Performing Provider: Community Care Collaborative

Project Name: Expand Primary Care Capacity via Mobile Health Clinics

Project Identifier: 307459301.1.3 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will expand primary care to underserved areas of Travis County and Austin through three mobile health teams that provide scheduled and same day appointments for comprehensive primary care. In conjunction with the fourteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project extends services to geographically isolated patients in more rural areas of the county and to those with transportation barriers to accessing care.

Need for the project: Travis County has pockets of great need, including areas in the East, Southeast, and Northeast, and Northwest portions of the county, where little primary care is available. Even in areas where more primary care is available, transportation challenges, especially for low-income residents, mean limited access to healthcare services.

Target population: The CCC's covered population will be approximately 50,000 patients at or below 200% of the FPL, many of whom will have chronic conditions. This project will target geographically underserved populations, including low-income residents with transportation barriers that limit access to primary care.

Category 1 or 2 expected patient benefits: Through the use of mobile health teams, the CCC expects to provide approximately 1,300 visits in DY3, 3000 visits in DY4, and 4000 annual visits in DY5. By DY5, this project will serve approximately 2000 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Category 3 outcomes:

- 1.11 Blood Pressure Control in Diabetics

Title of Project: Expand Primary Care Capacity via Mobile Teams
Category / Project Area / Project Option: 1.1.3

RHP Project Identification Number: 307459301.1.3 Pass 3

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459301

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will use the flexibility of mobile health teams (MHTs) to expand primary care to Travis County's geographically underserved populations. These patients will benefit from increased access as described in this project, but also the fourteen other DSRIP projects that the CCC is proposing. These thirteen projects are:

- Chronic Care Management Project
- Patient Centered Medical Homes
- Disease Management Registry
- Expanded Hours at Community Clinics
- Dental Care Expansion
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STI & HIV Screening and Treatment & Referrals
- Pregnancy Planning
- Community Paramedic Navigator Project
- Comprehensive Patient Navigation Centering Pregnancy

Through the purchase, outfitting and dispatch of three mobile health teams (MHTs), this project will reach patients who reside in areas without reliable access to care. Comprehensive primary care will include services for the elderly, children, and pregnant women; chronic disease management; on site basic blood tests and urinalysis; health risk screenings; and referral to behavioral health and social services.

The MHTs, staffed with a physician or nurse practitioner and clinical assistant will stop at specific locations on a pre-determined schedule and will see a combination of scheduled and same-day appointments. The locations for service may include public schools, shopping malls, public libraries, and banks, and the teams will be in operation four days a week.

The MHTs deployed by the CCC can serve as a medical home for patients without one and can refer patients with healthcare needs that require more resource-rich care to another appropriate CCC facility. A 2012 report developed for John Muir/Mt. Diablo Community Health Fund and the East and Central County Health Access Action Team in Contra Costa County, California, found that 40 to 80% of patients treated the mobile clinic as their medical home (http://www.johnmuirhealth.com/content/dam/jmh/ Documents/Community/Mobile_Health_Clinics-Increasing_Access_to_Care.pdf) The CCC expects that patients with multiple chronic conditions, previously isolated from regular care sources by their geographic location, will improve the management of their conditions by having regular access to MHTs.

Of the 50,000 patients within the CCC, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. This Mobile Health Teams project will increase access to care for these sickest patients closer to their homes, so that their conditions do not worsen to the point of needing hospitalization.

Project Goals

By DY5, the Project will:

- Deploy three mobile health teams to underserved areas and populations of Travis County.
- Serve 2000 patients in DY5
- Offer 4000 annual visits by DY5
- Improve patient satisfaction
- Improve management of chronic conditions

How the Project is Related to RHP Goals

This project is related to the following RHP 7 Goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

Challenges or Issues Faced by the Performing Provider

Mobile units require a fair amount of in-place infrastructure, which include: wastewater processing; restroom facilities; a waiting area; charging stations; internet access for electronic health records. Despite limited infrastructure in most targeted locations, sites will need to be identified that will allow the MHTs to provide services on an ongoing basis. Patients will need to be informed of the new services through appropriate channels, and made aware of the MHTs' schedules. Finally, recruiting providers and support staff, particularly those willing to work in a mobile environment, may be a challenge.

How the Project Addresses those Challenges

The CCC will utilize its existing relationships with safety net providers, social service organizations, and city and county agencies to identify and secure appropriate sites for MHTs. To encourage patients to take advantage of available appointments through MHTs, the CCC will advertise MHT locations and schedules through flyers in existing clinic lobbies and waiting rooms as well as through local emergency departments, as well as in those areas where teams will be deployed. Category 1 improvement milestones assume that MHTs will operate at approximately 50% capacity initially as the CCC continues to establish awareness within the community.
In order to ensure appropriate staffing, the CCC will offer financial or other incentives as needed to recruit qualified providers and support staff to work in a mobile environment. To minimize staffing future costs, existing medical assistants may be cross-trained to receive a Commercial Driver's License.

5-Year Expected Outcome for Providers and Patients

Through the use of mobile health teams, the CCC expects to provide 1,300 visits in DY3, 3,000 visits in DY4, and 4,000 annual visits in DY5. By DY5, this project will serve 2000 patients per year. This project aims to increase access to timely care, improve patient satisfaction, and improve management of chronic conditions.

Starting Point/Baseline

Baseline Data: Within Travis County, existing mobile health clinics provide targeted pediatric and dental health services. However, there are no mobile teams offering the described medical home services to the CCC patient population at this time.

Time Period for Baseline: 2012

Rationale

Reason for Selection of Project Options and Components

A 2011 analysis developed for Central Health evaluated demographic characteristics to identify geographic areas of need throughout Travis County. Families living below 100% of the Federal Poverty Level are concentrated primarily in the East, Southeast, and Central areas of Travis County.

While poverty is relatively sparse in the western half of Travis County, the far Northwest area also demonstrates high levels of need. This geographically isolated area is designated as a Primary Care Health Professional Shortage Area (HPSA) by the Department of Health and Human Services Health Resources and Services Administration. West and Northwest Travis County also include the greatest concentration of seniors ages 65 and older, who often have barriers to transportation.

In addition to current concentrations of need, data from Nielsen (formerly Claritas) evaluate historical population patterns as well as housing costs and construction trends to project future geographic shifts. Rising property values in Central Austin are forcing lower income families to relocate to the suburbs and more rural areas, with growth primarily in the East, Southeast, and Northeast parts of the county.

Development in these outlying areas is less densely populated than within the traditional urban core. A lack of transportation and other infrastructure presents challenges for adequate access to healthcare services, yet expected patient volumes are typically too low to support a standalone clinic.

A subsequent 2012 analysis developed for Central Health evaluated uninsured and underinsured patients in Travis County who accessed services at local hospitals but had no recorded visits at community-based outpatient clinics.

This analysis identified several pockets of need that were isolated from current healthcare safety net clinics, including:

- East and Southeast Travis County - Austin Colony and River Timber areas
- South Central Travis County - Manchaca area
- Southwest and Northwest Travis County - Greater Hudson Bend area
- Northwest Travis County - Anderson Mill and Fulkes Lane areas
- Northeast Travis County – East Pflugerville area

Transportation barriers also exist for patients who live in the urban core. As detailed in the Austin/Travis County 2012 Community Health Assessment, which drew heavily from focus groups and resident surveys, transportation challenges, especially for low-income residents, mean limited access to healthcare services. (http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/cha_report_8-24-12.pdf, p. vii)

Reason for Selection of Milestones & Metrics

DY2 reflects project planning (P-X) for implementation of a MHT program, including identification of potential locations that can accommodate mobile teams. In order to increase primary care capacity, DYs 3 and 4 include process milestones P-3 and P-5 to establish new MHTs and hire appropriate staff. Improvement milestones in DYs 3 through 5 will demonstrate improved access to primary care, including increased primary care visits and unique patients (I-12). Since this a new service line for the CCC and its providers, DYs 4 and 5 include P(X) to assess and then redesign processes.

Unique Community Need Identification Number

- CN.1 - Inadequate access to primary care
- CN.5 – Transportation access for people in the rural areas and also for low-income populations in urban areas
- CN.8 – High rates on non-emergent emergency room department usage and potentially preventable inpatient admissions.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative

This is a new initiative for the CCC.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

1.11 Blood Pressure Control in Diabetics

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Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

The CCC's fifteen projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Expanded Primary Care Capacity via Mobile Health Teams are outlined below.

While other projects will expand services in community-based outpatient settings, the MHC project will reach beyond the brick and mortar model to extend services to geographically underserved patients in more rural areas of the county and to those with transportation barriers to accessing care. Coordination with providers throughout the CCC will be essential to accommodate patients who require services beyond the scope of the MHC.

List of Related Category 1 & 2 Projects (RHP Project ID Number)

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.4 : Expansion of Dental Services
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- 307459301.1.6: Expanded Specialty Care at Community-Based Outpatient Settings: GI
- 307459301.1.7: Expanded Specialty Care at Community-Based Outpatient Settings: Pulmonology
- 307459301.1.8: Telepsychiatry in Community Health Clinics

List of Related Category 4 Projects

RD-1: Potentially Preventable Admissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

Central Texas Medical Center is proposing expanded primary care hours and capacity for uninsured and underinsured residents in Hays County (Project ID 121789503.1.1). In addition, this project offers a similar intervention to other mobile projects, laying the groundwork for a potential learning collaborative. These projects include ATCIC's Mobile Crisis Outreach Team (133542405.2.2), Hill Country MHDD's Hays County Mental Health Center Mobile Clinic (133340307.1.1), and the University Medical Center at Brackenridge Women's Oncology Care Screening (137265806.2.2).

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each others' implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health as RHP 7's anchor, will foster the development of topical learning collaborative; e.g. smaller meetings than the annual regional summit - that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This

multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.