## Category 1 Infrastructure Development - Narratives and Tables

* **Bluebonnet Trails Community Services**
  + 126844305.1.1
    - Category 3 Selection: OD 10, IT-10.1.b.ii – RAND Short Form 12 (SF12v2) Health Survey
  + 126844305.1.2
    - Category 3 Selection:OD 3, IT-3.14 - BH/SA 30-Day Readmission Rates
  + 126844305.1.3
    - Category 3 Selection: OD 9, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice settings such as jails or prisons
  + 126844305.1.4 (Pass 2)
    - Category 3 Selection: OD 3, IT-3.14 - BH/SA 30-Day Readmission Rates
  + 126844305.1.5 (Pass 2)
    - Category 3 Selection: OD 11, IT-11.8 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
* **Center for Life Resources**
  + 133339505.1.1
    - Category 3 Selection: OD 11, IT-11.26.e.i - Patient Health Questionnaire 9 (PHQ-9)
* **Central Counties Services**
  + 081771001.1.1
    - Category 3 Selection: OD 11, IT-11.26.d - Children and adolescent needs and strengths assessment (CANS-MH)
  + ~~081771001.1.2~~  \*\***Project Withdrawn by Provider – April 2015**\*\*
    - ~~Category 3 Selection: OD 3, IT-3.14 - BH/SA 30-day readmission rates~~
  + 081771001.1.3
    - Category 3 Selection: OD 10, IT-10.1.a.iv - Assessment of Quality of Life (AQoL-8D)
  + 081771001.1.4 (Pass 2)
    - Category 3 Selection: OD 9, IT-9.1 - Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons
  + 081771001.1.5 (Pass 2)
    - Category 3 Selection: OD 3, IT-3.14 - BH/SA 30-day readmission rates
  + 081771001.1.100 (3-Year Project)
    - Category 3 Selection: OD 10, IT-10.1.a.iv - Assessment of Quality of Life (AQoL-8D)
* **Little River Healthcare**
  + 183086102.1.1 (Pass 2)
    - Category 3 Selection: OD 9, IT-9.2.a - ED visits per 100,000
  + 183086102.1.2 (Pass 2)
    - Category 3 Selection: OD 12, IT-12.1 - Breast Cancer Screening
    - Category 3 Selection: OD 12, IT-12.2 - Cervical Cancer Screening
    - Category 3 Selection: OD 12, IT-12.3 - Colorectal Cancer Screening
* **Seton Medical Center Harker Heights**
  + 013122392.1.100 (3-Year Project)
    - Category 3 Selection:OD 1, IT-1.11 - Diabetes care: BP control (140/90mm Hg)
* **St. David’s Round Rock Medical Center**
  + 02095790.1.1
    - Category 3 Selection: OD 9, IT-9.2.a - ED visits per 100,000
* **Williamson County and Cities Health District**
  + 126936702.1.1
    - Category 3 Selection (3.1): OD 6, IT-6.2.a - OD Client Satisfaction Questionnaire 8 (CSQ-8)
    - Category 3 Selection (3.200): OD 15, IT-15.6 - Chlamydia screening in women
  + 126936702.1.2
    - Category 3 Selection (3.2): OD 3, IT-3.2 - CHF 30-day readmission rate
  + 126936702.1.3
    - Category 3 Selection (3.5): OD 1, IT-1.29 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
    - Category 3 Selection (3.201): OD 15, IT-15.6 - Chlamydia screening in women
    - Category 3 Selection (3.502): OD 12, IT-12.11 - Percentage of adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday

**Category 1 Project Narrative**

**Bluebonnet Trails Community Services – 126844305.1.1**

**Project Area, Option and Title:** 1.12.2 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas

**RHP Project Identification Number:** 126844305.1.1

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

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and six adjacent Counties in three other RHPs. Burnet and Williamson Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at
* 422,679. BTCS provides behavioral health, intellectual and developmental disabilities and early childhood services to over 10,000 poor, under and uninsured individuals in multiple locations throughout these two counties.
* **Intervention:** BTCS proposes to provide outpatient behavioral health services to low income and rural areas in Williamson and surrounding rural counties through a program internally known to BTCS as Expanded Access in order to provide services to a group of patients that are currently ineligible for services. BTCS will provide services to all behavioral health diagnostic groups including substance use disorders.
* **Project Status:** This is a new project opening during DY2 in a new location and in an area of Williamson County that does not have a clinic for behavioral health services.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment needs: CN.2.1 Limited access to behavioral health services to rural, poor and under and uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.13 – Limited access to adult behavioral health services in Williamson County.
* **Target Population:** The target population is all diagnostic categories of behavioral health disorders in this rural area. We anticipate serving 1,000 new patients. Of those served by BTCS in FY 2012, an average of 43% of the adults were Medicaid‐eligible; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. We estimate that approximately 70% of those benefitting from this project will be poor, under or uninsured.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project will seek to serve 1,500 adults and youth in DY4 and 2,000 in DY5 and to do so closer to their home communities. We expect this location will reduce barriers to access, improve adherence to appointments and satisfaction with access.
* **Category 3 Outcomes:** IT‐10.1.b.ii RAND Short Form 12 (SF-12v2) Health Survey

**Rationale**: Our goal is to improve the overall scores on the RAND Short Form 12 (SF-12v2) Health Survey and demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5. We selected this particular outcome because the SF-12 is an overall health survey and want to show improvement in overall health.

* **Baseline Information**: The baseline rate established in DY3 was 33.12. Our baseline measurement period established in DY3 was 03/01/2014-08/31/2014.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative and regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. BTCS and community leaders in eastern Williamson County consider this to be a transformative project because there are no behavioral health services in this area or in this community.

The residents have lower incomes and higher Medicaid percentages than the western part of the County but currently have no access.

**Project** **Description:**

*Expansion of Services*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to expand outpatient behavioral health services to low income and rural areas in eastern Williamson County and beyond as there are no residency restrictions in this project; and to expand services to a larger group of patients than are currently eligible for BTCS services. Expanded Access services, anchored at the Taylor Clinic, will be comprised of a behavioral health team including psychiatrists, Advanced Practice Nurses (APNs), Case Managers (CMs), Substance Abuse Counselors, Behavioral Analysts (to support care for Autistic and other IDD patients), Peer Support Specialists, Registered Nurses and business support staff. The team will be responsible for diagnosis and medication management, counseling, psychosocial rehabilitation, case management and benefits assistance provided to adults and youth seeking treatment. This team will be primarily located in a clinic in Taylor, Texas established and renovated through a grant from the St. David’s Foundation.

This behavioral health team has the potential to serve an additional 1,000 people a year. The team will provide a full range of behavioral health services based on a philosophy of wellness and recovery and will be supported with a certified Peer Support Specialist to help with personal recovery efforts. The location of the clinic addresses transportation and socio‐economic limitations and challenges by establishing a full service behavioral health clinic in the city of Taylor. It addresses eligibility limitations by providing care to all persons, regardless of diagnosis and by adopting the practice of open access for intake and scheduling. For persons requiring higher levels of medical expertise, and to ensure easy access to medical services, the clinic will be linked by telemedicine to our locations with additional physicians.

“Mental disorders are common in the United States, and in a given year approximately one quarter of adults are diagnosable for one or more disorders” (Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve‐month DSM‐IV disorders in the National Comorbidity Survey Replication (NCS‐R). Archives of General Psychiatry, 2005 Jun; 62(6):617‐27). Only 36% of those with a disorder are receiving treatment and only 13% of them are receiving minimally adequate treatment (NIMH Statistics; <http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml>) (Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve month use of mental health services in the United States. Archives of General Psychiatry. 2005 Jun; 62(6):629‐640). BTCS contracts with the Department of State Health Services (DSHS) to provide specialty behavioral health services to adults with Serious Mental Illnesses (SMI) and children with Severe Emotional Disturbance (SED), which DSHS identifies as the “priority population”. The DSHS contract with BTCS restricts the use of general revenue for ongoing services to individuals within limited diagnostic groups. The contract does not restrict BTCS from using non‐general revenue sources of funds (such as those available through this waiver) to serve other individuals. However, these contract restrictions, effectively limit our ability to care for all those in need in our communities. DSRIP allows us to broaden our scope of service beyond the restrictive “priority population” without violating our ability to perform under the contract with the State of Texas. These individuals who do not qualify for services funded through the DSHS contract are referred out. Unfortunately, those in poverty and those who are uninsured or underinsured cannot access care despite being referred to it, especially since all care is outside their local area. We will expand access to care by establishing this behavioral health clinic in a low income, rural area and opening access to all. The team is committed to providing care to this area and to the broader population of persons with behavioral health needs.

We propose to serve the area around Taylor, Texas and to open the clinic to all behavioral health diagnoses. According to 2010 Census data, eastern Williamson County has a poverty rate of 19.5% which is higher than the state average of 16.5%. By contrast western Williamson County, the Round Rock and Georgetown area, have poverty rates of only 5.5%. Services have tended to be aligned around the more affluent part of the County. This full service clinic with a responsive team integrated into the community will address this disparity.

**Goals and Relationship to Regional Goals:**

The goal of the expansion is to add a new clinic location in an underserved area of Williamson County, Taylor, Texas and to offer services to a broader population than the one served under contract with DSHS. With this expansion we expect to improve behavioral health outcomes for persons in this area who now have limited access to behavioral health services. The challenges facing individuals in the more rural area of Williamson County are that there are no behavioral health practitioners in the area. To receive services people must travel into Round Rock or Austin and Travis County. For those who are poor and uninsured, the dilemma is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, they could be treated only if they are eligible for DSHS services. Substance abuse treatment is limited and frequently unavailable even though the disorder is prevalent among those requesting services. This project allows us to open access to persons outside the narrow scope of eligible youth and adults through a clinic easily accessible to these individuals.

**Project Goals:**

(1) Establish a behavioral health clinic in eastern Williamson County; (2) develop a robust behavioral health team on site and supported by telemedicine; (3) provide behavioral health care that is multi‐disciplinary, recovery oriented and comprehensive; and (4) provide behavioral health care to all those in need regardless of income, insurance status or diagnosis.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs; and
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Expanded Access will offer a solution focused, multi‐faceted approach of care to include wraparound services and transition planning for effective functioning in their home communities and care that is local. We expect the variety of services available, responsiveness of the design, staffing, location, timely access, clear communication with providers and culturally competent providers to improve behavioral health functioning outcomes and significantly improve satisfaction. This project builds on the expertise and resources of BTCS related services for the patients with SMI. Patients utilizing Expanded Access will also have access to crisis intervention and respite if needed as well as housing and employment supports.

**Challenges:**

The primary challenges for this project are to establish a location that serves all persons in need of behavioral health services rather than just those in the priority population and for BTCS to be accepted in that role by the community and referring providers. Currently BTCS is known as the provider of care for those with SMI diagnoses and we have not accepted patients with other diagnoses. As a result, many people in need routinely access other providers as a first option when seeking behavioral health assessment and treatment. We can be successful with a comprehensive range of services for youth and adults with a behavioral health team that is accessible, responsive and integrated into the community.

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

BTCS expects to see a greater number of people served in Williamson County and surrounding rural counties with a broader range of diagnoses and conditions. We expect to see a growing level of satisfaction related to accessing care quickly, improved communication with clinicians, information provided to patients on treatment and self‐help resources, increased cultural competency and perceived improvement in functioning. The expected outcomes are a result of and related to project goals stated above, including the ability to serve an additional 1,000 persons more per year.

**Starting Point/Baseline:**

Currently no clinic exists in eastern Williamson County and services are not provided outside the DSHS guidelines for priority population at any BTCS location. Therefore, the baseline for the number of patients at that location and the number of patients not in the priority population is 0 in DY2. From December 2011 through August 2012, we served approximately 175 persons from eastern Williamson County at the BTCS location in Round Rock. All of those served had diagnoses within the priority population guidelines and all others were precluded from service and referred elsewhere.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to primary care
* Specific Community Need:

o CN.2.1 ‐ Limited access to behavioral health services to rural, poor and under & un‐uninsured populations (meds, case management, counseling, diagnoses) in Williamson County.

o CN.2.13 – Limited access to adult behavioral health services in Williamson County.

A project to expand the capacity to provide behavioral health services to adults with SMI and children/youth with SED in this rural underserved area as well as to individuals with diagnoses outside the priority population of DSHS is vital to improved behavioral health outcomes in Williamson County. A full service behavioral health clinic integrated into this rural community will provide a wide range of care and serve as a hub for community involvement undertaken by an accessible and responsive team of professionals. The team will provide physician and physician extender diagnosis, assessment and treatment, medication services, brief, solution focused counseling services, outpatient substance abuse services and community education and provider consultation.

As stated above, BTCS does not currently provide behavioral health care to all persons, only to those in the priority population. We also do not provide substance abuse treatment as part of the behavioral health service array. Both services are identified needs in this area. One critical disparity identified for RHP 8 is scarcity of behavioral health services throughout the region, especially in rural areas. As stated in the RHP Planning Protocol document, Texas ranks 50th in per capita funding for state mental health authority (DSHS) services and supports for people with serious and persistent mental illness and substance use disorders. Medically indigent individuals who are not eligible for Medicaid have no guarantee of access to needed services and may face extended waiting periods. Additionally, Texas ranks highest among states in the number of uninsured individuals per capita. One in four Texans lack health insurance. People with behavioral health disorders are disproportionately affected. Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many residents are unable to access either routine services or needed care in a timely manner because they lack transportation, are in poverty, lack insurance coverage or because they are unable to schedule an appointment due to work scheduling conflicts.

BTCS assessed the patient data in its Anasazi EHR and found that 175 people accessed services by traveling to the BTCS clinic in Round Rock. This is far lower than prevalence statistics indicate individuals in the area have a need for services. Community leaders in Taylor identified this as a need and assisted BTCS to apply for a grant to plan and initiate such a clinic. This clinic increases capacity and access to these specialty services. We expect to decrease the number of cancellations and no shows as compared to our current operations in other clinics. In DY5, we expect to demonstrate improved satisfaction with access as a result of this local, integrated service. With the assistance of Peer Support Specialists, we expect to improve functional status by assisting individuals to use transitional housing and employment supports which are currently only available in the larger urban areas or metropolitan area of Round Rock and Georgetown. Certified Peer Support Specialists will provide the training and supports in coordination with Qualified Mental Health Professionals. We expect to create an expanded model of care that goes beyond the DSHS priority population and meets the comprehensive needs of individuals in their own communities.

**Core Project Components:**

Although 1.12.2 does not have required core components listed with it, it is in the same Project Option as 1.12.1 and those required core components were used as a guide for our own components. We have reviewed the components, modified them and will address them as below:

1. *Evaluate existing locations of behavioral health clinics and to identify barriers to access including, transportation, operating hours, admission criteria and acceptable payment. If any of these barriers is a significant issue in care access, develop and implement improvements.* Patients currently accessing care at the Round Rock clinic in west Williamson County will be offered the opportunity to use the clinic in Taylor. Persons requesting services from BTCS but who are not in the priority population established by DSHS will be offered services at the Taylor clinic regardless of residency or home address. Operating hours outside the usual business hours will be available through Expanded Access.
2. *Review the interventions impact on access to behavioral health services and identify “lessons learned,” opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety‐net populations.* We will establish a Plan, Do, Study, Act (PDSA) cycle improvement process through the Quality Management department of BTCS to collect and analyze data related to these interventions. That data will include ECHOTM Satisfaction Survey results and Electronic Health Record (EHR) data related to functioning scales and frequency in the use of higher levels of care such as Emergency Departments (EDs) and inpatient psychiatric care. We will assess the results, make improvements in the operation of this Clinic, and develop plans to expand services to “non‐priority population” patients. We will hold community planning meetings with providers, patient advocates and community leaders in a number of communities to assess expansion opportunities.

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

BTCS uses the mental health block grant for routine mental health services on an outpatient basis. We will provide outpatient services in this expansion project for the Taylor, Texas clinic but those services are not for the same populations.

**Related Category 3 Outcome Measure:**

IT‐10.1.b.ii RAND Short Form 12 (SF-12v2) Health Survey

Rationale: Our goal is to improve the overall scores on the RAND Short Form 12 (SF-12v2) Health Survey and demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5. We selected this particular outcome because the SF-12 is an overall health survey and want to show improvement in overall health.

Baseline Information: The baseline rate established in DY3 was 33.12. Our baseline measurement period established in DY3 was 03/01/2014-08/31/2014.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing including: related to Crisis Respite for Persons in Behavioral Health Crisis (#126844305.1.2); and Emergency Services Diversion (#126844305.2.2); in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It also supports the Transitional Housing Guided by Peer Support (#126844305.2.1), by supporting peer specialists in this rural area and therefore offering the option of housing within the home community.

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

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improve and adjust the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care. The Williamson County Mental Health Task Force will be the primary conduit for our planning discussions.

**Project Valuation:**

We expect to serve 1,500 adults and youth in DY4 and 2,000 patients in DY5 and to do so in or closer to their home communities. The valuation calculated for this project used cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality‐adjusted life‐years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrails.org under the Medicaid 1115 Transformation Waiver tab. A complete write‐up of the project will be available online.

**Category 1 Project Narrative**

**Bluebonnet Trails Community Services ‐ 126844305.1.2**

**Project Area, Option and Title:** 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current crisis system

**RHP Project Identification Number:** 126844305.1.2

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

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the Local Mental Health Authority for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the public provider of behavioral health services for the poor, under and uninsured in Williamson County.
* **Intervention:** BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. A 48‐Hour Observation Unit will be established in Georgetown, Texas to provide for emergency and crisis stabilization services in a secure and protected, clinically staffed, psychiatrically supervised treatment environment. This 48‐Hour Observation Unit will provide assessment and active intensive treatment for adults.
* **Project Status:** This is a new project, no facility or service now exists in any of the Counties served by BTCS that accepts and evaluates adults on emergency detention orders. We expect to serve about 300 people a year when the project matures.
* **Project Need:** No 48 Hour Observation Units exist in BTCS’s area. This addresses RHP 8 Community Needs Assessment needs: CN.2.1 ‐ Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County; and CN.2.13—Limited access to adult behavioral health services in Williamson County.
* **Target Population:** The target population is adults presenting a significant threat to the safety of self or others and exhibiting behaviors consistent with acute psychiatric disorder. Of adults served by BTCS in FY 2012, an average of 43% were Medicaid‐eligible; 73% of BTCS clients are below the federal poverty level. We estimate approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 250 people in DY4 and 300 in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project helps patients by providing access to care locally and proactively so that they are not taken out of County and hospitalized. Quick local assessment supports local stabilization and reduces the number of short inpatient stays which result from using the hospital as an assessment location. The project seeks to provide assessment and stabilization services to 250 people in DY4 and 300 people in DY5.
* **Category 3 Outcomes:** IT‐3.14: Our goal is to reduce the behavioral health/substance abuse 30-day readmission rate to hospital by a percentage TBD based on baseline established DY3. What the achievement of this goal means is to provide services to the target population of people who have been hospitalized or experienced a crisis event and/or have been in the Crisis Respite facility and to assist them to regain functioning and self‐manage their wellness. Improvement in functioning and self‐management of symptoms and wellness are critical patient outcomes. When the goals are achieved, program participants should experience a reduction in symptoms and a reduction in crisis events. We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over using hospital and ED, but more importantly improves the lives of those who otherwise would have go to hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative and regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. This project is transformative in that it creates an alternative for those in behavioral health crisis that is local, reduces hospital admissions and use of EMS and EDs. There are no community- based crisis stabilization alternatives except hospitals and EDs.

**Project** **Description:**

*Crisis Stabilization for Persons in Behavioral Health Crisis*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. To do so, a 48‐Hour Observation Unit will be created to provide for emergency and crisis stabilization services provided to individuals in a secure and protected, clinically staffed, psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. This 48‐Hour Observation Unit will provide active intensive treatment for adults in need of acute inpatient psychiatric service; with suicidal indication; persons presenting a significant threat to the safety of self or others; and persons exhibiting behaviors consistent with acute psychiatric disorder which may include significant mental status changes.

The 48‐Hour Observation Unit will be fully compliant with all regulations and health and safety standards. This option will be accomplished by modifying our current voluntary Crisis Respite facility in Georgetown. A physical separation will be created between an area comprising two rooms and the remainder of the sixteen bed facility in order to establish a locked unit that is suitable for patients in crisis to be securely and safely detained for up to 48 hours. During the 48 hours, the individual in crisis will be assessed; will receive medication and intensive psychiatric treatment meeting their needs; and will be provided short term care, step down respite care and assisted transition into outpatient services and community resources. The facility will provide access to emergency care at all times and will safely and appropriately manage individuals with the most severe psychiatric symptoms. It is designed to provide a safe and secure environment for short‐term stabilization of behavioral health symptoms that may or may not require a continued stay in an acute care facility. Extended observation and treatment can take place for up to 48 hours. Individuals who cannot be stabilized within that timeframe would be linked to the appropriate level of care (inpatient hospital unit).

This involuntary behavioral health facility has the potential to serve an additional 300 people a year. The proposal builds on the current crisis system established by the LMHA and the relationships with local law enforcement agencies. To accomplish this we propose to make necessary building modifications, increase professional staff for the facility to meet standards requiring 24 hour nursing coverage, MD assessment within one hour and transfer capability to another inpatient facility if appropriate. Establishing the capacity to accept persons who are under Emergency Detention and hold them for assessment and short term stabilization will reduce the unnecessary utilization of Emergency Departments (EDs), psychiatric inpatient facilities and jail. This project reduces preventable readmissions to hospital by providing a community alternative for rapid stabilization and referral to appropriate residential options. Since the service is located in the same building as voluntary Crisis Respite, those who can achieve sufficient stability can transfer to the voluntary program to complete treatment. For persons requiring higher levels of medical expertise, and to ensure easy access to medical services, the clinic will be linked by telemedicine to our locations with additional physicians.

BTCS reviewed data related to admissions to the State Hospital and to the voluntary Crisis Respite facility. We found a large percentage of the 218 year to date admissions to the State Hospital‐‐17% accounting for 37 of the 218 admissions‐‐were made without prior screening and authorization by BTCS, the LMHA. In meetings with stakeholders in Williamson County, we learned that those admissions are being taken directly to the hospital by law enforcement officers because they have no local crisis alternative and have been requested to take individuals from ED’s or have taken them upon their own screening and assessment. They transport for direct admission to the State Hospital when in their judgment the individual needs an involuntary facility even for a short period of time. No such facility exists in Williamson County or any other County served by BTCS. Analysis of those State Hospital admissions reveals a substantial number with very short lengths of stay, indicating that they were inappropriately admitted and might be prevented with a community alternative for crisis stabilization. The number of individuals with lengths of stay less than 3 days reflects that 61 persons may have been inappropriately admitted year‐to‐date. When we reviewed the admission data for the voluntary Crisis Respite facility, it revealed that there were 252 admissions in FY 2012 and 95% of those were from Williamson County. Of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. Clearly, all of these individuals were candidates for crisis stabilization as a first option rather than hospitalization— expending valuable time and resources in the wrong setting. This project directly addresses the problem of inappropriate admission by creating the 2 beds for the 48‐Hour Observation Unit as an option for law enforcement in lieu of jail, ED or State Hospital. We will ensure that qualified assessment staff will be available at all times so that when an individual is brought to the facility he/she can be assessed and disposition made as quickly as possible, thereby allowing the law enforcement officer to return to regular duties. Social Service staff will provide for follow up to refer the individual to other levels of care upon stabilization or to prepare and process legal mental health commitment as needed.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

* Establish an involuntary crisis stabilization service in Williamson County through a 48‐HourObservation Unit
* Develop a professional team on site and supported by telemedicine
* Provide this crisis service in a safe and secure environment that allows for those in custody and under detention order to be detained and assessed
* Reduce or eliminate the inappropriate utilization by the mentally ill of ED’s, jails, private hospitals and the State Hospital for short stays

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs
* Reducing inappropriate utilization of services

We are proposing this project in Williamson County because it is the largest county in the BTCS catchment area, with 55% of the population. Additionally, data above indicates that 95% of the admissions for crisis residential services came from Williamson County. Williamson County also has a well‐developed mental health deputy program and provides the opportunity for expansion and refinement of that program. This location is a good strategic choice because the County shares a border with 3 of the other 8 Counties we serve. As the program matures, the number of beds can be expanded easily to serve half of the catchment area if needed.

**Challenges:**

The primary challenge for this project is to achieve widespread use of the 48‐Hour Observation Unit as a first option by law enforcement. There are established law enforcement patterns of detention and disposition for mental health cases in Williamson County—as well as Burnet County. Just providing a new option will not automatically lead to acceptance and utilization. We plan to communicate to law enforcement leadership in the county and to the front line officers. We currently provide training and have routine communication with the major law enforcement agencies, Williamson County Sheriff’s Office, Burnet County Sheriff’s Office and the police departments of Round Rock, Georgetown, Burnet and Marble Falls. We plan to continue these activities and add additional communication and education meetings for the first year of the project to foster acceptance and use of the services.

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

Over the next 5 years, we expect the outcomes to include reduction of hospitalizations for persons who are currently admitted for very short stays, reduction of ED utilization by law enforcement that have behavioral health clients in custody, and reduction in incarceration of the mentally ill.

**Starting Point/Baseline:**

Currently, no involuntary crisis stabilization service exists in Williamson County; therefore, the baseline is 0 in DY2. We do not have the data to estimate the number of people who were admitted to jail inappropriately, who were admitted to private psychiatric facilities in adjacent Counties or who were detained in EDs. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate. We will use the number of admissions into the State Hospital System and Psychiatric Inpatient Units during FY 2012 as our baseline for the performance indicators.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to primary care
* Specific Community Need:

o CN.2.1 – Limited access to behavioral health services to rural, poor and under & un‐ uninsured populations (meds, case management, counseling, diagnoses) in Williamson County

o CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson

County

o CN.2.13 – Limited access to adult behavioral health services in Williamson County

A secure and safe community based crisis stabilization alternative will give law enforcement officers and crisis responder’s new opportunities to help people. Someone experiencing a mental health crisis is assessed to determine if he/she is ‘a danger to self or others’. It is that standard in the law that must be met in order to detain someone, transport them to a safe place, conduct a thorough evaluation and determine the most appropriate course of action to assist the individual. A law enforcement officer, who has someone in custody under this circumstance, has little recourse other than to transport the person to the nearest safe and secure facility for evaluation. Jail, EDs and psychiatric hospitals are secure options and generally safe options. But as referenced in the RHP Planning Protocol – Category 1, page 141, *Behavioral Health News* Vol. 7 Issue 3 reported that “Community‐based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.” A project to improve stabilization services and add a missing part of the continuum of care, the capacity to assess and treat people who are on emergency detention orders, is needed in Williamson County. BTCS participates in the Mental Health Task force for Williamson County and this group of leaders and health care professionals report that mentally ill people are taken inappropriately to EDs, jail and the State Hospital. Other than the data reported above related to admissions to the voluntary Crisis Respite facility, the community need being expressed is, to a certain extent, anecdotal. However it is clear that we need to begin offering a community based crisis stabilization option even as we address the core components of this Project Option.

**Project Components:**

This project to provide involuntary Crisis Respite services for adults will address all of the required core project components:

a*) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.* We will work with health care and law enforcement stakeholders to identify gaps that lead to inappropriate admission to jail, EDs and short term stays in psychiatric hospitals. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services and assess root cause.

*b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* We know that law enforcement is transporting to and from EDs in their own community and in Austin and one cause is limited crisis response services and/or concern for the safety and security of the patient and the community. We will identify tools and agreements needed to access and analyze to determine capacity for service, current utilization patterns and to identify the key characteristics of the people to be served.

*c) Assess the behavioral health needs of patients currently receiving crisis services. Determine the types and volume of services needed to resolve crises in community‐based settings. Then conduct a gap analysis that will result in a data‐driven plan to develop specific community‐based crisis stabilization alternatives that will meet the behavioral health* *needs of the patients.* We will use BTCS staff to assess admissions and dispositions to voluntary Crisis Respite and to all psychiatric facilities in the area. We will focus on those detained and transported during the last year.

*d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Using the information from stakeholders, from capacity and utilization tools and from assessment of those detained, we will assess the intervention we are providing to determine if it is sufficient in bed capacity and scope of evaluation and treatment options available. We will use that information to recommend next steps for RHP 8.

*e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated* *with expansion of the intervention(s), including special considerations for safety‐net populations.* We will review the impact of involuntary Crisis Respite and identify lessons learned and adjust the model with respect to area, intensity and population.

**Continuous Quality Improvement:**

BTCS is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project provides crisis services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with Federal funds by a providing a local option to address crisis needs. We believe this crisis service will improve the healthcare outcomes for entire community, relieve pressure on law enforcement and ED’s and promote stable community tenure for our patients.

**Related Category 3 Outcome Measure:**

* OD‐3 Potentially Preventable Re‐Admissions‐ 30 day Readmission Rates (PPRs)

o IT‐3.14 Behavioral Health /Substance Abuse 30-day Readmission Rate

Reasons/rationale for selecting the outcome measure: Readmissions to psychiatric facilities are driven by a number of circumstances surrounding the initial hospital stay. Those include inaccurate assessment of acuity and early release, poor or hurried discharge planning, inadequate knowledge of community resources, inadequate resources to accommodate a sound community placement. Creating the option to provide involuntary detention and evaluation in the community provides the opportunity to address several of these drivers. We can provide timely evaluations and quick stabilization linked to community follow up. We know the community resources including housing and treatment options. It also gives us the chance to intervene with those who otherwise would be readmitted rather than getting community help. Admissions to inpatient settings should be more appropriate and readmissions reduced.

Baseline Information: The baseline rate established in DY3 was 6.04%. Our baseline measurement period established in DY3 was 09/01/2013-08/31/2014.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing related to Child Crisis Respite (#126844305.1.2) and Emergency Services Diversion (#126844305.2.2) in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It both supports and relies on the Transitional Housing (#126844305.2.1) projects which provide a place for people to continue recovery in the community after stabilization is achieved. This option supports substance abuse treatment as a back‐up for relapse and crisis events. Routine outpatient care is enhanced by the safety net of short term crisis resolution.

This project also supports the intensive outpatient crisis services (#126844305.1.4) project to be implemented by the LMHA in Burnet County, in RHP 8. By providing the involuntary crisis stabilization service in Williamson County, the providers in Burnet County (25‐45 minutes from the proposed 48‐Hour Observation Unit) will be supported by a resource previously unavailable for persons in crisis.

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

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. The exchange of ideas through both developing and existing relationships will keep the line of communication open and will help us adjust and refine our programs and approaches to behavioral health care.

**Project Valuation:**

We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Serving people in the community is a substantial savings over using hospital and ED, which are now the only options. The valuation calculated for this project used cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐ weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality‐adjusted life‐years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to [www.bbtrails.org](http://www.bbtrails.org/) under the Medicaid 1115 Transformation Waiver tab. A complete write‐up of the project will be available online.

**Category 1 Project Narrative**

**Bluebonnet Trails Community Services ‐ 126844305.1.3**

**Project Area, Option and Title:** 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

**RHP Project Identification Number:** 126844305.1.3

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

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the Local Mental Health Authority (LMHA) for Burnet and Williamson Counties located within RHP 8 and for 6 other counties in adjacent Regions. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the sole public behavioral health provider for all the counties it serves including those for youth.
* **Intervention:** BTCS will develop specialized Child Crisis Respite (CCR) to intervene with youth in crisis, diverting them from admission to hospitals or juvenile justice facilities. Our Child Crisis Respite project will foster children in need of intensive short‐term behavioral health services, but not in need of protection. Children receiving or eligible for Department of Family and Protective Services (DFPS) Foster Care are not in the target population for this project and, therefore, DFPS funding is not available for use for this project. No funding is available for children who are not in the CPS system but in need of crisis respite due to behavioral health crisis. We will establish placement resources to include foster homes, respite homes and emergency shelters in Williamson County and provide services to youth and families to stabilize the crisis and initiate ongoing services.
* **Project Status:** This is a new project. Not only are there not any CCR facilities, there are not any psychiatric stabilization facilities for youth in this region.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment: CN. 2.3 ‐ Limited access for youth with severe emotional disturbances to behavioral health community crisis services in Williamson and Burnet Counties; and CN. 2.15 ‐ limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.
* **Target Population:** The target population is high risk youth in behavioral health crisis the majority of them involved in Juvenile Justice; however, no incarcerated children will be admitted to the program. 39% of those admitted to Williamson County Juvenile Probation were diagnosed with behavioral health disorders. We will provide crisis respite for 30 youth annually based on the number of homes. BTCS served 1,292 youth in its 8 County region in FY 2012, 76% of the youth were eligible for CHIP or Medicaid. We expect over 80% of those benefitting from these services will be uninsured or enrolled in CHIP or Medicaid.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 730 crisis respite bed days in DY4 serving 16 youth; and to provide 1,460 crisis respite bed days in DY5 serving 30 youth. Our improvement measure is increasing the utilization of appropriate crisis alternatives and the metric is Target Population Reached; that will be 16 youth in DY4 and 30 youth in DY5. Local care that promotes family preservation is clearly a benefit to youth and families. The most appropriate crisis services are those that are local and responsive. Creating this option allows us to reduce out of county placement into residential and inpatient care in order to promote family participation and return to home for the youth. Improvement Milestone I‐12.1, increasing the utilization of appropriate crisis alternatives creates the opportunity to provide these patient benefits.
* **Category 3 Outcomes:** IT‐9.1: Our goal is to decrease in mental health admissions and readmissions to criminal justice settings; residential treatment out of County and detention services operated by Williamson County Juvenile Probation by a percentage TBD based on baseline established in DY3.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. We consider this project to be transformative because it will create a local system of services that supports youth who experience behavioral health crises to stay connected to community and family. Currently the only option is for youth to be removed from their home region and any proximity to their families. This crisis option will allow families to work on therapeutic issues while the youth is safe and working on those issues as well. It promotes family preservation.

**Project** **Description:**

*Child Crisis Respite*

BTCS is the LMHA for Burnet and Williamson Counties located within RHP 8 and for 6 other counties in adjacent Regions. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance (SED) that DSHS identifies as the “priority population”. The Federal Definition for youth diagnosed with SED can be found at: [http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc.](http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc) Youth diagnosed with SED are generally having adjustment or functioning difficulties in more than one life domain and therefore experience crisis episodes that disrupt schools and families alike. BTCS proposes to develop a specialized Child Crisis Respite project that will be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility. The *Texas Criminal Justice Coalition ‐ Williamson County Juvenile Justice Data Sheet*, reveals that of the 869 youth between the ages of 10 and 17 who were referred to Texas Juvenile Justice Department, 39% or 335 of them were diagnosed with mental illness: [http://tcjc.redglue.com/sites/default/files/youth\_county\_data\_sheets/Williamson%20County%](http://tcjc.redglue.com/sites/default/files/youth_county_data_sheets/Williamson%20County%25)

20Data%20Sheet%20(Sep%202012).pdf.

The conclusion is that “Reducing the number of youth adjudicated to residential facilities can only be achieved if stakeholders strongly invest in ‘a consistent, county‐based continuum of effective interventions, supports, and services’.” BTCS and leadership in the County agree that a part of the continuum that is missing is a community based alternative for crisis stabilization for these youth. The placement resources in this project will be used to provide safe environments to begin reintegration and family reunification as an alternative to detention or hospitalization at the point of crisis, thereby diverting the youth from those higher levels of care. The placement resources will also be available for transition care upon discharge from hospital or residential facility, thereby shortening lengths of stay. In CCR, the positive aspects of the nurturing and a therapeutic environment are combined with active and structured treatment. Our CCR program provides, in a clinically effective and cost‐effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings. BTCS is a member of the Mental Health Task Forces for Williamson County and they have identified a need for crisis services for youth from this area. Currently there are no behavioral health crisis options available in Williamson County.

**Goals and Relationship to Regional Goals:**

The goal of this proposal is to use CCR to provide crisis respite for youth in lieu of referral to a juvenile justice detention facility or a psychiatric hospital and to provide services that allow families and youth to remain together once the crisis is resolved. This community based respite alternative will be the foundation to successfully reintegrate youth with emotional and/or behavioral needs into their families—families who are trained to have the skills to meet those needs—and their communities.

**Project Goals:**

* Establish the Child Crisis Respite Program including identifying facilities and placement resources;
* Improve Clinical Resources to support services for families and youth; and
* Develop protocols to use to divert from residential care and to reunify after residential care.

**The Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Reducing inappropriate utilization of services.

The CCR program will safely reduce the number of children in out‐of‐home care and expedite permanency for children currently in out‐of‐home placements; effectively maintaining a child with emotional and/or behavioral needs in a family setting. Supporting effective growth and relationships of the child through an intensive support and treatment program, this program is designed to assist children transitioning to a less restrictive environment—and, ultimately, into a healthy family situation. We are committed to preserving families and support the following nationally recognized definition of permanency: an enduring family relationship that is safe and meant to last a lifetime; offers the legal right and social status of full family membership; provides for physical, emotional, social, cognitive, and spiritual well‐being; and assures lifelong connections to extended family, siblings, other significant adults, family history, traditions, race and ethnic heritage, culture, religion, and language. We believe that these family relationships help produce healthy and well‐adjusted adults which strengthens the safety and security of our communities.

**Challenges:**

A major challenge for this program will involve the regulation and infrastructure needed to operate Foster Care services and to develop the philosophy of care to carry it out. Another major challenge is the identification of suitable homes or facilities, suitable candidates for foster/respite parents and enhanced clinical expertise at the local clinic to carry out needed supports. We can address the challenge related to regulation and infrastructure because BTCS has reached agreement to collaborate with STARRY, a licensed Child Placing Agency that has been developing foster homes for several years. We will address the philosophy of care challenge by using resources related to the variety of evidenced based practices (EBP) that have been implemented in treatment foster care settings, as noted in *Evidenced Based Practices in Treatment Foster Care‐ a Resource Guide* produced by the Foster Family Based Treatment Association (<http://www.ffta.org/)>. Using the excellent reputation of BTCS we will initiate a strategy to provide enhanced community education and communication to recruit families and additional homes. We will provide specialized clinical training for foster/respite parents as specified in the licensure standards and will add licensed and certified clinical staff at the local BTCS clinics to provide professional support. The Community Needs Assessment for RHP 8 identifies poor access to mental/behavioral health services as a key health challenge for the region (see Section II of this Plan). We will need to make extra effort to resolve the provider shortage issues. We will use the innovative nature of this program as an inducement to recruit providers. We are confident that qualified professionals will want to participate in such a project.

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

Over the next 5 years, we expect the outcomes for the youth and families to be: higher success rate for reintegration from residential treatment facilities as evidenced by longer average tenure than currently recorded with their natural family after discharge; a reduction in removals and placements out of the Region by Juvenile Probation; and a reduction in inpatient psychiatric placements. Our improvement measure is increasing the utilization of appropriate crisis alternatives and the Metric is Target Population Reached; that will be 16 youth in DY4 and 30 youth in DY5. Local care that promotes family preservation is clearly a benefit to youth and families.

**Starting Point/Baseline**:

Currently no Child Crisis Respite program exists in Burnet of Williamson County; therefore, the baseline is 0 in DY2. We have some data related to the number of youth referred to juvenile justice and hospitalized in State Hospitals, but do not have comprehensive data on ED episodes, private hospital admissions. We will undertake to identify resources and methods to capture and share information across these various child serving agencies.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to primary care
* Specific Community Need:

o CN.2.3 ‐ Limited access for youth with severe emotional disturbances to behavioral health community crisis services in Williamson and Burnet Counties; and

o CN.2.15 ‐ Limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.

The CCR model involves placement of children experiencing emotional or behavioral disorders with specially trained respite providers who may be either foster parents, respite caregivers, or shelter staff. BTCS will develop sites in Williamson County and consider establishing sites in later years in Burnet County. All homes will have trained respite providers recruited from within the communities and professional support provided by licensed and certified staff currently working for BTCS outpatient sites in those counties. As mentioned earlier, CCR is not a part of the foster care program administered by the Department of Family and Protective Services. Our project is not designed for children in protective care and therefore, not eligible for DFPS foster care funding. Our target populations are frequently placed in residential care through juvenile probation but almost never placed in therapeutic home settings. We are proposing to use specially trained respite providers who are willing and able to work with youth who have intense behavioral health needs, and to wrap additional services around those youth using staff and resources available from our current operations. There is no foster care funding for this use of foster care. The respite providers offer a stable environment and safe, secure supervision. The respite provider and the professional service providers work together as a team with both youth and family. This team will provide a therapeutic environment that will enable children in the area to stay connected to their families and community while learning the skills and coping mechanisms needed to be successful. Professional support will also be provided to the parents and key family members to develop skills strengthening the family unit, supporting successful reunification. We selected this Project Area and Project Option because our goal is to implement a crisis response for youth that addresses identified community need. Caregivers and agencies involved with these children and adolescents have heretofore been left with few options other than to assess and transport to Austin or even farther outside of RHP 8 for admission to a hospital or secure residential facility for stabilization.

**Project Components:**

The Child Crisis Respite project will address all of the required core project components:

1. *Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.* Our focus will be to work with stakeholders who are child serving agencies and to identify gaps that lead to referral to juvenile justice. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services; the numbers of people removed by Juvenile Probation, taken to ED’s and admitted to private facilities.

*b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* We know that families transport their child to an Emergency Department in their own community or in Austin rather than contacting the LMHA because of the limited crisis response services and/or concern for the safety and security of their child and family. This creates a complex issue related to data identification and access. Working with community stakeholders and child serving agencies, we will identify tools to provide data to analyze the capacity for service, current utilization patterns and to identify the key characteristics of the people to be served.

*c) Assess the behavioral health needs of patients currently receiving crisis services.*

*Determine the types and volume of services needed to resolve crises in community‐based settings. Then conduct a gap analysis that will result in a data‐driven plan to develop specific community‐based crisis stabilization alternatives that will meet the behavioral health needs of the patients.* We will use the current staff to assess current needs of those who are now and have been detained in the last year.

*d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Using the information from stakeholders, from capacity and utilization tools and from assessment of those detained, we will assess the intervention we are providing as to acceptability and feasibility to scale into other adjacent counties or to increase capacity in Region 8.

*e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated* *with expansion of the intervention(s), including special considerations for safety‐net* *populations.* Finally, we will review the intervention and the changes to identify lessons learned and adjust the model with respect to area, intensity and population. There is guidance available and we plan to take care that the evidenced based practice (EBP) approach will evolve from a thorough needs assessment process that considers how well it fits with the clients, the staff and the organization.

**Continuous Quality Improvement:**

BTCS is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project significantly enhances delivery system reform by enhancing the holistic health care approach of BTCS and its partners in Williamson and Burnet Counties. BTCS currently receives funds from U.S. Department of Health and Human Services (DHHS) to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services; however, this project enhances and extends the care currently provided with Federal funds by a new and innovative approach to behavioral health crisis services. We are certain this intervention will improve the healthcare outcomes for entire community and improve the ability of these young people to become contributing members.

**Related Category 3 Outcome Measure:**

OD‐9 Right Care, Right Setting

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

Reason/Rationale for selecting the Outcome Measure:

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

Baseline Information: The baseline rate established in DY3 was 0. Our baseline measurement period established in DY3 was 06/05/2014-09/30/2014. This baseline is currently flagged for a TA for clarification.

**Relationship to Other Projects:**

This enhances the Emergency Services Diversion project (#126844305.2.2) that BTCS is proposing. That project is focused on diversion of persons with behavioral health issues from EDs and inpatient care. This project adds a community resource which can be used as a tool by those persons involved in ED diversion. BTCS is also proposing to provide an expanded clinic in East Williamson County (#126844305.1.1) and this project will act as a crisis alternative when needed for those patients. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities, especially youth with Autism, might require and access crisis respite services. Our IDD Assertive Community Treatment project (#126844305.2.3) is proposed in Pass 2 along with services to adults and youth in justice system and outpatient substance abuse services for adults and youth. These all fit together to continue building a continuum of care for youth with behavioral health needs in RHP 8.

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

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

**Project Valuation:**

The project seeks to provide crisis respite to 16 youth in DY4 and to provide crisis respite to 30 youth in DY5. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. The valuation calculated for this project used cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality‐adjusted life‐years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided).

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

**Category 1 Project Narrative – Pass 2**

**Bluebonnet Trails Community Services – 126844305.1.4**

**Project Area, Option and Title:** 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current crisis system

**RHP Project Identification Number:** 126844305.1.4

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

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. Burnet and Williamson Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the sole public behavioral health provider in these Counties.
* **Intervention:** BTCS proposes to collaborate with Burnet County Sheriff’s Office and Seton Highland Lakes Medical Center to provide crisis assessment, referral and short‐term stabilization in Burnet County. To establish this service, a space near the Emergency Department (ED) of the Seton Highland Lakes Medical Center in Burnet, Texas will be renovated so that it is suitable for law enforcement and members of the community to bring individuals in need of crisis screening, assessment and stabilization. The space in Burnet, Texas extends the reach of crisis services within Burnet County. The service will be available 24-hours a day 7 days a week. The service will include the partnering with a specially-trained Mental Health Deputy within the Burnet County Sherriff’s Office.
* **Project Status:** This is a new project, no facility or service now exists in any of the Counties served by BTCS that accepts and evaluates adults on emergency detention orders.
* **Project Need:** There is no facility in the counties served by BTCS that accepts persons on Emergency Detention for assessment and stabilization and therefore people have to be transported to hospitals in Austin, Texas. This project addresses RHP 8 Community Need CN.2.4 – Limited access for children, adolescents and adults with serious mental illness to crisis services in Burnet County.
* **Target Population:** The target population is children, adolescents, and adults presenting a significant threat to the safety of self or others and exhibiting behaviors consistent with an acute psychiatric disorder. Of those served by BTCS in FY 2012, an average of 43% of adults were Medicaid‐eligible; 73% of BTCS clients were below the federal poverty level. We estimate that approximately 70% of those benefitting from this project will be poor, uninsured or underinsured. We expect to serve 200 people in DY4 and 300 in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project provides access to behavioral health crisis services that are local and specific to these disorders. That access results in fewer hospitalizations for individuals, quicker recovery and stability in community living. Both the health and quality of life that individuals experience is improved when they can remain in the community and return quickly to productive community life. This directly addresses Improvement Milestone I‐12.1 utilization of appropriate crisis alternatives, even though the baseline for the number used to calculate the percentage increase is TBD in DY3. The project seeks to provide assessment and stabilization services to 200 people in DY4 and 300 people in DY5.
* **Category 3 Outcomes:** IT‐3.14: Our goal is to reduce the behavioral health 30-day readmission rate to hospital by a percentage TBD based on baseline established DY3. What the achievement of this goal means is to provide services to the target population of people who have experienced a crisis event and assist them in accessing community- based crisis services, as opposed to utilizing inpatient psychiatric facilities out of County or inappropriate Emergency Detentions. Community-based alternatives provide immediate intervention and symptom management, thereby providing improvement in functioning that is critical to individual outcomes. When the goals are achieved, program participants should experience a reduction in symptoms and a reduction in crisis events. We expect to serve 200 people in this community-based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over utilizing hospital and ED services, but more importantly improves the lives of those who otherwise would have go to a hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options and re‐hospitalization occurs because care is remote, not timely and discharge and referral is difficult and often inadequate.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Crisis Assessment for Persons in Behavioral Health Crisis – Burnet County*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to collaborate with Burnet County Sheriff’s Office and Seton Highland Lakes Medical Center to provide crisis assessment, referral and short-term stabilization in Burnet County. To establish this service, a space near the Emergency Department (ED) of the Medical Center in Burnet, Texas will be renovated so that it is suitable for law enforcement and crisis staff to provide services to individuals experiencing a crisis episode. Frequently, law enforcement will use this facility for persons who are being held under Emergency Detention and require evaluation to determine the best options for treatment and stabilization. The facility will be staffed by caseworkers, nursing and licensed professionals linked to psychiatric services via telemedicine. The project includes adding one Sherriff’s Deputy to serve as part of the Mobile Crisis Outreach Team working with the behavioral health professionals for BTCS and the health care staff of the Medical Center.

The facility will operate as an extended location within Burnet County where an individual’s urgent or emergent crisis care can be screened, assessed clinically, staffed and psychiatrically-supervised for immediate access to urgent or emergent medical evaluation and treatment 24- hours a day, 7 days a week. Individuals in crisis will be assessed and may receive medication and intensive and short‐term care, respite care and assisted transition into outpatient services and community resources. An advantage to locating this crisis assessment facility in the Medical Center is that it provides access to emergency care at all times and improves the capacity to safely and appropriately manage individuals with the serious psychiatric symptoms. Another advantage to the location is that it provides the opportunity to provide urgent care interventions for those who have come to the ED due to a behavioral health crisis but do not need the services of an ED. The facility space will be used to provide a safe environment for assessment of those in the custody of law enforcement and those who have come to the facility voluntarily or with family members or friends.

The proposal builds on the current crisis system established by BTCS and on the relationships with the Sherriff’s Office and the Medical Center. Over the last several years, BTCS has developed a crisis response system that includes: a 24-hour crisis line, crisis screening and assessment in every county and a 16-bed voluntary crisis respite facility in Georgetown, Texas. We have proposed DSRIP projects that add to that continuum including 48‐hour involuntary crisis observation unit in Georgetown, transitional housing guided by peer support in Round Rock and Crisis Respite for youth. The current and proposed elements of the continuum will be available for those assessed in this Crisis Assessment facility. Having these options will reduce the shorten lengths of stay in EDs, reduce utilization of psychiatric inpatient facilities and reduce the number of mentally ill who are taken to jail. This project reduces preventable readmissions to hospitals by providing a community alternative for assessment and referral to appropriate residential options. This behavioral assessment unit should be capable of addressing the needs of around 5 to 7 people at a time. That number will need to be assessed based on practice, number of step‐down alternatives and acuity of the individuals being assessed. The total number to be served will depend on the rate of crisis referrals and assessment request from the Medical Center ED.

BTCS reviewed data related to admissions to the State Hospital and to the voluntary Crisis Respite facility. We found a large percentage of the 218 year to date admissions to the State Hospital‐‐17% accounting for 37 of the 218 admissions‐‐were made without prior screening and authorization by BTCS, the LMHA. The Sheriff’s Office in Burnet County reports that they spend a great deal of time transporting individuals out of County for assessment and disposition. Also based on the electronic health record (EHR) for BTCS, there were 211 crisis screenings at the ED at the Medical Center. At times, the Deputies have no alternative but to transport for direct admission to the Austin State Hospital when, in their judgment, the individual needs further detention and thorough assessment. No suitable facility exists in Burnet County; therefore, the ED is being used, placing an undue burden on that facility.

Further analysis of those State Hospital admissions reveals a substantial number with very short lengths of stay, indicating that they were inappropriately admitted and might have been prevented with a community alternative for crisis assessment and referral. The number of individuals with lengths of stay less than 3 days reflects that 61 persons may have been inappropriately admitted year‐to‐date. When we reviewed the admission data for the voluntary Crisis Respite facility, it revealed that there were 252 admissions in FY 2012. Of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. Clearly, all of these individuals were candidates for thorough crisis assessment to determine the best referral option rather than expending valuable time and resources in the wrong setting. This project creates a local crisis assessment option that directly addresses the problems of wasted time for law enforcement to drive out of county for crisis assessment, long stays in the ED for those with behavioral health diagnoses and inappropriate referral and admission. It creates an option for law enforcement in lieu of jail, ED or State Hospital.

**Goals and Relationship to Regional Goals**:

The goals of this project are to improve the current crisis response system for behavioral health by developing a crisis assessment and referral facility to improve access to behavioral healthcare in the most appropriate and cost‐effective setting and to reduce unnecessary inpatient admissions, costly law enforcement trips and inappropriate incarceration or use of EDs.

**Project Goals:**

* Establish a crisis assessment and referral unit in Burnet County in partnership with the Sherriff’s Office and the Medical Center.
* Develop a professional team and a mobile team including a Mental Health Deputy to provide assessment and disposition.
* Provide this crisis service in a safe environment that allows for individuals in custody and under an Emergency Detention order to be detained and assessed.
* Reduce or eliminate the inappropriate utilization, by individuals with mental illness, of ED’s, jails, private hospitals and the State Hospital for short stays.

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.
* Reducing inappropriate utilization of services.

We are proposing this project in Burnet County because there are no specially-designated and trained Mental Health Deputies in this County and over 50% of the crisis screenings are now done at the ED. There is a sufficient volume of crisis events in Burnet County for the Sheriff to request a specially-trained officer to respond and transport. This project is an important part of the crisis services continuum in RHP 8, for BTCS and especially for the people of Burnet County.

**Challenges:**

The primary challenge for this project will be to create a seamless system of communication and collaboration among the partner entities: BTCS, Burnet County Sheriff’s Office and Seton Highland Lakes Medical Center. Each entity has its own set of rules and guidelines to work within, but each will need to find ways to meet current requirements and to achieve the objective of safely and efficiently assessing, referring and finding adequate placement for those in crisis or diverted from the ED. We will address this challenge by jointly designing the processes and protocols for the assessment facility and then holding operational meetings very frequently at first, to identify and eliminate problems with the processes. A second challenge is to engage other local law enforcement agencies, especially in the Cities of Burnet and Marble Falls, and other healthcare providers so that they are informed and comfortable referring or bringing individuals in crisis to this unit. We plan to continue current community outreach and education and to add additional communication and education meetings for the first year of the project to foster acceptance and use of the services.

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

Over the next 5 years, we expect the outcomes to include reduction of hospitalizations for persons who are currently admitted for very short stays, reduction of the length of stay in the ED for those presenting with a primary or secondary behavioral health diagnosis (including substance abuse diagnoses) and reduction in inappropriate incarceration of the mentally ill.

**Starting Point/Baseline:**

Currently, no crisis assessment unit exists in Burnet County; therefore, the baseline is 0 in DY2. We do not have the data to estimate the number of people who were admitted to jail inappropriately and who were admitted to private psychiatric facilities in adjacent Counties. We do know the number assessed in EDs but do not have length of stay or wait time data. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate. We will use the number of admissions into the State Hospital System and Psychiatric Inpatient Units during FY 2012, screenings at the ED and length of stay in the Medical Center ED as our baseline for the performance indicators.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.4 – Limited access for serious mentally ill adults to crisis services in Burnet County

A safe community based crisis assessment alternative will give law enforcement officers and crisis responder’s new tools to provide a thorough assessment and resolve issues locally. It also supports better assessment and diversion of individuals from the ED thereby decongesting and improving access to emergency care for those who truly need that service. Internal reports from the BTCS medical record, Anasazi, indicate that there were 418 crisis screenings performed in Burnet County over the last 12 months. Over half of those, 211, were performed at an ED. The second largest number of screenings, 77, was performed at the jail. This indicates the need to locate a robust crisis screening and assessment unit in this County. BTCS participates in the Mental Health Task force for Williamson County and this group of leaders and health care professionals report that individuals with mental illness are taken inappropriately to EDs, jail and the State Hospital. Other than the data reported above related to admissions to the voluntary Crisis Respite facility, the community need being expressed is, to a certain extent, anecdotal. However, it is clear that we need to begin offering a community based crisis stabilization option even as we address the core components of this Project Option.

**Project Components:**

This project is to provide Crisis Assessment services for children, adolescents, and adults and will address all of the required core project components:

a*) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.* We will work in cooperation with Burnet County Sheriff’s Office and the Medical Center staff to convene other healthcare and law enforcement stakeholders to identify gaps that lead to inappropriate admission to jail, EDs and short term stays in psychiatric hospitals. We will convene these community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services and assess root causes of inappropriate resource utilization.

*b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* We will work closely with the Burnet County Sheriff’s Office to review and analyze records from the prior year concerning law enforcement transports to and from EDs in their own community and in Austin. In partnership with the Sherriff’s Office and the Medical Center, we will engage other healthcare providers, law enforcement and emergency responders to assess the elements of the current crisis system.

*c) Assess the behavioral health needs of patients currently receiving crisis services. Determine the types and volume of services needed to resolve crises in community‐based settings. Then conduct a gap analysis that will result in a data‐driven plan to develop specific community‐based crisis stabilization alternatives that will meet the behavioral health* *needs of the patients.* We will use BTCS staff to assess admissions and dispositions to voluntary Crisis Respite and to all psychiatric facilities in the area. We will focus on those detained and transported during the last year.

*d) Explore potential crisis alternative service models and determine acceptable and feasible* *models for implementation.* Using the information gathered concerning client needs and current crisis response patterns, we will redesign the communication and transport flow with the Sherriff’s Office and the Medical Center. We will then identify tools and agreements needed to expand the use of the unit by all stakeholders in the County. We will use that information to recommend next steps for RHP 8.

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

We will review the impact of the Crisis Assessment facility in relation to the other elements of the crisis response continuum, identify lessons learned and adjust the model with respect to area, intensity and population.

**Continuous Quality Improvement:**

BTCS is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project provides crisis assessment services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening Assessment and Referral (OSAR) services in Burnet and Williamson Counties and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with those Federal funds by providing a local option to address crisis needs. We believe this crisis service will improve the healthcare outcomes for the entire community, relieve pressure on law enforcement and local EDs and promote stable community tenure for individuals receiving services.

**Related Category 3 Outcome Measure:**

* OD‐3 Potentially Preventable Re‐Admissions‐ 30 day Readmission Rates (PPRs)
  + IT‐3.14 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measure: Readmissions to psychiatric facilities are driven by a number of circumstances surrounding the initial hospital stay. Those include the accuracy of the assessment of acuity, early release, poor or hurried discharge planning, inadequate knowledge of community resources and inadequate resources to accommodate a sound community placement. Creating the option to provide a thorough screening and evaluation in the community provides the opportunity to address several of these drivers. We can provide timely evaluations and quick stabilization linked to community follow-up. We know the community resources, including housing and treatment options. It also gives us the chance to intervene with those who otherwise would be readmitted rather than getting community help. Admissions to inpatient settings should be more appropriate and readmissions reduced. This rate will be coupled with Stretch Activity CMHC.1, which is a best practice targeted to those who are admitted to inpatient settings. Our activities will improve timely and effective follow up after discharge to engage the person in community services. This metric focuses on a 7-day follow up for individuals discharging from the hospital and we expect it to further reduce readmissions.

Baseline Information: The baseline rate established for IT-3.14 in DY3 was 6.04%. Our baseline measurement period established in DY3 was 09/01/2013-08/31/2014. The baseline rate established for the CMHC.1 metric was 87%.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing related to Child Crisis Respite (#126844305.1.2) and Emergency Services Diversion (#126844305.2.2) in that it provides a site for thorough screening and assessment. We expect the other projects will demonstrate improved outcomes due to availability of crisis screening provided in the communities in which people live. It both supports and relies on Crisis Stabilization (#126844305.1.2) and the Transitional Housing (#126844305.2.1) projects which provide a place for people to stabilize and/or continue recovery in the community after stabilization is achieved. This option relies on expansion of Substance Abuse Services Adult and Youth in Williamson and especially Burnet County (#126844305.1.5) since some will need referral for that service.

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

This project is somewhat related to Central Counties crisis respite project (#081771001.1.4), Hill Country MHDD’s Co‐occurring Psychiatric and Substance Abuse Disorder project (#133340307.2.1) and Trauma-Informed Care (#1333403007.2.2).

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers, as we continue to do, through the Texas Council of Community Centers. The exchange of ideas through both developing and existing relationships will keep the line of communication open and will help us adjust and refine our programs and approaches to behavioral health care.

**Project Valuation:**

We expect to serve 200 people in this community-based crisis alternative in DY4 and 300 people in DY5. Our goal is to increase utilization by 10% in DY4 and 15% in DY5. Serving people in the community is a substantial savings over using hospital and ED, which are now the only options.

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

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

**Category 1 Project Narrative – Pass 2**

**Bluebonnet Trails Community Services – 126844305.1.5**

**Project Area, Option and Title:** 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas

**RHP Project Identification Number:** 126844305.1.5

**Performing Provider Name:** Bluebonnet Trails Community Mental Health and Mental Retardation

Center dba/ Bluebonnet Trails Community Services

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. Burnet and Williamson Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area.
* **Intervention:** BTCS will establish outpatient substance abuse treatment sites in Georgetown, Round Rock and Marble Falls to meet the needs of a growing population, especially the poor, under or uninsured. The sites will be in our current facilities and will be licensed for supportive outpatient and intensive outpatient services.
* **Project Status:** BTCS currently does not provide direct substance abuse treatment services, only assessment and referral. There are no intensive outpatient substance abuse programs in Williamson and Burnet County.
* **Project Need:** This project addresses RHP 8 Community Need CN. 2.5: Limited access to behavioral health services, primarily substance abuse services for adults and youth who are poor and under and uninsured populations in need of outpatient and intensive outpatient care in Burnet and Williamson Counties. Those without resources cannot travel into Austin for services to achieve and maintain sobriety.
* **Target Population:** Target population is community referrals, and those referred from ED’s in need of outpatient substance abuse services. BTCS served over 7,769 individuals with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid‐eligible; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients were below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 700 a year by DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project reduces inappropriate use of EDs by this population which improves their lives through stable services in a medical home; and improves community health by opening access for those who truly need ED services. The project seeks to provide services to 350 people in DY4 and 700 in DY5 at these new sites in Williamson and Burnet Counties. Providing services locally reduces ED utilization by reducing crises that stem from service gaps. Local services also improve treatment adherence and therefore satisfaction with access. Improvement Milestone I‐X is the number of patient interventions in these new community based settings.
* **Category 3 Outcomes:** IT‐11.8: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. The goal of this project is to increase access to treatment and to provide treatment services for those who are identified as both needing and wanting Substance Use services.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Outpatient Substance Addiction Services for Adult and Youth*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. In that capacity, we are responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area. That responsibility includes identifying gaps in service or barriers to access for persons residing in the area. BTCS proposes to establish outpatient substance abuse treatment sites in Georgetown, Round Rock and Marble Falls to meet the needs of a growing population, especially the poor, uninsured and/or underinsured. The services will be located in our current facilities in those cities and those sites will be licensed for both supportive outpatient counseling and intensive outpatient services. To accomplish this expansion of services we will renovate the spaces to prepare them for Facility Licensure, recruit and hire licensed counselors and prepare policies procedures and treatment protocols.

The goal of this project is to allow people who have limited resources to access intensive outpatient and supportive counseling substance abuse services in their home county. Many of these individuals will need this access following a detoxification stay in Travis County or after an Emergency Department (ED) visit in their home county or Travis County. Access to outpatient treatment following detoxification is essential to recovery. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies, “Admissions to detoxification treatment represent a special category of admissions. They are generally initiated because of an acute need for medical care. Detoxification is ideally followed by a transfer to outpatient or rehabilitation/residential treatment” (SAMHSA, Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1997‐2007. National Admissions to Substance Abuse Treatment Services*, DASIS Series: S‐47, DHHS Publication No. (SMA) 09‐4379, Rockville, MD, 2009). The relapse rate for those in treatment for substance use disorder is 40% to 60% and the variation in rate depends largely on the length of time sobriety is maintained following detoxification. The intensive outpatient substance abuse program and the supportive counseling services are well known in the industry and follow specific licensure and curriculum requirements. An intensive outpatient program will be provided four to six hours a day five days a week in group settings. Supportive outpatient services will be provided in group and individual sessions based on the stage of recovery and needs of the clients. We will provide psycho‐education, peer support groups, solution-focused and multi‐faceted approach to care to include motivational interviewing, co‐occurring psychiatric and substance use disorder services. We expect the variety of services available, responsiveness of the design, staffing and locations to improve behavioral health functioning outcomes and significantly improve satisfaction. This project builds on the expertise and resources of BTCS related to services for the individuals with substance use disorders. When these sites are fully operational, they will serve a total of 700 a year. Individual progress and treatment outcomes will be documented in the electronic health record, Anasazi, and available for summary reporting as required.

**Goals and Relationship to Regional Goals:**

The goal of the expansion is to add intensive and supportive outpatient substance abuse services in Burnet and Williamson County. With this expansion, we expect to improve health outcomes for persons in this area who now have limited access to behavioral health services. A challenge facing individuals in Williamson and Burnet County is that there are no intensive outpatient substance abuse programs in the area. To receive services people must travel into Travis County. For those who are poor and uninsured, the dilemma is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, they could be treated only if they are eligible for Department of State Health Services (DSHS) programs. Substance abuse treatment is limited and frequently unavailable even though the disorder is prevalent among those requesting services.

**Project Goals:**

* Establish intensive outpatient and supportive outpatient substance abuse services in Williamson and Burnet County.
* Provide behavioral health care that is multi‐disciplinary, recovery oriented and comprehensive.
* Provide behavioral health care, specific to substance use disorders, to all those in need regardless of income, insurance status or diagnosis.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs; and
* Increasing coordination of substance abuse and mental health care for residents.

**Challenges:**

The primary challenges for this project are to gain community acceptance as a provider of comprehensive substance abuse treatment services and to receive referrals from a broad range of community sources. Currently BTCS is known as the authority for substance abuse services and provides referrals for state‐funded treatment. BTCS must become accepted as a comprehensive treatment provider by the community and by referring providers. The ‘Treatment Episode Data Set’ cited above indicates that nationally 37% of the referrals to treatment are from criminal justice agencies and 33% are self‐referrals. We can license and offer a comprehensive range of services for adults and youth and a behavioral health team that is accessible, responsive and integrated into the community. This program will be successful only if referrals are forthcoming. We believe that establishing the services in our current locations will help with acceptance. Also, we have excellent relationships with justice entities and will use those relationships to achieve referrals. We will continue to participate in community task force meetings and forums to promote treatment and recovery as well as promote the success of treatment to the public.

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

BTCS’ goals are to establish outpatient substance abuse treatment sites in the two Counties and for a greater diversity of people with substance use disorders to be served in Williamson and Burnet County. We expect the outcome to be a greater acceptance of these treatment options as the sites are established in the community. We expect to see a growing level of satisfaction related to getting care quickly; integrated behavioral health care, cultural competency and perceived improvement in functioning. We believe that a successful program will reduce disparity in treatment for the poor and uninsured/underinsured and lead to a healthier more productive community. Over the next five years we expect the increase in the number of people accessing outpatient substance use disorder treatment to reach a capacity of 700 people served a year for Williamson and Burnet County residents. The goals stated above related to establishing this new service and educating the community about the need for intervention and treatment will directly affect achievement of the outcomes. The outcome expected is an increase in the quality of life for citizens of these Counties who access services.

**Starting Point/Baseline:**

This is a new project for BTCS in Burnet and Williamson County. There is no program for substance abuse treatment that targets the poor and uninsured in Williamson or Burnet County and therefore the baseline for DY2 is 0. We do not have current data to identify those from Burnet and Williamson County who are accessing detoxification and ED services due to substance abuse disorders, but an important first step in this project will be to identify a means of gathering and tracking that data. We are also aware that we must secure licensure for intensive outpatient substance abuse services.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐Limited Access to Mental Health/Behavioral Health Services
* Specific Community Need: CN.2.5 ‐ Limited access to behavioral health services, primarily substance abuse services for adults and youth who are poor and under & un‐uninsured populations in need of outpatient and intensive outpatient care in Burnet and Williamson Counties.

The primary intent of this project is to establish new substance abuse service locations in underserved areas. There are no substance abuse providers in Williamson or Burnet County that focus on providing services to the poor and uninsured. Locating services locally will increase utilization, eliminating the barrier of travel into Travis County that prevents the economically disadvantaged from accessing care. Through meetings with community stakeholders and participation in the Williamson County Mental Health Task Force and the Burnet County Mental Health Task Force, BTCS has identified that there is a lack of access to behavioral health care services in those Counties resulting in part from provider shortages and lack of insurance coverage. One of the most pressing deficiencies identified is lack of access to outpatient substance abuse treatment especially for the poor and uninsured or underinsured. By establishing intensive outpatient and supportive outpatient substance abuse treatment services in Williamson and Burnet County we will provide access for persons who have been diagnosed with and require treatment for substance use disorders. According to the Williamson and Burnet County Community Needs Assessment (<http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf>), Williamson County is one of the fastest growing counties in the state. It grew by 69% from 2000 to 2010. Both Burnet and Williamson Counties have a gap between segments of the population that leads to health care disparity. Areas of Williamson County have a population percentage below poverty of only 5.5% while other areas have a rate of 19.5% which is above the state average of 16.5%. Burnet County only grew by 22.5% during the same period but is picking up pace now. That county also shows a disparity in income, with the percentage below poverty being around 8% but in the segment of the population, female heads of household with children, it is 15%-- slightly below the state average. According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3% of persons aged 12 or older); of these, only 2.6 million—11.2% of those who needed treatment—received it at a specialty facility: <http://www.drugabuse.gov/publications/drugfacts/treatment>‐statistics

When access is problematic, the difficult decision to seek treatment is deferred or the problem denied. As stated above, BTCS does not currently provide behavioral health care to all persons, only to those in the priority population. We also do not provide substance abuse treatment as part of the behavioral health service array. Both of these are identified needs in this area. One critical disparity identified for RHP 8 is scarcity of behavioral health services throughout the region and especially in rural areas. As stated in the RHP Planning Protocol document, Texas ranks 50th in per capita funding for state mental health authority (DSHS) services and supports for people with serious and persistent mental illness and substance use disorders. Medically indigent individuals who are not Medicaid‐ eligible have no guarantee of access to needed services and may face extended waiting periods. Additionally, Texas ranks highest among states in the number of uninsured individuals per capita.

One in four Texans lack health insurance. People with behavioral health disorders are disproportionately affected. However, many residents are unable to access either routine services or needed care in a timely manner because they lack transportation, are in poverty, lack insurance coverage or because they are unable to schedule an appointment due to work scheduling conflicts.

**Core Project Components:**

Although 1.12.2 does not have required core components listed with it, it is in the same Project Option as 1.12.1 and those required core components were used as a guide for our own components. We have reviewed the components, modified them and will address them as below:

a*) Evaluate existing locations of behavioral health clinics and to identify barriers to access including, transportation, operating hours, admission criteria and acceptable payment. If any of these barriers is a significant issue in care access, develop and implement improvements.* We know that our current locations do not offer substance abuse services and that there are none in these counties for the poor and uninsured/underinsured. As we open for services, we will use satisfaction surveys and information from patients and families to determine how to eliminate barriers to service access.

b) *Review the interventions impact on access to behavioral health services and identify “lessons learned,” opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety‐net populations.* We will establish a Plan, Do, Study, Act (PDSA) cycle improvement process through the Quality Management department of BTCS to collect and analyze data related to these interventions. That data will include ECHOTM Satisfaction Survey results and Electronic Health Record (EHR) data related to functioning scales and frequency in the use of higher levels of care such as EDs and inpatient psychiatric care. We will assess the results and make improvements in the operation of this intensive outpatient service option as well as the supportive counseling service. We will hold community planning meetings with providers, patient advocates and community leaders in a number of communities to assess expansion opportunities.

We choose Milestones and Metrics for DY2 and 3 that represent the developmental nature of this new service. We will measure and report the development of policies and procedures, hiring staff and establishing the service. We know that achieving referrals and community acceptance is important to be able to serve the target population. Once the service is established and the referral base secure, we will measure reduction in use of ED and detoxification facilities as the Milestone and Metric for DY5.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** BTCS receives funds from U.S. Department of Health and Human Services (DHHS) including Substance Abuse Prevention and Treatment Block Grant used to operate substance abuse Outreach Screening and Referral services in Williamson, Burnet and several other counties; and Community Mental Health services block grant used for outpatient mental health services. These DHHS funds will not be used for direct services in this project; however, participants could be referred and treated in those other programs ongoing or upon discharge. This project enhances and extends those services in the community. Many persons with a mental health diagnosis also have a co‐ occurring substance use disorder and as indicated, there are no substance abuse services that are primarily for the poor and uninsured/underinsured. This project would continue the current direction of BTCS and provide integrated care; and to improve access in rural areas, for low income individuals and for everyone who requests and needs services.

**Related Category 3 Outcome Measure:**

OD‐ 11 Behavioral Health/Substance Abuse Care

IT‐11.8 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Reasons/rationale for selecting the outcome measure:

This is a stand‐alone measure. We selected this measure because the goal of this project is to help people with substance use disorders. We aim to increase access to treatment and to provide treatment services for those who are identified as both needing and wanting Substance Use services. Our goal is to achieve this metric in accordance with the improvement measure specifications and calculation methodology set forth for P4P measures, by a gap reduction of 10% compared to baseline in DY4 and by a gap reduction of 20% compared to baseline in DY5.

Baseline Information: The baseline rate established in DY3 rate 1 was 84.71% and for rate 2 was 71.76%. Our baseline measurement period established in DY3 was 10/01/2013-07/15/2014. This baseline has been identified as above HPL and has therefore been flagged for TA with HHSC. We anticipate further discussion on future Category 3 metrics.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing including: Crisis Stabilization for Persons in Behavioral Health Crisis (#126844305.1.2); and Emergency Services Diversion (#126844305.2.2); in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It also supports the Transitional Housing Guided by Peer Support (#126844305.2.1), by offering the option of housing within the home community if needed.

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

While this project shares a number of things in common with other LMHA’s, the project Hill Country MHDD is planning regarding Co‐occurring Psychiatric and Substance Use Disorders (#133340307.2.1) is the most similar.

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care. In an effort to ensure the exchange of ideas, the Williamson County Mental Health Task Force will be the primary conduit for our planning discussions.

**Project Valuation:**

The project reduces inappropriate use of ED by this population which improves their lives through stable services in a medical home; and improves community health by opening access for those who truly need ED. The project seeks to provide services to 350 people in DY4 and 700 in DY5 at these new sites in Williamson and Burnet County. The valuation calculated for this project used cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐weighted units that were applied to the factors existing in this underserved area, including: limited access to primary care and to behavioral health care, poverty and the link between chronic health conditions and chronic behavioral health conditions. The valuation study was prepared by professors H. Shelton Brown, Ph.D. and A. Hasanat Alamgir, Ph.D. both of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research based on a model that included quality‐adjusted life‐years (QALYs) and an extensive literature of similar interventions and cost savings and health outcomes related to those interventions. The QALY index incorporates costs averted when known (e.g., emergency room visits that are avoided

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

**Category 1 Project Narrative**

**Center for Life Resources – 133339505.1.1**

**Project Area, Option and Title:** 1.11.1 Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state

**RHP Project Identification Number:** 133339505.1.1

**Performing Provider Name:** Center for Life Resources

**Performing Provider TPI #:** 133339505

**Project Summary:**

* **Provider Description:** Center for Life Resources (CFLR) is a local mental health authority (LMHA) serving: Brown, Coleman, McCulloch, San Saba, Mills, Comanche, and Eastland Counties. CFLR serves a variable number of clients based on Department of State Health Services (DSHS)/Department of Aging and Disabled Services (DADS) contractual agreements. Currently, (FY2013) we are serving approximately 1,250 clients in a 7,074 square mile area with a population of approximately 102,497.
* **Intervention:** Through the implementation of a telemedicine model we will provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider throughout this expansive area. Thus improving consumer satisfaction/access where previously limited or unavailable.
* **Project Status:** This is a new project for this region (RHP 8 Counties of Mills and San Saba Counties). We will determine a baseline in DY2 that will serve as a foundation for future progress and monitoring. We expect to see a progressive increase in those served through DY5.
* **Project Need:** There currently is very limited to no access to psychiatric or other mental health care providers in this region (CN2.6). This fact has led to the federal distinction of mental health professional shortage area <http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm>. Further, as highlighted through the mental health professional shortage area map; there are inadequate numbers of providers willing to relocate to rural and frontier regions. We believe innovative solutions, such as telemedicine, must be considered and attempted to address the stated community need (CN 2.6).
* **Target Population:** The to be determined target populations we intend to serve are individuals residing in Mills and San Saba Counties suffering from serious mental illness. These primarily include but are not limited to individuals who either are Medicaid-eligible or are indigent. Our estimation based on current calculations and past billing is that no less than 50% of our clients currently meet this distinction. This would imply that at least half of those we serve in this new capacity through telemedicine would be Medicaid-eligible or indigent. The project seeks to provide 6 telemedicine encounters in DY3 due to completion of infrastructure, 120 telemedicine encounters in DY4, and 144 telemedicine encounters in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:**The project seeks to provide 6 telemedicine encounters in DY3 due to completion of infrastructure, 120telemedicine encounters in DY4 and 144 in DY5.Through the implementation and subsequent provision of telemedicine services this project seeks to provide a satisfying, individually tailored service that also works to reduce unnecessary ED usage. Customer satisfaction will be measured using evidenced based satisfaction tools in DY4 and DY5. These two years will be compared and steps to ensure continued satisfaction will be based on the subsequent data.
* **Category 3 Outcomes:** IT-11.26 e.g. Patient Health Questionnaire 9 (PHQ-9) which assesses and monitors depression severity. We will use this tool to determine a baseline and provide performance greater than baseline during DY4 using scenario 3. This specifies that in DY4 we will take the baseline average survey score +5% of range of possible survey scores. During DY5 we will take the baseline average survey score +10% of range of possible survey scores. We believe this measure a great tool to determine if we are making an appreciable impact from services provision.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. Through the TAMHSC allocation, CFLR is now better able to plan and afford increased clinician time and directly impact the number and frequency of available appointments in this mental health professional shortage area. This increase in available clinician time is believed to have the ability to significantly impact those we intend to serve by increasing access where there was limited to none previously.

**Project Description:**

Telemedicine in Mills and San Saba Counties

According to the Health Resources and Services Administration (HRSA) as presented through the Department of State Health Services, both Mills and San Saba Counties meet the federally designated status of mental health professional shortage areas <http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm>. Mills and San Saba Counties have very limited to no access to local psychiatric service providers. Further, the distances traveled for potential treatment require travel outside of county. This creates increased hardship for individuals and families who have limited or no funds to travel to areas with psychiatric availability. Despite the limited access to care, consumer need has not been diminished and is often provided by non-mental health agencies. Due to the difficult nature of obtaining and keeping psychiatric services in rural areas it is necessary to develop and implement other strategies to provide the needed services. Our project will address the issue of developing a community strategy by procuring and building the infrastructure needed to pilot or bring to scale a successful pilot of the selected form(s) of service in the proposed underserved areas (Mills and San Saba Counties) which will be combined with the following plan of action. CFLR proposes that we can better address the psychiatric need in these rural community settings through the implementation of a telemedicine system.

**Core Project Components:**

1. *Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state.* CFLR or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Mills and San Saba) Counties as defined as a mental health professional shortage area.
2. *Assess the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.* This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.
3. *Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.* Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This will be accomplished as we evaluate previously successful models also adopted in rural settings that might be successful in ours. This process will be done to determine feasibility and likely highlight the offsetting of costs associated with unnecessary ED services. Simply, we propose the use of a telemedicine system that will give greater access of care to citizens and reduce any unnecessary costs.
4. *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.

CFLR is committed to continuous quality improvement and learning related to this project. We will establish and implement quality improvement activities such as rapid cycle improvement, which utilizes plan-do-study-act, and will perform other activities such as “lessons learned” and identifying project impacts. In order to implement rapid cycle improvement, we will assemble a team of individuals who will meet monthly to evaluate implementation as related to the stated goals of the program. The team will identify areas needing improvement and determine a plan of action.

The team will then implement the changes and evaluate it over the next month. When the team reconvenes they will examine the results of the implementation to determine if the desired improvement has been reached. The team will use these results to establish future quality improvement plans. An agenda with minutes and materials presented at each meeting will be maintained for reference. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations. We will continue our monthly team meetings as well as our participation in our regional learning collaborative throughout DY3-DY5. Due to our agency placing high priority on the right care, in the right place, at the right time, our regional project focuses on RHP Milestone I-15: Satisfaction with telemental services. We expect to achieve 75% satisfaction in DY5, out of 144 encounters we expect 108 to be satisfied. We believe that satisfaction is an integral milestone when focusing on the right care, in the right place, and right setting. As telemedicine systems have not been indicated currently in this region other outside resources must be examined for efficacy. It is commonly accepted in private sector management that customer satisfaction is an important factor in determining utilization. It is believed that data will begin to demonstrate this belief after implementation in DY3. Our intention in the implementing of this project will be to show an increase in the number of those who would not normally be able to receive these services having greater access and greater satisfaction as a result.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

Our goal is directly related to providing the right care in the right time and in the right setting.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs; and
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

**Challenges:**

The challenges that we foresee are those seen with adopting any new system into a community where there was not one previously. This implementation is likely to have “growing pains” and adjustments will be made regarding being new as well as adjusting to customer desire/needs.

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

It is believed that each consequential year will see an increase in the number of people using this system. During DY2 we will use data sources (Anasazi systems, emergency room, and law enforcement) to determine a baseline need for services. Also during this time we will utilize surveys to monitor satisfaction of services provided. It is estimated that there will be an increase in use in DYs 3 and 4 as people begin to see the benefits of this program. Further, with continued education and implementation of proven techniques we expect to produce the foundation for a vibrant and growing program that adapts to customer need while reducing unnecessary emergency department use. For patients we expect to reduce the need for excessive or unnecessary driving while providing high quality services that were not previously available in their area. The project seeks to provide 6 telemedicine encounters in DY3 due to completion of infrastructure, 120 telemedicine encounters in DY4, and 144 telemedicine encounters in DY5.

**Starting Point/Baseline:**

Baseline will be determined over the course of DY2 and implemented in DY3. This will be found through data collection sources such as local hospitals, law enforcement, and other sources as indicated.

**Rationale**:

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.6 – Limited access to behavioral health services for rural populations in Mills and San Saba counties.

CFLR will meet all of the core project requirements (see Project Description). CFLR or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Mills and San Saba) Counties as defined as a mental health professional shortage area. This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology. Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This process will be done to determine first feasibility and then determine if the project would be capable of offsetting the costs associated with unnecessary emergency department services. Some of the possible cost deferments are listed below although are not limited to these specific examples. According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) is $6,030 a day with a median charge of $14,472. Another example of a possibly preventable condition is an acute adjustment & psychosocial dysfunction. BRMC has an average charge per day of $7,699 with a median charge of $16,939. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy’s average pay can range from $12.50 to $15 per hour, so in an average situation this would be an additional $30-$45 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $16,620 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $16,620 is solely an average and our best estimation based on prior experience. Even though these financial costs are significant, the human cost is much harder to measure and can be even more significant. It is believed that early intervention in appropriate settings could reduce unnecessary utilization of community resources and emergency departments as well as improve individual care. Our proposed project will address both of these issues by utilizing a tested application of technology through the use of telemedicine to address Community Need Area 2 and Specific Community Need 2.6. It is reasonably believed that the introduction of hi-speed internet in many of the rural areas greatly increases the viability of telemedicine. Given the need for the right care at the right time in the right place and addressing local needs, telemedicine provides great promise.

**Continuous Quality Improvement:**

CFLR is committed to continuous quality improvement and learning related to this project. We will establish and implement quality improvement activities such as rapid cycle improvement, which utilizes plan-do-study-act, and will perform other activities such as “lessons learned” and identifying project impacts. In order to implement rapid cycle improvement, we will assemble a team of individuals who will meet monthly to evaluate implementation as related to the stated goals of the program. The team will identify areas needing improvement and determine a plan of action. The team will then implement the changes and evaluate it over the next month. When the team reconvenes they will examine the results of the implementation to determine if the desired improvement has been reached. The team will use these results to establish future quality improvement plans. An agenda with minutes and materials presented at each meeting will be maintained for reference. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations. We will continue our monthly team meetings as well as our participation in our regional learning collaborative throughout DY3-DY5.

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

We do not currently receive any U.S. Department of Health and Human Services funding that will be directly used for the implementation of telemedicine services.

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

OD 11 Right Care, Right Setting IT-11.26 e.g. Patient Health Questionnaire 9 (PHQ-9) which assesses and monitors depression severity. CFLR has met with and spoken to several judges, law enforcement officials and county commissioners and has determined that there is a significant need for telemedicine services in their respective counties as telemedicine will assist in lowering costs for their departments while expanding and enhancing behavioral health services in these counties. Additionally, it will allow for the right care to be provided at the right place and the right time. We will develop a system to track the behavioral health clients served by this project through our internal database, Anasazi.

**Relationship to Other Projects:**

We are proposing to implement/enhance telemedicine services in seven counties covering RHP 8 (#133339505.1.1), RHP 11 (#133339505.1.1 & #133339505.1.2), and RHP13 (#133339505.1.1)**.** Each of these projects will work to in tandem with the intended purpose of greatly increasing the likelihood of right care, at the right time, in the right setting.

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

Two other providers are proposing telemedicine projects, Central Counties Services (#081771001.1.2) and Hill Country (#133340307.2.3)but each covers counties different than those covered by CFLR. Collaboration is greatly encouraged and will be a part of our overall implementation and success. Further, as part of DY2 or DY3 as appropriate, CFLR will contact other similar providers to discuss the planning necessary for a learning collaborative and implementation.

**Project Valuation:**

This project seeks to provide 6 telemedicine encounters in DY3, 120 telemedicine encounters in DY4 and 144 in DY5. We plan to do this where no known similar services are currently being provided. Due to the nature of these locations and their distinction as mental health professional shortage areas, it is often difficult or even prohibitive for individuals to receive appropriate services in the right setting. Our valuation places priority on patient and community benefit through our pursuit of providing the right care at the right time in the right place. We have attempted to demonstrate the current cost of providing these services and the advantages of providing them locally through our proposed telemedicine project. The data will clearly demonstrate the need to attempt telemedicine services in this area.

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $16,620 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 120 encounters we intend to provide in DY4 in the current system would cost over 1.9million dollars (120 \* 16,620 = 1,994,400). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 4.38 million dollars (144\* 16,620 = 1,396,080 + 2,393,280= 4,387,680). Given the total four-year incentive payment of $557,921 the cost savings and value of providing right care in the right setting is a fraction of the cost (13%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.

Similar to other projects in our region we also looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from $50,000 to $200,000 per (QALY) in the United States

(<http://www.ahrq.gov/research/iomqrdrreport/futureqrdrapf1.htm>).

Our project looked at the value to our community as a whole providing the funds, but also the value to the individuals receiving the services. Through the provision of quality local services in underserved areas, we would be afforded the unique opportunity to help those individuals who do not have the means to seek more expensive options outside of their area. We believe this availability has the direct effect of improving the quality of life for those suffering significant mental illness.

**Category 1 Project Narrative**

**Central Counties Services – 081771001.1.1**

**Project Area, Option and Title:** 1.1.1. Establish more primary care clinics

**RHP Project Identification Number:** 081771001.1.1

**Performing Provider Name:** Central Counties Services

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, the Center helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
* **Intervention:** This project will provide school-based mental health services for children (K-5th grade) who have difficulty adjusting to the classroom environment due to emotional/behavioral problems. Counseling services may include the child’s family. Services will be provided in Temple Independent School District (TISD) elementary schools.
* **Project Status:** This is a new project.
* **Project Need:** In FY2012, TISD had a grade retention rate for children K-5 of 4%, almost twice the state average retention rate (2.4%). The TISD staff identified 222 children in K-5(excluding special education children) who adjusted poorly to the classroom setting due to emotional/behavioral problems. See also CN2.7: Lack of school-based behavioral health services in Temple.
* **Target Population:** 222 children were identified in school year 2011-2012 as needing this service. The exact number of children who have Medicaid in this new project is unknown. Kids Counts from 2010 indicated that 24.2% of Bell County children were Medicaid clients in 2010. In addition, 80% of the children in K-3 at TISD participate in the subsidized/free meals program. It is anticipated the children the program serves will be at least similar to the Kids Counts figures, if not higher.
* **Category 1 or 2 Expected Project Benefit for Patients:** This project will help children address emotional/behavioral problems experienced in the classroom with the goal of moving children from being poorly-adjusted to being evaluated as moderately or well-adjusted to the classroom setting. Patient satisfaction with school-based mental health services is expected to improve each year the service is offered (see Improvement Milestone I-11.1). The goal will equate to a satisfaction survey that is 20 questions scored on a 100 point scale with the average score of 1-3 = poorly satisfied; 4 = moderately satisfied; & 5 = highly satisfied. The Center would expect the number of children who score in the moderate to high satisfaction range to increase from DY3-DY5 (50%, 60%, and 70% respectively), with satisfied children meaning there is positive value in the services.) This project is expected to provide 2,500 service encounters in DY-3, 3,000 service encounters in DY-4, and 3,500 services encounters in DY-5 for a cumulative (DY-3: 2500 encounters: + DY-4: 3,000 encounters: + DY-5: +3,500 encounters = 9,000) QPI of 9,000 encounters for this project.
* **Category 3 Outcomes:** IT-11.26.d: Improve quality of life functioning/level of adaptation to their school learning environment – DY4 to be 15% improvement above the baseline, and DY5 to be 25% above the baseline scores. The impact of behavioral changes for many children will make a higher quality of life, social and vocational difference in the 70 plus years for each child (14,700 person-years) that follow these effective interventions and skill development activities.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This new service for the region will be truly transformational for these children in that those children served will have increased academic achievement and vocational achievement for 70+ years for each child whose school-setting adjustment improves in these first years of school. The program intends to document this new service in a manner that it can be duplicated in other schools in the area, and throughout the state.

**Project Description:**

*School-based behavioral health services*

The Center will work with TISD to develop a behavioral health adjustment evaluation tool based on each child's behavior, attendance, and academic performance. This tool will then be applied to all kindergarten through fifth grade students (total of 4,228 children last school year) in TISD and will reflect a) those students who are well adjusted to scholastic achievement, b) those students who are moderately well adjusted to scholastic achievement, and c) those students who are poorly adjusted to scholastic achievement (222 K-5th grade children identified as such in school year 2010-2011).

For this project, the Center will employ 6 properly trained and credentialed clinical staff who will be housed within the different elementary schools of TISD to work with the TISD children identified as poorly adjusted to the scholastic environment/scholastic achievement goals. The staff will connect with the Center’s health record system or custom forms created by the project, which will document each child’s assessment, improvement plans and progress towards individual improvement goals. The children will be referred to this in-school clinic by TISD staff and will be jointly staffed with the assigned school counselor, the child’s teacher, and the attendance officer of that school (child’s guidance team). The Center staff will observe the children in the classroom setting and meet with the parent(s) to discuss the child’s adaptation difficulties. The child’s quality of life inventory will be completed by the appropriate parties upon enrollment to establish a base-line measure by which to measure improvement in the child’s quality of life. This will give the clinical staff another perspective on the child’s adaptive skills and deficits and will serve as a core element in shaping the clinical/social interventions chosen for each child. An individualized improvement plan will be developed and reviewed with the child’s guidance team, the child’s parent(s), and the child. The improvement plan will include such elements as: individual/group skill building activities to improve coping skills, attention to tasks, etc., role playing, social situation rehearsing, focused interventions to extinguish certain behaviors, while teaching alternate, more appropriate behaviors, family counseling, parent education, and other efforts to improve, when possible, the child's support in the home environment as well, etc. The child’s parent(s) and teacher will be advised of the child’s improvement plan content and goals and will be advised how parents and teachers can support the child’s improvement efforts in the classroom and at home. Each child’s progress towards improving his/her quality of life will be assessed upon enrollment and at the time of clinical discharge or at the end of the school year, whichever comes first. (Clinical discharge occurs when the child has demonstrated improved classroom behavioral functioning as determined by the teacher or parent or on the basis of the child’s quality of life scores. If the child moves abruptly from the area, is non-compliant, or is referred elsewhere within the school system, this is not considered a clinical discharge.) It is expected that each child served by this project will steadily improve level of school adjustment/functioning each time that it is measured (See Category 3 Outcomes section below) with an age-appropriate quality of life inventory. These assessments will be shared with the child’s guidance team and the child’s personal improvement plan will be adjusted accordingly to guide the child’s continued improvement.

The school-based behavioral health services will be designed to work with the children identified by the TISD staff as poorly adjusted to scholastic achievement, with the goal of moving 20% of the children evaluated as poorly adjusted up to the moderately adjusted category during the first full school year (2013-2014). It is expected that children with the poorest personal adjustment to the school setting/scholastic learning environment will stay enrolled in these services until an improvement in scores moves the child to the moderately well-adjusted group of children. This project should also have an impact of reducing the number of children held back in their grade due to behavioral/mental adjustment-related problems (TISD held back 4% of its K-5th grade students in the 2010-2011 school year compared to the state average of 2.95% being held back for these same grades). The 6 credentialed behavioral health staff who are trained in child mental health and behavioral counseling would work with the children identified as poorly adjusted scholastically to improve each identified.

**Continuous Quality Improvement**:

The Center is committed to continuous quality improvement and learning related to this project. The Center will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, the center is participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations. This project will also seek frequent satisfaction feedback from the students, family and other third party stakeholders regarding ways to improve the service engagement of the child and the family. The patient satisfaction survey will be administered 30 days after enrollment and by time of clinical discharge (see above) or at the end of the school year, whichever comes first. Initial resistance to these services is seen as a potential challenge/ barrier to children using these services, and this “plan, do, study, act” rapid assessment and process improvement efforts.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

Expand the capacity of/access to behavioral health services for children K-5th in TISD setting who are poorly adjusted to scholastic achievement due to personal or familial behavioral health problems in order to assist these children to improve the ability to successfully function in the school environment. Provide early intervention for behavioral health problems of young children which is often more successful than a later intervention, and is accomplished at less personal quality of life costs for the individual, as well as less financial cost to successfully intervene/reduce/resolve the behavioral health problem.

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Improving access to timely, high quality care for residents, including those with multiple needs.

**Challenges**:

The project may see some initial resistance on the part of parent(s) to allow the child to participate in services, and some reluctance on the part of the parent(s) to participate in these services due to the stigma associated with behavioral health problems/services. The clinical staff plan to put together a simply-worded brochure for the use of teachers and to be sent to parents. It will describe the benefits of this behavioral health school-based project and how to access these services. The clinical staff plan to closely monitor the patient/parent(s) satisfaction/dissatisfaction with service aspects to increase this project’s ability to engage both children and parents in addressing these behavioral health problems that affect each child’s ability to perform well in school.

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

Progressively assist those children served by this school-based project to increase personal quality of life functioning in the school environment and ability to successfully move up to the next grade level along with the children of same age group. By having this school-based behavioral health clinic in place for four consecutive years, a dramatic reduction of the number of children experiencing school adjustment-type behavioral problems as they enter the sixth grade should be seen. This school-based behavioral health clinic should have a dramatic effect on lowering the number of children who do not pass to the next grade. By DY5 the number children retained in grade 5 should be significantly below the state average (2.4%) for children being retained in grade5.

**Starting Point/Baseline:**

Within the first several months of this project,TISD staff and staff hired by this project will develop an evaluation tool/process to assess how well children are adapting to the school environment. This evaluation tool/process will be applied to all children in TISD grade K-5 (approximately 4,200) to determine level of functioning in the school environment. This process will establish the number of children assessed as poorly adjusted to scholastic achievement, and will establish a scholastic adjustment score. Those children with the lowest scholastic adjustment scores will be the first children to be referred to the school-based behavioral health clinic staff. The children selected for referral to this project will then have an age-appropriate quality-of-life survey completed. The child’s score/rating on this quality-of-life survey will serve as that child’s baseline score/ranking for measuring future progress.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.7 - Lack of school-based behavioral health services in the TISD

The Center has a child/adolescent behavioral health clinic in Temple. The Temple clinic serves about 180 children and has a waiting list for children/families seeking our services. The majority of our patients at this clinic are 10 years old and above. The Center finds that many families bring the child who has behavioral adjustment problems to the clinic almost as a last resort. The parents have exhausted the family’s network resources in attempts to cope with the multi-problem child. At this time, unfortunately, the project identifies that these children with severe problems often have very young parents who lack mature adult coping skills. The Center has long desired to find a way to intervene with these children and families of the children at earlier stages of the problems, before the child and parents adopt such oppositional ways of relating around the problem behaviors.

When the 1115 Waiver was approved for Texas, Central Counties Services approached the TISD Superintendent to determine if there were any ways that the center could implement school-based child behavioral health services for the youngest children in TISD and that discussion led to the development of this project which will focus on the youngest children in the TISD system. 4,228 K- 5th students were in the TISD system in school year 2011-2012, and 5.2% of these children were retained in the current grade, compared with the state of Texas average rate of 2.9% retention for children in these same grades. The TISD staff informally identified 222 students in these 6 grades who were poorly adjusted to the school environment and the scholastic expectations for learning achievement. The TISD staff informally evaluated all of these 222 students of having personal or family behavioral health problems that were affecting the child’s ability to function well in the school environment. These young children are just developing social-relational skills, behavior patterns and school attitudes and have the most potential to benefit from behavioral health intervention, skill building activities and their parents can be the most motivated to make changes to increase appropriate family support. School-based behavioral health services have “been shown to be effective because the health care is located conveniently for patients and is in a setting that is familiar and may feel ‘safe’ (see RHP Planning Protocol, p. 11, P-2.1.c.).” Such school-based services are viewed with less stigma than community-based behavioral health services. Effective early behavioral health intervention with these young children can have a very profound positive impact on educational experience and vocational success as young adults.

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

This project does not supplant any services or funds currently provided to Central Counties Services through the U.S. Department of Health and Human Services or the Texas Department of State Health Services. These services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

**Related Category 3 Outcome Measures:**

IT-11.26.d Quality of Life functioning/level of adaptation to their school learning environment

IT-11.26.d: Quality of Life; functioning for children enrolled in school-based behavioral health services.Quality of Life functioning scores would improve by 5% in DY4 and 10% in DY5. Showing improvement in the quality-of-life functioning of the children enrolled in these services will serve as the basis for demonstrating the positive impact of this school-based behavioral health clinic. The children’s quality of life functioning/level of adaptation to the scholastic environment will be measured through the use of an evaluation tool when the children are first referred to the clinic, and then again upon clinical discharge (see above) or the end of the school year, whichever comes first in order to demonstrate quality of life/level of adaptation to the scholastic environment improvement. The percentage of quality of life functioning/ adaptation to the scholastic environment improvement is expected to be 5% and 10% at the respective reassessment intervals. For many of the children served in this project these improvement levels will make possible their passing from one grade to the next due to increased behavioral and social adaptation to the school group-learning environment. The child will learn how to adapt and thrive in the socio-learning environment so that the child can successfully prepare for life as independent functioning adults. The long-term view of these children should show a lower than average school dropout rate, higher than average graduation rate and good educational/ vocational readiness for the next life stage as young adults.

It is expected that a very small number of children will have neurologically complicated behavioral adjustment problems will not thrive as significantly as most children are expected to do in this project. Early identification of children who are in this circumstance can lead to early referral to more sophisticated diagnostic evaluations and more intensely structured services that will be beyond the scope of this project. Even these children will be well served by the early identification of complex bio-neurological condition and an early referral to services qualified to care for these children’s complicated developmental needs.

**Relationship to Other Projects:**

This project is focused on increasing access to behavioral health services and is similar to the Center’s telemedicine (#081771001.1.2) and clinical efficiency improvement projects (#081771001.1.5) which have a similar goal of increasing patient access to behavioral health services. This project will rely heavily on wireless access to the Center’s electronic health record clinical system, (#081771001.1.5) and will require continuity of access to this record system throughout this project. The early identification and intervention with these young children are expected to reduce the likelihood of needing further behavioral health services as teenagers and young adults. By having these services school-based, the project aims to reduce the stigma attached to being involved with behavioral health services among the children served and the child’s classroom peers.

Other Center projects include:

* 081771001.1.3 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
* 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
* 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
* 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
* 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

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

Central CountiesServices is committed to improvement of services and broad-level delivery system transformation. To the Centers knowledge, no other provider is addressing the behavioral health needs of children. Therefore, the Center is willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve the target population and meet the community needs. Sharing information on at least a yearly basis will allow providers to strengthen partnerships and to continue providing services efficiently so, there is maximum positive impact on the healthcare delivery system in RHP 8.

**Project Valuation:**

This project is expected to provide 2,500 service encounters in DY3, 3,000 service encounters in DY4, and 3,500 service encounters in DY5 – most children’s services will be quite complex and will include family counseling as well as individual and group counseling. An encounter occurs when staff meets with the child, parent, and/or teacher face to face to provide skills training services and documents the visit. Just observing a child is not considered as an encounter. The valuation of this project includes: the development of a student assessment system that identifies children who are poorly adjusted to scholastic achievement; hiring 6 properly credentialed mental health/behavioral intervention staff; cost of on-going clinical training of direct-care staff on early childhood behavioral health issues; cost of equipment/ supplies that will be needed to perform the staffs work and to insure the confidentiality of the staffs work with TISD children and to remotely connect to the Center's clinical data system and/or use paper forms spreadsheets or custom forms; cost of satisfaction surveys and training to properly administer them; cost of formulating and delivering reports at the learning collaborative sessions; cost of clinical activity and teaching materials, and consumable activity supplies; design and printing of brochures/pamphlets describing the services provided by this project for distribution among teachers and parents; clinical supervisory time to insure clinical quality of services; communication devices to efficiently interact and receive clinical support/guidance from staff supervisor; the offsetting cost of children repeating a year of school; the value of early intervention and its positive impact on children's academic achievement in future school years and in the child’s beginning vocational years; valuation also includes program indirect costs and administration overhead costs; valuation for DYs 3-5 include provisions to cover staff compensation increases and inflation. Valuation includes the impact of significant behavioral change expected for at least 210 children that will make a quality of life, social and vocational difference in the 70 plus years for each child (14,700 person-years) that follow these effective interventions and skill development activities.

**Category 1 Project Narrative**

**Central Counties Services – 081771001.1.3**

**Project Area, Option and Title:** 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas

**RHP Project Identification Number:** 081771001.1.3

**Performing Provider Name:** Central Counties Services

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
* **Intervention:** The project will implement group social skills training for persons diagnosed with High-Functioning Autism or Asperger’s Disorder in the Bell County area.
* **Project Status:** This is a new project. There is currently no model like this project in the local service area.
* **Project Need:** CN.2.9 Lack of social support services for high intellectual functioning Autism & Asperger’s population (18 years & older) in Bell County.
* **Target Population:** Those persons currently served by the Center and the Department of Assistive and Rehabilitative Services (DARS) who are diagnosed with High-functioning Autism or Asperger’s disorder number between 90 – 100 people with approximately 80% of them being Medicaid eligible. We expect to serve 28-54 people per year.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to serve 14 of the 94 persons in DY 3 for a percentage of the target population of 14 %. The project will serve an additional 16 persons in the target population for DY 4 for a cumulative total by DY 4 year end of 30 or a percentage of 31 % of the target population. The project will serve an additional 24 persons in DY 5 for a cumulative total of 54 (57 % of the target population) in DY5. Group social skills training is expected to lead to enhanced social skills for the participant (Improvement Milestone I-11.1). Enhanced social skills would necessarily mean better attendance at training sites, medical clinics, schools and places of employment; less interaction issues with family and friends and the public at large; lower instances of involvement with law enforcement; and increases the person’s ability to cope with the community environment, making the person more independent.
* **Category 3 Outcomes:** IT-10.1.a.iv:In DY3, the baseline scores for the Assessment of Quality of Life (AQoL) will be obtained. In DY4, we anticipate 5% improvement over baseline. In DY5, we anticipate 10% improvement over baseline.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. The method of intervention is transformative in that there is no group social skills training in the local area that addresses the high need for services to those diagnosed with high-functioning autism or Asperger’s. Consumers have individual plans of intervention but the synergy associated with group social skills training does not exist. It is expected that the level of engagement will be enhanced via the social skills training provided in a group setting. Further, the framework for this training is expected to transform the way services are provided to this focused disabled population.

**Project Description:**

*“Coffeehouse” Model of Social Skills Training*

The social group setting or “coffeehouse” model for persons diagnosed with Asperger’s Disorder or High Functioning Autism will be a skills training program where people with these conditions can find a community of support and can learn and rehearse skills that promote their ability to find jobs, remain employed, go to college and manage satisfying relationships without exhibiting inappropriate behaviors including aggression.

There are an increasing number of consumers with a diagnosis of Autism or Asperger’s Disorder whose needs do not fit within the typical program areas of day habilitation or behavior management. Specifically, the goal is to create a “coffeehouse” model for intensive day service for adults with Asperger’s or High Functioning Autism with and without co-occurring mental illness. This represents a coordinated social skills training model that currently does not exist within the local provider network.

The Center would move to share space in a building to be purchased at a site in the Bell County area to house the model. The project will not involve mobile clinics. The program will be overseen by a Certified Behavioral Analyst. The “coffeehouse” will be staffed by professionals and paraprofessionals who are skilled in the specialty area of adult autism with its accompanying symptoms of poor social communications skills, failure to understand the subtleties of language, and obsessive or repetitive routines. Participants can attend daily or as their schedule permits. The “coffeehouse” will be a relaxed environment of interactive training and support, with peer support an integral part of the strategy.

The project will be scheduled approximately 240 days per year, five-days per week. A full day will be about 6 hours, which allows for transportation, to and from the training site. Several types of engagement activities will be carried out, based on evidenced-based social skills training curricula. Each consumer will participate in a highly interactive group learning session while attending.

The curriculum, to be developed, will be based on benchmark social skills training curricula chosen and developed by the professional staff involved. Over DYs 3-5, from 14 to 52 consumers will be trained and/or supported via this model. The day will include several interactive and engaging sessions facilitated by the staff, using evidenced-based social skills training curricula. If the consumer stays the day, he/she is expected to participate in 5-6 hours of social skills training; a half-day would be 3-4 hours. Group recreational activities will also be conducted as a way to teach and support normalization. Regular schedule of attendance will hopefully be maintained with a schedule of activities published and marketed. Transportation will be provided to those who are in need of transportation.

Three-ring binders will be kept for each person showing the progress (or lack of) for the training sessions. Regular meetings will be held at which time staff will discuss each case and the barriers, if any, to training.

**Goals and Relationship to Regional Goals:**

The goal is to create a social group setting for persons diagnosed with High Functioning Autism or Asperger’s Disorder in which social skills training becomes the focal point for learning and enhancing the person’s ability to interact with persons in the community and to function more appropriately.

**Project Goals:**

* Increase the number of persons participating in social skills training for those with high-Functioning Autism or Asperger’s Disorder;
* Enhance the quality of life for persons participating in the “coffeehouse” model of social skills training; and
* Transform the service delivery system for persons with High-Functioning Autism or Asperger’s disorder.

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

**Challenges:**

The challenges facing this project are varied including the fact that people with Asperger’s Disorder and High-functioning Autism are reluctant to leave the perceived security of their homes to participate in a group, even if the group is of like-minded individuals. They like their routine and the new routine of attending the “coffeehouse” must evolve. Program staff will need to exercise patience and a more involved approach to motivate people to take the first step and visit the group. Once in the group, people will find a community of others they did not know existed. The challenge of achieving a high level of “engagement” exists and a strong teacher/mentor/facilitator is needed. It is also expected that persons will separate or “graduate” from the group but will need at times a booster of support from the staff and peers.

Hiring the staff versed in these specialties will also be a challenge due to the dearth of specialists in the Central Texas rural area to address this type of disability. We expect to market the positions at the various graduate school programs around the State as well as consider contracting with key providers if a full time staff person cannot be attained.

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

The five-year outcome includes the expansion and enhancement of behavioral health services to better meet the needs of the patient population with High-Functioning Autism and Asperger's Disorder; a heightened awareness in the community of this model as a viable learning module; increased satisfaction on the part of the individual consumer, due to enhanced social skills; and the person’s increased ability to exhibit appropriate behavior in relationships, in family, community and employment settings. The person diagnosed with high-functioning autism or Asperger’s is expected to show improvement in social skills which leads to improved social and personal relationships, longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social activities.

**Starting Point/Baseline:**

Within, the local service area, there is currently not a formally structured social group setting in which persons with High-functioning Autism or Asperger’s Disorder participate in social skills training. Baseline for AQoL Satisfaction Survey and number of persons served will be established in DY3.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.9 - Lack of social support services for High, Intellectual-Functioning Autism & Asperger's population (18 years & older) in Bell County.

According to the August 23, 2010, State of Texas Study on the *Costs and Benefits of Initiating a Pilot Project to Provide Services to Adults with Autism Spectrum Disorders and Related Disabilities*, in 2009, 4,300 adults with autism spectrum disorders (ASD) received services from the Department of Aging and Disability Services (DADS), the Health and Human Services Commission (HHSC), and/ or the Department of Assistive and Rehabilitative Services (DARS)

(<http://www.dads.state.tx.us/autism/publications/HB1574Report.pdf>). An estimated 4,000 adults with ASDs have requested DADS services, but have been placed on an interest list due to a lack of funding. Nearly half of these 8,300 adults are between 18 and 25 years of age. The costs of providing supports to these individuals will only increase as they, and their caregivers, age. The Study states that the decisions that Texas makes in response to the unmet demand for services, the aging of the population, and increasing diagnoses of Autism will have significant human and financial consequences. The Study researched various pilots and initiatives in other states and determined that several benchmark outcomes needed to be present. Included were the need for services specifically designed to meet the needs of individuals with ASDs including training programs and outreach campaigns; and a team-based, person-centered planning process that focuses on the individuals’ strengths, interests, and goals to develop seamless service plans.

Within the local service area served by Central Counties Services, we have seen an increase in the number of individuals diagnosed with Autism or Asperger’s Disorder. These include referrals through intake, who have never received services from a social service agency, consumers served by the Children with Special Needs Network, individuals served in the public schools and persons discharged from State Supported Living Centers. We now have enough consumers with this diagnosis to form a separate caseload at Central Counties and the nuances associated with high-functioning autism or Asperger’s warrants a separate caseload with a special emphasis on the challenges of this group. Like the network of private providers in our area, we are serving these persons based on their individual needs but there is a need to provide a social group experience in which persons with similar challenges can participate.

Although this group of individuals has normal or above-average intelligence and language development, traditional mental health programs struggle to meet their needs because the characteristics of the Autism are so dominant that they interfere with standard treatment modalities. Likewise, traditional behavior management techniques used for persons diagnosed with pure developmental disability (formerly mental retardation) do not meet their needs. Further, the skill-set of the typical case manager working with those persons diagnosed with developmental disability is lacking as the Autism or Asperger’s consumer presents a whole new set of challenges.

According to the Texas Autism Research and Resource Center and the Autism Treatment Network, studies have shown that various social skills strategies such as social stories, structured teaching, thoughts and feelings activities, the use of peer mentors, role playing or behavioral rehearsal have a positive effect on the interpersonal skill enhancement of the person diagnosed with Autism or Asperger’s Disorder. Again, these are skill-set modalities not present within the skill-sets of the typical case manager. A variety of these strategies will be part of the on-going curriculum utilized at the “coffeehouse”. The intervening variables of social group setting and a structured curriculum are expected to result in an enhanced quality of life as reported by the person. This enhanced Quality of Life Satisfaction is reflected as the Category 3 Outcome Measure. This would include enhancing the quality of the person’s relationships with caregivers, their parents and members of the community. Enhanced social skills would necessarily mean better attendance at training sites, medical clinics, schools and places of employment. Enhanced social skills would mean less interaction issues with family and friends and the public at large and lower instances of involvement with law enforcement.

An enhanced social skill also increases the person’s ability to cope with the community environment, making the person more independent. The model of social skills training is wholly consistent with the recommendations set forth in the 2010 State of Texas Study mentioned above. Finally, we expect this model to transform the service delivery system for persons with High-functioning Autism or Asperger’s using a model of group social skills training as the core for learning.

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

In terms of funding, it should be noted that the U.S. Department of Health and Human Services does not fund services that address the needs of persons with High-functioning Autism or Asperger’s Disorder.

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

* OD-10 Quality of Life /Functional Status
* IT-10.1.a.iv: Quality of Life

Quality of Life - demonstrate improvement in quality of life satisfaction scores, as measured by the AQoL Survey, an evidence based and validated assessment tool. This survey will be given to participants upon entry into the program and again at each 3 month interval post initial survey. For participants who attend school (ages 18-22), and participate in Breakthru Central during the summer, AQoL posttest will be given prior to returning to school. It is expected that the scores on the survey will improve over time revealing an increase in the participant’s quality of life. In DY3, the baseline scores for the satisfaction survey will be obtained and in DY4, achievement levels will be an improvement over the DY3 average pretest score equal to 5% of the full possible range of survey scores. In DY5, achievement levels will be an improvement over the DY3 average pretest score equal to 10% of the full possible range of survey scores.

Scenario 2 was chosen as the method for determining baseline and achievement levels to reflect improvement over baseline because all participants in DY 3 took an initial AQoL survey, however, not all participants attended Breakthru Central for 3 months in order to have also taken an AQoL at the 3 month increment at the end of DY 3. Because Breakthru Central does not have exit criteria, potentially the participants will remain in attendance throughout DY4 and DY5. Therefore, posttests from each DY should be compared to baseline to show improvement.

**Relationship to Other Projects:**

The need to address services to persons with autism is a high priority need in the region. This has been recognized by the Central Texas Aging and Disability Resource Center (CTADRC), the A+ Support Group and the public at large through a series of public forums facilitated by Central Counties’ staff. It is also recognized by the Center’s Planning and Network Advisory Committee (PNAC) and the Center’s Board of Trustees. Within the local service area of the Center, there are informal groups of persons with Autism or Asperger’s Disorder. There is an Asperger’s support group (about 20 persons) that meets once per month for social activities. This group does not have a formal social skills training format. There is a current active census at the Center of 30-35 person diagnosed with High Functioning Autism or Asperger’s. These persons receive services according to individualized Plans. Also, within the local district of the Department of Assistive and Rehabilitative Services (DARS) there is a census count of 50-60 persons diagnosed with Autism or Asperger’s. Finally, the A+ Support Group in Belton is a support group for persons diagnosed with Autism. Programs are schedule for the parents/guardians once per month on a Saturday. Although these individuals participate informally in these activities, there is not a formal strategy to provide social skills training. These individuals and others could readily benefit from the “coffeehouse” model with its focus on social skills training.

Other Center projects include:

* 081771001.1.1 Establish more primary care clinics
* 081771001.1.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
* 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
* 081771001.1.5 Enhance improvement capacity through technology
* 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
* 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
* 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

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

Central Counties Services is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in a learning collaborative with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Within the Regional Healthcare Plan 8, there are two projects of a similar nature in which one provider is expanding the number of community based setting where behavioral health may be delivered (see Project #126844305.1.1 and #126844305.1.5). These two projects will occur in a different service area than the service area of this project.

Pertaining to the Project Milestones, an integral element of this project is the Learning Collaborative that will take place two times per year beginning in year three. It is expected that the project coordinator will hold a “summit” meeting of key stakeholders including ISD Special Education departments, the DARS, the A+ Support Group in Belton, Texas, and partners of the Aging and Disability Resource Center. Efforts to include the Texas A&M Medical School in Temple will also be made. What we have learned from this project will be shared with this stakeholder group to enhance a coordinated effort of services in the local community.

**Project Valuation:**

The project will be scheduled approximately 240 days per year, five-days per week. A full day will be about 6 hours, which allows for transportation to and from the training site. Several types of engagement activities will be carried out, based on evidenced-based social skills training curricula. Each consumer will participate in a highly interactive group learning session while attending. The person diagnosed with high-functioning autism or Asperger’s is expected to show improvement in social skills which leads to improved social and personal relationships longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social activities.

The benefit to the community of this “coffeehouse” model of social skills training lies in the consumer’s ability to cope with and function in a variety of community settings. The consumer should have an enhanced quality of life, feel more valued in inter-personal relations and is expected to interact positively in all phases of community life. There should be less crisis events, less hospitalizations, and less entanglement with law enforcement. Family members, friends, neighbors and the community-at-large should see a more positive stance from the individual participant in the group social skills training.

The valuation of this project also includes the following: staff time in marketing the positions required and interviewing and hiring the positions; staff time in researching appropriate sites for the social group setting; staff time in negotiating the lease arrangement; staff time in purchasing the van for transportation; staff time in developing the curriculum; staff time in researching the survey, both in terms of administering and scoring; staff time in selecting and purchasing the equipment involved. The valuation also includes direct costs of staff salaries and benefits, equipment, vehicle and lease, as well as program indirect costs, administrative costs and cost of inflation. It also includes a cost savings value reflected in savings on mental health/IDD benefits due to decreased incidents of behavioral crisis; less involvement with law enforcement and increased earnings in the workplace due to employment.

**Category 1 Project Narrative – Pass 2**

**Central Counties Services – 081771001.1.4**

**Project Area, Option and Title:** 1.13.1 Develop and implement crisis stabilization (respite and transitional) services to address the identified gaps in the current community crisis system.

**RHP Project Identification Number:** 081771001.1.4

**Performing Provider Name:** Central Counties Services

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
* **Intervention:** This project provides 24/7 residential-based crisis respite (15 beds), transitional living (15 beds) and supportive day services at a properly equipped facility within our service area to persons with severe and persistent mental illness who have experienced a recent mental health crisis, in lieu of these persons being sent to the state psychiatric hospital system or incarcerated in local jails.
* **Project Status:** This is a new project.
* **Project Need:** CN.2.10 Limited access for seriously mentally ill adults to crisis services in Bell, Lampasas and Milam Counties. Our service area currently does not have crisis residential services.
* **Target Population:** 97% of all of the Center’s patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population.
* **Category 1 or 2 Expected Project Benefit for Patients:**This project seeks to provide crisis services to patients in more appropriate and less costly setting than psychiatric hospitalization or incarceration (Improvement Milestone I-11.1 and I-11.2). This project intends to provide 700 crisis respite bed days in DY-3, 2,550 crisis respite bed days of service in DY4 and 3,180 bed days of crisis respite services in DY5. The maximum expected Quantity Patient Impact (QPI) is (DY-3: 700: + DY-4: 2,550: + DY-5: 3,180 = 6,430) 6,430 crisis respite bed days. It is important for this project that the QPI be measured in encounters (1 encounter = one bed day) instead of people served as it is unknown how many of the people served will be re-admissions to these services. Measuring bed days gives the Center full credit for actual resources consumed getting the same credit for a patient who stays ten days instead of one day.
* **Category 3 Outcomes:** IT-9.1: An expected outcome for this project is to reduce the mental health admissions/readmissions to criminal justice and psychiatric hospital settings with the percent of improvement to be determined once the baseline is set in DY3.From this point in the following DY’s such as DY4 the amount should increase from 5% over the baseline that is established and then in DY5 should be 10% over the baseline.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project Description:**

*Crisis Respite Services*

The Center’s service region has an immediate need for crisis respite services/transitional living services for those persons in mental health crisis who have no place to live (see Rationale Section below). The description of Crisis Respite Services to be implemented in this project is: Crisis Respite Services (CRS) provides short-term (3-7 days) structured residential treatment organized in a non-medical, psycho-social recovery-focused service model that focuses on the person’s strengths to manage/reduce their crisis. CRS provides a calm, protected, and supervised non-hospital setting where the patient can stabilize, resolve problems and link with possible sources of ongoing support. CRS includes supervised, structured room/board available 24 hours/day, 7 days/week and is an immediate alternative to acute hospitalization or incarceration in emergency situations. The CRS facility would be an unlocked unit that relies on voluntary patient participation. It serves as an early intervention for persons showing signs of deteriorating ability to self-manage their behavioral health problems/symptoms, and can be a “cooling off” place for persons whose home situation has become intolerable. It can serve as a “step-down” (less intensive service) for someone being discharged from inpatient psychiatric services. Treatment services offered at this CRS are intended to keep the person safe, stabilize the person’s acute psychiatric symptoms, and return the person to their familiar living situation and treatment quickly. Actual treatment services may include milieu therapy, psychotropic medications, solution-focused brief therapy, assertive case management, housing assistance, etc. The CRS target population is described as: adults with a diagnosed or suspected mental illness; in behavioral health crisis, but whose behavior is under sufficient control to not be considered an immediate risk of self-harm, or harm to others; agree to voluntarily participate in CRS; for whom CRS is deemed a safe, appropriate, beneficial level of care; and do not have medical problems requiring regular medical treatment beyond a self-care level. Persons excluded from CRS would be persons who are: under 18 years old, have a blood alcohol/drug level putting them at risk of withdrawal symptoms, or impaired judgment about their behavior; unwilling to voluntarily take part in services or comply with services rules; have a medical condition requiring intervention above a self-care level; have not yet fully recovered from the physical symptoms associated with a suicide attempt; or has any other condition/circumstance judged to be beyond the service capability of the crisis respite staff.

The description of Crisis Transitional Services (CTS) to be implemented in this project is: Crisis Transitional Services are a step-down service for the Crisis Respite Services that provides short –term (3-7 days) structured residential treatment organized in a social recovery model that focuses on the person’s strengths to get themselves re-established in their own living setting in the community of their choice. These services would include support to apply for any social support benefits for which the person might be eligible due to their disability, income or social status. Patients would have access to local telephone service and the internet in a computer lab set up to use to assist them in making living arrangements in the community of their choice. These services will include an assessment of each person’s independent living skills and knowledge needed to live successfully by themselves in their own apartment/home. Identification of skill/knowledge deficit areas will form the basis for a brief skills training program that is individualized to help meet each person’s need to increase his/her readiness to live successfully in their own setting. This service will also assist the patient in contacting their previous living arrangement(s) and extended family to determine if any of those living arrangements are still available to the patient. The patient would also be assisted with their application for public/subsidized housing in the community of their choice. This service would provide transportation for consumers to assist their getting settled in the community, and would also work with the consumer’s use of the public transportation system to meet their mobility need. This service would also link the patients to supportive day services if the patient desires such and can work out personal or public transportation to the day services upon discharge from crisis transitional services. The Crisis Transition Services target population would be adults who have become stabilized after a recent mental health crisis but do not have an immediate, stable living arrangement to go to upon discharge from Crisis Respite Services.

The Center is planning a multiphase project approach to address this unmet service need as soon as possible with interim arrangements while more desirable ways of addressing these unmet behavioral health needs gets worked out. The first step contracts for CRS with Heart of Texas Regional MHMR Services (HOTRMHMRS) in Waco Texas (40 miles north of Temple). While this CRS is not in our service region, it is closer than Austin State Hospital (68 miles from Temple). HOTRMHMRS has extra CRS capacity and can make 5-10 beds available to our Center, depending on their daily census. This will provide some immediate relief to our Center’s recent overuse of our state psychiatric hospitals. Within 3 months of project approval Coryell County will begin to remodel, furnish, and equip the former Coryell County Hospital for interim use as transitional living services, with a target start date of Oct. 1, 2013. This interim arrangement is limited to 8 bed capacity due to not having a fire/safety sprinkling system. This project may also include partnering with the Coryell Memorial Healthcare System (CMHS) for medical screening, patient minor health issues treatment, and food services contracting. It will have 16 beds and can serve both male and female patients. During DY2, the Center will convene the main stakeholders for behavioral health CRS, namely, every local law enforcement agency, hospital emergency department, and the Bell, Coryell, Hamilton, Lampasas and Milam County Judges to ask them to support an intense needs gap analysis process on the amount of CRS needed by our service area and the best location of these services. This gap analysis process would track the number of persons who present or are brought to local emergency departments in mental health crisis, and if a CRS care level would have met their needs. We will also collect data on the number of persons in mental health crisis arrested for minor crimes who could benefit more from CRS than jail. This gap analysis process will also document if post-crisis respite service is needed by the person in crisis (e.g. housing, day support services, transportation, transitional living support, medical care, substance abuse services, medicine, etc.). The maximum capacity of the new CRS will be set by Health and Safety code and licensing requirements – likely 16 beds. Two admissions per day would lead to someone having to be discharged by the 7th day to allow further admissions. If the patient is homeless, it is difficult to stabilize the patient and set up a new living situation in 7 days. The only way to have an effective, accessible CRS would be to also have step-down, transitional living services so patients who are stable, but homeless, could be in a crisis transitional living setting a few more days while living arrangements are worked out.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

This project’s goal is to establish crisis-responsive residential services within our service area that provide a less restrictive/costly level of care for persons in behavior health crisis than admission to the state psychiatric hospitals or jailed for a minor offense. The goal is to provide successful interventions for persons in early stages of crisis before the crisis situation reaches the complexity that institutional level of care becomes the only care option resulting in the person’s support system and living arrangements being disrupted and jeopardized.

**This Project meets the following Regional Goals:**

Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

**Challenges**:

Perhaps the biggest challenge will be managing the gap analysis, local planning, program design/documentation, securing an appropriate facility that meets licensing and health/safety codes requirements of CRS, and staffing up/fully operationalizing the services by the end of DY3 so project outcomes can be properly measured in DY4 and DY5. Our Center will do as much local organizational work with stakeholders, gap analysis partnering, and CRS planning as it can in early 2013 in order to have as much information in place as possible to expedite the actual establishment and operations of these CRS for our area.

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

In 5 years, our Center intends to have fully functioning CRS with step-down transitional living services available to our service area. It is also our goal to have strong working relationships with our local hospital EDs and our local law enforcement agencies such that persons are identified in early stages of behavioral health crisis and assisted through these proposed services, rather than admitted to the state psychiatric hospital system or local jails. We would expect that psychiatric hospitalizations and the incarceration of persons with mental illness would decrease/100,000 population in our service area.

**Starting Point/Baseline:**

Our Center and its staff have previously provided both crisis stabilization services (16 bed medical model) and transitional living services (15 bed capacity), and both were usually close to capacity by serving persons from our area until they closed due to funding reductions. Our service demand for residentially-based behavioral health crisis services exceeds our regional capacity at this time as shown by our Center’s overuse of state psychiatric hospitals, the keeping of patients in EDs while waiting for a state psychiatric hospital bed to be open, and the anecdotal reports from local law enforcement agencies/County Judges that persons who have committed minor crimes while in a behavioral health crisis who would be better served in a mental health residential facility than incarcerated as is currently occurring. The Bell County 2010 Community Needs Assessment that 27% of the 715 homeless persons interviewed had mental health problems and were at risk of mental health crisis due to homelessness: <http://www.tamhsc.edu/1115-waiver/rhp8/documents/counties/bell.pdf>.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.10 - Limited access for serious mentally ill adults to crisis services in Bell, Lampasas and Milam Counties

The Center provided Crisis Stabilization Services from the late 1980’s until June 2000 when the services closed due to higher service demand and less resources to provide them. The Center also provided transitional living services from the late 1980’s until 1995 when these services had to close due to state funding reductions. Now Bell, Lampasas, Milam, Coryell, and Hamilton Counties do not have any residential services to assist residents experiencing a mental health crisis. Persons in a mental health crisis in this service region must be guided to one of four options, namely, 1) admission to the state psychiatric hospital, 2) kept in a local ED for stabilization while waiting for a state psychiatric hospital bed (most recent severe case was for 13 days), 3) being jailed for a minor crime, or 4) released to community supports; at times, a less-than-desirable choice. Our county jails now track the number of inmates having a mental illness/take psychotropic medications and report that 28% of the inmates have mental health problems. The Center is allotted a portion of state psychiatric hospital days in proportion to its percent of the state’s population being in our service area.

Last fiscal year (ending 8/31/12), our service area used 110.87% of the bed days allotted for our service area, thus demonstrating a much greater demand for resources than are available to respond to persons in our region who experience severe mental health crises. Comparing our use of bed days to Local Mental Health Authorities (LMHA) who have CRS near us proves this point. The LMHA to the North used 99.27% of their bed days and the LMHA to the South used 71.9% in FY2012. HB2292 in the 78th Texas Legislature required each LMHA to have a Jail Diversion Task Force to expedite the diversion of mentally ill persons arrested for minor crimes while in a mental health crisis. The Center’s Community Jail Diversion Task Force consists of local law enforcement agencies, community social service agencies and local Judges. This Task Force’s jail diversion efforts are hampered by the lack of residential options needed to divert a mentally ill offender from incarceration.

**Core Project Components:**

1. *Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.* There was much stakeholder support for CRS prior to our having to close them.
2. *Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.* There are no residential crisis stabilization or CRS, and consequently, no crisis residential service capacity in our area at this time.
3. *Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings).* Having operated crisis stabilization and transitional living services for 10+ years in the past, we know that these two levels of CRS are needed in our area and were well received and supported by the EDs and law enforcement agencies in our service area. These partnering agencies were greatly disappointed and adversely affected when these services ended. Our partners had to transport crisis patients to Austin State Hospital instead of accessing local services.
4. *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Our past experience of providing CRS and transitional living services, which were in separate communities, has brought us to the conclusion that these two levels of care can operate best if they are proximate to each other, perhaps in the same building, if possible. Having them in the same building would give more flexible use of staff and gain various operating efficiencies, such as meal preparation, laundry facilities, etc.
5. *Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.* See Milestones 9 and 11. Our Center’s project #081771001.1.5 – Enhance Improvement Capacity through Technology, will also assist our Center with its commitment to continuous quality improvement of these services.
6. Continuous Quality Improvement: The Center is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

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

This project does not supplant any services or funds currently provided to Central Counties Service from the U.S. Department of Health and Human. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

**Related Category 3 Outcome Measures:**

* OD-9 – Right Care, Right Setting
  + IT-9.1 Decrease in mental health admissions and readmissions to institutional psychiatric hospitals or criminal justice settings such as jails or prisons.The goal of this project is to increase the number of persons in mental health crisis who have or are about to be involved in a mental breakdown situation and to be diverted from the legal justice system into an appropriate level of behavioral health care. This basis is based on central counties establishing a baseline in a period of 6 months or more and then improving over the following DY’s. This can be shown by improvement in DY4 of increasing the amount that is needed by improving 5% over the baseline number that was previously established. Then in DY5 there would be an improvement of 10% over the baseline that was established.

This outcome measure is chosen because it directly addresses and measures the impact of this project’s goal or purpose, namely to provide effective local crisis residential services that can be utilized by persons in behavioral health crisis in lieu of admissions and readmissions to more restrictive/expensive institutional levels of care in EDs, psychiatric hospitals or local jails.

**Relationship to Other Projects:**

This project is related to our Temple Day Services (#081771001.2.3) which also has the purpose of lowering the frequency of admissions/readmissions to psychiatric hospitalization and /or incarceration. Our telemedicine project (#081771001.1.2) is also intended to improve patients’ access to psychiatric care and compliance with anti-psychotic medication, both of which are key elements in persons with severe and persistent mental illness maintaining stability in their community setting. The Center’s “enhance improvement capacity through technology” project (#081771001.1.5) has as its service objective to increase the number of timely follow-up visits with patients after they have been discharge from psychiatric hospitalization – also a very important service that is aim at reducing hospital readmissions. The use of data dashboards created under this project will greatly assist the Center’s work with Milestones 6, 9, and 11 to continuously improve our crisis respite services.

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

Bluebonnet Trails is also proposing 3 crisis respite services projects (#126844305.1.2, #126844305.1.3, and #126844305.1.4) for Williamson and Burnet Counties. The Center is committed to improving services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis allows providers to strengthen their partnerships and continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

**Project Valuation:**

This project is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities. The project valuations takes into account that this project is of great value to our service region and is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities and the combined RHP-8 & RHP-16 cost of up to 4000 hospital ($461/day/FY12 at Austin State Hospital – average length of stay = 21 days\*)/incarceration ($50+/day with average time in pre-trial services is 145 days\*\*) days will be avoided by these services in DY5. Assuming that all days of crisis respite services would take the place of days in the state hospital, this project would save the State of Texas approximately $1,383,000 in DY4 and $1,844,000 in DY5. **\***Austin State Hospital Regional Planning Meeting Oct.31, 2012, pp.30, 35. **\*\***”A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. David Hughes, et al, Criminal Justice and Behavior, Vol. 39 No 4 April, 2012, p. 438.

DY2 project valuation includes contracting costs for CRS from HOTRMHMRS, a minivan, costs to trans-port persons to/from CRS in Waco, costs for screening and follow-up for persons referred to HOTRMHMRS, renovation, furnishing and equipping costs to make the former Coryell County Hospital building useable for our service region and hiring/training costs for staff to provide these post-crisis, respite transitional living services. DY2 also has costs for convening stakeholders multiple times, hiring consultants to complete the in-depth gap analysis/service planning implications and final project proposal required by this project. DY3 valuation continues the HOTRMYMRS contract for CRS, and includes transitional living service costs, while ramping up operation of CRS within our service area, which involves acquiring office and patient area equipment/furnishings, vehicles, operating supplies, food storage/handling equipment, telemedicine equipment, phone, electronic health record access, and data services, etc. needed to start CRS in our service area (see Milestone 8). DY3 also includes hiring/training crisis respite staff, including a psychiatric advance nurse practitioner, obtaining proper Dept. of State Health Services' site approval/licensing, the design and writing of service protocols and manuals. DY4 and DY5 valuation reflects the operations of the residential crisis services called for in the gap analysis, planning and design process. The DYs 2-5 valuation includes Center indirect program and administrative overhead costs. This project’s valuation also considers the psychiatric hospitalization and incarceration costs that can be saved by local access to CRS. If this project keeps half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days/event), it will save our state/communities considerable financial and personnel costs. Admission/ readmission to criminal justice settings is disruptive/deleterious to behavioral health crisis recovery. Studies of recidivistic criminal justice patients in Texas and other states show poorer physical health status, increased homelessness, and increased use of ED and inpatient services. Services that keep persons from cycling through the criminal justice system help avert poor health/ mental health outcomes, reduce long term medical costs and improve personal functioning. This valuation reflects 79.5% of the total valuation (Region 8 has 79.5% of our service region’s population) while 20.5% of this project’s valuation is reflected in our project submitted to RHP 16.

**Category 1 Project Narrative – Pass 2**

**Central Counties Services – 081771001.1.5**

**Project Area, Option and Title:** 1.10.2 Enhance improvement capacity through technology

**RHP Project Identification Number:** 081771001.1.5

**Performing Provider Name:** Central Counties Services (Center)

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
* **Intervention:** This project provides improved data management and organizational process improvement capacity which the Center wants to focus on reducing readmissions to state psychiatric hospitals and local jails by improving post discharge follow-up services. This project seeks to improve the efficiency of clinical service operations through improved technology, and thus increase the Center’s service capacity.
* **Project Status:** This is a new project.
* **Project Need:** CN.2.11 Improve behavioral health service access and capacity in Bell, Lampasas and Milam Counties. 41% of admissions to the state psychiatric hospital system in FY2012 were re-admissions and the Center overused its share of state psychiatric beds in FY2012 by 10.87%.
* **Target Population:** The focused target population for this project are persons with severe and persistent mental illness who have recently been discharged from a psychiatric hospital (394 in FY2012) or jail. 97% of all of the Center’s patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population.
* **Category 1 or 2 Expected Project Benefit for Patients:** The Center will create data dashboards to monitor and guide the clinical improvement processes for our 7 other direct service 1115 Waiver Service Enhancement Projects which will impact an additional 1,600 behavioral health encounters in DY4 and an additional 2,600 behavioral health encounters DY5 who will be served through these innovative/transformational behavioral health projects implemented through DYs 3-5. The cumulative impact of this project will be to increase behavioral health encounters by (DY-3: 500; + DY-4: 1,600 + DY-5: 2,600 = 4,700) 4,700. (Our Center serves significantly more people than our DSHS contract requires/pays for. To do this we are serving patients less frequently than desired [many are only seen once every 90 days]. When capacity improves we will provide more adequate/frequent services to existing patients, rather than adding more patients. Therefore increased encounters will better measure the project’s quantity patient impact [QPI]on our existing patient load)
* **Category 3 Outcomes:** IT- 3.14: Behavioral Health 30 day readmission rate: The Center expects to improve access to psychiatry services for our adult patients with severe and persistent mental illness in order to reduce possible readmissions back to a Texas State Psychiatric Hospital within 30 days of being discharged from a Texas State Psychiatric Hospital. The goal is to reduce these readmission rates by 5% in DY-4 over the baseline readmission rates obtained in DY-3, and by 10% in DY-5 over the baseline readmission rates obtained in DY-3 as documented in the Center’s electronic health record system and the Texas Client Assignment Registry (CARE) system used by both the Center and the Texas Psychiatric Hospital System.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project Description:**

*Process Improvements through Technology*

This project seeks to establish a process improvement approach to increasing the Center’s effective utilization of its talent and resources to serve persons in our local area who need behavioral health services, intellectual and developmentally disability services, and early childhood intervention services (addresses infant development/delay needs). For example, the Center had 496 state psychiatric hospital admissions in FY2011 for all 5 counties served (RHP-8: Bell, Lampasas & Milam Counties: RHP-16: Coryell & Hamilton Counties). Of the 496 admissions, 12 were children under 18 years of age. Twenty of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the referring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first admissions to the state psychiatric hospital system. In FY2011, between 9 and 10 patients were hospitalized each week, 4 of whom were re-admissions. Our Center wants to study the primary causes for these readmissions and, through organizational/service process improvement efforts, lower these readmissions to the state psychiatric hospital system. Finding ways to improve our post-discharge patient follow-up/engagement will be one of these improvement efforts.

The key to such an effort is easy, efficient and reliable access to a highly sophisticated clinical data system in which Center staff enter real-time patient demographic and service data that documents the clinical and support activities of Center staff, patient response to these activities and how these service activities interact with the patient to support the patient’s functional improvement. This project will regularly seek system improvement ideas and feedback from Center clinical line staff, support staff, clinical leadership staff, administrative staff and patients to harvest the creative ideas and insights of those who are closest to service production successes and failures. This project will include the implementation of sophisticated software tools and systems with the efficient and error reducing capability of auto-sharing/auto-filing patient demographic and event data across the Center’s internal divisions so that no data needs to be entered more than once and will have robust report writing capabilities. The project will include data/system analyst services that can design/redesign and implement data dashboards for the different parts and functions of our Center, to include the quality control/improvement strategies impacting the approximately 3,100 persons served through the Center’s proposed 1115 Waiver projects. This project will establish data interfaces with other agencies (law enforcement, state psychiatric hospitals, local and regional health agencies, Temple Independent School District, etc.) in order to regularly draw information from them regarding factors that affect Center service access, delivery, and outcomes. This project will proactively explore ways that advancing technology can bring efficiencies to our Center operations, and consequently stretch our service dollars to increase our service access, quality and capacity. This project will form the operational hub for gathering data and monitoring the Center’s performance outcomes associated with its eight Category 3 performance improvement plans. It will also utilize various internal and external sources of information to identify Center operational procedures (scheduling, use of telemedicine vs. in-person services, use of evening/ weekend clinics, etc.), practices (community based services vs. office based services, collaborative patient charting, use of dictation vs. direct record entry, etc.), and patient events (e.g., patient no-show rates by clinic and by provider, medication non-compliance, etc.) that are deemed key to the Center’s improving its operational efficiency, quality of services and service efficiency/capacity. This project will also focus on patient services as a customer service and seek to improve the Center’s workflow so as to increase patient satisfaction with their time spent waiting for and receiving services. This process will seek to identify and remove non-value-added activities in the patient service process, while maximizing the value-added activities in the best possible sequence that supports efficient/effective patient service delivery (p.3, Chapter 44, Patient Safety and Quality: An Evidence-Based Handbook, Ronda Hughes, chapter author-http://www.ncbi.nlm.nih.gov/books/NBK2682/?report=printable).

**Goals and Relationship to Regional Goals:**

**Project Goals:**

The goal of this project is to:

* Improve organizational service delivery efficiency, service quality and effectiveness of its service outcomes by enhancing access and use of operating data;
* Improving our data technology system to be more user-friendly, less cumbersome, highly reliable, high capacity, user responsive system for our 8 clinical operations over long distances (farthest distance between clinics is 120 miles – telemedicine providers are about 200 miles from Center clinics);
* Be able to have the right data at the right place at the right time;
* Use data to inform and support our Center’s improved performance and service capacity; and
* Provide the data management tools and capacity to effectively manage the Center’s direct care 1115 Waiver expansion/transformation projects.

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with multiple needs; and
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

**Challenges**:

The activities planned for DY2 are complex to accomplish if project approval comes in late-Spring 2013. The Center recognizes this potential challenge and has already begun its work on Milestone 1 (data system planning/selection) to prepare the Center to take action upon project approval notice. We will need to identify a source for the data analyst/system analyst support needed by this project. The Center will be hiring at least one staff person to assist with the data gathering, data monitoring, data analysis, and formulation of system improvement paths based on the analyzed data, so will insure that the person hired has the professional knowledge and skills to support this and the 7 other system improvement projects.

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

In 5 years, the Center expects to have a well-designed, user-friendly, high-speed data system that facilitates and supports multiple, simultaneous organizational improvement projects. The data system/technology will facilitate our service delivery system with unobtrusive, accurate automation support. This support will improve operation efficiency and improved service capacity/access to meet the behavioral health needs of our service area citizens. As a result, patient service episode time will be very efficiently organized and satisfying to the patients.

**Starting Point/Baseline:**

The Center is not currently using an organizational improvement process and does not have in place any quality management dashboards. The Center struggles with a data system that is dragging the clinical staff productivity down to unacceptable levels (around 40%). The data system is slow for our 80+ clinical users (all 5 counties) and at times unreliable due to its applications locking-up, which prompt staff to reboot their computers, having lost all work completed since last saving their work. Our data system is also vulnerable to power outages caused by storm damage, brown-outs due to power grid overuse in the hot summer months, and occasional utility work that disrupts the Center’s electricity. Electrical power interruptions in the Temple area prompt our data system, phone system and telemedicine system to be inaccessible to our 80+ clinical staff whose work depends on access to the Center’s electronic health record system. It is difficult and cumbersome to extract data from this system to be used for system monitoring and performance improvement. The Center recognizes that its 8 clinics all operate differently with various levels of efficiency and patient service satisfaction. Needless to say, we recognize that our service delivery system functions at a lower level than it can or should function. This recognition prompts us to undertake this project to enhance the Center’s improvement capacity through technology.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN2.11- Improve behavioral health service access and capacity in Bell, Lampasas, and Milam Counties

The Center recognizes that technology and operating practices for our current behavioral health service environment are increasingly complex and intrusive to our historical operating style of delivering behavioral health services. Our staff says they are spending more time documenting patient work than they are in delivering actual patient services. The Center has tried to get the best functional use from its technology and now clearly sees that our current data system and how it is applied in our practices is hampering our daily operations and has become a barrier to the Center’s ability to efficiently access operating information needed to undertake an efficient, effective organizational improvement process. We are eager to improve our data system capability and to initiate processes that will engage our staff in a Center-wide organizational improvement process that is within our reach through this project. The Center believes it has committed, willing, professional staff that will promote and support improvement processes to increase our operational efficiency, service capacity and service effectiveness with long term, difficult-to-serve populations. Staff will be energized by their input and inclusion in systems improvement processes. We expect this project’s outcome to be a well-designed workflow pattern that accommodates collaborative documentation (documenting services as they are being provided) and other technology supported efficiencies which enable us to operate with increased service access and capacity within the resources available to the Center. The outcome should also result in a fully functional, efficient data system that will address patient needs in a timely and accurate manner.

**Project Components**:

1. *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* The Center will have training sessions for all Center staff regarding our Center’s process improvement strategies, methodologies and work culture implications within DY2. The Center will also use its established means of communicating organizational change through our quarterly Leadership Forums (all supervisors) and our monthly Human Resources Newsletter.
2. *Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction.* The Center will organize a suggestion system that will accommodate both identified and anonymous suggests regarding areas of the Center operations that could be improved upon. We will also utilize periodic electronic surveys (Survey Monkey) on focused topics under consideration/study for improvement.
3. *Design data collection system to collect real-time data that is used to drive continuous quality improvement (possible examples include weekly run charts or monthly dashboards).* This component will be addressed in DY4 through Milestone 6. We will also work with leadership and Quality Management staff to determine what data will be monitored on the continuously evolving Dashboards that we design and put in place to guide and monitor our 7 direct care 1115 Waiver projects and general Center operations in DY4.
4. Continuous Quality Improvement: The Center is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations. On a semi-annual basis the Center staff involved with this project will summarize the outcome findings of the Center’s improvement projects, analyze these outcomes to establish the Center’s improvement progress, to set new goals for further organizational improvement, and to recommend new or related performance processes or indicators that would be considered for the Center’s next phase of organizational/operations improvement.

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

This project does not supplant any services or funds currently provided to the Center from the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance and expand, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

**Related Category 3 Outcome Measures:**

IT- 3.14: Behavioral Health 30 day readmission rate: The Center expects to improve access to psychiatry services for our adult patients with severe and persistent mental illness in order to reduce possible readmissions back to a Texas State Psychiatric Hospital within 30 days of being discharged from a Texas State Psychiatric Hospital. The goal is to reduce these readmission rates by 5% in DY-4 over the baseline readmission rates obtained in DY-3, and by 10% in DY-5 over the baseline readmission rates obtained in DY-3 as documented in the Center’s electronic health record system and the Texas Client Assignment Registry (CARE) system used by both the Center and the Texas Psychiatric Hospital System.

**Relationship to Other Projects:**

This project relates to the Center’s telemedicine project (#081771001.1.2; RHP 16 #081771001.1.1) which seeks to use highly reliable telemedicine and high-speed clinical EHR technology to increase timely access to psychiatric services in our service area. This project also relates to our School-based Mental Health project (#081771001.1.1) which will need to flawlessly access the Center’s EHR system in a remote wireless, secure manner to interact with the Center’s data system and make patient EHR entries. This project also relates to our Crisis Respite Services Project (#081771001.1.4; RHP 16 #081771001.1.2) that will need to use the Center’s new telemedicine technology, the EHR clinical data system and the VOIP telephone system in a quick and reliable manner. This project relates to all of our Category 3 Quality Improvement Outcome Projects (#081771001.3.1, #081771001.3.2, #081771001.3.3, #081771001.3.4, #081771001.3.5, #081771001.3.6, #081771001.3.7, and #081771001.3.8) which will depend on a robust, user-friendly, high-speed reliable data system to collect, monitor and manipulate data into reports that document our Center’s accomplishments through these projects.

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

Our Center is not aware of other Provider’s Projects which relate to this project. We are committed to service improvement and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8 (see Milestones 5, 7, 8, 9 and 10).

**Project Valuation:**

This project’s valuation includes the very core data functions and capabilities that are necessary for our Center to meet and manage the data needs of the Center’s eight Medicaid 1115 Waiver Transformation Projects (including this project) that are proposed by our Center (See“Relationship to Other Projects”paragraph above). This project’s valuation includes the value of improved service access by the people we serve, their improved quality of life and the cost-avoidance value gained from reduced psychiatric hospital readmissions through better discharge follow-up (over 900+ patients are expected to be discharged from a psychiatric hospital in DY3 through DY5 and will need this follow-up), as shown in the Project Description section above. It also reflects the value of the clinical hours gained by the ability to complete patient records while serving the patient, and being able to complete EHRs in the field rather than traveling back to offices to accomplish this – both of which translate into increased service capacity. It includes the cost-avoidance value of an inaccessible data system that halts the work of 80+ clinical staff. The valuation also includes the technology assessment team’s time spent in reviewing data systems, narrowing the choices, making site visits where different data systems are in use, understanding the computer hardware systems needed by each option, and then coming to a final data system recommendation. In addition, the valuation includes:

* Receiving our IT Department’s technical support to this team process;
* Procuring, implementing and training IT staff needed to efficiently update our data system and stabilize its power supply to insure its 24/7 availability;
* Establishing the external data interfaces with key organizations in our service area;
* Providing staff training for those who will use the new data system, to include the costs of taking them away from their regular work duties to participate in the training;
* Composing, assembling and printing instructional/procedural manuals to help staff learning how to operate and get the best organizational use from the updated data system, to include computer lab instruction for those staff who will train others (train-the-trainer);
* Getting data analyst and system analyst assistance in designing our use of our data system to support Center’s process improvement projects;
* Implementing process improvement training, the production of training documents/visual training presentations/ setting up an employee suggestion system and overseeing its use – evaluating the feasibility of suggestions for process improvement projects, etc.;
* Identifying technology applications that facilitate the Center’s workflow and efficiency (e.g. technology that assists with the reduction of patient no-show events, etc.);
* Reviewing and analyzing the data for its organizational improvement implications, and formulate a report/presentation for the RHP Collaborative Learning conferences; and
* The Center’s indirect program and central administrative costs.

This valuation reflects 79.5% of the total valuation (Region 8 contains 79.5% of our service region’s population) while 20.5% of this project’s valuation will be reflected in our project submitted to Region 16 (081771001.1.2).

**Category 1 DSRIP Project Summary**

**Central Counties Services – Project 081771001.1.100**

**Project Area, Option and Title:** 1.12.2 Expand the number of community based setting where behavioral health services may be delivered in underserved areas. Title: Model of Work Adjustment Training

**RHP Project Identification Number:** 081771001.1.100

**Performing Provider Name:** Central Counties Services

**Performing Provider TPI #:** 081771001

**Project Summary:**

* **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
* **Intervention:** The project will provide work adjustment training to those persons diagnosed with high-functioning Autism or Asperger’s in the target population. Community education will also be provided to employers in the local area related to employment services and the focused population.
* **Project Need:** Community Need (CN) Area addressed is CN.2 - Limited access to mental health/behavioral health services. The specific CN addressed is CN.2.9 - Lack of social support services for high intellectual functioning Autism & Asperger's population (18 years & older) in Bell County.
* **Target Population:** Those persons currently served by the Center, the Department of Assistive and Rehabilitative Services (DARS), and the private sector who have been diagnosed with High-functioning Autism or Asperger’s disorder. We expect the target population to be 94 people from the above sources with the total cumulative consumer impact DY 3 through DY 5 to be 41 persons. Approximately 80% of the population being Medicaid eligible and 20% uninsured.
* **Expected Category 1 Project Benefit for Patients and a Description of the QPI Metric(s):** The person diagnosed with high-functioning Autism or Asperger’s is expected to show improvement in vocational skills which leads to improved social and personal relationships, longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. An increase in employable-ready skills would necessarily mean better attendance in the work environment, better interpersonal relations while at work, increased ability to perform job-related tasks and more stability in the community workforce. Their quality of life will be enhanced through peer-support and reinforcement of social and vocational activities.
* The project will impact approximately 41individuals diagnosed with high-functioning Autism or Asperger’s who are of employment age (DY3: 8 individuals, DY4: 16 individuals, and DY5:17individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-11, allowing us to establish a baseline number of additional individuals receiving community behavioral services after access expansion. Each year, we aim to increase the number of individuals receiving this service, as measured by Milestone I-11, Metric I-11.2: Number of individuals utilizing community behavioral healthcare services.
* **Description of Category 3 Measure(s):** OD-10: Quality of Life/Functional status-IT-10.1.a.iv: Quality of Life Quality of Life – demonstrate improvement in quality of life satisfaction scores, as measured by the Assessment of Quality of Life (AQoL), an evidenced-based and validated assessment tool. This tool will be given to participants upon entry into the program and again at the end of the instructional phase. . It is expected that scores will improve over time. In DY 3, the baseline scores will be obtained and in DY 4, we desire 50% of the participants who have graduated from the training to show increased satisfaction. In DY 5, we desire 50% of the participants to show increased satisfaction. While this is a desired outcome, true measurement for reporting purposes will show a 5% increase over baseline in DY4 and a 10% improvement over baseline in DY5. The total number of surveys completed during the measurement period will be utilized. Each participant will transition in and out of the program in a three to six month period, therefore, it would be difficult to measure the same participants in different reporting years.

**Project Description:**

Work Adjustment Training: As a natural extension of project number 081771001.1.3, Breakthru Finish Line will bridge the gap between social skills training in the current project and work adjustment training in the new project. The participant will be screened into the program via the use of the Inventory of Client and Agency Planning (ICAP) and a review of existing diagnoses. This will ensure that the diagnosis of Autism or Asperger’s is present. Upon entry into Breakthru Finish Line, each participant will complete a series of research based vocational assessments, including the Institute for Community Inclusion Questionnaire from the University of Massachusetts. The information obtained will compose the participants' Employment Portfolio. Once the data has been collected to create the portfolio, the participants will be placed into work adjustment training with an individualized plan created for each participant. Each person will participate in work adjustment training for a period of up to 6 months, after which, the person “graduates”.

The project will create an interactive work adjustment and vocational training model for those with high-functioning Autism and Asperger’s that will enhance each participant's vocational skills to enable them to reach his/her highest potential with the ultimate goal of integrated employment for each participant. The curriculum of work adjustment training, to be developed, will be based on benchmark work adjustment training including the areas of:

* Attendance and punctuality
* Accepting supervision and expressing needs to supervision in the right way
* Career exploration and guidance
* Working cooperatively with others
* Attending to the task at hand and to minimize distractions
* Learning to follow directions and to ask questions
* How to use accommodations
* Improving physical or emotional stamina

Community Adjustment Training: As part of the model, we would also develop an assertive community education outreach effort to “adjust” the community in terms of its perception of this population. This community education model would impact the way employers think about the population in terms of their ability to perform work skills and be employed and the capability of employers to hire and work with this population. Based on the landmark article, “*From Work Adjustment to Community Adjustment*,” by Dr. Bruce Menchetti, any model of work adjustment needs to be extended to a broad-based model of community adjustment, which involves the community integration of persons with disabilities. We would move to partner with the Institute on Person Centered Practices, collaboration between the Center for Disability Studies at the University of Texas and Texas A&M University to create a community awareness campaign which addresses the needs of this population. UT and A&M are well-versed in the Person Thinking Concept as it relates to staff working with those persons with developmental disability and we want this concept to evolve into one of Employee-Centered Thinking, an initiative that will change the way employers think about persons with High-functioning Autism or Asperger’s. We would utilize the existing space at the Temple Training Center, a building owned by the provider, Central Counties Services. The site will be staffed by professionals and paraprofessionals who are skilled in the specialty areas of Autism/Asperger’s and in the area of work adjustment training and employment-related services.

**Goals and Relationship to Regional Goals:**

The goal is to create a model of work adjustment training and employability-skills training to enable the person to achieve the highest potential possible for inclusion into the world of community employment. This potential includes work behaviors, work attitudes, interpersonal relationships and work skills. An assertive community education outreach effort will be implemented to educate community employers on the advantages of hiring persons with Autism or Asperger’s and to raise their awareness on this type of potential employee. The community education effort will include an emphasis on Person Centered Thinking.

The goal is to provide the supports necessary for the participants to reach their ultimate goal of being employed for competitive pay. Participants complete training on completing applications independently, the interview process, filling out applications for employment, and attending job interviews. Once the participant in hired for a paid position, project staff, if needed, support the participants while on the jobsite by giving additional training to ensure maximum productivity, maintain high success rates, and create job stability.

**Project Goals:**

* to increase the number of persons participating in work adjustment training for those people with high-functioning Autism or Asperger’s
* to increase the employability skills and employability behaviors for those persons participating in the model
* to increase the community awareness and to “adjust” the community perception for persons with high-functioning Autism or Asperger’s in areas related to employment
* to increase the number of consumers employed who have high-functioning Autism or Asperger’s

**This Project meets the following Regional Goals:**

* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs

**Challenges:**

The challenges facing this project are varied including the fact that people with Asperger’s Disorder and high-functioning Autism are reluctant to leave the perceived security of their homes to participate in training, even if the training involves like-minded individuals. They like their routine and the new routine of attending work adjustment training must evolve. Likewise, their participation in employment will be a new routine and patience is needed for this to occur. Program staff will need to exercise patience and a more involved approach to motivate people to take the first step and visit the group and to take the next step to secure employment. The challenge of achieving a high level of “engagement” exists and a strong teacher/mentor/facilitator is needed. It is also expected that persons will separate or “graduate” from the group but will need at times a booster of support from the staff and peers. There should be a direct tie-in to active participation with goal achievement. The linking of the individual participant with the appropriate job will be a challenge due to the person’s lack of social and work adjustment skills. Hiring the staff versed in these specialties with employment assistance background will also be a challenge due to the dearth of specialists in the Central Texas rural area to address this type of disability. The challenge with the community education outreach effort will be overcoming the perceptions of many employers to hiring the disabled and those with Autism or Asperger’s in particular.

**3-Year Expected Outcome for Provider and Patients:**

The three-year outcome includes the expansion and enhancement of behavioral health services to better meet the needs of the patient population with high-functioning Autism and Asperger's Disorder; a heightened awareness in the community of this model as a viable learning module; a heightened community awareness of the advantages of hiring those persons with high-functioning Autism or Asperger’s; increased proficiency in employability skills; increased satisfaction on the part of the individual consumer due to enhanced vocational skills; and the person’s increased ability to exhibit appropriate behavior in relationships, in employment settings. The community education intervention would mean more employers having a better understanding of Autism or Asperger’s; more employers being receptive to hiring persons with High-functioning autism or Asperger’s and more opportunities for employment.

**Starting Point/Baseline:**

Within, the local service area, there is currently not a structured social group setting in which persons with High-functioning Autism or Asperger’s Disorder participate in work adjustment skills training. Baseline for and number of persons served will be established in DY 3.

**Quantifiable Patient Impact (QPI):**

Central Counties Services will use HHSC’s recommended QPI (individuals impacted) for this project. Each year we will seek to increase the number of patients that are receiving this service through our innovative program. Over the course of the project, we expect the total patient impact to be approximately 41 individuals diagnosed with high-functioning Autism or Asperger’s who are of employment age (DY3: 8 individuals, DY4: 16 individuals, and DY5:17 individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-11, allowing us to establish a baseline number of additional individuals receiving community behavioral services after access expansion. Each year, we aim to increase the number of individuals receiving this service, as measured by Milestone I-11, Metric I-11.2: Number of individuals utilizing community behavioral healthcare services. We expect the target population from the above sources to be 94 people with approximately 80% of the population being Medicaid eligible and the other 20% uninsured. The total cumulative consumer impact from DY 3 through DY 5 is 41. The census for this population comes from agencies who are already working with the population.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.9 - Lack of social support services for high intellectual functioning Autism & Asperger's population (18 years & older) in Bell County.

According to the U.S. Department of Labor, only 20 percent of people with disabilities either are employed or are seeking employment, compared to 69 percent of the population without disabilities. Of those with disabilities seeking employment, 15 percent have not found employment — compared to 8 percent for everyone else.

The Texas Department of Aging and Disability Services (DADS), along with the other health and human services (HHS) agencies, make employment for people with disabilities a priority. The following are projects that HHS agencies are engaged in to help put people to work. The Texas legislature passed four bills during the 2013 session to improve employment outcomes for people with disabilities:

* [Senate Bill (SB) 1226](http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB1226) directs HHSC, TEA and TWC to jointly adopt and implement an Employment First policy and establish an Employment First task force.
* [SB 45](http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB45) directs HHSC to add employment services to the state's Medicaid waivers.
* [SB 617](http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB617) directs TEA to require that each school district (or shared services arrangement) assign at least one employee as a transition and employment designee for students in special education programs.
* [SB 7](http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB7) outlines a system redesign for long-term services and supports through managed care expansions. It also describes quality improvement strategies and goals, including requirements to measure and promote employment outcomes.

Within the local service area served by Central Counties Services, we have seen an increase in the number of individuals diagnosed with Autism or Asperger’s Disorder. These include referrals through intake, who have never received services from a social service agency, consumers served by the Children with Special Needs Network, individuals served in the public schools, persons discharged from State Supported Living Centers, persons served by DARS and persons served by the network of private providers. We now have enough consumers with this diagnosis to form a separate caseload at Central Counties and the nuances associated with high-functioning autism or Asperger’s warrants a separate caseload with a special emphasis on the challenges of this group. Like the network of private providers in our area, we are serving these persons based on their individual needs but there is a need to provide a specialty training experience in which persons with similar challenges can participate.

Although this group of individuals has normal or above-average intelligence and language development, traditional mental health programs struggle to meet their needs because the characteristics of the Autism are so dominant that they interfere with standard treatment modalities. Likewise, traditional behavior management techniques used for persons diagnosed with pure developmental disability (formerly mental retardation) do not meet their needs. Further, the skill-set of the typical case manager working with those persons diagnosed with developmental disability is lacking as the Autism or Asperger’s consumer presents a whole new set of challenges.

According to the research on persons with Autism and Asperger’s, members of this population need support in work skills, work behaviors and work attitudes to assist with employment securement and job stability.

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

In terms of funding, it should be noted that the U.S. Department of Health and Human Services does not fund services that address the needs of persons with High-functioning Autism or Asperger’s Disorder.

**Project Core Components:**

Project milestones P-10.1 in DY4 and DY5 reflect that the provider will participate in face-to-face meetings or seminars organized by the RHP twice each year to promote collaborative learning around projects.

**Customizable Process or Improvement Milestones:**

At HHSC’s suggestion, the provider added customizable milestones I-X.1 in DY4 and DY5 to increase the number of employers receiving training on Autism and Asperger’s by 10 in DY4 and 12 in DY5.

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

OD-10: Quality of Life/Functional status -IT-10.1.a.iv: Quality of Life. Quality of Life – demonstrate improvement in quality of life satisfaction scores, as measured by the Assessment of Quality of Life (AQoL), an evidenced-based and validated assessment tool. This tool will be given to participants upon entry into the program and again at one month intervals. It is expected that scores will improve over time. In DY 3, the baseline scores will be obtained and in DY 4, we desire 50% of the participants who have graduated from the training to show increased satisfaction. In DY 5, we desire 50% of the participants to show increased satisfaction.

**Relationship to Other Projects/Regional Goals:**

The need to address services to persons with autism is a high priority need in the region. This has been recognized by the Central Texas Aging and Disability Resource Center (CTADRC), the A+ Support Group and the public at large through a series of public forums facilitated by Central Counties’ staff. It is also recognized by the Center’s Planning and Network Advisory Committee (PNAC) and the Center’s Board of Trustees. Within the local service area of the Center, there are informal groups of persons with Autism or Asperger’s Disorder. There is an Asperger’s support group (about 20 persons) that meets once per month for social activities. This group does not have a formal work adjustment or vocational skills training format. There is a current active census at the Center of 30-35 persons diagnosed with High Functioning Autism or Asperger’s. These persons receive services according to individualized Plans. Also, within the local district of the Department of Assistive and Rehabilitative Services (DARS) there is a census count of 50-60 persons diagnosed with Autism or Asperger’s. Although these individuals participate informally in these activities, there is not a formal strategy to provide employment-related skills training. These individuals and others could readily benefit from the model with its focus on work adjustment and vocational skills training.

Other Center projects include:

* 081771001.1.1 - Establish more primary care clinics
* 081771001.1.2- Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
* 081771001.1.4 - Develop and implement crisis stabilization services to address the identified gaps in the current community
* 081771001.1.5- Enhance improvement capacity through technology
* 081771001.2.1 - Apply evidenced-based care management model to patients identified as having high-risk care needs
* 081771001.2.2- Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
* 081771001.2.3 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population
* 126844305.2.1 - In an innovative manner, implement other evidence‐based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above

**Plan for Learning Collaborative:**

Central Counties Services will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. Participation in these learning collaborative meeting events, as well individual training opportunities, regional spotlights and routine collaborative communications in the region, will allow Central Counties Services to work with other Providers within this specific project area or with similar targeted outcomes in an effort to share what we are doing, what we are learning, and how we might all leverage this shared information to continually improve and benefit the projects. The results of each learning collaborative meeting will be compiled and disseminated electronically to the entire RHP within 30 days after the meeting and will be archived on the RHP website hosted by the anchor ([www.tamhsc.edu/1115-waiver](http://www.tamhsc.edu/1115-waiver)). In addition, opportunities may exist and will be explored for Central Counties Services to interact with providers in other RHPs who may have an expansion of the number of community based setting where behavioral health services may be delivered in underserved areas focus to expand learning and quality improvement initiatives. Additionally, Central Counties Services looks forward to participating in HHSC’s statewide learning collaborative activities as available.

**Project Valuation:**

The Center’s approach to valuing this project considered three primary factors: factors related to an improved patient experience, the benefit to our community, and cost reductions to the healthcare and criminal justice system. In considering the incentive portion of the valuation three principles and their subsequent impacts were considered. These principles included: investments required to initiate the projects, value associated with the services delivered for a period of time until outcomes/benefits could be demonstrated before receiving reimbursement, and incentives to the performing provider to accelerate transformation and expansion of the delivery system. The training will take place Monday, Wednesday and Friday with Tuesdays and Thursdays set aside for employment-related activities such as job searches and employer contacts. A full day will be about 6 hours, which allows for transportation, to and from the training site. Several types of engagement activities will be carried out based on evidenced-based work adjustment skills training curricula. Each consumer will participate in a highly interactive group learning session while attending. The person diagnosed with high-functioning autism or Asperger’s is expected to show improvement in work skills and work behaviors which leads to improved social and personal relationships and enhanced employment capability including longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social and vocational activities.

The benefit to the community of this training lies in the person’s ability to cope with and function in a variety of community settings including employment. The consumer should have an enhanced quality of life; feel more valued in inter-personal relations and is expected to interact positively in all phases of community life. There should be less crisis events, less hospitalizations, and less entanglement with law enforcement. Family members, friends, neighbors and the community-at-large should see a more positive stance from the individual participant in the group social skills training. The person should achieve an employment related activity of his/her highest potential and maintain this employment with a greater degree of stability. With the assertive community education outreach efforts, employers will gain a greater understanding of the person who is Autistic or who has Asperger’s and be more willing to hire this person as a result.

The valuation of this project also includes the following: staff time in marketing the positions required and interviewing and hiring the positions; staff time in researching appropriate sites for the social group setting; staff time in negotiating the lease arrangement; staff time in purchasing the van for transportation; staff time in developing the curriculum; staff time in researching the survey, both in terms of administering and scoring; staff time in selecting and purchasing the equipment involved. The valuation also includes direct costs of staff salaries and benefits, equipment, vehicle and lease, as well as program indirect costs, administrative costs and cost of inflation. It also includes a cost savings value reflected in savings on mental health/IDD benefits due to decreased incidents of behavioral crisis; less involvement with law enforcement and increased earnings in the workplace due to employment.

**Category 1 Project Narrative – Pass 2**

**Little River Healthcare – 183086102.1.1**

**Project Area, Option and Title:** 1.1.2 Expand Existing Primary Care Capacity

**Unique Project Identifier:** 183086102.1.1

**Performing Provider Name:** Little River Healthcare

**Performing Provider TPI:** 183086102

**Project Summary:**

* **Provider Description:** Little River Healthcare is the operator of a 25 bed Rural Hospital located in Rockdale, Milam County, Texas. Milam County is 1,016.93 square miles and has a population of approximately 24,757 according to the 2010 census report.
* **Intervention:** This project will increase the number of Primary Care Physicians (PCPs) which will allow the hospital to increase clinic hours by 5 hours per week and provide earlier diagnosis of chronic and life‐threatening disease states prior to the disease requiring an emergency department (ED) visit and urgent care. This will better utilize the ED for true emergencies.
* **Project Status:** This project is expansion of an existing initiative to better utilize the ED, provide a positive experience when visiting the clinic, and improving the health of Milam County residents.
* **Project Need:** Milam County is considered a physician shortage area and medically underserved area as evidenced by the 2010 Census report showing a ratio of residents to Primary Care Physicians of 2,071:1. This is almost double the ratio for the State of Texas which is 1,050:1 (see CN.1.1—Limited access to primary care within Milam County). Milam County also has a high premature death rate of 9,592 which is ranked 160 of 221, according to the most recent (2006‐2008) data from County Health Rankings & Roadmaps.
* **Target Population:** During the calendar year 2011, LRH treated over 1,500 individuals in the ED which were non‐emergent, of which 23% were Medicaid claims, 24% were Medicare Claims, and 24% were services for the uninsured and indigent. Targeting these non‐emergent visits by providing access to additional PCPs (I‐12.1) is projected to benefit a minimum of 75 patients during DY4 and a minimum of 113 patients during DY5 that would be considered non‐emergent patients. This will reduce claims by the Medicaid eligible, indigent, and uninsured patients while improving the care of Milam County residents.
* **Category 1 or 2 Expected Project Benefit for Patients:** By increasing access to PCPs, the project seeks to increase the volume of clinic appointments and visits (Improvement Milestone I‐12.1). As the confidence, comfort level, and willingness of patients to seek treatment from PCP’s in a primary care setting increases, the capacity to provide better care in this same setting will increase. We anticipate having an additional 500 new patient visits for primary care services in DY4 and 1,000 new visits in DY5. The additional PCPs will also benefit the over 17,000 people that visited the current clinics during the calendar year 2012 with improved convenience and shorter waiting times. A potential 4,828 individuals could benefit by the ability to have a convenient appointment that may prevent a condition from becoming an emergency. If only 25% or 1,200 individuals realize the benefit of the ability to have an appointment with a PCP, the cost savings would be over $2,000,000. Furthermore, the entire population of 24,757 of Milam County will benefit from the increased number of PCP’s. The convenience of being able to have an appointment with the same physician when necessary will build confidence and trust to use the LRH clinics rather than driving elsewhere when their illness may have become more serious because the patient did not want to drive, have the time, or did not have the transportation necessary. During the calendar year 2012 there were approximately 17,000 visits to the LRH clinics. Many of these visits were more than likely the same individuals due to follow ups and general poor health of the individuals. If you were to estimate that 50% of these were the same individuals, the result would be approximately 8,500 people within the population who for various reasons have not benefited from the local clinic being convenient. With an increased number of PCPs, the number of excuses of why they do not see a physician would decrease.
* **Category 3 Outcomes:** IT‐9.2.a: Our goal is to reduce all ED visits by a TBD% in DY4 and DY5. Using the base year of 2011 with the 1,500 non‐emergent cases treated by the ED, and the estimated increases over the baseline, a minimum of 5% or 75 individuals would not visit the ED in DY4 and a minimum of 113 individuals would not visit the ED in DY5. In addition, with an increased number of available hours by PCP’s, the State of Texas estimate of 19.5% residents of Milam County considered in poor or fair health will benefit also.

**Project** **Description:**

*Expand Existing Primary Care Capacity*

Within the State of Texas, 19.5% of rural residents report being in only “fair” or “poor” health compared with 15.6% of urban residents. Chronic conditions such as cardiovascular disease and diabetes are a bigger problem for rural populations than in urban or suburban areas. This is particularly the case in the South, and amongst rural minority communities, for whom obesity rates and other risk factors are markedly elevated. Rural clinics, community health centers and small rural hospitals provide the backbone of facility‐based rural health care.

Little River Healthcare (LRH) will expand existing primary care capacity so as to promote “the right care at the right time in the right setting”. LRH will accomplish the desired outcome of this project by hiring additional physicians and midlevel practitioners. The lack of timely and efficient access to physicians and midlevel practitioners in rural communities often result in over utilization of regional Emergency Departments (EDs) and/or Urgent Care Clinics.

LRH will extend clinic hours to provide better access to preventive and non‐emergent care services so as to avoid costly and unnecessary trips to the ED. Clinic hours will be extended by a minimum of 5 hours (either an additional hour per day or multiple hours on targeted high volume days of the week) each week by end of DY3 and then increase as needed based on availability of existing and new physicians. In addition, LRH will establish a hospital‐ based “Fast Track” process and program whereby patients will be able to see a primary care healthcare provider 24 hours a day 7 days a week as an alternative to utilizing the hospital ED for non‐emergent after hour care needs. LRH will triage patient appointments to ensure that same day appointment slots are available for most urgent patients. Patients will be identified as clinic candidates based on the level of a “tiered” triage system. The triage program and patient flow process will be researched and established during the planning process timeframe of DY2. Documentation of the medical care within the Fast Track program will be coordinated in a single hospital‐ owned electronic medical record. The Fast Track primary care provider will be able to interact electronically, via the “cloud based” electronic record system, with the patient’s routine primary care provider so as to improve efficiency and accuracy of care as well as aid in the reduction of unnecessary duplicate medical tests and treatment. Statistical data will be extracted from the EHR on a monthly basis. In addition and in cooperation with the Rockdale Independent School System (RISS), LRH will develop a school‐based clinic program to insure all children in the RISS have access to primary care.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

* Reduce ED utilization and redirect appropriate utilization to the primary care clinic; and
* Expand capacity to care for more children and young adults.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

A major challenge is attracting additional physicians to locate to Milam County. Milam County currently has a shortage of primary care physicians. That shortage impacts access to care which leads to poorer health outcomes. In Milam County, low income, uninsured and minority populations are steadily increasing due in part to the migratory nature of low income jobs prevalent to rural agricultural work opportunities, distressed rural economies, high unemployment rates as well as a migratory trends beginning to emerge where populations are leaving more urban areas looking for a lower cost of living generally thought to be associated with rural living in Texas. Because of a general lack of routine primary care, these groups of people are more likely to become chronically ill resulting in premature death. Lack of transportation, delays, and/or long wait times to see a physician can impact the outcome of the patient’s willingness to seek primary and preventive care. In addition, underserved populations and the under‐insured populations create critical issues for Milam County. In summary, increasing access to primary care physicians in Milam Count is imperative.

Little River plans to address these challenges in the following ways:

* Upgrade current facilities and equipment in the rural area;
* Educate the population about the availability of Primary Care Services available;
* Offer higher and competitive salaries;
* Continue to recruit providers having a rural background; and
* Loan repayment and scholarship programs

**5‐Year Expected Outcomes:**

The five year expected outcome will be to attract additional physicians to locate their practice in Milam County, or to have doctors that are established in larger cities to allocate a minimum of one day a week of their practice in Milam County. With the additional primary care physicians there will be more primary care visits for preventative services, reduced ED use, and better education about primary care availability and prevention, resulting in overall better health within Milam County. Increasing primary care availability in Milam County will improve access for low income, uninsured and minority populations. Such populations are steadily increasing and are more likely to become chronically ill resulting in premature death. We expect to impact that through improved primary care availability. We further anticipate reducing the current delay and long wait times. We anticipate the improved access will impact patient outcomes through early detection and patient’s willingness to seek primary and preventive care.

**Starting Point/ Baseline:**

Little River Healthcare currently employs 2.5 physician full time equivalents (FTEs) and 3 midlevel provider FTEs. While current patient needs are being served adequately, patient volume is growing and adequate accessibility and appointment availability will be difficult to maintain due to the increasing uninsured, underinsured and increasing minority population of Milam County. Milam County is a medically underserved population, not only do we need additional primary care providers for our current population but the ability to serve more patients as the county continues to grow. By increasing the number of physician FTE’s, mid‐ level provider FTE’s and hours of availability over the current baseline of FTE’s and hours of availability, the health needs of the residents of Milam County will be better served. The exact number of additional primary care providers and the expanded hours of coverage will be determined as a result of the DY2 Milestone 1 and Metric 1.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited Access to primary care
* Specific Community Needs:

o CN.1.1—Limited access to primary care within Milam County

o CN.1.8—Limited access to preventive care (cancer screenings) in Milam County

Milam County residents often utilize the Hospital’s ED for conditions that could be managed in a more coordinated manner if provided in a primary care setting. For certain segments of the population, it is culturally acceptable to seek non‐emergent care in the ED. This often results in more costly, less coordinated care and a lack of appropriate follow‐up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing these access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

Healthy People 2020 outlines several goals and objectives that also align with the goals of transformation waiver over the next 4 years:

1) Patients should have a source of ongoing care;

2) Have a usual primary care provider (PCP); and

3) Reduce avoidable hospitalizations. By increasing the number of available healthcare providers and resources to support a growing population in Milam County, these goals can be achieved.

Milam County is considered both a HPSA (physician shortage area) and MUA (Medically Underserved Area), bordered by counties of the same designation. In order to expand primary care services, LRH will have to expand staffing base, clinic resources and increased hours of operations during times convenient for patients. Due to the *Affordable Care Act*, an additional 6 million people will be eligible for healthcare benefits in 2014. According to the Texas

Department of Rural Affairs (2008), nearly 60% of office visits were for primary care, which puts severe strain on those providers.

**Project Components:**

The required core components will be fulfilled as follows:

a) *Expand primary care clinic space* – Existing space in the primary care clinic will be repurposed to expand primary care for additional practitioners.

b) *Expand primary care clinic hours* – In order to address overutilization in the ED for non‐ emergent care, clinic hours will be expanded as needed to provide better access in the primary care clinic.

c) *Expand primary care clinic staffing* – To meet the demand for additional hours and available appointments, LRH will add additional staff to meet patient’s expectations and utilization needs.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Expansion of primary care is absolutely necessary for system wide improvement. With this expansion, more patients have access to preventive care, which increases opportunities to prevent disease and further deterioration of health status and will keep people out of the hospital. It is especially important for inpatients to get follow‐up appointments after a hospital discharge for optimal recovery and to avoid readmission. The expansion of primary care and the increased availability of primary care level healthcare will reduce unnecessary ED utilization and streamline the delivery of primary care to the residents of Milam County and Rockdale, Texas. Reduced ED utilization will save Medicare and Medicaid dollars as well and aid in the prevention of chronic health issues as the result of early diagnosis and more coordinated care and prevention.

LRH receives funding from the U.S. Department of Health and Human Services for uncompensated trauma care; however, these funds will not be used for this project.

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

OD‐9 Right Care Right Setting

IT‐9.2.a ED Appropriate Utilization (Standalone measure)

Through expanding primary care capacity, patients will have more access to primary care which will improve patient experience, improve preventive screenings and outcomes but most importantly improve availability. With the additional primary care physicians there will be more primary care visits for preventative services, reduced ED use, and better education about primary care availability and prevention, resulting in overall better health within Milam County. This is why we choose ED Appropriate Utilization as an Outcome Measure.

**Relationship to Other Projects:**

This project will assist in our efforts to develop a more expansive primary care base. An expanded primary care base will aid our organization to identify patients who would benefit from our other projects associated with health promotion and disease prevention (#183086102.3.1) as well as the reportable metrics for Category 4 Population‐ Focused Improvements. LRH has another proposed project (#183086102.1.2) which will address limited access to specialty care providers. These proposed projects will work together and communicate with each other; however, the projects will not overlap or duplicate each other. The specialty care providers, e.g. gastroenterologists and gynecologists, will be providing screening services and specialty care where as the primary care providers will be promoting better health and identifying patients needing specialty care and screening.

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

LRH is proposing a project to expand primary care access. Two other providers are also expanding primary care: Williamson County and Cities Health Department (#126936702.1.1) and St. David’s Medical Center Round Rock (020957901.1.1).

LRH will participate in an RHP 8 learning collaborative that meets semi‐annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better serve the populations in their projects.

**Project Valuation:**

Milam County is considered both a HPSA (physician shortage area) and MUA (Medically Underserved Area). Expanding the hours of service and locations for providers will provide greater access to care to people who have to this point utilized ED service for non‐emergent health care needs. The 1,500 non‐emergency patients that visited the ED in 2011 would have been better and faster served if they had easier access to PCP’s through additional service hours or providers. In addition, the over 17,000 patients that visited LRH in calendar year 2012 would benefit from more convenient access to PCP’s. The more convenient access to a PCP will encourage the current number of 4,308 individuals over 65 in Milam County to seek medical attention early, rather than waiting until admittance to an ED is necessary. Using this segment of 17.4% the population, or only 4,308 individuals taking advantage of the increase in PCP’s and available hours over the project years of DYs 2–5, the cost of the project would equate to only $745 per individual. Which is much less than the $1,750 average charge of an ED visit. In addition, patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental health services. In 2011, Little River Healthcare experienced over 1,500 non‐emergent patients in the ED, with each visit having an associated charge of $1,750. Redirecting those patients would provide a cost savings of over $2,625,000 in the ED. Considering that Medicare and Medicaid comprise 71% of total ED utilization, this program would result in reduction of over $1,800,000 to State and Federal payers. Additional cost savings would unquestionably be realized as a result of increased primary care hours and providers, through early detection and prevention of chronic illnesses, and as a result, reduce the need for emergent care services or patients’ perceived need for emergent care services.

**Category 1 Project Narrative – Pass 2**

**Little River Healthcare – 183086102.1.2**

**Project Area, Option and Title:** 1.9.2 Improve access to specialty care

**Unique Project Identifier:** 183086102.1.2

**Performing Provider Name:** Little River Healthcare

**Performing Provider TPI:** 183086102

**Project Summary:**

* **Provider Description:** Little River Healthcare (LRH) is the operator of a 25 bed Rural Hospital located in Rockdale, Milam County, Texas. Milam County is 1,016.93 square miles and has a population of approximately 24,757 according to the 2010 census report.
* **Intervention:** This project will increase the access to Specialty Care Physicians (SCPs) by expanding the number of specialty providers and/or increasing clinic hours by 5 hours per week for the specialists most in demand. This will promote early diagnostic, screening, referral, and treatment services for at risk patients including low income and uninsured individuals.
* **Project Status:** This is a new project to improve access to timely, high quality and specialty care for the residents of Milam County.
* **Project Need:** CN.1.8 – Limited access to preventative care (cancer screenings) in Milam County. Milam County is considered a physician shortage area and medically underserved area. In addition to being older, the population of 24,757 has a higher percentage than the State of Texas for obesity and physical inactivity as well as a greater number of sexually transmitted infections which can lead to conditions and illnesses which are treatable when diagnosed early by the proper screening and diagnostic services. These risk factors warrant screening for breast cancer, (IT-12.1), cervical cancer, (IT-12.2), and colorectal cancer (IT-12-3). In addition, this project will address the need for referrals from other specialists in the same specialty, to oncologists for the treatment of positive screening results, and the referral to specialists and primary care providers when other health issues are diagnosed during a screening process, thus promoting general and long term health care, (I-25.1).
* **Target Population:** Milam County’s population consists of 56.1% of individuals between the ages of 18 to 64, 17.4% 65 and older with 50.6% of the population being female, according to the 2010 Census. LRH is estimating that with the proper referral system (P-2.1) and education about the importance of screening, 200 – 1,000 individuals within Milam County will seek diagnostic services over DYs 2-5. However, this quantity of total diagnostic services is a only a “hoped for” result as this may take longer to achieve due to human nature, even when a diagnostic test may result in early detection of a potentially life threatening disease. The older population of Milam County, which is also primarily female, will benefit from preventive care and screening services, for breast cancer (IT-12.1), cervical cancer (IT-12.2) and colorectal cancer (IT-12.3) and will also benefit from the regular follow up screenings for the years thereafter. For those patients that receive a positive diagnosis from a SCP, the referrals to another SCP for a second opinion or to an oncologist for a treatment plan will benefit the long term health and prognosis of the patient.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide SCPs and related access to preventive care and screenings, as well as oncologists and referrals to Primary Care Providers subject to the diagnosis of the SCP, for those groups which are considered to be at-risk, by increasing the number of providers, clinic hours, and procedure hours (I-22.1). According to the Agency for Healthcare Research and Quality, 19.5% of residents in rural areas consider themselves in only fair or poor health and could be labeled “at risk” because rural residents tend to smoke more, exercise less, and have less nutritional diets compared to urban areas. Currently, due to the shortage of SCPs there is a lack of access to preventive care and screenings and there is little to none targeting of these mentioned groups. Providing improved access to specialty care will be extremely important for referrals to other specialists (I-25) and follow up testing and care when there are positive test results from screening and diagnostics. Also, the expanded specialty care access will provide the patient the opportunity for follow up appointments in a familiar location in close proximity to their home or work rather than traveling a longer distance for an appointment. In addition, should a particular service or test not be available, the patient will be more likely to trust the referral of a specialty care physician that the patient has visited multiple times and is familiar with. The goal of the project with the improved access to SCP’s, is to have a minimum of 50% of the total referrals to be appropriately categorized in DY4 with a 20% increase to 60% of total referrals to be appropriately categorized in DY5. As residents of the community do become familiar with the specialty care physicians they will be more willing to have regular screenings annually or as prescribed by the specialty care physician. Thus, the specialty care physician will notice any changes or differences between screenings. Currently there is no access to these services in Milam County.
* **Category 3 Outcomes:** 
  + IT-12.1: Our goal is to increase by TBD% access to mammography and breast cancer screening services, as well as to inform and educate the Target population on detection.
  + IT–12.2: Our goal is to increase by TBD% access to cervical cancer screening services as well as to inform and educate the Target Population on prevention.
  + IT–12.3: Our goal is to increase by TBD% access to colorectal cancer screening services as well as inform and educate the Target Population on prevention.

**Project Description:**

*Specialty Care Access*

As of the census of 2010, Milam County had a population of 24,757 with a racial makeup of 78.1% White, 10.0% Black or African American, and 11.9% other races. The population was 6.9% under the age of 5, 26.5% under the age of 18, 49.2% over the age of 18 and under 64, and 17.4% over 65 years of age. The per capita income per household for the county was $21,509 and 17.6% of the population is below the poverty level. According to a report published by Agency for Healthcare Research and Quality, 19.5% of residentsin rural areas report being in only “fair” or “poor” health compared with urban residents in the United States. Chronic conditions such as cardiovascular disease, pulmonary disease and diabetes are a bigger problem for rural populations than in urban or suburban areas. This is particularly the case in the rural Texas for whom obesity rates and other risk factors are markedly elevated. In an excerpt from a CDC urban and rural chart book, “rural residents smoke more, exercise less, have less nutritional diets, and are more likely to be obese than suburban residents”. Rural clinics, community health centers and small rural hospitals provide the backbone of facility-based rural health care. Supplementing the primary care services offered in such rural and community clinics with specialty care physician services is a rare, but very necessary, opportunity. Despite the overwhelming need for access to specialty services in rural populations, the access often simply does not exist. Milam County is no exception to this rule. It has an older, poorer population and access to physician specialty services, such as gastroenterology, mammography, and gynecology are necessary to ensure the health and vitality of Milam County residents.

LRH will expand specialty care capacity by providing additional space and resources for physicians and mid-level practitioners such as physician assistants and nurse practitioners to meet the population of our community most struggling to gain access to high impact specialty care services. Initially, we will identify through patient surveys and LRH’s electronic health record (EHR) system the specialty services that are most critical to our population given current coverage and/or lack of coverage. We will then develop a clinical schedule that will increase the number of hours that are available to provide expanded specialty care for our patients by five (5) hours a week by either adding hours during the week or on Saturdays. We will implement a standardized referral processes across the system as well as expanding diagnostic testing capabilities specifically aimed at addressing medical screening and treatment needs of high impact specialty care services. We will provide improved access to specialty care and specialty diagnostic testing for our patients. We believe we will be able to aid our patients with avoiding costly trips to physicians located outside of Milam County and improve the overall health of our rural community.

Providing improved access to specialty care will be extremely important for follow up testing and care when there are positive test results from screening and diagnostics. The expanded specialty care access will provide the patient the opportunity for follow up appointments in a familiar location in close proximity to their home or work rather than traveling a longer distance for an appointment. In addition, should a particular service or test not be available, the patient will be more likely to trust the referral of a specialty care physician that the patient has visited multiple times and is familiar with.

In addition, as residents of the community become familiar with the specialty care physicians they will be more willing to have regular screenings annually or as prescribed by the specialty care physician. Thus, the specialty care physician will notice any changes or differences between screenings.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

* Conduct a gap analysis to determine the specific specialty care needs of the community;
* Expand the number of specialty providers and/or clinic hours for highest demand specialties; and
* Complete planning and installation of new specialty diagnostic systems.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

A major challenge is attracting additional physicians to locate to Milam County. Milam County currently has a shortage of primary care physicians, let alone specialty care physicians. Certain high impact specialty care physician coverage is nonexistent all together. That shortage impacts access to care which leads to poorer health outcomes. In Milam County, low income, uninsured and minority populations are steadily increasing and are more likely to become chronically ill resulting in premature death. Lack of transportation, delays and long wait times to see a physician can impact the outcome of the patient’s willingness to seek primary care, preventive care and specialty care. In addition, underserved populations and the under-insured populations create critical issues for Milam County. In summary increasing access to high impact specialty care physicians in Milam County is a must.

Little River plans to address these challenges in the following ways:

* Upgrade current facilities and equipment in the rural area;
* Educate the population about the availability of Specialty Care Services available;
* Offer higher and completive salaries;
* Continue to recruit providers having a rural background; and
* Loan repayment and scholarship programs.

**5-Year Expected Outcomes:**

The five year expected outcome will be to attract additional specialty physicians to locate their practice part-time and/or full-time in Milam County, thereby addressing the current shortage of high impact specialty care physician problem in Milam County. Addressing that issue will positively impact access to care which should lead to better health outcomes. Increasing specialty care availability in Milam County will improve access for low income, uninsured and minority populations. Such populations are steadily increasing and are more likely to become chronically ill resulting in premature death, we expect to impact that through improved specialty care availability. We further anticipate reducing the current delay and long wait times associated with our patients having to seek specialty care outside of Milam County. We anticipate improved access will impact patient outcomes and patient’s willingness to seek treatment for specialty care needs once the patient is referred for specialty care by their primary care provider.

**Starting Point/ Baseline:**

Milam County is a medically underserved population. As such, LRH often refers patients to physicians located at least 45 miles outside of Milam County, one-way. This is not sufficient to care for a growing and aging population and provide the level of services for those unable to afford or have access to suitable transportation over great distances from rural areas for care associated with high impact/most impacted medical specialties and specialty imaging and diagnostic services. The demand for services is reflected in the number of patients who are referred from our clinic to other physicians, the minority population and the number of citizens with Medicaid and those who are uninsured. LRH believes that the three (3) measures of testing for breast cancer (IT-12.1), cervical cancer (IT-12.2), and colorectal cancer (IT-12.3) are the basic level of specialty care necessary for Milam County and are the starting point for specialty care services.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited Access to Primary Care
* Specific Community Need: CN.1.8 – Limited Access to Preventive Care (cancer screenings) in Milam County

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.

**Project Components:**

1. *Increase service availability with extended hours.* LRH will review EHR records and conduct a patient survey to determine the specialties needed locally and the expanded hours that would satisfy the demand.
2. *Increase number of specialty clinic locations.* LRH will work with its specialty care physicians to increase the Hospital’s specialty care locations (1 clinic) to improve local access to high impact patient populations.
3. *Implement standardized referrals to specialty care providers across the system*. LRH will develop a process for the specialty and primary care physicians and clinics to have access to a specialty care referral system available through LRH’s “cloud” based EHR system. The referral system would be available whenever there is a positive screening result or a provider’s diagnosis is that a patient’s health would benefit from treatment by a specialty care provider. This will expedite patient care and improve patient access to a specific specialty care provider when treatment is prescribed.
4. *Conduct quality improvement for project using methods such as rapid cycle improvement.* LRH will develop a process where primary care providers and specialty care providers will be able to easily communicate concerning patient treatment plans as well as share test results and clinical findings within through the EHR and referral management system.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Expansion of specialty care is absolutely necessary for system-wide improvement of LRH’s services. With this expansion, more patients have access to preventive care, which increases opportunities to prevent disease and further deterioration of health status and will keep people out of the hospital. The expansion of specialty care and the increased availability of specialty healthcare will reduce unnecessary ED utilization and streamline the delivery of specialty care to the residents of Milam County and Rockdale, Texas. Reduced ED utilization will save Medicare and Medicaid dollars as well and aid in the prevention of chronic health issues as the result of early diagnosis and more coordinated care and prevention.

LRH receives funding from the U.S. Department of Health and Human Services; however, these funds will not be used for this project.

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

OD-12: Primary Care and Primary Prevention

* IT-12.1 – Breast Cancer Screening
* IT-12.2 – Cervical Cancer Screening
* IT-12.3 – Colorectal Cancer Screening

These three Category 3 Outcome measures were chosen because currently there is no known mammography screening available in Milam County. With females comprising 50.6% of the population, LRH foresees a need for this service as the population ages. Milam County also ranks above the State of Texas in percentage points for adult obesity and physical activity which are both factors on colorectal cancer. The incidences of sexually transmitted diseases and teen birth rate, which are risk factors of cervical cancer, are also higher in Milam County than Texas. Given these health related factors and Milam County ranked 201st out of 221, LRH feels that the three (3) outcome measures are needed to screen for potentially life-threatening conditions.

**Relationship to Other Projects:**

This project will assist in our efforts to address high impact specialty care services. An expanded specialty care base will aid our organization to identify patients who would benefit from our other projects (#183086102.3.2, #183086102.3.3 and #183086102.3.4) associated with health promotion and disease prevention as well as the reportable metrics for Category 4 Population-Focused Improvements. LRH has another proposed project (#183086102.1.1) which will address limited access to primary care providers. Through our primary care project (#183086102.1.1) and this project, local specialists will be able to better coordinate care and provide health status reports to the referring patient’s primary care providers.

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

LRH will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better serve the populations in their projects. As well as identify and agree on improvement initiatives to raise performance.

**Project Valuation:**

Milam County is considered an HPSA (physician shortage area) and MUA (Medical Underserved Area). Expanding the hours of service and diagnostic testing and screening capabilities for specialists will provide greater access to care for the target population. In addition, patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, case management and mental health services. Providing additional specialty services locally such as Hospitalist Coverage, Breast Cancer Screening and Mammography, Breast Biopsy and Breast Surgery, Gynecology, Gastroenterologist, Neurology, Pain Management, Cardiac and Pulmonary Rehabilitation, Wound Care and Geriatric Phycology should lead to lower hospitalization costs, better access to care and improved quality of life for those patients with chronic illnesses and those patients that screening and early detection prevented a life threatening condition. According to the 2010 Census, 17.6% of the Milam County population was below the poverty level and 27% of Milam County was uninsured. We expect that the benefits from this project will lead to lower costs to Little River Healthcare and Texas’ health care system overall and it will provide better patient satisfaction and outcomes since early detection and follow-up would be more readily available. Based on 2010 Census data and a publication by the Agency for Healthcare Research and Quality, this Project could benefit a range of Milam County residents of anywhere from 3,215 individuals that represent the 19.5% of rural Texas residents that only consider themselves in fair or poor health, to 8,344 individuals, representing the female population over the age of 18. This is largely due to rural residents smoke more, exercise less, and have less nutritional diets compared to urban areas, as published by Agency for Healthcare Research and Quality.

Screening services associated with specialty care physicians are unavailable in Milam County. Using the 2010 Census population for Milam County of 24,757, if only 10%, or 2,475 individuals over DY3, DY4 and DY5, take advantage of the screening tests which could result in early detection of cancer. The cost of the project, would equate to $1,212 per individual, which if anyone of these individuals have a positive result, would be less than the treatments for cancer or chronic diseases in later stages.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan and perform a gap analysis, the physician and support personnel that will need to be hired to effect the implementation of our plan and the on-going cost of support personnel and diagnostic technology to effect expanded specialty care screening, prevention and treatment. Other ongoing costs include but are not limited to patient education material needed to inform patients of their treatment plan and health condition as well as survey material needed to assess patient satisfaction level and monitor outcome.

**Category 1 DSRIP Project Summary**

**Seton Medical Center Harker Heights – 013122392.1.100**

**Project Area, Option and Title:** 1.1.2 Expand Existing Primary Care Capacity

**RHP Project Identification Number:** 013122392.1.100

**Performing Provider Name:** Seton Medical Center Harker Heights

**Performing Provider TPI #:** 013122392

**Project Summary:**

* **Provider Description:** Seton Medical Center Harker Heights (SMCHH)will support the Greater Killeen Free Clinic. This clinic serves a ­­1,060 square mile area and a population of approximately 300,000.
* **Intervention:** This project will expand existing primary care capacity to provide patients with increased access to primary care services. SMCHH proposes to support Greater Killeen Free Clinic by adding additional primary care staff. This project will provide delivery of more preventive, primary and chronic care services in our community by expanding existing capacity. Onsite provider care will be provided by a 0.5 FTE Nurse Practitioner, 0.5 FTE Registered Nurse, and 0.5 FTE Social Worker.
* **Project Need:** With twice the amount of population per primary care provider than the national average; in a 2013 needs assessment Bell County participants listed access to care as the highest ranking health priority. Access to primary care services is often delayed or not even initiated for uninsured individuals and members of medical aid programs who do not have established relationships with primary care physicians in Bell County. Delays in care can lead to symptom exacerbation and the need for emergency care that may be preventable.
* **Target Population:** The intervention of these services will increase access to primary care services for a number of low-income individuals in Bell County including, Medicaid beneficiaries, uninsured individuals, underinsured individuals, and enrollees in the Bell County Indigent Care Program. Other eligible patient groups may include current participants of the Free Clinics and Medicaid beneficiaries who are members of the Bell County Patient Navigator Program. Of the 4,492 primary care encounters this project anticipates providing, we believe 95% will serve Medicaid/indigent individuals.
* **Expected Category 1 Project Benefit for Patients and a Description of the QPI Metric(s):** Seton Medical Center Harker Heights will increase primary care clinic volume of visits and evidence of improved access for patients seeking services (I-12)

Increasing primary care capacity at the Greater Killeen Free Clinic will increase primary care services for the target population. This will include care for new patients and/or those that have already been diagnosed or show symptoms requiring evaluation for conditions such as hypertension, diabetes, COPD, or congestive heart failure. Seton Medical Center Harker Heights expects approximately 95% of these individuals to be Medicaid beneficiaries and/or low income patients. The project will include approximately 4,492 Nurse Practitioner total additional Primary Care visits (encounters) and 2,080 additional Social Worker visits (encounters), by the conclusion of Year 5 (DY3: 832 Nurse Practitioner encounters and 416 Social Worker encounters, DY4: 1,664 Nurse Practitioner encounters and 832 Social Worker encounters, and DY5: 1,996 Nurse Practitioner encounters and 832 Social Worker encounters). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-12, allowing us to establish the total number of visits (encounters) for the reporting period. Each year, we aim to increase the number of encounters at the greater Killeen Free Clinic, as measured by Milestone I-12, Metric I-12.1: Total number of visits (encounters) for reporting period.

* **Category 3 Measure(s):** IT – 1.11 Diabetes Care: BP control (<140/90mm Hg)

Reduced access to primary care physicians often prevents patients from seeking appropriate preventive care, especially for individuals with chronic conditions that require a more coordinated approach to managing and monitoring their ongoing needs. Expanding primary care capacity will result in patients being able to gain more access to care and also more timely access to care, avoiding long wait times for appointments. Chronic diabetes represents a significant challenge for the uninsured and Medicaid populations in Bell County, TX. This project will provide chronic disease management resource as a key indicator of the impact the project has on patients diagnosed with chronic diseases, SMCHH will collect and trend the blood pressure data of enrolled patients who have a diabetes diagnoses.

**Project Description:**

Seton Medical Center Harker Heights proposes to expand primary care capacity in order to increase the delivery of care and access to care for the patients of Bell County. It will keep individuals and families healthy and therefore avoid more costly ER and inpatient care. This project will expand primary care capacity in Bell County to better accommodate the needs of the 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. This project will provide more preventive, primary and chronic care in our community by expanding existing capacity. We propose to recruit and hire additional nurse practitioners, registered nurses and social workers. According to the U.S Census and Applied Geographic Solutions data, within our service population of over 300,000, we have both a high percentage of older adults (9%) and more low-income residents with the per capita income and the median income lagging both the Texas and U.S. averages. As found in other geographic locations with high percentages of low-income or high percentages of the elderly, our patients have high rates of chronic, but potentially preventable diseases such as diabetes, hypertension, and heart disease. Expanding primary care capacity for the Killeen community will provide additional access and services to the uninsured, underinsured, and Medicaid populations. Seton Medical Center Harker Heights’ project will improve access to primary care services and increase the volume of primary care visits that may otherwise have been treated episodically in an Emergency Department or other higher cost setting. Of the 4,492 primary care encounters this project anticipates providing, we believe 95% will serve Medicaid/indigent individuals.

*Goals and Relationship to Regional Goals*

Through our project, the primary care needs of patients will be better met, allowing them to receive the right care at the right time in the right setting. Achieving our project goals will improve access across the continuum of preventive, primary and chronic care and further increase efficiencies to maximize our current capacity.

**Project Goals:**

* Increase primary care capacity by hiring additional primary care providers
* Increase volume of primary care clinic visits for targeted population
* Reduce inappropriate utilization of the emergency department
* Reduce unnecessary health care expenses

This project supports the Region’s goals of providing patients with timely access to primary health care services in the most appropriate and cost-efficient settings, thereby improving patient outcomes and reducing acute care utilization.

**3 Year Expected Outcome:**

Seton Medical Center Harker Height plans to add 0.5 FTE nurse practitioner, 0.5 FTE registered nurse and 0.5 FTE social worker to better meet the needs of our patient population. In turn, this will provide the opportunity to better serve our target population with at least an additional 832 Nurse Practitioner and 416 Social Worker visits in DY3.

**Starting Point/Baseline:**

While the Greater Killeen Clinic had 3,030 patient visits in 2012, we will exclude these from our baseline data due to the providers included in this project are unrelated and will be entirely new. Only the volumes of these additional providers will be captured in our outcomes data. With this project the Greater Killeen Free Clinic intends to expand its primary care capacity and services to include care for chronic conditions in 2014.

**Quantifiable Patient Impact:**

Seton Medical Center Harker Heights will use HHSC’s recommended QPI (encounters) for this project. Each year we will seek to increase the number of patients that are receiving care in the Greater Killeen Free Clinic. Over the course of the project, we expect the total patient impact to be approximately 4,492 Nurse Practitioner total additional Primary Care visits (encounters) and 2,080 additional Social Worker visits (encounters), by the conclusion of Year 5 (DY3: 832 Nurse Practitioner encounters and 416 Social Worker encounters, DY4: 1,664 Nurse Practitioner encounters and 832 Social Worker encounters, and DY5: 1,996 Nurse Practitioner encounters and 832 Social Worker encounters). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-12, allowing us to establish the total number of visits (encounters) for the reporting period. Each year, we aim to increase the number of encounters at the greater Killeen Free Clinic, as measured by Milestone I-12, Metric I-12.1: Total number of visits (encounters) for reporting period.

**Rationale:**

Bell County is a designated Medically Underserved Area due to a shortage of primary care providers, high infant mortality, high poverty, and/or high elderly population (U.S. Department of Health & Human Services, Health Resources and Services Administration). The median household income in Bell County is $49,466 with approximately 15% of residents at or below the poverty level (U.S. Department of Health & Human Services, Health Resources and Services Administration). Low-income and elderly populations often lack resources for seeking medical care, are more likely to suffer from chronic disease conditions, and have been found to be more likely to use the emergency department for non-emergent care. These populations are also the most likely to benefit from an expansion of primary care capacity. With twice the amount of population per primary care providers than the national average, in a 2013 needs assessment Bell County participants listed access to care as the highest ranking health priority. One of the key themes that was repeatedly cited by survey respondents were the challenges to low-income patients accessing primary care. Per the Texas Medical Association, the number of Texas physicians accepting new Medicaid patients has declined by 36% from 67% in 2000 to 31% in 2012 (Bell County Community Health Needs Assessment, June 2013). Given the impact lifestyle choices have on chronic disease, lifestyle metrics are used to identify opportunities and needs; in Bell County, all of the healthy lifestyle metrics score below the desired national benchmarks (see the below table for an example) (Ibid).

|  |  |  |
| --- | --- | --- |
|  | **National 90th Percentile** | **Bell County** |
| Adult Smoking | 14% | 23% |
| Adult obesity | 25% | 29% |
| Physical Inactivity | 21% | 28% |

By increasing the overall primary care capacity, there are beneficial results like better health outcomes, improved patient satisfaction, more appropriate utilization of resources and reduced cost of services. Adding providers to increase access to primary care will play a key role in improved disease management and will better address the chronic care needs of many of our patients rather than episodic care. With an increase of providers in place we can focus on more primary care delivery and data driven care, using technology to assist us with models of care for conditions such as diabetes, hypertension, and heart disease. The following milestones have been chosen for our project based on the core components:

* P-5. Milestone: Train/hire additional primary care providers and staff
* I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

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

Currently, our community has insufficient access to primary care services placing a significant strain on our health care delivery system. By increasing the number of primary care providers this project will enhance our existing delivery system and provide much needed increased primary care capacity.

**Community need identification number addressed:**

* CN.1.6 Limited access to primary care for preventive services with same day or next day appointments and extended hours.
* CN.3.5 Discontinuity of care and limited awareness of available resources and services among indigent, uninsured and Medicaid populations in Bell County leads to potentially avoidable ED and hospital utilization.

**Project Core Components:**

Seton Medical Center Harker Heights’ project of expanding existing primary care capacity will meet the following required core project component:

*c) Expand primary care clinic staffing.* The recruitment and hiring of additional providers is the key component of this project. Within the overall intervention plan will be goals to ensure we are using the most appropriate strategies and resources in the recruitment/hiring of primary care providers.

Seton Medical Center Harker Heights’ project of expanding existing primary care capacity will not meet the following core project components:

*a) Expand primary care clinic space.*

*b) Expand primary care clinic hours.*

The Bell County Free Clinic in Killeen currently has space available for an increase in clinic staffing; therefore this project does not require expanding clinic space. And because the need during current clinic hours already exceeds available staffing, this project also does not require expanded clinic hours at this time. Instead, the increase of primary care staffing during current clinic hours will help mitigate the current demand for primary care services.

**Customizable Process or Improvement Milestones:**

By adding a 0.5 FTE clinic social worker Seton Medical Center Harker Heights will increase the volume of visits and improve access for patients seeking social services. As this service is a different scope than the traditional primary care encounter, we will use a customizable milestone (I-X.1) to capture these visits. In DY5, for example, Seton Medical Center Harker Heights will provide 832 social services visits. The description of this milestone is: total number of additional social services encounters provided.

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

IT – 1.11 Diabetes Care: BP control (<140/90mm Hg)

Reduced access to primary care physicians often prevents patients from seeking appropriate preventive care, especially for individuals with chronic conditions that require a more coordinated approach to managing and monitoring their ongoing needs. Expanding primary care capacity will result in patients being able to gain more access to care and also more timely access to care, avoiding long wait times for appointments. Chronic diabetes represents a significant challenge for the uninsured and Medicaid populations in Bell County, TX. This project will provide chronic disease management resource as a key indicator of the impact the project has on patients diagnosed with chronic diseases, SMCHH will collect and trend the blood pressure data of enrolled patients who have a diabetes diagnoses.

**Relationship to Other Projects/Regional Goals:**

Many of the projects in this region are related to expansion of care and improving access to care. This project’s focus on expanding care will support and enhance these Category 1 projects in our RHP:

* 183086102.1.1 - Expand existing primary care capacity
* 020957901.1.1 - Expand existing primary care capacity
* 126936702.1.1 - Expand existing primary care capacity

A portion of this expanded primary care will be used to support the patient navigator program, which is another performing provider’s project in RHP8.

**Plan for Learning Collaborative:**

Seton Medical Center Harker Heights will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. Participation in these learning collaborative meeting events, as well individual training opportunities, regional spotlights and routine collaborative communications in the region, will allow Seton Medical Center Harker Heights to work with other Providers within this specific project area or with similar targeted outcomes in an effort to share what we are doing, what we are learning, and how we might all leverage this shared information to continually improve and benefit the projects. The results of each learning collaborative meeting will be compiled and disseminated electronically to the entire RHP within 30 days after the meeting and will be archived on the RHP website hosted by the anchor ([www.tamhsc.edu/1115-waiver](http://www.tamhsc.edu/1115-waiver)).

In addition, opportunities may exist and will be explored for Seton Medical Center Harker Heights to interact with providers in other RHPs who may have an expansion of primary care focus to expand learning and quality improvement initiatives. Additionally, Seton Medical Center Harker Heights looks forward to participating in HHSC’s statewide learning collaborative activities as available.

**Project Valuation:**

SMCHH’s project valuation takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Expanding clinic staffing at the Killeen clinic will provide greater access to care to people who previously utilized ED services for non-emergent health care needs. The 175 non-emergency patients that visited the ED in 2012 and 2013 would have been better and faster served if they had easier access to additional primary care providers. By assisting this population in navigating the health care system and connecting them to a primary home rather than utilizing the ED results in significant cost savings to hospitals in the community. Patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental health services. In 2013, SMCHH experienced over 500 non-emergent visits in the ED, with each visit having an associated charge of $350. Redirecting those patients would provide a cost savings of over $175,000 in the ED. Considering that government payers comprise 60% of total ED utilization; this program would result in reduction of nearly $105,000 to State and Federal payers. Additional cost savings would unquestionably be realized as a result of increased primary care staffing, through early detection and prevention of chronic illnesses, and as a result, reduce the need for emergent care services or patients’ perceived need for emergent care services. Furthermore, the project seeks to accomplish delivery system reform by understanding that clinical primary care providers are in a shortage in this community and additional financial support is needed in order to maintain and expand the availability of primary care services. The systemic cost of providing health care to the community will be reduced in the aggregate by making this investment in local primary care access.

**Category 1 Project Narrative**

**St. David’s Round Rock Medical Center – 020957901.1.1**

**Project Area, Option and Title:** 1.1.2Expand Existing Primary Care Capacity

**RHP Project Identification Number:** 020957901.1.1

**Performing Provider Name:** St. David’s Round Rock Medical Center

**Performing Provider TPI #:** 020957901

**Project Summary:**

* **Provider Description:** Round Rock Medical Center (RRMC) is a 173 bed hospital located in Round Rock serving the Williamson and Travis County communities representing approximately 2,100 square miles and a population of approximately 1.5 million.
* **Intervention:** This project entails RRMC expanding the availability of primary care services to a targeted low-income population in Williamson County that does not have existing health coverage, by paying existing local clinics and/or FQHCs to provide services to the population.
* **Project Status:** This project represents a new initiative for RRMC.
* **Project Need:** CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL. In Williamson County, 16.5% of adult residents are uninsured (See Table 3-3). These patients often use hospital emergency departments (EDs) as their primary source for care and, between 2006 and 2010, Williamson County had almost $327 million in charges for Potentially Preventable Admissions (see Table 3-6). Low-income patients in Williamson County have a need for expanded availability of primary care services, which will only occur if primary care physicians are willing to see these patients. The only FQHC in Williamson County that accepts indigent patients currently, Lone Star Circle of Care, is at capacity for adult patients and has a three-four week waitlist for appointments.
* **Target Population:** The target population for this project is Williamson County residents who are uninsured or underinsured, can demonstrate income levels at or below 200% of the Federal Poverty Level, and do not have any source of payment such as existing public assistance programs. RRMC anticipates this will represent approximately 3,000-5,000 individuals, all of whom are low-income. This project will also benefit Medicaid and low-income patients who do not qualify for the program indirectly, by reducing utilization of EDs within the region and thereby increasing access for these other patients. Based on current volumes and patient demographics, RRMC provides between an estimated 40,000 to 45,000 distinct encounters of care in its ED annually, of which an estimated 40% to 45% represent Medicaid or low-income patients, which RRMC expects to increase over time.
* **Category 1 or 2 Expected Project Benefit for Patients:**In DY2, RRMC will establish a baseline for availability of these services and develop an implementation plan regarding eligibility determinations, partnering with local providers, and putting the program into action during DY3. In DY3, this project seeks to increase the number of service hours available in at least one participating clinic by 5 hours per week over DY2, and to implement the primary care expansion program by enrolling eligible patients and providing enrolled patients with at least 3096 primary care visits. During DY4, RRMC expects to provide enrolled patients with at least 3870 visits, and in DY5 RRMC expects to provide enrolled patients with at least 4834 visits (totaling 11,800 visits between DYs 3-5 provided through this project).
* **Category 3 Outcomes:** IT-9.2a: RRMC’s goal is to improve (i.e. decrease) the rate of Emergency Department visits per 100,000 out of all uninsured individuals age 18 years and older eligible for ED encounter to its facility in Region 8, St. David’s Round Rock Medical Center, and RRMC aims to demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5..

**Project Description:**

*Community Clinic Services Project*

RRMC wishes to expand the availability of primary care services to a targeted low income population in the Williamson community that is currently uninsured or underinsured and does not qualify for existing public assistance programs but still meets the following income thresholds: at or below 200% FPL and has no other payment source (“working poor”). RRMC also sees the potential to add specialty physician services, pharmacy services and laboratory services as necessary based on an assessment of the population that utilizes these primary care services. RRMC plans to expand the availability of these primary care services by paying existing local clinics and/or FQHCs in Williamson County to provide services to this population, and potentially by partnering with clinics and FQHCs in other communities to expand their services into Williamson County. A “visit” for the purposes of measuring the success of this project will be defined as: “a face-to-face encounter by an eligible patient with a mid-level provider or physician, resulting in screening, diagnosis and/or treatment, as appropriate.” The Williamson County and Cities Health District (District) will provide infrastructure and resources to assist in the delivery of care to the population RRMC wishes to serve.

**Goals and Relationship to Regional Goals:**

The goal of this project is to improve health outcomes and access for the target population by allowing them to receive the right care in the right setting and to help address the current challenges for these patients. Specifically, these patients often do not receive primary and preventative care from the current health care safety net in Williamson County and, as a result, miss the opportunity to obtain early screening and treatment for conditions that can be managed and/or prevented with proper early intervention. The consequence of this lack of care is that these patients suffer from worse short- and long-term health outcomes and quality of life, while the end cost of treating their conditions to the health care system is increased, as the patients will likely end up in the emergency department (ED) or admitted to the hospital if and when their conditions become acute.

**Specific Project Goals:**

* A 5-hour increase in service hours in at least one participating clinic over the baseline established in DY2 – RRMC believes that increasing the hours of availability will allow local clinics to see new patients, both because some patients cannot access clinics during normal business hours and because some patients cannot obtain appointments due to local clinics being at or above their current capacity. A fivehour increase in available hours per week in at least one clinic is intended to provide meaningful change while being realistic in consideration of the resources available in the community.
* Provide the target population with 3096 primary care visits through participating providers in DY3; 3870 visits in DY4; and 4834 visits in DY5. RRMC is targeting an increase in the volume of uninsured, working-poor patients seen at local clinics because RRMC believes more primary care will result in improved patient outcomes and reduced systemic costs for treating these patients. The targeted increases in patient volume and primary care visits will create a meaningful impact on the community (health- and cost-wise) and is a realistic goal in light of current capacity and resources.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing the proportion of residents with a regular source of care;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

Expected challenges in implementing and maintaining this project include: identifying providers willing to serve this population on top of the current population they serve; allocation of resources in the most efficient manner to reach the maximum number of underserved patients; patient education on the availability of services; and eligibility screening. RRMC expects to address these challenges by effectively leveraging existing primary care capabilities to create additional capacity to treat a new population of patients.

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

RRMC expects this project to result in increased primary care access for a currently underserved patient population. The increased primary care access should result in increased hours of availability by providers, increased patient encounters, and increased volume of patients, which will ultimately allow providers to more effectively manage and/or prevent the onset of chronic conditions linked to poor lifestyle, lack of medication management, or lack of early intervention. The new patients seen in the existing clinics are expected to experience improved short- and long-term health outcomes, greater satisfaction with the healthcare system, great quality of life when managing chronic diseases, and a reduction in the misuse of the ED for primary care (which will reduce the systemic cost of providing healthcare for the Region).

**Starting Point/Baseline:**

Currently, Williamson County uninsured, indigent patients only have local access to care through Lone Star Circle of Care, which is a local FQHC. Lone Star is currently at capacity for adult patients and has a three to four week waitlist for appointments. The District and other local providers have already screened over 2000 Williamson County residents who may be eligible to enroll in this program, thereby allowing them access to primary care visits with participating providers.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 - Limited access to primary care
* Specific Community Need: CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL.

From a population perspective, 16.5% of Williamson County’s adult residents are uninsured and 10.7% of children are uninsured (RHP Plan, Section III, Table 3-3), 5.5% live below poverty levels (RHP Plan, Section 3, Table 3-1), and 7.4% are unemployed. These groups have very little access to primary and preventative care, especially in circumstances where their household income is slightly above the thresholds for existing public assistance programs in the County.

Between 2006 and 2010, Williamson County had $326,889,520 in charges for Potentially Preventable Admissions Hospitalizations (RHP Plan, Section III, Table 3-6) with especially high rates of PPAs for angina, bacterial pneumonia, COPD, diabetes, and urinary tract infections (RHP Plan, Section III, Table 3-6). Each of those conditions can be either prevented or managed through regular access to primary health care, and avoiding hospitalization will benefit both patient outcomes and systemic healthcare costs. Specifically, these conditions can be prevented or managed with proper screening, intervention, patient education, and monitoring by primary care providers. It is imperative for improving Williamson County’s overall health outcomes that underserved patients have access to primary care services. The District will assist in the provision of care to these patients by working with participating clinics to track the number of targeted patients served by this project, the number of visits provided to targeted patients, and to obtain documentation of increased hours at participating clinics. This project will seek to treat patients who are unable to receive primary care elsewhere, which will improve patient health outcomes and reduce the overall cost of treating these patients.

**Core Project Components:**

Project area 1.1.2 includes three core requirements: a) expand primary care clinic space, b) expand primary care clinic hours, and c) expand primary care clinic staffing. However, Section IV of the CMS-approved Planning Protocol allows providers to exclude core requirements if justified in the project narrative. With this project, RRMC envisions the local clinics with which it partners will necessarily expand their available hours to see additional patients, and RRMC will meet that core requirement with this project. However, RRMC does not intend to expand the physical clinic space available in the community, or to add additional clinical staff as a milestone, but RRMC will require contractors to maintain adequate staff levels in order to meet the needs of the patient population served by this program. This project is intended to make use of existing clinic space and staffing in the community and expand the population treated by the existing staff in the existing space. By using existing primary care clinic settings, the need to achieve the core component of expanding clinic space is unnecessary. Participating clinics will be selected based on the accessibility for population served and willingness to provide an increased number of patient visits annually.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** RRMC does not receive funding from other U.S. Department of Health and Human Services initiatives that would be used for this project.

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

OD – 9: Right Care, Right Setting

* Process Milestones: P1, P2
* Improvement Target: 9.2a – Emergency Department (ED) visits per 100,000

Expanding primary care is intended to improve patient health outcomes and satisfaction and transform the delivery system in a manner that reduces the institutional cost of providing healthcare to the indigent community. A large portion of the high cost of healthcare stem from inappropriate use of the ED, which is often the first and only destination for indigent patients seeking primary care services. RRMC intends for this project to give indigent patients currently unable to afford primary care an easier, earlier, and more appropriate setting in which to obtain the care they need. As a result, RRMC’s goal is to improve (i.e. decrease) the rate of Emergency Department visits per 100,000 out of all uninsured individuals age 18 years and older eligible for ED encounter to its facility in Region 8, St. David’s Round Rock Medical Center, and RRMC aims to demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5.

The baseline rate established in DY3 was 16.51%. RRMC’s baseline measurement period established in DY3 was 10/01/2012–09/30/2013.

**Relationship to Other Projects:**

Category 4 population focused measures: This project should impact RD1 (Potentially Preventable Admissions), RD2 (30 day readmissions), and RD4 (Patient-centered Healthcare).

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

This project relates to other RHP 8 projects performed by the District, including:

* 126936702.1.1 Expanded Capacity to Access to Care;
* 126936702.1.2 Expand Access to Urgent Care and Enhance Urgent Medical Advice;
* 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data; and,
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

Utilizing a multi-disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our service area in the community, we can work to link residents to needed resources (i.e. medical home, programs that will promote a healthy lifestyle), assist with their preventive health needs, and capture the data necessary to identify community needs. Additional access to this type of primary care would reduce the elevated costs associated with urgent and emergent care services by allowing earlier screening, diagnosis, treatment and/or management, before the condition reaches the level that necessitates a higher level of care.

**Project Valuation:**

The valuation of each RRMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. RRMC considers this project as high need because local providers have already screened over 2000 residents in the community who are currently without primary care access and may be eligible for this program—through which these patients will experience improved health outcomes and providers will experience a reduction in the rate of this population misusing emergency departments for primary care services. Assisting this population in navigating the health care system and connecting them to a primary care home rather than utilizing the ED results in significant cost savings to hospitals in the community. In addition, the return on investment for serving this population will also result in fewer number of work hours missed, which in turn increases productivity and economic values. Furthermore, the project seeks to accomplish delivery system reform by understanding that clinical primary care providers are in a shortage in this community, the existing wait time for a primary care visit is more than 9 days, and additional financial support is needed in order to maintain and expand the availability of primary care services. The systemic cost of providing health care to the community will be reduced in the aggregate by making this investment in local primary care access.

**Category 1 Project Narrative**

**Williamson County & Cities Health District ‐ 126936702.1.1**

**Project Area, Option and Title:** 1.1.2 Expanded Capacity for Access to Care

**Unique Project ID:** 126936702.1.1

**Performing Provider Name:** Williamson County & Cities Health District (WCCHD)

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description**: Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** This project will expand capacity of access to preventive clinical care through availability of same day or next day appointments by increasing the number of healthcare professionals and extending hours.
* **Project Status:** This project is an expansion of an existing initiative and will add a total of 9,000 encounters in addition to the current 10,000 encounters by the end of DY 5.
* **Project Need:** CN.1.6 – Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County. Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day clinical services refers to those focused services for which access to walk‐in or same day appointments is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: Pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening /immunization. WCCHD currently has one nurse per site, limiting the maximum number of appointments and walk‐in patients able to be seen on any given day. With the limited number of appointments offered and the wait time of 3‐4 weeks for a new patient visit to the local FQHC, patients are using the Emergency Department (ED) for preventable health services.
* **Target Population:** The target population of this project is approximately 80,000 uninsured or underinsured patients in need of preventive clinical services which also includes pregnancy confirmation offered through extended hours with same or next day appointment and/or walk‐in basis. There were approximately 10,000 preventive health services delivered at WCCHD in 2012. Approximately 50% of our current patients are either Medicaid eligible, low income uninsured or indigent, so we expect them to benefit from about half of the proposed project’s services.
* **Category 1 or 2 Expected Project Benefit for Patients:** A pre-DSRIP baseline of 10,000 encounters was established in 2012. By adding additional same or next day appointments and increasing health care personnel, the project seeks to provide 13,000 encounters in DY4 (3,000 over baseline) and 16,000 encounters in DY5 (6,000 over baseline (see Improvement Milestone I‐12.1).
* **Category 3 Outcomes:** The following category 3 measures have been approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-15.6 (Chlamydia screening in women).
  + IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by clients seen at any one of the WCCHD Public Health Centers (facility subset).
  + IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years old who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Includes patients seen at any one of the WCCHD Public Health Centers (facility subset).
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. Approximately 75,000 individuals are identified as uninsured in Williamson County. Increasing the capacity for access to primary care services where no public transportation is offered, will address a key need that currently exists in the region. Barriers to care lead to delayed care, overutilization of EDs for preventive health needs, and preventable hospitalizations. WCCHD feels that there is a direct correlation between expanded capacity for access to care, improving utilization rates of clinical preventive services, and improved patient satisfaction by having increased capacity to offer an appropriate level of care in at a timely manner, we will be able to improve utilization rates of clinical preventive services in our targeted population. Those patients should be able to report that their needs were met in the primary care setting (not necessitating care at an inappropriate level setting), which will have further positive impact on the medical community by reducing uncompensated care costs.

**Project** **Description:**

*Clinical Prevention Program ‐ WCCHD proposes to expand capacity and access to same day clinical preventive services and care through a) extended service hours and b) enhanced scope of services through expansion of clinic staffing.*

Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day or next day appointments for preventive clinical services refers to those focused services for which access is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening/ immunization. To achieve maximum coordination with medical homes in FQHCs or private practices and benefit appropriate emergency department (ED) utilization, expansion of hours, staff and scope of care is needed, as well as leveraging the IT infrastructure, to allow coordination of this care in and among the medical neighborhood. In contrast to the related St. David’s Medical Center – Round Rock (RRMC) RHP 8 project, our project is focused on preventive health services (i.e. screening, counseling) for any uninsured or underinsured individual, while the RRMC is primarily focused on acute care for individuals under 200% of the FPL. WCCHD will not serve as a medical home; rather, we will complement the continuum of care received in other settings. By offering the availability for same day or next day services that do not require a physician, clients will be diverted to our offices rather than utilizing EDs for these types of services. In addition, women with positive pregnancy tests will also be counseled and connected to a medical home to ensure access to care within the first trimester.

WCCHD currently has one nurse per site, limiting the maximum number of appointed and walk‐in clients able to be seen on any given day. Nursing services are currently available 32 hours per week. With this project, increasing staff will allow us to add nursing services outside of business hours and through the lunch hours, for a total of 40 nursing service hours per site.

This would enable client access to health services through the lunch hour and into the evening. Recent pilots of enhanced weekday hours have documented patient approval because of accessing same day service and/or next day appointments.

We plan to continue our current services (pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; STIs screening and expedited partner therapy and vaccine preventable disease screening/immunization), but also add on new services including well woman exam, adolescent well child care, tobacco cessation counseling, adult physicals, sport physicals, and annual wellness visits. These new services will enhance our scope of services. By expanding our services through employing two nurse practitioners and a physician, the patients will have access to much broader preventative medicine services. These visits will be much more in depth and provide an entry way into our health clinics that was not previously present. The patients will be able to get their full preventative medicine needs met with immunizations, history, physical exam, lab tests, diagnosis and treatment for any newly diagnosed disease states, while also preventing serious disease. We will be able to screen for diabetes, hypertension and cancer using USPTF guidelines. We will be able to identify and treat tobacco addiction. While we do not plan to provide acute care, we will be able to, in most cases, address issues related to a patient’s present medical state without seeking outside care. This will prevent ER visits, by dealing with the issue in the clinic, and avoiding instances where the nurse would need to send the patient to the ER because the issue was beyond what a nurse would be able to handle on his or her own. The nurse practitioner and physician will be able to cover extended hours when appropriate to capture the additional patients who would not normally be able to come in during normal working hours.

In addition to providing clinical preventive services, this project would also offer more same‐ day appointments and walk‐in services for women seeking pregnancy confirmation. In this integrative model, staff will ensure that clients receive coordinated, timely, culturally competent and appropriate health care services and/or referrals, assist in communicating and coordinating health care services with the client’s medical home to avoid inappropriate usage of EDs for primary/preventive health services. Staff will provide care coordination, when applicable, to ensure early entry into prenatal care and establishment of a medical home. Consequently, over the next four project years, it is anticipated that improved access to same‐day or next day services will significantly increase enrollment into prenatal care within the first trimester, and decrease the number of clients seeking to use an ED or urgent care facility for preventive health services.

**Goals and Relationship to Regional Goals:**

In alignment with the regional goals of improving access to timely, high quality care and reducing inappropriate utilization of urgent and emergent services, the goals of this project are:

**Project Goals:**

* Increase access points to care;
* Increase availability of same day and next day appointments;
* Offer enhanced level of preventive health services; and
* Pregnant women accessing care within the first trimester.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing the proportion of residents with a regular source of care;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

Health disparities exist in this community, specifically among minority women of child‐bearing age. Recent Williamson County data collected by WCCHD Epidemiology staff suggest that fewer minority women, specifically Hispanic women, seek prenatal care in the first trimester than their non-Hispanic counterparts. From 2009‐2010, for example, 64.3% of Hispanic women were reported to have had prenatal care in the first trimester in contrast to 68.7% Black women and 85.7 % of white non-Hispanic women. Although this is an improvement over the previous two years (51.4% of Hispanic women, 54.6% Black women, and 75.9% of White women are reported to have had prenatal care in the first trimester in 2007‐2008), evidence suggests that women, overall, and specifically Hispanic women, still need better connection to prenatal care. Furthermore, over the past year, financial cutbacks and the subsequent loss of healthcare settings which offered primary women’s health services, have led to further limitations in this area of primary care. Thus, women are seeking care for preventable women’s health services through urgent and emergent care settings.

We realize that one primary reason that people delay accessing care is the difficulty navigating program eligibility. Many clients are overwhelmed with navigating the health care system, thereby giving up or seeking care through an inappropriate level of care (such as an ED). By incorporating a patient navigator in each of our Public Health Centers, clients who access health services at our agency can be directly referred for a quick eligibility screening for internal and external programs and application assistance. Furthermore, in regard to scope of services, our current healthcare professionals on staff, specifically nurses, have a limited scope of practice, limited to screening and treatment under standing delegation orders which precludes them from being able to provide more comprehensive care to symptomatic clients seeking clinical preventive health services.

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

The goal is to consistently define and redefine gaps and needs and increase client access to preventive health services by 10% each project year, beginning DY4.

**Starting Point/Baseline:**

Currently, WCCHD serves as a safety net for the community in the provision of a number of preventive health services. There were approximately 10,000 client encounters for such services in 2012. There are five full‐time nurses and one hourly nurse in the entire health district delivering these types of direct care services.

According to the WCCHD Annual Service Report, from 2009 through 2011, there were an average number of inquiries into the Healthcare Helpline equaling 4,421 contacts by 3,354 persons. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of clients who do not have health insurance coverage, according to the 2012 Community Health Rankings and Roadmaps. This is clear evidence of the need for linkage to healthcare resources through expansion of services within our agency. With the recent loss of some of this county’s Title 10 and Title 20 clinics, the lead time for new patient appointments at the local FQHC is 3‐4 weeks. Clients may not be admitted sooner based on more immediate needs, delaying treatment or leaving no option for them but to seek care at an urgent or emergent care setting.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 ‐ Limited access to primary care
* Specific Community Need: CN.1.6 ‐ Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care or outpatient setting. This often results in more costly, less coordinated care, a lack of appropriate follow‐up care and missed opportunities. Patients who experience barriers in accessing primary care services due to lack of transportation, cost, lack of assigned provider, physical disability, and/or inability to receive appointments in a timely manner are those who benefit from and utilize same day and walk‐in services to greatest advantage. The fact that the local FQHC lead time for new patients is 3‐4 weeks demonstrates that the need for preventive health services exceeds the current capacity for primary care. Many WCCHD clients access services by taking advantage of the flexibility of our walk‐in hours and an increasing number of clients are taking advantage of our extended hours for preventive health services. WCCHD has only been doing evening hours for just over a year and these clinics have been well‐ attended, especially in our high‐volume sites (Round Rock and Cedar Park). Patients relay their gratitude for these services being offered outside of business hours, as it prevents them from having to take time off of work, which is sometimes a luxury they cannot afford. According to data obtained from 30,714 patients surveyed for the Medical Expenditure Panel Survey between 2000 and 2008, patients with access to care during extended hours reported less use and lower associated expenditures for office visits, prescription medications, ED visits, and hospitalizations (10.4% lower for the group with access to extended hours versus the group without such access). This was reported the September 2012 issue of the *Annals of Family Medicine* (*Ann Fam Med*. 2012; 10:388‐395). By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services (see Related Category 3 Outcomes).

**Core Project Components:**

Our goals address two of the three core components of this project: *expansion of primary care clinic hours and expansion of primary care clinic staffing*. With our Public Health Centers located in the heart of four of our major cities in the county, we offer close proximity for our clients that need to access our sites. Health Services, WIC, and social services are co‐located within each of our Public Health Centers. This is designed to allow the clients to access various services at one location, keeping in mind that they are more likely to follow‐through with care/referrals, when related services are more immediately available. Although *expanding outpatient primary care clinic space* is a core component of this project area, WCCHD does not believe expanding physical clinic space is the best use of resources at this time. Instead, the agency will re‐purpose existing space to accommodate increased staff and client volume. Since the goal of the Waiver is to reform health care in a cost‐effective manner, we feel that we can accommodate the increased clinic volume within existing space, and believe our clients are better served by investing project dollars in increased staffing (thereby allowing us to serve our clients more hours each weekday) and enhancing the delivery of care by adding mid‐level providers to our staff.

Clients currently seek services at urgent and emergent care settings, for conditions that could be managed or treated through a primary care setting. Many of these clients presenting to these facilities could have avoided that route, had the client sought access to care sooner. Reasons for this delayed entry into care may include: cost, desire for anonymity, lack of transportation, or the inability to receive appointments in a timely manner. By expanding service hours, increasing staffing, and offering an enhanced level of services at all four Public Health Center sites, clients may have increased access points to care, and become more aware of preventive health services available at an appropriate level of care. Consequently, earlier access to care can prevent inappropriate usage of our hospitals and urgent care settings, thereby decreasing uncompensated care costs.

* Williamson Burnet County Opportunities 2011 Community Needs Assessment:

<http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf>

* Community Health Profile of Williamson County Precincts (2011)

<http://www.wcchd.org/statistics_and_reports/>

* Central Texas Sustainability Indicators Project‐2009 Data Report:

<http://www.centex‐indicators.org/annual_rept/ar2009.pdf>

* County Health Rankings (2012)

[www.countyhealthrankings.org](http://www.countyhealthrankings.org/)

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** WCCHD does not receive U.S. Department of Health and Human Services program initiative funds which would be associated with this project.

**Related Category 3 Outcome Measure:**

The following category 3 measures have been approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-15.6 (Chlamydia screening in women).

* IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by clients seen at any one of the WCCHD Public Health Centers (facility subset).
* IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years old who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Includes patients seen at anyone of the WCCHD Public Health Centers (facility subset).

Reasons/rationale for selecting the outcome measure:

This particular domain was chosen to help evaluate this project’s interventions. As mentioned above, our goal is expanded capacity to access primary care. By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention, and a positive impact on the community. As we do not currently capture this data on our client survey, we will perform a needs assessment DY2, so we can select a tool that will help us best capture all data in this domain. In DY3, we will be continuing to perform project planning activities, establishing a baseline for patient satisfaction. Simultaneously, we will have had time to increase staff and begin offering an enhanced level of services at all four sites. These interventions will have allowed us to begin increasing service hours, ultimately increasing access points. Meeting the needs of the clients in the primary care setting for preventive health services will decrease the possibility of their needing to seek care at an urgent or emergent care setting. Furthermore, this particular domain is centered on patient satisfaction in getting timely care, appointments, and information. Our second outcome addresses the rate of chlamydia screenings as an indicator of improved access to preventive health services. Once the DY3 baseline is established, we will then set improvement targets based on the QISMC standards.

**Relationship** **to** **Other** **Projects:**

This project relates to all other WCCHD projects, including:

* 126936702.1.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non‐emergent conditions and increase patient access to health care;
* 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data;
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
* 126936702.2.2 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

Utilizing a multi‐disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our clinics, and out in the community, we can work to link residents to needed resources (i.e. medical home, programs that will promote a healthy lifestyle), assist with their preventive health needs, and capture the data necessary to identify community needs. WCCHD seeks to remain easily identifiable as the local health department, with the understanding that the role of this agency is to protect and promote the health of the community, and prevent illness. The identification of and addressing of health disparities in the community follows the essential public health services that this agency strives to deliver. Conditions that lead to preventable urgent and emergent care utilization are conditions that could be screened, treated, and/or managed by a mid‐level provider in the community (i.e. STIs, pregnancy confirmation). Additional access to this type of primary care would reduce the elevated costs associated with urgent and emergent care services by allowing earlier screening, diagnosis, treatment and/or management, before the condition reaches the level that necessitates a higher level of care.

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

We realize that our community’s needs are not unique. Other communities within the RHP face similar issues in addressing the preventive health needs of their residents. Therefore, we anticipate that other projects will be developed and implemented to address these needs. It is the hope that in collaborating with other performing providers in this region working on similar projects, we can share our ideas, challenges, and successes. Conference calls and periodic meetings will be held, and newsletters will be distributed regularly to share progress of the projects and data related to interventions.

**Project Valuation:**

The valuation of each WCCHD project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. In 2012, 10,000 preventive health services were delivered by WCCHD, with approximately 370 clients presenting for STD services. The cost of treating STDs in EDs can be six times higher than treating in a primary care setting. Hospitalizations from complications of untreated or undertreated infections can cost 12 times higher than if having been identified and treated in a primary care setting. Providing timely, well‐informed care, at the appropriate level and setting for targeted population will redirect them from unnecessary use of urgent and emergent care facilities. The ability to access theses services at an appropriate and affordable level of care will consequently reduce the amount of associated uncompensated care costs encountered through delivery of services to targeted population.

Overall, the project seeks to accomplish delivery system reform by understanding that there is a shortage of clinics that provide preventive health services in this community; that due to this shortage, the average wait time for a new patient can be three weeks or longer; and that in order to fill in this gap in care, additional funding sources and support is needed. Moreover, the diversion of inappropriate non‐emergent care services through urgent and emergent care facilities, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. The value cost of this project, including Category 3, for DYs 2‐5 is estimated at $4,483,549 which is an added savings of over $4,000,000 when compared to the costs of ED visits.

**Category 1 Project Narrative**

**Williamson County & Cities Health District - 126936702.1.2**

**Project Area, Option and Title:** 1.6.2Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care

**RHP Project Identification Number:** 126936702.1.2

**Performing Provider Name:** Williamson County Cities and Health District

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** This project will implement Community Paramedicinein rural communities as an expanded scope of practice which will increase access to proactive health care, provide timely, well-informed care, appropriate transports and referrals which would prevent the cycle of accessing Emergency Medical Systems (EMS) for non-emergent events, leaving EMS to handle emergent needs.
* **Project Status:** Community Paramedicine is a new project.
* **Project Need-Community Need Area:** CN.1. (2, 3, 6 & 7) – Limited access to primary care: This project would increase access to primary care for individuals who reside in the rural areas of Williamson County with limited or inadequate access to care. In FY2012, 11,683 calls to EMS were identified for service that were generated from outside of an incorporated city and considered to be in the rural areas of the County. Of these calls, it is estimated that 40% of these events were generated as a result of the patient needing access to primary health care and were not related to an immediate life threatening emergency. Williamson County does not have a public transportation system and individuals living in the targeted rural areas of the county in need of health care for their chronic condition most often utilize the EMS system for transportation to a hospital.
* **Target Population:** Currently, a Community Paramedicine program does not exist for residents of Williamson County; however the initiative has the potential to reduce the established baseline approximately 6-10% for non-emergent responses in rural areas of the county which equates to approximately 470 responses. The target population is Medicaid-eligible, low income uninsured and indigent patients residing in rural areas with limited health care resources and diagnosed with a chronic condition.
* **Category 1 or 2 Expected Project Benefit for Patients**: This project seeks to establish a baseline in DY3. The baseline is anticipated to be 2,000 patient encounters in DY3. Our goal is to increase our baseline by 10% in DY4 or 200 additional patient encounters and 20% in DY5 or 400 additional patient encounters (see Improvement Milestone I-17.1). Benefit for the patients includes improved access to care, linking to a medical home, empowering and educating them about their chronic condition and appropriate utilization of their medical care.
* **Category 3 Outcomes:** IT-3.2 – CHF 30-day Readmission Rate: In DY4 and DY5, we will report the readmission rate among 45-80 year olds with index admission for Congestive Heart Failure (CHF) at hospitals participating in the Health Information Exchange (HIE). This includes the St. David’s hospital system and Seton hospital system. Reported numbers will reflect readmissions within the same hospital system only. In DY5, we will demonstrate improvement by completing Stretch Activity 4 (SA4) – Emergency Department Improvements.
  + - **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. Our goal is to expand our scope of practice providing outreach to underserved areas, educating the community about available resources for primary healthcare and identifying individuals with chronic health conditions. This will redirect patients to the appropriate types of services and building partnerships with local hospitals and agencies.

**Project Description:**

*Community Paramedicine – Improving, Expanding & Delivering Healthcare to Rural Communities*

This project would increase access to healthcare for individuals who are uninsured or under insured and reside in the rural areas of Williamson County with limited or inadequate access to primary health care. WCCHD proposes to incorporate the use of a team consisting of Paramedics, clinical support, education staff and medical direction to provide early primary medical assessment for those with limited access to care. In addition to primary care and preventive services, emergency medical services (EMS) are identified as crucial link in the chain of care. EMS, which includes basic and advanced life support, ensures that all persons have access to rapidly responding, pre-hospital EMS. WCCHD recognizes Community Paramedicine as an expansion of delivering healthcare services to rural communities and as a connection to an infrastructure in appropriate medical direction and system follow up. The landscape of healthcare is continuously evolving to becoming a more effective utilization of appropriate level of health care rather than the current system of using emergency departments (EDs) for primary and/or preventive care services.

WCCHD will position Community Paramedics in rural areas of the County on a scheduled and pre-determined basis to screen patients for chronic conditions such as diabetes, hypertension, obesity, congestive heart failure risk factors, and chronic respiratory risk factors. Positioning the team in rural areas identified with limited access to care, will reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care. In addition, the team will be trained to recognize possible risk for prescription drug interactions, monitor medication compliance, and provide diet counseling with the oversight and coordination of the patient’s primary care physician.

Services provided by the Community Paramedicine team will include:

* Coordinating appropriate level of care;
* Facilitating follow-ups after discharge from hospital;
* Educating on when and how to access emergent and non-emergent services;
* Positioning team and Peak Demand Unit in underserved areas; and
* Community outreach and building partnerships with local hospitals and agencies.

According to the Computer Aided Dispatch (CAD) system, 11,683 calls were identified for service during FY2012 that were generated from outside of an incorporated city and considered to be in the rural areas of the County. Of these calls, it is estimated that 40% of these events were generated as a result of the patient needing access to primary health care and were not related to an immediate life-threatening emergency. The Community Paramedicine project has the potential to reduce the established baseline approximately 6-10% for non-emergent responses in rural areas of Williamson County.

In addition to the CAD system data, the *Williamson County Community Profiles* identifies rural areas with targeted zip codes in having a higher rate of hospitalizations for chronic conditions such as Diabetes and Asthma as compared to the State rate. For example, in zip code area 76574 the hospitalization rate for diabetes was 22 per 10,000 population. The State rate was 16 per 10,000 population. Targeted zip codes identified are:

|  |  |  |  |
| --- | --- | --- | --- |
| 76574 | 76527 | 76537 | 76578 |
| 78634 | 78664 | 78641 | 78681 |

**Goals and Relationship to Regional Goals:**

This project works to apply best practices and continuous quality improvement by reaching out to the underserved areas of the county. The Community Paramedicine Program will use a patient-centered and coordinated care navigation model which will improve appropriate and timely access to healthcare.

**Goals:**

* Reduce unnecessary emergency department visits;
* Reduce non-emergency EMS calls for service and help direct those in need to the appropriate care through available resources and case managers;
* Increase the number of patients connected to a medical home; and
* Decrease the rate of hospitalizations for targeted population as a result of their chronic condition.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing the proportion of residents with a regular source of care; and
* Reducing inappropriate utilization of services.

**Challenges:**

The primary challenge will be reaching out to the appropriate residents in need of these specific services and maintaining contact throughout the system. Next, identify the needs and match the appropriate resources to provide the necessary education and alternative ways to access the system specific to their needs. Lastly, correlate all the data, so we can improve our delivery of service and find other ways to achieve objectives in a fiscally responsible manner. Through appropriate level of training in health literacy, medication management, care coordination, cultural competency, and involvement of hospitals, the team can address the needs and resources to facilitate patient and provider engagement.

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

WCCHD expects to see improvements for this expanded scope of practice for patients clearly in need of appropriate medical care direction and system follow-ups. The provider expects to improve the hospitalization rates for targeted zip code areas.

**Starting Point/Baseline:**

Currently, an expanded scope of practice, such as Community Paramedicine does not exist for targeted population in the WCCHD system. Therefore, the baseline was established in DY3.

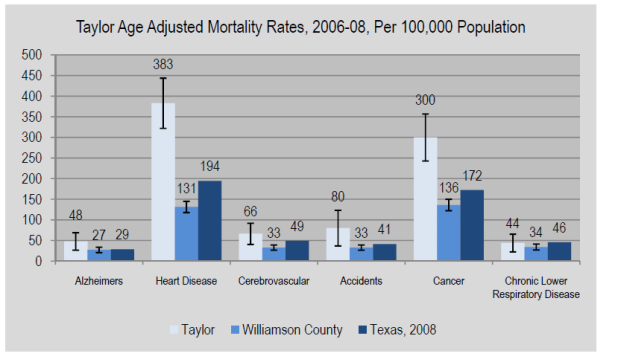
**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited Access to Primary Care
* Specific Community Needs:
* CN.1.2 – Limited to access to primary care for residents under 200% FPL
* CN.1.3 – Limited access to primary care
* CN.1.6– Limited access to primary care for rural residents
* CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease

In the current landscape of healthcare, EMS, as in the majority of the nation is considered a stand-alone public service like police and fire, with little or no integration into the larger health care system at the local level. Establishing Community Paramedicine in rural communities as an expanded scope of practice will increase access to proactive health care, provide timely, well-informed care, appropriate transports and referrals which would significantly decrease the overall cost of care and improve the quality of life for rural patients. This would also prevent the cycle of accessing EMS for non-emergent events, leaving EMS to handle emergent needs.

As noted in the table below, the age-adjusted death rate due to heart disease was over twice as high in the Taylor, TX zip code 76574 (383 per 100K population) when compared to both Texas (194 per 100K population) and Williamson County (131 per 100K population). The rate for cerebrovascular diseases (e.g. stroke) was twice as high in zip code 76574 (66 per 100K population) when compared to Williamson County (33 per 100K population) (Source: DSHS Vital Statistics analysis by WCCHD, 2006-08, <http://www.wcchd.org/statistics_and_reports/docs/Precinct_4_Profile2011.pdf>).



The ICare database includes health care encounters for the uninsured, and publically insured population, excluding Medicare patients, in Williamson County. Encounters at all but one hospital provider network are included, as are those from the local FQHC clinics.

* In 2010, ICare data showed that there were 144 frequent users of emergency departments (6 or more visits in a single quarter). This population averaged 15 visits annually and accounted for 2,111 patient visits.
* Analysis of vulnerable populations in Williamson County (defined as the near elderly, homeless, those with a behavioral health condition, and the disabled) showed that there were about are 10,600 vulnerable patients in the ICare database in 2011.
* This population averaged 2.3 emergency department visits each, with the maximum number of visit for a single patient being 52. Vulnerable frequent users (6 or more visits in a single quarter) averaged 15 visits per patient.

Key findings from the EMS data system, of all cardiac related calls in the first 3 quarters in 2011, 46 percent were in the target counties (n=693).

One simple conclusion can be drawn from this data and that is the expanded scope of practice would be advantageous to the targeted population zip code areas where a need is clearly demonstrated. While the primary mission of an EMS system is to provide readily available, accessible and cost efficient pre-hospital care, expanded scope programs such as Community Paramedicine improve the quality of care and life for individuals and decrease the utilization of EMS transports for accessing primary care within the emergency departments without compromising the integrity of the emergency response system. Incorporating an Electronic Health Record, utilizing a screening eligibility tool and enhancing the current database capturing EMS transports, will track and monitor activities and metrics associated with this project.

A variety of data will be collected and aggregated to determine priority areas for project efforts. These data sources may include:

* ICare data to identify frequent ED utilizers related to target conditions.
* Hospital discharge data to identify readmissions for target conditions.
* EMS data systems to identify non-emergent calls for target conditions.

By aggregating data from the data systems listed above, as well as others as needed, we will be able to best identify where our priority populations live and what services they need.

**Project Components:**

Through the Community Paramedicine, WCCHD proposes to meet all required project components.

1. *Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.* In this project, we are not establishing a nurse advice line; rather, we are utilizing paramedic calls and systems to proactively assess patients and referring to external partners to provide patient navigation.
2. *Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.* Our goal is to have a collaborative effort by utilizing existing data from ICare and our electronic patient care records to identify the patients in need. This will improve communications between the ED, EMS, primary care and urgent care, allowing for the patient to gain education, find available resources and provide direction to the most appropriate avenue of care based on their specific needs. This will strengthen the linkage between community and healthcare in the underserved areas of Williamson County.
3. *Conduct quality improvement for project using methods such as rapid cycle improvement--* With the addition of a quality improvement Captain, they will be able to manage the project based on a rapid cycle improvement model. First, help establish what needs to be accomplished, secondly what changes can we make to result in an improvement and thirdly, how will we know an improvement has been made. Each step is defined in the outline of the template which defines the goals, baselines and measuring improvement.

**Continuous Quality Improvement:**

WCCHD is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations. This collaboration will streamline the appropriate delivery of healthcare to the citizens who do not have access to primary healthcare or have used the 911 system or emergency departments as their primary healthcare.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Currently, a Community Paramedicine program does not exist for residents of Williamson County. Our system offers case management and patient navigation services, but these are typically only accessible to patients who call into our Healthcare Helpline and/or enrolled in the County Indigent Health Care Program. The initiative will improve access for targeted patients while diverting patients from emergency rooms to a medical home for healthcare needs.

WCCHD does not receive funding from the U.S. Department of Health and Human Services that will be used for this program.

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

* The following Category 3 measure has been approved in 2014 to describe improvements to the patient population: IT-3.2 (Congestive Heart Failure [CHF] 30-day Readmission Rate)
  + IT-3.2 – CHF 30-day Readmission Rate: In DY4 and DY5, we will report the readmission rate among 45-80 year olds with index admission for Congestive Heart Failure (CHF) at hospitals participating in the Health Information Exchange (HIE). This includes the St. David’s hospital system and Seton hospital system. Reported numbers will reflect readmissions within the same hospital system only. In DY5, we will demonstrate improvement by completing Stretch Activity 4 (SA4) – Emergency Department Improvements.

Reasons/Rational for selecting the outcome measure:

Selection of this Category 3 outcome is aligned with the Community Paramedicine focus on chronic disease education and intervention to decrease hospitalizations. Congestive Heart Failure (CHF) hospital readmissions are typically preventable. This project was therefore chosen to demonstrate the effectiveness of the Community Paramedicine Team interventions. The Community Paramedicine team will empower, educate and link individuals to right care/right setting to increase appropriate level of care. Linking to medical services and determining eligibility through the WCCHD Patient Navigation Program (126936702.2.1), patients are more likely to be compelled in seeking services for their chronic disease. Education and health literacy introduce opportunities for health promotion and knowledge of their chronic condition in order to control and manage their disease.

**Relationship to Other Projects:**

This project is one in a system of DSRIP projects that will increase access to health care, improve quality of care, and improve health outcomes for rural populations including:

* 126936702.1.1 Expanded Capacity for Access
* 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data;
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
* 126936702.2.2 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

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

No other providers in RHP 8 are establishing a Community Paramedicine. We have collaborated with other performing providers in the RHP to include the continuum of care necessary for targeted population served. Through the St. David’s Round Rock Medical Center project (#020957901.1.1), referring and connecting uninsured individuals under the 200% FPL seeking acute care services. In addition, working with Bluebonnet Trails Community Services – Emergency Services Diversion Project (#126844305.2.2) will identify frequent utilizers of emergency services; provide early intervention or intensive wraparound services and supports for a targeted behavioral health population, including people with co-occurring disorders. By coordinating the above mentioned projects, we can contain costs by avoiding the duplication of services, and provide meaningful delivery system reform to the underserved and low-income populations. Several learning collaboratives of professionals from the areas of primary care and mental health services exist in Williamson County. These active groups, who meet monthly, strive to provide continuous quality improvements, seek new ideas and solutions to improve patient outcomes, and share with others across the State of Texas and the nation.

**Project Valuation:**

The valuation of each WCCHD project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Integrated Care Collaboration has identified an estimated approximately 2,500 emergency room visits per year that could have been diverted to a more appropriate resource. With an estimated $500 per visit, this equates to an estimated valuation of $1,250,000 per year. In addition, Emergency Medical Services has identified approximately 2,000 calls for service per year in the rural areas that could have been managed by primary care or outpatient services. The cost of an average Advanced Life Support call is $1,100 or an estimated valuation of $2,200,000 per year. With the implementation of the community paramedic project, the opportunity for cost savings could offset the cost of program and provide the most appropriated healthcare resources to our citizens with the result of better patient outcomes. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. Providing timely, well-informed and appropriate level care will divert these types of needs from the urgent and emergent care facilities. Being able to access theses services at an appropriate and more affordable level of care will reduce the associated uncompensated care costs. Overall, the project seeks to accomplish delivery system reform by understanding that there is a shortage of clinics that provide preventive health services in this community; that due to this shortage, the average wait time for a new patient can be three weeks or longer; and that in order to fill in this gap in care, additional funding sources and support is needed. Moreover, the diversion of inappropriate non-emergent care services through urgent and emergent care facilities, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. Estimated costs for DYs 2-5 for hiring qualified staff, purchasing equipment, unit vehicle and necessary supplies has a cost value of $3,930,304.

**Category 1 Project Narrative**

**Williamson County & Cities Health District ‐ 126936702.1.3**

**Project Area, Option and Title:** 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data

**Unique Project ID:** 126936702.1.3

**Performing Provider Name:** Williamson County Cities and Health District

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** The project will enhance and improve the quality and consistency of public health client demographic (race, ethnicity, gender, and language) data collection and interpretation to ensure health disparities are addressed appropriately.
* **Project Status:** This is a new project.
* **Project Need:** CN.3.3 – Inconsistency in data collection which identifies health disparities and populations at risk. This project will address problems with data collection, particularly for race/ethnicity. For example, WCCHD analysis of reported sexually transmitted disease cases for Round Rock shows a growing proportion of cases in the “unknown” category for race/ethnicity from 2006 to 2011 (analysis by WCCHD of data from the Texas Department of State Health Services) and case data from the 2009 – 2010 pertussis epidemic mirror national trends indicating that Hispanic infants have a higher incidence of clinically significant pertussis, which place them at greater risk for hospital admission. Factors leading to an increased risk for Hispanic infants including language/communication and cultural issues that may serve as barrier to obtaining health care services. The insignificant of poor data could misinform key policy and program decisions, leading to interventions that are counterproductive and unintentionally increasing the impact of a disparity and coordinated care for those with multiple needs.
* **Target Population:** This project will leverage existing groups and organizations such as hospitals, community clinics and community health centers. The target populations identified are individuals with Medicaid, low income uninsured and indigent with disparate health outcomes to ensure appropriate level of care is addressed and met which makes up approximately 60% of our population served.
* **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to structure a framework for reliable Race, Ethnicity and Language fields to improve the collection of data in identifying health disparities and reducing empty REAL (race, ethnicity, and language) data fields. This project will increase completed REAL data fields from baseline of 57% to 67% in DY4 and 80% in DY5.
* **Category 3 Outcomes:** The following Category 3 measures were submitted in August 2014 to describe improvements to the patient population’s health: IT-15.6 (Chlamydia screening in women), IT-1.29 (Weight assessment and counseling for nutrition and physical activity for children/adolescents), and IT-12.11 (HPV vaccine for adolescents).
  + IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This includes patients seen at any one of the WCCHD Public Health Centers (facility subset).
  + IT-1.29 (Weight assessment and counseling for nutrition and physical activity for children/adolescents): We will demonstrate improvement by increasing the percentage of children 3-17 years of age who received a non-immunization WCCHD service and had evidence of BMI percentile documentation, nutrition counseling, and physical activity counseling.
  + IT-12.11 (HPV vaccine for adolescents): We will demonstrate improvement by increasing the percentage of adolescents 13 years of age who were seen at any one of the WCCHD Public Health Centers in the past five years and who had received three doses of the HPV vaccine.
* Each of the three measures proposed above will be stratified by race, ethnicity, and language in an effort to identify any health disparities in our patient population.
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. WCCHD intends to develop and pilot a continuous quality improvement (CQI) based process for improving data quality, using analyses of the data to identify disparities and plans to address these gaps. WCCHD will share the results of the pilot with providers throughout the region and through existing forums (Health Data Users Group and WilCo Integrated Care Collaboration). Improved data are a vital need to help drive policy and planning decisions which have a measurable meaningful impact on residents throughout the region.

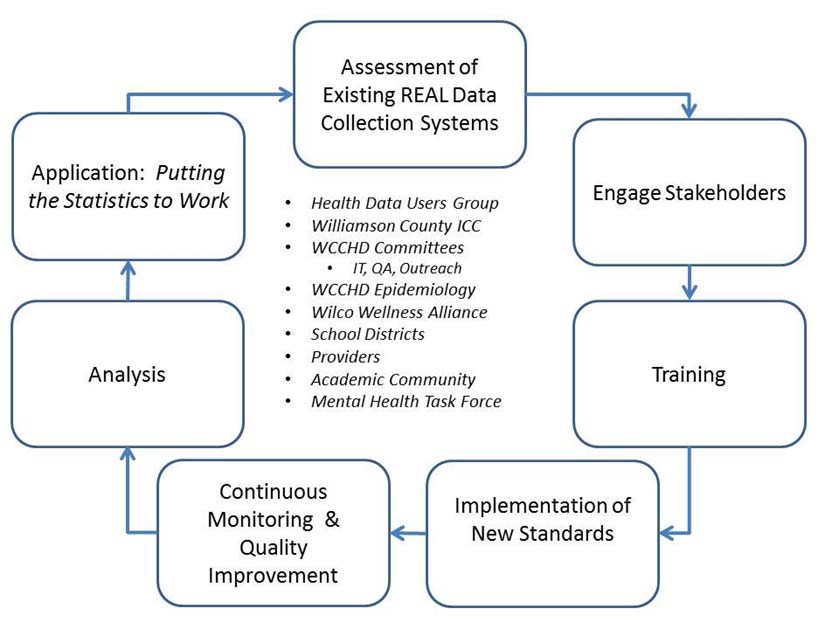
**Project** **Description:**

*Addressing and Developing Strategies for Reducing Health Disparities through Improved Data Collection Systems and Analytics ‐ The Williamson County and Cities Health District (WCCHD) proposes to improve the quality and consistency of public health client demographic (race, ethnicity, gender, and language) thereby improving the quality of information supplied to decision makers addressing health disparities.*

This project will involve significant changes in administrative and training policies and procedures throughout WCCHD at all four public health centers (Georgetown, Cedar Park, Round Rock, and Taylor). Staff at all levels, including program navigators, case managers, social workers, customer service representatives, nutritionists, public health and prevention specialists, administrative support staff, and management would receive training as part of a Data 101 course (currently being developed) on the importance of collecting accurate demographic information on all clients served. There are clearly problems with data collection, particularly for race/ethnicity. WCCHD analysis of reported sexually transmitted disease cases for Round Rock shows a growing proportion of cases in the “unknown” category for race/ethnicity from 2006 to 2011 (analysis by WCCHD of data from the Texas Department of State Health Services). The reasons for this negative trend are unclear but needs to be addressed.

The intent of the Data 101 course is not only to improve data quality and consistency but also to raise awareness and understanding of the relationship between social disparities and community health outcomes. After being piloted at WCCHD, the Data 101 curriculum will be shared with other organizations with the ultimate goal of improving the quality of data feeding into the regional ICare system managed by the Integrated Care Collaboration (ICC). The ICC is a nonprofit alliance of health care providers in Central Texas dedicated to the collection, analysis and sharing of health information with the goal of improving health care quality and cost efficiency across the continuum of care. One of the ICC primary functions is the operation and management of a regional Health Information Exchange called ICare. Through the analysis of clinical data in ICare, the ICC is able to identify needs in the Central Texas health care system and create programs to improve health outcomes for vulnerable populations.

The concepts of continuous quality improvement and the community health assessment (WCCHD follows the Mobilizing for Action through Planning and Partnership (MAPP) process) will also be reviewed during Data 101, introducing the concept of a community dashboard as a means to continuously monitor and share updates on community health related statistics. Examples of how data are used will be featured during the training including WCCHD Community Health Profiles, Condition/Disease Briefs, and Epidemiology Annual Reports. These documents, combined with dashboard demonstrations ([http://www.healthysonoma.org/,](http://www.healthysonoma.org/) [www.healthyntexas.org](http://www.healthyntexas.org)) will provide Data 101 participants with a clear understanding of the importance of collecting data in a systematic fashion, and that the process for appropriately targeting public health interventions starts with data collection at the client interview and data entry level.



**Goals and Relationship to Regional Goals:**

This project will leverage existing groups and organizations wherever possible to provide venues or forums for discussions on improving the quality of data used to make key programmatic and policy decisions related to community health assessment. The emphasis on partnership will improve the credibility of the public health system and help WCCHD to expand upon existing coalition building activities under the Wilco Care Alliance.

**Goals:**

* Increase the % of WCCHD clients with accurate race/ethnicity information recorded in their electronic health record;
* Improve the quality of data analysis based on demographic data used to inform policy decisions focused on reducing health disparities; and
* Enhance the information technology infrastructure for the public health system to improve ability to exchange data with the ICare system electronically.

Actions aimed at addressing disparities which are based on poor data will have limited impact on the problem. At worst, poor data could misinform key policy and program decisions, leading to interventions that are counterproductive, unintentionally increasing the impact of a disparity and using up critical resources. Achieving the primary goals should ultimately result in improved customer satisfaction and health outcomes for populations experiencing disparities.

**This Project meets the following Regional Goals:**

* increasing the proportion of residents with a regular source of care; and
* increasing coordination of prevention and care for residents, including those with behavioral or mental health needs

**Challenges:**

One of the greatest challenges may be in sharing the results. For some measures, improving the quality of REAL data collection may actually produce results that do not support the notion of a disparity or may point to inequities in different groups or populations. Reaching consensus on how race/ethnicity is handled may be difficult. For example, decisions about whether or not to record multiple races may impact database design and mapping fields for import/export between systems. To address differences between systems and possible problems with mapping, we anticipate (1) comparing different organizations’ data collection requirements and determining whether or not there is any flexibility in these requirements, and (2) using the results of this assessment to guide negotiations on establishing standards for collecting REAL data. These negotiations would occur in existing venues such as HDUG or the Williamson County ICC.

**5‐year Expected Outcome for Provider and Patients:**

* Improved understanding by front line employees of the importance of REAL data entry as measured by pre‐ and post‐training and client satisfaction surveys;
* 90% of all clients with WCCHD electronic health records with race/ethnicity fields populated or “unknown” entered;
* 75% of all clients with WCCHD electronic health records with the race/ethnicity fields populated; and

**Starting Point/Baseline:**

In 2012, records from CHASSIS showed 57% of all patients registered have all three REAL data fields completed. Completed does not include blank fields or fields marked “unknown”. Our goal is to increase the percent of registered patients with all three REAL data fields completed to 67% in DY4 and 80% in DY5.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.3 – Lack of coordinated care for those with multiple needs.
* Specific Community Need: CN.3.3 – Inconsistency in data collection which identifies health disparities and populations at risk.

Process milestones were selected to reflect a Continuous Quality Improvement (CQI) process, serving as an indicator of whether or not an established plan is followed and incorporating stakeholder feedback throughout the process. Milestones signal a significant and sustainable change in how data is collected, processed, and analyzed. Collecting valid and reliable data fields using a uniform framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers to address the identification of disparities and address appropriately.

Although Williamson County ranks as one of the healthiest counties in Texas according to the County Health rankings, it is clear there is still room for improvement when the health of Texas is compared to other states. There are some populations in Williamson County that experience disparities in health, quality of care, health outcomes, and incidence as related to conditions such as cardiovascular disease, pertussis, Chlamydia, cancer, obesity, and diabetes. Disparities can been seen among groups based on race and ethnicity, language, economic factors, education, insurance status, geographic location (rural vs. urban, zip code), gender, sexual orientation and many other social determinants of health.

Based on analysis of vital statistics data by WCCHD in 2012 (unpublished results) both the capacity for delivering prenatal care and the prenatal care rate have increased in recent years. However, the analysis suggests that prenatal care continues to be underutilized by minority women. Case data from the 2009 – 2010 pertussis epidemic mirror national trends indicating that Hispanic infants have a higher incidence of clinically significant pertussis, putting them at greater risk for being admitted to a hospital. There are many factors leading to an increased risk for Hispanic infants including language/communication and cultural issues that may serve as barrier to obtaining health care services. The 2011 WCCHD Epidemiology Report [(http://www.wcchd.org/statistics\_and\_reports](http://www.wcchd.org/statistics_and_reports/docs/2011_Epidemiology_Report.pdf))/docs/2011\_Epidemiology\_Report.pdf) contains an article describing the impact of the 2009 – 2010 epidemic on communities throughout Williamson County.

**Core Project Components:**

1. *Redesign care pathways to collect valid and reliable data on race, ethnicity, and language at the point of care.* Key stakeholders from throughout the region will be invited to participate in discussions around the collection standardization and processing procedures for REAL data. WCCHD will facilitate meetings to discuss basic definitions for REAL data and identify any existing procedures which may need to be modified as well as any training needs for front line staff.
2. *Implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.* WCCHD will assess its current and future data needs by examining how existing systems are being used (e.g. TWICES for immunizations and TB, CHASSIS for case management). Based on the results of this internal assessment, combined with the requirements and standards established with stakeholders (see project component 1), WCCHD will solicit proposals from vendors for a health record management system.
3. *Develop improvement plans, which include a continuous quality improvement plan, to address key root causes of disparities with the selected population.* An improvement plan, which includes a continuous quality improvement plan, will be developed by WCCHD research group in conjunction with the external stakeholders who serve on the Health Data Users Group. The plan will include a process for identifying and addressing key root causes of disparities. This includes developing a curriculum which will include guidelines and techniques for capturing quality REAL data and further developing of policy and procedures.
4. *Use data to undertake interventions aimed at reducing health and health care disparities (tackling “gap”) for target patient populations through improvements in areas such as preventive care, patient experience, and/or health outcomes.* With improved data collection identifying and addressing a more defined health care disparities within the targeted population, appropriate levels of interventions will be implemented. Data is a key to ensuring suitable interventions which aim at reducing health and health care disparities specifically where there’s a gap in services. Improved data will allow for assessing current interventions available for targeted population and improve or expand where necessary. Continuous quality assurance and improvement of data collection will result in higher quality health data driving the creation of activities and projects that impact patient outcomes.

**Continuous Quality Improvement:**

WCCHD is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** WCCHD does not receive U.S. Department of Health and Humans Services program initiative funds that will be used for this project.

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

The following Category 3 measures were submitted in August 2014 to describe improvements to the patient population’s health: IT-15.6 (Chlamydia screening in women), IT-1.29 (Weight assessment and counseling for nutrition and physical activity for children/adolescents), and IT-12.11 (HPV vaccine for adolescents).

* IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. This includes patients seen at any one of the WCCHD Public Health Centers (facility subset).
* IT-1.29 (Weight assessment and counseling for nutrition and physical activity for children/adolescents): We will demonstrate improvement by increasing the percentage of children 3-17 years of age who received a non-immunization WCCHD service and had evidence of BMI percentile documentation, nutrition counseling, and physical activity counseling.
* IT-12.11 (HPV vaccine for adolescents): We will demonstrate improvement by increasing the percentage of adolescents 13 years of age who were seen at any one of the WCCHD Public Health Centers in the past five years and who had received three doses of the HPV vaccine.

Each of the three measures proposed above will be stratified by race, ethnicity, and language in an effort to identify any health disparities in our patient population.

Reasons/rationale for selecting outcome measures: Improved data is necessary for building a foundation for effective policy and program development, and building the credibility necessary to advocate for addressing disparities, justifying local spending, and obtaining grant funding. Quality data is vital for the evaluation process and an integral part of the community health assessment process. Achievement levels would be reported for all three Category 3 measures. These measures provide solid and measurable outcome data for health issues that frequently have the greatest racial, ethnic, and linguistic disparities – STI screening, Body Mass Index (BMI) assessment and nutritional counseling, and vaccination in adolescents against human papillomavirus. With REAL data, WCCHD will be able to examine differences in these subpopulations for the very first time. In addition, the systematic and reliable collection of quality REAL data will help providers to delineate potential categories of differences in observed health status.

**Relationship to Other Projects:**

This project improves the quality of data supporting the need for the other WCCHD projects, ensuring disparities are being appropriately measured and monitored:

This project relates to all other WCCHD projects, including:

* 126936702.1.1 Expanded Capacity for Access to Care
* 126936702.1.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non‐emergent conditions and increase patient access to health care;
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
* 126936702.2.2 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

A robust public health information technology infrastructure, supported by trained staff, is a vital component of any system intended to identify and serve high risk populations in the county. Furthermore, the ongoing monitoring of REAL data and the analysis of these data are needed to determine if performance measures are met. This project provides a basic foundation for improving communication between public health and providers across the county by improving the integrity of information as it passes from the provider to the Health Information Exchange level. The fact that individual providers will have real‐time access to a unified patient record of the highest quality will provide the platform providers need to make informed decisions toward positive outcomes for their patients. Finally, improved aggregate REAL data allows public health officials to more effectively track the progress of projects short and long term, allowing for more informed policy and decision making by leadership.

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

For the WCCHD expansion of safety‐net services to succeed in reducing health disparities, robust data collection systems and training are needed to ensure WCCHD and the public health system meet information technology standards and practices followed by hospitals and other providers throughout the region. By necessity, the project will require intense collaboration with providers throughout the region. Much of the learning opportunities will occur early on as WCCHD implements the Data 101 curriculum. As the project matures, there will be many opportunities to share best practices and collaborate on special projects.

**Project Valuation:**

This project increase the percentage of registered patients with all three REAL data fields completed to 67% in DY4 and 80% in DY5 (see Improvement Milestone I‐9.1). The valuation of this project takes into account the degree to which the value of improved data linked in health care systems requires the development of tools, protocols and training curriculum for collecting and utilization of REAL data elements. The consolidation of many different data collection systems for reporting and syndromic surveillance, as well delivery of high quality care, is essential in keeping the overall costs of health care from escalating, specifically for the targeted population. Improving the information technology infrastructure will result in fewer clinical errors, improve diagnostic ability through improved access to critical historical information maintained in a Health Information Exchange, and allow for more sophisticated analytics to focus interventions for targeted population where they are most needed. In conclusion, the valuation and impact of this project to targeted population will result in patients receiving more culturally sensitive and appropriate care, improve the quality of care delivered, and focus on efforts to reduce health disparities and improve the accuracy in reported cases to Department of State Health Services for disease surveillance purposes.