Section II. Executive Overview of RHP Plan

Region 7 is pleased to present the attached Regional Healthcare Partnership (RHP) Plan for the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. Region 7 is diverse in many aspects: both rural and urban, with areas that contain developed infrastructure and other areas with very limited infrastructure. Region 7 stakeholders embrace the opportunity provide through the waiver to improve access to care substantially for seriously underserved populations by creating infrastructure where none currently exists while also strengthening care delivery and coordination in areas that have more robust services.

RHP Goals / Vision

Region 7 stakeholders envision creating a coordinated healthcare system where **Good health is achievable for all people in Region 7**.

In support of this vision, Region 7 stakeholders have identified the following goals for delivery system transformation during the 5-year waiver period:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 population to include the right mix of providers, better data, and service delivery locations that are more accessible.
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
3. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
4. Bolster individual and population health by improving chronic disease management.
5. Support prevention education and healthy lifestyles to improve population health.
6. Expand access to behavioral health services to ensure timely, effective treatment that minimizes the use of crisis services and promotes recovery.
7. Improve the patient experience of care by increasing the quality of care and patient safety.

Existing RHP Healthcare Environment

Region 7 includes six counties in Central Texas with approximately 1.3 million residents. Together, Travis and Hays Counties account for almost 90% of the population within the region. The remaining four counties (Bastrop, Caldwell, Fayette, and Lee) are primarily rural with relatively small populations. Approximately 285,000 (22%) Region 7 residents are uninsured, and nearly 150,000 (12%) residents, mostly children, rely on Medicaid.

The majority of healthcare infrastructure in Region 7 is concentrated in Travis County. Counties outside Travis experience shortages across a number of critical healthcare provider categories. All Region 7 counties are designated in whole or in part as Health Professional Shortage Areas and Medically Underserved Areas. Transportation access for healthcare services has been identified as a challenge for people in rural areas as well as low-income populations in urban areas.

The population for all counties in Region 7 is projected to increase throughout the waiver period, with Hays and Bastrop counties each expected to grow more than 30% between 2000 and 2016. Population growth will further strain already limited healthcare resources.

The region is projected to become increasingly diverse through 2016, which will exacerbate existing racial and ethnic disparities across many health conditions. An aging population will also contribute to additional demand for specialists as well as the need for resources to address chronic conditions.

Key Health Challenges

As noted, inadequate access to care (including primary care, specialty care, dental care, and behavioral health care) is a key health challenge for Region 7. The lack of providers and services available is particularly prevalent for specific populations, such as homeless, children, and elderly.

County representatives throughout Region 7 have identified chronic disease as one of the top health concerns for their residents. Cardiovascular disease, cancer, and pulmonary disease are among the leading causes of death in Region 7. Rates of adult diabetes in many Region 7 counties exceed Texas state averages and continue to rise. Obesity, physical inactivity, and tobacco use are critical factors contributing to chronic disease.

Patients with more than one chronic condition have a higher risk of potentially preventable hospitalizations, contribute to significantly higher healthcare costs, and are a greater challenge for coordination of care. Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition.

Behavioral health is also a key health concern among Region 7 stakeholders. Conservative estimates indicate that more than 20% of the region's population that is under 200% of the Federal Poverty Level with a severe mental illness is presently not receiving care. And of those who are receiving care, their needs are complex; approximately 70% of the population has additional complicating co-morbidities such as a substance use disorder, one or more chronic health conditions, or all three conditions.

People with co-morbidities, including multiple physical health conditions and co-occurring behavioral health concerns, must navigate a complicated and disconnected system of healthcare providers. Region 7 providers are recognizing the need to address these issues simultaneously. Achieving these improved outcomes will require integration of healthcare delivery that bridges and integrates currently separate physical and behavioral health delivery systems.

Inadequate access to care and a lack of care coordination also contribute to potentially preventable utilization of healthcare services. A 2011 analysis of emergency department (ED) visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. An additional 6% required emergent care which potentially could have been prevented with appropriate ambulatory care.

In addition, adult residents of Region 7 have more than 8,500 potentially preventable inpatient hospitalizations per year for conditions such as bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and diabetes complications. Potentially preventable conditions requiring inpatient care contributed to over $1 billion in hospital charges between 2005 and 2010. Please refer to the Community Needs Assessment in Section III for additional detail regarding key health challenges facing Region 7.

Proposed DSRIP Projects to Realize the RHP Vision

Region 7 projects address a basic lack of infrastructure and services in rural areas as well as launching innovative projects focused on changing how we deliver care and decreasing costs. Across Region 7, participants are proposing upgrades to infrastructure that will significantly improve access to care to prevent the escalation of physical and mental health problems and/or utilization of inappropriate or expensive treatment settings such as criminal justice systems and emergency departments. The Community Care Collaborative, a newly launched accountable care-like integrated delivery system that will knit together Travis County's fragmented safety net healthcare delivery providers, will implement multiple infrastructure improvements such as expanding the medical home network and standardizing care delivery protocols among other innovative projects. Mobile services in multiple counties will improve access to

primary care and behavioral health services, bringing care to individuals who are not able to reach established clinic locations. Multiple projects will use telemedicine to fill the gap in psychiatric care, expanding care to individuals experiencing crisis and to providers needing support to care for complex patients.

System transformation and costs savings depend upon expanding access to the right care in the right setting. Region 7 addresses this goal in a number of ways: intervening at critical junctures, expanding access points, implementing new care delivery strategies and addressing both physical and behavioral health needs simultaneously. Mobile Crisis Outreach Teams and Assertive Community Treatment teams will focus on intervening with individuals experiencing behavioral health crisis and providing and/or connecting them with appropriate stabilization services in order to prevent them from entering the criminal justice system or inpatient psychiatric services. Expansion of primary care, urgent care, specialty care and integrated behavioral health services in every county will improve patient access to care while preventing utilization of more expensive services. This includes expansion of integrated care by adding behavioral health services to existing medical settings and adding medical care to existing behavioral clinics. School based behavioral health services in Fayette, Lee and Travis counties will help children and youth receive the care they need, minimize the strain on families and help keep kids in school, a long term strategy for improved health outcomes.

Region 7 is focused on improving patient experience by providing translation services in native languages, expanding navigation programs that help the seamless connection to services, providing patient centered comprehensive care and providing care at every stage of health, including palliative care.

High rates of chronic disease within Region 7 require the expansion of targeted chronic disease management programs. Multi-disciplinary teams intervening with obese children and their families and children with chronic disease address the complex needs of patients and help prevent the development of more serious complications. The care transitions program takes care to the patient in his/her home. This program focuses on individuals with multiple chronic conditions who are released from inpatient services and focuses on prevention of re-hospitalization.

In order to truly change course in Central Texas, it is essential to not only focus on intervention but also prevention and health promotion. Innovative strategies include deploying peer counselors who have successfully achieved health and wellness goals to encourage and support individuals with co-occurring behavioral health diagnoses and chronic conditions and/or unhealthy lifestyles to achieve their own health goals. These programs are particularly important given the early mortality of individuals with behavioral health issues. A tobacco cessation initiative targeting young adults addresses a top contributor to mortality/morbidity while intervening before tobacco induced chronic disease develops. Disease prevention and promotion of healthy lifestyles are essential to empowering individuals to improve their quality of life.

Region 7 is committed to continuous quality improvement to ensure that patients receive the care they need. Increasing access to data and continually analyzing data will enable providers to adjust interventions to better meet the needs of patients and reduce costs of care. The proposed projects will expand access to care, fill critical gaps, drive utilization away from emergency departments and the criminal justice system and improve the overall care and experience for patients.

Table of Category 1 & 2 Projects

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
Category 1: Infrastructure Development			
133542405.1.1 Pass 2 Mental Health First Aid and Suicide Prevention Austin Travis County Integral Care 133542405	Implement evidence-based Mental Health First Aid training program for primary care staff on how to identify, understand and respond to signs of mental illness and chemical dependency disorders and how to prevent suicide.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$1,967,599
133542405.1.2 Pass 2 Expand Specialty Behavioral Healthcare Prescriber Capacity Austin Travis County Integral Care 133542405	Employ additional practitioners with prescribing capability to provide outpatient medication management and care management services to maximize the ability of patients to remain stable and living within the community.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-up after hospitalization for mental illness	$10,699,341

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.1.3 Pass 2 Introduce, Expand, or Enhance Telemedicine/Telehealth Austin Travis County Integral Care 133542405	Expand access to psychiatric evaluation and consultation and prescribing capabilities via telemedicine to Mobile Crisis Outreach Teams (MCOT) serving individuals experiencing psychiatric crisis. Maximizes the ability of MCOT to effectively and efficiently address patient needs and avoid need for more intensive and expensive services.	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores	$1,400,743
126844305.1.1 Pass 1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Youth Counseling for Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Develop counseling and early intervention services that are delivered on school campuses in collaboration with the school districts in Fayette and Lee Counties.	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$1,633,660

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.1.2 Pass 1 Development of behavioral health crisis stabilization services as alternatives to Hospitalization: Child Crisis Respite through Therapeutic Foster Care Bluebonnet Trails Community Services 126844305	Develop specialized Therapeutic Foster Care setting that can be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility.	OD-9: Right Care, Right Setting IT-9.1: Decrease in mental health admission and readmissions to criminal justice settings such as jails or prison	$3,274,447
126844305.1.3 Pass 2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Outpatient Substance Addiction Services for Adult and Youth in Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Add intensive outpatient and supportive counseling substance abuse services in Bastrop, Caldwell, Fayette and Lee Counties and ensure availability of services for individuals who are low-income and uninsured in order to improve health outcomes for persons who have limited access to behavioral health services.	OD-3 Potentially Preventable Re-Admissions-30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rate	$4,020,311

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
121789503.1.1 Pass 1 Expanding Primary Care capacity for low-income adult residents of Hays County, TX Central Texas Medical Center 121789503	Create the Central Texas Healthcare Collaborative Clinic to offer primary services to low-income adult residents of Hays County.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$11,677,250
307459301.1.1 Pass 3 The Community Care Collaborative's Implementation and enhancement of chronic disease management registry functionalities Community Care Collaborative 307459301	Implement and use chronic disease management registry (DMR) functionalities to systematically coordinate care for patients with two or more chronic diseases. The DMR will assist the provider care team to: ensure that these patients receive the proper care at the appropriate time; track progress and outcomes of care; identify the need for follow-up services; empower patients to take an active role in their treatment; and identify and target individuals with highest needs.	OD-1: Primary Care and Chronic Disease Management IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic IT-1.12 Diabetes care: Retinal eye exam (NQF 0055) IT-1.14 Diabetes care: Microalbumin/Nephropathy (NQF 0062)	$19,534,105

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.2 Pass 3 Expanded Primary Care Hours at Community-Based Outpatient Settings Community Care Collaborative 307459301	Expands access to routine and acute walk-in primary care by increasing operating hours of Community Collaborative Network Providers beyond Monday – Friday 8 to 5 and developing new capacity at the Southeast Hub. Provides access to care when patients need it most, reducing use of Emergency Departments for non-emergent issues.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$15,199,402
307459301.1.3 Pass 3 Expand Primary Care via Mobile Health Clinics Community Care Collaborative 307459301	Expands access to comprehensive primary care to geographically underserved areas of Travis County by deploying three mobile health clinics. Mobile clinic can serve as a primary care medical home as well as refer to other facilities with additional resources to support patient health outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) IT-1.8: Depression management : Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) IT-1.10: Diabetes care: HbA1c poor control (>9.0%) (NQF 0059)	$4,338,879

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.4 Pass 3 Expansion of Dental Services Community Care Collaborative 307459301	Expands availability of dental services low-income uninsured patients through addition of dentists and hygienists and expansion of dental service hours.	OD-7: Oral Health Outcomes IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider	$12,898,784
307459301.1.5 Pass 3 Expand Specialty Care Capacity to Treat Chronic and Acute Musculoskeletal Conditions Community Care Collaborative 307459301	Expands access to non-surgical musculoskeletal specialty services for uninsured, Medicaid and Medicare patients. Emphasis will be on physical therapy and rehabilitation for individuals not needing surgery but who have mobility issues or job related injuries.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment OD-10: Quality of Life/Functional Status IT-10.1: Quality of Life IT-10.7 Other Outcome Improvement Target : Improvement on OPTIMAL	$12,864,288

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.6 Pass 3 Expand Specialty Care Capacity for Gastroenterology Community Care Collaborative 307459301	Expands specialty care appointments at community based health centers for gastroenterology in order to reduce current 4 month wait time. Reducing wait times for visits will result in fewer visits to the emergency room and improved patient experience.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment IT-1-8: Depression Management - Screening and Treatment Plan for Clinical depression IT 1-20: Other Outcome Improvement Target – Annual Monitoring for Patients on Persistent Medications OD-12: Primary Care and Primary Prevention IT-12.3: Colorectal Cancer Screening (HEDIS 2012)	$11,364,114

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.1.7 Pass 3 Expand Specialty Care Capacity for Pulmonology Community Care Collaborative 307459301	Expands specialty care appointments for pulmonology for uninsured, Medicaid and Medicare patients. Services will be provided in community based health centers and reduce the current 4 month wait appointments resulting in fewer visits to the emergency room and improved patient experience.	OD-2: Potentially Preventable Admissions IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5	$10,268,806
307459301.1.8 Pass 3 Telepsychiatry in Federally Qualified Primary Health Clinics Community Care Collaborative 307459301	Expands access to psychiatric assessment and consultation through telemedicine for physicians and patients within community based health centers. Improves timely access to appropriate specialty services and improves patient health outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.9: Depression Management: Remission at 12 Months IT-1.20: Other Outcome Improvement Target - Anxiety Remission at 12 Months	$8,000,577

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
186599001.1.1 Pass 1 School Campus Counseling Dell Children's Medical Center 186599001	Expand campus based therapeutic behavioral health services, including access to telepsychiatry, to additional high school students and additional campuses, based on successful pilot program in Austin Independent School District.	OD-1 Primary Care and Chronic Disease Management IT-1.20 Other Outcome Improvement Target: Increase the number of patient visits for program participants aged 6 through 17 years of age with a diagnosis of major depressive disorder with an assessment for suicide risk.	$2,279,343
133340307.1.1 Pass 2 Hays County Mental Health Center Mobile Clinic Hill Country MHDD Centers 133340307	Deploy a Mobile Clinic to expand availability of comprehensive behavioral health services (including Case Management, Counseling, Pharmacological Management, Medication Training and Support, Psychiatric Rehabilitation, Skills Training, Engagement Activities, Supported Employment and Supported Housing) to individuals in outlying areas of Hays and Blanco counties.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$4,053,360

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.1 Pass 3 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Development of behavioral health crisis stabilization services as alternatives to hospitalization Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Creates a 24-7 Licensed Psychiatric Emergency Department for individuals experiencing psychiatric crises who need access to both emergency medical and psychiatric services, including assessment and treatment, followed by release or continued short term observation. Service will meet patient needs in a more appropriate setting and reduce use of Hospital Emergency Departments for psychiatric services.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health / Substance Abuse 30 day readmission rate	$16,326,906

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.2 Pass 3 Implement strategies defined in the plan to encourage behavioral health practitioners to serve medically indigent public health consumers in HPSA areas or localities within non-HPSA counties which do not have access equal to the rest of the county: Expand Post Graduate Training for Psychiatric Specialties/Psychiatric Residency Programs Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Adds post-graduate training positions to increase the number of mental health professionals in the region, including psychiatrists, psycho-pharmacologists, psychosomatic and psychologists, thereby reducing wait times for appointments, easing the strain on emergency psychiatric care, and improving patient outcomes.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-Up After Hospitalization for Mental Illness	$8,180,595

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.3 Pass 3 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers: Psychiatric telemedicine for emergency services Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Expand access to provide 24/7 psychiatric consultations at the regional Level 1 Trauma Center emergency department by utilizing after-hours telemedicine services. Assess all patients presenting with primary or secondary mental health diagnosis, initiate treatment and/or refer appropriately to other services.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$5,767,094
137265806.1.4 Pass 3 Expand access to written and oral interpretation services: Language Services Resource Center Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Increase and improve language access to Spanish-speaking patients with Limited English Proficiencies (LEP) by increasing the number of qualified health care interpreters and creating a Language Resources Center that will coordinate and optimize the delivery of interpretation services.	OD-11: Addressing Health Disparities in Minority Populations IT-11.6: Other Outcome Improvement Target	$11,661,934

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.1.5 Pass 3 Clinical Cultural Competence: Develop cross-cultural training program that is a required, integrated component of the training and professional development of health care providers at all levels: Culturally Competent Care Training Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Provide culturally competent care training, awareness and education to healthcare providers and staff at UMCB and four other Seton hospitals in Travis County in order that a diverse population of patients with access to health care delivered by culturally competent professionals who understand and respond effectively to the cultural needs.	OD-6: Patient Satisfaction IT- 6.1: Percent improvement over baseline of patient satisfaction scores	$6,821,304
176692501.1.1 Pass 1 Expanding Access to Specialty Care St. Mark's Medical Center 176692501	Expand access to specialty care physician services by recruiting additional physicians to provide OB/GYN, specialty care, and wound care services in Lee and Fayette Counties.	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$256,130

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
Category 2: Program Innovation and Design			
133542405.2.1 Pass 1 Integrate Primary and Behavioral Health Care Services Austin Travis County Integral Care 133542405	Launch new outpatient behavioral health clinic with integrated medical care in the Dove Springs neighborhood in Austin to increase access to services for adults and children.	OD-1: Primary Care and Chronic Disease Management IT-1.18: Follow-Up After Hospitalization for Mental Illness OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$19,942,170
133542405.2.2 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting : Mobile Crisis Outreach Team Expansion Austin Travis County Integral Care 133542405	Expand Mobile Crisis Outreach Team crisis intervention to multiple locations to provide specialty behavioral health services and divert inpatient admissions, jail bookings and emergency department usage.	OD-3: Potentially Preventable Readmissions - 30 day Readmission Rates IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$19,826,460

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.2.3 Pass 2 Hospital and Jail Alternative Project: Crisis Residential Program, Development of behavioral health crisis stabilization services as alternatives to hospitalization Austin Travis County Integral Care 133542405	Expand psychiatric crisis residential treatment services to provide short-term, community-based intensive psychiatric treatment for persons experiencing a psychiatric crisis and/or with severe functional impairment, thereby creating hospital and jail diversion treatment alternatives for individuals with co-occurring disorders.	OD-3: Potentially Preventable Re-Admissions IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$16,013,859
133542405.2.4 Pass 2 Community Behavior Support (CBS) Team Austin Travis County Integral Care 133542405	Create a Community Behavior Support (CBS) Team that provides medically complex treatment including crisis prevention, intervention and stabilization for people who have a co-occurring diagnosis of a developmental disability (DD) and mental illness (MI) or mental health disorder.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$4,315,618

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133542405.2.5 Pass 2 Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults Austin Travis County Integral Care 133542405	Implement multi-component, evidence-based health promotion programming in chronic disease management for adults with SMI to help individuals better understand their disease and how to manage it, and in the longer term, see reductions in negative health indicators (weight, cholesterol, etc.).	OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores for patient's overall health/functional status using the CG-CAHPS Survey.	$6,612,177
133542405.2.6 Pass 2 Integrate Whole Health Peer Support: Recruit, train, and support consumers of mental health services to provide peer support services Austin Travis County Integral Care 133542405	Implement a multi-component, evidence-based peer support training curriculum to expand the role of mental health peer supports to help peers living with Serious Mental Illness to adopt whole health life styles (e.g., tobacco-free, good nutrition, regular exercise).	OD-6: Patient Satisfaction IT-6.1: Percent Improvement over baseline of patient satisfaction scores	$1,190,380

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.2.1 Pass 1 Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner not described in the project options above: Transitional Housing Guided by Peer Support Bluebonnet Trails Community Services 126844305	Implement a transitional housing project grounded in best practice recovery principles and guided by peer support in order to improve self-management and independent living for people exiting crisis services.	OD-3: Potentially Preventable Re-admissions - 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$2,614,016
126844305.2.2 Pass 2 Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD); for Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Provide Assertive Community Treatment (ACT) services for individuals with IDD who are experiencing crisis and/or life transitions in order to divert people with IDD from higher cost, institutional placement and into local resources. Provide specialized consultation to attending physicians.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$1,038,183

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
126844305.2.3 Pass 2 Services for Justice-Involved Youth and Adults: Bastrop, Caldwell, Fayette and Lee Counties Bluebonnet Trails Community Services 126844305	Decrease incarceration of individuals with behavioral health diagnoses who commit minor offenses. Collaborate with juvenile and adult Court systems in Bastrop, Fayette, Caldwell and Lee counties to provide screening, assessment and diversion recommendations prior to long-term incarceration.	OD-9: Right Care, Right Setting IT- 9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	$914,764
126844305.2.4 Pass 2 Design, implement, and evaluate project that provides integrated primary and behavioral health care services: Primary Care / Behavioral Health Care Integration Clinic – Caldwell County Bluebonnet Trails Community Services 126844305	Partner with Community Health Centers of South Central Texas (CHCSCT) to establish and jointly operate a primary care / behavioral health care clinic site in Lockhart, Texas.	OD-1: Primary Care and Chronic Disease Management IT-1.8: Depression management: screening and treatment plan for clinical depression IT-1.9: Depression management: depression remission at twelve months	$17,994,377

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.1 Pass 1 Provide ACT Model for Participants of HF PSH City of Austin Health & Human Services Department 201320302	Provide additional supports to recently housed persons with co-occurring psychiatric, substance abuse, and medical diagnoses through an Assertive Community Treatment model implemented at existing non-profit housing units.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$874,500
201320302.2.2 Pass 1 Expansion of Community Diabetes Project City of Austin Health & Human Services Department 201320302	Train and deploy community health workers to deliver culturally appropriate chronic disease self-management education to Hispanic and African-American patients.	OD-10: Quality Of Life/Functional Status IT-10.1: Quality of Life	$1,750,000
201320302.2.3 Pass 1 Prevention and Cessation Program for 18-24 years olds in Travis County City of Austin Health & Human Services Department 201320302	This project is an evidence-based comprehensive tobacco prevention and cessation intervention to reduce tobacco use among the 18-24 year old population in Travis County.	OD-12: Primary Care and Primary Prevention IT-12.6: Other Outcome Improvement Target: Adult Current Smoking Prevalence.	$2,390,000

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.4 Pass 2 Prenatal, Post-Natal Program City of Austin Health & Human Services Department 201320302	The Prenatal & Postnatal Program will use Community Health Workers (CHWs) to improve birth and twelve-month postnatal outcomes with an emphasis on African American women in the community through increased access to pre- and post-natal care and health literacy.	OD-8: Perinatal Outcomes IT-8.2 Percentage of Low Birthweight births	$2,390,669
201320302.2.5 Pass 2 Healthy Families Program Expansion City of Austin Health & Human Services Department 201320302	Provide home visiting and family support services based on the evidence-based Healthy Families America model to improve families' access to preventive services including establishing a medical home, immunizations, well-child checks, developmental assessments, parenting education, and home and personal safety practices such as car seats. Program targets family at risk for child abuse.	OD-11: Addressing Health Disparities in Minority Populations IT-11.2: Improvement in disparate health outcomes for target population including identification of the disparity gap IT-11.3: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity	$1,190,000

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
201320302.2.6 Pass 2 Adult Immunizations to High Risk Populations City of Austin Health & Human Services Department 201320302	Increase the number of vaccinations available to six targeted high-risk populations with complex needs who are at risk for vaccine preventable diseases.	OD- 11: Addressing Health Disparities in Minority Populations IT-11.1: Improvement in Clinical Indicator in identified disparity group	$7,626,891
307459301.2.1 Pass 3 The Community Care Collaborative's Patient-Centered Medical Home Community Care Collaborative 307459301	The goal of this project is to establish or enhance shared care standards, data exchange protocols, and organizational approaches to care that will allow for a coordinated, collaborative provider network to improve patient health management.	OD-1: Primary Care and Chronic Disease Management IT-1.1: Third Next Available Appointment IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012): angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) IT-1.13 Diabetes care Foot exam (NQF 0056) OD-6: Patient Satisfaction IT-6.1: Percent improvement over baseline of patient satisfaction scores	$18,003,925

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.2 Pass 3 Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions Community Care Collaborative 307459301	Research, design and implement Chronic Care Management models to be used across the Community Care Collaborative network of safety net providers to manage 18,000 patients with multiple chronic conditions.	OD-1: Primary Care and Chronic Disease Management IT-1.6: Cholesterol management for patients with cardiovascular conditions IT-1.11: Diabetes Care: Blood Pressure Control (<140/90 mm/Hg) OD-10: Quality of Life/Functional Status	$18,710,458
307459301.2.3 Pass 3 Integrated Behavioral Health Intervention for Chronic Disease Patients Community Care Collaborative 307459301	Identifies and refers patients with co-occurring chronic diseases and behavioral health issues to on site behavioral health counseling services designed to improve daily well-being and support treatment compliance.	OD-1: Primary Care and Chronic Disease Management IT - 1.9: Depression management: Depression Remission at Twelve Months (NQF# 0710) IT-1.10: Diabetes Care: HbA1c Poor Control (>9.0%)	$9,728,463

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.4 Pass 3 Sexually Transmitted Disease Screening, Treatment, and Prevention Community Care Collaborative 307459301	Expand access to screenings and treatment for sexually transmitted diseases, and HIV tests and referrals for high risk low-income and Medicaid eligible individuals who lack access to these critically needed exams. Outreach and education efforts will target those most at risk for exposure/ infection.	OD-11 Addressing Health Disparities in Minority Populations IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Gonorrhea IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, treatment) in target population with identified disparity – Chlamydia IT-11.3: Improve utilization rates of clinical preventative services (testing, preventative services, referral for treatment) in target population with identified disparity – HIV	$3,372,979

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
307459301.2.5 Pass 3 Adolescent and Young Adult Pregnancy Prevention Community Care Collaborative 307459301	Provide long-acting reversible contraception, as medically appropriate, to low-income, uninsured adolescents and young adult females who currently do not have access to these services to reduce unintended pregnancies, reduce public health costs and promote population health.	OD-1: Primary Care and Chronic Disease Management IT-1.20: Other Outcome Improvement Target: Reduction of Pregnancy Rate among Females at risk for unintended pregnancy	$4,674,285
307459301.2.6 Pass 3 Community Health Paramedic Navigation Program Community Care Collaborative 307459301	Expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and frequent recent Emergency Department (ED) utilization.	OD-9: Right Care, Right Setting IT-9.2: ED Appropriate Utilization	$6,689,613

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
186599001.2.1 Pass 1 Family and Child Obesity Dell Children's Medical Center 186599001	Expand multi-disciplinary weight management treatment team for obese children and their families and provide individual, family and community support and ancillary services to encourage and maintain positive health behaviors.	OD-9: Right Care, Right Setting IT-9.4: Other Outcome Improvement Target: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	$9,479,798
186599001.2.2 Pass 1 Chronic Care Management – Pediatrics Dell Children's Medical Center 186599001	Deliver comprehensive medical care with accompanying psychosocial supports using team approach for children with complex chronic disease and their families.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$14,414,008
133340307.2.1 Pass 1 Hays County Mental Health Center Integrated Care Hill Country MHDD Centers 133340307	Integrate primary care into the Hays County Mental Health Clinic as a means to address potentially preventable admissions of Diabetes and Hypertension with a secondary diagnosis of mental illness for individuals with severe and persistent mental illness.	OD-10: Quality Of Life/Functional Status IT-10.1: Quality of Life - SF-12	$3,131,599

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.2 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting Hays County Mental Health/Intellectual & Developmental Disability Crisis Center Hill Country MHDD Centers 133340307	Provide temporary emergency respite to reduce the recurrence of the crisis in the future to individuals with dual diagnosis of Intellectual & Developmental Disability and Mental Health issues who are in crisis.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target - Supports Intensity Scale	$2,094,226
133340307.2.3 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Co-occurring Psychiatric and Substance Use Disorder Hill Country MHDD Centers 133340307	Identify and train licensed chemical dependency counselors in the provision of co-occurring psychiatric and substance use disorder services such as substance abuse services, cognitive processing therapy, psychosocial rehabilitation and wrap around services to help the individual with co-occurring diagnosis.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living – DLA-20	$878,668

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.4 Pass 1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Trauma Informed Care Hill Country MHDD Centers 133340307	Offer Mental Health First Aid training and Trauma Informed Care training to schools, law enforcement, hospitals, physicians, and community organizations to help professionals understand the role trauma plays in individual lives and the early warning signs of mental health issues.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,120,842
133340307.2.5 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services Hill Country MHDD Centers 133340307	Expand Veteran Peer Coordinators program in Hays County to recruit additional peer volunteers and develop a drop-in center in order to connect veterans to needed community resources and make medical and behavioral referrals. This project will also include provision of clinical behavioral health services from clinicians who have been trained in cultural competency for the military environment.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$2,947,902

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.6 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Children's Mental Health Crisis Center Hill Country MHDD Centers 133340307	Establish the Children's Mental Health Crisis Respite Center for children with mental health issues in order to provide temporary emergency respite and by organizing more appropriate resources in order to reduce psychiatric hospital utilization by children in crisis.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target: Traumatic Events Screening Inventory	$3,242,689
133340307.2.7 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Children's Trauma Informed Care Hill Country MHDD Centers 133340307	Design and establish a Child Focused Trauma Informed Care program throughout Hays County to offer evidence based trauma counseling such as Seeking Safety, Trust Based Relational Intervention, and Cognitive Processing Therapy in order to help children deal with trauma they have experienced.	OD-10: Quality of Life/Functional Status IT-10.7: Other Outcome Improvement Target: Traumatic Events Screening Inventory	$2,358,318

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.8 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Mental Health Courts Hill Country MHDD Centers 133340307	Establish Mental Health Courts in order to increase treatment compliance of individuals with mental illness who are identified as having frequent utilization of Emergency Departments, the criminal justice system, and/or psychiatric inpatient services. Case Managers will deliver and/or connect appropriate community-based interventions including psychosocial rehabilitation, Cognitive Behavioral Therapy, Cognitive Processing Therapy, supported employment, transportation, peer support, and other services.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,870,853

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.9 Pass 2 Recruit, train and support consumers of mental health services to provide peer support services: Adult Whole Health Peer Support Hill Country MHDD Centers 133340307	Expand peer services at 7 mental health clinics. Deploy consumers of mental health services who have made substantial progress in managing their own illness and recovering a successful to provide behavioral health services targeting individuals with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity. Improve Daily Living Activities and health outcomes and decrease utilization of Emergency Departments.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,644,488

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.10 Pass 2 Recruit, train and support consumers of mental health services to provide peer support services: Adolescent Whole Health Peer Support Hill Country MHDD Centers 133340307	Develop an Adolescent Whole Health Peer Support Network using consumers of adolescent mental health services who have made substantial progress in managing their own illness and recovering a successful life to assist other adolescents with hypertension, diabetes, and health risks such as obesity, tobacco use and physical inactivity. Improve Daily Living Activities and health outcomes and decrease utilization of Emergency Departments.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$1,233,364

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
133340307.2.11 Pass 2 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Family Partner Program Hill Country MHDD Centers 133340307	Expand Family Partner Services to provide support to primary caregivers who have children with mental illness or behavioral issues. Provide peer mentoring and support including modeling self-advocacy skills, providing information, referral and non-clinical skills training, and assisting in the identification of natural/non-traditional and community support systems.	OD-10: Quality of Life/Functional Status IT-10.2: Activities of Daily Living	$3,168,991
133340307.2.12 Pass 2 Hays County Virtual Psychiatric and Clinical Guidance Hill Country MHDD Centers 133340307	Provide 24 hour a day 7 day a week Psychiatric Consultation to Primary Care Providers and hospitals within Hays County to improve care and connection to services for individuals who present with behavioral health conditions.	OD-12: Primary Care and Primary Prevention IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9) IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE & AUDIT)	$2,506,310

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.1 Pass 1 OB Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	The project would improve access to pre- and post-natal care for uninsured Hispanic women with limited English proficiency through comprehensive, effective patient navigation services.	OD- 8 Perinatal Outcomes IT-8.1 Timeliness of Prenatal/Postnatal Care IT-8.9 Other Outcome Improvement Target	$1,958,200
137265806.2.2 Pass 2 Women's Oncology Care Screening Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This project expands access to timely breast and cervical cancer screening via a mobile unit for uninsured and underinsured women in Travis County, who, without this expansion likely would not receive these life-saving services.	OD- 12 Primary Care and Primary Prevention IT-12.6-Other Outcome Improvement Target	$4,569,448

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.3 Pass 3 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Substance abuse navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Develop a care transition program for un- and underinsured patients who are at risk for a Substance Use Disorder. Direct individuals toward early intervention/ treatment opportunities and education in order to identify and provide treatment and educational options to patients at risk for SUD.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30 day readmission rate	$5,593,480
137265806.2.4 Pass 3 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Behavioral Health Assessment and Resource Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	The Behavioral Health Assessment and Resource Navigation project creates a program to support uninsured individuals needing behavioral health care by providing free behavioral health assessments and referral to community treatment providers.	OD-3: Potentially Preventable Re-Admissions 30-day Readmission Rates (PPRs) IT-3.8: Behavioral Health/Substance Abuse 30-day Readmission Rate	$5,551,659

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.5 Pass 3 Care Transitions Intervention Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This project creates a multi-disciplinary team that monitors and coordinates the care of patients with chronic disease immediately following discharge from hospital to home, and from home to primary care. This project is expected to optimize the patient's recovery and avoid readmission.	OD-9: Right Care, Right Setting IT-9.2 ED: appropriate utilization	$14,902,218
137265806.2.6 Pass 3 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Chronic care management for adults Seton Healthcare Family: University Medical Center at Brackenridge 137265806	This is a chronic care management program that provides direct health care and care coordination for adults who have been seriously injured and to those who have experienced a serious illness due to multiple chronic conditions. Project will prevent avoidable hospitalizations and inappropriate utilization of the emergency room.	OD-9: Right Care, Right Setting IT-9.2: ED appropriate utilization	$16,645,628

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.7 Pass 3 Use of Palliative Care Programs: Implement a Palliative Care Program to address patients with end of life decisions and care needs Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Creates a new palliative care (PC) program devoted to providing palliative care to patients through a serious illness that may be chronic, terminal or acutely devastating. Services will be provided to inpatients and outpatients at UMCB, primary care clinics, patient homes and at specialty settings such as oncology, congestive heart failure and heart transplant clinics.	OD-13: Palliative Care IT-13.1: Pain Assessment (NQF 1637) IT-13.2: Treatment Preferences (NQF 1641) IT-13.6 Other Improvement Target: Increase the percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before Day Five of ICU admission.	$6,340,905
137265806.2.8 Pass 3 Women's Oncology Care Navigation Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Expands existing patient navigation services that connect women with breast/gynecologic cancer diagnoses to treatment and/or survivorship support services. Expands support to survivors of breast/gynecologic cancers.	OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$4,611,402

Project Title	Brief Project Description	Related Category 3 Outcome Measure(s)	Estimated Incentive Amount (DSRIP), DY2-5
137265806.2.9 Pass 3 Reduction in 30 Day Hospital Readmission Rates: Adult diabetes inpatient chronic care management Seton Healthcare Family: University Medical Center at Brackenridge 137265806	Develop an Interdisciplinary Diabetes Team to address the clinical, safety, and psychosocial needs of inpatients with diabetes while preparing for a successful discharge. Ensure that patients are evaluated and given customized tools for managing their disease post-discharge.	OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs) IT-3.3: Diabetes 30 day readmission rate	$10,919,329