**Category 1 Project Narrative**

**Center for Life Resources – 133339505.1.1**

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

**RHP Project Identification Number:** 133339505.1.1

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

**Performing Provider TPI #:** 133339505

**Project Summary:**

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

**Project Description:**

Telemedicine in Mills and San Saba Counties

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

**Core Project Components:**

1. *Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state.* CFLR or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Mills and San Saba) Counties as defined as a mental health professional shortage area.
2. *Assess the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.* This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.
3. *Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.* Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This will be accomplished as we evaluate previously successful models also adopted in rural settings that might be successful in ours. This process will be done to determine feasibility and likely highlight the offsetting of costs associated with unnecessary ED services. Simply, we propose the use of a telemedicine system that will give greater access of care to citizens and reduce any unnecessary costs.
4. *Conduct quality improvement for project using methods such as rapid cycle improvement*. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety‐net populations.

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

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

**Goals and Relationship to Regional Goals:**

**Project Goals:**

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

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

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

**Challenges:**

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

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

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

**Starting Point/Baseline:**

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

**Rationale**:

**Community Need Addressed:**

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

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

**Continuous Quality Improvement:**

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

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

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

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

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

**Relationship to Other Projects:**

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

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

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

**Project Valuation:**

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

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

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

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

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