## Category 2 Innovation and Redesign - Narratives and Tables

* **Bell County Public Health District**
  + 088334001.2.1
    - Category 3 Selection: OD 6, IT-6.2.b - Visit-Specific Satisfaction Instrument (VSQ-9)
  + 088334001.2.2 (Pass 2)
    - Category 3 Selection: OD 6, IT-6.2.b - Visit-Specific Satisfaction Instrument (VSQ-9)
* **Bluebonnet Trails Community Services**
  + 126844305.2.1
    - Category 3 Selection: OD 11, IT-11.26.c - Adult Needs and Strength Assessment (ANSA)
  + 126844305.2.2
    - Category 3 Selection: OD 9, IT- 9.4.e - Reduce ED visits for Behavioral Health/Substance Abuse
  + 126844305.2.3 (Pass 2)
    - Category 3 Selection: OD 11, IT-11.26.b - Aberrant Behavior Checklist (ABC)
  + 126844305.2.4 (Pass 2)
    - Category 3 Selection: OD 9, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice settings such as jails or prisons
* **Central Counties Services**
  + 081771001.2.1
    - Category 3 Selection: OD 1, IT-1.11 - Diabetes care: BP control (140/90mm Hg)
  + 081771001.2.2
    - Category 3 Selection: OD 15, IT-15.6 - Chlamydia screening in women
    - Category 3 Selection: OD 15, IT-15.9 - Syphilis screening
    - Category 3 Selection: OD 15, IT-15.12 - Gonorrhea screening rates
  + 081771001.2.3
    - Category 3 Selection: OD 9, IT-9.1 - Decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons
  + 081771001.2.100 (3-Year Project)
    - Category 3 Selection: OD 09, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice setting such as jails or prisons
* **Hill Country MHDD Centers**
  + 133340307.2.1
    - Category 3 Selection: OD 11, IT-11.25 – Daily Living Activities DLA-20
  + 133340307.2.2
    - Category 3 Selection: OD 11, IT-11.25 – Daily Living Activities DLA-20
  + 133340307.2.3
    - Category 3 Selection: OD 11, IT-11.16 – Assessment for Substance Abuse Problems of Psychiatric Patients
    - Category 3 Selection: OD 11, IT-11.19 - Assessment for Psychosocial Issues of Psychiatric Patients
    - Category 3 Selection: OD 11, IT-11.21 - Assessment of Major Depressive Symptoms
  + 133340307.2.4 (Pass 2)
    - Category 3 Selection: OD 11, IT-11.25 – Daily Living Activities DLA-20
  + 133340307.2.5 (Pass 2)
    - Category 3 Selection: OD 11, IT-11.25 – Daily Living Activities DLA-20
* **Scott & White Hospital - Llano**
  + 020840701.2.1
    - Category 3 Selection: OD 9, IT-9.2.a - ED visits per 100,000
  + 020840701.2.2 (Pass 2)
    - Category 3 Selection: OD 9, IT-9.2.a - ED visits per 100,000
* **Scott & White Memorial Hospital**
  + 7249208.2.1
    - Category 3 Selection: OD 9, IT-9.2.a - ED visits per 100,000
* **Seton Highland Lakes Hospital**
  + 094151004.2.1 (Pass 2)
    - Category 3 Selection: OD 11, IT-11.25 – Daily Living Activities DLA-20
* **Williamson County and Cities Health District**
  + 126936702.2.1
    - Category 3 Selection (3.6): OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
    - Category 3 Selection (3.500): OD 1, IT-1.7 - The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
  + 126936702.2.2 (Pass 2)
    - Category 3 Selection (3.7): OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
    - Category 3 Selection (3.501): OD 1, IT-1.7 - The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
  + 126936702.2.100 (3-Year Project)
    - Category 3 Selection (3.100): OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
    - Category 3 Selection (3.202): OD 1, IT-1.29 - Weight assessment and counseling for nutrition and physical activity for children/adolescents

**Category 2 Project Narrative**

**Bell County Public Health District - 088334001.2.1**

**Project Area, Option and Title:** 2.7.1 Implement Evidence-based Health Promotion & Disease Prevention Programs. Implement evidence-based strategies to increase screenings and referral for targeted populations.

**RHP Project Identification Number:** 088334001.2.1

**Performing Provider Name:** Bell County Public Health District

**Performing Provider TPI #:** 088334001

**Project Summary:**

* **Provider Description:** Bell County Public Health District (Health District), is a Local public health district, and provides public health services to the men and women of Bell County and the surrounding area. The Health District provides services in the following programs: Immunizations, Sexually Transmitted Disease (STD) testing and treatment, Family Planning, Pregnancy testing and counseling, Preparedness, Disease Surveillance, Environmental Health, Food Protection, and Women Infant Children (WIC) program. The Health District serves Bell County with a 1060 square mile area and a population of 284,408 (DSHS Health Facts Profile, 2009). The Health District operates two clinics in east and west Bell County in the neighborhoods of the targeted populations.
* **Intervention:** The purpose of this project is to increase the availability of STD testing at Health District clinics. Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control’s (CDC’s) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures. The Health District plans to increase the times and days that STD testing is offered from ½ day to 4 days per week. Additionally, the Health District will increase the number of clients seen in Health District STD clinics. In this 2.1 project, the focus will be to increase the number of males seen (the 2.2 project focuses on females) In DY2, the Health District established a baseline, and saw 518 **males** who tested for Chlamydia, Gonorrhea, and Syphilis. The Health District estimates that they can see an additional 52 males in DY3, 104 males in DY4, and 155 males in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. (The Category 2.2 project addresses STD services to females in Health District clinics). The Health District plans to monitor clinic numbers and times, and adjust the schedule accordingly.
* **Project Status:** Currently, STD testing and treatment is offered one afternoon per week in each of the Health District clinics. We will expand to four 8 hour work days (Monday through Thursday) to accommodate clients and partners accessing services.
* **Project Need:** CN.1.9: Increase access to testing and treatment of STDs in Bell County. Bell County has some of the highest STD rates in the State of Texas. In 2011, the Chlamydia cases/rate in Bell County was 3,933 cases or 1,325.7 per 1,000, or the highest in Texas. For Gonorrhea, the 2011 cases/rate were 1,075 cases or a rate of 362.4 per 1.000. Again, this rate was also the highest in the State. Syphilis cases in 2010 were 16 with a rate of 5.5; in 2011 there were 5 syphilis cases with a rate of 1.7 (Texas STD Surveillance Report, DSHS, 2011). Statistics for the incidence of all 3 of diseases is similar for 2010. The STD Clinics at the Health District are the only low cost STD testing and treatment clinics in Bell County.
* **Target Population:** One hundred percent of the Health District clients who were provided STD services in FY2011 were uninsured or Medicaid clients. There were 586 clients seen in FY2011 (males and females). At thebeginning of this project, the Health District counted both males and females in its calculations for the QPI data. When the Pass 2 project 088334001.2.2 was added that counts females only, this project should have been changed to count only males (so that the females were not counted twice). By making it clear that males only will be counted in this project, it will be in line with the Pass 2 project that counts only females. Between the 2.1 & 2.2 projects, the males and females accessing services at the Health District will be counted. The target population in this project is MALES (and the target population in 2.2 is females). In DY2, the Health District established a baseline, and saw 518 males who tested for Chlamydia, Gonorrhea, and Syphilis. The Health District estimates that they can see an additional 52 males in DY3, 104 males in DY4, and 155 males in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. (The Category 2.2 project addresses STD services to females in Health District clinics). The Health District will increase the number males who access care by expanding availability of STD services and by providing those services on a walk-in basis, and to reduce the number of Medicaid clients who utilize the Emergency Department for routine STD testing services.
* **Category 1 or 2 Expected Project Benefit for Patients:**The project seeks to increase access to routine STD testing and treatment by increasing the number of days and clinics where testing and treatment is available to clients on a walk-in basis, going from providing services ½ day per week to 4 days per week (see Improvement Milestone 1-7.2). The project will be able to test 52 additional males in DY3, 104 males in DY4, and 155 males in DY5 for Gonorrhea, Chlamydia, and Syphilis. The original project included numbers for both male and female clients; the Health District’s 2.2 project addresses increasing the number of females tested in Bell County Public Health District Clinics, and this 2.1 project will address increasing the number of males tested in Bell County Public Health District Clinics.
* **Category 3 Outcomes** OD-6 Patient Satisfaction IT-6.2.b VSQ-9

Percent improvement over baseline of patient satisfaction scores.

The VSQ-9 was developed for use in the Medical Outcomes Study and focuses specifically on satisfaction with a visit to a physician or other health care provider. The VSQ-9 survey measures patient satisfaction with access to care (questions 1 to 4); direct interaction with the physician (questions 5 to 8); and, the visit overall (question 9).

* **Core Component: A (CQI)** The Health District is committed to continuous quality improvement and learning

related to this project. The Health District will conduct quality improvement as a core component for the project using the following methods: The Health District has a Quality Assurance Plan in place and conducts the following QA activities on a regular basis by designated staff: monthly chart audits in all clinics with corrections made; annual Exposure Control Clinic assessment, annual building and Fire Equipment inspections, twice a year Fire Drills, annual evaluations on all staff, annual emergency response drills, annual client satisfaction surveys, annual staff development needs assessment, verification of licensed personnel as needed, CPR training, and quarterly QA meetings. At the quarterly QA meetings, staff discuss: problems encountered with staff performance, documentation, clinic flow, patient issues, or any area of the project where improvements are needed. The QA Committee provides recommendations for improvement in all areas of the project. The Director is responsible for ensuring designated staff in each clinic carry out the recommendations of the QA committee to improve the overall project. In addition, we will participate in regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

**Project Description:**

*Increase access to Sexually Transmitted Disease Testing*

The purpose of this project is to increase the availability of Sexually Transmitted Disease (STD) testing at Health District clinics. The Health District plans to increase the times and days that STD testing is offered (from ½ day to 4 days per week). Currently, the STD clinics is one afternoon per week, and the Health District is considering expanding to four 8 hour work days (Monday through Thursday) to accommodate males accessing services in the afternoons. The Health District provided STD services to 586 clients in FY2011. In DY2, the Health District established a baseline of clients seen, and saw 518 males who tested for Chlamydia, Gonorrhea, and Syphilis. The Health District estimates that they can see an additional 52 males in DY3, 104 males in DY4, and 155 males in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. (The Category 2.2 project addresses STD services to females in Health District clinics). It is the hope, by expanding STD service hours the Health District can increase the number of clients tested and decrease the Gonorrhea, Chlamydia, and Syphilis rates in Bell County, which are some of the highest rates in the state. (The Category 2, Pass 2 Project # 088334001.2.2 addresses increasing the number of females tested in Bell County Public Health District Clinics, and this 2.1 project will concentrate on males.)

Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control’s (CDC’s) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures. The Health District nursing staff has 5-10 years of experience in conducting risk assessment and risk reduction STD counseling and testing. They will provide one-on-one, individualized counseling for each STD client, to include counseling regarding the need for medication compliance, medication education, partner treatment, abstinence until partner treated, and importance of future safe sex practices. Staff will provide each client with written educational materials, as well as condoms. Nursing staff will treat symptomatic clients at the time of testing, and will encourage abstinence until partners are treated, if positive. Clients with positive results are notified regardless if they were treated at testing, so that counseling can occur with regard to abstinence and partner treatment. Clients whose partners refuse to be treated will be offered Expedited Partner Therapy (EPT) according to established procedures.

Clients who test positive for Gonorrhea and/or Chlamydia are strongly encouraged to return to the clinic in three months for a retest due to the possibility of re-infection with an untreated partner or a new infection from a new partner. Clients who test positive for syphilis are staged and treated appropriately, and will have blood redraws to retest and ensure treatment effectiveness. Partner elicitation for positive syphilis clients is done by the Texas Department of State Health Services (DSHS) Disease Intervention Specialists. Clinic staff keeps records of positive clients and send reminders of need for retest or redraws. Client numbers are kept by clinic clerical staff for completion of reports.

Community Educators provide information in the community on the expansion of services in the hopes of getting the word out about extended hours, which will happen by increasing the hours that STD testing and treatment is available. It is the expectation that with increased utilization of Health District STD clinics that there will be less use of the local Emergency Departments (ED) for routine STD testing and treatment. In 2011, the Chlamydia cases / rate in Bell County were 3,933 cases, with a rate of 1,325.7 (compared to 2010 - 4,007 cases, rate of 1,375.2). The Chlamydia rates are the highest in the state in Bell County for 2010 & 2011. For Gonorrhea, the 2011 cases / rate were 1,075 cases, with a rate of 362.4 (compared to 2010 - 1,181 cases, rate of 405.3). These rates were also the highest in the State for 2010 & 2011 (Texas STD Surveillance Report, DSHS, 2011).

**Goals and Relationship to Regional Goals:**

**Project Goals:**

For the past several years, Bell County has had some of the highest STD rates in Texas. The Health District would like to see the case numbers and rates come down for Gonorrhea, Chlamydia, and Syphilis in Bell County. The Health District would also like to see clients in Bell County utilize the clinics in Killeen and Temple instead of the ED for routine STD testing.

**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:**

Possible challenges are clients reporting inability to pay for services. Staff will work with clients on a payment plan if they report they cannot pay, and they are symptomatic. The Health District recently began accepting credit and debit cards, which may help clients pay. The Health District has changed the way clients are assessed fees for STD clinic. Client fees are based on family size and income instead of a flat fee. This will enable more clients to be seen, and eliminate a financial barrier to care. Another challenge is partners refusing to get treated. Extensive education is provided on the importance of partner treatment. The expanded hours will allow partners more opportunity for treatment. For those partners who refuse to come in (or go to their provider) for treatment, EPT will be provided. EPT is done only in cases where the client’s partner refuses to get treated, and the client is at high risk for re-infection. Strict procedures are followed for EPT, since medications are provided to one person for another. Another challenge is that Fort Hood, the largest military base in the world, is located in Bell County. There is a constant influx of soldiers returning from a war campaign and they often bring STD’s home with them. This may affect the expected reductions in STD case numbers and rates, since the population base will have grown.

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

It is expected in the first five years of the project that the number of clients accessing services will increase by 30%. In addition, STD rates in Bell County will be reduced. With the Gonorrhea and Chlamydia rates in Bell County being the highest in Texas, the Health District expects to reduce the number of cases of Gonorrhea, Chlamydia, and Syphilis. However, the Health Department needs time to understand how our intervention will impact rates. Targets will be determined in DY3.

**Starting Point/Baseline:**

Bell County Public Health District saw 586 Gonorrhea clients, 586 Chlamydia clients, and 500 Syphilis clients in FY 2011 (BCPHD clinic records). Bell County STD case numbers 2011: Chlamydia 3933, Gonorrhea 1075. Bell County STD case rates: Chlamydia 1,325.7, Gonorrhea 362.4 (DSHS Texas 2011 STD Surveillance Report, cases reported from January 1 to December 31, 2011. The report is available at <http://www.dshs.state.tx.us/hivstd/reports/default.shtm>).

In DY2, the Health District established a baseline of clients seen, and saw 518 males who tested for Chlamydia, Gonorrhea, and Syphilis. The Health District estimates that they can see an additional 52 males in DY3, 104 males in DY4, and 155 males in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. (The Category 2.2 project addresses STD services to females in Health District clinics).

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited access to primary care
* Specific Community Need: CN.1.9 – Increase access to testing and treatment of sexually transmitted diseases in Bell County

This project addresses the high Chlamydia and Gonorrhea rates in Bell County for the latest statistic year available 2011. Bell County has the highest Chlamydia and Gonorrhea case rates in the entire state in 2011. Bell County also has the 6th highest Gonorrhea case number and 7th highest Chlamydia numbers in the state in 2011. Bell County has one of the highest Chlamydia infection rates in the State (DSHS, Texas 2011 STD Surveillance Report).

This project was selected in an effort to decrease the high STD rates in Bell County. Bell County is ranked 16th by population (latest census figures from 2010 from US Census Bureau, updated February 2012), but is 6th and 7th in number of STD rates, and first in numbers of cases of Gonorrhea and Chlamydia. The consistently high numbers and rates of STD infections in Bell County could be due to the close proximity of Fort Hood Army base, the largest military base in the world. Clients, who are often active duty military, frequently utilize the STD services in Bell County clinics to avoid having this information in their military record. The large number of military clients adds to the transient nature of Bell County, which can also contribute to the spread of STDs and the high STD numbers. With the expansion of availability of STD services, the Health Department’s goal is to reach and test/treat this population of clients.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** The Health District receives funds from the U.S. Department of Health and Human Services through state agencies; however, these funds will not be used in this project.

**Relationship to Other Projects:**

In Pass 2, the Health District will focus on a project (#088334001.2.2)on the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea and Chlamydia infections. According to the CDC, the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for chlamydia is still not routine in many clinical settings (CDC, 2012). Undetected and/or untreated Chlamydia infections are one of the leading causes of sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).

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

Central Counties Services (CCS) is proposing a project (#081771001.2.2)to increase testing of STD’s in their clinics, as they feel their clients may not go to the Health District to access these services. CCS believes, by nature of many of their clients’ disease processes, they cannot or will not seek out testing and treatment, especially if they are asymptomatic. CCS will provide STD education, testing, and treatment on site in their clinics to decrease STD infections among their target population. The Health District will work with CCS to assist them to reach their goals in their project. CCS and the Health District are also working on a project (#081771001.2.1) to assist CCS clients that are suffering the side-effects of prolonged use of psychotropic medications. Williamson County & City Health District, south of Bell County, is proposing a broader primary care project (#126936702.1.1),but it will also increase availability of STD testing in their county.

The Health District is committed to improvement of services and broad-level delivery system transformation. The Health District has an excellent working relationship with the providers in RHP 8, and is willing to participate in learning collaboratives 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.

**Project Valuation:**

The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs for administrative staff overseeing the project, and for advertising costs to increase awareness of the project. The funds for the project are for salaries and fringe benefits only, as testing supplies, lab tests, and medications are provided at no cost to the Health District.

**Category 2 Project Narrative – Pass 2**

**Bell County Public Health District – 088334001.2.2**

**Project Area, Option and Title:** 2.7.1 - Implement Evidence-based Health Promotion & Disease Prevention Programs. Implement evidence-based strategies to increase screenings and referral for targeted populations.

**RHP Project Identification Number:** 088334001.2.2

**Performing Provider Name:** Bell County Public Health District

**Performing Provider TPI #:** 088334001

**Project Summary:**

* + - * **Provider Description:** Bell County Public Health District (Health District), is a Local public health district, and provides public health services to the men and women of Bell County and the surrounding area. The Health District provides services in the following programs: Immunizations, Sexually Transmitted Disease (STD) testing and treatment, Pregnancy testing and counseling, Preparedness, Disease Surveillance, Environmental Health, Food Protection, and Women Infant Children (WIC) program. The Health District serves Bell County with a 1060 square mile area and a population of 284,408 (DSHS Health Facts Profile, 2009). The Health District operates two clinics in east and west Bell County in the neighborhoods of the targeted populations.
* **Intervention:** The purpose of this project is to increase the number of females of child bearing age tested for STDs in Health District clinics to ultimately decrease the possible sequelae from untreated infections. Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control’s (CDC’s) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures. The Health District plans to monitor clinic numbers and times, and adjust the schedule accordingly.
* **Project Status:** This project is an expansion of existing STD services. We currently serve 297 female clients but intend to increase the number of females tested for STD’s by 20% over baseline in DY4 and 30% over baseline in DY5. The Health District planned to implement this project in DY3 but implemented the project in DY2 and plans to increase the number of females seen in DY3 by 10% using the baseline from 2012 (297).
* **Project Need:** CN.1.10: Increase STD testing of females age 14-45 to reduce potential complications of untreated STDs. This project addresses the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea, Chlamydia, and Syphilis infections, to reduce the potential sequelae such as Pelvic Inflammatory Disease (PID), sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).
* **Target Population:** The target population is females who are uninsured or on Medicaid, of child bearing age who are sexually active, and who may be unaware of having a sexually transmitted infection. The target population in this project is FEMALES. In DY2, the Health District established a baseline, and saw 297 females who tested for Chlamydia, Gonorrhea, and Syphilis. The Health District estimates that they can see an additional 30 females in DY3, 59 females in DY4, and 89 females in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. (The Category 2.1 project addresses STD services to males in Health District clinics). The Health District will increase the number of females who access care by expanding availability of STD services and by providing those services on a walk-in basis, to decrease potential sequelae of untreated STD’s such as PID, ectopic pregnancy, pregnancy complications, neonatal infections, pelvic pain: and reduce the number of Medicaid clients who utilize the Emergency Department for routine STD testing services.
* **Category 1 or 2 Expected Project Benefit for Patients:**The project seeks to increase the number of females tested for STD’s in Health District clinics by 10% over baseline in DY3, 20% over baseline in DY4 and 30% over baseline in DY5. The Health District estimates that they can see an additional 30 females in DY3, 59 females in DY4, and 89 females in DY5 who test for Chlamydia, Gonorrhea, and Syphilis.
* **Related Category 3 Outcome Measure(s):** OD-6 Patient Satisfaction. IT-6.2.b VSQ-9 Percent improvement over baseline of patient satisfaction scores

**Project Description:**

*Increase number of females aged 14-45 who are tested for Gonorrhea, Chlamydia, and Syphilis in Bell County Public Health District Clinics*

The purpose of this project is to increase the number of females of child bearing age tested for Sexually Transmitted Diseases (STDs) in Health District clinics to ultimately decrease the possible sequelae from untreated infections. The Health District staff will provide STD risk reduction counseling utilizing the Centers for Disease Control’s (CDC’s) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Outreach will be conducted in the community to inform females of the availability of services, and also the importance of finding and treating STD’s prior to complications anddamage occurring. Quality clinical services will be provided by licensed nurses according to Health District STD Testing Policies and Procedures. The Health District staff has 5-10 years of experience in conducting risk assessment and risk reduction STD counseling and testing. They will provide one-on-one, individualized counseling for each STD client, to include counseling regarding the need for medi~~ca~~**t**ion compliance, medication education, partner treatment, abstinence until partner treated, and importance of future safe sex practices. Staff will provide each client with written educational materials, as well as condoms. Nursing staff will treat symptomatic clients at the time of testing, and will encourage abstinence until partners are treated, if positive. Clients with positive results are notified regardless if they were treated at testing, so that counseling can occur with regard to abstinence and partner treatment. Clients whose partners refuse to be treated will be offered Expedited Partner Therapy (EPT) according to established procedures.

Clients who test positive for Gonorrhea and/or Chlamydia are strongly encouraged to return to the clinic in three months for a retest due to the possibility of re-infection with an untreated partner or a new infection from a new partner. Clients who test positive for syphilis are staged and treated appropriately, and will have blood redraws to retest and ensure treatment effectiveness. Pregnant women who test positive for syphilis are treated and referred for prenatal care. Counseling is provided on the potential effects of untreated STD’s on the pregnancy and/or baby. Partner elicitation for positive syphilis clients is done by the Texas Department of State Health Services (DSHS) Disease Intervention Specialists. Clinic staff keeps records of positive clients and send reminders of need for retest or redraws. Client numbers are kept by clinic clerical staff for completion of reports.

Community Educators provide information in the community on the Health District services and importance of STD testing and treatment for sexually active females. It is the expectation that with increased utilization of Health District STD clinics that there will be less use of the local Emergency Departments (ED) for routine STD testing and treatment, as well as decrease the hospitalizations for sequelae of untreated STD’s such as PID, ectopic pregnancy, pregnancy complications, neonatal infections, pelvic pain (DSHS, Infertility Prevention Project, 2012), [miscarriages](http://en.wikipedia.org/wiki/Miscarriage), [premature births](http://en.wikipedia.org/wiki/Premature_birth), [stillbirths](http://en.wikipedia.org/wiki/Stillbirth), or deaths of newborn babies (U.S. Department of Health and Human Services, Office on Women’s Health, Syphilis Fact Sheet, July 8, 2011).

**Goals and Relationship to Regional Goals:**

**Project Goals:**

It is the goal of the project to increase the number of female clients in Bell County who access STD testing and treatment services in Health District clinics to decrease the potential complications associated with untreated STD’s. For the past several years, Bell County has had some of the highest STD rates in Texas. The Health District would like to see the case numbers and rates come down for Gonorrhea, Chlamydia, and Syphilis in Bell County. The Health District would also like to see clients in Bell County utilize the clinics in Killeen and Temple instead of the ED for routine STD testing.

**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:**

Possible challenges are clients reporting inability to pay for services. Staff will work with clients on a payment plan if they report they cannot pay, and they are symptomatic. The Health District recently began accepting credit and debit cards, which may help clients to be able to pay. The Health District has changed the way clients are assessed fees for STD clinic. Client fees are based on family size and income instead of a flat fee. This will enable more clients to be seen, and eliminate financial barrier to care. Another challenge is partners refusing to get treated. Extensive education is provided on the importance of partner treatment. The expanded hours will allow partners more opportunity for treatment. For those partners who refuse to come in (or go to their provider) for treatment, EPT will be provided. EPT is done only in cases where the client’s partner refuses to get treated, and the client is at high risk for re-infection. Strict procedures are followed for EPT, since medications are provided to one person for another. Another challenge is that Fort Hood, the largest military base in the world, is located in Bell County. There is a constant influx of soldiers returning from a war campaign and they often bring STD’s home with them.

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

It is expected in the first five years of the project that the number of female clients accessing services will increase by 10% in DY3, 20% in DY4, and 30% in DY5. The Health District estimates that they can see an additional 30 females in DY3, 59 females in DY4, and 89 females in DY5 who test for Chlamydia, Gonorrhea, and Syphilis. Targets based on FY 12 client numbers. It is the intent with this project, that potential complications associated with untreated STD’s will be reduced with the increase in testing of female patients. In addition, ED visits and hospital admission for sequelae from untreated STD’s will go down.

**Starting Point/Baseline:**

297 females accessed STD services in Bell County Public Health clinics in FY2012. Increase number of females seen in STD clinic by 20% over baseline in DY4 and 30% over baseline in DY5.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 - Limited access to primary care
* Specific Community Need: CN.1.10 – Increase STD testing of females age 14-45 to reduce potential complications of untreated STDs (i.e., Pelvic Inflammatory Disease)

This project addresses the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea, Chlamydia, and Syphilis infections. According to the CDC, the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for chlamydia is still not routine in many clinical settings (CDC, 2012). Untreated Gonorrhea and Chlamydia have the potential to cause Pelvic Inflammatory Disease (PID), sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012). Untreated syphilis can lead to severe illness and even death. Having syphilis increases the risk of acquiring or spreading HIV. Untreated syphilis also can cause problems during pregnancy such as increasing the potential for [miscarriages](http://en.wikipedia.org/wiki/Miscarriage), [premature births](http://en.wikipedia.org/wiki/Premature_birth), [stillbirths](http://en.wikipedia.org/wiki/Stillbirth), or death of newborn babies. Infected babies may be born without signs or symptoms, but may develop health problems such as developmental delays and seizures within weeks of birth (U.S. Department of Health and Human Services, Office on Women’s Health, Syphilis Fact Sheet, July 8, 2011).

Bell County had the highest Chlamydia and Gonorrhea case rates in the entire state in 2010. Bell County also had the 6th highest Gonorrhea case numbers, and 7th highest Chlamydia numbers in the state in 2010. Bell County has one of the highest Chlamydia infection rates in the State (DSHS, Texas 2010 STD Surveillance Report). Bell County STD cases numbers 2010: Chlamydia 4007, Gonorrhea 1181. Bell County STD case rates: Chlamydia 1375.2, Gonorrhea 405.3 (DSHS Texas 2010 STD Surveillance Report). In 2010, Bell County had 16 cases of primary and secondary syphilis with a rate of 5.5. In 2011, there were 5 cases of primary and secondary syphilis, with a rate of 1.7 in Bell County. DSHS Region 7, in which Bell County resides, had 7 cases of congenital syphilis in 2011 (there are no figures for Bell County) (DSHS 2011 STD Surveillance Report).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** The Health District receives funds from the U.S. Department of Health and Human Services through state agencies; however, these funds will not be used in this project.

**Core Component:**

1. CQI

The Health District is committed to continuous quality improvement and learning related to this project. The Health District will conduct quality improvement as a core component for the project using the following methods: The Health District has a Quality Assurance Plan in place and conducts the following QA activities on a regular basis by designated staff: monthly chart audits in all clinics with corrections made; annual Exposure Control Clinic assessment, annual building and Fire Equipment inspections, twice a year Fire Drills, annual evaluations on all staff, annual emergency response drills, annual client satisfaction surveys, annual staff development needs assessment, verification of licensed personnel as needed, CPR training, and quarterly QA meetings. At the quarterly QA meetings, staff discuss: problems encountered with staff performance, documentation, clinic flow, patient issues, or any area of the project where improvements are needed. The QA Committee provides recommendations for improvement in all areas of the project. The Director is responsible for ensuring designated staff in each clinic carry out the recommendations of the QA committee to improve the overall project. In addition, we will participate in regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

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

* OD-6 Patient Satisfaction
* IT-6.2.b VSQ-9 Percent improvement over baseline of patient satisfaction scores

Baseline patient satisfaction scores will be determined in DY3 and targets will be set for DY4 and DY5 at that time. The Health District will show a TBD improvement in DY4, and TBD improvement in DY5, over baseline of patient satisfaction scores for patients surveyed in BCPHD STD clinics to establish if patients are getting timely care, appointments, and information. The agency plans to use the VSQ-9 which is a 9 item survey that measures patient satisfaction with access to primary care, with the direct interaction with the physician, and with the visit overall on a scale ranging from 1(poor) to 5 (excellent). The VSQ-9 focuses specifically on satisfaction with a visit to a physician or other health care provider.

Some clients may feel embarrassed to seek STD testing and treatment with their primary provider, or may feel more comfortable accessing these services at the Health District clinics.

It is important for clients to feel comfortable when being tested and/or treated for STD’s. Assessing client satisfaction will enable changes to increase quality of services provided and ensure continued use of Health District clinic for these services. Additionally, there are no other low-cost STD clinics available for individuals in Bell County. There are many physicians, EDs, and acute care clinics, but the cost for STD testing and treatment can be in the hundreds of dollars. The Health District offers a single test for Gonorrhea, Chlamydia, and Syphilis – all for a single fee, and the treatment is included in the fee and provided on site. Client fees are based on family size and income (self-reported) instead of a flat fee. This will enable more clients to be seen, and eliminate a financial barrier to care. The fee for all these tests and treatment is as low as some insurance plan’s co-pay.

**Relationship to Other Projects:**

In Pass 1, the Health District is focusing on a project (#088334001.2.1)to implement Evidence-based Health Promotion & Disease Prevention Programs. The purpose of the project is to increase the availability of STD testing at the Health District clinics. It is the hope, by expanding STD service hours, that the Health District can increase access to STD testing and treatment, and decrease the Gonorrhea, Chlamydia, and Syphilis case numbers and rates in Bell County, which are some of the highest rates in the state. The proposed Pass 2 project focuses on females only with the goal of finding and treating STD’s before they can cause complications and damage; whereas the Pass 1 project focus is increasing access to services to males, and to decrease overall Gonorrhea, Chlamydia, and Syphilis case numbers and rates.

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

Central Counties Services (CCS) is proposing a project (#081771001.2.2)to increase testing of STD’s in their clinics, as they feel their clients may not go to the Health District to access these services. CCS believes, by nature of many of their clients’ disease processes, they cannot or will not seek out testing and treatment, especially if they are asymptomatic. CCS will provide STD education, testing, and treatment on site in their clinics to decrease STD infections among their target population. The Health District will work with CCS to assist them to reach their goals in their project. CCS and the Health District are also working on a project (#081771001.2.1) to assist CCS clients that are suffering the side-effects of prolonged use of psychotropic medications. Williamson County & City Health District, south of Bell County, is proposing a broader primary care project (#126936702.1.1),but it will also increase availability of STD testing in their county.

The Health District is committed to improvement of services and broad-level delivery system transformation. The Health District has an excellent working relationship with the providers in RHP 8, and is willing to participate in learning collaboratives 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 semi-annual 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.

**Project Valuation:**

The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs for administrative staff overseeing the project, and for advertising costs to increase awareness of the project. The funds for the project are for salaries and fringe benefits only, as testing supplies, lab tests, and medications are provided at no cost to the Health District. The value of the project also includes the potential savings from possible ED visits, hospitalizations, surgeries, medications, and long term costs of care associated with untreated STD sequelae (i.e. PID, ectopic pregnancy, pregnancy complications, neonatal infections, chronic pain, [miscarriages](http://en.wikipedia.org/wiki/Miscarriage), [premature births](http://en.wikipedia.org/wiki/Premature_birth), [stillbirths](http://en.wikipedia.org/wiki/Stillbirth), or deaths of newborn babies).

**Category 2 Project Narrative**

**Bluebonnet Trails Community Services – 126844305.2.1**

**Project Area, Option, and Title:** 2.13.1 Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population.

**RHP Project Identification Number:** 126844305.2.1

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

**Performing Provider TPI #:** 126844305

**Project Summary:**

* **Provider Description:** Bluebonnet Trails Community Services (BTCS) is the state designated Local Mental Health Authority (LMHA) for Williamson and Burnet Counties in RHP 8. 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. We are responsible for behavioral health planning and coordination throughout our local service area and are the sole provider of public behavioral health services in these counties.
* **Intervention:** BTCS proposes to implement a Peer led transitional support services program. We will secure, prepare and staff community living settings suitable for no more than 6 individuals at a time who will be provided behavioral health services in this transitional service program to improve community living skills and residential stability with the goal of achieving permanent supportive housing.
* **Project Status:** This is a new project for BTCS. No such service exists from any provider in these Counties and there are limited affordable housing options and Permanent Supportive Housing options in the area.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment: CN.2.1 - Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.
* **Target Population:** The target population is people with mental illness referred from crisis services, criminal justice and inpatient settings. We will prioritize admissions to those with long or repeated stays in those settings or with frequent contacts with the criminal justice system. BTCS served 7,769 persons with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; and 73% of BTCS clients were below the federal poverty level. We expect 70% of those benefitting from this project will be poor, under or uninsured. This project will serve 48 people in DY5.
* **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to provide transitional housing services for 36 people in DY4 and 48 people in DY5. Stable living provides an opportunity to improve life skills and functioning.
* **Category 3 Outcomes:** IT‐11.26.c: Our goal is to improve functioning demonstrated by progress made on the Adults Needs and Strengths Assessment (ANSA) by a percentage TBD based on a 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. This project is transformative to the community because there are no affordable housing options for those who are treated and released from inpatient psychiatric settings or who have experienced a crisis event that dislocates them from community and family. Psychiatric/medical stability is impossible without housing.

**Project Description:**

*Peer Supported Transitional Services Program*

BTCS is the state designated LMHA for Williamson and Burnet Counties in RHP 8. We are responsible for an array of public 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 with behavioral health issues residing in the area. We serve a variety of persons through various contracts and payors. Among those, BTCS has a contract with the state to serve adults who are primarily diagnosed with Serious Mental Illnesses (SMI); the Federal definition can be found at (Federal Definition for SMI <http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc>).

This group of patients generally suffers from the most profound deficits in functioning and are often unemployed, homeless or living in sub-standard housing and without natural family or community supports. Recovery is possible for these individuals but it is a difficult journey requiring help and supports. BTCS and community partners are responsible for aftercare upon release from hospital and for stability in the community following Emergency Department (ED) visits, jail stays and the number disruptive of events that happen for those with SMI. Community stability cannot occur for anyone without access to housing.

BTCS proposes to implement a transitional support services program that is provided consistent with SAMHSA recognized recovery principles (National Consensus Statement on MH Recovery, <http://www.samhsa.gov/SAMHSA_News/VolumeXIV_2/article4.htm>) and staffed in large part by peer support specialists. Based on our treatment efforts and with the consensus of community leaders, we realize that with few permanent supportive housing options client transition from crisis services to recovery can entail additional barriers. BTCS is developing a program that includes not only transitional services but staff and resources to improve housing stock and locate and help individuals achieve Permanent Supportive Housing that comports with SAMHSA guidelines (<http://homeless.samhsa.gov/channel/Permanent-Supportive-Housing-KIT-557.aspx>).

We will identify suitable sites in Williamson and Burnet Counties that provide a safe place to live on a temporary basis and in which peer led transitional services can be provided. The program will accept referrals from our Crisis Respite Unit, State psychiatric inpatient facilities, criminal justice diversion programs and the local Community Center. The referrals will be screened and considered based on need. The program will be for individuals who have a need for housing. We will offer an array of services for voluntary client directed Recovery-Based Program participation options led by the Peer support staff and integrated into additional support services. We will encourage but not require individuals to accomplish their goals and objectives to increase financial, psychological and financial stability. While in the program, Peer Specialists will teach skills to improve the likelihood of a successful transition to residential stability with the goal of achieving permanent supportive housing. Peer Specialists in Recovery will assist those in the program to better understand their particular recovery needs while providing hope and encouragement. All admissions to the program will participate in a Wellness, Recovery, Action Plan (WRAP) to help target the individual needs. This evidenced based program focuses on promoting recovery and self –responsibility (*Developing a Recovery and Wellness Based Lifestyle Guide*, <http://store.samhsa.gov/product/Developing-a-Recovery-and-Wellness-Lifestyle-A-Self-Help-Guide/SMA-3718> ; and *Consumer Operated Services – EBP*, <http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD> ).

WRAP is listed on the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) registry of evidenced based practices. WRAP is an effective, manual-based group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources (wellness tools) and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness symptoms. These peer led services will lead into and be supported with client directed choice into community-based interventions which are comprehensive. The comprehensive and multispecialty services offered include permanent supportive housing services, supportive employment services, psychosocial rehabilitation and transitional assistance. Each program participant will have access to a Qualified Mental Health Professional (QMHP) Psychosocial Rehab Specialist, (QMHP) Supportive Housing Specialist and a (QMHP) Supportive Housing Specialist. These support services center on the person centered recovery plan developed through interaction with the peer support specialists.

Recognizing limited area housing resources and client income limitations, the program will provide client assistance to establish a basic household, including security deposits, essential furnishings, moving expenses and bed and bath linens. These interventions will have significant flexibility to add more components if they are appropriate to meet the needs of the target population.

Community‐based tools and practices such as these will stem from client direction and client choice identified and supported during ongoing activities. The program will be evaluated quarterly and outcomes will be closely monitored. We plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed. All services will be documented in our electronic information system. Data will determine the amount and frequency of the services being provided and will be utilized to help guide the program quarterly. Satisfaction surveys will be provided for individuals leaving the program to ensure we gather personal attitudes regarding the effectiveness of the program. The program and the additional staff as described above are charged with providing direct service and developing community resources that will facilitate rapid access to Permanent Supportive Housing including transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses and bed and bath linens so that individuals can smoothly move into community living.

**Goals and Relationship to Regional Goals:**

Over the next five years we expect to fully develop this program of peer led transitional support services based on recovery principles with an average census of around 10 persons who will stay from between one to six months depending on assessed need. We expect to serve 36 to 48 people each year after the program is underway. The goal of the program is to facilitate the change process for individuals with SMI through skills building, self-awareness, self-advocacy and providing the supports necessary for stable lives in a community setting.

**Project Goal:**

* Establish a Peer Led Transitional Services program based on Recovery Principles;
* Recruit, train and certify Peers to provide transitional services;
* Provide services to the target population of people who have been hospitalized or experienced a crisis event and have been in the Crisis Respite facility;
* Assist people to regain functioning and self-manage their wellness;
* Identify project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population. As stated above, we plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed both for the target population and any expanded populations.

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

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

As this program is established and grows, we expect individuals will have fewer ED visits, fewer state hospitalizations, a lower rate of arrests and fewer days incarcerated. An additional benefit of this program is that it can serve as a recovery resource to the broader community of persons in Williamson County with SMI who are in the process of recovery.

**Challenges:**

Challenges include the limited stock of affordable housing for persons who are ready to exit the criminal justice system, crisis and emergency services and illness related skill deficits needed to live independently or in a supportive living situation in the community. We have a long standing presence in the community and the support of community leaders who can assist in identifying suitable locations for Permanent Supportive Housing. Staff will work with clients to continually assess opportunities for Affordable, Accessible and Integrated Permanent Supportive housing choices for clients. Another key challenge is training and certifying peer support specialists and ensuring they have the knowledge necessary to make linkages with other programs such as crisis respite and federally qualified health clinics. During DY2 we will be actively recruiting individuals with SMI for training and certification as Peer Support Specialists. We will also begin a review and inventory of community resources.

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

Over the next 5 years, we expect the outcomes to include a reduction of readmissions to psychiatric hospitals within 30 days. The goals of this project are to establish a service that helps people live successfully and gives them the opportunity to be assisted by their peers as they make that transition. Community tenure will improve with these supports and readmissions will be reduced.

**Starting Point/Baseline:**

Currently no Transitional Services Program exists in the Counties; therefore, the baseline is 0 in DY2. Baseline data is expected to be based on patients entering the peer led transitional services program DY3. The precise metrics are to be determined based on the planning and research cycle of the project. As stated, we expect to impact ED visits, arrests, utilization of crisis respite services and state hospitalizations but we must determine the baseline number during the initial phase.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
  + Specific Community Need: CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.

In Category 2 - Innovation and Redesign; Project Area and Option: 13 –“Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ED, urgent care etc.); 2.13.1 Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population. The project incorporates at least six of the community‐based interventions including:

* Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services);
* Psychosocial Rehabilitation;
* Supported Employment;
* Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
* Transportation to appointments and community‐based activities;
* Prescription medications; and
* Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.

**Project Components:**

Required Core Components:

1. *Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.* We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gaps that must be filled to secure housing and to gain the skills for a smooth transition. With these stakeholders, we will identify tools to provide data to obtain an inventory of community resources currently utilized and those needed by the people we expect to serve.
2. *Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* We will use the current staff to assess current needs of those who are now hospitalized and soon to be discharged and those experiencing crisis events needing transition to community housing. Using the information from stakeholders, from capacity and utilization tools, from further literature reviews and from assessment of those potential referrals, we will assess the intervention we are planning to provide.
3. *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes*. As we implement the project, we will plan a rapid cycle quality improvement component through our Quality Management Department at BTCS. As discussed above, we plan for active peer participation in the PDSA cycle to assess the efficacy of WRAP and explore other wellness and recovery EBP’s if options are needed both for the target population and any expanded populations.
4. *d) Design models which include an appropriate range of community‐based services and residential supports.* We plan to continuously improve the program over the next 5 years as we adjust the interventions, peer supports and make changes based on lessons learned and client need. Those changes may include adjustments to the model with respect to interventions, intensity and population.
5. *e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* BTCS is a Community Mental Health Center and during FY 2014 we will be using the ANSA as a standard tool for assessment. Every program participant will be assessed and those documented in the electronic health record and available for report and analysis.

We expect the milestones and metrics in the first 2 years to reflect the innovative and developmental nature of this project. We will measure progress toward community assessment and development of infrastructure such as policies, training materials, contracts and support. This innovative community alternative to institutional care not only saves money through reduced hospitalizations but also provides people the opportunity for recovery with the help of their peers.

The Milestones selected for DY’s 2 and 3 are:

* P‐1 Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources;
* P-2 Milestone: Design community‐based specialized interventions for target populations. Interventions may include (but are not limited to)
  + Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services);
  + Psychosocial Rehabilitation;
  + Supported Employment;
  + Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
  + Transportation to appointments and community‐based activities;
  + Prescription medications; and
  + Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.
  + Residential Assistance;
* P‐4 Milestone: Evaluate and continuously improve interventions.

We selected these because we are starting a new program that has not been implemented in this Region and must ensure that the right population is targeted with the right interventions and then continuously adjusted as we learn how to help people succeed through the use of peers, supports and transitional services. The metrics are a combination of program reports and logs and census numbers.

The Milestone for DY’s 4 and 5 are:

* I-5 Functional Status: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on ANSA; we selected the target 30% in DY4 and 40% in DY5.

We selected Functional Status because we expect the period of Transition will improve functioning and our goal is to return to community life.

These Milestones and Metrics are specifically related to the targeted population of individuals who have recent crisis events that sometimes result in hospitalizations with the aim of providing them the best opportunity to make a recovery oriented transition to the community and thereby prevent further crises and hospitalizations.

**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 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 housing 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. BTCS currently employs Peer Support Specialists to enhance services in all outpatient programs. Peer Support and services based on Recovery Principles are system reform initiatives that we are proud to support. This system reform initiative will be enhanced by utilizing additional Peers in the vital role of promoting wellness and self-management. Also as stated above, this will create a community hub for Recovery activities.

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

* OD‐11 Behavioral Health/Substance Abuse Care
  + IT‐11.26.c: Adult Needs and Strength Assessment (ANSA)

Reasons/ rationale for selecting the outcome measure: This is a stand-alone measure. The goal of the program is to secure, prepare and staff community living settings suitable for individuals in need who will be provided behavioral health services in this transitional service program to improve community living skills and residential stability with the goal of achieving permanent supportive housing. Our goal is to improve functioning demonstrated by progress made on the Adults Needs and Strengths Assessment (ANSA) by a percentage TBD based on a baseline established in DY3. This assessment will be coupled with Stretch Activity CMHC.1.

Baseline Information: The baseline rate established in DY3 was 3.76. Our baseline measurement period established in DY3 was 10/01/2013-09/30/2014.

**Relationship to Other Projects:**

The project will be intertwined with new projects proposed by BTCS and existing programs. It is anticipated that some referrals will come from individuals who have been diverted from county jails or emergency services in our Emergency Service Diversion Project (#126844305.2.2). Also we expect persons to be admitted from the Crisis Respite Project (#126844305.1.2) and to use that program in lieu of hospitalization if short term stabilization is required. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities (IDD) who are provided WRAP around services through our IDD Assertive Community Treatment project (#126844305.2.3), in Pass 2 may be eligible for and need these transitional support services. Currently, BTCS has an active effort underway to recruit and certify peer specialists and this program will provide a great fit for the skills and commitment of those individuals.

**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:**

This project seeks to provide peer led transitional support services for 18 people in DY4 and 48 people in DY5. Although this is a small number of people, the acuity is such that we expect 1,080 bed days in DY4 and 1,620 bed days in DY5 since this is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Transitional services leading to Permanent Supportive Housing with community supports provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for inpatient psychiatric facilities and substantial patient benefit in that it supports a healthy life in the community. 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 2 Project Narrative**

**Bluebonnet Trails Community Services – 126844305.2.2**

**Project Area, Option, and Title:** 2.13.1 Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population.

**RHP Project Identification Number:** 126844305.2.2

**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 (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 public provider of behavioral health services for the poor, under or uninsured in Williamson County and coordinates and provides crisis services.
* **Intervention:** BTCS proposes to use healthcare teams to reduce utilization of emergency services by individuals identified as a high utilizers. Those identified will be offered proactive care in settings other than emergency departments (EDs), including their homes. Services will be provided immediately in the short‐term and ongoing wellness activities and behavioral health treatment will be initiated in the long‐term.
* **Project Status:** This is a new project to be established in partnership with the Williamson County Emergency Medical Services (EMS).
* **Project Need:** A study revealed of 144 High Utilizers of emergency services, 105 had a mental health diagnosis and accounted for 2,071 ED visits during 2010. This project addresses the RHP 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.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County.
* **Target Population:** This project will identify high utilizers of emergency services through the use of EMS records, Indigent Care Collaboration EMR statistics and ED reporting. BTCS served 6,429 persons with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid‐eligible; and 73% of BTCS clients were below the federal poverty level. We expect 70% of those benefitting from this project will be poor, under or uninsured.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide care to at least 45 people in DY4 and 60 people in DY5. Access to a broader range of services, a medical home and wellness activities will improve functioning, improve quality of life for these patients and will reduce the multiple inappropriate trips to the ED. This is a substantial benefit to these patients who have improved access to ED services due to reductions of inappropriate utilizers and to healthcare costs in the RHP.
* **Category 3 Outcomes:** IT‐9.4.e: Our goal is to reduce Emergency Department visits for Behavioral Health/Substance Abuse.
* **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 is a transformative project as indicated by the broad community support and participation by Williamson County Emergency Services and the healthcare community. This group of patients has presented a substantial challenge to the community and a drain on community resources. All healthcare providers are looking forward to reducing this inappropriate utilization.

**Project** **Description:**

*Emergency Services Diversion Project/Community Health Initiative*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to use teams consisting of a project coordinator, licensed social workers (LSW), advanced Paramedic and nurse practitioner (NP) to reduce utilization of emergency services by individuals identified as high utilizers of such services. This project will identify high utilizers of emergency services through the use of Emergency Medical Services (EMS) records, Indigent Care Collaboration Electronic Medical Record (EMR) statistics, and emergency department (ED) reporting. When individuals are identified, they will be offered the opportunity to receive proactive assistance in settings other than hospital EDs, including their homes. To participate patients must be enrolled and sign a Consent for Care form, which will also allow sharing of information in order to improve continuity of care. Enrolled participants medical records will be reviewed by a Professional Peer Review Committee (PPRC) made up of medical and mental health professionals from five local public hospitals, the Williamson County & Cities Health District (WCCHD), Mobile Outreach Team (MOT), EMS and Bluebonnet Trails Community Services. The PPRC will create unique comprehensive care plans for patients identified that often have mental illness and co‐occurring disorders. The collaboration and sharing of information by professionals will allow improved coordination of community resources, continuity of care, avoidance of over prescribing, or contra‐indication of numerous medications prescribed by multiple sources. Once a comprehensive plan has been created local hospitals should follow the plan which will help avoid duplication of services and unnecessary lab and medical tests.

Another important component of the project is the use of non‐physician health professionals to help coordinate care and connect patients with multiple and complex needs to appropriate resources. Teams of professionals including an advanced paramedic, Advanced Nurse Practitioner and Licensed Social Workers will make home visits to check vital signs, help with medication compliance, assess home safety and ensure basic needs are met with appropriate resources. By providing proactive care with multidisciplinary teams, patients can learn to manage their chronic conditions, avoiding costly emergency room and hospital admissions can be avoided, while reducing costs and improving quality of care.

To initiate appropriate disposition of calls into the field, the 11 Williamson County EMS dispatchers will be trained to recognize critical primary and behavioral health issues. A centralized health information management system will be used to collect patient access information from the participating emergency and crisis services providers including the local EDs, EMS, MOT and BTCS. A data analyst will be hired to review the patient access information from each participating emergency and crisis services provider. On a monthly basis high utilizers of the emergency and crisis services will be identified by the data analyst and presented to the PPRC. The PPRC is comprised of key staff from the participating emergency and crisis services. A collaborative treatment plan will be developed for the individual identified as a high utilizer of emergency and crisis services.

The treatment plan will be shared with each participating emergency and crisis services provider‐‐and will drive the treatment provided in the field by the team of professionals including the advanced Paramedic, Advanced Nurse Practitioner and Licensed Social Workers. Each participating provider will be able to follow the treatment to ensure the individual receives a comprehensive approach to care‐‐ reducing the use of unnecessary ED visits; reducing readmissions into critical care; assisting the persons without a medical home to engage with a medical home; and positively impacting the overall health of each individual served.

This team has the capability to serve 30 identified patients at any given time. The PPRC may establish other comprehensive care plans that do not involve the use of the team for coordination of care purposes.

**Goals and Relationship to Regional Goals:**

This project proposes to use multi‐disciplinary teams to reduce utilization of emergency services by individuals identified as a high utilizer of such services. Patients who have been identified as high utilizers of EMS and ED services will receive a care plan that reduces high utilization of EMS and ED services.

**Project Goals:**

* Establish a Professional Peer Review Committee for the purpose of establishing care plans for patients with a history of high utilization. The PPRC allows for discussion of treatment related issues in a protected environment, for the purpose of improving care at any location
* Establish a team of a LSW and NP to provide coordination of care, patient education, and linkage to needed services to prevent unnecessary use of EMS and ED services.
* Reduce inappropriate emergency transports, ED use
* Improve quality of care and access to healthcare for patients with complex medical needs
* Reduction of inpatient hospitalizations and costs associated with providing emergency services.

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

health needs.

We are proposing this project in Williamson County because an August, 2011 study by the WCCHD and the Integrated Care Collaboration of ED use in Williamson County zip codes found that a small cohort of individuals account for a disproportionate share of acute medical cases, and while consuming significant resources they were achieving poor health outcomes. There were 144 High Utilizers (HU) of emergency services, as defined as having 6 or more ED visits during a 3 month period. Of these HUs, 105 had a mental health diagnosis and accounted for 2,071 ED visits during 2010. Overall MH utilization had 44% growth from 2008 to 2010 while HUs of MH had a 74% increase. 50% of HUs have Medicaid as a payment source with the majority of the remainder having no payment source. Baseline data from the above referenced study shows that the 144 HUs accounted for approximately 2,100 ED visits. With an average ED visit being $3,700 this equals approximately $7.8 million dollars of medical care, which does not account for the cost of EMS transport. Assuming half of the visits were transported by EMS at a cost of $1,361/transport that would equal approximately another $1.43 million.

**Challenges:**

It will be a challenge to coordinate a monthly meeting of appropriate healthcare professionals in order to provide services to high users (HU) of emergency services. It will be a challenge to create an authentication system to ensure users view appropriate sensitive medical information based on assigned roles and responsibilities. It will be a challenge to develop patient consents and methods for sharing data that meets the needs of all of the partners. Finally, it will be a challenge to identify the appropriate patients to serve, as there is anticipated to be more need than there are resources to provide care.

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

Over the next 5 years, we expect the outcomes to include: patients with high utilization of emergency services will be continuously identified and served in the most appropriate and efficient setting; and that will result in a reduction of ED utilization by the targeted population.

**Starting Point/Baseline:**

Currently no Emergency Services Diversion project exists in Williamson County; therefore, the baseline is 0 in DY2. As presented above, we do have data reflecting the number of people identified as high utilizers, with 6 or more visits to the ED during a 3 month period, but we do not know the number who will accept the services and be enrolled in the project. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to mental health/behavioral health services
* Specific Community Needs include:
  + 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.
  + CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County

A project to establish a PPRC among local hospitals, the health department, the mobile outreach team, EMS, and BTCS provides an opportunity to create comprehensive treatment plans for patients identified as high utilizers of emergency services. The plan may involve the use of teams consisting of an advanced paramedic, nurse practitioner and licensed social workers to coordinate services, improve patient compliance, monitor chronic conditions, and reduce duplicative services and link to needed services within the community. The skill set of the team will allow for assessment of medical conditions, psychiatric conditions, and substance use problems. Patients with chronic conditions will receive proactive, ongoing care keeping patients healthy and empowering patients to self‐manage their conditions in order to avoid a decline in health or needing ED or inpatient care. This project provides the opportunity to improve the quality of care while reducing reliance on unneeded emergency services.

**Core Project Components:**

This project to provide Emergency Services Diversion will address all of the required core project components:

a*) Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic* *involvement.* Although the initial study, cited above, revealed the number of high utilizers and some characteristics of the population, the contributing factors are not completely described. We will gather information from electronic health records and case management reports to further refine the characteristics and needs.

*b) Review literature / experience with populations similar to target population to determine*

*community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* The community team has done some literature review. The basic design of this project as well as the information sharing protocol and implementation steps originated from those reviews.

We will use the PPRC to continue those reviews to expand the community based interventions to be developed in subsequent years.

*c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS and hospital business intelligence and quality management staff to facilitate the development and documentation of our evaluation plan. Oversight will be provided by the PPRC who will ensure qualitative and quantitative metrics will be used to measure outcomes.

*d) Design models which include an appropriate range of community‐based services and residential supports.* Using the information from stakeholders, PPRC, evaluation metrics, patient assessments and reports; we will evaluate available interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

*e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety‐net populations.* The impact of interventions will be assessed on an individual patient level by using the ANSA and SF 36. Aggregated data from those assessments along with number of ED visits, cost of medical care pre and post intervention, will be used to assess community impact and identify and respond to lessons learned.

**Continuous Quality Improvement:**

The 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 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**:

As presented above, the August, 2011 study by the WCCHD and the Integrated Care Collaboration of ED use in Williamson County zip codes found that a small cohort of individuals account for a disproportionate share of acute medical cases, consuming significant resources they were achieving poor health outcomes. There were 144 high utilizers (HU) of emergency services, as defined as having 6 or more emergency department visits during a 3 month period. Of these, HU MH had a 74% increase. The high utilizer case management program implemented by the University of Washington Medicine, (The University of Washington Medicine, Harborview Medical Center in 2009 which *A High Utilizer Case Management Program* [(http://www.wsha.org/files/2012](http://www.wsha.org/files/2012) June 15 Behavioral Health Web Conf.pptx;) indicates that one common cause of frequent ED use is lack of access to primary care and another is the presence of behavioral health diagnoses. BTCS is a recipient of a grant through the Health Resources and Services Administration Division of the U.S. Department of Health and Human Services (DHHS) to develop a primary care/behavioral health care another RHP in partnership with the Federally Qualified Health Center for Guadalupe County. BTCS also receives funds from 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 in this project; however, this project enhances and extends those by identifying and directing those in need to re care currently provided with federal funds.

**Related Category 3 Outcome Measure:**

* OD‐ 9 Right Care, Right Setting
  + IT‐9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse

Reasons/rationale for selecting the outcome measure:

Rationale: Our goal is to decrease the emergency department visits for those with behavioral health and substance abuse issues. We aim to demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5. We selected this particular outcome because we believed it would measure the impact of the diversions. However, the number of persons in the intervention population is very small compared to the total number of ED visits. This measure might not be an accurate measure of the impact.

Baseline Information: The baseline rate established in DY3 was 9.59%. Our baseline measurement period established in DY3 was 10/01/2013-09/30/2014.

**Relationship to Other Projects:**

This enhances additional projects that BTCS is pursuing related to Emergency Services Diversion in that it provides access to care following emergency interventions. As a part of graduation from Emergency Services Diversion, we will be able to offer:

* The Transitional Housing initiative [#126844305.2.1] will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
* The Expansion of Services in Eastern Williamson County [#126844305.1.1] will allow for ongoing outpatient services for persons who currently do not meet the eligibility criteria through existing funding from the Community Mental Health services block grant provided through the Department of State Health Services from DHHS;
* The Crisis Stabilization plan [#126844305.1.2] for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital.
* Like the Crisis Stabilization plan, the Substance Addiction Treatment option [#126844305.1.5] will offer substance abuse treatment as a back‐up for relapse and crisis events.

We expect these interrelated projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. This Emergency Services Diversion plan supports and relies upon the projects noted above in developing a strong community network of resources for people to continue their recovery.

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

This project works in relation with Williamson County and Cities Health District project (126936702.1.2) for Community Paramedicine. 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:**

We expect to serve 45 patients in DY4 and 60 in DY5. As described above, this represents over 700 ED visits and millions of dollars in trips by EMS, ED cost and hospital cost. 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. asanat 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.bbtrrails.org](http://www.bbtrrails.org/) under the Medicaid 1115 Transformation Waiver tab. A complete write‐up of the project will be available at performing provider site.

**Category 2 Project Narrative – Pass 2**

**Bluebonnet Trails Community Services – 126844305.2.3**

**Project Area, Option and Title:** 2.13.1 – Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population**.**

**RHP Project Identification Number:** 126844305.2.3

**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 state designated Local Authority (LA) for persons with Intellectual and Developmental Disabilities (IDD) for Burnet and Williamson Counties in RHP 8. The two Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. The LA designation includes the requirement to serve as the Safety Net for individuals with IDD in the region.
* **Intervention:** BTCS proposes to provide intensive wrap around services called Assertive Community Treatment (ACT) for individuals with IDD at the point of crisis and during life transitions to prevent them from being placed in institutions or inappropriately using EDs and crisis services. These services include crisis response, assessment, behavior plans and management. We will also train and educate health care providers on serving those with IDD.
* **Project Status:** This is a new service and an innovative application of ACT teams.
* **Project Need:** This project addresses RHP 8 Community Needs Assessment needs: CN.2 – Limited Access to Mental Health/Behavioral Health Services; and CN.2.14 ‐ Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County.
* **Target Population:** The target population is individuals with IDD who are taken to EDs in our region or in jeopardy of losing community living placements due to behaviors that are challenging or dangerous. We anticipate serving about 50 persons annually once the program is matured. BTCS served 882 persons with IDD in these counties in FY 2012 and 50% were Medicaid eligible. We expect at least 50% of those benefitting from these services to be Medicaid beneficiaries.
* **Category 1 or 2 Expected Project Benefit for Patients:** We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve and regain their functioning level and return to community living. Services will continue until the individual is stable and comfortable in their setting.
* **Category 3 Outcomes:** IT‐11.26.b: Our goal is to improve upon problem behaviors identified by the Aberrant Behavior Checklist (ABC) and exhibited by those individuals served in this program.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and* *Developmental Disabilities (IDD*)

BTCS is the state designated LA for Burnet and Williamson Counties in RHP 8. That designation includes the requirement to serve as the Safety Net for individuals with Intellectual and Developmental Disabilities (IDD) in the region (TAC Title 40, Part I, Chapter 2, Subchapter G, Rule 2.303). In that capacity we are responsible for assessing the service and support needs of individuals with IDD, coordinating service planning for them and assembling a network of providers to meet those needs. In our role as LA, BTCS has identified that individuals who experience behavioral issues in foster care, group homes and Intermediate Care Facilities/Intellectual Disabilities‐Related Condition (ICF/ID‐RC) settings are frequently brought to Emergency Departments (EDs) in Williamson and Burnet Counties for treatment and stabilization of what is identified by the provider as a mental illness. Persons with IDD are frequently misdiagnosed and responded to improperly when they are exhibiting behavioral issues. These behavioral issues are often preceded by times of stress such as changes in care giver, changes in living situations, other life changes that might be customary but still result in a need for crisis response. Sometimes the behavior issues are a result of co‐occurring mental illness. Research indicates that as many as 33% of individuals with IDD have a co‐existing mental illness (*Social Work Today*, Vol. 10 No. 5; Quintero & Flick, 2010: [http://www.socialworktoday.com/archive/092310p6.shtml).](http://www.socialworktoday.com/archive/092310p6.shtml))

BTCS has developed specialized interventions for persons diagnosed with Autism Spectrum Disorders and currently provides ACT Team services for persons who need intensive mental health services. We plan to build on these areas of expertise. BTCS proposes to provide ACT Team services for individuals with IDD at the point of crisis and during life transitions such as when individuals move from natural supports, discharge from State Supported Living Centers (SSLC) or ICF/ID‐RC facilities. Through this project we will divert people with IDD from higher cost, institutional placement and into local resources. The project will also provide specialized consultation to attending physicians providing primary care and emergency medicine services, allowing them to provide proper care rather than expending resources trying to diagnose and treat outside of their area of expertise. Stakeholders in the region have provided the impetus for the project with their requests for assistance to avoid disruption of long‐term residential placements. Families of individuals with IDD report an inability to address needs of their family members or to find a skilled provider to assist them to keep family members at home or be accepted into residential placement because of repeated visits to EDs and admissions to mental health facilities or jails.

ACT Teams are well documented best practice as intervention for persons with Serious Mental Illnesses (SMI) who have a difficult time maintaining community tenure. The intervention is included in the Substance Abuse and Mental Health Services Administration (SAMHSA), Evidence Based Practices registry and a Toolkit for implementation of ACT is available through SAMHSA (<http://store.samhsa.gov/product/Assertive>‐Community‐Treatment‐ACT‐Evidence‐ Based‐Practices‐EBP‐KIT/SMA08‐4345). We plan for the ACT Team for persons with IDD to be led by a Licensed Masters Level professional and will include a psychologist who is a behavioral expert and a psychiatric consultant, nursing, service coordinator and community skills trainers. We will locate the team in Round Rock to respond to requests for intervention from either County we serve. At the time of referral we expect to go where the individual is and provide assessment and intervention to stabilize the situation. Following that we will continue assessment that leads to the development and implementation of a behavioral plan to help the individual return to his/her current living situation and to successfully maintain in that setting. Wrap around services will continue until transition to other community resources can be achieved and the person is comfortable and stable with the new resource provider. Team intervention is envisioned to be short‐term and intensive with the goal of helping persons retain community placement, with referral to long term provider resources where appropriate. In addition to direct client intervention, we propose to use the resources of the team to begin educating law enforcement and emergency rooms as well as IDD group home providers to create referral paths that are well known and easy to use. For DYs 2 and 3 we selected Process Milestones, P‐2, designing the intervention; P‐3, enroll and serve persons in the targeted population with complex needs; and P‐7, participation with other providers and the RHP to promote collaborative learning. We will document the activities associated with design in implementation plans and the adjustment of that design in the CQI notes, minutes and real time data from electronic health record (EHR) as relates to assessment of functioning, treatment participation and patient goal achievement. We will document enrollment and service in the EHR. We selected these Milestones because we are starting a new program, reflecting an innovative use of the well‐known ACT team concept. This approach, as we have proposed it, has not been implemented in this RHP or anywhere else. We must ensure that the right population is targeted with the right interventions and that the program is continuously adjusted as we learn how to help people succeed. We selected the I‐5 Milestone: Functional Status, for both DYs 4 and 5. We have identified preliminary research indicating that the BPI‐01 and/or ICAP could be useful as a functional assessment for this project (*Research in Developmental Disabilities* 2010 Jan‐Feb 31(1) 97‐107 [http://www.ncbi.nlm.nih.gov/pubmed/19800760#).](http://www.ncbi.nlm.nih.gov/pubmed/19800760#)) We selected this Milestone because it is important to us that persons with IDD remain in their long‐term placements. Achieving the goal of improved functioning will preserve placements and reduce ED utilization.

**Goals and Relationship to Regional Goals:**

This project proposes to use multi‐disciplinary ACT Teams to intervene during the utilization of emergency services and reduce further ED use by persons with IDD.

**Project Goals:**

* Develop an ACT Team model specializing in the assessment and stabilization of persons with IDD and utilizing existing resources in the community where appropriate;
* Provide training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non‐residential providers regarding the project and how to access the services;
* Implement the project to target group as requests for services are received; and
* Gather data for outcome measures reflecting services utilized and effectiveness of these services to ameliorate crisis and preserve undisrupted community living for persons with IDD.

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

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

**Challenges:**

The biggest challenge is that there is a pervasive misunderstanding in the health care community and in broader community concerning the differences in diagnosis and treatment between behavioral issues for persons with IDD and mental health crises for persons with SMI. Another challenge will be acceptance by caregivers that the intervention will work and that services will be wrapped around the individual until the crisis is resolved. This project will address the first challenge through education by engaging emergency medical professionals, IDD consumers and advocates throughout the RHP 8 to assist us in developing a protocol to implement ACT Teams for persons with IDD. We will then widely disseminate that protocol through a communication plan that utilizes resources of community partners. This same education and communication approach will be used with caregivers in order to address the second challenge.

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

Over the next five years we expect the outcome of this project to include providing training to law enforcement, ED personnel, health care providers, psychiatric hospital providers, and community residential and non‐residential providers regarding how to recognize behavioral issues in persons with IDD and how to access appropriate services. The outcome for program participants will be avoidance of unnecessary inappropriate ED utilization and the resulting loss of community living arrangements and overuse of institutional care. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

**Starting Point/Baseline:**

Currently no ACT Team Services for persons with IDD exists in the four Counties; therefore, the baseline is 0 in DY2. We will enroll and serve individuals in DY3; therefore, the baseline will be established during DY3.

**Rationale:**

**Community need addressed:**

* Community Need Area: CN.2 – Limited Access to Mental Health/Behavioral Health Services
* Specific Community Need: CN.2.14 – Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County. There is no ACT team for persons with IDD currently in place in RHP 8 but there is evidence that a specialized intervention is needed for these individuals when they are taken to EDs. An ACT Team that includes specialists in IDD who can assess needs and apply behavioral plans or other IDD specific interventions will reduce time in the ED, misdiagnosis and placement in more restrictive settings. Currently available data does not accurately identify the number of persons with IDD who have been taken to EDs due to behavior problems. We can identify the number of persons in service through the LA who have been removed from placement and admitted or referred to a higher level of care. However, visits to EDs are coded as interventions for mental illness diagnoses regardless of the presence of IDD, frequently resulting in the misidentification of behavior problems as other mental illnesses. Our estimate of the number whose admission is a result of behavior problems is around 30% based on experience working with this group of persons.

BTCS participates in a pilot program through the Department of Aging and Disability Services (DADS) the aim of which is to reduce institutional placement using the team approach. There are an increased numbers of individuals that have been referred at intake that are in crisis due to the lack of appropriate resources to respond to the behavioral crisis. The persons that are at high risk display one or more of the following needs: danger or risk of losing their support system, especially those supports a person requires to continue living in their own or family home; at risk of being abused or neglected; basic health and safety needs are not being met through current supports including mental health needs; at risk for loss of the functional skills that keep them in their community; or repeated criminal behavior or dangerous behaviors or threats, but incarceration is not an option because of their low level of cognitive ability. An increase of referrals from SSLCs is expected for individuals transitioning to community living. They will need a crisis intervention plan developed to insure supports are in place prior to the move for successful community living. At this time 5 referrals from the SSLC have been made. The ACT Team will enhance this current pilot project and serve as a safety net for those individuals.

**Project Components:**

The ACT team services for persons with IDD will address all of the required core components:

a*) Assess size, characteristics and needs of target population.* Although the initial data cited above, gives a picture of the number of persons with IDD referred to EDs, all EDs are not included and the cause of referral does not differentiate for behavioral issues. We will define the data needs and then gather information from electronic health records and case management reports to further refine the characteristics and needs.

*b) Review literature / experience with populations similar to target population to determine community‐based interventions that are.* The staff for the LA has done some literature review to identify basic design of this project and the application of ACT to persons with IDD. As described above, we need to engage stakeholders to develop specific protocols for the intervention. We will use that coalition to promote community understanding and response.

*c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS quality management staff to facilitate the formation of learning collaboratives with the other community centers in RHP 8, all of which provide services and supports to persons with IDD. We will meet and disseminate information among the group to ensure qualitative and quantitative metrics will be used to measure outcomes.

*d) Design models which include an appropriate range of community‐based services and residential supports.* Using the information from stakeholders, community centers, evaluation metrics, functional assessments and reports; we will evaluate interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

*e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* As indicated below, preliminary research leads us to consider using Behavior Problems Inventory ‐01 (BPI‐01) or the Inventory of Client and Agency Planning (ICAP) as a functional assessment. Our staff is familiar with both and we expect one of these will give us the best measure of individual improvement. However we will perform additional research prior to implementation of the tools. Aggregated data from the assessment selected along with number of ED visits will be used to assess community impact and identify and respond to lessons learned.

**Continuous Quality Improvement:**

The 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:**

As stated above, BTCS currently participates in a team based pilot to reduce institutional care through the DADS. This project supports and enhances that system reform initiative that supports the Promoting Independence goals of DADS. BTCS is also a recipient of a grant through the Health Resources and Services Administration Division of the US Department of Health and Human Services (DHHS) to develop a primary care/behavioral health care another RHP in partnership with the Federally Qualified Health Center for Guadalupe County. BTCS also receives funds from 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 in this project; however, this project enhances and extends those services that will be needed as the ACT Team assists in transitioning individuals back to their long‐term living environment and community living.

**Related Category 3 Outcome Measure:**

* OD‐ 11 Behavioral Health/Substance Abuse Care
  + IT‐11.26.b Aberrant Behavior Checklist (ABC)

Reasons/rationale for selecting the outcome measure:

Rationale: The goal of the program is to develop community assessment and intervention options that result in a reduction of inappropriate hospital admissions for this special population. The results of those interventions will be measured by improvements in the ABC scale and the stretch activity will connect any person that is admitted to timely effective community services.

Baseline Information: The baseline rate established in DY3 was 96.94. Our baseline measurement period established in DY3 was 04/01/2014-09/30/2014.

**Relationship to Other Projects:**

This project to intervene and stabilize persons with IDD in Crisis enhances additional projects that BTCS is pursuing in that they relate to additional crisis services and supportive aftercare such as Transitional Housing. Related Projects include:

* The Transitional Housing initiative (#126844305.2.1) will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
* The Crisis Stabilization project (#126844305.1.2) for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital; and
* Crisis Assessment for Persons in Behavioral Health Crisis (Burnet County) (#126844305.1.5) to support and enhance the ACT for persons with IDD responses in this County.

We expect these interrelated projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. The plans and supports employed by ACT Teams depend on community resources. The projects noted above improve the community network of resources for people.

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

While this project shares a number of things in common with other LMHA’s, the project Central Counties is planning regarding a Coffeehouse for High Functioning IDD (#081771001.1.3) addresses the same audience.

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:**

We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve and regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. 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.bbtrrails.org](http://www.bbtrrails.org/) under the Medicaid 1115 Transformation Waiver tab. A complete write-up of the project will be available at performing provider site.

**Category 2 Project Narrative – Pass 2**

**Bluebonnet Trails Community Services – 126844305.2.4**

**Project Area, Option and Title:** 2.13.1 – Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population.

**RHP Project Identification Number:** 126844305.2.4

**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 only public behavioral health provider in these Counties.
* **Intervention:** BTCS proposes to expand the clinical capacity and eligibility criteria for youth and adults arrested or incarcerated in these two Counties. We will provide screening, assessment and diversion recommendations prior to long‐term incarceration. We will ensure linkage to community behavioral health care.
* **Project Status:** This expands current services in Burnet and Williamson. We will add staff and open eligibility beyond current limitations.
* **Project Need:** This addresses RHP 8 Community Needs: 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; CN.2.13 – Limited access to adult behavioral health services in Williamson County; 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 includes those in contact with law enforcement, arrested or in the process of booking and those on probation, parole or otherwise released from detention in these Counties who are also diagnosed with behavioral health disorders. Jail match records indicate 17% of those jailed in Burnet County and 15% of those in Williamson County in 2012 had prior treatment in the state mental health system. BTCS served 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 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 75 individuals a year.
* **Category 1 or 2 Expected Project Benefit for Patients:** We expect to serve an additional 50 people in DY4 and 75 in DY5 achieving our Improvement Milestone I‐X for Target Population Reached. Behavioral health treatment stabilizes thinking, mood and behavior and thereby improves the functioning of these individuals. We will measure that improvement by administration of standardized instruments, ANSA for adults and CANS for youth on admission and at intervals during treatment. We expect 30% receiving specialized interventions will demonstrate improved functional status in DY4 and 40% in DY5 (Improvement Milestone I‐5.1).
* **Category 3 Outcomes:** IT‐ 9.1: Our goal is to decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Behavioral health treatment improves the lives of those who are diverted from incarceration and when treatment is provided upon release from detention it allows the opportunity to participate fully in community life.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Services to Justice‐Involved Youth and Adults – Burnet and Williamson Counties*

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. The LMHA has responsibility to identify gaps in service or barriers to access for persons with behavioral health issues residing in the area. We also provide direct treatment services under contracts with a variety of payers, including the Department of State Health Services (DSHS) and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) to provide specialty behavioral health services to the “priority population.” BTCS proposes to enhance its current services in Burnet and Williamson Counties for justice‐involved youth and adults by expanding the clinical capacity of those programs, expanding the eligibility criteria to include a broader range of mental illnesses including substance use disorders and to serve those who are charged, adjudicated and proposed for release within the County justice systems.

The goal of the program is to provide screening, assessment and diversion recommendations prior to long‐term incarceration. To carry out this project, we will hire and train licensed professional staff and additional case management support staff. The services will be located in our current offices in Burnet and Williamson Counties. These staff will work toward enhancing and expanding treatment services provided to current TCOOMMI patients and to a new broader range of eligible program participants.

The ‘priority population’ includes children and adolescents with Serious Emotional Disturbance (SED) and adults, who are primarily diagnosed with Serious Mental Illnesses (SMI), (Federal Definition for SED and SMI can be found at: [http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc).](http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc).%20) These groups of patients need services and are in serious jeopardy when placed in prison and juvenile probation facilities; however, there are a large number of individuals who also need services and could benefit from treatment and potentially be diverted from incarceration. BTCS operates a service funded by TCOOMMI in Williamson County that serves this ‘priority population’ and provided care in FY 2012 to 38 adolescents. The *Texas Criminal Justice Coalition‐ Williamson County Juvenile Justice Data Sheet* reveals that of the 869 youth between the age 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.’” There is no youth program in Burnet County, which reports that 95% of the children in court Appointed Special Advocates program needed mental health services. They also report that only 10% of the youth in Juvenile Probation received needed mental health services (*FY 2011‐2013 Burnet, Blanco and Llano Counties Community Plan for Coordination of Criminal Justice* *and Related Activities*, February 2011). Regarding adults, DSHS data regarding those arrested who have been treated in the state mental health system shows that for the four month period during the beginning of 2011, 383 individuals jailed in Burnet and Williamson Counties had been treated prior to incarceration. That represents 17% of those jailed in Burnet County and 15% of those in Williamson County.

There are 2 aspects to improving services for justice‐involved youth and adults. First is the assessment, treatment planning and referral combined with linkage through the court of probation and parole system. The second is the treatment services required to meet the needs identified by the assessment and treatment planning. This project addresses the later by adding professional licensed staff to the current program and by increasing the case management staff, i.e. linkage and court liaison staff. The treatment availability issue is addressed through several other DSRIP projects BTCS has proposed. The project staff will provide a critical assessment, evaluation and linkage function to those new programs and services. BTCS has made excellent progress over the last several years in obtaining permission and installing telemedicine connections and equipment at County jails which will allow for screening and diversion prior to incarceration. When clinically appropriate and depending on the nature of the charges, recommendations may be made for community based services based on the condition that the appropriate judicial authority drops criminal charges. This recommendation will give judges alternatives to incarceration. If the judge agrees to release the person, a BTCS case manager will arrange transportation, temporary housing and necessary services. Services and client functioning improvement are documented in court orders and in

Anasazitm, the EHR for BTCS.

**Goals and Relationship to Regional Goals:**

The vision or overarching goal for RHP8 is to “… transform the local and regional health care delivery systems to improve access to care, efficiency, and effectiveness.” Reducing inappropriate use of justice systems by adults with SMI and youth with SED will not only improve the lives of those individuals, but improve overall health and well‐being in the Region. Making resources available to provide effective and efficient health care in lieu of incarceration improves quality of life, community health outcomes and criminal justice outcomes. The goals for the program are to provide early intervention and treatment to individuals in custody but **not yet incarcerated** for the long‐term in county jails or in prisons and to reduce multiple arrests by providing behavioral health treatment that stabilizes behavior, improves functioning and reduces social deficits. This intervention will reduce potential psychiatric hospitalizations as well. We expect to be able to reduce the percentage of those who are incarcerated and have an exact behavioral health system match by 25% over the five years of the project.

**Project Goals:**

* Expand the scope of the services for justice‐involved adults and youth by adding licensed staff;
* Expand the range of eligible participants in the services for justice‐involved youth and adults; and
* Implement the project in collaboration with juvenile and adult Court systems and other components of the justice system.

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

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

**Challenges**:

A major challenge will be working with the Courts and other components of the criminal justice systems to identify opportunities for early intervention and diversion. Even though someone might be eligible for diversion to treatment, the judicial system must act on that recommendation by dropping charges or taking other legal steps. Judges, prosecutors and defense attorneys must feel confident that treatment will be provided and that it has a reasonable chance of success. This challenge will be addressed by providing ongoing training and continuing education for jail staff and law enforcement. Communication between BTCS and jail staff, local law enforcement, prosecutors and judges is currently part of the justice‐ involved intervention program, but is limited to the specialty interventions and special populations or long‐range planning. BTCS will strengthen an ongoing dialogue with judges, prosecutors, attorneys, adult and juvenile probation by focusing on new services and access for new populations. We will engage in joint implementation planning, joint treatment planning and presentation of outcome data available so they can achieve confidence and fully utilize the services.

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

The expected outcome over five years is that fewer adults and youth with behavioral health diagnoses and who commit minor crimes stemming from the deteriorated mental state will need to be incarcerated and instead can receive needed services in a community setting where they have a greater opportunity to lead a stable life. Early intervention and diversion will reduce the number initially incarcerated and ongoing services will reduce recidivism. As a result, we expect to reduce the number of matches in the behavioral health data system to 25% of the level as determined in data extracted for DY2, during the discovery and assessment period of the project for adult jail matches and assessed youth in the juvenile probation system.

**Starting Point/Baseline:**

Currently, some services for the ‘priority population’ who are also justice‐involved are provided in Williamson County and some jail diversion screening, assessment and referral services are provided in Burnet County. However, the eligibility criteria have not been expanded, nor have clinical services and oversight been added to the program.

Therefore, the baseline census for the new project is 0 in DY2. Additionally, we have not begun the uniform administration of functional assessments and do not have a baseline for changes in functioning as a result of the programs. We will use the remainder of DY2 to initiate needed processes. We will enroll and serve individuals in DY3; therefore, the baseline for census and the baseline for Functional Improvement will be established during DY3 as those assessments are completed.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to mental health/behavioral health services
* Specific Community Needs:
  + 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.
  + CN.2.13 – Limited access to adult behavioral health services in Williamson County.
  + 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.

Texas has historically utilized the criminal justice system as the default provider of mental health services for adults. As a consequence, many individuals with serious and persistent mental illness spend months and years incarcerated for misdemeanors. Texas spends even less on services for youth in need of behavioral health services and in recent years juvenile probation departments have had to increase mental health services to meet the growing demand. According to the Williamson County Juvenile Services 2011 Annual Report, they conducted 1202 follow up assessments for mental health issues based on initial screenings and “…(t)he department conducted a total of 368 psychiatric appointments for youth in the Academy, Juvenile Justice Alternative Education Program (JJAEP), TRIAD, Detention, and Field Probation;” (page 45). These statistics and the jail match data presented above indicate the consequences of limited access to behavioral health services in Williamson and Burnet Counties.

A second consequence is demonstrated in the absence of referral and follow‐up treatment as individuals are released in the same condition or more deteriorated condition than the one that probably lead to their incarceration. The next time they are detained they are once more mentally ill and/or substance abusing and in jail. An approach based on early identification and treatment will provide more opportunity for successful assimilation into a community setting with ongoing community supports. We selected the process milestones P‐1 for DY2 because we need to understand the new population and the demand of that population. We selected P‐3 because there is clearly a great need to enroll individuals and initiate services. We will conduct a Plan, Do, Study, Act (PDSA) cycle as indicated by process milestone for DY3 and utilize the information concerning enrollment and demand and as we begin to track increase in service volume to this special population. Improvement milestone selected for DY4 and 5 is to measure improvement in functioning. We will measure and report reduction in criminal justice involvement for Category 3. We selected improvement in functioning because we are certain that outcome improves community tenure, reduces recidivism and will lead to a reduction in criminal justice involvement.

**Core Project Components:**

This project to provide Services to Justice‐Involved Youth and Adults – Burnet and Williamson

Counties will address all of the required core project components:

a*) Assess size, characteristics and needs of target populations (e.g., people with forensic involvement).* There is a current program and this project expands that to a broader group of eligible participants. We have experience and anecdotal information about them but more precise assessment is needed concerning the size, characteristics and needs.

*b) Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as forensic encounters and in promoting correspondingly positive health and social outcomes*

*/quality of life.* We have familiarity with the literature concerning this program and interventions. We are adding clinical services and oversight and will conduct additional reviews. This is also an opportunity to engage community stakeholders in the justice systems to participate in the review, planning and design of the project.

*c) Develop project evaluation plan using qualitative and quantitative metrics to determine* *outcomes.* We will use BTCS, hospital business intelligence and quality management staff to facilitate the development and documentation of our evaluation plan. Oversight will be provided by the community stakeholders who will ensure qualitative and quantitative metrics will be used to measure outcomes relevant to the justice systems.

*d) Design models which include an appropriate range of community‐based services and residential supports.* Using the information from stakeholders, evaluation metrics, patient assessments and reports, we will evaluate available interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

*e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* The impact of interventions will be assessed on an individual patient level by using the ANSA for adults, the CANS for youth and the SF-36. Aggregated data from those assessments along with number of juvenile referrals or adult incarcerations will be used to assess community impact and identify and respond to lessons learned.

**Continuous Quality Improvement:**

The 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**: 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 that will be needed as these individuals are diverted from incarceration and provided behavioral health care in the community.

**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.

Reasons/rationale for selecting the outcome measure: It is our goal to provide community care at the right time and in the right setting and reduce inappropriate arrest and incarceration for adults and youth. We believe that achieving the project goal and providing early intervention and treatment leads directly to the outcome of right care, right setting. Allowing people to languish in jail due to mental illness or substance abuse is wrong and counterproductive for them and for our society.

Baseline Information: The baseline rate established in DY3 was 11.76%. Our baseline measurement period established in DY3 was 10/01/2013-09/30/2014.

**Relationship to Other Projects:**

This project enhances or supports additional projects below that BTCS has proposed by improving access to community based aftercare and outpatient services.

* The Transitional Housing initiative (#126844305.2.1) will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
* The Crisis Stabilization plan (#126844305.1.2) for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital;
* Crisis Assessment for Persons in Behavioral Health Crisis (Burnet County) (#126844305.1.4) to support and enhance the ACT for persons with IDD responses in this County; and
* Outpatient Substance Addiction Services for Adult and Youth ‐ Burnet and Williamson Counties (#126844305.1.5) for persons needing routine outpatient counseling and intensive outpatient services.

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

While this project shares a number of things in common with other LMHA’s, the project Central Counties is planning regarding Temple Day Services is most similar (#081771001.2.3). 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:**

We expect to serve an additional 50 people in DY4 and 75 in DY5. 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.bbtrrails.org](http://www.bbtrrails.org/) under the Medicaid 1115 Transformation Waiver tab. A complete write‐up of the project will be available at performing provider site.

**Category 2 Project Narrative**

**Central Counties Services – 081771001.2.1**

**Project Area, Option and Title:** 2.2.2 Apply evidenced-based care management model to patients identified as having high-risk care needs

**RHP Project Identification Number**: 081771001.2.1

**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, 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 education, training, and support by a registered nurse for persons with severe and persistent mental illness (SPMI) having chronic health conditions (hypertension, diabetes, weight gain, etc.) due to prolonged psychiatric medicine use. This project builds the patient’s ability/desire to improve their self-managing of chronic health condition(s), instead of stopping psychotropic medicine that helps their psychiatric symptoms. This project has both personal training sessions and support groups for patients trying to self-manage the same type of chronic health condition.
* **Project Status:** This project is a new service.
* **Project Need:** CN.3.1: Limited coordinated care exists in Bell County for disparity groups with co-occurring behavioral health needs and chronic physical conditions due to prolonged psychiatric medicine use. Studies show people with SPMI die 25 years earlier, on average, than non-mentally ill peers. Factors that lead to the early death of people with SPMI include negative effects caused by medication needed to treat their mental illness (*Morbidity and Mortality in People with Serious Mental Illness.* <http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm>).
* **Target Population:** The prevalence of chronic conditions among our patients is not known at this time, but it is estimated to be around 10% of the patients served at our Killeen, Texas and Temple, Texas clinics, which would be about 140 patients. Actual number to be served is TBD in DY3*.* 97% of all of the Center’s patients are Medicaid (41.89%), uninsured or indigent. We anticipate the same percentages of Medicaid, uninsured and indigent patients will benefit from this project
* **Category 1 or 2 Expected Project Benefit for Patients:** Increase number SPMI patients with chronic condition self-management plans to 50 patients in DY3, 75 patients in DY4 and 100 patients in DY5 (Improvement Milestone I-18.1). We are expecting to provide these services for 100 patients in DY3, 150 patients in DY4, and 200 patients in DY5 under this project, thus the cumulative QPI for this project DY3-5 would be 450 patients served. (See **“Rationale”** paragraph below regarding shortened life expectancy of persons with severe and persistent mental illness).
* **Category 3 Outcome:** IT 1-11: Diabetes Care: BP Control (140/90 mm Hg)

As persons with SPMI taking psychotropic medications are at a high risk for exacerbating or developing chronic health conditions such as diabetes or hypertension, this measure looks at the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is, 140/90 mm Hg during the measurement year. The denominator is defined as patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type2) during the measurement year or the year prior to the measurement year. The numerator is defined as patients whose most recent BP reading is, 140/90 mm Hg during the measurement year. It is intended that we will establish a baseline following which we will improve over the established baseline by 5% in DY4. This will then allow for a 10% improvement over established baseline rate during DY5.

* **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. There are several reasons why this project is truly a transformational project and they are: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center’s first focused effort to address our patient’s physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) providing assistance with managing the negative side effects of strong psychiatric medications needed by our patients is viewed as a strong means to reinforce medication compliance – a major problem with the people we serve; and, 4) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, and master the control of their chronic health condition’s symptoms.

**Project Description:**

*Self-management of chronic conditions resulting from prolonged psychotropic/ antidepressant medication use by adults with severe and persistent mental illness*

The Center has as its priority to serve adults with severe and persistent mental illness in their own community. Antipsychotic and antidepressant medications have made it possible for severely mentally ill persons to reside in their own community as opposed to being held in the asylums of decades gone by. Antipsychotic and antidepressant medications are very strong medications that have a profound effect of being able to reduce many of the negative symptoms of these severe and persistent mental illnesses (Schizophrenia, Major Depressive Disorder, Bipolar Disorder, Schizoaffective, etc. disorders). These powerful and effective medications frequently induce one or more physical side-effects in persons who must take these medications over a prolonged period of time. These side-effects can result in chronic health conditions. Examples of some of these chronic health conditions are: hypertension, diabetes, obesity, nervous ticks, excessive dry mouth, distorted sense of balance, etc. This project is being undertaken to help our patients with severe and persistent mental illnesses understand how these side effects occur, how to monitor the severity of these side-effects, and how to prevent the chronic health conditions caused/aggravated by these powerful medicines from getting progressively worse, and more quality-of-life impairing.

Each patient participating in this project will be offered:

1. An assessment of the severity of their chronic health condition(s),
2. An explanation of how our bodies normally regulate these biological functions which become out of balance (written information in layman’s terms will be given),
3. What common self-help remedies are used to stabilize or reduce the level of these chronic health problems,
4. A mutually developed personal plan with attainable goals for improvement will be given to the patient, documented in the patient’s electronic health record, and self-management progress updated in the health record after each visit, and
5. Professional coaching/feedback on how their plan is going and how to improve the outcome of their plan.

Topics available to the patients will be:

1. Increased knowledge of importance of psychotropic or antidepressant medication compliance despite the potential side effects;
2. Increased knowledge of weight change side effects, strategies for weight loss, and information to manage these effects;
3. Increased knowledge of hypertensive side effects, consequences of long-term hypertension (stroke, MI), how to manage the condition, use of blood pressure measuring devices will be demonstrated, and importance of regular evaluation by a healthcare provider;
4. Increased knowledge of diabetes side effects, importance of management of blood sugars to decrease long-term effects of diabetes (cardiovascular, peripheral, eye, kidney), how to check and track blood sugars will be demonstrated, and the importance of regular evaluation by a healthcare provider; and
5. Increased knowledge about the negative health effects of excessive smoking and caffeine use.

The assessment of the patient’s chronic health condition level and subsequent follow-up contacts when levels are re-checked would be recorded in the patient’s health record, along with each person’s self-management plan to manage/improve his/her chronic health condition. Assistance will be given to our patients for their obtaining a blood pressure monitoring device, and/or glucose testing equipment and supplies. As patients become involved with these efforts to strengthen their ability to self-manage their chronic health conditions, we would envision starting focused support groups among our patients with similar chronic health conditions to encourage their mutually supporting each other in their endeavors to improve their health status (attendance rosters would be kept). It is our longer term goal that some of the patients who really learn how to manage their medication-induced/aggravated chronic health conditions well might become peer facilitators for new patients who are just being referred to this service. We have seen this model work very well with our patients around their acknowledgement and management of their severe and persistent mental illness.

**Goals and Relationship to Regional Goals:**

**Project Goal:**

The goal of this service is to help adult behavioral health patients learn how to stabilize or reduce their chronic health condition(s) caused/aggravated by their prolonged use of psychotropic/antidepressant medications such that their chronic health conditions do not pre-morbidly shorten the patient’s life expectancy or influence the patient to discontinue their psychotropic/antidepressant medications that have helped stabilize their severe and persistent mental illness symptoms.

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

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

**Challenges**:

* The patient's ability to grasp the instructional information due to their mental illness (disorganized thought patterns).
* The patient's lack of support system or encouragement to maintain healthy changes.
* Client's inability to retain information for extended length of time due to their mental illness.

This project will take these challenges into account as the nurse uses repetition of information with our patients, and reviews written materials as many times as necessary for patients to grasp the information being taught/shared. Our interaction with the patients will be transformed from educator to coach as we strive to help our patients put into practice the information they have learned about the management of their chronic health condition. We anticipate that within the first year of this project we will form chronic health condition specific support groups to assist and support our patients with the life-style changes often needed to successfully stabilize/reduce the severity of their chronic health condition.

**5 Year Expected Outcome:**

The severely and persistently mentally ill adults served by the Temple, TX and Killeen, TX clinics who are experiencing chronic health conditions as a result of prolonged psychotropic/ antidepressant medication use will be offered the opportunity to learn about their chronic health condition(s) and ways to manage/reduce its health impact. It is expected that those patients who effectively engage in this project for 3 or more months will make significant progress at being able to stabilize their chronic health condition and begin to reduce the severity of their chronic health condition. Those participants who are actively engaged in this project for 6 months or more should see a significant reduction in their chronic condition. While adults with severe and persistent mental illness often struggle with their sense of personal worth, improvement of their ability to proactively manage their chronic health condition should give them more sense of control over their life and personal health, thus benefiting their sense of personal worth and well-being. We envision patient support groups being formed among our patients who have similar chronic health conditions to encourage their persistence in managing the lifestyle changes often needed for successful management/reduction of these chronic health conditions. We also will work to groom the patients who achieve the most progress so that they can become peer mentors to new patients just entering the service.

**Starting Point/Baseline:**

This type of service has not been previously performed at the Center. Baseline ratings for the severity of medication induced/aggravated chronic health conditions are therefore not available for this project prior to DY2. As the Center patients are referred to this project, their chronic health condition severity will be evaluated and recorded as the patient’s individual baseline measurement.

**Rationale:**

**Community Need Addressed:**

* Community Need: CN.3 Lack of coordinated care for those with multiple needs
* Specific Community Need: C.N. 3.1 Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and chronic physical conditions resulting from prolonged use of psychotropic medications

Persons with severe and persistent mental illness have shorter life expectancy due to many factors. Studies have shown that people with severe and persistent mental illness die 25 years earlier, on average, than their non-mentally ill peers as shown in *Morbidity and Mortality in People with Serious Mental Illness* (authors: Joe Parks, MD, Dale Svendsen, MD, Patricia Singer, MD, Mary Ellen Foti, MD, (<http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm>). Several factors that influence the premature death of people with severe and persistent mental illness include negative effects caused by the medications needed to control their mental illness. Some psychotropic medications can cause weight gain, diabetes, and hypertension. Education on these conditions and ways to manage the effects in a proactive manner can decrease the long-term negative effects of these conditions and increase life expectancy. This project will partner nursing staff from Health District and Center patients to increase patient education about these chronic side effects of psychotropic medications and increase their ability to self-manage these conditions successfully, thus increasing their potential longevity.

While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI). The National Survey on Drug Use and Health (NSDUH), which defines SMI as:

• A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders)

• Diagnosable currently or within the past year

• Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

• Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

The Substance Abuse and Mental Health Services Administration (SAMHSA) examines the mental health treatment each year through the National Survey on Drug Use and Health (NSDUH). In 2008, 13.4% of adults in the United States received treatment for a mental health problem. This includes all adults who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems. SAMHSA’s NSDUH also found in 2008 that just over half (58.7%) of adults in the United States with a serious mental illness (SMI) received treatment for a mental health problem. Treatment for SMI differed across age groups. The most common types of treatment were outpatient services and prescription medication.

SAMHSA’s NSDUH further found in 2008 that 71% of adults who had major depression used mental health services and treatment to help with their disorder.

Education is essential to managing side effects encountered with any medication, and psychotropic medications are no exception. Behavioral or lifestyle changes are also important to improve chronic health conditions and the personal plan and goal setting involved with this project will help motivate and reinforce positive behavior change among our patients.

**Core Components:**

1. 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 shares information such as challenges, lessons learned, and considerations for safety net populations. The CQI efforts connected with this project will focus on improving the educational materials used with the patients, enhancing the recovery culture aspects of taking responsibility for self-improvement, and establishing social support networks to encourage the life-style changes needed to improve many chronic health conditions. The Center is committed to improvement of 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 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.

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 through the U.S. Department of Health and Human Services. 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 Measure(s):**

IT 1-11: Diabetes Care: BP Control (140/90 mm Hg)

As persons with SPMI taking psychotropic medications are at a high risk for exacerbating or developing chronic health conditions such as diabetes or hypertension, this measure looks at the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is, 140/90 mm Hg during the measurement year. The denominator is defined as patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type2) during the measurement year or the year prior to the measurement year. The numerator is defined as patients whose most recent BP reading is, 140/90 mm Hg during the measurement year. It is intended that we will establish a baseline following which we will improve over the established baseline by 5% in DY4. This will then allow for a 10% improvement over established baseline rate during DY5.

**Relationship to Other Projects:**

This project will attempt to empower clients to manage chronic conditions brought on by the long-term use of psychotropic medications. If clients can successfully manage their condition, there will be fewer ED visits from preventable sequelae, and less long-term complications of the chronic conditions. This project also relates to our desire to have improved patient involvement in their behavioral and personal health care, and the patient’s sense of satisfaction that our Center is trying to relate to them as a whole person whose general quality of life is of great importance to our Center and its staff (Temple Day Services Project #081771001.2.3). This project is one of our Center’s first attempts to bring more physical medicine into our behavioral health clinic environment. Our patients are fairly well motivated to come to our clinic for the care they receive, and if we can combine our behavioral health services with more general health services, we are expanding our patients’ experience of having a medical home.

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
* 081771001.2.2 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 Providers’ projects and Plan for Learning Collaboratives:**

This project works with the Health Department, who is planning a Sexually Transmitted Disease testing and treatment project (#088334001.2.1) and one to work with women of child-bearing age (#088334001.2.2).

**Project Valuation:**

The valuation of this project takes into account the value of: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center’s first focused effort to address our patient’s physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) providing assistance with managing the negative side effects of strong psychiatric medications needed by our patients is viewed as a strong means to reinforce medication compliance – a major problem with the people we serve; and, 4) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, and master the control of their chronic health condition’s symptoms. The valuation of the project also takes into consideration the salaries and fringe benefits of the nursing staff performing these services, the informational materials that will be used with patients, the equipment and consumable supplies to assist patients in monitoring their glucose levels and blood pressure levels, as well as the administrative overhead and indirect costs to run the project. The valuation of this project also takes into account the value of extended life expectancy (see Rationale section above) when chronic medical conditions are well managed. It is expected that this project will serve 200+ persons with severe and persistent mental illness per year and that at least half (100) of these individuals will be able to accomplish significant improvement in managing their chronic medical condition.

The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful chronic health condition management. If such improvement in chronic health conditions could add 5-10 years to each patient’s life span, that would result in a net gain of 500 - 1,000 person years for each of the 3 full years of this project. The successful management of their chronic health conditions through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advanced stages of these chronic health conditions.

**Category 2 Project Narrative**

**Central Counties Services – 081771001.2.2**

**Project Area, Option, and Title**: 2.7.1Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations

**RHP Project Identification Number**: 081771001.2.2

**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 persons (adults and adolescents) with severe and persistent mental illness (SPMI) easy access to STD education, testing and treatment by a registered nurse within the Center’s mental health clinics in Temple and Killeen (Bell County) where the patients are already accustomed to attending.
* **Project Status:** This is a new project.
* **Project Need:** CN 3.2 Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and sexually transmitted diseases. For the latest statistical year Bell County had the highest Chlamydia and Gonorrhea case rates in the State of Texas. Studies show that people with SPMI die 25 years earlier, on average, than non-mentally ill peers. Several factors that influence the pre-mature death of people with SPMI include unsafe sexual behavior (p.16) “Morbidity and Mortality in People with Serious Mental Illness” (<http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm>).
* **Target Population:** 97% of the Center’s patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project. We expect this project to serve 100+ patients per year, but the actual number of patients who will use this service is not known.
* **Category 1 or 2 Expected Project Benefit for Patients:** This project will increase access of approximately 1,000 behavioral health patients (combined census of the Center’s Killeen and Temple Clinics) to STD education, assessments and treatment in the familiar setting of our Killeen and Temple TX Clinics (Improvement Milestone I-7.1) which they already arrange to attend. Expected encounters for this project are: DY3 = 40, +DY4 =60, + DY5 = 80 for a total QPI of 180 persons served.
* **Category 3 Outcomes:**
  + IT-15.6 Assesses the percentage of men & women 16 and older who were identified as sexually active and who had at least one test for chlamydia during the measurement year. The opening year will be considered the baseline period for the project. The following years of DY4 and DY5 will be the periods of expanding the projects established baseline numbers. In DY4 the expansion will include the baseline that was established plus 5% of growth over this baseline. In DY5 the expansion will include the baseline that was established plus 10% of growth over the baseline.
  + IT-15.9 Assesses the percentage of patients 16 years of age and older who were identified as sexually active and who had at least one test for syphilis during the measurement year. This information will then be turned in at the reporting periods for the semi annul reporting time (April, October).
  + IT-15.12 Assesses the percentage of patients 16 years of age and older who were identified as sexually active and who had at least one test for gonorrhea during the measurement year. This information will then be turned in at the reporting periods for the semi annul reporting time (April, October).

Bell County had the highest Chlamydia and Gonorrhea case rates in the State of Texas. Several factors that influence the pre-mature death of people with SPMI include unsafe sexual behavior. Early detection and treatment avoids the personal health risks and costs of treating these same diseases at their advanced stages and avoids passing STDs on to their newborn infants, thus avoiding personal and financial costs of coping with potential birth defects and physical condition complications for their newborn children. An improvement in patient health conditions could add 5-10 years to each patient’s life span.

* **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. There are several reasons why this project is truly a transformational project and they are: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center’s first focused effort to address our patient’s physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, treating an STD and to take charge of their lifestyle choices to avoid future STD infections; 4) this project is forward looking in helping our patients avoid STD complications for their newborn children.; and, 5) the successful treatment of persons with one or multiple STDs reduces the personal and financial costs of treating advanced disease symptoms and helps avoid the personal and financial costs of treating future potential STDs.

**Project Description:**

*Provide increased access to STD screenings for behavioral health patients in their behavioral health clinic settings.*

Persons with severe and persistent mental illness have shorter life expectancy due to many factors. Studies have shown that people with severe and persistent mental illness (SMI) die 25 years earlier, on average, than their non-mentally ill peers as shown in *Morbidity and Mortality in People with Serious Mental Illness* (Parks, Svendsen, Singer and Foti authors). On page 16 of this research document, the authors identify Patient, Provider and System Factors Contributing to Morbidity and Mortality to Persons with SMI – “unsafe sexual behavior”. *Morbidity and Mortality in People with Serious Mental Illness*, (<http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm>).

This project will provide nursing staff from Bell County Public Health District (Health District), under contract arrangements with the Center to conduct Sexually Transmitted Disease (STD) testing, treatment and educational counseling at Central Counties Services offices in Killeen, TX and Temple, TX. Both clinics are designated by the Texas Dept. of State Health Services as serving Medically Underserved Populations (MUP). Bell County has one of the highest Chlamydia and Gonorrhea rates in the State of Texas. This project will partner nursing staff from the Health District and Center clients to increase availability of STD services in an effort to increase testing for Chlamydia, Gonorrhea, and Syphilis. The Health District nursing staff will be available at the Center’s offices in Temple and Killeen to provide STD testing, treatment, and education. One day of these services will be offered each week in each clinic.

Clients with chronic and persistent mental illness may not otherwise seek out STD testing and treatment services due to the disorganizing effects of their mental illness. Persons with severe and persistent mental illness most often do not have a medical home, and consequently obtain most of their physical health services from local hospital emergency departments (EDs). When receiving medical care in the ED, medical attention is usually given only to the patient’s presenting health crisis, and not to the patients’ general health status. This project intends to bring the STD testing, treatment and educational counseling services to the behavioral health patients when they are in the Centers’ clinics for their mental health visit. The outcome of these screening, educational, treatment services, and condition improvement/ progress made by each patient will be recorded in each patient’s health record and aggregated into monthly and quarterly reports to both document the activity of this project, but also to serve as the basis for continual process improvement of this service. Patients participating in this service will be randomly surveyed regarding their satisfaction level with the services they received and how these services might be improved.

**Goals and Relationship to Regional Goals**

**Project Goal:**

The goal of this project is to decrease the incidence, prevalence and long term health effects of sexually transmitted diseases among persons with severe and persistent mental illness served in our Temple, TX and Killeen, TX clinics. This goal will be accomplished through increasing behavioral health patients’ access to sexually transmitted disease education, testing and treatment services in the same clinic that each patient receives his/her behavioral health services.

**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**:

* Overcoming the stigma associated with potentially having a sexually transmitted disease;
* Incorporation of a new service into the clinic patient flow;
* Increasing patient awareness regarding the availability of STD services; and
* Maintaining the discreetness of this service in the clinic setting so that other patients will not be made aware that a particular patient is seeking/receiving these services.

Our Center will thoroughly plan the initiation of these services with the Bell County Health District nurse to resolve any potential logistic issues that might impact on the above. Educational information about these services will be placed in our waiting areas and in our staff offices. We will make this information available in the various languages of our patient group. Our Center has Spanish-speaking staff in both the Killeen and Temple clinics to assist the nurse, if needed.

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

* Increased screening for Chlamydia, Gonorrhea, and Syphilis among adolescent and adult behavioral health patients;
* Decreased Chlamydia and Gonorrhea case rates among the behavioral health patients served in the Temple, TX and Killeen, TX clinics, and in general, among the citizens of Bell County;
* Increased knowledge of STD risk factors and reduction strategies among adolescent and adult behavioral health patients; and
* Avoidance or minimalizing the occurrence of the newly identified drug-resistance strains of gonorrhea and the potential threat of an untreatable strain of gonorrhea emerging.

**Starting Point/Baseline:**

This type of service has not been offered at the Center in the past, so baseline numbers for this project in DY1 and the beginning of DY2 is zero. The baseline for the number of behavioral health patients seeking STD education and testing will be set by the level of such sessions during the month of September 2013. In subsequent years, the project will strive to increase the numbers of patients tested for STDs over the previous year.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.3 - Lack of coordinated care for those with multiple needs
* Specific Community Need: CN 3.2 - Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and sexually transmitted diseases.

See also p. 16 of Patient, *Provider and System Factors Contributing to Morbidity and Mortality to Persons with SMI – “unsafe” sexual behavior* (*Morbidity and Mortality in People with Serious Mental Illness*, Parks, Svendsen, Singer and Foti authors) (<http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm>).

This project addresses the high Chlamydia and Gonorrhea rates in Bell County for the latest statistic year available 2010. Bell County had the highest Chlamydia and Gonorrhea case rates in the entire state in 2010 (DSHS, Texas 2010 STD Surveillance Report). Bell County also had the 6th highest Gonorrhea case numbers and 7th highest Chlamydia numbers in the state in 2010. In an October 18, 2012 Houston Chronicle newspaper article (Falkenberg: *Sex-Ed Program is Effective* by Lisa Falkenberg) statistics were given that 11% of sixth graders are sexually active, 35% of ninth graders are sexually active, and nearly 70% of twelfth-graders were sexually active. These startling statistics are probably even higher among adolescents with behavioral health problems who engage in risk-taking behaviors.

According to the Centers for Disease Control (CDC), the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for Chlamydia is still not routine in many clinical settings (CDC, 2012). Undetected and/or untreated Chlamydia infections are one of the leading causes of sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).

The Center’s behavioral health patients are both medically underserved and have a higher than normal likelihood of engaging in risk-taking behaviors, such as sexual promiscuity, etc. This project brings a needed service to a group of people who likely have higher than average need for this service.

**Core Components:**

1. 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. CQI efforts will be directed at lowering the stigma associated with STDs and developing methods to increase the number of the Center’s patients who avail themselves of these educational, testing and treatment services.

**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 through the U.S. Department of Health and Human Services. 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 Measure(s):**

OD-11 Addressing Health Disparities in Minority Populations

IT-15.6, IT-15.12, and IT- 15.9: Improvement in Clinical Indicator in identified disparity group – increase the percentage of those patients who test positive for an STD and follow up to receive treatment for that STD. Our Center realizes that, unfortunately, society often sees a stigma attached to pursuing STD education and testing services, similar to the stigma attached to seeking behavioral health services. By offering STD education/testing services within our clinics, we are both seeking to diminish the stigma attached to seeking these services and to increase access to these services by a medically underserved and disparate population. We therefore chose to measure/monitor the number of patients served by this project within the two days per week that they are offered and the number of persons testing positive for STD who follow up with treatment of that STD. We have every expectation that through the ease of access to these services, general education among our behavioral health patients about sexually transmitted diseases, informal support for these services among the patient group by patients who have had positive results from treatments for sexually transmitted diseases, and the supportive encouragement of our behavioral health staff, that the number of behavioral health patients seeking these services will increase over time to fill the nurses service schedule. We are also hopeful of achieving over time a much lower incidence rate of sexually transmitted diseases among our patient population than the average rate in Bell County.

**Relationship to Other Projects:**

This project is focused on increasing access to health and behavioral health services and is similar to our telemedicine (#081771001.1.2) and performance improvement and reporting capacity (#081771001.1.5) project which have a similar goal of increasing patient access to behavioral health services. Therefore we judge that increasing the number of patients participating in STD education/testing sessions will be a strong indicator that this project is successful. The number of education sessions leading to STD testing; the number of tests which identify the presence of a sexually transmitted disease; and the number of patients with confirmed sexually transmitted disease who receive successful treatment will also be monitored. These statistics will be aggregated on a monthly and quarterly basis to demonstrate the progress and success of this most beneficial project.

Other Center projects include:

* 081771001.1.1 Establish more primary care clinics
* 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
* 081771001.2.3 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:**

This project also correlates with two Health District projects: STD Testing (#088334001.2.1) and Prevent Potentially Preventable Conditions for Women of Child bearing age (#088334001.2.2). There are several projects in Region 8 that seek to integrate behavioral health services with general health, or primary care services. There also are projects that seek to encourage persons to establish a medical home so that their care can be better coordinated and that health conditions can be identified in their earlier and more treatable stages. This project is in harmony with these regional efforts and is seen as one of the first steps to ultimately achieve integrated health and behavioral health services in our area.

**Project Valuation:**

The valuation of the project takes into consideration the salaries and travel costs, and fringe benefits of the nursing staff performing services, the educational and consumable supplies needed for this project, as well as the administrative overhead and indirect costs to run the project. The valuation of this project also takes into account the monetary and personal quality of life costs saved by early detection and treatment of STDs.

The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful early treatment of sexually transmitted diseases and the prevention/education services which assist the patients in avoiding future sexually transmitted diseases. Part of this project’s valuation is based on how it strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, treating an STD(s) and to take charge of their lifestyle choices to avoid future STD infections. Early detection and treatment avoids the personal health risks and costs of treating these same diseases at their advanced stages and avoids passing these STDs on to their newborn infants, thus avoiding personal and financial costs of coping with potential birth defects and physical condition complications for their newborn child. If such improvement in patient health conditions could add 5-10 years to each patient’s life span, that would result in a net gain of 500 - 1,000 person years for each of the 3 full years of this project.The successful treatment of STDs and avoidance of future STD episodes by improved management of their life styles through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advance stages of STD infections.

**Category 2 Project Narrative**

**Central Counties Services – 081771001.2.3**

**Project Area, Option and Title:** 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.

**RHP Project Identification Number:** 081771001.2.3

**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 (MUP).
* **Intervention:** This project provides supportive day services for adults with severe and persistent mental health problems, who were recently discharged from a psychiatric hospital or jail, or have recently experienced a crisis that put them at risk for hospitalization/incarceration. Services include work skills training, medicine management, and daily living skills training to support patients’ ability to live on their own. It will use a recovery service model and have at least one peer counselor to assist patients.
* **Project Status:** This is a new project.
* **Project Need:** CN.2.17 Lack of community support services for persons with severe and persistent mental health diagnosis in Bell County.
* **Target Population:** The target population for these services are adults with severe and persistent mental illness, most of whom are indigent since their mental illness severity is a major barrier to regular employment. We intend to serve 20 adults in DY4and 25 adults in DY5. We anticipate most clients will be from Temple, TX. 97% of the Center’s patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.
* **Category 1 or 2 Expected Project Benefit for Patients:**The improvement goal of this project is to increase the average enrollment in these supportive day services to 20 in DY4 and 25 in DY5. The total QPI impact of this project would be (DTY-2: 10 patients: + Dy-3: 15 patients: +DY-4: 20 patients: +DY-5: 25 patients = 70 patients) supportive day services provided to 70 patients.
* **Category 3 Outcomes:** IT-9.1: Decrease in mental health admissions and readmissions to institutional psychiatric hospitals or criminal justice settings such as jails or prisons by 30% in DY4 and 40% in DY5.
* **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.

**Project Description:**

*Supportive Behavioral Health Day Services for persons with Severe and Persistent Mental Illness - Temple*

This project is transformational as there are currently no supportive behavioral health day services in this service region. This project will educate and support the participants in the recovery model of mental health care in which the patient is empowered to take control over his/her recovery process. This project will offer daily support to encourage medication compliance and lifestyle changes that are more conducive to living independently in the Temple community. This project will also provide a safe/supportive place to practice those new lifestyle choices. This project would be organized on a recovery model which holds out the expectation that every patient, no matter how impaired they are at the time, can improve their condition. The recovery model emphasizes the patient’s personal responsibility to accept his/her illness and take personal responsibility to work to improve their level of personal functioning and their quality of life. This project would be staffed to provide supportive day services for up to 20 adults at a time who have a severe and persistent mental illness and reside in the Temple/Belton, TX area. The project participants would be chosen from patients who have experienced frequent psychiatric hospitalizations or incarcerations, or who are imminently at risk of psychiatric hospitalization or incarceration. Patients involved with these services would receive skills training on how to manage: a) their medications, b) their negative symptoms of their mental illness, c) to improve their ability to manage their own living environment and d) to improve their ability to utilize the public transportation system in the Temple/ Belton, TX area. The program would occasionally provide lunch for those attending and would use the shopping for food and meal preparation process as skill-building activities to better equip the patients to live independently. Many of the skill training sessions and social skill building activities would be done as a group to assist the participants in forming mutually supportive relationships with the other program participants.

This project would also provide transportation for the patients to assist them with getting settled in the community, and would also work on the patient's use of the public transportation system (bus-stop is one block from the service site). The services would include computers on which to train the patients on how to use them and the internet as a personal resource in their mental health recovery and stabilization. This computer/internet literacy training will be available to participants of the program with staff also educating participants on computer/literacy recourses available elsewhere, such as the Temple Library. This project would include helping the patients to learn more about community resources that are available to them (parks, city wellness/recreation facilities, etc.). This project would also include the recruitment, training, and employment of peer specialists (Menu Category 2.8). The supportive counseling of the peer specialist would both increase the patient’s buy-in with the program, and patient’s sense of support from someone who has managed their severe and persistent mental illness symptoms sufficiently well to be able to support others in their recovery.

Each patient participating in this project would have a detailed personal history written up by the staff regarding the patient’s past use of state psychiatric hospital services, local emergency medicine department usage, and criminal/incarceration events in their life. Center staff would help patients explore these events and what led up to them occurring so that alternate choices/behaviors could be identified for the patient. Center staff would work with each patient to develop a practical recovery plan that would strive to put supports in place to assist the patient’s ability to deal with problems without needing institutional support/intervention. All of the above information would be entered into the patient’s electronic health record system of the Center. A medication support group would be formed as part of the services to encourage each patient to comply with their medications, and the follow-up appointments necessary to maintain their medication access/supply. Center staff would also assist the participants to apply for any disability support, housing support, or vocational training support for which they may be eligible, and will also assist the participants in applying for pharmaceutical assistance programs to offset the costs of their medications. A daily attendance roster would also be maintained. If an enrolled patient is absent from the services on a day that he/she was supposed to attend, staff will contact the patient to determine why he/she is not attending. If the patient cannot be contacted, staff will contact local hospitals and jails to determine if the patient has been admitted.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

This service has as its goal to reduce the "revolving-door" of hospitalizations/incarcerations of the chronically and persistently mentally ill persons in the Temple/Belton, TX area. This is to be accomplished by the skills training activities available to the patients in this program. It is expected that the longer a patient participates in this service, the greater the length of time will be before further hospitalization/incarceration caused by a mental health crisis occurs. During this stable time it is the service goal to enroll each patient in whatever benefit programs he/she might be eligible for, to include Section-8 housing, Medicaid, Social Security Disability, etc. Accessing these support services will assist the patient in re-structuring his/her community living supports and add to the options for the patient to use to effectively avoid hospitalization or incarceration in the future.

**This 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.

**Challenges**:

One of the challenges of this project will be finding an appropriate facility in which to offer these services. The facility will need to be close to the local public transportation stops, and convenient to downtown Temple. It will also be a challenge to find a living arrangement for those patients who are coming out of the hospital/jail, or have been living on the street. Ideally the facility used for this service would have shower facilities to facilitate personal hygiene of the patients, a simple kitchen/food storage area in which to teach simple food handling and preparation skills, and sufficient space to have a small computer lab with 6-10 places for patients to practice their computer literacy skills and do simple internet searches. Our Center is exploring a neighborhood just northeast of our downtown Temple area to find a suitable building. This neighborhood is in the vicinity of our Child/Adolescent Behavioral Health Clinic and the Temple main post office. The Center is hesitant to secure a building for this project prior to knowing the approval of this project proposal.

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

It is expected that these services will engage those persons being released from psychiatric hospitalization, those diverted from a psychiatric hospitalization, and those diverted from incarceration into participating in skills training-based, supportive day services. The expected outcome would be improved medication compliance, longer periods of staying in the community without hospitalization, arrest, or involvement with emergency department services. Another expected outcome will be in the improvement of the patient’s daily living skills needed for independent living, to include the ability to utilize the local public transportation system, preparing simple one-person menus, shopping for groceries, simple meal preparation, food storage knowledge, and how to put together a simple personal budgeting system.

The longer term goals (5+ years) for this project would be to have it evolve into a peer support/drop-in Center that could be used as a support system by person’s who have made major progress in reconstituting their lives – much like the very effective social support system of Alcoholics Anonymous groups.

**Starting Point/Baseline:**

This is a new service for the Center so there is no baseline regarding how many days this program will help a person with severe and persistent mental illness stay out of an institutional setting (psychiatric hospital or incarceration). The baseline for each patient will be obtained within two weeks of them becoming involved with these services and will be documented in the patient’s electronic health record. We are optimistic that these services will make a significant difference in the length of time the patients can stay out of an institution.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.17 - Lack of community support services for persons with severe and persistent mental health diagnoses in Bell County

Persons with severe and persistent mental illness often become more and more isolated from their families and their personal support network. The more their illness progresses, the more withdrawn and isolated they become. We are convinced that bringing a severely and persistently mentally ill person into a supportive environment will make a significant difference in their ability to reverse their isolation and feelings of low self-worth. It is our belief that being able to daily reinforce the tenants of this recovery-model approach to helping patients manage their symptoms and build their personal skills through this day service program will have high impact results in the lives of those served by this program.

**Core Project Components:**

a*) Assess size, characteristics and needs of target populations (e.g., people with SPMI).* This component is addressed in Milestone 1. Central Counties will research different models of day services, interview staff from other programs where this service is offered, conduct an internet search for reference materials/ service models, etc. to be used as the basis for developing our Center’s Implementation plan.

*b) Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* This component is also addressed in Milestone 1. This component is also addressed in Milestones 6 and 8 below. Examples of source documents for service design are: “Effectiveness of peer support in reducing readmissions of persons with multiple hospitalizations” W. H. Sledge, et al, Psychiatric Services, 62(5), 541-544; “Planning and creating successful adult day services” Marilyn Martle, LaDonna Jensen, NADSA-AAHSA Whitepaper; “Report of the Mental Health Day Support Work Group, Recovery, Employment, and Rehabilitation Services” Renee Alberts, et al, Falls Church Community Services Board Report, “Peer Support, Whole Health & Resiliency” ; Appalachian Consulting Group, Inc. Cleveland Ga.

*c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* The qualitative aspect of this component is also addressed in Milestones 6 and 8 below which are the continuous quality improvement components of this project that strive to continuously improve the quality and effectiveness of the services delivered to each patient under this project. Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services. Revise the items to be tracked and reported upon for future improvement. The quantitative aspects of this component are addressed under Milestones 3 and 5 in which we which seek to increase the number of patients served by this project.

*d) Design models which include an appropriate range of community‐based services and residential supports.* This component will be addressed in Milestone 1 and will be part of the continuous improvement efforts of Milestones 6 & 8. Also see the Project Description paragraph above which describes the service components to be offered under this project.

*e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* This component will be addressed in our Category 3 Milestone which evaluates the reduction of admissions and readmissions into psychiatric hospitals and into criminal justice settings by the severe and persistently mentally ill group of patients served by this project. This component will also be addressed every time the patients’ personal treatment plan is updated through a re-assessment of the patient’s functioning level and recorded in the patient’s electronic health record.

*f)* 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 Services. 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 Measure(s):**

* 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 reduce the number of days people with severe and persistent mental illness spend in state psychiatric hospital services, or incarcerated in local jails due to minor crimes committed in the midst of a mental health crisis. The outcome we will be measuring is the number of days a person with severe and persistent mental illness is able to be in the community rather than in one of these more restrictive and costly institutional settings. We will use the number of days each person was able to stay in the community between their last two admissions, or mental health crisis episodes in which they were at risk of institutionalization as the baseline measure. We will then periodically measure how many days a patient has been able to stay out of an institutional setting with the support of the services offered in this project, and compare that number of days with their personally established baseline. We expect that the longer a patient actively participates in these supportive day services, the more likely that the length of time between institutional episodes will likewise increase significantly.

**Relationship to Other Projects:**

This project would provide supportive day services for up to 20 adults with severe and persistent mental illness residing in the Temple/Belton, TX area, and who have experienced frequent psychiatric hospitalizations, or who are imminently at risk of psychiatric re-hospitalization. This project relates to our proposed Crisis Respite Project (#081771001.1.4), as both are aimed at decreasing the use of the state psychiatric hospital system and the criminal justice system in Texas. This project could eventually provide “step-down” services to patients who are just getting out of our proposed crisis respite services

The Center has the following projects:

* 081771001.1.1 Establish more primary care clinics
* 081771001.1.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
* 081771001.1.3 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
* 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

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

Bluebonnet Trails Community Center is proposing several services that are similar to this supportive day service, and which are aimed at reducing the cyclical use of the state psychiatric hospital system and local jails. Heart of Texas Regional Center has crisis residential services in place already, as well as a supportive day services site in a large, historic home in Waco, in RHP 16. The Center is committed to improvement of 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 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.

**Project Valuation:**

The valuation of the project for DY2 includes the purchase of a mini-van, office and program furniture, equipment for a computer lab, audio-video presentation equipment, cooking utensils and equipment, food processing and storage equipment, the hiring and training of staff, supervision of staff, the cost of patient training materials and consumable supplies. The valuation also includes community orientation and recreation activities that promote personal physical wellness. The valuation includes mental health indirect services costs, and administrative costs for this project. Valuation of DYs 3-5 will include increases in staff salaries, and other inflationary cost adjustments. Valuation of this project also takes into account the psychiatric hospitalization and incarceration costs that can be avoided by good, supportive, skill building day services and improved medication compliance. If this project can keep half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days per incarceration event) , it will save our state and communities close to the entire value of this project, not to mention the personal and social costs/tolls these experiences take on the patient’s sense of well-being and physical health.

**Category 2 Project Summary**

**Central Counties Services – 081771001.2.100**

**Project Area, Option and Title:** 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e. criminal justice system, ER, urgent care).

**RHP Project Identification Number:** 081771001.2.100

**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 is 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.
* **Intervention:** This project provides trained law enforcement officers to assess the behavioral health acuity of someone involved in a minor criminal event, and to direct that person into the behavioral health service system instead of the criminal justice system
* **Project Need:** CN.2.17 Lack of community support services for persons with severe and persistent mental health diagnosis in Bell County.
* **Target Population:** The target population for these services is adults with severe and persistent mental illness, who come into contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness, and who may therefore be appropriate for diversion from the criminal justice system into behavioral health care services. Most of the target population will be indigent since their mental illness severity is a major barrier to regular employment. 97% of the Center’s patients are Medicaid (41.89%), uninsured (56%), or indigent. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP). We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.
* **Expected Category 2 Project Benefit for Patients and a Description of the QPI Metric(s):** The improvement goal of this project is to increase the number of adult individuals with severe and persistent mental illness who are diverted from the criminal justice system. Over the course of the project, we expect the total patient impact to be approximately 300 adult individuals (DY3: 50 individuals, DY4: 100individuals, and DY5: 150 individuals). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-6.1, allowing us to increase the number of individuals diverted from jail to mental health services. Each year, we aim to increase the number of individuals receiving this service, as measured by Milestone I-6, Metric I-6.1: Number of targeted individuals served in the project.
* **Description of Category 3 Measure(s):** IT-9.1: 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 misdemeanor crime to be diverted from the legal justice system into an appropriate level of behavioral health care.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 misdemeanor crime 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.

**Project Description:**

The goal of this service is to increase the number of persons in mental health crisis who have or are about to be involved in a misdemeanor crime to be diverted away from the legal justice system into an appropriate level of behavioral health care. This project will work towards improvement of the health status of the persons served both with positive health interventions and the avoidance of negative health impacts. The positive health interventions will be: A) timely mental health status review in the community by a trained mental health peace officer and a licensed mental health clinician, B) timely, if not immediate, access to community mental health care services, C) timely access to a full psychiatric evaluation, if needed. The avoidance of negative health impacts will be: A) avoidance of an average incarceration of 90 days (The legal processes for someone charged with a misdemeanor crime are lengthened by the screenings and evaluations which must be performed and reviewed by the assigned judge and then the assignment of a public defender, sufficient time for the defendant to meet with this assigned attorney (not always productive, depending on the person’s mental state) lengthen the period of incarceration to an average of 90 days ( “Another look at Mental Illness and Criminal Justice Involvement in Texas: Correlates and Costs,” p. 13 Texas Dept. of State Health Services’ Decision Support Unit for Mental Health and Substance Abuse Services). B) avoidance of an experience that contributes to the worsening of mental health symptoms (RHP Planning Protocol, Category 3, IT-9.1d (p. 405) states that “Admission and readmission to criminal justice settings such as jails, and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency departments and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.”

This project will recruit, hire and train 4 full-time mental health deputies and one full-time supervising mental health deputy to form a Mental Health Deputy Unit within the Bell County Sheriff’s office. All Deputies in this project are expected to achieve Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE) certification, and participate in ongoing training to maintain a high level of knowledge and skill in intervening with persons with mental illness in the community. Having this Mental Health Deputy Unit would provide 24/7 availability of Mental Health Deputy services to respond to criminal activity calls and domestic disturbance calls involving persons with severe and persistent mental illness who have been, or are about to be, involved in misdemeanor criminal behavior. Having trained peace officers available to respond to such calls will improve the identification of individuals who come in contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness and who may therefore be appropriate for diversion from the criminal justice system into routine behavioral health care services.

This project is transformational in that the Mental Health Deputy Unit will work closely with the Center’s Mobile Crisis Outreach Team (MCOT) to access a professional-level of behavioral health acuity assessment and to facilitate the referral hand-off to the Center’s behavioral health care service system. This project puts into place missing Intercept One Services by avoiding incarceration (see Project Core Components, b) below). The referral hand-off may include the safe law enforcement transport of the person in mental health crisis to an appropriate level of care (transitional living unit, crisis respite unit, hospital emergency department, local psychiatric hospital, or the nearest state psychiatric hospital). This project includes the purchase of two (2) unmarked patrol cars so that if a person in mental health crisis needs to be transported, they would not be further stigmatized by the mental health deputies’ intervention. These interventions by the Mental Health Deputies will reduce the need for intervention by other elements of the local law enforcement and the criminal justice system. This project would also improve health outcomes for persons served, supporting the objective of delivering the right care at the right time in the right setting, and improve the experience of care, in which law enforcement officers, in collaboration with the Center’s MCOT, makes community assessments of persons experiencing severe mental illness symptoms and diverts them from a jail admission to local mental health services instead. This 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.

**Starting Point/Baseline:**

This is a new service for the Center so there is no baseline regarding how many persons who have committed or are about to commit a misdemeanor crime due to their impaired judgment resulting from their behavioral health problems could be diverted out of the criminal justice system into the behavioral health service system through the intervention provided by a specially trained Mental Health Deputy Unit. The baseline will be determined in DY-3 and is expected to be approximately 50 persons diverted from incarceration to the behavioral health care system (5 less/month of delayed approval).

**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 adult individuals with severe and persistent mental illness who are diverted from the criminal justice system. Over the course of the project, we expect the total patient impact to be approximately 300 adult individuals (DY3: 50 individuals, DY4: 100 individuals, and DY5: 150 individuals). In DY4, the quantifiable patient impact (QPI) will be measured by Milestone I-X, allowing us to increase the number of individuals diverted from jail to mental health services. Each year, we aim to increase the number of individuals receiving this service, as measured by Milestone 6, Metric 6.1: Number of targeted individuals served in the project. Most of the target population will be indigent since their mental illness severity is a major barrier to regular employment. 97% of the Center’s patients are Medicaid (41.89%), uninsured (56%), or indigent. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP). We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.

**Rationale:**

Community Needs Addressed:

* CN.2 Limited access to mental health/behavioral health services.
* CN.2.8 Lack of access for adult behavioral health care in Bell, Lampasas, and Milam Counties.
* CN.2.10 Limited access for serious mentally Ill adults to crisis services in Bell, Lampasas, and Milam Counties
* CN 2.11 Improve behavioral health services access and capacity in Bell, Lampasas and Milam Counties.
* CN.2.17 - Lack of community support services for persons with severe and persistent mental health diagnoses in Bell County.
* 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.
* RHP Planning Protocol, Category 3, IT-9.1d states that “Admission and readmission to criminal justice settings such as jails, and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency departments and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.”(p. 405).
* While incarcerations are detrimental to the severe and persistent mentally ill person’s recovery, they are also quite expensive to the criminal justice system. The legal processes for someone charged with a misdemeanor crime are lengthened by the screenings and evaluations which must be performed and reviewed by the assigned judge and then the assignment of a public defender, sufficient time for the defendant to meet with this assigned attorney (not always productive, depending on the person’s mental state) lengthen the period of incarceration to an average of 90 days. The Texas Dept. of State Health Services’ Decision Support Unit for Mental Health and Substance Abuse Services reports that the combined arrest costs, local jail costs, and court costs averages $2,104 per month in the state of Texas (“Another look at Mental Illness and Criminal Justice Involvement in Texas: Correlates and Costs,” p. 13) The Center’s Bell County Mental Health Deputy Unit project is expected to save Bell County from $315,600 in DY-3, $631,200 in DY-4, and $946,800 in DY-5 through the jail diversions into the behavioral health service system by this project. The jail costs saved could be used to sustain this project if waiver funding ends with DY-5.

**Project Core Components:**

1. Assess the size, characteristics, and needs of the project target population: The target population for this project is adults with severe and persistent mental illness, who come into contact with law enforcement for misdemeanor offenses determined to be related to the symptoms of their mental illness, and who may therefore be appropriate for diversion from the criminal justice system into routine behavioral health care services. Most of the target population for this project will be indigent since their mental illness severity is a major barrier to regular employment. This component is met by 1) noting that The Rationale section above lists six regional needs that are addressed by this project; 2) applying national indicators of prevalence for severe and persistent mental illness among the general population and the jail population in the area to be served; 3) documentation in the 2010 Bell County Human Services Needs Assessment pp. 79, 88, 103, 236; and 4) information collected by the Bell County Sheriff’s Dept. over an eight-month (Nov.2012 to June 2013) period. The National Institute of Mental Health states in its publication “Mental Disorders in America” states that about 6% (21,133) of the population (352,218) in our service area suffer from a serious mental illness. . The National Institute for Mental Health white paper on Inmate Mental Health indicates that a 2002 Survey of Inmates in Local Jails showed that 64.2 % of inmates surveyed reported having mental health problems in the last 12 months. The jail capacity of Bell, Lampasas and Milam Counties is approximately 875 beds, so 64.2% or approximately 562 in our service area have experienced a mental health problem in the last 12 months. Our Center requested the Bell County Sheriff’s Dept. to track the number of mental health related calls they responded to over an 8 month period to demonstrate the need for specialized mental health deputies. During this eight month period they responded to 440 mental health-related calls for an average of 55 calls per month. It is clear that Mental Health Deputy Early intervention/Jail Diversion is a needed service in our RHP area.
2. Review literature regarding the target population to determine community-based intervention: To prepare for this project I reviewed the Texas Dept. of State Health Services’ Decision Support Unit for Mental Health and Substance Abuse Services report entitled “Another look at Mental Illness and Criminal Justice Involvement in Texas: Correlates and Costs.” We also reviewed the SAMHSA Gains Center’s “Sequential Intercept Model” developed by Mark R. Munetz, MS and Patricia A. Griffin, PhD., and the Moral Reconation Therapy as reported in the “Correctional Health Care Management”, Vol.1, Number 10, and Oct. 1993. This project is based on the Sequential Intercept Model of decriminalizing persons with mental illness. It identifies 5 points of diversion where persons with mental illness can be targeted within the criminal justice system, and suggests strategies for effective intervention at each intercept point.
3. Develop project evaluation plans using qualitative and quantitative metrics to determine outcomes: This project will be evaluated by the number of seriously mentally ill adults who are diverted from jail into community mental health services. The qualitative aspects of this project compares the quality of life for patients being in behavioral health treatment versus being confined in a local jail, e.g. the number of jail days avoided through successful diversion of the mentally ill person into the local behavioral health care system. This project will track the number of jail days avoided (90 days avoided per diversion\*) and the cumulative jail costs avoided by these diversion ($2,104 per month of jail time\*). \*(“Another look at Mental Illness and Criminal Justice Unit for Mental Health and Substance Abuse Services) This component is implemented in DY4 and DY5 by the addition of Milestone I-X Other program output measure as identified by the performing provider. I-X.1 tracking the funds saved by avoided jail days.
4. Design models which include an appropriate range of community-based services and residential supports: The Center’s current community-based services consist of 7 community-based components. They are: outpatient skills/ rehabilitation services, Medication Management, Assertive Community Treatment, Mobile Crisis Outreach Services, Peer Support Services, Supportive Behavioral Health Day Services Project (#081771001.2.3) and our Crisis Respite Project (#081771001.1.4). This core component will be demonstrated by the implementation of this project, which will add two components (1. early community intervention and 2. jail diversion) to the Center’s current community-based services. The Center does not have sufficient funds at this time for implementing other community service components, such as: transitional living, supported employment, supported housing or transportation services.
5. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population: This core component is similar to c) above. This project will track the number of new patients (not enrolled in local mental health services) who are diverted from jail into the local behavioral health care system by tracking how many of the patients who are diverted remain in active treatment for 90 days or more after their diversion referral. This component will be implemented through the addition of a new Milestone in DY3, DY4 and DY5, namely I-X Short Term Outcomes, I-X.i Tracking the number of new patients diverted into mental health services who remain in services for 90 days or more.
6. Continuous Quality Improvement: Central Counties Services plans to implement a similar Mental Health Deputy Early Intervention/Jail Diversion project in Coryell County (RHP-16). This component will be met by the Mental Health Deputies from Bell and Coryell Counties will have a monthly training day to improve their knowledge and skills, and to discuss lessons learned and how to improve their intervention process with mentally ill persons in the community. The Center will also engage in continuous quality improvement activities as it studies how to increase the number of diversion referrals who remain in active treatment for more than 90 days after their diversion referral. In addition, the Center intends to participate in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

**Customizable Process or Improvement Milestones:**

The primary Category 2 improvement Milestone for this project will be I-6: I-6.1 (QPI) Metric: Number of targeted individuals served in the project. The Center has chosen to implement two customizable improvement milestones to document the implementation of two core components described above. Central Counties Services is currently evaluating which Category 3 Outcome Measure best represents the intended outcomes of the project. Category 3 Outcome Measure will be submitted via Updated Provider Cat 3 selection tool.

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

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 misdemeanor crime 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.

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

This project relates to our Crisis Respite Project (#081771001.1.4), and our Supportive Behavioral Health Day Services Project (#081771001.2.3), as both are aimed at decreasing the use of the state psychiatric hospital system and the criminal justice system in Texas. These two projects would be available to the Bell County Mental Health Deputies Unit as possible service entry points for persons with severe and persistent mental illness who are being diverted from the legal justice system. Many of the projects in this region are related to expansion of behavioral health care. This project’s focus on diverting persons from the legal justice system supports another Provider in the region implementing a project similar to this:

* 126844305.2.2 - Design, implement, and evaluate research‐supported and evidence‐based interventions tailored towards individuals in the target population

**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 intervention being provided for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e. criminal justice system, ER, urgent care) 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 valuation of the project for DY3 includes the recruiting, hiring, training and employment costs for 4 mental health deputies and one supervising mental health deputy. It includes the costs of uniforms and unique working equipment/supplies needed by every sworn law/patrol officer to do his/her job. DY-3 valuation includes the purchase of two (2) unmarked patrol cars to be used in the intervention and transport of persons experiencing a mental health crisis who have, or are about to, commit a misdemeanor offense. It includes the costs associated with each deputy participating in training for the purpose of becoming a Texas certified mental health deputy. The valuation includes mental health indirect services costs, and administrative costs for this project. Valuation of DYs 3-5 will include increases in staff salaries, and other inflationary cost adjustments. Valuation of this project also takes into account the psychiatric hospitalization and incarceration costs that can be avoided by good, supportive, skill building day services and improved medication compliance. If this project can keep between 50 to 150 behavioral health patients out of the criminal justice system (90 days per incarceration event), it will save our state, Bell County, and our communities between $315,600 (4,500 jail days avoided) to $946,800 (13,500 jail days avoided) per year, not to mention the personal and social costs/tolls these experiences would have taken on the patients’ sense of well-being and physical health. If the desired number of persons are diverted from incarceration in DY-3, 4, &5, this project would avoid the financial and human deterioration costs of 73.97 years of avoided jail time by persons with severe and persistent mental illness. The valuation of this project includes the demonstration that this project can be sustained based on funds saved from not incarcerating persons with severe and persistent mental illness symptoms who may commit minor crimes due to their poor judgment affected by their mental illness.

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

**Category 2 Project Narrative**

**Hill Country MHDD – 133340307.2.1**

**Project Area, Option, and Title**: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder

**RHP Project Identification Number:** 133340307.2.1

**Performing Provider Name:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

**Performing Provider TPI #:** 133340307

**Project Summary:**

* **Provider Description:** Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
* **Intervention:** This project will implement Co-occurring Psychiatric and Substance Use Disorder Services (COPSD) within the 2 counties served by Hill Country in RHP 8 in order to meet the needs of individuals with psychiatric and substance use issues within the community setting. Our goal is to reduce emergency department (ED) utilization, inpatient utilization, and incarceration.
* **Project Status:** This is a new project for Blanco and Llano counties.
* **Project Need:** Of the 283 individuals receiving mental health services through Hill Country in RHP 8 in November 2012, 71.7% report substance use while 14.5% report substance use at a level that interferes with their daily lives and/or medications (CN.2.20). In meeting with area hospitals, they have indicated that individuals with psychiatric disorders who also abuse substances end up in their EDs.
* **Target Population:** The target population includes individuals within Blanco and Llano counties who have a psychiatric diagnosis and abuse substances. According to the SAMHSA’s National Survey on Drug Use and Health this is 1.84% of the population or 563 individuals for the two counties. Based on the population served in Hill Country’s existing behavioral health program in RHP 8, it is anticipated that approximately 26% of our patients within RHP 8 have Medicaid and an additional 60% have income below 200% of the Federal Poverty Level and do not have insurance. We expect the target population will be similar to this.
* **Category 1 or 2 Expected Project Benefit for Patients:**The project aims to establish COPSD services in a community setting within the 2 counties served by Hill Country in RHP 8 which will reduce inappropriate ED use and incarceration. The project seeks to provide services to a minimum of 30 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5
* **Category 3 Outcomes:** IT-11.25: The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals with Co-Occurring Psychiatric and Substance Use Disorder divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.

**Project Description:**

*Intervention for Co-occurring Psychiatric and Substance Use Disorders*

According to Substance Abuse and Mental Health Services Administration (SAMHSA) statistics on co-occurring disorders, 25.7% of all adults with serious mental illness also suffer from substance use dependence and 19.7% of adults with any mental illness also suffer from substance use dependence. Hill Country currently serves over 283 adults with Severe and Persistent Mental Illness on an annual basis within two counties of RHP 8 (Blanco and Llano). According to the Substance Use Dimension Rating Scale on the latest Texas Recommended Assessment Guidelines, of the 283 individuals served, 71.7% report substance use while 14.5% report substance use at a level that interferes with their daily lives and/or medication. Throughout the 22,000 square mile service delivery area of Hill Country, there is one individual dedicated to Co-occurring service delivery who serves Kerr and Gillespie counties in RHP 6. By expanding this service, Hill Country can better address the need of individuals with co-occurring psychiatric and substance use disorder.

Hill Country is planning to add Co-occurring Psychiatric and Substance Use Disorder services throughout the two county area served by Hill Country in RHP 8. In establishing the project, Hill Country will review literature and experiences regarding Co-occurring Psychiatric and Substance Use Disorder (COPSD) services to establish appropriate training for staff on the most effective interventions for COPSD services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for COPSD services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact psychiatric illness and substance use have on the individuals daily lives will be completed upon entry into the program and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on COPSD services delivered within the program as well as by location within the program.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

The goal of this project is to establish COPSD services throughout Llano and Blanco counties in order to reduce emergency department (ED) utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

**Relationship to the Regional Goals:**

The goal of this project is to establish Co-occurring Psychiatric and Substance Use Disorder services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

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

**Challenges:**

The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

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

By the end of five years, Hill Country will have established Co-occurring Psychiatric and Substance Use Disorder specialists which will have provided services to a minimum of 20 consumers within the community over the life of the project.

**Starting Point/Baseline:**

Hill Country currently has one individual specializing in delivering COPSD services who serves forty individuals on an annual basis in RHP 6. This project will expand the service to the residents in the two counties served by Hill Country in RHP 8. The DLA-20 assessment will be performed on each individual entering the program as their baseline and the percentage of individuals who have improved DLA-20 scores on a subsequent assessment after treatment will be utilized to show improvement.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 - Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.20 - Limited access to behavioral health services for individuals with both psychiatric issues and substance use disorders in Blanco and Llano counties

Based on the data provided in the project description, need for additional services for co-occurring psychiatric and substance use disorders is necessary in these areas. Hill Country will identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual Project Components:

**Core Components:**

Through the COPSD services, Hill Country MHDD Centers proposes to meet all required project components:

1. *Assess size, characteristics and needs of target population*. Hill Country will collect and analyze information on individuals who have co-occurring psychiatric and substance use disorder and review contributing factors to episodes in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations.
2. *Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals co-occurring psychiatric and substance use disorder in order to provide targeted training for staff. Primary concentration will be based on SAMSHA’s Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices Kit.
3. *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes*. Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment (DLA-20).
4. *Design models which include an appropriate range of community-based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train COPSD specialists in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.
5. *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA-20) to determine progression of individuals receiving COPSD services. In addition, Hill Country will do follow up surveys with individuals who receive services to determine satisfaction with services and to help ensure stabilization of symptoms.

**Continuous Quality Improvement:**

Hill Country 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:**

Hill Country MHDD Centers currently has one individual specializing in delivering Co-occurring Psychiatric and Substance Use Disorder services who serves forty individuals on an annual basis in Kerr and Gillespie counties. This individual is funded through the Texas Department of State Health Services contract which includes federal and state funds, including SAMHSA Block Grant funds. This project will expand the service beyond the two counties served in RHP 6 to the two counties served by Hill Country in RHP 8 (Llano and Blanco Counties).

Hill Country will ensure there is not duplicate payment through SAMHSA by having a designated position separate from the 1115 Waiver positions to deliver services under the Texas Department of State Health Services Co-occurring Psychiatric and Substance Use Disorder services contract. Individuals will be served by either the Texas Department of State Health Services Co-occurring Psychiatric or Substance Use Disorder contract or through the 1115 waiver but will not be served by both funding streams. Services for the Texas Department of State Health Services contract will be entered into the state database (CMBHS) showing the state contract as primary payor. Services through the 1115 waiver will be entered into the local Information Technology system (Anasazi) under a specific subunit for the individual project.

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

The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals with Co-Occurring Psychiatric and Substance Use Disorder divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.

Reasons/rationale for selecting the outcome measure: COPSD impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self-care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, evaluate interventions and monitor progress and plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA-20 Functional Assessment.

The DLA-20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA-20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA-20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals with Co-occurring Psychiatric and Substance Use Disorder, the DLA-20 will identify and address areas the disorders have impacted such as Alcohol/Drug Use, Social Network, Productivity, Housing Stability and Maintenance and Managing Money.

**Relationship to Other Projects:**

Provision of COPSD services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 8 by providing specialized services addressing COPSD for an individual that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

Hill Country has several other projects in RHP 8. These include:

* 133340307.2.2 Trauma Informed Care
* 133340307.2.3 Virtual Psychiatric and Clinical Guidance
* 133340307.2.4 Whole Health Peer Support
* 133340307.2.5 Veteran Mental Health Services

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country MHDD Centers will participate in learning collaboratives that meet at least annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost-utility analysis which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program’s value is based on a monetary value of $50,000 per QALY gained due to the intervention multiplied by number of participants. The valuation on this project is based on 230 consumers over the life of the project

**Category 2 Project Narrative**

**Hill Country MHDD – 133340307.2.2**

**Project Area, Option, and Title**: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care

**RHP Project Identification Number:** 133340307.2.2

**Performing Provider Name:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

**Performing Provider TPI #:** 133340307

**Project Summary:**

* **Provider Description:** Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
* **Intervention:** This project will implement Trauma Informed Care Services within the 2 counties served by Hill Country in RHP 8 to meet the needs of individuals who have experienced trauma that is impacting their behavioral health. The project will incorporate community education on the impact of trauma through Mental Health First Aid training and Trauma Informed Care training, and provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy to help individuals deal with trauma they have experienced.
* **Project Status:** This is a new project in Blanco and Llano Counties.
* **Project Need:** Studies have shown that the majority of individuals who are incarcerated have suffered traumatic experiences and that individuals who suffer traumatic experiences are Kaiser’s Adverse Childhood Experiences Study shows that individuals are 300% more likely to develop ischemic heart disease. By treating trauma, individuals address the trauma in their life and reduce the chance of internalizing the trauma resulting in physical illnesses, a behavioral health crisis, or in reactions that may result in incarceration or inappropriate emergency department (ED) use. The 2011 Department of Family and Protective Services statistics, Llano County has 18.3 confirmed cases of child abuse per 1,000 children and Blanco County has 5.4 confirmed cases of child abuse per 1,000 children. This equates to 65 confirmed cases of trauma caused by child abuse or neglect each year.
* **Target Population:** The target population is individuals within Blanco and Llano counties who have suffered trauma. This project will target a minimum of 25 individuals who have suffered trauma to the degree that the trauma is impacting their daily life. Based on the population served in Hill Country’s behavioral health program in RHP 8, it is anticipated that approximately 26% of our patients in RHP 8 have Medicaid and another 60% have income below 200% of the Federal Poverty Level and do not have insurance.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 25 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5 (number anticipated beginning service by year, 6 in DY3; 8 in DY4; and 11 in DY5).
* **Category 3 Outcomes:** IT-11.25: The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals suffering from trauma divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.
* **Collaboration:** TAMHSC’s Pass 1 allocation was not used for this project.

**Project** **Description:**

*Trauma Informed Care*

According to Dr. Eric Kandel’s New Intellectual Framework for Psychology, studies show that medication doesn’t change molecular structure of the brain – experiences do. When an individual is exposed to trauma over long periods, it drastically affects their mental health. Further research indicates that many children diagnosed with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are actually suffering from trauma and Post‐Traumatic Stress Disorder (PTSD). In the article *Diagnosis: ADHD – or Is It Trauma?,* it is noted that seven of 10 children have been exposed to at least one potentially traumatic event and that preschoolers who had experienced multiple traumatic events were 16 times more likely to have attention problems and 21 times more likely to be overly emotionally reactive including showing symptoms of depression and anxiety than children who had not had such experiences.

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. In the July‐ Sept. 2012 Youth Law New, *Trauma‐Informed Care Emerging as Proven Treatment for Children, Adults with Behavioral, Mental Health Problems,* states, “Children who are physically or sexually abused, or who go through other trauma‐inducing experiences can develop mental health disorders and related problems. Indeed, trauma can fundamentally affect how a young person grows and develops”. According to a study cited in *Trauma among Girls in the Juvenile Justice System, a* person traumatized in childhood may resort to criminal behavior. When a survey of all juvenile detainees nationwide was conducted, 93.2% of males and 84% of females reported having had a traumatic experience. In Kaiser’s Adverse Childhood Experiences (ACE) study researchers looked at patients with ACE scores of 7 or higher who didn’t smoke, didn’t drink to excess, and weren’t overweight. The study revealed that the risk of ischemic heart disease (the most common cause of death in the United States) was 360 percent higher than for patients who scored a 0 on the ACE. (Paul Tough, *The Poverty Clinic: Can a Stressful Childhood Make You a Sick Adult?* The New Yorker, March 21, 2011).

Trauma‐informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The National Center for Trauma Informed Care, a division of SAMHSA, facilitates the adoption of trauma‐informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support.

In establishing the project, Hill Country will review literature and experiences regarding Trauma Informed Care to establish appropriate training for staff on the most effective interventions for trauma. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for Trauma Informed services. As a means to determine the success of the interventions, a functional assessment (DLA‐20) determining what impact trauma has on the individuals daily lives will be completed upon entry into the program and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on Trauma Services delivered within the program as well as by location within the program.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

The goal of this project is to establish Trauma Informed Care throughout the two counties served by Hill Country in RHP 8. The project will consist of developing Healthy Communities through the use of Mental Health First Aid Training and Trauma Informed Care training as a means to help the community understand the impact of trauma and to help identify symptoms of trauma for earlier treatment. In addition, a system of trauma counseling will be developed including practices such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help individuals deal with trauma they have experienced. The primary challenge of the project will be recruitment and training of staff for initial implementation.

**Relationship to the Regional Goals:**

The goal of this project is to establish Co‐occurring Psychiatric and Substance Use Disorder services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

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

**Challenges:**

The primary challenge for implementation of the project is recruiting behavioral health staff. Hill Country will address the challenge by offering incentives as necessary.

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

By the end of five years, Hill Country’s goal is to have trained at least 50 individuals in Mental Health First Aid and/or Trauma Informed Care and will have established Trauma Informed Care throughout Llano and Blanco counties and provided services to at least of 25 consumers within the community over the life of the project

**Starting Point/Baseline:**

Hill Country currently provides Cognitive Behavioral Therapy to individuals suffering from Major Depression and Cognitive Processing Therapy for individuals who have experienced a crisis episode and suffer from PTSD. During fiscal year 2011, Hill Country provided 1050 hours of Cognitive Behavioral Therapy and Cognitive Processing Therapy combined. This program would enable Hill Country to acquire and train additional clinicians to provide Cognitive Behavioral Therapy and Cognitive Processing Therapy to a broader population at an earlier stage to avoid the exacerbation of symptoms into a crisis episode resulting in utilization of Emergency Departments (ED), potential psychiatric hospitalizations and utilization of the criminal justice system. Activities of Daily Living (DLA‐20) assessments will be completed when individuals enter the program as a baseline and subsequent DLA‐20s will be conducted to show progress throughout treatment.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.19 ‐ Limited access to behavioral health services for individuals who have suffered trauma in Blanco and Llano counties

Based on the data provided in the project description, need for additional services for Trauma Informed Care is necessary in these areas. Hill Country will educate the community through Mental Health First Aid and Trauma Informed Care Training and identify and train clinical staff in the provision of Trauma Informed Care services such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy.

**Core Components:**

Through the Trauma Informed Care services, Hill Country MHDD Centers proposes to meet all required project components:

a. *Assess size, characteristics and needs of target population*. Hill Country will collect and analyze information on individuals who have issues due to an experienced trauma and review contributing factors such as homelessness, noncompliance with medication, diagnosis, unemployment, economic struggles and other factors contributing to trauma in order to determine appropriate staffing and skill sets necessary for service provision as well as specific locations for service providers.

*b. Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving individuals in Trauma Informed Care in order to provide targeted training for staff and to develop innovative wrap around services to help avert future impact of the trauma.

c. *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes*. Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the issues leading to the trauma, the services received, the number of individuals receiving follow up services, the number of individuals with recurring symptoms, and progression on the Activities of Daily Living (DLA‐20) assessment.

*d. Design models which include an appropriate range of community‐based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train Trauma Informed staff in the most appropriate interventions to address the needs of the individuals and in connecting the individuals with other appropriate resources within the community.

*e. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA‐20) to determine progression of individuals receiving Trauma Informed Care. In addition, Hill Country will do follow up surveys with individuals who receive Trauma Informed Care services to determine satisfaction with services and to help ensure stabilization of symptoms in order to avert additional recurrence of trauma symptoms.

**Continuous Quality Improvement:**

Hill Country 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:** Hill Country does not currently have a Trauma Informed Care initiative within RHP 8. The addition of the Trauma Informed Care would give committed staff to providing ongoing trauma services in order to reduce the number psychiatric hospitalizations and avert recurrence of the psychiatric crisis due to triggers related to past trauma.

Hill Country receives funding through the U.S. Department of Health and Human Services; however, none of those funds will be used for this project.

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

The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals suffering from trauma divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population.

CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.

Reasons/rationale for selecting the outcome measure: Trauma impacts an individual’s mental health and thus their quality of life. It impacts the individual’s self‐care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, and establish a baseline for treatment, provide a guide for intervention planning, evaluate interventions and monitor progress and plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA‐20.

The DLA‐20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA‐20 is intended to be used by all disabilities and ages. THE DLA‐20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress. For the targeted population, individuals needing Trauma Informed Care, the DLA‐20 will help identify areas the trauma has impacted in their lives such as coping skills, problem solving, family relationships, communication, and safety and be able to track improvement in the areas of the course of treatment.

**Relationship to Other Projects:**

Provision of Trauma Informed Care services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through RHP 8 by providing specialized services addressing trauma experienced by individuals that if not addressed in the community may result in needing inpatient psychiatric services. Addressing trauma symptoms in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing trauma symptoms in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD‐1‐3). In addition, Hill Country has several projects in RHP 8. These include:

|  |  |  |
| --- | --- | --- |
| *  | 133340307.2.1 | Co‐occurring Psychiatric and Substance Use |
| *  | 133340307.2.3 | Virtual Psychiatric and Clinical Guidance |
| *  | 133340307.2.4 | Whole Health Peer Support |
| *  | 133340307.2.5 | Veteran Mental Health Services |

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country MHDD Centers will participate in learning collaboratives that meet at least annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost‐ utility analysis which measures program cost in dollars and the health consequences in utility‐ weighted units called quality‐adjusted life‐years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program’s value is based on a monetary value of $50,000 per QALY gained due to the intervention multiplied by number of participants. The valuation on this project is based on 25 consumers over the life of the project.

**Category 2 Project Narrative**

**Hill Country MHDD – 133340307.2.3**

**Project Area, Option and Title:** 2.16.1 Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients regionally: Hill Country Virtual Psychiatric and Clinical Guidance

**RHP Project Identification Number:** 133340307.2.3

**Performing Provider Name:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

**Performing Provider TPI #:** 133340307

**Project Summary:**

* **Provider Description:** Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
* **Intervention:** This project will implement psychiatric and clinical guidance 24 hour a day, 7 day a week for primary care physicians and hospitals within the 2 counties served by Hill Country in RHP 8 to help physicians identify and treat behavioral health symptoms earlier to avoid exacerbation of symptoms into a behavioral health crisis.
* **Project Status:** This is a new project for Blanco and Llano counties.
* **Project Need:** Both counties served by Hill Country are designated as Entire County Healthcare Provider Shortage Areas for Mental Health ([http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm).](http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm)) As such, resources for psychiatric and clinical guidance to primary care providers delivering services to behavioral health patients is very limited and not formalized throughout this area (CN.2.18).
* **Target Population:** The target population is individuals within Blanco and Llano counties who demonstrate behavioral health symptoms and seek treatment at area hospitals or with their primary care physician. Based on a 12‐month mental illness prevalence of 26.2% as reported by the National Institute of Mental Health, the target population consists of approximately 7,900 individuals. Based on the population served in Hill Country’s behavioral health program in RHP 8, it is anticipated that approximately 26% of patients within RHP 8 have Medicaid and an additional 60% with income below 200% of the Federal Poverty Level and no insurance
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 400 psychiatric consultations by the end of DY5 (50 during DY3; 150 during DY4; and 200 during DY5) for the 2 counties served by Hill Country in RHP 8 and that at least 20% of primary care physicians report improved satisfaction with psychiatric consultation over the life of the project (I‐9.1).
* **Category 3 Outcomes:** The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population.
  + IT-11.16 Assessment for Substance Abuse Problems of Psychiatric Patients

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation whose medical record indicates explicit evidence of assessment of current substance abuse problems divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review.

* + IT-11.19 Assessment for Psychosocial Issues of Psychiatric Patients

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation whose medical record indicates a psychosocial/developmental history divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review.

* + IT-11.21 Assessment of Major Depressive Symptoms

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation for whom 5 of the 9 diagnostic criteria for major depression are identified divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review

* **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 project will work collaboratively with all Primary Care Physicians and Hospitals within Llano and Blanco counties in order to transform the system of care by identifying behavioral health issues early and beginning treatment before symptoms exacerbate into crisis episodes.

**Project** **Description:**

*Virtual Psychiatric and Clinical Guidance*

According to *Mental Health Care by Family Physicians,* a paper prepared by the American Academy of Family Physicians, “Mental health issues are frequently unrecognized and even when diagnosed are often not treated adequately. Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. In a recent national survey of mental health care, 18% of the surveyed population with and without a DSM‐IV diagnosis of a mental health disorder sought treatment during a 12 month period, with 52% of those visits occurring in the general medical (all primary care) sector. Estimates are that 11% to 36% of primary care patients have a psychiatric disorder, with one recent survey of mental health conditions in urban family medicine practices revealing that over 40% of survey respondents met criteria for a mental health disorder.”

Recognition and treatment of mental illness are significant issues for primary care physicians, who provide the majority of mental health care. Due to both of the counties served by Hill Country MHDD Centers (Hill Country) being designated as Mental Health Professional Shortage areas, there is a need to develop Psychiatric Consultation services and have them available for Primary Care Physicians and hospitals throughout the region to assist with complex psychiatric needs.

In establishing the project, Hill Country will identify primary care physicians and hospitals where patients would receive the greatest benefit, determine needed telecommunication equipment based on anticipated volume of service, and recruit and hire appropriate clinical staff with the expertise to provide remote psychiatric consultative services. After reviewing models for deployment that have been successful in other areas, Hill Country will work with primary care physicians and hospitals to determine the most appropriate method for consultative service delivery (telephonic, video, etc.) to determine needed improvements to telecommunication equipment for 24 hour a day 7 day a week consultation.

Appropriate legal and clinical expertise will be utilized to develop necessary agreements for sharing of patient information. In addition, participating primary care physicians and area hospital will be requested to complete screenings for depression substance use disorder as a means to identify individuals who would benefit from early treatment. The screening tools to be utilized include the PHQ‐9 (depression screening for adults), the PHQ‐A/BDI‐PC (depression screenings for adolescents, and the CAGE/AUDIT (screening tools for substance use disorder). The screenings would be performed at the primary care physician’s office or local hospital and the number of individuals receiving each assessment would be reported to Hill Country. All consultative services will be recorded in Hill Country’s electronic database (Anasazi) within units and subunits that will keep track of the number of services performed and the location of the services.

**Goals and Relationship to Regional Goals:**

**Goals:**

The goal of this project is to provide Primary Care Providers (PCPs) and hospitals within Blanco and Llano counties with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions through Psychiatric Consultation. The goal of this project is to establish Virtual Psychiatric and Clinical Guidance to PCPs and Hospitals.

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

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

**Challenges:**

The greatest challenge of the project will be recruitment of necessary personnel due to being Mental Health Professional Shortage areas. Hill Country will address the challenge by offering incentives as necessary.

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

By the end of five years, Hill Country will have an established psychiatric consultation service available for all primary care providers and hospitals within the two counties with at least eight providers enrolled and a minimum of twenty percent of PCPs within the counties utilizing the service will be satisfied with the psychiatric consultation provided for patients in their care. Overall, the availability of Psychiatric Consultation should result in earlier identification and treatment of mental health issues and increase integration of services for individuals seeking psychiatric assistance in the primary care setting.

**Starting Point/Baseline:**

There are currently no dedicated resources for behavioral health consultation available to hospitals and PCPs within Blanco and Llano counties. No formal structure currently exists for PCPs and hospitals to obtain clinical guidance regarding patients presenting with behavioral health issues.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 ‐ Limited access to mental health/behavioral health services
* Specific Community Needs:
  + CN.2.18 ‐ Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County
  + CN.2.16 ‐ Lack of behavioral health professionals in Llano and Blanco counties

Hill Country serves two counties (Blanco and Llano) within Regional Healthcare Partnership 8 (RHP 8). Both counties served by Hill Country are designated as Entire County Healthcare Provider Shortage Areas for Mental Health. As such, resources for psychiatric and clinical guidance to primary care providers delivering services to behavioral health patients is very limited and not formalized throughout the area.

According to population estimates by the Texas Department of State Health Services (DSHS), the counties served by Hill Country within RHP 8 have a total population of 30,582 in 2012. Within the two counties, there is one general hospital and thirty‐two physicians with their primary practice location listed in the area. Of these thirty‐two physicians, fourteen have their specialty listed as Family Practice or General Practice.

**Project Components:**

As a formal structure for psychiatric consultation for primary care physicians and hospitals does not exist within the two counties, Hill Country MHDD Centers proposes to meet all required project components:

1. *Establish the infrastructure and clinical expertise to provide remote psychiatric* *consultative services.* Hill Country will review and improve telecommunication equipment based on estimated volume of services and recruit appropriate clinical staff with the clinical expertise to provide remote psychiatric consultative services.
2. *Determine the location of primary care settings with a high number of individuals with behavioral health disorders (mental health and substance abuse) presenting for services, and where ready access to behavioral health expertise is lacking. Identify what expertise primary care providers lack and what they identify as their greatest needs for psychiatric and/or substance abuse treatment consultation via survey or other means.* Hill Country will survey area hospitals and PCPs to determine the potential volume of consultation needed as well as the primary types of issues where consultation is needed. The survey will include areas of needed consultation, estimated of occurrences for consultation, as well as the means by which the primary care physician wishes to receive consultation.
3. *Assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models.* Based on feedback from primary care physicians and hospitals, Hill Country will review successful models of psychiatric consultation and assess the models for applicability to the region being served to determine the most appropriate methods to implement.
4. *Build the infrastructure needed to connect providers to virtual behavioral health* *consultation.* Hill Country will review current telecommunication capacity and improve telecommunication and telemedicine equipment based on estimated volume of services and connections needed to perform consultation efficiently and effectively based on the volume of services estimated and the model of consultation being provided. Hill Country will also develop staffing patterns and acquire all necessary personnel to ensure appropriate clinical expertise is available for consultation regarding both adult and children’s mental health needs.
5. *Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24‐hour basis.* Hill Country will staff the program for 24 hour a day coverage, will survey hospitals and primary care physicians to ensure clinical guidance is available 24 hours a day as needed, and conduct random mystery calls for clinical guidance to ensure 24 hour virtual psychiatric consultative services are available.
6. *Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation*. Based on the recommended model of implementation for the service area and feedback from primary care physicians, area hospitals and other medical providers, Hill Country will conduct needs assessments to determine which primary care settings could benefit from remote psychiatric consultation.
7. *Provide outreach to medical disciplines in primary care settings that are in need of telephonic behavioral health expertise and communicate a clear protocol on how to access these services.* Based on needs assessments and survey, Hill Country will develop protocol and enter memorandums of understanding which define a clear protocol on how to access the remote psychiatric consultation.
8. *Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation.* Hill Country will add necessary service codes and modifiers to the EHR and other tracking documents within the agency to track all activity of the telephonic behavioral health consultation.
9. *Develop and implement data collection and reporting standards for remotely delivered* *behavioral health consultative services.* Hill Country will formalize procedures for collecting and reporting on activities associated with remotely delivered behavioral health consultative services.
10. *Review the intervention(s) impact on access to telephonic psychiatric consults 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.* Hill Country will continually review with primary care providers how the service has supported their practice, ways to improve the service, and how to expand the service to additional providers.

**Continuous Quality Improvement:**

Hill Country 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:** There are currently no Virtual Psychiatric Consultation services available within the counties served by Hill Country in RHP 8.

Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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

Category 3 measures have been proposed in 2014 to describe improvements to the patient population.

* IT-11.16 Assessment for Substance Abuse Problems of Psychiatric Patients

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation whose medical record indicates explicit evidence of assessment of current substance abuse problems divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review.

* IT-11.19 Assessment for Psychosocial Issues of Psychiatric Patients

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation whose medical record indicates a psychosocial/developmental history divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review.

* IT-11.21 Assessment of Major Depressive Symptoms

In DY4 and DY5 we will report the number of patients who receive psychiatric consultation for whom 5 of the 9 diagnostic criteria for major depression are identified divided by the total number of individuals receiving psychiatric consultation. The subset is individuals who receive psychiatric consultation as other medical records are not available for review

Reasons/rationale for selecting the outcome measure: The screening instruments were selected as a method for PCPs to identify issues that may require virtual psychiatric consultation. The determination to track depression screenings for adults, depression screening for adolescents, and substance use disorder screening were chosen due to the prevalence of depression and substance use disorder. By performing the instruments, early diagnosis and intervention of potential symptoms may be addressed in order to avoid escalation of symptoms into a crisis episode.

**Relationship to Other Projects:**

Provision of Virtual Psychiatric Consultation services reinforces objectives for all other behavioral health services provided by Hill Country through Regional Healthcare Partnership 8 by providing specialized consultative services addressing behavioral health issues before they become a crisis. Addressing the behavioral health issues in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by addressing crisis in the community, exacerbation of symptoms are reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions. In addition, Hill Country has several other projects in RHP 8:

|  |  |  |
| --- | --- | --- |
| *  | 133340307.2.1 | Co‐Occurring Psychiatric and Substance Use Disorder |
| *  | 133340307.2.2 | Trauma Informed Care |
| *  | 133340307.2.4 | Whole Health Peer Support |
| *  | 133340307.2.5 | Veteran Mental Health Services |

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. Two of the authorities are proposing telemedicine projects: Center for Life Resources (#133339505.1.1) and Central Counties (#081771001.1.2).

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation is supported by cost‐ utility analysis which measures program cost in dollars and the health consequences in utility‐ weighted units called quality‐adjusted life‐years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program’s value is based on a monetary value of $50,000 per QALY gained due to the intervention multiplied by number of participants. The valuation on this project is based on an estimated 400 consultations for individual patients over the life of the project.

**Category 2 Project Narrative – Pass 2**

**Hill Country MHDD – 133340307.2.4**

**Title of Project Area, Option and Title:** 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services

**RHP Project Identification Number:** 133340307.2.4

**Performing Provider Name:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

**Performing Provider TPI #:** 133340307

**Project Summary:**

* **Provider Description:** Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP8 with a population of approximately 30,582 in 2012.
* **Intervention:** This project will implement Whole Health Peer Support services within the 2 counties served by Hill Country in RHP 8 to meet the overall health needs of individuals who have behavioral health issues. The project will identify and train behavioral health peers on whole health risk assessments and working with peers to address overall health issues to treat symptoms prior to the need for utilization of emergency departments (EDs) or inpatient hospitalization.
* **Project Status:** This is a new project for Blanco and Llano counties*.*
* **Project Need:** According to SAMHSA, individuals with severe and persistent mental illness die 25 years earlier than the general population. Identifying and addressing overall health symptoms, such as hypertension, diabetes, obesity, tobacco use and physical inactivity, of individuals with severe and persistent mental illness helps address this issue while reducing emergency department utilization and potentially preventable admissions to hospitals.
* **Target Population:** The target population is individuals within Blanco and Llano counties who have severe and persistent mental illness and other health risk factors. There are currently 283 individuals identified that meet target population. Based on the population served in Hill Country’s behavioral health program in RHP 8, it is anticipated that approximately 26% of our behavioral health patients within RHP8 have Medicaid and an additional 60% who have income below 200% of the Federal Poverty Level and do not have insurance.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 60 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5 (10 in DY3; 20 in DY4 and 30 in DY5)
* **Category 3 Outcomes:** IT-11.25:The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Whole Health Peer Support*

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide are supportive in nature. By expanding peer services as an integral portion of the seven mental health clinics operated by Hill Country and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of emergency departments (EDs). Hill Country’s is planning to utilize consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful life in the community to provide behavioral health services. Through Via Hope, a state wide organization established under the State’s Mental Health Transformation grant, consumers are being trained to serve as whole health peer support specialists. Upon completion of training, peers are working with consumers to set achievable goals to prevent chronic diseases such as diabetes or to address when they exist. While Hill Country has begun the process of incorporating peer support services, there have been challenges with maintaining peer support specialists and fully incorporating peer services throughout the treatment process. The advancement to Whole Health Peer Support is needed along with increased emphasis on peer services in order to help individuals advance in their recovery.

In implementing this project, Hill Country will continue to train and educate clinicians on the importance of peer services, recruit and train peer specialists in the provision of Whole Health Peer Support, and utilize peer services to identify health risks and provide appropriate education and referrals regarding the health risks identified. Peer services will be tracked in Hill Country’s information technology system (Anasazi) by location and consumer in order to monitor services delivered and outcomes of the services. In addition, Hill Country will conduct consumer satisfaction surveys for individuals receiving peer support services.

**Goals and Relationship to Regional Goals**:

**Project Goals:**

The goal of this project is to establish Whole Health Peer Support throughout the two counties served by Hill Country in RHP 8. The project will consist of identifying and training peers of mental health services in the delivery of Whole Health Peer Support and integrating their work into the recovery oriented treatment plan of the individual being served. The primary challenge of the project will be recruitment, training and retention of peers for implementation of Whole Health Peer Support.

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

The goal of this project is to use Whole Health Peer Support to provide guidance and support for the consumer’s journey of recovery based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

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

**Challenges**:

The challenges Hill Country has faced in establishing a robust peer support program have been in relation to retaining individuals in the positions for extended periods of time. Hill Country plans to address this challenge by shifting the focus of peer support to a whole health model that becomes more fully integrated into the regular practice of the mental health clinics. In addition, Hill Country intends to increase the percentage of full time equivalent for peer support specialists in order to increase retention.

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

By the end of five years, Hill Country’s goal is to have peer support specialists at each mental health clinic with a minimum full time equivalency of 1.0. Currently, Hill Country has 0.07 full time equivalency for peer support services at the Llano Mental Health Clinic within RHP 8.

**Starting Point/Baseline:**

Hill Country MHDD Centers has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery. Currently, Hill Country has ten peer specialists with only four having certifications through the state training program. The Llano Mental Health Clinic within RHP 8 currently has 0.07 full‐time equivalency for provision of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the Llano Mental Health Clinic operated by Hill Country within RHP 8 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.22 – Limited access to whole health peer behavioral health services for individuals in Llano and Blanco counties

Peers are one of the most valuable assets in helping consumers with mental illness gain hope and begin to progress on their road to recovery. The services they provide are supportive in nature. By expanding peer services as an integral portion of the Llano Mental Health Clinic operated by Hill Country and including whole health risk assessments and supported services targeted to individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity, improved Daily Living Activities and improved health outcomes can be achieved, helping address the disparate life expectancy and poor health outcomes and ultimately decreasing utilization of Emergency Departments. Through this project Hill Country will acquire and maintain Whole Health Peer Support Specialists equivalent to a minimum of

1.0 full time equivalency at the Llano Mental Health Clinic operated by Hill Country.

**Project Components:**

Through the Whole Health Peer Support, Hill Country proposes to meet all required project components.

1. *Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system*. Hill Country is currently participating in the Person Centered Recovery Initiative through Via Hope. The initiative is designed to promote mental health system transformation by 1) helping organizations develop culture and practices that support and expect recovery, and 2) promoting consumer voice in the transformation process and the future, transformed mental health system. On October 24, 2012, the clinical leadership of Hill Country completed a one day training on integrating peer support and incorporating the patient in developing and implementing their treatment plan.
2. *Conduct readiness assessments of organization that will integrate peer specialists into* *their network*. Hill Country will review readiness at each of the seven mental health clinics within RHP 8 and address any potential barriers to full integration of Whole Health Peer Support.
3. *Identify peer specialists interested in this type of work.* Hill Country will recruit peer specialists who have interest, first and foremost, in helping other on their journey of recovery and who also wish to receive training in providing whole health peer services and are interested in employment with Hill Country MHDD to provide whole health peer services.
4. *Train identified peer specialists in whole health interventions, including conducting health risk assessments, setting SMART goals, providing educational and supportive services to targeted individuals with specific disorders (e.g. hypertension, diabetes, or health risks (e.g. obesity, tobacco use, physical inactivity).* Hill Country will make arrangements for interested peer specialists to attend Whole Health Peer Support trainings and certifications available through the state of Texas Via Hope program. If training space becomes restrictive, Hill Country will find or develop similar training to bring peer specialists on board until such time as the certification training is available.
5. *Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.* Hill Country will have trained peer specialists utilize the health risk assessment tool to determine potential or current health risks, will track the completion of health risk assessments in the information technology system, and will address potential health risks with the patient.
6. *Identify patients with serious mental illness who have health risk factors that can be modified.* Patients identified through the health risk assessment tool will receive education and information regarding potential health risks and, if appropriate, referred to primary care and preventive resources.
7. *Implement whole health peer support.* Hill Country will track the occurrence of health risk assessments by location and patient in order to determine the project is fully implemented.
8. *Connect patient to primary care and preventive services.* If risk factors or medical conditions are identified that require more than basic education, individuals will be referred to the appropriate primary care and preventive services.
9. *Track patient outcomes. Review the intervention(s) impact on participants and identify* *“lessons learned,” opportunities to scale all or part of the interventions(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety‐net populations.* Hill Country will utilize the Daily Living Activities assessment to determine progression of individuals receiving Whole Health Peer Support services. In addition, Hill Country will do follow up surveys with individuals who receive Whole Health Peer Support services to determine satisfaction with services and to help ensure stabilization of symptoms.

**Continuous Quality Improvement**:

Hill Country 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:**

Hill Country has utilized Peer Specialists in a limited capacity over the past seven years as a means to help support individuals with behavioral health issues deal with their symptoms and advance in their recovery. The Llano Mental Health Clinic currently has 0.07 full‐ time equivalency of peer support services. In order to reemphasize the importance of peer support services, to fully integrate peer support services into the network of services provided through the Llano Mental Health Clinic operated by Hill Country MHDD Centers with RHP 8 and to expand the peer support services offered to include whole health interventions including health risk assessments, Hill Country will recruit additional peer specialists, arrange for appropriate training, and emphasis the peer specialists roles regarding whole health and serving as navigator for consumers.

Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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

The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population.

IT11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines

Reasons/rationale for selecting the outcome measure: Whole Health Peer Support services impact an individual’s mental and physical health and thus their quality of life. It impacts the individual’s self‐care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living (DLA‐20) will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, and provide a guide for intervention planning, to evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA‐20 Functional Assessment.

The DLA‐20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA‐20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses. THE DLA‐20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

**Relationship to Other Projects:**

Provision of Whole Health Peer Support services as an alternative to inpatient and ED services reinforces objectives for all other behavioral health services provided by Hill Country through RHP 8 (#133340307.2.1 Co‐occurring Psychiatric and Substance Use Disorder, #1333340307.2.2 Trauma Informed Care, and #133340307.2.3 Virtual Psychiatric and Clinical Guidance, and #133340307.2.5 Veteran Services) by providing specialized services addressing Whole Health Peer Support for an individual that if not addressed in the community may result in needing inpatient psychiatric services or inpatient medical services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms are reduced, resulting in a reduction of ED utilization and potentially preventable hospital admissions (RD‐1‐3).

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

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. However, some of the projects proposed by these authorities are similar in nature. One such project (#081771001.2.1) is proposed by Central Counties, which addresses chronic diseases that result from prolonged use of psychotropic medications.

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

Hill Country MHDD Centers will participate in a learning collaborative that meets annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on an economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐weighted units called quality‐adjusted life‐years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program’s value is based on the average of benefit‐cost studies from Sari et al. 2008 and Kuyken et al. (2008) with an average benefit cost ratio of $23.36 for every dollar invested, resulting in an average cost of $15,573 per patient served.

**Category 2 Project Narrative – Pass 2**

**Hill Country MHDD – 133340307.2.5**

**Project Area, Option and Title:** 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health and Support Services

**RHP Project Identification Number:** 133340307.2.5

**Performing Provider Name:** Hill Country Community MHMR Center (dba Hill Country MHDD Centers)

**Performing Provider TPI #:** 133340307

**Project Summary:**

* **Provider Description:** Hill Country Community MHMR Center (Hill Country) is a community mental health center providing mental health, substance use disorder, early childhood intervention and intellectual and developmental disability services to the following counties of RHP8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP8 with a population of approximately 30,582 in 2012.
* **Intervention:** This project will implement Veteran Mental Health Services within the 2 counties served by Hill Country in RHP 8 to meet the overall health needs of veterans dealing with behavioral health issues. The project will expand peer support services in an effort to identify veterans and their family members who need comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration and provide the community based wrap around behavioral health services for these veterans and their family members to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.
* **Project Status:** The project will expand Veteran Peer Support and implement community based wrap around behavioral health services for Veterans and their families within Blanco and Llano counties.
* **Project Need:** Hill Country’s service area within RHP 8 has a veteran population of 4,251 and veterans seeking behavioral health services currently have to travel and take a full day off of work to receive behavioral health services (CN.2.21). Based on an average family size for Blanco and Llano counties of 2.25, the veterans and their families are a total target population base for the project of 9,564. In addition, a recent study of death certificates in Texas revealed that the percentage of deaths by suicide for Texas veterans was nearly double the same rate for civilians.
* **Target Population:** The target population is veterans within Blanco and Llano counties who have behavioral health issues. The target population consists of the 9,564 veterans and their families in Blanco and Llano counties, including reservists who only receive Veteran Administration benefits for 180 days after federal deployment. Based on the population served in Hill Country’s behavioral health program in RHP 8, it is estimated that approximately 27% of our behavioral health patients within RHP 8 have Medicaid and approximately 81% have income below $15,000 per year.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 60 veterans and/or their family members from the 2 counties served by Hill Country in RHP 8 by the end of DY5 and 20% of the veterans served show improved functional status (I‐5.1) based on the Adult Needs and Strengths Assessment (ANSA). The cumulative anticipated number of veterans or their family members served by demonstration year is as follows: DY3 12; DY4 30; DY5 60. The anticipated number of individuals served is shown as an unduplicated number since services will carry over between demonstration years. The anticipated number of veterans or their family members beginning the program in each demonstration year is as follows: DY3 12; DY4 18; DY5 30.
* **Category 3 Outcomes:** IT-11.25. The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals receiving Veteran services divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

**Project** **Description:**

*Veteran Mental Health Services*

Studies conducted by the Veterans Administration state that nearly 20% of the suicides that occur in the U.S. are committed by veterans. According to a study of death certificates completed by the Austin American Statesman, the percentage of deaths of Texas veterans caused by suicide from 2003 through 2011 was 21.5% compared to 12.4% for the overall Texas population. Of Texas veterans with a primary diagnosis of post‐traumatic stress disorder who died during this period, 80% died of overdose, suicide or a single‐vehicle crash. According to population estimates from the Texas Department of State Health Services (DSHS) Population Data System for Texas Population Estimates Program and statistics from the Veteran’s Administration 9/30/08 Projection of veteran’s by 110th Congressional District, Vet Pop 2007, Llano and Blanco Counties within Hill Country’s service area has a total population of 28,807 with a veteran population of 4,251 and estimated veteran family population of 9,564, or 33.20% of the total population. During discussions with County Veteran Service Officers, it was noted that there is a need for Mental Health services for veterans due to the transportation and time commitment needed to access Veteran Administration services as well as the reluctance of veterans to acknowledge a potential mental health issue with the Veterans Administration.

Hill Country currently has two Veteran Peer Coordinators who recruit volunteer veterans to provide peer support services throughout Hill Country’s 19 county, 22,000 square mile service area. Through this project, Hill Country will acquire an additional Veteran Peer Coordinator who can actively work to recruit and train veteran peer support providers in a concentrated area such as Blanco and Llano Counties. The Veteran Coordinator acquired through this project will be committed to serving Blanco and Llano Counties and will create liaisons within the counties, seek out veterans and establish drop‐in centers, recruit volunteers, connect veterans with other community resources, create jail outreach and jail diversion for veterans involved with the criminal justice system, coordinate medical and behavioral health referrals as appropriate and serve as a liaison with the local National Guard and Reserve units. This project will also include provision of comprehensive community based wrap around behavioral health services, such as psychiatric rehabilitation, skills training, crisis intervention, supported housing and supported employment, that would complement, but not duplicate, potential services through the Veterans Administration for both Veterans and their families in Blanco and Llano counties, including reservists who only receive Veteran Administration benefits for a few months after active deployment. Wrap around services will be delivered by clinicians who have been trained in cultural competency for the military environment. Wraparound services provided through this project in the local community will complement the Psychiatrist and Counselor services provided by the Veteran Administration at the VA clinics. During the last 6 months, the Veteran Peer Support services have referred 60 individuals for mental health treatment.

Hill Country will expand Veteran Peer Services and Veteran Mental Health services throughout the two county area served by Hill Country in RHP 8. In establishing the project, Hill Country will review literature and experiences regarding Veteran Peer and Mental Health services to establish appropriate training for staff on the most effective interventions for veteran services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for veteran peer and community based wrap around behavioral health services. As a means to determine the success of the interventions, a functional assessment (DLA‐20) will identify what impact the various stressors have on the individual’s daily life. The DLA‐20 will be completed when a veteran is referred for mental health services and at determined intervals during treatment. In order to track individuals receiving treatment in the program, Hill Country will establish specific units and subunits within its information technology system (Anasazi) that will enable reporting on Veteran Peer and Mental Health services delivered within the program, as well as by location within the program.

**Goals and Relationship to Regional Goals:**

**Project Goal:**

The goal of this project is to establish Veteran Peer and Mental Health services throughout Llano and Blanco counties in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

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

The goal of this project is to establish Veteran Peer and Mental Health services based on each individual’s needs within the community setting. By providing these services in the community, Hill Country will be meeting the regional goals of:

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

**Challenges:**

The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

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

By the end of five years, Hill Country will have established concentrated Veteran Peer and Mental Health services within Llano and Blanco Counties which will have provided services to a minimum of 60 consumers within the community over the life of the project.

**Starting Point/Baseline:**

Hill Country currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the number of Veteran Peer Coordinators and provide a dedicated Veteran Peer Coordinator to serve Blanco and Llano Counties served by Hill Country in RHP 8 in order to recruit and train veteran peer service providers. In addition, Hill Country will increase behavioral health services in Blanco and Llano counties to meet the behavioral health needs of the veterans needing more than peer services and for their family members. The DLA‐20 assessment will be performed on each individual entering the program as their baseline and the percentage of individuals who have improved DLA‐20 scores on a subsequent assessment after treatment will be utilized to show improvement.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.21 – Limited access to behavioral health services for veterans in Blanco and Llano counties

Hill Country will identify and train Veteran Peer Coordinators in the provision of veteran peer support services including identifying and seeking out veterans needing services, recruit veteran peer support providers, creating drop‐in centers for veterans, identify and connecting with current resources, and incorporating jail diversion as appropriate for veterans in touch with the criminal justice system.

**Project Components:**

Through the Veteran Mental Health services project, Hill Country proposes to meet all required project components:

1. *Assess size, characteristics and needs of target population*. Hill Country will collect and analyze information on veterans with mental health issues and review contributing factors to episodes to determine appropriate staffing and skill sets necessary for service provision and identify locations.
2. *Review literature / experience with populations similar to target population to determine community‐based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* Based on the size, characteristics and needs for the target population, Hill Country will review appropriate literature and experiences regarding serving veteran mental health issues to provide targeted training for staff.
3. *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes*. Hill Country will develop a project evaluation plan that will review items such as the number of individuals served, the services received, the number of individuals receiving follow up services, the number of individuals with recurring issues, and progression on the Activities of Daily Living assessment (DLA‐20).
4. *Design models which include an appropriate range of community‐based services and residential supports.* Based on the size, characteristics and needs for the target population, Hill Country will train staff in the most appropriate interventions to address the needs of the individuals and connecting the individuals with other appropriate resources within the community.
5. *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population based on information from the Adult Needs and Strength Assessment and/or participant surveys, and identify 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.* Hill Country will utilize the Activities of Daily Living assessment (DLA‐20) to determine progression of veterans referred for Veteran Mental Health services. In addition, Hill Country will do follow up surveys with individuals who receive Veteran Peer Services to determine satisfaction with services and to help ensure stabilization of symptoms.

**Continuous Quality Improvement:**

Hill Country 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:** Hill Country currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the number of Veteran Peer Coordinators and provide a dedicated Veteran Peer Coordinator to serve Blanco and Llano Counties served by Hill Country in RHP 8 in order to recruit and train veteran peer service providers. In addition, Hill Country will increase behavioral health services in Blanco and Llano counties to meet the therapy and psychiatric needs of the veterans needing more than peer services. Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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

The following Category 3 measures have been proposed in 2014 to describe improvements to the patient population. IT-11.25 Daily Living Activities (DLA-20) In DY4 and DY5 we will report the sum of the average DLA score of all DLA-20 questionnaires completed during the measurement period for a denominator subset of all completed DLAs at Hill Country MHDD Centers for individuals receiving Veteran services divided by the total number of DLA-20 questionnaires completed during the measurement period for the same population. CMHC.5 Adherence to Antipsychotic Medications: In DY4 and DY5 will report adherence to antipsychotic medications in accordance with measure guidelines.

Reasons/rationale for selecting the outcome measure: Behavioral health issues impact veterans’ mental health and thus their quality of life. It impacts the individual’s self‐care as well as their ability to cope with their environment. When an individual is unable to properly care for themselves or to cope with their local environment, they are at greater risk of unemployment and poor health. The Activities of Daily Living will be utilized to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, evaluate interventions and monitor progress and to plan for future and for discharge. The Activities of Daily Living will be measured utilizing the DLA‐20 Functional Assessment.

The DLA‐20 Functional Assessment is a functional assessment, proven to be reliable and valid, designed to assess what daily living areas are impacted by mental illness or disability. The assessment tool identifies where outcomes are needed so clinicians can address those functional deficits on individualized service plans. THE DLA‐20 is intended to be used by all disabilities and ages. Developmental Disabilities and Alcohol/Drug Abuse forms are personalized for daily functional strengths and problems associated with those diagnoses.

THE DLA‐20 utilizes the following 20 domains: Health Practices, Housing Stability and Maintenance, Communication, Safety, Managing Time, Nutrition, Problem Solving, Family Relationships, Alcohol/Drug Use, Leisure, Community Resources, Social Network, Sexuality, Productivity, Coping Skills, Behavior Norms, Personal Care/Hygiene, Grooming, and Dress.

**Relationship to Other Projects:**

Provision of Veteran Mental Health services as an alternative to inpatient and emergency department services reinforces objectives for all other behavioral health services provided by Hill Country through RHP 8 (#133340307.2.1 Co‐occurring Psychiatric and Substance Use Disorder, #133340307.2.2 Trauma Informed Care, and #133340307.2.3 Virtual Psychiatric and Clinical Guidance, and #133340307.2.4 Whole Health Peer Support) by providing specialized services for veterans that if not addressed in the community may result in needing inpatient psychiatric services. Providing the services in the community enables the individual to move forward with treatments and to be more successful in their recovery. In addition, by providing services in the community, exacerbation of symptoms is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD‐1‐3).

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

Hill Country is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. No other provider in RHP 8 is specifically seeking to assist veterans; however, a number of the providers are targeting specific populations. These include Central Counties Temple Day Service project (#081771001.2.3), Bluebonnet Trails ACT Team Services project (#126844305.2.3) and Bluebonnet Trails’ Transitional Housing project (#126844305.2.1). Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country will participate in learning collaboratives that meets semi‐annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in the projects.

**Project Valuation:**

Project valuation is based on a weighted average of Achieving Waiver Goals, Addressing Community Needs, Project Scope, and Project Investment. The valuation for this project was based on economic evaluation model and extensive literature review conducted by professors at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research. The valuation is supported by cost‐utility analysis which measures program cost in dollars and the health consequences in utility‐weighted units called quality‐ adjusted life‐years (QALYs). QALYs incorporate costs averted when known (e.g., emergency room visits that area avoided). The proposed program’s value is based on a monetary value of $50,000 per QALY gained due to the intervention multiplied by number of participants. The valuation on this project is based on 60 consumers over the life of the project.

**Category 2 Project Narrative**

**Scott & White Hospital--Llano 020840701.2.1   
(formerly Llano Memorial Hospital)**

**Project Area, Option and Title:** 2.8.1. Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency

**RHP Project Identification Number:** 020840701.2.1

**Performing Provider Name:** Baylor Scott & White Health Llano

**Performing Provider TPI #:** 020840701 (New TPI: 220798701)

**Project Summary:**

* **Provider Description:** Scott & White Hospital-Llano is a 30‐bed hospital in Llano, TX, serving a 934 square mile area and a population of approximately 19,301. It is part of Baylor Scott & White Healthcare, a large integrated system in Central Texas.
* **Intervention:** This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model, to identify causes of avoidable Emergency Medical System (EMS) and Emergency Department (ED) utilization, prioritize potential solutions, and launch PDSA cycles on chosen improvements.
* **Project Status:** This is a new project. At the start of this project, no team is dedicated to reducing avoidable EMS and ED visits at the hospital.
* **Project Need:** Llano County and the hospital identified a need for increased capacity in EMS services in the county. The group chose to work on rapid process improvement to improve the appropriate utilization of EMS and associated ED visits to address this need. This project addresses the following community need: CN.1.5 ‐ Limited access to emergent care and limited awareness of which levels of care are appropriate for different health needs places undue burden on the Emergency Department and Emergency Medical System in Llano County.
* **Target Population:** The target population within Llano County will be determined in DY2. A review of ED and EMS revenue and volume reports indicate 7,005 ED visits were completed in FY 2012; 1,981 EMS transports occurred. Approximately 16% of ED visits and 9% EMS transports were for Medicaid, uninsured and/or indigent populations. We expect to impact the majority of persons using EMS transport who are also Medicaid beneficiaries, uninsured patients and indigent care program members with process changes to improve the appropriateness of utilization for this group. Process changes introduced by the project will reach a cumulative total of 400 individuals in DY2‐5, including 150 in DY4 and 200 in DY5. While some will necessarily still utilize EMS and ED services, the process improvement work should improve decision‐making and utilization choices for the full population considering use of EMS services.
* **Category 1 or 2 Expected Project Benefit for Patients:** The project is designed to improve the appropriateness of EMS service utilization and the resulting ED utilization that comes from EMS utilization. Process improvements will work to better address unmet needs leading to inappropriate EMS and ED utilization for County residents (Improvement Milestone I‐13.1). Reducing inappropriate ED visits will help maintain timely and effective use of EMS and ED services for patients experiencing a true emergency.
* **Category 3 Outcomes:** IT‐9.2.a: Our goal is to reduce all‐cause ED visits by 5% over baseline by the end of DY4 and 10% over baseline by the end of DY5.

**Project** **Description:**

*Continuous Rapid Process Improvement for Emergent Services*

This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model, to identify causes of avoidable Emergency Medical System (EMS) and Emergency Department (ED) utilization, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles to implement iterations of chosen improvements. The core project components include:

a) *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* Staff members and other stakeholders on our quality improvement team will be trained in the IHI Model to establish common language and basic competency for group participation. Teams will be facilitated by system personnel trained and experienced in quality improvement, implementation and evaluation methodology.

b) *Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.* Solicitation of employee suggestions will be systematic and purposeful. It will be important to capture the suggestions of EMS personnel in particular. Quality improvement teams will be made up of local champions for change and staff members involved in key process steps (as identified by process mapping exercises). Informal discussions, surveys, and existing employee or patient feedback mechanisms will be utilized as appropriate to the teams’ work.

c) *Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures ((i.e. weekly or monthly dashboard).* Frequency of data feedback to the quality improvement team(s) and broader audiences will be determined by the nature of changes tested—some will require more frequent feedback than others. In all cases, we intend to measure for improvement *and* for unintended consequences (e.g., adding unintended barriers to care, adding unnecessary steps to processes) of all changes. A project manager will be responsible for documenting key actions in our PDSA cycles and collating data gathered to test each change. The nature of those data will depend on the change being tested. Data on the improvement target of ED utilization can be extracted from the hospital’s billing data. Data on volume of EMS calls will come from the EMS records, the format and frequency of which needs to be determined by teams to match their planned PDSA cycles.

d) *Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.*

Implementation guides will be customized to process improvement iterations, as appropriate.

e) *Implement software to integrate workflows and provide real‐time performance feedback*.

Software will be integrated only if determined to be necessary for process improvement but not for the sake of adding software alone.

*f) Evaluate the impact of the process improvement programs and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.* Key performance indicators must be selected for each test of change. This will largely be indicators of implementation—for example, number of people reached with the change, and potential unintended impacts of the change.

**Goals and Relationship to Regional Goals:**

The primary goals of this project are to reduce inappropriate utilization of EMS and reduce inappropriate utilization of ED services such that those services are more readily available for responding to emergencies and transferring patients to higher levels of care outside the county quickly when needed. Our goal is to reduce inappropriate utilization of these specific services. This fits within the regional goal of reducing inappropriate service utilization is a regional goal.

**Project Goals:**

* Reduce avoidable utilization of EMS services (e.g., for conditions that are not urgent); and
* Decrease ED utilization by reducing use of the ED for concerns that do not require urgent or emergency services.

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

Reducing inappropriate utilization of services.

**Challenges:**

We expect our biggest challenge to be collaboration across stakeholder groups. While appropriate utilization of services is a shared goal, definitions of current problems and ideas for how to address those problems are likely to differ across groups. These differences are essential for choosing effective changes that can be sustained long‐term, but differences also require effective and mutually‐respectful strategies for collaboration. The team’s work will be facilitated by someone from Baylor Scott & White Health’s System Quality & Safety team. This person is trained and experienced in facilitating the QI process and will use facilitation strategies designed to engender trust and foster effective communication across stakeholder groups.

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

In five years, we expect to increase the availability of EMS services for timely patient transfers out of the County for higher levels of service when necessary because community members’ needs will be met in more appropriate ways that do not require EMS transfer to the ED. We also expect increased capacity in the ED because of a reduction in visits for conditions that are not urgent or do not require emergency care. Reduction in inappropriate ED use should represent a shift in the community’s ability to meet individuals’ needs at the right place and right time.

**Starting Point/Baseline:**

Baseline will be established in DY2 after the quality improvement team specifies the program targets and project‐ specific metrics.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 ‐ Limited access to primary care
* Specific Community Need: CN.1.5 ‐ Limited access to emergent care and limited awareness of which levels of care are appropriate for different health needs places undue burden on the Emergency Department and Emergency Medical System in Llano County.

The project will address RHP 8 community need listed above.

At the start of this project, no team is dedicated to reducing avoidable EMS and ED visits at the hospital. Locally, there is a belief that additional ambulance services would be useful for helping alleviate burdens on existing EMS teams, especially when transfers to sites of care out of the county require significant time for one or more teams at a time. Rather than adding capacity, the Performing Provider and Llano County have agreed to partner to try to reduce avoidable EMS utilization, freeing up existing EMS crews for out‐of‐county transfers and reducing avoidable ED utilization.

We selected continuous, rapid cycle improvement processes to address the problem because no solution is obvious. The iterative work of stakeholders will be required to identify key leverage points and launch tests of change to address the problem. All required project components will be employed (see Core Components in “Project Description”). The milestones chosen represent key steps in the Model for Improvement, the model to be deployed by the team. Before launching our first test of change, we need to identify the target metrics that would indicate a change is an improvement (P‐2). We then need to identify current processes and generate a list of potential changes to those processes that may lead to improvement.

Once that list is generated, the team can prioritize the potential changes and select at least one to launch [P‐1] [P‐1.1]. This pre‐work is planned for DY2. Completion of the pre‐work will position the team to launch its first test of change (PDSA cycle) in DY3 [P‐7]. Consistent with the Model for Improvement, the first test of change will lead to iterations of tests of change, informed by data gathered during PDSA cycles and by the pre‐work in DY2. We expect that iterations of test of change should have impact on the chosen metrics by DY4 and increasing impact by DY 5 [I‐13] [I‐13.1]. Progress toward the targeted process‐related metrics should be an indicator of progress toward achieving our Category 3 Outcome Measure—IT‐9.2.a Emergency Department (ED) visits per 100,000, the indicator of impact on the community need for reduced inappropriate ED utilization.

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

The project does not overlap with other initiatives funded by the U.S. Department of Health and Human Services.

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

IT‐9.2.a Emergency Department (ED) visits per 100,000

The project is designed to improve the appropriateness of EMS service utilization and the resulting ED utilization that comes from EMS utilization. Appropriate ED utilization is a priority because we need to maintain timely, effective ED services for individuals with urgent or emergency conditions but want to reduce use of EMS and ED services for other types of concerns. Doing so should free‐up EMS and ED provider time for meeting the needs each service was designed to address. The measure was chosen because it directly reflects the project goals, described above. We will meet our improvement targets by launching iterative rapid process improvement initiatives and monitoring their impact on our targets. Ineffective changes will be dropped or adjusted to better impact our targets.

**Relationship to Other Projects:**

The proposed Pass 2 project (#020840701.2.2 and #020840701.3.2) at Scott & White Hospital--Llano will also use rapid cycle improvement cycles to address the related problem of ED utilization as part of behavioral health transports. Both projects will follow the Model for Improvement and some of the same stakeholders will be represented on both projects. Depending on target populations selected by the teams and identified potential tests of changes, there may be opportunities to leverage the two improvement initiatives to more broadly address utilization of ED and transport services by serving the underlying community needs proactively.

The project is also related to our Category 4 for project #020840701.2.1 in that it has the potential to reduce potentially avoidable hospital admissions following ED visits for the same conditions even though hospital admissions are not the target of the project. As of November 1, ED utilization is not a listed metric for Category 4; this project is not expected to impact time to transfer in the ED.

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

This project is related to the Category 2 project (#137249208.2.1, #137249208.3.1, and #137249208.3.2) submitted by Scott & White Memorial Hospital for a patient navigator program in Bell County with one of its goals also being reduction of inappropriate ED utilization. The strategies in the two counties will be different, but each was selected in collaboration with the IGT partners and each is expected to best meet the local needs of residents in ways that reduce need or perceived need for ED services. This project is also related to a patient navigation project (#126936702.2.1 and #126936702.3.6) proposed by Williamson County and Cities Health Department. Scott & White Hospital--Llano will participate in a 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 served the populations in their projects.

**Project Valuation:**

The scope of this project was determined by the availability of funds from IGT entities to serve the residents of Llano County, who used local EMS services for 1,981 transports from Sept 2011 through August 2012. By the end of DY5, the process changes introduced through this project will reach at least 400 individuals in the target population in Llano County (Cat 2 Milestones 4 and 5). The value is the sum of a) direct costs of program implementation, measurement, and management to affect at least the processes for Medicaid beneficiaries, charity care program members, and indigent care program members (approximately 178 transports/year), and b) indirect costs of participation in this waiver and of administering the program (e.g., hiring, communication, offices, personnel management, and information technology). Because data collection and reporting is inextricably tied to process improvement, the project valuation was done across all four categories and four years then divided by 4 to estimate the per‐year value or divided by the minimum required percent allocation to each category to estimate the per‐ category value. When all activities are considered, the average per‐year direct program cost is expected to be $252,212. This value includes a process improvement “allowance” for the quality improvement team of $24,948 per year to implement selected changes.

An indirect cost of 19% was applied to average annual direct program costs to account for cost of communication, printing, personnel time for meeting, and other incidental costs of gathering the quality improvement team and conducting program activities. Estimated per‐year indirect costs are $40,269.

**Category 2 Project Narrative – Pass 2**

**Scott & White Hospital--Llano – 020840701.2.2**

**(Formerly Llano Memorial Hospital)**

**Project Area, Option and Title:** 2.8.1. Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency

**RHP Project Identification Number:** 020840701.2.2

**Performing Provider Name:** Scott & White Hospital--Llano

**Performing Provider TPI #:** 020840701 (New TPI: 220798701)

**Project Summary:**

* **Provider Description:** Scott & White Hospital--Llano is a 30-bed hospital in Llano, TX, serving a 934 square mile area and a population of approximately 19,301. The hospital is part of Baylor Scott & White Healthcare, a large integrated system in Texas.
* **Intervention:** This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, to identify causes of avoidable Sheriff Department Transport of behavioral health patients in crisis, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles on chosen improvements.
* **Project Status:** The project represents a new activity in the County and does not overlap with other U.S. Department of Health and Human Services initiatives.
* **Project Need:** The County identified the need for this project because the Sheriff’s Department is conducting multiple transfers each month to an out-of-county facility for persons who are a danger to themselves or others due to behavioral health challenges. These transfers represent potentially avoidable costs for the county, emergency department (ED) visits to determine safety for transport, and disruption of families and individuals. This project addresses the following Community Need: CN.2.18 – Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County.
* **Target Population:** The target subpopulation of persons with behavioral health needs who are at risk of being a danger to themselves or others because of their condition will be determined in DY2 of the project. This target population must be broad enough to reach individuals at risk for sheriff transports. Currently, the approximate number of sheriff transports is 60 per year; an estimated 16% of this population (10 individuals per year) is uninsured or are beneficiaries of Medicaid or the Llano County Indigent Care Program. We expect process changes to reach 50 individuals in DY3, 100 individuals in DY4 and 150 in DY5, for a cumulative total of 300 individuals in DYs 2-5. This estimate will be adjusted based on DY2 planning work and individual process changes selected.
* **Category 1 or 2 Expected Project Benefit for Patients:** At the end of the five-year demonstration, we expect to have developed new processes in Llano County for connecting individuals and families to behavioral health resources that will reduce the number of crises they experience, thereby reducing the need for forced transfers of individuals to behavioral health care by the Sheriff’s Department (Improvement Milestone I-13.1). We also expect that this reduction of behavioral health crises will reduce avoidable ED visits.
* **Category 3 Outcomes:** IT-9.2.a: Our goal is to reduce ED visits by 5% over baseline in DY4 (approximately 34 ED visits averted in DY4) and 10% over baseline in DY5 (approximately 56 ED visits averted in DY5).

**Project Description:**

*Partnership to Reduce Avoidable Sheriff Deputy Transport of Persons with Behavioral Health Needs in Llano County*

This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, to identify causes of avoidable Sheriff Department Transport of behavioral health patients in crisis, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles to implement iterations of chosen improvements. A trained quality improvement team facilitator from Baylor Scott & White Healthcare’s System Quality & Safety division will guide a team of community stakeholders through the model to a) identify the problem, b) define metrics of desired change (if any are needed in addition to those outlined in Categories 2 and 3), and c) describe potential changes that may lead to improvement. The team will prioritize these potential changes then launch iterative tests of change to move the community toward reduction of behavioral health transports and related Emergency Department (ED) visits. Initial stakeholders will include representatives Scott & White Hospital--Llano (e.g., ED, mental health), Llano County government (IGT), and Llano County Sheriff’s department. The group will identify additional stakeholders based on their knowledge of the community and scope of identified changes to be tested. These may include, for example, community members with experience in behavioral health, other community-based community health providers, and organizations with whom families of persons with behavioral health needs may have contact (e.g., churches, workplaces). For each test of change, the group will plan the launch of the change for a specified period. They will measure, with the assistance of a project manager as needed, both implementation and impact of each change. They will use data on both to review progress and plan future PDSA cycles.

**Goals and Relationship to Regional Goals:**

The primary goals of this project are to reduce inappropriate utilization of EMS and reduce inappropriate utilization of ED services by identifying and addressing behavioral health needs before crises occur that require Sheriff Department deputies to forcibly transfer individuals to behavioral health facilities. These transfers require medical clearance through EDs, usually the Performing Provider ED. Our goal to reduce inappropriate utilization of these specific services fits within the regional goal of reducing inappropriate service utilization.

**Project Goal:**

* Decrease ED utilization by reducing Sheriff Department transfers of individuals to behavioral health facilities.

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

* Reducing inappropriate utilization of services.

**Challenges:**

The two strongest anticipated challenges are a) facilitating the team’s systematic use of the Model for Improvement, and b) fidelity of implementation of tests of change. Stakeholders will vary dramatically in their experience with quality improvement and may find group work around problem definition and brainstorming possible solutions to be unlike their usual processes. We will mitigate this challenge by setting expectations for use of the model in team meetings and utilizing a trained facilitator who works for Baylor Scott & White Healthcare but on a different campus. Using an outside facilitator will allow the model to come from an outside source and allow the team leader (local to Llano County) to avoid the perception of trying to influence the team’s work by facilitating toward a particular solution. We have also chosen metrics that will require systematic work by the team. For the second challenge, the team will include measures of implementation in its iterative tests of change. For example, they may choose to audit the degree to which new protocols are being fully implemented or the number of personnel using new processes. Information on implementation will help the team design new iterations of process change with both our Category 3 outcomes and full implementation as goals.

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

At the end of the five-year demonstration, we expect to have developed new processes in Llano County for connecting individuals and families to behavioral health resources that will reduce the need for forced transfers of individuals to behavioral health care by the Sheriff’s Department. We also expect that this reduction of behavioral health crises will reduce avoidable ED visits.

**Starting Point/Baseline:**

Baseline will be established in DY2 after the quality improvement team specifies the program targets.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.2 – Limited access to mental health/behavioral health services
* Specific Community Need: CN.2.18 – Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County.

**Project Components:**

The core project components include:

1. *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* Staff members and other stakeholders on our quality improvement team will be trained in the Model of Improvement to establish common language and basic competency for group participation. Teams will be facilitated by Baylor Scott & White Healthcare personnel trained and experienced in quality improvement, implementation and evaluation methodology.
2. *Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement.* Solicitation of employee suggestions will be systematic and purposeful. It will be important to capture the suggestions of deputies who carry out transfers, ED personnel who conduct exams to provide health clearance for transports, and hospital/clinic personnel who care for persons with poorly controlled behavioral health symptoms. Quality improvement teams will be made up of local champions for change and staff members involved in key process steps (as identified by process mapping exercises). Informal discussions, surveys, and existing feedback mechanisms will be utilized as appropriate to the teams’ work.
3. *Define key safety, quality, and efficiency performance measures and develop a system for continuous data collection, analysis, and dissemination of performance on these measures ((i.e. weekly or monthly dashboard).* Frequency of data feedback to the quality improvement team(s) and broader audiences will be determined by the nature of changes tested—some will require more frequent feedback than others. In all cases, we intend to measure for improvement and for unintended consequences (e.g., adding unintended barriers to care, adding unnecessary steps to processes) of all changes.
4. *Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.* Implementation guides will be customized to each process improvement iteration.
5. *Implement software to integrate workflows and provide real‐time performance feedback.* Software will be integrated only if determined to be necessary for process improvement but not for the sake of adding software alone.
6. *Evaluate the impact of the process improvement programs and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.* Beyond the indicators of Sheriff Department transfers to behavioral health and ED visits, key performance indicators must be selected for each test of change. This will largely be indicators of implementation—for example, number of people reached with the change, and potential unintended impacts of the change.

At the start of this project, the Sheriff’s Department in Llano County is carrying out multiple transfers to an out-of-county facility each month for persons who are a danger to themselves or others due to behavioral health challenges. These transfers represent potentially avoidable costs for the county, ED visits to determine safety for transport, and disruption of families and individuals. Partners on this project believe these transfers could be avoided in many cases by addressing the needs of behavioral health patients before crises occur. Doing so would reduce burden on the Sheriff’s Department, reduce ED visits (including those required as part of protocols for these transfers), and improve care for behavioral health needs. The solution to the problem is not obvious. By conducting collaborative process improvement work with stakeholders, we will have the opportunity to conduct rapid tests of change to find better ways to meet the needs of behavioral health patients before crises occur.

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

The project does not overlap with other Baylor Scott & White Healthcare initiatives funded by the U.S. Department of Health and Human Services, none of which include inpatient services in Llano County.

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

Selected Category 3 measures include:

* OD-9 Right Care, Right Setting
  + IT-9.2.a ED Appropriate Utilization

ED appropriate utilization was chosen because County stakeholders have indicated that a) some portion of behavioral health transfers are avoidable, possibly with improved access to services before challenges become crises, and b) all such transfers require ED visits for medical clearance of individuals for transfer to behavioral health settings.

**Relationship to Other Projects:**

This project is related to the Pass 1 Category 2 project (#020840701.2.1) submitted by Scott & White Hospital--Llano to undertake continuous quality improvement to address appropriate utilization of EMS services and associated ED utilization in the same County. Efforts on these two projects will be coordinated to leverage the work of teams in ways that makes work on both projects more efficient. For example, we may be able to coordinate solicitation of input from personnel and other stakeholders regarding these two problems in the County. The processes targeted for improvement will be different, but the processes for conducting rapid-cycle improvements will be the same—both are based on the IHI Model for Improvement.

The project is also related to our Pass 2 Category 4 project in that hospital-level reporting will be conducted; however, ED utilization is not among the measures currently included in Category 4.

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

This project is related to the Category 2 project (#137249208.2.1, #137249208.3.1, and #137249208.3.2) submitted by Scott & White Memorial Hospital for a patient navigator program in Bell County with one of its goals also being reduction of inappropriate ED utilization. The strategies in the two counties will be different, but each was selected in collaboration with the IGT partners and each is expected to best meet the local needs of residents in ways that reduce need or perceived need for ED services. This project is also related to two projects proposed by Williamson County and Cities Health Department. One is for a patient navigation project (#126936702.2.1 and #126936702.3.6). The other is a paramedicine project (#126936702.1.2). Bluebonnet Trails is also proposing an Emergency Services Diversion project (#126844305.2.2). There are several local mental health authorities proposing projects to reduce the number of behavioral health clients from jails. Scott & White Hospital--Llano will participate in a 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 served the populations in their projects.

**Project Valuation:**

The scope of this project was determined by the availability of funds from IGT entity and the available allotments in Pass 1 and 2, the known history of approximately 60 transports per year in the County, and the estimated need to touch 300 individuals in DY2-5 (100 in DY4, 150 in DY5) with process changes in order to reduce transports and related ED visits. The value is the sum of a) direct posts of program implementation, measurement, and management and b) indirect costs of participation in this waiver and of administering the program (e.g., hiring, communication, offices, personnel management, and information technology). Because data collection and reporting is inextricably tied to process improvement, the project valuation was done across all four categories and four years then divided by 4 to estimate the per-year value or divided by the minimum required percent allocation to each category to estimate the per-category value. When all activities are considered, the average per-year direct program cost is expected to be $98,901. This value includes a process improvement “allowance” for the quality improvement team of $59,555 per year to implement selected changes.

An indirect cost of 19% was applied to average annual direct program costs to account for cost of communication, printing, personnel time for meeting, and other incidental costs of gathering the quality improvement team and conducting program activities. Estimated per-year indirect cost is $18,791.

**Category 2 Project Narrative**

**Scott & White Memorial Hospital -- 137249208.2.1**

**Project Area, Option, and Title:** 2.9.1 Patient Navigation and Chronic Illness Support for

Patients with Limited Resources

**RHP Project Identification Number:** 137249208.2.1

**Performing Provider Name:** Scott & White Memorial Hospital

**Performing Provider TPI #:** 137249208

**Project Summary:**

* **Provider Description:** Scott & White Memorial Hospital is a 636‐bed hospital in Temple, TX, and the only Level 1 Trauma Center between Dallas and Austin. SWHM serves a 29,000 square mile area and a population of approximately 3 million people. The hospital is part of Baylor Scott & White Healthcare, a large integrated system in Texas.
* **Intervention:** This project will provide patient navigation and selected chronic illness supports for a target group of patients who are members/beneficiaries of the Bell County Indigent Care Program, Medicaid, and/or participating hospitals’ charity care programs. Project components include patient navigators, chronic disease self‐management workshops, additional mental health practitioners at a free clinic, and an improved network of coordinated support for program participants.
* **Project Status:** This is a new initiative for all partners.
* **Project Need:** The impetus for this project was stakeholders’ call for improved supports for low income patients that would ultimately reduce unnecessary utilization of high cost ED and hospital services. The project addresses two main areas: 1) inappropriate utilization of the ED; and 2) fragmentation of the health care system; difficulty navigating services. This project ties to the following community need: CN.1.4 ‐ Limited access to primary health care for indigent and uninsured populations in Burnet County.
* **Target Population:** In DY2, the team will select a subpopulation for which patient navigation services will be available from among the estimated 20,000+ Bell County population of Medicaid beneficiaries and members of indigent care or charity care programs. Subpopulation selection will be based on risk for potentially avoidable ED and hospital utilization and will capture approximately 6% of the target population to allow manageable caseloads for patient navigators. The project will deliver at least one patient navigator service (e.g., screening, chronic illness self‐management workshop, mental health appointment, referrals) to 2,400 individuals across all project years. In DY4, 1,000 will be served. In DY5, 1,200 will be served.
* **Category 2 Expected Project Benefit for Patients:** Patient navigation and the planned increase in capacity for self‐management education and mental health services will connect individuals in the patient navigator program to the right care and the right community resources to meet their needs. In DYs 2‐5 the program is expected to provide at least one type of service (e.g., screening, workshops, and referrals) to 2,400 individuals. The program will help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self‐management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care). It is also expected to reduce exacerbation of health conditions sensitive to outpatient care and self‐care.
* **Category 3 Outcomes:** Our goal is IT‐9.2a: Reduce ED utilization among program members by at least 5% over baseline by end of DY4 and 10% over baseline by the end of DY5.

**Project** **Description:**

*Patient Navigation*

This project will provide patient navigation and selected chronic illness supports for a target group among those with financial limitations, including those on the Bell County Indigent Care Program, Medicaid, and/or participating hospitals’ charity care programs. The specific target audience will be chosen part of DY2 activities (Milestone P‐1). Core program components will be launched before or during DY3 (Milestone 3: P‐2) and will include 1) patient navigators embedded at Bell County Indigent Care Program office and at three hospitals in the county, 2) Chronic Disease‐Self Management Program (Lorig/Stanford model) workshops for program participants, 3) mental health practitioners added at one free clinic to increase accessibility of services for participants with chronic mental health needs, and 4) shared protocols and communication across sites and program components to maintain a network of coordinated support for program participants.

Scott & White Health Memorial, the performing provider, will subcontract with Bell County Indigent Care Program, Cedar Crest Hospital & RTC, Metroplex Health System, and the Central Texas Area Agency on Aging (AAA) for the cost of embedded services at those sites and for chronic disease self‐management workshops. In addition, Metroplex Hospital will also receive funds through subcontracts for.5FTE Licensed Clinical Social Worker or other qualified therapist to deliver care for program participants (and other patients at local free clinics if capacity allows). Scott & White Health Memorial will employ a .5FTE nurse practitioner to deliver mental health services in partnership with the therapist employed by Metroplex Hospital. The team will collaborate to determine the target population, develop patient navigation protocols, and create protocols for referrals and cross‐site communication. Ongoing iterations of protocols are expected as the partners recognize and respond to challenges.

The anticipated long‐term outcomes of this program are a) improved access to and utilization of appropriate levels of care, and b) reduced utilization and need for ED services among program members.

**Goals and Relationship to Regional Goals:**

The project goal is to meet the health needs of program participants in ways that reduce unnecessary ED utilization. Patient navigation and the planned increase in capacity for self‐management education and mental health services will connect persons with resource limitations and health needs to the right care and right community resources to meet their needs. The program will help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self‐management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care).

**Project Goals:**

* Reduce avoidable ED visits in the target population; and

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

* Improving access to timely, high quality care for residents of the County, 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.

**Challenges:**

The two primary challenges anticipated by the partners are 1) creating and maintaining an efficient and secure data system for sharing information about program participants and navigator actions across sites, and 2) identifying timely sources of healthcare and social services to meet participants’ needs in the community. The hospitals, AAA, and County have collaborated closely on the development of this plan and will leverage our effective working relationships to address these and other challenges throughout the project. Regular program calls/meetings will use standard agendas to review program data and day‐to‐day challenges, develop action plans, and agree on how best to disperse program funds to meet program challenges. We expect protocols to go through iterations as we try processes, identify opportunities to improve, and adjust to better meet program participant needs.

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

In five years, we expect to reduce overall ED visits for all Indigent Care Program members, Medicaid beneficiaries, and hospital charity care program members by impacting both metrics in the selected subgroups of this low‐income population. The patient navigator program will be developed and improved over time to meet the needs of this population such that they perceptions of need and medical need for high‐intensity services are reduced because needs are met in other ways through outpatient services and community services.

**Starting Point/Baseline:**

No patient navigation exists for the target population in Bell County. Therefore, no baseline exists. Baseline will be established in DY2 (Milestone 1: P‐1) after the project team reviews administrative billing data from the participating hospitals and claims data from the County Indigent Health Care Program (CIHCP) as part of its work to identify the target population for the program (among individuals who are part of the CIHCP, Medicaid, or hospital charity care programs). Once the target population for the patient navigation program has been established, we will use the same data sources to establish baseline ED utilization within the target group. Our intention is to establish baseline rates based on data from July 2011 – June 2012 because this period best represents the most accurate estimates of utilization for Bell County Indigent Care Program. Claims payment was temporarily suspended for that program later in the summer of 2012 through the end of the County’s fiscal year and is therefore not an accurate representation of utilization for Indigent Care Program members, one important group to be represented in the target population. Baseline for Category 3 is set on Calendar Year 2013 data.

**Rationale:**

**Community Needs Addressed:**

* Community Need Areas: C.3 – Lack of coordinated care for those with multiple needs
* Specific Community Need: C.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.

The impetus for this project was the expressed need for improved support for Indigent Care Program members. This need was identified by the program director and county officials. The identification of that need resonated with the hospital partners on this application. While

health services are generally available in Bell County, Texas, connecting citizens to the right care at the right time is a challenge, especially for citizens with limited financial and other resources (e.g., transportation, health literacy). Multiple studies are underway at Scott & White Healthcare to understand the experiences of members of medical aid programs (e.g., Medicaid, our internal charity care program) when they return home from the hospital and to understand how primary care utilization is associated with ED utilization among Medicaid beneficiaries nationally. Preliminary, unpublished data point to the complexity of needs affecting where and when persons with resource limitations seek care. At the same time, the demand for Bell County Indigent Care Program reimbursement for members’ care exceeded that program’s capacity in Fiscal Year 2011. That is, the cost of care for at least one program in our County is beyond our resources.

Patient navigation was chosen as the intervention to address complex patient needs and the growing economic burden of healthcare in our County because Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.21 Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. The intent of this patient navigator program is to empower citizens with resource limitations to access the medical and human services they need when those services are most needed to prevent exacerbation of health conditions leading ED and hospital services. Preventing ED and hospital services is expected to also reduce the cost of care for this population while more appropriately meeting persons’ needs.

This project is a unique partnership among hospitals, the county, and a community‐based organization. We recognize that the needs of persons with resource limitations cannot be met from any of our locations alone. We will therefore form a network of support for the target population to better meet their needs at the times and places program participants want and need support. No similar network exists currently. This is a new initiative for all partners, including Scott & White Healthcare.

**Core Components:**

Shared protocols will include the core components for this Category 2.9.1 project in the following ways:

1. *Identify frequent Emergency Department (ED) users among the target population and use navigators as part of a preventable ED reduction program.* The details of the program’s efforts to prevent avoidable ED utilization will be determined by the program partners in Demonstration Year 2 (Milestone 1: P‐1) after looking at patterns of use and gathering information from partners about potential causes in our region. One improvement expected from the program’s efforts is an increase in referrals to PCPs for program participants who use the ED. Cultural competency will be among the topics of required patient navigator training.
2. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* In this project, the team of navigators—embedded in and employed by various partners, will be trained in multiple disciplines such that the shared expertise of the navigator group can address the varied needs of program participants. For example, we expect to need nursing, social work, and social services training represented among the navigators. We also expect to need expertise working with Hispanic/Latino patients, with military families, and with medical aid programs.
3. *Connect patients to primary and preventive care.* One of several advantages of embedding navigators in local healthcare systems is the opportunity to optimize referral processes to each setting by partnering with a patient navigator form within each system. Sufficient primary and preventive care services are available in the County through multiple community‐based clinics affiliated with two of the participating hospitals and three free clinics. Protocols will address proactive evaluation of participants’ needs for recommended preventive services (e.g., vaccinations) and protocols for coaching patients to choose where to access services and then to make/attend appointments for those services.
4. *Increase access to care management and/or chronic care management, including education in chronic disease self‐management.* Protocols will include referrals to self‐ management education programs offered through this program to participants and to other area self‐management education (e.g., diabetes education). Self‐management education will be launched in DY2 (Milestone 2: P‐4) to help increase patient engagement, and will continue through DY5. The addition of mental health services at one local free clinic will give navigators and participants improved access to mental health services to address chronic mental health issues.
5. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Regularly‐scheduled program meetings/calls will have the primary purpose of continuous quality improvement. The Model of Improvement will be among the content areas in patient navigator training. The partners will use PDSA cycles to create iterations of protocols throughout the project. Data on program implementation (e.g., types of navigation services provided to patients) will be employed by the team to help monitor quality and test the impact of program changes (Milestone 4: P‐5).

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

IT‐9.2.a ED Appropriate Utilization

Patient navigation services will address needs identified by the team as influences on inappropriate ED utilization for individuals with resource limitations in Bell County. This measure was chosen because it represents the consequences of gaps in services or patient engagement that lead to unnecessary utilization of high‐cost, high intensity services. In some cases, services are needed because steps to prevent illness or exacerbations of conditions were not taken. In other cases, utilization of these services may represent a lack of access to or lack of awareness of access to other services designed to meet individuals’ non‐urgent and non‐emergent needs. The multidisciplinary network of patient navigators that will be deployed for this project will be embedded across the county in both healthcare and community locations to help ensure that program members have easy and continued access to coaches, educators, and clinicians to connect them to the services that best match their needs. We will meet our improvement targets by reviewing data on processes (e.g., fidelity of implementation of program protocols) and outcomes over time. When problems with processes or lack of progress toward targets are identified, we will launch changes to address identified problems. Navigators will meet regularly to discuss challenges and progress. A project manager will help gather and report on program to allow the navigator team to monitor progress and make appropriate adjustments.

**Relationship to Other Projects:**

This project is related to the Pass 1 and Pass 2 projects proposed for Baylor Scott & White Health Llano. All three projects will address avoidable utilization of services. The Llano hospital projects will work with stakeholders in the county to identify areas for reducing unnecessary use of EMS services and avoiding court orders to transfer persons with behavioral health crises. The demand for both types of emergent services are believed to be higher than necessary in that county and both may be leading to unnecessary ED utilization. All three projects will be monitored by personnel on Baylor Scott & White Healthcare’s Quality & Safety team to identify opportunities to exchange lessons learned in the two counties for addressing needs proactively in ways that reduce avoidable utilization of services.

Category 4 reporting for this project may show changes in hospital‐wide rates of potentially avoidable hospital admissions and 30‐day hospital readmissions if the impact on the program‐ population is strong enough to show in the rates for the entire hospital population.

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

Baylor Scott and White Health Llano has two projects that are related to this one:

* #020840701.2.1 Patient Navigation
* #020840701.2.2 Sheriff Transport
* Williamson County and Citied Health District also has a navigation project (#126936702.2.1).

Scott & White Health Memorial will participate in a 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 served the populations in their projects.

**Project Valuation:**

The scope of this project was determined by the available IGT and number of hospitals and community organizations that indicated a willingness to partner. The project value is based on two categories of cost and a hospital incentive for participation. The incentive is intended to cover cost of program planning, unanticipated program costs or new program aspects needed to fully address needs, and assumption of risk inherent in program participation.

* Estimated direct cost of personnel for service delivery, project management, data reporting per year
  + At Baylor Scott & White Healthcare: $234,045
  + Subcontracts for services: $484,944
* Estimated indirect cost cost/year (off‐campus rate = 19%): $117,559
* Incentive to Performing Provider: $15,275

**Category 2 Project Narrative – Pass 2**

**Seton Highland Lakes Hospital – 094151004.2.1**

**Project Area, Option and Title:** 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

**RHP Project Identification Number:** 094151004.2.1

**Performing Provider Name:** Seton Highland Lakes Hospital

**Performing Provider TPI #:** 094151004

**Project Summary:**

* **Provider Description:** Seton Highland Lakes Hospital (SHL) is a 25-bed Critical Access Hospital, providing acute care services, emergency services and intensive care in a predominately rural area. It also operates several rural healthcare clinics that offer primary care services, as well as a home health agency. The hospital is located in the City of Burnet which has a population of approximately 6,000, and is located in Burnet County, with a population of approximately 43,000.
* **Intervention:** This project will implement a patient navigation system to connect indigent and uninsured patients with primary care or medical homes in order to reduce emergency department (ED) utilization and provide cost-effective, timely, and site-appropriate health care services. Patients will be routed to a medical home by care navigators responsible for managing long-term relationships with the patients to reduce the patient’s need for advanced medical care, including the (ED).
* **Project Status:** This project is a new initiative and plans to navigate approximately 400 patients during the course of the waiver.
* **Project Need:** CN.1.4 - Limited access to primary health care for indigent and uninsured populations in Burnet County. There is insufficient access to primary care available in Burnet County to provide for the needs of the indigent and uninsured population.
* **Target Population:** The target population is the medically indigent patient population currently served by the Burnet County Indigent Health Program, as well as other indigent and uninsured patients who are frequent visitors to SHL’s ED.
* **Category 1 or 2 Expected Project Benefit for Patients:** Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the costs of preventable hospital admissions, readmissions and ED visits, save lives and keep families healthy through referrals to a primary care setting and empanelment to a medical home. Patients will also be offered the opportunity for preventive health care and disease self-management education. When appropriate, home health visits will be offered. The program will of 60 individuals in DY2, 70 in DY3, 120 in DY4 and 150 in DY5. Cumulative impact will be 400 by end of DY5, program enrollment will be 400.
* **Category 3 Outcome(s):** IT-6.1.a.v: HCAHPS Communication about Medicine.

Rationale: In DY4 and DY5 we will improve top box scores for the HCAHPS domain Communication about Medicine out of all surveys administered at Seton Highland Lakes during the measurement period. We selected this particular outcome because effective communication about medicine is an essential component of preventative health care and disease self-management. The SHL Navigation project seeks to reinforce this communication as a means to ensuring that patients are successfully navigated out of the hospital setting with a good understanding of their medications.

Baseline Information: The baseline rate established in DY3 was 65.8%. Our baseline measurement period established in DY3 was 4/1/14-9/30/14.

* **Category 3 Outcome(s):** IT-9.5. Reduce low acuity ED visits and Stretch Activity (SA3) Stretch Activity: Alternative Approaches to Program and Outcome Linkages

Rationale: In DY4 and DY5 we will report the rate of ED utilization at Seton Highland Lakes (SHL) among low acuity presenting patients per 100,000. We selected this particular outcome because the primary goal of this project is to ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators will assist in connecting patients to primary care physicians and/or medical home sites. As such, we hope to reduce inappropriate use of the ED for low acuity patients by connecting them to a primary care home where these conditions can be managed more appropriately. This survey will be coupled with Stretch Activity 3, in which a report in DY5 will address program aims, participation, changes implemented, and quantitative assessment of impact on service delivery and patient outcomes.

Baseline Information: The baseline rate established in DY3 was 98.02%. Our baseline measurement period established in DY3 was 4/1/14-9/30/14.

**Project Description:**

*Patient Care Navigation*

Provider, SHL, will develop a comprehensive, effective patient navigation services for indigent and uninsured patients from Burnet County, Texas. Patients will be routed to a medical home by care navigators responsible for managing long-term relationships with the patients to reduce the patient’s need for advanced medical care, including the (ED).

A collaborative care team of Navigators, including Community or Home Health Workers, Licensed Nurses, and/or Case Managers will provide proactive care management, navigate patients to a medical home, perform home environment assessments, and provide medication management assistance. The care team will also provide education to enrolled patients regarding chronic conditions, disease prevention and medication management.

Below are the anticipated roles and responsibilities of the care team of navigators:

* Medical Director (Physician) and/or Nurse Practitioner: Care management of the most vulnerable enrollees in the care management program. Those patients requiring a higher level of care coordination and oversight, education and medication reconciliation.
* Coordinator of the Program: Coordinates all activities related to developing enrollment materials, managing enrollment into the care coordination program
* Director of Home Health and Clinics: Operations oversight of clinics, Home Health & Hospice and development of care coordination program
* Case Manager, RN: Case Manager RN to be the first point of contact for patients enrolled in the program who can proactively manage preventive and educational visits to enrollees and who can be the first point of contact when enrollees interact with the hospital for complex services.
* Visiting Nurses: Team of multiple nurse positions who combine to visit, evaluate, educate and coordinate across the continuum care of all enrollees on a regular basis.
* Social Worker: Team of two qualified social workers at SHL who coordinate care and assist with patient navigation through the care continuum.
* Pharmacist: Proactively evaluate patient medication lists and assist clinicians with appropriate delivery of medications

SHL is an integrated, multi-level healthcare provider which is part of a larger system, Seton Healthcare Family, with provides the region with a full range of adult and pediatric tertiary and trauma care. To facilitate and support the medical home model, SHL will leverage its existing network of nine multi-specialty clinics and its home health and hospice services. It will also develop a network of other healthcare providers and community partners to provide timely access to primary and specialty care and other support services. Care coordinators will work with all of these entities with a goal of providing care in the most appropriate setting.

All medical interactions with the enrollees will be managed through the SHL electronic medical record system. Seton has a separate cost center for all activities related to the care coordination program which allows for financial tracking of the resources and investments in the program. The program coordinator, in combination with data from the above sources will develop a monthly activity report which will be used in correlation meetings with other community providers and in quarterly meetings with Burnet County on program progress.

**Goals and Relationship to Regional Goals:**

The goal of this project is to ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators will assist in connecting patients to primary care physicians and/or medical home sites. The target population is estimated at 745 based on the number of indigent or uninsured patients who sought care at SHL between September 2011-August, 2012. Of these, approximately 110 were part of the Burnet County Indigent Health Program. Of the total, 474 visited the ED sometime in the last year. One of the goals of this project is to reduce the number of ED visits per capita by this population each year over the life of the program.

**Project Goals:**

* The care provided by the care team at the medical home of the enrollees and the relationship they will share with will result in improved access to timely, appropriate and high quality care for the residents of the SHL community.
* Patients will be enrolled in a medical home program with dedicated home health clinicians including physicians and physician extenders and dedicated care coordinators responsible for managing long-term relationships with the patients and their families.
* The care team will provide patient education on appropriate disease and prescription self-management. This will include prevention and how to appropriately interact with the SHL system to ensure optimal results at the lowest costs.
* The entire system will be focused on minimizing the patient’s need for advanced medical care and to manage their care to the most appropriate setting including reduction of the number of ED visits.

**This 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.

**Challenges:**

The following are major challenges related to implementation of the program:

* A major challenge of the program is the potential growth of the uninsured or underinsured in the SHL service area and the corresponding strain on implementation and long-term management of the health status of the population. SHL is building a scalable infrastructure complete with appropriate software, staffing and leadership oversight to absorb fluctuations in the size of the population.
* The program will ultimately rely on compliance by enrollees who have previously not been asked to be compliant with rules and protocols associated with a care management program. Our solution has been to bring skilled, culturally competent and personable healthcare providers to their homes to develop lasting relationships which we believe will ultimately result in improved coordination and care.
* The program depends largely on the IGT source (Burnet County) which is, in turn, depending on this program remaining financially feasible for them throughout the entire four years. We have developed a collaborative spirit between SHL and Burnet County to proactively address issues and barriers which may arise to impact the viability of the program.

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

SHL expects to see improvement in ambulatory conditions of patients and a reduction in the number unnecessary hospitalization of the indigent and Burnet County patients enrolled in the program and seeking treatment at a SHL facility.

**Starting Point/Baseline:**

This is a new delivery system initiative for RHP 8 and will begin with a gap analysis and program development. The baseline for enrollment begins at 0; with a goal of enrolling 60 individuals into the program by the end of DY2.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 - Limited access to primary care
* Specific Community Need: CN.1.4 - Limited access to primary health care for indigent and uninsured populations in Burnet County

Patient navigators help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out‐patient centers, payment systems, support organizations and other components of the healthcare system. Services provided to patients enrolled in this navigation program will include:

* Coordinating care among providers;
* Arranging financial support and assisting with paperwork;
* Assist with transportation needed;
* Facilitating follow‐up appointments; and
* Community outreach and building partnership with local agencies and groups.

The navigation team will have close ties to the local community and serve as important links between underserved communities and the healthcare system. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities. Patient navigators will be:

* Compassionate, sensitive, and culturally attuned to the people and community;
* Knowledgeable about the environment and healthcare system; and
* Connected with critical decision makers inside the system.

SHL selected Process Milestone P-1: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. This milestone was selected because detailed needs assessment will serve as the basis for design of the program and related materials to best serve the needs of the enrolled patients. Gaps in current services and resources needed to fill those gaps will be a primary focus of the needs assessment.

Process Milestone P-3.1, to provide navigator services to targeted individuals was selected to begin in DY2 to serve the community need as soon as possible.

SHL selected Improvement Measure I-102, to increase the number of PCP referrals and medical empanelment in DYs 4 and 5 to ensure that the majority of enrollees’ health care needs are managed in a cost-effective, timely and site appropriate manner.

**Core Project Components:**

* + 1. *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* Low incomepatients using the ED for primary care services with social or economic barriers to accessing primary care will be offered navigation services. Patient Navigators will create social services notes in the health record that will be associated with the patients’ medical record by medical record number. These notes will include sections on reason for services, assessment, subsequent referrals and follow‐up activities. Further, Patient Navigators will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, and chronic disease management.
    2. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.*We plan to utilize bilingual Patient Navigators with a background in community health, social services, mental health, or public health, with experience providing direct care to disadvantaged populations.
    3. *Connect patients to primary and preventive care.*The care team will be trained to assess enrollees and their environments and to provide education regarding disease self-management and prevention. Contact with enrollees may occur at three points: 1) when contacted by the patient using a centralized care coordination phone number; 2) through periodic medical home health visits; and 3) when enrollees enter the SHL network and referred to the program**,** with special attention paid to patients in SHL’s ED.
    4. *Increase access to care management and/or chronic care management, including education in chronic disease self-management.* At the initial assessment meeting with the patient and their family, which may occur in their home, patients will be educated on the benefits and inner-workings of the program and chronic disease self-management, if applicable. The patient and/or the family will be proactively contacted and visited by the care team to improve patient compliance in disease self-management.
    5. *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.* SHL will conduct periodic internal coordination meetings between multiple areas of the health system and externally with other healthcare providers and non-healthcare partners in the community to identify best practices and implement or pilot new ideas.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Currently, a patient navigation program does not exist for these patients at SHL. SHL offers case management services, but this is typically only offered during an inpatient admission and requires a physician order.

This project complements, but does not duplicate other current initiatives funded by the U.S. Department of Health and Human Services, either directly or indirectly or through state initiatives. SHL participates in the Medicare and Medicaid Electronic Health Records Incentive Program for hospitals; extension of this program to SHL-affiliated physician offices and clinics is in development; participation in the EHR program is expected to support the care delivered under this project and coordination between providers. SHL’s parent company, Seton Healthcare, is a participant in the Pioneer ACO, however, it is not expected to serve this project’s target population. SHL also benefits indirectly from the participation of Ascension Health, Seton Healthcare Family’s parent company, in CMS’ Partnership for Patients.

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

* Category 3 Outcome(s): IT-6.1.a.v: HCAHPS Communication about Medicine.

Rationale: In DY4 and DY5 we will improve top box scores for the HCAHPS domain Communication about Medicine out of all surveys administered at Seton Highland Lakes during the measurement period. We selected this particular outcome because effective communication about medicine is an essential component of preventative health care and disease self-management. The SHL Navigation project seeks to reinforce this communication as a means to ensuring that patients are successfully navigated out of the hospital setting with a good understanding of their medications.

Baseline Information: The baseline rate established in DY3 was 65.8%. Our baseline measurement period established in DY3 was 4/1/14-9/30/14.

* Category 3 Outcome(s): IT-9.5. Reduce low acuity ED visits and Stretch Activity (SA3) Stretch Activity: Alternative Approaches to Program and Outcome Linkages

Rationale: In DY4 and DY5 we will report the rate of ED utilization at Seton Highland Lakes (SHL) among low acuity presenting patients per 100,000. We selected this particular outcome because the primary goal of this project is to ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators will assist in connecting patients to primary care physicians and/or medical home sites. As such, we hope to reduce inappropriate use of the ED for low acuity patients by connecting them to a primary care home where these conditions can be managed more appropriately. This survey will be coupled with Stretch Activity 3, in which a report in DY5 will address program aims, participation, changes implemented, and quantitative assessment of impact on service delivery and patient outcomes.

Baseline Information: The baseline rate established in DY3 was 98.02%. Our baseline measurement period established in DY3 was 4/1/14-9/30/14.

**Relationships to Other Projects:**

Related Category 4, population-Improvement measures (based on hospital data) are:

* Domain 1 – Potentially Preventable Admissions
* Domain 2 – Potentially Preventable Readmissions
* Domain 4 - Patient-Centered Healthcare

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

There are three other patient navigation projects in RHP 8:

* Scott & White Memorial Hospital #137249208.2.1
* Scott & White Hospital – Llano #020840701.2.1
* Williamson County & Cities Health Department #126936702.2.1

In addition, there are a several projects which are associated with patient navigation. These include Bluebonnet Trials’ Emergency Services Diversion project (#126844305.2.2), Scott & White Hospital – Llano’s Sheriff Transport project (#020840701.2.2) and Williamson County & Cities Health Department’s Paramedicine project (#126936702.1.2).

SHL will fully participate in RHP-wide learning collaboratives for projects that directly address patient navigation and chronic care management. Because of the wide scope of such services and the integration of care at all levels, plans to participate in learnings regarding care transitions, enhancement of interpretation services, culturally competent care, palliative care and telemedicine. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

**Project Valuation:**

Project valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project’s ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost efficient way for the patient and family unit. SHL is on pace to see more than 18,500 visits in its Emergency Department this year and 1,250+ admissions. SHL is anticipating this program will result in approximately 300 fewer visits per year including inpatient and outpatient resulting in an approximate cost avoidance of $700,000. Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the cost of preventable hospital admissions, readmissions and ED visits, save lives and keep families healthy.

**Category 2 Project Narrative**

**Williamson County and Cities Health District – 126936702.2.1**

**Project Area, Option and Title:** 2.9.1 Provide patient navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

**RHP Project Identification Number:** 126936702.2.1

**Performing Provider Name:** Williamson County and Cities 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:** This project will provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care to prevent hospital admissions and readmissions.
* **Project Status:** This project is an expansion of an existing initiative and will provide navigation services to a total of 3,600 unique patients in addition to the current pre-DSRIP baseline of 2,824 patients by the end of DY5.
* **Project Need:** CN.3.4 Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005‐2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congestive Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years. The current safety‐net providers have waiting lists for new patients, making it difficult for chronically‐ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.
* **Target Population:** The number of patients/clients the project will target is approximately 10,900 by DY5. The target population is patients that need assistance navigating the healthcare system to access appropriate level of care without utilizing the Emergency Department for services. Approximately 45% of patients are either Medicaid eligible, low income uninsured or indigent, so we expect they will benefit from about half of the proposed navigation services.
* **Category 1 or 2 Expected Project Benefit for Patients:** Baseline established in DY2 was 2,824 unique individuals. The project seeks to provide an additional 600 individuals with navigation services in DY3, an additional 1,200 individuals in DY4, and an additional 1,800 individuals in DY5. This reflects a total impact of 3,600 individuals by the end of DY5. (See Improvement Milestone 1‐6.4).
* **Category 3 Outcomes:** The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.
  + 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 individuals receiving patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.
* **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 project addresses the key need of diverting individuals from the emergency department for preventive care services that can be obtained through a medical home. Navigating the healthcare system when individuals are uninsured, can be complex and leave the uninsured individual to a route for care where they know they’ll be seen regardless. This practice increases unnecessary cost to hospitals but more importantly the ultimate result is the lack in continuity of care for the patient. Transforming this process will ensure individuals are connected to the appropriate level of medical care for preventive or acute instead of through the emergency department.

**Project** **Description:**

Navigation Program ‐ *The Williamson County and Cities Health District proposes to provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care.*

The project would improve accessibility to health care services for Williamson County individuals who have a diagnosed chronic condition or pregnancy and who are at high risk of disconnect from institutionalized health care, to prevent hospital admissions and readmissions, while improving their experience of timely care. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005‐2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congestive Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) <http://www.wcchd.org/statistics> and\_reports/) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (diabetes example). The current safety‐net providers have waiting lists for new patients, making it difficult for chronically‐ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

The WCCHD Navigation Program proposes to optimize and individualize services of a collaborative team of community health workers, Program Navigators, Case Managers (Social Workers and Public Health Nurses) and other types of health care professionals to persons by:

* Hiring community health workers/promotoras within each of the 4 smaller sectors of the county. The team will cover all 4 Public Health Center sites in Georgetown, Round Rock,
* Cedar Park and Taylor. These Public Health Centers are geographically spread through the larger cities in the county and are central to each of the major rural areas.
* Cross‐training with staff in other agencies with some similarity of functions, such as EMS personnel, to support consistency of core purpose and processes.
* Having Patient Navigators able to meet people in their own communities to build trust and find those in need of healthcare services before they present to an Emergency
* Department (ED) or for late prenatal care.
* Helping patients’ access care by connecting them with enabling services, such as transportation.
* Using electronic tools such as Health Information Exchange (HIE) and Electronic Health Records (EHR) to support consistent communication about health needs and treatment for people with chronic diseases, pregnancy, and high‐ED utilization.

Patients will be identified for navigation services proactively through intake calls received from the community (quite often from citizens with chronic health conditions seeking access to care), from daily hospital reports, HIE ICare reports, other agency and provider referrals, and ongoing personalized visits within communities by members of the team. Additionally, another project is focused on outreach and communication strategies that will supplement connection to those in need of patient navigation services, with an emphasis on reaching pregnant women.

Patients will, based on their condition or need, be able to participate in assessments to include health literacy, risk stratification, and health risk appraisals, while navigators work to ensure financial access to care, appointment with a Primary Care Provider (PCP)/ Obstetrician (OB), and enabling services in place, such as transportation. Patients may choose to also participate in case management and health education services within their home communities. These multi‐agency/multi‐community services will be offered in a culturally and linguistically appropriate manner.

Documentation of patient navigation will be initiated in the WCCHD CHASSIS electronic system. Tracking of encounters, services/service types, appointments with PCP/OB, dates of entry into prenatal care, completion of eligibility for healthcare funding programs will be monitored and tracked. A process for patient satisfaction measure tracking will be developed during DY2. Hospitalization and ED usage will be monitored through HIE reports to assist in compiling a complete picture of the needs and results from patient navigation services.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use community health workers, case managers, social workers and registered nurses as patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to high‐risk patients with COPD, CHF, hypertension and/or diabetes. Patient navigators will help and support these patients to navigate through the continuum of health care services, and establish a medical home. Patient Navigators will ensure that patients receive coordinated, timely, and site‐appropriate health care services, and are linked to chronic disease education and/or self‐management tools.

**Project Goals:**

* Increase over baseline in patients with a PCP appointment to establish a medical home
* Increase in patient satisfaction with receiving timely care, appointments and information

**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 and mental health needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

Williamson County is among the ten fastest growing counties in the US, with 16.5% of the population uninsured (approximately 80,000 people). The challenge for this project in such a rapidly changing environment, is to target and reach populations and people in need in the most direct and streamlined fashion, in a culturally competent manner with understanding of each person’s unique situation. Lack of public transportation has been consistently identified as a priority need in Williamson County, especially in the rural areas. WCCHD will continue to work with existing community transportation coalitions addressing this challenge.

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

WCCHD expects to see reductions in inappropriate hospitalizations and ED use for patients with targeted chronic conditions, increase in patients accessing prenatal care in their first trimester of pregnancy and increased use of a medical home, while meeting the project goals above.

**Starting Point/Baseline:**

WCCHD has had a nurse and social worker case management programs for many years. These have been for a variety of patient populations and each program has answered to different goals and metrics of the funding source. Additionally, there has been a “Health Care Helpline” in place for many years, again, acting as an entry point into the health care system for people who are lost in navigating to meet their needs. There are currently four positions that have been “re‐purposed” this fall to begin a Patient Navigation system within WCCHD. This project will allow for substantial expansion of Patient Navigators into the communities, thereby increasing access for those most difficult to reach. Additionally, this program will allow for a community‐wide system of care to develop with unified data, reporting and communications. Mechanisms to gather more standardized data on which to build improvements and manage it electronically, is essential to moving away from the current fragmented system internally and externally.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.3 ‐ Lack of coordinated care for those with multiple needs
* Specific Community Need: CN.3.4 ‐ Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents
* Other Community Needs:
  + CN.1.6 – Limited access to primary care and preventive services
  + CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals diagnosed with chronic disease

This project option supports the integration of many of the initiatives of both WCCHD and the community at large. WCCHD was one of the first “integrated eligibility” sites in Texas in the 1980s, looking for ways to reduce redundancy in patient applications and verifications to receive funding for healthcare services. This quest for integration of processes to support vulnerable populations in accessing health care in the broadest sense is the catalyst for selecting this project option. As noted earlier, the vulnerable citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five‐ year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to tie those to other community services in a more seamless and effective system. Currently, clients continue to call the “Healthcare Helpline” for assistance in navigation, but the need has exceeded the capacity of this model. This project will allow for expansion of the comprehensive patient navigation services through the team model into the community. The project will:

* Help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out‐patient centers, payment systems, support organizations and other components of the healthcare system;
* Ensure that patients receive coordinated, timely, and site‐appropriate health care services;
* Assist in connecting patients to primary care physicians and/or medical home sites;
* Coordinate with other RHP projects that focus on diversion of non‐urgent patient care from the ED to site‐appropriate locations;
* Assist in connecting patients to potential healthcare funding programs; and
* Assist nurse and social work case managers in connecting patients/families to appropriate health education and community resources.
* Through an Electronic Health Record, screening and eligibility tool and Healthcare Helpline, staff will monitor and track metrics, activities and patients assisted by this project.

While there is no one common definition of patient navigators, the WCCHD project will use a team‐based model that includes nurses, social workers and community health workers/promotoras based in their respective communities. While there is no set education required for a patient navigator to be successful, a successful navigator should be:

* Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
* Knowledgeable about the environment and healthcare system.
* Connected with critical decision makers inside the system.
* Hiring practices will focus on these key interpersonal skills and abilities.

**Project Components:**

We propose to meet all of the required project components through the Patient Navigation program.

1. *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* The hospital partners will initially identify ED frequent users through daily reporting. Connection to navigators will be geographically‐based, so that outreach into communities will be facilitated. Initial and ongoing training in cultural competency will be part of the work in DY2 and 3.
2. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* Based on the Public Health Center model, many of the various professionals and staff will be deployed in navigation roles.
3. *Connect patients to primary and preventive care.* Connection to a medical home is imperative in this project, with follow‐up to assess barriers and completion of transition to this medical home.
4. *Increase access to care management and/or chronic care management.* Patient Navigators will assist patients in connecting to these services that are offered through WCCHD and other providers in a comprehensive and coordinated manner.
5. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the patient navigation program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications, community relations and research staff.

**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:** This project allows for a large enhancement of patient navigation into the community, using multiple venues and partners in a coordinated approach. As noted above, the “skeleton” of this project is in place; this project will allow for full transition from the

“Health Care Helpline” concept to a fully‐integrated patient navigation program serving patients in a coordinated, rather than episodic fashion.

WCCHD receives funding from the U.S. Department of Health and Human Services but will not use those funds for this project.

**Related Category 3 Outcome Measures:**

The following category 3 measure has been proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.

* + 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 individuals receiving patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.

Reasons/rationale for selecting the outcome measures: We selected these two measures as representative outcomes to reflect: IT-6.2a: The patient‐centered model of care we will be providing and the patient’s perception of timeliness, appointments and information in meeting perceived needs. This increase in satisfaction should be reflective of continuously improving the Patient Navigation process and relationships to support patients more individually, effectively and efficiently. Ensuring linkage to a medical home by navigating the health care system will provide patients with opportunities to seek appropriate level of care, knowledge of chronic condition, and promotion through encounters with the medical provider. IT-1.7: If the patients are receiving the benefit of the combined efforts of the WCCHD Interdisciplinary Team and the Williamson County EMS Community Paramedicine Team, we should expect that patients with hypertension would have their blood pressure under control as a result of these interventions. Thus, the IT-1.7 outcome is an appropriate measure of our effectiveness.

**Relationships to Other Projects:**

All the proposed projects are oriented toward providing more coordinated care throughout Williamson County, to simplify healthcare system access for patients, to lower costs and to improve the quality of care at the place of service.

This project will coordinate with the following other WHHCD projects in Williamson County:

* Expanded Capacity to Access Care (#126936702.1.1)
* Implement project to enhance collection, interpretation, and/or use of REAL data (#126936702.1.3)
* Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for Non‐emergent conditions (#126936702.1.2)
* 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 (#126936702.2.2)

This project also coordinates with a project performed by St. David’s Round Rock Medical

Center will expand access to primary care (#020957901.1.1).

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

Scott & White Memorial Hospital (#137249208.2.1) and Scott & White Hospital – Llano (#020840701.2.1) have patient navigation projects.

The Williamson County Wellness Alliance (WWA) and the WilCo Integrated Care Collaborative are forums where we will be exchanging ideas, successes and needs as we move through this delivery system improvement. Both of these groups include other performing providers, as well as schools, businesses, consumers, agencies, government, etc., so that we will have a full‐ focus on progress in these areas.

**Project Valuation:**

The valuation of each WCCHD 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. WCCHD considers this project as high value because it will serve a significant number of residents in the community, where they “live, work, play and pray.” Helping people navigate the healthcare system proactively will significantly decrease the overall cost of care by assisting in avoidance of ED visits for primary care services, teaching about and supporting healthier lifestyles and choices to help prevent or manage chronic illness, and by giving babies a “Healthy Start”. Additionally, the project seeks to accomplish delivery system reform by understanding that the diversion of inappropriate non‐emergent care services through the ED, to connection to appropriate level of care, would improve patient care and decrease the cost for preventable services currently performed in the ED and decrease preventable hospitalizations. The cost of this project for DYs 2‐5 is estimated at $844,630 which is an added savings of over $4,000,000 when compared to the costs of ED visits*.*

**Category 2 Project Narrative – Pass 2**

**Williamson County and Cities Health District – 126936702.2.2**

**Project Area, Option and Title:** 2.6.1- Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

**Unique Project ID:** 126936702.2.2

**Performing Provider Name:** Williamson County & Cities 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 use an interdisciplinary team to promote preventive health awareness by offering health education classes, case management, social media messaging and health literacy education in the community, specifically women of child bearing age, high incidence rate of frequent hospitalizations for chronic conditions and women entering prenatal care after the first trimester.
* **Project Status:** This is a new project.
* **Project Need:** CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease. According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health and the county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; low health literacy and access to healthy food options, which indicates that residents are in need of accessible health promotion options and connection to available resources. Currently, health educators offer health education programs consistent with evidence-based models to the community at no cost; however, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.
* **Target Population:** The project seeks to increase the availability of access to health promotion programs and activities strategically located in identified areas with a high rate of incidence in chronic illness and/or women of child bearing age. According to the latest Behavioral Risk Factor Surveillance Survey (BRFSS) from 2007-2010, 117,725 of the total population of Williamson County reported being diagnosed with either heart disease, diabetes, obesity or asthma. That is 31.7% of the total population. And, according to the 2100 Census Data, there are 96,246 women of children bearing age in the county. The target population is our patients that need access to health education programs in venues accessible to them, specifically those with limited or no transportation. Approximately 60% of our current patients are either indigent, Medicaid -eligible or low-income uninsured, so we expect they will benefit from more than half of the proposed project.
* **Category 1 or 2 Expected Project Benefit for Patients:** The target population is patients that need access to health education programs/activities in venues accessible to them, specifically those with limited or no transportation. Because there are no public transportation services in Williamson County, geographically placing these services in venues that are within walking distance and utilizing trained community health workers will augment the patient’s knowledge related to their chronic illness or their pregnancy, thereby increasing the probability they will maintain their health through self-management and/or appropriate primary care. It is estimated that approximately 261 patients attended over 26 health promotion-related classes/programs which were hosted by WCCHD Health Educators at one of the four Public Health Center locations. By the end of DY4, the goal is to increase the number of targeted population reached by 20% or 42,000 through health promotion activities and/or awareness campaigns (social media included). In DY5, approximately 25% of targeted population reached or 54,000 through health promotion activities and/or awareness campaigns (social media included). The increase in classes/activities, awareness campaigns and strategically placing community health workers in areas with high incidence rate of chronic illness and/or women of child bearing age, will bring a robust awareness in healthy lifestyle thereby potentially reducing hospitalization costs related to services that could have been prevented.
* **Category 3 Outcomes:** The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.
  + 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 individuals receiving patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project. The project would promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. Plans include the development of a team consisting of community health workers, health educators, registered dietitians, and marketing professionals. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Marketing strategies, methods and interventions will be tailored to the specific needs of the targeted population within each community. In alignment with WilCo Wellness Alliance (WWA) community initiatives, WCCHD will develop health promotion activities through this interdisciplinary approach. WWA is a coalition built with representation of community business leaders, health care providers, school personnel and community based organizations.

**Project Description:**

The team will strategically position themselves in identified areas to promote, educate, empower and link targeted populations towards appropriate utilization and knowledge of their health care and medical homes, if applicable. WCCHD will utilize current methods of marketing and promotion as well as education such as; social media (i.e. Facebook and You Tube) and texting. Without reinventing the system for social media campaigns, WCCHD will reference the Centers for Disease Control (CDC) and Prevention toolkit for connecting the community through social media. In addition to utilizing social media, the team will engage targeted populations through local venues where they live, work and pray. WCCHD understands these methods and others will need to be culturally competent, English proficient and literacy level appropriate.

According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of residents who do not have health insurance coverage (County Health Rankings (2012) [www.countyhealthrankings.org](http://www.countyhealthrankings.org)). This statistic, in addition to the fact that this county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; and access to healthy food options, indicates that Williamson County residents are in need of accessible health promotion options and connection to available resources. Currently, WCCHD health educators offer health education programs and self-management education consistent with evidence-based models to the community, at no cost to attendees. However, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.

WCCHD proposes to target zip codes in Williamson County with the poorest perinatal outcomes, low rates of entry to prenatal care within the first trimester, highest hospital utilization rate for targeted chronic conditions (Diabetes, Asthma, Hypertension and Obesity), and available resources. This data is currently available from the State, Community Health Profiles and County Rankings.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use an interdisciplinary team to promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. This is in alignment with regional goals of developing projects and interventions designed to reduce the need for inappropriate utilization of services.

**Project Goals:**

* Health promotion in targeted population of women of child bearing age;
* Health promotion in targeted population of individuals with chronic disease;
* Improved health literacy among targeted populations;
* Self-management education and information for individuals with chronic disease;
* Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
* Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction

**This 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.

**Challenges:**

The challenge in working with a population who has limited understanding and knowledge base of their health with obstacles in transportation could have an effect in engaging targeted population. For this project to be effective, we must build rapportwith the targeted populations. Training community health workers in cultural competency, health literacy, and health education along with positioning them in identified areas within the county will help to establish rapport and encourage/support participation in programs.

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

WCCHD expects to increase the number of health promotion programs accessible to clients, in the targeted populations—women of child bearing age and residents with chronic disease, eventually leading to a reduction in health disparities related to prenatal care and chronic disease. WCCHD proposes to expand programs each year to the broader community, taking into consideration the population that is currently served by this agency (the safety-net population who is uninsured and underinsured).

**Starting Point/Baseline:**

Currently, population-based campaigns or a program to promote healthy lifestyles using evidence-based methodologies through social media and the incorporation of Community Health Workers does not exist at this time. Therefore, the baseline for number of participants, as well as the number reached by these efforts, begins at 0 in DY2.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited Access to Primary Care
* Specific Community Need: CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease

According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report*, 2005-2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congenital Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) ([http://www.wcchd.org/statistics and\_reports/](http://www.wcchd.org/statistics%20and_reports/)) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (e.g.; diabetes). The current safety-net providers have waiting lists for new patients, making it difficult for chronically-ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver, learn, and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

Vulnerable RHP 8 citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five-year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to direct these patients to other community services in a more seamless and effective system.

As the United States health care system strives to promote healthy lifestyles, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Community health workers can increase access to care and facilitate appropriate use of health promotion resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, and improve quality by contributing to patient‐provider communication, continuity of care, and consumer protection. In addition, community health workers will incorporate case management services for high risk patients. According to the latest issue of *Guide to Community Preventive Services 2005,* case management is effective when delivered in conjunction with education and support interventions. Interventions combined with case management include self-management education, home visits, telephone call outreach, and client reminders. Utilizing Community Health Workers to strengthen case management services will prove improvements within the targeted population. Several studies related to the utilization of community health workers reported significant improvements in participants' self-management behaviors, including appointment keeping and adherence to antihypertensive medications. Similar studies reported positive changes in healthcare utilization and in systems outcomes (Addressing Chronic Disease through Community Health Workers: A Policy and Systems-level Approach <http://www.cdc.gov/dhdsp/docs/chw_brieft.pdf>). Reducing illness, disability, and premature death and improving the quality of life for people is a major public health objective found in Healthy People 2020.

One simple conclusion can be drawn and that is a project promoting healthy lifestyles and access to care is needed in Williamson County. It already has been proven to be effective when combining case management, community support, interventions and promotion.

**Project Core Components:**

We propose to meet the following required project component through the health promotion program:

1. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the health promotion program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications, community relations and research staff.

**Continuous Quality Improvement:**

Continuous quality improvement is a core component of the health promotion project. 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:** Currently, an initiative utilizing community health workers in the community does not exist for Williamson County. However, providing case management is a service offered but only to patients enrolled in the County Indigent Health Care Program. This initiative is in alignment with the U.S. Department of Health and Human Services (DHHS) initiative on patients with multiple chronic conditions. Managing these clients in the community (such as with self-management educations and case management) can have a significant impact on their need for accessing the emergency departments (EDs) or hospitals. This project seeks to augment the work of the community health centers in providing coordinated care to clients and connect them to a medical home. Furthermore, by utilizing a multi-disciplinary team approach, client’s medical, social, and diet needs will be addressed, in a culturally-competent manner. WCCHD does not receive funding from DHHS that will be used for this program.

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

The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.

* 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 individuals receiving patient navigation services provided by WCCHD staff (facility subset).
* IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.

Reasons/rationale for selecting the outcome measure: This particular domain was chosen to help evaluate this project’s interventions. We propose to address the community’s limited access to preventive interventions.

* IT-6.2a: By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention and a positive impact on the community. In DY3, we worked to increase access to health promotion programs and activities, performed project planning activities, and established a baseline for patient satisfaction. Simultaneously, we will develop health promotion programs and increase access points to health promotion activities. Meeting the needs of the clients in the community will augment their knowledge related to their chronic disease or their pregnancy, increasing the chance that they will maintain their health through self-management and appropriate primary care.
* IT-1.7: If the patients are receiving the benefit of the combined efforts of the WCCHD Health Promotions Team and the Williamson County EMS Community Paramedicine Team, we should expect that patients with hypertension would have their blood pressure under control as a result of these interventions. Thus, the IT-1.7 outcome is an appropriate measure of our effectiveness.

**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 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;
* 126936702.1.3 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.

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

No other providers in RHP 8 are establishing this type of initiative, though several are working with chronic disease. This project is focused on increasing access to preventive interventions in Williamson County, ultimately reducing health disparities. 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), Williamson County residents under 200% FPL will be referred and connected to acute care type of services. In addition, we are working with Bluebonnet Trails Community Services – Emergency Services Diversion Project (#126844305.2.2) which will identify high 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 with these projects and providers, 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. In addition, WCCHD will participate in RHP 8 learning collaboratives on at least a semi-annual basis.

**Project Valuation:**

The value cost of this project for DYs 2-5 is estimated at $1,342,175. Cost covers recruitment, hiring, and training staff; tools and equipment necessary for the implementation of the project; and promotional campaigns, material and literature. The valuation of this 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 health promotion services. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Use of methodologies such as social media and text messaging will make the programs even more accessible to the increasingly tech-savvy population. Providing these types of health promotion services/programs, such as self-management programs, will serve to divert these types of needs from the urgent and emergent care facilities.

See also:

* American Journal of Preventive Medicine – 2007 May; 32(5): 435-47
* [www.ncbi.nlm.nih.gov/pubmed/17478270](http://www.ncbi.nlm.nih.gov/pubmed/17478270);
* Texas Department of State Health Services – Health Facts Profiles (2009) <http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/>;
* FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report: <http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf>; and
* Community Health Profile of Williamson County Precincts (2011) <http://www.wcchd.org/statistics_and_reports/>

**Category 2 DSRIP Project Summary**

**Williamson County and Cities Health District – 126936702.2.100**

**Project Area, Option and Title:** 2.7.5 Implement innovative evidence‐based strategies to reduce and prevent obesity in children and adolescents.

**RHP Project Identification Number:** 126936702.2.100

**Performing Provider Name:** Williamson County and Cities 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:** Project plans include the development of an interdisciplinary team consisting of health educators, registered dietitians, community health workers, social workers, marketing staff, and healthcare professionals. Utilizing this team is a fundamental approach to providing health education consistent with evidence-based models, nutrition counseling, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community.
* **Project Need:** CN 3 .3 – Lack of coordinated care for those with multiple needs - Inconsistency in data collection which identifies health disparities and populations at risk.Williamson County ISD’s collection of Fitnessgram and Texas Risk Assessment for Type 2 Diabetes in Children data is inconsistent, including different data collection time frames and grade levels. There is a lack of consistent coordinated care for children identified as at risk through Fitnessgram and Texas Risk Assessment for Type 2 Diabetes in Children.
* **Target Population:** We will be targeting the 18 and under population in Williamson County, which makes up 28.7% of our county’s population (2010 Census data). Additionally, we will focus on low-income children enrolled in Medicaid, uninsured, and underinsured. According to Medicaid enrollment reports from May 2013, there were 14,874 children age 1-18 enrolled in Medicaid. By the end of DY5, we will provide interventions to 810 unique individuals. We estimate that approximately 30% of the individuals will be Medicaid eligible and 5% uninsured.
* **Expected Category 2 Project Benefit for Patients and a Description of the QPI Metric(s):** The improvement goal of this project is to provide approximately 810 individuals with access to childhood obesity prevention and management programs (DY3: 180 individuals, DY4: 270 individuals, and DY5: 360 individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-5, allowing us to increase the number of individuals participating in the innovative intervention. Each year, we aim to increase the number of individuals participating in this intervention, as measured by Milestone I-5, Metric I-5.2: Number of individuals of target population reached by the innovative project.
* **Category 3 Measure(s):** The following category 3 measures were proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents).
  + 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 individuals receiving one of the health education services provided by WCCHD staff (facility subset).
  + IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents): We will demonstrate improvement in the percentage of children 3-17 years of age who had a WCCHD visit and had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity. This includes health education services and excludes children *only* receiving an immunization services

**Project Description:**

Implement innovative strategies consistent with evidence-based models to reduce and prevent obesity in children and adolescents.The purpose of this project is to prevent and reduce childhood and adolescent obesity, specifically in the underinsured, uninsured, low-income and indigent populations. According to the CDC, children and adolescents who are obese are likely to be obese as adults and are more at risk for adult health problems such as heart disease, type-2 diabetes, and stroke. By tracking and monitoring the early childhood, middle childhood, and adolescent populations, this project has the potential to prevent youth from developing chronic diseases or conditions as adults.

Project plans include the development of an interdisciplinary team consisting of health educators, registered dietitians, community health workers, social workers, marketing staff, and healthcare professionals. Utilizing this team is a fundamental approach to providing health education, nutrition counseling, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community. WCCHD currently provides obesity prevention awareness and weight management education in the community which is open to all.

Program components will vary based on children and adolescent age groups – 2-5 years, 6-13 years, and 14-17 years – and their families. Since the project will work with both adolescents and adults, this project will focus on capturing QPI for individuals. Primary components include outreach, marketing, and health education classes. Extensive nutritional counseling, case management, and social support will be provided to those with obesity-related comorbidities. In Year 3, the project will serve 180 individuals, 270 individuals in Year 4, and 360 individuals in Year 5. All activities will be documented and analyzed by WCCHD Data Reporting & Information Management team.

The WilCo Wellness Alliance, an established coalition focused on preventing and reducing chronic diseases as part of the community efforts. Therefore, the likelihood of project success is high utilizing these existing partnerships and structure. Sustainability will be achieved through education as well as policy, systems, and environmental changes through schools, communities, workplaces, and families making this truly a combination of individual and population based health transformation. Further analysis at the neighborhood level will help drive targeted interventions and education. The WilCo Wellness Alliance is a countywide health and wellness coalition comprised of government, schools, healthcare, business, faith-based, and non-profits. WCCHD will implement new programs and activities specifically for targeted populations that are in alignment with existing programs and WilCo Wellness Alliance initiatives. Current initiatives focus on healthy eating, active living, use of the built environment, and behavioral health.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use an interdisciplinary team to provide a culturally competent and holistic approach in the prevention and reduction of obesity in children and adolescents. Key partners in this endeavor include the school districts and the health department through the WilCo Wellness Alliance’s School Health Forum. The approach, consisting of health education, nutrition counseling, case management, outreach, care coordination, and social support, will ensure program participants receive support and services necessary to positively managing their health.

**Project Goals:**

1. Implement innovative strategies consistent with evidence-based models to reduce and prevent obesity in children and adolescents

Milestones are provided below for DY 3-5:

In DY 3:

1. P-2: Implement evidence-based innovational project for targeted population.
2. I-5: Identify 180 unique patients in defined population receiving innovative intervention consistent with evidence-based models.
3. P-X.1: Hire and train 5 FTE equivalents. Train an additional 9 FTE’s existing staff for the interdisciplinary team. A total of 14 staff will be trained for the interdisciplinary team.
4. P-6.1: Documentation of tested ideas, practices, tools, and/or solutions In DY 4-5:
5. I-5: Identify 270 (DY4) and 360 (DY5) unique patients in defined population receiving innovative intervention consistent with evidence-based models.
6. P-6.1: Documentation of tested ideas, practices, tools, and/or solutions

**This 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

This project is related to the above Regional Goals. Children and adolescents who are overweight and obese, or at risk will have increased access to programs and activities; those with multiple needs (i.e., obesity-related comorbidities) will receive additional services including care coordination, social support, nutrition counseling, and case management.

**Challenges:**

Challenges in this project include lack of transportation to services, perceived low health literacy, cultural traditions pertaining to food, and family time constraints. For this project to be effective, we must build rapport with the targeted populations. Strategies to build rapport and participation include using an interdisciplinary team trained in cultural competency, health literacy, and health education and positioning programs and activities in identified areas of need within the county.

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

WCCHD expects to increase the number of childhood obesity prevention programs accessible to clients, in the targeted populations – children and adolescents with high incidence of overweight and obesity and associated risk factors – eventually leading to a reduction in health disparities related to childhood obesity. WCCHD proposes to expand programs each year to the broader community, taking into consideration the population that is currently served by this agency (the safety-net population who is uninsured and underinsured).

**Starting Point/Baseline:**

Currently, childhood and adolescent obesity prevention and management programs are provided in the community sporadically. The WCCHD existing weight management program reached 120 individuals (2010-2011).

**Quantifiable Patient Impact (QPI):**

WCCHD will use HHSC’s recommended QPI (individuals impacted) for this project. Each year we will seek to increase the number of patients that are participating in the innovation intervention. Over the course of the project, we expect the total patient impact to be approximately 810 individuals with access to childhood obesity prevention and management programs (DY3: 180 individuals, DY4: 270 individuals, and DY5: 360 individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-5, allowing us to increase the number of individuals participating in the innovative intervention. Each year, we aim to increase the number of individuals participating in this intervention, as measured by Milestone I-5, Metric I-5.2: Number of individuals of target population reached by the innovative project.

**Rationale:**

Community Need Addressed: 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. Comprehensive overweight and obesity rates for adolescents in Williamson County are not known at this time. However, we do have snapshot indicators that give a glimpse into the prevalence of obesity and overweight adolescents.

What we do know:

*In Texas-*

* Approximately 27.8% of Texas population is under the age of 18, making up to 1.5 million young people at risk of developing serious medical conditions.
* In 2011, Texas was ranked as the 12th most obese state in America (Obesity in Texas).
* In 2011-12, 37% of the children age 10-17 in Texas were either overweight or obese(Kids Count)

*In Williamson County-*

* Approximately 67% of adults in Williamson County are overweight or obese
* 77% reported consuming four or fewer servings of fruits and vegetables per day (HCI).
* According to available Fitnessgram data from 2011-2012 for Williamson County ISD’s, out of 56,373 students who had their BMI measured, 23% of students had a BMI that put them “at risk” for weight-related health conditions.
* Approximately 13% of children aged 2-4 living in households with an income less than 200% of the federal poverty level are obese (HCI).

Projected outcomes of current rates of overweight and obesity-

* By 2030, rising obesity rates in Texas are projected to triple the cost of health care to a total of $325 billion dollars (Texas Comptroller of Public Accounts, 2011).
* According to the CDC, obese children may experience immediate health consequences which can lead to weight-related health problems in adulthood
* Further, In addition to suffering from poor physical health, overweight and obese children can often be targets of early social discrimination which can hinder academic and social functioning that may persist into adulthood (CDC)*.*

Healthy lifestyle habits, such as healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases (CDC). Using the information available, we can see that overweight and obesity are serious conditions that are projected to continue to increase without intentional comprehensive lifestyle interventions. Through our health management programs and outreach, we will be able to target both families and children and with the goal of impacting the lifestyle habits of the entire family.

Fitnessgram1 is a comprehensive educational and reporting tool used in Williamson County ISDs to assess physical fitness and physical activity levels for children. Components of the tool include measures related to aerobic capacity, muscular strength, muscular endurance, flexibility, and body composition. Fitnessgram measurements are now required in Texas schools. A key component of this project will be to gather Fitnessgram data from all school districts in Williamson County to provide a more substantive baseline of childhood overweight and obesity rates. Additionally, we will work with our WIC program to identify the magnitude of overweight and obesity in children ages 0-5.

**Project Core Components:**

1. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications and research staff.

**Continuous Quality Improvement:**

Continuous quality improvement is a core component of this project. 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.

As part of P-6.1, provider will document tested ideas, practices, tools, and/or solutions through:

* Healthy Communities Section meeting minutes
* Integrated Care Team meeting minutes
* Plan-Do-Check-Act cycle
* Review of evidence-based curriculums

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

This project will significantly enhance the existing childhood obesity weight management program provided by WCCHD. This project will provide the opportunity to utilize curricula consistent with evidence-based models for the 2-5, 6-13, and 14-17 year old populations. While WCCHD is the primary provider of the childhood and adolescent obesity prevention and management program, community support will be through stakeholders involved in the WilCo Wellness Alliance. This includes schools, healthcare agencies, nonprofits and community-based organizations, faith-based community, governmental agencies, and businesses.

Initiatives that will enhance the existing delivery system reform include menu labeling at local restaurants or local food establishments, health education messaging on local parks and trails, healthcare providers participating in the Health Information Exchange (HIE), and physician or healthcare provider prescribed exercise. School personnel and members of the School Health Advisory Committees (SHACs) will participate in a School Health Forum at least quarterly to discuss health and wellness for school age children. Stakeholders will also be involved in the implementation of health education classes through referral system, facility space, personnel, and/or supplemental materials. WCCHD does not have additional funding through DSHS that will duplicate these services. The existing Medicaid 1115 waiver projects will enhance the project by maximizing the utilization of Community Health Workers for health promotion and wellness activities as well as connecting clients to medical and social services through patient navigation, community paramedicine, clinical preventive services, and expanded access to care.

Customizable Process or Improvement Milestone:

The interdisciplinary team will consist of 14 staff including health educators, registered dietitians, community health workers, social worker, marketing professionals, and marketing staff. There will be 9 existing staff trained for the team and 5 new FTE equivalents hired and trained for the team.

Initial training will include review and application of the program consistent with evidence-based models to be implemented, electronic documentation required to track participation and outcomes, and ongoing review and training on findings in the obesity literature. Ongoing CQI will be integrated into all training activities.

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

The following category 3 measures were proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents).

* 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 individuals receiving one of the health education services provided by WCCHD staff (facility subset).
* IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents): We will demonstrate improvement in the percentage of children 3-17 years of age who had a WCCHD visit and had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity. This includes health education services and excludes children *only* receiving an immunization services.

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

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 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
* 126936702.1.3 - 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
* 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 unified population
* 133340307.2.4 - Recruit, train and support consumers of mental health services to provide peer support services
* 081771001.2.1 - Apply evidenced-based care management model to patients identified as having high-risk care needs

**Plan for Learning Collaborative:**

WCCHD 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 WCCHD 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 WCCHD to interact with providers in other RHPs who may have an implementation of an innovative evidence‐based strategy to reduce and prevent obesity in children and adolescents focus to expand learning and quality improvement initiatives. Additionally, WCCHD looks forward to participating in HHSC’s statewide learning collaborative activities as available.

**Project Valuation***:*

The value cost of this project for DY 3-5 is estimated at $307,998. Cost covers recruitment, hiring, and training staff; tools and equipment necessary for the implementation of the project; and promotional campaign materials and literature. The valuation of this 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 obese children and adolescents residing in the community, specifically those that encounter barriers to accessing health promotion services. Utilizing the interdisciplinary team is a fundamental approach to providing health education, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community.

See also:

* Fitnessgram. *Program Overview*. 2013. <http://www.fitnessgram.net/programoverview/>;
* CDC. *Childhood Obesity Facts*. 2013. <http://www.cdc.gov/healthyyouth/obesity/facts.htm>;
* HHSC. *Medicaid Enrollment by County*. May 2013. <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME/201305.html>;
* Healthy Communities Institute (HCI). *Williamson County Community Dashboard*. <http://www.healthywilliamsoncounty.org/modules.php?op=modload&name=NS-Indicator&file=index>; and
* Kids Count. *Children and teens overweight or obese by gender*. <http://datacenter.kidscount.org/data/tables/27-children-and-teens-overweight-or-obese-by-gender?loc=1&loct=2#detailed/2/10-19,2,20-29,3,30-39,4,40-49,5,50-52/false/1021,18,14/14,15,16/296>