

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

ED Throughput (2.8.1)

Doctors Hospital at Renaissance is a 550 bed facility that is continuing to grow within the community. With this continued growth, DHR is one of the largest hospitals without a dedicated Lean or Process Improvement team that is solely dedicated to these endeavors. This project aims at creating this team focusing first on ED throughput due to its importance throughout the organization. DHR is focusing on improving the process flow as it relates to the quality of care for the patient in terms of ED throughput. Best practices from these endeavors will be applied to other departments starting with those that directly affect ED processes.

Intervention(s)

Improvement of ED throughput encourages healthy patient flow through the hospital. As improvement is developed through implementation of best practices such as improving communication, providing training, and empowering frontline staff, more patients are able to be seen, stabilized and registered. This becomes increasingly important with the growth of the community and an increased need of emergent, and often times primary, health care when it isn't available elsewhere.

DHR believes in transitional case management, meaning following up with the patient from the hospital to the home, and providing education to the patient to promote self-management in an effort to reduce readmissions. Patients that are eligible for these services are only those that come through the ED and are considered high-risk. Access to a physician in dire times is crucial to the health of the community, but the added value of this transitional health care also becomes invaluable when applied on an increasingly growing scale.

Need for the project

RHP5 is an area with approximately 1/3 of its population either on Medicaid or with no health insurance¹. Often this segment of population becomes disenfranchised as their health care options become continuously more limited. Given these circumstances, emergent health care is the only method of health care that is available, and these patients have gone extended periods with no primary health care resulting in one or more chronic conditions that require serious management. Many studies show that these patients with major complications not only suffer from a lower quality of life but also create an unsustainable model of healthcare overall. Increasing the productivity and efficiency of throughput within the ED not only will increase the amount of patients that are able to be seen, it does so in a manner that is more sustainable while delivering quality care.

Target population

By law the ED cannot turn anyone away. Given the socioeconomics of this region, the dominant payor mix stems from Medicaid patients. DHR provides healthcare to approximately 180,000 patients per year, 52% of which are on Medicaid.

¹ RHP5 Community Needs Assessment

Category 1 or 2 expected patient benefits

The classification of this project is 2.8.1 which targets the improvement of increasing safety, quality, and efficiencies of care throughout the ED. The patients benefit stems from a major hospital being able to better communicate with the patient, treating the patient in a more efficient manner, while increasing core measures that revolve around quality and patient satisfaction.

Category 3 outcomes expected patient benefits

IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

- a.) Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
- b.) Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Estimate of Project Valuation for DY 3 – DY 5

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

TBD / Local

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501

Provider Name/TPI: DOCTORS HOSPITAL AT RENAISSANCE - 160709501

Project Description

Doctors Hospital at Renaissance (DHR) is partnering with the Hope Family Health Center to expand its facilities and increase services. HOPE is a nongovernmental nonprofit organization who is sustained through grants, individual donations, volunteer services and fundraisers. DHR is wanting to greatly increase the Hope clinic's service capacity in efforts of maintain a clinic to refer to that are serviced within DHR and are considered high-risk and in-need of follow-up healthcare to help manage their chronic conditions. By doing this, an invaluable service is being provided to the community helping to improve the overall quality of life and moving towards a sustainable health care model as frequent, high-risk, ED users have access to follow-up care. As a result, these efforts create the opportunity for the patient to stabilize and improve on their chronic conditions preventing further advancement and readmissions.

Intervention(s)

The Hope clinic provides the following interventions:

- Access to basic primary health care primarily for the uninsured
- Access to mental health care primarily for the uninsured

Need for the project

1 in 3 people in the South Texas community are uninsured, while 40% of the families in RHP5 live at or below the federal poverty line. Nearly half of all insured, non-elderly adults report having a chronic condition, and these people are far less likely to visit a health professional than their insured counterparts¹. Hope Family Health Center provides medical and counseling care to the uninsured living in RHP5. Often times this clinic is considered a last resort for many of the patients seeking services within this clinic.

Target population

The clinics goal is to serve as a medical resource for those that have nowhere to go. The targeted population are those that are uninsured. To qualify for services, patients must not have medical and/or mental health insurance coverage and must be at or below 200% of the Federal Poverty Level.

¹ National Health Interview Survey: http://www.urban.org/UploadedPDF/411161_uninsured_americans.pdf. Note: information stated is regarding the nation as whole.

Category 1 or 2 expected patient benefits

40% of RHP5 families live below the federal poverty line while 1 in 3 of south Texas residents are uninsured². The HOPE clinic serves as a beacon of last resort for these patients seeking primary healthcare benefits. Patients are expected to benefit by receiving the education and healthcare needed to help stabilize and manage their conditions (diabetes, hypertension, high cholesterol, asthma, and heart disease).

Category 3 outcomes expected patient benefits

IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

a Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

b Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Disparities in healthcare are often a result of environmental conditions, social and economic factors, insufficient health resources and poor disease management that lead to the advancement of chronic conditions. Focusing the HOPE clinic to help patients prevent readmission due to their diabetics plays a crucial in elongating their life span and increasing that quality of life all-together as these patients are granted access to the education on the basics of managing diabetes.

Estimate of Project Valuation for DY 3 – DY 5

The three year estimated project valuation is \$6,000,000.00

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

TBD / Local

² Urban InSTITUTE analysis of data from the American FActFinder, Tables B27001, B27002, and B27003, American Community Survey 2008. Note: Public coverage is defined as employer/union provided, direct purchase, and TRICARE/military. Health insurance coverage types are not mutually exclusive.

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501

Provider Name/TPI: DOCTORS HOSPITAL AT RENAISSANCE - 160709501

Project Description

Joslin Diabetic Clinic is one of the largest clinics that is dedicated to the treatment and study of diabetes. With a growing population, diabetes continues to be on the rise and Joslin will eventually meet the limit of patients it can service. Doctors Hospital at Renaissance is expanding the Joslin Diabetes Clinic by opening another location in Starr County (approximately 60,000+ population). The new location would include the recruitment of endocrinologists, RN's, diabetic educator(s), and integration of a diabetic registry through EMR to enhance population studies.

Intervention(s)

The Joslin clinic specializes in the treatment of diabetes from understanding the behaviors that are associated with this condition, to education of its patient base, and everything in-between. Its strategic location places it in a county where approximately 50% of the community has either been diagnosed or is affected by diabetes.

- Specialty care directed specifically at the diabetic population
- Diabetic education focusing on self management
 - Dietary Intervention
 - Exercise Intervention
 - Cognitive Behavioral Intervention (group behavioral support sessions are conducted)
 - Medication Management Intervention (there is a major language barrier preventing many learning how to properly take their medications)
- Increase of diabetic population specific research

Need for the project

The cost of diabetes has increased 41 percent over a five year period to \$245 billion in 2012 from \$174 billion in 2007 (this includes \$167 billion in direct medical costs and \$69 billion in reduced productivity)¹. According to the RHP5 community needs assessment, the primary health issues within the region are rooted in extreme levels of economic and health disparities and unprecedented epidemics of chronic disease, particularly diabetes and related chronic conditions.

Of the many studies identifying regions such as Texas as an area with a high population percentage affected by diabetes², there are very little studies done in any concentrated areas. One such area is RHP5 where approximately 30% of the population is on Medicaid, and approximately 31% of the population is affected by diabetes³. Joslin Diabetes Center is the world's largest diabetes research and clinic care organization. RHP5 serves as a wealth of knowledge and foundation for innovation towards outreach and general understanding of the diabetic condition as it relates to such a unique population.

Diabetes helps promote other major chronic conditions such as obesity (estimated \$190 billion in national healthcare costs⁴), heart conditions (estimated \$444 billion in healthcare costs⁵), hypertension, premature low-weight births, and organ failure to name a few. A lack of expansion of specialized diabetes care is especially damaging to the unique at-risk, poverty stricken uninsured population in this region. This community resource will serve as a wealth of prevention services and education that can encourage true health care transformation.

Target population

This project targets the diabetic population regardless of their insurance status (private, Medicare, Medicaid, indigent) The majority of the patient base (approximately 50%) that is seen within Starr County's Sole Community Provider, Starr County Memorial Hospital, is Medicaid / uninsured. This serves as a fair representation of the patient demographic that will be seen within the clinic.

¹ American Diabetes Association. <http://www.diabetes.org/advocate/resources/cost-of-diabetes.html>

² <http://www.cdc.gov/diabetes/pubs/factsheets/hispanic.htm>

³ RHP5 Community Needs Assessment

⁴ Forbes. <http://www.forbes.com/sites/rickungar/2012/04/30/obesity-now-costs-americans-more-in-healthcare-costs-than-smoking/>

⁵ Centers for Disease Control and Prevention. <http://www.forbes.com/sites/rickungar/2012/04/30/obesity-now-costs-americans-more-in-healthcare-costs-than-smoking/>

Category 1 or 2 expected patient benefits

The project falls under the categorization of 1.9.2, expanding specialty care. The primary patient benefit will stem from a new location in a location that is largely underserved (Rio Grande City, approximately an hour away). Expanding through opening another clinical site is core measure “b” where referrals will stem from physicians that have clinics within this area, the local hospital (Starr County Memorial Hospital), and from DHR. Starr County, a county that contains over 60,000 people, will now have access to resource that is purely dedicated to the treatment of diabetes.

Category 3 outcomes expected patient benefits

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (Standalone measure)

This category 3 measure serves as one of the fundamental goals in treating patients. These goals include:

- Education
- Self-Management (through education)
- Studies
- HbA1c control (as a product of education, self-management, and adjusted outreach according to results stemming from the clinic’s research)

Estimate of Project Valuation for DY 3 – DY 5

Estimated Project Valuation of DY3 – DY5 (Combined):

	DY3	DY4	DY5	TOTAL
Category 1	\$ 4,500,000	\$ 4,250,000	\$ 3,350,000	\$ 12,100,000
Category 3	\$ 500,000	\$ 750,000	\$ 1,650,000	2,900,000
Estimated Total	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 15,000,000

IGT Source

IGT Source is TBD. There is available IGT sources available from various sources.

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Project Description

MEDICATION RECONCILIATION (2.11.2)

Doctors Hospital at Renaissance is implementing evidence-based interventions that put in place teams, technology and processes to avoid medication errors. This project option will include one or more of the following components:

- a) Implement a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations
- b) Implement Computerized Physician Order Entry (CPOE)
- c) Implement pharmacist-led chronic disease medication management services in collaboration with primary care and other health care providers

Intervention(s)

- a) Implementation of a medication management program that serves the patient across the continuum of care targeting one or more chronic disease patient populations
- b) Implement Computerized Physician Order Entry (CPOE)
- c) Implement pharmacist led chronic disease medication management services in collaboration with primary care and other health care providers

Each of these interventions are currently in place at Doctors Hospital at Renaissance and are ready to be bolstered significantly as this organization continues to grow. This project is a necessity to this organization as it strives to maintain its ethical model of health care that revolves around the patients' satisfaction while providing care in an efficient, safe manner.

Need for the project

The two most commonly identified drug therapy problems in patients receiving comprehensive medication management services are: (1) the patient requires additional drug therapy for prevention, synergistic, or palliative care; and (2) the drug dosages need to be titrated to achieve therapeutic levels that reach the intended therapy goals. According to the World Health Organization, adherence to therapy for chronic diseases in developed countries averages 50 percent, and the major consequences of poor adherence to therapies are poor health outcomes and increased health care cost. Some of the major barriers to adherence include:

- Lack of education on what the drugs do for the patient
- Lack of education on how to properly take the drugs
- Patients simply do not have the means to continue the drug therapy

Target population

This project will primarily target the patient population that is served by DHR. DHR treats approximately 180,000 patients annually of which an estimated 52 percent are Medicaid and 12 percent are self-pay uninsured¹.

¹ Doctors Hospital at Renaissance proprietary information available upon request.

Category 1 or 2 expected patient benefits

The specific purpose of this project area is to provide the platform to conduct Medication Management so that patients receive the right medications at the right time across the Performing Provider in order to reduce medication errors and adverse effects from medication use. Patients will also benefit by receiving the education necessary to be able to take their medications appropriately to increase their quality of life and avoid endangerment through medication errors.

Category 3 outcomes expected patient benefits

- IT-1.2 Annual monitoring for patients on persistent medications - ACE inhibitors or ARBs (Non- standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- IT-1.4 Annual monitoring for patients on persistent medications– diuretic (Non-standalone measure). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.
- IT-1.5 Annual monitoring for patients on persistent medications - anticonvulsant (Non-standalone). Our goal is to increase the appropriate monitoring tests from at least 2% in DY3 to at least 6% in DY5.

Estimate of Project Valuation for DY 3 – DY 5

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

TBD / Local

**PROPOSED THREE YEAR DSRIP PROJECT
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Unique Project Identifier: 160709501

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

MFM Women's Specialty Outreach Clinic – 1.9.1

Doctors Hospital at Renaissance is proposing to open maternal fetal medicine (MFM) woman's clinics. MFM Clinic provides high quality, comprehensive obstetrical (Ob) outpatient care for women who have a maternal, fetal, or obstetric complication. The MFM doctors can provide a consultation, co-manage prenatal care with the referring doctor, or provide all prenatal care at the referring doctor's request.

Intervention(s)

RHP5 is underserved in numbers and range of health services and falls behind Texas by 20% within the specialty of OBGYN physicians. This project is designed to improve access to women that are identified as high-risk pregnancies and are in need of specialized Ob services available through MFM care. The clinical staff includes specialty-trained physicians, registered nurses, nutritionists and social workers who provide the following services:

- High-risk obstetrics care
- Medical consultation
- Diabetes in Pregnancy Program

Need for the project

In 2010 RHP5 had a population of 1.26 million with a current of 31% (388,000) of adults with diabetes, over half (197,000) undiagnosed, and 56% (216,500) untreated. These numbers translate into almost a half million people with diabetes in this region alone. Forty percent of all families live below the federal poverty line, twice the rate for Texas. Costs for premature and low-birth-weight babies are also higher in terms of combined medical costs for the mother and child -- \$64,713, compared with \$15,047 for uncomplicated births, according to the March of Dimes. Due to the region's high poverty rates, elevated levels of diabetes, a historically underserved region, and a growing population an increase of obstetrical and MFM care is an essential need within the community. Access to this services can help avoid the following conditions:

- High blood sugar levels can be harmful to babies during the first few weeks of pregnancy. This is the time when a baby's brain, heart, kidneys and lungs begin to form.
- Babies of women with preexisting diabetes are more likely than other babies to have a birth defect, including heart defects and neural tube defects. The neural tube is the part a developing baby that becomes the brain and spinal cord.
- Extremely preterm infants (less than 29 weeks gestational age) are at increased risk for childhood impairments in brain function due to brain injury and disruptions in early brain development.¹
- Women with preexisting diabetes are more likely than women who don't have diabetes to have a miscarriage or stillbirth. Miscarriage is the death of a baby in the womb before 20 weeks of pregnancy. Stillbirth is the death of a baby in the womb after 20 weeks of pregnancy but before birth.

Access to MFM care not only benefits the patients but it helps create a more sustainable healthcare. The effects of low birth weight and prematurity strain the community as a whole. In 2001, hospital costs for preterm birth/low birth weight births, during the first year of life, totaled \$5.8 billion, representing 47 percent of all infant hospitalization costs and 27 percent of all pediatric hospital costs. Preterm/low birth weight infant hospital stays have an average cost of \$15,000 and an average length of 12 days, versus \$600 and 1.9 days for full-term, normal birth weight babies. In 50 percent of cases, private/commercial insurance is the designated payer. Medicaid is the designated payer in 42 percent of cases.²

Target population

Target population is women that are on Medicaid and meet the medical criteria for being identified as having a high-risk pregnancy. The clinics strategic location is geared for optimal access by the public for those that are in need of MFM/OB care.

¹ deRegnier RA. Neurophysiologic evaluation of brain function in extremely premature newborn infants. *Seminars in Perinatology*. 2008; 32:2-10.

² Ruseell R, et al. Cost of hospitalization for preterm and low birth weight infants in the United States. *Pediatrics*. 2007; 120(1): e1-e9

Category 1 or 2 expected patient benefits

The focus of this project is expanding high impact specialty care capacity for an at-risk population. There is a high female diabetic and obese population within RHP5 that are in need of this specialty throughout the term of their pregnancies. When the clinics are opened a strong referral base will come from Doctors Hospital at Renaissance. DHR delivers, on average, over 700-800 babies a month. With this type of high volume, MFM clinics provide an invaluable benefit to this population as this specialty promotes pregnancies coming to full-term and delivering the healthiest baby possible.

Access to these clinics will give first time mothers the clinical support they need to make educated lifestyle decisions throughout their pregnancy to encourage healthy fetus development. Such support will include dietary interventions providing the patient with an overview of vital nutritional needs. Other vital support stems from diabetic education and informing the mother of the importance of strict glucose control and the detrimental affect it will have on the baby otherwise. MFMs will be able to access the baby’s development throughout the course of the pregnancy to determine if treatment plans need to be adjusted.

The benefits not only affect the mother, but directly impact the baby as a healthy baby has greater percentages of living a healthier life overall as compared to those born into complications and typically accrue higher healthcare costs versus that of a healthy newborn.

Category 3 outcomes expected patient benefits

IT-8.2 Percentage of Low Birth-Weight births (CHIRPA/NQF # 1382) (Standalone measure)

- a. Numerator: The number of babies born weighing < 2,500 grams at birth
- b. Denominator: All births
- c. Data Source: HER, claims

Estimate of Project Valuation for DY 3 – DY 5

Three Year estimated project value: \$15,000,000.00

	DY3	DY4	DY5	TOTAL
Category 1	\$ 4,500,000	\$ 4,250,000	\$ 3,350,000	\$ 12,100,000
Category 3	\$ 500,000	\$ 750,000	\$ 1,650,000	2,900,000
Estimated Total	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 15,000,000

IGT Source

TBD / Local

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Provider Name/TPI: DOCTORS HOSPITAL AT RENAISSANCE / 160709501

Project Description

PATIENT CENTERED MEDICAL HOME: 2.1.3

RHP5 has been long considered a medically underserved area. With the proven effectiveness that comes with correctly implementing a patient-centered medical home (PCMH), barriers have continued to prevent the adoption of this model throughout the region. Doctors Hospital at Renaissance over the years has worked towards positioning itself towards creating these types of clinics and is now ready to do so through the assistance of the waiver program.

Intervention(s)

Throughout RHP5 obesity and diabetes affects a disproportionate percentage of population versus the national and state averages. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.

Need for the project

Non-communicable diseases (NCDs), mainly chronic diseases, have reached pandemic proportions and are considered to be the greatest threat to the global economy and health at this time, with a total predicted cost by 2030 of \$47 trillion.² The leading NCDs are mostly obesity driven, particularly diabetes and cardiovascular diseases; the leading health concerns of the RHP5¹

Target population

Forty percent of all families live below the federal poverty line, twice the rate for Texas. Unemployment ranges from 12 to 17%¹. Eighty percent live in urban and suburban settings, many in 'colonias' which are informal settlements with mostly substandard housing and poor infrastructure. It is this segment of population that is primarily on Medicaid or uninsured altogether. This project is targeting all available patient demographics with a special emphasis on the Medicaid population.

As an additional referral basis, DHR has a transitional case management team that is able to identify high-risk patients that are admitted through the ED. Those patients that qualify for Medicaid/Medicare and have been identified as a high-risk for readmission will be eligible to be referred to the PCMH to help ensure quality outcomes and prevent readmissions.

¹ RHP5 Community Needs Assessment

Category 1 or 2 expected patient benefits

This PCMH is focusing on category 2 type benefits as this model of health care is relatively new in this area where the traditional single physician's clinic will undergo a major redesign to offer comprehensive healthcare to the patient base. Benefits will include:

- Care that is designed around the patients chronic conditions
- Better follow-up care through a team approach
- Enhanced condition (such a diabetes) education

As a healthcare system, emergency room visits and hospital admissions are expected to decrease demonstrating effective plans of care within the patient centered medical home. These outcomes will be demonstrated through EMR records. For those that do experience an emergency room visit or hospital admission, the PCMH will be notified so that the care team can readjust / bolster their plan of care to ensure a better outcome for this individual.

Category 3 outcomes expected patient benefits

IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

a.) Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

b.) Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Diabetes has turned into an epidemic within RHP5 affecting well over 30% of the population within the region. For this cause DHR is strongly committed to utilizing multiple fronts of resources in combating this disease and increasing the quality of life for the surrounding community.

Estimate of Project Valuation for DY 3 – DY 5

Estimated three year project valuation: \$6,000,000.00

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

TBD / Local

**PROPOSED THREE YEAR DSRIP PROJECT
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Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Implement a Chronic Disease Management Registry (1.3.1)

Doctors Hospital at Renaissance (DHR) is a 500+ bed facility with a busy ED, over 500 on-staff physicians, and is home to one of the Joslin Diabetic Clinics. Although EMR is heavily integrated throughout the hospital, there is no developed chronic disease registry. DHR, through the assistance of the 1115 waiver, is now in a position to develop a comprehensive, meaningful, chronic disease registry. The registry is going to serve as a tool to provide reports about how well overall provider organizations within DHR are doing in delivering evidenced based care to specific patient populations. The registry is intended to stratify patients into risk categories in order to target interventions towards patients with the highest needs. Implementation is targeted towards the ED department, the Cancer Center at Renaissance, Joslin Diabetes Clinic, and will be integrated within the oncoming residency programs (160709501.1.1 through 160709501.1.4).

Intervention(s)

DHR is the largest hospital organization in the county with high volumes of patients that come from a stratified payor mix (primarily Medicaid). The goal is to build a user friendly registry that is used to register the various conditions and circumstances of these patients in which this registry. The registry can be disseminated throughout the communities healthcare providers to be further populated and create evidence based researched that is specific to this region. RHP5 has been long identified as an underserved area yet there has been little to no in-depth studies focused on this fast growing Medicaid population. A patient registry creates an opportunity to take a look at the patient demographics on a scalable level in efforts to adjust outreach and treatment methods.

Need for the project

Non-communicable diseases (NCDs), mainly chronic diseases, have reached pandemic proportions and are considered to be the greatest threat to the global economy and health at this time, with a total predicted cost by 2030 of \$47 trillion.² The leading NCDs are mostly obesity driven, particularly diabetes and cardiovascular diseases; the leading health concerns of the RHP5¹ The implementation and complete adoption of a chronic disease registry will assist in the following:

- Prompt physicians and their teams to conduct appropriate assessments and deliver condition-specific recommended care;
- Provide reports about how well individual care teams and overall provider organizations are doing in delivering recommended care to specific patient populations;
- Stratify patients into risk categories in order to target interventions toward patients with highest needs.

A continued lack of such a healthcare community resource prohibits meaningful outreach and treatment adjustments due to quantifiable patient metrics not being accessible on a large scale. Currently, evidence based practices are used within this region, but these practices are not developed for this unique region, and a result may not produce the optimal efficiencies and effectiveness.

¹ RHP5 Community Needs Assessment

Target population

Forty percent of all families live below the federal poverty line, twice the rate for Texas. Unemployment ranges from 12 to 17%. Eighty percent live in urban and suburban settings, many in ‘colonias’ which are informal settlements with mostly substandard housing and poor infrastructure. It is this segment of population that is primarily on Medicaid or uninsured altogether. This project will target all available patient demographics with a special emphasis on the Medicaid population. More specifically this project’s most valuable asset is data and being able to categorize it in a meaningful way. The more patients that are added within the registry the better the socioeconomics of RHP5 will be understood.

Category 1 or 2 expected patient benefits

This project falls under Category 1 infrastructure development. Once the changes have been within the providers’ facilities, patients will benefit by receiving adjusted healthcare according to their chronic condition. The research that will be available through this project will also increase awareness of the patient demographics unique situations so that outreach can be altered to best meet the needs of the hospitals inpatient population, participating outpatient populations, and the overall community.

Category 3 outcomes expected patient benefits

IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061 (Standalone measure)

Blood pressure is monitored during hospital treatment because it’s arguably one of the quickest ways to tell a patient’s current health. As a sudden rise or drop in blood pressure signals a major problem monitoring a patient’s blood pressure can give doctors and nurses the fastest notification that a patient is in crisis. It’s definitely not the most precise measurement, but it is one of the most important to monitor. Being able to pull up patient’s recent BP screen, apply it to the historical screenings, and create a trend will be an indicator if the treatment plans are working or not. Patients will benefit because according to their BP and various other tests such as HbA1c will enable the care team to readjust their treatment plan within and outside of the clinic to improve outcomes. Using the patient registry, BP trends as well as other important factors of a patient’s health are able to be assessed and treatment strategies adjusted.

Estimate of Project Valuation for DY 3 – DY 5

Estimated project valuation for DY3-DY5: \$6,000,000

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

TBD / Local

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Establishing School Clinics (1.1.1)

The development of this project is in response to the need for primary health care (PCP) for the Edinburg Consolidated Independent School District (“Edinburg CISD”) employee community as a whole while focusing on increasing ease of accessibility and limiting the amount of time an employee must be away from their work in order to receive needed healthcare. School-based health centers play a critical role in efforts to reduce disparities in health care access and child health status by providing a consistent source of primary health care in the most accessible environment. The goal will be to establish a centralized school district clinic with the location to be chosen by the district leadership and to supplement this clinic with streamlined access and reduced costs at certain private physician clinics located in strategic areas in Hidalgo County.

Edinburg CISD has an increasing trend of Medicaid enrollment rates that exceed 50%. The clinic will be open to the school district’s employees, their covered dependents, and the Medicaid student population. Electronic medical records (EMR) will be implemented at the clinic. To ensure that these patients have the most efficient care, and in any response to necessary specialty care, health information exchange technology (HIE) will also be adopted so that a consulting physician has immediate access to the patient’s information.

These clinics are intended to meet the “triple aim” of healthcare; reduce costs, improved quality and create an excellent patient experience. The clinic will administer vaccines, intercept early onset of chronic diseases, provide education on chronic disease management, and directly increase access to a primary care physician and nurse practitioner. An expected outcome will be reduced costs to the district in both funds paid for emergency care, funds paid to treat chronic conditions, and decreases in lost work productivity including absenteeism.

Specific attention will be given to those that have been diagnosed with diabetes and morbid obesity, as these two conditions have been the underlying cause of half of the admissions to hospitals in the Rio Grande Valley. Preferred access will be given at The Joslin Center at Renaissance for the newly diagnosed diabetic patients. The clinics will also be open to the Medicaid population that is in need of primary healthcare.

Intervention(s)

The primary goal of this project is to establish a school district clinic that will be centrally located for easy access as well as provide preferred access in certain private physician clinics. Additionally we are proud to offer access to the Joslin Diabetes Center at Renaissance the only one of its kind in South Texas. The Center treats diabetics with protocols developed at the world renowned Harvard Medical School as well as provides our community with access to research not otherwise available in our area.

These clinics are intended to support decreased absenteeism of staff. The methods that will be employed to reach this overarching goal will include proper vaccine administration and chronic disease detection with a management component.

The secondary goals of this project will focus on preventable conditions (such as preventing Type II diabetes progressing to Type I diabetes), admissions, and readmissions. The preventable conditions and admissions will be focused on by the initial vaccine administration to help reduce the number of patients coming down with the flu. Readmissions will be dealt with through the registries, EMR, and HIE, in the fact that the primary care providers can keep track of the patients that have been hospitalized in any given time and initiate a follow-up.

Need for the project

With thousands of employees, maintaining a healthy school district population can be challenging. The cost of office copays can be a barrier to accessing primary health care. A general lack of understanding of the significance of a healthy lifestyle can be a major barrier to the employees and their dependents obtaining preventative healthcare even when it is offered at no cost to the employee.

School-based health center care has been shown to be an important option for reducing both financial and non-financial barriers to health care, such as lack of insurance, lack of confidentiality, inconvenient office hours and locations, inability of working parents to leave their jobs to get children to care, lack of transportation, and apprehension and discomfort discussing personal problems affecting health. These clinics will provide a special attention to obesity as it serves as the major underlying cause of the majority of chronic diseases such as diabetes and hypertension. With such a large percent being disenfranchised from traditional primary health care, chronic conditions are left unmanaged, vaccinations are gone without, and overall health is left unattended to.

Target population

The target population for this project is the Edinburg CISD Staff, their dependents, with a special focus on the Medicaid student enrollees, and secondary the overall Medicaid population within the surrounding community when access is available to the clinics.

Category 1 or 2 expected patient benefits

Category 1 expected patient benefits is an expansion of available health care via a consistently available clinic that is designed to reduce the disparities and gap of health care for the children that don't normally have reliable access to a PCP. Community health benefits include a healthier student base, a healthier academic staff, and a model of healthcare that is accessible to thousands from those affiliated within the Edinburg CISD, their independents, and the surrounding community.

Category 3 outcomes expected patient benefits

IT-9.2 ED appropriate utilization (Standalone measure)

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)

Measures would be taken to compare the patient base available within the Edinburg CISD and compare those patients identification within the EMR at DHR to see who has used the ED within the past two years (FY11 & FY12) to create a trend and baseline.

Estimate of Project Valuation for DY 3 – DY 5

	DY3	DY4	DY5	TOTAL
Category 1	\$ 4,500,000	\$ 4,250,000	\$ 3,350,000	\$ 12,100,000
Category 3	\$ 500,000	\$ 750,000	\$ 1,650,000	2,900,000
Estimated Total	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 15,000,000

IGT Source

TBD / Local School District

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier:

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Increasing Mental Health Access (1.12.2)

DHR is proposing to expand the behavioral health service line through creation of an additional outpatient clinic. Outpatient clinics will help increase patient access to partial hospitalization programs and follow-up support management programs. Inpatient availability will be created and allow for medical supervision and unit stabilization. Additionally, a post-discharge support system will be created to help self-management and avoid episode reoccurrence.

Intervention(s)

Increasing access to behavioral health will take place at an individual and group level depending on the circumstances of the patients (such as a diabetic support group; or a geriatric anxiety session; or other behavioral needs). The clinic will be open to the public for those that need the help but will also help increase access to the Renaissance Behavioral Center. The clinic will serve as a follow-up clinic to encourage stabilization and prevent episode reoccurrence in the patient further preventing readmissions.

The clinic will also dramatically increase access to substance and addiction support programs.

Need for the project

Hidalgo County is considered a Health Professional Shortage Area. This project expands the accessibility of services by creating additional clinical space and the recruitment of professionals to allow for more patients to be seen. Population focus is directed towards the Medicaid population throughout the community that typically has difficulties accessing professional behavioral help. According to the RHP 5 Community Needs Assessment an estimated 28.6% of people have a measurable level of depression. An additional 30% of adults have been surveyed as having a measurable level of anxiety. These levels are expected to be further exacerbated when applied to the diabetic population due to conflicts of medication management. Some anti-psychotics and anti-depressants may increase the risk of diabetes or diabetic control by promoting weight gain, glucose intolerance and insulin resistance¹.

Within the Doctors Hospital at Renaissance spectrum of services there are no designated follow-up clinics that are designed specifically for mental health. Once patients leave the inpatient setting, DHR currently has limited resources to assist an individual in maintaining a healthy lifestyle and to avoid further and unnecessary hospitalizations. These additional outpatient-based services will allow DHR to provide enhanced resources to the patient that will help them maintain a healthy condition and keep up with their mental healthcare needs.

¹Arizona Dept. of Health Services – Division of Behavioral Health Services:
http://www.azdhs.gov/bhs/qhi/files/qhi9_provider.pdf

Target Population

Target population is the Medicaid community in need of mental health services. This project will primarily focus on currently diagnosed, at-risk, patients that are in need of follow-up care. This care will in turn help reduce readmissions.

Category 1 or 2 Expected Patient Benefits

Hidalgo County, within RHP5 is identified as a Healthcare Professional Shortage Areas (HPSA). This project directly addresses the problem by increasing service availability. Patients will have increased access to mental health care services in both the inpatient and outpatient care setting. Through these services, hospital readmissions will be reduced and preventable mental health care needs will be addressed in the right setting in the right time. Without these services, patients will experience an elevation in their current condition, a diminished quality of life, and can lead to an emergent situation.

Category 3 outcomes expected patient benefits

- IT-9.2 ED appropriate utilization (Standalone measure)
- Reduce all ED visits (including ACSC)271
 - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272
 - Reduce Emergency Department visits for target conditions
 - o Congestive Heart Failure
 - o Diabetes
 - o End Stage Renal Disease
 - o Cardiovascular Disease /Hypertension
 - o Behavioral Health/Substance Abuse***
 - o Chronic Obstructive Pulmonary Disease
 - o Asthma

Estimate of Project Valuation for DY 3 – DY 5

	DY3	DY4	DY5	TOTAL
Category 1	\$ 4,500,000	\$ 4,250,000	\$ 3,350,000	\$ 12,100,000
Category 3	\$ 500,000	\$ 750,000	\$ 1,650,000	2,900,000
Estimated Total	\$ 5,000,000	\$ 5,000,000	\$ 5,000,000	\$ 15,000,000

IGT Source

Local/TBD

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Diabetic Mental Health (2.12.2)

DHR is proposing to expand mental health services on an inpatient and outpatient level focusing on the patient population within DHR and Joslin Diabetes Clinic. These services will also be provided to the surrounding community pending program availability. The University of Houston will be collaborating on the project through utilizing their resources within the Graduate College of Social Work, Texas Obesity Research Center, Behavior Analysis Program at UH Department of Health & Human Services and the Department of Psychology at UH. The mental health services are geared towards the diabetic, Medicaid populations as they serve as a large and unique population throughout the nation, and is prominent throughout RHP5.

Intervention(s)

This project caters to the particular mental health issues that are faced by diabetic patients on an everyday basis. There are not many in-depth studies regarding the mental condition of a diabetic patient on a day-to-day basis and how it relates to depression, denial, anger, and anxiety. This outreach project expands mental care access to this at-risk population and provides invaluable information on how providers can better treat patients with diabetes.

Need for the project

RHP5 is a community that lacks access to mental health providers as a whole. Patients diagnosed with diabetes often have their own mental health care issues aside from the general population. This translates into even more limited mental health care as many behavioral providers do not have the background in diabetes to fully comprehend the issues at hand regarding diabetes. This project aims to help increase access to this patient base and better understand the mental conditions of patients that have been diagnosed with diabetes to better understand this disease in efforts to treat it.

Target population

This project targets diabetic patients within the surrounding RHP5 Medicaid population.

Category 1 or 2 expected patient benefits

Category 2 projects are intended to transform the model of healthcare. This project is unique as not only does it increase the accessibility of mental health care, it is segmented towards understanding diabetic mental conditions. This increase of access and understanding will allow the providers to help patients cope with their conditions and move towards self-management.

Category 3 outcomes expected patient benefits

IT-9.2 ED appropriate utilization (Standalone measure)

- **Reduce all ED visits (including ACSC)271**
- **Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272**
- **Reduce Emergency Department visits for target conditions**
 - o Congestive Heart Failure
 - o Diabetes
 - o End Stage Renal Disease
 - o Cardiovascular Disease /Hypertension
 - o Behavioral Health/Substance Abuse***
 - o Chronic Obstructive Pulmonary Disease
 - o Asthma

Estimate of Project Valuation for DY 3 – DY 5

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

Local / TBD

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier:

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Expanding Ophthalmic Services (1.9.2)

DHR is collaborating with the University of Houston to create eye care clinics for Medicaid eligible and indigent care patients. The goal of the project is to increase accessibility to ophthalmic healthcare for at-risk populations. The clinics will provide access to comprehensive eye care that can detect, prevent, or treat many common eye conditions.

Intervention(s)

This project provides/expands comprehensive eye care to an at-risk, Medicaid population specifically those that are diabetic (approximately 1 in 3). Common eye diseases which are more prominent for the a diabetic patient include the following:

- Diabetic retinopathy – a leading cause of blindness in American adults
- Cataract – clouding of the eye’s lens.
- Glaucoma – increase in fluid pressure inside the eye that leads to optic nerve damage and loss of vision.

Need for the project

Within RHP5 a disproportionate percentage of population (compared to national and state averages) is either diagnosed or affected by diabetes. Eye sight becomes a real concern as it serves as crucial element in self-management within any demographic but particularly those afflicted by diabetes. Diabetic retinopathy is the most frequent cause of new cases of blindness among adults aged 20-74 years. During the first two decades of disease, nearly all patients with type 1diabetes and greater than 60% of patients with type 2diabetes have retinopathy. Timely diagnosis and treatment can help prevent or delay the onset of diabetic eye disease such as retinopathy, cataract, and Glaucoma.

The comprehensive eye exam is focused on detecting systemic hypertension and vascular disease which are both indicators of diabetes within the patient, and can also be used to assess the patients overall condition to determine the method of triage after.

Target population

The project’s targeted population are patients that are on Medicaid and the working poor that are uninsured.

Category 1 or 2 expected patient benefits

This project is a specialty healthcare expansion project. The primary benefit to the targeted population is increased access to eye care. An overarching benefit that aligns itself with the entire menu of RHP5 projects is maintaining and improving a patient’s quality of life that comes with having healthy eye sight.

Without this project many patients will be denied access to eyesight care which is serves as a key element in maintaining the overall health of the community as it relates to a patient’s ability to self-manage. If vision is impaired, self-management becomes very difficult and chronic conditions will be more likely to advance ending up in an increase of preventable conditions, admission, and readmissions.

Category 3 outcomes expected patient benefits

IT-1.12 Diabetes care: Retinal eye exam235—NQF 0055 (Non - stand alone measure)

a.) Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
- A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

b.) Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

Estimate of Project Valuation for DY 3 – DY 5

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

Local / TBD

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier:

Provider Name/TPI: Doctors Hospital at Renaissance / 160709501

Project Description

Pharmacist Led Medication Management (2.11.1)

DHR, in combination with the University of Houston, will create pharmaceutical care services through an ambulatory setting for patients with Type 1 & 2 diabetes. The clinic's staffing will be comprised of academic clinical pharmacy faculty, and community ambulatory care clinical pharmacists. Each staff member within the clinical locations will complete a diabetes certificate program geared towards education as it relates to medication therapy plans.

Intervention(s)

The medication management clinics will be created to address the major causes of medication errors and low levels of medication utilizing throughout RHP5. The major causes of medication errors are as follows:

- A language barrier between physician and patient.
- Patients do not know what the medication is specifically for.
- There is little patient knowledge on proper medication administration.
- There is little communication between healthcare providers preventing proper medication management.

This project reaches out to the diabetic community to educate and manage the patient's medication panel over a period of time to encourage stabilization of their condition and develop a level of self-management.

Need for the project

Medication errors account for over \$17 billion in costs throughout the healthcare system. The most common errors are improper dose of medicine, giving the wrong drug, and using the wrong route of administration. The most at-risk patients are those with multiple chronic conditions since they are on a panel of prescription medications. These types of errors can be reduced by increased communication of the physician and pharmacist, electronic ordering to ensure accuracy, and educating the patient on how to properly take their medications. In RHP5, over 30% of the population is diagnosed or affected by diabetes a chronic condition that often takes administration of insulin within the blood stream. The process of administration requires:

1. Knowing the difference between good and bad glucose levels
2. Ability & know-how to do math calculations to administer the proper dosage of insulin.
3. Being able to properly inject the insulin; or know-how of when to take insulin pill.

Without proper education and attention to detail, poor adherence to this crucial element of glucose control for diabetics can result in long-term adverse effects that only complicate the condition and requires a more involved level of healthcare management. (loss of eye sight, organ damage, amputations, ulcers, diabetic coma)

TARGET POPULATION

Target population is the Medicaid diabetic population and the elderly dual eligible population (those that are on both Medicaid and Medicare at the same time due to circumstances). The program is open to all Medicaid patients pending program capacity to further benefit the RHP5 community.

Category 1 or 2 expected patient benefits

This is a category 2 project that will transform the model of healthcare within the RHP5 population. Patient benefits within this project include:

- Individualized medication management and education
- Increased patient satisfaction in the level of care received.
- Increased safety and quality

Studies show that this targeted population, without access to follow-up care and healthcare management typically have the poorest health comes. This project serves as a component within the overall RHP5 plan towards increasing the patients’ quality of life through ensuring proper drug treatment and self-management.

Category 3 outcomes expected patient benefits

The use of medication for diabetic patients, even with proper diet, is a crucial element in maintaining healthy glucose levels. When medications are not used correctly, glucose levels can either crash or escalate quickly putting the patient in harm’s way escalating to an emergent situation leading to admission or readmission to the ED. The category 3 project that is going to be implemented to help decrease preventable readmissions is:

IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

- a.) Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
- b.) Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Estimate of Project Valuation for DY 3 – DY 5

DY2	DY3	DY4	TOTAL
\$1,800,000.00	\$1,700,000.00	\$1,340,000.00	\$4,840,000.00
\$200,000.00	\$300,000.00	\$660,000.00	\$1,160,000.00
<i>Cat. 3 Min 10%</i>	<i>Cat. 3 Min 15%</i>	<i>Cat. 3 Min 33%</i>	
\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$6,000,000.00

IGT Source

Local / TBD.

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501.1.6

**Provider Name/TPI:
Doctors Hospital at
Renaissance / 160709501**

Project Description

Project Option 1.2.4 Establish Primary Care/Pediatric Residency Training Program, with emphasis in communities designated as health care provider shortage areas (HPSAs)

Doctors Hospital at Renaissance (DHR) proposes to create an ACGME-accredited primary care pediatric residency training program at DHR in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.

Intervention(s)

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Doctors Hospital at Renaissance (DHR) will establish a new primary care/Pediatric residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce. Allaying the shortage of primary care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.

Need for the project

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide. This project will greatly increase the pipeline for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community. Although RHP 5 has 13.8 pediatricians per 100,000 population (compared to 12.8) statewide, RHP 5 has a younger population than the rest of the state. In Hidalgo County, the median age is 28.3 years compared to 33.6 years for Texas. In addition, the four counties of RHP has among the highest proportion of children living in poverty, ranging from 45% to 55%. In addition, more than half of RHP 5 adolescents are overweight or obese, which contributes to diabetes and other health issues throughout youth and into adulthood. More adolescents are obese than overweight.

CN. 1 Shortage of primary and specialty care providers and inadequate access to primary or preventive care

Target population

The target population for this project will be children, especially children enrolled in Medicaid and low income uninsured children.

Category 1 or 2 expected patient benefits

New program faculty will increase access to care in the early years of the project. After the residency program is accredited in 2015, residents will be recruited to begin training and providing care to patients in 2016. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic disease management, and quality improvement.

QPI: DY 3: Provide 2,000 patient care encounters by new providers
DY 4: Provide 4,000 patient care encounters by new providers
DY 5: Provide 6,000 patient care encounters by new providers

At least 50% of the patients served will be Medicaid enrollees or low income uninsured.

Category 3 outcomes expected patient benefits

IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Estimate of Project Valuation for DY 3 – DY 5

Category 1: DY 3	\$3,150,000	Category 3: DY 3	\$450,000
DY 4	\$3,210,000	DY 4	\$685,000
DY 5	<u>\$2,110,000</u>	DY 5	<u>\$1,365,000</u>
	\$8,470,000		\$2,500,000

I GT Source

The University of Texas Health Science Center at San Antonio.

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 160709501.1.7

**Provider Name/TPI:
Doctors Hospital at
Renaissance / 160709501**

Project Description

Project Option 1.2.4 Establish Primary Care/Preventive Medicine Residency Training Program, with emphasis in communities designated as health care provider shortage areas (HPSAs)
Doctors Hospital at Renaissance (DHR) proposes to create an ACGME-accredited primary care Preventive Medicine residency training program at DHR in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.

Intervention(s)

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA) and address the overwhelming health disparities present in RHP 5. Doctors Hospital at Renaissance (DHR) will establish a new primary care/Preventive Medicine residency training program in partnership with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce. Allaying the shortage of primary care providers will increase access to care in the appropriate time and place, reduce inappropriate and costly emergency department utilization, increase patient satisfaction, and improve the health of the community.
Preventive Medicine focuses on the promotion, protection, and maintenance of health and well-being, the prevention of disease and disability, and the premature death of individuals in defined populations. Public health and general preventive medicine focuses on health promotion and disease prevention in communities and other defined populations. This area of medicine is especially needed in RHP 5 where poverty and disease burden are greatest.

Need for the project

In RHP 5, there are only 55 primary care physicians per 100,000 population, as noted in the community needs assessment of this Plan. This compares to 70 per 100,000 statewide. This project will greatly increase the pipeline for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.

The five leading causes of death for adults in RHP 5 are heart disease, cancer, diabetes, strokes, and accidents. In addition, diabetes and obesity are critical health issues for adults and children in RHP 5.

CN. 1 Shortage of primary and specialty care providers and inadequate access to primary or preventive care

Target population

The target population for this project will be those most prone to chronic illness: children and adults with obesity and/or diabetes as well as those who have low incomes and minimal access to health care and health education.

Category 1 or 2 expected patient benefits

New program faculty will increase access to care in the early years of the project. After the residency program is accredited in 2015, residents will be recruited to begin training and providing care to patients in 2016. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic disease management, and quality improvement.

QPI: DY 3: Provide 2,000 patient care encounters by new providers
DY 4: Provide 4,000 patient care encounters by new providers
DY 5: Provide 6,000 patient care encounters by new providers

At least 50% of the patients served will be Medicaid enrollees or low income uninsured.

Category 3 outcomes expected patient benefits

IT-14.1 Our goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Estimate of Project Valuation for DY 3 – DY 5

Category 1: DY 3	\$3,150,000	Category 3: DY 3	\$450,000
DY 4	\$3,210,000	DY 4	\$685,000
DY 5	<u>\$2,110,000</u>	DY 5	<u>\$1,365,000</u>
	\$8,470,000		\$2,500,000

I GT Source

The University of Texas Health Science Center at San Antonio.

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 154504801.2.1

Provider Name/TPI: Harlingen Medical Center / 154504801

Project Description

This project will implement a medication management program using an outpatient pharmacist, electronic medical records, and computerized physician order entry (CPOE). The medication management program will conduct medication reconciliation, track medications being taken by patients (including use of printed lists), and monitor medication administration. Medication management can help increase patient compliance with an appropriate medication related treatment. Such a program improves patient safety and clinical outcomes because proper medication usage helps patients to control health conditions and improve health outcomes, as well as prevent readmission due to non-adherence to the prescribed medication regimen.

Intervention(s)

We have selected Project Option 2.11.2 Conduct Medication Management: Evidence-based interventions that put in place the teams, technology and processes to avoid medication errors. This project implements medication management, CPOE, and pharmacist-led chronic disease medication management in order to promote appropriate use of medications to improve health and control conditions.

Need for the project

As sited in the community needs assessment, the region experiences inadequate integration of care for individuals with multiple health issues (CN.3) and a lack of patient-centered care (CN.4). Many patients do not understand their care regimen or may be receiving contradicting information from various providers. This project would improve medication management so that patients – particularly those with multiple health issues – are appropriately and safely using medications to improve their health.

Target population

This project will provide medication management services to 5,459 unique individuals in DY 4 and 5,500 unique individuals in DY 5. Of those patients, we estimate approximately 26% would be Medicaid, indigent, or uninsured.

Category 1 or 2 expected patient benefits

The project seeks to improve medication management through evidence-based interventions that put in place the teams, technology, and processes to avoid medication errors and prevent readmissions, as evidenced by an anticipated total of 5,459 unique individuals in DY 4 and 5,500 unique individuals in DY 5 receiving medication management services. Medication management is especially important for patients taking multiple medications to address chronic illness and co-occurring diseases such as acute myocardial infarction (AMI) and congestive heart failure (CHF). This project will increase the percentage of targeted patients consistently receiving medication management counseling at the point of care; increase the percentage of discharged patients who received medication reconciliation; and increase the number of unique patients that have medications reconciled as a standard part of the discharge process.

Patients would benefit from:

- Improved medication reconciliation
- Medication orders
- Pharmacist consultation
- Patient-centered and better coordinated care
- Increased understanding of and compliance with the medication regimen
- Higher quality health care
- Improved health status
- Improved patient safety
- Reduced risk of re-hospitalization

Category 3 outcomes expected patient benefits

This project will reduce the rate of readmission for high-risk patients:

- 1) IT-3.2 Congestive Heart Failure (CHF) 30-day Readmission Rate (Standalone measure) – our goal is to reduce this rate by 20% over baseline by DY 5
- 2) IT-3.5 Acute Myocardial Infarction (AMI) 30-day Readmission Rate (Standalone measure) – our goal is to reduce this rate by 20% over baseline by DY 5

Estimate of Project Valuation for DY 3 – DY 5

Category 2 Project:

DY 3: 500,000

DY 4: 500,000

DY 5: 500,000

TOTAL: 1,500,000

IGT Source

Cameron County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 154504801.2.2

Provider Name/TPI: Harlingen Medical Center / 154504801

Project Description

This project will improve care transitions so that patients receive appropriate and timely follow-up care and avoid being re-hospitalized for reasons that could have been prevented. This project will adopt a proven care transitions model for patients at risk of readmission, develop standardized clinical protocols and a care delivery model, implement optimum hospital discharge planning and processes, connect patients to outpatient settings for timely access to care following a hospitalization, use data and information to drive decision-making and promote care coordination, and conduct quality improvement. We plan to utilize nurses specifically in charge of care transitions to meet with patients from the time they are admitted through their discharge. After discharge, the nurses make home calls, ensuring medications and discharge instructions are being followed and patients are attending follow-up appointments with primary care physicians. The overall goal of this project is to implement smooth transitions of care from inpatient to outpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk of avoidable readmissions.

Intervention(s)

We have selected Project Option 2.12.1 Implement/Expand Care Transitions Programs: Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions. This project improves care transitions from inpatient to outpatient settings in order to reduce unplanned readmissions.

Need for the project

As sited in the community needs assessment, the region experiences: a shortage of primary and specialty care providers (CN.1), inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). Many patients do not receive appropriate, ongoing care in community-based settings. This project would improve care transitions from the hospital so that patients receive the post-hospitalization care they need, reducing the risk of re-hospitalizations.

Target population

This project will serve 5,459 unique individuals in DY 4 and 5,500 unique individuals in DY 5 according to care transitions guidelines. Of those patients, we estimate approximately 26% would be Medicaid, indigent, or uninsured.

Category 1 or 2 expected patient benefits

The project seeks to improve care transitions from acute care to community-based settings, as evidenced by an anticipated total of 5,459 unique individuals in DY 4 and 5,500 unique individuals in DY 5 receiving care according to care transitions guidelines. We will implement care transitions evidence-based protocols and standardized care transition processes; increase the percentage of discharged patients eligible for care transitions services that receives those services; and increase the number of patients in the case management related registry. Patients would benefit from:

- Improved hospital discharge processes
- Timely post-hospitalization care
- Reduced risk of needing acute care services 30-60 days post-discharge
- Right care at the right time in the right setting
- Improved patient health

Category 3 outcomes expected patient benefits

We have selected outcome measure IT-3.1 Hospital-Wide All-Cause Unplanned Readmission Rate – (Standalone measure). This project would reduce the 30-day readmission rate by 20% over baseline by DY 5.

Estimate of Project Valuation for DY 3 – DY 5

Category 2 Project:

DY 3: 500,000

DY 4: 500,000

DY 5: 500,000

TOTAL: 1,500,000

IGT Source

Cameron County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 135035706.1.1

Provider Name/TPI: Knapp Medical Center / 135035706

Project Description

We propose to establish a new primary care clinic. This clinic would provide Mid-Valley residents with primary care services so that residents would not need to use the ED for primary care, or forgo seeking care altogether. This clinic will also serve a key community benefit role in participating in the new primary care residency program that is desperately needed in the Rio Grande Valley, given the area's severe primary care workforce shortage (anticipated program start date July 2015). Finally, this clinic would further enhance Knapp Medical Center's ability to provide needed prevention, primary and chronic care services. The clinic would be promoting ongoing, evidence-based screenings and tests so that patients' care is proactive, managed and patient-centered. The new clinic would be operated based on the medical home model.

Intervention(s)

We have selected Project Option 1.1.1 Expand Primary Care Capacity: Establish more primary care clinics. This project establishes a primary care clinic in Mid-Valley for a low-income patient population.

Need for the project

As cited in the community needs assessment, the region experiences: a shortage of primary and specialty care providers (CN.1), inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). Many Mid-Valley residents do not receive timely, ongoing and patient-centered care in community-based settings. The clinic would help a market struggling to meet the primary care needs of its population. South Texans experience extreme levels of economic and health disparities that are exacerbated by low levels of health insurance, including a lack of access to and utilization of needed health care services. The South Texas area faces a shortage of primary care professionals to serve a growing population, with only half to three-quarters of the physician-to-population ratios of Texas for primary care specialists (e.g., family practice, general practice, OB/GYN). The current delivery system does not have the capacity to identify individuals with or at risk for chronic conditions and to navigate them into appropriate programs to help prevent, diagnosis and manage their health conditions. The region has an unprecedented epidemic of chronic disease – particularly diabetes and related chronic conditions – that is fueled by high levels of adult and childhood obesity. Many residents seek primary care in the ED, or let their conditions go untreated, which puts the patient at increased risk of needing ED or acute care services. This project would establish a new primary care clinic so that patients can receive more preventative, primary and chronic care in order to stay healthy and out of the ED/hospital.

Target population

This project would provide 2,500 primary care encounters in DY 4 and 3,000 in DY 5. Of those patients, we estimate approximately 25% would be Medicaid, indigent or uninsured individuals.

Category 1 or 2 expected patient benefits

The project expands primary care capacity so that Mid-Valley residents have increased access to primary care services, as evidenced by an anticipated total of 2,500 primary care encounters in DY 4 and 3,000 in DY 5. Patients would benefit from:

- Increased access to preventative, primary and chronic care
- Reduced risk of delayed or forgone needed treatment
- Right care at the right time in the right setting
- Improved preventative tests/screening/vaccination rates
- Improved chronic care management
- Improved patient care
- Improved health outcomes
- More patient-centered care
- Reduced need for ED/hospital services

Category 3 outcomes expected patient benefits

We have selected outcome measure IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – (Standalone measure). As a result of expanding primary care capacity, we expect to reduce the number of diabetics with HbA1c levels out of control, signifying improved health and better managed care.

Estimate of Project Valuation for DY 3 – DY 5

Overall Valuation:

DY 3: \$999,529

DY 4: \$1,069,853

DY 5: \$1,169,400

TOTAL: \$3,238,782

Breakdown:

Category 1 Project:

DY 3: \$799,529

DY 4: \$801,853

DY 5: \$662,400

TOTAL: \$2,263,782

Category 3 Outcome:

DY 3: \$100,000

DY 4: \$161,000

DY 5: \$390,000

TOTAL: \$651,000

Category 4 Reporting:

DY 3: \$100,000

DY 4: \$107,000

DY 5: \$117,000

TOTAL: \$324,000

OVERALL: \$3,238,782

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.2.1

Provider Name/TPI: South Texas Health System / 094113001

Project Description

South Texas Health System proposes to work with Nuestra Clinica (a nine-clinic network) to implement a certified patient centered medical home (PCMH) model of care to provide safety net primary health care services to targeted patients who live in HPSA, rural, and impoverished areas of Hidalgo County. As such, this project would improve access to comprehensive, primary, preventative and chronic care through the implementation of the medical home model.

Although Nuestra Clinica is a Federally Qualified Health Center and receives grant funding to help with operations, no federal grant dollars will be expended for the positions budgeted for in the 1115 waiver contract. These positions are vital to the successful progression to a Joint Commission PCMH designation and to the improvement in health care outcomes for the population in RHP 5. The nine clinics of Nuestra Clinica network participate in the Medicaid Managed Care program, Title V Maternal & Child Health, Title V Dental, CHIP Perinatal, Texas Family Planning, Healthy Start program, and CHIP Outreach.

UTHSCSA/RAHC and Nuestra Clinica also work closely with area hospitals including McAllen Medical Center, Edinburg Regional Medical Center, Mission Regional Medical Center and Rio Grande Regional Medical Center.

Intervention(s)

This project will implement a certified patient centered medical home (PCMH) model of care to provide safety net primary health care services to targeted patients who live in HPSA, rural, and impoverished areas of Hidalgo County. This will be achieved through a partnership with Nuestra Clinica, a primary care clinic network that serves the poor and underserved of Upper Valley.

Need for the project

As cited in the community needs assessment, RHP 5 suffers from a shortage of primary care (CN.1), inadequate integration of care for individuals with multiple chronic conditions (CN.3), and a lack of patient-centered care (CN.4). More than 67% of the population has one or more chronic conditions. A similar proportion currently does not have health insurance. These statistics mean that preventive care and intervention is largely neglected and patients often only present when they develop severe illnesses requiring Emergency Department or Inpatient care.

Therefore, there is a need for ongoing, coordinated care, including preventative, primary and chronic care. The PCMH model is viewed as a foundation for such care by providing patients with a regular source of care. This project would convert nine Nuestra Clinica sites into patient-centered medical homes in order to provide more preventative and proactive primary and chronic care that is both coordinated and patient-centered.

Target population

The project would cover nine existing service sites located in San Juan (3), Mission (2), Edinburg, Donna, Edcouch and Mercedes. These sites served 31,887 medical and dental patients, equating to approximately 4.0% of the total population of Hidalgo County. The target population includes the uninsured and under-served, those below 200% of poverty, migrant and seasonal farmworkers, Hispanics, women and children. The clinic's service area ranks as one of the poorest in the nation: Approximately 83.19% of our patients are at or below 100% of Poverty; 98.29% are at or below 200% of Poverty. Of the 31,887 patients, 81.94% are uninsured, 8.34% are on Medicaid/CHIP, 6.16% are on Medicare, and 3.56% are covered by other 3rd party forms of payment. All patients are expected to benefit from the Patient Centered Medical Home model. We expect to serve at least 30,000 unique individuals in DY 3; 31,000 individuals in DY 4 and 32,000 in DY 5 under the patient-centered medical home model, of whom we expect approximately 82% to be Medicaid, indigent or uninsured.

Category 1 or 2 expected patient benefits

Patients will benefit from a regular source of preventative, primary and chronic care that is proactive, comprehensive and coordinated. As such, patients can better manage their conditions, thereby staying healthy and out of the ED/hospital. Thus, this project will improve patient care and reduce health system costs. We are targeting enrolling 10% of the population to get enrolled into the PCMH model.

Category 3 outcomes expected patient benefits

By DY 5, the clinic expects a 10% decrease in the percentage of diabetic patients whose HbA1c levels are greater than 9.0% (poor control) (IT-1.10). For the baseline year of 2012, that percentage was 45.71%.

Estimate of Project Valuation for DY 3 – DY 5Total Valuation Categories 1 - 4:

DY 3: \$1,403,870

DY 4: \$1,888,279

DY 5: \$2,791,303

TOTAL: \$6,083,452

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.1.2

Provider Name/TPI: South Texas Health System / 094113001

Project Description

STHS will pursue designation as an American College of Surgeons Level III Trauma Center at Edinburg Regional Medical Center. This project will require the development and implementation of new trauma care processes, expansion and renovation of current trauma care clinical facilities, improved access to specialty physicians to care for an expanded population of injured patients, and the development of a comprehensive care system in the local community that brings together ground and air EMS, the emergency department, referring hospitals, freestanding emergency centers, trauma surgeons, multiple subspecialties and rehabilitation facilities.

The target population is trauma care patients who reside in the primary and secondary service areas. Edinburg Regional Medical Center had approximately 8,880 trauma patient encounters last year, and approximately 40% of these encounters were with Medicaid or uninsured patients. Therefore, we are expecting that a similar number of trauma patients will benefit from the enhanced trauma services each year and a similar percentage of the patients benefiting from this project will be Medicaid or uninsured patients each year.

This project will involve the following core 1.9.2 project components as these relate to the development and expansion of trauma care clinical facilities:

- a. Increase specialty trauma service availability with extended trauma care services/procedure hours. We will facilitate the increase in total specialty care trauma services/procedure hours by recruiting additional specialty care physicians in targeted specialty areas.
- b. Increase/expand specialty trauma care clinical facilities. The specialty care physicians will be located in new and/or enhanced trauma facilities. The new/enhanced trauma facilities will have space for the new physicians to provide specialty trauma care services to patients in the community.
- c. Implement transparent, standardized referrals across STHS' trauma system. A referral system will be used to ensure that patients receive timely access to appropriate trauma care services.
- d. Conduct quality improvement for project using methods such as rapid cycle improvement. STHS' quality improvement activities will include implementing a comprehensive performance improvement review process for trauma and create actions plans to address deficiencies in criteria, coverage or performance.

Intervention(s)

We have selected Project Option 1.9.2 Expand Specialty Care Capacity: Improve access to specialty care. This project will expand access to specialized trauma services through the development and implementation of new trauma care processes, expansion and renovation of current trauma care clinical facilities, and improved access to specialty care physicians.

Need for the project

Currently, Edinburg Regional Center which is part of STHS is designated by the Texas Department State of Health Services as a Level IV Trauma Center. Year to date in 2012, ERMC received 740 trauma patients per month. Of these, approximately 2% were admitted and an additional 1% were transferred to a higher level of care because subspecialty services are not readily available in the local community. These statistics do not include patients transported to higher levels care from the scene or those transferred from other area health care facilities.

Target population

The target population is trauma care patients who reside in STHS’s primary and secondary service areas. STHS had approximately 8,880 trauma patient encounters last year, and approximately 40% of these encounters were with Medicaid or uninsured patients.

Therefore, we are expecting to provide 9,058 trauma care encounters in DY 3; 9,239 encounters in DY 4 and 9,425 encounters in DY 5, with a similar percentage of Medicaid or uninsured patients.

Category 1 or 2 expected patient benefits

The development and implementation of a Level III Trauma Center at Edinburg Regional Medical Center will enhance specialty care services in Hidalgo County while reducing the number of patients transferred to higher level Trauma Centers. This will result in:

- Higher patient satisfaction
- Reduction in time to definitive care
- Improved patient outcomes
- Expanded availability of specialty care in the local community
- Reduction of health system costs.

Our goal is to increase Trauma Services (via Trauma Registry) up to 2750 patients for DY 3, 2% improvement of DY 3 patients for DY 4, and 2% improvement of DY 4 patients for DY 5.

Category 3 outcomes expected patient benefits

OD-4 Potentially Preventable Complications, Healthcare Acquired conditions and Patient Safety-Intensive Care: Incidence of Hospital-acquired Venous Thrombembolism (VTE) (SA)-Our goal is to initiate prophylaxis from intake to disposition to prevent VTE.

OD-4 Potentially Preventable Complications, Healthcare Acquired conditions and Patient Safety-Intensive Care:

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat 1 - 4:

DY 3: \$2,725,764
DY 4: \$2,935,163
DY 5: \$3,809,109
TOTAL: \$9,470,036

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.2.1

Provider Name/TPI: South Texas Health System / 094113001

Project Description

The goal of this project is to increase primary care access and capacity by expanding and restructuring clinic hours, decreasing the amount of time for patients to obtain appointments, and by enhancing same-day walk-in clinics to accommodate patients with acute illnesses and/or in need of preventive care. This project will expand the capacity of primary care to better accommodate the needs of the regional patient population and community. Expanding providers in our extended hour clinics will improve access and care for patients. Valley Care Clinic is the area's preferred multi-specialty medical group, 57 physicians and mid-levels representing 6 specialties in 10 clinic locations. VCC provides almost 24,000 visits and 41,000 procedures, Medicaid and self-pay represents nearly 24% of VCCs total volume and the costs to treat those patients was over \$3 million.

Intervention(s)

Goal is to expand and enhance primary care with a minimum of 10 full time providers, physicians and mid-levels, to open access and lower wait time. A mid-level will work with nursing homes to improve care, better coordinate the appointments and accommodate the needs of the patients. Clinic hours and additional locations will be enhanced based on the demand for services, access to providers, wait time for appointments, and gap analysis providing additional new access capacity.

Need for the project

Shortage of primary care providers has resulted in a waiting list for Medicaid and Medicare patients and extremely limited access for uninsured patients.

Target population

We anticipate at least 2,000 additional patient visits will be achieved by DY 5. Openings will be available to all patients with an expectation that 40% of the patient population will be Medicaid and/or uninsured.

Category 1 or 2 expected patient benefits

VCC will hire 10 additional physicians and mid-level staff by DY 5 and will increase extended hours during the evenings and weekends. Space availability will be determined and measures implemented to best accommodate the patient population. Additional expansion will occur using current providers who will extend their work days. As the largest provider of primary care in Region 5 this will address the need for additional primary care capacity. For reporting purposes the following visits are anticipated:

DY 3: 1,000 DY 4: 1,250 and DY 5: 1,500.

Category 3 outcomes expected patient benefits

IT-6.1 Percent improvement over baseline of patient satisfaction scores is the outcome measure.

Surveys provide feedback on accessing care in our facilities, set benchmarks, and trends over time. Our goal will be to identify predictors of patient satisfaction and experience with access to primary care using the CG-CAPHS survey.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat. 1 -4:

DY 3: \$5,000,000

DY 4: \$5,000,000

DY 5: \$5,000,000

TOTAL: \$15,000,000

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.1.6

Provider Name/TPI: South Texas Health System / 094113001

Project Description

The goal for this project is to increase the capacity to provide psychiatry services, and increase the availability of psychiatry providers to better accommodate the high demand for psychiatry care so that patients have increased access. The project goal will be to add capacity through hiring for the equivalent of two Psychiatrist Board Certified for both adults and children in order to address access and capacity issues.

Intervention(s)

We have selected Project Option 1.14.1 Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas: Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or in localities within non-HPSA counties which do not have access equal to the rest of the county. This project will enable STHS to expand psychiatry access by the equivalent of two full time Board Certified Adult and Child psychiatrist through employment of services. The project will be an expansion of STHS' current psychiatric service.

Need for the project

As cited in the community needs assessment, there is a shortage of behavioral health care providers (CN.2). Currently, STHS provides access to one Child Psychiatrist, resulting in lengthy wait times for initial and follow up appointments. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations.

Target population

Our target population is the estimated 298,500 (28.6%) people in the RHP5 adult population with a measurable level of depression based on a random population based survey. This excludes the VA population in RHP5. We expect to provide 2,000 unique individuals with behavioral health services in DY 3; 2,500 in DY 4 and 3,500 in DY 5. Of these, we expect 40% to be Medicaid, indigent or uninsured patients.

Category 1 or 2 expected patient benefits

This project will increase access to behavioral health care services, providing 2,000 unique individuals with behavioral health services in DY 3; 2,500 in DY 4 and 3,500 in DY 5, resulting in 5% reduction in inappropriate use of Emergency Department care by individuals with mental illness or substance use disorders. Patients would benefit from increased access to psychiatrists, resulting in right care at the right time in the right location. This project will improve timely access to psychiatric care following an inpatient stay and reduce readmissions. Increased capacity will positively impact the ability to see patients in a timely manner following inpatient stays.

Category 3 outcomes expected patient benefits

We have selected the following outcome:

IT-1.18 Follow-Up After Hospitalization for Mental Illness (Standalone Measure). By DY 5, an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner will occur within 7 days after discharge.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat. 1 – 4:

DY 3: \$3,291,206

DY 4: \$2,753,893

DY 5: \$3,584,745

TOTAL: \$9,629,844

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier:

Provider Name/TPI: South Texas Health System / 094113001

Project Description

This project will expand specialty capacity by locating Freestanding EDs in the Rio Grande Valley. The Rio Grande Valley is experiencing significant population growth in almost every geographic sector. Because of the population size of Hidalgo County 800,000 and the MSA 1.25 million and this projected growth will continue to be underserved by primary care providers and emergency health care services. The target population is our patients that need emergency services in areas demonstrating community need. Approximately 40% of patients are either Medicaid and/or indigent patients, and are expected to benefit from this project.

Intervention(s)

Project components included in the Freestanding ED:

- Increase service availability with extended hours – operating hours are 24 hours/365 days of the year
- Increase number of specialty clinic locations
- Implement transparent, standardized referrals across the system
- Conduct quality improvement for project

Need for the project

The project addresses the Community Needs Assessment for these items:

- CN.1 – Texas ranks last in the nation on health care quality. RHP 5 is challenged to deliver improved quality and patient satisfaction.
- CN.3 – Many residents of RHP 5 lack access to medical and dental care due to high rates of uninsurance and health care provider shortages.

Target population

The target population is our patients that need emergency services in areas demonstrating community need. Approximately 45% of patients are either Medicaid and/or indigent patients, are expected to benefit from this project. These patients will be served equally as any other patient presenting to this emergency center.

Category 1 or 2 expected patient benefits

The project seeks to provide increase emergency room visits in an area of community need by 5,000 visits in DY 3; 12,500 visits in DY 4; and 13,750 visits in DY 5.

Category 3 outcomes expected patient benefits

IT-6.1 Patient Satisfaction

Our goal is to increase number of patient's surveys by 4% by DY 4 and reach the 50th percentage of patient satisfaction.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Category 1 – 4:

DY 3 - \$5,000,000

DY 4 - \$5,000,000

DY 5 - \$5,000,000

Total - \$15,000,00

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.1.2

Provider Name/TPI: South Texas Health System / 094113001

Project Description

STHS will pursue designation as an American College of Surgeons Level II Trauma Center. This project will require the development and implementation of new trauma care processes, expansion and renovation of current trauma care clinical facilities, improved access to specialty physicians to care for an expanded population of injured patients, and the development of a comprehensive care system in the local community that brings together ground and air EMS, the emergency department, referring hospitals, freestanding emergency centers, trauma surgeons, multiple subspecialties and rehabilitation facilities. As a result, fewer patients will need to be transferred to Level I Trauma Centers in San Antonio.

The target population is trauma care patients who reside in STHS's primary and secondary service areas. STHS had approximately 17,483 trauma patient encounters last year, and approximately 40% of these encounters were with Medicaid or uninsured patients. Therefore, we are expecting that a similar number of trauma patients will benefit from the enhanced trauma services each year and a similar percentage of the patients benefiting from this project will be Medicaid or uninsured patients each year. Further, approximately 181 STHS (ECH/ERMC =92, MHH =4, MCC = 85) trauma patients each year will be able to avoid transfer from STHS to a higher level facility, in addition to those patients that will benefit from being transported to STHS directly from the scene instead of having to be transported from the scene to another higher level trauma care facility.

This project will involve the following core 1.9.2 project components as these relate to the development and expansion of trauma care clinical facilities:

- a. Increase specialty trauma service availability with extended trauma care services/procedure hours. We will facilitate the increase in total specialty care trauma services/procedure hours by recruiting additional specialty care physicians in targeted specialty areas.
- b. Increase/expand specialty trauma care clinical facilities. The specialty care physicians will be located in new and/or enhanced trauma facilities. The new/enhanced trauma facilities will have space for the new physicians to provide specialty trauma care services to patients in the community.
- c. Implement transparent, standardized referrals across STHS' trauma system. A referral system will be used to ensure that patients receive timely access to appropriate trauma care services.
- d. Conduct quality improvement for project using methods such as rapid cycle improvement. STHS' quality improvement activities will include implementing a comprehensive performance improvement review process for trauma and create actions plans to address deficiencies in criteria, coverage or performance.

Intervention(s)

We have selected Project Option 1.9.2 Expand Specialty Care Capacity: Improve access to specialty care. This project will expand access to specialized trauma services through the development and implementation of new trauma care processes, expansion and renovation of current trauma care clinical facilities, and improved access to specialty care physicians.

Need for the project

The need for additional trauma care has been recognized by community stakeholders as one of the most significant healthcare issues facing Region 5. Because there is no Level I or Level II trauma centers in Region 5, many trauma patients must be transported to San Antonio or Corpus Christi, which takes 120 to 240 minutes by ground depending on the starting location within the Region. The additional time required to be transported to the Level I trauma centers or remaining at a non- or lesser-designated facility can result in increased morbidity and mortality for trauma patients. As noted in the community health needs assessment, there is a lack of patient-centered care (CN.4).

Currently, McAllen Medical Center with is part of STHS is designated by the Texas Department State of Health Services as a Level III Trauma Center. Year to date in 2012, STHS receives 1457 trauma patients per month. Of these, approximately 10.3% are admitted and an additional 1.04% are transferred to a higher level of care because subspecialty services are not readily available in the local community. These statistics do not include patients transported to higher levels care from the scene or those transferred from other area health care facilities.

Target population

The target population is trauma care patients who reside in STHS's primary and secondary service areas. STHS had approximately 17,483 trauma patient encounters last year, and approximately 40% of these encounters were with Medicaid or uninsured patients.

Therefore, we are expecting to provide 17,833 trauma care encounters in DY 3; 18,190 in DY 4 and 18,554 in DY 5, with a similar percentage of Medicaid or uninsured patients.

Category 1 or 2 expected patient benefits

The development and implementation of a Level II Trauma Center at STHS will enhance specialty care services in Hidalgo County while reducing the number of patients transferred to Level I Trauma Centers in San Antonio. This will result in:

- Higher patient satisfaction
- Reduction in time to definitive care
- Improved patient outcomes
- Expanded availability of specialty care in the local community
- Reduction of health system costs.

Our goal is to increase Trauma Services (via Trauma Registry) up to 1,250 patients for DY 3, 2% improvement of DY 3 patients for DY 4, and 2% improvement of DY 4 patients for DY 5.

Category 3 outcomes expected patient benefits

OD-4 Potentially Preventable Complications, Healthcare Acquired conditions and Patient Safety-Intensive Care: Incidence of Hospital-acquired Venous Thrombembolism (VTE) (SA)-Our goal is to initiate prophylaxis from intake to disposition to prevent VTE.

OD-4 Potentially Preventable Complications, Healthcare Acquired conditions and Patient Safety-Intensive Care:

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat. 1 - 4:

DY 3: \$5,000,000

DY 4: \$5,000,000

DY 5: \$5,000,000

TOTAL: \$15,000,000

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.1.4

Provider Name/TPI: South Texas Health System / 094113001

Project Description

Through the development of a mobile primary care unit, the surrounding rural and McAllen/Edinburg communities will have the opportunity to access a variety of health resources in a timely and cost effective manner. Specifically, STHS will equip the mobile unit with capabilities that will offer preventive screenings particular to the RHP population. These screenings will begin with cardiac related studies to include: High Blood Pressure, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings. Radiology technicians capable of performing these studies will staff the clinic along with mid-level support. Radius of travel and clinic hours will be dependent on capabilities of the unit. The mobile clinic will look to expanding capabilities once implemented and will look at increasing its primary care capabilities in order to reach a bigger population within RHP 5.

Intervention(s)

We have selected Project Option 1.1.3 Expand Primary Care Capacity: Expand mobile clinics. The Mobile Health Clinic will serve STHS' primary service area, along with outreaching communities that might not have access to primary care services. STHS will identify a service area in which to deploy the mobile clinic in order to be most effective in reaching a larger population. The clinic will be set up to offer various primary care services, including screenings recommended by the American Heart Association.

Need for the project

As sited in the community needs assessment (CN.1), there is inadequate access to primary and preventive care. Many patients have to drive long distances for medical services making distance a barrier. While the supply is lacking, the need is great: More than half of RHP 5 Mexican-American adolescents and 76% of the region's adults are overweight or obese. As a result, chronic disease rates are high: heart failure is among the top diseases resulting in hospitalization in RHP 5, renal disease is the second leading cause of hospitalization in RHP 5, South Texas has one of the highest rates of chronic liver disease in the country, 31% of survey respondents reported high cholesterol, and researchers estimate that 273,831 Mexican Americans in the RHP 5 have diabetes, for which 56% are not being treated; 292,271 have hypertension for which 50% are not being treated; and 441,634 have elevated cholesterol for which 85% are not receiving treatment (RHP 5 Community Health Needs Assessment).

Target population

The target population will be patients within our primary and secondary services areas that are unable to access appropriate care due to distance. We expect to provide 1,000 encounters through the mobile clinic in DY 3; 1,200 in DY 4 and 1,400 in DY 5; of which we expect approximately 40%, will be Medicaid, indigent or uninsured.

Category 1 or 2 expected patient benefits

Patients that would otherwise not have access to care due to distance; will now have the opportunity to receive primary care services, as evidenced by 1,000 encounters through the mobile clinic in DY 4 and 1,200 in DY 5. We expect patients to benefit from increased access to preventive and primary care, increased screenings and vaccinations/immunizations, more chronic care, improved health outcomes and fewer hospitalizations.

Category 3 outcomes expected patient benefits

We have selected the following outcome:

- IT- 12.6 Influenza Immunization – Ambulatory (NSA)
Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization.
- IT – 1.21 Comprehensive Diabetes Care Lipid Testing (NSA)
Percentage of patients 18 – 75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.
- IT – 1.22 Preventive Care & Screening: BMI Screening & Follow Up (NSA)
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat.1-4:
DY 3: \$1,184,211
DY 4: \$771,536
DY 5: \$1,350,454
TOTAL: \$3,306,200

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.1.1

Provider Name/TPI: South Texas Health System / 094113001

Project Description

This project will expand the capacity of OB/GYN primary care services to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. The focus would be on the residents residing in the following zip codes: 78539, 78541, 78501, 78503 and 78504. OB/GYNs will provide community education on the importance of prenatal care and wellness to promote health and wellness for the patient and baby. We have a largely low-income population in the community. Expanding access to primary care in the community can help better serve this population as many primary care providers are no longer taking Medicaid patients.

Intervention(s)

This project will expand the capacity of primary care services – particularly obstetrics and gynecological services – in the community, prenatal care management, and education that can be provided in the most appropriate setting in a timely manner.

Need for the project

The region faces a shortage of primary care professionals to serve a growing population, lagging behind Texas in the supply of OB/GYN physicians by 25% (CN.1). South Texas Health System currently has 8 OB/GYNs who are at or beyond capacity. Their patient population is 70% Medicaid, indigent, and self-pay. Much of the region is medically underserved.

Target population

The target population will increase and have improved access as evidenced by 800 deliveries encounters provided in DY 3; 1,300 deliveries in DY 4 and 1,700 in DY 5. Currently 70% of the payor mix in the labor and delivery unit is Medicaid, Indigent, and Self Pay. Hidalgo County has a significant number of Medicaid and uninsured. Medicaid enrollees total 107,000 and the uninsured population is 80,000.

Category 1 or 2 expected patient benefits

Patients will benefit from increased access to OB/GYN services, improved prenatal care, and education on various healthcare needs. We expect to provide 500 visits in DY 3; 750 deliveries in DY 4 and 1,000 visits in DY 5 as evidence of increased access to OB/GYN services. Patients will receive preventative, primary, and maternal care. As a result, we expect to improve patient outcomes, specifically reducing early elective deliveries and increasing safe delivery practices in accord with HRU standards. Consequently, health system costs should be reduced.

Category 3 outcomes expected patient benefits

We have selected two outcomes:

1) IT-8.3 Early Elective Delivery – (Standalone measure), therefore promoting improved health for both the mother and baby. A decrease in early elective deliveries will result in fewer complications, healthier infants, and lower healthcare costs. The goal will be to see a 10% reduction in elective deliveries by DY5 from the baseline numbers established in DY 3.

2) IT-12.1 High Reliability Unit – (Non-standalone measures). By DY 5 we also anticipate improving the safety of all deliveries by implementing HRU standards and decreasing the high risk rate by 10% for Medicaid, indigent, and uninsured individuals within the community. Studies have shown that low socioeconomic status is an important predictor associated with low rates of regular mammography screening and delayed diagnosis and treatment of breast cancer resulting in poor outcomes.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Category 1 – 4:

DY 3 - \$5,000,000

DY 4 - \$5,000,000

DY 5 - \$5,000,000

Total - \$15,000,00

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.2.3

Provider Name/TPI: South Texas Health System / 094113001

Project Description

The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. STHS' 3-year goal is to increase the number of primary care provider referrals for patients without a medical home who use the ED.

Intervention(s)

We have selected Project Option 2.9.1 Establish/Expand a Patient Care Navigation Program: Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care. This project establishes a patient navigator program to track, follow-up on and help manage care for chronically ill patients who have a history of frequently visiting the ED. A team of nurses would connect patients from our hospital to physicians so that patients can receive regular care in the primary care setting. In addition the patient navigator could assist patients without health insurance coverage to acquire appropriate coverage through Medicaid, the federal Health Care Exchange program, and other venues. The patient navigators would remotely monitor patients via frequent telephone check-ups to detect early signs of changes in a patient's condition as well as to make appropriate interventions and referrals to prevent unnecessary and costly ED and/or hospital visits.

Need for the project

As cited in the community needs assessment, there is a shortage of primary care capacity (CN.1). As a result, patients tend to over utilize the emergency department for problems that a primary care provider could better treat, which is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.

Target population

The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to enroll at least 250 targeted patients in DY 3; 500 patients in DY 4 and 1,000 targeted patients in DY 5 into the patient navigator program. Of these enrollees, we expect approximately 60% will represent low-income (Medicaid, indigent and uninsured) patients.

Category 1 or 2 expected patient benefits

STHS' 3-year goal is to increase the number of primary care provider referrals for patients without a medical home who use the ED. We expect to enroll at least 250 500 targeted patients in DY 3; 500 patients in DY 4 and 1,000 targeted patients in DY 5 into the patient navigator program. Patients will benefit from access to a primary care provider and follow-up care, resulting in better patient outcomes and the prevention of avoidable ED visits.

The expected benefits would include:

- Help patient better navigate the health care system to receive right care, right time, right place;
- Increase patient access to ongoing primary and chronic care;
- Provide care management and coordinated care;
- Provide access to health insurance coverage via Medicaid, Health Insurance Exchanges, etc.
- Improve at-risk patients' health conditions; and
- Reduce preventable ED and/or hospital visits.

Category 3 outcomes expected patient benefits

We have selected the following outcome:

IT-9.2.d ED Diversion. Decrease utilization of ED for patients in the navigation program by 65% by helping them receive care through a primary care physician in the appropriate care setting

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat. 1 – 4:

DY 3: \$1,295,802

DY 4: \$1,360,747

DY 5: \$1,796,447

TOTAL: \$4,452,996

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier:

Provider Name/TPI: South Texas Health System / 094113001

Project Description

This project is designed to improve patient access to primary care by increasing the physician workforce in RHP 5, a designated health care provider shortage area (HPSA). Edinburg Regional Medical Center which is part of STHS will establish a new Pediatric residency training program with The University of Texas Health Science Center at San Antonio's Regional Academic Health Center (UTHSCSA RAHC). The new faculty, the resident trainees, and the graduates of the training program will expand the primary care workforce.

Intervention(s)

This project will create a Pediatric Residency Program at Edinburg Regional Medical Center in collaboration with The University of Texas, adding faculty, resident trainees, and graduates to the primary care physician workforce in RHP 5.

Need for the project

Currently there are 55 primary care physicians per 100,000 population in RHP 5 compared to 70 per 100,000 statewide. This project will greatly increase the physician pool for new primary care physicians and provide near-term relief with faculty physicians. Texas has a high retention rate for residents who train in a community to practice in that community.

Target population

The target population is the entire RHP 5; about 45% of county population lives in poverty and more than 255 are Medicaid beneficiaries. Academic medicine and resident training programs have a long tradition of providing significant portions of care to safety net populations.

Category 1 or 2 expected patient benefits

New program faculty will increase access to care in the early years of the project. Once the residency program is accredited, residents will be recruited to begin training and provide care to patients in the region. In addition, the program will feature an innovative curriculum incorporating PCMH, population health analytics, chronic diseases management, and quality improvement.

Category 3 outcomes expected patient benefits

We have selected the following outcome:

IT- 14.1 Number of Practicing Primary Care Physicians per 100,000 individuals in HPSA or MUA
Goal is to increase the number of practicing primary care physicians per 100,000 people in HPSA/MUA of RHP 5.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat. 1 – 4:

DY 3: \$5,000,000

DY 4: \$5,000,000

DY 5: \$5,000,000

TOTAL: \$15,000,000

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 094113001.

Provider Name/TPI: South Texas Health System / 094113001

Project Description

This project will implement a telemedicine program with psychiatric specialists to be able to consult, evaluate and treat patients at remote sites. For this program South Texas Behavioral Hospital which is part of STHS will contract with 2 psychiatrics to provide access to psychiatric providers to hospitals in the region. To obtain the services necessary from these specialists. These specialists may be located in the region but due to travel and distance limitations they cannot see patients in multiple locations in an efficient manner. The telemedicine program would allow access to those specialists for consultations and treatments. Medical staff credentialing and program policies and procedures will be developed as well as equipment procurement in order to implement the program.

Intervention(s)

We have selected Project Option: 2.16.1. A team of behavioral health specialists will be available to be onsite as well to do an assessment to determine if a telemedicine psychiatric consult is appropriate. If appropriate, a consult with a psychiatrist will take place. The outcome of the psychiatric consults will vary but they can determine appropriate medications, treatment courses, clearance for discharge and appropriate level of care for discharge.

Need for the project

As cited in the community needs assessment, there is a shortage of behavioral health providers (CN.2) and inadequate integration of care for individuals with co-occurring medical and mental illness conditions (CN.3). The community needs assessment finds that the entire region has a shortage of mental health professionals, in a state that has the lowest per capita spending on mental health services in the country. Texans with a serious mental illness are eight times more likely to be incarcerated in jails than treated in hospitals, at tremendous public and personal cost.

Target population

We plan to provide 1,500 tele-psychiatry consults in DY 3; 2,000 consults in DY 4 and 2,500 in DY 5. We estimate that 40% of the patients receiving these consults would be Medicaid, indigent or uninsured individuals.

Category 1 or 2 expected patient benefits

Patients will benefit from increased access to behavioral health care, and receive the right care at the right time in the right setting. This care will be better coordinated with the patient's physical health care.

Category 3 outcomes expected patient benefits

We have selected the following outcome:

IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone measure)

Due to lack of access of specialists, patients are often admitted until consult can be obtained.

By giving physician and staff access to specialists, they can determine appropriate treatment and level of care necessary to reduce admission rate. Patients admitted require more intense service such one on one care leaving other resource stretched and other care exposed position to care for other patients. By DY 5, our goal is to reduce this rate by 5%.

Estimate of Project Valuation for DY 3 – DY 5

Total Valuation Cat 1 -4:

DY 3: \$1,875,193

DY 4: \$1,892,001

DY 5: \$2,873,509

TOTAL: \$6,640,703

IGT Source

Hidalgo County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 138708601.1.5

Provider Name/TPI: Tropical Texas Behavioral Health/138708601

Project Description

Project Option 1.12.1: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care.

This project will:

- extend operating days and hours at our Weslaco outpatient clinic from 2 days per week to 5 days per week;
- expand the operating capacity of the clinic;
- introduce scheduled transportation services prioritizing the needs of uninsured and indigent clients; and
- improve access to our full array of behavioral health services for individuals and families in the cities and towns of the Mid-Valley by eliminating the existing burden of travel to our Edinburg or Harlingen clinics to receive services.

Intervention(s)

Building on our efforts to remove barriers to access routine behavioral health care for the residents of the RGV, we will extend the days and hours of operation at our Weslaco outpatient clinic. We will also increase available clinic space, add clinical program staff and implement transportation services targeting those with the greatest need for assistance traveling to the clinic. The combination of expanded hours, infrastructure, staffing and transportation for low-income and uninsured clients will significantly improve access to and the experience of care for those in the many communities along Expressway 83 that are equidistant from the metropolitan areas of Harlingen and McAllen/Edinburg. This promotes the Waiver objectives of ensuring access to the right care at the right time in the right setting and decreasing the costs of delays in receiving care, and reinforces our efforts to reduce and ultimately eliminate existing waiting lists.

Need for the project

Transportation has been identified as a general barrier to health care in a number of broad based studies focusing on underserved populations. When getting to health care services is a barrier, patients often end up not seeking care, missing appointments, or delaying care until their condition deteriorates and requires emergency attention. Many low income residents of the RGV struggle with significant barriers to reliable transportation due to the disabling effects of poverty and the complications associated with using inadequate public transit systems. For persons with mental illness this can be compounded by difficulties understanding how to navigate public transit. In its 2011 Human Service-Public Transit Coordination Plan, the Lower Rio Grande Valley Development Council (LRGVDC) identified several areas of unmet public transportation needs in the RGV including insufficient fixed-route public transportation, difficulty using the existing transit systems to travel from one city to another and a lack of regularly scheduled transit services between rural areas and the many low-income colonias throughout the Valley, to the larger cities. This project addresses these and other service access issues through multiple operational enhancements to our Weslaco clinic; conveniently located for our service population in the Mid-Valley.

Target population

Those areas most impacted by this project will be the municipalities of the Mid-Valley including Alamo, Weslaco, Donna, Mercedes, Progresso, Elsa, La Villa, La Feria, Santa Maria and others. We estimate roughly 40% of the population that will be served has Medicaid and 52% are uninsured and indigent.

Category 1 or 2 expected patient benefits

- Expanded behavioral health service access through the expansion of clinic hours, space and staffing.
- Expedited admission to services for individuals on waiting lists due to resource limitations.
- Availability of transportation to appropriate levels of care for indigent persons in need of routine behavioral health services.
- Increased access to the right care at the right time in the right setting.
- Increased utilization of routine behavioral health services.
- Decreased need for more costly emergency and inpatient interventions.
- Improved health outcomes and experience of care.

Category 3 outcomes expected patient benefits

To be determined. TTBH is reviewing the draft of proposed revisions to the menu of Category 3 outcomes that is pending CMS approval. Accordingly, the minimum Category 3 valuation allocations set forth in the Program Funding and Mechanics Protocol are included in the valuation figures that follow.

Estimate of Project Valuation for DY 3 – DY 5

DY 3	DY 4	DY 5	Total
\$ 755,142.98	\$ 1,929,987.32	\$ 3,953,951.38	\$ 6,639,081.68

IGT Source

Tropical Texas Behavioral Health

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 138708601.1.6

Provider Name/TPI: Tropical Texas Behavioral Health/138708601

Project Description

Project Option 1.12.3: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care. Develop and staff a number of mobile clinics that can provide access to care in very remote, inaccessible, or impoverished areas of Texas.

This project will fund the acquisition and operation of two mobile clinics to provide access to comprehensive behavioral health care to individuals and families living in the numerous colonias and other outlying areas in Hidalgo and Cameron counties. The project will enable more individuals to receive treatment for mental illness by bringing clinical staff to the residents of the colonias (physically or by telemedicine) instead of requiring them to travel to receive services.

Intervention(s)

TTBH will purchase, equip and staff two customized recreational vehicles, one each dedicated to the delivery of mobile behavioral health care to our clients residing in the many colonias in Hidalgo and Cameron counties. Doing so will bring Each mobile clinic will be staffed by one Licensed Practitioner of the Healing Arts (LPHA) and one Qualified Mental Health Professional of Community Services (QMHP-CS) to deliver services including screening and intake, case management, therapy, psychosocial rehabilitative and skills training services and medication training and support services. Physician services will be made available through the mobile clinic via telemedicine technology.

Need for the project

As previously noted, in 2011 the LRGVDC reported “Some of the highest [transportation] needs continue to be in the colonias spread all over Hidalgo County, with many in Willacy and Cameron Counties as well. These areas need regularly scheduled service throughout the day to meet a variety of needs including commuter, medical, and shopping.” The Office of the Secretary of State defines colonias as residential areas along the Texas-Mexico border that frequently lack the most basic living necessities: potable water and sewer systems, electricity, paved roads, and safe and sanitary housing. While colonias are found in Texas, New Mexico, Arizona and California, Texas has both the largest number of colonias and the largest colonia population. In 2009, there were more than 2,294 Texas colonias located primarily along the state's 1,248 mile border with Mexico, with approximately 400,000 Texans living in them. Based on 2009 figures from the Texas Secretary of State, TTBH’s catchment area had the following number of colonias and respective populations:

<u>County</u>	<u>Number of colonias</u>	<u>Population</u>
Hidalgo	934	156,132
Cameron	178	47,606
Willacy	16	3,460
Total	1,128	207,198

In FY 2011, TTBH served an average of 2,115 people from local colonias each month, and a total of 25,405 for the year. Just as the overall population of the RGV continues to experience growth rates exceeding those of many regions across the state and country, increasing the demand for behavioral health care, the population and needs within the colonias continues to rise as well. Our mobile clinics represent a new and innovative approach to address this longstanding and growing regional need.

Target population

The primary focus of the mobile clinics will be the impoverished and elderly residents of the many colonias in Hidalgo, Willacy and Cameron counties. Where many of our projects are projected to serve a roughly 40% Medicaid to 52% uninsured/indigent population, it is likely the percentage of uninsured and indigent impacted by mobile clinic services will be considerably higher, especially in the colonias.

Category 1 or 2 expected patient benefits

The project will:

- Develop and implement action plans for mobile clinic behavioral health services;
- Increase community outreach teams to screen more people;
- enhance and expand our impact with community-based mobile outreach to some of the most remote areas in our catchment area;
- reach clients who might otherwise forego or delay initiation of services due to transportation barriers or other socio-economic barriers;
- result in Improved early screening of behavioral health risks among low income and low or uninsured health insurance populations;
- improve prevention and early intervention among high-risk clients; and
- reduce unnecessary use of behavioral crisis services, emergency department and inpatient hospital utilization, hospitalizations by ensuring availability of services to outlying portions of the service area and identify problems earlier.

Category 3 outcomes expected patient benefits

To be determined. TTBH is reviewing the draft of proposed revisions to the menu of Category 3 outcomes that is pending CMS approval. Accordingly, the minimum Category 3 valuation allocations set forth in the Program Funding and Mechanics Protocol are included in the valuation figures that follow.

Estimate of Project Valuation for DY 3 – DY 5

DY 3	DY 4	DY 5	Total
\$ 472,670.80	\$ 1,039,247.55	\$ 1,984,018.04	\$ 3,495,936.39

IGT Source

Tropical Texas Behavioral Health

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 138708601.2.9

Provider Name/TPI: Tropical Texas Behavioral Health/138708601

Project Description

Project Option 2.13.1: 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.).

The project will:

- provide prompt access to inpatient substance abuse detoxification treatment for individuals with co-occurring mental illness and substance abuse issues in need of acute detoxification;
- facilitate discharge from inpatient care and a smooth transition to outpatient substance abuse aftercare and integrated mental health and primary care services; and
- increase opportunities for successful maintenance of abstinence from illicit substances and recovery from mental illness.

Intervention(s)

TTBH will use project funding to contract with experienced local substance abuse treatment providers for (1) increased access to inpatient medical detoxification beds and (2) outpatient substance abuse follow-up and aftercare services for residents of the Rio Grande Valley with co-occurring mental health and substance abuse issues, and their families. Upon discharge and referral from inpatient detox, TTBH will coordinate continuity of care referrals to outpatient aftercare service providers and will provide comprehensive outpatient mental health services including specialized services integrating treatment of co-occurring psychiatric and substance use disorders. Additionally, integrated primary care services will be available to individuals served by this project who lack a medical home.

Need for the project

One-fifth of the residents of Cameron, Hidalgo and Willacy counties responding to the 2011 Professional Research Consultants (PRC) Community Health Report considered their mental health to be fair or poor compared to less than 12% in the United States. Additionally, 39% said they had experienced chronic depression compared to 27% in the U.S. When participants in the focus groups that were part of the PRC community health needs assessment were asked to identify their top five health priorities for their community, substance abuse ranked 3rd behind diabetes and obesity, and mental health. Substance abuse is a common disorder among individuals with severe mental illness, highlighting the need to increase prevention efforts and improve access to treatment for substance abuse and co-occurring disorders. Untreated mental illnesses and substance use disorders increase state spending in other areas including emergency rooms, hospitals, jails, prisons and detention centers, education, and homeless shelters.

Target population

The target population is individuals in the RGV diagnosed with co-morbid mental health and substance use disorders in need of acute substance abuse detoxification and aftercare services. We estimate approximately 40% of the population to be served by this project has Medicaid and approximately 52% are uninsured and indigent.

Category 1 or 2 expected patient benefits

The project will:

- improve access to and address the demand for local medical detox services;
- improve continuity of substance abuse aftercare and follow-up;
- integrate mental health, substance abuse and primary care interventions to treat the whole person; and
- reduce outcomes resulting from interrupted and disintegrated care including homelessness, incarceration and extended or repeated psychiatric and medical inpatient stays.

Category 3 outcomes expected patient benefits

To be determined. TTBH is reviewing the draft of proposed revisions to the menu of Category 3 outcomes that is pending CMS approval. Accordingly, the minimum Category 3 valuation allocations set forth in the Program Funding and Mechanics Protocol are included in the valuation figures that follow.

Estimate of Project Valuation for DY 3 – DY 5

DY 3	DY 4	DY 5	Total
\$ 3,630,000.00	\$ 4,356,000.00	\$ 5,544,000.00	\$ 13,530,000.00

IGT Source

Tropical Texas Behavioral Health

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 111810101.1.1
1.3.1 Implement a Chronic Disease Management Registry; Implement/enhance and use chronic disease management registry functionalities

Provider Name/TPI: UT Health Science Center Houston

Project Description

This project will allow for the creation and oversight of a diabetes management registry through the integration of an electronic medical record (EMR) system in community diabetes self-management education (DSME), diabetes self-management support (DSMS) programs, independent non-hospital-based community health centers (FQHC), and integrated chronic disease management programs in hospitals, in public health clinics and implementation of a health information exchange (HIE) system. The EMR is an electronic version of a patient's medical history that is maintained, over time, by the provider and may include all of the key data relevant to that person's care under a particular provider, including demographics, diagnoses, progress notes, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. Additionally, the EMR contains data that support other activities such as quality management, and outcomes reporting. For the patient, this translates into the availability of pertinent information and coordination of services between any potential provider. Importantly for this Data relating to diabetes is also available from the EMR to create the diabetes registry. This centralized data will provide invaluable support to designing customized treatment plans, setting self-management goals, and improving quality of care (QI).

Intervention(s)

This project is designed to implement a chronic disease registry, specifically diabetes, in RHP5. In doing so it will sustain and expand the Rio Grande Valley Health Information Exchange and create the first network of providers connected through the new HIE in RHP5, and provide a means to give integrated care to patients across a range of RHP5 providers. The registry will provide integrated management and intervention in a population where 31% of the adults have diabetes.

Need for the project

Over 70% of the adult population has one or more chronic conditions. Over 50% of the adult population is obese and another 30% are overweight. Diabetes is present in 31% of adults, of whom less than half are diagnosed and only about 50% of those who know they have diabetes are on adequate treatment. Thus the need for a much improved system of registry, tracking and management. Diabetes results in \$227million in lost wages in RHP5 region. For all chronic disease, especially diabetes, prevention and intervention is largely neglected and patients often only receive care when they develop severe disease requiring Emergency Department or Inpatient care. So continuous and integrated care is vital to controlling diabetes in RHP5.

Target population

The RGVHIE covers 26 hospitals, clinics and other organizations that provide primary care, that covers about 500,000 population. We will target those with diabetes identified in these institutions and create a registry that will be available across the set of institutions so that patients with diabetes, identified in the RGVHIE, will be part of the disease registry. This will make their data available to all of the participating institutions in order to improve the integration and continuity of care and reduce redundant tests and evaluations.

Category 1 or 2 expected patient benefits

Our goal is to make the registry functional for at least 60% of the participating organizations by end of year 3, and to increase enrollment in the registry by 10% over baseline for each subsequent year.

Category 3 outcomes expected patient benefits

1-20. Improve diabetes control in registry patients by 5% by year 4 and another 10% by year 5.

Estimate of Project Valuation for DY 3 – DY 5

\$6,043,070 includes categories 1 and 3

IGT Source

University of Texas Health Science Center Houston

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 11810101.2.3
2.7.5 Implement innovative Evidence-based Strategies to Reduce and Prevent Obesity in Children and Adolescents.

Provider Name/TPI: UT Health Science Center Houston 11810101.2.3

Project Description

UTHealth proposes to implement the MEND Community Based Obesity Prevention Program to address the obesity epidemic by applying a nationally recognized and scientifically sound method for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits. We will use one of the most thoroughly researched (129) and proven obesity prevention programs in the world: MEND (*Mind, Exercise, Nutrition ... Do It!*). MEND was developed in the United Kingdom in 2001 and has since then been delivered and evaluated in Europe, Australia, Canada and the United States. In Texas, MEND is currently being delivered in Austin, Dallas and Houston, where it is the focus of a large randomized control trial (RCT) study funded by the U.S. Centers for Disease Control and Prevention (CDC). The Texas research team includes senior faculty from the University of Texas Health Science Center (UTHEATH) School of Public Health at Austin among others. MEND's evidence base, clinical rigor and academic links are significant differentiators in a healthcare marketplace that demands measureable outcomes and clinical effectiveness. In the area of community-based child weight management, MEND is the only program with a completed successful RCT showing efficacy on a wide range of health and psychosocial outcomes. Evaluation of over 10,000 children in the UK and 1,660 in the US has demonstrated similar effectiveness when the program was delivered at scale by leaders from diverse backgrounds and varied settings (130). The RCT results (131) demonstrated that children who attended the MEND 7-13 program, compared to controls, had a statistically significantly reduced waist circumference, zBMI score and increased their cardiovascular fitness, physical activity levels and self-esteem at 3 and 6 months. Half the children were then followed up at 12 months where the majority of outcomes were either improved or sustained.

Intervention(s)

This project is designed to implement the MEND Community Based Obesity Prevention Program to address the youth obesity epidemic by applying a nationally recognized and scientifically sound method for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits.

Need for the project

The need for this project in RHP 5 is vital. Over 50% of youth are above a healthy weight for their age and gender. Over 70% of the adult population has one or more chronic conditions. A similar proportion currently has no health insurance.

Target population

The target population is youth patients and their families living in the RHP 5. The project will establish baseline numbers in DY 3 and show incremental increases through DY 5. 1080 children will be served by project. Approximately 75% of those reached will be CHIP / Medicaid eligible or indigent. They will benefit from the MEND project through decreased zBMI leading to prevention of chronic diseases.

Category 1 or 2 expected patient benefits

[I-5.1]: Our goal is to have 2% annual incremental improvements in number of eligible patients in the CHIP / Medicaid population receiving MEND program.

Category 3 outcomes expected patient benefits

1-20. Other Outcome Improvement Target

Our goal is to have 40% of the program participants achieve a reduction in the zBMI score at the completion of the program by DY 5

Estimate of Project Valuation for DY 3 – DY 5

\$4,788,225

IGT Source

University of Texas Health Science Center Houston

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 111810101..2.2 Implement medical homes in HPSA Brownsville Community Health Center

Provider Name/TPI: UT Health Science Center Houston

Project Description

The UTHSC Houston School of Public Health Campus-Brownsville (UTHealth)) proposes to work with Brownsville Community Health Center to implement a certified patient centered medical home (PCMH) model of care to provide safety net primary healthcare services to targeted patients who live in HPSA, rural, and impoverished areas of Cameron County.

The project would improve access to comprehensive, primary and preventive care through the implementation of the medical home model. The project would cover 2 existing service sites located in Brownsville. These sites touch 21,000 medical and dental patients, equating to approximately 4% of the total population of Cameron county.

The project greatly enhances the current comprehensive, primary health and wellness services for Cameron County in South Texas by developing a medical home model that will improve the service to patients and greatly improve the efficiency and effectiveness of helping them control their chronic health conditions.

Intervention

UTHealth proposes to implement a certified patient centered medical home (PCMH) model of care to provide safety net primary healthcare services to targeted patients who live in HPSA, rural, and impoverished areas of Cameron and Willacy County. This will be achieved through a partnership with Brownsville Community Health Center, a primary care clinic that serves the poor and underserved in RHP5.

Need for the project

Over 70% of the population has one or more chronic condition. A similar proportion has currently no health insurance. This means that preventive care and intervention is largely neglected and patients often only present when they develop severe disease requiring Emergency Department or Inpatient care. No integrated chronic care management programs are provided currently available in RHP5. Therefore there is a need to eliminate fragmented and uncoordinated care, which can lead to emergency department and hospital over-utilization. The PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform.

Target population

The target population includes the uninsured and under-served, those below 200% of poverty, migrant and seasonal farmworkers, Hispanics, women and children. Approximately 77.34% of our patients are at or below 100% of Poverty, 96.09% are at or below 200% of Poverty. Of the over 21,000 patients, over 60% are uninsured, about 20% are on Medicaid/CHIP or Medicare. All patients are expected to benefit from the Patient Centered Medical Home model and from the meaningful exchange of health information.

Category 1 or 2 expected patient benefits

The key functional element of the project is to become a certified patient centered medical home for primary care access so that the clinic can have a lasting and meaningful impact on over 21,000 patients, and reduce the growth in health care costs by working collaboratively with other healthcare partners.

The project meets the following regional goal:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, team-based model.

Category 3 outcomes expected patient benefits

Once process and implementation milestones are reached, the clinic expects a decrease in the percentage of diabetic patients whose HbA1c levels are greater than 9.0% (poor control).

Estimate of Project Valuation for DY 3 – DY 5

\$4,716,490 includes categories 2 and 3.

IGT Source

University of Texas Health Science Center Houston

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: [111810101].2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Provider Name/TPI: UT Health Science Center Houston

Project Description

We propose to work with South Texas Health System, Migrant Health Promotion and the Rio Grande Valley Health Information Exchange to expand proactive, ongoing chronic care management to keep patients with chronic diseases healthy. It will also empower them to self-manage their conditions. The ultimate goal is to prevent worsening health precipitating the need for Emergency Department or Inpatient care. Most chronic diseases fall into the category of non-communicable diseases (NCDs). NCDs are the pandemic of the 21st century, and the World Health Organization reported in 2010 that they now account for more disability and death globally than all other causes combined. Texas, particularly South Texas, is among the leaders in our nation in prevalence of NCDs, and in the highest proportion (25%) without health insurance. To meet this growing threat in RHP5, our chronic disease management initiative will use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms early to prevent complications and managing utilization of acute and emergency care. Chronic disease management also enhances the ability to identify one or more chronic health conditions or co-occurring chronic conditions that merit intervention across a patient population. Effective management of this chronic disease is imperative because it is more prevalent in our RHP than nationally. Through this initiative and its partnering hospital, clinics, and community-based partners we will transform the health care delivery system for chronic disease by implementing multicomponent practice changes in the six recommended categories. This project will therefore include elements of the Chronic Care Model (CCM) for ambulatory care that lead to the greatest improvements in health outcomes.

Intervention(s)

This project is designed to expand proactive, ongoing chronic care management to keep patients with chronic diseases healthy. This project will include elements of the Chronic Care Model (CCM) for ambulatory care that have been shown to lead to the greatest improvements in health outcomes. This is a replication of an already approved project in the lower RGV area.

Need for the project

The need for this project in RHP 5 is vital. Over 70% of the population has one or more chronic condition. A similar proportion currently has no health insurance. This means that preventive care and interventions are largely neglected and patients often only seek care when they develop severe disease requiring Emergency Department or inpatient care. No chronic care management programs are currently provided among the proposed partners.

Target population

The target population is adult diabetic patients. The project will reach at least 5000 patients over the life of project. Additionally, 1600 people will receive diabetes self-management education programs. Approximately 60% of those reached will be Medicaid eligible or indigent. They will benefit from the chronic care management services associated with this project through better control of HbA1c.

Category 1 or 2 expected patient benefits

Our goal is to have 2000 patients receiving care under the chronic care management program

Category 3 outcomes expected patient benefits

Our goal is to have a 5% decrease in percentage of patients with HbA1c control > 9.0% over baseline (at least 100 patients)

Estimate of Project Valuation for DY 3 – DY 5

\$14,199,869 including categories 2 and 3

IGT Source

University of Texas Health Science Center Houston

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 085144601.1.4

**Provider Name/TPI: The
University of Texas
Health Science Center at
San Antonio/085144601**

Project Description

Cancer Grand Rounds and Consults

Project Option 1.7.5 and 1.7.6 Use telehealth services to provide medical education and specialized training for targeted professionals in remote locations. And Implement an electronic consult or electronic referral processing system to increase efficiency of specialty referral process by enabling specialists to provide advice and guidance to primary care physicians that will address their questions without the need for face-to-face visits when medically appropriate.

Intervention(s)

This project is designed to educate health professionals in RHP 3 with regard to early diagnosis and treatment of cancer, especially those cancers which have a higher incidence and mortality rate among Hispanics. Primary care professionals will be the focus but the programs will also be open to local specialists. Using teleconferences and video conferences, experts from the Cancer Treatment and Research Center (CTRC) at UTHSCSA will provide quarterly Grand Rounds to physicians, physician assistants, and nurses in RHP 3. Videoconferences will take place at sites in Cameron and Hidalgo Counties using facilities at UT Brownsville, UT Pan Am and the UT Regional Academic Health Center. We will open the conferences to local health departments, FQHCs and other safety net clinics, as well as physicians in private practice. The conferences will meet the requirements for professional Continuing Education for nurses, physician assistants, and physicians. The videoconferences will also be available on the internet for health professionals in Starr and Willacy Counties. In addition CTRC and UTHSCSA physicians will make themselves available for electronic consults and commit to performing necessary diagnostic or therapeutic procedures as necessary after electronic consults.

Need for the project

In Fall 2013, "A Comprehensive Report on Cancer among Hispanics in Texas" was published in the Texas Public Health Journal. The report found that "rates of newly diagnosed cancer of the liver and stomach were twice as high in both Hispanic men and women." Fewer Hispanics are diagnosed at the earliest and most treatable stage than non-Hispanic Whites. Hispanic men and women have higher mortality rates than non-Hispanic Whites with cancer of the stomach and liver. In addition, in the Border Area of Texas, breast, cervical and colorectal cancer screening rates for Hispanics are significantly lower than the rates for non-Hispanic whites.

CN. 1 Shortage of primary and specialty care providers and inadequate access to primary or preventive care

Target population

The target population for this project will be the general population in RHP 5, with a special focus on Hispanic men and women either enrolled in Medicaid or low income uninsured.

Category 1 or 2 expected patient benefits

Increase number of electronic “curbside consults” provided by specialists to primary care physicians through electronic consults or electronic referral processing system.

QPI: DY 3: Provide 25 electronic consults related to liver and stomach cancer
DY 4: Provide 50 electronic consults related to liver and stomach cancer
DY 5: Provide 75 electronic consults related to liver and stomach cancer

At least 50% of the patients served will be Medicaid enrollees or low income uninsured.

Category 3 outcomes expected patient benefits

IT-12.1 Breast Cancer Screening
IT-12.2 Cervical Cancer Screening
IT-12.3 Colorectal Cancer Screening
IT-12.11 HPV Vaccine for Adolescents

Estimate of Project Valuation for DY 3 – DY 5

Category 1: DY 3	\$2,200,000	Category 3: DY 3	\$315,000
DY 4	\$2,250,000	DY 4	\$480,000
DY 5	<u>\$1,500,000</u>	DY 5	<u>\$955,000</u>
	\$5,950,000		\$1,750,000

I GT Source

The University of Texas Health Science Center at San Antonio.

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 085144601.2.5

**Provider Name/TPI: The
University of Texas
Health Science Center at
San Antonio/085144601**

Project Description

Health Fairs with Cancer Focus

Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations.

Intervention(s)

This project is designed to improve appropriate use of cancer screenings primarily among the Hispanic population in RHP 5. The University of Texas Health Science Center at San Antonio will conduct several health fairs annually in RHP 3 to increase health literacy about cancer. Health fairs will take place in or near schools, grocery stores, FQHCs and other safety net providers such as local county health departments. Nurses and nursing students, medical students, and community health workers will educate attendees about cancer prevention, risk reduction, appropriate screening, treatment and survivorship. Health fair attendees will be offered, as appropriate, HPV vaccines, FIT tests, and tests to detect *Helicobacter pylori*. Attendees will be referred to local providers if needed for cervical cancer screenings, mammograms, and follow-up. Flu and pneumonia inoculations will also be provided as appropriate.

Need for the project

In Fall 2013, “A Comprehensive Report on Cancer among Hispanics in Texas” was published in the Texas Public Health Journal. The report found that “rates of newly diagnosed cancer of the liver and stomach were twice as high in both Hispanic men and women.” Fewer Hispanics are diagnosed at the earliest and most treatable stage than non-Hispanic Whites. Hispanic men and women have higher mortality rates than non-Hispanic Whites with cancer of the stomach and liver. In addition, in the Border Area of Texas, breast, cervical and colorectal cancer screening rates for Hispanics are significantly lower than the rates for non-Hispanic whites.

CN. 1 Shortage of primary and specialty care providers and inadequate access to primary or preventive care

Target population

The target population for this project will be Hispanic women, men and children enrolled in Medicaid and low income uninsured.

Category 1 or 2 expected patient benefits

QPI: DY 3: Provide health fair education and appropriate screenings/inoculations to 1,000 people
DY 4: Provide health fair education and appropriate screenings/inoculations to 2,000 people
DY 5: Provide health fair education and appropriate screenings/inoculations to 3,000 people

At least 50% of the patients served will be Medicaid enrollees or low income uninsured.

Category 3 outcomes expected patient benefits

- IT-12.1 Breast Cancer Screening
- IT-12.2 Cervical Cancer Screening
- IT-12.3 Colorectal Cancer Screening
- IT-12.4 Pneumonia vaccination status for older adults
- IT-12.6 Influenza immunization- ambulatory
- IT-12.11 HPV Vaccine for Adolescents

Estimate of Project Valuation for DY 3 – DY 5

Category 2: DY 3	\$1,500,000	Category 3: DY 3	\$225,000
DY 4	\$1,500,000	DY 4	\$342,500
DY 5	<u>\$1,000,000</u>	DY 5	<u>\$682,500</u>
	\$4,000,000		\$1,250,000

I GT Source

The University of Texas Health Science Center at San Antonio.

PROPOSED THREE YEAR DSRIP PROJECT
RHP 05

Unique Project Identifier:

Provider Name/TPI: University of Texas Health Science Center at San Antonio/085144601

Project Description

Our hepatitis C virus (HCV) screening and linkage to care program for baby boomers will use procedures and tools developed in our current CDC funded project to implement HCV testing in patients in a safety net hospital in San Antonio and apply it to five clinics in RHP Region 5. From 12/1/13-9/15/13, we have screened 2,182 boomers with HCV antibody (anti-HCV) and identified 195 (9%) as anti-HCV+. Of these, 109 (56%) were HCV RNA+, 60 (32%) HCV RNA-, 23 (13%) HCV RNA not yet done. Of the 109 chronically HCV-infected patients, 86% have been linked to primary and/or specialty care. These individuals have been counseled about the adverse effects of alcohol use and risky medications (e.g., excessive acetaminophen) as well as reduction risk of HCV transmission. They are also tested for HIV as well as receive hepatitis A and B immunizations if needed. All of these approaches can slow the progression of the disease. In addition, patients are referred for HCV specialty care and treatment. For this project, we will implement HCV screening for baby boomers in outpatient primary care practices in RHP region 5. These diverse outpatient settings include a federally qualified health center (FQHC), a resident clinic, and 3 solo practices. We will evaluate all facets of implementation and results of screening as well as subsequent care.

Intervention(s)

First, we will educate the providers in the 5 participating practices about the need for and processes to achieve HCV screening of baby boomers. These presentations and educational materials have already been developed. Second, we will develop and implement electronic medical record (EMR) algorithms to screen patients in each practice for HCV screening eligibility including: birth year 1945-65 and no prior record in the EMR of HCV testing or HCV diagnosis. Eligible individuals will be flagged in the EMR as part of their routine health maintenance standards and the practice team will order anti-HCV screening. Third, patients will be informed about national HCV screening guidelines from posters and flyers with the opportunity to opt out. As in our inpatient program, we expect <10% will refuse screening. Fourth, in 3 practices, patients with an anti-HCV+ test will review in the practice a previously developed mobile App educational program in English or Spanish about HCV infection and its care. In 2 practices, we will offer a web-based version of the educational program to anti-HCV + patients. We will compare the impact on acceptance of follow-up testing for these two approaches. On-site personal counseling by a bilingual LVN case manager/counselor will address risks for progression, assessment/treatment of depression, and barriers to specialty care. A bilingual patient navigator will also help to coordinate follow-up testing and linkage to HCV specialty care. All aspects will be coordinated following the team-based model of the patient centered medical home that incorporates the EMR and patient education as key features. We had substantial experience in overcoming barriers to care for newly diagnosed HCV infected patients including lack of insurance, transportation, poor health literacy, mental health disorders (depression) and substance abuse (especially alcohol).

Goal 1) To educate providers about baby boomer HCV screening and processes to achieve this in clinic.

Goal 2) To increase the proportion of eligible baby boomers who have been tested for HCV.

Goal 3) To increase the proportion persons with a HCV RNA+ result who receive prevention counseling and are linked to care, treatment, and prevention services.

Need for the project

The Centers for Disease Control and Prevention (CDC) and the United States Preventive Services Task Force (USPSTF) both recommend one-time testing all baby boomers (born 1945 - 1965) for hepatitis C virus (HCV) infection. Over ¾ of persons with chronic HCV are baby boomers and most are unaware of this. Based on CDC estimates, over 100,000 baby boomers in Texas have chronic HCV. HCV is the most common chronic blood borne infection in the U.S. (1) and the most common reason for liver transplant in Texas. Serious complications of chronic HCV such as cirrhosis and hepatocellular carcinoma can be mitigated or eliminated by addressing factors that accelerate the disease such as alcohol use, hepatitis A and B, and treatment with much more effective “new era” HCV drugs (2).. Two recent studies based largely on data estimates from experts support cost-effectiveness of screening baby boomers for HCV infection (4, 5). However, cost-effectiveness studies have not been conducted using data from real-world implementation of new recommendations for one-time screening of baby boomers by both the CDC and the USPSTF (6, 7).

Target population

Target population includes persons born from 1945-1965. Exclusions include prior HCV diagnosis, any prior HCV test, dementia, unstable psychiatric disease, or poor prognosis (e.g. metastatic cancer). This project will target nearly 60% Medicaid or low-income uninsured patients across all the practices. The study sites include group practices and solo practices in the RHP region 5 area.

Category 1 or 2 expected patient benefits

Category 2 expected benefits include screening baby boomers for HCV and providing outreach to those patients who are newly diagnosed with HCV. Our goal is to screen a total of 650 baby boomers for HCV in our five clinics the first year (QPI DY3 = 6500). Our goal is to screen a total of 1,300 baby boomers for HCV in our five clinics in the second and third years (QPI DY4 = 1,300; QPI DY5 = 1,300). We will also provide outreach to patients who are newly diagnosed with chronic HCV. We expect to provide outreach through prevention counseling and linkages to care, treatment, and prevention services to approximately 65 patients who will receive outreach (QPI DY3 = 13; QPI DY4 = 26; QPI DY5 = 26).

Category 3 outcomes expected patient benefits

Category 3 outcomes:

IT-5.1C: Cost Effectiveness Analysis (CEA)

IT-5.1D: Cost Utility Analysis (CUA)

IT-5.2: Per episode cost of care

Reducing the per capita cost of health care will be addressed through this project as HCV screening in conjunction with confirmatory testing and education/linkage to care is expected to be at least as cost-effective as routine screening for hypertension or colorectal cancer (4). Our goal is to conduct a cost-effectiveness analysis of universal one time HCV screening in diverse outpatient settings using primary data to fill the identified gaps in evidence, and also to provide policymakers and stakeholders with information on the costs and health benefits of HCV screening through a refined screening system in such settings. Our analyses will include: primary data from inpatient settings, published literature, public databases, and expert opinion. The primary measure of cost-effectiveness will be incremental costs per Quality Adjusted Life Year (QALY) gained from the health care system’s perspective because it is paying for the costs of the program. To explore uncertainty around health and cost outcomes, a comprehensive sensitivity analysis will be conducted, including both deterministic (one-way/multi-way and scenario analysis) and probabilistic sensitivity analysis. The findings of the analysis will be highly valuable to guide the implementation and sustainability of HCV testing in similar inpatient settings. We expect to find the cost to be \$35,000-\$60,000 per QALY gained, from the health care perspective, and a range of \$50,000-\$100,000 per QALY gained as conventional willingness-to-pay (WTP) thresholds.

Estimate of Project Valuation for DY 3 – DY 5

	DY3	DY4	DY5	Total 3 Year Value
Cat 1 or 2	\$ 797,220	\$ 797,220	\$ 797,220	\$2,391,660
Cat 3	\$ 79,722	\$ 79,722	\$159,444	\$239,166

Cat 1 or 2: Based on previous research, the estimated annual health care costs for patients with chronic hepatitis C infection are approximately \$21,453. The average annual cost among patients with end-stage liver disease is \$59,995 (8). Health care costs for HCV-infected patients with end-stage liver disease are nearly 2.5 times higher than those in the early stages, according to a Henry Ford Hospital study. If we are able to diagnose even one patient with HCV and stop them from developing end-stage liver disease, we will save thousands of dollars in health care costs. Averting one liver transplant will save nearly half a million dollars (9).

Cat 3: Determining the cost effectiveness of this new standard of care as determined by the Institute of Medicine informs clinicians and the general population about the importance of HCV screening and the economic burden that this chronic disease carries.

IGT Source

University of Texas Health Science Center at San Antonio, TIN: 741586031

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**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 020947001.2.1

Provider Name/TPI: Columbia Valley Healthcare System, L.P. d/b/a Valley Regional Medical Center / 020947001

Project Description

2.6 - (Implement Evidence Based Health Promotion Programs) - Valley Regional Medical Center (Valley Regional) intends to implement evidence based health promotion in Cameron County, Texas to target reducing the incidence of diabetes in school-aged residents through school-based interventions. Valley Regional will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients, particularly young residents in our low-income and Medicaid eligible communities. Establishing self-management and wellness programs for our targeted population will provide the best opportunity for positive results and ongoing outcomes.

Intervention(s)

Valley Regional will hire a health promotion specialist to establish community outreach and school-based interventions for diabetic children, and the patient population susceptible to diabetes (specifically the overweight / obese population in the surrounding school districts. This program will focus on evaluation, education, nutrition, and ongoing assessment to reduce the incidence of diabetes and help our diabetic population better manage their disease. This project will address the core requirement of this project option which is to establish self-management programs and wellness using evidenced-based designs.

This project will be comprised of the following milestones:

P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.

I-8: Increase access to health promotion programs and activities through this project.

- Total patient impact: 3,750 patient encounters; Medicaid and Uninsured patient impact: Valley Regional is currently working with the surrounding school districts to determine the potential Medicaid / uninsured patient population to be impacted the overall project.

This project will conduct quality improvement 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.

Need for the project

The RHP 5 plan notes diabetes and obesity as its first “key health challenge.” (RHP 5 Plan, Page 7). The plan cites diabetes and obesity as the third leading cause of mortality in this region behind heart disease and cancer, and an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke. (RHP Plan, Page 29-30). Two community needs identified in the RHP 5 plan include the inadequate integration of care and the lack of patient-centered care. (CN3 and CN4). This project will attempt to target a more patient centered model and integrate care and address one of the biggest health challenges in the region.

Target population

This program intends to target students in the surrounding school districts. Valley Regional expects to have a large impact on the Medicaid and uninsured population in the region. Currently, Valley Regional serves a patient population that is at least 47% Medicaid eligible or uninsured. Valley Regional expects this project's impact to be at least that level for the Medicaid and uninsured population of Cameron County.

Category 1 or 2 expected patient benefits

Valley Regional expects an increase rate of prevention of the onset of Type II diabetes for targeted pre-diabetics in the community through provider-furnished education and management about lifestyle choices, medications, and risks. Additionally, Valley Regional expects a higher rate of controlled diabetes among community members with this chronic disease. Valley Regional intends to provide 500 patient encounters in DY3, 1,250 patient encounters in DY4, and 2,000 patient encounters in DY5 for a total intervention of 3,750 patient encounters in DY3-DY5.

Category 3 outcomes expected patient benefits

IT-1.11 Diabetes care: BP control (<140/80mm Hg)²³⁴ – NQF 0061 (Standalone measure) – helping patients control their blood pressure.

Valley Regional aims to improve the percentage of patients in Cameron County with uncontrolled blood pressure by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of diabetic conditions. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Valley Regional to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Valley Regional cannot force patients to do on a regular basis. Valley Regional intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Estimate of Project Valuation for DY 3 – DY 5

\$2,200,000

IGT Source

Cameron County Healthcare Funding District

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 020947001.2.2

Provider Name/TPI: Columbia Valley Healthcare System, L.P. d/b/a Valley Regional Medical Center / 020947001

Project Description

2.12.2 – Implement Care Transitions Programs – Focused on Chronic Disease Management of Diabetes - Valley Regional Medical Center (Valley Regional) intends to implement a program to facilitate the transition of care for patients with diabetes, which will implement a discharge planning program and post-discharge support program. Establishing self-management and wellness programs for our targeted population will provide the best opportunity for positive results and ongoing outcomes.

This project can focus on the development of pilot interventions to improve patient care using tactics such as:

- Discharge checklists
- “Hand off” communication plans with receiving providers in the community
- Wellness initiatives targeting high-risk patients
- Patient and family education initiatives including patient self-management skills and “teach-back”
- Post-discharge medication planning

Intervention(s)

Valley Regional will focus on preventing readmissions for diabetes patients. Under the program, a nurse practitioner and certified diabetes educator will facilitate an interdisciplinary collaboration to transition patients from hospital to home self-care. The nurse practitioner will facilitate the intervention from discharge through the month following discharge by identifying and meeting with the patient, and conducting a follow-up visit post-discharge. In addition, the nurse practitioner will conduct 3 follow-up calls.

This project will be comprised of the following milestones:

- P-3: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to diabetes to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge
- I-11: Improve the percentage of diabetic patients receiving standardized care according to the approved clinical protocols and care transitions policies.
 - Total patient impact: 12,000 patient encounters; Medicaid and Uninsured patient impact: 4,000 patient encounters.

Need for the project

The RHP 5 plan notes diabetes and obesity as its first “key health challenge.” (RHP 5 Plan, Page 7). The plan cites diabetes and obesity as the third leading cause of mortality in this region behind heart disease and cancer, and an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke. (RHP Plan, Page 29-30). Two community needs identified in the RHP 5 plan include the inadequate integration of care and the lack of patient-centered care. (CN3 and CN4). This project will attempt to target a more patient centered model and integrate care and address one of the biggest health challenges in the region.

Target population

Valley Regional expects to have a large impact on the Medicaid and uninsured population in the region. Currently, Valley Regional serves an overall patient population that is 47% Medicaid eligible or uninsured. Valley Regional expects this project’s impact to be at least 30% for the Medicaid and uninsured inpatient diabetic population at Valley Regional.

Category 1 or 2 expected patient benefits

Valley Regional expects to implement a diabetes-targeted Care Transition program over the course of the Waiver in order to improve patient outcomes through a more comprehensive approach to diabetes care. Valley Regional expects this program to help facilitate a higher rate of controlled diabetes among community members with this chronic disease. Valley Regional intends to provide 3000 patient encounters in DY3, 4,000 patient encounters in DY4, and 5,000 patient encounters in DY5 for a total intervention of 12,000 patient encounters in DY3-DY5.

Category 3 outcomes expected patient benefits

IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure) –helping patients control their blood sugar levels.

Valley Regional aims to improve the percentage of patients in Cameron County with uncontrolled blood sugar levels by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of diabetic conditions. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Valley Regional to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Valley Regional cannot force patients to do on a regular basis. Valley Regional intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Estimate of Project Valuation for DY 3 – DY 5

\$4,000,000

IGT Source

Cameron County Healthcare Funding District

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 020947001.1.1

Provider Name/TPI: Columbia Valley Healthcare System, L.P. d/b/a Valley Regional Medical Center / 020947001

Project Description

1.9.2 - (Expand Specialty Care Capacity – Improve Access to Specialty Care) - Valley Regional Medical Center (Valley Regional) intends to improve access to specialty care by expanding the hours of availability for its diabetes clinic. This region has had deficient service availability to diabetics and the patient population susceptible to diabetes. Valley Regional has had success with a diabetes clinic, but has had limited availability because of financial constraints. The objective of this project is to increase the capacity to provide specialty care services. This project will increase service availability with extended hours.

Intervention(s)

Valley Regional will expand the services provided at the diabetes outpatient clinic. This program will focus on evaluation, education, nutrition, and ongoing assessment to reduce the complications of diabetes and help our diabetic population better manage their disease.

This project will be comprised of the following milestones.

P-11 – Expand specialty care clinic

I-22. Increase the number of clinic hours available for the diabetes clinic.

- Total patient impact: 4,500 patient encounters; Medicaid and Uninsured patient impact: 1,800 patient encounters.

Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Need for the project

The RHP 5 plan notes diabetes and obesity as its first “key health challenge.” (RHP 5 Plan, Page 7). The plan cites diabetes and obesity as the third leading cause of mortality in this region behind heart disease and cancer, and an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke. (RHP Plan, Page 29-30). Two community needs identified in the RHP 5 plan include the inadequate integration of care and the lack of patient-centered care. (CN3 and CN4). This project will attempt to target a more patient centered model and integrate care and address one of the biggest health challenges in the region.

Target population

Valley Regional expects to have a large impact on the Medicaid and uninsured population in the region. Currently, Valley Regional serves a patient population that is at least 47% Medicaid eligible or uninsured. Valley Regional expects this project's impact to be at 40% for the Medicaid and uninsured population.

Category 1 or 2 expected patient benefits

Valley Regional expects an increase rate of prevention of the onset of Type II diabetes for targeted pre-diabetics in the community through provider-furnished education and management about lifestyle choices, medications, and risks. Additionally, Valley Regional expects a higher rate of controlled diabetes among community members with this chronic disease. Valley Regional intends to provide 1000 patient encounters in DY3, 1,500 patient encounters in DY4, and 2,000 patient encounters in DY5 for a total intervention of 4,500 patient encounters in DY3-DY5.

Category 3 outcomes expected patient benefits

IT-1.11 Diabetes care: BP control (<140/80mm Hg)²³⁴ – NQF 0061 (Standalone measure) – helping patients control their blood pressure.

Valley Regional aims to improve the percentage of patients in Cameron County with uncontrolled blood pressure by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of diabetic conditions. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Valley Regional to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Valley Regional cannot force patients to do on a regular basis. Valley Regional intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Estimate of Project Valuation for DY 3 – DY 5

\$2,800,000

IGT Source

Cameron County Healthcare Funding District

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.2.__

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

2.6 - (Implement Evidence Based Health Promotion Programs) – Rio Grande Regional Hospital (Rio) intends to implement evidence based health promotion in Hidalgo County, Texas to target reducing the complications of asthma in school-aged residents through school-based interventions. Rio will provide guidance to at-risk community members to accomplish the goal of prevention and management of asthma for at-risk patients, particularly young residents in our low-income and Medicaid eligible communities. Establishing self-management and wellness programs for our targeted population will provide the best opportunity for positive results and ongoing outcomes. This project will involve asthma screenings, counseling, referrals to specialists, and ongoing education regarding disease management.

Intervention(s)

Rio will transition a respiratory therapist and potentially hire a social worker to establish community outreach and school-based interventions for asthmatic children, and the patient population susceptible to asthma in the surrounding school districts. This program will focus on evaluation, education and ongoing assessment to reduce the complications of asthma and help our population better manage their disease. This project will address the core requirement of this project option which is to establish self-management programs and wellness using evidenced-based designs.

This project will be comprised of the following milestones:

P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.

I-8: Increase access to health promotion programs and activities through this project.

- Total patient impact: 3,060 patient encounters; Medicaid and Uninsured patient impact: 2,448 patient encounters.

This project will conduct quality improvement 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.

Need for the project

Region 5's community needs include inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). Children in our community are not receiving early intervention to address potential asthma issues, which can be controlled with regular maintenance. Unfortunately, because such a large portion of our patient population does not have sufficient primary care (CN.1), their children often do not receive adequate early intervention for this condition. As such, Rio expects to have a significant impact on reducing incidence of asthma related admissions to the ED through this project.

Target population

The target population is the school aged population of the surrounding school districts, which have a very high Medicaid-eligible and uninsured population. Currently, the McAllen area pediatric population is 79% Medicaid and uninsured. Rio's pediatric patient population is 84% Medicaid and uninsured. As such, Rio expects this project to reach approximately 80% Medicaid and uninsured pediatric patients. At the scale of the project, Rio expects approximately 4,080 patient encounters over the three remaining years of the demonstration.

Category 1 or 2 expected patient benefits

Rio expects to educate a large section of its pediatric patient population regarding asthma related issue, prevention, and management. Rio will likely have two practitioners working in area schools to improve disease recognition and options. Over the three remaining years of the demonstration, Rio expects the following patient impact:

DY3: 360 total patient encounters, of those 288 will be from the Medicaid/uninsured population

DY4: 1,080 total patient encounters, of those 864 will be from the Medicaid/uninsured population

DY 5: 1,620 total patient encounters, of those 1,296 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 – Rio expects to improve the rates of emergency department visits by pediatric patients and young adults caused by asthma related complications.

Estimate of Project Valuation for DY 3 – DY 5

\$2,900,000

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.2.__

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

2.6 - (Implement Evidence Based Health Promotion Programs) – LACTATION PROGRAM ENHANCEMENT

Rio Grande Regional Hospital (Rio) intends to implement evidence based health promotion in Hidalgo County, Texas to target new mothers and provide education surrounding the benefits of breastfeeding and supply additional support through additional lactation consultations and follow up calls to encourage continuing to breastfeed. This project is aimed at increasing the percentage of new mothers that report breastfeeding upon follow-up calls after they have been discharged. Establishing this additional support system will help young mothers understand the benefits and potential consequences of choosing not to breastfeed, which is a growing problem among low income and teen mothers in our community.

Intervention(s)

Rio will utilize its current lactation specialist and trained RNs to increase encounters with women who have delivered in the hospital to increase the new mother’s exposure to the education material surrounding the benefits of breastfeeding. Rio intends to establish new clinic space within the hospital to focus these efforts. This project would include a supplemental visit from the lactation outreach team, as well as an enhanced presentation on the benefits to the infant. Additionally, the hospital-based team will perform follow-up calls and provide in-home support on a case-by-case basis to encourage new mothers to breastfeed their newborns. This project will be comprised of the following milestones:

- P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.
- I-8: Increase access to health promotion programs and activities through this project.

This project will conduct quality improvement 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.

Need for the project

Region 5’s community needs includes a lack of patient-centered care (CN.4). Texas, and Hidalgo County in particular, have relatively low rates of breastfeeding in the first year of a baby’s life. This is due to a variety of factors including being separated from the baby for long periods immediately after birth, lack of education, lack of support materials, inconvenience, and in some cases, pain or sensitivity. Many studies have found that there are significant benefits to breastfeeding including a decreased risk of death between 28 days and 1 year, increased immune system, which can prevent disease, a reduction in the risk of some childhood cancers, as well as protection from diseases that occur later in life, such as diabetes, high cholesterol, and Crohn’s disease. Rio expects that an increase in community education and support to new mothers will have a significant impact on increasing the rate of mothers that report exclusively breastfeeding on follow up calls from the lactation specialist and trained personnel.

Target population

The target population is patients that deliver in the hospital, which includes a high percentage of Medicaid-eligible and uninsured patients. Currently, of the total births at Rio in a given year, over 78% of the patients are Medicaid and uninsured. As such, Rio expects this project to reach approximately 78% Medicaid and uninsured pediatric patients.

Category 1 or 2 expected patient benefits

Rio expects to provide education and support to new mothers that deliver in the hospital to encourage breastfeeding. Based on the research in this area, it is clear that breastfeeding has significant benefits to both mother and baby. Rio is seeking to triple the encounters that each new mother has with a lactation specialist or specifically trained RN or nurse practitioner. Over the three remaining years of the demonstration, Rio expects the following patient impact:

DY3: 776 new patient encounters, of those 535 will be from the Medicaid/uninsured population

DY4: 3,105 new patient encounters, of those 2,142 will be from the Medicaid/uninsured population

DY 5: 4,140 new patient encounters, of those 3,229 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT-8.15b – Rate of Exclusive Breastfeeding – Rio expects to improve the rates of new mothers that report exclusive breastfeeding upon follow up calls from the lactation outreach team.

Estimate of Project Valuation for DY 3 – DY 5

\$3,600,000

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.1.__

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

1.1.2: Expand Primary Care Capacity: PRIMARY CARE PHYSICIAN RECRUITMENT

Rio Grande Regional Hospital (Rio) seeks to increase primary care capacity at its local outpatient clinics. This project will allow Rio to recruit and retain a primary care physician to support primary care services in the North Central and Northwest areas of the Region entail implementing creative strategies for attracting the needed practitioners to the community. We have an ongoing mission to draw talented, qualified physicians to our facility. In addition to current efforts, we continue to seek and develop innovative ways to attract physicians to the area. We will develop a plan for adding additional incentives to the recruitment and retention efforts and implement strategies we have identified.

Intervention(s)

Rio plans to hire an additional primary care physician to expand access to primary care. This increase in provider presence will result in an increase in primary care clinic volume.

This project will focus on the following milestones:

- [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
- [I-12]. Increase primary care clinic volume of visits and evidence of improved access

Need for the project

Region 5 ranked the shortage of primary and specialty care providers and inadequate access to primary or preventive care as its most prevalent community need (CN.1) as well as inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). The community needs assessment utilized by Region 5 shows that the Region has only half the rate of general practitioners per 100,000 population compared to Texas. The supply of physicians in OB/GYN lags behind Texas by 25%. To address this severe shortage in the Rio Grande Valley, we have actively engaged in marketing and incentive strategies to recruit physicians into our community.

This project will increase the number of physicians and scope of services offered in the community by facilitating the recruitment of primary care physicians to the area. This increase in the primary care workforce will result in strengthen and integrated health care system and play a key role in implementing disease management programs, which a strong primary care framework is necessary. The goal of this project is to recruit more workforce members to serve as primary care providers and clinicians to address the substantial primary care workforce shortage.

Target population

The target population is the patient population with the need for a primary care physician, new families moving into the area and patients who are in need of annual screenings and other preventative care to maintain healthy lives. About 35% of the patients that will benefit from this project are Medicaid eligible or indigent.

Category 1 or 2 expected patient benefits

The increased availability of primary care resources should reduce inappropriate usage of hospital Emergency Departments for basic medical services. An additional primary care physician will promote comprehensive health care outside of the Emergency Department, which will help in achieving the Waiver aim of providing the right care in the right setting. Expanding access to primary care is a foundational issue for transforming the delivery of care and improving patient outcomes in the Region.

Patient impact

DY3: 1,000 total patient encounters, of those 350 will be from the Medicaid/uninsured population

DY4: 1,500 total patient encounters, of those 525 will be from the Medicaid/uninsured population

DY 5: 1,800 total patient encounters, of those 630 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT 2.11 – Reduce Ambulatory Care Sensitive Conditions Admissions Rate – Rio expects that the improved accessibility to primary care will cause a reduction in non-emergent ED admissions for the target population. Rio believes patients in the targeted outlying communities will have better access to primary care through the recruitment of an additional primary care practitioner.

Estimate of Project Valuation for DY 3 – DY 5

\$3,300,000

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.1.__

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

1.9.1 - Expand Specialty Care Capacity – EXPAND UROLOGICAL SERVICE CAPACITY

Rio Grande Regional Hospital (Rio) intends to expand the provision of specialty care in the region by recruiting one (1) new Urologist. Increased Urological specialty care capacity will allow patients to be seen with less wait times, which will result in better patient outcomes. The Region faces a severe shortage of specialty care physicians. This project aims to increase access to that care, regardless of a patient's ability to pay.

Intervention(s)

Rio will meet the core requirements of this project by identifying high impact / most impacted specialty service gaps and recruiting a specialist to meet those needs. An additional specialist will provide expanded access to these critical patients.

This project will focus on the following milestones:

- [P-1]: Conduct specialty care gap assessment based on community need.
- [I-22]: Increase the number of specialist providers in targeted specialties.
- [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

Need for the project

This region experiences a shortage of primary and specialty care providers and inadequate access to primary or specialty care (CN.1), inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). An increase of one Urologist will allow more patients to receive care on a more timely basis. Early detection of healthcare problems results in earlier medical intervention and earlier identification and intervention has been shown to lead improved patient outcomes and decreased overall healthcare costs. Addressing this specific shortage in the region should help reduce overall costs by providing ongoing treatment and care management. The current shortage in Urology services often leads to long wait time for appointments.

Target population

This project targets the patient population in the hospital in need of Urology services, regardless of ability to pay. Rio's Urology department payor mix is comprised of about 40% Medicaid and uninsured patients. Rio expects that this project will have a similar impact on the Medicaid and uninsured population.

Category 1 or 2 expected patient benefits

Rio expects that, by recruiting an additional Urology provider to the community to expand specialty serve capacity will increase access for the patient population, patient satisfaction and health outcomes will improve.

Patient impact

DY3: 90 total patient encounters, of those 36 will be from the Medicaid/uninsured population

DY4: 180 total patient encounters, of those 72 will be from the Medicaid/uninsured population

DY 5: 180 total patient encounters, of those 72 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT 3.1 – All Cause 30-day Readmission Rate - Rio expects that increase capacity for Urology services will increase patient interaction with a physician and increased coordination of care; therefore, Rio expects that the patient outcomes will improve and have less risk of readmission. A reduction in the readmission rate will allow the hospital to serve more patients overall, and decrease costs to the overall healthcare delivery system.

Estimate of Project Valuation for DY 3 – DY 5

\$975,000 – this valuation is based on the high acuity and complication rate associated with these specialty services, and cost associated with implementing this project.

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.2. __

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

2.6 - (Implement Evidence Based Health Promotion Programs) - Rio Grande Regional Hospital (Rio) intends to implement evidence based health promotion in Hidalgo County, Texas to target reducing the incidence of diabetes in school-aged residents through school-based interventions. Rio will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients, particularly young residents in our low-income and Medicaid eligible communities. Establishing self-management and wellness programs for our targeted population will provide the best opportunity for positive results and ongoing outcomes.

Intervention(s)

Rio will repurpose a dietician, nutritionist, and administrative staff to establish community outreach and school-based interventions for diabetic children, and the patient population susceptible to diabetes (specifically the overweight / obese population in the surrounding school districts. This program will focus on evaluation, education, nutrition, and ongoing assessment to reduce the incidence of diabetes and help our diabetic population better manage their disease. Additionally, Rio intends to conduct school visits and home visits with the targeted patient population. This project will address the core requirement of this project option which is to establish self-management programs and wellness using evidenced-based designs.

This project will be comprised of the following milestones:

P-2: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community.

I-8: Increase access to health promotion programs and activities through this project.

- Total patient impact: 3,060 patient encounters; Medicaid and Uninsured patient impact: 2,448 patient encounters.

This project will conduct quality improvement 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.

Need for the project

The RHP 5 plan notes diabetes and obesity as its first “key health challenge.” (RHP 5 Plan, Page 7). The plan cites diabetes and obesity as the third leading cause of mortality in this region behind heart disease and cancer, and an underlying component of over half of hospital admissions for heart attack, hypertension, sepsis and stroke. (RHP Plan, Page 29-30). The lack of primary care in the community (CN.1) means that providers must try more innovative approaches to addressing the region’s top health challenge, including community outreach and school-based programs. Two additional community needs identified in the RHP 5 plan include the inadequate integration of care and the lack of patient-centered care. (CN3 and CN4). This project will attempt to target a more patient centered model and integrate care and address one of the biggest health challenges in the region.

Target population

The target population is the school aged population of the surrounding school districts, which have a very high Medicaid-eligible and uninsured population. Currently, the McAllen area pediatric population is 79% Medicaid and uninsured. Rio's pediatric patient population is 84% Medicaid and uninsured. As such, Rio expects this project to reach approximately 80% Medicaid and uninsured pediatric patients. At the scale of the project, Rio expects approximately 4,080 patient encounters over the three remaining years of the demonstration.

Category 1 or 2 expected patient benefits

Rio expects to reduce the onset and complications of diabetes for targeted pre-diabetics in the community through provider-furnished education and management about lifestyle choices, medications, and risks. Additionally, Rio expects a higher rate of controlled diabetes among community members with this chronic disease. Over the three remaining years of the demonstration, Rio expects the following patient impact:

DY3: 360 total patient encounters, of those 288 will be from the Medicaid/uninsured population

DY4: 1,080 total patient encounters, of those 864 will be from the Medicaid/uninsured population

DY 5: 1,620 total patient encounters, of those 1,296 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT-1.11 Diabetes care: BP control (<140/80mm Hg)²³⁴ – NQF 0061 (Standalone measure) – helping patients control their blood pressure.

Rio aims to improve the percentage of patients in Hidalgo County with uncontrolled blood pressure by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of diabetic conditions. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Rio to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Rio cannot force patients to do on a regular basis. Rio intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Estimate of Project Valuation for DY 3 – DY 5

\$2,900,000

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.2.__

Provider Name/TPI: Rio Grande Regional Hospital (Rio) / 112716902

Project Description

2.12.2: Implement Pilot Intervention – EMERGENCY DEPARTMENT CARE TRANSITIONS

This project is twofold and focuses on improving the efficiency of operations of Rio’s Emergency Department – from a patient’s initial triage and coordination efforts upon arrival to the ED through follow up care and partnership with community providers. The project first focuses on patients brought to the ED from the scene of an accident or home – typically patients are brought to Rio with very little lead-time or detailed information on the severity of the injury or condition of the patient; therefore, every moment is critical in getting the patient the right care by the right personnel. Case management staff will partner with first responders to get ED physicians as much information as possible prior to arrival, and ensure that ED protocols are followed, which will result in a support staff framework ready to accept the patient.

The second part of this project focuses on the patient’s transition to post-acute care – whether that is to the home, or to another local community provider for more comprehensive follow up care. This project will add at least 3 new staff to the ED care team to manage patients throughout the continuum of care (including a social worker, a community provider liaison, and an additional case manager, as well as training for current ED personnel and physicians to more efficiently guide patients through an acute injury. This project will also include investment in technology, including connecting the ED staff with follow up care providers through HealthPost – a software that aids in finding a follow up appointment in a non-acute setting. This follow up care will reduce readmissions by providing patients a resource for questions and issues after a hospital stay, as well as better identification of patients with persistent chronic conditions that are high-risk for readmission.

Intervention(s)

In DY3, Rio plans to develop a staffing and implementation plan and implement standardized care transition processes in specified patient populations. This project will create a more efficient emergency response from the time the patient presents to the ED through the patient’s discharge and follow up care.

This project will include the following milestones:

- P-7 Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions.
- I-14 Implement standard care transition processes in specified patient populations
- I-11 Increase % of patients and families in defined population receiving standardized communication per developed protocols.

Need for the project

This region experiences a lack of patient-centered care (CN.4), and inadequate integration of care for individuals with multiple health issues (CN.3). Efficient response to emergent conditions, as well as early identification and intervention of chronic conditions has been shown to lead improved patient outcomes and decreased overall healthcare costs. Addressing health concerns specific to this population should help reduce overall costs by providing ongoing treatment to this population.

In addition to receiving delayed or inappropriate care, patients relying on the emergency department for primary care services and chronic care case management do not receive care coordination and case management that is proven to improve patient health and outcomes. Uncoordinated care can be unsafe – even fatal – when test results are not communicated to the patient or providers, patients receive prescription medications that cause serious reactions, or patients fail to receive necessary follow-up care when dismissed from a hospital. It also adds to duplicative services that increases costs and exposes patients to unnecessary risks associated with certain services. According to a study published in the American Journal of Managed Care, roughly 30 percent of annual health care spending is estimated to be unnecessary. This project, focused on reducing readmission rates for chronically ill patients, supports the overall goal of the Waiver to implement strategies to decrease health care costs through the provision of preventative medicine and delivery of care in the appropriate setting. The Region has a high rate of patients suffering from chronic illnesses, and these patients are frequently readmitted for avoidable reasons.

Evidence indicates that appropriate follow-up care and monitoring of patients with chronic illnesses is a key component to reducing readmission rates and lowering health care costs associated with repetitive readmissions. This project (focused on efficient operations including reducing readmission rates for chronically ill patients) supports the overall goal of the Waiver to implement strategies to decrease health care costs through the provision of preventative medicine and delivery of care in the appropriate setting. This project is a new initiative because it creates a new process establishing contact with post-discharged chronically ill patients.

Target population

The target population consists of: (1) patients transitioned to the ED from first responders and local EMS providers, and (2) the patient population with a high-risk of readmission due to chronic disease or other factors. This project will target these populations in order to effectuate better health outcomes, which will benefit the overall healthcare delivery system, as well as individual patient outcomes. Approximately 64% of the ED patient population is Medicaid eligible or uninsured. We expect that this project will reflect a similar benefit to Medicaid eligible and indigent patients.

Category 1 or 2 expected patient benefits

Rio expects to develop standardized protocols for patients that come through the ED, and increase the percentage of patients that are receiving care under those standardized protocols over the three remaining years of the demonstration. Rio expects the following patient impact in each remaining demonstration year:

DY3: 4,653 total patient encounters, of those 2,978 will be from the Medicaid/uninsured population

DY4: 18,615 total patient encounters, of those 11,913 will be from the Medicaid/uninsured population

DY 5: 24,820 total patient encounters, of those 15,884 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT 3.1 – Reduce the all-cause 30-day readmission rate - Populations affected by frequent readmissions include patients with chronic diseases, complex medical and social needs and patients with little or no funding resources for post-acute care needs. Evidence suggests that the rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital, and by improving transitions and care coordination at the interfaces between care settings. A measurable reduction in Rio’s all-cause 30-day readmission rate will indicate that Rio has made progress towards these goals.

Estimate of Project Valuation for DY 3 – DY 5

\$13,500,000

IGT Source

Hidalgo County through the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT
RHP 05**

Unique Project Identifier: 112716902.1.__

Provider Name/TPI: Rio Grande Regional Hospital / 112716902

Project Description

1.1.2 - Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity - Rio Grande Regional Hospital (Rio) intends to expand the provision of primary care in the region by adding to its OB/GYN care capacity in the existing community clinics by recruiting one (1) new primary care provider for OB/GYN Care Capacity, and at least one (1) additional patient navigator serving the 5 existing OB/GYN clinics. Rio plans to provide more access to essential health services to this target population. The Region faces a shortage of primary care physicians. This project aims to increase access to primary care. This project will improve access to primary care in the Region through a variety of measures, including identifying the locations most in need of primary care services, enhancing educational outreach to ensure members of the community know that they have access to these critical OB/GYN services for prenatal care and follow up visits. This project, focused on primary care providers, supports the overall goal of the RHP to provide increased access and availability of primary care trained physicians to meet the healthcare needs of the area and to provide more integrated care.

Intervention(s)

Rio will meet the core requirements of this project by expanding the hours of primary clinic service and increasing primary care staffing by one additional provider in its community clinics. Additionally, Rio anticipates hiring additional administrative or support staff to improve the provision of care and adjust to the added patient load.

This project will focus on the following milestones:

- [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours.
- [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services

Need for the project

This region experiences a shortage of primary and specialty care providers and inadequate access to primary or specialty care (CN.1), inadequate integration of care for individuals with multiple health issues (CN.3), and a lack of patient-centered care (CN.4). Additionally, The supply of physicians in OB/GYN lags behind Texas by 25%. To address this severe shortage in the Rio Grande Valley, we have actively engaged in marketing and incentive strategies to recruit physicians into our community.

Early detection of healthcare problems results in earlier medical intervention, and earlier identification and intervention has been shown to lead improved patient outcomes and decreased overall healthcare costs. Addressing women's health concerns specific to this region should help reduce overall costs by providing ongoing treatment and care management. The current shortage in primary care OB/GYN services often leads to long wait time for appointments, particularly in rural areas served by Rio's clinics. This project seeks to add health accessibility for women in our region and increase the availability of primary care.

Target population

Rio expects to have a large impact on the Medicaid and uninsured population in the region. Currently, Rio's outpatient OB/GYN clinics serve a patient population that is at approximately 97% Medicaid eligible or uninsured. Rio expects this project will serve a similar percentage of patients that are Medicaid – eligible or uninsured.

Category 1 or 2 expected patient benefits

Rio expects that, by recruiting additional OB/GYN providers to the community to maintain and expand obstetrical and gynecological care access for the patient population, patient satisfaction and health outcomes will improve. These healthcare providers are able to provide primary care in the form of annual checkups for women of reproductive age in the community, and also to provide services for women with specific gynecological and obstetric needs. Improving patient access to these services in a preventative and ongoing capacity is expected to result in improved health outcomes for pregnant women and women at risk for gynecological conditions, and to result in reduced long-term costs for treating women in need of regular gynecological and obstetric services.

Patient impact

DY3: 480 total patient encounters, of those 465 will be from the Medicaid/uninsured population

DY4: 960 total patient encounters, of those 931 will be from the Medicaid/uninsured population

DY 5: 960 total patient encounters, of those 931 will be from the Medicaid/uninsured population

Category 3 outcomes expected patient benefits

IT 8.2 – **Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)** - Rio intends to reduce the number of low-weight births to its clinic clients by reducing the number of unhealthy pregnancies and early deliveries through regular access to OB/GYN care. Those reductions should increase the infants' short- and long-term health outcomes, and reduces the cost of providing care to the mothers and infants.

Estimate of Project Valuation for DY 3 – DY 5

\$2,200,000

IGT Source

Hidalgo County through the Local Provider Participation Fund