenue. Notwithstanding the foregoing, to the extent Spohn discovers that any such transfer inadvertently includes any funds that do not qualify as Net Patient Revenue as defined in Section 7.01, Spohn shall notify the District in writing within five (5) business days of such discovery and shall work collaboratively with the District to correct any such inadvertent discrepancy.

Section 7.03. Member Revenue Allocation Percentage.

(a) Not later than June 1st each year of this Agreement, Spohn, CHRISTUS Health, and the District shall confer regarding the support necessary for the operations of Spohn over the ensuing year from October 1 of the current calendar year through September 30 of the following calendar year (the "Ensuing Year"). Spohn shall prepare a budget for the Ensuing Year that contemplates any modifications or additions in its provision of services at the Nueces County Facilities, changes in expected patient utilization or demographics in Nueces County, Texas that would alter the need for economic support to Spohn from the Members, and other factors that bear on Spohn's need for financial support in the Ensuing Year. Upon review of the budget, economic resources of Spohn and the Members and other factors, Spohn and the Members shall agree to the percentage of the Net Patient Revenue that will be made available to CHRISTUS Health (the "Specified Annual Percentage"), in exchange for its contributions to support the operations of Spohn, and the remaining percentage of the Net Patient Revenue that will be made available to the District in exchange for its continued support for the operations of Spohn as a public, safety-net hospital in Nueces County, Texas.

(b) In the event the parties fail to agree to a Specified Annual Percentage by July 1 of any year of this Agreement, then Spohn's Board of Directors, or its designee, shall determine the Specified Annual Percentage for the Ensuing Year. Notwithstanding the foregoing, the Specified Annual Percentage for the first year of this Agreement shall be established on or before October 1, 2012. Both Spohn and the Members agree to take any and all reasonable measures to ensure that the Bank has whatever information it may require to authorize and implement the Net Patient Revenue allocations and transfers set forth in this Article VII.
(c) Nothing in this Agreement shall provide the District with any right to share in any revenue generated from the operations of any or all of Spohn's hospitals or other facilities that are excluded from the defined term "Nueces County Facilities."

ARTICLE VIII. MAINTENANCE OF EFFORT

Section 8.01. Maintenance of Effort. The parties to this Agreement recognize Spohn's historical role as the public, safety net hospital for low income and indigent patients in the Nueces County community as more fully described in Section 8.03 below, as well as the role of the District Owned Facilities in facilitating Spohn's role in serving low income and indigent patients. The parties intend for this role to continue during the term of this Agreement.

Section 8.02. Spohn's Occupancy of the Memorial Facility and Related Matters. During the term of this Agreement, Spohn will not pay rent to the District for use of the District Owned Facilities. However, Spohn's occupancy will be governed by the terms set forth in Schedule 1, attached.

Section 8.03. Spohn's Indigent Care Obligations. Spohn has historically served as the safety net hospital for the Nueces County Indigent patient population and the parties intend for that role to continue during the term of this Agreement. Except as otherwise set forth in the Handbook, during the term Spohn will continue to provide health care services to Indigents (as defined below) without charge at the level and to the extent set forth in the Handbook, which shall include at a minimum such level of service as is presently being delivered by Spohn to such Indigents. The determination of whether an individual is an "Indigent" eligible to receive health care services from Spohn shall be made by the District in accordance with the eligibility standards and procedures from time-to-time established by the District, following consultation with Spohn, and set forth in the Handbook. Spohn shall continue to treat Nueces County indigent patients pursuant to the terms set forth in Section 1.01 above and Schedule 2, attached.

ARTICLE IX. TERM AND TERMINATION

Section 9.01. Term. This Agreement shall remain in effect for an initial term of ten (10) years and shall automatically renew for another five (5) year term, unless a party provides ninety (90) days advance written notice to the other parties of its intent to terminate the Agreement at the end of the initial term. Notwithstanding anything herein to the contrary, this Agreement may be terminated by:

(a) The mutual agreement of CHRISTUS Health and the District;

(b) Either party, upon the expiration of ninety (90) days from written notice of election to terminate this Agreement, with or without cause;

(c) Either party, immediately upon the termination or expiration without renewal of the Waiver;

Spohn Membership Agreement

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(d) The District, immediately in the event that CHRISTUS Health voluntarily transfers its membership in Spohn in accordance with Section 4.1 of the Bylaws or if Spohn provides notification to the District pursuant to Section 5.02 above;

(e) CHRISTUS Health, immediately in the event compliance with Section 7.02 or any other provision of this Agreement would cause CHRISTUS Health and/or Spohn to be in material breach, default, or violation of the terms of the CHRISTUS Indenture.

Section 9.02. Effect of Termination. In the event of termination pursuant to Section 9.01 of this Agreement, then the 1996 Transaction Agreements shall be immediately reinstated effective upon the expiration or early termination of this Agreement; provided, however, that reinstatement of the payment provisions under the ICA for the year of reinstatement shall be contingent upon the District's review of the District's then current fiscal year budget to confirm financial ability to pay under the ICA for the remainder of such fiscal year. In addition, upon termination of this Agreement pursuant to Section 9.01, the District hereby consents to the amendment of Spohn's Certificate of Formation and Bylaws for the purpose of removing the District as a member of Spohn. The termination of this Agreement under Section 9.01 shall not affect the District's right to receive, or Spohn's obligation to fund, the District's share of the Net Patient Revenues for periods prior to the effective date of termination in accordance with Article VII of this Agreement.

ARTICLE X. MISCELLANEOUS

Section 10.01. Waivers and Amendments. Any waiver of any term or condition of this Agreement, or any amendment or modification of this Agreement, shall be effective only if set forth in a written document executed by a duly authorized officer or representative of each of the parties. A waiver of any breach or failure to enforce any of the terms or conditions of this Agreement shall not in any way affect, limit or waive a party's other rights hereunder at any time to enforce strict compliance thereafter with every term or condition of this Agreement.

Section 10.02. Notices. Any notice, request, instruction, demand or other communication to be given hereunder by either party hereto to the other shall be given in writing and shall be delivered either by hand, by telecopy or similar facsimile means (with follow-up hard copy sent by U.S.
Mail), or by registered or certified U.S. mail, postage prepaid, return receipt requested, as follows:

(a) If to Spohn, addressed to:

CHRISTUS Spohn Health System Corporation
1702 Santa Fe Street
Corpus Christi, Texas 78404
Attention: President/CEO
Telexcopy No.: (361) 885-0566
Telephone No.: (361) 881-3405

With a copy to:

Gjerset & Lorenz, LLP
2801 Via Fortuna, Suite 500
Austin, Texas 78746
Attention: Lance J. Ramsey
Telexcopy No.: (512) 899-3939
Telephone No.: (512) 899-3995

(b) If to CHRISTUS Health, addressed to:

CHRISTUS Health
919 Hidden Ridge
Irving, Texas 75038
Attention: President
Telexcopy No.: (214) 492-8518
Telephone No.: (214) 492-8500

With a copy to:

Gjerset & Lorenz, LLP
2801 Via Fortuna, Suite 500
Austin, Texas 78746
Attention: Lance J. Ramsey
Telexcopy No.: (512) 899-3939
Telephone No.: (512) 899-3995

(c) If to District, addressed to:

Nueces County Hospital District
555 N. Carancahua St., Suite 950
Corpus Christi, Texas 78401
Attention: Administrator
Telexcopy No.: (361) 808-3274
Telephone No.: (361) 808-3300
with a copy to:

William Dewitt Alsup, Esq.
Alsup and Alsup
555 North Carancahua St., Suite 1560
Corpus Christi, Texas 78401
Telecopy No.: (361) 884-6000
Telephone No.: (361) 884-6321

and

Gary W. Eiland, Esq.
King & Spalding LLP
1100 Louisiana, Suite 4000
Houston, TX 77002
Telecopy No.: (713) 751-3290
Telephone No.: (713) 751-3207

or such other address or number as either party shall have previously designated by written notice given to the other party in the manner hereinafore set forth. Notices shall be deemed given when received, if sent by telecopy or similar facsimile means, and when delivered and receipted for, if mailed or hand-delivered.

Section 10.03. Headings and Terminology. The Article and Section headings herein are for convenience only and shall not affect the construction hereof. Unless the context of this Agreement clearly requires otherwise, (a) pronouns, wherever used herein, and whatever gender, shall include natural persons and corporations and associations of every kind and character, (b) the singular shall include the plural and the plural shall include the singular wherever and as often as may be appropriate, (c) the word “includes” or “including” shall mean “including without limitation,” (d) the word “or” shall have the inclusive meaning represented by the phrase “and/or,” and (e) the words “hereof,” “herein,” “hereunder,” and similar terms in this Agreement shall refer to this Agreement as a whole and not any particular section or article in which such words appear. Unless otherwise stated, references to Sections, Subsections, Paragraphs, Exhibits and Schedules mean Sections, Subsections, Paragraphs, Exhibits and Schedules of and to this Agreement. All accounting terms not specifically defined herein shall be construed in accordance with GAAP. Unless otherwise specified, all references to a specific time of day in this Agreement shall be based upon Central Standard Time or Central Daylight Time, as applicable on the date in question.

Section 10.04. Parties in Interest. This Agreement is made solely for the benefit of Spohn, CHRISTI'S Health, and the District and their permitted successors and assigns, and no other Person shall acquire or have any right under or by virtue of this Agreement.

Section 10.05. Entire Agreement. This Agreement (including all Exhibits and Schedules hereto) constitute the entire agreement between the parties pertaining to the subject matter hereof and supersede all other prior and contemporaneous agreements and understandings, both oral and written, of the parties in connection therewith, except as expressly
retained and continued by this Agreement. No covenant or condition not expressed in this Agreement shall affect or be effective to interpret, change, or restrict this Agreement.

Section 10.06. Severability. If any term, provision, covenant or condition of this Agreement is held by any court of competent jurisdiction to be invalid, void or unenforceable in any respect, the remainder of such term, provision, covenant or condition in every other respect and the remainder of the terms, provisions, covenants or conditions of this Agreement shall continue in full force and effect and shall in no way be affected, impaired or invalidated.

Section 10.07. Governing Law. THIS AGREEMENT HAS BEEN EXECUTED IN THE STATE OF TEXAS AND IS TO BE PERFORMED IN NUECES COUNTY, TEXAS AND SHALL BE CONSTRUED IN ACCORDANCE WITH AND GOVERNED BY THE LAWS OF THE STATE OF TEXAS AND THE LAWS OF THE UNITED STATES OF AMERICA APPLICABLE TO TRANSACTIONS WITHIN THE STATE OF TEXAS.

Section 10.08. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective permitted successors and assigns; provided, however, that this Agreement shall not be assignable by Spohn, CHRISTUS Health, or the District to any person (other than a wholly-owned affiliate) without the express prior written consent of the other parties. No such assignment shall relieve the assigning party of any of its obligations hereunder, and the assigning party shall remain fully liable hereunder.

Section 10.09. Counterparts. This Agreement may be executed simultaneously in two (2) or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

Section 10.10. Dispute Resolution. The term “Dispute” means any and all questions, claims, controversies, or disputes arising out of or relating to this Agreement, including the validity, construction, meaning, performance, effect, or breach of this Agreement.

(a) Except as otherwise provided herein, in the event of a Dispute, the parties acknowledge and agree that they may seek recourse only for (i) temporary or preliminary injunctive relief or (ii) to toll any applicable statute of limitations relating to the matter in dispute, to the courts having jurisdiction thereof, and if any relief other than injunctive relief or the tolling of the statute of limitations is sought, the parties shall promptly, amicably, and in good faith attempt to resolve the Dispute through negotiations. A disputing party shall give written notice of the Dispute to the other applicable party(ies) that shall contain a brief statement of the nature of the Dispute (“Notice of Dispute”). If the parties are unable to resolve the Dispute within thirty (30) days of receipt of Notice of Dispute, the parties shall submit the Dispute to mediation as set forth below.

(b) In the event negotiation is unsuccessful, any party wishing to commence mediation shall send a written notice of intent to mediate to the other party(ies), specifying in detail the nature of the Dispute and proposing a resolution thereof (“Mediation Notice”). Within fifteen (15) days after such Mediation Notice is received by the other party(ies), if the parties cannot agree on a proposed
mediator, one shall be appointed in accordance with the rules and procedures of the American Health Lawyers Association ("AHLA"). Each party shall designate no more than three (3) representatives who shall meet with the mediator to mediate the Dispute. Mediation shall be commenced as soon as reasonably possible. The mediator shall be a person having no conflict of interest with a party. The mediation shall be conducted in Corpus Christi, Texas, or at such other venue as agreed to by the parties, and shall be non-binding. Subject to the Texas Public Information Act, Texas Open Meetings Act, and other applicable law, any non-binding mediation conducted under the terms of this Section shall be confidential within the meaning of Texas law. The cost of the mediation shall be borne equally by the parties, except for expenses of the individual parties. The mediation must be conducted and completed within thirty (30) days of the date of the Mediation Notice. Should the mediation not achieve a solution agreeable to the applicable parties, the parties must proceed with arbitration as set forth below.

(c) Mediation shall be a prerequisite to arbitration. If unsuccessful in resolving an issue submitted to mediation as outlined above, the applicable parties shall resolve such Dispute by binding arbitration in accordance with the provisions set forth below. Arbitration shall be conducted in Corpus Christi, Texas, or at such other venue as agreed to by the parties, in accordance with this Section of the Agreement and the rules and procedures of the AHLA. This matter shall be heard and decided, and awards rendered by a panel of three (3) Arbitrators (collectively, the "Arbitration Panel") within one hundred and eighty (180) days of the date a party delivers written notice ("Arbitration Notice") to the other party to this Agreement of its intention to resolve a matter by arbitration pursuant to this Section 10.10(c). Within twenty (20) business days of the date that the Arbitration Notice is received by the addressee, each party to arbitration shall select one Arbitrator from the panel of AHLA's arbitrators and such party-appointed Arbitrators shall select a third Arbitrator from the panel of AHLA arbitrators within thirty (30) business days after the date that the Arbitration Notice is received by the addressee. If the Party-appointed Arbitrators cannot agree within a reasonable period of time on the third, neutral arbitrator, then AHLA will select such third arbitrator. The arbitrators selected pursuant to this Section 10.10(c) shall be qualified by training, education, and experience to rule on the issues presented. In the event a party files suit for the purpose of tolling the statute of limitations, the parties intend that the court in which such suit is filed shall be bound by the Arbitrator's determination on the subject matter being arbitrated. The award rendered by the Arbitration Panel shall be final and binding as between the parties hereto and their successors and assigns, and judgment on the award may be entered by any court having jurisdiction thereof.

Section 10.11. Consent to Jurisdiction. Any legal action, suit or proceeding in law or equity arising out of or relating to this Agreement and the transactions contemplated hereby may be instituted in any state court in Nueces County, Texas or federal court in Nueces County, Texas.
mediator, one shall be appointed in accordance with the rules and procedures of the American Health Lawyers Association ("AHLA"). Each party shall designate no more than three (3) representatives who shall meet with the mediator to mediate the dispute. Mediation shall be commenced as soon as reasonably possible. The mediator shall be a person having no conflict of interest with a party. The mediation shall be conducted in Corpus Christi, Texas, or at such other venue as agreed to by the parties, and shall be non-binding. Subject to the Texas Public Information Act, Texas Open Meetings Act, and other applicable law, any non-binding mediation concluded under the terms of this Section shall be confidential within the meaning of Texas law. The cost of the mediation shall be borne equally by the parties, except for expenses of the individual parties. The mediation must be conducted and completed within thirty (30) days of the date of the Mediation Notice. Should the mediation not achieve a solution acceptable to the applicable parties, the parties must proceed with arbitration as set forth below.

(e) Mediation shall be a prerequisite to arbitration. If unsuccessful in resolving an issue submitted to mediation as outlined above, the applicable parties shall resolve such dispute by binding arbitration in accordance with the provisions set forth below. Arbitration shall be conducted in Corpus Christi, Texas, or at such other venue as agreed to by the parties, in accordance with this Section of the Agreement and the rules and procedures of the AHLA. This matter shall be heard and decided, and awards rendered by a panel of three (3) Arbitrators (collectively, the "Arbitration Panel") within one hundred and eighty (180) days of the date a party delivers written notice ("Arbitration Notice") to the other party to this Agreement of its intention to resolve a matter by arbitration pursuant to this Section. Within twenty (20) business days of the date that the Arbitration Notice is received by the addressee, each party to arbitration shall select one arbitrator from the panel of AHLA's arbitrators and such party-appointed arbitrators shall select a third arbitrator from the panel of AHLA arbitrators within thirty (30) business days after the date that the Arbitration Notice is received by the addressee. If the party-appointed arbitrators cannot agree within a reasonable period of time on the third, neutral arbitrator, then AHLA will select such third arbitrator. The arbitrators selected pursuant to this Section shall be qualified by training, education, and experience to rule on the issues presented. In the event a party files suit for the purpose of compelling the arbitration of a controversy, the parties intend that the court in which such suit is filed shall be bound by the arbitrator's determination on the subject matter being arbitrated. The award rendered by the Arbitration Panel shall be final and binding as between the parties hereto and their successors and assigns, and judgment on the award may be entered by any court having jurisdiction thereof.

Section 10.11. Consent to Jurisdiction. Any legal action, suit or proceeding in law or equity arising out of or relating to this Agreement and the transactions contemplated hereby may be instituted in any state court in Nueces County, Texas or federal court in Nueces County, Texas.
IN WITNESS WHEREOF, the parties hereto by their duly authorized representatives have executed this Agreement effective as of the date first written above.

CHRISTUS SPOHN HEALTH SYSTEM CORPORATION,
a Texas nonprofit corporation

By: ____________________________
    Pamela S. Robertson, Chief Executive Officer

CHRISTUS HEALTH,
a Texas nonprofit corporation

By: ____________________________
    Ernie Sadau, Chief Executive Officer

NUECES COUNTY HOSPITAL DISTRICT,
a political subdivision of the State of Texas

By: [Signature]
    Jonny F. Hipp, Administrator/Chief Executive Officer

APPROVED BY THE NUECES COUNTY COMMISSIONERS COURT

By: [Signature]
    S. Loyd Neal, Jr., County Judge
IN WITNESS WHEREOF, the parties hereto by their duly authorized representatives have executed this Agreement effective as of the date first written above.

CHRISTUS SPOHN HEALTH SYSTEM CORPORATION,  
a Texas nonprofit corporation  
By: ________________________________  
Pamela S. Robertson, Chief Executive Officer

CHRISTUS HEALTH,  
a Texas nonprofit corporation  
By: ________________________________  
Brian Sadler, Chief Executive Officer

NUCES COUNTY HOSPITAL DISTRICT,  
a political subdivision of the State of Texas  
By: ________________________________  
Jonny P. Hegg, Administrator/Chief Executive Officer

APPROVED BY THE NUCES COUNTY COMMISSIONERS COURT  
By: ________________________________  
S. Loyd Neil, Jr., County Judge
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF
NUECES COUNTY HOSPITAL DISTRICT
AND
CHRISTUS SPOHN HEALTH SYSTEM CORPORATION
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM CERTIFICATION OF NUÉCES COUNTY HOSPITAL DISTRICT AND CHRISTUS SPOHN HEALTH SYSTEM CORPORATION

TPI Number: 121775403

On behalf of the Nuéces County Hospital District ("District") and CHRISTUS Spohn Health System, a Texas nonprofit corporation, in good standing under the laws of the State of Texas ("Spohn"), we, Jonny F. Hipp, Administrator/CEO of the District, and Pamela S. Robertson, CEO of Spohn, respectively, to the best of our knowledge and belief and after consultation with the Health and Human Services Commission ("HHSC"), affirm and certify the following with respect to any period on or after October 1, 2012:

1. Authorization.
   a. Pursuant to that certain Spohn Membership Agreement ("Membership Agreement") entered into by and among the District, CHRISTUS Health, a Texas nonprofit corporation and Spohn effective as of October 1, 2012, the District and CHRISTUS Health are joint members in Spohn which serves as the public, safety-net hospital in and for Nuéces County and surrounding communities.
   b. As a public hospital, Spohn is eligible to receive, and does receive, supplemental Medicaid payments ("Supplemental Payments") from HHSC pursuant to regulations at 1 Tex. Admin. Code§355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Public Adoption and Access.
   a. The governing body of the District approved and adopted the Membership Agreement by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
b. Copies of the Membership Agreement will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.

3. **Funding of Intergovernmental Transfers and Supplemental Payments.**

   a. **District Source of Funds.** As a body politic and corporate and a political subdivision of the State of Texas, the District levies and collects ad valorem tax revenue and may generate other public revenue. Pursuant to the Membership Agreement, Spohn transfers a portion of its “net patient revenue” to the District, in the District’s capacity as a member of Spohn, on a weekly basis, where “net patient revenue” excludes any Medicare reimbursement, Medicaid reimbursement, or other federally funded reimbursement. The remaining net patient revenue is transferred by Spohn to CHRISTUS Health, in CHRISTUS Health’s capacity as a member of Spohn. Neither Spohn nor the terms of the Membership Agreement has imposed, nor will impose any limitations on the District’s use of the net patient revenue funds received from Spohn, nor is there any obligation for the District to contribute any specified amount for Supplemental Payments to Spohn or any other hospital.

   b. The District may use its discretion to transfer public funds to HHSC via intergovernmental transfer ("IGT") for use as the non-federal share of Supplemental Payments to Spohn and other hospitals in accordance with the Waiver Program.

4. **Assurances and Representations.**

   a. **Use of Supplemental Payments.**

   i. No funds derived from any Supplemental Payments received by Spohn have been or will be returned or reimbursed to the District.

   ii. No other funds have been used to reimburse the District in consideration of any Supplemental Payments to Spohn.

   iii. Neither the District nor Spohn has entered into any contingent fee arrangement regarding its participation in the Waiver Program, and Spohn will not use any of the Supplemental Payments it receives to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.
b. *Agreements with Governmental Entity.*

i. Spohn has not entered and will not enter into any agreement with the District to condition either the amount of the public funds transferred by the District or the amount of Supplemental Payments Spohn receives on the amount of indigent care Spohn has provided or will provide;

ii. Spohn has not entered and will not enter into any agreement with the District to condition the amount of Spohn’s indigent care obligation on either the amount of public funds transferred by the District to HHSC or the amount of Supplemental Payments Spohn maybe eligible to receive;

iii. Aside from the various contributions of the District, CHRISTUS Health, and Spohn set forth in the Membership Agreement, including the contributions related to facilities, provision of health care services to the indigent, and sharing of net patient revenue, neither Spohn nor the District is aware of any affiliated hospital or other entity acting on behalf of an affiliated hospital or group of affiliated hospitals that has made or agreed to make cash or in-kind transfers to the District other than transfers and transactions that:

1. Are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the District to a hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Spohn and the District.

c. *Use of Financial Mechanisms.* With regard to any escrow, trust or other financial mechanism (an” Account"”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that Spohn or an affiliated hospital provided or will provide;
ii. The District has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of Spohn or any affiliated hospitals.

5. Deferral or Disallowance of Federal Financial Participation.

a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Spohn to HHSC for Supplemental Payments, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Spohn's rights of administrative appeal.

b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.
On behalf of the District and Spohn, whereby certify that we have read and understood the above statements; that the statements are true, correct, and complete; and that we are authorized to bind the District and Spohn, respectively, and to certify to the above.

For the District:

Jonny F. Hipp
Administrator/CEO

Date

For Spohn:

Pamela S. Robertson
President & CEO

Date
INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (the “Agreement”) is entered into as of the 28th day of September, 2012 (“Effective Date”), by and between Nueces County Hospital District (“District”), and Victoria of Texas, LP d/b/a DeTar Healthcare System, a Delaware limited partnership (“Hospital”).

RECITALS:

WHEREAS, reductions in reimbursement under the Medicaid program and the growing uninsured population have created a gap between the costs Hospital incurs for treating Medicaid patients and the Indigent and the reimbursement Hospital actually receives;

WHEREAS, the District and Hospital recognize that the Indigent numbers in Nueces County and other counties in the Region will continue to increase, and that the burden of providing Health Care Services to the Indigent will continue to shift to the Hospital, District and local communities in Nueces County and other counties in the Region;

WHEREAS, the District is empowered by the Chapter 281 of the Texas Health and Safety Code and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code, as amended from time to time (the “Indigent Health Care and Treatment Act”), to enter into contracts relating to or arranging for the provision of Health Care Services;

WHEREAS, District and Hospital desire to collaborate to ensure the Indigent have access to and receive quality Health Care Services;

WHEREAS, District and Hospital recognize that it is in the best interest of all to increase funding for the Medicaid population and to access federal funding for the Indigent to which the Hospital will be entitled under the current Texas Medicaid Section 1115 Waiver (“Waiver”);

WHEREAS, the Waiver requires providers to work collectively and collaboratively to develop and submit a regional plan for health care delivery system reform through the formation of Regional Healthcare Partnerships (“RHPs”);

WHEREAS, these RHPs are to be based on regions determined by the Texas Health and Human Services Commission (“HHSC”);

WHEREAS, funds to finance the Waiver may be provided by public hospital districts and other units of government through intergovernmental transfers (“IGTs”);

WHEREAS, District and Hospital recognize that they need to collaborate to ensure their ability to deliver Health Care Services;
WHEREAS, Hospital desires to participate with the District and other entities to join in an affiliation with the District for purposes of forming an RHP; and

WHEREAS, the Waiver is intended to effect reform and improvement of healthcare delivery systems in four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) population-focused improvement and (4) clinical improvements in care.

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 PURPOSE

1.1 “Charity Care” means the provision of hospital services to the uninsured, as well as services defined by Texas Health and Safety Code §311.031(2).

1.2 “Health Care Services” means those services necessary to enhance the delivery of health care to the Indigent, as defined in Section 1.4 of this Agreement.

1.3 “HHSC” means the Texas Health and Human Services Commission.

1.4 “Indigent” means any person who meets (i) the income and other guidelines established for participation in the Texas Medicaid program, (ii) the income and other guidelines established for participation in the Children’s Health Insurance Program (“CHIP”), (iii) the income and other guidelines established in the Nueces County Hospital Indigent Care Program Handbook for participation in the District’s Indigent Health Care Program, (iv) the income and other guidelines established for participation in an indigent care program of a county or other hospital district in accordance with the Indigent Health Care and Treatment Act, or (v) the income and other guidelines to qualify as “financially indigent” or “medically indigent” under Section 311.031 of the Texas Health and Safety Code.

1.5 “Indigent Care” means treatment, services and education concerning the inpatient and outpatient hospital and medical professional needs of the Indigent, including both the performance of services and the provision for services.

1.6 “IGT” means intergovernmental transfer.

1.7 “Waiver” means the Section 1115 Demonstration Waiver for the Texas Healthcare Transformation and Quality Improvement Program.

1.8 “Waiver Payments” means any Medicaid payments received by Hospital in accordance with the Waiver Program.
1.9 "Public Funds" means public revenue, generated by the District, which the District may transfer in part to HHSC through IGTS to serve as the non-federal share of Waiver Payments.

1.10 "Region" means the HHSC designated RHP Region 4 that includes the following counties: Aransas County, Bee County, Brooks County, DeWitt County, Duval County, Goliad County, Gonzales County, Jackson County, Jim Wells County, Karnes County, Kenedy County, Kleberg County, Lavaca County, Live Oak County, Nueces County, Refugio County, San Patricio County, and Victoria County.

2.0 PURPOSE

The purpose of this Agreement is to memorialize District's and Hospital's agreement to collaborate with each other and other RHP members to improve access of Indigents to quality Health Care Services, reduce health care costs, improve the health of populations, transform the health care delivery system, and facilitate Hospital's participation in the Waiver pursuant to Title 1 of the Texas Administrative Code Section 355.8201(c)(1)(C).

3.0 REPRESENTATIONS AND WARRANTIES

3.1 Hospital's Representations and Warranties. Hospital represents and warrants that:

a. Hospital is a Delaware limited partnership licensed to due business in Texas and is duly established and created pursuant to applicable laws with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the Public Funds transferred by District or the amount of Waiver Payments on the amount of Indigent Care Hospital has provided or will provide to the Indigent;

c. There is no agreement to condition the amount of Hospital's Indigent Care obligation on the amount of Public Funds transferred by District or the amount of any Waiver Payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District will be disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;
e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT that the District may make to fund Hospital’s Waiver Payments;

f. To the best of Hospital’s knowledge, Hospital has complied and will continue to comply with all requirements of HHSC’s Waiver Certification of Hospital Participation;

g. The execution, delivery, and performance by Hospital of this Agreement are within Hospital’s powers, are not in contravention of any other instruments governing Hospital, and have been duly authorized and approved by Hospital as and to the extent required by applicable law;

h. Neither Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Hospital, or any of its representatives from participation in Federal health care programs; and

i. This Agreement has been duly and validly executed by Hospital.

3.2 District Representations and Warranties. District represents and warrants that:

a. District is a unit of local government and more specifically a county hospital District, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by District or the amount of Medicaid Waiver payments on the amount of Indigent Care Hospital has provided or will provide;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount transferred by District or the amount of any Medicaid Waiver payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District has
been disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;

e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT District may make to fund Medicaid Waiver payments;

f. To the best of District's knowledge, District has complied and will continue to comply with HHSC's Waiver Certification of Government Entity Participation;

g. The execution, delivery, and performance by District of this Agreement are within District's powers, are not in contravention of any other instruments governing District and have been duly authorized and approved by District as and to the extent required by applicable law;

h. Neither District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7(b)(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of District, or any of its representatives from participation in Federal health care programs; and

i. Notwithstanding anything in this Agreement to the contrary, any decision by District to provide funding for the Medicaid program for or on behalf of Hospital is at its sole discretion and subject to the appropriation of sufficient funds by District.

4.0 RESPONSIBILITIES AND OBLIGATIONS OF HOSPITAL

4.1 Agreement to Collaborate with District. Hospital agrees to work collaboratively with District and other RHP members to improve access to and the quality of healthcare, reduce health care costs, improve the health of populations and transform the healthcare delivery system.

4.2 Provision of Indigent Care. Hospital agrees to provide Health Care Services to the Indigent, including, without limitation, the availability to provide out-of-county Health Care Services to the Indigent residents of Nueces County, Texas.

4.3 Documentation. Hospital agrees to provide District documentation at regular intervals, but not less often than quarterly, that demonstrates the amount and types of Health Care Services provided by the Hospital to the Indigent.
4.4 **Compliance with State and Federal Law.** Hospital will assure that health care is provided in compliance with state and federal Charity Care laws, anti-trust laws, any other applicable laws, and the requirements for participation in the Medicare and the Medicaid programs.

4.5 **Indigent Care Program Participation.** At all times during the term of this Agreement, Hospital shall use its best efforts to maintain its qualification for participation in the Medicaid and Medicare programs.

4.6 **Compliance with HIPAA and Access to Records.** To the extent applicable to this Agreement, Hospital agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the “HITECH Act”), the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d et seq. (“HIPAA”) and any current and future regulations promulgated under the HITECH Act or HIPAA, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the “Federal Privacy Regulations”), the federal security standards contained in 45 C.F.R. Parts 160 and 164 (the “Federal Security Regulations”), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the “Federal Electronic Transactions Regulations”), all as amended from time to time and, all collectively referred to herein as “HIPAA Requirements.” Hospital agrees not to use or further disclose any Protected Health Information, including Electronic Protected Health Information (as those terms are defined in the HIPAA Requirements), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Hospital agrees to comply with any state laws and regulations that govern the confidentiality, privacy, security of, and electronic transactions pertaining to health care information.

As and to the extent required by law, upon the written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. § 1395x(v)(l) and the regulations thereto.

5.0 **RESPONSIBILITIES AND OBLIGATIONS OF THE DISTRICT**

5.1 **Agreement to Collaborate with Hospital.** District agrees to work collaboratively with Hospital and other members of the RHP to improve access to
and the quality of healthcare, reduce healthcare costs, improve the healthcare populations and transform the healthcare delivery system.

5.2 **No Condition on Medicaid Funding.** District agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective Indigent Care.

5.3 **Retrospective Evaluation of Services.** District may retrospectively evaluate the amount and impact of Hospital's Indigent Care delivery and can rely on such historical information in determining whether and to what degree it may provide an IGT in the future.

5.4 **Documents Publicly Available.** District agrees to make publicly available any documentation utilized in connection with any IGTs of funds.

6.0 **GENERAL PROVISIONS**

6.1 **Term and Termination.** The term of this Agreement shall be from the Effective Date through the later of September 30, 2016, or the date the Waiver or any extension thereof is terminated.

6.2 **Voluntary Termination.** Any party may terminate this Agreement without reason at any time during the term by providing written notice to all other parties at least thirty (30) days prior to the date of withdrawal.

6.3 **Notices.** All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

**District:** Nucces County Hospital District  
555 N. Carancahua St., Suite 950  
Corpus Christi, Texas 78401  
Attention: Administrator  
Telecopy No.: (361) 808-3274  
Telephone No.: (361) 808-3300
with a copy to: William DeWitt Alsup
Alsup and Alsup
555 N. Carancahua St., Suite 1560
Corpus Christi, Texas 78401
Telecopy No.: (361) 884-6000
Telephone No.: (361) 884-6321

and

Gary W. Eiland, Esq.
King & Spalding LLP
1100 Louisiana, Suite 4000
Houston, TX 77002
Telecopy No.: (713) 751-3290
Telephone No.: (713) 751 3207

Hospital: Victoria of Texas, LP d/b/a DeTar Healthcare System
506 E San Antonio St.
Victoria, TX 77901-6060
Attn: William Blanchard, CEO, FACHE

with a copy to: Legal Department
4000 Meridian Boulevard
Franklin, Tennessee 37067
Attn: General Counsel

and with a copy to: Eric J. Weatherford
Brown McCarroll, L.L.P.
2001 Ross Avenue, Suite 2000
Dallas, Texas 75201

6.5 Relationships Among the Parties. Each party to this Agreement is an independent contractor and not an agent, servant, joint enterprise, or employee as to the other parties to the Agreement and unless otherwise specified in this Agreement or another agreement, is responsible for its own acts, omissions, forbearance, negligence and deeds, and for those of its agents or employees in conjunction with the performance of services covered under this Agreement, and shall be specifically responsible for sufficient supervision and inspection to ensure compliance in every respect with the Agreement requirements. There shall be no contractual relationship between any subcontractor, agent, employee or supplier of Hospital and the District by virtue of this Agreement. The rights and obligations of each of the parties are individual, separate and independent.

6.6 Governing Law. This Agreement shall be governed by the laws of the State of Texas. This Agreement is performable and enforceable in Nueces County, Texas,
where the principal office of the District is located, and the state or federal courts in the county shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding as between the parties that may be brought, or arisen out of, in connection with, or by reason of this Agreement. Hospital understands that the District is a political subdivision of the State of Texas and governed by certain applicable statutes.

6.7 **Assignment or Subcontract.** No party may assign or subcontract any right, obligation, or responsibility under this Agreement except to a successor in interest without the prior written consent of the Anchor Facility.

6.8 **No Third Party Beneficiary.** This Agreement does not confer any right or benefit on any third party and may be enforced solely by the parties.

6.9 **Articles and Other Headings.** The division of this Agreement into articles and sections, and the use of captions and headings, are solely for convenience of reference, and shall have no legal effect in construing the provisions of this Agreement or in governing the rights, obligations, or liabilities of the parties.

6.10 **Multiple Originals.** This Agreement may be executed in one or more counterparts with multiple signature pages, each fully executed copy shall be deemed an original, and all of which together shall constitute one and the same instrument.

6.11 **Amendment or Modification.** This Agreement may only be amended or modified in writing by the mutual agreement of all parties hereto.

**IN WITNESS WHEREOF,** the parties have hereunto set their hand as of the date set forth above.

Nueces County Hospital District

By [Signature]

Jonny F. Hipp, Administrator/CEO

Victoria of Texas, LP d/b/a DeTar Healthcare System, by its General Partner, DeTar Hospital, L.L.C.

By [Signature]

Martin G. Schweinhardt, President
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION
FOR HOSPITAL AFFILIATES
Version 2012-1 (09/05/2012)
# DOCUMENT HISTORY LOG

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2 Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., "1.2" refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
On behalf of Nueces County Hospital District, a Hospital District organized under the laws of the State of Texas (hereinafter referred to as “the Governmental Entity”), I, Jonny F. Hipp, affirm and certify the following:

1. Legal Authorization.

   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds (“Public Funds”);

   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals (“the Affiliated Hospitals”) for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.

   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;

   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

   i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

   ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

   iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

   i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

   ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital’s historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

[Signature]
Jonny F. Hipp, Administrator/CEO
Name and Title

10-18-2012
Date
NUECES COUNTY INDIGENT CARE AFFILIATION AGREEMENT

This Nueces County Indigent Care Affiliation Agreement (the "Agreement") is entered into as of the 1st day of October, 2012 ("Effective Date"), by and between Nueces County Hospital District ("District"), and Driscoll Children's Hospital ("Hospital").

RECITALS:

WHEREAS, reductions in reimbursement under the Medicaid program and the growing uninsured population have created a gap between the costs Hospital incurs for treating Medicaid patients and the Indigent and the reimbursement Hospital actually receives;

WHEREAS, the District and Hospital recognize that the Indigent numbers in Nueces County and other counties in the Region will continue to increase, and that the burden of providing Health Care Services to the Indigent will continue to shift to the Hospital, District and local communities in Nueces County and other counties in the Region;

WHEREAS, the District is empowered by the Chapter 281 of the Texas Health and Safety Code and Section 61.056 of the Indigent Care and Treatment Act, codified at Chapter 61 of the Texas Health and Safety Code (as amended from time to time, the "Indigent Health Care Act"), to enter into contracts relating to or arranging for the provision of Health Care Services;

WHEREAS, District and Hospital desire to collaborate to ensure the Indigent have access to and receive quality Health Care Services;

WHEREAS, District and Hospital recognize that it is in the best interest of all to increase funding for the Medicaid population and to access federal funding for the Indigent to which the Hospital will be entitled under the current Texas Medicaid Section 1115 Waiver ("Waiver");

WHEREAS, the Waiver requires providers to work collectively and collaboratively to develop and submit a regional plan for health care delivery system reform through the formation of Regional Healthcare Partnerships ("RHPs");

WHEREAS, these RHPs are to be based on regions determined by the Texas Health and Human Services Commission ("HHSC");

WHEREAS, funds to finance the Waiver may be provided by public hospital Districts and other units of government through intergovernmental transfers ("IGTs");

WHEREAS, District and Hospital recognize that they need to collaborate to ensure their ability to deliver Health Care Services;
WHEREAS, Hospital desires to participate with the District and other entities to join in an affiliation with the District for purposes of forming an RHP; and

WHEREAS, the Waiver is intended to effect reform and improvement of healthcare delivery systems in four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) population-focused improvement and (4) clinical improvements in care.

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 PURPOSE

1.1 “Charity Care” means the provision of hospital services to the uninsured, as well as services defined by Texas Health and Safety Code §311.031(2).

1.2 “Health Care Services” means those services necessary to enhance the delivery of health care to the Indigent, as defined in Section 1.4 of this Agreement.

1.3 “HHSC” means the Texas Health and Human Services Commission.

1.4 “Indigent” means any person who meets (i) the income and other guidelines established for participation in the Texas Medicaid program, (ii) the income and other guidelines established for participation in the Children’s Health Insurance Program (“CHIP”), (iii) the income and other guidelines established in the Nueces County Hospital Indigent Care Program Handbook for participation in the District’s Indigent Health Care Program, (iv) the income and other guidelines established for participation in an indigent care program of a county or other hospital district in accordance with the Indigent Health Care Act, or (v) the income and other guidelines to qualify as “financially indigent” or “medically indigent” under Section 311.031 of the Texas Health and Safety Code.

1.5 “Indigent Care” means treatment, services and education concerning the inpatient and outpatient hospital and medical professional needs of the Indigent, including both the performance of services and the provision for services.

1.6 “IGT” means intergovernmental transfer.

1.7 “Waiver” means the Section 1115 Demonstration Waiver for the Texas Healthcare Transformation and Quality Improvement Program.

1.8 “Waiver Payments” means any Medicaid payments received by Hospital in accordance with the Waiver Program.
1.9 "Public Funds" means public revenue, generated by the District, which the District may transfer in part to HHSC through IGTs to serve as the non-federal share of Waiver Payments.

1.10 "Region" means the HHSC designated RHP Region 4 that includes the following counties: Aransas County, Bee County, Brooks County, DeWitt County, Duval County, Goliad County, Gonzales County, Jackson County, Jim Wells County, Karnes County, Kenedy County, Kleberg County, Lavaca County, Live Oak County, Nueces County, Refugio County, San Patricio County, and Victoria County.

2.0 PURPOSE

The purpose of this Agreement is to memorialize District’s and Hospital’s agreement to collaborate with the other and other RHP members to improve access of Indigents to quality Health Care Services, reduce health care costs, improve the health of populations, transform the health care delivery system, and facilitate Hospital’s participation in the Waiver pursuant to Title 1 of the Texas Administrative Code Section 355.8201(e)(1)(C).

3.0 REPRESENTATIONS AND WARRANTIES

3.1 Hospital’s Representations and Warranties. Hospital represents and warrants that:

a. Hospital is a Texas non-profit corporation, duly established and created pursuant to applicable laws with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the Public Funds transferred by District or the amount of Waiver Payments on the amount of Indigent Care Hospital has provided or will provide to the Indigent;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount of Public Funds transferred by District or the amount of any Waiver Payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District will be disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;

e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT that the District may make to fund Hospital’s Waiver Payments;
f. To the best of Hospital’s knowledge, Hospital has complied and will continue to comply with all requirements of HHSC’s Waiver Certification of Hospital Participation;

g. The execution, delivery, and performance by Hospital of this Agreement are within Hospital’s powers, are not in contravention of any other instruments governing Hospital, and have been duly authorized and approved by Hospital as and to the extent required by applicable law;

h. Neither Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of Hospital, or any of its representatives from participation in Federal health care programs; and

i. This Agreement has been duly and validly executed by Hospital.

3.2 District Representations and Warranties. District represents and warrants that:

a. District is a unit of local government and more specifically a county hospital District, duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by District or the amount of Medicaid Waiver payments on the amount of Indigent Care Hospital has provided or will provide;

c. There is no agreement to condition the amount of Hospital’s Indigent Care obligation on the amount transferred by District or the amount of any Medicaid Waiver payments Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of Indigent Care services provided or to be provided by Hospital; and that any escrow, trust or other funding mechanism utilized in connection with any IGT from District has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of Indigent Care services by or on behalf of Hospital;
e. District has not received and will not receive refunds of payments from Hospital for any purpose in consideration for any IGT District may make to fund Medicaid Waiver payments;

f. To the best of District’s knowledge, District has complied and will continue to comply with HHSC’s Waiver Certification of Government Entity Participation;

g. The execution, delivery, and performance by District of this Agreement are within District’ powers, are not in contravention of any other instruments governing District and have been duly authorized and approved by District as and to the extent required by applicable law;

h. Neither District, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the “Federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the Federal health care programs; and (iii) under investigation or otherwise aware of any circumstances which may result in the exclusion of District, or any of its representatives from participation in Federal health care programs; and

i. Notwithstanding anything in this Agreement to the contrary, any decision by District to provide funding for the Medicaid program for or on behalf of Hospital is at its sole discretion and subject to the appropriation of sufficient funds by District.

4.0 RESPONSIBILITIES AND OBLIGATIONS OF HOSPITAL

4.1 Agreement to Collaborate with District. Hospital agrees to work collaboratively with District and other RHP members to improve access to and the quality of healthcare, reduce health care costs, improve the health of populations and transform the healthcare delivery system.

4.2 Provision of Indigent Care. Hospital agrees to provide Health Care Services to the Indigent.

4.3 Documentation. Hospital agrees to provide District documentation at regular intervals, but not less often than quarterly, that demonstrates the amount and types of Health Care Services provided by the Hospital to the Indigent.

4.4 Compliance with State and Federal Law. Hospital will assure that health care is provided in compliance with state and federal Charity Care laws, anti-trust laws, any other applicable laws, and the requirements for participation in the Medicare and the Medicaid programs.
4.5 **Indigent Care Program Participation.** At all times during the term of this Agreement, Hospital shall use its best efforts to maintain its qualification for participation in the Medicaid and Medicare programs.

4.6 **Compliance with HIPAA and Access to Records.** To the extent applicable to this Agreement, Hospital agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d et seq. ("HIPAA") and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time and, all collectively referred to herein as "HIPAA Requirements." Hospital agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement. In addition, Hospital agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after the rendering of such services. If Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of 42 U.S.C. § 1395x(v)(I) and the regulations thereto.

5.0 **RESPONSIBILITIES AND OBLIGATIONS OF THE District**

5.1 **Agreement to Collaborate with Hospital.** District agrees to work collaboratively with Hospital and other members of the RHP to improve access to and the quality of healthcare, reduce healthcare costs, improve the healthcare populations and transform the healthcare delivery system.

5.2 **No Condition on Medicaid Funding.** District agrees that it will not condition the amount to which it funds the non-federal share of supplemental payments on a specified or required minimum amount of prospective Indigent Care.
5.3 **Retrospective Evaluation of Services.** District may retrospectively evaluate the amount and impact of Hospital's Indigent Care delivery and can rely on such historical information in determining whether and to what degree it may provide an IGT in the future.

5.4 **Documents Publicly Available.** District agrees to make publicly available any documentation utilized in connection with any IGTs of funds.

6.0 **GENERAL PROVISIONS**

6.1 **Voluntary Termination.** Any party may terminate this Agreement without reason at any time during the term by providing written notice to all other parties at least thirty (30) days prior to the date of withdrawal.

6.2 **Term and Termination.** The term of this Agreement shall be from the Effective Date through the later of September 30, 2016, or the date the Waiver or any extension thereof is terminated; provided, however, that this Agreement shall terminate immediately in the event that District terminates this Agreement.

6.3 **Notices.** All notices required or permitted hereunder shall be in writing and shall be sufficiently given and deemed to have been received upon personal delivery, by overnight carrier, by email, or by United States mail, postage prepaid, registered or certified mail, addressed to the parties as follows:

**District:**

Nueces County Hospital District  
555 N. Carancahua St., Suite 950  
Corpus Christi, Texas 78401  
Attention: Administrator  
Telecopy No.: (361) 808-3274  
Telephone No.: (361) 808-3300
with a copy to:  

William DeWitt Alsup  
Alsup and Alsup  
555 N. Carancahua St., Suite 1560  
Corpus Christi, Texas 78401  
Telecopy No.: (361) 884-6000  
Telephone No.: (361) 884-6321 

and 

Gary W. Eiland, Esq.  
King & Spalding LLP  
1100 Louisiana, Suite 4000  
Houston, TX 77002  
Telecopy No.: (713) 751-3290  
Telephone No.: (713) 751 3207 

Hospital:  
Driscoll Children’s Hospital  
3533 S. Alameda St.  
Corpus Christi, TX 78411  
Attention: President/Chief Executive Officer  
Telecopy No.: (361) 694-5010  
Telephone No.: (361) 694-5021 

with a copy to: 

6.5 Relationships Among the Parties. Each party to this Agreement is an independent contractor and not an agent, servant, joint enterprise, or employee as to the other parties to the Agreement and unless otherwise specified in this Agreement or another agreement, is responsible for its own acts, omissions, forbearance, negligence and deeds, and for those of its agents or employees in conjunction with the performance of services covered under this Agreement, and shall be specifically responsible for sufficient supervision and inspection to ensure compliance in every respect with the Agreement requirements. There shall be no contractual relationship between any subcontractor, agent, employee or supplier of Hospital and the District by virtue of this Agreement. The rights and obligations of each of the parties are individual, separate and independent.

6.6 Governing Law. This Agreement shall be governed by the laws of the State of Texas. This Agreement is performable and enforceable in Nueces County, Texas, where the principal office of the District is located, and the state or federal courts in the county shall be the sole and exclusive venue for any litigation, special proceeding, or other proceeding as between the parties that may be brought, or arisen out of, in connection with, or by reason of this Agreement. Hospital
understands that the District is a political subdivision of the State of Texas and governed by certain applicable statutes.

6.7 Assignment or Subcontract. No party may assign or subcontract any right, obligation, or responsibility under this Agreement except to a successor in interest without the prior written consent of the Anchor Facility.

6.8 No Third Party Beneficiary. This Agreement does not confer any right or benefit on any third party and may be enforced solely by the parties.

6.9 Articles and Other Headings. The division of this Agreement into articles and sections, and the use of captions and headings, are solely for convenience of reference, and shall have no legal effect in construing the provisions of this Agreement or in governing the rights, obligations, or liabilities of the parties.

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6.11 Amendment or Modification. This Agreement may only be amended or modified in writing by the mutual agreement of all parties hereto.

IN WITNESS WHEREOF, the parties have hereunto set their hand as of the date set forth above.

Nueces County Hospital District

By [Signature]
Jonny F. Hipp, Administrator/CEO

Driscoll Children's Hospital

By [Signature]
Steve Woerner, President and CEO
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
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TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of Nueces County Hospital District, a _______ Hospital District _______, organized under the laws of the State of Texas (hereinafter referred to as “the Governmental Entity”), I, Jonny F. Hipp, affirm and certify the following:

1. **Legal Authorization.**

   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds (“Public Funds”);

   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals (“the Affiliated Hospitals”) for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. **Public Adoption and Access.**

   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;

   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. Funding of Intergovernmental Transfers and Supplemental Payments.

a. The Governmental Entity does or has agreed to transfer Public Funds to the Health and Human Services Commission ("HHSC") via intergovernmental transfer ("IGT") for use as the non-federal share of supplemental waiver payments (the "Supplemental Payments") to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program");

b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:

   i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

   ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. Assurances and Representations.

a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

e. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. Evaluation.
a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital's historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:

i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital's participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

[Signature]

Jonny F. Hipp, Administrator/CEO

Name and Title

10-18-2012

[Official Seal]
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF HOSPITAL PARTICIPATION
Version 2012-1 (09/05/2012)
# DOCUMENT HISTORY LOG

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1 “Baseline” indicates initial document issuances, “Revision” indicates changes to the Baseline version, and “Cancellation” indicates withdrawn versions.

2 Numbering conventions: Revisions are numbered according to the version of the document and the sequential revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM
CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number: 094118902

On behalf of Victoria of Texas, L.P. d/b/a DeTar Healthcare System, a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, Martin G. Schweinhart, President, affirm and certify the following:

1. Authorization.

   a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between the Texas A&M University System Health Sciences Center ("Governmental Entity") and Hospital or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

   b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to regulations at 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the "Waiver Program").

2. Assurances and Representations.

   a. Validity of Claims. All claims filed by Hospital for reimbursement by Medicaid have complied and will comply with the applicable state and federal regulations.
b. Use of Supplemental Payments.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. Agreements with Governmental Entity.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

1. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an affiliation agreement;

2. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to Hospital; or

3. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;
d. Assignment/Assumption of Governmental Entity Obligations.

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. Use of Financial Mechanisms. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.
3. **Deferral or Disallowance of Federal Financial Participation.**

   a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital’s rights of administrative appeal.

   b. The set-off or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. **Public Access to Affiliation Agreement.** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

[Signature]  
[Date]

Victoria of Texas, L.P., by its General Partner, DeTar Hospital, LLC,  
by Martin G. Schweinhart, President  
Name and Title (print or type)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM
1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION
FOR HOSPITAL AFFILIATES
Version 2012-1 (09/05/2012)
HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 DEMONSTRATION WAIVER PROGRAM

CERTIFICATION OF GOVERNMENTAL ENTITY PARTICIPATION FOR HOSPITAL AFFILIATES

On behalf of The Texas A&M Health Science Center, an agency of the State of Texas and a member of the Texas A&M System organized under the laws of the State of Texas (hereinafter referred to as “the Governmental Entity”), I, E.J. “Jere” Pederson, affirm and certify the following:

1. Legal Authorization.
   a. The Governmental Entity is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds (“Public Funds”);
   b. The Governmental Entity is legally authorized to enter into and has entered into Affiliation Agreements with one or more private hospitals (“the Affiliated Hospitals”) for, among other purposes, providing indigent care in the community served by the Governmental Entity.

2. Public Adoption and Access.
   a. The governing body of the Governmental Entity adopted the conditions described in this certification by recorded vote taken in a public meeting held in compliance with the Texas Open Meetings Act, Chapter 551, Government Code;
   b. Copies of all Affiliation Agreements will be made available as provided under the Texas Public Information Act, Chapter 552, Government Code, and will be provided to HHSC on request.
3. **Funding of Intergovernmental Transfers and Supplemental Payments.**

   a. The Governmental Entity has or has agreed to transfer Public Funds to the Health and Human Services Commission (“HHSC”) via intergovernmental transfer (“IGT”) for use as the non-federal share of supplemental waiver payments (the “Supplemental Payments”) to the Affiliated Hospitals in accordance with 1 Tex. Admin. Code §355.8201, Waiver Payments to Hospitals (the “Waiver Program”);

   b. All transfers of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments to the Affiliated Hospitals under the Waiver Program comply with:
      
      i. The applicable regulations that govern provider-related donations codified at section 1903(w) of the Social Security Act (42 U.S.C. §1396b(w)), and Title 42, Code of Federal Regulations, Part 433, subpart B, sections 433.52 and 433.54;

      ii. HHSC administrative rules codified at 1 Tex. Admin Code §355.8201, Waiver Payments to Hospitals.

4. **Assurances and Representations.**

   a. The Governmental Entity does not and will not at any time receive any part of the supplemental payments that are made by HHSC to the Affiliated Hospitals under the Waiver Program;

   b. The Governmental Entity has not entered into a contingent fee arrangement related to the Governmental Entity’s participation in the Waiver Program;

   c. The Governmental Entity has not entered and will not enter into any agreement to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Supplemental Payments an Affiliated Hospital receives on the amount of indigent care the Affiliated Hospital has provided or will provide;

   d. The Governmental Entity has not entered and will not enter into any agreement to condition the amount of any Affiliated Hospital’s indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment an Affiliated Hospital may be eligible to receive;

   e. With regard to any escrow, trust or other financial mechanism (an “Account”) utilized in connection with an indigent care Affiliation Agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:
      
      i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or
will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals;

f. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to an Affiliated Hospital for any purpose in consideration for an IGT of Public Funds by the Governmental Entity to HHSC to support the Supplemental Payments;

g. The Governmental Entity has not received and will not receive any cash or in-kind transfers from an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals other than transfers and transactions that:

i. Following the date this Certification was executed, are unrelated to the administration of the Waiver Program or the delivery of indigent care services under an Affiliation Agreement;

ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to an Affiliated Hospital; or

iii. Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between the Affiliated Hospital and the Governmental Entity;

h. The Governmental Entity has not:

i. Following the date this Certification was executed, assigned or agreed to assign a contractual or statutory obligation of the Governmental Entity to an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals; or

ii. Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

5. **Evaluation.**

a. Consistent with its constitutional, statutory, and fiduciary obligations, the Governmental Entity may evaluate a private hospital’s historical experience in providing indigent care in the community or performance under an Affiliation Agreement including the impact and amount of indigent care provided by the hospital, for the following purposes:
i. To determine whether the Governmental Entity will enter into an Affiliation Agreement with a private hospital;

ii. To determine whether and to what degree the Governmental Entity will supply an IGT, provided such decision does not include consideration of matters prohibited under paragraph 4 of this Certification;

iii. To determine whether an Affiliated Hospital’s participation benefited the community and whether its continued participation in the indigent care program is likely to continue to benefit the community; or

iv. To provide accountability to local taxpayers;

b. The Governmental Entity’s evaluation under this paragraph 5 may:

i. Be documented in a manner sufficient to confirm achievement of the Governmental Entity’s mission and provide an appropriate and constitutional basis on which to transfer the Public Funds to HHSC; and

ii. Not include consideration of matters prohibited under paragraph 4 of this Certification;

On behalf of the Governmental Entity, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind the Governmental Entity and to certify to the above.

[Signature]

[February 1, 2012]

E.J. “Jere” Pederson,
Interim President, Texas A&M Health Science Center
Interim Vice Chancellor for Health Affairs, Texas A&M System
Name and Title
INDIGENT CARE AFFILIATION AGREEMENT

This Indigent Care Affiliation Agreement (the “Agreement”) is entered into as of November 24, 2012, to be effective as of November 30, 2012 (“Effective Date”), by and between The Texas A&M University System Health Sciences Center, a member of The Texas A&M University System and an agency of the State of Texas (“the Governmental Entity”) and Victoria of Texas, L.P. d/b/a DeTar Healthcare System (“Affiliated Hospital”), a Delaware limited partnership located at 506 East San Antonio Street, Victoria, Texas 77901.

RECITALS

WHEREAS, the Affiliated Hospital and the Governmental Entity collectively provide substantial uncompensated care to indigent persons annually;

WHEREAS, reduced funding and eligibility for Medicaid has increased the volumes of indigent patients who rely on hospital emergency room services as the source of primary healthcare and shifted the burden for indigent care to the Affiliated Hospital, the Governmental Entity, and the greater community;

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that there will be continued challenges in funding of the Texas Medicaid program due to future demographic changes and possible increases in the number of indigent patients;

WHEREAS, the Governmental Entity and the Affiliated Hospital desire to ensure that the indigent have access to and receive health care services;

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that it is in their best interest to increase funding for the Medicaid population and to access federal funding for the indigent to which the Affiliated Hospital will be entitled under the State’s Medicaid program; and

WHEREAS, the Governmental Entity and the Affiliated Hospital recognize that they need to cooperate to ensure their ability to deliver cost efficient healthcare services to indigent patients in their community;

NOW, THEREFORE, in consideration of the promises and covenants contained in this Agreement, and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and agreed, the parties agree as follows:

1.0 INDIGENT CARE COLLABORATION

1.1 Improving Access to Healthcare for Indigent. The Governmental Entity and the Affiliated Hospital will assess the opportunities to improve access to healthcare for indigent persons residing in the community through participation in the Medicaid program including the Medicaid payments
authorized by the Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver (the “Section 1115 Waiver”).

1.2 Discretion of Governmental Entity to Provide Funding. Notwithstanding anything in this Agreement to the contrary, although the Governmental Entity may provide funding for the Medicaid program, any decision by the Governmental Entity to provide funding for the Medicaid program is at the sole discretion of the Governmental Entity.

2.0 REPRESENTATIONS AND WARRANTIES

2.1 Affiliated Hospital Representations and Warranties. The Affiliated Hospital represents and warrants that:

a. It is a Delaware limited partnership duly established and created pursuant to applicable law with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition any amounts transferred by the Governmental Entity nor the amount of Medicaid payments received on the amount of indigent care the Affiliated Hospital has provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospital’s indigent care obligation on the amount transferred by the Governmental Entity or the amount of any Medicaid payment the Affiliated Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital; and that any escrow, trust or other funding mechanism utilized in connection with an anticipated intergovernmental transfer ("IGT") from the Governmental Entity has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. The Affiliated Hospital will not return or refund any Medicaid payments received to the Governmental Entity;

f. No part of any Medicaid payment received under the Section 1115 Waiver program will be used to pay a contingent fee, consulting fee, or legal fee associated with the Affiliated Hospital’s receipt of payments under the Section 1115 Waiver program;

g. The execution, delivery, and performance by the Affiliated Hospital of this Agreement are within the Affiliated Hospital’s powers, are not in contravention of any other instruments governing the Affiliated Hospital and have been duly authorized and approved by the Board of Directors of the Affiliated Hospital as and to the extent required by applicable law;
h. Neither the Affiliated Hospital, nor any of its representatives are (i) currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. Section 1320a-7b(f) (the “federal health care programs”); (ii) convicted of a criminal offense related to the provision of health care items or services but not yet excluded, debarred, or otherwise declared ineligible to participate in the federal health care programs; or (iii) under investigation or otherwise aware of any circumstance which may result in the exclusion of the Affiliated Hospital or any of its representatives from participating in federal health care programs; and

i. This Agreement has been duly and validly executed and delivered by the Affiliated Hospital.

2.2 **Governmental Entity Representations and Warranties.** The Governmental Entity represents and warrants that:

a. It is a member of The Texas A&M University System and an agency of the State of Texas with all requisite power and authority to enter into this Agreement in all respects;

b. There is no agreement to condition the amount transferred by the Governmental Entity nor the amount of Medicaid supplemental payments on the amount of indigent care the Affiliated Hospital have provided or will provide;

c. There is no agreement to condition the amount of the Affiliated Hospital’s indigent care obligation on the amount transferred by the Governmental Entity nor the amount of any Medicaid supplemental payment the Affiliated Hospital might receive;

d. No escrow, trust, or other funding mechanism exists, the amount of which is conditioned or contingent on the amount of indigent care services provided or to be provided by the Affiliated Hospital; and that any escrow, trust or other funding mechanism utilized in connection with an anticipated IGT from the Governmental Entity has been disclosed to HHSC and is not used to effect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospital;

e. The Governmental Entity has not received and will not receive refunds of payments the Governmental Entity made or makes to the Affiliated Hospital for any purpose in consideration for an IGT by the Governmental Entity to fund Medicaid supplemental payments;

f. The execution, delivery, and performance by the Governmental Entity of this Agreement are within the Governmental Entity’s powers, are not in contravention of any other instruments governing the Governmental Entity and have been duly authorized and approved by the Board of Directors of the Governmental Entity as and to the extent required by applicable law;
g. This Agreement has been duly and validly executed by the Governmental Entity;

h. The Governmental Entity has not received and has no agreement to receive any portion of any Medicaid payments made to Affiliated Hospital;

i. The Governmental Entity has not entered into a contingent fee arrangement related to its participation in the Section 1115 Waiver program; and

j. The Governmental Entity is authorized to participate in the Section 1115 Waiver program pursuant to a vote of its governing body in a public meeting preceded by public notice published in accordance with its usual and customary practices or the Texas Open Meetings Act, as applicable.

3.0 OBLIGATIONS OF THE AFFILIATED HOSPITAL

3.1 Agreement to Collaborate with the Governmental Entity. The Affiliated Hospital agrees to work cooperatively with the Governmental Entity to improve access to health care for indigent persons.

3.2 Documentation. The Affiliated Hospital agrees to provide the Governmental Entity documentation that demonstrates the amount and types of health care (including indigent health care and Medicaid services historically provided in its community) as requested by the Governmental Entity, but no more frequently than quarterly.

3.3 Compliance with State and Federal Law. The Affiliated Hospital agrees to retain qualified professionals to ensure health care is provided in compliance with state and federal charity care laws, anti-trust laws, and any other applicable laws, and the Medicare and Medicaid programs.

3.4 Indigent Care Program Participation. At all times during the term of this Agreement, the Affiliated Hospital shall use its best efforts to maintain its qualifications for participation in the Medicaid and Medicare programs.

3.5 Compliance with HIPAA. To the extent applicable to this Agreement, the Affiliated Hospital agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 1320d, et seq. ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as "HIPAA Requirements." The Affiliated
Hospital agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of the Agreement. In addition, the Affiliated Hospital agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the Affiliated Hospital shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after rendering of such services. The Affiliated Hospital will also indemnify and hold the Governmental Entity harmless if any amount of reimbursement is denied or disallowed because of the Affiliated Hospital’s failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties and legal costs. If the Affiliated Hospital carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by the requirements of, 42. U.S.C. § 1395x(v)(1) and the regulations thereto.

4.0. OBLIGATIONS OF THE GOVERNMENTAL ENTITY

4.1 Agreement to Cooperate with the Affiliated Hospital. The Governmental Entity agrees to work cooperatively with the Affiliated Hospital to improve access to health care for indigent persons.

4.2 No Condition on Medicaid Funding. The Governmental Entity agrees that it will not condition the amount to which it funds the non-federal share of Medicaid supplemental payments on a specified or required minimum amount of prospective indigent care.

4.3 Retrospective Evaluation of Services. The Governmental Entity may retrospectively evaluate the amount and impact of the Affiliated Hospital’s indigent care delivery and can rely on such historical information in determining whether and to what degree it will provide an IGT in the future.

4.4 Documents Publicly Available. The Governmental Entity agrees to make publicly available any documentation utilized in connection with intergovernmental transfers of funds and any documentation executed by the
Governmental Entity related to its participation in the Section 1115 Waiver, including this Agreement.

4.5 **Use of Public Funds.** To the extent the Governmental Entity decides to provide funding for Medicaid supplemental payments, the Governmental Entity agrees to use public funds for such funding.

4.6 **Compliance with HIPAA.** The Governmental Entity agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Sections 1320d, *et seq.* ("HIPAA"), and any current and future regulations promulgated thereunder, including, without limitation, the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transaction Regulations"), all as amended from time to time, and all collectively referred to herein as “HIPAA Requirements.” The Governmental Entity agrees not to use or further disclose any Protected Health Information (as defined in the Federal Privacy Regulations) or EPHI (as defined in the Federal Security Regulations), other than as permitted by the HIPAA Requirements and the terms of the Agreement. In addition, the Governmental Entity agrees to comply with any state laws and regulations that govern or pertain to the confidentiality, privacy, security of, and electronic transactions pertaining to, health care information.

As and to the extent required by law, upon the written request of the Secretary of Health and Human Services, the Comptroller General or any of their duly authorized representatives, the Governmental Entity shall make available those contracts, books, documents and records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available for up to four (4) years after rendering of such services. To the extent allowed by the laws of the State of Texas, the Governmental Entity will also indemnify and hold the Affiliated Hospital harmless if any amount of reimbursement is denied or disallowed because of the Governmental Entity’s failure to comply with the obligations set forth in this section. Such indemnity shall include, but not be limited to, the amount of reimbursement denied, plus any interest, penalties and legal costs. If the Governmental Entity carries out any of the duties of this Agreement through a subcontract with a value of $10,000.00 or more over a twelve (12) month period with a related individual or organization, the Affiliated Hospital agrees to include this requirement in any such subcontract. This section is included pursuant to, and is governed by the requirements of, 42. U.S.C. § 1395x(v)(1) and the regulations thereto.
5.0 GENERAL PROVISIONS

5.1 Term and Termination. The term of this Agreement shall be one year from Effective Date and shall automatically continue thereafter for additional terms of one year unless the parties agree otherwise; provided, however, that this Agreement shall terminate immediately upon written notice by either the Governmental Entity or the Affiliated Hospital to the other party.

5.2 Notices. All notices, requests, claims, demands and other communications required or permitted hereunder shall be in writing and shall be deemed to have been duly given (a) when received if delivered personally, (b) when transmitted by facsimile (with confirmation of successful transmission), (c) upon receipt, if sent by registered or certified mail (postage prepaid, return receipt requested) and (d) the day after it is sent, if sent for next-day delivery to a domestic address by overnight mail or courier, to the parties as follows:

Governmental Entity:  Texas A&M Health Science Center  
Vice President for Finance & Administration  
200 Technology Way, Suite 2079  
College Station, TX 77845-3424  
Facsimile: (979) 436-0075

With a Copy to:  The A&M Health Science Center  
Office of the President  
8441 State Highway 47  
Clinical Building I, Suite 3100  
Bryan, Texas 77807  
Facsimile: (979) 436-0072

Affiliated Hospital:  DeTar Healthcare System  
506 East San Antonio Street  
Victoria, Texas 77901  
Attn: William Blanchard, CEO, FACHE

With a Copies to:  Legal Department  
4000 Meridian Boulevard  
Franklin, Tennessee 37067  
Attn: General Counsel

Eric J. Weatherford  
Brown McCarroll, L.L.P.  
2001 Ross Avenue, Suite 2000  
Dallas, Texas 75201
5.3 **Relationship Between the Parties.** The relationship between the Governmental Entity and the Affiliated Hospital is solely a contractual relationship between independent contractors. No party hereto is an agent or employee of any other party. Nothing in this Agreement shall prevent any affiliation or contracting by any party with any third party, with the exception that no party may contract or affiliate with other party to gain entitlement to Medicaid supplemental payments pursuant to this Agreement.

5.4 **Governing Law.** This Agreement shall be governed by the laws of the State of Texas. The Affiliated Hospital understands that the Governmental Entity is an agency of the State of Texas and has certain Constitutional and statutory rights and privileges.

5.5 **Venue.** Pursuant to Section 85.18 of the Texas Education Code, venue for any suit filed against the Governmental Entity shall be in the County in which the primary office of the chief executive officer of the Governmental Entity is located. At the execution of this Agreement, such county is Brazos County, Texas.

5.6 **Assignment.** No party may assign any right, obligation, or responsibility under this Agreement except to a successor in interest.

5.7 **Third Party Beneficiaries.** The parties to this Agreement do not intend to establish any third party beneficiary relationship by virtue of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date(s) set forth below.

THE TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER

By: [Signature] Date: 12/13/12

VICTORIA OF TEXAS, L.P. D/B/A DETAR HEALTH SYSTEM, BY ITS GENERAL PARTNER, DETAR HOSPITAL, LLC

By: [Signature] Martin G. Schweinhart, President Date: 12-11-12
December 18, 2012

Pamela Robertson
President and Chief Executive Officer
CHRISTUS Spohn Hospital System
600 Elizabeth St.
Corpus Christi, TX  78404

Dear Ms. Robertson:

Based on our discussions about an additional DSRIP project for which CHRISTUS Spohn Hospital Beeville, TPI: 20811801 ("Beeville") will be the performing provider, CHRISTUS Spohn Hospital Kleberg, TPI: 09422902, allocates the entirety ($1,144,563) of its DSRIP Pass 2 allocation to Beeville for the project designed to effectuate transformation within our catchment area.

This letter is executed freely and voluntarily for transformation of the healthcare delivery system in our common service area.

Sincerely,

Estela Chapa, FACHE
Executive Vice President and Chief Operating Officer

96415

1702 Santa Fe  •  Corpus Christi TX 78404-1857  •  Phone 361.888.0566  •  Fax 361.885.0566
December 18, 2012

Pamela Robertson
President and Chief Executive Officer
CHRISTUS Spohn Hospital System
600 Elizabeth St.
Corpus Christi, TX 78404

Dear Ms. Robertson:

Based on our discussions about an additional DSRIP project for which CHRISTUS Spohn Hospital Beeville, TPI: 20811801 ("Beeville") will be the performing provider, CHRISTUS Spohn Hospital Alice, TPI: 09422902, allocates a portion ($562,431) of its DSRIP Pass 2 allocation to Beeville for the project designed to effectuate transformation in our shared catchment area.

This letter is executed freely and voluntarily for transformation of the healthcare delivery system in our common service area.

Sincerely,

[Signature]

Estela Chapa, FACHE
Executive Vice President and Chief Operating Officer
CHRISTUS Spohn Health System

96414
December 18, 2012

Pamela Robertson
President and Chief Executive Officer
CHRISTUS Spohn Hospital System
600 Elizabeth St.
Corpus Christi, TX 78404

Dear Ms. Robertson:

Based on our discussions about an additional DSRIP project for which CHRISTUS Spohn Hospital Corpus Christi, TPI: 121775403 ("Corpus") will be the performing provider, CHRISTUS Spohn Hospital Alice, TPI: 09422902, allocates a portion ($1,218,368) of its DSRIP Pass 2 allocation to Corpus for the project designed to effectuate transformation in our shared catchment area.

This letter is executed freely and voluntarily for transformation of the healthcare delivery system in our common service area.

Sincerely,

Estela Chapa, FACHE
Executive Vice President/Chief Operating Officer
CHRISTUS Spohn Health System
### B. Delivery System Reform Incentive Payments (DSRIP) Projects Modified or Not Adopted

**Anchor: Nueces County Hospital District**  
**Counties: Aransas, Bee, DeWitt, Gonzales, Jackson, Jim Wells, Karnes, Kleberg, Lavaca, Nueces, Refugio, Victoria**

The following DSRIP Projects were considered for inclusion in the Regional Health Care Plan, but were not ultimately selected, or were revised to fit within a different DSRIP Category.

<table>
<thead>
<tr>
<th>Category 1: Infrastructure Development</th>
<th>Title</th>
<th>Summary</th>
<th>Performing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Implement an “Open Access” model for BH and SA individuals in Karnes County. Use telemedicine opportunities.</td>
<td>Camino Real Community Services</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Assess and develop a long-term crisis intervention and stabilization services to improve access for persons with dual diagnosis of IDD/MH.</td>
<td>Camino Real Community Services</td>
<td></td>
</tr>
<tr>
<td>Increase Training of Primary Care Workforce</td>
<td>Recruit mid-level professionals to community clinics</td>
<td>Christus Spohn</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Expand behavioral healthcare services by meeting both mental health and substance abuse needs.</td>
<td>Coastal Plains Community Center</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Provide comprehensive, health quality health to adults with serious mental illness (SMI) through integration of primary care services into our CMHC setting.</td>
<td>Coastal Plains Community Center</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Develop a Psychiatry Residency Program</td>
<td>Corpus Christi Medical Center</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity – Crisis Intervention</td>
<td>Develop a partial hospitalization program for BH and SA individuals</td>
<td>DeTar Healthcare System</td>
<td></td>
</tr>
<tr>
<td>Exclusive Breast Feeding</td>
<td>Increase staffing for diseases such as COPD, diabetes, asthma</td>
<td>DeTar Healthcare System</td>
<td></td>
</tr>
<tr>
<td>Health Promotion/Disease management</td>
<td>Develop health lifestyle options to pregnant women that reduces incidence of low birth weight infants.</td>
<td>DeTar Healthcare Systems</td>
<td></td>
</tr>
<tr>
<td>Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities</td>
<td>Capture race, ethnicity and language as self-reported.</td>
<td>Gulf Bend</td>
<td></td>
</tr>
<tr>
<td>Enhance Performance Improvement and Reporting Capacity</td>
<td>Generate data reports to prioritize RHP decisions for quality improvement initiatives.</td>
<td>Gulf Bend</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Provide an early intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting</td>
<td>Gulf Bend</td>
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<tr>
<td>(i.e., the criminal justice system, ER, urgent care, etc.)</td>
<td>Determine target population and calculate baseline screening rate using evidence-based national guidelines.</td>
<td>Implement an integrated multi-disciplinary care system to promote team-based care.</td>
<td>Provide an early intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care, etc.).</td>
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<tr>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Develop workforce enhancement initiative to support access to providers in underserved markets and areas (i.e., physicians, psychiatrists, psychologist, LMSW, LRC, and LMFT).</td>
<td>Develop care management function that integrates the primary and behavioral health needs of individuals.</td>
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<tr>
<td>Gulf Bend</td>
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<td>Gulf Bend</td>
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</tr>
<tr>
<td>Expand Primary Care Access</td>
<td>School-based health clinics – enhance serve availability to appropriate levels of care.</td>
<td>School based health centers – screen patients for health literacy using evidenced-based tool.</td>
<td>Implement an integrated multi-disciplinary care system to promote team-based care (i.e., school based health clinics).</td>
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<tr>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
<td>Gulf Bend</td>
</tr>
<tr>
<td>Introduce, Expand, or Enhance Telemedicine/Telehealth</td>
<td>School-based health clinic - implement technology-assisted services (telemedicine, telephonic guidance) to support or deliver behavioral health services.</td>
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<tr>
<td>Gulf Bend</td>
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<tr>
<td>Expand or Enhance Emergency Medical Transportation Services</td>
<td>Expand emergency medical services in the county.</td>
<td></td>
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<tr>
<td>Jackson County Hospital District</td>
<td></td>
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<tr>
<td>Expand Primary Care Access – add transportation here</td>
<td>Expand hours on Saturdays in community clinic</td>
<td></td>
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<tr>
<td>Jackson County Hospital District</td>
<td></td>
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<tr>
<td>Improve Patient Experience</td>
<td>CAPSCS</td>
<td></td>
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<tr>
<td>Jackson County Hospital District</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduce, Expand, or Enhance</td>
<td>Develop a telehealth program with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 1: Infrastructure Development</td>
<td>Telemedicine/Telehealth</td>
<td>behavioral health services facilities within the region.</td>
<td>MHMR Nueces County</td>
</tr>
<tr>
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</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Transitional housing program run by Peer Specialists for individuals discharging from inpatient psychiatric treatment to ensure continued stabilization as they transition back into the community.</td>
<td>MHMR Nueces County</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Establish post-discharge support for behavioral health and substance abuse. Individuals.</td>
<td>MHMR Nueces County</td>
<td></td>
</tr>
<tr>
<td>Enhance Interpretation Services and Culturally Competent Care</td>
<td>Develop a training program for all staff to provide interpretation services and cultural competency.</td>
<td>Otto Kaiser Memorial Hospital</td>
<td></td>
</tr>
<tr>
<td>Expand Specialty Care Capacity</td>
<td>Expand specialty care services and realignment of hospital services</td>
<td>Refugio County Hospital District</td>
<td></td>
</tr>
<tr>
<td>Expand Specialty Care Capacity</td>
<td>Expand/improve subspecialty access (e.g. pediatric psychiatry, ophthalmologist &amp; pediatrics)</td>
<td>Refugio County Hospital District</td>
<td></td>
</tr>
<tr>
<td>Expand Behavioral Healthcare Capacity</td>
<td>Expand geriatric psychosocial services</td>
<td>Yoakum Community Hospital</td>
<td></td>
</tr>
<tr>
<td>Expand Specialty Care Capacity</td>
<td>Establish dialysis clinic to expand specialty care services</td>
<td>Yoakum Community Hospital</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category 2: Innovation and Redesign</th>
<th>Title</th>
<th>Summary</th>
<th>Performing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand Chronic Care Management Models</td>
<td>Implement cardiopulmonary patient centric accountable care intervention system.</td>
<td>Care Regional Medical Center</td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Develop a home visitation program for rural populations in San Patricio and Aransas counties.</td>
<td>Care Regional Medical Center</td>
<td></td>
</tr>
<tr>
<td>Implement/Expand Care Transitions Program</td>
<td>Develop transitional care teams to improve quality and reduce costs for rural patients in Aransas Pass and San Patricio counties.</td>
<td>Care Regional Medical Center</td>
<td></td>
</tr>
<tr>
<td>Improve Patient Flow in Emergency Department/Rapid Medical Evaluation</td>
<td>Reduce wait times in the ED and improve overall satisfaction.</td>
<td>Corpus Christi Medical Center</td>
<td></td>
</tr>
<tr>
<td>Redesign to Improve Patient Experience</td>
<td>Improve overall patient experience scores on HCAPHS</td>
<td>Corpus Christi Medical Center</td>
<td></td>
</tr>
<tr>
<td>Expand Chronic Care Management Models</td>
<td>Develop chronic care multi-disciplinary training programs for nurses, pharmacists, social, registered dietitians, mid-level providers and physicians.</td>
<td>Gulf Bend</td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Formalize relationships and referrals to community partners that have capacity to promote wellness and</td>
<td>Gulf Bend</td>
<td></td>
</tr>
<tr>
<td><strong>Category 2: Innovation and Redesign</strong></td>
<td><strong>Implement Evidence-Based Health Promotion and Disease Prevention Programs</strong></td>
<td>healthy behaviors (i.e., school-based health clinics)</td>
<td><strong>Gulf Bend</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Implement evidenced-based strategies to reduce tobacco use.</td>
<td><strong>Gulf Bend</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Establish self-management education programs in community settings including self-enrollment in the program and appropriate follow-up with a health care professional. Engage in wellness at non-medical locations using CHWs.</td>
<td><strong>Gulf Bend</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>School based health centers – engage in population-based campaigns or programs to promote healthy lifestyles using new media such as social media and text messaging in an identified targeted population.</td>
<td><strong>Gulf Bend</strong></td>
<td></td>
</tr>
<tr>
<td>Improve Patient Experience of Care</td>
<td>Survey patients using CAHPS PCMH item set to improve three composite measures.</td>
<td><strong>Jackson County Hospital District</strong></td>
<td></td>
</tr>
<tr>
<td>Redesign to Improve Patient Experience</td>
<td>Survey patients using CAHPS PCMH item set to improve three composite measures.</td>
<td><strong>Jackson County Hospital District</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Develop a program to provide smoking cessation services ancillary to primary behavioral health care in an outpatient community services setting.</td>
<td><strong>MHMR Nueces County</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Transitional housing program run by Peer Specialists for individuals discharging from inpatient psychiatric treatment to ensure continued stabilization</td>
<td><strong>MHMR Nueces County</strong></td>
<td></td>
</tr>
<tr>
<td>Implement Evidence-Based Health Promotion and Disease Prevention Programs</td>
<td>Create a program for health promotion and disease prevention in Karnes County that targets a population at high risk for obesity and diabetes.</td>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Implement/Expand Care Transitions Program</td>
<td>Improve patient outcomes and decrease readmissions through a care transitions program.</td>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Improve Patient Experience of Care</td>
<td>Improve HCAHPS scores through redesign of care delivery processes and education for staff.</td>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Redesign to Improve Patient Experience</td>
<td>Improve HCAHPS scores through redesign of care delivery processes and education for staff.</td>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Enhance/Expand Medical Homes</td>
<td>Establish an outpatient pulmonary</td>
<td><strong>Refugio County Hospital District</strong></td>
<td></td>
</tr>
</tbody>
</table>

**RHP Plan for Region 4**
<table>
<thead>
<tr>
<th>Category 2: Innovation and Redesign</th>
</tr>
</thead>
<tbody>
<tr>
<td>rehabilitation service and managed by a multi-disciplinary team and create health education programs and support for pulmonary patients.</td>
</tr>
</tbody>
</table>
## C. Supporting Evidence of Stakeholder Participation

### Table 1. Past and Current Participant Engagement Activities

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Meeting Sponsor(s)</th>
<th>Organizations Represented</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-2012</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>RHP 4 Hospital, LMHA, and Public Health Performing Providers</td>
<td>RHP Organizational Meeting</td>
</tr>
<tr>
<td>All Mondays from 03-19-12 to 08-10-12</td>
<td>Standing RHP 4 Conference Call originated from Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>RHP 4 Hospital, LMHA, and Public Health Performing Providers, State Rep. Todd Hunter</td>
<td>Weekly Conference Call: Update HHSC Activities &amp; Timelines, RHP 4 Timelines, Planned RHP 4 Activities, Consultant Feedback, Q&amp;A</td>
</tr>
<tr>
<td>All Mondays from 08-22-12 to 03-11-13; regular meetings as needed</td>
<td>Standing RHP 4 Conference Call originated from Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>RHP 4 Hospital, LMHA, and Public Health Performing Providers, State Rep. Todd Hunter, Nueces County Medical Society</td>
<td>Weekly Conference Call: Update HHSC Activities &amp; Timelines, RHP 4 Timelines, Planned RHP 4 Activities, Consultant Feedback, Q&amp;A</td>
</tr>
<tr>
<td>07-30-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Gjerset &amp; Lorenz, LP, Nueces County MHMR, Texas A&amp;M Health Science Center, Christus Spohn Health System, San Patricio Health Department, Diabetes Community Coalition, Nueces County Medical Society, Port Aransas ISD, Driscoll Children’s Hospital, Office of Rep. Todd Hunter, Amistad FQHC, Coastal Plains MHMR, Tuloso-Midway ISD, Corpus Christi Medical Center, Missions of Mercy, RIST, Texas Department of State Health Services, Region 11, Corpus Christi-Nueces County Health Department, Corpus Christi ISD, Driscoll Children’s Health Plan</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Solicit Public Input</td>
</tr>
<tr>
<td>07-31-12</td>
<td>Victoria, TX</td>
<td>Nueces County Hospital District</td>
<td>Yoakum Hospital District, Goliad County Indigent Health Care, Goliad County, Lavaca Medical Center, Citizens Medical Center, Victoria Pediatrics &amp;</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Solicit Public Input</td>
</tr>
</tbody>
</table>

RHP Plan for Region 4
<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Meeting Sponsor(s)</th>
<th>Organizations Represented</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-06-12</td>
<td>Corpus Christi, TX</td>
<td></td>
<td>Nueces County Hospital District, Nueces County MHMR, Nueces County Hospital District,</td>
<td>Performing Provider,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Driscoll Children’s Hospital, Community Action Corp. of South Texas, San Patricio County</td>
<td>Stakeholder, and Public</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health Department, Amistad FQHC, Corpus Christi Medical Center, Corpus Christi-Nueces</td>
<td>Meeting: Waiver Overview,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>County Health Department, Catholic Charities, Diabetes Community Coalition, Charlie’s</td>
<td>Health Needs Assessment,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Place, Corpus Christi ISD, Texas A&amp;M Health Science Center – Coastal Bend Health Education</td>
<td>Priorities, Pass 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Center, Nueces County Hospital District, Nueces County Medical Society, Christus Spohn</td>
<td>Projects, Solicit Public</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor(s)</td>
<td>Organizations Represented</td>
<td>General Topic or Purpose</td>
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<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>10-27-11, 11-16-11, 4-05-12, 10-24-12</td>
<td>Community Health Centers of South Central Texas, Gonzales, TX</td>
<td>Bluebonnet Trails Community Services</td>
<td>Community Health Centers of South Central Texas</td>
<td>Consideration of patient navigator project</td>
</tr>
<tr>
<td>6-05-12</td>
<td>Gonzales County Memorial Hospital, Gonzales, TX</td>
<td>Bluebonnet Trails Community Services</td>
<td>Community Health Centers of South Central Texas, Gonzales County Memorial Hospital</td>
<td>Consideration of patient navigator project</td>
</tr>
<tr>
<td>8-29-12</td>
<td>Community Health Centers of South Central Texas, Gonzales, TX</td>
<td>Bluebonnet Trails Community Services</td>
<td>Community Health Centers of South Central Texas, Gonzales County Memorial Hospital</td>
<td>Consideration of patient navigator project</td>
</tr>
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<tr>
<td><strong>Bluebonnet Trails Community Mental Health and Mental Rehabilitation</strong></td>
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<tr>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
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<tr>
<td>Twice weekly</td>
<td>Otto Kaiser Memorial Hospital, Kenedy, TX</td>
<td>Otto Kaiser Memorial Hospital, CFO and CNO</td>
<td>Potential vendors for DSRIP project contracts</td>
<td>Planning DSRIP projects and obtaining quotes from vendors</td>
</tr>
<tr>
<td><strong>Yoakum Community Hospital</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3-19-12, 4-16-12, 5-21-12, 7-16-12, 8-13-12, 9-20-12, 10-15-12</td>
<td>Yoakum, TX</td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Hospital District</td>
<td>Monthly Yoakum Hospital District meetings – 1115 waiver updates and discussions</td>
</tr>
<tr>
<td>Throughout 2012</td>
<td>Yoakum, TX</td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Community Hospital, Yoakum Hospital District</td>
<td>Meetings with clinical personnel regarding DSRIP projects</td>
</tr>
<tr>
<td><strong>Driscoll Children’s Hospital</strong></td>
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</tr>
<tr>
<td>8-13-12</td>
<td>Driscoll Children’s Hospital, Corpus Christi, TX</td>
<td>Driscoll Children’s Hospital</td>
<td>Corpus Christi Medical Center, CHRISTUS Spohn Hospital, Nueces County Medical Society, Nueces County Hospital District, Driscoll Children’s Hospital</td>
<td>Discuss RHP 4 project development</td>
</tr>
<tr>
<td>9-17-12</td>
<td>Driscoll Children’s Hospital, Corpus Christi, TX</td>
<td>Driscoll Children’s Hospital</td>
<td>MHMR of Corpus Christi, Driscoll Children’s Hospital</td>
<td>Discuss RHP 4 project development</td>
</tr>
<tr>
<td><strong>Citizens Medical Center</strong></td>
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</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor(s)</td>
<td>Organizations Represented</td>
<td>General Topic or Purpose</td>
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</tr>
<tr>
<td>8-15-12</td>
<td>Victoria, TX</td>
<td>Gulf Bend Center &amp; Texas AHEC East, Victoria Region</td>
<td>L. Voskamp &amp; J. Phelps</td>
<td>LMHA 1115 Waiver planning meeting</td>
</tr>
<tr>
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</tr>
<tr>
<td>7-7-12</td>
<td>Portland, TX</td>
<td>Coast Plains Community Center</td>
<td>Planning and Network Advisory Committee of CPCC</td>
<td>Planning meeting</td>
</tr>
<tr>
<td>8-4-12</td>
<td></td>
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<td></td>
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<tr>
<td>11-13-12</td>
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<tr>
<td><strong>Coastal Plains Community Center</strong></td>
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<tr>
<td>5-2-12</td>
<td>Corpus Christi, TX</td>
<td>MHMR of Nueces County</td>
<td>MHMR Board of Trustees, Planning Advisory Committee, Executive Management Team</td>
<td>Workshop with Texas Council of Community Centers staff Melissa Rowan - Introduction to 1115 Waiver</td>
</tr>
<tr>
<td>5-16-12</td>
<td></td>
<td></td>
<td>MHMRNC Board, Planning Committee Members</td>
<td>Planning meeting</td>
</tr>
<tr>
<td>6-22-12, 8-20-12, 10-3-12, 10-5-12, 10-9-12</td>
<td>Corpus Christi, TX</td>
<td>MHMR of Nueces County</td>
<td>MHMR of Nueces County internal staff</td>
<td>DSRIP project planning</td>
</tr>
<tr>
<td>8-14-12, 10-2-12</td>
<td>Conference calls</td>
<td>Texas Council of Community Centers</td>
<td>MHMR of Nueces County staff</td>
<td>1115 waiver and DSRIP projects</td>
</tr>
<tr>
<td>9-11-12</td>
<td>Corpus Christi, TX</td>
<td>MHMR of Nueces County</td>
<td>MHMRNC Planning Advisory Committee</td>
<td>Discuss DSRIP projects, timeline, planning</td>
</tr>
<tr>
<td>9-27-12, 10-25-12</td>
<td>Corpus Christi, TX</td>
<td>MHMR of Nueces County</td>
<td>MHMRNC Board, Planning Committee Members</td>
<td>DSRIP projects</td>
</tr>
<tr>
<td><strong>MHMR of Nueces County</strong></td>
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<tr>
<td>6-29-12</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>MHMR of Nueces County, Corpus Christi Medical Center</td>
<td>Discuss possible DSRIP projects and collaboration opportunities</td>
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</tr>
<tr>
<td><strong>Corpus Christi Medical Center</strong></td>
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<tr>
<td>10-15-12</td>
<td>Corpus Christi, TX</td>
<td>CCNCPHD</td>
<td>Population Health Institute of Texas, Diabetes Community Coalition, Catholic Charities, CCNCPHD</td>
<td>Collaboration on childhood obesity DSRIP project</td>
</tr>
<tr>
<td>10-22-12, 10-26-12, 10-29-12</td>
<td>Conference calls</td>
<td>CCNCPHD</td>
<td>Population Health Institute of Texas, Diabetes Community Coalition, Catholic Charities, Health District</td>
<td>Collaboration on childhood obesity project</td>
</tr>
<tr>
<td>10-15-12</td>
<td>Corpus Christi, TX</td>
<td>CCNCPHD</td>
<td>Diabetes Community Coalition, Amistad FQHC, Catholic Charities, Health District</td>
<td>Collaboration on diabetes project</td>
</tr>
<tr>
<td>10-22-12, 10-31-12</td>
<td>Conference calls</td>
<td>CCNCPHD</td>
<td>Diabetes Community Coalition, Amistad FQHC, Catholic Charities, Health</td>
<td>Collaboration on diabetes project</td>
</tr>
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</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor(s)</td>
<td>Organizations Represented</td>
<td>General Topic or Purpose</td>
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</tr>
<tr>
<td>8-15-12, 10-24-12</td>
<td>Conference calls</td>
<td>CCNCPHD</td>
<td>Nueces County Hospital District, City of Corpus Christi, Health District</td>
<td>IGT for Health Department</td>
</tr>
<tr>
<td>10-19-12</td>
<td>Corpus Christi, TX</td>
<td>CCNCPHD</td>
<td>City of Corpus Christi, Nueces County, Health District, Nueces County Hospital District</td>
<td>IGT for Health Department</td>
</tr>
</tbody>
</table>

**CHRISTUS Spohn Health System**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Meeting Sponsor(s)</th>
<th>Participating Organizations</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-2-11 to 10-24-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn (Dr. Volk)</td>
<td>Computerized Patient Order Management (CPOM) leads, CPOM IT support, Nursing Informatics representatives, VPMAs</td>
<td>Gap analysis for implementation readiness, Oversight Steering Committee – weekly Marketing strategies, CPOM Education for general medical staff</td>
</tr>
<tr>
<td>4-25-12</td>
<td>Beeville, TX</td>
<td>CHRISTUS Spohn - Beeville</td>
<td>Hospital staff, Physicians, Volunteers</td>
<td>Beeville Facility Townhall meeting</td>
</tr>
<tr>
<td>4-26-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>AT&amp;T Diabetes Manager</td>
<td>Project management</td>
</tr>
<tr>
<td>5-2-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn - Memorial Hospital</td>
<td>Hospital staff, physicians, volunteers</td>
<td>Memorial Facility Townhall meeting</td>
</tr>
<tr>
<td>5-24-12</td>
<td>Conference Call</td>
<td>CHRISTUS Spohn</td>
<td>CHRISTUS Executive Team</td>
<td>1115 Waiver Update Teleconference</td>
</tr>
<tr>
<td>8-1-12, 9-5-12</td>
<td>Conference Call</td>
<td>CHRISTUS Spohn</td>
<td>CHRISTUS Executive Team</td>
<td>CHRISTUS Advocacy &amp; Public Policy Monthly Update</td>
</tr>
<tr>
<td>10-18-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Strategy Finance Board of Directors</td>
<td>Presentation on DSRIP projects</td>
</tr>
<tr>
<td>10-19-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Board of Directors and community members</td>
<td>Presentation on DSRIP projects</td>
</tr>
</tbody>
</table>

**Table 2. Anticipated Ongoing Participant Engagement Activities**

<table>
<thead>
<tr>
<th>Anticipated Date</th>
<th>Location</th>
<th>Meeting Sponsor</th>
<th>Participating Organizations (to be invited or targeted)</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly beginning 1-14-13 to 3-11-13</td>
<td>RHP 4 Conference Call originate from Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>RHP 4 Hospital, LMHA, and Public Health Performing Providers, State Rep. Todd Hunter, Nueces County Medical Society</td>
<td>Weekly Conference Call: Update HHSC Activities &amp; Timelines, RHP 4 Timelines, Planned RHP 4 Activities, Consultant Feedback, Q&amp;A</td>
</tr>
<tr>
<td>Anticipated Date</td>
<td>Location</td>
<td>Meeting Sponsor</td>
<td>Participating Organizations (to be invited or targeted)</td>
<td>General Topic or Purpose</td>
</tr>
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</tr>
<tr>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
<td>Otto Kaiser Memorial Hospital, CFO and CNO</td>
<td>Chosen vendors for DSRIP project contracts</td>
<td>Maintaining progress for Pass 1 and Pass 2 DSRIP projects</td>
</tr>
<tr>
<td>Twice weekly</td>
<td>Otto Kaiser Memorial Hospital, Kenedy, TX</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Yoakum Community Hospital</strong></td>
<td></td>
<td>Yoakum Hospital District</td>
<td>Discussion and update on 1115 Waiver at Yoakum Hospital District meetings</td>
<td></td>
</tr>
<tr>
<td>11-19-12, and monthly thereafter</td>
<td>Yoakum, TX</td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Hospital District</td>
<td></td>
</tr>
<tr>
<td><strong>Cuero Community Hospital</strong></td>
<td></td>
<td>Cuero Community Hospital</td>
<td>Cuero Community Hospital Executive Committee</td>
<td>Discussion of DSRIP project</td>
</tr>
<tr>
<td>7-3-12, 7-10-12, 7-31-12, 10-2-12, 10-16-12, 10-30-12 (future dates TBD)</td>
<td>Cuero, TX</td>
<td>Cuero Community Hospital</td>
<td>Cuero Community Hospital Executive Committee</td>
<td>Discussion of DSRIP project</td>
</tr>
<tr>
<td><strong>Corpus Christi-Nueces County Public Health District (CCNCPHD)</strong></td>
<td></td>
<td>Conference call</td>
<td>CCNCPHD</td>
<td>Population Health Institute of Texas, Diabetes Community Coalition, Catholic Charities, Health District</td>
</tr>
<tr>
<td>Quarterly</td>
<td>CCNCPHD</td>
<td>Conference call</td>
<td>CCNCPHD</td>
<td>Diabetes Community Coalition, Amistad FQHC, Catholic Charities, Health District</td>
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</tbody>
</table>

### Table 3. Past and Current Public Engagement Activities

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Meeting Sponsor</th>
<th>Organizations Invited or Targeted</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nueces County Hospital District (Anchoring Entity)</strong></td>
<td></td>
<td>Nueces County Hospital District</td>
<td>State Representative Todd Hunter &amp; Gaye White</td>
<td>Waiver Overview &amp; Regional Health Needs, Chronic Diseases within RHP, Solicit Stakeholder Input</td>
</tr>
<tr>
<td>3-01-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>State Representative Todd Hunter &amp; Gaye White</td>
<td>Waiver Overview &amp; Regional Health Needs, Chronic Diseases within RHP, Solicit Stakeholder Input</td>
</tr>
<tr>
<td>5-25-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Diabetes Community Coalition: J. Siller, G. Bradshaw, M. Wilson, MD, &amp; A. Hernandez, PhD</td>
<td>Waiver Overview, Health Needs Assessment, Priorities, Solicit Stakeholder Input, Chronic Diseases within RHP</td>
</tr>
<tr>
<td>7-12-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Amistad FQHC: E. Herrera, Comm. J.A. Gonzalez</td>
<td>Waiver Overview, Health Needs Assessment, Priorities, Solicit Stakeholder Input, Contractor Services Integration</td>
</tr>
<tr>
<td>7-12-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County</td>
<td>Social Services Community</td>
<td>Waiver Overview</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor</td>
<td>Organizations Invited or Targeted</td>
<td>General Topic or Purpose</td>
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<tr>
<td>7-30-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Gjerset &amp; Lorenz, LP, Nueces County MHMR, Texas A&amp;M Health Science Center, Christus Spohn Health System, San Patricio Health Department, Diabetes Community Coalition, Nueces County Medical Society, Port Aransas ISD, Driscoll Children’s Hospital, Office of Rep. Todd Hunter, Amistad FQHC, Coastal Plains MHMR, Tuloso-Midway ISD, Corpus Christi Medical Center, Missions of Mercy, RIST, Texas Department of State Health Services, Region 11, Corpus Christi-Nueces County Health Department, Corpus Christi ISD, Driscoll Children’s Health Plan</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Solicit Public and Stakeholder Input</td>
</tr>
<tr>
<td>7-31-12</td>
<td>Victoria, TX</td>
<td>Nueces County Hospital District</td>
<td>Yoakum Hospital District, Goliad County Indigent Health Care, Goliad County, Lavaca Medical Center, Citizens Medical Center, Victoria Pediatrics &amp; Adolescents, Gulf Bend MHMR, Jackson County Hospital District, Community Health Centers of South Texas, DeTar Medical Center, Crossroads MRI, Victoria Upright MRI, Victoria College – Area Health Education Center</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Solicit Public and Stakeholder Input</td>
</tr>
<tr>
<td>8-13-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Nueces County Medical Society: J. Stafford, MD, E. Buck, MD, &amp; M. Peterson, MD</td>
<td>Chronic Diseases within RHP, Priority Initiatives for Nueces County, Solicit Stakeholder Input</td>
</tr>
<tr>
<td>9-15-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Nueces County Commissioners Court</td>
<td>County &amp; Regional Health Needs, Funding, Solicit Stakeholder</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor</td>
<td>Organizations Invited or Targeted</td>
<td>General Topic or Purpose</td>
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<tr>
<td>11-06-12</td>
<td>Corpus Christi, TX</td>
<td>Nueces County Hospital District</td>
<td>Nueces County MHMR, Nueces County Hospital District, Driscoll Children’s Hospital, Community Action Corp. of South Texas, San Patricio County Health Department, Amistad FQHC, Corpus Christi Medical Center, Corpus Christi-Nueces County Health Department, Catholic Charities, Diabetes Community Coalition, Charlie’s Place, Corpus Christi ISD, Texas A&amp;M Health Science Center – Coastal Bend Health Education Center, Nueces County Medical Society, Christus Spohn Health System, Coastal Plains MHMR Center, Brooks County, Women’s Shelter of South Texas, Texas A&amp;M Health Science Center, Driscoll Children’s Health Plan, Mission of Mercy, Texas A&amp;M University-Corpus Christi Diabetes Community Coalition (See Attached Sign-In Sheets for Names)</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Pass 1 Projects, Solicit Public &amp; Stakeholder Input</td>
</tr>
<tr>
<td>11-07-12</td>
<td>Victoria, TX</td>
<td>Nueces County Hospital District</td>
<td>Victoria ISD, Gulf Bend MHMR Center, Gonzales Healthcare Systems, Refugio Memorial Hospital, DeTar Healthcare System, Population Health Consultants, Texas Tech University School of Nursing, Citizens Medical Center, Victoria College – Area Health Education Center, Jackson County Hospital District, Victoria Community Health Center, Yoakum Hospital District, Cuero Community Hospital (See Attached Sign-In)</td>
<td>Performing Provider, Stakeholder, and Public Meeting: Waiver Overview, Health Needs Assessment, Priorities, Pass 1 Projects, Solicit Public &amp; Stakeholder Input</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor</td>
<td>Organizations Invited or Targeted</td>
<td>General Topic or Purpose</td>
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<tr>
<td>12-20-12</td>
<td>Webinar</td>
<td>Nueces County Hospital District</td>
<td>Stakeholders and Public</td>
<td>Waiver Overview, Pass 1 &amp; 2 Projects, Solicit Public &amp; Stakeholder Input on RHP4 plan</td>
</tr>
<tr>
<td>12-21-12</td>
<td>Webinar</td>
<td>Nueces County Hospital District</td>
<td>Stakeholders and Public</td>
<td>Waiver Overview, Pass 1 &amp; 2 Projects, Solicit Public &amp; Stakeholder Input on RHP4 plan</td>
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<tr>
<td>9-24-12</td>
<td>Bluebonnet Trails Community Mental Health and Mental Rehabilitation</td>
<td>Bluebonnet Trails Community Services Gonzales, TX</td>
<td>Bluebonnet Trails Community Services Board of Trustees</td>
<td>Monthly board meeting, open to the public, reviewed Patient Navigator Project as well as all 1115 waiver projects</td>
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<tr>
<td></td>
<td>Otto Kaiser Memorial Hospital</td>
<td>Otto Kaiser Memorial Hospital Kenedy, TX</td>
<td>Board of Directors</td>
<td>Texas Healthcare, Medicaid, uncompensated care, former UPL Program</td>
</tr>
<tr>
<td></td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Hospital District and public</td>
<td>1115 Waiver discussed at all Yoakum Hospital District meetings, which are open to the public</td>
</tr>
<tr>
<td></td>
<td>Refugio County Hospital District</td>
<td>Refugio, TX</td>
<td>Hospital Board Members</td>
<td>Refugio County Hospital Board Meeting - 1115 Waiver questions and answers</td>
</tr>
<tr>
<td>10-31-12</td>
<td>Refugio, TX</td>
<td>Louis Willeke Administrator, Refugio County Memorial Hospital</td>
<td>Hospital Board Members</td>
<td>Refugio County Hospital Board Meeting - 1115 Waiver update</td>
</tr>
<tr>
<td>7-3-12, 8-29-12</td>
<td>Texas A&amp;M University – Corpus Christi Corpus Christi, TX</td>
<td>MHMR of Nueces County</td>
<td>MHMR MH Director, TRR supervisor, Director of TAMUCC Health Science Center</td>
<td>Collaboration 1115 Waiver, DSRIP projects</td>
</tr>
<tr>
<td>8-28-12</td>
<td>Corpus Christi TX</td>
<td>MHMR of Nueces County</td>
<td>Via-Media, MHMR of Nueces County</td>
<td>Collaboration with potential contractor</td>
</tr>
<tr>
<td></td>
<td>Cuero Community Hospital</td>
<td>Cuero Community Hospital</td>
<td>Hospital Board Members</td>
<td>RHP 4 roles and responsibilities, proposed DSRIP project</td>
</tr>
<tr>
<td></td>
<td>Corpus Christi Medical Center</td>
<td>Monthly since Corpus Christi, TX</td>
<td>Corpus Christi CCMC Medical Executive</td>
<td>DSRIP projects,</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Sponsor</td>
<td>Organizations Invited or Targeted</td>
<td>General Topic or Purpose</td>
</tr>
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<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>June 2012</td>
<td>Medical Center</td>
<td>Committee</td>
<td>updates, and discussions</td>
<td></td>
</tr>
<tr>
<td>Bi-monthly since June 2012</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>CCMC Board of Trustees</td>
<td>DSRIP project updates and discussions</td>
</tr>
<tr>
<td>6-20-12</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>CCMC Medical Executive Committee, CCMC Board of Trustees</td>
<td>Discussion on proposed projects, opportunities for collaboration, timelines</td>
</tr>
<tr>
<td>7-20-12, 8-31-12</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>Amistad FQHC, Corpus Christi Medical Center</td>
<td>Collaboration on expansion of primary care projects</td>
</tr>
</tbody>
</table>

**Corpus Christi-Nueces County Public Health District (CCNCPHD)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Sponsor</th>
<th>Organizations Invited or Targeted</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly in 2012 (January, April, July, October)</td>
<td>Amistad Community Health Center, Corpus Christi, TX</td>
<td>Diabetes Community Coalition</td>
<td>Texas A&amp;M University, Corpus Christi, PRIDE, Corpus Christi, Food Bank of Corpus Christi, City of Corpus Christi, Education Service Center, ADA, CHRISTUS Spohn, Metro Ministries, Gabbard Health Clinic, Corpus Christi ISD, Driscoll Children’s Hospital, Lichtenstein Foundation, Texas AgriLife, Catholic Charities Healthy Living and Advocacy Center, United Way of the Coastal Bend, Amistad FQHC, YMCA, Nueces County Community Action Agency, MAXIMUS, Transportation Coordination Network, CCNCPHD, Nueces Medical Society, Del Mar School of Nursing, Mayor’s Fitness Council, Novo Nordisk, San Patricio County Department of Health</td>
<td>General Membership Meeting – updates on 1115 waiver and DSRIP projects</td>
</tr>
</tbody>
</table>

**CHRISTUS Spohn Health System**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Sponsor</th>
<th>Organizations Invited or Targeted</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-26-12, 5-24-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Medical Executive Committee</td>
<td>1115 Waiver update</td>
</tr>
<tr>
<td>4-24-12</td>
<td>Conference Call</td>
<td>CHRISTUS Spohn</td>
<td>Care Transition Manager</td>
<td>AT&amp;T Cellphone Application</td>
</tr>
<tr>
<td>7-24-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Medical Staff Leaders</td>
<td>RHP plan, 1115 Waiver</td>
</tr>
<tr>
<td>8-8-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Medical Staff</td>
<td>General Medical Staff meeting (Memorial Facility) – State and Federal Legislative Healthcare Update</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Meeting Sponsor</td>
<td>Organizations Invited or Targeted</td>
<td>General Topic or Purpose</td>
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</tr>
<tr>
<td>8-8-12, 8-10-12,</td>
<td>Corpus Christi, TX (Shoreline, South, and Memorial Facilities)</td>
<td>CHRISTUS Spohn</td>
<td>Professional Review Committee</td>
<td>DSRIP presentations</td>
</tr>
<tr>
<td>8-13-12</td>
<td></td>
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<tr>
<td>11-1-12</td>
<td>Corpus Christi, TX</td>
<td>CHRISTUS Spohn</td>
<td>Physician IT Advisory Council</td>
<td>Computerized Patient Order Management</td>
</tr>
</tbody>
</table>

### Table 4. Anticipated Ongoing Public Engagement Activities

<table>
<thead>
<tr>
<th>Anticipated Date</th>
<th>Location</th>
<th>Meeting Sponsor</th>
<th>Participating Organizations (to be invited or targeted)</th>
<th>General Topic or Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Otto Kaiser Memorial Hospital</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Monthly</td>
<td>Otto Kaiser Memorial Hospital Kenedy, TX</td>
<td>Board of Directors</td>
<td>Public</td>
<td>Public comments pertaining to hospital operations including uncompensated care, DSRIP, and RHP activities</td>
</tr>
<tr>
<td><strong>Yoakum Community Hospital</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>November 2012 and monthly thereafter</td>
<td>Yoakum, TX</td>
<td>Yoakum Community Hospital</td>
<td>Yoakum Hospital District and public</td>
<td>1115 Waiver update and discussion to be included on agenda for all monthly Hospital District meetings</td>
</tr>
<tr>
<td><strong>Refugio County Hospital District</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 2012 and monthly thereafter</td>
<td>Refugio, TX</td>
<td>Louis Willeke Administrator, Refugio County Memorial Hospital</td>
<td>Hospital Board Members</td>
<td>Updates and status reports on 1115 Waiver</td>
</tr>
<tr>
<td><strong>Corpus Christi Medical Center</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly through 2012</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>CCMC Medical Executive Committee</td>
<td>Continued updates with project details and metrics</td>
</tr>
<tr>
<td>Bi-monthly through 2012</td>
<td>Corpus Christi, TX</td>
<td>Corpus Christi Medical Center</td>
<td>CCMC Board of Trustees</td>
<td>Continued updates with project details and metrics</td>
</tr>
<tr>
<td><strong>CHRISTUS Spohn Health System</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bi-weekly</td>
<td>Corpus Christi, TX or via webinar</td>
<td>CHRISTUS Spohn</td>
<td>AT&amp;T, CHRISTUS Spohn</td>
<td>AT&amp;T Cellphone application</td>
</tr>
</tbody>
</table>

RHP Plan for Region 4
## D. RHP 4 Pass 2 Potential Projects

<table>
<thead>
<tr>
<th>Project Category</th>
<th>Potential Pass 2 Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Expand Primary Care Capacity</td>
</tr>
<tr>
<td>1.3</td>
<td>Implement a chronic disease registry</td>
</tr>
<tr>
<td>1.7</td>
<td>Introduce, Expand, or Enhance Telemedicine/Telehealth</td>
</tr>
<tr>
<td>1.9</td>
<td>Expand Specialty Care Capacity</td>
</tr>
<tr>
<td>1.11</td>
<td>Implement technology-assisted services to support, coordinate, or deliver behavioral health services</td>
</tr>
<tr>
<td>1.12</td>
<td>Enhance service availability</td>
</tr>
<tr>
<td>1.14</td>
<td>Develop Workforce enhancement initiatives to support access of behavior health providers in underserved markets and areas</td>
</tr>
<tr>
<td>2.2</td>
<td>Expand Chronic Care Management Models</td>
</tr>
<tr>
<td>2.6</td>
<td>Implement Evidence-Based Health Promotion</td>
</tr>
<tr>
<td>2.9</td>
<td>Establish/Expand a Patient Care Navigation Program</td>
</tr>
<tr>
<td>2.11</td>
<td>Conduct Medication Management</td>
</tr>
<tr>
<td>2.12</td>
<td>Implement/Expand Care Transitions Programs</td>
</tr>
<tr>
<td>2.15</td>
<td>Integrate primary and behavioral health care services</td>
</tr>
<tr>
<td>2.16</td>
<td>Provide virtual psychiatric and clinical guidance to all participating primary care providers delivery services to behavioral patients regionally</td>
</tr>
<tr>
<td>**</td>
<td>Other Projects currently being discussed by the Performing Provider and Anchor</td>
</tr>
</tbody>
</table>

Note: This project listing is subject to change based on available DSRIP Pass 2 Allocations and/or Performing Provider preferences.
RHP 4: There are no performing providers that will be expanding upon the federal initiatives.

**Federal Initiatives**

*CMS has indicated that they are interested in whether Performing Providers (PPs) are participating in or are implementing DSRIP projects to expand upon the following federal initiatives.*

<table>
<thead>
<tr>
<th>CMS Innovation Center Grants:</th>
<th>Add &quot;X&quot; if PP's DSRIP project will expand upon a federal initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Care Organizations (ACOs)</td>
<td></td>
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<tr>
<td>Advance Payment Model</td>
<td></td>
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<tr>
<td>Pioneer ACO Model</td>
<td></td>
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<tr>
<td>Bundled Payments for Care Improvement</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Primary Care Initiative</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</td>
<td></td>
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<tr>
<td>Graduate Nurse Education Demonstration</td>
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<tr>
<td>Health Care Innovation Awards</td>
<td></td>
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<tr>
<td>Independence at Home Demonstration</td>
<td></td>
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<tr>
<td>Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</td>
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</tr>
<tr>
<td>Medicaid Emergency Psychiatric Demonstration</td>
<td></td>
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<tr>
<td>Partnership for Patients</td>
<td></td>
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<tr>
<td>State Innovation Models Initiative</td>
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<tr>
<td>Strong Start for Mothers and Newborns</td>
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</tbody>
</table>

**HITECH payments:**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>EHR incentive payments</td>
<td></td>
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<tr>
<td>Health Information Exchange Grant</td>
<td></td>
</tr>
<tr>
<td>Other HITECH grant or payment</td>
<td></td>
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</tbody>
</table>

**HRSA grants:**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>FQHC/ RHC/ School-based health center grants, including capital grants</td>
<td></td>
</tr>
<tr>
<td>Health professions loans and workforce development grants</td>
<td></td>
</tr>
<tr>
<td>Ryan White funding</td>
<td></td>
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<tr>
<td>Maternal and child health grants</td>
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</tbody>
</table>

**SAMSHA Funding (list of SAMSHA grants by state):**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Community Mental Health services block grant</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Prevention and Treatment Block Grant</td>
<td></td>
</tr>
<tr>
<td>Other mental health and substance abuse grants</td>
<td></td>
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</tbody>
</table>

**CDC grants (list of CDC funding by state):**

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<thead>
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<tbody>
<tr>
<td>Immunization grants</td>
<td></td>
</tr>
<tr>
<td>CLASBI/ Hospital acquired infection initiatives</td>
<td></td>
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</tbody>
</table>