House Bill 2725 Report

Feasibility of Providing Home and Community-Based Services For Individuals with Repeat 46B Commitments

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Texas Department of State Health Services
Texas Health and Human Services Commission

Table of Contents

I. Executive Summary

Individuals with multiple forensic commitments to state psychiatric facilities have complex needs which are not adequately addressed by existing community mental resources. Issues include psychiatric, cognitive and physical complications, compounded by chronic homelessness and lack of natural support systems. Individuals are generally committed to have their mental competence restored so they can stand trial for felony or misdemeanor offenses. Those with relatively minor offenses may have charges dismissed and return to the community. Without sufficient support, individuals decompensate and cycle repeatedly through state psychiatric facilities, reducing resources needed to treat other individuals.

Providing home and community-based services (HCBS) to this population is feasible. An HCBS program could help reduce recidivism to state facilities and free needed bed space to serve more individuals. It would not, in itself, reduce state psychiatric facility costs, since existing state facility beds are needed to meet demand for services and thus would not be converted to HCBS slots. An even greater impact on state facility bed space could be realized by including long term commitment patients (one year or more) in an HCBS program, irrespective of their forensic status.

Potential strategies for financing HCBS under Medicaid include a State Plan Amendment under Section 1915(i) of the Social Security Act, and Regional Healthcare Partnership Delivery System Reform Projects under the Texas 1115 transformation waiver. Such strategies, if approved by the federal Medicaid agency, could provide a federal match to state or local costs. Each strategy has different advantages, limitations and risks. For example, a 1915(i) amendment would only provide match to serve Medicaid eligible individuals. An 1115 project could potentially provide match for both Medicaid and non-Medicaid clients, but the project would need to achieve defined improvements and outcomes in order to obtain the federal matching funds.

The total state or local cost of an HCBS program would be greatly affected by the percentage of Medicaid eligible individuals in the served population. Administrative resources should be invested in obtaining Medicaid eligibility for as many clients as possible. Additionally, state or local costs would be significantly impacted by the type and amount of services and supports used.

HCBS should be provided in a variety of residential settings appropriate to each individual's evolving needs and preferences. The goal is to achieve the maximum level of independence and functioning possible for each individual. Residential options include congregate care models (small group homes, assisted living, and adult foster care homes) and assistance to lease or purchase individual apartments or homes. Partnerships with state and local housing authorities and housing interest groups are important as housing resources can be complex to navigate. Finally, any HCBS program should be developed in close collaboration with local and state stakeholders including consumers, peers, family members, housing resources, local mental health authorities and state facilities.

II. Legislative Charge

H.B. 2725, Section 20, 82nd Legislature, Regular Session, 2011, directed the Department of State Health Services (DSHS) and Health and Human Services Commission (HHSC) with examining the feasibility of providing HCBS in lieu of institutional services to individuals with repeated

commitments to state psychiatric facilities to restore their competence to stand trial under Chapter 46B.004 (c-1), Code of Criminal Procedure. Providing HCBS services would reduce recidivism into state psychiatric facilities, freeing beds to serve more individuals with severe mental illness who need inpatient care.

III. Background

The Texas state psychiatric hospital system is nearing or already over capacity. Lack of sufficient capacity of both inpatient and community-based treatment resources is a public health concern in Texas. Repeated forensic commitment of individuals with mental illness is a significant contributing factor to this problem. Individuals are committed under Chapter 46B to restore their mental competence to stand trial for felony or misdemeanor offenses. Persons are considered incompetent to stand trial if they do not have sufficient ability to consult with their lawyer with a reasonable degree of rational understanding or do not have a rational and factual understanding of the proceedings against them. Once restored to competence, these individuals are adjudicated and often return to the community. Most individuals committed under 46B do not return to state facilities. Over 75 percent are committed only once (See Table 1). In addition, outpatient Competency Restoration (OCR) programs, which provide basic legal education, medication, community mental health services (such as Assertive Community Treatment) and temporary housing /residential services can effectively divert individuals with more moderate needs from facility commitment altogether.

The most common 46B offense is assault, which does not necessarily indicate that the individual poses a threat. For example, under the Penal Code, an individual who touches a law enforcement officer in a manner interpreted as a threat can be charged with a felony. Homeless individuals may be confused or frightened when awakened by law officers enforcing park curfews. Grabbing an officer's hand or pushing the officer could result in a felony charge and 46B commitment.

Table 1: Number and Length of Stay of 46B Commitments[1]

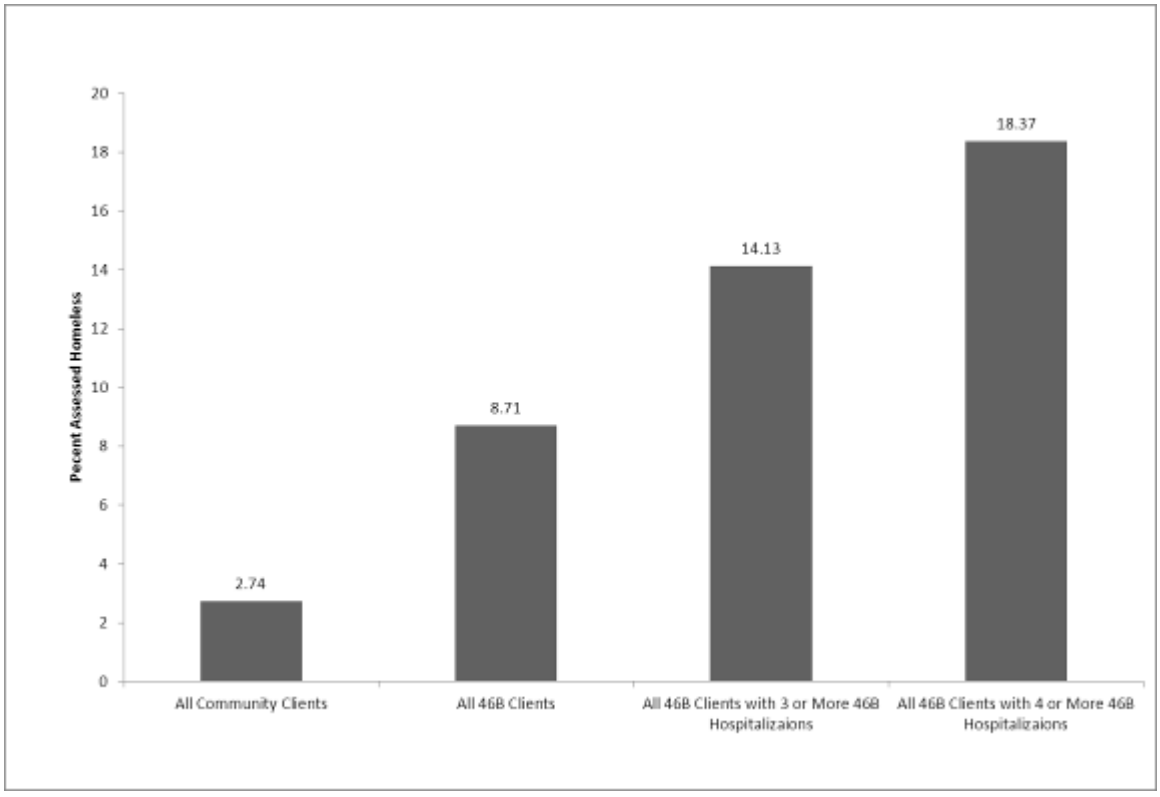
Number of 46B Commitments	Number of Individuals	Percent
1	5,416	75.75
2	1,110	15.52
3	416	5.82
4	132	1.85
5	37	0.52
6	24	0.34
7	11	0.15
8	4	0.06
TOTAL	**7,150**	**100%**

[1] DSHS state facilities data March 2003 through August 2011

People who experience **multiple** 46B commitments, however, have greater need for supports and services than are available through existing community mental health programs. Issues include:

- Unstable housing / homelessness – repeated commitments are associated with significantly increased homelessness. Individuals with four or more 46B commitments are almost **seven times more likely to be homeless** when in the community than DSHS mental health clients in general.[2]
- Co-occurring physical health issues including hypertension, obesity, diabetes, high cholesterol, mobility impairment and co-occurring developmental disabilities.[3]
- Cognitive issues including dementias, traumatic brain injuries, cognitive processing issues due to mental illness and a higher incidence of complex mental health diagnoses, such as schizoaffective disorder, which involves both psychosis and depression (see Table 2).
- Less family support – for example, only 8 percent are married and the percent decreases with an increase in the number of 46B commitments.[4]

Figure 1: Percentage of DSHS Clients who are Homeless[5]



[2] DSHS Community mental health assessment data
[3] DSHS State Facilities data system
[4] DSHS Community mental health assessment data
[5] Ibid

Table 2: Psychiatric Diagnoses by Number of 46B Commitments

Primary Diagnosis - all 46B	**Percent**
Schizoaffective Disorder	26
Paranoid Schizophrenia	16
Psychosis Not Otherwise Specified	13
Schizophrenia Not Otherwise Specified	11
Bipolar Disorder With Psychosis	5
Manic-Depressive Disorder Not Otherwise Specified	2
Combination Drug Dependency	2
Other Diagnosis	24
Primary Diagnosis 3+ Admissions	**Percent**
Schizoaffective Disorder	35
Paranoid Schizophrenia	19
Schizophrenia Not Otherwise Specified	15
Psychosis Not Otherwise Specified	10
Bipolar Disorder With Psychosis	3
Hebephrenia	3
Manic-Depressive Disorder Not Otherwise Specified	2
Other Diagnosis	14
Primary Diagnosis 4+ Admissions	**Percent**
Schizoaffective Disorder	40
Paranoid Schizophrenia	18
Schizophrenia Not Otherwise Specified	18
Psychosis Not Otherwise Specified	7
Bipolar Disorder With Psychosis	3
Hebephrenia-Unspecified	2
Combination Drug Dependency	1
Other Diagnosis	11

Individuals with multiple 46B commitments are most often male, African-American or Caucasian. They range in age from 17 to over 65, with 92 percent between the ages of 21 and 64. Forty per cent come from large urban counties, including Harris, Travis and Dallas.

Table 3: 46B Commitment Population Demographics: Gender

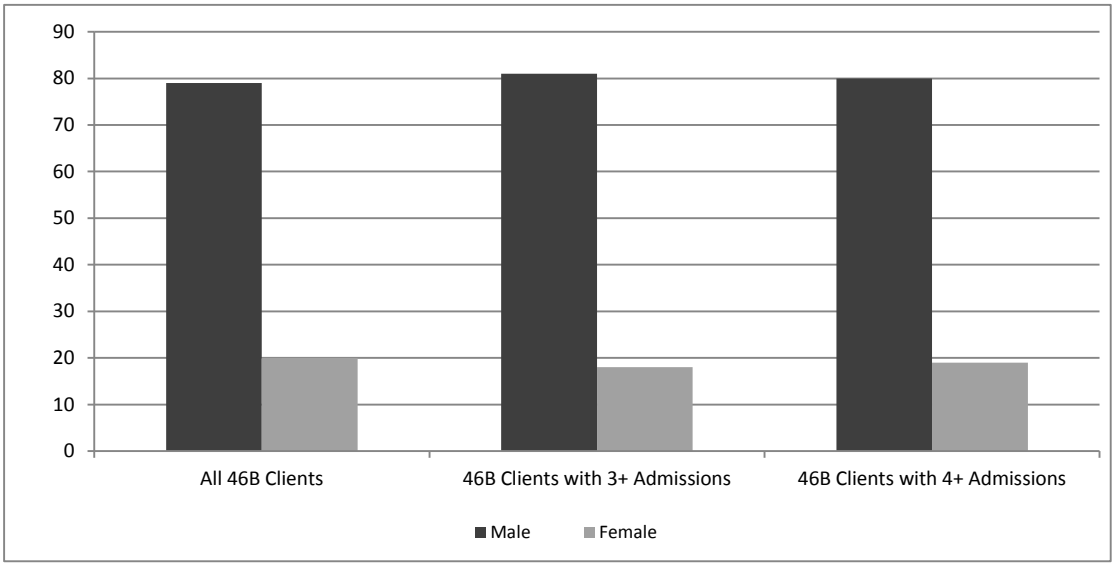
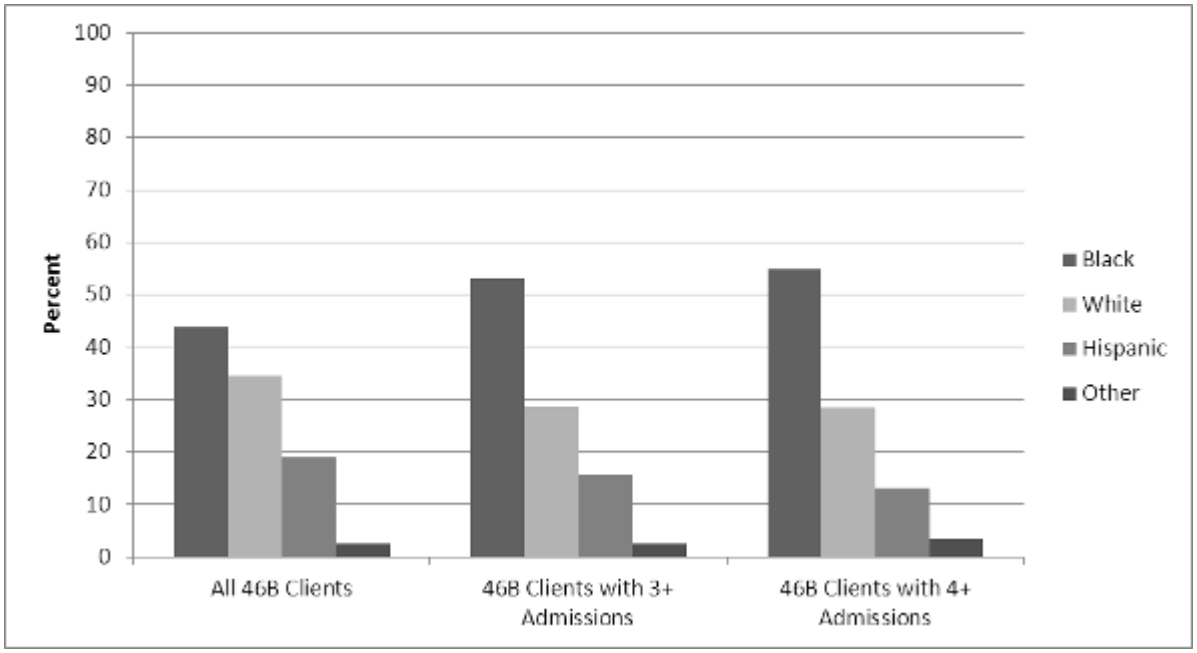


Table 4: 46B Commitment Population Demographics: Race



Repeated 46B commitments reduce state facility bed capacity significantly. Overall, individuals with 46B repeat commitments used over 27 percent of all bed days in state facilities despite the fact that they constituted only 16 percent of discharges.[6]

The Continuity of Care Task Force,[7] convened by DSHS, developed a report which included recommendations for improving services to individuals who move through multiple systems, such as criminal justice and mental health. The report included recommendations such as further development of:

- Supported housing,
- Assisted living,
- Smaller, community-based living options, and
- Cognitive rehabilitation to address a participant's limitations in organizing, planning and completing daily living activities.

Residential options linked to a range of support services can effectively improve health outcomes for vulnerable individuals, such as the long-term homeless with severe mental illness. One such model in Colorado demonstrated an 80 percent decrease in overnight hospital stays and a 76 percent decrease in nights in jail[8]. Research indicates that among residents of permanent supportive housing:

- Rates of arrest and days incarcerated are reduced by 50 percent;
- Emergency room visits decrease by 57 percent;
- Emergency detoxification services decrease by 85 percent; and
- Nursing home utilization decreased by 50 percent.[9]

IV. HCBS Target Population

Individuals with multiple challenges who require continuous, longer term support to successfully remain in the community would be the target population for receiving HCBS services. Individuals with four or more 46B commitments are more likely to have these characteristics / needs. This relatively small (200+) number of individuals use a large number of bed days in state facilities. Providing additional services to this group would have the best potential for achieving significant reduction in state facility use. Therefore, the target population used in this analysis is:

An individual who is at least 18 years of age with a history of repeated forensic commitments under Chapter 46B (4 or more inpatient commitments), who requires assistance with at least one activity of daily living and/or instrumental activity of daily living and demonstrates at least one of the following characteristics:

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[6] DSHS Admissions data, December 2003 - November, 2011.
[7] See *Continuity of Care Task Force Report* at: http://www.dshs.state.tx.us/mhsa/continuityofcare/)
[8] Wortzel, H., Binswanger, I.,Martinez, R., Filley, C.M., & Anderson C.A. (2007), Crisis in the Treatment of Incompetence to Proceed to Trial: Harbinger of a Systemic Illness, *Am. Acad. Psychiatry Law*, 35:357–63. Retrieved from http://www.jaapl.org/cgi/reprint/35/3/357
[9] Lewis, D., Corporation for Supportive Housing, *Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010*. Retrieved from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf

- Inadequate family support in the community;
- History of "chronic homelessness," as defined by the Department of Housing and Urban Development;[10]
- Has experienced one or more unsuccessful community relocations from state hospitals during the past year.

V. HCBS Service Array

Home and community-based services could be provided in a variety of settings, including individual homes, apartments, adult foster homes, assisted living facilities, and small group (three to four-bed) community-supported residential settings. Other Medicaid state plan services, such as psychologist or master's level therapist services, would be coordinated with HCBS. HCBS would be specified in each client's individualized plan. Some services, such as residential assistance and rehabilitative services, would be more commonly used while others, such as specialized behavioral therapies, would be employed for smaller subsets of the population. Examples of potentially relevant services that could be provided under an HCBS program include, **but are not limited** to:

- Residential assistance (foster/companion care, supervised living, residential support services);
- Assisted living;
- Cognitive adaptation training (an evidence-based rehabilitative service that uses tools and motivational techniques to establish and refine daily living skills such as taking prescribed medications, keeping appointments, paying bills, cooking, cleaning, bathing, etc.);
- Psychosocial rehabilitation;
- Supported employment;
- Minor home modifications;
- Home delivered meals;
- Transition assistance (assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens);
- Adaptive aids (e.g., medication-adherence equipment, communication equipment, etc.);
- Non-medical transportation;
- Specialized behavioral therapies:
    - Cognitive behavioral therapy (an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking); and
    - Dialectical behavior therapy (a treatment program, derived from cognitive behavioral therapy, that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings);
- Prescription medications beyond those available through Medicaid or other insurance;
- Peer support (a service that models successful independent living behaviors, provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders);
- Respite care (short term);
- Specialized substance abuse treatment services;
- Nursing;

[10] In general, a chronically homeless person is an unaccompanied, disabled individual who has been continuously homeless for over one year.

- Occupational therapy, speech and language therapy, and physical therapy.

A more detailed description of some example HCBS services adapted from Texas HCBS waivers and DSHS projects / programs is provided in Appendix 1.

VI. Housing Resources

Affordable, community-integrated housing is a key component of any HCBS program. HCBS services can be provided to individuals in their own home or apartment or in small group living arrangements of their choice. Some examples of how housing might be provided and financed are described below. A variety of models are typically used in an HCBS program as appropriate to each individual's preferences, needs and resources.

The goal of the mental health system is recovery, which means that each individual with severe mental illness achieves and maintains the highest level of functioning and independence possible for that person. Recovery is a continual process. For example, some individuals with severe mental illness in the 46B population who initially relocate to more structured settings, such as group homes, could transition to more independent living situations, such as apartments and individual homes, as their recovery progresses. Other individuals may require structured supports over a more extended period of time.

HCBS Congregate Living Models
Historically, Texas HCBS programs, such as the Home and Community-based Services (HCS) waiver program for people with intellectual disabilities, have relied on options such as provider owned or leased small group homes (3 to 4 beds). The small group home model is typically used for individuals with limited means and medium to high support needs. In this model of housing, the HCS service provider or another entity such as a foundation or consumer group leases or purchases the residence and the individual residents pay the owner for room and board. In this model, the entity leasing or purchasing the dwelling assumes the housing start-up costs, which are not reimbursed by Medicaid. The costs for starting a small group residence are detailed in Appendix 2. The average historical start-up costs for such a residence are approximately $12,050. HCBS group homes are licensed or certified by state or local entities to ensure that they meet standards of quality, community integration and safety. Other congregate living models include adult foster care homes, in which the provider /owner lives with up to four clients in the family home providing meals / laundry services and assisted living facilities, which provide more structured assistance with activities of daily living.

Apartments and Individual Homes
Under this model, an individual apartment or home is leased or purchased by the individual. HCBS services can be brought to the individual and/or received elsewhere in the community. In this model, housing may be entirely independent of services, which can afford the individual more flexibility but also entails increased individual responsibility. The cost to rent or purchase decent housing is often prohibitive for individuals with disabilities. Federal, state, local and private resources exist to assist with housing. Waiting lists and funding limitations often apply and housing resources vary by geographic area.

Strategies for increasing individual affordability include federal Housing and Urban Development (HUD) programs such as:

- Public housing,
- Privately owned subsidized multifamily housing, and
- Housing Choice Vouchers (tenant-based housing assistance, such as Project Access and Section 811 for people with disabilities)

These options can provide affordable, community-integrated housing but may also have significant limitations. Some programs are temporary and/or site-based, while others enable the individual to move from one residence to another. Over time, more federal options have emerged for people with mental illness, although available resources still fall short of demand. For example, Texas recently submitted a competitive application for $12 million in HUD Section 811 vouchers to serve target populations, including people with severe mental illness who are receiving DSHS mental health services, people leaving nursing facilities and children transitioning out of foster care. If the Texas application is successful, it could serve up to 385 people in the three target populations. It is estimated that over 3000 DSHS clients alone have significant need for such vouchers. The 811 process is highly competitive, with $85 million total federal dollars allocated for the entire national effort.

People with multiple 46B commitments face additional challenges, including landlord and lender restrictions on serving individuals with a forensic past and societal fear / prejudice regarding this population, which may constrain choices, even when rental assistance is available.

Resources are also potentially available to finance **development** of housing for the homeless and people with disabilities. Potentially, these resources could be leveraged by interest groups to create affordable housing options more welcoming to this population. For example, HUD Neighborhood Stabilization Program (NSP) funds may be used to purchase, demolish, redevelop, rehabilitate, or land bank foreclosed, blighted, or vacant properties in order to stabilize communities. Foundation Communities, an Austin-based non-profit organization, recently utilized an NSP deferred, forgivable loan to help acquire a vacant extended stay hotel in Austin to create efficiency apartment units to provide supportive housing to chronically homeless individuals.[11]

Other examples of potential resources include the U.S. Department of Agriculture rural housing, and the Low Income Housing Tax Credit via the Internal Revenue Service. In addition, the Department of Veterans Affairs offers a number of housing programs that help veterans with mental and physical disabilities, some in conjunction with HUD and others with state agencies**.**

VII. Financing HCBS Services

HCBS services are already available to individuals with physical or developmental disabilities under Medicaid HCBS waivers authorized under Section 1915(c) of the Social Security Act. These waivers provide community-based services as an alternative to care in nursing facilities (NFs) or intermediate care facilities (ICFs) for people with intellectual or developmental disabilities. HCBS programs include a range of services and residential options that are not covered under the regular Medicaid program. In Texas, Medicaid HCBS programs receive close to a 60 percent federal match for services. Historically, adults with mental illness were not able to access Medicaid-funded HCBS services unless they also met the criteria to receive services in an ICF or NF. Recently, two

[11] Texas Housing & Health Services Coordination Council, Service-Enriched Housing Case Studies: Development Finance Report, November 2011.

Medicaid options have become available for potentially funding HCBS services to adult Texans with severe mental illness.

1915(i) HCBS State Plan Amendment

Section 1915(i) of the Social Security Act, as amended by the Affordable Care Act of 2010, enables states to offer HCBS via the state's Medicaid Plan to individuals in **existing** Medicaid eligibility categories with income below 150 percent of poverty. Individuals would need to meet needs-based criteria, defined by the state, which are less stringent than institutional criteria, enabling the state to target groups that cannot qualify for 1915(c) waivers.[12] The state is not required to demonstrate federal Medicaid cost neutrality, as it is under a 1915(c) waiver. The state can **target** HCBS to populations the state specifies, such as adults with severe mental illness and set specific criteria for receiving each service. The federal Medicaid agency must approve the amendment, including the targeting criteria and needs-based criteria for receiving services. A state cannot restrict services geographically or limit access to a specific number of eligible individuals, which creates some budgetary risk. However, adults with severe mental illness and repeated forensic involvement comprise a very small number of individuals statewide. If 1915(i) services were specifically directed to individuals at this level of need under an approved state plan amendment, the budget uncertainty associated with entitlement to service would be greatly reduced.

The state is also required to ensure an independent assessment of the individual's needs by someone other than the provider of HCBS and to create an individualized service plan for each client. A 1915(i) state plan amendment will not fund start-up costs such as lease or purchase of housing stock or an individual's room and board costs and can only be used to serve individuals who receive Medicaid. 1915(i) services could potentially be provided under fee for service Medicaid or Medicaid managed care.

In Texas, individuals with mental illness typically become eligible for Medicaid through the federal Supplemental Security Income (SSI) program. The individual SSI income level is approximately 74 percent of federal poverty level - well within the 1915(i) ceiling. Currently, a large percentage of the subject population (approximately 60 percent) is not enrolled in Medicaid. Some individuals (e.g., undocumented non-citizens) will not qualify for Medicaid; however others may be eligible but not enrolled due to various factors such as lack of stable residence and institutional cycling. If 1915(i) were chosen as the means to finance HCBS, state or local staff resources should be dedicated to assist all eligible individuals in attaining and retaining Medicaid eligibility. This could significantly reduce state costs for HCBS and local indigent care costs for their medical services.

1115 Medicaid Transformation Waiver

In 2011, HHSC received federal approval of a waiver that allows the state to provide incentive payments for health care improvements. The Texas Healthcare Transformation and Quality Improvement Program (the transformation waiver) contains two funding pools – the Uncompensated Care and Delivery System Reform Incentive Payment (DSRIP) pools**.** DSRIP pool payments provide incentives for regional healthcare partnerships to develop programs or strategies to enhance access to health care, quality of care, cost-effectiveness and the health of the people served. Governmental entities, including Community Mental Health Centers, participating in these partnerships may provide public funds, known as intergovernmental transfers (IGT) for projects

[12] States can also elect to cover individuals with incomes of up to 300 percent of the Supplemental Security Income (SSI) rate, but these individuals must meet 1915(c) eligibility criteria, including institutional level of care.

approved by HHSC and the federal Medicaid agency and obtain federal matching dollars for meeting benchmarks approved for the projects.

Behavioral health conditions, such as mental illness, contribute to significantly higher medical costs in general. In the Texas Medicaid program, for example, mental health and substance abuse conditions comprised 8 percent of initial admissions but 24 percent of potentially preventable readmissions to acute care hospitals.[13] Consequently, HHSC encourages consideration of projects under the transformation waiver that focus on individuals with behavioral health conditions. For example, the DSRIP Category 2, Behavioral Health Project Option 2.13 enables Regional Health Partnerships (RHPs) to propose projects to serve specialized populations, such as people with severe mental illness, who cycle in and out of state facilities, acute hospitals and / or criminal justice settings, because they lack appropriate home and community-based supports such as transition services, peer support, specialized therapies, medical services, personal assistance, and short or long term residential options, such as supported housing. Evidence from supported housing efforts in other states indicates that stable housing, combined with appropriate supports, can significantly reduce medical costs and improve health outcomes for complex needs populations.[14] DSRIP Option 2.13 is included as Appendix 4.

Potentially, a DSRIP project could focus on the repeat 46B commitment population. Transformation projects are not subject to the same requirements as 1915(i) services. For example, a project would not have to be available statewide, would not be required to enroll all potential providers or recipients or require that the person be Medicaid eligible or remain Medicaid eligible. Medical services and housing start-up costs might also be included if integral to the project, subject to HHSC and federal approval. Matching funds would need to meet federal criteria to qualify as IGT funds. To receive federal matching funds, projects would be required to meet process and improvement milestones, such as decreasing preventable inpatient admissions or improving client functioning. In addition, the overall transformation waiver, of which these projects would be part, must be cost effective to the federal Medicaid program. However, the 1115 transformation waiver is a five year research and demonstration project. Future prospects for obtaining federal matching funds beyond the initial waiver term are unknown at this time.

VIII. HCBS Service Costs

Costs were derived from experience / data on existing HCBS programs in Texas which serve populations at similar levels of need / complexity and from consultation with subject matter experts including the DSHS Mental Health Medical Director's Office, State Facilities Policy and Decision Support, DADS HCBS policy and operations, HHSC Rate Analysis; HHSC State Medicaid Office and HHSC Decision Support.

NOTE: Cost assumptions are derived / extrapolated from the state's historical experience in operating HCBS waiver programs for other moderate to high need populations. If a different service model is used to serve the population or Medicaid eligibility levels are different than anticipated, costs could differ from these estimates. For example, per person service costs could be lower than

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[13] Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010 *Public Report, HHSC,* January 2012

[14] Medicaid-Financed Services in Supported Housing for High Need Homeless Beneficiaries: The Business Case, Canter for Health Care Strategies, Inc., June 2012.

estimated if significantly fewer individuals require more structured congregate services such as group homes.

Table 5: 1915(i) HCBS Hypothetical Program Costs

1915(i) HCBS Cost for Medicaid Eligible Consumers (N=142 in year 1; 149 in year 2)

Year	State Cost	Federal Cost	Total Cost	State Cost per Person
Year 1	$4,532,762	$6,386,125	$10,918,887	$31,894
Year 2	$4,635,395	$6,530,723	$11,166,118	$31,169
Total	$9,168,158	$12,916,847	$22,085,005	$31,523

1915(i) HCBS Cost for Non-Medicaid Eligible Consumers (N=67 in year 1; 70 in year 2)

Year	State Cost	Federal Cost	Total Cost	Local Cost per Person
Year 1	$5,919,713	$0	$5,919,713	$88,512
Year 2	$5,965,670	$0	$5,965,670	$85,243
Total	$11,885,383	$0	$11,885,383	$86,841

1915(i) HCBS Total Program Costs (N=209 in year 1; 219 in year 2)

Year	State Cost	Federal Cost	Total Cost	State Cost Per Person
Year 1	$10,452,475	$6,386,125	$16,838,600	$50,012
Year 2	$10,601,065	$6,530,723	$17,131,788	$48,473
Total Cost	$21,053,541	$12,916,847	$33,970,388	$49,242

In the above analysis the major assumptions were as follows:

- A total of 219 individuals would be served in the biennium (individuals with four or more 46B commitments) 209 in year one and 219 in year 2.

- Medicaid eligibility: 32 percent of individuals will not be Medicaid eligible (7 percent of these ineligible due to lack of documented citizenship and 25 percent ineligible or not enrolled for other reasons). Individuals ineligible for Medicaid are also assumed to be financially indigent, since they will not be receiving SSI. Because of the assumed percentage of non-Medicaid eligible individuals, the state funds would be required to finance 60.98 percent of the total cost for the population. Sixty percent of DSHS adult mental health consumers are generally medically indigent (without insurance or Medicaid). People with repeated inpatient commitments often lose or are unable to establish Medicaid eligibility. This analysis assumes that more intensive services and better housing stability will contribute to greater levels of eligibility. If the number of individuals ineligible for Medicaid services is higher than 32 percent, state costs would also increase. For example, if 50 percent were ineligible the state per person cost would be $59,205; if 60 percent were ineligible the state per person cost would increase to $64,739.

- Service utilization
    - Over 84 percent are assumed to use supervisedlLiving or residential support Services. These services constitute over 70 percent of the total state / federal cost.
    - 100 percent of individuals are assumed to use rehabilitative services (psychosocial rehabilitation or cognitive adaptation training).

- Administrative costs are assumed at 15 percent with a 50 percent federal/state match available for Medicaid-related activities. Administrative costs include: management, quality assurance, licensure and certification, required federal reporting, agency indirect costs and development of information technology infrastructure.

- Other medical costs are assumed to be covered outside the 1915(i) program under Medicaid or through the indigent care system.

Table 6: 1115 HCBS Hypothetical Program Costs

1115 HCBS Cost for Medicaid Eligible Consumers (N=194 in year 1; 203 in year 2)

Year	RHP Cost	Federal Cost	Total Cost	Local Cost per Person
Year 1	$6,199,219	$8,733,964	$14,933,183	$31,894
Year 2	$6,339,585	$8,931,723	$15,271,308	$31,169
Total	$12,538,804	$17,665,688	$30,204,492	$31,523

1115 HCBS Cost Non-Medicaid Eligible Consumers (N=15 in year 1; 15 in year 2)

Year	RHP Cost	Federal Cost	Total Cost	Local Cost per Person
Year 1	$1,294,937	$0	$1,294,937	$88,512
Year 2	$1,304,990	$0	$1,304,990	$85,243
Total	$2,599,928	$0	$2,599,928	$86,841

1115 HCBS **Total** Program Costs (N=209 in year 1; 219 in year 2)

Year	RHP Cost	Federal Cost	Total Cost	Local Cost per Person
Year 1	$7,494,156	$8,733,964	$16,228,121	$35,857
Year 2	$7,644,575	$8,931,723	$16,576,299	$34,955
Total Cost	$15,138,731	$17,665,688	$32,804,419	$35,406

In the preceding analysis the major assumptions were as follows:

- Target population is the same as in the 1915(i) option.
- Utilization of services is the same as is the 1915(i) option.
- Federal match is available to offset costs for both Medicaid and non-Medicaid participants, with the exception of undocumented non-citizens, who constitute seven percent of target population.
- Other medical costs are assumed to be covered outside the 1115 project under Medicaid or via the local indigent care system.

IX. Transition Services

Individuals with multiple 46B commitments face a number of challenges in transitioning from psychiatric institutions to life in the community. These include lack of state identification such as a driver's license or Social Security Card, lack of family and peer support, terminated or lapsed Medicaid eligibility, unaddressed substance abuse issues and lack of daily living skills. Appropriate transition services ideally would begin before discharge and could include cognitive training in daily living skills, establishing identification, helping the individual apply for benefits, establishing a bank

account, establishing informal (peer) relationships, initiating substance use treatment services, and facilitating enrollment in Medicaid and initiation of services. Similar tactics have proven successful in transitioning individuals with severe mental illness from nursing facilities under the Texas Money Follows the Person Behavioral Health Pilot. Unfortunately, Medicaid does not generally allow services to be funded in Institutions for Mental Disease, such as state psychiatric hospitals; however administrative support, such as housing relocation specialists and administrative support to existing state facility staff / peer specialists providing transition services could potentially be funded under other sources such as the Money Follows the Person Federal Demonstration grant dollars. DSHS and DADS are currently exploring the feasibility of funding transition services under Money Follows the Person with the federal Medicaid agency, the Centers for Medicare and Medicaid Services (CMS).

Under the Texas 1115 transformation waiver, subject to HHSC and federal approval, housing start-up costs could potentially be included in a Category 2 DSRIP project if these costs were integral to meeting the process and improvement milestones approved for the project.

X. Potential Impact of HCBS on State Facility Use

State hospital data examined over 92 months[15] showed that individuals who had four or more inpatient commitments used an average of approximately 86 days per year in the state hospital. Providing community based services that prevent multiple state re-institutionalizations for this population would free up state hospital bed days. For example, if HCBS averted 90 percent of state hospital admissions for 209 individuals, an additional 16,093 state hospital bed days per year would be available. Assuming an average length of stay of 90 days, an additional 179 individuals could be served statewide using those freed bed days. Table 7 summarizes the total state hospital bed days hypothetically made available as a result of admissions that might be averted.

Table 7: Hypothetical Impact on State Facility Bed Days

SF Admissions Averted	SF Bed Days Saved (per person / per yr.)	Total bed days saved per year (based on 209 served for a full year in HCBS program)	Additional people who could be served
100%	86	17,974	200
90%	77	16,093	179
80%	69	14,421	160
70%	60	12,540	139
60%	52	10,868	121
50%	43	8,987	100
40%	34	7,106	79
30%	26	5,434	60
20%	17	3,553	39

HCBS could have an **even greater impact** on state facility capacity if the long term commitment population (people hospitalized continuously for one year or more) were included in an HCBS

[15] March 1, 2004 to November 1st, 2011

program. These individuals have similar (and often greater) need for supports. They are not necessarily forensic commitments.

XI. Conclusions

Providing HCBS to individuals with repeated 46B commitments is feasible. It would require investment of state or local funds. If approved by the federal Medicaid agency, federal matching funds could potentially be used to offset some of the state or local costs. Providing services to this population could increase bed days available to serve people with severe mental illness, reducing waiting time for services and improving system performance.

Although the charge of this analysis is to determine HCBS feasibility for the 46B repeat commitment population, HCBS could potentially realize a larger impact on state facility capacity by including individuals with long term commitments (1+ year) in an HCBS program.

Appendix 1: Examples of Potential HCBS Service Definitions

Service	Definition	Provider Qualifications
Transition Assistance Services (TAS)	TAS pays for non-recurring, set-up expenses for participants transitioning from institutions into the community. Allowable expenses are those necessary to enable participants to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; and set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water. TAS may also include services necessary for the participants' health and welfare, such as pest eradication and one-time cleaning prior to occupancy, and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge). Room and board are not allowable expenses. TAS are furnished only to the extent that: the expense is reasonable and necessary as determined through the individual service plan development process and clearly identified in the individual service plan and participants are unable to meet such expenses or the services cannot be obtained from other sources. TAS does **not** include: monthly rental or mortgage expenses; food; regular utility charges; or household appliances or items that are intended for purely recreational purposes. There is a $1,500 cost cap per participant.	TAS Provider The TAS provider must comply with the requirements for delivery of transition assistance services, which include requirements such as allowable purchases, costs limits and time frames for delivery. TAS providers must demonstrate knowledge of, and history in, successfully serving individuals who require home and community-based services.
Cognitive Adaptation Training (CAT)	CAT provides assistance and environmental modifications to help people establish daily routines, organize their environment, and build social skills, with the ultimate goal of increasing independence. CAT compensates for cognitive deficits from mental illness (such as psychomotor speed, attention, and memory) by providing visual clues, signage, and organization of the participant's environment that results in increased independent functioning. CAT improves the individual's ability to perform activities of daily living such as dressing, hygiene, social skills and communication, medication management, toileting, leisure skills, and transportation. Services may be provided to up to 180 consecutive days prior to discharge and post-discharge in home and community-based settings in the individualized plan.	The CAT intervention is provided by a bachelors or masters level clinician (mental health or related field) that is trained as a CAT Specialist by the University of Texas Health Science Center at San Antonio.
Adaptive Aids and Medical Supplies	Adaptive aids and medical supplies are specialized medical equipment and supplies which include devices,	The provider agency must comply with the

Service	Definition	Provider Qualifications
	controls, or appliances, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid state plan. Adaptive aids are offered elsewhere under the state plan which must be accessed prior to accessing HCBS. However the scope of adaptive aids is broader in HCBS than elsewhere under the state plan. Adaptive aids that are not provided in the state plan include vehicle modifications, service animals and supplies, environmental adaptations, and aids for daily living, such as reachers, adapted utensils, and certain types of lifts. This broadens the scope of these services beyond extended state plan services. Items reimbursed are in addition to any medical equipment and supplies furnished under the state plan and do not include those items which are not of direct medical or remedial benefit to the individual. All items must meet applicable standards of manufacture, design, and installation. The annual cap is $10,000 per individual, per year. Should an individual require adaptive aids/medical supplies after the cost limit has been reached, the service planning team assists the individual/family to access any other resources or alternate funding sources. Adaptive aids and medical supplies are available only after benefits available through Medicare, other Medicaid benefits, or other third party resources have been exhausted.	requirements for delivery of adaptive aids and medical supplies, which include requirements such as types of allowed items, time frames for delivery, training on use of adaptive aids, and follow-up on the purchase of the item. Adaptive aids and medical supplies must be provided by contractors/suppliers capable of providing products meeting applicable standards of manufacture, design and installation.
Supported Employment	Supported employment provides ongoing individualized support services in an integrated setting that enables individuals for whom competitive employment at or above the minimum wage is unlikely without the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. Employment is work for which an individual is compensated by his or her employer in accordance with the Fair Labor Standards Act. Supported employment includes services and supports, such as supervision and training, essential to sustain paid work by an individual.	Providers must have experience in vocational assistance for people with psychiatric disabilities.

Service	Definition	Provider Qualifications
	Supported employment is provided away from the individual's place of residence and does not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation is maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: • Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; • Payments that are passed through to users of supported employment programs; or • Payments for training that is not directly related to an individual's supported employment program. * Supported Employment cannot be provided at the same time as Employment Assistance.	
Transportation	Transportation is offered in order to enable individuals served to gain access to services, activities, and resources, as specified in the individualized service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the state plan, defined at 42 CFR 440.170(a) (if applicable), and will not replace them. *Transportation services will be offered in accordance with the individual's service plan. Whenever possible family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized. This service does not include escort, which is provided under personal assistance services, and does not duplicate transportation provided as part of other services. There is a limit of $2000 per individual per year for this service.	Individual provider must be 18 years of age or older; must have a valid driver's license and proof of insurance; and may use specialized transport, buses, or taxis.

Service	Definition	Provider Qualifications
Cognitive Behavioral Therapy (CBT) Dialectical Behavior Therapy (DBT)	An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking DBT is a form of CBT directed at individuals with borderline personality disorder or other disorders with chronic suicidal ideation and unstable relationships. It is a manualized treatment program that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings. It requires specialized training by the original developer or other entity approved by original developer (Marcia Linehan). The treatment program includes individual and group therapy sessions as well as requires homework by the individual.	Direct care psychotherapists trained and credentialed in this specialized psychotherapy
Prescription Medications	This service provides prescription medications beyond those covered by Medicaid or other insurance. Note: Applicable to non-dual eligible clients who are not enrolled in capitated Medicaid managed care.	Licensed pharmacy
Peer Support	Peer support services are provided by self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Peer support providers are supervised by mental health professions, and are trained to deliver services. The services are coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. A person-centered planning process will be used to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.	Services can be provided individually or in a group setting. The majority of peer support contacts should occur in community locations where the person lives, works, attends school, and/or socializes.
Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services, etc.)	In a foster care arrangement, the foster care provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the individual. Foster/companion care provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities;	The provider must be at least 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and

Service	Definition	Provider Qualifications
	assistance with medications [level of assistance with medication is based upon the results of an assessment completed by a registered nurse (RN)]; the performance of tasks delegated by an RN (delegated tasks are determined on an individual basis by the RN according to the Texas Board of Nursing rules and in accordance with state law); and supervision of the individual's safety and security. This component includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Residential assistance services cannot be provided at the same time as day habilitation services. The supervised living component provides residential assistance as needed by individuals who live in residences in which the program provider agency holds a property interest and that meet program certification standards. This service component is provided to individuals who do not require routine supervision or support by direct service providers who remain awake during normal sleeping hours. Supervised living providers provide services and supports as needed by individuals and are present in the residence and able to respond to the needs of individuals during normal sleeping hours. The supervised living component provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications (level of assistance with medication is based upon the results of an assessment completed by an RN); the performance of tasks delegated by an RN (delegated tasks are determined on an individual basis by the RN according to the Texas Board of Nursing rules and in accordance with state law); and supervision of the individual's safety and security. This component includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. The residential support component provides residential assistance to individuals who require supervision and	competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The provider must also have at least three personal references from persons not related by blood that evidence the ability to provide a safe and healthy environment for the individual(s) to be served. Transportation of individuals must be provided in accordance with applicable state laws. Assisting with tasks delegated by a RN must be in accordance with state law. Providers of residential assistance must complete initial and periodic training provided by program provider.

Service	Definition	Provider Qualifications
	support from direct service providers who are awake and present in the residence whenever an individual is present in the residence. Residential support is provided in residences in which the program provider agency holds a property interest and that meet certification standards. Services and supports are provided by residential support providers assigned on a shift schedule that includes at least one complete change of staff each day. The residential support service component provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications (level of assistance with medication is based upon the results of an assessment completed by an RN); the performance of tasks delegated by a RN (delegated tasks are determined on an individual basis by the RN according to the Texas Board of Nursing rules and in accordance with state law); and supervision of the individual's safety and security. This component includes activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual. The program provider must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation. Periodic training, as needed, is required to make sure service providers are qualified to provide services in accordance with state and federal laws and regulations. Payments for residential assistance are not made for room and board, items of comfort or convenience, or the costs	

Service	Definition	Provider Qualifications
	of facility maintenance, upkeep and improvement. An individual may receive only one type of residential assistance at a time. Individuals who receive residential assistance are not eligible to receive either supported home living or respite, as these services are available only to individuals who live in their own or family home. Individuals receiving either adult foster care or Department of Family and Protective Services foster care services may not also receive residential assistance.	
Respite	Respite services are furnished on a short-term basis to relieve those persons normally providing the services. In-home respite will be provided in the individual's home or place of residence, or in the home of a family member or friend. Out-of-home respite will be provided in the following locations: • Hospital; • Adult foster care home; • 24-hour residential habilitation home; • Assisted living facilities; and • Centers operated by certified peer specialists The respite provider must not live with the individual. Since respite services are defined as care provided to an individual to relieve those persons normally providing the care, individuals residing in adult foster care homes, 24-hour residential habilitation homes, and in assisted living facilities are not eligible to receive respite services. Other services, such as residential habilitation and personal assistance services may be provided on the same day as respite services, but the two services cannot be provided at the exact same time. In-home and out-of-home respite is limited to 45 days, combined, per year per individual. Individuals residing in adult foster care homes, 24-hour residential habilitation homes, and in assisted living facilities are not eligible to receive respite services. The provision of respite care precludes the provision of, or payment for, other duplicative services.	Individual— Must be 18 years of age or older; trained in CPR/first-aid; pass criminal history checks; not be on list of Employee Misconduct Registry or Nurse Aide Registry; maintain current Texas driver's license and proof of automobile insurance if transporting clients; and be familiar with client-specific competencies. Adult foster care— If serving four participants must be licensed as a Type C assisted living facility under 40 Texas Administrative Code, Part 1, Chapter 92. No license is required for homes serving less than four individuals. All providers must meet program standards for adult foster care for fewer than four individuals under 40 Texas Administrative Code, Chapter 98, Subchapter K.

Service	Definition	Provider Qualifications
		Assisted living facility— Licensed as an assisted living facility under 40 Texas Administrative Code, Part 1, and Chapter 92. Hospital— State license deemed via Medicare participation under 25 Texas Administrative Code, Part 1, Chapter 133. Other setting certified or licensed by the state ental Health Authority.
Substance Abuse Services in Addition to State Plan	Substance abuse services beyond those available under the Texas Medicaid state plan may include services of longer duration than those offered under the state plan and / or services more specialized than those provided under the state plan (e.g., specialized individual and group therapy for people with co-occurring disorders).	Substance abuse programs licensed by DSHS.
Assisted Living	Assisted living services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community facility, but the services provided by these other entities supplement that provided by the community facility and does not supplant it. Personal care is furnished to individuals who reside in their own living units, which may include dually-occupied units when both occupants consent to the arrangement, that contain bedrooms and toilet facilities, and may or may not include kitchenette and/or living rooms. The individual has a right to privacy. Living units may be locked at the discretion of the individual, except when a physician or mental health professional has certified in	Licensed as an assisted living facility under 40 Texas Administrative Code, Part 1, Chapter 92.

Service	Definition	Provider Qualifications
	writing that the individual is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The individual retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Services must be furnished in a way that fosters the independence of each individual to facilitate aging in place. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. Nursing and skilled therapy services (except periodic nursing evaluations) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. Federal financial participation is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility. Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period. *Separate payments will not be made for respite, personal assistance or habilitation services, emergency response services, home-delivered meals, minor home modifications, child support services, or transportation. Individuals are responsible for their room and board costs. Assisted living services will not be provided at the same time as adult foster care or 24-hour residential habilitation.	
Home Delivered Meals	Home delivered meals services provide a nutritionally sound meal to participants. They provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The meal is delivered to the participant's home. The provision of home delivered meals does not provide a full nutritional regimen.	A home delivered meals provider must follow procedures and maintain facilities that comply with all applicable state and local laws and regulations related to fire, health, sanitation, and safety; and food preparation, handling, and service activities.

Service	Definition	Provider Qualifications
Minor Home Modifications	Minor home modifications are those physical adaptations to an individual's home that are necessary to ensure the individual's health, welfare, and safety, or that enable the individual to function with greater independence in the home. The individual would require institutionalization without these adaptations. Such adaptations may include widening of doorways, modification of bathroom facilities, or installation of ramps. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. Minor home modifications are not made to settings that are leased, owned, or controlled by service providers. All services are provided in accordance with applicable state or local building codes. *There is a limit of $7,500 per seven years until the individual reaches age 21, and then the limit is $7500 for life. Once the $7,500 cap is reached, only $300 per year per individual will be allowed for repairs or maintenance. The agency is responsible for obtaining cost-effective modifications authorized on the individual's plan. Should an individual require environmental modifications after the cost cap has been reached, the service planning team will assist the individual/family to access any other resources or alternate funding sources.	Agencies holding a provider agreement with state operating agency for the 1915(i) services. The agency must comply with the requirements for delivery of minor home modifications, which include requirements as to type of allowed modifications, time frames for completion, specifications for the modification, inspections of modifications, and follow-up on the completion of the modification. Qualified building contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.
Nursing	Nursing services are those services that are within the scope of the Texas Nurse Practice Act and are provided by an RN (or licensed vocational nurse under the supervision of an RN), licensed to practice in the state. In the Texas state plan, nursing services are provided only for acute conditions or exacerbations of chronic conditions lasting less than 60 days. Services cover ongoing chronic conditions such as wound care, medication administration (including training, monitoring, and evaluation of side effects) and supervising delegated tasks. This broadens the scope of these services beyond extended state plan services. Nursing services provide treatment and monitoring of health care procedures prescribed by a physician/medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel. Nursing services are provided only after benefits available through Medicare, Medicaid, or other third party resources	RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state. The agency must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the nurse practice act and delegation of nursing tasks.

Service	Definition	Provider Qualifications
	have been exhausted.	
Occupational therapy (extended state plan service)	Occupational therapy services consist of the full range of activities provided by an occupational therapist, or a licensed occupational therapy assistant under the direction of a licensed occupational therapist, within the scope of his state licensure. Texas assures that occupational therapy is cost-effective and necessary to avoid institutionalization. The scope of occupational therapy services offered exceeds the state plan occupational therapy benefit. In the Texas state plan, occupational therapy services are provided only for acute conditions or exacerbations of chronic conditions lasting less than 180 days. Services provided address ongoing chronic conditions even after rehabilitation has reached a plateau. (e.g., range of motion). Occupational therapy services include: • Screening and assessing; • Developing therapeutic treatment plans; • Providing direct therapeutic intervention; • Recommending adaptive aids; • Training and assisting with adaptive aids; • Consulting with other providers and family members; and • Participating on the team developing the individualized plan, when appropriate. Occupational therapy services are available through 1915(i) only after benefits available through Medicare, other Medicaid state plan services, or other third party resources have been exhausted.	Agencies holding a provider agreement with DSHS for the 1915(i) services. The occupational therapist / occupational therapy assistant must be licensed by the Texas Executive Council of Physical Therapy and Occupational Therapy Examiners.
Speech and Language Therapy	Speech and language therapy consists of evaluation and treatment of impairments, disorders, or deficiencies related to an individual's speech and language. Services consist of the full range of activities provided by a licensed speech/language pathologist or a licensed associate in speech/language pathology under the direction of a licensed speech/language pathologist, within the scope of his/her licensure. In the Texas state plan, speech and language therapy is offered only to children. Speech and language therapy services include: • Screening and assessing; • Developing therapeutic treatment plans; • Providing direct therapeutic intervention;	Agencies holding a provider agreement with DSHS for the 1915(i) services Licensed as a speech/language pathologist under 22 Texas Administrative Code, Part 32, Chapter 741.

Service	Definition	Provider Qualifications
	• Recommending augmentative communication devices; • Training and assisting with augmentative communication devices; • Consulting with other providers and family members; and • Participating on the individualized planning team as appropriate. *Speech and language therapy services are available only after benefits available through Medicare or other third party resources have been exhausted.	
Physical Therapy Services	Physical therapy services consist of specialized techniques for evaluation and treatment related to functions of the neuro-musculo-skeletal systems provided by a licensed physical therapist or a licensed physical therapy assistant, directly supervised by a licensed physical therapist. Physical therapy is the evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents including, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment. Physical therapy services consist of the full range of activities provided by a physical therapist, or a licensed physical therapy assistant under the direction of a licensed physical therapist, within the scope of state licensure. Texas assures that physical therapy is cost-effective and necessary to avoid institutionalization. The scope of physical therapy services offered under HCBS exceeds the state plan physical therapy benefit. Under HCBS, physical therapy will be provided to maintain the participant's optimum condition. Physical therapy services include: • Screening and assessing; • Developing therapeutic treatment plans; • Providing direct therapeutic intervention; • Recommending adaptive aids; • Training and assisting with adaptive aids; • Consulting with other providers and family members; and • Participating in the development of the individualized plan, when appropriate. Physical therapy services are available through HCBS only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted.	The physical therapist / physical therapy assistant must be licensed by the Texas Executive Council of Physical Therapy and Occupational Therapy Examiners.

Appendix 2: HCBS Group Home Start Up Costs

Capital Costs	**85 Percent Financing**	**100 Percent Financing**
New Building Purchase	140,000	140,000
Sprinkler System	22,000	22,000
Total Property Cost	162,000	162,000
15 Percent Down Payment	24,300	-
Amount Financed	137,700	162,000
15 Year Loan Amortized 30 years at 10% Interest	1,208	1,422
Initial Cash Requirements		
Down Payment	24,300	-
Furniture/Fixtures/Appliances	12,050	12,050
Closing Costs (5% of Amount Financed)	6,885	8,100
Total Initial Cash Requirements	**43,235**	**20,150**
Monthly Capital Costs		
Mortgage	1,208	1,422
Property Insurance Estimate ($600/yr.)	50	50
Property Tax Estimate ($4000/yr.)	333	333
Total	**1,592**	**1,805**
Per person Cost - 3 Person Home	**531**	**602**
Per Person Cost - 4 Person Home	**398**	**451**

ITEM	**Quantity**	**Price**	**Extended**	
Furniture/Fixtures/Appliances				
Bedrooms:				
Queen Bed (Mattress & Frame)	3	500	1,500	
Queen Headboard/Footboard	3	200	600	
Dresser & Mirror	3	300	900	
Nightstand	3	150	450	
	Total Bedroom		**3,450**	
Living Room:				
Sofa & Loveseat	1	1,100	1,100	
Chair & Ottoman	1	600	600	
Entertainment Center or TV Stand	1	500	500	
End table	2	200	400	
Coffee Table or Set of 3 Tables	1	500	500	
	Total Living Room		**3,100**	
Dining Room:				

ITEM	Quantity	Price	Extended	
7 pc. Dinette set	1	1,200	1,200	
	Total Dining Room		**1,200**	
	Total Furniture - $7,800 max			**7,750**
Electronics/Appliances:				
Electronics:				
Television	1	500	500	
VCR/DVD Player	1	100	100	
Kitchen:				
Refrigerator	1	1,100	1,100	
Microwave	1	150	150	
Dishwasher				
Utility Room:				
Washer	1	450	450	
Dryer	1	400	400	
	Total Electronics/Appliances			**2,700**
	Total Furniture & Appliances - $10,500 max			**10,450**
Household Items				**1,600**
(includes dishes, pots & Pans, linens, lamps, decorations, vacuum, mops, brooms, iron, clocks, etc.				
Total Start-up Costs				**12,050**

Appendix 3: HCBS Service Costs

FY 2014		
Service	**% Utilizing Service**	**Total Cost**
Supervised Living and Residential Support Services (3 - 4 bed)	89%	$10,176,579
CAT or Psychosocial Rehab	100%	$2,708,640
Rent Support	32%	$679,490
Foster / Companion Care	0%	$0
Personal Care III	7%	$368,617
Transition Assistance	70%	$219,450
Peer Support	15%	$156,499
Nonmedical Transportation	80%	$132,422
Assisted Living	3%	$94,448
Nursing	30%	$32,647
Supported Employment	10%	$16,603
CBT, DBT	6%	$9,081
Physical Therapy	10%	$8,091
Speech Therapy	10%	$7,972
Occupational Therapy	10%	$7,623
Substance Abuse Services - Individual	10%	$6,688
Minor Home Modifications	1%	$6,270
Home Delivered Meals	1%	$4,669
Adaptive Aids	4%	$3,696
Substance Abuse Services- Group	10%	$1,777
Respite Care	1%	$997

FY 2015		
Service	**% Utilizing Service**	**Total Cost**
Supervised Living and Residential Support Services (3 - 4 bed)	84%	$10,451,835
CAT or Psychosocial Rehab	100%	$2,947,493
Rent Support	32%	$711,026
Foster / Companion Care	5%	$391,816
Personal Care III	5%	$286,516
Transition Assistance	50%	$170,573
Peer Support	15%	$170,300
Nonmedical Transportation	80%	$144,100
Assisted Living	5%	$171,295
Nursing	25%	$29,605
Supported Employment	10%	$18,067
CBT, DBT	6%	$9,882
Physical Therapy	10%	$8,805

FY 2015		
Service	**% Utilizing Service**	**Total Cost**
Speech Therapy	10%	$8,675
Occupational Therapy	10%	$8,296
Substance Abuse Services - Individual	10%	$7,278
Minor Home Modifications	1%	$6,823
Home Delivered Meals	1%	$5,080
Adaptive Aids	4%	$4,022
Substance Abuse Services - Group	10%	$1,933
Respite Care	6%	$6,512

Appendix 4: Delivery System Reform Initiative 2.13
Source: Regional Health Partnership Planning Protocol, HHSC, October 2012
(http://www.hhsc.state.tx.us/1115-docs/RHP/RHP-techcorrects.pdf)

RHP Planning Protocol
Category 2

2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.).

Project Goal:
Provide specialized services to complex behavioral health populations such as people with severe mental illnesses and/or a combination of behavioral health and physical health issues. These populations often have multiple concomitant issues such as substance use, traumatic injuries, homelessness, cognitive challenges, and lack of daily living skills and lack of natural supports. The State's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not
provide the range of services needed to deal with complex psychiatric and physical needs. These complex populations become frequent users of local public health systems.

The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions in settings including general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community. This can be done by providing community based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient
system; and the mental health system. Examples of interventions could include integrated medical and non-medical supports such as transition services to help individuals establish a stable living environment, peer support, specialized therapies, medical services, personal assistance, and short or long term residential options.

Residential options linked to a range of support services can effectively improve health outcomes for vulnerable individuals, such as the long-term homeless with severe mental illness. One such model in Colorado demonstrated a drastic 80 percent decrease in overnight hospital stays and a 76 percent decrease in nights in jail (Wortzel, 2007). Research indicates that among residents of permanent supportive housing:

- Rates of arrest and days incarcerated are reduced by 50%;
- Emergency room visits decrease by 57%;
- Emergency detoxification services decrease by 85%; and
- Nursing home utilization decreased by 50%.[201]

201 Lewis, D., Corporation for Supportive Housing, Permanent Supportive Housing Program & Financial Model for Austin/Travis County, TX, 2010. Retrieved from http://www.caction.org/homeless/documents/AustinModelPresentation.pdf

Project Options:

2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. Required core components:

- **a)** Assess size, characteristics and needs of target population(s) (e.g., people with severe mental illness and other factors leading to extended or repeated psychiatric inpatient stays. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.
- **b)** Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.
- **c)** Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- **d)** Design models which include an appropriate range of community-based services and residential supports.
- **e)** Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population. Examples of data sources include: standardized assessments of functional, mental and health status (such as the ANSA and SF 36); medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient populations, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

2.13.2 "Other" project option: Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project.

Note: All of the project options in project area 2.13 should include a component to conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations.

Note: Community-based interventions should be comprehensive and multispecialty. They should incorporate two or more components, such as those listed below depending on the needs of the target populations being served. These interventions should have significant flexibility to add more components if they are appropriate to

meet the needs of the target population. Community-based components may include (but are not limited to):

- Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services)
- Assisted living;
- Cognitive Adaptation Training (CAT) – an evidence-based service that uses tools and motivational techniques to establish and refine daily living skills;
- Psychosocial Rehabilitation;
- Supported employment;
- Minor home modifications;
- Home delivered meals;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Adaptive aids (e.g., medication-adherence equipment, communication equipment, etc.);
- Transportation to appointments and community-based activities;
- Specialized behavioral therapies:
    - Cognitive Behavioral Therapy – An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking; and
    - Dialectical Behavior Therapy – A manualized treatment program (derived from cognitive behavioral therapy) that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings;
- Prescription medications;
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals;
- Respite care (short term);
- Substance abuse services (specialized for individuals who have experienced prolonged or repeated institutionalization);
- Visiting Nursing and / or community health worker services;
- Employment supports
- Nutritional counseling
- Occupational therapy; Speech and language therapy; and Physical therapy.

Components must be articulated into a system which uses a CQI design such as the CMS Quality Framework for HCBS services. (Anita Yuskauskas, 2010) and/or be informed by guidance such as the SAMHSA evidence-based toolkit for permanent supported housing (http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510) or other evidence-based system

Process Milestones:

P-1. Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources.

P-1.1. Metric: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization

a. Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review

P-2. Milestone: Design community-based specialized interventions for target populations. Interventions may include (but are not limited to) Residential Assistance (Foster/Companion Care, Supervised Living, Residential Support Services)

- Assisted living;
- Cognitive Adaptation Training (CAT) – an evidence-based service that uses tools and motivational techniques to establish and refine daily living skills;
- Psychosocial Rehabilitation;
- Supported employment;
- Minor home modifications;
- Home delivered meals;
- Transition assistance – assistance to establish a basic household, including security deposits, essential furnishings, moving expenses, bed and bath linens;
- Adaptive aids (e.g., medication-adherence equipment, communication equipment, etc.);
- Transportation to appointments and community-based activities;
- Specialized behavioral therapies:
    - Cognitive Behavioral Therapy – An empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking; and
    - Dialectical Behavior Therapy – A manualized treatment program (derived from cognitive behavioral therapy) that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings;
- Prescription medications;
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals;
- Respite care (short term);
- Substance abuse services (specialized for individuals who have experienced prolonged or repeated institutionalization);
- Visiting Nursing and / or community health worker services;
- Employment supports
- Nutritional counseling
- Occupational therapy; Speech and language therapy; and Physical therapy.

P-2.1. Metric: Project plans which are based on evidence / experience and which address the project goals

a. Project documentation

P-3. Milestone: Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness with concomitant circumstances such as chronic physical health conditions, chronic or intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in extended or repeated stays at inpatient psychiatric facilities.)

P-3.1. Metric: Number of targeted individuals enrolled / served in the project.

a. Project documentation

P-4. Milestone: Evaluate and continuously improve interventions

P-4.1. Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)

P-5. Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Participation should include: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come.

P-5.1. Metric: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.

a. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers to share best practices, learn how other providers have overcome similar challenges, and rapidly disseminate successful improvement ideas from other providers.

P-5.2. Metric: Share challenges and solutions successfully during this bi-weekly interaction.

a. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction. Could be summarized at quarterly intervals.

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers to share best practices, learn how other providers have overcome similar challenges, and rapidly disseminate successful improvement ideas from other providers.

P-6. Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement.

P-6.1. Metric: Number of new ideas, practices, tools, or solutions tested by each provider.

a. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals

b. Rationale/Evidence: The rate of testing of new solutions and ideas is one of the greatest predictors of the success of a health care system's improvement efforts.

P-7. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

P-7.1. Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

a. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers.

P-7.2. Metric: Implement the "raise the floor" improvement initiatives established at the semiannual meeting.

a. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting.

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" and "raise the bar" for performance across providers.

Customizable Process Milestone P-X: This milestone(s) may be used to include process milestones and metrics that are not otherwise included for this project area. If customizable milestones are included, the provider should explain the justification for using this milestone and the rationale and evidence supporting its use in the project narrative in the RHP Plan.

P-X Milestone: [Plan should include text describing process milestone intended to assist in achieving improvements in project area]

P-X.1 Metric: [Plan should include text describing a quantitative or qualitative indicator of progress toward achieving the process milestone]

a. Baseline/goal [Plan should include the appropriate baseline or goal relevant to the process metric]

b. Data Source: [Plan should include data source]

Examples of Metrics to be further refined and described by the performing provider for Process Milestone P-X:

- Metric: Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context
- Metric: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan (including implementation, evaluation, and sustainability).
- Metric: Community or population outreach and marketing, staff training, implement intervention.
- Metric: Evaluate intervention, modify intervention as appropriate, develop policies/procedures, and share lessons learned

Improvement Milestones:

I-1. Milestone: Criminal Justice Admissions/Readmissions

I-1.1. Metric: X% decrease in preventable admissions and readmissions into Criminal Justice System;

a. Numerator: The percentage of individuals receiving specialized interventions that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period.

b. Denominator: The number of individuals receiving specialized interventions.
This would be measured at specified time intervals throughout the project to determine if there was a decrease.

c. Data Source: a. Claims/ encounter and clinical record data; anchor hospital and other hospitals, criminal justice system records, local MH authority and state MH (CARE) data system records

d. Rationale/Evidence: See Project Goal

I-2. Milestone: Nursing Facility Admissions/Readmissions

I-2.1. Metric: X% decrease in preventable admissions and readmissions to nursing facilities;

a. Numerator: The percentage of individuals receiving specialized interventions who had a potentially preventable admission/readmission within the measurement period.
b. Denominator: The number of individuals receiving specialized interventions.
This would be measured at specified time intervals throughout the project to determine if there was a decrease.
c. Data Source: Nursing facility admission data from Medicaid / DADS
d. Rationale/Evidence: See Project Goal

I-3. Milestone: Adherence to Antipsychotics for Individuals with Schizophrenia

I-3.1. Metric: The percentage of individuals with schizophrenia receiving the specialized interventions who are prescribed an antipsychotic medication that had a Proportion of Days Covered (PDC) for antipsychotic medications greater than or equal to 0.8 during the measurement period (12 consecutive months)

a. Numerator: The percentage of individuals with schizophrenia who filled at least two prescriptions for an antipsychotic and had a PDC for antipsychotic medication that is greater than or equal to 0.8.
b. Denominator: The number of individuals at the end of the measurement
period with schizophrenia with at least two claims for an antipsychotic during the measurement period.
This would be measured at specified time intervals throughout the project to determine if there was a decrease.
c. Data Source: Claims and Encounter Data
d. Rationale/Evidence: NOTE: This metric is currently under review by NQF; not finalized.

I-4. Milestone: Anti-depressant medication management over six months for Major Depressive Disorder and anti-depressant medication during acute phase over 12 weeks (NQF# 0105)

I-4.1. Metric: The percentage of individuals with Major Depressive Disorder receiving the specialized interventions who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.

a. Numerator:
i. Effective Acute Phase Treatment: The number of individuals with Major Depressive Disorder receiving specialized interventions with at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the Inpatient Service Day (IPSD) (inclusive).
ii. Effective Continuation Phase Treatment: The number of

individuals with Major Depressive Disorder receiving specialized interventions with at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

b. Denominator: The number of individuals with Major Depressive Disorder receiving specialized interventions who are diagnosed with a New Episode of major depression and treated with antidepressant medication.

c. Data Source: Claims and Encounter Data

d. Rationale/Evidence: See project goal.

NOTE: RHP may also select from physical health measures, including but not limited to: NQF# 0549--Pharmacotherapy Management of COPD Exacerbation (PCE); NQF# 0047--Asthma: Pharmacologic Therapy for Persistent Asthma; NQF#0575-- Comprehensive Diabetes Care: HbA1c control (< 8.0%); and NQF# 0074 Chronic Stable Coronary Artery Disease: Lipid Control.

I-5. Milestone: Functional Status

I-5.1. Metric: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.)

a. Numerator: The percent of individuals receiving specialized interventions who demonstrate improvement from baseline to annual functional assessment.

b. Denominator: The number of individuals receiving specialized interventions.

c. Data Source: Standardized functional assessment instruments (e.g. ANSA, CANS, etc.)

d. Rationale/Evidence: See project goal.

Customizable Improvement Milestone I-X: This milestone(s) may be used to include improvement milestones and metrics that are not otherwise included for this project area. If customizable milestones are included, the provider should explain the justification for using this milestone and the rationale and evidence supporting its use in the project narrative in the RHP Plan.

I-X. Milestone: [Plan should include text describing improvement milestone]

I-X.1. Metric: [Plan should include text describing a quantitative or qualitative indicator of progress toward achieving the improvement milestone]

a. Baseline/goal [Plan should include the appropriate baseline or goal relevant to the improvement metric]

b. Data Source: [Plan should include data source]

Examples of metrics to be further refined and described by the Performing Provider for Improvement Milestone I-X:

- Metric: Target population reached
- Metric: Short-term outcomes (e.g., increased knowledge and awareness, increased skills, adoption of new guidelines, policies or practices, policy development.

- Metric: Intermediate outcomes (e.g., changes in provider norms, increased adherence to guidelines by providers, increased adherence to guidelines by patients)
- Metric: Long-term outcomes (e.g., changes in patient utilization rates, changes in provider behavior).
- Metric: Other program output measure as identified by the performing provider.