# Section V. DSRIP Projects

## RHP Plan Development

### RHP 17 Requirements

RHP 17 is a Tier 4 region, which carries a minimum requirement of four projects from Categories 1 and 2 with at least two from Category 2. In the final plan, RHP 17 has included 16 projects from Category 1 and 15 projects from Category 2; 28 of these projects were selected in Pass 1 and 3 in Pass 2. Addendum 4 summarizes all the proposed projects considered but not selected by the RHP for Pass 1 and Pass 2 combined.

### Pass 1 / Pass 2

As a smaller region, RHP 17 used a relatively simple process for Pass 1 and Pass 2 project selection. As mentioned in Section III, each IGT entity was provided with the local and regional assessment data and asked to determine its priorities early in the process. These priorities were communicated in public meetings, and were summarized and disseminated to eligible performing providers to inform them what IGT entities would be willing to fund. Based on the then-current list of project areas and options, the anchor created a form, and the performing providers were asked to submit 2-page concept proposals for the IGT entities to review. The anchor compiled the concept proposals and facilitated meetings with the IGT entities and performing providers to discuss their ideas, and they began to negotiate IGT. As the planning protocol evolved, so did the projects.

Once the final planning protocol was approved, most of the performing providers and IGT entities had agreements in place as to what funds were available for which projects; the amount of DSRIP for the region did not approach the regional DSRIP cap. Based on this, RHP 17 proceeded through Pass 1 focused on meeting the Pass 1 requirements and ensuring that our eligible Pass 1 providers were able to include projects that would enable them to participate in Pass 2. RHP 17 has only one major safety net hospital and no public hospitals. The process utilized the performing providers’ Pass 1 workbooks for information to ensure the following:

1. The region met the minimum number of projects from Categories 1 and 2;
2. The major safety net hospital participated in DSRIP in Pass 1;
3. The hospital providers’ DSRIP projects met the 5 percent allocation guideline;
4. The local mental health centers were each represented in Pass 1 so that they could participate in Pass 2 in case they exceeded their Pass 1 allocation; and
5. The local health departments were represented in Pass 1 so that they could participate in Pass 2.

In this process, we were able to include everything in Pass 1 except for what the entities with smaller percent allocations had in excess of those allocations—one of the community mental health centers and one hospital provider. Pass 2 then consisted of projects that would not fit under the Pass 1 allocations, as well as those from providers not eligible under Pass 1.

In order to be eligible to submit new three-year DSRIP projects, a region had to have met all of the requirements defined for Pass 1 in the Program Funding and Mechanics Protocol and been eligible to move to additional passes. As a Tier 4 region, RHP 17 carried a minimum requirement to implement four projects from Categories 1 and 2 with at least two from Category 2. In addition, any identified safety net hospital was required to implement a DSRIP project and a minimum of 5% participation among private hospitals in the region was also required. As outlined in the original RHP 17 Plan submitted in November 2012, the region met all of these Pass 1 funding requirements and submitted two projects funded through the Pass 2 process. All of these requirements continued to be met in RHP 17, thereby allowing eligible providers in the region to develop and submit new three-year projects for approval and implementation in December 2013.

### RHP 17 Goals

The overarching goal of RHP 17 is to transform the local and regional health care delivery systems to improve access to care, efficiency, and effectiveness. Specifically, RHP 17 will address the key challenges listed above and will aim to resolve these by reaching four primary goals. The plans for achieving those goals are outlined below under each goal:

1. Expanding the availability of and access to timely, high quality primary, specialty, and behavioral health care for residents, including those with multiple needs;

Providers in RHP 17 will achieve this goal by expanding the availability and capacity of primary care in the region, as well as expanding the services available through primary care providers. In addition to expanded clinic hours, rural fellowships will allow for residents to be placed in rural areas, expand capacity at safety net clinics, mobile primary care screenings, targeting disparities groups with evidence based health promotion, disease prevention, and chronic care management, and increasing behavioral health care via telehealth and mobile clinics in rural communities. Some of these new services will focus on managing chronic conditions, while others will focus on decreasing potentially preventable admissions/readmissions, inappropriate ED use, and/or aim to improve patient satisfaction, an indicator of quality of care.

1. Increasing the proportion of residents with a regular source of care;

The expansion of primary care capacity in the region will provide opportunities for residents to establish a regular source of care. Enhanced training of primary care providers will also contribute to more care capacity and better quality of care for primary care patients. In addition to availability, new patient navigation programs will refer patients who are currently without a regular source of care to available primary care providers.

1. Increasing coordination of preventive, primary, specialty, and behavioral health care for residents, including those with multiple needs; and

The coordination of care in the region will better address the community needs by integrating primary and behavioral health services, integrating behavioral health services with services for the intellectually and developmentally disabled, and creating patient navigation programs to ensure residents who access more inappropriate settings of care can develop a regular source of care.

1. Reducing costs by minimizing inappropriate utilization of services.

Given the largely rural nature of RHP 17, inappropriate utilization of services is a critical issue as many needed services simply are not available locally. All of the activities described under Goals 1, 2 and 3 above, in theory, will reduce inappropriate utilization of the emergency department (ED), the criminal justice system and emergency medical services. The expansion of primary care availability and accessibility, care coordination through patient navigation, targeted behavioral health services, and evidence-based health promotion/disease prevention targeting high risk and disparate populations all serve to get people into the right care at the right time. Specific outcomes of interest include, but are not limited to, appropriate utilization of the ED and reducing the ambulatory care sensitive admission rate.

Process for Four-Year Project Selection

In the Program Funding and Mechanics Protocol, the requirements for project selection outline criteria for provider participation and that every DSRIP project should meet a specific regional need identified in the community needs assessment that is supported by data. In addition, community stakeholders were assured and providers were directed that all projects proposed and selected should: a.) benefit the Medicaid and indigent population in RHP 17; b.) demonstrate regional transformation, integrating with other providers where able, and c.) represent a cohesive strategy implemented across all four protocol categories.

In RHP 17, the initial allocations were outlined for the region as a whole, and then Pass 1 allocations were given by HHSC for each hospital. The designated percentages of the regional allocation were also calculated for named categories of providers: academic health science centers, community mental health centers, and public health departments. Given these allocations, RHP 17 went through the steps described above in the “Pass 1 / Pass 2” Section:

1. Prioritization of community need within each community and as a region;
2. Solicitation of project concepts based on identified priorities and the then-current DSRIP menu;
3. Presentation of project concepts by providers to IGT entities;
4. Revision of project concepts with the new and final DSRIP Planning Protocol;
5. Review of proposed projects by anchor entity to highlight any potential issues related to the fit with the Planning Protocol;
6. Review of the proposed projects by IGT entities to determine fit with local needs and priorities, as well as the scope and potential impact of each project;
7. Selection of projects to support by IGT entities; and
8. Negotiation of project specifics and amount of IGT available to support each project.

Once the IGT entities committed support to the projects they selected, the anchor conducted a cursory review to ensure that the requirements were met, which was subsequently verified through the provider and anchor workbooks.

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### Process for Three-Year Project Selection

In addition to adhering to all the main components used in the four-year project selection process, RHP 17 also followed the proposal submission, scoring and prioritization process for three-year projects outlined in Section II. Given the small number of Performing Providers able to secure IGT for new projects and the large remaining DSRIP allocation in RHP 17, all projects with a confirmed source of IGT support were selected for implementation and inclusion in the regional plan.

In accordance with initial requirements for all DSRIP Projects as outlined in the Program Funding and Mechanics Protocol, each project had to meet a specific regional need identified in the community needs assessment that is supported by data. Again as outlined above, community stakeholders were once again assured and interested providers were directed that all projects proposed and selected should: a.) benefit the Medicaid and indigent population in RHP 17 and include data related to estimated quantifiable patient impact; b.) demonstrate regional transformation, integrating with other providers where able; and c.) represent a cohesive strategy implemented across all four protocol categories as applicable.

Category 4 Exemptions

No performing providers in RHP 17 are exempt from Category 4 reporting.

## Project Valuation

RHP 17 adopted a general five-step approach to guide project valuation across the RHP, with each provider able to determine the ultimate valuation of each project with its related IGT entity. Once each provider had determined the content of the project, including tasks, timelines, milestones, and metrics, it was asked to consider the following steps:

1. Determine how much the project, including the Category 1/2 portion, the Category 3 portion, and where applicable the Category 4 portion, will cost to implement.

It is critical that each provider understand the actual cost to their organization of implementing a project, to ensure feasibility of implementation, long-term sustainability, and to ensure that the valuation at least covers these costs. When determining the actual implementation costs, several factors influence variations in costs across seemingly similar projects, including:

• Size of the organization (existing infrastructure, resources, administrative costs);

• Complexity of the project and project implementation;

• Size and scope of the project;

• Size of the target area (geography) if the project is in multiple locations or including transportation as a supporting service;

• Size and characteristics of the target population; and

• Resource needs for implementation and long-term sustainability.

The initial estimated project costs were suggested to include all implementation costs, including personnel, equipment/supplies, travel, training, expert consultants, subcontracts, and any administrative support costs. This bottom line for the project gives providers a starting point for valuing their project.

1. Calculate any cost savings or costs avoided, both short- and long-term.

Substantial variability arises from this step, as each project focuses on different target outcomes, where the cost-savings or costs avoided may be calculated in a variety of ways. For each project, providers were encouraged to estimate additional value of the project in consideration of the following:

• Collaboration of resources or services with other providers that reduces the costs of service delivery;

• Cost-savings for potentially preventable admissions, readmissions, and complications;

• Costs potentially avoided that had historically been incurred through:

* + Transportation of patients to services;
  + Inappropriate emergency department utilization;
  + Poor prevention or chronic care management that leads to the need for acute care;
  + Disability and long-term care needs resulting from lack of care;
  + Unnecessary criminal justice institutionalization; and
  + State mental health hospital utilization.

As a final step in estimating value, providers were asked to consider other sources of value to patients, to the health care system, and to the community—particularly those sources that are more difficult to put dollar amounts to but can be significantly impacted in the long-term. These include:

* Overall patient and community quality of life;
* Increased stability for patients and their families;
* Reduced missed workdays and increased productivity;
* Better overall health outcomes for patients and their families; and
* Others community factors—better quality of life allows for stronger economic development, which contributes to having more resources for health and human services.

1. Determine how much IGT is available for the project.

Once the provider had an estimated amount for the entire project, including both cost and value, they were recommended to then work with their IGT entities to determine how much IGT would be available for the project by year. This was also influenced by each provider’s DSRIP allocation in Pass 1 and Pass 2 that determined maximum amounts for projects they could propose. There is variability among seemingly similar projects based on IGT availability, given IGT entities’ available resources and their willingness to commit them to specific projects.

1. Scale the project appropriately based on the support available.

With an understanding of the IGT available and how much incentive that may generate for a provider, given that they are able to meet their metrics, providers were encouraged to use their cost and value estimates to determine the feasible and sustainable scale of the project. In many cases, limited IGT forced providers to reduce the scope of their projects and to select specific target areas or target populations, or limit the number of clients they could see each year. Thus, much variability is a result of limited IGT in this RHP.

1. Once a total value determined for each project, those values divided between Category 1/2, Category 3, and Category 4 (if a hospital performing provider).

The final step in the process was for the provider to take the entire project valuation and divide it appropriately among the project component categories (1/2, 3, and if a hospital, 4), at the minimum meeting the required percentages for each category but with discretion left to the provider to determine what was appropriate for their project.

Within this valuation framework, each performing provider has the flexibility to consider factors unique to its project. Thus, there is variability among seemingly similar projects based on aspects of the organizations, project complexity, investment needed to implement and sustain activities, target population, scope of the project, and available IGT.