RHP 5/South Texas
Pass 1 DSRIP Projects:
Category 1 and Category 2 Project Narratives

Border Region Behavioral Health Center- Category 1: Infrastructure Development

The narrative for each Category 1 Project is limited to 6 pages.

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

Project Narrative 1.11.2

Border Region Behavioral Health Center TPI:1219891-02

Unique RHP Project Identification Number: 1219891-02.1.1

Implement technology assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

Border Region Behavioral Health Center will expand telemedicine services to all counties of Border Region's rural service area, one of which is in Region 5. These services will be available for children and adults and will include psychiatric evaluation, medication management and crisis intervention. Because the region is sparsely populated, it is a challenge to provide accessible behavioral health services to the population. The availability of behavioral health providers is extremely limited. Via telemedicine is the only way some parts of Region 5 will have access to behavioral health care.

Starting Point/Baseline:

e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Border Region currently has in place Telemedicine technology to support Laredo and nearby communities. This project will expand telemedicine technology to Starr county, which currently has no capacity for telemedicine.

Rationale:

A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that

are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).

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

- Improve the time between initial request for services and first appointment.
- Decrease transportation costs of traveling providers and clients for crisis intervention.
- Reduce staff time lost to travel, and ensure more service delivery and improved billing of staff time.
- Enables clients from Starr County to benefit from additional services available after implementation of Project Option 1.14.1 and 2.15.1

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

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

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

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Outcome Domain IT 2.4 – Potentially Preventable Inpatient Admissions.

Telemedicine technology will help our Community Mental Health clinic in Starr County deliver outpatient services at the same level as the Laredo clinic. The Laredo clinic has telemedicine technology operatives. Adult clients at the Region 5 office of Border Region Behavioral Health Center receive 35% less psychiatric visits per year than individuals in Laredo do. Child Clients in Region 5 receive 30% fewer visits than those in Laredo do. By providing more care in the outpatient setting via telemedicine, Border Region will be able to reduce preventable inpatient admissions.

Inpatient admission rates to state behavioral health hospitals for adults and children in Starr County are 12% higher than rates in Webb County.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

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

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

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

N/A

Plan for Learning Collaborative:

If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

N/A

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

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

1219891-02 P 1.11	***1.11.2***	***1.11.2.Q***	**Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*Category 3 IT 2.4*	1219891-02.1.11	*IT 2.4 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-4 Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment <u>Metric 1</u> P 4.1.Inventory of new equipment purchased a. Data Source: Review of inventory or receipts for purchase of equipment b. Rationale/Evidence: See project	**Milestone 2** P-8. Training for providers/peers on use of equipment /software <u>Metric 1</u> P 8.1. Documentation of completions of training on use of equipment/ software a. Data Source: Training roster. b. Rationale/Evidence:		**Milestone 3** P-11: Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and / or telemonitoring services for treatment of mental illness or alcohol and drug dependence. <u>Metric 1</u> Metric: TBA% increase in number of individuals residing in underserved areas of the health partnership region who have used telemedicine, telehealth and telemonitoring services for treatment of mental illness or	**Milestone 4** [I-15]: Satisfaction with telemental services <u>Metric 1</u> [I-15.1]: Metric: TBA % of consumer, peer and provider surveys indicate satisfaction with telemental services Goal: TBA Data Source: batched and analyzed survey data

1219891-02 P 1.11	***1.11.2***	***1.11.2.Q***	**Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*Category 3 IT 2.4*	1219891-02.1.11	*IT 2.4 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
goal. Rationale/Goal: No equipment or lines exist in Starr County Goal: Establish working telemedicine hardware. Data Source: Center inventory Milestone 1 Estimated Incentive Payment *(maximum*	Baseline: TBA/Goal: Establish baseline for first operational years use. Milestone 2 Estimated Incentive Payment: $18,346		alcohol and drug dependence. Goal: Begin telemedicine encounters Data Source: Anasazi Client Encounter system Milestone 3 Estimated Incentive Payment: $19,626	Milestone 4 Estimated Incentive Payment: $ $18,962

1219891-02 P 1.11	***1.11.2***	***1.11.2.Q***	**Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*Category 3 IT 2.4*	1219891-02.1.11	*IT 2.4 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
amount): $ $17,586				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each*	Year 3 Estimated Milestone Bundle Amount:		Year 4 Estimated Milestone Bundle Amount:	Year 5 Estimated Milestone Bundle Amount: $18,962

1219891-02 P 1.11	***1.11.2***	***1.11.2.Q***	**Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*Category 3 IT 2.4*	1219891-02.1.11	*IT 2.4 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**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): $17,586	$18,346		$19,626	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ $74,520				

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas

Unique RHP Project ID number: 1219891-02.1.14

Border Region Behavioral Health Center TPI: 1219891-02

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

This project is designed to address the lack of licensed Behavioral Health providers and other Behavioral Health workers residing in and serving Region 5. Licensed positions have been historically under filled. New initiatives and changes in the health care law will exacerbate this situation unless new efforts can be initiated to recruit and train behavioral health care and primary care workers. The project will involve hiring a physician, a RN, a coordinating case worker, and a LPHA (licensed practitioner of the healing arts), and a telemedicine 0.11 child psychiatrist and 0.11 adult psychiatrist. Border Region will begin this effort by analyzing the delivery system to quantify and prioritize areas of need. The process will include input from local stakeholders about how to best attract or recruit and train the positions identified. Contracted telemedicine resources will be investigated as viable alternatives to face-to-face encounters.

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

Challenges:

- Competition for licensed people from school system
- Difficulty attracting people to live in borderlands.
- Lack of patient data on access to care provided by other agencies.

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

Starting Point/Baseline:

e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Typically in this Region one part time contract Licensed Practitioner of the Healing Arts is available for approximately 520 clients. No child psychiatrist is available for the over 175 clients in the children's program. Children and adults are served by the same psychiatrist.

One Licensed Vocational Nurse provides the nursing services for the behavioral health clients in Region 5.

Rationale:

A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).

Overall there is a lack of behavioral health staff serving Region 5. Staff shortages cause frequent delays in service delivery and screening for services. LPHAs are needed for authorization, CBT and utilization review.

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

Currents needs for licensed staff for programs in place identified as:

Child Psychiatrist: .1 FTE (via telemedicine)

Adult Psychiatrist .1 FTE (via telemedicine)

LPHA: 1 FTE

RN: .5 FTE (via telemedicine)

LVN: 2 FTE

Project Components:

a. Border Region will conduct a gap analysis

b. Border Region will develop a plan for remediation of needs addressed by the gap analysis. The plan will specify recruitment targets by specialty over time, and specific recruitment strategies. For primary care staff who may be hired or contracted, training will be provided in behavioral health client and service delivery, as well as principals and protocols for the integration project.

c. Qualitative and quantitative data will be collected as a routine part of Milestone 4, Evaluate and Continuously Improve Strategies. As appropriate, strategies may be exported to other needs identified in the gap analysis for serving the safety-net population.

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Outcome Domain 2 – Potentially Preventable Inpatient Admissions.

With additional behavioral health services, populations in Region 5 should be able to avoid preventable inpatient admissions.

National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.

Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population[1]. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness.

[1] 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,

Relationship to other Projects:
A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

This project relates to 1.11.2 - *Implement technology assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified provider,* and to 2.15.1 - *Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.* It is expected that some specialty providers will be available only via telemedicine and trainings may be done with the same technology infrastructure. This will be especially true for provider and clients in the outlying counties of Jim Hogg and Zapata.

Project 2.15.1 will rely on personnel hired or contracted and trained through this project almost entirely. Current DSHS state contract does not provide for treatment of primary care needs.

Relationship to Other Performing Providers' Projects in the RHP:
If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.
None established at this time.

Plan for Learning Collaborative:
If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.
None established at this time.

Project Valuation:
A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.
This project will result in less emergency room utilization and avoided admissions. The project will lessen the impact on the criminal justice system. It will also increase licensed personnel available for crisis management.

1219891-02.1.11	***1.14.1***	***1.14.1.A.B.C.***	**Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*IT-2.4*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-3 Resource Identification <u>Metric 1</u> P-3.1. Identify specific disciplines and knowledge base that would assist primary care providers to expand their score of practice to address the needs of individuals with complex behavioral health conditions		**Milestone 2**. P-4 Evaluate and continuously improve strategies <u>Metric 1</u> P-4.1 Project planning and implementation documentation describes plan, do, study act quality improvement cycles a. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement	**Milestone 3** P-5 Number of behavioral health providers serving medically indigent public health clients <u>Metric 1</u>. 5.1 Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis.	**Milestone 5** P-5 Number of behavioral health providers serving medically indigent public health clients <u>Metric 1</u> 5.1 Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis.

1219891-02.1.11	***1.14.1***	***1.14.1.A.B.C.***	**Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*IT-2.4*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline: TBA/Goal: Data Source: Written plan from Regional Partnerships Milestone 1 Estimated Incentive Payment *(maximum amount):* $413,267	to guide continuous quality improvement Baseline: TBA/Goal: Establish baseline for first operational years use. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 2 Estimated		Goal: Data Source: Milestone 3 Estimated Incentive Payment: $230,603 **Milestone 4** I-11 Consumer satisfaction with	Goal: TBA Data Source: batched and analyzed survey data Milestone 5 Estimated Incentive Payment: $222,805

1219891-02.1.11	***1.14.1***	***1.14.1.A.B.C.***	**Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*IT-2.4*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment: $431,128		Care Metric 1. I-11.1 TBA% People reporting satisfaction with care Data Source: Provider registration and survey data. Metric 2 I-11.2 TBA% State Psychiatric Facility Bed Utilization	**Milestone 6** I-11 Consumer satisfaction with Care Metric 1. I-11.1 TBA% People reporting satisfaction with care Metric 2 I-11.2 TBA% State Psychiatric Facility Bed Utilization

1219891-02.1.11	***1.14.1***	***1.14.1.A.B.C.***	**Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*IT-2.4*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 4 Estimated Incentive Payment: $230,603	Milestone 6 Estimated Incentive Payment: $222,805
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each*		Year 3 Estimated Milestone Bundle Amount: $431,128	Year 4 Estimated Milestone Bundle Amount: $461,206	Year 5 Estimated Milestone Bundle Amount: $445,610

1219891-02.1.11	***1.14.1***	***1.14.1.A.B.C.***	**Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas**	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*IT-2.4*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)		**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): $413,267				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,751,211				

Border - Category 2: Program Innovation and Redesign

The narrative for each Category 2 Project is limited to 6 pages.

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. 2.1), Performing Provider name/TPI.

Unique RHP Project Id Number 121989102.2.1

Project: 2.15.1

Border Region Behavioral Health Center TPI: 1219891-02

Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

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

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

1. Behavioral Health Services
2. Primary care services
3. Health behavior education and training programs
4. Case Management services to help patient navigate the services provided in the community.

Border Region will implement the IMPACT Model of collaborative care.

Challenges/Barriers:

- Finding and employing primary care provider
- Costs
- Cultural barriers
- Lack of health literacy

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

Starting Point/Baseline:
e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.
No integrated primary care and behavioral health services are currently available in Region 5.

Rationale:
A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components were not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).

Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have had improved outcomes in physical health, which has benefited various populations and resulted in lower costs of care over the long term[2]. Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had significantly greater improvement in their health.[3]

The expected outcomes for this project are:

- Increase in access to primary care

[2] http://www.impact-uw.org/about/research.html
[3] Druss, B et al. Integrated medical care for patients with serious psychiatric illness. Archives of General Psychiatry, Vol 58, September 2001

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

Required Project Components:

a) The Border Region Behavioral Health Center clinic in Starr County will be the project location site.
b) Scheduling and client information will reside with the Border Region client information system.
c) Under process standard P3 (milestone 1, DY2), processes and protocols for communication, data sharing and referral will be developed. The number and types of referrals will be measured.
d) Specialty providers will be recruited as per Project 1.14.1 and/or contract providers will provide telemedicine services.
e) Provider training will be addressed as per development of protocols and processes for milestone 1, DY2.
f) Data and reporting systems are already in place and used daily.
g) Legal agreements will be explored as a function of DY3 metric for milestone 3.
h) Utilities and building services already exist for selected site.
i) Data systems and reporting mechanisms are in place. New reporting codes will be developed to isolate data pertinent to this project.
j) Quality improvement will be addressed under milestones 2 (DY2), 5 (DY 4) and 9 (DY 5).

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

Related Category 3 Outcome Measure(s):
Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*

- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Outcome Domain 2 – Potentially Preventable Inpatient Admissions. This domain was chosen because research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population[4]. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness.

National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders.

Treating patients in an integrated behavioral health primary care model will reduce preventable inpatient admissions.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

Projects 1.14.1 will provide recruitment and training efforts to provide licensed and other primary care workers. Project 1.11.2 will expand telemedicine services to permit inclusion of geographically distant clients and expend the number and type of specialty services that may be offered under this integrated care effort.

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

None established at this time.

Plan for Learning Collaborative:

If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

None established at this time.

[4] 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.

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

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

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-3 Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. <u>Metric 1</u> P 3.1. Number and types of referrals that are made between providers at the location Baseline: No integrated services or standards exist.	**Milestone 3** P-2. Milestone: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners. <u>Metric 1</u> P-2.1. Metric: Discussions/Interviews with community healthcare providers		**Milestone 4** P-6 Develop integrated behavioral health and primary care services within co- located sites. <u>Metric 1</u> P-6.1. Metric: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Data Source: Project data Goal: Complete first full year of service to clients of integrated clinic.	**Milestone 7** P-6 Develop integrated behavioral health and primary care services within co- located sites. <u>Metric 1</u> P-6.2. Metric: Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system) Data Source: Project data Goal: Service delivery indicates full integration Data Source: batched and

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Goal: Incorporate industry standards as per chosen integration model. Data Sources: Surveys of providers to determine the degree and quality Of information sharing Payment *(maximum amount):* $224,219 **Milestone 2** P-9 Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should	(physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. Baseline: Informal discussion with Regional partners at planning meetings. Goal: Involve and document providers need and willingness to support and participate in this project. Data Source: Information from		Data Source: Client Data system Milestone 4 Estimated Incentive Payment: $166,819 **Milestone 5** P 7. Evaluate and continuously improve integration of primary and behavioral health services.	analyzed survey data Milestone 8 Estimated Incentive Payment: $161,178 **Milestone 8** P 7. Evaluate and continuously improve integration of primary and behavioral health services. <u>Metric 1</u> P 7.1. Project planning and implementation documentation

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
be based on self-reported data and sampling that is sufficient for the purposes of improvement. Metric 2 P 9.1. Number of new ideas, practices, tools, or solutions tested by each provider. Baseline: Idea testing not instituted Goal: Institute system of regular evaluation of service by providers Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week.	persons interviewed Milestone 3 Estimated Incentive Payment: $467,819		Metric 1 P 7.1. Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles Goal: Assure system is achieving integration, and moving toward positive outcomes Data Source: Client Data system, Documented PDSA sessions. Milestone 5 Estimated Incentive	demonstrates plan, do, study, act quality improvement cycles Goal: Assure system is achieving integration, and moving toward positive outcomes Data Source: Client Data system, Documented PDSA sessions. Milestone 9 Estimated Incentive Payment: $161,178 **Milestone 9**

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Could be summarized at quarterly intervals. Milestone 2 Estimated Incentive $224,219			Payment: $166,819 **Milestone 6** I-10. Milestone: No-Show Appointments I-10.1. Metric: TBA% decrease the "no shows" for behavioral and physical health appointments. a. Numerator: Number of appointments for behavioral or physical health services that were not kept in the project sites. b. Denominator: Number of scheduled	I-10. Milestone: No-Show Appointments I-10.1. Metric: TBA% decrease the "no shows" for behavioral and physical health appointments. a. Numerator: Number of appointments for behavioral or physical health services that were not kept in the project sites. b. Denominator: Number of scheduled appointments for behavioral and physical health services in the project site. This would be measured at baseline and at

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			appointments for behavioral and physical health services in the project site. This would be measured at baseline and at specified time intervals throughout the project. c. Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data Milestone 6 Estimated Incentive Payment $ 99,758	specified time intervals throughout the project. c. Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data Milestone 10 Estimated Incentive Payment: $161,178
Year 2 Estimated Milestone	Year 3 Estimated Milestone		Year 4 Estimated Milestone	Year 5 Estimated Milestone

1219891-02. 2.15	***2.15.1***	***2.15.1.Q***	Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.	
[Border Region Behavioral Health Center]				1219891-04, 03 & 02
Related Category 3 Outcome Measure(s):	*1219891-02.3.2*	*[Reference number(s) from RHP PP]*	*IT 2.11 Potentially Preventable Admissions*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Bundle Amount: *(add incentive payments amounts from each milestone):* $448,439	Bundle Amount: $467,819		Bundle Amount: $500,458	Bundle Amount: $483,534
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,900,250				

Doctors Hospital Renaissance - Category 1: Infrastructure Development

Identifying Project and Provider Information:

Project Option 1.2.4 - Establish Primary Care/Internal Medicine Residency Training Program

Unique Project ID: 160709501.1.1
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Project Description:

Doctors Hospital at Renaissance proposes to establish a primary care/Internal Medicine residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Internal Medicine residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The resident trainees, the graduates, and the new faculty will expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction.

When fully implemented in 2018, the new Internal Medicine residency will have the capacity to train as many as 24 residents – 8 residents in each of three classes. The DHR Internal Medicine residency training program will complement other new residency programs at DHR in Family Medicine, Obstetrics & Gynecology, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Internal Medicine residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:

This project has the following goals**:**

- To create an Internal Medicine Residency program with residents, graduates, and faculty members who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and

- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combing the resources of a major safety net hospital, DHR, and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- 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.
- 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 existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Internal Medicine Residency Review Committee (IM-RRC) meets to review proposals only a few times each year. Residency programs must be either near-approval or accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Internal Medicine Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of six to eight Internal Medicine residents will have joined the initial cohort of six to eight residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2018. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 24 Internal Medicine residents at DHR (8 PG1; 8 PG2; and 8 PG3).

Starting Point/Baseline :

DHR currently hosts no residency programs. In all of RHP 5, existing residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center.

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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In South Texas excluding Bexar County, there are only 43 primary care physicians per 100,000 population, according to an April 2012 report by the Texas Higher Education Coordinating Board. This compares to 65 per 100,000 for greater South Texas including Bexar County and 78 per 100,000 for Central Texas.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the Association of American Medical Colleges Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80.2% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:

This project has several components:

- Identify high impact services and gaps in care and coordination
- Recruit Internal Medicine Program Directors and core faculty
- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course.

- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Internal Medicine resident education at DHR.
- Complete and submit the Program Information Form (PIF) to the RRC
- Attain ACGME approval for the program
- Recruit and enroll Internal Medicine residents

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

Currently, RHP 5 has no teaching hospital, and no residency training programs exist at DHR. The faculty for the Internal Medicine residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs in RHP 5.

Data Driving this Project:

The need for enhanced primary care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally: http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):

OD-14 Primary Care Workforce

Stand-alone:

IT - 14.1 Number of practicing primary care practitioners per 1,000 individuals in HPSA or MUA

Non-stand-alone but related:

Bundle of 3:

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

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 1,000 individuals in RHP 5.

Relationship to other Projects:

This project is related to the following DHR projects:

- 160709501.1.2 Establish Primary Care/Family Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:

The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:

All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. In addition, all of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components

related to population health management, chronic disease registries, team-based community care, and data analytics.

Project Valuation:

DHR has chosen to dedicate its entire Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region and in Hidalgo County. South Texas has historically been a medically underserved area. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in south Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $1,343,866 **Milestone 2** [P-2]: Expand primary care training for primary care physicians.	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Program Information Form (PIF) to be submitted by no later than 2/2014 for Residency Review Committee (RRC) 9/2014 meeting Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional precepting faculty members in various specialties, as required for accredited programs. Baseline: At the beginning of DY 2, no faculty are in place for		**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $686,162 **Milestone 8** [P-3]: Expand positive primary care exposure	**Milestone 11** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Cohort 1 begins in DY 4. Goal: Enroll second cohort of 6 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 12. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-2.X]: Hire the Program Director, Associate Program Director, and two Core Faculty members by 7/1/2013. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Build the founding faculty infrastructure for the residency to begin the accreditation process. Data Source: Human Resources documents. Milestone 2 Estimated Incentive Payment: $1,343,866	the residency program. Goal: Increased training faculty members. Data Source: Human Resources documents. Milestone 3 Estimated Incentive Payment: $687,227 **Milestone 4** [P-9]: Develop/disseminate clinical teaching tools for primary care. Metric 1 [P-9.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/materials. Milestone 4 Estimated		for residents. Metric 1 [P-3.1] Develop mentoring program with practicing primary care physicians/faculty and new residents. Baseline: No mentoring program exists currently. Goal: Develop mentoring program for residents with practicing primary care physicians. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care model and/or disease registry use; have primary care trainees participate in medical homes by managing panels.	DY2 or in DY2-3. Goal: Enroll second cohort of 6 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 12. Data Source: Program enrollment records. Milestone 11 Estimated Incentive Payment: $692,555 **Milestone 12** [I-15]: Increase primary care training in Continuity Clinics. Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available for primary care residents. Baseline: No training program or Continuity Clinic in DY2. Goal: Documented increase over baseline and as compared to DY 4.

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment: $687,228 **Milestone 5** [P-8] Establish a faculty development program. <u>Metric 1</u> [P-8.1] Enrollment of faculty staff into primary care education and training program. Baseline: No faculty development program exists currently. Goal: Better prepared faculty will create a better training program. Data Source: Program documents. Milestone 5 Estimated Incentive Payment: $687,227 **Milestone 6** [I-14] Increase the number of faculty staff completing educational		Baseline: No training exists currently. Goal: Primary care training program should reflect evolving delivery models. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. <u>Metric 3</u> [P-3.3] Include residents in quality improvement projects. Baseline: No training exists currently. Goal: Resident participation in QI efforts. Data source: Curriculum or QI project documentation. Milestone 8 Estimated Incentive Payment: $686,162 **Milestone 9** [I-11]: Increase primary care training and/or	Data Source: Number of resident office visits from EHR or claims data. <u>Metric 2</u> [I-15.2]: Increase number of patients assigned to primary care residents' panels. Baseline: No training program or Continuity Clinic in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Patient panel, registry, or EHR. Milestone 12 Estimated Incentive Payment: $692,555 **Milestone 13** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement.

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 6 Estimated Incentive Payment: $687,228		rotations. Metric 1 [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 6 residents as of 7/15/2015. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: 6 PY1 trainees in rotation at DHR. Data Source: Resident training schedule.	Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. Metric 1 [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Data Source: Curriculum and practicum documentation. Milestone 13 Estimated Incentive Payment: $692,555 **Milestone 14** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E)

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)		**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 Estimated Incentive Payment: $686,162 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 10 Estimated Incentive Payment: $686,162	course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 14 Estimated Incentive Payment: $692,554
Year 2 Estimated Milestone Bundle Amount: $2,687,732		Year 3 Estimated Milestone Bundle Amount: $2,748,910	Year 4 Estimated Milestone Bundle Amount: $2,744,648	Year 5 Estimated Milestone Bundle Amount: $2,770,219

UNIQUE IDENTIFIER: ***160709501.1.1***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,951,509				

Identifying Project and Provider Information:

Project Option 1.2.4 - Establish Primary Care/Family Medicine Residency Training Program

Unique Project ID: 160709501.1.2
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Project Description:

Doctors Hospital at Renaissance proposes to establish a primary care/Family Medicine residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Family Medicine residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The resident trainees, the graduates, and the new faculty will expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction.

When fully implemented in 2018, the new Family Medicine residency will have the capacity to train as many as 18 residents – 6 residents in each of three classes. The DHR Family Medicine residency training program will complement other new residency programs at DHR in Internal Medicine, Obstetrics & Gynecology, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Family Medicine residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create a Family Medicine Residency program with residents, graduates, and faculty members who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a Family Practice Center for the residency program to focus on transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and

- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combing the resources of a major safety net hospital, DHR, and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- 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.
- 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 existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Family Medicine Residency Review Committee (FM-RRC) meets to review proposals only a few times each year. Residency programs must be either near-approval or accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Family Medicine Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of four to six Family Medicine residents will have joined the initial cohort of four to six residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2018. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 18 Family Medicine residents at DHR (6 PG1; 6 PG2; and 6 PG3).

Starting Point/Baseline:

DHR currently hosts no residency programs. In all of RHP 5, existing residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center.

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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In South Texas excluding Bexar County, there are only 43 primary care physicians per 100,000 population, according to an April 2012 report by the Texas Higher Education Coordinating Board. This compares to 65 per 100,000 for greater South Texas including Bexar County and 78 per 100,000 for Central Texas.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the Association of American Medical Colleges Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80.2% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:

This project has several components:

- Identify high impact services and gaps in care and coordination
- Recruit Family Medicine Program Directors and core faculty

- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Family Medicine resident education at DHR
- Complete and submit the Program Information Form (PIF) to the RRC
- Attain ACGME approval for the program
- Recruit and enroll Family Medicine residents

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

Currently, RHP 5 has no teaching hospital, and no residency training programs exist at DHR. The faculty for the Family Medicine residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs at other hospitals in RHP 5.

Data Driving this Project:

The need for enhanced primary care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally: http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):

OD-14 Primary Care Workforce

Stand-alone:

IT - 14.1 Number of practicing primary care practitioners per 1,000 individuals in HPSA or MUA

Non-stand-alone but related:
Bundle of 3:
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

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 1,000 individuals in RHP 5.

Relationship to other Projects:

This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:

The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:

All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical

facilities. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. In addition, all of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics.

Project Valuation:

DHR has chosen to dedicate its entire Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region and in Hidalgo County. South Texas has historically been a medically underserved area. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in south Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $1,343,866 **Milestone 2** [P-2]: Expand	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Program Information Form (PIF) to be submitted by no later than 2/2014 for Residency Review Committee (RRC) 10/2014 meeting Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional precepting faculty members in various specialties, as required for accredited programs.		**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $686,162	**Milestone 11** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Cohort 1 begins in DY 4. Goal: Enroll second cohort of 4 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 8. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
primary care training for primary care physicians. Metric 1 [P-2.X]: Hire the Program Director, Associate Program Director, and two Core Faculty members by 7/1/2013. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Build the founding faculty infrastructure for the residency to begin the accreditation process. Data Source: Human Resources documents. Milestone 2 Estimated Incentive Payment: $1,343,866	Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Increased training faculty members. Data Source: Human Resources documents. Milestone 3 Estimated Incentive Payment: $687,227 **Milestone 4** [P-9]: Develop/disseminate clinical teaching tools for primary care. Metric 1 [P-9.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical		**Milestone 8** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with practicing primary care physicians/faculty and new residents. Baseline: No mentoring program exists currently. Goal: Develop mentoring program for residents with practicing primary care physicians. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care model and/or	Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll second cohort of 4 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 8. Data Source: Program enrollment records. Milestone 11 Estimated Incentive Payment: $692,555 **Milestone 12** [I-15]: Increase primary care training in Family Practice Center. Metric 1 [I-15.1]: Increase number of Family Practice Center sessions available for primary care residents. Baseline: No training program

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	teaching tools. Data source: Clinical teaching tools documents/materials. Milestone 4 Estimated Incentive Payment: $687,228 **Milestone 5** [P-8] Establish a faculty development program. <u>Metric 1</u> [P-8.1] Enrollment of faculty staff into primary care education and training program. Baseline: No faculty development program exists currently. Goal: Better prepared faculty will create a better training program. Data Source: Program documents.		disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No training exists currently. Goal: Primary care training program should reflect evolving delivery models. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. <u>Metric 3</u> [P-3.3] Include residents in quality improvement projects. Baseline: No training exists currently. Goal: Resident participation in QI efforts. Data source: Curriculum or QI	or Family Practice Center in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Number of resident office visits from EHR or claims data. <u>Metric 2</u> [I-15.2]: Increase number of patients assigned to primary care residents' panels. Baseline: No training program or Family Practice Center in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Patient panel, registry, or EHR. Milestone 12 Estimated

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 Estimated Incentive Payment: $687,227 **Milestone 6** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 6 Estimated Incentive Payment: $687,228		project documentation. Milestone 8 Estimated Incentive Payment: $686,162 **Milestone 9** [I-11]: Increase primary care training and/or rotations. <u>Metric 1</u> [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 4 residents as of 7/15/2015. Data Source: Program enrollment records. <u>Metric 2</u> [I-11.2]: Increase the number of primary care	Incentive Payment: $692,555 **Milestone 13** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. <u>Metric 1</u> [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Data Source: Curriculum and practicum documentation.

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: 4 PY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $686,162 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or	Milestone 13 Estimated Incentive Payment: $692,555 **Milestone 14** [I-14] Increase the number of faculty staff completing educational courses. Metric 1 [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 14 Estimated Incentive Payment: $692,554

UNIQUE IDENTIFIER: ***160709501.1.2***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/FAMILY MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*TPI - 160709501*
Related Category 3 Outcome Measure(s):	*160709501.3.5; 160709501.3.6; 160709501.3.7; 160709501.3.8*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 10 Estimated Incentive Payment: $686,162	
Year 2 Estimated Milestone Bundle Amount: $2,687,732		Year 3 Estimated Milestone Bundle Amount: $2,748,910	Year 4 Estimated Milestone Bundle Amount: $2,744,648	Year 5 Estimated Milestone Bundle Amount: $2,770,219
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,951,509				

Identifying Project and Provider Information:

Project Option 1.2.4 - Establish Primary Care/Obstetrics & Gynecology Residency Training Program

Unique Project ID: 160709501.1.3
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

Project Description:

Doctors Hospital at Renaissance proposes to establish a primary care/Obstetrics & Gynecology residency training program.

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Obstetrics & Gynecology residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The resident trainees, the graduates, and the new faculty will expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction.

When fully implemented in 2019, the new Obstetrics & Gynecology residency will have the capacity to train as many as 16 residents – 4 residents in each of four classes. The DHR Obstetrics & Gynecology residency training program will complement other new residency programs at DHR in Internal Medicine, Family Medicine, and General Surgery to fulfill DHR's goal to become a teaching hospital for the region. DHR's new Obstetrics & Gynecology residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:

This project has the following goals**:**

- To create an Obstetrics & Gynecology Residency program with residents, graduates, and faculty members who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on women's health, perinatal care, and transitions of care, reduce hospital readmissions and function as a patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and

- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combing the resources of a major safety net hospital, DHR, and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- 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.
- 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 existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The Obstetrics & Gynecology Residency Review Committee (OG-RRC) meets to review proposals only a few times each year. Residency programs must be either near-approval or accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the Obstetrics & Gynecology Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including the patient-centered medical home model and chronic care disease management to address the unique needs of RHP5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of three to four Obstetrics & Gynecology residents will have joined the initial cohort of three to four residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2019. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Primary care capacity and patients' access to primary care will increase as the program matures to full, maximum build-out of 16 Obstetrics & Gynecology residents at DHR (4 PG1, 4 PG2, 4 PG 3, and 4 PG4).

Starting Point/Baseline:

DHR currently hosts no residency programs. In all of RHP 5, existing residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center.

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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In South Texas excluding Bexar County, there are only 43 primary care physicians per 100,000 population, according to an April 2012 report by the Texas Higher Education Coordinating Board. This compares to 65 per 100,000 for greater South Texas including Bexar County and 78 per 100,000 for Central Texas.

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the Association of American Medical Colleges Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80.2% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:

This project has several components:

- Identify high impact services and gaps in care and coordination
- Recruit Obstetrics & Gynecology Program Directors and core faculty

- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for Obstetrics & Gynecology resident education at DHR
- Complete and submit the Program Information Form (PIF) to the RRC
- Attain ACGME approval for the program
- Recruit and enroll Obstetrics & Gynecology residents

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

Currently, RHP 5 has no teaching hospital, and no residency training programs exist at DHR. The faculty for the Obstetrics & Gynecology residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs in RHP 5.

Data Driving this Project:

The need for enhanced primary care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally: http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):

OD-14 Primary Care Workforce

Stand-alone:

IT - 14.1 Number of practicing primary care practitioners per 1,000 individuals in HPSA or MUA

Non-stand-alone but related:
Bundle of 3:
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

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 1,000 individuals in RHP 5.

Relationship to other Projects:

This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/ Family Medicine Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Relationship to Other Performing Providers' Projects in the RHP:

The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:

All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical

Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. In addition, all of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics.

Project Valuation:

DHR has chosen to dedicate its entire Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region and in Hidalgo County. South Texas has historically been a medically underserved area. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in south Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. Metric 1 [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $1,343,866 **Milestone 2** [P-2]: Expand	**Milestone 3** [P-2]: Expand primary care training for primary care physicians. Metric 1 [P-2.1]: Expand the primary care residency training programs. Baseline: Program does not exist at beginning of DY 2. Goal: Program Information Form (PIF) to be submitted by no later than 4/2014 for Residency Review Committee (RRC) 10/2014 meeting Data Source: Training program documentation. Metric 2 [P-2.2.]: Hire additional precepting faculty members in various specialties, as required for accredited programs.		**Milestone 7** [P-10]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents. Metric 1 [P-10.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $686,162	**Milestone 11** [I-11]: Increase primary care training and/or rotations. Metric 1 [I-11.4]: Increase the number of primary care residents and/or trainees, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Cohort 1 begins in DY 4. Goal: Enroll second cohort of 3 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 6. Data Source: Program enrollment records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
primary care training for primary care physicians. Metric 1 [P-2.X]: Hire the Program Director, Associate Program Director, and two Core Faculty members by 7/1/2013. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Build the founding faculty infrastructure for the residency to begin the accreditation process. Data Source: Human Resources documents. Milestone 2 Estimated Incentive Payment: $1,343,866	Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Increased training faculty members. Data Source: Human Resources documents. Milestone 3 Estimated Incentive Payment: $687,227 **Milestone 4** [P-9]: Develop/disseminate clinical teaching tools for primary care. Metric 1 [P-9.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical		**Milestone 8** [P-3]: Expand positive primary care exposure for residents. Metric 1 [P-3.1] Develop mentoring program with practicing primary care physicians/faculty and new residents. Baseline: No mentoring program exists currently. Goal: Develop mentoring program for residents with practicing primary care physicians. Data Source: Mentoring program curriculum and/or program participant list. Metric 2 [P-3.2] Train residents in the medical home model, chronic care model and/or	Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll second cohort of 3 as of 7/15/2015. Total residents in Cohorts 1 and 2 = 6. Data Source: Program enrollment records. Milestone 11 Estimated Incentive Payment: $692,555 **Milestone 12** [I-15]: Increase primary care training in Continuity Clinics. Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available for primary care residents. Baseline: No training program

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	teaching tools. Data source: Clinical teaching tools documents/materials. Milestone 4 Estimated Incentive Payment: $687,228 **Milestone 5** [P-8] Establish a faculty development program. <u>Metric 1</u> [P-8.1] Enrollment of faculty staff into primary care education and training program. Baseline: No faculty development program exists currently. Goal: Better prepared faculty will create a better training program. Data Source: Program documents.		disease registry use; have primary care trainees participate in medical homes by managing panels. Baseline: No training exists currently. Goal: Primary care training program should reflect evolving delivery models. Data Source: Curriculum, rotation hours, and/or patient panels assigned to residents. <u>Metric 3</u> [P-3.3] Include residents in quality improvement projects. Baseline: No training exists currently. Goal: Resident participation in QI efforts. Data source: Curriculum or QI	or Continuity Clinic in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Number of resident office visits from EHR or claims data. <u>Metric 2</u> [I-15.2]: Increase number of patients assigned to primary care residents' panels. Baseline: No training program or Continuity Clinic in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Patient panel, registry, or EHR. Milestone 12 Estimated Incentive Payment: $692,555

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 Estimated Incentive Payment: $687,227 **Milestone 6** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 6 Estimated Incentive Payment: $687,228		project documentation. Milestone 8 Estimated Incentive Payment: $686,162 **Milestone 9** [I-11]: Increase primary care training and/or rotations. <u>Metric 1</u> [I-11.4]: Increase the number of primary care residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 3 residents as of 7/15/2015. Data Source: Program enrollment records. <u>Metric 2</u> [I-11.2]: Increase the number of primary care	**Milestone 13** [P-4] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Baseline: no curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. <u>Metric 1</u> [P-4.1] Quality assessment and improvement curriculum and practicum for residents. Data Source: Curriculum and practicum documentation. Milestone 13 Estimated Incentive Payment: $692,555

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: 3 PY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $686,162 **Milestone 10** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or	**Milestone 14** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 14 Estimated Incentive Payment: $692,554

UNIQUE IDENTIFIER: ***160709501.1.3***	***RHP PP REFERENCE NUMBER:*** ***1.2.4***	***PROJECT COMPONENT(S):***	***ESTABLISH PRIMARY CARE/OBSTETRICS & GYNECOLOGY TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.1; 160709501.3.2; 160709501.3.3; 160709501.3.4*	*IT-14.1; IT-14.6; IT-14.7; IT-14.8*	*Number of practicing primary care practitioners per 1,000* *Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 10 Estimated Incentive Payment: $686,162	
Year 2 Estimated Milestone Bundle Amount: $2,687,732		Year 3 Estimated Milestone Bundle Amount: $2,748,910	Year 4 Estimated Milestone Bundle Amount: $2,744,648	Year 5 Estimated Milestone Bundle Amount: $2,770,219
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,951,509				

Project Option 1.9.1 - Establish General Surgery Residency Training Program

Unique Project ID: 160709501.1.4
Performing Provider/TPI: Doctors Hospital at Renaissance / 160709501

PROJECT DESCRIPTION:
Doctors Hospital at Renaissance proposes to expand specialty care capacity by establishing a General Surgery residency training program.

This project is designed to improve patient access to specialty care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new General Surgery residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The resident trainees, the graduates, and the new faculty will expand the workforce, allaying the shortage of specialty care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction.

When fully implemented in 2020, the new General Surgery residency will have the capacity to train as many as 20 residents – 4 residents in each of five classes. The DHR General Surgery residency training program will complement other new residency programs at DHR in Internal Medicine, Family Medicine, and Obstetrics & Gynecology to fulfill DHR's goal to become a teaching hospital for the region. DHR's new General Surgery residency training program will also complement the existing and expanding Internal Medicine residency training program and the new Psychiatry and General Surgery residency training programs at Valley Baptist in Cameron County. The DHR program will also complement the existing UTHSCSA Family Medicine program affiliated with McAllen Medical Center in Hidalgo County.

Goals and Relationship to Regional Goals:
This project has the following goals**:**

- To create an General Surgery Residency program with residents, graduates, and faculty members who will increase patients' access to care;
- To create and implement an innovative curriculum that incorporates integration of primary care and specialty care and clinical safety and effectiveness training;
- To transition Doctors Hospital at Renaissance to be a primary teaching hospital for UTHSCSA RAHC in South Texas;
- To create a continuity clinic for the residency program to focus on transitions of care, reduce hospital readmissions and integrate with the patient-centered medical home;
- To conduct quality improvement projects to continuously improve clinical outcomes and efficiency; and
- To collaborate with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

This project meets the following regional goals:

- By combining the resources of DHR as a major safety net hospital and The University of Texas, 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 rapidly growing, yet historically underserved region.
- Increase access to specialty care services in the short-term with new faculty, in the intermediate term with resident trainees, and in the long-term with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- 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.
- 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 existing health care system.

Challenges and issues:
Creating a new residency program from the ground up is time consuming and requires approval of the Accreditation Council on Graduate Medical Education (ACGME). The General Surgery Residency Review Committee (GS-RRC) meets to review proposals only a few times each year. Residency programs must be either near-approval or accredited before the programs can begin to recruit fourth-year medical students who will enter the residency training program in the following academic year.

Addressing the challenges:
DHR will partner with UTHSCSA RAHC. UTHSCSA RAHC will provide the Program Director and core faculty for the General Surgery Residency Program. UTHSCSA faculty and staff have extensive experience with the accreditation process. DHR and UTHSCSA will work together collaboratively to establish an innovative curriculum including integrate primary and specialty care in the patient-centered medical home model and chronic care disease management to address the unique needs of RHP5.

5-year expected outcome for Performing Provider and patients:
By the end of the Demonstration Period in September 2016, DHR will be well on the road to establishing itself as a teaching hospital. The second cohort of three to four General Surgery residents will have joined the initial cohort of three to four residents who start in July 2015. The initial cohort of residents will complete the program and enter practice in 2020. Supervised residents will begin providing care to patients in 2015. The Program Directors and core faculty members will dedicate 25-50% of their time to clinical care. Specialty care capacity and patients' access to specialty care will increase as the program matures to full, maximum build-out of 20 General Surgery residents in RHP 5 (4 PG1, 4 PG2, 4 PG3, 4 PG4, and 4 PG5).

STARTING POINT/BASELINE

DHR currently hosts no residency programs. In all of RHP 5, existing residency training programs include an internal medicine program with 15 residents at Valley Baptist in Cameron County and a family medicine program with 18 residents at McAllen Medical Center.

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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762, in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry-level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions in 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In South Texas excluding Bexar County, there are only 43 primary care physicians per 100,000 population, according to an April 2012 report by the Texas Higher Education Coordinating Board. This compares to 65 per 100,000 for greater South Texas including Bexar County and 78 per 100,000 for Central Texas. ***Add General Surgery data***

The University of Texas' Board of Regents and the Texas Legislature have authorized the development of UTHSCSA RAHC into a future medical school in RHP 5. The first cohort of students for the South Texas medical school will matriculate in the fall of 2014 in San Antonio, later transitioning to and graduating from an independent, freestanding regional medical school in South Texas. In order to retain the future graduates of the new medical school in RHP 5 for eventual community practice, new residency training programs must be established and existing programs must be expanded. The *2011 State Physician Workforce Data Book* published by the Association of American Medical Colleges Center for Workforce Studies shows that among students who complete both their undergraduate and graduate medical education in Texas, 80.2% remained in the state to practice. In Texas, combining the effect of in-state graduate medical education with in-state undergraduate medical education increases the retention rate by approximately twenty percentage points.

Project components:

This project has several components:

- Identify high impact services and gaps in care and coordination
- Recruit General Surgery Program Directors and core faculty

- Create innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System CS&E course.
- Develop and organize inpatient and ambulatory clinical training/patient care opportunities for General Surgery Medicine resident education at DHR.
- Complete and submit the Program Information Form (PIF) to the RRC
- Attain ACGME approval for the program
- Recruit and enroll General Surgery residents

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

Currently, RHP 5 has no teaching hospital, and no residency training programs exist at DHR. The faculty for the General Surgery residency program at DHR will collaborate with the faculty for the other new training programs at DHR as well as with the faculty for the new and existing residency programs in RHP 5.

Data Driving this Project:

The need for enhanced specialty care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally: http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP 5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed and under care. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer.

Related Category 3 Outcome Measure(s):

OD-14 Physician Workforce

<u>Non-stand-alone</u>:

Bundle of 3:

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

Rationale for selecting the outcome measures:
It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinic practice.

Because the Program Directors and core faculty will be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing specialty practitioners per 1,000 individuals in RHP 5.

Relationship to other Projects:
This project is related to the following DHR projects:

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/Family Medicine Training Program; and
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program.

Relationship to Other Performing Providers' Projects in the RHP:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.1 Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen;
- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Plan for Learning Collaborative:
All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. In addition, all of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, the integration of primary care and specialty care, the use of chronic disease registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the

common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics.

Project Valuation:
DHR has chosen to dedicate its entire Pass One allocation to the four new residency training programs and the related Category 3 metrics in keeping with its strategic plan to become the primary teaching hospital for the South Texas region and in Hidalgo County. South Texas has historically been a medically underserved area. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in South Texas if they complete their residency training programs locally. The DHR residency projects, along with the other new and expanding residency projects can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospitals.

UNIQUE IDENTIFIER: ***160709501.1.4***	***RHP PP REFERENCE NUMBER:*** ***1.9.1***	***PROJECT COMPONENT(S):*** ***1.9.1 (A-D)***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.13; 160709501.3.14; 160709501.3.15*	*IT-14.6; IT-14.7; IT-14.8*	*Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Goal: Produce a comprehensive report documenting existing and needed specialty care resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $1,343,866 **Milestone 2** [P-14]: Expand targeted specialty care (TSC) training. Metric 1 [P-14.X]: Hire the	**Milestone 3** [P-14]: Expand targeted specialty care (TSC) training. Metric 1 [P-14.1]: Expand the TSC residency training program. Baseline: Program does not exist at beginning of DY 2. Goal: Program Information Form (PIF) to be submitted by no later than 5/2014 for Residency Review Committee (RRC) 11/2014 meeting Data Source: Training program documentation. Metric 2 [P-14.2.]: Hire additional precepting TSC faculty members. Baseline: At the beginning of DY 2, no faculty are in place for the residency program.		**Milestone 7** [P-16]: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents. Metric 1 [P-16.1]: Documentation of ACGME approval for residency program accreditation and position expansion. Baseline : No accredited residency program exists at the beginning of DY 2. Goal: ACGME approval. Data Source: ACGME documentation. Milestone 7 Estimated Incentive Payment: $686,162	**Milestone 11** [I-31]: Increase TSC training and/or rotations. Metric 1 [I-31.4]: Increase the number of TSC residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 3 residents as of 7/15/2015. Data Source: Program enrollment records. Metric 2 [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: 3 PY1 trainees in rotation at DHR. Data Source: Resident training

UNIQUE IDENTIFIER: ***160709501.1.4***	***RHP PP REFERENCE NUMBER:*** ***1.9.1***	***PROJECT COMPONENT(S):*** ***1.9.1 (A-D)***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.13; 160709501.3.14; 160709501.3.15*	*IT-14.6; IT-14.7; IT-14.8*	*Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Program Director, Associate Program Director, and two Core Faculty members by 7/1/2013. Baseline: At the beginning of DY 2, no faculty are in place for the residency program. Goal: Build the founding faculty infrastructure for the residency to begin the accreditation process. Data Source: Human Resources documents. Milestone 2 Estimated Incentive Payment*:* $1,343,866	Goal: Increased training faculty members. Data Source: Human Resources documents. Milestone 3 Estimated Incentive Payment: $687,227 **Milestone 4** [P-X]: Develop/disseminate clinical teaching tools for TSC training program. <u>Metric 1</u> [P-X.1]: Clinical teaching tools. Baseline: No clinical teaching tools exist at the beginning of DY2. Goal: Documentation and dissemination of clinical teaching tools. Data source: Clinical teaching tools documents/materials.		**Milestone 8** [P-3]: [I-22] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. <u>Metric 1</u> [I-22.1] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Baseline: No faculty in place in DY2. Goal: Improvement in absolute numbers. Data Source: Program records. Milestone 8 Estimated Incentive Payment: $686,162 **Milestone 9** [I-31]: Increase TSC training and/or rotations. <u>Metric 1</u> [I-31.4]: Increase the	schedule. Milestone 11 Estimated Incentive Payment: $692,555 **Milestone 12** [I-32]: Recruit/hire more trainees to TSC positions in the Performing Provider's facilities or practices. <u>Metric 1</u> [I-32.1]: Percent change in number of trainees accepting positions in the Performing Provider's facilities or practices over baseline. Baseline: No trainees in DY2. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Number of resident office visits from EHR or claims data.

UNIQUE IDENTIFIER: ***160709501.1.4***	***RHP PP REFERENCE NUMBER:*** ***1.9.1***	***PROJECT COMPONENT(S):*** ***1.9.1 (A-D)***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.13; 160709501.3.14; 160709501.3.15*	*IT-14.6; IT-14.7; IT-14.8*	*Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment: $687,228 **Milestone 5** [P-12] Implement a specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long term, conclusions. <u>Metric 1</u> [P-12.1] Documentation of specialty care access plan. Baseline: No baseline data exists currently. Goal: Better prepared faculty will create a better training program. Data Source: Plan documents. Milestone 5 Estimated		number of TSC residents, as measured by absolute number over baseline. Baseline: No residents prior to DY2 or in DY2-3. Goal: Enroll first cohort of 3 residents as of 7/15/2015. Data Source: Program enrollment records. <u>Metric 2</u> [I-31.2]: Increase the number of TSC trainees rotating at the Performing Provider's facilities. Baseline: No residents prior to DY2 or in DY2-3. Goal: 3 PY1 trainees in rotation at DHR. Data Source: Resident training schedule. Milestone 9 Estimated Incentive Payment: $686,162	Milestone 12 Estimated Incentive Payment: $692,555 **Milestone 13** [P-X] Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement. Baseline: No curriculum exists in DY2. Goal: Provide training and practicum opportunity for residents to master QI methodology. <u>Metric 1</u> [P-X.1] Quality assessment and improvement curriculum and practicum for residents. Data Source: Curriculum and practicum documentation.

UNIQUE IDENTIFIER: ***160709501.1.4***	***RHP PP REFERENCE NUMBER:*** ***1.9.1***	***PROJECT COMPONENT(S):*** ***1.9.1 (A-D)***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.13; 160709501.3.14; 160709501.3.15*	*IT-14.6; IT-14.7; IT-14.8*	*Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Incentive Payment: $687,227 **Milestone 6** [I-22] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. <u>Metric 1</u> [I-22.1] Increase the number of specialist providers, clinic hours and/or procedure hours available for General Surgery. Baseline: No faculty in place in DY2. Goal: Improvement in absolute numbers. Data Source: Program records. Milestone 6 Estimated Incentive Payment: $687,228		**Milestone 10** [P-21] Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around share or similar projects. <u>Metric 1</u> [PI-21.1] Participate in semi-annual face-to-face meetings organized by the RHP (may be CS&E training sessions and/or project discussions). Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two face-to-face meetings per year. Data Source: Documentation of meetings including meeting agendas, slides from presentations, etc.	Milestone 13 Estimated Incentive Payment: $692,555 **Milestone 14** [I-X] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-X.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Baseline: No faculty in place or trained in CS&E as of DY2. Goal: Two faculty members complete the CS&E training. Data Source: Program records. Milestone 14 Estimated Incentive Payment: $692,554

UNIQUE IDENTIFIER: ***160709501.1.4***	***RHP PP REFERENCE NUMBER:*** ***1.9.1***	***PROJECT COMPONENT(S):*** ***1.9.1 (A-D)***	***ESTABLISH PRIMARY CARE/INTERNAL MEDICINE TRAINING PROGRAM***	
Performing Provider Name: Doctors Hospital at Renaissance				*[160709501]*
Related Category 3 Outcome Measure(s):	*160709501.3.13; 160709501.3.14; 160709501.3.15*	*IT-14.6; IT-14.7; IT-14.8*	*Percent of trainees who have spent at least 5 yrs living in a HPSA* *Percent of trainees who plan to practice in HPSA based on survey* *Percent of trainees who plan to serve Medicaid pop. based on survey*	
Year 2 (10/1/2012 – 9/30/2013)	**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 10 Estimated Incentive Payment: $686,162	
Year 2 Estimated Milestone Bundle Amount: $2,687,732	Year 3 Estimated Milestone Bundle Amount: $2,748,910		Year 4 Estimated Milestone Bundle Amount: $2,744,648	Year 5 Estimated Milestone Bundle Amount: $2,770,219
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,951,509				

Starr County Memorial Hospital- Category 1: Infrastructure Development

The narrative for each Category 1 Project is limited to 6 pages.

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

Increase OB Primary Care [1.1]
Starr County Memorial Hospital [136332705]
Unique RHP Project ID Number: 136332705.1.1

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

The purpose of the project is to increase the availability of primary care to the residents of Starr County to include physician services. Currently, the Rio Grande City Rural Health Clinic sees a-n average of approximately 10,000 patients per year[5]. Of this number, approximately 70 percent were seen by an advanced nurse practitioner. The in-depth knowledge possessed by an MD specialized in family medicine and OB is what many of these patients truly need. This project's goal is to recruit a family practice physician that is also able to practice obstetrical care for the surrounding community. In addition to providing services at the rural clinic, he/she will be recruited to perform OB delivery services at Starr County Memorial Hospital.

Additionally, literacy adjusted diabetic education will be incorporated in-house in a group setting during the waiting times to see a provider. There will be a set schedule of classes and topics regarding diabetes. Materials will be developed in such a way that anyone can understand and take home to share in their own support group. HCAHPS will also be conducted with focus on the education outreach and newly added physician services. The family practitioner will also practice OB and help diabetic pregnant women control their HbA1C scores, which promotes healthy development of babies and keeps the mothers from having labor complications. The diabetic women will be documented in a registry and their HbA1c scores will be monitored with each visit.

Goals: The goal of the project will be to increase the volume of physician services currently available to our community. Far too many patients are left without physician-rendered services and either seek services elsewhere or simply go without them.

Challenges/Issues: Due to the limited availability of Ob/Gyn services in Starr county, patient demand quickly exceeds physician resources. The present ability to remedy this situation is challenging given the region's poor socioeconomic status and payer mix of patients.

Issue Resolution: Increasing the number of physicians where they are severely lacking, with adequate mid-level staffing, can dramatically increase the volume of patients that are able to be seen. Where patients are seeking services elsewhere, a greater amount will now be able to receive the quality health care they deserve in their local community.

5 year expected outcome for provider and patients: With the community and provider population relatively small in relation to the rest of RHP5, outcome measures will eventually stabilize as the increased number of providers continue to meet their own caps of patient care to ensure safety and

[5] Starr County Proprietary Information

quality. Over the five years of this project, Improvements should increase by DY3 all the way through DY5. The addition of a family practitioner will increase the clinic encounters by 5% in DY 3 and 3% in DY4 and DY5 consecutively.

Starting Point/Baseline:
e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Rationale:
A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).
Expansion of primary care with an increase in a physician will better serve the community and create a foundation of care that is crucial. Access to care is jeopardized with a very limited supply of physicians, requiring the hiring of an additional physician to remedy.
The project will also add a Diabetes educator. Milestone 1 & 2 are both "P-5" so that there is time allowed to recruit both a physician and a qualified educator in DY2.
Due to the nature of this project, improvement milestones can be implemented rather quickly. Patient satisfaction is a cornerstone of this project (I-2). As satisfaction increases, it will serve as a good indicator that the project planning was done correctly and we can continue in the right direction. Once the clinic has added the physician and educator, improvement milestone I-3 (Increase primary care clinic volume of visits and evidence of improved access for patients seeking services) can be documented with a demonstrated increase in volume and quality of care. Improvement milestone I-3 was also added in the project once more in DY5 with a focus on the diabetic population (accomplished with the diabetic educator and the increase in primary care access). Special attention will be provided to diabetic pregnant woman as they are automatically deemed "high-risk". The overall goal of the provider addition will be to increase the volume of patients treated, but also to provide education, prevention, and maintenance of diabetic conditions for a community where these services weren't readily available before. This effort will be geared towards helping those at high-risk control their HbA1c levels, and help ensure others don't become "high-risk".

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

The recruitment of a family physician, in a medically underserved area with a high volume of indigent patients is related to improving the outcome measure of OD-1 (Primary Care and Chronic Disease Management). Of course access to quality primary care is also likely to improve the rate of potentially preventable admissions (OD 2). .

OD-1.IT-10 (HbA1c control) will be a perfect milestone for this type of clinic. Where over 10,000 patients are seen per year, a high percentage will be diabetic. Starr County is one of a handful of areas where diabetes rates are exceptionally high. A full 50% of adults over the age of 35 in Starr County either have diabetes themselves or have a first degree relative with the disease.[6] In 2007, Starr County had a live birthrate of 1468[7]. Combining the two prior statistics results in a potential of 800 diabetic high-risk pregnancies just in that year alone. This improvement target (IT: 1.10) will focus on decreasing HbA1c levels. To accomplish this goal, the clinic will include: group classes for diabetic literacy, segmented one-on-ones with NP's and/or MD for diabetic women, follow-up plans, and ensuring that their HbA1c levels improve to help result in healthy fetus development. Not only will this milestone improve the lives of high risk diabetics, it will also create an environment of prevention for a generation that is yet to come, which is invaluable.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative:

If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

[6] http://txtell.lib.utexas.edu/stories/d0006-full.html

[7] http://www.plannedparenthood.org/ppahc/files/Hidalgo-County/Valley_Family_Planning_Stats_05-07.pdf

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

This project is valued around prevention of costly complications, admissions, and readmissions that come with a lack of family care specialty access for the community. Diabetic education creates value for the diabetic community with an opportunity to self-manage their condition. Diabetes services may reduce the probability of admissions. This expansion of services will focus on diabetic and Ob care, with a goal of decreasing pregnancy complications such as premature birth. The nation as a whole spends on average $13,000 on each person with diabetes, compared to $2500 for those who don't have diabetes, and incurs 2.4 times higher medical expenses.[8] Starr County is one of a handful of areas where diabetes rates are exceptionally high. A full 50% of adults over the age of 35 in Starr County either have diabetes themselves or have a first degree relative with the disease.

Studies show that HbA1c levels over 7% have been associated with preterm delivery.[9] The value created by helping to decrease these numbers becomes evident when the cost of just one premature baby averages $49,000[10] in the first year of life. When there is prevalence of bad diabetes control, prematurity rates can range from 30-50 percent. Prematurity may contribute to problems such as cerebral palsy, vision problems, learning disabilities, and developmental delays. To decrease these rates will save on long-term costs and provide an increased quality of life for the mother and child[11].

This project is pushing for a cultural change with the educational component being offered to the community. With an increase in Ob/Gyn availability, woman will have access to more adequate follow-up care. When combined with the category 3 goal to lower the HbA1c levels, possibility preventable conditions such as birth complications can be reduced. A combination of Ob/Gyn access, a diabetic stabilizing initiative, and an education component create high value for the community.

[8] http://www.foh.dhhs.gov/NYCU/diabetescost.asp
[9] http://care.diabetesjournals.org/content/27/12/2824.full
[10] http://www.cnn.com/2009/HEALTH/03/17/premature.babies/index.html
[11] http://www.ncbi.nlm.nih.gov/pubmed/11398596

136332705.1.1	1.1.4	1.1.4.P-5.1 1.1.4.I-2.1 1.1.4.I-3.1	Increase OB Primary Care	
Starr County Memorial Hospital				136332705
Related Category 3 Outcome: OD1	IT-1.10	[Reference numbers from RHP PP]	Primary Care Prevention Initiative	

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-5) Hire additional primary care provider **Metric 1 (P-5.1)** Documentation of all project plans; Physician contractual documentation **Baseline/Goal:** Addition of 1 extra physician; 5% unique patient consultation at end of DY3 over baseline of patients consulted by a physician in FY11. **Data Source:** Patient documentation and billing for physician. *Milestone 1 Estimated Incentive Payment (maximum amount): $75,000* **Milestone 2: (P-5):** Hire additional primary care staff (educator) **Metric 1:** (P-5.1): Contractual documentation of diabetes educator **Baseline/Goal:** Create baseline of	**Milestone 3 [I-2]:** Patient satisfaction with primary care services **Metric [I-2.1]:** Patient Satisfaction scores, specific ranges and items to be determined by assessment tool scores. **Baseline/Goal:** Create baseline at the end of DY2 for DY3 comparison: goal will be an average increase of satisfaction to start with and adjust percentage improvement or maintenance from new baseline. **Data Source:** CG-CAHPS or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. *Milestone 3 Estimated Incentive Payment: $150,000*	**Milestone 4 [I-3]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 [I-3.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** Net 8% percent increase in unique patient provider encounters. **Data Source:** Claims history for reporting period; EMR registry (if applicable) *Milestone 4 Estimated Incentive Payment: $75,000* **Milestone 5 [I-3]:** Increase primary care clinic volume of visits and evidence of improved access for *diabetic* patients seeking services. **Metric 1 [I-3.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** 15% of diabetic patients given	**Milestone 6 [I-3]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 [I-3.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline) **Goal:** Net 11% percent increase in unique patient provider encounters. (3% increase from DY4) **Data Source:** Claims history for reporting period; EMR registry (if applicable) *Milestone 6 Estimated Incentive Payment: $75,000* **Milestone 7 [I-3]:** Increase primary care clinic volume of visits and evidence of improved access for *diabetic* patients seeking services. **Metric 1 [I-3.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2 baseline)

136332705.1.1	1.1.4	1.1.4.P-5.1 1.1.4.I-2.1 1.1.4.I-3.1	Increase OB Primary Care	
Starr County Memorial Hospital				136332705
Related Category 3 Outcome: OD1	IT-1.10	[Reference numbers from RHP PP]	Primary Care Prevention Initiative	
Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)		Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
average number of patients attending class per month at the end of DY2 **Data Source:** Sign-in Documentation and/or billing code on consultation *Milestone 2 Estimated Incentive Payment (maximum amount): $75,000*			physician priority with emphasis on pregnant woman. **Data Source:** Claims history for reporting period; EMR registry (if applicable) *Milestone 5 Estimated Incentive Payment: $75,000*	**Goal:** 15% of diabetic patients given physician priority with emphasis on pregnant woman. **Data Source:** Claims history for reporting period; EMR registry (if applicable) *Milestone 7 Estimated Incentive Payment: $75,000*
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $404,237	Year 3 Estimated Milestone Bundle Amount: $404.237		Year 4 Estimated Milestone Bundle Amount: $404,237	Year 5 Estimated Milestone Bundle Amount: $404,237
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $2,216,948				

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

136332705.1.2
Expand Surgery Service Capacity [1.9]
Starr County Memorial Hospital [136332705]

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

Description: Starr County Memorial Hospital wants to contract with a general surgeon in an effort to provide full-time surgical services in their facility for the community. As this service becomes more available, the processes and protocols regarding full-time general surgery will be streamlined to increase its efficiency. In an effort to create maximum value relative to cost and time, and to increase possibly preventable admissions (PPAs), foot exams will be conducted with every surgical patient. The nurse will inspect the patient's feet for any minor cuts, rashes, abrasions, etc. If the patient is diabetic (self-reported or on file) extra precaution will be taken during the exam. If there are any injuries to the foot, they will also be addressed by the surgeon and nurse to decrease possibly preventable conditions (PPCs) and increase quality of life for the patient.

Goals: As of right now, surgical services are able to be done with-in Star County Memorial Hospital two days of the week. With the addition of a full-time general surgeon, we hope to be able to provide these services 5 days a week.

Challenges/Issues: Specialty care such as surgical type services are seen as generally out of reach in this community. As of right now Starr County Memorial Hospital is able to provide this service only two days out of the week. Due to the lack of services, our emergency department is forced into transferring, on average, 10 patients per month to other facilities[12] that can handle the procedures due to surgeon availability (The nearest hospital is 51 minutes away[13]). This situation results in a facility that is capable of providing services with the proper staffing. Due to these circumstances, capacity is wasted, the patients aren't able to be seen in a timely manner, quality is strained, and patient satisfaction decreases.

Issue Resolution: Starr County has a population of 60,000+ people [14](*see link below for visual of that statistic*). With that type of population, the physician service capacity for surgery at the hospital easily reaches its thresholds creating a need for an increase in that cap. Recruitment of a general surgeon will open up the surgical service line capacity directly where fewer patients have to be transferred out of the emergency department.

Expected Outcomes: Starr County Memorial Hospital believes this project will be of great value to the community for the next five years. With increased revenues from the service line capacity, and less patients being transferred out, over the five years of this project, we would expect that this

[12] Starr County Proprietary Information

[13] http://maps.google.com/maps?q=south%20texas%20uninsured&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a&um=1&ie=UTF-8&hl=en&sa=N&tab=wl

[14] http://www.google.com/publicdata/explore?ds=kf7tgg1uo9ude_&met_y=population&idim=county:48427&dl=en&hl=en&q=starr+county+tx+population

service be available five days out of the week. Additionally, our expectation is to be able to serve each patient within the surgeon's capabilities assuming he/she hasn't met the threshold of maximum output at any given time. To help ensure that this doesn't happen, processes will also have to be created to ensure efficiency of this provider's time. With the expectations of service availability, days and capacity, admissions and readmissions will be expected to decrease for those patients that have been seen.

Starting Point/Baseline:

e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Rationale:

A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).

Starr County Memorial Hospital chose this project as a necessity because they currently do not have a full-time general surgeon servicing their facility or region. For the only hospital in the county, servicing 60,000 plus lives, the lack of full-time surgery capacity is unsustainable and costly. Currently these services are only offered two days out of the week, with an average of 10 cases per month having to be referred out to other facilities[15]. The most rational solution would be to begin the process to recruit this service for our community. With the approval of this project, this necessity can be resolved.

The nature of this project is very simple and straight forward resulting in a clear cut choice of milestones. The goal was to increase the service availability for surgical care due to the fact there was no general surgeon currently on staff, full time, at Starr County Memorial Hospital. With the initial scope of the project revolving around the recruitment of this specialty, 1.9.5 (Design workforce enhancement initiatives to increase the availability of targeted specialty providers) was the obvious choice. Category 1.9 to expand specialty capacity is the appropriate project.

To justify the necessity of this physician, P-12 (listed on the metrics spreadsheet) was selected to demonstrate to the state and CMS such components as problem, background, findings, short and long-term implications, and conclusions. The act of actually coming into contractual agreement with

[15] Starr County Proprietary Information

a provider is Improvement milestone 1 (I-1). There is no other rationale of this selection besides the necessity of recruiting a full-time surgeon into the hospital.

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Patient satisfaction or OD 6 would be impacted by the addition of surgical capacity.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

With such an integral part of the health care system being at such a far reach for availability, frustrations throughout the community arise when minor surgical procedures have to be referred out to another facility that is 45 minutes away. It can be understood why patient satisfaction would be low with timely care, appointments, and information. With suppressed patient satisfaction, disenfranchised patients don't even bother coming in for the service unless it's an emergency and we are able to service their needs.

OD-6 Patient Satisfaction is directly tied into this project, with **IT-6.1** (percent improvement over baseline of patient satisfaction scores) being the focus. At the epicenter of RHP5's goals lie's the foundation of patient/community value maximization.

With that in mind, while we have the surgeon in-house, full-time, in an underserved (highly diabetic %) population, it would be smart to implement **OD-1.IT-1.13** into the mix of the Category 3 outcomes. Although it is not included in the milestones or metrics, this outcome has the potential for a very high value to cost regarding prevention.

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

The expansion of surgical services is tied into the throughput project [2.8] for Starr County Memorial Hospital. This project's, 136332705.1.9, relationship to project 136332705.2.8 is such that efficiencies of throughput time throughout the hospital and emergency department will have to take this service expansion into consideration.

Plan for Learning Collaborative:

If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

This projects valuation revolves around all the potential cost prevention and that comes with accessible, preventative care. With the increased availability of this service, fewer patients have to be transferred out. That results in a faster turnaround and follow-up care for the patient addressing possibility preventable conditions and readmissions. Additionally, transportation costs are reduced as well, where a patient has to be transferred out for a procedure that could have been handled at the outpatient clinic or hospital. High value to cost is placed on the category 3 improvement target 1.13, diabetic foot exams as well. With surgical capacities increased, and the high cost potential for the diabetic population, any minor wounds can be addressed on the spot preventing potentially costly conditions.

136332705.1.9	1.9.5 – workforce enhancement	P-12.1 I-1.1	Increase Surgical Care Availability	
Starr County Memorial Hospital				136332705
Related Category 3 Outcome: OD1 & OD6	IT-1.13 IT-6.2	[Reference numbers from RHP PP]	Increase of Surgical Care Access & Mandatory foot exams	

Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-12) Implement a specialty care access pan to include such components as state of problem, background and methods, findings, implication of findings in short and long term, conclusions **Metric (P-12.1)** Documentation of specialty care access plan **Baseline/Goal:** Assess complications and value lost of not adding an additional surgeon. **Data Source:** Documentation of provider plan. *Milestone 1 Estimated Incentive Payment (maximum amount): $150,000* **Milestone 2: (I-1):** Hire additional surgeon to work at the hospital **Metric 1:** (P-5.1): Contractual documentation for provider	**Milestone 3 [I-1]:** Patient satisfaction with primary care services **Metric [I-1.1]:** ***numerator:*** number of patients transferred out (average per month) ***Denominator:*** FY11 baseline # of patients transferred away. **Goal:** Decrease transfer out number that could have been serviced by the surgeon otherwise ***by 50% by end of DY3*** **Data Source:** Transfer records for DY3 *Milestone 3 Estimated Incentive Payment: $300,000*	**Milestone 4 [I-1]:** Patient satisfaction with primary care services **Metric [I-1.1]:** ***numerator:*** number of patients transferred out (average per month) ***Denominator:*** FY11 baseline # of patients transferred away. **Goal:** Decrease transfer out number that could have been serviced by the surgeon otherwise by ***70% by end of DY3*** **Data Source:** Transfer records for DY3 *Milestone 4 Estimated Incentive Payment: $300,000*	**Milestone 5 [I-1]:** Patient satisfaction with primary care services **Metric [I-1.1]:** ***numerator:*** number of patients transferred out (average per month) ***Denominator:*** FY11 baseline # of patients transferred away. **Goal:** Decrease transfer out number that could have been serviced by the surgeon otherwise by ***70% by end of DY3*** **Data Source:** Transfer records for DY3 *Milestone 5 Estimated Incentive Payment: $300,000*

136332705.1.9	1.9.5 – workforce enhancement	P-12.1 I-1.1	Increase Surgical Care Availability	
Starr County Memorial Hospital				136332705
Related Category 3 Outcome: OD1 & OD6	IT-1.13 IT-6.2	[Reference numbers from RHP PP]	Increase of Surgical Care Access & Mandatory foot exams	
Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)		Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Baseline/Goal: Baseline will be created by how many patients were turned away on average per month in FY11 **Data Source:** Patient documentation of transfer records and reasoning. *Milestone 2 Estimated Incentive Payment (maximum amount): $150,000*				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $808,475	Year 3 Estimated Milestone Bundle Amount: $808,475		Year 4 Estimated Milestone Bundle Amount: $808,475	Year 5 Estimated Milestone Bundle Amount: $808,475
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $4,433,900				

Starr County Memorial Hospital- Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

Apply Process Improvement Methodology Through Out the ED [2.8]

Starr County Memorial Hospital [136332705]

Unique RHP Project ID number: 136332705.2.2

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

Description:

Starr County is one of the largest underserved areas in RHP5 with Starr County Memorial Hospital serving as the primary choice for primary care throughout the local community. When there is a high influx of patients, the waiting times in the emergency department can become severe. There will need to be a meticulous analysis of the bottlenecks in this service line to accurately target specific workflows, process, and clinical areas to improve on.

One such method of analysis will be the Lean methodology of continuous care quality improvement with a focus on value creation; Value in the sense that all future thinking and protocol modifications will be dictated around creating optimizations with the needs of the customers/patients in mind to increase organization effectiveness. Last year alone (FY11), Starr County Memorial Hospital's emergency department (ED) had approximately 1500[16] patients leave our facility without having seen a physician, not only does this increase the possibilities for readmission, it also creates a lack of patient satisfaction with the services. This project will aim towards directly reducing that number. In order for that to happen, this project will not only have to have proper analysis for correct set up, but also in-depth training of our providers and staff to have a successful implementation.

Goals: The goal of employing this project through our facility will be to increase capacities and turnaround of our ED without sacrificing the quality and safety of our patient population. Throughout the 5 years of this project, a 20% increase in capacity would be ideal due to multiple area enhancements throughout the organization.

Challenges/Issues: Starr County generally turns to our hospital to care for the indigent care. As numbers increase, the capacity of our current facility quickly reaches its maximum, leaving many

[16] Starr County proprietary information

patients without the quality care that can lead to prevention of more serious/costly conditions. There is generally a lack of providers in the facility, as well as a need for protocol improvements that can create a smoother workflow.

Issue Resolution: With a new focus on rapid improvement through resource investment in key areas of optimal value creation, bottlenecks will be identified and improved. With resource availability a central challenge, the focus will be on processes and/or additions that create the most value for our patients while still boosting throughput time.

5 year Expected Outcome for provider and patients: Over the five year period, Starr County Memorial Hospital expects to identify bottlenecks in our ED, adjust with adequate additions, and stay on track with a lean methodology that revolves around constant quality improvement and patient value creation. **As stated in our "goals", a 20% decrease in throughput time will be targets while increasing quality and safety for our patients.** While a decrease of throughput time is desired, increased physician availability will also be a goal. **Starr County Memorial Hospital wants to decrease the baseline by 5% in the first year (DY3), then by 3% increases every year through year five (DY4&5).**

Starting Point/Baseline:
e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Rationale:
A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).
Due to its position as the gateway to services in the facility, streamlining the emergency department was selected. Increasing the efficiencies of the emergency department will be a great step towards that goal of better serving the community. Upon project initiation, there will be an evaluation completed that targets specific workflows and processes that can be improved on **(P-1)**.

Once the targets have been made, processes will be adopted that will correct or enhance those areas. This project will revolve around Lean methodology due to its focus on a range of techniques to create a more efficient and effective workplace developing smooth work flows and eliminating waste in time, effort, and resources. These resources can then be invested back into the process where its value can be optimized **(P-7).**

With the adoption and buy-in of any major process revamp, there will have to be staff training on the process improvements **(P-8).** The endgame of this project is to increase the amount of people we are able to serve in the emergency department as well as increase the number of patients that are able to receive physician services. Efficiency development and quality improvement will be focused on in order to reach this goal. There will be variables, such as patient flow times, that will be kept track of in order to access our goals **(I-16).** Every milestone, process and improvement, revolves around the systematic improvement of our service line goals from begining to end.

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Starr County is an area with a high percentage of uninsured patients, a low level of primary care utilization, and limited rural health clinic resources. For this reason, people turn to the hospital to have their urgent care tended to. Unfortunately, with the demographics of the county, the "Right Care, Right Setting" will have to be the emergency department for a large percentage of the community population. The primary reason that improvements in patient flows are desired are so that some sort of prevention type services can be rendered to the population before a percentage of them develop further complications. The outcome measures will be within OD-9 & OD-6, to increase the amount of care available to our patients that have been previously turned away (over 1500 per year), and to increase patient satisfaction over all. With goals of the right care being increased, the CG-CAHPS goals will have to revolve around timely care, quality, and satisfaction.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

Relationship to Other Performing Providers' Projects in the RHP:
If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative:
If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

Project Valuation:
A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

136332705.2.8	2.8.3	2.8.3.P-1.1 2.8.3.P-7.1 2.8.3.P-8.1 2.8.3.I-16.1	Improvement of ED Patient Flow	
Starr County Memorial Hospital				136332705
OD6 & OD9	IT-6.1 IT-9.3	[Reference numbers from RHP PP]	Increasing Service Availability and Patient Satisfaction	

Year 2 (10/1/12 - 9/30/12)	Year 3 (10/1/13-9/30/14)	Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-1) Target specific workflows process and/or clinical areas to improve **Metric 1:** (P-1.1) Performing Provider review and prioritization of areas or process to improve upon. **Baseline/Goal:** Complete the review and decide on what areas to improve on. **Data Source:** Documentation of the review with detailed analysis of which improvement will create the most value. *Milestone 1 Estimated Incentive Payment (maximum amount): $150,000*	**Milestone 2 [P-7]:** Implement a rapid improvement project using a proven methodology **Metric [P-7.1]:** Rapid Improvement Cycle (documentation that all of the steps included in the cycle methodology were performed) **Baseline/Goal:** Complete the documentation and reasonable implementation of the new methods in DY3 **Data Source:** Provider submitted documentation of rapid improvement such as idea sheets, cost analysis, etc. *Milestone 2 Estimated Incentive Payment (maximum amount): $150,000*	**Milestone 3 [P-8]:** Train providers/staff in process improvement **Metric 1 [P-8.1]:** Number of providers/staff trained – ***numerator:*** number of providers/staff trained ***Denominator:*** total number of providers/staff **Baseline/Goal:** 40% of provider/staff trained at the end of DY4 **Data Source:** Training schedules, sign-in sheets, certification numbers. *Milestone 3 Estimated Incentive Payment: $75,000* **Milestone 4 [I-16]:** Improve Quality and efficiency using innovative project option. **Metric 1 [1-16.1]:** Achieve a percentage of improvement based on performance indicators: ***numerator:*** Number of patients seen by physician ***Denominator:*** Number of patients	**Milestone 5 [I-16]:** Improve Quality and efficiency using innovative project option. **Metric 1 [1-16.1]:** Achieve a percentage of improvement based on performance indicators: ***numerator:*** Number of patients seen by physician ***Denominator:*** Number of patients seen by physician in FY11. **Goal:** Have an additional 5% increase of patients seen by the physician in DY4 over the FY11 baseline. **Data Source:** Patient documentation with service codes. *Milestone 5 Estimated Incentive Payment: $150,000*

136332705.2.8	2.8.3	2.8.3.P-1.1 2.8.3.P-7.1 2.8.3.P-8.1 2.8.3.I-16.1	Improvement of ED Patient Flow	
Starr County Memorial Hospital				136332705
OD6 & OD9	IT-6.1 IT-9.3	[Reference numbers from RHP PP]	Increasing Service Availability and Patient Satisfaction	
Year 2 (10/1/12 - 9/30/12)	Year 3 (10/1/13-9/30/14)		Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
			seen by physician in FY11. **Goal:** Have a 5% increase of patients seen by the physician in DY4 over the FY11 baseline. **Data Source:** Patient documentation with service codes. *Milestone 4 Estimated Incentive Payment: $75,000*	
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $404,237	Year 3 Estimated Milestone Bundle Amount: $404,237		Year 4 Estimated Milestone Bundle Amount: $404,237	Year 5 Estimated Milestone Bundle Amount: $404,237
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $2,216,948				

Identifying Project and Provider Information:

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1), Performing Provider name/TPI.

136332705.2.2

Process Improvement through Patient Centered Healthcare [2.11.3]

Conduct Medication Management

Starr County Memorial Hospital [136332705]

Project Description:

Describe project, including project goal(s) and challenges or issues faced by the Performing Provider, how the project addresses those challenges, and 5-year expected outcome for Performing Provider and patients. Also describe how the project is related to the regional goals.

Description: Starr County is one of the largest underserved areas in RHP5 with Starr County Memorial Hospital serving as the sole community acute care provider throughout the county. The hospital also owns and operates two Rural Health clinics for outpatient primary care services.

Physicians and mid level practitioners at Starr County Memorial Hospital are still using paper pads to issue prescriptions to their patients. Our in house pharmacist currently employs an antiquated software system that makes her count all medication administered to patients at our hospital. This manual system is tedious and takes a long time to reconcile. The system may also cause some medication errors that are not easy to detect within a short time period. Starr County Memorial Hospital should obtain a modern software system that would include e-prescribing for all our doctors and mid level practitioners at our two clinics.

This project would include putting in place modern technology, teams and processes to implement a medication management program at Starr County Memorial Hospital. This project requires that we develop criteria and identify targeted patient populations.

Goals: The goal of employing this project through our facility will be to manage medications so that patients receive the right medications at the right time across the Performing Provider in order to reduce medication errors and adverse effects from medication use. We also plan to provide an avenue for access to medications for patients treated and discharged from the hospital clinics. Throughout the 5 years of this project, we expect to put in place teams, technology and process. We will develop criteria and identify targeted patient populations. Finally, we will implement a medication management program that will allow us to manage medications prior to, at, and after discharge.

Challenges/Issues: Indigent residents from Starr County generally turn to our hospital and clinics to access health care. Assisting the clients to access prescribed medications after discharge is frequently a challenge.

Issue Resolution: Investment of financial resources in a new software system that is able to support e-prescribing for all our physicians and electronically manage our medications will help us achieve our goals. Through resource investment, we could implement the 340B Pharmacy Drug Program to provide much needed help to our indigent patient population. This program will improve access to needed medication for our patients after discharge from the hospital and after discharge from our rural health clinics.

5 year Expected Outcome for provider and patients: Over the five year period, Starr County Memorial Hospital expects to contract with a network of pharmacies to serve patients without any type of insurance coverage. The hospital will also enhance quality improvement efforts to meet compliance with this project's goals of administering the right medications and at the right time in order to reduce medication errors, adverse effects and compliance with patients being able to access prescribed medications.

Starting Point/Baseline:

e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.

Rationale:

A narrative describing the reasons for selecting the project option, project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project), milestones, and metrics based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point. Provide the unique community need identification number the project addresses. Include how the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services. Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community).

To enhance our mission of providing quality care at all times to all our clients, implementation of a process to avoid errors in medication administration and to assist the clients to access their medications at discharge will be an excellent means to improve medication administration in the inpatient setting. We will also increase the number of patients that are able to access needed medication at the time of discharge from inpatient settings.

Related Category 3 Outcome Measure(s):

Indicate the Category 3 Outcome Measure(s) and reasons/rationale for selecting the outcome measure(s). At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, including:

- *Data supporting why these outcomes are a priority for the RHP;*
- *Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or*
- *Explanation of how focusing on the outcomes will help improve the health of low-income populations.*

Starr County is an area with a high percentage of uninsured patients, a low level of primary care utilization, and limited rural health clinic resources. For this reason, people turn to the hospital to have their urgent care tended to.

The outcome measures will be within OD-3 under IT 3.12 other preventable re-admissions of discharged patients that did not purchase their medications due to lack of insurance and other financial resources.

Another related category 3 outcome falls under OD-6 (IT 6.2) Patient satisfaction due to the new processes implemented by our hospital. Patients will not have to wait in line at the pharmacy and will get their prescription submitted electronically and uninsured patients will have access to prescribed medications at very low costs through our 340B pharmacy drug program.

With goals of the right medication at the right time being achieved, the CG-CAHPS goals will have to revolve around timely care, quality, and satisfaction.

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative:

If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

136332705.2.2				
Starr County Memorial Hospital				136332705
OD3 & OD6	IT-3.12 IT-6.3	[Reference numbers from RHP PP]	Increasing Service Availability and Patient Satisfaction	
Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)		Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
Milestone 1: (P-1) Update software system to support e-prescribing and electronic medication management. **Metric 1:** (P-1.1) Performing Provider writes a Medication Management Plan. **Baseline/Goal:** Complete the review and decide on what areas to improve on. **Data Source:** Written medication management plan including workflow for providers. *Milestone 1 Estimated Incentive Payment (maximum amount): $100,000*	**Milestone 2 [P-7]:** Implement a rapid improvement project using a proven methodology **Metric [P-7.1]:** Rapid Improvement Cycle (documentation that all of the steps included in the cycle methodology were performed) **Baseline/Goal:** Complete the documentation and reasonable implementation of the new methods in DY3 **Data Source:** Provider submitted documentation of rapid improvement such as idea sheets, cost analysis, etc. *Milestone 2 Estimated Incentive Payment (maximum amount): $100,000*		**Milestone 3 [P-8]:** Train providers/staff in process improvement **Metric 1 [P-8.1]:** Number of providers/staff trained – ***Numerator:*** Number of patients in targeted patient population that consistently receive medication management counseling. ***Denominator:*** Number of patients in targeted patient population in FY13. **Baseline/Goal:** **Goal:** Have a 10% increase of patients seen receive medication management counseling. **Data Source:** Paper or electronic medical record citing medication management counseling provided; medication reconciliation documented in paper or electronic medical record.	**Milestone 5 [I-16]:** Improve Quality and efficiency using innovative project option. **Metric 1 [1-16.1]:** Achieve a percentage of improvement based on performance indicators: ***Numerator:*** Number of patients who receive medication reconciliation as part of the transition from acute to ambulatory care in a defined time period. ***Denominator:*** Number of patients discharged from acute to ambulatory care in a defined time period. **Goal:** Have an additional 5% increase of patients seen by the physician in DY4

136332705.2.2				
Starr County Memorial Hospital				136332705
OD3 & OD6	IT-3.12 IT-6.3	[Reference numbers from RHP PP]	Increasing Service Availability and Patient Satisfaction	
Year 2 (10/1/12 - 9/30/13)	Year 3 (10/1/13-9/30/14)		Year 4 (10/1/14-9/30/15)	Year 5 (10/1/15 - 9/30/16)
			Milestone 3 Estimated Incentive Payment: $50,000 **Milestone 4 [I-16]:** Improve Quality and efficiency using innovative project option. **Metric 1 [1-16.1]:** Achieve a percentage of improvement based on performance indicators: **Goal:** Have a 10% increase of patients seen receive medication management counseling. *Milestone 4 Estimated Incentive Payment: $50,000*	over the FY11 baseline. **Data Source:** Patient or electronic medical records. *Milestone 5 Estimated Incentive Payment: $100,000*
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): 538,984	Year 3 Estimated Milestone Bundle Amount: $538,984		Year 4 Estimated Milestone Bundle Amount: $538,984	Year 5 Estimated Milestone Bundle Amount: $538,984
Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5): $2,555,936				

Tropical Texas Behavioral Health (TTBH) - Category 1: Infrastructure Development

Identifying Project and Provider Information:

Expand Primary Care Capacity, 138708601.1.1

Tropical Texas Behavioral Health 138708601

Project Description:

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. TTBH will expand capacity to deliver additional services primary to our mission as the LMHA for the Rio Grande Valley, namely community-based services addressing the behavioral health needs of individuals who meet criteria for a diagnosis of severe mental illness to x individuals by the end of the waiver period. TTBH will also expand access to transportation services with this project.

TTBH will expand behavioral health service capacity to enhance access to the right care at the right time in the right setting and improve behavioral health outcomes and the experience of care for those served. By Waiver DY 5, TTBH will expand behavioral health service capacity at our three largest clinic locations across the Valley through the expansion of clinic space and staffing, and provide services to at least 900 new individuals, including those meeting the state's clinical eligibility criteria to receive ongoing behavioral health services but are on waiting lists due to resource limitations. Over the term of the waiver, TTBH will significantly reduce the number of people waiting to access comprehensive and culturally sensitive preventative behavioral health services, resulting in increased utilization of routine behavioral health services, improved health outcomes and experience of care, and decreased need for more costly emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments. This project addresses community need CN. 2, related to shortage of behavioral health professionals and inadequate access to behavioral health care.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services, prescribed

and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:
In FY 2011 TTBH had approximately 820 persons on waiting lists for behavioral health services**.**

Rationale:
In 2003, Texas began rationing state-provided mental health services in order to address budget shortfalls. Ongoing mental health services were targeted primarily to people with schizophrenia, bipolar disorder and major depression. Those with other illnesses, such as anxiety and post-traumatic stress disorder, and the uninsured, were placed on waiting lists for months, or longer, awaiting access to essential services including medication, therapy and substance abuse care. As a result, according to the Department of State Health Services (DSHS), more than 6,800 adults and children with schizophrenia, bipolar disorder and major depression were on waiting lists for community mental services statewide in 2009. This number peaked at 10,354 in 2010, and has hovered at a quarterly average of over 9,400 people waiting for necessary services since then. TTBH has expanded our array of services and service capacity since 2007 through state and alternative funding sources, and consistently exceeded our state-mandated monthly targets for the number adults and children served by an average of 115% and 475%, respectively, during the same period. In spite of this, similar to statewide trends, TTBH's waiting lists for adults and children have risen steadily since 2005, peaking at approximately 850 combined individuals in 2010, and have remained relatively constant in the years since. Delays in the ability to access appropriate behavioral health care have been linked to disproportionately high rates of a range of negative and expensive consequences for people diagnosed with mental illness including disability, unemployment, homelessness, substance abuse, incarceration, hospital emergency department visits, psychiatric and medical inpatient hospitalization, preventable complications of co-morbid medical illnesses and suicide. From a financial perspective, evidence suggests that delays in accessing community-based mental health services can translate to significantly greater costs to intervene with an individual with mental illness in other, often less appropriate, settings. In their 2011 study of proposed budget cuts to community-based mental health services, Health Management Associates found 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.

TTBH's planned expansion of service capacity will also address longstanding transportation barriers to service access. Many residents of the Rio Grande Valley, in particular those seeking behavioral health services, experience significant barriers to reliable transportation due to the disabling effects of poverty and the complications associated with using public transit systems including service coverage areas and schedules that limit users' ability to get where they need to go when they choose. Individuals with mental illness often don't know about available transportation opportunities or how to use them, and uninsured residents with mental illness aren't eligible to participate in transportation programs that are limited to people with Medicaid or other insurance. Among the areas of unmet public transportation needs identified by the Lower Rio Grande Valley Development Council in its 2011 Human Service-Public Transit Coordination Plan were insufficient fixed-route public transportation vehicles for the more than 600,000 residents of the Mission, McAllen, Edinburg, Pharr area; difficulty using the existing transit systems to travel from one city to another; lack of regularly scheduled transit services for those residing in the many low-income colonias throughout

the Valley; the extra burden on existing transit systems from the growing number of Mexican nationals using the systems and inadequate availability of transit from rural areas like Willacy County to cities like Harlingen. In July 2012, 2150 adults served by TTBH responded to survey questions concerning patterns of health care use and ability to access care. Forty three percent (43%) reported that they lacked health insurance; more than 25% indicated their home was 10 or more miles from the nearest medical facility; 30% reported that they had only occasionally reliable transportation or none at all; only 3% reported using public transportation to get to their appointments; and although a majority of respondents said they relied on personal vehicles or the support of family or friends to get to their appointments, nearly half (48%) indicated they did not access routine checkups or preventative care on a regular basis.

TTBH will increase behavioral heath service infrastructure and capacity through the expansion of clinic space and staffing at our 3 largest clinics in the Rio Grande Valley. Insofar as TTBH stakeholder input does not support extended operating hours at our behavioral health clinics and doing so would require a more comprehensive and expensive expansion of staffing than is currently planned, TTBH will not extend our clinic hours at this time. Through the expansion of our behavioral health service capacity including expanded clinic space and staffing and the implementation of contracted services to increase transportation to appropriate care for low-income and uninsured persons, TTBH will significantly reduce our waiting lists, increase access to and utilization of evidence-based preventative health care services, increase opportunities for recovery and wellness, and decrease avoidable costs associated with delays in accessing care.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Expanding behavioral healthcare capacity is fundamental to the success of related projects to expand and enhance TTBH's behavioral health services including projects to provide necessary behavioral health services to an increasing number of individuals diverted from the criminal justice system (Project 138708601.2.2), to persons with co-occurring substance use disorders (Project 138708601.1.2) and/or to persons with co-occurring Intellectual and Developmental Disabilities (Project 138708601.1.3).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to expand behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY 2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY 5 is calculated to be $7,352,230.

- Homelessness: Of our current mental health population served, 5% were identified as at risk or homeless by either our PATH (Projects for Assistance in Transition from Homelessness) or Supported Housing programs. According to a two-year University of Texas survey of homeless individuals, each homeless person costs taxpayers $14,480 per year. The overall value is calculated to be $1,214,191.

- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated to be $1,047,854.

- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $287,522.

- Transportation: With transportation readily accessible to our high use clients we anticipate of seeing a reduction not only in hospital and emergency room visits, but homelessness and jail diversion as well. The overall value is calculated to be $3,864,117

- Overall Project Valuation: The total project valuation is $13,765,914.

PROJECT ***138708601.1.1***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional /expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. • Baseline/Goal: Baseline N/A, goal is to develop a plan for the expansion of service capacity including building construction and renovation, purchase of necessary equipment and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum*	**Milestone 4** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 275 new individuals from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,736,436 **Milestone 5** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation		**Milestone 6** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 275 new individuals from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 6 Estimated Incentive Payment *(maximum amount):* $2,885,696 **Milestone 7** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation	**Milestone 8** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Add 275 new individuals from waiting lists into services. • Data Source: MBOW Waiting List reports. Milestone 8 Estimated Incentive Payment *(maximum amount):* $2,238,902 **Milestone 9** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation

PROJECT ***138708601.1.1***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
	Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
amount): $2,490,940 **Milestone 2** [P-X]: Evaluate and continuously improve services <u>Metric 1</u>: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,096,266 **Milestone 3** [I-12]: Increase in	documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 5 Estimated Incentive Payment *(maximum amount):* $297,724		documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 7 Estimated Incentive Payment *(maximum amount):* $313,964	documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 9 Estimated Incentive Payment *(maximum amount):* $168,365

PROJECT ***138708601.1.1***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
	Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
primary care clinic volumes of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. • Baseline/Goal: In FY 2011 TTBH had approximately 820 people on waiting lists for behavioral health services. The goal is to add 100 new individuals from waiting lists into services. • Data Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) Waiting List reports. Milestone 3 Estimated				

PROJECT ***138708601.1.1***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.1*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment *(maximum amount):* $537,621				
Year 2 Estimated Milestone Bundle Amount: $5,124,827	Year 3 Estimated Milestone Bundle Amount: $3,034,160		Year 4 Estimated Milestone Bundle Amount: $3,199,660	Year 5 Estimated Milestone Bundle Amount: $2,407,267
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $13,765,914				

Identifying Project and Provider Information:

Expand Primary Care Capacity, 138708601.1.2,

Tropical Texas Behavioral Health/138708601

Project Description:

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. By Waiver DY 5, TTBH will expand behavioral health service capacity at our three largest clinic locations across the Valley through the expansion of clinic space and staffing including the addition of 4 trained Co-occurring Psychiatric and Substance Use Disorder (COPSD) specialists at our three largest clinics and increase the volume of COPSD service encounters by 45% over baseline to 1,995 encounters by Waiver DY 5. Insofar as TTBH stakeholder input does not support extended operating hours at our behavioral health clinics and doing so would require a more comprehensive and expensive expansion of staffing than is currently planned, TTBH will not extend our clinic hours at this time. By expanding the delivery of integrated mental health and substance use services, TTBH will deliver comprehensive behavioral health services to more individuals with COPSD than was previously possible. Services will be provided according to a collaboratively developed person-centered plan and established evidence-based practice guidelines to improve opportunities for those served to achieve recovery for both disorders. The expansion of COPSD services will result in increased utilization of routine behavioral health services, improved health outcomes and experience of care, and a decrease in the utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments. This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:

In FY 2011, TTBH delivered 1374 COPSD service encounters.

Rationale:
Substance abuse is a common disorder among individuals with severe mental illness. Individuals with mood or anxiety disorders are reported to be twice as likely to have a substance use disorder, and vice versa, in comparison to the general population. Other estimates place the prevalence of substance abuse and dependence among those with severe mental illness from 30% to as high as 50% depending on the psychiatric diagnosis, compared to only 8% in those without mental illness. Establishing a clear causal relationship between the co-occurrence of mental and substance use disorders is difficult, but three scenarios have been offered to explain the connection: use of a particular drug results in symptoms of a mental illness; individuals suffering from a mental illness "self-medicate" with illicit drugs in an attempt to reduce symptoms of their illness; or both disorders are the result of underlying genetic and/or environmental factors. The prognosis for individuals with co-occurring mental and substance use disorders is significantly worse than for those with a mental illness or substance use disorder alone, including increased rates of relapse, medical illness, violence, hospitalization, work and school problems, incarceration, suicide and early death. While the treatment of the mental illness or the substance abuse disorder separately may reduce the risk, lessen the severity or increase a person's amenability to treatment of the co-occurring disorder, navigating separate and complex systems of care can result in barriers to treatment access and recovery. A growing body of evidence has demonstrated that integrated and concurrent treatment of both disorders results in the best possible outcomes for those with co-occurring disorders.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Expanded COPSD services may lead to the identification of medical issues appropriate for referral to TTBH's planned co-located primary care clinics and care management services (Projects 138708601.2.1 and 138708601.2.4). Evidence suggests it is likely that many of the individuals served who come into contact with law enforcement and are identified for diversion to treatment by Mental Health Officers (Project 138708601.2.2) will have COPSD related needs.

Relationship to Other Performing Providers' Projects in the RHP:
N/A

Plan for Learning Collaborative:
N/A

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY 2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY 5 is calculated to be $4,220,391.

- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated to be $601,498.

- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $165,046.

- Overall Project Valuation: The total project valuation is $4,986,935.

PROJECT ***138708601.1.2***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.2*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional /expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. • Baseline/Goal: Baseline N/A, goal is to develop a plan for the expansion of service capacity including building construction and renovation, purchase of necessary equipment and recruitment, hiring and training of new COPSD staff. • Data Source: Documentation of work plan and time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,248,980	**Milestone 3** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Baseline/Goal: In FY 2011, TTBH delivered 1374 COPSD service encounters. Goal is to increase COPSD services by 15% over baseline to 1,580 encounters. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,137,370 **Milestone 4** [P-X]: Evaluate and continuously improve services		**Milestone 5** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Increase COPSD services by 30% over baseline to 1,786 encounters. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,199,409 **Milestone 6** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation	**Milestone 7** [I-12]: Increase in primary care clinic volumes of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. • Goal: Increase COPSD services by 45% over baseline to 1,995 encounters. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment *(maximum amount):* $930,576 **Milestone 8** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation

PROJECT ***138708601.1.2***	***PROJECT OPTION*** ***1.1.2***	***PROJECT COMPONENT(S)*** ***1.1.2.a, 1.1.2.c***	***EXPAND PRIMARY CARE CAPACITY***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.2*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $146,380	Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $123,745		documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $130,496	documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $69,979
Year 2 Estimated Milestone Bundle Amount: $1,395,360	Year 3 Estimated Milestone Bundle Amount: $1,261,115		Year 4 Estimated Milestone Bundle Amount: $1,329,905	Year 5 Estimated Milestone Bundle Amount: $1,000,555
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $4,986,935				

Identifying Project and Provider Information:

Development of behavioral health crisis stabilization services as alternatives to hospitalization, 138708601.1.3,

Tropical Texas Behavioral Health/138708601

Project Description:

Develop crisis stabilization alternatives to more expensive and preventable crisis resolution mechanisms. TTBH will add two Mobile Crisis Outreach Team (MCOT) staff at each of our three main clinics trained in the delivery of crisis services to individuals with co-occurring behavioral health needs and Intellectually and Developmentally Disabled, and increase the volume of crisis encounters to individuals with co-occurring behavioral health needs and IDD by 30% over baseline. Additionally, TTBH staff will collaborate with the Rio Grande State Center and the Wood Group to make respite and crisis respite services, respectively, available to this targeted population, and to implement behavior management plans when clinically indicated to prevent admission/readmission to inpatient psychiatric care. By enhancing our MCOTs through the addition of specially trained staff, TTBH will ensure more consistent identification of co-occurring mental illness in individuals with IDD who experience behavioral health crises. Based on their training and experience, these staff will have the knowledge and skills needed to comprehensively address the co-occurring disorders and recommend and coordinate levels of care appropriate to stabilize behavioral health crises in the community. This will prevent or reduce repeat cycles of higher-cost, restrictive institutional alternatives, increase utilization of routine behavioral health services, and improve health outcomes and the experience of care for the person served. This project addresses community need CN.2, related to shortage of behavioral health care professionals and inadequate access to behavioral health

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:

Baseline will be established in Waiver DY 2, based on data currently being collected by the Texas Department of Aging and Disability Services (DADS).

Rationale:
While the existence of co-occurring mental illness in persons with IDD has been acknowledged within the field of behavioral health, as has their increased risk of developing mental illness compared to people without IDD, the realization of successful mental health treatment outcomes for this population has not kept pace with this knowledge. A study commissioned by the Texas Legislature determined that a fundamental barrier to appropriate care for people with co-occurring mental health disorders and IDD is a lack of adequately trained clinicians who are competent to respond to behavioral health crises with this population. The lack of available clinicians skilled in addressing the behavioral health needs of this population results in undiagnosed, untreated or undertreated mental illness and an increased risk of behavioral health crisis. This problem is compounded by the cognitive and intellectual limitations experienced by this population. The resulting poor outcomes for persons with co-occurring mental illness and IDD include more frequent and longer psychiatric hospitalizations with little improvement in behavioral functioning. The alternatives to competent community-based treatment are repeated and extended stays in psychiatric hospitals and institutionalization in State Supported Living Centers; expensive and often ineffective intervention options.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Enhancement of behavioral health services to those with co-occurring mental illness and IDD is linked to and supports the Center's goal for the overall expansion of behavioral healthcare capacity (Project 138708601.1.1). Persons receiving integrated MH/IDD crisis stabilization services may be assessed as having physical health needs that would benefit from the planned integration of primary care within TTBH clinics (Projects 138708601.2.1 and Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
N/A

Plan for Learning Collaborative:
N/A

Project Valuation:

- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. In DY 2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day. The overall value for jail diversions by the end of DY 5 is calculated to be $2,069,024.

- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678. The overall value is calculated at $294,881.

- Emergency Room: Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of $986 per visit and a total emergency room valuation of $80,913.

- Overall Project Valuation: The total project valuation is $2,444,818.

PROJECT 138708601.1.3	***PROJECT OPTION 1.13.2***	***PROJECT COMPONENT(S) N/A***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION.***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.3*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]: Number of staff hired and trained. • Baseline/Goal: Baseline, NA. Goal is to develop a plan to expand service capacity at TTBH's 3 main clinics for the delivery of crisis services to persons with co-occurring IDD and behavioral health needs, including building construction and renovation, purchase of necessary equipment, revision to applicable policies and procedures and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames	**Milestone 3** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Baseline/Goal: Baseline will be established in Waiver DY 2, based on data being collected by DADS. Goal is to increase the number of crisis encounters with individuals with co-occurring behavioral health and IDD needs by 10% over baseline. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $683,636 **Milestone 4** [P-6]: Evaluate and continuously improve crisis		**Milestone 5** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Goal: Increase the number of crisis encounters with individuals with co-occurring behavioral health and IDD needs by 20% over baseline. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $720,925 **Milestone 6** [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates	**Milestone 7** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives. • Goal: Increase the number of crisis encounters with individuals with co-occurring behavioral health and IDD needs by 30% over baseline. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $559,338 **Milestone 8** [P-6]: Evaluate and continuously improve crisis services Metric 1: [P-6.1]: Project planning and implementation documentation demonstrates

PROJECT ***138708601.1.3***	***PROJECT OPTION*** ***1.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION.***	
	Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.3*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
including building construction and renovation, purchase of necessary equipment, development of necessary policies and procedures and recruitment, hiring and training of staff. Milestone 1 Estimated Incentive Payment *(maximum amount):* $256,033 **Milestone 2** [P-6]: Evaluate and continuously improve crisis services <u>Metric 1</u>: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time	services <u>Metric 1</u>: [P-6.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $74,379		plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $78,437	plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $42,062

PROJECT ***138708601.1.3***	***PROJECT OPTION*** ***1.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION.***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.3*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $30,007				
Year 2 Estimated Milestone Bundle Amount: $286,040	Year 3 Estimated Milestone Bundle Amount: $758,015		Year 4 Estimated Milestone Bundle Amount: $799,362	Year 5 Estimated Milestone Bundle Amount: $601,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,444,817				

TTBH - Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Integrate Primary and Behavioral Health Care Services, 138708601.2.1, Tropical Texas Behavioral Health/138708601

Project Description:

Integrate primary care and behavioral health care services in order to improve care and access to needed services. TTBH will co-locate primary healthcare clinics at each of our three largest behavioral health clinics to provide integrated primary health care through a healthcare home model to 900 individuals receiving behavioral health services. This project is an innovation for the Center, as TTBH has never provided primary care services in our more than 45 year history as the Rio Grande Valley's LMHA. Integrated primary care will include services promoting education, prevention, recovery and wellness. The co-location of primary care within TTBH's behavioral health clinics will facilitate access to preventative primary care for individuals who frequently access routine care through hospital emergency departments or who forgo routine medical care until undiagnosed or untreated illnesses require intervention in the emergency department or result in inpatient admission. TTBH has identified our 3 largest clinic sites for the co-location of primary care services. The clinics are well-established within the local communities and the locations are familiar to the residents. The sites have established utilities and building services, and while relatively accessible at the present time, they will be more so with the implementation of added transportation services. Services will be delivered by primary care staff employed by TTBH and coordinated and documented in our existing EHR; facilitating co-scheduling and information sharing between physical health and behavioral health providers, in addition to data collection and reporting. Internal protocols and processes for communication and referral between behavioral and physical health providers will be established during the development of the primary care clinics. Behavioral and physical health staff will receive training on the protocols as applicable, including training on team approaches to treatment, information sharing through consultative meetings and case conferences and co-developed comprehensive treatment planning. The results will be improved coordination of behavioral and primary health care, improved health outcomes and wellness for persons served through early primary care intervention, and reduced costs to the health care system as a result of reduced inappropriate emergency department usage and inpatient admissions. This project addresses community need CN.3, inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are

routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:
N/A

Rationale:
The elevated rates of co-morbid chronic medical illnesses in people with mental illness, the unique challenges they face in effectively managing their illnesses and their high rates of premature mortality relative to the general population have been well documented. In a 2006 technical report on Morbidity and Mortality in People with Serious Mental Illness (SMI), the Medical Directors Council of the National Association of State Mental Health Program Directors suggested that people with SMI die, on average, 25 years earlier than the general population. The report asserted the increased mortality and morbidity rates were largely due to preventable conditions including cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza) and infectious diseases (including HIV/AIDS). The researchers argued that having SMI may be a risk factor and lead to problems in access to health care due to, among other things, the lack of motivation, fearfulness, and social instability of persons with SMI, and the fragmentation of mental health and primary health care systems. Factors identified as placing people with SMI at higher risk of morbidity and mortality included higher rates of smoking, alcohol consumption, poor nutrition /obesity, lack of exercise, unsafe sexual behavior, drug use and exposure to infectious diseases, as well as homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation. The report also cited research suggesting the population of people with SMI had high use of somatic emergency services, fewer routine preventive services, lower rates of cardiovascular procedures and worse diabetes care. For those in the Rio Grande Valley living with mental illness, these health concerns are compounded by the overarching health issues impacting the general population along the Texas/Mexico Border more negatively than other areas of the state and nationally, and in relation to science-based nationally established health benchmarks. Examples include an increased likelihood of being uninsured; difficulty accessing health care; not seeing a physician regularly due to cost or transportation barriers; a decreased likelihood of having routine blood pressure or cholesterol tests; higher rates of kidney disease, liver disease, tuberculosis, diabetes, overweight and obesity; and a higher rate of reported depressive symptoms accompanied by a lower likelihood of seeking mental health treatment. The benefits of integrating primary and behavioral health both from a health improvement and a health system cost perspective have also been demonstrated. A recent study involving the integration of primary care services within a mental health clinic treating veterans with mental illness reported that "enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals." The study found that the veterans who received primary care services co-located within the mental health setting realized "significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI." Researchers have also demonstrated that for populations served in community mental health centers, the implementation of care management delivered in an integrated primary care setting can result in sustainable improvements in physical health outcomes (e.g. cardiovascular risk, physical functioning and pain)

and patient and provider satisfaction, as well as significant potential cost savings to health care systems relative to care as usual (i.e., referral to their primary care provider). Co-location of Primary care services improves access to care by reducing the cost and inconvenience to those served of arranging for added transportation to multiple locations for behavioral and physical health care. Through this project, TTBH will co-locate primary health care clinics at each of our three main behavioral health clinics. These co-located clinics will allow TTBH to provide a targeted group of persons receiving behavioral health services with access to integrated primary health care, including services to promote education, prevention, recovery and wellness through a health care home design.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
Expanding infrastructure and capacity for preventative primary health care services will support the completion of the medical clearances needed for many psychiatric inpatient admissions by the physicians employed at the co-located clinics and reduce the use of emergency departments for this service (Project 138708601.2.3). It is also necessary to accommodate the implementation of integrated care management functions to educate persons served about their primary and behavioral health conditions, monitor their response and adherence to treatment and coordinate care (Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to integrate primary and behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and

reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to a research done by University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.
- Overall Project Valuation: The total valuation for Integrated Primary Care is $16,810,467.

PROJECT ***138708601.2.1***	***PROJECT OPTION*** ***2.15.1***	***PROJECT COMPONENT(S)*** ***2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.4*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 1 [P-5.2]: Number of primary care providers newly located in behavioral health settings. • Baseline/Goal: Baseline N/A, goal is to develop a plan to co-locate primary care services at TTBH's 3 main clinics including building construction and renovation, purchase of necessary equipment, development of policies and procedures and recruitment, hiring and training of staff. • Data Source: Documentation of work plan and time frames.	**Milestone 3** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Baseline/Goal: In FY2012 TTBH served approximately 23,000 unduplicated individuals. The goal is to increase the percentage of unduplicated persons receiving both physical and behavioral health care to 1.3% of baseline. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $3,712,877 **Milestone 4** [P-7]: Evaluate and continuously improve		**Milestone 5** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of unduplicated persons receiving both physical and behavioral health care to 2.6% of baseline. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $3,915,398 **Milestone 6** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services	**Milestone 7** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of unduplicated individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of unduplicated persons receiving both physical and behavioral health care to 3.9% of baseline. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $4,187,809 **Milestone 8** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services

PROJECT ***138708601.2.1***	***PROJECT OPTION*** ***2.15.1***	***PROJECT COMPONENT(S)*** ***2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.4*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,445,670 **Milestone 2** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services <u>Metric 1</u>: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):*	integration of primary and behavioral health services <u>Metric 1</u>: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $403,961		<u>Metric 1</u>: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $425,996	<u>Metric 1</u>: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $314,923

PROJECT ***138708601.2.1***	***PROJECT OPTION*** ***2.15.1***	***PROJECT COMPONENT(S)*** ***2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.4*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$403,833				
Year 2 Estimated Milestone Bundle Amount: $3,849,503	Year 3 Estimated Milestone Bundle Amount: $4,116,838		Year 4 Estimated Milestone Bundle Amount: $4,341,394	Year 5 Estimated Milestone Bundle Amount: $4,502,732
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $16,810,467				

Identifying Project and Provider Information:

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.), 138708601.2.2, Tropical Texas Behavioral Health/138708601

Project Description:

Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. Through funding associated with this project, 18 certified Mental Health Officers will be recruited to serve on a specially trained law enforcement task force with the objective of decreasing preventable admissions and readmissions into the Criminal Justice System. In 2011, the police departments in the three largest cities in the Valley (McAllen, Harlingen and Brownsville) reported an average rate of arrests per service call of approximately 5.8%. Assuming the same arrest rate for officers on the mental health taskforce, by Waiver DY 5 TTBH will target a decrease of at least 1.5% in the arrest rate for the Mental Health Officers as a result of an increase in the number of individuals identified as appropriate for diversion from jail into behavioral health treatment services. The task force will be will be created through the execution of an interlocal agreement between several local county and municipal law enforcement agencies; each of which will contribute officers to serve on the task force. The personnel, supplies and operating expenses for the task force will be funded by this project. While serving on the task force, the assigned Mental Health Officers and related personnel will remain employees of their respective law enforcement agencies. Officers serving on the task force will have the authority to intervene in cases involving individuals exhibiting signs and symptoms of a possible mental illness anywhere outside of the jurisdiction in which they are regularly employed throughout Willacy, Cameron and Hidalgo Counties, in accordance with applicable statutes and the terms of the agreement. Through the interlocal agreement and the task force, the participating agencies will cooperate to improve the identification of individuals who come in contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness and who may therefore be appropriate for diversion from the criminal justice system into routine behavioral health care services. This will reduce the need for intervention by other elements of local law enforcement, hospital emergency department visits and medical and psychiatric inpatient hospital admissions. The program will also improve health outcomes for persons served, supporting the objective of delivering the right care at the right time in the right setting, and improve the experience of care. This project addresses community need CN. 2, related to shortage of behavioral health professionals and inadequate access to behavioral health care.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with

TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:
N/A. The Mental Health Officer taskforce will be the first initiative of its kind in the Rio Grande Valley.

Rationale:
What has been referred to as the "criminalization of mental illness" describes the problem that developed in the U.S. mental health care system during the 1960s and 1970s when the planned availability of community behavioral health services failed to meet the increased demand resulting from large scale efforts to deinstitutionalize persons with mental illness. The lack of sufficient availability of community-based behavioral health treatment options is one of a number of factors increasing the likelihood that a person with mental illness will come in contact with the criminal justice system in their lifetimes. Others issues include reluctance to seek treatment for a mental illness due to the associated stigma; fear of navigating a complex system of care; complications from co-morbid substance use disorders; joblessness and homelessness. Consequently, over time the criminal justice system has played an increasingly significant role in intervening with people with mental illness. The numbers of individuals with mental illnesses in jails and prisons exceeds the number receiving treatment in psychiatric hospitals by a 3:1 ratio; in Texas the ratio has been reported to be as high as 8:1. People with mental illness are significantly disproportionally represented among criminal justice populations. Studies of the have estimated the prevalence of severe mental illness in jail and prison populations from 8% to as high as 31%, as compared to approximately 3% in the general population. Further, more than 70% of inmates with severe mental illness also have co-morbid substance abuse or dependence disorders. To ensure the most appropriate outcomes when individuals with mental illness encounter law enforcement, and given that interactions with individuals with mental illness take up a considerable, and growing, amount of law enforcement officers' direct service time, the interests of persons served and the law enforcement and health care systems are best served by the development of elements within law enforcement with the necessary training to effectively intervene with this population. This delivery system reform project will support the operation of a Mental Health Peace Officer task force serving throughout TTBH's catchment area, drawing on the experience and successes of similar programs implemented by LMHAs in other parts of the state. The officers in the program will be licensed peace officers from several county and municipal law enforcement agencies who have previous patrol experience and will receive specialized and ongoing training through the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) and TTBH clinical staff as needed, to maintain a high level of knowledge and skill in intervening with persons with mental illness in the community. The task force will collaborate with TTBH's MCOT teams and other service departments to ensure 24-hour access to necessary behavioral health consultations, appropriate outcomes for the individuals served and to optimize the effectiveness of the program.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they

receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
The Mental Health Officer task force is linked to the overall expansion of TTBH's behavioral healthcare capacity (Project 138708601.1.1) and supports the Center's goals to expand the delivery of comprehensive behavioral health services to more people with co-occurring substance use disorders (Project 138708601.1.2) and co-occurring Intellectual and Developmental Disabilities (Project 138708601.1.3).

Relationship to Other Performing Providers' Projects in the RHP:
N/A

Plan for Learning Collaborative:
N/A

Project Valuation:

- Jail Diversion: According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives. Interventions by Mental Health Officers have the potential to divert individuals from jail. In DY 2 TTBH foresees a savings of $10,960 per jail diversion based on an average incarceration of 80 days at a cost of $137/day.

- Overall Project Valuation: The total valuation for MH Officers project is $13,443,573 by end of DY 5.

PROJECT ***138708601.2.2***	***PROJECT OPTION*** ***2.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.)***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.5*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Design community-based specialized interventions for target populations. Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals. • Baseline/Goal: Baseline N/A, goal is the development and execution of an interlocal agreement between participating municipal and county law enforcement agencies, and the recruitment, hiring and training of personnel. • Data Source: Project documentation including work plan and	**Milestone 3** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Baseline/Goal: The major municipal Police Departments in the Rio Grande Valley reported an arrest per service call rate of 5.8% in 2011. The goal is a decrease in preventable admissions and readmissions into the Criminal Justice System by .5% from this baseline for persons encountered by Mental Health Officers. • Data Source: Encounter data		**Milestone 5** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Goal: Decrease in preventable admissions and readmissions into the Criminal Justice System by 1% from baseline for persons encountered by Mental Health Officers. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $3,246,370 **Milestone 6** [P-4]: Evaluate and continuously improve interventions	**Milestone 7** [I-1]: Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Percent decrease in preventable admissions and readmissions into Criminal Justice System. • Goal: Decrease in preventable admissions and readmissions into the Criminal Justice System by 1.5% from baseline for persons encountered by Mental Health Officers. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $2,518,735 **Milestone 8** [P-4]: Evaluate and continuously improve interventions

PROJECT ***138708601.2.2***	***PROJECT OPTION*** ***2.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.)***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.5*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
implementation time frames. Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,331,958 **Milestone 2** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.	Milestone 3 Estimated Incentive Payment: $3,078,454 **Milestone 4** [P-4]: Evaluate and continuously improve interventions Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $334,936		Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $353,205	Metric 1: [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $189,409

PROJECT ***138708601.2.2***	***PROJECT OPTION*** ***2.13.2***	***PROJECT COMPONENT(S)*** ***N/A***	***PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING (I.E., THE CRIMINAL JUSTICE SYSTEM, ER, URGENT CARE ETC.)***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.5*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $390,506				
Year 2 Estimated Milestone Bundle Amount: $3,722,464	Year 3 Estimated Milestone Bundle Amount: $3,413,390		Year 4 Estimated Milestone Bundle Amount: $3,599,575	Year 5 Estimated Milestone Bundle Amount: $2,708,144
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $13,443,573				

Identifying Project and Provider Information:

Integrate Primary and Behavioral Health Care Services, 138708601.2.3, Tropical Texas Behavioral Health/138708601

Project Description:

Integrate primary care and behavioral health care services in order to improve care and access to needed services. TTBH will co-locate primary healthcare clinics at each of our three main behavioral health clinics and, utilizing the physicians and medical support staff assigned to the clinics, increase the volume of medical clearance assessments completed to 45 services by Waiver DY 5. Completing medical clearances internally will improve the quality of care and reduce costs. If the person evaluated for inpatient admission is admitted to TTBH services, detailed medical information may be readily available to the physician completing the medical clearance. This would be especially important if the person served is unwilling or unable to provide accurate information during the crisis. Information from medical clearances gathered internally will be more readily available to behavioral health staff for post-discharge follow-up and if an individual is admitted to outpatient services upon discharge. Completing medical clearances internally will reduce the involvement of law enforcement and the utilization of hospital emergency department resources that are more appropriately dedicated to medical emergencies. It will also allow the evaluation to be completed in a setting that may be familiar to the person in crisis and allow the behavioral health clinicians to facilitate "warm hand-offs" to primary care staff, improving the experience of care. This project addresses community need CN. 3, related to inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:

N/A. Currently, individuals requiring medical clearance for inpatient psychiatric admission are evaluated in hospital emergency departments.

Rationale:

TTBH serves a population with unique health and health care related challenges relative to the rest of the state and the country including the elevated rates of co-morbid chronic disease and substance

abuse experienced by persons with mental illness; numerous health risk factors specific to the population residing along the Texas/Mexico border and in particular, to Hispanics and low-income families within the region; and a confluence of barriers to appropriate care faced by all of these groups. This suggests the considerable benefit potential to those served and to the local and state health care systems of making integrated primary care available at each of the Center's largest behavioral health clinics in the Valley. An additional benefit of the planned integration of primary care will be the ability for TTBH to complete, in-house, medical evaluations to clear individuals in need of inpatient psychiatric hospitalization. Further, use of emergency room resources by individuals with mental illness for non-emergent medical or psychiatric issues has been linked to emergency room crowding and delays in access to treatment for those needing emergency medical care. In 2011, the Bazelon Center for Mental Health Law reported that individuals with mental illness have higher rates of emergency room use and are more likely to use the emergency room on multiple occasions than persons without psychiatric disorders, and that while overall use of emergency rooms in the U.S. increased by 23% between 1997 and 2007 (a much higher rate than would be expected due to population growth), mental health-related emergency room visits during the period from 1992 to 2003 increased by 75%. The report went on to say that a majority of emergency room physicians attributed longer wait times and decreased service capacity in emergency rooms to the increased usage by persons with mental illness. Currently, persons served by TTBH who are in need of medical clearance for psychiatric hospitalization must be transported by law enforcement to hospital emergency departments. Officers must then wait at the emergency room for the clearance to be completed before transporting the person to the applicable inpatient facility. The process results in significant avoidable costs including loss of time and money, safety concerns for the communities served by the officers removed from the field for considerable durations to facilitate the process and the use of hospital emergency department resources that could be dedicated to true medical emergencies. Through this project, TTBH will utilize the physicians, nurses and medical support staff assigned to our planned co-located primary care clinics (referenced in Project 138708601.2.1) to complete medical clearance evaluations in-house during normal business hours. (Refer to Project 138708601.2.1 for information addressing fulfillment of the project option core components as required by the RHP Planning Protocols).

Related Category 3 Outcome Measure(s):

TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only

improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
This project is dependent on the implementation of the Center's project to develop the infrastructure and capacity necessary to integrate preventative primary health care with existing behavioral health services (Project 138708601.2.1), and is linked to the implementation of integrated care management functions to educate persons served about their primary and behavioral health conditions, monitor their response and adherence to treatment and coordinate care (Project 138708601.2.4).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center, the LMHA serving Starr County, to develop and participate in a learning collaborative related to our respective projects to integrate primary and behavioral health care services.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Hospital: According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. From this resource, we gathered psychiatric care data pertaining to our local counties, and calculated a weighted average hospital stay of 5.3 days and a weighted average collection cost of $678.

- Overall Project Valuation: The total project valuation is $106,488.

PROJECT 138708601.2.3	***PROJECT OPTION 2.15.1***	***PROJECT COMPONENT(S) 2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.6*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Develop and implement clinical protocols, program policies and staff training for the completion of medical clearance evaluations in co-located TTBH primary care clinics. Metric 1 [P-X.1]: Submission of medical clearance protocols, program policies and staff training materials. • Baseline/Goal: Baseline N/A, goal is to develop and implement protocols, policies and training to be utilized by medical staff in the co-located primary clinics to complete in-house medical clearance evaluations of individuals in need of inpatient psychiatric hospitalization. • Data Source: Documentation of		**Milestone 3** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Baseline/Goal: As this will be a new service, the baseline of persons receiving the specified service is zero. In FY2012 approximately half of the 1,800 individuals admitted to psychiatric hospitals through TTBH required medical clearances and all clearances were completed in local emergency rooms. The goal is to increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 3%	**Milestone 5** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 4% of the baseline of 900 admissions, to 36 persons served. • Data Source: Encounter data Milestone 5 Estimated Incentive Payment: $29,739 **Milestone 6** [P-7]: Evaluate and continuously improve	**Milestone 7** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals served receiving both physical and behavioral health care at the established locations. • Goal: Increase the percentage of persons receiving medical clearance services in co-located TTBH primary care clinics by 5% of the baseline of 900 admissions, to 45 persons served. • Data Source: Encounter data Milestone 7 Estimated Incentive Payment: $23,073 **Milestone 8** [P-7]: Evaluate and continuously improve

PROJECT ***138708601.2.3***	***PROJECT OPTION*** ***2.15.1***	***PROJECT COMPONENT(S)*** ***2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
	Tropical Texas Behavioral Health			*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.6*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
development and implementation of clinical protocols, program policies and staff training. Milestone 1 Estimated Incentive Payment *(maximum amount):* $15,607 **Milestone 2** [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 • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement.	of the baseline of 900 admissions, to 27 persons served. • Data Source: Encounter data Milestone 3 Estimated Incentive Payment: $28,201 **Milestone 4** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services Metric 1: [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous		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 • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $3,236	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 • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,735

PROJECT ***138708601.2.3***	***PROJECT OPTION*** ***2.15.1***	***PROJECT COMPONENT(S)*** ***2.15.1.a – 2.15.1.j***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.6*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,829	quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $3,068			
Year 2 Estimated Milestone Bundle Amount: $17,436	Year 3 Estimated Milestone Bundle Amount: $31,269		Year 4 Estimated Milestone Bundle Amount: $32,975	Year 5 Estimated Milestone Bundle Amount: $24,808
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $106,488				

Identifying Project and Provider Information:

Expand Chronic Care Management Models, 138708601.2.4, Tropical Texas Behavioral Health/138708601

Project Description:

Develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. TTBH will add 1 Nurse Care Manager to the staff of the primary care clinics co-located at each of our 3 main behavioral health clinics, implement a patient self-management program and increase the number of individuals receiving care management services and who have self-management goals to 300 persons served. TTBH's nurse care managers will coordinate the care of clients with chronic co-morbid medical conditions who are identified as being at elevated risk of deterioration of their medical and/or mental illness; increasing the need for emergency care or other more costly services. Through assessment and the development of a person-centered self-care plan, the care manager will work collaboratively with the person served to help them set goals for improved self-management of their specific condition and to problem solve barriers using community resources, personal support systems and formal treatment services. By maintaining rapport with the person served and their providers, educating the person served about their conditions, monitoring symptoms and communicating findings to the person served and providers, and negotiating solutions to emergent problems, the care managers will help improve the chances that persons served will achieve their self-management and recovery goals. This will result in increased utilization of routine and preventative health services, improved health outcomes and experience of care, and decreased utilization of more expensive emergency interventions by mobile crisis teams, law enforcement and hospital emergency departments. This project addresses community need CN.3, related to inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions.

All services funded by this waiver will be monitored through TTBH's Quality Management (QM) and Utilization Management (UM) structures. The QM/UM programs utilize several internal committees including but not limited to the Performance Improvement and Compliance and Utilization Management Committees, and the support of the Management of Information Systems (MIS) and Quality Management (QM) Departments, to continuously monitor performance indicators related to service quality, health outcomes and business performance through a plan, do, study, act quality improvement process. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against the Center's past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Recommendations for identified performance improvement actions are routed to TTBH's Executive Management and Board of Trustees when necessary. In keeping with TTBH's existing quality improvement structures, and as recommended by the Texas HHSC and the Centers for Medicare and Medicaid Services, prescribed and customized quality improvement process milestones reflecting plan, do, study, act quality improvement cycles have been incorporated into this plan.

Starting Point/Baseline:
N/A. This is an innovative project for TTBH; the Center has not delivered primary care services or care management for co-occurring medical and behavioral health needs previously.

Rationale:
The elevated rates of co-morbid chronic medical illnesses in people with mental illness, the unique challenges they face in effectively managing their illnesses and their high rates of premature mortality relative to the general population have been well documented. In a 2006 technical report on Morbidity and Mortality in People with Serious Mental Illness (SMI), the Medical Directors Council of the National Association of State Mental Health Program Directors suggested that people with SMI die, on average, 25 years earlier than the general population. The report asserted the increased mortality and morbidity rates were largely due to preventable conditions including cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza) and infectious diseases (including HIV/AIDS). The researchers argued that having SMI may be a risk factor and lead to problems in access to health care due to, among other things, the lack of motivation, fearfulness, and social instability of persons with SMI, and the fragmentation of mental health and primary health care systems. Factors identified as placing people with SMI at higher risk of morbidity and mortality included higher rates of smoking, alcohol consumption, poor nutrition /obesity, lack of exercise, unsafe sexual behavior, drug use and exposure to infectious diseases, as well as homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation. The report also cited research suggesting the population of people with SMI had high use of somatic emergency services, fewer routine preventive services, lower rates of cardiovascular procedures and worse diabetes care. For those in the Rio Grande Valley living with mental illness, these health concerns are compounded by the overarching health issues impacting the general population along the Texas/Mexico Border more negatively than other areas of the state and nationally, and in relation to science-based nationally established health benchmarks. Examples include an increased likelihood of being uninsured; difficulty accessing health care; not seeing a physician regularly due to cost or transportation barriers; a decreased likelihood of having routine blood pressure or cholesterol tests; higher rates of kidney disease, liver disease, tuberculosis, diabetes, overweight and obesity; and a higher rate of reported depressive symptoms accompanied by a lower likelihood of seeking mental health treatment. The benefits of integrating primary and behavioral health both from a health improvement and a health system cost perspective have also been demonstrated. A recent study involving the integration of primary care services within a mental health clinic treating veterans with mental illness reported that "enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals." The study found that the veterans who received primary care services co-located within the mental health setting realized "significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI." Researchers have also demonstrated that for populations served in community mental health centers, the implementation of care management delivered in an integrated primary care setting can result in sustainable improvements in physical health outcomes (e.g. cardiovascular risk, physical functioning and pain) and patient and provider satisfaction, as well as significant potential cost savings to health care systems relative to care as usual (i.e., referral to their primary care provider). Similarly, two pilot programs implemented in 2009 by the Pennsylvania Department of Public Welfare and the Center for Health Care Strategies to integrate physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness and co-occurring physical health conditions, including the use

of care navigators to coordinate care and treatment related information sharing between physical and behavioral health providers and promote the early recognition of symptoms that could lead to a decline in physical or mental health, demonstrated success at reducing the rate of mental health hospitalizations, all-cause readmissions and emergency department visits.

Related Category 3 Outcome Measure(s):
TTBH will measure outcomes for each of our proposed projects by assessing the satisfaction of persons served across several treatment and health related domains. Ultimately, the individuals served are at the center of health care delivery reform efforts and their experience of the care they receive is critical. Although a patient's perception of the quality of treatment is influenced by many aspects of their care, a growing body of evidence supports the use of patient satisfaction as a legitimate measure of treatment outcomes. Research has demonstrated strong positive relationships between patients' reported satisfaction and characteristics of the service delivery system including the amount of time providers spend with patients, the amount of information given to the patient, continuity of provider and when providers show personal interest in their patients. Higher levels of satisfaction have also been shown to be predictive of increased adherence to treatment recommendations and increased health-seeking behaviors, while lower levels of satisfaction with and confidence in the quality of services correlates with an increase in complaints and a decreased willingness to seek care, potentially leading to serious health complications. Accordingly, focusing on the satisfaction of those served is directly linked to ensuring that the services provided not only improve the experience of care, but meet the individual needs of the person served and promote wellness and recovery-oriented behaviors in the individual as well.

Relationship to other Projects:
The nurse care managers will be an integral component of the primary care treatment teams that will staff TTBH's co-located primary care clinics, contributing to the integration of primary and behavioral healthcare services (Project 138708601.2.1). In addition to the focus on co-occurring medical conditions, assessments completed by the care managers may identify new or worsening issues necessitating referrals to the Center's expanded COPSD services (Project 138708601.1.2).

Relationship to Other Performing Providers' Projects in the RHP:
TTBH will coordinate with Border Region Behavioral Health Center to develop and participate in a learning collaborative related to our respective projects for the implementation of integrated care management functions for persons with co-morbid chronic diseases and behavioral health disorders.

Plan for Learning Collaborative:
TTBH will host bi-weekly conference calls with regional partners engaged in similar transformation projects to review data, discuss ideas and share challenges, solutions and the results of performance improvement activities. TTBH will make its website available for web-based information sharing and reporting. TTBH will request that the Texas Council of Community Centers consider coordinating bi-annual face-to-face learning meetings related to health care transformation initiatives.

Project Valuation:

- Cost-utility analysis: Measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality-adjusted life years (QALYs) which combines health quality (utility) with length of time in a particular health state. According to

a research by the University of Texas Austin Center for Social Work, the monetary value per life-year gained due to the interventions is $50,000.

- Overall Project Valuation: The total valuation for nurse care managers is $12,360,811.

PROJECT ***138708601.2.4***	***PROJECT OPTION*** ***2.2.5***	***PROJECT COMPONENT(S)*** ***N/A***	***EXPAND CHRONIC CARE MANAGEMENT MODELS***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.7*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-11]: Develop and implement a program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase number of patients enrolled in self-management program. • Baseline/Goal: Baseline is zero (new program). Goal is to develop a plan to co-locate primary care services at TTBH's 3 main clinic locations, implement care management services and enroll 30 individuals in a self-management program. • Data Source: Documentation of work plan and time frames, and client data from EHR.	**Milestone 3** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Baseline/Goal: Baseline is zero (new program). Goal is to increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 50% of persons with the specified condition/MCC. • Data Source: EHR Milestone 3 Estimated Incentive Payment: $2,982,146 **Milestone 4** [P-X]: Evaluate and		**Milestone 5** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Goal: Increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 55% of persons with the specified condition/MCC. • Data Source: EHR Milestone 5 Estimated Incentive Payment: $3,371,354 **Milestone 6** [P-X]: Evaluate and continuously improve	**Milestone 7** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. • Goal: Increase the percentage of individuals with the specified chronic condition/MCC in the registry with at least one recorded self-management goal to 60% of persons with the specified condition/MCC. • Data Source: EHR Milestone 7 Estimated Incentive Payment: $4,838,120 **Milestone 8** [P-X]: Evaluate and continuously improve

PROJECT ***138708601.2.4***	***PROJECT OPTION*** ***2.2.5***	***PROJECT COMPONENT(S)*** ***N/A***	***EXPAND CHRONIC CARE MANAGEMENT MODELS***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.7*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment *(maximum amount):* $102,133 **Milestone 2** [P-X]: Evaluate and continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 2 Estimated Incentive Payment *(maximum amount):* $11,970	continuously improve services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 4 Estimated Incentive Payment *(maximum amount):* $324,457		services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 6 Estimated Incentive Payment *(maximum amount):* $366,804	services Metric 1: [P-X.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles • Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment *(maximum amount):* $363,827

PROJECT ***138708601.2.4***	***PROJECT OPTION*** ***2.2.5***	***PROJECT COMPONENT(S)*** ***N/A***	***EXPAND CHRONIC CARE MANAGEMENT MODELS***	
Tropical Texas Behavioral Health				*138708601*
Related Category 3 Outcome Measure(s):	*138708601.3.7*	*3.IT-6.1*	*Patient Satisfaction (Percent improvement over baseline of patient satisfaction scores)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $114,103	Year 3 Estimated Milestone Bundle Amount: $3,306,603		Year 4 Estimated Milestone Bundle Amount: $3,738,158	Year 5 Estimated Milestone Bundle Amount: $5,201,947
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $12,360,811				

UT Health Science Center-San Antonio (UTHSCSA) - Category 1: Infrastructure Development

Unique Project ID: 085144601.1.1

Project Option 1.2.4 - Establish Primary Care/Internal Medicine Residency Training Program at Valley Baptist – Harlingen

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

PROJECT DESCRIPTION

The primary goal of this DSRIP project is to increase the number of primary care providers (i.e., physicians, residents) in RHP 5 by expanding and deepening the existing internal medicine residency program sponsored by the Regional Academic Health Center of The University of Texas Health Science Center San Antonio (UTHSCSA-RAHC). The project will build on the partnership among UTHSCSA-RAHC, Valley Baptist Medical Center – Harlingen (VBMC-H), Su Clinica Familiar (Su Clinica), and the Veterans Administration Coastal Bend Health System (VA) to expand the training program from its current 15 residents (5 in each year of the 3-year program) to a capacity of up to 30 (10 per year), and will expand the full time faculty leadership and staff in the program commensurately. It will build on the success of the program in training clinicians who locate their practices in RHP 5, helping to alleviate the area's substantial primary care workforce shortage and will update the training program to include more organized care delivery models and related research and scholarly work. The new faculty (over the near term), and new resident trainees (over the medium term), and graduates (over the longer term) will expand the workforce, allaying the shortage of primary care providers thereby reducing delays in care seeking, reducing inappropriate and costly emergency department utilization, and increasing patient satisfaction. It will complement the other existing and new residency programs of UTHSCSA-RAHC and be a foundational element for development of the UTHSCSA-RAHC into a full four-year medical school in RHP 5 as envisioned by the Texas legislature and planned by the Regents. The Texas 1115 Medicaid waiver provides an important opportunity to increase access to primary care through increasing the number of primary care physicians and expanding the pipeline of well trained and culturally aware physicians for the underserved RHP5.

Additional Project Goals: Beyond the goal of expanding the RHP5 primary care workforce to increase access and capacity, this expansion is designed to strengthen an integrated health care system and to play a key role in implementing disease management programs, through:

- implementing an innovative curriculum that incorporates population health management, chronic disease management, and clinical safety and effectiveness training;
- conducting quality improvement projects to continuously improve clinical outcomes and efficiency; and
- collaborating with other new and expanding residency training programs in the region to transform the delivery system for the South Texas community.

A greater focus on primary care will be crucial to the success of an improved, reformed and more integrated health services delivery system in which patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

Relationship to Regional Goals:
This project will advance achievement of regional goals identified in RHP 5:

- By combining the resources of a major safety net hospital, VBMC-H; safety net ambulatory care provider, Su Clinica; the VA; and The University of Texas, leverage and improve on existing programs and infrastructure to ensure that the health delivery system will be adequately developed to meet the primary care needs of residents throughout a rapidly growing, yet historically underserved region.
- Increase access to primary care services in the short-term with new faculty, in the intermediate term also with resident trainees, and in the long-term also with graduate physicians, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition.
- 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.
- 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 existing health care system.

Challenges or Issues faced:
At the dawn of the implementation of health care reform, Texas is experiencing a dramatic shortage of primary care workforce including physicians and a dearth of medical students choosing careers in primary care. South Texas has long been a medically underserved region, and is particularly underserved for primary care with 55 physicians per 100K population compared to 70 per 100K in Texas (80% of Texas average). Similarly there are 103 direct care physicians per 100K in RHP5 compared 165 per 100K in Texas. The need for enhanced primary care resources in Region 5 is challenging.

Designing interventions to meet the need also is challenging. Doubling the size of the existing internal medicine residency will require approval by the Internal Medicine Residency Review Committee (RRC), which meets only three times each year to review well documented requests that must be submitted at least two months prior to the meeting. Approval for expanding the program must be obtained before the program can recruit more than 5 residents to enter the next year's class. Over the past several years, the RRC's requirements for program accreditation have become increasingly specific on requirements for protected academic time for core faculty members, scholarly activity by faculty and residents, and limitations on the work hours and schedules for residents. Meeting these requirements in an expanded program will require the hiring and development of a cadre of full-time UTHSCSA-RAHC faculty who will become the faculty core for the program, taking over a range of duties formerly performed by community volunteer faculty.

How the Project addresses these Challenges

Expanding the faculty physicians who will provide patient care services and expanding the pipeline of primary care physicians through this project is an important part of the solution to the constellation of health problems documented in the RHP-5 Health Needs Assessment. To meet the challenges of accrediting the expanded program, UTHSCSA-RAHC will draw on its strong and successful history of relationships with VBMC-H, Su Clinica and the VA; its ability to recruit faculty nationally; and the extensive experience of UTHSCSA faculty and staff with accreditation processes.

Five-year expected outcomes:
By the end of the Demonstration Period in September 2016, increase the number of internal medicine residents from 15 to 25 (toward 30 in full development), increase in the full-time Core faculty in the program commensurately, and increase access to primary care through expansion of the continuity clinic now in operation and new ambulatory care established by the new full time faculty.

STARTING POINT/BASELINE

Currently, December 2011, the benchmark for internal medicine residents is 15 (5 per year in a three-year training program). The other UTHSCSA-RAHC primary care residency in RHP5 is the family medicine program in Hidalgo County, which provides training for 18 residents (6 per year in a three-year training program).

RATIONALE

Reasons for selection this project option. Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians—especially in South Texas.

The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population -- a state ranking of 46 and 47, respectively. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce, however, grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry level GME positions offered in Texas in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage.

In South Texas excluding Bexar County, there are only 43 primary care physicians per 100,000 population, according to an April 2012 report by the Texas Higher Education Coordinating Board. This compares to 65 per 100,000 for greater South Texas including Bexar County and 78 per 100,000 for Central Texas.

The pool of undiagnosed and untreated chronic disease in RHP5 is a social, economic and psychological drain on this population and represents one of the most substantial levels of health disparities in the country. This has a great impact on the community and affects its ability to improve its levels of education and economic productivity. The extremely low level of primary care providers in RHP5 makes it even more imperative to increase access to primary care for those with undiagnosed and untreated chronic diseases. One of the most cost saving measures that can be taken is to expand primary care to move people with undiagnosed and untreated chronic disease to programs for management and prevention the keep them from costly complications that promote eventual presentation at emergency care facilities and to being hospitalized with advanced disease.

Project components:

- Identify high impact services and gaps in care and coordination
- Recruit Internal Medicine Associate Program Director and full-time core faculty
- Implement innovative curriculum including population health management, chronic disease registries, team-based community care, data analytics, and quality improvement projects using the PDSA and other methodologies contained in the UT System Clinical Safety & Effectiveness (CS&E) course
- Attain ACGME approval for the program
- Recruit and enroll Internal Medicine residents

Unique community need identification number the project addresses:

- CN.1 – Shortage of primary and specialty care providers and inadequate access to primary or preventive care

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

The Internal Medicine residency training program has had good success in producing graduates who have remained in RHP-5 to provide primary care services. Expansion of the program seeks to expand on that success. It also will expand the ability of the residents and faculty to provide primary care services through the continuity clinic organized at Su Clinica as well as providing comprehensive follow-up care for previously undiagnosed patients admitted to VBMC. The faculty for the Internal Medicine residency program will collaborate with the faculty for the new and existing training programs throughout RHP 5. Expansion of the program faculty also will allow enhancement of the program through greater scholarly activity focused on the clinical conditions especially prominent in RHP 5 and greater involvement of faculty and residents in quality improvement efforts at VBMC.

Data Driving this Project:

The need for enhanced primary care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally (http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer. The underlying conditions are essentially preventable or treatable. The long term cost of neglect will be huge. Prevention and early intervention are key. These health needs need to be first addressed through primary care, providing diagnosis, preventive care and simple interventions for patients before their disease is advanced. Expansion of the residency program and its faculty will allow RHP5 to make significant progress toward this end.

Related Category 3 Outcome Measure(s): OD-14 Primary Care Workforce

Stand-alone:

IT - 14.1 Number of practicing primary care practitioners per 1,000 individuals in HPSA or MUA

Non-stand-alone but related:

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

Rationale for selecting the outcome measures:

It is challenging to select outcome measures in the early stages of planning the residency program, given the lack of clarity and complete plans about when and where faculty will practice, the part-time nature of that practice, and the fact that three or more years of training are required before the first-matriculated residents will begin independent clinical practice.

Because the Associate Program Director and core faculty be recruited and in place even before the programs are accredited and will dedicate 25-50% of their time to clinical care, they will have an impact on the number of practicing primary care practitioners per 1,000 individuals in RHP-5.

The bundle of three non-standalone measures above, in the program's experience to date, is a set of strong predictors of the future decisions of residents in the program to enter practice in RHP5 or elsewhere in South Texas.

Relationship to other Projects:
The project is related to UTHSCSA's Projects in RHP 5:

- 085144601.1.2 Expand high impact specialty care capacity in Behavioral Health at Valley Baptist - Brownsville; and
- 085144601.1.3 Increase faculty to support an expanded Family Medicine residency program at McAllen Medical Center.

Relationship to Other Performing Providers' Projects in the RHP:
This project is related to the following projects by other performing providers in RHP5 (all at Doctors Hospital at Renaissance):

- 160709501.1.1 Establish Primary Care/Internal Medicine Training Program;
- 160709501.1.2 Establish Primary Care/Family Medicine Training Program;
- 160709501.1.3 Establish Primary Care/Obstetrics & Gynecology Training Program; and
- 160709501.1.4 Expand high impact specialty care capacity in most impacted medical specialties (Establish General Surgery Training Program).

Plan for Learning Collaborative:

All of the new and existing residency training programs in RHP 5 will be/are directed by UTHSCSA faculty. The University of Texas System and UTHSCSA, specifically, have a nationally known Clinical Safety & Effectiveness (CS&E) training program embedded in their medical schools and clinical facilities. In addition, UTHSCSA requires all new resident trainees to complete the core curriculum of the IHI Open School prior to joining the training programs. In addition, all of the residency training programs will feature innovative curriculum components focused on population health management, team-based community care, the use of chronic disease registries, and the application of data analytics. The Program Directors will meet quarterly to discuss and share quality improvement efforts within the context of the CS&E program as well as the common core curriculum components related to population health management, chronic disease registries, team-based community care, and data analytics.

Project Valuation:
South Texas has historically been a medically underserved area and as documented above Region 5 has a very large pool of undiagnosed chronic disease that leads to high rates of emergency visits and admissions that could be avoided through primary care. The University of Texas System has committed to expand medical education in South Texas and graduate the first class of medical students in 2018. These graduates will be far more likely to stay and practice in south Texas if they complete their residency training programs locally. This residency expansion project, along with the

other new and expanding residency projects in RHP5, can transform the medical community and the healthcare delivery system in South Texas. With innovative curricula designed to meet community needs, UT faculty will train new physicians for practice, engage community physicians as preceptors, and embed the UT Clinical Safety & Effectiveness program in local hospital quality improvement efforts.

[Unique Category 1 Project Identifier, e.g. Project 085144601.1.1	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]* *1.2.4*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Milestone 1 [P-1]: Conduct a primary care gap analysis to determine workforce needs. <u>Metric 1</u> [P-1.1]: Gap assessment of workforce shortages and delivery system, i.e., patient-centered medical homes, disease registries, HIE. Goal: Produce a comprehensive report documenting existing and needed primary care	**Milestone 3** [P-2]: Expand primary care training for primary care physicians <u>Metric 1</u>: [P-2.1]: Expand the primary care training program Baseline: Program limited to 15 residents at the beginning of DY2. Goal: Application for increase to 30 residents to be submitted by 2/2014 for Residency Review Committee (RRC) 9/2014 meeting Data Source: Training	**Milestone 6 [**P-10]. Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents to 30. <u>Metric 1</u> [P-10.1] Documentation of ACGME approval for residency position expansion Baseline: Program limited to 15 residents at the beginning of DY2. Goal: receive GME approval for expansion Data Source: Training program records	**Milestone 10** [I-11]: Increase primary care training and/or rotations. <u>Metric 1</u> [I-11.4]: Increase the number of primary care residents in training. Baseline: Program limited to 15 residents at the beginning of DY2 Goal: Recruit second cohort of 5 additional residents as of 7/15/2016. Total residents in program = 25. Data Source: Program enrollment	

[Unique Category 1 Project Identifier, e.g. Project 085144601.1.1	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]* *1.2.4*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
resources. Data Source: Assessment results. Milestone 1 Estimated Incentive Payment*:* $699,794 **Milestone 2** [P-2]: Expand primary care training for primary care internal medicine providers: Metric 1 [P-2.2]. Hire Associate Program Director and 2 additional Core full-time faculty members.	program records Metric 2 [P-2.2]. Hire 2 additional Core full-time faculty members. Baseline: At the beginning of DY 2, the program has no Associate Program Director or Core full-time faculty Goal: build the Core full-time faculty to begin the application to the RRC for program expansion Data Source: HR documents, faculty lists Milestone 3 Estimated Incentive Payment*:* $1,175,610	Milestone 6 Estimated Incentive Payment*:* $543,674 **Milestone 7 [**P-2]. Expand primary care training for primary care internal medicine. Metric 1 [P-2.2]. Hire 1 additional Core full-time faculty member. Baseline: At the beginning of DY 2, the program has no Associate Program Director or Core full-time faculty Goal: build the Core full-time faculty to begin the application to the RRC for program expansion Data Source: HR documents,	records. Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Inpatient rotations from program records. Milestone 10 Estimated Incentive Payment*:* $2,349,723 **Milestone 11** [I-15]: Increase	

[Unique Category 1 Project Identifier, e.g. Project 085144601.1.1	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]* *1.2.4*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
Baseline: At the beginning of DY 2, the program has no Associate Program Director or Core full-time faculty Goal: build the Core full-time faculty to begin the application to the RRC for program expansion Data Source: HR documents, faculty lists Milestone 2 Estimated Incentive Payment*:* $699,794	**Milestone 4** [P-3]: Expand positive primary care exposure for residents. <u>Metric 1</u> [P-3.3] Include residents in quality improvement projects. Baseline: No specific training experience incorporated with the hospital exists currently. Goal: Resident participation in QI efforts. Data source: Curriculum or QI project documentation.	faculty lists Milestone 7 Estimated Incentive Payment*:* $543,674 **<u>Milestone 8 [</u>**I-11]. Increase primary care training and/or rotations. <u>Metric 1</u> [I-11.4]. Increase the number of primary care residents in training Baseline: Program limited to 15 residents at the beginning of DY2. Goal: Demonstrate improvement over prior reporting period (baseline for DY2): recruit 10 residents into the PY1 class beginning 7/1/2015; residents in	primary care training in Continuity Clinics. <u>Metric 1</u> [I-15.1]: Increase number of Continuity Clinic sessions available for primary care residents. Goal: Documented increase over baseline and as compared to DY 4. Data Source: Number of resident continuity clinic sessions from program records Milestone 11 Estimated Incentive

[Unique Category 1 Project Identifier, e.g. Project 085144601.1.1	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]* *1.2.4*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	Milestone 4 Estimated Incentive Payment: $587,805 **Milestone 5** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Goal: Two full-time faculty members complete the CS&E	program to 20. Data source: Program records Milestone 8 Estimated Incentive Payment: $1,087,348 **Milestone 9** [I-15]: Increase primary care training in Continuity Clinics. <u>Metric 1</u> [I-15.1]: Increase number of Continuity Clinic sessions available for primary care residents. Baseline: In DY2, continuity clinic sessions are limited to those required for 15 residents.	Payment: $2,174,696 **Milestone 12** [I-14] Increase the number of faculty staff completing educational courses. <u>Metric 1</u> [I-14.1] Number of faculty staff completing Clinical Safety & Effectiveness (CS&E) course. Goal: Two full-time faculty members complete the CS&E training. Data Source: Program records.	

[Unique Category 1 Project Identifier, e.g. Project 085144601.1.1	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]* *1.2.4*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
	training. Data Source: Program records. Milestone 5 Estimated Incentive Payment: $587,805	Goal: Documented increase over baseline and as compared to DY 3. Data Source: Number of resident continuity clinic sessions from program records Milestone 9 Estimated Incentive Payment: $2,174,696	Milestone 12 Estimated Incentive Payment: $587,805	
Year 2 Estimated Milestone Bundle Amount: $1,399,588	Year 2 Estimated Milestone Bundle Amount: $2,939,025	Year 4 Estimated Milestone Bundle Amount: $4,349,392	Year 5 Estimated Milestone Bundle Amount: $5,112,224	

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT 085144601.1.1	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 1.X.X]* *1.2.4*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G. 1.X.X.X]*	*[PROJECT TITLE]:* Expand Primary Care/Internal Medicine Training Program at Valley Baptist - Harlingen	
[RHP Performing Provider involved with this project - UTHSCSA]				*[RHP Performing Provider - TPI]:* 085144601
Related Category 3 Outcome Measure(s): ***TBD (awaiting HHSC/CMS)***	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $13,800,228				

Identifying Project and Provider Information:

085144601.1.2

Include: title of project, unique RHP project identification number (e.g. [TPI].1.1),
Performing Provider name/TPI: UTHSCSA/085144601
Project Option: 1.9.1: Expand high impact specialty care capacity in Behavioral Health

Project Description:

The primary goal of this DSRIP project will be to establish a psychiatry residency program within the University of Texas Regional Health Campus, a site designated by the UT Reagents and the Texas Legislature as being the site of a future Medical School in Region 5 of South Texas. This residency will complement the existing residency programs in internal medicine and family and community medicine in the Region, programs that have excellent track records in training outstanding physicians who go on to careers as primary care clinicians for this medically underserved population with major health disparities. As the program matures and the number of faculty and local psychiatrists grow, multidisciplinary clinical programs will emerge to meet the regional behavioral health needs.

A.2 Describe Challenges:

At the dawn of the implementation of health care reform, Texas is experiencing a dire shortage of behavioral health workforce including physicians. South Texas has long been a medically underserved region, and is particularly underserved for behavioral health with 2.8 psychiatrists per 100,000 population and virtually no child psychiatrists compared to the entire state of Texas that has 6.8 psychiatrists per 100,000 population. Similarly there are 9.2 psychologists per 100,000 in RHP5 compared to 25.8 per 100,000 in Texas. The DSRIP process of the Texas 1115 Medicaid waiver provides an important opportunity to increase the number of behavioral health physicians with an emphasis on creating a pipeline of well trained and culturally aware physicians for the Rio Grande Valley region. In Region 5, one out of every five adults reports that their mental health is fair or poor, which is much worse than the national average. Given that the region is among the poorest in the US, and that the burdens of chronic disease and poverty are high, it is not surprising that mental health is an issue. National data show that when mental illness co-occurs with general medical illnesses such as diabetes, cardiovascular disease, rheumatoid arthritis, or cancer, morbidity and mortality is greater. In studies carried out in the region, the level of measurable depression and anxiety is 29% and 30% of the adult population, respectively, (CCHC unpublished data). The self-reported low ratings of mental health are particularly significant among women (overall), people over age 40 (often associated with a chronic illness such as diabetes or heart disease), and the poorer Hispanic population (Needs Assessment of RHP5). Depression and anxiety were significantly associated with greater BMI and waist circumference, and less physical activity. Depression was positively associated with fasting glucose. Similarly, anxiety was positively associated with elevated HbA1c. Consistent with the lack of access to health services, particularly behavioral health services, only about half of people who report behavioral health problems have sought any help. Because of the lack of mental health services, the last resort is usually a hospital emergency room, when the problem becomes overwhelming, and as a result also increases cost and resource utilization.

A.2.1 how the project addresses these challenges

In order to be competitive and to meet full requirements for accreditation, this program will have more than the minimum number of residents per year and include both adult and child and adolescent training components. There is a total dearth of local information on child mental health, particularly on autism spectrum disorders and the ADHD complex of conditions. Thus a child psychiatry program will focus on defining the problem as well as on developing interventions. One proven strategy to increase behavioral health resources is to establish robust training programs in underserved regions, especially those that train psychiatrists.

A.3 How is the project related to Regional Goals?

A major regional goal is to increase the number of behavioral health professionals and to create a pipeline for continuing to develop and supply behavioral health professionals. This program achieves that goal.

A.4 5-year expected outcomes:

An approved Psychiatry residency program, the first and only in the region
7 new faculty preceptors in Psychiatry residency
14 psychiatry residents

Reasons for selecting the project option:

Project components (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project)

B.1 Identification of high impact/most impacted specialty services and gaps in care and coordination

B.2 Increase in number of residents/trainees choosing targeted shortage specialties

B.3 Design of workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention)

B.5 Activities: identifying project impacts, i “lessons learned,” opportunities to scale all or part of the project to a broader patient population, key challenges associated with expansion of the project, including special considerations for safety-net populations.

How does the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative. Projects should be data-driven and based on community needs and local data

D Innovation: new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative, including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services

Starting Point/Baseline:

e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.Current baseline is zero cause there are no pscychiatry residents now, correct?

F. Describe the specific challenge(s) faced, such as a specific gap, need, or issue.

F.1 Over 20% of RHP5 adults characterize their mental health as less than good. There is a very high rate of chronic disease, particularly diabetes, in the population and in an ongoing study chronic illness is associated with higher levels of depression and anxiety. There are only 2.8 psychiatrists per 100,000 population; 40% of the average in Texas. This program is aimed at developing a pipeline of psychiatrists by establishing both adult and child/adolescent residency training programs in RHP5.

Rationale:

F.2 Describe the major delivery system solution(s) identified to address the challenge(s) by implementing the particular project, including how the project will work to fill the gap/need or solve the issue.

Creation and expansion of residency programs for psychiatry residents will not only increase the available service to the population, but those who complete the training have a high likelihood of practicing in the region.

F.3 Describe the starting point of the Performing Provider related to the project, such as a benchmark, if one exists, and/or the baseline on or around December 1, 2011 for the Improvement Measures.

Currently there are no psychiatry residents, few child psychiatrists, and only 2.8 psychiatrists per 100,000 population in Region 5. These unfortunate figures represent the starting point benchmark for the improvement measures of this project.

G.4 Describe the overall target goal and the significance of that goal to the Performing Provider, the RHP, and patients.

The target goals include 1) Recruitment of an Adult Psychiatry Program Director, Child and Adolescent Psychiatry Program Director, four adult psychiatry faculty members, and two child and adolescent psychiatry faculty members.; 2) Submission of a proposal (Program Information Form (PIF)) for the residency program to the national accrediting body, the Accreditation Council for Graduate Medical Education (ACGME) and obtaining approval; and 3) begin recruiting and training

psychiatry residents in both the adult and child and adolescent programs. Program approval by the ACGME and matriculation of the first cohort of residents is planned for July 2015. As a four year program, the first cohort of 5 adult program residents will graduate in 2019. Child and adolescent training includes two years? of training and candidates must have completed two years of adult psychiatry training before matriculating into a child and adolescent program. Candidates have the option to count one of the years of child and adolescent training towards the four years required for adult certification, so most psychiatrists that complete training in child and adolescent psychiatry will have had a total of 5 years of training (3 adult + 2 child). Most often, residents within a program will transfer from the adult program to the child and adolescent program, doing so in either the Post Graduate Year–3 (PGY-3) or PGY-4 year. This internal attrition usually results in 1-2 less residents remaining in the adult program by the PGY-4 year. Matriculation into the child and adolescent program will begin in July 2015 with 2 residents. The first cohort of child and adolescent residents will complete their training in 2017. By the time both programs reach maturity, they will be graduating 4-5 adult and 1-2 child and adolescent psychiatrists per year. This will increase the number of psychiatrists per 100,000 population to a level much closer to the average for all of Texas (6.8) in a few short years, providing a much needed increase in behavioral health service capacity. Child and adolescent psychiatrists are board certified practitioners of adult psychiatry as well

H Describe reasons for selecting this project, milestones, metrics, improvements, and targeted goals based on relevancy to the Performing Provider's population and circumstances, community need, and Performing Provider's priority and starting point.

There is a large actual and identified need by the community of RHP5 for increased availability of behavioral health services. Psychiatrists are the anchors for these services. The poor population in this region has a high level of reported less than good behavioral health, and this is supported by data on depression in this population with high levels of chronic disease and disabilities from the chronic disease. This has a great economic and social impact on the community and affects its ability to improve its levels of education and economic productivity.

Related Category 3 Outcome Measure(s):

IT-1.9 Depression management[231] : Depression Remission at Twelve Months (NQF# 0710)[232]
(Standalone measure)
a Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
b Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
□ Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

c Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records
[231] http://

Relationship to other Projects:

A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

Relationship to Other Performing Providers' Projects in the RHP:

If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

Plan for Learning Collaborative:

Project Valuation:

A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.

[Unique Category 1 Project Identifier, e.g. Project [TPI].1.2]	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-1. Milestone: Conduct specialty care gap assessment based on community need. Metric 1 P-1.1. Documentation of gap assessment. (baseline for DY2). Baseline: 0 faculty and 0 residents at baseline. Data Source: Needs assessment Estimated Incentive Payment:	**Milestone 3** P-16. Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of TSC residents Metric 3 P-16.1. ACGME approval for residency position expansion a. Number of newly approved TSC residency slots. Goal: ACGME approval. Data Source: Documentation of ACGME approval for residency.		**Milestone 5** P-14 Expand targeted specialty care (TSC) training in psychiatry. Metric 5 P 14.2 Hire additional precepting TSC faculty members. a. Number of additional training faculty members. Goal: Increase faculty over year 3 by 2 faculty. Data source: HR documents, residency documents. Milestone 5 Estimated	**Milestone 7** P-14 Expand targeted specialty care (TSC) training in psychiatry. Metric P 14.2 Hire additional precepting TSC faculty members. a. Number of additional training faculty members. Goal: Increase faculty over year 4 by 2 faculty. Data source: HR documents, residency documents. Milestone 7 Estimated

[Unique Category 1 Project Identifier, e.g. Project [TPI].1.2]	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 P-14 Expand targeted specialty care (TSC) in psychiatry. Metric 2 P-14.1. Metric: Expand the TSC residency clinician training programs and/or rotations. Goal: Complete and submit applications and agreements for psychiatry residency approval. Data: Documents submitted. a. Documentation of applications and agreements to expand training programs	Estimated Incentive Payment: **Milestone 4** P-14 Expand targeted specialty care (TSC) training in psychiatry . Metric 4 P 14.2 Hire additional precepting TSC faculty members a. Number of additional training faculty members Goal: 2 new faculty preceptors. Data source: HR documents, residency documents.		Incentive Payment: **Milestone 6** I-31. Milestone: Increase TSC training and/or rotations (must select one of the following): Metric 6 I-31.1. Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline. . a. Percent increase of psychiatry resident class size. Goal: 7 new residents. Data: Documented enrollment	Incentive Payment: **Milestone 8** I-31. Milestone: Increase TSC training and/or rotations (must select one of the following): Metric 6 I-31.1. Increase the number of TSC residents and/or trainees, as measured by percent change of class size over baseline. . a. Percent increase of psychiatry resident class size. Goal: 7 new residents. Data: Documented enrollment

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT [TPI].1.2]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 1.X.X]*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G. 1.X.X.X]*	*[PROJECT TITLE]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	.		by class by year by psychiatry training Program. Milestone 6 Estimated Incentive Payment:	by class by year by psychiatry training Program. Milestone 8 Estimated Incentive Payment:
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: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $				

Identifying Project and Provider Information

085144601.1.3
Title: New faculty for family medicine residency
Increase training of Primary Care Workforce
Project identification number1.2.3
Performing provider name SOM/RAHC - 085144601
Unique community need identification number
Project address

Project Description:

The primary goal of this DSRIP project is to increase the number of primary care providers (i.e., physicians). The project will expand the RHP5 primary care workforce, increasing access and capacity. This will occur by providing more faculty to improve the quality and variety of training of family medicine residents and build a program that can eventually be expanded to train more residents. These faculty will therefore increase access to health services through the new clinics that they conduct in the course of training family medicine residents, as well as in the clinics created to train the residents in a wider variety of primary care areas. This project applies to primary care providers in Family medicine. The Texas 1115 Medicaid waiver provides an important opportunity to increase access to primary care through increasing the number of primary care physicians with an emphasis on creating a pipeline of well trained and culturally aware physicians for the underserved Rio Grande Valley region (RHP5). This expansion will be an important part of the programs in integrated care that will be conducted in parallel to strengthening the family medicine residency. These include a chronic disease management program in multiple hospitals, and prevention programs in several communities. An improved primary care training program is crucial to the success of an improved, reformed and more integrated health services delivery system. It will also 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.

Challenges or Issues faced:

Texas is experiencing a dramatic shortage of primary care workforce including physicians and a dearth of medical students choosing careers in primary care. South Texas has long been a medically underserved region, and is particularly underserved for primary care with 55 physicians per 100K population compared to 70 per 100K in Texas (80% of Texas average). Similarly there are 103 direct care physicians per 100K in RHP5 compared 165 per 100K in Texas.

The need for enhanced primary care resources in Region 5 is challenging. The region has a very large pool of undiagnosed chronic disease including diabetes, hypercholesterolemia, liver disease and hypertension. Seventy five percent of all adults have one or more of these conditions. About 48% of the adult population is obese contributing substantially to the 31% prevalence of diabetes in adults, half of whom are undiagnosed. Out of those 49% who know they have diabetes only half are on

treatment. Forty nine percent have serum cholesterol above 200 mg/dl and only half are even aware of their condition. Among those who do know only 15% are on any treatment regimen. Similarly over 45% of people have elevated liver enzymes and virtually all are unaware of their status. Yet the rate of chronic liver disease, primarily attributable to obesity-related non-alcoholic fatty liver disease (NAFLD) is one of the highest in the nation. Finally 32% of the adult population is hypertensive, 15% of whom are not aware of their condition. Even among those who are aware nearly half are not on medication. Given that the region is among the poorest in the US, and that the burdens of chronic disease and poverty are high, with insurance rates only about 30%, it is not surprising that a large pool of undiagnosed and untreated chronic disease persists.

How the Project addresses these Challenges

Part of the solution to this constellation of health problems is to increase access to primary care by expanding the primary care faculty who will provide improved training, but will ultimately help increase the pipeline for the future needs. The enlarged faculty will improve the quality of training of family medicine residents and ultimately provide the foundation for increasing the number of physicians in the Family Medicine Residency of the Regional Academic Health Center in Region 5 and begin to reduce the current disparity of primary care physicians in RHP5.

Five-year expected outcomes:

Increase in the Family medicine faculty by 6.
Increase access to primary care through the new or expanded clinics established by the new faculty.
Increase in the knowledge base and quality of training of family medicine residents.

How the project is related to Regional Goals

A major regional goal is to increase the number of primary care professionals and to create a pipeline for continuing to develop and supply such professionals. This program achieves that goal.

- Increased Family medicine faculty
- Increased number of people seen in the clinics created by the new faculty.
- Improved quality of training of residents by increasing the faculty

Starting Point/Baseline: *(e.g., number of clients currently served by project; percent of providers trained in project; number of encounters. Indicate time period for baseline.)*

Currently, December 2011, the benchmark for Family medicine faculty is XX . The overall RHP5 benchmark of primary care physicians is 55/100,000 compared to 70 in Texas.

Rationale:

Reasons for selection this project option. Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this waiver. It is difficult to recruit and hire primary care physicians—especially in South Texas.

The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. 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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. From 2002 to 2011, Texas increased medical school enrollment 31% from 1,342 to 1,762 in line with the national call by the Association of American Medical Colleges to increase medical school enrollments by 30%. In 2011, there were 1,445 medical school graduates. Coincidentally, there were 1,445 allopathic entry -level GME positions offered in the annual National Resident Matching program. (There were 31 osteopathic slots.) The Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level GME positions for each Texas medical school graduate. The number of Texas medical school graduates is expected to peak at over 1,700 in 2015. This implies a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's physician shortage. RHP5 is poorly served. The rate of Primary Care Physicians per 100,000 Population varies by region from 43 (South Texas) to 78 (Central Texas). Resident physicians provide low-cost care to needy populations and tend to remain in the state in which they complete their residency training.

The amount of undiagnosed and untreated chronic disease is a social, economic and psychological drain on this population. and represents one of the most substantial levels of health disparities in the country. This has a great impact on the community and affects its ability to improve its levels of education and economic productivity. The high level of those with undiagnosed and untreated chronic diseases and the low level of primary care providers make it imperative to increase the number of family practice physicians. Providing more primary care to a population with undiagnosed and untreated chronic disease should result in savings from reduced emergency room and inpatient utilization when costly complications are avoided with early treatment. Project components: (if the selected project option includes required core project components, all required core components must be included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components are not included in the project),

Milestones and metrics: *(based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point.)*

Unique community need identification number addressed.This project addresses Community need number (insert number and description.

New initiative or significantly enhancing existing delivery system reform initiative (*including any initiatives that may have related activities that are funded by the U.S Department of Health and Human Services)*

Data Driving this Project: Community needs

The need for enhanced primary care in this health disparity population is difficult to overstate and is extensively documented. Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas and 13.8% nationally: http://quickfacts.census.gov/qfd/states/00000.html). Currently only 31.4% of RHP5 citizens have insurance of any kind, more than half of which is Medicare or Medicaid. Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia are diagnosed. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and diabetes leading to liver failure and liver cancer. We have unpublished data showing that prevalence of cancers associated with obesity and diabetes such as gut cancers is high. Some more unusual cancers are more common than elsewhere, particularly stomach, liver and ovarian cancers. The underlying conditions are essentially preventable or treatable. The long term cost of this neglect will be huge.

Prevention and early intervention are key. These health needs should be addressed through access to high quality primary care, providing diagnosis, preventive care and simple interventions for patients to prevent progression to advanced disease. 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. (Comparable ratios for US Total are 219.5 and 90.5, respectively.) From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Primary care physician workforce grew only 25% in the same period. The addition of more faculty for training family medicine physicians to achieve these prevention and disease control goals is essential for RHP5. These new faculty will be key to improving the quality of resident training and to prepare for future expansion of the residency. As stated above, there is a need for 400 additional GME positions by 2015. The shortage of GME positions or residency slots may be the single most problematic bottleneck in Texas' efforts to alleviate the state's primary care physician shortage.

Related Category 3 Outcome Measure(s):

(Data supporting why these outcomes are a priority for the RHP; Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
Explanation of how focusing on the outcomes will help improve the health of low-income populations.)

The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated. In years 2 and 3, Milestone 1 ……..data, Milestone 2 ……., Milestones 3 and 4 ……Milestone 5 ……..and milestone 6 …….. Milestones 9 and 10 increases the number of referrals and avoidable emergency department visits or hospitalizations…….

Evolving from these milestones, Category 3 outcome measures will be:

Stand-alone: ……..
Non-stand-alone but related: …….

Relationship to Other Projects:

(*A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.)*

Provides the primary care which will be needed by patients entering the health care system from the Mobile Clinic, Patient Navigator project.

Works with primary medical care homes

Relationship to Other Performing Providers' Projects in the RHP:

(*If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP)*

Plan for Learning Collaborative: (*If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.)*

Project Valuation:

[Unique Category 1 Project Identifier, e.g. Project [TPI].1.3]	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 P-2. Expand primary care training for primary care providers in a Family Medicine residency: Metric 1 P-2.2. Hire 2 additional precepting primary care faculty members. a. Documentation: Increased number of additional training faculty/staff members b. Data Source: HR documents, faculty lists, or other documentation Goal: Increase Family medicine faculty by 2	**Milestone 2** P-2. Milestone: Expand primary care training for Family medicine. Metric 2 P-2.2. Hire 2 additional precepting primary care faculty members. a. Increased number of additional training faculty/staff members Data Source: HR documents, faculty lists, or other documentation Goal: Increase faculty by 2.		**Milestone 4** P-2. Expand primary care training for primary care Family medicine providers. Metric 4 P-2.2. Hire 1 additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2). a. Increased number of additional training faculty/staff members Data Source: HR documents, faculty lists, or other documentation Data Source: Residency Director's	**Milestone 6** P-2. Expand primary care training for primary care internal medicine providers (must include at least one of the following metrics) P-2.2. Hire 1 additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2). a. Documentation: Increased number of additional training faculty/staff members b. Data Source: HR documents, faculty lists, or other

[Unique Category 1 Project Identifier, e.g. Project [TPI].1.3]	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
including at least one faculty able to help with creating a PCMH.Need milestone incentive payments thruout chart.	**Milestone 3** P 6. Develop/Expand enrollment in programs that provide primary care training that lead to retain the graduates and commit to serve in specific communities e.g. HRSA designated Health Care Provider Shortage Areas (HPSAs)5 or HRSA FQHCs. a. Documentation of developed program(s) and enrollment in program(s)	Administrative records Goal: Recruit 1 additional faculty for internal medicine. **Milestone 5** I-11. Increase primary care training and/or rotations Metric 5 I-11.5. Improvement in trainee satisfaction with specific elements of the training program a. Numerator: Sum of trainee satisfaction scores b. Denominator: total number of trainees Data Source: Trainee satisfaction assessment tool Goal: Increase satisfaction scores by 10% over DY2 baseline.	documentation Data Source: Residency Director's Administrative records Goal: Recruit 1 additional faculty for internal medicine. **Milestone 7** I-11. Increase primary care training and/or rotations Metric 7 I-11.5. Improvement in trainee satisfaction with specific elements of the training program a. Numerator: Sum of trainee satisfaction scores b. Denominator: total number of trainees Data Source: Trainee satisfaction assessment tool	

[Unique Category 1 Project Identifier, e.g. Project [TPI].1.3]	*[Reference number of Project Option from RHP PP – e.g. 1.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g. 1.X.X.X]*	*[Project Title]*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)	
		I-11.6. Metric: Improvement in trainee knowledge assessment scores a. Numerator: Sum of differences in pre and post training assessment scores. b. Denominator: Number of graduates from training program. Data: Knowledge assessment tool Goal: Increase knowledge assessment scores by 5% over baseline from DY2.	Goal: Increase satisfaction scores by 10% over DY3 baseline. I-11.6. Metric: Improvement in trainee knowledge assessment scores a. Numerator: Sum of differences in pre and post training assessment scores. b. Denominator: Number of graduates from training program. Data: Knowledge assessment tool Goal: Increase knowledge assessment scores by 5% over baseline from DY2.	
		Year 4 Estimated Milestone Bundle Amount: $	Year 5 Estimated Milestone Bundle Amount: $	

UTHSCSA - Category 2: Program Innovation and Redesign

Identifying Project and Provider Information:

Unique Project ID: 085144601.2.1

Project Option: 2.1.3 – Implement medical homes in HPSA and other rural and impoverished areas using evidence-approached change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative: Medical Home

Performing Provider Name/TPI: UTHSCSA / 085144601

Project Description:

Su Clinica proposes to implement a certified patient centered medical home (PCMH) model of care to provide safety net primary healthcare services to targeted patients who live in HPSA, rural, and impoverished areas of Cameron and Willacy County.

The project would improve access to comprehensive, primary and preventive care through the implementation of the medical home model. The project would cover five service sites located in Brownsville, Raymondville (2), Santa Rosa, and Harlingen. The project has the potential to touch 31,000 medical and dental patients, equating to approximately 6.0% of the total population of Cameron and Willacy counties.

The community clinic provides comprehensive, primary health and wellness services for Cameron and Willacy counties in South Texas. The clinic responds to the needs of the community by providing quality primary care and prevention services regardless of ability to pay. The community clinic is accredited by the Joint Commission. The target population includes the uninsured and under-served, those below 200% of poverty, migrant and seasonal farmworkers, Hispanics, women and children. The clinic's service area ranks as one of the poorest in the nation.

The Provider Team consists of the following Full Time Equivalents (FTEs): Primary Care Physicians (22.01 FTE); Other providers including Nurse Practitioners/Physician Assistants/Certified Nurse Midwives/Podiatrist (13.10 FTE); Dentists and Dental Hygienists (8.7 FTE). Services include: pediatrics, internal medicine, family practice, OB/GYN, Behavioral Health, Dental, minor surgery, podiatry, pharmacy, and WIC services. Outreach, Lab & x-ray, 24-hour on-call hospital coverage, health professions training, nutrition, health education, social services, case management, integrated eligibility screening, and specialty referral coordination round out the core services.

Through a partnership with the University of Texas Health Science Center at San Antonio's Regional Academic Health Center (RAHC), the clinic addresses medical provider shortages by providing medical residents and medical students a unique opportunity to gain frontline experience in treating many of the perplexing medical conditions prevalent along the U.S.-Mexico border. To address dentist shortages, the clinic also hosts rotations from University of Texas Health Science Center San Antonio dental students.

The clinic participates in the Medicaid Managed Care program, Title V Maternal & Child Health, Title V Dental, CHIP Perinatal, Texas Family Planning, Healthy Start program, & CHIP Outreach. The clinic also works closely with area hospitals including Knapp Medical Center, Valley Baptist Medical Center, and Valley Regional Medical Center to coordinate care.

The clinic currently serves 4,373 patients who have been diagnosed with diabetes. Using the patient centered medical home model, the clinic will be able to provide a more effective model of care focused on prevention and a patient/medical team model.

Given the low income levels, high uninsured rates, and high percentage of Hispanics living in RHP 5, we propose to serve the following zip codes through this project: 78520,78521, 78523, 78526, 78535, 78537, 78538, 78539, 78541, 78549, 78550, 78551, 78552, 78553, 78559, 78561, 78566, 78567, 78568, 78569, 78570, 78572, 78575, 78577, 78578, 78579, 78580, 78583, 78586, 78589, 78590, 78592, 78593, 78594, 78596, 78597, 78598.

GOAL:

RHP 5 is a medically underserved area with a population that is 30 – 40% uninsured and that has no public hospital or hospital district. All of the hospitals are private for profit and are therefore limited in their ability to meet the needs of the population for primary and specialty care, based on current reimbursement/financing mechanisms and levels of insurance. Furthermore, the population suffers from very substantial health disparities:

- 50% of the adult population is obese
- 31% of the adult population has diabetes
- Over 75% of adults have a chronic condition of diabetes, hypertension, hypercholesterolemia, heart disease, or other condition.

In addition, diabetes care and treatment is a major barrier to increasing access to care for the uninsured working poor. Also, the service area has an 88% Hispanic population.

Two supplementary goals of the project are to:

- Develop meaningful digital health information collection and exchange between providers of care for this demographic segment, and
- Develop actionable health information and analytical capability for reporting provider network performance, patient risk stratification and population management.

The key functional element of the project is to become a certified patient centered medical home for primary care access. By achieving patient centered medical home status, the community clinic can have a lasting and meaningful impact on the over 31,000 potential patients, reduce the growth in health care costs by working collaboratively with other healthcare partners, and increase patient satisfaction with the healthcare system.

The project meets the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, team-based model while also building a regional, coordinated model of care designed to reduce costs, lower duplicative work, and increase patient satisfaction.

Challenges.

The transformation to a new model of care is never an easy one. It involves the rethinking and redesign of clinic systems and care team thought processes. The entire organization must undergo a coordinated transformation at the same time that clinical systems are being converted to electronic health records, new government regulations are being implemented, and reimbursement systems are being revised.

Strong leadership from administration and from the clinical team are essential for success. Just as important, the patient must be educated and must buy in to the new system of care. Staff must be retrained and work processes must be revised.

An additional challenge is to accomplish the transformation to a patient centered medical home while maintaining sufficient productivity levels and controlling costs to retain a sound business case.

Finally, it has been the experience of this health center that implementing comprehensive change within a population that is overwhelming Hispanic and Spanish speaking can be a challenge. Translating materials into Spanish and ensuring that they are at the appropriate literacy level can hinder an otherwise steady flowing project.

5-Year Expected Outcome for Provider and Patients:
Su Clinica expects to see a complete transformation of its care systems to a medical home model. Improvements in coordination with area hospitals are expected through the implementation of the Health Information Exchange. Once process and implementation milestones are reached, the clinic expects a decrease in the percentage of diabetic patients whose HbA1c levels are greater than 9.0% (poor control).

Starting Point/Baseline:

The community clinic currently uses an electronic medical records system and has participated in a number of training opportunities regarding the patient centered medical home. The Administrative Leadership Team is knowledgeable of patient centered medical home concepts and has integrated the goal of PCMH certification into the organization's board approved strategic plan. Currently, no clinic sites have been certified as a patient centered medical home so the baseline is zero in DY2.

With respect to diabetes, the clinic collects data on the percentage of patients with HbA1c greater than 9% (poor control). For the baseline year of 2011, that percentage was 34.27%.

Rationale

Federal, state, and local health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see

their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers.

This initiative aims to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The projects associated with Medical Homes establish a foundation for transforming the primary care landscape in Texas by emphasizing enhanced chronic disease management through team-based care.

With respect to the concept of the Patient Centered Medical Home, the National Committee for Quality Assurance (NCQA) found the following:

Primary care is a foundation of the health care system. The NCQA PCMH standards reflect elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual; thus, patient access to care is an important issue. Clinicians must have a broad knowledge of many health care conditions and often follow their patients over years; thus, the quality of the clinician/patient relationship and the clinician's ability to track care over time are also important. Many primary care clinicians need to refer patients to specialists; thus, communication among providers is important—and often challenging.

Just as patient-centeredness is an integral part of the program, so too is a practice's ability to track care over time and across settings. The amount of clinical information for some patients—particularly those with chronic illnesses—and the fragmented nature of the U.S. health system make this aspect of primary care challenging. Experts agree that health information technology can help clinicians coordinate patient care, but merely having an electronic health record system in a practice is not enough. The health information system itself must be useful, and practices must use it to achieve the goals of coordination and high quality of care.

The Patient-Centered Primary Care Collaborative recently released a report that summarized findings from PCMH demonstrations (http://www.pcpcc.net/content/pcmh-outcome-evidence-quality) and concluded that findings from PCMH demonstrations show success in increasing the quality of care and in reducing cost of care on some measures. In the academic literature, a recent article also found reduced use of hospitalization and emergency room visits and overall savings (Fields, Leshen, Patel, 2010). Another study evaluating a PCMH demonstration project in an integrated group practice showed significant improvement in patient and provider experiences and in the quality of clinical care (Reid, 2009). A study of the impact of the PCMH model on costs of care indicated a relationship between practices with established systems/processes and a decreased use of inpatient and emergency care by diabetic patients (Flottemesch, under review).

Implementing a patient centered medical home model in an area of the state with the highest uninsurance rates, high rates of diabetes, high percentage of Hispanic population, and

lowest incomes in the nation will have a positive effect on reducing health disparities within the state of Texas.

Related Category 3 Outcome Measures:

The Category 3 goal for this project is to reduce the percentage of community clinic patients with Type 1 or 2 diabetes whose most recent hemoglobin A1c (HbA1c) is greater than 9% (poor control) to 27%.

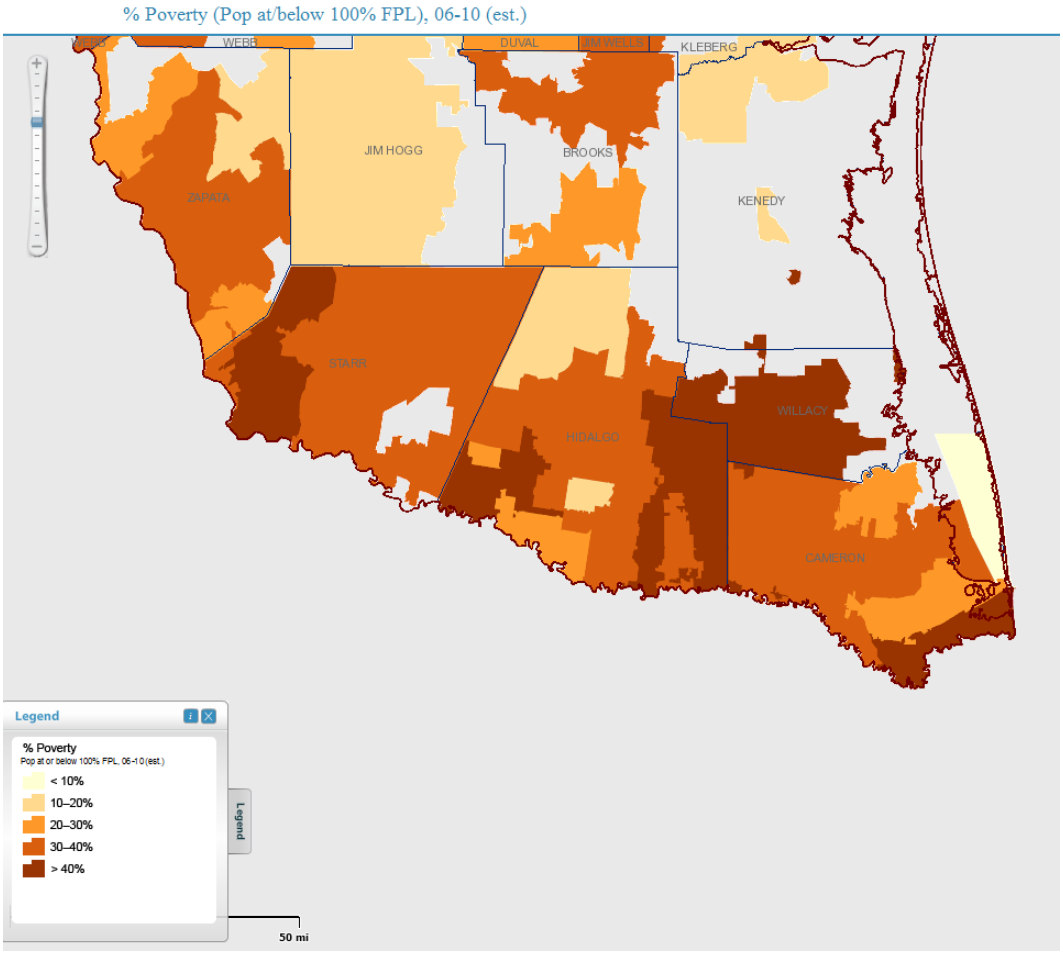
2009 Data from the Centers for Disease Control indicates that the Age-Adjusted Estimates of the Percentage of Adults Diagnosed with Diabetes in South Texas was as follows:

County	Percentage
Cameron	8.5%
Hidalgo	10.2%
Starr	8.5%
Willacy	8.8%

Providing a patient centered medical home where a diabetic patient has a direct relationship with a provider and care team has shown a relationship with decreased use of inpatient and emergency care (see Rationale above). Community clinics offer a variety of services in one location, including medical, dental, podiatry, nutrition counseling, social services, behavioral health, care management, and social services. Combining the power of the medical home model with the services offered at our clinic, we believe we can have a positive, early impact on helping diabetic patients control their HbA1c.

Through a host of national projects funded by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid, it has been shown that the implementation of a Health Information Exchange among hospitals, providers, and related healthcare providers can have a positive impact on health care coordination, patient satisfaction, and total healthcare costs. RHP5 is characterized by being home to a number of small communities and metropolitan areas strung along a 90 mile stretch of highway along the U.S. – Mexico border. The resident population is very mobile and often lives in one community, works in another, and gets their healthcare/hospital care in another. Having the ability to effectively share health information in a secure manner among providers will prove beneficial to all.

As stated above, RHP5 is among the highest poverty regions in the nation. Over 70% of patients served by our clinic are at or below 100% of poverty. The figure below depicts the percentage of the population below poverty by Zip Code Tabulation Area.



Relationship to Other Projects:

This project reinforces the projects being proposed by RHP5 hospitals and other performing providers by strengthening the network of care, particularly those services aimed at the lowest income and highest uninsured groups in the region. Underpinning the pioneering proposals from the hospital community with a strong and vibrant medical home model has proven, in many communities, to increase the coordination of care and reduce the burden on hospitals caused by unnecessary emergency department visits. Any project that strengthens the cooperative relationships among healthcare providers and reduces unnecessary delays and waste, can only prove beneficial to the region.

This project also meshes with other initiatives currently under way in the region such as the develop of Accountable Care Organizations, development of a fully functioning medical school, and increased medical research on a variety of topics including obesity, nutrition, and diabetes among Hispanic populations.

Relationship to Other Performing Providers' Projects in the RHP:

This project is one of several that will be focused on the journey toward certification as a patient centered medical home. We are fully committed to working with other performing providers to share progress, best practices, and lessons learned throughout the project period.

Plan for Learning Collaborative:

We plan to work with the UT School of Public Health as the facilitator to encourage the development of a learning collaborative during the project period. Working together to develop and implement a Health Information Exchange will bring to light many similarities among performing providers and will also highlight those areas where challenges can be overcome. We will bring the capability to host online, interactive meetings and information exchange as well as being able to provide a 100-seat conference/meeting room to bring the various program participants together from time to time.

Our internal Information Technology team has already begun forming working collaborations with many healthcare providers in the region and is recognized as a leader in customizing and optimizing the GE Centricity EMR platform. Working through the Regional Education Center for health IT, we anticipate a strong working relationship among universities, hospitals, and private performing providers.

Project Valuation:

The project will be valued based upon the successful attainment of the following expected results:

- Develop and implement action plans for a patient centered medical home.
- Improve data exchange between hospitals and affiliated medical home sites.
- Management and coordination for shared, high-risk patients
- Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license.
- Collaborate with the RGV Health Information Exchange to develop the capacity to use EMR for effective patient management across hospitals, PCMHs, community clinics, and other clinics.

Project Su Clinica 2.xx	Reference Number 2.1.3	Project Components 2.1.3.a-f	Implement medical homes in HPSA and other rural and impoverished areas using evidence-based approaches and change concepts for practice transformation developed by the Commonwealth Fund's Safety Net Medical Home Initiative.
Su Clinica			Su Clinica TPI#
Related Category 3 Outcome Measure: IT-1.10	Reference Number IT-1.10	Reference Numbers: IT-1.10 a-d	Diabetes Care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1: P-3. Reorganize staff into primary care teams. Metric 1. P-3.1. Primary Care Team. Number of staff organized into primary care teams. **Process Milestone 2: P-4. Develop staffing plan to expand primary care team roles.** Metric 1. P-4.1 Expanded primary care team roles. Revised Job Descriptions.	**Process Milestone 3: P-5. Determine the appropriate panel size.** Metric 1: Determine panel size. Panel size determination tool, patient registry, EMR, or needs assessment tool to determine panel size. **Process Milestone 4: P-9. Train medical home personnel on PCMH change concepts.** Metric: P-9.1 Number of medical home personnel trained.	**Improvement Milestone 5:I-12. Based on criteria, improve the number of eligible patients that are assigned to the medical homes.** Metric: Number or percent of eligible patients assigned to medical homes (primary care provider team). **Improvement Milestone 6: I-14. Patient access to medical home.** Metric: I-14.1 Third Next Available Appointment. The length of time in calendar days between day an existing patient makes a request and the third next available	**Milestone 7: I-18. Obtain medical home recognition by a nationally recognized agency.** Metric: I-18.1 Medical Home recognition/accreditation.

		appointment with the patient's primary care provider/care team.	
Year 2 Estimated Milestone Bundle Amount: $	Year 3 Estimated Milestone Bundle Amount: $	Year 4 Estimated Milestone Bundle Amount: $	Year 5 Estimated Milestone Bundle Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FO 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $			

Identifying Project and Provider Information:

085144601.2.2

Title Expand Model of Management of Chronic Diseases in Lower Valley of RHP 5

Project options and identification numbers

2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Performing Provider UTHSCSA

TPI

Project Description:

This project is designed to expand proactive, ongoing care to keep patients with chronic diseases healthy. It will also empower them to self-manage their conditions. The ultimate goal is to prevent worsening health precipitating the need for Emergency Department or Inpatient care.

Most chronic diseases fall into the category of non-communicable diseases (NCDs). NCDs are the pandemic of the 21st century, and the World Health Organization reported in 2010 that they now account for more disability and death globally than all other causes combined.(World Health Organisation, 2011) In 2011 the World Economic Forum estimated that by 2030 they will cost $47 Trillion globally.(Bloom DE et al., 2011) Texas, particularly South Texas, is among the leaders in our nation in prevalence of NCDs. To meet this growing threat in RHP5, our chronic disease management initiative will use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms early, with the goal of preventing complications and managing utilization of acute and emergency care. Chronic disease management also enhances the ability to identify one or more chronic health conditions or co-occurring chronic conditions that merit intervention across a patient population. This ability is based on assessment of patients' risk of developing complications, comorbidities or likelihood of utilizing acute or emergency services. These chronic health conditions include, prominently, diabetes, congestive heart failure, chronic obstructive pulmonary disease, renal disease, non-alcoholic fatty liver disease (NAFLD), all of which are liable to progress to complicating health conditions and a range of severe or end-stage diseases, such as renal failure or cancer. Effective management of chronic disease is therefore imperative.

Through this initiative and its partnering hospitals, clinics, and community-based partners we will transform of the health care delivery system for chronic disease by implementing multicomponent practice changes in the six recommended categories. This project will therefore include elements of the Chronic Care Model (CCM) for ambulatory care that have been shown to lead to the greatest improvements in health outcomes:

1) Delivery system redesign (changes in the organization of care delivery)
2) Self-management support strategies (efforts to increase patients involvement in their own care)
3) Decision support (guidelines, education, and expertise to inform care decisions)
4) Information systems (changes to facilitate use of information about patients, their care and their outcomes),
5) Community linkages (activities increasing community involvement)
6) Health system support (leadership, practitioner, and financial support).

We plan to implement an outcome evaluation and a 'plan, do, study, act' (PDSA) strategy. Quality improvement cycles will ensure long-term health benefits are achieved and that improvement processes are incorporated throughout the funding period. Based on meta-analysis findings for

Chronic Care Management models, this approach does improve outcomes, but it can take years to see true improvements.(Coleman et al., 2009) However, we believe that by using CCM and the PDSA cycles we will see sustained improvements as we proceed to further dissemination of the model across our partner organizations during the life of this project. To further this end, we plan to incorporate Information system changes including computerized reminders and communication (clinical information systems), involvement of practitioners on quality improvement teams (delivery system redesign), guidelines supported by clinician education or computer support (decision support), formal self-management programs (self-management support), a registry (clinical information systems), and community health workers health promotion support (community linkages for lifestyle changes and navigation).

All services implemented through this initiative will be monitored by two oversight entities that cut across the partners in anticipation of creating greater collaboration for clinical care in the RHP 5. These will be a clinical care and a clinical information management team. The clinical care team will be comprised of medical personnel appointed from participating providers, clinics and community partners. The clinical information management team will be comprised of health information exchange representatives and appointed health information representatives from clinical and community based partners. The University of Texas will be responsible for ensuring actions of these two entities are in line with project milestones and that PDSA and evaluation activities are continuous and reported to the two teams. In addition to specified Category 3 Waiver outcome targets, relevant data will be evaluated regularly against past performance, national benchmarks, state mandated performance targets and applicable accreditation standards to drive performance improvement activities when indicated. Validation of this approach can be found in "Evidence on the Chronic Care Model in the New Millennium" available at http://content.healthaffairs.org/content/28/1/75.full),(Coleman et al., 2009)

Project Goals: this project has the following goals**.**

a. **To design and implement comprehensive chronic care teams who can efficiently respond to patient's health needs**
b. **Ensure that patients can access care teams in person, via phone or email**
c. **Increase patient engagement in their health care treatment**
d. **Implement projects that empower patients to make lifestyle choices**
e. **Conduct quality improvement projects to continuously improve impact and efficiency.**

Challenges and issues facing this project:

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

- Rushed practitioners not following established practice guidelines
- Lack of care coordination

• Lack of active follow-up to ensure the best outcomes
• Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition, Improving Chronic Illness Care created the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. Evidence on the effectiveness of the Chronic Care Model has recently been summarized.

In RHP 5, 70% of the population has one or more chronic condition (Fisher-hoch et al, 2012). A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. Obesity is the underlying and exacerbating issue, but patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for those in these rural areas. The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. With the high prevalence of patients with chronic conditions, the demand for treatment is heavy and ongoing. There is a need for greater connectivity among hospital and primary care providers and community based chronic disease management resources so that patients are able to learn and have support for creating lifestyle changes that can effectively achieve wellness. Additionally, multidisciplinary care teams are not established to focus on managing and supporting patients with chronic conditions outside the hospital setting.

Facing the challenges: In order to face these challenges we will implement several steps associated with the required core project components for this project option. We have assembled the partner institutions who are committed to working together to implement this project.

1) Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (2.2.1)

   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.

5-year expected outcome for Performing Provider and patients:

Relationship of the project to regional goals:

Starting Point/Baseline:

No project of this kind is currently implemented in the RHP 5 area or with these partners. Patients in this RHP5 are currently not receiving the CCM model services at any clinical care facility.

Rationale

Reasons for Selecting the Project Option: Chronic diseases are the leading health threat to the RHP5 region. Seventy percent of the population has one or more chronic condition, with obesity being the underlying and exacerbating issue for most. Creating a comprehensive chronic care model directly addresses the population management care needs of the population and creates more comprehensive and cost effective approaches to supporting wellness among the population.

Project components: This project has several components:

- Development of a comprehensive care management program based on the CCM.
- Application of the CCM to targeted chronic diseases which are prevalent locally (e.g. diabetes, hypertension, renal and liver diseases)
- Development and implementation of a plan for standing orders (e.g. prescriptions, laboratory orders)
- Implementation and evaluation with ongoing quality improvement programs.

Milestones and Metrics: *(based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point.)*

Unique community need identification number the project addresses.

This project addresses community need CN. , related to .

How the project represents a new initiative: There is currently no coordinated approach to management of chronic disease in RHP5. With published rates of the uninsured as high as 70%, the community receives inadequate care even for diagnosed chronic disease. This project is therefore unique for this region which is one of the poorest and least served in our nation. It will therefore be developed for patients who currently have little or no care. The project is also unique is that it seeks to coordinate will other DSRIP proposals in a network of projects designed to reach those at need, provide comprehensive management of chronic diseases, empower the patient and in the long term reducing the needs for Emergency Room or Inpatient care.

Data Driving this Project: Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas as a whole). Health along the entire US border with Mexico is among the worst in the nation.(Diaz-Apodaca et al., 2010) Obesity is the underlying and exacerbating issue. Published data from our locally recruited, randomized community cohort show that the prevalence of obesity in adults in the region is 48.5% and that 8.0% are morbidly obese.(Fisher-Hoch et al., 2012) Pediatric obesity is also high with half the children studied obese or overweight, most of whom were obese.(Rentfro et al., 2011) The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Currently only 31.4% have insurance of any kind, more than half of which is Medicare or Medicaid. Eighty-four

percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis and heart failure. About half have evidence of NAFLD associated with obesity and diabetes which can lead to liver failure and liver cancer. Unpublished data from our group shows that prevalence of cancers associated with obesity and diabetes such as gut cancers is high. Some less common cancers are more frequently seen than elsewhere, particularly stomach, liver and ovarian cancers. The underlying conditions are essentially preventable or treatable, and the long term cost of their neglect will be huge.

Related Category 3 Outcome Measure(s):

(These *assess the effectiveness of Categories 1 and 2. At least one stand-alone measure must be selected or at least three non-stand-alone measures within a domain. The rationale should be data-driven, data supporting priority outcomes, validated rationale showing how this project achieves Category 3, and how this helps improve health of low-income populations.*

The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated.

This project is related to category 3 Outcome domains PPR, Patient Satisfaction, Primary Care and Prevention

Stand-alone:	Fewer visits to the Emergency Department visits and hospitalizations.
Non-stand-alone but related:	More knowledgeable patients monitoring their own disease
	Improved adherence to regimes and medication
	Improved quality of life

Relationship to other Projects:

(A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.)

This project is related to project 2.2.2 Apply evidence-based care management model to patients identified as having high-risk health care needs

Relationship to Other Performing Providers' Projects in the RHP:

(*If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.)*

Plan for Learning Collaborative:

(*If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.)*

Project Valuation:

(*A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.)*

References:

Bloom DE, Cafiero ET, Jane-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, Feigi AB, Gaziano T, Mowali M, Randya A, Prettner K Rosenberg L Seligman B, Stein AZ, and Weinstein C. The Global Economic Burder of Non-communicable Diseases. 1-46. 10-9-2011. Geneva, Switzerland, World Economic Forum.

Coleman,K., Austin,B.T., Brach,C., and Wagner,E.H. (2009). Evidence on the Chronic Care Model in the new millennium. Health Aff. (Millwood.) 28, 75-85.

Diaz-Apodaca,B.A., Ebrahim,S., McCormack,V., de Cosio,F.G., and Ruiz-Holguin,R. (2010). Prevalence of type 2 diabetes and impaired fasting glucose: cross-sectional study of multiethnic adult population at the United States-Mexico border. Rev. Panam. Salud Publica 28, 174-181.

Fisher-Hoch,S.P., Vatcheva,K.P., Laing,S.T., Hossain,M.M., Rahbar,M.H., Hanis,C.L., Brown,H.S., III, Rentfro,A.R., Reininger,B.M., and McCormick,J.B. (2012). Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. Prev. Chronic. Dis. 9, E135.

Rentfro,A.R., Nino,J.C., Pones,R.M., Innis-Whitehouse,W., Barroso,C.S., Rahbar,M.H., McCormick,J.B., and Fisher-Hoch,S.P. (2011). Adiposity, biological markers of disease, and insulin resistance in Mexican American adolescents, 2004-2005. Prev. Chronic. Dis. 8, A40 PMCID: PMC3073433.

World Health Organisation. Global Status Report on non-communicable diseases. Alwan A. 1-176. 4-1-2011. Italy, World Health Organisation.

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-5.1]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Baseline/Goal: establish formalized team with at least	**Milestone 4** [P-5]: Develop a comprehensive care management program Metric 1 [P-5.1]: Documentation of Care management program. Baseline/Goal: Care management program protocols and activities will be expanded in year 3 over year 2 but remain similar across RHP 5 partners Data Source: Program materials Metric 2 [P-5.3]: Increase the number of patients enrolled in a care management program		**Milestone 8** [*RHP PP Milestone* – P-Y]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [*RHP PP Metric* – P-Y.Z]: Increase percent of staff trained Baseline/Goal: train 80% of relevant staff across performing provider and contractors in Chronic Care Model Data Source: HR, training program materials Milestone 8 Estimated Incentive Payment: $	**Milestone 15** [*RHP PP Milestone* – P-Y]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [*RHP PP Metric* – P-Y.Z]: Increase percent of staff trained Baseline/Goal: train 85% of relevant staff across performing provider and contractors in Chronic Care Model Data Source: HR, training program materials Milestone 15 Estimated

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
5 members Data Source: Organizational chart, Job duties Milestone 1 Estimated Incentive Payment: $ **$730,010** **Milestone 2** [*RHP PP Milestone* – P-Y]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care <u>Metric 1</u> [*RHP PP Metric* – P-Y.Z]: Increase percent of staff trained Baseline/Goal: train 50% of	over baseline Baseline/Goal: 30% increase in number of patients enrolled over year 2 Data Source: program enrollment records Milestone 4 Estimated Incentive Payment: $ **$885,991** **Milestone 5** [*RHP PP Milestone* – P-Y]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic		**$620,413** **Milestone 9** [P-5]: Develop and implement program to assist patient to better self-manage their chronic conditions <u>Metric 1</u> [P-5.1]: Increase the number of patients enrolled in a self-management program Baseline/Goal: 10% increase in number of patients enrolled in a self-management program over baseline year 3 Data Source: EHR, patient registry, class enrollment and attendance records Milestone 9 Estimated	Incentive Payment: $ **$630,912** **Milestone 16** [P-5]: Develop and implement program to assist patient to better self-manage their chronic conditions <u>Metric 1</u> [P-5.1]: Increase the number of patients enrolled in a self-management program Baseline/Goal: 10% increase in number of patients enrolled in a self-management program over baseline year 4 Data Source: EHR, patient registry, class enrollment and

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
relevant staff across performing provider and contractors in Chronic Care Model Data Source: HR, training program materials Milestone 2 Estimated Incentive Payment (*maximum amount)*: $ **$730,010** **Milestone 3** [P-5]: Develop a comprehensive care management program <u>Metric 1</u> [P-5.1]: Documentation of Care management program.	disease care <u>Metric 1</u> [*RHP PP Metric* – P-Y.Z]: Increase percent of staff trained Baseline/Goal: train 70% of relevant staff across performing provider and contractors in Chronic Care Model Data Source: HR, training program materials Milestone 5 Estimated Incentive Payment: $ **$885,991** **Milestone 6** [P-5]: Develop and implement program to assist		Incentive Payment: $ **$620,413** **Milestone 10** [P-8]: Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types <u>Metric 1</u> [P-8.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: 20% increase number of patients receiving interaction beyond one – to – one visits over year 3	attendance records Milestone 16 Estimated Incentive Payment: $ **$630,912** **Milestone 17** [P-8]: Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types <u>Metric 1</u> [P-8.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: 20% increase

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.2]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 2.X.X]*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]*	*[PROJECT TITLE]* *CHRONIC CARE MANAGEMENT COORDINATED CARE IN LOWER VALLEY OF RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Care management program protocols and activities will be similar across RHP 5 partners Data Source: Program materials <u>Metric 2</u> [P-5.3]: Increase the number of patients enrolled in a care management program over baseline Baseline/Goal: enroll 100 patients into CCM Data Source: program enrollment records Milestone 3 Estimated		patient to better self-manage their chronic conditions <u>Metric 1</u> [P-5.1]: Increase the number of patients enrolled in a self-management program Baseline/Goal: 10% increase in number of patients enrolled in a self-management program over baseline year 2 Data Source: EHR, patient registry, class enrollment and attendance records Milestone 6 Estimated Incentive Payment: $ **$885,991**	Data Source: EHR, billing records, communication logs Milestone 10 Estimated Incentive Payment: $ **$620,413** **Milestone 11** [P-9]: Improve the percentage of patients with self-management goals99 <u>Metric 1</u> [P-9.1]: Patients with self-management goals Goal: 10% increase in number of patients with self-management goals over year 3	number of patients receiving interaction beyond one – to – one visits over year 4 Data Source: EHR, billing records, communication logs Milestone 17 Estimated Incentive Payment: $ **$630,912** **Milestone 18** [P-9]: Improve the percentage of patients with self-management goals99 <u>Metric 1</u> [P-9.1]: Patients with self-management goals Goal: 10% increase in number

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* **Chronic care management coordinated care in Lower Valley of RHP 5**	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Incentive Payment: $ **$730,010**		**Milestone 7** [P-8]: Milestone: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric 1 [P-8.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: 20% increase number of patients receiving interaction beyond one – to – one visits over year 2 Data Source: EHR, billing records, communication logs Milestone 7 Estimated Incentive Payment: $	Data Source: Registry Milestone 11 Estimated Incentive Payment: $ **$620,413** **Milestone 12** [I-1]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [I-1.2]: Increase the number of patients enrolled in a self-management program Goal: 5% increase patients enrolled in self-management program over year 3 Data Source: EHR, patient	of patients with self-management goals over year 4 Data Source: Registry Milestone 18 Estimated Incentive Payment: $ **$630,912** **Milestone 19** [I-1]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [I-1.2]: Increase the number of patients enrolled in a self-management program Goal: 5% increase patients

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	$885,991		registry, class enrollment and attendance records Milestone 12 Estimated Incentive Payment: $ **$620,413** **Milestone 13** [P-5]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 1</u> [P-5.1]: Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC Baseline/Goal: 10% increase in number of patients who receive care under the CCM	enrolled in self-management program over year 4 Data Source: EHR, patient registry, class enrollment and attendance records Milestone 19 Estimated Incentive Payment: $ **$630,912** **Milestone 20** [P-5]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally <u>Metric 1</u> [P-5.1]: Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			for a chronic disease over year 3 Data Source: Registry Milestone 13 Estimated Incentive Payment: $ **$620,413** **Milestone 14** [I-3]: 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	Baseline/Goal: 5% increase in number of patients who receive care under the CCM for a chronic disease over year 4 Data Source: Registry Milestone 20 Estimated Incentive Payment: $ **$630,912** **Milestone 21** [I-3]: 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

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			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 [I-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 70% of providers participating in a CCM DSRIP for RHP 5 will be present and identify "raise the floor" improvement. Data Source: Documentation of	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 [I-3.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 80% of providers participating in a CCM DSRIP for RHP 5 will be present and identify "raise the floor"

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <u>Metric 2</u> [I-3.3]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: 50% of providers participating in the CCM DSRIP in RHP5 will document raise the floor implementation within 6 months of semi-annual meeting Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and	improvement. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <u>Metric 2</u> [I-3.3]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting Goal: 60% of providers participating in the CCM DSRIP in RHP5 will document raise the floor implementation within 6 months of semi-annual meeting Data Source: Documentation of "raise the floor" improvement

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.2]	*[Reference number of Project Option from RHP PP – e.g. 2.X.X]*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* *Chronic care management coordinated care in Lower Valley of RHP 5*	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 14 Estimated Incentive Payment: $ **$620,413**	initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 21 Estimated Incentive Payment: $ **$630,912**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ $2,190,029	Year 3 Estimated Milestone Bundle Amount: $ $3,543,963		Year 4 Estimated Milestone Bundle Amount: $ $4,342,894	Year 5 Estimated Milestone Bundle Amount: $ $4,416,384

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.2]	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 2.X.X]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	***[PROJECT TITLE]*** ***CHRONIC CARE MANAGEMENT COORDINATED CARE IN LOWER VALLEY OF RHP 5***	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ $14,493,270				

Identifying Project and Provider Information:

085144601.2.3

Title 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model

UTHSCSA/085144601

Project options and identification numbers

2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

Performing Provider UTHSCSA

Project Description:

This project expands the use of an existing Mobile Clinic in a customized van providing primary care in underserved rural areas by enhancing and expanding its impact with Patient Navigators. The Mobile Clinic is currently manned by one Physician's Assistant and one community health worker (CHW), and is equipped with interactive mobile consulting equipment connected to specialist centers for telemedicine activities. This Mobile Clinic will be used to establish this project and a second van may be added later. The Mobile Clinic parks for up to 5 weeks at a time in 5 different secured sites (such as school grounds) but typically rural unincorporated areas each year throughout the county.
Patient Navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient, but often include:

1. Identifying individuals in the community in need of medical care and directing them to the van for primary appointments.
2. Facilitating communication among patients, family members, survivors and healthcare providers.
3. Coordinating care among providers.
4. Arranging financial support and assisting with paperwork.
5. Arranging transportation and child care.
6. Ensuring that appropriate medical records are available at medical appointments.
7. Facilitating follow-up appointments.
8. Community outreach and building partnership with local agencies and groups.
9. Ensuring access to clinical trials.

There is no one common definition of Patient Navigators and the profile varies widely by program. Many use trained Community Health Workers (CHWs) who may be full-time employees or volunteers. CHWs have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. CHWs are also known as community health advisors, lay health advocates and *promotoras de salud*. Healthcare navigators also include trained social workers, nurses and nurse practitioners as well as trained lay persons/volunteers. Some

navigation programs also use a team based approach that combines CHWs with one or more professionals with experience in healthcare or social work.
While there is no set education required for a patient navigator to be successful, a successful navigator should be:

1. Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
2. Knowledgeable about the environment and healthcare system.
3. Connected with critical decision makers inside the system, especially financial decision makers.

Relationship of the project to regional goals

This project addresses two major goals of RHP5. Increase access to primary care of those with Medicaid or without health insurance. This project addresses this goal by providing mobile health service to a poor and uninsured rural population.
Improve control of chronic disease that afflicts 70% of our adult population. This project will connect those with chronic disease to an integrated chronic disease program either through a PCMH or an integrated chronic disease management program.

Project Goals

The goal of this project is to utilize CHWs as Patient Navigators to identify seek out vulnerable and/or high-risk patients in poor rural areas for primary care at an accessible medical van as a mobile hub.
Patient Navigators will be provided primary medical care including vaccination.
Patient Navigators will ensure that patients receive coordinated, timely health care services.
For those identified with one or more chronic disease trained CHWs will help and support these patients to reach and then navigate through the continuum of health care services.
Patient Navigators will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.
The Patient Navigators will engage with patients in a culturally and linguistically appropriate manner to guide the patients through integrated health care delivery systems and increase access to health promotion and disease prevention services.

Challenges and issues facing this project

In RHP 5, 70% of the population has one or more chronic conditions. A similar proportion has currently no health insurance, such that preventive care and intervention is neglected and patients often only present to clinics or emergency departments with advanced severe disease. Obesity is the underlying and exacerbating issue. Patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for these in those rural areas.

Facing the challenges

This project will build on a medically equipped Mobile Clinic in a van operated by the University of Texas in Deep South Texas, serving extremely rural and impoverished areas. We will hire, train, and monitor CHWs to be navigators in the locations visited by the UT Mobile Clinic, and perhaps adding at least one additional van (Mobile Clinic) as the project progresses. These Patient Navigators will identify people (of all age) in the community who are in need of care and support and guide them through the system. The patient navigators will also provide health promotion disease prevention services.

5-year expected outcome for Performing Provider and patients.

- Creation of a model of low cost primary care and patient navigation for the rural poor.
- Enrollment of 3000 people into the system and referral to integrated care of those with chronic conditions.
- Establish training program for CHWs as patient navigators
- Connection of the program to integrated care at PCMH and chronic care models in RHP5 clinics and hospitals.
- Improved education on chronic disease prevention and management by the CHW/patient navigators.

Starting Point/Baseline:

Number of clients currently served by project.

Number of people contacted by CHWs
# of persons seen at the mobile van
Number of clients screened for type 2 diabetes
Number of clients screened for hypertension
Number of clients referred for chronic disease management
Number of unvaccinated children seen at the van
Number of children vaccinated
Number of CHWs trained for this project.
Baseline 201

Rationale:

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.

Reasons for Selecting the Project Option

The RHP5 needs assessment demonstrates the high prevelance of chronic diseases, such as type 2 diabetes, high cholesterol, hypertension, and chronic liver disease in this population. Furthermore published data demonstrate that poverty is high, and that the majority of people do not have access to health services through insurance. These problems are compounded in the rural areas. Therefore this project will serve a number of important purposes, increasing screening for chronic disease in a poor rural population that is medically underserved and is therefore at risk for presenting at ED or clinics with advanced manifestations of chronic disease. Those are the reasons for choosing this project.

Project Components
All required components are included in this project and are addressed fully.
Creating a project plan including screening strategy and referral strategy.
Identifying and training CHWs from local communities as patient navigators.
Creating a connection with the HIE to be able to track patients (EHRs already in place).
Screening of rural population.
Patients seen at van for primary care. Referrals as needed to integrated care programs.

Milestones and Metrics *based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point.*
Complete this after revision of the milestones and metrics.

Unique community need identification number the project addresses.
CN.3 Inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions

CN.4 Lack of Patient-Centered Care

How the project represents a new initiative
This project is a much expanded and revised form of an existing project. It reforms the existing system by training and engaging Community Health Workers as patient navigators who will contact people in the rural areas where the van is located and arrange for them to be seen and then for those with chronic disease conditions the navigators will help those individuals enter into an integrated care program to mitigate the progression of the condition and reduce the likelihood of appearing at an emergency department or clinic with advance complications.
Furthermore this project is a new initiative because patients currently seen on the van are not identified as frequent ED users and are not followed to reduce preventable admissions. Innovative health care personnel are currently not employed to work with patients seen on the mobile van. Patients are referred to primary care facilities, but due to lack of staff are not specifically provided navigation services. Preventive care is not the focus of services provided. Chronic care management including education and self-management is not routinely provided. A PDSA cycle is not used to implement quality improvement activities.

Data Driving this Project.
Data published by the United States Census Bureau in 2012 show that 88.1% (Cameron County) and 90.7% (Hidalgo County) of the population is Mexican American or Latino in origin and that 34.7% live below the poverty line (compared with 16.8% for Texas as a whole). Obesity is the underlying and exacerbating issue. Published data (Fisher-Hoch et al, 2012) from our locally recruited, randomized community cohort show that the prevalence of obesity is 48.5% and that 8.0% are morbidly obese. The prevalence of diabetes is an alarming 30.7% in adults 18 years or over. Currently only 31.4% have insurance of any kind, more than half of which is Medicare or Medicaid. Eighty-four percent of those with hypertension are diagnosed, but only half of those with diabetes or hypercholesterolemia. Many participants with diabetes (55.5%) and hypertension (50.0%) are untreated as are 85% of those with hypercholesterolemia. Multiple complications of diabetes and obesity include renal failure requiring dialysis, and heart failure, and at least 12% have evidence of liver disease associated with obesity and

diabetes leading to liver failure and liver cancer. We have unpublished data showing that prevalence of cancers associated with obesity and diabetes such as gut cancers is high. Some more unusual cancers are more common than elsewhere, particularly stomach, liver and ovarian cancers. The underlying conditions are essentially preventable or treatable. The long term cost of this neglect will be huge.

Related Category 3 Outcome Measure(s):
The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated.
Evolving from goal, Category 3 outcome measures will be:
IT-12.5 Other USPSTF-endorsed screening outcome measures

a Numerators: Number of people identified with blood glucose or HbA1c consistent with diabetes. Number of people identified with hypertension. Number of people with elevated cholesterol.
b Denominators: Number of people screened for diabetes, hypertension and elevated cholesterol.
c Data Source: EHR, Claims, HIE data.
d Rationale/Evidence: 70% of people in RHP5 have one or more chronic conditions, diabetes, hypertension or elevated cholesterol. 50% are undiagnosed and of those diagnosed only about half are on treatment. This project aims to address this disparity in the rural poor part of RHP5.

The Category 3 goal for this project is to identify those with previously undiagnosed diabetes, hypertension or high cholesterol and get them into a control program to received education, treatment and support. The people from this project will be referred to and enrolled in the PCMH at Su Clinica Familiar, or to the chronic disease management program at Valley Baptist Hospital or to one of the several Federally Qualified Health Clinics in the region.

This project will identify those with chronic conditions and place them into integrated care programs in a PCMH or integrated care program or FQHC, depending on the location of the patient, their insurance status and their condition.

Through a host of national projects funded by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid, it has been shown that the implementation of a Health Information Exchange among hospitals, providers, and related healthcare providers can have a positive impact on health care coordination, patient satisfaction, and total healthcare costs. RHP5 is home to a number of small communities and metropolitan areas along a 90 mile stretch on the U.S. – Mexico border. The resident population is very mobile and often lives in one community, works in another, and gets their healthcare/hospital care in another. Having the ability to effectively share health information in a secure manner among providers will prove beneficial to all.

As stated above, RHP5 is among the highest poverty, and most medically underserved regions in the nation.

Relationship to other Projects: *A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.)*
This project is related to project 2.2 through the option of referring patients from the van to the chronic care team for comprehensive follow-up care.
This project is related to 2.1 through the option of referring patients from the van to the PCMH at Su Clinica for comprehensive follow-up.
Patients with relevant conditions identified by the primary care provided at the mobile van will be navigated into an integrated care program by the CHW patient navigators trained and assigned to the rural populations associated with the van project plan.
Relationship to Other Performing Providers' Projects in the RHP: Not Applicable, as there are no other similar projects.

Plan for Learning Collaborative: Not Applicable.

Project Valuation: (*A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.)*

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] UTHSCSA				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [*RHP PP Milestone* – P-Y]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program Metric 1 [*RHP PP Metric* – P-Y.Z]: Provide report identifying the following: o Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). o Gaps in services and service		**Milestone 5** [P-5]: 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 [I-3.1 number of continuing education sessions for patient navigators Goal: to provide 1 continuing education sessions every 6 month	**Milestone 10** [P-5]: 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 [I-3.1 number of continuing education sessions for patient navigators Goal: to provide 1 continuing education sessions every 6 month	**Milestone 17** [P-5]: 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 [I-3.1 number of continuing education sessions for patient navigators Goal: to provide 1 continuing education sessions every 6 month

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
needs, o How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). Baseline/Goal: there has not been such assessment conducted. Goal is to review a minimum of 300 patient records in needs assessment Data Source: Program documentation, EMR, claims, needs assessment survey Milestone 1 Estimated	Data Source: Continuing education records and Class participation logs <u>Metric 2</u> [P-5.3]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Year 2 enrollment / the goal would be to have cumulatively achieved 20% of unique patients seen per six months enrolled in navigation services Data Source: Patient navigation program materials and database, EHR <u>Metric 3</u> [P-8.1]: Frequency of		Data Source: Continuing education records and Class participation logs <u>Metric 2</u> [P-5.3]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Year 3 enrollment / the goal would be to have cumulatively achieved 25% of unique patients seen per six months enrolled in navigation services Data Source: Patient navigation program materials and database, EHR <u>Metric 3</u> [P-8.1]: Frequency of	Data Source: Continuing education records and Class participation logs <u>Metric 2</u> [P-5.3]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Year 4 enrollment / the goal would be to have cumulatively achieved 30% of unique patients seen per six months enrolled in navigation services Data Source: Patient navigation program materials and database, EHR <u>Metric 3</u> [P-8.1]: Frequency of

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.3	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP] 2.9.1*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]*	*[PROJECT TITLE]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
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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)**
Incentive Payment (*maximum amount)*: $ 350,000 **Milestone 2** [P-5]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. <u>Metric 1</u> [P-5.1]: Number of people trained as patient navigators, number of	contact with care navigators for high risk patients Baseline/Goal: Year 2 / goal would be for 25% of high risk patients to receive care navigators. Data Source: Patient navigation program materials and database, EHR Milestone 5 Estimated Incentive Payment: $ 400,000 **Milestone 6** [P-5]: Provide care management/navigation services to targeted patients <u>Metric 1</u> [P-5.1]: Increase in the number or percent of targeted		contact with care navigators for high risk patients Baseline/Goal: Year 3 / goal would be for 30% of high risk patients to receive care navigators. Data Source: Patient navigation program materials and database, EHR Milestone 10 Estimated Incentive Payment: $ 343,000 **Milestone 11** [P-5]: Provide care management/navigation services to targeted patients <u>Metric 1</u> [P-5.1]: Increase in the number or percent of targeted	contact with care navigators for high risk patients Baseline/Goal: Year 4 / goal would be for 35% of high risk patients to receive care navigators. Data Source: Patient navigation program materials and database, EHR Milestone 17 Estimated Incentive Payment: $ 343,000 **Milestone 18** [P-5]: Provide care management/navigation services to targeted patients <u>Metric 1</u> [P-5.1]: Increase in the number or percent of targeted

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.3	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP] 2.9.1*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]*	*[PROJECT TITLE]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
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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)**
navigation procedures, or number of continuing education sessions for patient navigators. a. Workforce development plan for patient navigator recruitment, training and education Baseline/Goal: No one has been trained as navigators or done navigation procedures. To train 5 people as navigators, identify a minimum of 3 navigation procedures and have 2 continuing education sessions each year	patients enrolled in the program Baseline/Goal: Year 2 enrollment / Goal would be that 25% of those patients needing navigation services would receive them Data Source: Enrollment reports Milestone 6 Estimated Incentive Payment: $ 400,000 **Milestone 7** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care.		patients enrolled in the program Baseline/Goal: Year 3 enrollment / Goal would be that 30% of those patients needing navigation services would receive them Data Source: Enrollment reports Milestone 11 Estimated Incentive Payment: $ 342,000 **Milestone 12** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. <u>Metric 1</u> [P-5.1]: Collect and	patients enrolled in the program Baseline/Goal: Year 4 enrollment / Goal would be that 35% of those patients needing navigation services would receive them Data Source: Enrollment reports Milestone 18 Estimated Incentive Payment: $ 342,000 **Milestone 19** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. <u>Metric 1</u> [P-5.1]: Collect and

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Patient navigation program materials and database, HER <u>Metric 2</u> [P-5.3]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: there are no patients receiving navigation services / the goal would be 15% of unique patients seen per six months will be enrolled in navigation services Data Source: Patient navigation program materials and database, EHR <u>Metric 3</u> [P-8.1]: Frequency of	<u>Metric 1</u> [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline/Goal: Currently no patients are receiving services and reports are not kept / a report of all types of navigation services covering at least 87% of patients serviced Data Source: Report submitted based on enrollment reports and tracking logs Milestone 7 Estimated Incentive Payment: $285,000		report on all the types of patient navigator services provided. Goal: a report of all types of navigation services covering at least 90% of patients serviced Data Source: Report submitted based on enrollment reports and tracking logs Milestone 12 Estimated Incentive Payment: $225,000 **Milestone 13** [P-5]: Milestone: Increase patient engagement, such as through patient	report on all the types of patient navigator services provided. Goal: a report of all types of navigation services covering at least 93 % of patients serviced Data Source: Report submitted based on enrollment reports and tracking logs Milestone 19 Estimated Incentive Payment: $225,000 **Milestone 20** [P-5]: Milestone: Increase patient engagement, such as through patient

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
contact with care navigators for high risk patients Baseline/Goal: there are current no high risk patients receiving navigation services / goal would be for 20% of high risk patients to receive at least two contacts from care navigators. Data Source: Patient navigation program materials and database, EHR Milestone 2 Estimated Incentive Payment: $ 410,000 **Milestone 3** [P-5]: Provide care management/navigation services to targeted patients	**Milestone 8** [P-5]: Milestone: Increase patient engagement, such as through patient education, self management support, improved patient-provider communication techniques, and/or coordination with community resources <u>Metric 1</u> [P-5.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Baseline/Goal: No patients are enrolled in patient		education, self management support, improved patient-provider communication techniques, and/or coordination with community resources <u>Metric 1</u> [P-5.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Baseline/Goal: year 3 / self-management based on navigation services / 25% of patients needing such services will be enrolled in program	education, self management support, improved patient-provider communication techniques, and/or coordination with community resources <u>Metric 1</u> [P-5.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program Baseline/Goal: year 4 / self-management based on navigation services / 30% of patients needing such services will be enrolled in program

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-5.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline/Goal: No patients are enrolled in a navigation program / Goal would be that 20% of those patients needing navigation services would receive them Data Source: Enrollment reports Milestone 3 Estimated Incentive Payment: $ 406,000 **Milestone 4** [P-5]: Provide	education / self-management based on navigation services / 20% of patients needing such services will be enrolled in program Data Source: Class offering records and class participation lists Milestone 8 Estimated Incentive Payment: $145,000 **Milestone 9** [P-8]: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote		Data Source: Class offering records and class participation lists Milestone 13 Estimated Incentive Payment: $145,000 **Milestone 14** [P-8]: 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	Data Source: Class offering records and class participation lists Milestone 20 Estimated Incentive Payment: $145,000 **Milestone 21** [P-8]: 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

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
reports on the types of navigation services provided to patients using the ED as high users or for episodic care. <u>Metric 1</u> [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline/Goal: Currently no patients are receiving services and reports are not kept / a report of all types of navigation services covering at least 85% of patients serviced Data Source: Report submitted based on	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. <u>Metric 1</u> [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: currently there are no regularly		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. <u>Metric 1</u> [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: year 3 / Goal would be to participate in 35% of organized meetings for every 6 month period. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or	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. <u>Metric 1</u> [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: year 4 / Goal would be to participate in 40% of organized meetings for every 6 month period. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
enrollment reports and tracking logs Milestone 4 Estimated Incentive Payment: $285,000	occurring collaborative learning meetings / Goal would be to participate in 30% of organized meetings for every 6 month period. 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. <u>Metric 2</u> [I-3.3]: Share challenges and solutions successfully during this bi-weekly interaction.		webinars including agendas for phone calls, slides from webinars, and/or meeting notes. <u>Metric 2</u> [I-3.3]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline / Goal: year 3 / Goal will be to share / solve one challenge each 6 month period Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during	webinars including agendas for phone calls, slides from webinars, and/or meeting notes. <u>Metric 2</u> [I-3.3]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline / Goal: year 4 / Goal will be to share / solve one challenge each 6 month period Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Baseline / Goal: This sharing / solving process does not exist currently / Goal will be to share / solve one challenge each 6 month period Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction summarized at quarterly intervals. Milestone 9 Estimated Incentive Payment: $158,000		each bi-weekly interaction summarized at quarterly intervals. Milestone 14 Estimated Incentive Payment: $138,000 **Milestone 15** [I-3]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program <u>Metric 1</u> [I-3.1]: ED visits and/or avoidable hospitalizations Goal: 10% lower than year 3 Data Source: EHR, navigation program database, ED records,	each bi-weekly interaction summarized at quarterly intervals. Milestone 22 Estimated Incentive Payment: $138,000 **Milestone 23** [I-3]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program <u>Metric 1</u> [I-3.1]: ED visits and/or avoidable hospitalizations Goal: 5% lower than year 4 Data Source: EHR, navigation program database, ED records,

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			inpatient records Milestone 15 Estimated Incentive Payment: $200,000 **Milestone 16** [I-3]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 1</u> [I-3.3]: Increase medical home empanelment of patients referred from navigator program. Goal: 5% increase from year 3 Data Source: Performing	inpatient records Milestone 23 Estimated Incentive Payment: $200,000 **Milestone 24** [I-3]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. <u>Metric 1</u> [I-3.3]: Increase medical home empanelment of patients referred from navigator program. Goal: 3% increase from year 4 Data Source: Performing

[Unique Category 2 Project Identifier, e.g. Project [TPI].2.3	*[Reference number of Project Option from RHP PP] 2.9.1*	*[Reference Number of Project Component(s) from RHP PP - e.g.2.X.X.X]*	*[Project Title]* 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Provider administrative data on patient <u>Metric 2</u> [I-3.3]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 5% increase over year 3 Data Source: Performing Provider administrative data on patient Milestone 16 Estimated Incentive Payment: $200,000	Provider administrative data on patient <u>Metric 2</u> [I-3.3]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 5% increase over year 4 Data Source: Performing Provider administrative data on patient Milestone 24 Estimated Incentive Payment: $200,000

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.3	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP] 2.9.1***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	***[PROJECT TITLE]*** 2.9 Establish/Expand a Patient Care Navigation Program with a Mobile Clinic model	
[RHP Performing Provider involved with this project - Name] *UTHSCSA*				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,551,000	Year 3 Estimated Milestone Bundle Amount: $1,388,000		Year 4 Estimated Milestone Bundle Amount: $1,593,000	Year 5 Estimated Milestone Bundle Amount: $1,430,044
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $5,962,000				

DSRIP Category: Category 2: Innovation and Redesign
Unique project ID: 085144601.2.4

IDENTIFYING PROJECT AND PROVIDER INFORMATION:

Project Area: 2.6 Title: Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles

Project options and identification numbers

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.

Performing Provider UTHSCSA

TPI: Number 085144601

PROJECT DESCRIPTION

UTHSCSA proposes to implement an evidenced-based Community Wide Campaign (CWC) that will include text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of healthy lifestyles. The Community Wide Campaign will address lack of physical activity and healthful food choices in our population leading to multiple chronic conditions which were noted in the RHP needs assessment including hypertension, obesity, diabetes and cardiovascular diseases. This project option will focus on implementation of the population-based campaign to promote healthy lifestyles in several municipalities within RHP 5. The CWC project ties to CN.1 by addressing shortages of primary care / preventive services in RHP 5 by making preventive information and lifestyle changes easily accessible and actionable through mass media venues, social media and text messaging.

In RHP 5, approximately 70% of the population has at least one chronic condition, particularly driven by the high rates of obesity and overweight.(Fisher-Hoch et al., 2012) The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting.

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. With the high prevalence of patients with chronic conditions, the longer-term cost savings will come from moving up stream and implementing health promotion interventions that prevent and control chronic conditions. The proposed project will support health by following Centers for Disease Control and Prevention recommendations for a proven-effective intervention. The Guide to Community Preventive Services (Guide) recommends multi-component community-wide campaigns as a strategy to increase physical activity and nutrition, the underlying causes of many chronic conditions.(Community Preventive Services Task Force, 2012) The Guide defined community-wide campaigns as:

"…large-scale campaigns deliver(ing) messages that promote physical activity by using television, radio, newspaper columns and inserts, and trailers in movie theaters. They use many components and include individually focused efforts such as support and self-help groups; physical activity counseling; risk factor screening and education at worksites, schools, and community health fairs; and environmental activities such as community events and the creation of walking trails."

The meta-analysis reported in the Guide provided evidence that community-wide campaigns increase energy expenditure by increasing the proportion of people who report being physically active. The Guide also stated that these community-wide campaigns address other health issues including nutrition.

CWCs have the following core components to achieve physical activity and healthy eating.

1) Mass media providing communication about lifestyle changes
2) Social support including self-help groups, exercise groups, community health worker home visits, text messages, and social media
3) Screening for risk factors and chronic disease including diabetes, high blood pressure, high BMI
4) Education about physical activity and nutrition in community locations
5) Environmental or policy changes to support healthy lifestyles

Through this project people will be exposed to targeted and scientifically accurate information about healthy lifestyles via mass media and social media. Text messages based on a bank of hundreds of text messages in Spanish and English will be sent. Patients will be referred to self-help and exercise groups in their local area. Within their cities, increased opportunities for health risk screenings will occur in easily accessible community locations with referrals to medical homes. Increased physical activity and nutrition education opportunities will be offered in community centers including parks and recreation facilities and schools. Changes to the environment to support physical activity and healthy food choices will also be implemented including protect paths for cycling and walking. Results will include controlled blood pressure and management of chronic diseases.

The CWC implementation team will consist of healthcare professionals, prevention experts, health communication experts and municipality-based leadership. People living in several municipalities will be targeted with the community wide campaign required core components listed above. Given the low income levels, high uninsured rates, and high percentage of Hispanics living in RHP 5, the locales targeted, but not limited to include San Benito, Los Indios, Los Fresnos, Harlingen, Brownsville, Rancho Viejo, Combes, Rio Hondo, Port Isabel. These municipalities fall within one of the poorest in the nation.

PROJECT GOAL:

The whole population (88% Hispanic) of RHP 5 suffers from substantial health disparities:

- 50% of the adult population is obese
- 31% of the adult population has diabetes
- Over 75% of adults have a chronic condition of diabetes, hypertension, hypercholesterolemia, heart disease, or other condition.

The goals of this project are to

1) implement innovative evidence-based community-wide campaign activities with fidelity to the recommended core components in selected municipalities of RHP 5: 2) to address the lack of physical activity and healthful food choices in RHP 5 so as to reduce risks for chronic disease, particularly hypertension. This project meets the following regional 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.

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 and issues facing this project: Transforming the health care delivery system to include a demonstrable focus on prevention and primary care is essential, but not without challenges. It involves redirecting training, staff time and resources to prevention initiatives such as a community wide campaign. In RHP 5 this is vital because 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. Obesity is the underlying and exacerbating issue, but patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for those in these rural areas.

Addressing the challenges: We will implement the evidenced-based Community Wide Campaign (CWC) which will include its core components including media messages, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The Community Wide Campaign will address lack of physical activity and healthful food choices which is prevalent in our community.

STARTING POINT/BASELINE

How the project represents a new initiative: This project will expand and innovate health care service delivery by creating an expansive base of preventive behavior change in the region. Mexican Americans have been documented in our area to have low participation in physical activity and consumption of fruits and vegetables. It is also common for our population not to consumer appropriate portions of food. The combination of these three factors leads to energy imbalance which is driving the obesity epidemic and explosion of chronic conditions in the community, even among the very young. The high obesity rate was noted in the RHP 5 needs assessment. The CWC has been selected because it is evidenced based for addressing these behaviors.

Our baseline data indicates that adults living in RHP 5 are substantially less likely to meeting physical activity (PA) guidelines or consume sufficient number of fruits and vegetables each day.

Comparing Two Samples on Meeting Health Guidelines (%)

	RHP5	Hispanic BRFSS (national)
Meet PA Guideline	30.59	41.00
Meet Dietary Guideline	16.29	22.68

The proposed community wide campaign activities have only been implemented in one of the partnering communities involved with this project. Funding for activities in that community is ending February 28, 2013. This was National Institutes of Health, National Center on Minority Health and Health Disparities funding. During this project's time of implementation 31% of the Spanish and non-Spanish speaking population indicated they were aware of the campaign. People reporting more intensive exposure to the campaign also were more likely to meet physical activity guidelines and more likely to consume fruits and vegetables. (Table 1 and 2) These results provide us additional evidence of the need for this community wide campaign, not only more expansively in this one community, but now more broadly disseminated. The limitations of this early iteration of the CWC include its primary focus on those who spoke Spanish. We will now expand the campaign to be fully in English and Spanish. Another limitation was its focus on one community. We will now expand the campaign to reach communities across RHP 5. Additionally, the earlier iteration of the campaign did not fully rely on text messaging support or social media. These elements will be added to the campaign to expand its reach and intensity.

Table 1: Odds ratios for Physical Activities, **Spanish Speakers (n=1187)**

Exposures	all n=1187	[a]Meet Physical Activities guidelines, n (%)		[b]OR (95% CI)	P value	[c]OR (95% CI)	P value
		No n=854 (72.37%)	Yes n=326 (27.63%)				
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	733(62.65)	506(60.02)	227(70.28)	**1.39(1.04,1.87)**	**0.0275**	**1.34(1.01,1.86)**	**0.0403**
Newsletter	635(55.51)	428(52.07)	207(65.09)	**1.53(1.14,2.04)**	**0.0042**	**1.51(1.12,2.04)**	**0.0075**
Discussion	418(36.35)	271(32.69)	147(46.37)	**1.62(1.22,2.13)**	**0.0007**	**1.59(1.20,2.11)**	**0.0135**
TV	332(29.12)	217(26.43)	115(36.51)	**1.49(1.13,1.98)**	**0.0055**	**1.49(1.12,1.99)**	**0.0066**
Radio	114(9.90)	67(8.05)	47 (14.87)	**1.88(1.26,2.81)**	**0.002**	**1.86(1.23,2.79)**	**0.0030**
Web	30(2.63)	20(2.43)	10(3.19)	1.22(0.56,2.64)	0.6152	1.14(0.52,2.5)	0.7489
Newsletter &Discussion & TV& Radio	47(4.01)	26(3.08)	21(6.50)	**2.00(1.11,3.63)**	**0.0218**	**1.86(1.02,3.41)**	**0.0434**

[a]Meet physical activity guidelines of 150 moderate and vigorous minutes per week
[b]Odds Ratios from Mixed Logistic Regression Models accounting for version differences of questionnaire
[c]Odds Ratios from Mixed Logistic Regression Models accounting for version differences of questionnaire adjusted for age, diabetic, gender, marital status, school years, language, insurance

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.

The implementation of evidenced based health promotion development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing preventive care to large, at risk populations in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

This initiative aims to eliminate fragmented, uncoordinated preventive care by creating a health promotion information regarding two health behaviors that underlie countless chronic conditions. The projects establish a foundation of transformation in RHP 5 and support the prevention and control of chronic disease at a population level.

We will implement quality improvement activities for this proposed project. We will conduct a rapid cycle improvement (PDSA) process to identify problems, and study and implement solutions.

5-year expected outcome for Performing Provider and patients

The expected outcome in five years is a fully implemented CWC in multiple municipalities across RHP 5. Once process and implementation milestones are reached, we expect an increase in the percentage of patients with controlled blood pressure. We also expect an increase in percentage of people meeting guidelines for minutes of physical activity reported and servings of fruits and vegetables consumed each day. These changes will lead result in several positive health outcomes. For persons with hypertension, engagement in CWC activities will result in controlled blood pressure.

RELATED CATEGORY 3 OUTCOME MEASURES

Because low levels of physical activity and food choices are related to hypertension, the category 3 goal for this project is to increase the percentage of patients enrolled in the evidenced based community wide campaign services who report controlled blood pressure.

In RHP 5 based on BRFSS data from 2009 27.7% of respondents indicate they have been diagnosed with high blood pressure. These rates are lower than the state as a whole, which is reminiscent of the fact that our population in RHP 5 does not access health care in a preventive fashion. In fact, in another study (Fisher-Hoch et al, 2012) the weighted prevalence of hypertension is 30.7% and 50% of those with the condition were unaware they had the condition and were not being treated.

Implementing the community wide campaign activities will increase screening for health risk factors such as high blood pressure, opportunities for physical activity and healthful food choices, and social support and social media support for long-term lifestyle changes to sustain controlled blood pressure readings.

Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in

mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure.

As stated above, RHP5 is among the highest poverty regions in the nation. The communities served by the community-wide campaign have over 20% of their population at or below 100% of poverty. The figure below depicts the percentage of the population below poverty by Zip Code Tabulation Area.

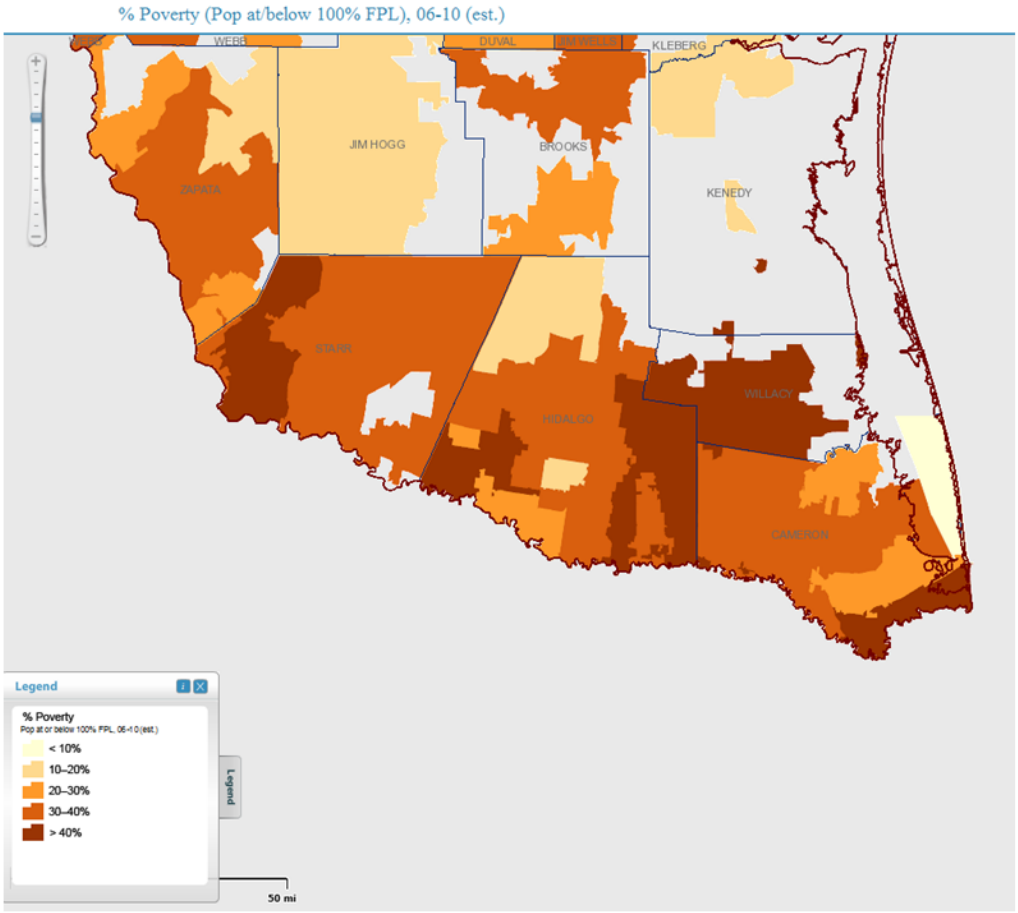

Figure 1. RHP 5 Percentage of Families living at or below 100% of Poverty Level

Relationship to Other Projects.

This project reinforces the projects being proposed by RHP5 hospitals and other performing providers by strengthening the focus on preventive care, conducting early screening and referrals, and working in population centers with low income and high uninsurance rates. This project will connect populations with scientifically proven strategies for improving healthy lifestyles, provide them with access to environmental and social support to initiate and sustain the lifestyle changes. The hospitals and clinics will find unprecedented media and environmental support for their recommendations to exercise more and consume a healthy diet. We will work to increase the coordination of care and reduce the burden on hospitals caused by unnecessary emergency department visits. Any project that strengthens the

cooperative relationships among healthcare providers and reduces unnecessary delays and waste, can only prove beneficial to the region.

Relationship to Other Performing Providers' Projects in the RHP.

No other performing provider is implementing this same community wide campaign initiative. However, this project will work in coordination with all other performing providers in the region to refer patients who present with health risks for follow-up and comprehensive care. We are fully committed to working with the other performing providers to ensure the triple aims are achieved.

Plan for Learning Collaborative

We plan to work with the UT School of Public Health as the facilitator to encourage the development of a learning collaborative during the project period. Working together to develop and implement a community wide campaign and with other projects implementing health information exchange initiatives will bring to light many similarities among performing providers and will also highlight those areas where challenges can be overcome. Our experience with preventive care, health communication, and text message support for lifestyle changes will be resources we plan to bring to the learning collaborative. We anticipate a strong working relationship among universities, hospitals, and private performing providers.

Project Valuation:

The project will be valued based upon the successful attainment of the following expected results:

- Develop and implement action plans for a community wide campaign
- Improved early screening of health risks among low income, low health insurance populations
- Prevention and early intervention among high-risk patients
- Restructure staffing into community outreach teams that conduct proven effective community wide campaign activities to patients.
- Collaborate with other performing providers to efficiently refer at risk pateints into care.

References

- *Bodenheimer,T., Lorig,K., Holman,H., and Grumbach,K. (2002). Patient self-management of chronic disease in primary care. JAMA 288, 2469-2475.*
- *Community Preventive Services Task Force. The Guide to Community Preventive Services. 2012. Centers for Disease Control and Prevention.*
- *Fisher-Hoch,S.P., Vatcheva,K.P., Laing,S.T., Hossain,M.M., Rahbar,M.H., Hanis,C.L., Brown,H.S., III, Rentfro,A.R., Reininger,B.M., and McCormick,J.B. (2012). Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. Prev. Chronic. Dis. 9, E135.*
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- *Witmer,A., Seifer,S.D., Finocchio,L., Leslie,J., and O'Neil,E.H. (1995). Community health workers: integral members of the health care work force. Am. J. Public Health 85, 1055-1058.*

TPI2.4	***[2.6.1]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**	
		UTHSCSA		085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*[*Category 3 outcome measure: IT-1.7	*[Reference number(s) from RHP PP]*	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)**[228] ***(Standalone measure)***	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community Metric 1 [P-2.1]: Document innovational strategy and plan Baseline/Goal: have action plan for each partnering community Data Source: Performing Provider evidence of		**Process Milestone** 3: [P-3]. Implement, document and test an evidence-based innovative project for targeted population Metric 1 : P-3.1. Metric: Document implementation strategy and testing outcomes. Metric 2 [I-1.2]: Conduct staff training on how to implement CWC evidenced based intervention. Goal: to train a team of people in each partnering community. Data Source: Training and participation records.	**Process Milestone 5** [P-4]: Execution of a learning and diffusion strategy for testing spread and sustainability of best practices and lessons learned. Metric 1 [P-4.1]: Document learning and diffusion strategic plan Data Source: Performing provider report summarizing challenge faced and learning, testing and spread of best practice. Milestone 5 Estimated	**Process Milestone 7** [P-5]: Execution of evaluation process for project innovation. P-5.1. Metric: Document evaluative process, tools and analytics. Data Source: Performing Provider contract or other documentation of evaluation Milestone 7 Estimated Incentive Payment: $ **279,366** **Improvement Milestone 8** [I-6]: Identify percentage of

TPI2.4	***[2.6.1]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**	
		UTHSCSA		085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*[*Category 3 outcome measure: IT-1.7	*[Reference number(s) from RHP PP]*	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)**[228] ***(Standalone measure)***	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
innovational plan Milestone 2 Estimated Incentive Payment: $ **Process Milestone 2** [P-5]: Execution of evaluation process for project innovation. P-5.1. Metric: Document evaluative process, tools and analytics. Data Source: Performing Provider contract or other documentation of evaluation		Milestone 3 Estimated Incentive Payment: $ **Process Milestone 4** [P-4]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-4.1]: Document learning and diffusion strategic plan Data Source: Performing provider report summarizing challenge faced and learning,	Incentive Payment: $ **275,926** **Improvement Milestone 6 [I-8]** Increase access to health promotion programs and activities using innovative project option. <u>Metric 1</u> [I-8.1]: Increase percentage of target population reached. Baseline/Goal: 10% increase in population reached by CWC than in year 3 Data Source: population awareness surveys	patients in defined population receiving innovative intervention consistent with evidence-based model over baseline. <u>Metric 1</u> [i-6.1]: 15% Increase in percentage of target population reached. Data Source: population awareness surveys Milestone 8 Estimated Incentive Payment: $

TPI2.4	***[2.6.1]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	**Implement Evidence-based Health Promotion Programs through a community wide campaign to promote healthy lifestyles**	
UTHSCSA				085144601
Related Category 3 Outcome Measure(s): OD-1 Primary Care and Chronic Disease Management	*[*Category 3 outcome measure: IT-1.7	*[Reference number(s) from RHP PP]*	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)**[228] ***(Standalone measure)***	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	testing and spread of best practice. Milestone 4 Estimated Incentive Payment: $		Milestone 6 Estimated Incentive Payment: $	
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: $ $1,117,462
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $4,292,954				

Category 3: Quality Improvements

Outcome Measure: IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)[228] ***(Standalone measure)***

Measure Description:

We propose to measure outcomes resultant for Process and Improvement milestones by trending improvements in the percentage of patients with controlled high blood pressure. As the CWC is implemented we will screen and identify people who have been diagnosed with hypertension but it is uncontrolled as well as people who have undiagnosed hypertension that is also uncontrolled. Implementing the core components of the CWC will identify engage these individuals in lifestyle changes, provide them support as they make behavior changes, and provide referrals to medical homes. All of these programmatic elements will results in their blood pressure will be brought under control. This will yield an increased percentage of people with controlled blood pressure.

We expect to use CWC registry data to measure this standalone measure. Patients who are enrolled in the CWC will receive a range of services that lead to a percentage increase in the number of adult patients with controlled blood pressure. We expect to see a 10% increase among the population who is aware of their hypertension status and a 5% increase in those with this condition who have it controlled. Currently 50% are unaware of their hypertension diagnosis and are therefore untreated (Fisher-Hoch et al, 2012). It is not clear how many people with hypertension, but are aware of their disease who have it controlled.

Rationale:

Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee. Many CVD risk factors such as high blood pressure, excess weight, poor diet, and diabetes can be prevented or treated through health behavior change and appropriate medication. We propose to create a CWC that increases physical activity, healthy food choices and referrals to medical homes so that holistic treatment of high blood pressure is achieved and sustained.

Outcome Measure Valuation:

a Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during the measurement year
b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

Controlled blood pressure was selected due to the prevalence of this condition in our local population and its related impact on health care costs. As demonstrated in our needs assessment, among diabetics, hypertension is the leading cause of hospitalization in RHP 5. Through the community wide campaign patient education, prevention, and care coordination will occur to improve the health of population and reduce the per capita cost of health care.

We expect to use registry records of the CWC to demonstrate improvements in this outcome measure. Patient records will be kept for those receiving services with the CWC. The baseline measure will be their initial blood pressure reading. Of those characterized with hypertension, a standalone measure of controlled high blood pressure will be taken at a follow-up measure within one year of their initial measure. BP less than 140 / 90 mm Hg will be considered adequately controlled. Patients enrolled during each performance year will be included in the outcome measure assessment.

Category 3 outcome measure: IT-1.7	Reference Number 2.4	Project Components 2.6.1	Controlling High Blood Pressure **(NCQA-HEDIS 2012, NQF 0018)**[228] ***(Standalone measure)***
UTHSCSA			UTHSCSA TPI#
Related Category 1 or 2 Projects: 2.6.1			Identifier TPI# 085144601
Starting Point/Baseline		50% of hypertensive patients are unaware of diagnosis and do not have controlled blood pressure	

Year 2 (10/1/2012 – 9/30/2013	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P- 2 Establish baseline rates Metric 1. P-2.1. Determine baseline of controlled blood pressure among patients with hypertension enrolled in CWC services	**Process Milestone 2: P-3. Develop and test data system** Metric 1: P-3.1 Establish data system for tracking CWC patients. Enter data and conduct test of system.	**Process Milestone 3: P-4.** Conduct a plan Do Study Act (PdSA) cycle to improve data collection and intervention activities Metric 1: implement PDSA cycle on issue identified by project partners, jointly study and implement solution **Improvement Target 4: I-7. Controlling high blood pressure** Metric: incremental increase in number or percent of patients with controlled high blood pressure Data source: CWC registry data	**Improvement Target 5: I-7. Controlling high blood pressure** Metric: incremental increase in number or percent of patients with controlled high blood pressure Data source: CWC registry data
Year 2 Estimated Outcome Amount: $	Year 3 Estimated Outcome Amount: $	Year 4 Estimated Outcome Amount: $	Year 5 Estimated Outcome Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FO 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $			

085144601.2.5
DSRIP Category: Category 2: Innovation and Redesign

IDENTIFYING PROJECT AND PROVIDER INFORMATION:

Project Area: 2.6 Title: Implement Evidence-based Health Promotion Programs

Project options and identification numbers

2.6.2 Establish self-management programs and wellness using evidence-based designs.

Performing Provider UTHSCSA **TPI:** 085144601

PROJECT DESCRIPTION

We will implement the evidenced-based Community Wide Campaign (CWC) which will include community health worker outreach, self-management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The Community Wide Campaign will address lack of physical activity and healthful food choices. This project option focuses on the implementation of self-management and wellness within the context of the evidenced based community wide campaign in partnering communities within RHP 5.

In RHP 5, approximately 70% of the population has at least one chronic condition, particularly driven by the high rates of obesity and overweight.(Fisher-Hoch et al., 2012) The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. With the high prevalence of patients with chronic conditions, the longer-term cost savings will come from moving up stream and implementing health promotion interventions that prevent and control chronic conditions. The proposed project will provide self-management programs providing education and wellness.

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. The Guide to Community Preventive Services (Guide) recommends multi-component community-wide campaigns as a strategy to increase physical activity and nutrition, the underlying causes of many chronic conditions.(Community Preventive Services Task Force, 2012) The Guide defined community-wide campaigns as:

"…large-scale campaigns deliver(ing) messages that promote physical activity by using television, radio, newspaper columns and inserts, and trailers in movie theaters. They use many components and include individually focused efforts such as support and self-help groups; physical activity counseling; risk factor screening and education at worksites, schools, and community health fairs; and environmental activities such as community events and the creation of walking trails."

The meta-analysis reported in the Guide provided evidence that community-wide campaigns increase energy expenditure by increasing the proportion of people who report being physically active. The Guide also stated that these community-wide campaigns address other health issues including nutrition.

CWC have the following core components to achieve physical activity and healthy eating.

6) Mass media providing communication about lifestyle changes
7) Social support including self-help groups, exercise groups, community health worker home visits, text messages, and social media
8) Screening for risk factors and chronic disease including diabetes, high blood pressure, high BMI
9) Education about physical activity and nutrition in community locations
10) Environmental or policy changes to support healthy lifestyles

Delivery Mechanisms:
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.(Bodenheimer et al., 2002; Witmer et al., 1995; Thorpe, 2012)

PROJECT GOAL: The goal of the project is to implement innovative evidence-based health promotion strategies to address two behaviors underlying chronic conditions found in RHP 5: Lack of physical activity and healthful food choices. We will implement innovative evidence based health promotion strategies using a community wide campaign model that couples the use of community health workers, social and mass media to provide health messages and behavior change support for people living in RHP 5.

Challenges and issues facing this project: In RHP 5, 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. Obesity is the underlying and exacerbating issue, but patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for those in these rural areas.

Addressing the challenges: We will implement the evidenced-based Community Wide Campaign (CWC) which will include media messages, community health worker outreach, self-management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The Community Wide Campaign will address lack of physical activity and healthful food choices which is prevalent in our community. This project addresses needs associated with the lack of self-management programs and wellness in RHP 5.

2.6.2 Establish self-management programs and wellness using evidence-based designs.

STARTING POINT/BASELINE

How the project represents a new initiative
This project will expand and innovate health care service delivery by creating an expansive base of preventive behavior change in the region. Mexican Americans have been documented in our area to have low participation in physical activity and consumption of fruits and vegetables. It is also common for our population to not consumer appropriate portions of food. The combination of these three factors leads to energy imbalance which is driving the obesity epidemic and explosion of chronic conditions in the community, even among the very young. The CWC has been selected because it is evidenced based for addressing these behaviors.

Community wide campaign activities have only been implemented in one of the partnering communities involved with this project. Funding for those activities in that community is ending February 28, 2013. This was National Institutes of Health, National Center on Minority Health and Health Disparities funding. During this project's time of implementation 31% of the population indicated they were aware of the campaign. People reporting more intensive exposure to the campaign also were more likely to meet physical activity guidelines and more likely to consume fruits and vegetables. These results provide us additional evidence of the need for this community wide campaign, not only more expansively in this one community, but now more broadly disseminated. The limitations of this early iteration of the CWC include its primary focus on those who spoke Spanish. We will now expand the campaign to be fully in English and Spanish. Another limitation was its focus on one community. We will now expand the campaign to reach at least seven communities in RHP 5. Additionally, the earlier iteration of the campaign did not fully rely on text messaging support or social media. These elements will be added to the campaign to expand its reach and intensity.

Table 1: Odds ratios for Physical Activity

Exposures	[a]Meet Physical Activities guidelines, n (%)		[b]OR (95% CI)	P value
	No	Yes		
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	**353(36.21%)**	**179(41.72%)**	**1.26(1.00,1.59)**	**0.0497**
Newsletter	**246(25.60%)**	**131(31.04%)**	**1.31(1.02,1.68)**	**0.0366**
Discussion	135(14.02%)	69(16.27%)	1.19(0.87,1.63)	0.2751
TV	162(17.11%)	86(20.53%)	1.25(0.94,1.68)	0.1312
Radio	**42(4.35%)**	**31(7.33%)**	**1.74(1.08,2.81)**	**0.0237**
Web	10(1.06%)	6(1.44%)	1.37(0.49,3.79)	0.5477
Radio & Newsletter	27(2.77%)	20(4.69%)	1.73(0.96,3.11)	0.0697

[a]Meet physical activity guidelines of 150 moderate and vigorous minutes per week

[b]Odds Ratios from Logistic Regression Models

Table 2: Odds ratios for Fruits and Vegetables

Exposures	[c]Meet Nutrition guidelines, n (%)		[d]OR (95% CI)	P value
	No	Yes		
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	462(38.73%)	72(33.49%)	1.01(0.73,1.41)	0.9475
Newsletter	329(28.02%)	50(23.47%)	1.03(0.71,1.49)	0.8825
Discussion	186(15.78%)	19(8.96%)	0.70(0.42,1.19)	0.1855
TV	211(18.17%)	37(17.79%)	1.15(0.77,1.73)	0.4975
Radio	**57(4.84%)**	**17(7.91%)**	**1.99(1.09,3.64)**	**0.0252**
Web	16(1.39%)	0(0%)	N/A	N/A
Radio & TV	**28(2.36%)**	**10(4.65%)**	**2.37(1.07,5.23)**	**0.0326**
Radio & TV & newsletter	**16(1.34%)**	**8(3.72%)**	**3.90(1.55,9.80)**	**0.0038**

[c]Meet recommended guidelines of 5+ portions of fruit & veg a day

[d]Odds Ratios from Logistic Mixed Effects Models accounting for version differences of questionnaire

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.

The goal of the project is to implement innovative evidence-based health promotion strategies to address two behaviors underlying chronic conditions found in RHP 5: Lack of physical activity and healthful food choices which lead to high rates of obesity and other chronic conditions. Media messages, community health workers, text message support and environmental changes will be implemented to support prevention and early intervention health promoting activities for at risk populations. Addressing physical activity and healthy food choices through a community wide campaign will also prevent cardiovascular diseases, and certain cancers. Importantly in will also prevent and control diabetes. INSERT SPECIFIC NEEDS NUMBERS HERE

5-year expected outcome for Performing Provider and patients

The expected outcome in five years is patients with better controlled diabetes and blood pressure and a population reporting increased minutes of physical activity and servings of fruits and vegetables each day.

RELATED CATEGORY 3 OUTCOME MEASURES

The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated. In years 2 and 3, Milestone 1 ,,,,,,,,,,,,,,,,,,,,,,,, Milestone 2 ……., Milestones 3 and 4 …… Milestone 5

This project is related to category 3 Outcome domains

Stand-alone:

IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)[228] *(Standalone measure)*

a Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during

the measurement year
b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension
c Data Source: EHR, Registry
d Rationale/Evidence: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*[233] *- NQF 0059 (Standalone measure)*

a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c Data Source: EHR, Registry, Claims, Administrative clinical data
d Rationale/Evidence: 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.

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IT-1.11 Diabetes care: *BP control (<140/80mm Hg)*[234] *– NQF* 0061 *(Standalone measure)*

a 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.
b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c Data Source: EHR, Registry, Claims, Administrative clinical data

d Rationale/Evidence: 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

Non-stand-alone but related:

IT-13.6 Other Outcome Improvement Target: must be evidence based, appropriate for proposed project, and meet the definition of an outcome measure.
a Numerator: TBD by performing provider
b Denominator: TBD by performing provider
c Data Source: TBD by performing provider
d Rationale/Evidence: Rationale to include citation, evidence base and significance of target towards intervention population or community of need

- Data supporting why these outcomes are a priority for the RHP;
- Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
- Explanation of how focusing on the outcomes will help improve the health of low-income populations.]

Relationship to other Projects: *(A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.)*

Relationship to Other Performing Providers' Projects in the RHP: (*If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.)*

Plan for Learning Collaborative: (*If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.)*

Project Valuation: (*A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums.)*

References

- *Bodenheimer,T., Lorig,K., Holman,H., and Grumbach,K. (2002). Patient self-management of chronic disease in primary care. JAMA 288, 2469-2475.*
- *Community Preventive Services Task Force. The Guide to Community Preventive Services. 2012. Centers for Disease Control and Prevention.*
- *Fisher-Hoch,S.P., Vatcheva,K.P., Laing,S.T., Hossain,M.M., Rahbar,M.H., Hanis,C.L., Brown,H.S., III, Rentfro,A.R., Reininger,B.M., and McCormick,J.B. (2012). Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. Prev. Chronic. Dis. 9, E135.*
- *Thorpe,K.E. (2012). Analysis & commentary: The Affordable Care Act lays the groundwork for a national diabetes prevention and treatment strategy. Health Aff. (Millwood.) 31, 61-66.*
- *Witmer,A., Seifer,S.D., Finocchio,L., Leslie,J., and O'Neil,E.H. (1995). Community health workers: integral members of the health care work force. Am. J. Public Health 85, 1055-1058.*

[UNIQUE CATEGORY 2 PROJECT IDENTIFIER, E.G. PROJECT [TPI].2.5]	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – E.G. 2.X.X]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - E.G.2.X.X.X]***	***[PROJECT TITLE]***	
[RHP Performing Provider involved with this project - Name]				*[RHP Performing Provider - TPI]*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community <u>Metric 1</u> [P-5.1]: Document innovational strategy and plan Baseline/Goal: have action plan for each partnering community to implement self-management programs Data Source: Performing Provider action plan documents Milestone 1 Estimated Incentive Payment: $		**Milestone 3** [P-5]: Implement, document and test an evidence-based innovative project for targeted population <u>Metric 1</u> [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least two self-management programs and test Data Source: Performing Provider and contractor documentation of implementation Milestone 3 Estimated Incentive Payment: $	**Milestone 5** [P-5]: Implement, document and test an evidence-based innovative project for targeted population <u>Metric 1</u> [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least three self-management programs and test Data Source: Performing Provider and contractor documentation of implementation Milestone 5 Estimated Incentive Payment: $	**Milestone 8** [P-5]: Implement, document and test an evidence-based innovative project for targeted population <u>Metric 1</u> [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least four self-management programs and test Data Source: Performing Provider and contractor documentation of implementation Milestone 8 Estimated Incentive Payment: $

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505,931 **Milestone 2** [P-5]: Implement, document and test an evidence-based innovative project for targeted population <u>Metric 1</u> [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: identify one self-management program to implement, document and test Data Source: Performing Provider and contractor documentation of implementation	**529,965** **Milestone 4** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months Data Source: Performing provider report summarizing challenge faced and learning,		367,901 **Milestone 6** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months Data Source: Performing provider report summarizing challenge faced and learning,	372,487 **Milestone 9** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months Data Source: Performing provider report summarizing challenge faced and learning,

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Milestone 2 Estimated Incentive Payment: $ **505,931**	testing and spread of best practice. Milestone 4 Estimated Incentive Payment: $ **529,965**		testing and spread of best practice. Milestone 6 Estimated Incentive Payment: $ 367,901 **Milestone 7** [P-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [P-8.1]: Increase percentage of target population reached. Baseline/Goal: 10% increase in population reached by self-management programs offered within CWC over year 3	testing and spread of best practice. Milestone 9 Estimated Incentive Payment: $ 372,487 **Milestone 10** [P-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [P-8.1]: Increase percentage of target population reached. Baseline/Goal: 5% increase in population reached by self-management programs offered within CWC over year 4 Data Source: population

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			Data Source: population awareness surveys Milestone 7 Estimated Incentive Payment: $ 367,901	awareness surveys Milestone 10 Estimated Incentive Payment: $ 372,487
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ $1,011,861	Year 3 Estimated Milestone Bundle Amount: $ $1,059,929		Year 4 Estimated Milestone Bundle Amount: $ $1,103,702	Year 5 Estimated Milestone Bundle Amount: $ $1,117,462
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $ $4,292,954				

Identifying Project and Provider Information:

085144601.2.6

Project Area: 2.6 Title: Implement Evidence-based Health Promotion Programs

Project options and identification numbers

2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

Performing Provider UTHSCSA **TPI:** 085144601

Project Description:

We will implement the evidenced-based Community Wide Campaign (CWC) which will include community health worker outreach, self-management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The Community Wide Campaign will address lack of physical activity and healthful food choices. This project option will focus on engaging community health workers in the implementation of a community wide campaign to increase health literacy of populations in the partnering communities within RHP 5.

In RHP 5, approximately 70% of the population has at least one chronic condition, particularly driven by the high rates of obesity and overweight.(Fisher-Hoch et al., 2012) The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. With the high prevalence of patients with chronic conditions, the longer-term cost savings will come from moving up stream and implementing health promotion interventions that prevent and control chronic conditions. The proposed project will provide community health worker outreach to enhance health literacy of populations on topics associated with lifestyle changes.

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. The Guide to Community Preventive Services (Guide) recommends multi-component community-wide campaigns as a strategy to increase physical activity and nutrition, the underlying causes of many chronic conditions.(Community Preventive Services Task Force, 2012) The Guide defined community-wide campaigns as:

"…large-scale campaigns deliver(ing) messages that promote physical activity by using television, radio, newspaper columns and inserts, and trailers in movie theaters. They use many components and include individually focused efforts such as support and self-help groups; physical activity counseling; risk factor screening and education at worksites, schools, and

community health fairs; and environmental activities such as community events and the creation of walking trails."

The meta-analysis reported in the Guide provided evidence that community-wide campaigns increase energy expenditure by increasing the proportion of people who report being physically active. The Guide also stated that these community-wide campaigns address other health issues including nutrition.

CWC have the following core components to achieve physical activity and healthy eating.

1) Mass media providing communication about lifestyle changes
2) Social support including self-help groups, exercise groups, community health worker home visits, text messages, and social media
3) Screening for risk factors and chronic disease including diabetes, high blood pressure, high BMI
4) Education about physical activity and nutrition in community locations
5) Environmental or policy changes to support healthy lifestyles

Delivery Mechanisms: Community Health Workers (CHW) 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.

PROJECT GOAL: The goal of the project is to Implement innovative evidence-based health promotion strategies to address two behaviors underlying chronic conditions found in RHP 5: Lack of physical activity and healthful food choices. We will implement innovative evidence based health promotion strategies using a community wide campaign model that couples the use of community health workers, social and mass media to provide health messages and behavior change support for people living in RHP 5.

Challenges and issues facing this project: In RHP 5, 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. Obesity is the underlying and exacerbating issue, but patients in our rural underserved areas often lack transportation, primary care access, and preventive services. No navigation services are in place for those in these rural areas.

Addressing the challenges: We will implement the evidenced-based Community Wide Campaign (CWC) which will include media messages, community health worker outreach, self-

management education, text-message support for lifestyle changes, and evidenced based environmental changes to support maintenance of health. The Community Wide Campaign will address lack of physical activity and healthful food choices which is prevalent in our community. This project addresses the low health literacy needs of populations living in RHP 5:

2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

Starting Point/Baseline:

How the project represents a new initiative

This project will expand and innovate health care service delivery by creating an expansive base of preventive behavior change in the region. Mexican Americans have been documented in our area to have low participation in physical activity and consumption of fruits and vegetables. It is also common for our population to not consumer appropriate portions of food. The combination of these three factors leads to energy imbalance which is driving the obesity epidemic and explosion of chronic conditions in the community, even among the very young. The CWC has been selected because it is evidenced based for addressing these behaviors.

Community wide campaign activities have only been implemented in one of the partnering communities involved with this project. Funding for those activities in that community is ending February 28, 2013. This was National Institutes of Health, National Center on Minority Health and Health Disparities funding. During this project's time of implementation 31% of the population indicated they were aware of the campaign. People reporting more intensive exposure to the campaign also were more likely to meet physical activity guidelines and more likely to consume fruits and vegetables. These results provide us additional evidence of the need for this community wide campaign, not only more expansively in this one community, but now more broadly disseminated. The limitations of this early iteration of the CWC include its primary focus on those who spoke Spanish. We will now expand the campaign to be fully in English and Spanish. Another limitation was its focus on one community. We will now expand the campaign to reach at least seven communities in RHP 5. Additionally, the earlier iteration of the campaign did not fully rely on text messaging support or social media. These elements will be added to the campaign to expand its reach and intensity.

Table 1: Odds ratios for Physical Activity

Exposures	[a]Meet Physical Activities guidelines, n (%)		[b]OR (95% CI)	P value
	No	Yes		
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	**353(36.21%)**	**179(41.72%)**	**1.26(1.00,1.59)**	**0.0497**
Newsletter	**246(25.60%)**	**131(31.04%)**	**1.31(1.02,1.68)**	**0.0366**
Discussion	135(14.02%)	69(16.27%)	1.19(0.87,1.63)	0.2751
TV	162(17.11%)	86(20.53%)	1.25(0.94,1.68)	0.1312
Radio	**42(4.35%)**	**31(7.33%)**	**1.74(1.08,2.81)**	**0.0237**
Web	10(1.06%)	6(1.44%)	1.37(0.49,3.79)	0.5477
Radio & Newsletter	27(2.77%)	20(4.69%)	1.73(0.96,3.11)	0.0697

[a]Meet physical activity guidelines of 150 moderate and vigorous minutes per week

[b]Odds Ratios from Logistic Regression Models

Table 2: Odds ratios for Fruits and Vegetables

Exposures	[c]Meet Nutrition guidelines, n (%)		[d]OR (95% CI)	P value
	No	Yes		
Have you regularly read, seen, or heard any health messages from the TSSC campaign? (yes)	462(38.73%)	72(33.49%)	1.01(0.73,1.41)	0.9475
Newsletter	329(28.02%)	50(23.47%)	1.03(0.71,1.49)	0.8825
Discussion	186(15.78%)	19(8.96%)	0.70(0.42,1.19)	0.1855
TV	211(18.17%)	37(17.79%)	1.15(0.77,1.73)	0.4975
Radio	**57(4.84%)**	**17(7.91%)**	**1.99(1.09,3.64)**	**0.0252**
Web	16(1.39%)	0(0%)	N/A	N/A
Radio & TV	**28(2.36%)**	**10(4.65%)**	**2.37(1.07,5.23)**	**0.0326**
Radio & TV & newsletter	**16(1.34%)**	**8(3.72%)**	**3.90(1.55,9.80)**	**0.0038**

[c]Meet recommended guidelines of 5+ portions of fruit & veg a day

[d]Odds Ratios from Logistic Mixed Effects Models accounting for version differences of questionnaire

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.

The goal of the project is to implement innovative evidence-based health promotion strategies to address two behaviors underlying chronic conditions found in RHP 5: Lack of physical activity and healthful food choices which lead to high rates of obesity and other chronic conditions. Media messages, community health workers, text message support and environmental changes will be implemented to support prevention and early intervention health promoting activities for at risk populations. Addressing physical activity and healthy food choices through a community wide campaign will also prevent cardiovascular diseases, and certain cancers. Importantly in will also prevent and control diabetes. INSERT SPECIFIC NEEDS NUMBERS HERE

5-year expected outcome for Performing Provider and patients

The expected outcome in five years is patients with better controlled diabetes and blood pressure and a population reporting increased minutes of physical activity and servings of fruits and vegetables each day.

Related Category 3 Outcome Measures:

The overall goal of this project is improvement in the health of a health disparity population with high rates of essentially treatable and preventable diseases which are undiagnosed and untreated. In years 2 and 3, Milestone 1 ,,,,,,,,,,,,,,,,,,,,,,,, Milestone 2 ……., Milestones 3 and 4 …… Milestone 5

This project is related to category 3 Outcome domains

Stand-alone:

IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)[228] ***(Standalone measure)***
a Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg)during the measurement year

b Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension
c Data Source: EHR, Registry
d Rationale/Evidence: Approximately 76.4 million (33.5 percent) of people in the United States have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure; results are particularly striking in elderly hypertensives, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53 percent to 75 percent of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the USPSTF and the Joint National Committee.

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*[233]*- NQF 0059 (Standalone measure)*
a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c Data Source: EHR, Registry, Claims, Administrative clinical data
d Rationale/Evidence: 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.

IT-1.11 Diabetes care: *BP control (<140/80mm Hg)*[234]*– NQF* 0061 *(Standalone measure)*
a 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.
b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)
c Data Source: EHR, Registry, Claims, Administrative clinical data
d Rationale/Evidence: 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

Non-stand-alone but related:

IT-13.6 Other Outcome Improvement Target: must be evidence based, appropriate for proposed project, and meet the definition of an outcome measure.
a Numerator: TBD by performing provider
b Denominator: TBD by performing provider
c Data Source: TBD by performing provider
d Rationale/Evidence: Rationale to include citation, evidence base and significance of target towards intervention population or community of need

- Data supporting why these outcomes are a priority for the RHP;
- Validated, evidence-based rationale describing how the related Category 1 or 2 project will help achieve the Category 3 outcome measure selected; and/or
- Explanation of how focusing on the outcomes will help improve the health of low-income populations.]

Relationship to Other Projects:

(A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.)

Relationship to Other Performing Providers' Projects in the RHP:

(If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.)

Plan for Learning Collaborative:

(If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.)

Project Valuation:

(A narrative that describes the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance,

addressing priority community need, estimated local funding). Supporting information may be included in the addendums.)

References

- *Bodenheimer,T., Lorig,K., Holman,H., and Grumbach,K. (2002). Patient self-management of chronic disease in primary care. JAMA 288, 2469-2475.*
- *Community Preventive Services Task Force. The Guide to Community Preventive Services. 2012. Centers for Disease Control and Prevention.*
- *Fisher-Hoch,S.P., Vatcheva,K.P., Laing,S.T., Hossain,M.M., Rahbar,M.H., Hanis,C.L., Brown,H.S., III, Rentfro,A.R., Reininger,B.M., and McCormick,J.B. (2012). Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a mexican american population, cameron county Hispanic cohort, 2003-2008. Prev. Chronic. Dis. 9, E135.*
- *Thorpe,K.E. (2012). Analysis & commentary: The Affordable Care Act lays the groundwork for a national diabetes prevention and treatment strategy. Health Aff. (Millwood.) 31, 61-66.*
- *Witmer,A., Seifer,S.D., Finocchio,L., Leslie,J., and O'Neil,E.H. (1995). Community health workers: integral members of the health care work force. Am. J. Public Health 85, 1055-1058.*

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Milestone 1 [*RHP PP Milestone* – P-Y]: Conduct an assessment of health promotion programs that involve community health workers at local and regional level Metric 1 [*RHP PP Metric* – P-Y.Z]: Document regional assessment Baseline/Goal: examine the health literacy needs and role of community health works in filling need in assessment Data Source: Performing Provider assessment and summary of findings	**Milestone 3** [P-5]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least two health literacy programs by community health workers and test Data Source: Performing Provider and contractor documentation of implementation		**Milestone 5** [P-5]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least three health literacy programs by community health workers and test Data Source: Performing Provider and contractor documentation of implementation	**Milestone 8** [P-5]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-5.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implement at least four health literacy programs by community health workers and test Data Source: Performing Provider and contractor documentation of implementation

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Milestone 1 Estimated Incentive Payment (*maximum amount)*: $ **505,931** **Milestone 2** [P-5]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community <u>Metric 1</u> [P-5.1]: Document innovational strategy and plan Baseline/Goal: have action plan for each partnering community	Milestone 3 Estimated Incentive Payment: $ **529,965** **Milestone 4** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months		Milestone 5 Estimated Incentive Payment: $ 367,901 **Milestone 6** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months	Milestone 8 Estimated Incentive Payment: $ 372,487 **Milestone 9** [P-5]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. <u>Metric 1</u> [P-5.1]: Document learning and diffusion strategic plan Baseline/Goal: conduct at least one learning, testing, spread and sustainability of best practice cycle every six months

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Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			population reached by healthy literacy programs offered within CWC over year 3 Data Source: population awareness surveys Milestone 7 Estimated Incentive Payment: $ 367,901	literacy programs offered within CWC over year 4 Data Source: population awareness surveys Milestone 10 Estimated Incentive Payment: $ 372,487
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ $1,011,861	Year 3 Estimated Milestone Bundle Amount: $ $1,059,929		Year 4 Estimated Milestone Bundle Amount: $ $1,103,702	Year 5 Estimated Milestone Bundle Amount: $ $1,117,462
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $$4,292,954				

Driscoll Children's Hospital – Category 1 Infrastructure Development

132812205.1.1

1.8 –Increase, Expand, and Enhance Oral Health Services - Driscoll Children's Hospital [TPI: 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 (State Fiscal Year 2012)
- 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.
- Prevent number of children requiring surgical intervention to treat severe dental caries.

Also describe how the project is related to the regional goals.]

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 4,200 dental education and fluoride varnish treatments for State Fiscal year 2012 baseline metric. Today, X trained medical providers 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.

Based on the Community Needs Assessment (CNA) for Region 5 of the State of Texas 1115 Waiver, only 48% of those in RHP 5 had seen a dentist or dental clinic during the past year, well under the proportion of Texas (62%) or the US (67%). Since only 35% of RHP5 (ranging from 17% to 38% in counties) have dental insurance compared to 61% in the US it is commonplace for individuals with dental problems to visit the hospital emergency room or seek care in Mexico for dental care.

Related Category 3 Outcome Measure(s):

OD-7 Oral Health –IT-7.10 Other Outcome Improvement Target

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 XX%.

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 in other markets. 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:

TPI -1.8 – Expand Access to Oral Health Services complements other projects that expand access to services for children, including TPI 1.1 (Expand Access to Primary Care Services) and TPI 1.9 (Expanding Access to Subspecialty Care). The Oral Health project does not have a corresponding Category 4 Population-focused measure.

Relationship to Other Performing Providers' Projects in the RHP:

Anchor to provide

Plan for Learning Collaborative:

Anchor to provide

Project Valuation:

We believe the Oral Health project is a highly valuable initiative in the RHP 5 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 $6,000,000 (inclusive of Categories 3 and 4).

Unique Category 1 Project Identifier, e.g. Project [TPI 132812205] [1.8]	***[Reference number of Project Option from RHP PP – 1.8]***	***[Reference Number of Project Component(s) from RHP PP - 1.8.12]***	**Expand and Improve Pediatric Oral Health**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): *OD-7 Oral Health*	*[Unique Category 3 IT identifier(s)]: OD- IT-7.10*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)] Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)	**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-11]: 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-11.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 1**: Estimated Incentive Payment *(maximum amount):* $ 318,750	**Milestone 5** [P-12]: Task Force leads quality improvement initiative for oral health care project. **Metric 5a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 5b**: [P-12.2] Documentation of Task Force report, findings and/or action plan to further enhance oral health project. **Data Source:** Hospital/health plan record **Milestone 5**: Estimated Incentive Payment *(maximum amount):* $ 400,000		**Milestone 8** [P-12]: Task Force leads quality improvement initiative for oral health care project **Metric 8a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 8.b** [P-12.2]: Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project **Data Source:** Hospital/health plan record **Milestone 8**: Estimated Incentive Payment *(maximum amount): $ 375,000*	**Milestone 11** [P-12]: Task Force leads quality improvement initiative for oral health care project **Metric 11a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 11b** [P-12.2]**:** Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project **Data Source:** Hospital/health plan record **Milestone 11**: Estimated Incentive Payment *(maximum amount): $ 285,000*

Unique Category 1 Project Identifier, e.g. Project [TPI 132812205] [1.8]	***[Reference number of Project Option from RHP PP – 1.8]***	***[Reference Number of Project Component(s) from RHP PP - 1.8.12]***	**Expand and Improve Pediatric Oral Health**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): *OD-7 Oral Health*	*[Unique Category 3 IT identifier(s)]: OD- IT-7.10*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)] Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: [P-12]: Develop plan to increase training of PCP providers on how to administer dental education and fluoride varnish treatments for pediatric patients. **Metric 2** [**P-12.1**]: Copy of the plan. **Data Source:** Roster/ attendance sheets for grand rounds and training **Milestone 2**: Estimated Incentive Payment *(maximum amount):* $318,750 **Milestone 3:** [P-13]: Conduct an initial assessment to	**Milestone 6** [I-11]: Increase dental care training **Metric 6** [I-11.3]: Train an additional 10 providers to perform dental education and fluoride varnish treatments in a PCP office above the SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 6**: Estimated Incentive Payment *(maximum amount):* $ 400,000		**Milestone 9** [I-11]: Increase dental care training **Metric 9** [I-11.3]: Train an additional 20 providers to perform dental education and fluoride varnish treatments in a PCP office above SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 11**: Estimated Incentive Payment *(maximum amount):* $ 375,000	**Milestone 12** [I-11]: Increase dental care training **Metric 12** [I-11.3]: Train an additional 30 providers to perform dental education and fluoride varnish treatments in a PCP office above the SFY 2012 baseline. **Data Source:** Enrollment/ attendance at training **Milestone 12**: Estimated Incentive Payment *(maximum amount):* $ 285,000

UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT [TPI 132812205] [1.8]	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – 1.8]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - 1.8.12]***	**Expand and Improve Pediatric Oral Health**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): *OD-7 Oral Health*	*[Unique Category 3 IT identifier(s)]: OD- IT-7.10*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)] Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
expand, increase, and enhance pediatric oral health services performed by a primary care provider. **Metric 3:** [P-13.1]: Documentation of plan assessment **Data Source**: Hospital/health plan records **Milestone 3**: Estimated Incentive Payment *(maximum amount):* $318,750 **Milestone 4:** [I-15]: Expand Preventive Dental services by PCP. **Metric 4:** [I-15.1]: Goal: Increase the number of education and dental fluoride varnish treatments performed		**Milestone 7:** [I-15]: Expand Preventive Dental services performed by PCP office. **Metric 7:** [I-15.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 10% above the SFY 2012 baseline **Data Source**: Hospital/health plan records **Milestone 7**: Estimated Incentive Payment: $ 400,000	**Milestone 10:** [I-15]: Expand Preventive Dental services performed by PCP office. **Metric 10:** [I-15.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 15% above the SFY 2012 baseline **Data Source**: Hospital/health plan records **Milestone 10:** Estimated Incentive Payment: $ 375,000	**Milestone 13:** [I-15]: Expand Preventive Dental services performed by PCP office. **Metric 13:** [I-15.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll's delivery service area by 20% above the SFY 2012 baseline **Data Source**: Hospital/health plan records **Milestone 13**: Estimated Incentive Payment: $ 285,000

UNIQUE CATEGORY 1 PROJECT IDENTIFIER, E.G. PROJECT [TPI 132812205] [1.8]	***[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – 1.8]***	***[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - 1.8.12]***	**Expand and Improve Pediatric Oral Health**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): *OD-7 Oral Health*	*[Unique Category 3 IT identifier(s)]: OD- IT-7.10*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)] Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
by PCP in Driscoll's delivery service area by 5% above the SFY 2012 baseline. **Data Source**: Hospital/health plan records **Milestone 4**: Estimated Incentive Payment: $ 318,750				
Year 2 Estimated Milestone Bundle Amount: $ 1,275,000		Year 3 Estimated Milestone Bundle Amount: $ 1,200,000	Year 4 Estimated Milestone Bundle Amount: $ 1,125,000	Year 5 Estimated Milestone Bundle Amount: $ 855,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 4,455,000				

Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

OD-7 Oral Health –IT-7.10, Other Outcome Improvement Target, TPI -1.8 –Increase, Expand, and Enhance Oral Health Services - Driscoll Children's Hospital [TPI: 132812205]

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 in other markets. 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 prevent severe dental caries that result in operative interventions for targeted population in the Driscoll Service area by XX%.

a. **Numerator:** Total number of Driscoll's Health plan children with severe dental caries requiring operative intervention in SFY'12
b. **Denominator:** Total number of Driscoll's Health plan participants who received dental education and fluoride varnish treatment for prevention of severe dental caries in SFY'12
c. **Data Source:** Claims data for fluoride varnish treatment as well as operative interventions will be tracked and trended.
d. **Rationale/Evidence:** 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.[17]

Rationale:

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.

[17] (Billings, D., Eller, A., Harris, J., Hemric, S., Tucker, T., & Whitesides, S. (2006). Dental Fluoride Varnishing. Wilkesboro: Wilkes County Health Department.Weintraub JA, Ramos-Gomez F, Jue B, Shain S, Hoover CI, Featherstone JD, Gansky SA. Fluoride Varnish Efficacy in Preventing Early Childhood Caries. J Dent Res. 2006; 85:172-176, Stearns, SC, et al, Cost -Effectiveness of Preventive Oral Health Care in Medical Offices for Young Medicaid Enrollees. Arch Pediatr Adolesc Med/Vol. 166 (no 10), Oct 2012 p 945-951.)

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 in other markets. The preventive treatment of dental education and fluoride varnish treatment versus dental operating room procedures creates significant value to our community.

[Unique Category 3 outcome measure identifier(s)] *OD-7: Oral Health*	*IT-7.10*	*[Operative Dental Care Needs in Children]*	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	**TPI -1.8 –Increase, Expand, and Enhance Oral Health Services - Driscoll Children's Hospital [TPI: 132812205]**		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Hospital/Health plan records. **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $150,000	**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 in SFY'12 Denominator: Total number of Driscoll's Health plan participants who received dental education and fluoride varnish treatment for prevention of severe dental caries during a 12-month	**Outcome Improvement Target 1** [IT-7.10]: **Improvement Target**: Decrease XX% 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*:* $225,000	**Outcome Improvement Target 2** [IT-7.10]: **Improvement Target**: Decrease XX% 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*:* $495,000

[Unique Category 3 outcome measure identifier(s)] *OD-7: Oral Health*	*IT-7.10*	*[Operative Dental Care Needs in Children]*	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	**TPI -1.8 –Increase, Expand, and Enhance Oral Health Services - Driscoll Children's Hospital [TPI: 132812205]**		
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)**
	period **Data Source**: Documentation of claims data. **Process Milestone(s):** Estimated Incentive Payment: $150,000		
Year 2 Estimated Outcome Amount: $150,000	Year 3 Estimated Outcome Amount: $150,000	Year 4 Estimated Outcome Amount: $225,000	Year 5 Estimated Outcome Amount: $495,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,020,000			

Driscoll Children's Hospital Category 2: Innovation and Redesign

132812205.2.1

2.6– Implement Evidence-based Health Promotion Programs

Driscoll Children's Hospital [TPI: 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 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.

The consultation visits reinforce the concepts presented at the baby showers, but also allow team members to ensure that the mother seeks postpartum care, infant care, and family planning consideration. 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 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 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 20 percent.
- Expand consultation visits by 5 percent
- Reduce NICU Average Length of Stay (ALOS)
- Expand Cadena Healthplan participants by 5 percent

Preterm infants are at an 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

Metropolitan Statistical Area	% Preterm	State Average	Percent Higher
Brownsville- Harlingen	15.4	13.2	2.2
Corpus Christi	14.9	13.2	1.7
Laredo	13.8	13.2	0.6
Victoria	14.0	13.2	0.8

Also describe how the project is related to the regional goals.]

Starting Point/Baseline:

During State Fiscal Year 2012, Driscoll provided over 300 prenatal educational sessions, 50 Cadena Healthplan participants and over X 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). 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.

Provide the unique community need identification number the project addresses.

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcome: IT-8.9
Reduce the Neonatal ICU Average Length of Stay 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). 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. This project will increase community participation and education through these services targeted to serve low-income populations.

Relationship to other Projects:

The TPI 2.6– Implement Evidence-based Health Promotion Programs supports TPI 2.7- Implement Evidence-based Disease Prevention Programs through education to high-risk pregnant patients. The related Category 4 Population-focused measure would not be applicable to this project.

Relationship to Other Performing Providers' Projects in the RHP:

Anchor to provide

Plan for Learning Collaborative:

Anchor to provide

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 and the Average Length of Stay (ALOS) for a NICU patient 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.

Driscoll provides educational sessions and consultations for multiple reasons, one of which is to help reduce ALOS for NICU patients. 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 Average Length of Stay (ALOS) for a NICU patient, we estimated a total saving and value to the state of approximately $5.4 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DSRIP funding to be allocated to this project is $10,000,000 (inclusive of Categories 3 and 4).

[Unique Category 2 Project Identifier, Project 132812205.2.1.	*[Reference number of Project Option from RHP PP – 2.6*	*[Reference Number of Project Component(s) from RHP PP - 2.6.2.*	*Implement evidenced- based health promotion program: Expand Cadena de Madres program*	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*[unique Category 3 IT identifier(s)] OD-8*	*[Reference number(s) from RHP PP] IT 8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Year 2 (10/1/2012 – 9/30/2013)	**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-9]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing the Cadena de Madres Program. **Metric 1** [P-9.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 1**: Estimated Incentive Payment *(maximum amount): $425,000* **Milestone 2:** [P-10] Develop	**Milestone 6** [P-12]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 6a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 6b**: [P-12.2] 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 6**: Estimated		**Milestone 10** [P-12]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 10a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 10b**: [P-12.2] 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 10**: Estimated	**Milestone 14** [P-12]: Task Force leads quality improvement initiative for Cadena de Madres program **Metric 14a** [P-12.1]: Documentation of Quality Improvement meetings held twice per year **Metric 14b**: [P-12.2] 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

[Unique Category 2 Project Identifier, Project 132812205.2.1.	*[Reference number of Project Option from RHP PP – 2.6*	*[Reference Number of Project Component(s) from RHP PP - 2.6.2.*	*Implement evidenced- based health promotion program: Expand Cadena de Madres program*	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*[unique Category 3 IT identifier(s)] OD-8*	*[Reference number(s) from RHP PP] IT 8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
plan to expand Cadena de Madres program to women with high risk pregnancies **Metric 2**: [P-10.1]: Evidence of plan **Data Source: Hospital/health plan record** **Milestone 2:** Estimated Incentive Payment *(maximum amount): $425,000* **Milestone 3** [I.9] Increase access to prenatal education sessions for target population **Metric 3**: [I.9.1] Increase number of prenatal education sessions for target population by 5 percent above SFY 12 baseline.	Incentive Payment *(maximum amount):* *$500,000* **Milestone 7:** [I.9] Increase access to prenatal education sessions for target population **Metric 7**: [I-9.1] Increase number of prenatal education sessions for target population by 10 percent above SFY 12 baseline **Data Source:** Hospital/health plan record **Milestone 7:** Estimated Incentive Payment *(maximum amount):* *$500,000*		Incentive Payment *(maximum amount):* $468,750 **Milestone 11:** [I.9] Increase access to prenatal education sessions for target population **Metric 11 [I.9.1]**: Increase number of prenatal education sessions for target population by 15 percent above SFY 12 baseline. **Data Source:** Hospital/health plan record **Milestone 11:** Estimated Incentive Payment *(maximum amount):* $468,750	Incentive Payment *(maximum amount):* *$356,250* **Milestone 15:** [I.9] Increase access to prenatal education sessions for target population **Metric 15**: [I.9.1] Increase number of prenatal education sessions for target population by 20 percent above SFY 12 baseline. **Data Source:** Hospital/health plan record **Milestone 15:** Estimated Incentive Payment *(maximum amount):* *$356,250*

[Unique Category 2 Project Identifier, Project 132812205.2.1.	*[Reference number of Project Option from RHP PP – 2.6*	*[Reference Number of Project Component(s) from RHP PP - 2.6.2.*	*Implement evidenced- based health promotion program: Expand Cadena de Madres program*	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*[unique Category 3 IT identifier(s)] OD-8*	*[Reference number(s) from RHP PP] IT 8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Hospital/health plan record **Milestone 3:** Estimated Incentive Payment *(maximum amount): $425,000* **Milestone 4:** [I.10] Increase access to prenatal education consults for target population **Metric 4**: [I-10.1] Increase number of prenatal education consults above baseline for target population by 5 percent above SFY 12 baseline. **Data Source:** Hospital/health plan record **Milestone 4:** Estimated Incentive Payment *(maximum amount):* $425,000	**Milestone 8:** [I-10] Increase access to prenatal education consults for target population **Metric 8**: [I-10.1] Maintain Year 2 (SFY 2013) number of prenatal education consults for target population **Data Source:** Hospital/health plan record **Milestone 8:** Estimated Incentive Payment *(maximum amount): $500,000* **Milestone 9:** [I-11] Increase number of Cadena Healthplan participants **Metric 9**: [I-11.1] Maintain		**Milestone 12:** [I.10] Increase access to prenatal education consults for target population **Metric 12**: [I.10.1] Maintain Year 2 (SFY 2013) number of prenatal education consults for target population **Data Source:** Hospital/health plan record **Milestone 12:** Estimated Incentive Payment *(maximum amount):* $468,750 **Milestone 13:** [I-11] Increase number of Cadena Healthplan participants	**Milestone 16** [I.10] Increase access to prenatal education consults for target population **Metric 16**: [I.10.1] Maintain Year 2 (SFY 2013) number of prenatal education consults for target population **Data Source:** Hospital/health plan record **Milestone 16:** Estimated Incentive Payment *(maximum amount): $356,250* **Milestone 17:** [I-11] Increase number of Cadena Healthplan participants

[Unique Category 2 Project Identifier, Project 132812205.2.1.	*[Reference number of Project Option from RHP PP – 2.6*	*[Reference Number of Project Component(s) from RHP PP - 2.6.2.*	*Implement evidenced- based health promotion program: Expand Cadena de Madres program*	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s): Perinatal Outcomes	*[unique Category 3 IT identifier(s)] OD-8*	*[Reference number(s) from RHP PP] IT 8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: [I-11] Increase number of Cadena Healthplan participants **Metric 5**: [I-11.1] Increase number of Cadena Healthplan participants by 5 percent above SFY 12 baseline. **Data Source:** Hospital/health plan record **Milestone 5:** Estimated Incentive Payment *(maximum amount):$425,000*	Year 2 (SFY 2013) number of Cadena Healthplan participants for target population **Data Source:** Hospital/health plan record **Milestone 9:** Estimated Incentive Payment *(maximum amount):$500,000*		**Metric 13**: [I-11.1] Maintain Year 2 (SFY 2013) number of Cadena Healthplan participants for target population **Data Source:** Hospital/health plan record **Milestone 13:** Estimated Incentive Payment *(maximum amount):$468,750*	**Metric 17**: [I-11.1] Maintain Year 2 (SFY 2013) number of Cadena Healthplan participants for target population **Data Source:** Hospital/health plan record **Milestone 17:** Estimated Incentive Payment *(maximum amount):$356,250*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,125,000	Year 3 Estimated Milestone Bundle Amount: $2,000,000		Year 4 Estimated Milestone Bundle Amount: $1,875,000	Year 5 Estimated Milestone Bundle Amount: $1,425,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 7,425,000				

Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 NICU Average Length of Stay, TPI 2.6– Implement Evidence-based Health Promotion Programs, Driscoll Children's Hospital [TPI: 132812205]

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). 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.

Decrease the Neonatal ICU Average Length of Stay for the targeted population by XX percent for DY4-5.

IT-8.9 Reduce the Neonatal ICU Average Length of Stay for the targeted population

a. Numerator: Total Discharge Days in the NICU for targeted population
b. Denominator: Total number of Discharges in the NICU for targeted population
c. Data source: Claims data/Hospital documentation

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 NICU inpatient days and pre-term 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). Neonatal ICU use is a high cost service line. Decreasing the number of premature infant admissions less than 37 weeks and the Average Length of Stay (ALOS) for a NICU patient 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 provided counseling sessions on tobacco and alcohol use for pregnant women of will create significant savings and value.

[Unique Category 3 outcome measure identifier(s]: *OD-8: Perinatal Outcomes*	*IT-8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	TPI 2.6– Implement Evidence-based Health Promotion Programs Driscoll Children's Hospital [TPI: 132812205]		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of Meeting minutes/plans **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $250,000	**Process Milestone 2[P-2]:** Undertake steps and actions to establish baselines for Reduce the Neonatal ICU Average Length of Stay for the targeted population **Numerator:** Total Discharge Days in the NICU for targeted participants **Denominator:** Total number of Discharges in the NICU for target population **Data Source**: Claims data/Hospital documentation **Process Milestone 2**	**Outcome Improvement Target 1** [IT-8.9]: Improvement Target: Reduce the Neonatal ICU Average Length of Stay for the targeted population by X percent over baseline. **Data Source**: Claims data/Hospital documentation **Outcome Improvement Target 1** Estimated Incentive Payment*:* $375,000	**Outcome Improvement Target 2** [IT-8.9]: Improvement Target: Reduce the Neonatal ICU Average Length of Stay for the targeted population by X percent over baseline. **Data Source**: Hospital record **Outcome Improvement Target 2** Estimated Incentive Payment*:* $825,000

[Unique Category 3 outcome measure identifier(s]: *OD-8: Perinatal Outcomes*	*IT-8.9*	Reduce the Neonatal ICU Average Length of Stay for the targeted population	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	TPI 2.6– Implement Evidence-based Health Promotion Programs Driscoll Children's Hospital [TPI: 132812205]		
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)**
	Estimated Incentive Payment: $250,000		
Year 2 Estimated Outcome Amount: $250,000	Year 3 Estimated Outcome Amount: $250,000	Year 4 Estimated Outcome Amount: $375,000	Year 5 Estimated Outcome Amount: $825,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,700,000			

132812205.2.2
TPI 2.7– Implement Evidence-based Disease Prevention Programs
Driscoll Children's Hospital [TPI: 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.

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. MFMs receive two to three years of additional training after an OB/GYN residency that focuses on high-risk pregnancies, ultrasound techniques and fetal anomalies.

A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% 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. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby's heart.

This team approach in prenatal diagnosis allows for better pregnancy counseling and improved neonatal outcomes. Driscoll Health System will coordinate this initiative with local Maternal-Fetal Medicine specialists, Pediatric Cardiologists, managed care organizations, and community collaborators. Driscoll Health System will form a Disease Prevention Task Force and will hold quality improvement meetings twice a year to review. The task force will be multidisciplinary in

composition and will assess progress on Maternal Fetal Medicine project milestones and metrics. The task force meeting will serve as a structure for activity such as, but not limited to: identifying project impacts and "lessons learned", reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Disease Prevention Project.

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 10 percent
- Expand MFM clinics and outreach program facility hours by 2.5 percent
- Increase the number of detected related fetal anomalies in high-risk pregnant patients

Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. 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

Metropolitan Statistical Area	% Preterm	State Average	Difference
Brownsville- Harlingen	15.4	13.2	2.2
Corpus Christi	14.9	13.2	1.7
Laredo	13.8	13.2	0.6
Victoria	14.0	13.2	0.8

Also describe how the project is related to the regional goals.]

Starting Point/Baseline:

The MFM clinics and outreach program facilities in Driscoll's service area for baseline measurement will begin at approximately 2,700 hours of operation in CY 2011 The MFM echocardiogram program in Driscoll's service area for baseline measurement will begin at approximately 10,800 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.

Provide the unique community need identification number the project addresses.

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies

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:

The TPI 2.7– Implement Evidence-based Disease Promotion Programs supports TPI 2.6-Implement Evidence-based Health Prevention Programs through early intervention with high-risk pregnant patients. The related Category 4 Population-focused measure would not apply to this project plan at this time.

Relationship to Other Performing Providers' Projects in the RHP:

Anchor to provide

Plan for Learning Collaborative:

Anchor to provide

Project Valuation:

The quantitative value is based on a determination that the NICU is a high cost service. Decreasing the number of patients and the average length of stay (ALOS) for a NICU patient is a more efficient use of resources. Increasing the hours and use of a MFM clinic/outreach program and increasing the number of Maternal Fetal echocardiogram procedures will create significant savings and value.

Driscoll 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 Perinatalogists 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 $5.4 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 $16 million (inclusive of Categories 3 and 4).

[Unique Category 1 Project Identifier, [TPI 132812205] Project [2.2]	*[Reference number of Project Option from RHP PP – 2.7*	*[Reference Number of Project Component(s) from RHP PP - 2.7.1*	**Implement Evidence-based Disease Prevention Programs: Expand Maternal Fetal Medicine Program in Driscoll Service Area**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]* **Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-8]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing Driscoll's Maternal Fetal Medicine (MFM) Program. **Metric 1** [P-8.1]: Documentation of Task Force establishment **Data Source:** Hospital/health plan record **Milestone 2**: Estimated Incentive Payment *(maximum amount): $1,133,333*	**Milestone 4**[P-9]: Task Force leads quality improvement initiative for MFM program **Metric 4a** [P-9.1]: Documentation of Quality Improvement meetings held twice per year **Metric 4b**: [P-9.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 4**: Estimated Incentive Payment *(maximum amount): $1,066,666*	**Milestone 7** [P-9]: Task Force leads quality improvement initiative for MFM program **Metric 7a** [P-9.1]: Documentation of Quality Improvement meetings held twice per year **Metric 7b**: [P-9.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 7**: Estimated Incentive Payment *(maximum amount): $1,000,000*	**Milestone 10** [P-9]: Task Force leads quality improvement initiative for MFM program **Metric 10a** [P-9.1]: Documentation of Quality Improvement meetings held twice per year **Metric 10b**: [P-9.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM **Data Source:** Hospital/health plan record **Milestone 10**: Estimated Incentive Payment *(maximum amount): $760,000*
Milestone 2 [P-1]: Develop plan /strategy to expand the Maternal Fetal Medicine	**Milestone 5 [I-7]:** Increase access to MFM program **Metric 5** [I-7.2]: Increase number of MFM echocardiogram program procedures by 5	**Milestone 8 [I-7]:** Increase access to MFM program **Metric 8** [I-7.2]: Increase number of MFM echocardiogram program procedures by 10	**Milestone 11 [I-7]:** Increase access to MFM program **Metric 11** [I-7.2]: Maintain 10 percent target increase of

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, [TPI 132812205] PROJECT [2.2]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – 2.7*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - 2.7.1*	**Implement Evidence-based Disease Prevention Programs: Expand Maternal Fetal Medicine Program in Driscoll Service Area**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]* **Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area**	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Program in Driscoll serve area **Metric 2:** [P-1.1] Document innovational strategy and plan **Data Source:** **Milestone 2**: Estimated Incentive Payment *(maximum amount): $1,133,333* **Milestone 3 [P-10]:** Increase hours of accessibility of MFM clinics/outreach program **Metric 3** [P-10.1]: Increase MFM clinics/outreach program hours by 2.5% above CY 2011 baseline. **Data Source:** Hospital/health plan record **Milestone 3**: Estimated Incentive Payment *(maximum amount): $1,133,334*	percent above CY 2011 baseline. **Data Source:** Hospital/health plan record **Milestone 5**: Estimated Incentive Payment *(maximum amount): $1,066,666* **Milestone 6 [P-10]:** Increase hours of accessibility of MFM clinics/outreach program **Metric 6** [P-10.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 **Data Source:** Hospital/health plan record **Milestone 6**: Estimated Incentive Payment *(maximum amount): $1,066,667*	percent above CY 2011 baseline. **Data Source:** Hospital/health plan record **Milestone 8**: Estimated Incentive Payment *(maximum amount): $1,000,000* **Milestone 9 [P-10]:** Increase hours of accessibility of MFM clinics/outreach program **Metric 9** [P-10.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 **Data Source:** Hospital/health plan record **Milestone 9** Estimated Incentive Payment *(maximum amount): $1,000,000*	number of MFM echocardiogram procedures above the CY 2011 baseline. **Data Source:** Hospital/health plan record **Milestone 11**: Estimated Incentive Payment *(maximum amount): $ 760,000* **Milestone 12 [P-10]:** Increase hours of accessibility of MFM clinics/outreach program **Metric 12** [P-10.1]: Maintain 2.5% target increase of MFM clinics/outreach program hours in DY 2 **Data Source:** Hospital/health plan record **Milestone 12**: Estimated Incentive Payment *(maximum amount): $760,000*

[UNIQUE CATEGORY 1 PROJECT IDENTIFIER, [TPI 132812205] PROJECT [2.2]	*[REFERENCE NUMBER OF PROJECT OPTION FROM RHP PP – 2.7*	*[REFERENCE NUMBER OF PROJECT COMPONENT(S) FROM RHP PP - 2.7.1*	**Implement Evidence-based Disease Prevention Programs: Expand Maternal Fetal Medicine Program in Driscoll Service Area**	
Driscoll Children's Hospital				*TPI: 132812205*
Related Category 3 Outcome Measure(s):	*[unique Category 3 IT identifier(s)]*	*[Reference number(s) from RHP PP]*	*[Outcome Measure (Improvement Target) Title(s)]* **Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,400,000	Year 3 Estimated Milestone Bundle Amount: $3,200,000		Year 4 Estimated Milestone Bundle Amount: $3,000,000	Year 5 Estimated Milestone Bundle Amount: $2,280,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $11,880,000				

Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies: TPI 2.7– Implement Evidence-based Disease Promotion Programs

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%.

a. **Numerator:** Total number of early detected maternal fetal anomalies over a 12-month period
b. **Denominator:** Total number of early detected maternal fetal anomalies over the prior 12-month period
c. **Data Source:** Hospital records

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 outcome measure identifier(s]OD-8 Perinatal Outcomes	IT-8.9	Early Detection of Maternal Fetal Anomalies	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	TPI 2.7– Implement Evidence-based Disease Promotion Programs Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area		
Starting Point/Baseline:			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **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. 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 $400,000	**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%. **Data Source**: Hospital records Outcome Improvement Target 1 Estimated Incentive Payment*:* $600,000	**Outcome Improvement Target 3** [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%. **Data Source**: Hospital records Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,320,000

[Unique Category 3 outcome measure identifier(s]OD-8 Perinatal Outcomes	IT-8.9	Early Detection of Maternal Fetal Anomalies	
Driscoll Children's Hospital			*TPI: 132812205*
Related Category 1 or 2 Projects:	TPI 2.7– Implement Evidence-based Disease Promotion Programs Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $400,000	Year 3 Estimated Outcome Amount: $400,000	Year 4 Estimated Outcome Amount: $600,000	Year 5 Estimated Outcome Amount: $1,320,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $2,720,000			