TEXAS HEALTHCARE TRANSFORMATION & QUALITY IMPROVEMENT PROGRAM

Regional Healthcare Partnership
Region 4

Driscoll Children’s Hospital

Delivery System Reform Incentive Payment (DSRIP) Projects
Category 1 DSRIP Projects:
Infrastructure Development
Driscoll Children’s Hospital
1.1.2 (B & C) - Expand Primary Care Capacity
132812205.1.1

- **Provider**: Driscoll Children’s Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s)**: This project will expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll’s Urgent Care Center and selected clinics.

- **Need for the project**: When a patient’s pediatrician’s office is closed, Driscoll's non-emergent care clinics are a low-cost, reliable source of care and an appropriate alternative to the emergency room for patients seeking treatment(s) for a minor illness or injury.

- **Target population**: Medicaid patients account for more than 70 percent of Driscoll’s patient base. The project will help improve access to primary care services during after-hours and reduce the number of preventable emergency department visit. Patients will also experience greater convenience and less expensive care compared to what they would experience at the Emergency Room.

- **Category 1 or 2 expected patient benefits**: By the end of Year 5, the project expects to accomplish the following:
  - Increase access to After Hour facilities by increasing clinic hours by 2% over baseline in DY3, 4% over baseline in DY4 and 6 percent over baseline in DY5;
  - Improve access to care by Increasing the number of patient visits during After-Hours at Driscoll non-emergent care clinics by an additional 200 visits in DY3, 400 visits in DY 4, and 600 visits in DY5;

- **Category 3 outcomes**: IT-9.4 Our goal is to reduce the number of non-emergency pediatric Emergency Department visits that would have occurred absent the project.
Project Option: 1.1.2 (B & C) - Expand Primary Care Capacity
Unique Project ID: 132812205.1.1
Performing Provider name/TPI: Driscoll Children’s Hospital/ 132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties, including non-emergent care currently located at our out-patient clinics in Corpus Christi, Victoria and McAllen. Since 1953, the mission of Driscoll Children’s Hospital has impacted the lives of children all over South Texas. Driscoll is the only free-standing children’s hospital with specialized medical and surgical services in the South Texas region. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United State: Medicaid patients account for more than 70 percent of Driscoll’s patient base. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care.

This project will expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll’s Urgent Care Center and selected clinics. When a patient’s pediatrician’s office is closed, Driscoll’s non-emergent care clinics are a low-cost, reliable source of care and an appropriate alternative to the emergency room for patients seeking treatment(s) for a minor illness or injury. In Year 2, Driscoll will develop a plan to expand clinic after-hours care based on community need and appoint an interdisciplinary Task Force to oversee the plan development and implementation during the project period. The Task Force will meet twice per year and be charged with activities such as, identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Primary Care Expansion Project. Also in DY 2, Driscoll will begin a media campaign to inform our target population about the planned service expansion. In Years 3-5, Driscoll will expand After Hour clinic hours and increase the number of primary care patient visits during the new expansion hours.

Driscoll expects that the service expansion will translate into prevented emergency department visits. For this project’s Category 3 outcome measure, we will develop and administer a patient survey that will be used to identify those patients who would have otherwise visited the emergency department if they did not have access to the after-hours clinic. For this improvement target, only those individuals who report they would have otherwise visited the ED based on the severity of the patient’s condition will be included in the Category 3 IT 9.4 improvement target measurement.

Driscoll Health System’s Urgent Care Center is the only center of its kind in the region. The Urgent Care Center provides treatment for minor emergencies and illnesses and offers more convenience to patients by offering shorter wait times than an emergency room. Additionally, if a patient needs more comprehensive care than can be provided at the Urgent Care Center, they can be transported by Driscoll ambulance to the main hospital campus for further evaluation or extended care. Also, Driscoll will have two other facilities in our geographic service delivery area: McAllen Quick Care Clinic and Victoria After Hours Clinic. Driscoll’s Children’s Quick Care offers quality care in a hometown atmosphere with a staff of doctors and nurse from the community. The doctors are independent practitioners who work in partnership with the clinic. They deliver healthcare with pride.
and strive to make a difference in the lives of children who need outpatient services. Both the McAllen Quick Care Clinic and the Victoria After Hours Clinic, offer timely treatment to a wide range of common problems like coughs, colds, asthma, allergies, minor lacerations, fractures and sprains. They are both good alternatives to hospital emergency rooms by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. In FY 2012, Driscoll’s non-emergent care clinics recorded approximately 27,000 patient visits during after-hours compared to approximately 35,000 patient visits in Driscoll Children’s Hospital Emergency Room.

Project Goals & Challenges:
Expanding pediatric primary care access and services is essential to improving overall health care delivery and health outcomes in the region. The project will help achieve this goal by improving access to primary care services during after-hours and reducing the number of preventable emergency department visit. Patients will also experience greater convenience and less expensive care compared to what they would experience at the Emergency Room.

By the end of Year 5, the project expects to accomplish the following:
1. Increase access to After Hour facilities by 2 percent over baseline in DY3, 4% over baseline in DY4, and 6 percent over baseline in DY5;
2. Increase access to care as measured by the total number of patient visits during After-Hours at Driscoll non-emergent care clinics by 200 visits in DY 3, 400 visits in DY4 and 600 visits in DY 5;
3. Increase the number of prevented Emergency Department visits that would have occurred absent the project. Results will be determined through a survey of after hour patients. Numerator will be those patients who report in the survey that, without access to the after-hours clinic, they would have otherwise taken the patient to the emergency department (i.e., prevented pediatric ED visits). The denominator will be after-hours surveyed patients. The goal will be to increase the number of prevented ED visits over baseline in DY4 and in DY5. Baseline will be established in DY3.

The project will help advance several health care goals in Region 4 related to expanding primary care services and reducing inappropriate utilization of Emergency Department services. As described in the RHP plan and the community needs assessment, Region 4 is a medically underserved area with a shortage of primary care physicians and services. The region also experiences high rates of inappropriate emergency department utilization and dissatisfaction of emergency department services. This project will help will help address these issues by expanding primary care services at Driscoll’s non-emergent care clinics during after-hours, providing residents an appropriate and convenient alternative source of care to the Emergency Room.

Some of the challenges that Driscoll expects to face with this project include changing the behavior of clients who are accustomed to receiving routine or non-emergency care in Driscoll’s emergency department rather than seeking such care in one of our After-Hours Clinics. Educating clients about our planned clinic after-hours expansion and greater patient convenience at our non-emergent care clinics will help to address these challenges.
Starting Point/Baseline:
The FY 2012 baseline measurement for Urgent Care, After Hours, and Quick Care facilities in Driscoll’s service area will begin at approximately 5,800 hours. The baseline number for patient visits during expanded after-hours is zero visits since the plan for expansion will not be implemented until DY3.

Rationale:
The Emergency Department (ED) is often the first contact many patients have with our hospital. Data suggest there is a high utilization of emergency room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expanding pediatric primary care access and services in our non-emergent care clinics during After Hours is essential to improving overall health care delivery and health outcomes in the region and will help reduce unnecessary ED utilization. An After Hours Clinic(s) setting provide a convenient and more appropriate setting for treating minor illnesses and injuries to the Emergency Department. This project includes project components: Expand primary care clinic space and Expand primary care clinic hours. Driscoll Children’s Hospital does not include any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services. This project addresses CN.1 (Inadequate Access to Primary Care Services) and CN.5 (High Rates of Emergency Department utilization).

Project Components:
Through the expansion of primary care capacity project, we propose to meet the required project components:

a) *Expand primary care clinic hours* – We will develop a plan within different committees and management teams to access the highest need for expanding After Hours facility hours. These teams and/or committees will review the current emergency room patient flow by focusing on past trending patient volumes during the week and time of day. Based on this data, expanded hours will be assigned accordingly. This information along with trending data will be assessed and use on a yearly basis for the need of additional improvement to the existing expansion plan.

b) *Expand primary care clinic staffing* – We will develop a plan within different committees and management teams to access the highest need for training and hiring additional clinical staff for After Hours facilities. These teams and/or committees will review the current staff labor trending for these facilities in relation to current patient flow (hourly volumes). With this information and execution of Project Component (a), we will forecast patient flow patterns and volumes which will be used to assign additional clinical staff. This information along with labor trending data will be assessed and use on a yearly basis for the need of additional improvement to the existing expansion plan.

We, however, will not be able to meet the require project component of:

a) *Expand primary care clinic space.* – We will not increase the current space available for our primary care clinics due to our current underutilization. We are not currently utilizing the total available space within these facilities though we will plan to consider utilizing this space if any future need develops.
Related Category 3 Outcome Measure(s): The related Category Outcome Measure selected for this project is OD-9 Right Care, Right Setting - IT-9.4 ED Prevention: Increase the number of prevented pediatric ED visits. This outcome will be measured by a survey of patients using the after-hours services, to identify patients who would have otherwise sought services at the Emergency Department if they did not have access to the After Hours clinic.

Relationship to other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. Specific projects that will be enhanced and supported include the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FZHC providers. Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
Drsicoll Children’s Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. While no other providers have submitted projects related to expansion of oral health services, almost all providers are participating in projects that expand access to care, including Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, Lavaca Medical Center, and Jackson County Hospital District. We will be collaborating with each of these as well as other region participants.

Project Valuation:
The quantitative value is based in part on a determination that emergency room use is a high cost service line. For certain levels of care, an After Hours clinic or pediatric primary care office is a more appropriate and efficient use of resources. Increasing the hours and use of an After Hour Clinic versus utilizing the ED creates significant savings and value. The extended hours will also support improved continuity of care for patients needing follow-up treatment. Whereas patients visiting the ED must obtain follow-up care from a provider who does not have access to their ED records, which may result in duplication of tests and services provided in the ED, patients visiting the clinic will be able to receive follow-up services from a clinic-based physician who has full access to the patient’s records.

The net payment for an After Hours clinic Managed Medicaid patient visit differs significantly from Emergency Room visit by location and level. An Emergency Room cost to Medicaid is consistently higher than an Urgent Care, Quick Care, or After Hours clinic visit. A payment difference exists between a visit at Driscoll’s Urgent Care vs. a Driscoll Children’s Hospital Emergency Room visit for a Level 1, a Level 2, and Level 3. Based on the most recent 12 months, we calculated the difference in potential savings by these levels for a Medicaid patient visit in an After Hours clinic versus an emergency department. The historical data and savings potential included Corpus Christi, Victoria, and McAllen. These payments include all ancillary services and the performing provider’s payment.
If improved patient access were not provided in an After Hours clinic setting in Driscoll’s service area, patients would over utilize the emergency room, a more costly and less convenient source of care. In addition to providing a more appropriate setting for non-emergency services, patients who are able to access the After Hours clinic instead of the emergency room will also benefit from reduced waiting times and increased satisfaction with their health care experience. Enabling these patients to avoid unnecessary ED visits will also reduce wait times for other patients visiting the ED and allow providers to more quickly treat patients with more serious conditions.

Based on the Calendar 2011 patient population and the estimated savings from diversion of patients from the ED to the After Hours clinic, we estimate a total savings and value to the state of approximately $8.8 million per year for this proposed project, or more than $25 million for DY 3-5. Based on these savings and the additional benefits to patients and the community as a whole, the requested DRSIP funding to be allocated to this project is $15,376,388 (inclusive of Categories 3 and 4).
### Project Title: Expand Primary Care Capacity

#### Performing Provider Name: Driscoll Children’s Hospital

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<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>TPI: 132812205</th>
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<tbody>
<tr>
<td>132812205.3.1</td>
<td>IT-9.4</td>
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<tr>
<td>Increase the number of prevented pediatric emergency department visits</td>
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<table>
<thead>
<tr>
<th>Milestone 1 [P-X]: Develop a plan to expand access to primary care services in the Driscoll Service Area</th>
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<tbody>
<tr>
<td><strong>Metric 1</strong> [P-X.1]: Documentation of plan</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Hospital records</td>
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<tr>
<td><strong>Milestone 1</strong>: Estimated Incentive Payment (maximum amount): $690,625</td>
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<thead>
<tr>
<th>Milestone 2 [P-X1]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing after hours primary care services for children in the Driscoll service area</th>
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<tbody>
<tr>
<td><strong>Metric 2</strong> [P-X.1.1]: Documentation of Task Force establishment</td>
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<tr>
<td><strong>Data Source</strong>: Hospital record</td>
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<tr>
<td><strong>Milestone 2</strong>: Estimated Incentive Payment (maximum amount): $690,625</td>
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<tr>
<th>Milestone 3: [P-X2] Begin media campaign to inform target patient population about Driscoll’s planned After Hours Clinic Expansion.</th>
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<tbody>
<tr>
<td><strong>Metric 3</strong> [P-X.2.1]: Evidence of marketing (e.g., billboards, radio announcements, etc.).</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Hospital/Clinic documentation</td>
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<tr>
<td><strong>Milestone 3</strong>: Estimated Incentive Payment (maximum amount): $690,625</td>
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<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
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<tr>
<td><strong>Milestone 5</strong> [P-X3]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area.</td>
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<tr>
<td><strong>Metric 5a</strong> [P-X.3.1]: Documentation of Quality Improvement meetings held twice per year</td>
</tr>
<tr>
<td><strong>Metric 5b</strong>: [P-X.3.2] Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area.</td>
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<tr>
<td><strong>Data Source</strong>: Hospital record</td>
</tr>
<tr>
<td><strong>Milestone 5</strong>: Estimated Incentive Payment (maximum amount): $1,000,000</td>
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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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<tr>
<td><strong>Milestone 6</strong> [P-4]: Expand After Hours Clinic hours</td>
</tr>
<tr>
<td><strong>Metric 6</strong> [P-4.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 2% above the FY 2012 baseline.</td>
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<tr>
<td><strong>Data Source</strong>: Clinic Documentation</td>
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<tr>
<td><strong>Milestone 6</strong>: Estimated Incentive Payment (maximum amount): $1,000,000</td>
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<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tr>
<td><strong>Milestone 7</strong>: Expand After Hours Clinic hours</td>
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<tr>
<td><strong>Metric 7</strong> [P-4.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 4% above the FY 2012 baseline.</td>
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<tr>
<td><strong>Data Source</strong>: Clinic Documentation</td>
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<td><strong>Milestone 7</strong>: Estimated Incentive Payment (maximum amount): $1,000,000</td>
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<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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<tr>
<td><strong>Milestone 8</strong> [P-X3]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area.</td>
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<tr>
<td><strong>Metric 8a</strong> [P-X.3.1]: Documentation of Quality Improvement meetings held twice per year</td>
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<tr>
<td><strong>Metric 8b</strong>: [P-X.3.2] Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area.</td>
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<tr>
<td><strong>Data Source</strong>: Hospital record</td>
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<tr>
<td><strong>Milestone 8</strong>: Estimated Incentive Payment (maximum amount): $1,000,000</td>
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<th>Milestone 10 [I-12]: Increase primary</th>
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<tr>
<td><strong>Milestone 11</strong> [P-X3]: Task Force leads quality improvement initiative for expanding children’s After-Hours primary care services in the Driscoll service area.</td>
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<tr>
<td><strong>Metric 11a</strong> [P-X.3.1]: Documentation of Quality Improvement meetings held twice per year</td>
</tr>
<tr>
<td><strong>Metric 11b</strong>: [P-X.3.2] Documentation of Task Force report, findings and/or action plan to further improve access to after-hours primary care services in the Driscoll area.</td>
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<td><strong>Data Source</strong>: Hospital record</td>
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<tr>
<td><strong>Milestone 11</strong>: Estimated Incentive Payment (maximum amount): $826,500</td>
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<tr>
<th>Milestone 12 [P-4]: Expand After Hours Clinic hours</th>
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<tr>
<td><strong>Metric 12</strong> [P-4.1]: Increase After Hours clinic hours of availability in Driscoll Service delivery area by 6% above the FY 2012 baseline.</td>
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<tr>
<td><strong>Data Source</strong>: Clinic Documentation</td>
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<tr>
<td><strong>Milestone 12</strong>: Estimated Incentive Payment (maximum amount): $826,500</td>
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#### RHP Plan for Region 4

**Unique Identifier:** 132812205.1.1  
**RHP PP Reference Number:** 1.1.2  
**Project Components:** 1.1.2. (B & C)

**Project Title:** Expand Primary Care Capacity

**Performing Provider Name:** Driscoll Children's Hospital  
**TPI:** 132812205

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

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<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Payment (maximum amount):** $690,625

**Milestone 4:** [P-5] Train/hire additional primary care providers (i.e. nursing and etc.) and staff and/or increase the number of primary care clinics for existing providers (i.e. nursing and etc.)

**Metric 4 [P-5.1]:** Documentation of increased number of providers and staff and/or clinic sites.

**Data Source:** Documentation of HR records

**Milestone 4: Estimated Incentive Payment (maximum amount):** $690,625

**Metric 7 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services

**Data Source:** Clinic Documentation

**Milestone 7: Estimated Incentive Payment (maximum amount):** $1,000,000

**Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):** $2,762,500

**Year 3 Estimated Milestone Bundle Amount: $3,000,000**

**Year 4 Estimated Milestone Bundle Amount: $3,000,000**

**Year 4 Estimated Milestone Bundle Amount: $2,479,500**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $11,242,000
• **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

• **Intervention(s):** This project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s (PCP’s) office. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery.

• **Need for the project:** In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%.

• **Target population:** Medicaid patients account for more than 70 percent of Driscoll’s patient base. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

• **Category 1 or 2 expected patient benefits:** By the end of year 5, the oral health project will accomplish the following:
  - Increase, expand, and enhance oral health services performed by PCPs in the Driscoll’s delivery service area by 20 percent over the baseline (State Fiscal Year 2012). The project is estimated to serve 350 additional patients in DY 2 (5% increase); 700 additional patients in DY 3 (10% increase); 1,050 additional patients in DY 4 (15% increase); and 1,400 additional patients in DY 5 (20% increase).
  - Train 30 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (SFY12), which represents an increase of more than 30 percent.

• **Category 3 outcomes:** Driscoll Children’s Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 10%.
Project Option: 1.8.12 – Increase, Expand, and Enhance Oral Health Services

Unique Project ID: 132812205.1.2
Performing Provider Name/TPI: Driscoll Children’s Hospital / 132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)'s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

The DSRIP project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s (PCP’s) office. In the U.S., millions of children are predisposed to dental disease because of dietary, behavioral, and socio-environmental factors that overwhelm preventive interventions available to them. For children with extreme dental disease, dental caries frequently contribute to distracted behavior and associated poor educational performance. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Today, Driscoll Children’s Hospital collaborates with Driscoll Children’s Health Plan and Primary Care Provider (PCP) to offer dental fluoride varnish treatments to Medicaid-enrolled children in the office of their PCP. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

To further enhance the Oral Health Program, Driscoll Health System will form an Oral Health Services Task Force that will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Oral Health services milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges
identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Oral Health Services Project.

**Project Goals and Challenges:**
Expanding access to education and preventive dental care to children in a PCP’s office will improve and promote better oral health care for low-income children and help to prevent severe dental caries that often result in loss of teeth and surgical interventions.

**By the end of year 5, the Oral Health project will accomplish the following:**
- Increase, expand, and enhance oral health services performed by PCPs in the Driscoll’s delivery service area by 20 percent over the baseline (Calendar Year 11)
- Train 30 additional providers to perform dental education and fluoride varnish treatments in a PCP office over the baseline (CY 11), which represents an increase of more than 30 percent.
- Prevent number of children requiring surgical intervention to treat severe dental caries.

This project advances Region 4 goals identified in the RHP Plan and in the Community Needs Assessment of expanding access to oral health services and reducing preventable health care complications that result from poor oral health, such as severe dental caries that often must be treated with surgery. The project also promotes care coordination between PCPs and traditional oral health care providers.

Driscoll faces several challenges and barriers to implement the fluoride varnish program; including the high rate of early childhood dental caries in our target population, a need to reach underserved populations to deliver preventative services; the need to educate PCPs in appropriate evaluation and preventive oral health.

**Starting Point/Baseline:**
For Project option 1.8.12, Driscoll provided 7,000 dental education and fluoride varnish treatments for Calendar Year 2011 baseline metric. Today, one hundred thirty five trained medical providers who represent approximately 60 percent of our target provider population in the Driscoll service area are qualified to perform Driscoll oral health services today.

**Rationale:**
The United States Surgeon General identified tooth decay as the most common chronic childhood disease in a 2000 report, “Oral Health in America.” Tooth decay is five times more common than asthma. In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%. Many parents and even physicians do not understand the importance of healthy primary teeth. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

Data suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The project goal is to increase access to dental fluoride varnish treatments in our service delivery area. Driscoll Children’s Hospital does not include any
project components and does not receive any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

RHP 4 Plan and Community Needs Assessment expressed a strong need for additional dental care and recommends increasing the number of residents’ access to dental care. Consistent with this assessment this project addresses CN.5 (Inadequate Access to Dental Care) and CN.8 (High Rates of Poor Dental Health and associated Medical Issues).

**Related Category 3 Outcome Measure(s):** OD-7 Oral Health –IT-7.10 Other Outcome Improvement Target – Reduce incidence of severe dental caries that result in operative interventions

Driscoll Children’s Hospital has selected an Oral Health outcome improvement target (IT-7.10) to prevent severe dental caries that result in operative interventions in the Driscoll Service area by 5% in DY 4 and 10% in DY 5

The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in preventing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30% of all cases performed in the operating room for Calendar Year 2011. Application of dental education and fluoride varnish treatments will prevent dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

**Relationship to other Projects:**
This project, Expand Access to Oral Health Services, complements and enhances other projects that expand access to services for children, including projects 137907508.1.1 and 1309585095.1.1, and 020973601.1.1 – expansion of primary care capacity; and 121775403.2.3 – Redesign of primary care to improve continuity of care, decrease average length of stay, and increase patient satisfaction. The only related category 4 measure is RD-4 patient Satisfaction.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
Driscoll Children’s Hospital is pleased that we will be participating in a regional learning collaborative that will bring together other providers within our region to discuss our progress and implementation activities with individuals engaged in similar projects. The learning collaborative will serve as a valuable resource that allows us to share our successes and challenges and benefit from the experiences of other performing providers. While no other providers have submitted projects related to expansion of oral health services, almost all providers are participating in projects that expand access to care, including Corpus Christi Medical Center, Memorial Hospital, Yoakum Community Hospital, Lavaca Medical Center, and Jackson County Hospital District. We will be collaborating with each of these as well as other region participants.

**Project Valuation:**
We believe the Oral Health project is a highly valuable initiative in the RHP 4 Region in terms of cost avoidance, population served, and community benefit and need. In 2011, Medicaid spent $4.6 million at Driscoll Hospital on operating room (OR) and related follow up services to treat children with severe dental caries. Dental cases account for 30 percent of all OR cases at Driscoll hospital. A large share of these surgical procedures and costs could have been avoided if the patients had access to appropriate preventive dental care. Over the demonstration period, the proposed DSRIP project will expand Driscoll’s oral health program by 20 percent, serve more children, and reduce even further surgical interventions and cost to treat severe dental caries. In addition, the project will
significantly expand qualified providers in the Driscoll area to perform dental education and fluoride varnish treatments in a PCP’s office by more than 30 percent. These improvements will have a significant impact on improving health status of under-served, low-income children in our region. Based on these reasons, the value of the Oral Health project is $15,424,370 (inclusive of Categories 3 and 4).
**RHP Plan for Region 4**

<table>
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<tr>
<th>UNIQUE IDENTIFIER</th>
<th>RHP PP REFERENCE NUMBER</th>
<th>PROJECT COMPONENTS</th>
<th>Increase, Expand, and Enhance Oral Health Services</th>
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<td>132812205.1.2</td>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 3**  
**Outcome Measure(s):** 132812205.3.2 IT-7.10

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|--------------------------|--------------------------|--------------------------|--------------------------|

**Milestone 1** [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing pediatric oral health services performed by a primary care provider  
**Metric 1** [P-X.1]: Documentation of Task Force establishment  
Goal: Appointment and activation of Task Force  
**Data Source:** Hospital/health plan record  
**Estimated Incentive Payment (maximum amount):** $ 724,680

**Milestone 2** [P-X.2]: Develop plan to increase training of PCP providers on how to administer dental education and fluoride varnish treatments for pediatric patients.  
**Metric 2** [P-X.2.1]: Copy of the plan.  
Goal: Complete and submit plan development  
**Data Source:** Roster/attendance sheets for grand rounds and training  
**Estimated Incentive Payment (maximum amount):** $724,680

**Milestone 5** [P-X.1]: Task Force leads quality improvement initiative for oral health care project.  
**Metric 5a** [P-X.1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 5b** [P-X.1.2]: Documentation of Task Force report, findings and/or action plan to further enhance oral health project.  
Goal: Successful completion of task force report and quality improvement meetings  
**Data Source:** Hospital/health plan record  
**Estimated Incentive Payment (maximum amount):** $ 976,267

**Milestone 8** [P-X.1]: Task Force leads quality improvement initiative for oral health care project  
**Metric 8a** [P-X.1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 8.b** [P-X.1.2]: Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project  
Goal: Successful completion of task force report and quality improvement meetings  
**Data Source:** Hospital/health plan record  
**Estimated Incentive Payment (maximum amount):** $ 976,267

**Milestone 11** [P-X.1]: Task Force leads quality improvement initiative for oral health care project  
**Metric 11a** [P-X.1.1]: Documentation of Quality Improvement meetings held twice per year  
**Metric 11b** [P-X.1.2]: Documentation of Task Force report(s), findings, and/or action plan to further enhance oral health project  
Goal: Successful completion of task force report and quality improvement meetings  
**Data Source:** Hospital/health plan record  
**Estimated Incentive Payment (maximum amount):** $827,475

**Milestone 12** [I-11]: Increase dental care training  
**Metric 12** [I-11.3]: Train an additional 30 providers to perform dental education and fluoride varnish treatments in a PCP office above the CY 2011 baseline.  
Goal: Successfully complete provider training
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<th><strong>Year 5</strong></th>
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<td><strong>Milestone 3:</strong> [P-X3]: Conduct an initial assessment to expand, increase, and enhance pediatric oral health services performed by a primary care provider.</td>
<td><strong>Metric 3:</strong> [P-X3.1]: Documentation of plan assessment Goal: Completion of plan assessment</td>
<td><strong>Data Source:</strong> Hospital/health plan records</td>
<td><strong>Milestone 6:</strong> Estimated Incentive Payment (<em>maximum amount</em>): $976,267</td>
<td><strong>Data Source:</strong> Enrollment/attendance at training</td>
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<td><strong>Milestone 4:</strong> [I-X]: Expand Preventive Dental services performed by PCP.</td>
<td><strong>Metric 4:</strong> [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 5% above the CY 2011 baseline. Estimated patient impact is 350 additional patients treated.</td>
<td><strong>Data Source:</strong> Hospital/health plan records</td>
<td><strong>Milestone 7:</strong> Estimated Incentive Payment: $976,267</td>
<td><strong>Milestone 10:</strong> Estimated Incentive Payment: $987,500</td>
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**Related Category 3**

**Outcome Measure(s):** 132812205.3.2, IT-7.10

**Year 2**
(10/1/2012 – 9/30/2013)

- **Milestone 3:** [P-X3]: Conduct an initial assessment to expand, increase, and enhance pediatric oral health services performed by a primary care provider.
- **Metric 3:** [P-X3.1]: Documentation of plan assessment Goal: Completion of plan assessment
- **Data Source:** Hospital/health plan records
- **Milestone 4:** [I-X]: Expand Preventive Dental services performed by PCP. **Metric 4:** [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 5% above the CY 2011 baseline. Estimated patient impact is 350 additional patients treated. **Data Source:** Hospital/health plan records
- **Milestone 6:** Estimated Incentive Payment (*maximum amount*): $976,267

**Year 3**
(10/1/2013 – 9/30/2014)

- **Milestone 7:** [I-X]: Expand Preventive Dental services performed by PCP office. **Metric 7:** [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 10% above the CY 2011 baseline. Estimated patient impact is 700 additional patients treated. **Data Source:** Hospital/health plan records
- **Milestone 10:** [I-X]: Expand Preventive Dental services performed by PCP office. **Metric 10:** [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 15% above the CY 2011 baseline. Estimated patient impact is 1,050 additional patients treated. **Data Source:** Hospital/health plan records
- **Milestone 11:** Estimated Incentive Payment (*maximum amount*): $987,500

**Year 4**
(10/1/2014 – 9/30/2015)

- **Milestone 13:** [I-X]: Expand Preventive Dental services performed by PCP office. **Metric 13:** [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 20% above the CY 2011 baseline. Estimated patient impact is 1,400 additional patients treated. **Data Source:** Hospital/health plan records
- **Milestone 12:** Estimated Incentive Payment (*maximum amount*): $827,475

**Year 5**
(10/1/2015 – 9/30/2016)

- **Milestone 14:** [I-X]: Expand Preventive Dental services performed by PCP office. **Metric 14:** [I-X.1]: Goal: Increase the number of dental education and fluoride varnish treatments performed by PCP in Driscoll’s delivery service area by 25% above the CY 2011 baseline. Estimated patient impact is 1,750 additional patients treated. **Data Source:** Hospital/health plan records
- **Milestone 13:** Estimated Incentive Payment (*maximum amount*): $827,475
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<td><strong>Performing Provider Name:</strong> Driscoll Children’s Hospital</td>
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<th><strong>Related Category 3 Outcome Measure(s):</strong></th>
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<th><strong>Reduce incidence of severe dental caries that result in operative interventions in the Driscoll Service Area</strong></th>
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<td><strong>Year 3 (10/1/2013 – 9/30/2014)</strong></td>
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<td>Year 2 Estimated Milestone Bundle Amount: $2,898,719</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,928,800</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,962,500</td>
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**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $11,272,443**
Driscoll Children’s Hospital
1.9.3 – Expand Specialty Care Capacity
132812205.1.3

- **Provider:** Driscoll Children’s Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** This project will expand access to specialized pediatric health care services for children in South Texas, specifically endocrinology services.

- **Need for the project:** Nueces County has more than 9% of the population diagnosed with diabetes and other Coastal Bend counties have 8.3% to 8.9% of their populations diagnosed with diabetes. Expansion and access of sub-specialty services is key to improving overall health care delivery and health outcomes in the region.

- **Target population:** Low-income residents have difficulty accessing timely care for endocrinology services. Medicaid patients account for more than 70 percent of Driscoll’s patient base.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, this project proposes to:
  - Increase number of patient visits at selected specialty clinics for endocrinology services with an additional 100 patient visits in DY 3 (5% increase over baseline); 201 additional patient visits in DY 4 (10% increase over baseline); and 300 additional patient visits in DY 5 (15% increase over baseline)
  - Increase the number of endocrinology pediatric specialists serving South Texas by the addition of 0.5 FTEs in DY 3, 1.0 FTE in DY 4, and 1.5 FTEs in DY 5 over a 2013 baseline of 9 FTEs.
  - Increase patient satisfaction in patient’s rating of doctor access to specialty care

- **Category 3 outcomes:** IT-1.1, IT-I Our goal is to reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment and increase patient satisfaction in patient’s rating of doctor access to specialty care.
Project Option: 1.9.3 – Expand Specialty Care Capacity
Unique Project ID: 132812205.1.3
Performing Provider Name/TPI: Driscoll Children’s Hospital / 132812205

Project Description:

Expand Specialty Care Capacity

Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. Since 1953, the mission of Driscoll Children’s Hospital has impacted the lives of children all over South Texas. Driscoll is the only free-standing children’s hospital with specialized medical and surgical services in the South Texas region. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing “safety net” children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care.

This project will expand access to specialized endocrinology pediatric health care services for children in South Texas. Today, Driscoll offers complex and comprehensive medical and surgical services to the pediatric population (0-21 years old) in 31 counties of South Texas. The geographic area covers 33,000 square miles and extends from rural South Texas, to Corpus Christi, and throughout the Rio Grande Valley. Driscoll’s main facility is located in Corpus Christi and satellite clinics are located in McAllen, Brownsville, Harlingen, Laredo, Victoria and other locations. Driscoll's clinics are the only ones in the Valley entirely comprised of pediatric, board certified medical staff that are trained to care exclusively for children. The subspecialty services, provided by Driscoll, range from Behavior/Child Psychiatry, Neurology, Sports Medicine, Pulmonology, Cardiology, Surgery, GI, Orthopedic, Child Abuse, Endocrinology, Dermatology, Rheumatology, Bariatric, Hematology/Oncology and several others. These specialty services provide a variety of care to children with suspected developmental and/or learning problems, obesity, diabetes, growth disorders, metabolic bone disease, cardiac diseases, skin disorders, gastrointestinal and liver disorders, chronic illnesses that affect respiratory functionality and more.

In Year 3, the project will focus on expanding access to endocrinology services in the Corpus Christi service area. The expansion will include but is not limited to increasing providers and patient visits. Endocrinology is concerned with the study of the biosynthesis, storage, chemistry, biochemical and physiological function of hormones and with the cells of the endocrine glands and tissues that secrete them. The endocrinology service specializes in treating disorders of the endocrine system, such as diabetes, obesity, hyperthyroidism, puberty and sexual development disorders, growth disorders, pituitary disorder and long term management of disorder of deficiency or excess of one or more hormones. These services provide assistance to children as they advance through childhood and into adulthood. Endocrinology services are currently underserviced in the Corpus Christi and Driscoll Service area.

To further enhance the project, Driscoll will form an internal Task Force that will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the endocrinology project services milestones and metrics. The task force meetings will serve as a structure for activity such as: identifying project impacts and “lessons
learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the project.

**Project Goals and Challenges:**
Driscol has one of the highest percentages of Medicaid patients (over 70 percent) of any free standing children’s facility in the nation. To ensure that children throughout the region have access to pediatric specialists, Driscoll provides multiple points of access to sub-specialty clinics in the Driscoll Service Area. Driscoll physicians and staff travel every day by plane and car from Corpus Christi to Driscoll’s specialty clinics in outlying service areas. This minimizes travel and time that patients and families must spend in order to access high-quality, pediatric care. Driscoll Children’s Hospital is dedicated to giving every child access to the same high quality care regardless of economic status, in an environment of hope and healing. The goal of this project is to improve access to specialty care services for children in South Texas. Improving access to sub-specialty services is key to improving overall health care delivery and health outcomes in the region.

**By the end of Year 5, this project proposes to:**
- Increase number of patient visits for endocrinology services at selected specialty clinics by an estimated additional 100 patient visits in DY3 (5% increase), 200 patient visits in DY4 (10% increase), and 300 patient visits in DY 5 (15% increase)
- (specifically Endocrinology services in Corpus Christi) serving South Texas by an increase of one 0.5 FTE over baseline in DY 3; 1 FTE over baseline in DY 4; and 1.5 FTE over baseline in DY5. Increase patient satisfaction in patient’s rating of doctor access to specialty care
- Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment

The challenges associated with this project are access to specialty care, particularly for patients with multiple disorders or complications and patient compliance to provider care instructions. Diabetes is one of the most common chronic diseases among children in the United States. Multiple issues arise with endocrine patients; approximately 80% of visits are for endocrine disorders other than diabetes. The demand for consultation with a DCH Endocrinologist far exceeds the ability to deliver this care to the children of South Texas with the current availability of specialists.

This project advances RHP 4 goals of expanding access to specialty care services in rural areas. As described in the RHP plan and the community needs assessment, Region 4 is a medically underserved area with a shortage of specialty care physicians and services. This shortage is most acutely felt in rural areas of the region. This project will help to address this community need by increasing the number of pediatric specialists and patient visits in the region.

**Starting Point/Baseline:**
For Project Option 1.9.3. – The starting point / baseline for the number of providers in Endocrinology for Federal Calendar Year 2012 was a total of 9 providers which included medical doctor (MD), registered nurse (RN), medical assistant (MA), RN/Certified Dietary Educator (CDE) and Dietician/CDE. The starting point/baseline for the increase in patient visits will be determined in DY 2 but is estimated at approximately 2000 patient visits for endocrinology services.
Rationale:
Low-income residents have difficulty accessing timely sub-specialty services. Patients that are especially vulnerable include those with asthma, diabetes, thyroid issues and epilepsy. According to the Centers for Disease Control, a total of 23.6 million people or 7.8% of the population have diabetes. Nueces County has more than 9% of the population diagnosed with diabetes and other Coastal Bend counties have 8.3% to 8.9% of their populations diagnosed with diabetes. Expansion and access of sub-specialty services is key to improving overall health care delivery and health outcomes in the region. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

RHP 4 plan and the Community Needs Assessment identifies a need for additional pediatric specialists, especially in rural areas of the region. Consistent with the community needs assessment, this project supports CN.2 (Inadequate access to specialty Services) and CN.9 (Shortage of specialty care physicians) and CN.15 (Inadequate health care access in rural areas).

Related Category 3 Outcome Measure(s):
The related Category 3 Outcome measures are:
- OD-6, IT-I Percent improvement over baseline of patient satisfaction scores –(2) how well their doctors communicate
- OD-1, IT-1.1 Third next available appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Relationship to other Projects:
This project’s focus on improving access to care also enhances care for chronic conditions and improves patient outcomes. The project also will assist patients in navigating the maze of difficult healthcare options, and will reduce health care costs while improving patient satisfaction. Specific projects that will be enhanced and supported include the following: 020973601.1.3 and 121775403.1.5 – Expand high impact specialty care in most impacted medical specialties and 137907508.1.1 – Expand primary care capacity through FZHC providers. Related Category 4 measures included potentially preventable admissions measures in RD-1, potentially preventable readmissions measures in RD-2, and patient satisfaction in RD-4.

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other Performing Providers with similar projects with which we will collaborate include Corpus Christi Medical Center and Christus Spohn.

Project Valuation:
Our method of valuation is based on expanding availability of pediatric endocrinology specialty care and access to Medicaid members in more than 30 counties, estimated savings of providing preventive sub-specialty care, and investment of providing these services for a geographic location the size of South Carolina.
Endocrinology services to children living in these aforementioned regions, many of whom would not be served without Driscoll Children’s providing pediatric sub-specialty access to Medicaid members for over 30 counties. In determining the value of this project, we considered the estimated savings that will accrue as a result of children receiving preventive services that will prevent the need for more complicated and costly medical care, the benefits of providing more timely access to services for children with chronic conditions and who might otherwise be forced to delay necessary care or obtain more costly care from an emergency room, as well as the savings from preventable admissions that result from improved access to care. We also included the value of patient satisfaction, particularly for those patients who would otherwise be forced to travel long distances for services without these improvements. Finally, we considered the costs associated with providing these additional services. Based on these factors, the investment of providing these services for our geographic location is valued at more than $18 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DRSIP funding to be allocated to this project is $14,358,720 (inclusive of Categories 3 and 4).
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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### Year 2
(10/1/2012 – 9/30/2013)

**Milestone 1** [P-X]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing endocrinology services for children in the Driscoll service area.

**Metric 1** [P-X.1]: Documentation of Task Force establishment

**Goal:** Complete appointment and organization of Task Force

**Data Source:** Hospital/health plan record

**Milestone 1:** Estimated Incentive Payment (maximum amount): $850,000

**Milestone 2** [P-12]: Implement an endocrinology specialty care access plan to include such components as statement of problem, background and methods, findings, implications of findings in short and long term, conclusions. **Metric 2** [P-12.1]: Documentation of specialty care access plan

**Goal:** Complete development of access plan

**Data Source:** Hospital meeting records

**Rationale/Evidence:**

**Milestone 2:** Estimated Incentive Payment (maximum amount): $807,500

### Year 3
(10/1/2013 – 9/30/2014)

**Milestone 4** [P-X.1]: Task Force leads quality improvement initiative for expanding children’s endocrinology services in the Driscoll service area.

**Metric 4a** [P-X-1.1]: Documentation of Quality Improvement meetings held twice per year

**Metric 4b** [P-X-1.2]: Documentation of Task Force report, findings and/or action plan to further improve access to endocrinology services

**Goal:** Completion of Task Force report on Quality Improvement meetings held twice per year

**Data Source:** Hospital meeting records

**Milestone 4:** Estimated Incentive Payment (maximum amount): $906,666

**Milestone 5** [I-23]

Increase specialty care clinic volume of visits

**Metric 5** [I-23.1]: Increase in number of endocrinology patient visits in targeted clinic(s) by 5 percent over Year 2 baseline, for an estimated 100 additional patient visits

**Goal:** Increase number of visits by 5%

**Data Source:** Clinic records

**Milestone 5:** Estimated Incentive Payment (maximum amount): $906,666

**Milestone 6** [I-22]

Increase the number of specialist providers, clinic hours and/or procedure

**Metric 6** [I-22.1]: Increase targeted specialty care clinic volume of visits

**Metric 8** [I-23.1]: Increase number of patient visits in endocrinology by 10 percent over the Year 2 baseline for an estimated additional 200 patient visits

**Data Source:** Clinic records

**Milestone 8:** Estimated Incentive Payment (maximum amount): $927,180

### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 7** [P-X.1]: Task Force leads quality improvement initiative for expanding children’s endocrinology services in the Driscoll service area.

**Metric 7a** [P-X.1.1]: Documentation of Quality Improvement meetings held twice per year

**Metric 7b** [P-X-1.2]: Documentation of Task Force report, findings and/or action plan to further improve access to endocrinology services

**Goal:** Completion of Task Force report on Quality Improvement meetings held twice per year

**Data Source:** Hospital record

**Milestone 7:** Estimated Incentive Payment (maximum amount): $927,180

**Milestone 9** [I-22]

Increase the number of specialist providers, clinic hours and/or procedure

**Metric 9** [I-22.1]: Increase targeted specialty care clinic volume of visits

**Metric 10** [I-23.1]: Increase endocrinology specialty care clinic volume of visits

**Goal:** Increase patient visits by 15% over baseline

**Data Source:** Clinic records

**Milestone 10:** Estimated Incentive Payment (maximum amount): $807,500

**Milestone 11** [I-23.1]

Increase endocrinology specialty care clinic volume of visits

**Metric 11** [I-23.1]: Increase number of patient visits in targeted specialty area by 15 percent over the Year 2 baseline for an estimated 300 additional patient visits

**Goal:** Increase patient visits by 15% over baseline

**Data Source:** Clinic records

**Milestone 11:** Estimated Incentive Payment (maximum amount): $807,500
## RHP Plan for Region 4

### Unique Identifier: 132812205.1.3
### RHP PP Reference Number: 1.9.3
### Project Components: N/A
### Expand Specialty Care Capacity

#### Performing Provider Name: Driscoll Children’s Hospital

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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
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### Milestone 3 [P-X2]: Establish baseline(s) to measure improvements in patient visits to endocrinology specialists at targeted Driscoll specialty clinics –

**Metric 3**: [P-X2.1]:
Documentation of baseline development
Goal: Development of baseline information
**Data Source**: Clinic records
**Milestone 3**: Estimated Incentive Payment (maximum amount): $850,000

- $850,000

- **Milestone 3**: Establish baseline(s) to measure improvements in patient visits to endocrinology specialists at targeted Driscoll specialty clinics –

**Metric 6**: [I-22.1] Increase number of Endocrinology specialist providers by 0.5 FTE in the Corpus Christi service area.
Goal: Increase number of providers
c. **Data Source**: HR documents or other documentation demonstrating employed/contracted specialists
**Milestone 6**: Estimated Incentive Payment (maximum amount): $906,667

- hours available for high impact/most impacted medical specialties (Target #1).

**Metric 9**: [I-22.1] Increase number of Endocrinology specialist providers by 1.0 FTE over baseline.
Goal: Increase number of providers by 1.0 FTE
c. **Data Source**: HR documents or other documentation demonstrating employed/contracted specialists
**Milestone 9**: Estimated Incentive Payment (maximum amount): $927,180

- hours and/or procedure hours available for the high impact/most impacted medical specialties identified by Task Force in Year 3 (Target #2).

**Milestone 12**: [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties identified by Task Force in Year
**Metric 12**: [I-22.1] Increase number of endocrinology specialist providers by 1.5 FTE over baseline.
Goal: Increase number of providers by 1.5 FTE
c. **Data Source**: HR documents or other documentation demonstrating employed/contracted specialists
**Milestone 12**: Estimated Incentive Payment (maximum amount): $807,500

**Year 2 Estimated Milestone Bundle Amount**: (add incentive payments amounts from each milestone): $2,550,000

**Year 3 Estimated Milestone Bundle Amount**: $2,720,000

**Year 4 Estimated Milestone Bundle Amount**: $2,781,540

**Year 5 Estimated Milestone Bundle Amount**: $2,422,500

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: (add milestone bundle amounts over Years 2-5): $10,474,040
Driscoll Children’s Hospital
1.7.7 – Expand and Enhance Tele-psychiatry services in the Driscoll Service Area
132812205.1.4 – Pass 2

- **Provider** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care. Driscoll entered into a contractual relationship with the University of Texas Medical Branch at Galveston (UTMB) to provide child and adolescent tele-psychiatric services through the Nueces County Mental Health and Mental Retardation Center.

- **Need for the project:** Driscoll Children’s Health System serves children in 24 counties of South Texas. In this 24 county region, there are only 7 child psychiatrists for a population of 713,667 children for a ratio of less than 1 child psychiatrist per 100,000 children. In the 24 county region of South Texas, there are 20 counties without a child psychiatrist. These shortages in South Texas are worse than Alaska (3.1/100,000) which is considered the worst in the US. With the significant shortage of child psychiatrists, many primary care physicians have taken on the temporary burden of providing care to these children until patients can be seen by a psychiatrist, which even for crisis care can take up to six weeks.

- **Target population:** The goal of this project is to provide telehealth/telemedicine services to Driscoll Healthplan children in the Driscoll Service area. Telemedicine/Telehealth project will help and support patients by improving patient care satisfaction, increasing access to care and distributing care specialists across underserved areas.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, the project will accomplish the following goals: Increase the number of patients who received diagnostic and treatment services via a specific telemedicine delivered service by 69 additional telemed visits (25% above baseline) in DY 3; 138 additional telemed visits (50% above baseline) in DY 4; and 207 additional telemed visits (75% above baseline) in DY 5; Increase the number of telemedicine clinics by one location; Increase the number of telemedicine/telehealth sessions provided via video-conferencing for remote health care providers by increasing the number of hours by 25% in DY 3 (an additional 48 hours); by 50% in DY 4 for an additional 96 hours; and by 75% in DY 5 for an additional 144 hours.

- **Category 3 outcomes:** IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236. Our goal is to provide follow-up visits following hospitalization at 7 days after discharge and 30 days after discharge. We will establish our Improvement Targets no later than DY 3. The increased availability of follow-up visits will improve health care outcomes and will reduce the likelihood of hospital readmissions.
Project Option 1.7.7 – Expand and Enhance Tele-psychiatry services in the Driscoll Service Area

Unique Project ID: 132812205.1.4 – Pass 2
Performing Provider Name/TPI: Driscoll Children’s Hospital / 132812205

Project Description:

*Introduce, Expand, or Enhance Telemedicine/Telehealth*

Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital -- the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

Driscoll Children’s Health System serves children in 24 counties of South Texas. These counties have a critical shortage of child psychiatrists. The US average is 8.7 child psychiatrists per 100,000 children (Thomas and Holzer, 2006). In this 24 county region, there are only 7 child psychiatrists for a population of 713,667 children for a ratio of less than 1 child psychiatrist per 100,000 children. In the 24 county region of South Texas, there are 20 counties without a child psychiatrist. These shortages in South Texas are worse than Alaska (3.1/100,000) which is considered the worst in the US. With the significant shortage of child psychiatrists, many primary care physicians have taken on the temporary burden of providing care to these children until patients can be seen by a psychiatrist, which even for crisis care can take up to six weeks.

In DY 2, Driscoll entered into a contractual relationship with the University of Texas Medical Branch at Galveston (UTMB) to provide child and adolescent telepsychiatric services through the Nueces County Mental Health and Mental Retardation Center due to the increased need and the mal-distribution of psychiatrists in Texas. This program started in October 2012 with one half day of these services. New patients are allocated one hour per visit and follow-up patients have 30 minutes per visit. Driscoll is working with UTMB to increase the number of days in the Driscoll Service area.

Goals and Relationship to Regional Goals:
The goal of this project is to provide telehealth/telemedicine services to Driscoll Health plan members in the Driscoll Service area. These psychiatric services will be provided to Driscoll Health plan members by a health care child psychiatrist professional. Telemedicine/Telehealth project will help and support patients by improving patient care satisfaction, increasing access to care and distributing care specialists across underserved areas.

**Project Goals:**
- Increase the number of telemedicine visits per year by 25% in DY 3 for an additional 69 visits; by 50% in DY 4 for an additional 138 visits; by 75% in DY5 for an additional 207 visits.
- Increase the hours of availability for telemedicine services by 25% in DY 3 for an additional 48 hours; by 50% in DY4 for an additional 96 hours; by 75% in DY5 for an additional 144 hours.

This project meets the following regional goals:
- Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care.

**Challenges:**
Because the time of a child psychiatrist is so valuable, the primary challenge is ensuring that the Medicaid patients arrive for their appointments and arrive on time. Many of these families have difficulties maintaining their appointments because of transportation, being able to leave work, or other issues. Other challenges include ramping up this program through the grossly underserved large geographic area previously described (about the size of South Carolina). To address these challenges, we will increase patient awareness of transportation service opportunities offered to Medicaid and CHIP patients. We also plan to track and address patient No-Show ratings in collaboration with MHMR.

RHP 4 plans and the Community Needs Assessment identify an inadequate access to behavioral health care services. In 2009, Coastal Bend hospitals reported that schizoaffective disorder and manic depressive disorder were the third and fourth most common principal admission diagnosis for patients aged 18 to 49 years. About 23% of those responding to a telephone survey of Coastal Bend residents stated they had depression, and 12.5 % reported that one of their children needed mental health services. Of that group, 33% said they did not receive the mental health services they needed.

**5-Year Expected Outcome for Provider and Patients:**
Driscoll Children’s Health System expects to see expansions in the number of half days contracted with UTMB to 3 days a week in the Nueces MHMR as well as starting this program in the Laredo MHMR within the Driscoll Service Area. The provider expects to expand and enhance telemedicine visits within the Driscoll service area for targeted population. Expected outcomes will relate to the project goals described above.
Starting Point/Baseline:
Telepsychiatry services provided to Driscoll Children Health Plan patients began in DY2 in the Driscoll Service area. The number of visits and number of available hours is 0 at the beginning of DY2. Driscoll plans to establish baselines during DY2 but increase in services are estimated to be approximately 276 patient visits and 192 available patient access hours.

Rationale:
Telepsychiatry services will help patients and their families to access child psychiatrists in a timelier manner. Services provided will include:
- Diagnostic evaluation
- Medication management
- Psychotherapy

The RHP 4 providers, stakeholders and other partners comprise a wide assortment of public and private institutions coming together to address the region’s heavy burden of behavioral health care services and treatment. The telehealth/telemedicine project will:
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

About 20 percent of U.S. children and adolescents (15 million), ages 9 to 17, have diagnosable psychiatric disorders (MECA, 1996, the Surgeon General, 1999). The Center for Mental Health Services (1998), a federal agency, estimated that 9 to 13 percent of U.S. children and adolescents, ages 9 to 17, meet the definition of “serious emotional disturbance” and 5 to 9 percent of U.S. children and adolescents, “extreme functional impairment.” Only about 20 percent of emotionally disturbed children and adolescents receive some kind of mental health services (the Surgeon General, 1999), and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists. The demand for the services of child and adolescent psychiatry is projected to increase by 100 percent between 1995 and 2020, and for general psychiatry, by 19 percent (U.S. Bureau of Health Professions, DHHS, 2000). The population of children and adolescents under age 18 is projected to grow by more than 40 percent in the next 50 years from the current 70 million to more than 100 million by 2050 (U.S. Bureau of the Census, 2000).44

In Texas, communities are struggling to care for an increasing number of underserved, disadvantaged, and at-risk populations. Nowhere is this more evident than for children in Texas. Statistics from HHSC estimated that 13.8% of children lived in one of the state’s 177 rural counties, but only five percent of general pediatricians practiced in these counties. The shortage of pediatric subspecialists such as psychiatry is even more pronounced in these same geographic regions since most of the subspecialists are located in metropolitan areas, most often associated with major medical centers. At the time of this project, there are 178 out of 254 counties with no psychiatrists. According to the Texas Department of Health Services, there

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44 Texas Workforce Commission, Coastal Bend Workforce Development Area (June 2012)
were only 333 child psychiatrists in Texas and only 7 in the 24 county South Texas regions in 2012 and that the supply gap in mental health providers is likely to become even larger as we see fewer people entering the mental health profession and as the aging workforce retire. 45

**Project Components:**
This project has no required core components.

**Unique community need identification numbers the project addresses:**
- CN.4 - Inadequate access to behavioral health services
- CN.16 - Lack of integration of physical and behavioral health services

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is a new initiative for this region to expand child psychiatry in particular. With the acute shortage of child psychiatrists in South Texas, this telemedicine project will be used to provide these services bringing the child psychiatrists who live in the major metropolitan areas of Texas to the children of South Texas.

**Related Category 3 Outcome Measures:**
OD-1- Primary Care and Chronic Disease Management
IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236
- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

**Reasons/rationale for selecting the outcome measures:**
Currently, it is difficult for patients discharged from inpatient behavioral health to get an appointment with a child psychiatrist, essentially impossible within 7 days. This project will improve the ability of patients to get an appointment with a child psychiatrist in a timelier manner.

**Relationship to other Projects:**
This project’s focus is on Introduce, Expand, or Enhance Telemedicine/Telehealth services in the region. Specific projects that will be enhanced and supported include the following: 020973601.1.4 Enhance Service Availability of Appropriate Levels of Behavioral Health Care. Related Category 4 measures include RD-2 Thirty day readmissions – (3) Behavioral Health and Substance Abuse: 30-day Readmissions.

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

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center, Nueces County Mental Health Mental Retardation and Christus Spohn.

**Project Valuation:**

In most communities, especially in rural areas, care is not organized to promote prevention and early intervention, coordinate services, or monitor access to and quality of care. Moreover, public and private funding to subsidize care remains inadequate, despite growing community needs associated with increases in the uninsured and aging populations. Consequently, many people are left to seek care in emergency rooms, often as a last resort, in an unmanaged and episodic manner. The costs of such care are borne by care-giving institutions, local governments, and, ultimately, taxpayers, many of whom are already burdened with the costs of meeting health-related costs of their own.\(^{46}\) The quantitative value is based on a determination that inpatient and Emergency Room use is a high cost setting for providing behavioral care services. Decreasing the number of behavioral inpatient and emergency encounters is a more cost efficient use of resources. Expanding accessibility to behavioral telemedicine services will create significant savings and value.

\(^{46}\) http://telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf
RHP Plan for Region 4

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**TPI: 132812205**

**Follow-Up After Hospitalization for Mental Illness- NQF 0576236**

**Outcome Measure(s):**

Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 [P-3]:** Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.

Metric 1 [P-3.2]: Documentation of the number of consults delivered by each specialty

Baseline: At the beginning of DY2, the telehealth/telemedicine services were starting to be implemented; therefore, baseline will be established within the first six months of DY2.

Goal: To provide telehealth/telemedicine services to Driscoll Health plan patients in the service area.

Data source: clinic log of health services by telemedicine service;

**Milestone 1 Estimated Incentive Payment (maximum amount):**

$510,000

Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 [I-12]:** Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine visits

Goal: Increase the number of patient visits in the Driscoll service area by 25% from the baseline to provide 69 additional visits.

Data source: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 4 [P-X1]:** Increase accessibility for telemedicine services

Metric 1 [P-X1.1]: Increase the number of telemedicine/telehealth hours of operation.

Goal: Increase the number of patient access hours in the Driscoll service area by 25% from the baseline for an additional 48 hours.

Data source: Documentation of operational hours/contracted hours

**Milestone 5 [I-12]:** Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine visits

Goal: Increase the number of patient visits in the Driscoll service area by 50% from the baseline to provide 138 additional visits.

Data source: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 6 [P-X1]:** Increase accessibility for telemedicine services

Metric 1 [P-X1.1]: Increase the number of telemedicine/telehealth hours of operation.

Goal: Increase the number of patient access hours in the Driscoll service area by 50% from the baseline for an additional 96 hours.

Data source: Documentation of operational hours/contracted hours

**Milestone 7 [I-12]:** Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine visits

Goal: Increase the number of patient visits in the Driscoll service area by 75% from the baseline to provide 207 additional visits.

Data source: EHR or electronic referral processing system; encounter records from telemedicine program

**Milestone 8 [P-X1]:** Increase accessibility for telemedicine services

Metric 1 [P-X1.1]: Increase the number of telemedicine/telehealth hours of operation.

Goal: Increase the number of patient access hours in the Driscoll service area by 75% from the baseline for an additional 144 hours.

Data source: Documentation of operational hours/contracted hours

**Milestone 3 Estimated Incentive Payment (maximum amount):**

$595,620

**Milestone 4 Estimated Incentive Payment (maximum amount):**

$590,149

**Milestone 5 Estimated Incentive Payment (maximum amount):**

$590,149

**Milestone 6 Estimated Incentive Payment (maximum amount):**

$466,650

**Milestone 7 Estimated Incentive Payment (maximum amount):**

$466,650

**Milestone 8 Estimated Incentive Payment (maximum amount):**

$466,650
### RHP Plan for Region 4

**Unique Identifier:** 132812205.1.4  
**RHP PP Reference Number:** 1.7.7  
**Project Components:** N/A  
**Introduce, Expand, or Enhance Telemedicine/Telehealth**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 3 Outcome Measure(s):**
- 132812205.3.7
- IT-1.18

**Follow-Up After Hospitalization for Mental Illness- NQF 0576236**

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- **Goal:** To provide access to telehealth/telemedicine services to Driscoll Health plan patients in the service area.

- **Data source:** Documentation of operational hours/contracted hours

  **Milestone 2 Estimated Incentive Payment (maximum amount):** $510,000

  **Milestone 4:** Estimated Incentive Payment (maximum amount): $595,621

  **Payment (maximum amount):** $590,149

  **Milestone 8:** Estimated Incentive Payment (maximum amount): $466,650

- **Year 2 Estimated Milestone Bundle Amount:** $1,020,000
- **Year 3 Estimated Milestone Bundle Amount:** $1,191,241
- **Year 4 Estimated Milestone Bundle Amount:** $1,180,298
- **Year 5 Estimated Milestone Bundle Amount:** $933,300

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**  
(add milestone bundle amounts over Years 2-5): $4,324,839

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RHP Plan for Region 4  
299
Category 2 DSRIP Projects:
Program Innovation & Redesign
Driscoll Children’s Hospital
TPI: 132812205
2.7.1– Implement Evidence-based Disease Prevention Programs
Unique ID: 132812205.2.1

- **Provider:** Driscoll Children’s Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby’s heart.

- **Need for the project:** A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5%-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States.

- **Target population:** MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. This project does not overlap with RHP5 project ID 132812205.2.2 or RHP 20 132812205.2.1 because each of these projects serves a distinct and unique patient population that is specific to that region.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, the project will accomplish the following goals:
  - Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an additional 850 patient procedures; 7 percent in DY4 for an additional 1190 patient procedures; 10 percent in DY5 for an additional 1700 procedures
  - Expand MFM clinics and outreach program facility hours by 2 percent in DY 3 for an additional 98 hours; by 4 percent in DY4 for an additional 196 hours; and 6 percent in DY5 for an additional 294 hours

- **Category 3 outcomes:** IT-8.9 Our goal is to Increase the number of detected related fetal anomalies in high-risk pregnant patients.
Project Description:

Implement Evidence-based Disease Prevention Programs

Driscoll Children's Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)'s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

MFM specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. All of these expectant mothers can benefit from the care of a maternal-fetal medicine specialist. MFMs receive two to three years of additional training after an OB/GYN residency that focuses on high-risk pregnancies, ultrasound techniques and fetal anomalies.

A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby’s heart.

This team approach in prenatal diagnosis allows for better pregnancy counseling and improved neonatal outcomes. Driscoll Health System will coordinate this initiative with local Maternal-Fetal Medicine specialists, Pediatric Cardiologists, managed care organizations, and community collaborators. Driscoll Health System will form a Disease Prevention Task Force and will hold quality
Improvement meetings twice a year to review. The task force will be multidisciplinary in composition and will assess progress on Maternal Fetal Medicine project milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Disease Prevention Project.

**Project Goals and Challenges:**
Since it was established, the MFM outreach program has proven highly successful in the early detection of fetal anomalies in patients with high risk pregnancies. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region. The challenges with this project are the patient compliance of provider care instructions and the availability of timely access to care.

**By the end of Year 5, the project will accomplish the following goals:**
- Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an increase of 850 procedures; 7 percent in DY4 for an increase of 1190 procedures; and 10 percent in DY5 for an additional 1700 procedures.
- Expand MFM clinics and outreach program facility hours by 2 percent in DY 3 for an additional 98 hours; 4 percent in DY4 for 196 additional hours; and 6 percent in DY5 for an additional 294 hours.
- Increase the number of detected related fetal anomalies in high-risk pregnant patients

This project advances RHP 4 goals and community needs assessment by expanding access to early detection program for fetal anomalies in patients with high-risk pregnancies. The 2010 Coastal Bend community needs assessment indicated preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. The preterm birth rate for Texas is 13.3%, which is slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

<table>
<thead>
<tr>
<th>Metropolitan Statistical Area</th>
<th>% Preterm</th>
<th>State Average</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownsville- Harlingen</td>
<td>15.4</td>
<td>13.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Corpus Christi</td>
<td>14.9</td>
<td>13.2</td>
<td>1.7</td>
</tr>
<tr>
<td>Laredo</td>
<td>13.8</td>
<td>13.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Victoria</td>
<td>14.0</td>
<td>13.2</td>
<td>0.8</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**
The MFM clinics and outreach program facilities in Driscoll’s service area for baseline measurement will begin at approximately 4,900 hours of operation in CY 2011. The MFM echocardiogram program
in Driscoll’s service area for baseline measurement will begin at approximately 17,000 completed procedures in CY 2011.

**Rationale:**
Low-income pregnant women are at higher risk for pre-term births for a variety of known as well as unknown reasons. Expectant mothers and their unborn babies who are at high risk for certain health problems such as heart disease, high blood pressure, diabetes or other endocrine disorders, kidney or gastrointestinal disease, infectious diseases and maternal immune disorders should seek maternal-fetal medicine specialists. Healthy women whose pregnancy is at high risk for complications includes abnormal maternal serum screening, twins, triplets or more, advanced maternal age, recurrent pregnancy loss and more. Every year, Driscoll’s Transport Team transfers more than 840 neonatal and pediatric patients to or from Driscoll’s Children’s Hospital to receive the highest standard of care in the region. Maternal-fetal medicine specialists offer a wide range of care including a variety of therapies and programs that make sure that any high-risk baby in South Texas will have the best chances of living a healthy, normal life. This initiative will improve access to Maternal and Fetal Medicine care programs for Medicaid recipients. We are not currently able to provide all types of services to the entire diabetic population, which are considered high risk patients. This shortfall in services has created a demand for services that we are currently unable to meet. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

This project does not overlap with RHP5 project ID 132812205.2.2 or RHP 20 132812205.2.1 because each of these projects serves a distinct and unique patient population that is specific to that region.

**Unique community need identification numbers the project addresses:**
Consistent with RHP 4’s community need assessment, this project addresses CN.11 (High rates of poor birth outcomes and low birth-weight babies), CN.12 (Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services), and CN.13 (Insufficient access to services for pregnant women, particularly low income women).

**Related Category 3 Outcome Measure(s):** OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies

**Reasons/rationale for selecting the outcome measures:**
The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. Increased access to MFM clinics/outreach programs will provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Fetal anomalies are defined as any conditions that are not normal anatomical structure or function. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as
well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

**Relationship to other Projects:**
Implement Evidence-based Disease Promotion Programs supports 2.6-Implement Evidence-based Health Prevention Programs through early intervention with high-risk pregnant patients. This project is related to and will support other regional projects including but not limited to Expanding Primary Care Capacity Projects 020973601.1.1, and 020973601.1.2; and 130958505.2.1, Implement an innovative and evidence based health promotion program using community health workers and certified diabetes educators. Unique Project 132812205.2.1- Implement Evidence-based Disease Promotion Programs supports RHP5 Unique Project 132812205.2.2- Implement Evidence-based Disease Promotion Programs though does not create any overlap within the financial valuation. Related Category 4 outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will collaborate include Christus Spohn, Corpus Christi Medical Center, and Corpus Christi-Nueces County Public Health District.

**Project Valuation:**
The quantitative value is based in part on a determination that the NICU is a high cost service. By expanding the number of patients served by the MFM echocardiogram, we will decrease the number of patients who need NICU services, and will reduce the average length of stay (ALOS) for a NICU patient. Through expanding the availability of these services, our project will improve both the short and long-term health outcomes of the patients served, reducing future health care costs. Increasing the hours and use of a MFM clinic/outreach program and increasing the number of Maternal Fetal echocardiogram procedures will create significant savings and value and will support a more efficient use of resources as future costs savings attributed to this program may be used to fund other critical health care services.

Driscoll provides MFM services to the community for multiple reasons, one of which is to help reduce ALOS for NICU patients. Since the beginning of the MFM program, ALOS for a NICU patient has decreased significantly, resulting in reductions of NICU payment dollars between FY2010 and FY2012.

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Pediatric Cardiologists working in
collaboration with the Maternal Fetal Medicine program give Perinatalists adjunctive support in diagnosing congenital heart disease, aiding in management of arrhythmias and congestive heart failure from various causes. Additionally, it allows for detailed counseling using the expertise of a Pediatric Cardiologist.

Maternal fetal echocardiogram programs provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. In addition, having an established prenatal diagnosis allows for plans to be set for delivery in facility with a level three neonatal service. Based on the change in NICU ALOS between Calendar 2010 and 2012 plus the Calendar 2012 NICU admissions, we estimate a total saving and value to the state of approximately $7.5 million per year for this proposed project. Based on these reasons and value of project to the region, the maximum DSRIP funding to be allocated to this project is $18,250,000 (inclusive of Categories 3 and 4).
<table>
<thead>
<tr>
<th><strong>Related Category 3</strong></th>
<th><strong>Outcome Measure(s):</strong></th>
<th><strong>Implement Evidence-based Disease Prevention Programs</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performing Provider Name:</strong> Driscoll Children’s Hospital</td>
<td></td>
<td></td>
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<tr>
<td><strong>TPI:</strong> 132812205</td>
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</tr>
</tbody>
</table>

**Implement Evidence-based Disease Prevention Programs**

| **Year 2** | 
| **(10/1/2012 – 9/30/2013)** | 
| **Milestone 1 [P-X]:** Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing Driscoll’s Maternal Fetal Medicine (MFM) Program.  
**Metric 1 [P-X.1]:** Documentation of Task Force establishment  
**Data Source:** Hospital/health plan record | 
| **Milestone 2:** Estimated Incentive Payment (maximum amount): $1,700,000 | 

**Milestone 3 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 3a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 3b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record

| **Year 3** | 
| **(10/1/2013 – 9/30/2014)** | 
| **Milestone 3 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 3a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 3b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record | 
| **Milestone 4 [I-7]:** Increase access to MFM program  
**Metric 4 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 5 percent above CY 2011 baseline for an additional 850 procedures above baseline  
**Data Source:** Hospital/health plan record | 
| **Milestone 5 [P-X].** Task Force leads quality improvement initiative for MFM program  
**Metric 5a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 5b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record

| **Year 4** | 
| **(10/1/2014 – 9/30/2015)** | 
| **Milestone 6 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 6a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 6b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record | 
| **Milestone 6 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 6a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 6b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record | 
| **Milestone 7 [I-7]:** Increase access to MFM program  
**Metric 7 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 7 percent above CY 2011 baseline for an additional 1190 procedures above baseline  
**Data Source:** Hospital/health plan record

| **Year 5** | 
| **(10/1/2015 – 9/30/2016)** | 
| **Milestone 9 [P-X2]:** Task Force leads quality improvement initiative for MFM program  
**Metric 9a [P-X.2.1]:** Documentation of Quality Improvement meetings held twice per year  
**Metric 9b [P-X.2.2]:** Documentation of Task Force report, findings and/or action plan to further improve the MFM  
**Data Source:** Hospital/health plan record | 
| **Milestone 10 [I-7]:** Increase access to MFM program  
**Metric 10 [I-7.2]:** Increase number of MFM echocardiogram program procedures by 10 percent above the CY 2011 baseline for an additional 1700 procedures above baseline  
**Data Source:** Hospital/health plan record | 
| **Milestone 10 [P-X1]:** Increase hours  
**Milestone 11 [P-X1]:** Increase hours |
<table>
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<th><strong>UNIQUE IDENTIFIER:</strong></th>
<th><strong>RHP PP REFERENCE NUMBER:</strong></th>
<th><strong>PROJECT COMPONENTS:</strong></th>
<th><strong>Implement Evidence-based Disease Prevention Programs</strong></th>
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<td><strong>TPI:</strong></td>
<td>132812205</td>
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<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>132812205.3.5</td>
<td>IT-8.9</td>
<td>Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area</td>
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<table>
<thead>
<tr>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
<th><strong>Year 4</strong></th>
<th><strong>Year 5</strong></th>
</tr>
</thead>
</table>

**Milestone 5 [P-X1]:** Increase hours of accessibility of MFM clinics/outreach program

**Metric 5 [P-X1.1]:** Increase MFM clinic/outreach program hours by 2% above baseline for an additional 98 hours

**Data Source:** Hospital/health plan record

**Milestone 5: Estimated Incentive Payment (maximum amount):** $1,200,000

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $3,400,000

**Milestone 8 Estimated Incentive Payment (maximum amount):** $1,187,500

**Metric 8 [P-X1.1]:** Increase of MFM clinics/outreach program hours by 4% above baseline for an additional 196 hours

**Data Source:** Hospital/health plan record

**Year 3 Estimated Milestone Bundle Amount:** $3,600,000

**Milestone 11 Estimated Incentive Payment (maximum amount):** $950,000

**Metric 11 [P-X1.1]:** Increase of MFM clinics/outreach program hours by 6% above baseline for an additional 294 hours

**Data Source:** Hospital/health plan record

**Year 4 Estimated Milestone Bundle Amount:** $3,562,500

**Year 5 Estimated Milestone Bundle Amount:** $2,850,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $13,412,500
Driscoll Children’s Hospital
TPI: 132812205
2.6.2 – Implement Evidence-based Health Promotion Programs
132812205.2.2

- **Provider:** Driscoll Children’s Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** The goal of this project is to educate and provide support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery.

- **Need for the project:** Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU). Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care.

- **Target population:** This project will increase community participation and education through these services targeted to serve low-income populations.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, Driscoll plans to:
  - Expand prenatal educational sessions by 5% in DY 2, serving an additional 20 patients; by 10% in DY3, serving an additional 40 patients; by 15% in DY 4, serving an additional 60 patients; by 20 percent in DY 5, serving an additional 80 patients.
  - Expand consultation visits by 5% in DY2 for an additional 100 patient consults; by 10% in DY3 for an additional 200 patient consults; by 15% in DY4 for an additional 300 patient consults; by 20 percent in DY5 for an additional 400 patient consults
  - Expand Cadena Health plan participants by 5% in DY3 for an additional 65 participants; by 8% in DY3 for an additional 104 participants; by10% in DY4 for an additional 130 participants; by 12% in DY5 for an additional 156 patients

- **Category 3 outcomes:** Our goal is to reduce the Neonatal ICU Average Length of Stay for the targeted population, TPI 2.6– Implement Evidence-based Health Promotion Programs.

RHP Plan for Region 4

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Project Option: 2.6.2 – Implement Evidence-based Health Promotion Programs

Unique Project ID: 132812205.2.2
Performing Provider Name/TPI: Driscoll Children’s Hospital/132812205

Project Description:
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital’s medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in South Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital -- the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c) (3)’s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

In collaboration with Driscoll Health Plan, Driscoll Hospital plans to expand a highly successful prenatal program that promotes healthy behavior and provides supports to low-income women with high-risk pregnancies. The program, called Cadena de Madres Project (Mother’s network), seeks to reduce low birth weight and premature deliveries in targeted Texas counties by providing enhanced educational and social support for indigent, predominately Hispanic, women considered to be high risk for adverse birth outcomes. The Project focuses on improving maternity social and healthcare supports available to indigent women during pregnancy. The overall goal of the program is to reduce prematurity and thereby reduce admissions and days in the neonatal intensive care unit (NICU).

The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery. The baby showers focus on encouraging prenatal care, improving nutrition, promoting breast feeding, avoiding dangerous behaviors, and recognizing the signs and symptoms of premature labor. Pregnant women enrolled in Driscoll Children’s Health Plan are mailed an invitation each month of their pregnancy. After attending our baby shower sessions the participant will be educated on how to distinguish healthy choices during their pregnancy and recognize the negative impact of smoking, alcohol, and drugs can have on their health and comprehend the advantages of prenatal care and understand the complications that may occur during their pregnancy. Educational baby showers also recognize signs of preterm labor, and pre labor signs, and understand when medical intervention is needed.
Nutritional advice can be reinforced or further advice can be sought from the dietitian, particularly for those with diabetes or gestational diabetes which comprise 13 percent of the population.

The consultation visits encourage postpartum care of the mother, timely infant care, successful breastfeeding, and good nutrition for the mother and the infant, consideration of family planning to gain appropriate birth spacing, and re-enrollment for continuing medical insurance coverage. The consult visitor can also teach important infant safety points like “back to sleep”, the importance of proper car seat use, the appropriate use of the medical office and the emergency room for medical issues. Convincing a mother to breast feed promotes further bonding to the new infant. This can be aided by having consultations with a certified lactation consultant. Breast fed infants have less visits to the physician for medical illness than those that bottle feed. Most mothers will consider delaying the next pregnancy until they wean the current infant.

This team approach in prenatal and postnatal care allows for better pregnancy counseling and improved neonatal outcomes. Driscoll will coordinate this initiative with local maternal-fetal medicine specialists, managed care organizations, and community collaborators. To further enhance the project, Driscoll Health System will form a Health Promotion Task Force and will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Health Promotion milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Health Promotion Task Force.

**Project Goals and Challenges:**
The goal of this project is to reduce preterm births by educating and providing support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The increased consults, Cadena participants and educational sessions may include one or all of the different program locations.

By the end of Year 5, Driscoll plans to:
- Expand prenatal educational sessions by 5% in DY 2, serving an additional 20 patients; by 10% in DY 3, serving an additional 40 patients; by 15% in DY 4, serving an additional 60 patients; by 20 percent in DY 5, serving an additional 80 patients.
- Expand consultation visits by 5% in DY2 for an additional 100 patient consults; by 10% in DY3 for an additional 200 patient consults; by 15% in DY4 for an additional 300 patient consults; by 20 percent in DY5 for an additional 400 patient consults Reduce NICU days per delivery
- Expand Cadena Healthplan participants by 5% in DY3 for an additional 65 participants; by 8% in DY3 for an additional 104 participants; by10% in DY4 for an additional 130 participants; by 12% in DY5 for an additional 156 patients

This project advances RHP 4 goals and community needs assessment by expanding access to prenatal education and consultations to support low-income pregnant women deliver healthy babies and reduced need for neonatal intensive care services. The 2010 Coastal Bend community needs
assessment indicated Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. For the U.S. in 2008, 12.3% of all births were preterm. Preterm births declined from 2006 to 2008 for mothers of all age groups under age 40, for the largest race and Hispanic origin groups and for most U.S. states including Texas. The preterm birth rate for Texas, however, is 13.3%, slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

%Preterm (<37 weeks gestation) - Texas 2012

<table>
<thead>
<tr>
<th>Metropolitan Statistical Area</th>
<th>% Preterm</th>
<th>State Average</th>
<th>Percent Higher</th>
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<tbody>
<tr>
<td>Brownsville- Harlingen</td>
<td>15.4</td>
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<td>Victoria</td>
<td>14.0</td>
<td>13.2</td>
<td>0.8</td>
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</tbody>
</table>

Starting Point/Baseline:
During calendar year 2011, Driscoll provided over 400 prenatal educational sessions, 1,300 Cadena Healthplan participants and over 2,000 educational consult visits to high risk pregnant women.

Rationale:
Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This initiative will expand health education to high risk pregnant Medicaid patients as well as provide counseling and education on tobacco and alcohol use for pregnant women. Driscoll Children’s Hospital does not include any project components or any initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

Consistent with RHP 4’s community need assessment, this project addresses CN.11 (High rates of poor birth outcomes and low birth-weight babies), CN.12 (Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services), and CN.13 (Insufficient access to services for pregnant women, particularly low income women).

Related Category 3 Outcome Measure(s): OD-8 Perinatal Outcome: IT-8.9
Reduce the Neonatal ICU days per delivery for the targeted population, TPI 2.6– Implement Evidence-based Health Promotion Programs.

Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in pre-term births with a resultant decrease in NICU days are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy
pregnancies, deliveries, and infant care. This project will increase community participation and
education through these services targeted to serve low-income populations.

**Relationship to other Projects:**
Implement Evidence-based Health Promotion Programs supports TPI 2.7-Implement Evidence-based Disease Prevention Programs through early intervention with high-risk pregnant patients. This project is related to and will support other regional projects including but not limited to Expanding Primary Care Capacity Projects 020973601.1.1, and 020973601.1.2; and 130958505.2.1, Implement an innovative and evidence based health promotion program using community health workers and certified diabetes educators. Related Category 4 outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Although no providers have projects that duplicate our plan, other providers with projects with similar components whom we will collaborate include Christus Spohn, Corpus Christi Medical Center, and Corpus Christi-Nueces County Public Health District.

**Project Valuation:**
The quantitative value is based on a determination that Neonatal ICU (NICU) use is a high cost service. Decreasing the number of premature infant admissions less than 37 weeks with a resultant decrease in NICU days per delivery is a more efficient use of resources. Expanding health education to high risk pregnant patients as well as increasing the number of provided counseling sessions on tobacco and alcohol use for pregnant women will create significant savings and value.

Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients.

Based on the decreasing number of premature infant admissions less than 37 weeks and the decrease in NICU days per delivery, we estimated a total saving and value to the state of approximately $5.5 million per year for this proposed project. However, consistent with DSRIP requirements, the maximum DSRIP funding to be allocated to this project is $15,740,479 (inclusive of Categories 3 and 4).
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<th>Project Components:</th>
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**Related Category 3 Outcome Measure(s):**

- Reduce the Neonatal ICU Average Length of Stay for the targeted population
- 

<table>
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<tr>
<th>Milestone 1 [P-X]:</th>
<th>Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing the Cadena de Madres Program.</th>
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<td>Metric 1 [P-X.1]:</td>
<td>Documentation of Task Force establishment</td>
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<td>Data Source:</td>
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<td>Goal:</td>
<td>Appoint Task Force</td>
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<td>Milestone 1:</td>
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<th>Milestone 2 [P-X1]:</th>
<th>Develop plan to expand Cadena de Madres program to women with high risk pregnancies</th>
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<tbody>
<tr>
<td>Metric 2 [P-X1.1]:</td>
<td>Evidence of plan</td>
</tr>
<tr>
<td>Goal:</td>
<td>Complete development of plan</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Hospital/health plan record</td>
</tr>
<tr>
<td>Milestone 2:</td>
<td>Estimated Incentive Payment (maximum amount): $510,000</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Milestone 3 [I.X]:</th>
<th>Increase access to prenatal education sessions for target population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 3 [I.X.1]:</td>
<td>Increase number of prenatal education sessions for target population</td>
</tr>
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<thead>
<tr>
<th>Milestone 4 [P-X2]:</th>
<th>Task Force leads quality improvement initiative for Cadena de Madres program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 4a [P-X2.1]:</td>
<td>Documentation of Quality Improvement meetings held twice per year</td>
</tr>
<tr>
<td>Metric 4b:</td>
<td>Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Hospital/health plan record</td>
</tr>
<tr>
<td>Goal:</td>
<td>Complete report on QI findings</td>
</tr>
<tr>
<td>Milestone 4:</td>
<td>Estimated Incentive Payment (maximum amount): $800,075</td>
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<thead>
<tr>
<th>Milestone 5 [I.X]:</th>
<th>Increase access to prenatal education sessions for target population</th>
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</thead>
<tbody>
<tr>
<td>Metric 5a [I.X.1]:</td>
<td>Increase number of prenatal education sessions for target population by 10 percent above CY 11 baseline for an additional 40 sessions</td>
</tr>
<tr>
<td>Goal:</td>
<td>Increase number of sessions by</td>
</tr>
<tr>
<td>Milestone 5:</td>
<td>Estimated Incentive Payment (maximum amount): $796,875</td>
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</table>

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<tr>
<th>Milestone 6 [P-X2]:</th>
<th>Task Force leads quality improvement initiative for Cadena de Madres program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 6a [P-X2.1]:</td>
<td>Documentation of Quality Improvement meetings held twice per year</td>
</tr>
<tr>
<td>Metric 6b:</td>
<td>Documentation of Task Force report, findings and/or action plan to further improve the Cadena de Madres program</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Hospital/health plan record</td>
</tr>
<tr>
<td>Goal:</td>
<td>Complete report on QI findings</td>
</tr>
<tr>
<td>Milestone 6:</td>
<td>Estimated Incentive Payment (maximum amount): $800,075</td>
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<tr>
<th>Milestone 7 [I.X]:</th>
<th>Increase access to prenatal education sessions for target population</th>
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</thead>
<tbody>
<tr>
<td>Metric 7 [I.X.1]:</td>
<td>Increase number of prenatal education sessions for target population by 10 percent above CY 11 baseline for an additional 40 sessions</td>
</tr>
<tr>
<td>Goal:</td>
<td>Increase number of sessions by</td>
</tr>
<tr>
<td>Milestone 7:</td>
<td>Estimated Incentive Payment (maximum amount): $796,875</td>
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<tr>
<th>Milestone 8 [I.X]:</th>
<th>Increase access to prenatal education sessions for target population</th>
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</thead>
<tbody>
<tr>
<td>Metric 8a [I.X.1]:</td>
<td>Increase number of prenatal education sessions for target population by 15 percent above CY 11 baseline for an additional 60 sessions</td>
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<tr>
<td>Goal:</td>
<td>Increase number of sessions by</td>
</tr>
<tr>
<td>Milestone 8:</td>
<td>Estimated Incentive Payment (maximum amount): $641,250</td>
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<tr>
<th>Milestone 9 [I.X]:</th>
<th>Increase access to prenatal education sessions for target population</th>
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</thead>
<tbody>
<tr>
<td>Metric 9a [I.X.1]:</td>
<td>Increase number of prenatal education sessions for target population by 20 percent above CY 11 baseline for an additional 80 sessions</td>
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<tr>
<td>Goal:</td>
<td>Increase number of sessions by</td>
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<tr>
<td>Milestone 9:</td>
<td>Estimated Incentive Payment (maximum amount): $641,250</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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<tr>
<td>Prenatal education sessions for target population by 5% above CY 11 baseline for an additional 20 patient sessions. Goal: Increase number of sessions provided</td>
<td>Data Source: Hospital/health plan record</td>
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<tr>
<td>Milestone 8: [I-X1] Increase access to prenatal education consults for target population</td>
<td>Metric 8: [I-X1.1] Increase number of prenatal education consultations above baseline for target population by 10% above CY 11 baseline for an additional 200 consultations Goal: Increase number of consultations by 10%</td>
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<td>Milestone 9: [I-X2] Increase number of Cadena Healthplan participants</td>
<td>Metric 9: [I-X2.1] Increase number of Cadena Healthplan participants for target population by 8% for an additional 104 participants</td>
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<tr>
<td>UNIQUE IDENTIFIER: 132812205.2.2</td>
<td>RHP PP REFERENCE NUMBER: 2.6.2</td>
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<td>Performing Provider Name: Driscoll Children’s Hospital</td>
<td>TPI: 132812205</td>
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**Related Category 3 Outcome Measure[s]:**
- 132812205.3.6
- IT-8.9
- Reduce the Neonatal ICU Average Length of Stay for the targeted population

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
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</thead>
<tbody>
<tr>
<td>participants</td>
<td>Goal: increase number of participants by 8%</td>
<td>Goal: increase number of participants by 10 percent</td>
<td>by 12 percent</td>
</tr>
<tr>
<td>Data Source: Hospital/health plan record</td>
<td>Data Source: Hospital/health plan record</td>
<td>Data Source: Hospital/health plan record</td>
<td>Data Source: Hospital/health plan record</td>
</tr>
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**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $2,550,000

**Year 3 Estimated Milestone Bundle Amount:** $3,200,330

**Year 4 Estimated Milestone Bundle Amount:** $3,187,500

**Year 5 Estimated Milestone Bundle Amount:** $2,565,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $11,502,830
Driscoll Children’s Hospital
2.12.3 – Develop, Implement and evaluate a specialize follow-up clinic program for High Risk infants and young children in the Driscoll Service Area
132812205.2.3 – Pass 2

- **Provider:** Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area.

- **Intervention(s):** The High Risk Infant Follow-up Program is designed to assist pediatricians and families in follow-up care for infants and young children who are at high risk for developmental and neurological problems following discharge from an intensive care unit (ICU) at Driscoll Children’s Hospital or other local Neonatal ICU’s.

- **Need for the project:** This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Babies who are born experiencing unusual or difficult birth circumstances are at major risk for death or a lifetime of health problems unless they receive intense care immediately and for months and years after birth.

- **Target population:** Medicaid patients account for more than 70 percent of Driscoll’s patient base. The type of patients seen in the High Risk Follow-up Clinic setting are infants and young children from birth to three years of age who are at risk for developmental problems due to prematurity, low birth weight or other complications at birth.

- **Category 1 or 2 expected patient benefits:** By the end of Year 5, the project will accomplish the following goals:
  - Implement the Bayley Scales of Infant and Toddler Development 3rd Ed. developmental exam performed in the high risk follow-up program, serving an estimated baseline of 10 patients in DY 2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY 4 for an additional 1 patient; and 15% in DY5 for an additional 2 patients.
  - Implement the high risk follow-up program to serve an estimated baseline of 25 patients in DY 2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY4 for an additional 3 patients; 15% in DY5 for an additional 4 patients.
  - Increase the number of clinic hours by 5% over baseline for an additional 10 hours in DY3; by10% above baseline in DY4 for an additional 19 hours; by 15% over baseline for an additional 29 hours.

- **Category 3 outcomes:** IT-6.1, Our goal is to demonstrate a percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making. The Target Improvement will be established no later than DY 3.
Project Option 2.12.3 – Develop, Implement and evaluate a specialize follow-up clinic program for High Risk infants and young children in the Driscoll Service Area

**Unique Project ID:** 132812205.2.3 (Pass 2)
**Performing Provider Name/TPI:** Driscoll Children’s Hospital / 132812205

**Project Description:**
*Implement/Expand Care Transition Programs*
Driscoll Children’s Hospital is a tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. The hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties. For nearly 60 years, Driscoll Children’s Hospital has shown a commitment to pediatric healthcare for the children of South Texas. Through the generosity and vision of its founder, Clara Driscoll, the pediatric hospital became one of the first – and today still remains the only – free-standing children’s hospital in South Texas. Remembering always our commitment to relieve suffering and meet the needs of children, it is the mission of Driscoll Children’s Hospital to offer hope and healing in an environment of trust, compassion and care. Unique to our rural location, the population we serve in south Texas is one of the poorest in the United States. In FY 2012, Medicaid patients accounted for more than 70 percent of inpatient days (24,236) at Driscoll Children’s Hospital --the highest percentage in Texas.

The hospital is part of the Driscoll Health System, a freestanding nonprofit system, which is also comprised of Driscoll Health Plan, Four Physician Groups (501(c)(3)‘s comprised of pediatric subspecialists), The Driscoll Children’s Hospital Auxiliary, and the Driscoll Children’s Hospital Development Foundation. With the Hospital, Health Plan, and Pediatric Subspecialty Physician groups all under the Driscoll Health System umbrella, Driscoll is uniquely positioned to meet the health care needs of South Texas and to implement innovative, DRSIP projects that improve patient care and outcomes across the care continuum.

The High Risk Follow-Up Program is a service that we propose to offer to families of children cared for in a Neonatal/ Pediatric Intensive care and other care type units who meet the eligible criteria. This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Babies who are born experiencing unusual or difficult birth circumstances are at major risk for death or a lifetime of health problems unless they receive intense care immediately and for months and years after birth. The High Risk Infant Follow-up Program is designed to assist pediatricians and families in follow-up care for infants and young children who are at high risk for developmental and neurological problems following discharge from an intensive care unit (ICU) at Driscoll Children’s Hospital or other local Neonatal ICU’s. The type of patients seen in the High Risk Follow-up Clinic setting are infants and young children from birth to three years of age who are at risk for developmental problems due to prematurity, low birth weight or other complications at birth. Children, who have had typical neonatal courses, can also be seen if their Pediatrician has concern for developmental delay.

During a patient’s visit, the child and family are seen by a licensed provider (neonatal nurse practitioner and/or registered nurse). They will gather information about the child's
health history since discharge from the NICU or last visit. Next, they will evaluate the patient using a developmental exam called The Bayley Scales of Infant and Toddler Development 3rd Ed. Assessment followed by a physical exam, specifically looking for neurological findings. Parents will be asked to report early language milestones. At the end of the exam, the patient’s weight, height and head circumference will be measured. Finally, testing results and recommendations will be discussed and a copy of the findings will be forwarded to the child’s PCP. These visits can take several hours to perform on a patient.

To further enhance the project, Driscoll Health System will form an Outreach Council and will hold quality improvement meetings twice a year. The task force will be multidisciplinary in composition and will assess progress on the Care transition milestones and metrics. The task force meeting will serve as a structure for activity such as: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Care Transition Program.

**Goals and Relationship to Regional Goals:**
The goal of this project is to have a specialized program for babies born with birth complications and other criteria, identified by a neonatologist, available through referral by the primary care physicians. The project would also provide developmental age-appropriate testing and enhance development as well as enable the family to become knowledgeable about their baby’s developmental needs, help the infant to achieve maximum potential and to empower families with information to access healthcare.

**Project Goals:**
- Implement the Bayley Scales of Infant and Toddler Development 3rd Ed. developmental exam performed in the high risk follow-up program, serving an estimated baseline of 10 patients in DY2 with a target increase of 5% in DY 3 for an additional 1 patient; 10% in DY 4 for an additional 1 patient; and 15% in DY 5 for an additional 2 patients.
- Implement the high risk follow-up program, serving an estimated baseline of 25 patients in DY2 with a target increase in subsequent years of 5% in DY 3 for an additional 1 patient; 10% in DY4 for an additional 3 patients; and 15% in DY4 for an additional 4 patients
- Increase accessibility to High Risk patients in targeted population

This project meets the following regional goals:
- Transform health care delivery to a patient–centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
Challenges:
Driscoll faces several challenges and barriers to implement the high risk infant follow-up program; including the high rate of patient no-shows to appointments and to provide timely access to patients and their families.

The High Risk Infant Follow-up Program will work to overcome No Show Rate challenges by performing positive initiatives, such as:
- Providing a blanket to patients at the three month visit
- Developing a patient of the month bulletin
- Establishing a Reach Out and Read Program
- Providing a Monthly Newsletter to patients and families
- Enhancing services accessibility to patients

5-Year Expected Outcome for Provider and Patients:
Driscoll Children’s Hospital expects to see improvements in care transition program for patients. The provider expects to improve accessibility to the High Risk Infant Follow-up program across the Driscoll Service area. This program provides developmental evaluation which may suggest a need for early intervention. Prompt detection and early intervention can help a child reach their fullest potential for growth and development. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Currently the High Risk Infant Follow-up clinic does not exist within the Driscoll Children’s Hospital. Therefore, the baseline for number of participants as well as the number of participating providers begins at 0 in DY2. Driscoll plans to establish baselines during DY2 but the increase in services are estimated to be approximately 25 patient visits and 10 Bayley exams.

Rationale:
Developmental delays and conditions are common in early childhood, affecting at least 10 percent of children. Early developmental delays are markers for later developmental conditions such as autism, intellectual disability, hearing or vision impairment, cerebral palsy, speech and language disorders, and learning disabilities. Risk factors such as family poverty, parents’ mental illness, and child neglect and abuse increase the likelihood of developmental delays.141

Recent studies emphasize the importance of the interaction of brain development and environment on children’s developmental and behavioral outcomes. The tremendous adaptability of the brain in the first three years of life means that early treatment of delays leads to improved outcomes, whereas later intervention is less effective. To improve children’s outcomes through provided treatment, early identification of delays and sensory impairments (i.e., vision and hearing problems) is critical. Pediatricians and other primary care medical providers who see children for regularly scheduled preventive care visits during their first three

years of life, and who are trained in child development, could play a key role in the early identification of developmental delays.

In response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region, Driscoll Children’s Hospital care transition program is designed to:

- Increase the capacity of safety net providers in the region to provide patient-centered care and care management, particularly for patients with chronic conditions, to improve health literacy, self-care management skills, and more effectively access or navigate the health care system appropriately.

**Project Components:**
This project has no required core components.

**Unique community need identification numbers the project addresses:**
- CN.2 – Inadequate access to specialty services.
- CN.12 – Lack of patient navigation, patient and family education, health promotion, and information programs to prevent illness and increase utilization of health services

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently, a High Risk Follow-up program does not exist for NICU patients in the Driscoll Children’s Service Area. Our hospital will offer developmental evaluation services through a multidisciplinary team which include neonatal nurse practitioner, registered dietician, speech therapist, occupational therapist, and physical therapist. The initiative will improve access to specialized services for targeted patients while helping the hospital reach capacity for treating high-risk patients.

**Related Category 3 Outcome Measures:**
OD-6 – Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

**Reasons/rationale for selecting the outcome measures:**
Most studies of developmental screening in practice have reported positive results in terms of increased rates of detection/referral and/or parental satisfaction. Parents who reported that their children had received a developmental assessment were more likely to be satisfied with their child’s medical care; these visits were also associated with higher quality ratings. These results suggest that providers and practices who take a structured approach to developmental assessment are providing a higher level of care overall, thereby potentially contributing to improved child health outcomes.142

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**Relationship to other Projects:**
This project’s focus is on enhancing a care transition program which ties to these Category 1 and 2 projects in our RHP: 020973601.2.1 Implement/Expand Care Transitions Programs, 0942220902.2.5 Expand Care Transitions Program and 121775403.2.10 Expand Care Transitions Program. Related Category 4 measures include potentially preventable admissions measures in RD-1 and Patient Satisfaction in RD-4.1.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 4, Nueces County Hospital District. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Other providers with similar projects with whom we will participate in the learning collaborative include Corpus Christi Medical Center, Early Childhood Intervention program and Christus Spohn.

**Project Valuation:**
According to the article: *Developmental Screening in Primary Care: The Effectiveness of Current Practice and Recommendations for Improvement*, early developmental delays are often not identified in a timely way. Many children are not identified until kindergarten entry or later—well beyond the period in which early intervention is most effective. Therefore, in many cases, opportunities to intervene early to improve children’s developmental outcomes are missed. Validated developmental screening tools that could increase identification of developmental delays exist, but most physicians do not use them systematically to screen all patients. Recently revised guidelines from the American Academy of Pediatrics recommend routine screening at three specific ages in early childhood, and may lead to the increased use of screening tools.

We are using an estimated program patient volume and conservative Quality Adjusted Life Year (“QALY”) per year valuation to demonstrate a one-time improvement in the quality of life. Although our estimates are based on a one-time improvement, the project’s value and community benefit is realized throughout many years.

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**Implement/Expand Care Transition Programs**

Performing Provider Name: Driscoll Children’s Hospital  
TPI: 132812205

**Related Category 3**  
Outcome Measure(s):  
132812205.3.8  
IT-6.1

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<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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**Milestone 1** [P-2]: Implement standardized care transition processes  
**Metric 1** [P-2.1]: Care transitions policies and procedures  
Goal: Submission of protocols  
Data Source: Policies and procedures of care transitions program materials

**Milestone 1**: Estimated Incentive Payment *(maximum amount)*: $153,638

**Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objects of the care transitions program.  
**Metric 1** [P-7.1]: Documentation of the staffing plan.  
Goal: Create staffing and implementation plan.  
Data Source: Completed Staffing and implementation plan.

**Milestone 2**: Estimated Incentive Payment *(maximum amount)*: $153,638

**Milestone 3** [P-X]: Plan and establish baseline clinic hours for  

**Milestone 7** [P-X]: Provide patient accessibility to the High Risk Infant Follow-up Program in the Driscoll Service area.  
**Metric 1** [P-X]: Increase patient accessibility to the High Risk Infant Follow-up Program through increased hours.  
Goal: Increase the number of program hours by 5% above the baseline, for an additional 10 hours.  
Data Source: Documentation of operational hours.

**Milestone 7**: Estimated Incentive Payment *(maximum amount)*: $225,000

**Milestone 8** [I-X]: Implement standard care transition processes in specified patient populations.  
**Metric 1** [I-X.1]: Increase the number of patient visits seen in the High Risk Infant Follow-up Program  
Goal: Increase the number of patient visits seen in the High Risk Infant Follow-up by 5% above the baseline estimate of 25 patients, for an estimated 1 additional patient.  
Data Source: Hospital administrative data and the patient medical record.

**Milestone 8**: Estimated Incentive Payment *(maximum amount)*: $253,125

**Milestone 11** [P-X]: Provide patient accessibility to the High Risk Infant Follow-up Program in the Driscoll Service area.  
**Metric 1** [P-X]: Increase patient accessibility to the High Risk Infant Follow-up Program through increased hours.  
Goal: Increase the number of program hours by 10% above the baseline for an additional 19 hours.  
Data Source: Documentation of operational hours.

**Milestone 11**: Estimated Incentive Payment *(maximum amount)*: $225,000

**Milestone 12** [I-X]: Implement standard care transition processes in specified patient populations.  
**Metric 1** [I-X.1]: Maintain standard care transition processes in specified patient populations.  
Goal: Increase the number of patient visits seen in the High Risk Infant Follow-up Program by 15% over baseline for an estimated 4 additional patient visits  
Data Source: Hospital administrative data and the patient medical record.

**Milestone 12**: Estimated Incentive Payment *(maximum amount)*: $247,716

**Milestone 15** [P-X]: Provide patient accessibility to the High Risk Infant Follow-up Program in the Driscoll Service area.  
**Metric 1** [P-X]: Increase patient accessibility to the High Risk Infant Follow-up Program through increased hours.  
Goal: Increase the number of program hours by 15% above baseline for an additional 29 hours.  
Data Source: Documentation of operational hours.

**Milestone 15**: Estimated Incentive Payment *(maximum amount)*: $247,716

**Milestone 16** [I-X]: Implement standard care transition processes in specified patient populations.  
**Metric 1** [I-X.1]: Maintain standard care transition processes in specified patient populations.  
Goal: Increase the number of patient visits seen in the High Risk Infant Follow-up Program by 15% over baseline for an estimated 4 additional patient visits  
Data Source: Hospital administrative data and the patient medical record.

**Milestone 16**: Estimated Incentive Payment *(maximum amount)*: $247,716

Driscoll Children’s Hospital  

671
**Implement/Expand Care Transition Programs**

**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

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<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
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<tbody>
<tr>
<td><strong>High Risk Follow-up clinic</strong></td>
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<tr>
<td><strong>Metric 1 [P-X.1]:</strong> Documentation of operational hours. Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for hours is zero. Goal: Develop the operational hours for the program. Data Source: Outreach council implementation plan.</td>
<td><strong>Milestone 8:</strong> Estimated Incentive Payment <em>(maximum amount)</em>: $225,000</td>
<td><strong>Milestone 12:</strong> Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 16:</strong> Estimated Incentive Payment <em>(maximum amount)</em>: $247,716</td>
</tr>
<tr>
<td><strong>Metric 3:</strong> Estimated Incentive Payment <em>(maximum amount)</em>: $153,638</td>
<td><strong>Milestone 9 [I-X.1.1]:</strong> Provide Bayley Infant Neurodevelopment assessment exams to targeted patients. Metric 1: [I-X.1.1] Increase Bayley Infant Neurodevelopment assessment exams in the Driscoll Service area. Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 5% above the baseline estimate of 10 exams, for one additional exam. Data Source: Claims data</td>
<td><strong>Milestone 13 [I-X.1.1]:</strong> Provide Bayley Infant Neurodevelopment assessment exams to targeted patients. Metric 1[I-X.1.1]: Increase Bayley Infant Neurodevelopment assessment exams in the Driscoll Service area. Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 10% above the baseline for one additional exam. Data Source: Claims data</td>
<td><strong>Milestone 17 [I-X.1.1]:</strong> Provide Bayley Infant Neurodevelopment assessment exams to targeted patients. Metric 1: [I-X.1.1]: Increase the number of Bayley Infant Neurodevelopment assessment exams by 15% over baseline in the Driscoll Service area. Goal: Increase the number of Bayley Infant Neurodevelopment assessment exams by 15% over baseline for 2 additional exams. Data Source: Claims data</td>
</tr>
<tr>
<td><strong>Metric 4 [P-X1]:</strong> Plan and Establish baseline for the number of Bayley Infant Neurodevelopmental assessment exams. Metric 1[P-X1.1]: Documentation of the estimated assessment exams to be performed during DY2. Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for assessment exams is zero. Goal: Develop the High Risk Infant Follow-up Program with assessment exams to be performed data and the patient medical record.</td>
<td><strong>Milestone 10 [P-X2]:</strong> Task Force continues to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program.</td>
<td><strong>Milestone 14 [P-X2]:</strong> Task Force continues to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program. Metric 1[P-X2.1]: Documentation of Quality Improvement meetings</td>
<td><strong>Milestone 18 [P-X2]:</strong> Task Force continues to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program. Metric 1 [P-X2.1]: Documentation of Quality Improvement meetings</td>
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<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>TPI:</td>
<td>Implement/Expand Care Transition Programs</td>
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<td>132812205.2.3</td>
<td>2.12.3</td>
<td>N/A</td>
<td>Performing Provider Name: Driscoll Children’s Hospital</td>
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<td>132812205.3.8</td>
<td>IT-6.1</td>
<td></td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4</strong>: Estimated Incentive Payment <em>(maximum amount)</em>: $153,638</td>
<td><strong>Milestone 10</strong>: Estimated Incentive Payment <em>(maximum amount)</em>: $225,000</td>
<td><strong>Milestone 14</strong>: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong>: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
</tr>
<tr>
<td><strong>Milestone 5</strong> [P-X2]: Appoint an interdisciplinary Task Force to provide oversight for Implement/Expand Care Transition Programs specific to the High Risk Infant Follow-up Program. Metric 1 [P-X2.1]: Documentation of Task Force establishment. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 6</strong> [P-X3]: Plan and Establish baseline for the number of patient visits. Metric 1[P-X3.1]: Documentation of Quality Improvement meetings held twice per year.</td>
<td><strong>Milestone 12</strong> [P-X4]: Estimated Incentive Payment <em>(maximum amount)</em>: $225,000</td>
<td><strong>Milestone 16</strong> [P-X5]: Estimated Incentive Payment <em>(maximum amount)</em>: $225,000</td>
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<td><strong>Milestone 8</strong> [P-X6]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X6.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X7]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X8]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 12</strong> [P-X9]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X9.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X10]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X11]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 16</strong> [P-X12]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X12.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X13]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X14]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 20</strong> [P-X15]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X15.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X16]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X17]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 24</strong> [P-X18]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X18.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X19]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X20]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
<td></td>
</tr>
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<td><strong>Milestone 28</strong> [P-X21]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X21.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X22]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X23]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 32</strong> [P-X24]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X24.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X25]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X26]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 36</strong> [P-X27]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X27.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X28]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X29]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td><strong>Milestone 40</strong> [P-X30]: Appoint an interdisciplinary Task Force to implement program specifics. Metric 1 [P-X30.1]: Documentation of Quality Improvement meetings held twice per year. Goal: Participate in all semi-annual Quality Improvement meetings. Data Source: Hospital/health plan record.</td>
<td><strong>Milestone 14</strong> [P-X31]: Estimated Incentive Payment <em>(maximum amount)</em>: $253,125</td>
<td><strong>Milestone 18</strong> [P-X32]: Estimated Incentive Payment <em>(maximum amount)</em>: $247,717</td>
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<td>132812205.3.8</td>
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</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>the estimated assessment exams to be performed during DY2. Baseline: At the beginning of DY2, High Risk Infant Follow-up Program did not exist; therefore, baseline for patient visits is zero. Goal: Develop an estimated number of the patient visits in the High Risk Infant Follow-up Program. Data Source: Claims data</td>
<td>Year 2 Estimated Milestone Bundle Amount: $921,828</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,000,000</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,012,500</td>
<td>Year 5 Estimated Milestone Bundle Amount: $990,865</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 3,925,193**
Category 3 DSRIP Projects:
Quality Improvements
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
OD-9 Right Care, Right Setting, IT-9.4 ED Prevention: Increase the number of prevented pediatric emergency department visits, 132812205.1.1 Expand Primary Care Capacity - Driscoll Children’s Hospital [TPI: 132812205]
Unique Identifier: 132812205.3.1

Outcome Measure Description:
IT-9.4 ED Prevention: Increase the number of prevented pediatric emergency department visits

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-7- Develop a patient survey attending After Hours Clinic at Driscoll locations to measure outcome improvement target
- DY3:
  - P-2- Establish a baseline on the number of preventable and unnecessary pediatric emergency department visits

Outcome Improvement Targets for each year:
- DY4:
  - IT-9.4: Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline
- DY5:
  - IT-9.4: Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline

Pediatric primary care facilities like an Urgent Care, Quick Care or an After Hours, is a good alternative to a hospital emergency room by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. An ED visit is a higher cost than an Urgent Care, Quick Care, or After Hours clinic visit. If patients were seen in the Emergency Room setting rather than the After Hours clinic setting, the cost of providing care would increase. The outcome would be to increase the number of prevented pediatric ED visits by increasing access to pediatric primary care facilities. The outcome measure will be to increase the number of prevented pediatric emergency department visits XX% starting in DY4. The outcome targets will be established once the baseline is determined.

Rationale:
Low-income residents are disenfranchised from the medical system and have difficulty accessing pediatric primary care services. Pediatric primary care facilities like an Urgent Care, Quick Care or an After Hours, is a good alternative to a hospital emergency room by offering prompt treatment, local medical staff, convenient hours and legacy of exceptional care. An ED visit is a higher cost than an...
Urgent Care, Quick Care, or After Hours clinic visit. If patients were seen in the ED setting rather than the After Hours clinic setting, the cost of providing care would increase. The outcome would be to increase the number of prevented pediatric ED visits by increasing access to pediatric primary care facilities.

To measure the outcome, a patient survey will be developed in DY2 to collect information on the patient’s decision to utilize the after care facility. The patient’s parent/guardian will be surveyed to determine whether they would have sought services at the Emergency Department if they did not have access to the after-hours clinic. For measurement purposes, the numerator will include those patients who would have otherwise sought treatment in the ED; the denominator will be the total number of surveyed patients.

**Outcome Measure Valuation:**
An Emergency Room visit cost to Medicaid is consistently higher than an Urgent Care, Quick Care, or After Hours clinic visit. A payment difference exists between a visit at Driscoll’s Urgent Care vs. a Driscoll Children’s Hospital Emergency Room visit for a Level 1, a Level 2, and Level 3. Based on the most recent 12 months, we calculated the difference in potential savings by these levels for a Medicaid patient visit in an After Hours clinic versus an emergency department. If improved patient access is not provided in an After Hours clinic setting in Driscoll’s service area, patients will over utilize the emergency room. If patients were seen in the Emergency Room setting rather than the After Hours clinic setting, the cost of providing care would increase.
**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

<table>
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<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 1 Identifier – 132812205.1.1</th>
</tr>
</thead>
</table>

**Starting Point/Baseline:**  
To be determined in DY 3

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone [P-1]</strong></td>
<td><strong>Process Milestone 3: [P-2]</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-9.4]</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-9.4]</strong></td>
</tr>
<tr>
<td>Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish a baseline on the number of preventable and unnecessary pediatric emergency department visits</td>
<td>Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline</td>
<td>Increase the number of preventable and unnecessary pediatric emergency department visits by XX% over the baseline</td>
</tr>
</tbody>
</table>
| *Data Source:* Documentation of meeting minutes. | *Numerator:* Total number of patients surveyed at Driscoll’s clinics during expanded after hours, who would have chosen the ED as their alternative source of care  
*Denominator:* Total number of patients surveyed during expanded hours | *Numerator:* Total number of patients surveyed at clinic during expanded after hours who indicate they would have chosen the ED as their alternative source of care  
*Denominator:* Total number of patients surveyed during expanded hours | *Numerator:* Total number of patients surveyed at clinic during expanded after hours who indicate they would have chosen the ED as their alternative source of care  
*Denominator:* Total number of patients surveyed during expanded hours |
| **Process Milestone 1** Estimated Incentive Payment (*maximum amount*): $162,500 | **Process Milestone 3** Estimated Incentive Payment (*maximum amount*): $375,000 | **Outcome Improvement Target 1** Estimated Incentive Payment: $600,000 | **Outcome Improvement Target 2** Estimated Incentive Payment: $1,435,500 |
| **Process Milestone 2** [P-7]: Develop a patient survey attending After Hours Clinic at Driscoll locations to measure outcome improvement target | **Data Source:** Clinic Records  
**Process Milestone 3:** Estimated Incentive Payment (*maximum amount*): $375,000 | **Data Source:** Patient surveys  
**Outcome Improvement Target 2:** Estimated Incentive Payment: $1,435,500 |
| **Data Source:** Clinic Documentation  
**Milestone 2:** Estimated Incentive Payment (*maximum amount*): $162,500 |

**Year 2 Estimated Outcome Amount:** $325,000  
**Year 3 Estimated Outcome Amount:** $375,000  
**Year 4 Estimated Outcome Amount:** $600,000  
**Year 5 Estimated Outcome Amount:** $1,435,500

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add outcome amounts over DYS 2-5*): $2,735,500
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:
OD-7 Oral Health – IT-7.10, Other Outcome Improvement Target, 132812205.1.2–Increase, Expand, and Enhance Oral Health Services - Driscoll Children’s Hospital [TPI: 132812205]
Unique RHP outcome identification number: 132812205.3.2

Outcome Measure Description:
The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in reducing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011. Application of dental education and fluoride varnish treatments will reduce dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

IT-7.10 Other Outcome Improvement Target will be to decrease severe dental caries that result in operative interventions for targeted population in the Driscoll Service area by 5%.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area.

Outcome Improvement Targets for each year:
- DY4:
  - IT-7.10: Decrease by 5% severe dental caries from the baseline that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments
- DY5:
  - IT-7.10: Decrease by 10% severe dental caries from the baseline that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments

Rationale:
Studies have shown that application of fluoride varnish to erupting primary teeth can prevent the incidence of severe early childhood caries as shown in many studies and in our own pilot. By increasing the number of young children who have received the fluoride varnish, we expect a decrease in costly dental procedures under general anesthesia with the attendant risks.\(^{178}\)

suggest a high utilization of dental procedures in the operating room and acute care services by low-income pediatric patients who would be the target population for this initiative. Expansion of pediatric primary care oral health services is one key to improving overall health care delivery and health outcomes in the region. The outcome improvement target is by increasing access to dental education and fluoride varnish treatments we would then decrease carries that would result in operative intervention in our service delivery area.

**Outcome Measure Valuation:**
Application of dental fluoride varnish treatments coupled with education will reduce dental operating room procedures. Dental cases comprised of approximately 30 percent of all cases performed in the operating room for Calendar Year 2011. The preventive treatment of dental education and fluoride varnish treatment versus dental operating room procedures creates significant value to our community.
### Unique Cat 3 ID:
132812205.3.2

### Ref. Number from RHP PP:
3.IT-7.10

### Other Outcome Improvement Target:
Operative Dental Care Needs in Children

### Performing Provider Name:
Driscoll Children’s Hospital

### TPI:
132812205

### Related Category 1 or 2 Projects:

**Unique Cat 1 ID:** 132812205.1.2

### Starting Point/Baseline:
To be determined in DY3

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<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
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<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong></td>
<td><strong>Process Milestone 2: [P-2]</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-7.10]:</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-7.10]:</strong></td>
</tr>
<tr>
<td>Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline of pediatric patients who receive treatment for severe dental caries in the operating room(s) for Driscoll service area. Numerator: Total number of Driscoll’s Health plan children with severe dental caries requiring operative intervention during CY 2011. Denominator: Total number of Driscoll’s Health plan participants who received dental education and fluoride varnish treatment for prevention of severe dental caries during CY 2011. Data Source: Documentation of claims data.</td>
<td>Improvement Target: Decrease by 5% below baseline severe dental caries that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments Data Source: Documentation of claims data.</td>
<td>Improvement Target: Decrease by 10% below baseline severe dental caries from the baseline that result in operative interventions in the Driscoll Service area by application of dental education and fluoride varnish treatments Data Source: Documentation of claims data.</td>
</tr>
<tr>
<td><strong>Process Milestone(s):</strong> Estimated Incentive Payment (maximum amount): $341,026</td>
<td>Process Milestone(s):</td>
<td>Outcome Improvement Target 1 [IT-7.10]: Estimated Incentive Payment: $592,500</td>
<td>Outcome Improvement Target 2: Estimated Incentive Payment: $1,437,193</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $341,026 | Year 3 Estimated Outcome Amount: $366,100 | Year 4 Estimated Outcome Amount: $592,500 | Year 5 Estimated Outcome Amount: $1,437,193 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $2,736,819
Category 3: Quality Improvements
Identifying Outcome Measure and Provider Information:

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit, 132812205.1.9 – Expand Specialty Care Capacity- Driscoll Children’s Hospital [TPI: 132812205] Unique RHP outcome identification number(s): 132812205.3.3

Outcome Measure Description:
OD-1, IT-1.1 Third next available appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-7- Project Planning – select a targeted specialty clinic to measure Third Next Available appointment in proceeding demonstration year
- DY3:
  - P-2 -Establish baseline for reducing the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam at targeted specialty clinic(s) selected in DY2

Outcome Improvement Targets for each year:
- DY4:
  - IT-1.1: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam for specialty clinic(s)
- DY5:
  - IT-1.1: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam for specialty clinic(s)

Rationale:
The Third Next Available measurement demonstrates quality health care through:
- Improved access of children to pediatric specialty care,
- Decreased risk of health complications if timely care is accessible,
- Potential reduction in no-shows – patients who experience delays in accessing appointments are more likely to seek emergency care or other alternatives

Outcome Measure Valuation:
The Third Next Available measurement demonstrates an economic impact by:
- Increased number of patients able to be seen with improved access,
• Reduced organization threat to financial viability if patients cannot access appointments in a time manner,
• Delays in care can result in patients needing more expensive level of care that results in higher costs for the healthcare organization.
### Outcome Improvement Target: Third next available appointment

Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

#### Performing Provider Name: Driscoll Children’s Hospital

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<th>Related Category 1 or 2 Projects:</th>
<th>TPI: 132812205.1.3</th>
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#### Starting Point/Baseline:

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<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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</table>

**Process Milestone 1 [P-1]**

Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Data Source:** Hospital records

**Process Milestone 1** Estimated Incentive Payment (*maximum amount*): $75,000

**Process Milestone 2 [P-7]**

Project Planning – select a targeted specialty clinic to measure Third Next Available appointment in proceeding demonstration year

**Data Source:** Hospital records

**Process Milestone 2** Estimated Incentive Payment (*maximum amount*): $75,000

**Performing Provider Name:** Driscoll Children’s Hospital

**Starting Point/Baseline:**

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<td>Year 3 (10/1/2013 – 9/30/2014)</td>
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**Process Milestone 3 [P-2]**

Establish baseline for reducing the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam at targeted specialty clinic(s) selected in DY2.

**Numerator:** Average number of days to third next available appointment for an office visit for each clinic and/or department

**Denominator:** The measure applies to providers within a reported clinic and/or department

**Data Source:** Hospital records

**Outcome Improvement Target 1 [IT-1.1]:**

**Improvement Target:** Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam for specialty clinic(s)

**Data Source:** Hospital records

**Estimated Incentive Payment:** $278,154

| Year 2 Estimated Outcome Amount: $150,000 | Year 3 Estimated Outcome Amount: $170,000 | Year 4 Estimated Outcome Amount: $278,154 | Year 5 Estimated Outcome Amount: $701,250 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add outcome amounts over FYs 2-5*): $1,299,404

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**RHP Plan for Region 4**
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:
OD-6 Patient Satisfaction, IT-6.1 – Percent improvement over baseline of patient satisfaction scores pertaining to the patient’s rate of doctor access to endocrinology specialist, 132812205.1.9 – Expand Specialty Care Capacity- Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.4

Outcome Measure Description:
The outcome measure will be to increase the Patient satisfaction score percentage for targeted specialty care clinics by XX% starting in DY4.

OD-6 Patient Satisfaction
IT-6.1 – Percent improvement over baseline of patient satisfaction scores-(2)-how well their doctors communicate

Process Milestone:
- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline for improvement of patient satisfaction scores through patient’s rating of how well their doctor communicate

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1: Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%
- DY5:
  - IT-6.1: Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%

Rationale:
Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction would help to increase patient compliance which in time would result in better continuum of care for the patient.

Outcome Measure Valuation:
Providing specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.
<table>
<thead>
<tr>
<th><strong>Unique Category 3 ID:</strong></th>
<th><strong>Ref Number from RHP PP:</strong></th>
<th><strong>Outcome Improvement Target:</strong> Percent improvement over baseline of patient satisfaction scores-(2) How well their doctors communicate</th>
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<tbody>
<tr>
<td>132812205.3.4</td>
<td>3.IT-6.1</td>
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**Performing Provider Name:** Driscoll Children’s Hospital  
**TPI:** 132812205

**Related Category 1 or 2 Projects:**  
**Unique Category 1 Identifier –** 132812205.1.3

**Starting Point/Baseline:**  
*To be determined in DY3*

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong></td>
<td><strong>Process Milestone 2: [P-2]</strong></td>
<td><strong>Improvement Target 1 [IT-6.1]</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-6.1]:</strong></td>
</tr>
<tr>
<td>Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline for improvement of patient satisfaction scores through patient’s rating of how well their doctor communicate</td>
<td>Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%</td>
<td>Increase the Patient satisfaction score percentage for targeted specialty care clinics through patient’s rating of how well their doctor communicate by XX%</td>
</tr>
</tbody>
</table>
| **Data Source:** Hospital records | **Numerator:** Percent improvement in targeted patient satisfaction domain  
**Denominator:** Number of patients who were administered the survey  
**Data Source:** NRC Picker | **Data Source:** NRC Picker  
**Outcome Improvement Target 1:**  
Estimated Incentive Payment: $278,164 | **Data Source:** NRC Picker  
**Outcome Improvement Target 2:**  
Estimated Incentive Payment: $701,250 |
| **Process Milestone(s):** | | | |
| Estimated Incentive Payment (maximum amount): $150,000 | | | |

**Year 2 Estimated Outcome Amount:** $150,000  
**Year 3 Estimated Outcome Amount:** $170,000  
**Year 4 Estimated Outcome Amount:** $278,154  
**Year 5 Estimated Outcome Amount:** $701,250

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,299,404.
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 Early Detection of Fetal Anomalies: 132812205.2.7– Implement Evidence-based Disease Promotion Programs

Unique RHP outcome identification number(s): 132812205.3.5

Outcome Measure Description:

IT-8.9 Other Outcome Improvement Target will be to increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.

Process Milestone:

- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients

Outcome Improvement Targets for each year:

- DY4:
  - IT-8.9: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%

- DY5:
  - IT-8.9: Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%

Rationale:
The early detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. This potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

Outcome Measure Valuation:
The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and
medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities.
**Unique Category 3 ID:** 13281225.3.5

**Other Outcome Improvement Target:** Early Detection of Maternal Fetal Anomalies

**Performing Provider Name:** Driscoll Children’s Hospital

**TPI:** 132812205

**Related Category 1 or 2 Projects:** Unique Category 2 Identifier: 132812205.2.1

<table>
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<tr>
<th>Starting Point/Baseline:</th>
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<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2: [P-2]</strong> Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients. <strong>Numerator:</strong> Total number of early detected maternal fetal anomalies over a 12-month period less total number of early detected maternal fetal anomalies over the prior 12-month period. <strong>Denominator:</strong> Total number of early detected maternal fetal anomalies over the prior 12-month period. <strong>Data Source:</strong> Hospital Record</td>
<td><strong>Outcome Improvement Target 2 [IT-8.9]:</strong> Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from prior demonstration year. <strong>Data Source:</strong> Hospital records</td>
<td><strong>Outcome Improvement Target 3 [IT-8.9]:</strong> Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from baseline year. <strong>Data Source:</strong> Hospital records</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $400,000</td>
<td><strong>Process Milestone 2:</strong> Estimated Incentive Payment $450,000</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $712,500</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $1,650,000</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> (add incentive payments amounts from each milestone/outcome improvement target): $400,000</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $450,000</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $712,500</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $1,650,000</td>
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</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $3,212,500
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

OD-8 Perinatal Outcome: IT-8.9 NICU Average Days Per Delivery, 132812205.2.2—Implement Evidence-based Health Promotion Programs, Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.6

Outcome Measure Description:
The Project focuses on the current lack of informative and structured maternity social and healthcare supports available to indigent women during pregnancy as potential risk factors for these outcomes. Low-income pregnant women are prone to pre-term births for a variety of known as well as unknown reasons. Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in NICU inpatient days and pre-term/low-weight births are keys to improving overall health care delivery and health outcomes in the region.

IT-8.9: Reduce the Neonatal ICU days per delivery for the targeted population by 5 percent for DY4-5. The targeted population is defined within Category 3 Outcome table.

Process Milestone:

- DY2:
  - P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Undertake steps and actions to establish baselines to Reduce Average NICU days per delivery for the targeted population

Outcome Improvement Targets for each year:

- DY4:
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 5% less than a Non-Cadena member (using CY2011 baseline information)

- DY5:
  - IT-8.9: Improvement Target: Average NICU days per Cadena member delivery will be at least 10% less than a Non-Cadena member (using CY2011 baseline information)

Rationale:
Since the beginning of the Cadena de Madres Program, the number of Premature Infant Admissions less than 37 weeks has decreased significantly and as a result has reduced NICU costs for Managed Medicaid patients. Reduction in pre-term births with a corresponding reduction in NICU utilization are keys to improving overall health care delivery and health
outcomes in the region. This outcome will be implemented in DY3 with improvement targets starting in DY4. Driscoll provides educational sessions and consulting visits to the public for multiple reasons, one of which is to help reduce ALOS for NICU patients.

**Outcome Measure Valuation:**
Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Neonatal ICU use is a high cost service line. Decreasing the number of premature infant admissions less than 37 weeks with a resulting decrease in the average NICU days per delivery is a more efficient use of resources as well as significantly decreasing complications for the infant. Expanding health education to high risk pregnant patients as well as increasing the number of women provided counseling sessions on tobacco and alcohol will create significant savings and value.
| Process Milestone 1 | Process Milestone 2 [P-2]: Undertake steps and actions to establish baselines for Reduce the Average NICU days per delivery for the targeted population Numerator: Total Discharge Days for Non-Cadena members in the NICU during 2011 Denominator: Total number of Non-Cadena member discharges in the NICU during CY2011 Data Source: Claims data/Hospital documentation (utilizing Region 4 data) Process Milestone 2 Estimated Incentive Payment: $400,041 |
| Year 2 (10/1/2012 – 9/30/2013) |

Year 2 Estimated Outcome Amount: $300,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $2,822,541
Title of Outcome Measure (Improvement Target): IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236

Driscoll Children’s Hospital [TPI: 132812205]
Unique RHP outcome identification number(s): 132812205.3.7 – Pass 2

Outcome Measure Description:
IT-1.18 - Follow-Up After Hospitalization for Mental Illness- NQF 0576236
- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2- Establish baseline of patients who receive a follow-up visit after hospitalization for a mental illness within 7 days and within 30 days of discharge.

Outcome Improvement Targets for each year:
- DY4:
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.
- DY5:
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
    - Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.
  - IT-1.18 Follow-Up After Hospitalization for Mental Illness
Rate 2: Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.

Rationale:
Process milestones – P-1 through P-2 were chosen due to the recent development of telehealth and telemedicine services provided to Driscoll Children Health Plan patients within the Driscoll Children Health System. In order to report accurate data and establish baselines, P-1 and P-2 must be completed in DY2-DY3. In DY3 we will establish the baseline of our project outcome. Improvement targets will be chosen based on the timeframe in which the intervention will occur and expectations are established in DY3. The outcome being addressed for this project is based on the impact that telehealth/telemedicine services will have on providing earlier service interventions. By decreasing barriers of access to these specialty services, children are able to seek services early rather than later. If services are not provided to these patients, hospitalization or emergency care is likely to occur. Services provided in an emergency room or hospital cost more than those services provided in a telehealth/telemedicine setting.

Outcome Measure Valuation:
While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009. An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year. Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge. This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services.¹⁷⁹ The quantitative value is based on a determination that inpatient and Emergency Room use is a high cost setting for providing behavioral care services. Decreasing the number of behavioral inpatient and emergency encounters is a more cost efficient use of resources. Expanding accessibility to behavioral telemedicine services will create significant savings and value.

¹⁷⁹ http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf
**Performing Provider Name:** Driscoll Children’s Hospital  
**Ref. Number from RHP PP:** 3.IT-1.18  
**Follow-Up After Hospitalization for Mental Illness- NQF 0576236**  
**TPI:** 132812205

### Related Category 1 or 2 Projects:
**Unique Cat 1 ID:** 132812205.1.4

### Starting Point/Baseline:
To be determined in DY3

### Year 2 (10/1/2012 – 9/30/2013)
**Process Milestone 1 [P-1]** Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Data Source:** Documentation of plan

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $120,000

### Year 3 (10/1/2013 – 9/30/2014)
**Process Milestone 2: [P-2]** Establish baseline of patients who receive a follow-up visit after hospitalization for a mental illness within 7 days and within 30 days of discharge.

**Data Source:** Documentation of claim data

**Process Milestone(s):** Estimated Incentive Payment: $148,905

### Year 4 (10/1/2014 – 9/30/2015)
**Outcome Improvement Target 1: [IT-1.18]: Improvement Target:** Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.

**IT-1.18 – Rate 2:** Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.

**Data Source:** Documentation of claims data

**Outcome Improvement Target 2: Estimated Incentive Payment:** $236,060

### Year 5 (10/1/2015 – 9/30/2016)
**Outcome Improvement Target 2:**

**IT-1.18:** [IT-1.18]: Improvement Target: Rate 1: Increase above baseline is to be determined for the percentage of members who received follow-up within 30 days of discharge once baseline is established.

**IT-1.18 – Rate 2:** Increase above baseline is to be determined for the percentage of members who received follow-up within 7 days of discharge baseline is established.

**Data Source:** Documentation of claims data

**Outcome Improvement Target 2:** Estimated Incentive Payment: $540,331

### Year 2 Estimated Outcome Amount:
$120,000

### Year 3 Estimated Outcome Amount:
$148,905

### Year 4 Estimated Outcome Amount:
$236,060

### Year 5 Estimated Outcome Amount:
$540,331

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,045,296
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

Driscoll Children’s Hospital [TPI: 132812205]

Unique RHP outcome identification number(s): 132812205.3.8 – Pass 2

Outcome Measure Description:
OD-6 – Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 – Establish baseline for patient satisfaction rating (%) for targeted population

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1 - Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.
- DY5:
  - IT-6.1 - Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.

Rationale:
Process milestones – P-1 through P-2 were chosen for reporting accurate data and establish baselines, P-1 and P-2 must be approached in DY2-DY3. In DY3 we will establish baselines for the improvement target. Improvement targets were chosen during DY4 and DY5 based on the timeframe of patient interaction and early intervention services are provided.

Data suggests that parents who reported that their children had received a developmental assessment were more likely to be satisfied with their child’s medical care; these visits were also associated with higher quality ratings. These results suggest that providers and practices who take a structured approach to developmental assessment are providing a higher level of care overall, thereby potentially contributing to improved child health outcomes.

Outcome Measure Valuation:
Data suggest that early intervention to patients that qualify as a High Risk Infant Follow-up, have a direct impact on the quality and long-term benefits in a patient’s life. Early treatment of developmental delays leads to improved outcomes for children, and therefore reduced costs to society. Early intervention has been shown to be particularly effective at
improving outcomes for children who are at increased risk for developmental delays, or later academic underachievement, based on socioeconomic, medical, or other risk factors. A systematic review of early childhood development programs aimed at narrowing the achievement gap for children at risk because of poverty found that participation in such programs resulted in a mean 14 percent reduction in special education placement later in childhood, 13 percent reduction in not passing a grade in school, and an increase in IQ test scores of about 6.5 points. In addition, participation had significant long-terms benefits in terms of reducing rates of teen pregnancy, increasing rates of high school graduation, and increasing rates of employment in early adulthood. The Infant Health and Development Program, a randomized, multi-site trial of a comprehensive early intervention effort aimed at premature children, from birth to 36 months, demonstrated sustained benefits, particularly for heavier infants in the cohort.\textsuperscript{180} We are using an estimated program patient volume and conservative Quality Adjusted Life Year ("QALY") per year valuation to demonstrate a one-time improvement in the quality of life.\textsuperscript{181} Although our estimates are based on a one-time improvement, the project’s value and community benefit is realized throughout many years.

\textsuperscript{180} http://www.commonwealthfund.org/usr_doc/1082_Sices_developmental_screening_primary_care.pdf?section=4039
<table>
<thead>
<tr>
<th>132812205.3.8</th>
<th>3.IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores: (4) – patient’s involvement in shared decision making.</th>
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<tr>
<td>Performing Provider Name: Driscoll Children’s Hospital</td>
<td>TPI: 132812205</td>
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**Related Category 1 or 2 Projects:**

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**Starting Point/Baseline:**

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<td>Year 4 (10/1/2014 – 9/30/2015)</td>
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<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
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</table>

**Process Milestone 1 [P-1]:**

**Project Planning:**
- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Data Source:** Planning documentation and internal reports

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $108,450

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<td>$108,450</td>
<td>$125,000</td>
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**Process Milestone 2: [P-2]:** Establish baseline for patient satisfaction rating (%) for targeted population

**Data Source:** Patient survey

**Process Milestone 2 Estimated Incentive Payment:** $125,000

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<th>Year 4 Estimated Outcome Amount:</th>
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<tbody>
<tr>
<td>$202,500</td>
<td>$573,658</td>
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</table>

**Outcome Improvement Target 1 [IT-6.1]:**

**Improvement Target:** Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.

**Data Source:** Patient survey

**Outcome Improvement Target 1 Estimated Incentive Payment:** $202,500

**Total Estimated Incentive Payments for 4-Year Period (add outcome amounts over DYs 2-5):** $1,009,608

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**Outcome Improvement Target 2 [IT-6.1]:**

**Improvement Target:** Increase in patient satisfaction rating to be determined in Driscoll Service area when baseline is established in DY3.

**Data Source:** Patient survey

**Outcome Improvement Target 2 Estimated Incentive Payment:** $573,658
Category 4 DSRIP Projects:
Population-Focused Improvements
Category 4: Population-Focused Improvements: Driscoll Children’s Hospital [TPI: 132812205]

Domain 1: Potentially Preventable Admissions (8 measures)

Domain Description
Because Driscoll Children’s Hospital is a pediatric facility, reporting measure # 3 Behavioral Health and Substance Abuse Admission Rate and #6 Pediatric Asthma are the only Domain 1 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 1 because all other measures (1.1, 1.2, 1.4, 1.5 and 1.7) apply to populations age 18 and above. However, we will provide the reporting data as required. For reporting measure 6, we anticipate Project 1.1 – Expand primary care capacity will have an impact on PPAs for children with asthma and behavioral health and substance abuse admissions. By expanding services through increased hours and the number of patient visits, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospitalization is required. The increase in appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to hospitalization if left undetected. Additionally, the availability of after-hour appointments should reduce the number of children who seek care in an emergency room and who might require admittance due to delays in obtaining timely care.

Domain Valuation and Rationale:
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. As we increase our access to outpatient services for children throughout this region, we will provide services in a more timely and effective manner and will be able to treat patients before their condition becomes critical. By preventing hospital admissions through improved outpatient care, we will not only save money but will also improve the patient’s outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain Description:
Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 2.6 Pediatric Asthma is the only Domain 2 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 2 because all other
measures (RD 2.1, 2.2, 2.3, 2.4, 2.5, and 2.7) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospital readmission is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to a readmission if left undetected.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital readmissions through improved outpatient care, we will not only save money but will also improve the patient’s outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

**Domain 3: Potentially Preventable Complications (64 measures)**
**Domain Description:**
Although many of the measures included in domain 3 are specific to adult care, Driscoll Children’s Hospital is prepared to report on all measures found applicable by the state PPC data. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on many of the measures included in domain 3. However, we will provide the reporting data as required.

We do not anticipate any project impact at this time. However, Driscoll is prepared to report on all non-exempted measurements in an effort to understand the causes of PPCs and make changes to reduce complications within our organization.

**Domain Valuation and Rationale:**
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. By tracking and reporting PPCs, Driscoll will be required to evaluate its own performance, and will drive organizational change to reduce the potential for complications associated with hospitalization. This will not only reduce cost but will also improve the patient’s outcome and quality of life. Avoiding PPCs also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.
Domain 4: Patient-Centered Healthcare (2 measures)
Domain Description
Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 4.2 Medication Management is the only Domain 4 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, RD 4.1 patient satisfaction is not applicable to the pediatric population due to HCAHPS requirements. However, we will provide the reporting data as required.

Although Driscoll is exempted from the patient satisfaction measure we are dedicated to improving patient satisfaction whenever possible and recognize the value of tracking and reporting such measures. Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction and medication management would help to increase patient compliance which in time would result in better continuum of care for the patient.

Domain Valuation and Rationale:
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. The valuation is based on a determination that Providing pediatric specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.

Domain 5: Emergency Department (1 measure)
Domain Description:
Driscoll Children’s Hospital will measure the admit decision time to ED departure time for admitted patients. Driscoll supports a commitment to streamlining the patient transfer process and positively impacting the overall health and well-being of the children we serve. Although none of our projects directly impact the domain 5 measure, Driscoll is committed to improving the patient transfer process.

Domain Valuation and Rationale:
The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by streamlining the patient transfer process, and estimated availability of funding. Emergency room use is a high cost service line. The ED is the first contact that many patients have with our hospital. Driscoll Children Hospital ED cares for varying levels of acuity. It is imperative that the throughput is as efficient and effective as possible in order to treat these patients and improve patient flow throughout the system. Reducing the decision time to make the first call from arrival in transferring ED until call initiated the ED creates significant savings and value.
Optional Domain 6: Children and Adult Core Measures (8 measures)
Driscoll Children’s Hospital opts out of this domain
### Category 4: Population-Focused Measures

**Driscoll Children’s Hospital – TPI 132812205**

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
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<tbody>
<tr>
<td><strong>Capability to Report Category 4</strong></td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 3.</td>
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<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$947,238</td>
<td>$441,009</td>
<td></td>
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<tr>
<td><strong>Domain 1: Potentially Preventable Admissions (PPAs)</strong></td>
<td>Planned Reporting Period: 2</td>
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<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$441,009</td>
<td>$471,649</td>
<td>$516,617</td>
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<tr>
<td><strong>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</strong></td>
<td>Planned Reporting Period: 2</td>
<td>2</td>
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<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$441,009</td>
<td>$471,649</td>
<td>$516,617</td>
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<tr>
<td><strong>Domain 3: Potentially Preventable Complications (PPCs)</strong></td>
<td>Includes a list of 64 measures identified in the RHP Planning Protocol.</td>
<td>Planned Reporting Period: 2</td>
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<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td></td>
<td>$471,649</td>
<td>$516,617</td>
<td></td>
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<tr>
<td><strong>Domain 4: Patient Centered Healthcare</strong></td>
<td><strong>Patient Satisfaction - HCAHPS</strong></td>
<td>Planned Reporting Period: 2</td>
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<tr>
<td>Measurement period for report</td>
<td>6 months prior to due date</td>
<td>6 months prior to due date</td>
<td>6 months prior to due date</td>
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<tr>
<td><strong>Medication Management</strong></td>
<td>Planned Reporting Period: 2</td>
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<td>Measurement period for report</td>
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<td>6 months prior to due date</td>
<td>6 months prior to due date</td>
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<td>Domain 4 - Estimated Maximum Incentive Amount</td>
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<td>$471,649</td>
<td>$516,617</td>
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<tr>
<td><strong>Domain 5: Emergency Department</strong></td>
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<td>6 months prior to due date</td>
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<td>Planned Reporting Period: 2</td>
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<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$441,009</td>
<td>$471,650</td>
<td>$516,617</td>
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</tbody>
</table>

**OPTIONAL Domain 6: Children and Adult Core Measures**

**Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**

- Measurement period for report
- Planned Reporting Period: 1 or 2

**Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)**

- Measurement period for report
- Planned Reporting Period: 1 or 2

<table>
<thead>
<tr>
<th>Domain 6 - Estimated Maximum Incentive Amount</th>
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**Grand Total Payments Across Category 4**

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<th>$2,358,246</th>
<th>$2,583,085</th>
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