Community Care Collaborative

Expand Specialty Care Capacity for Gastroenterology

307459301.1.6 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): This project will contract with or hire additional gastroenterologists and support staff to practice in community based, primary care settings. In addition to adding rotating specialists to current community clinics, these services will be integrated into the new Southeast Health and Wellness Center, in a low-income area of Travis County will also be developed as a new location to provide these services, alongside expanded primary care, dental, behavioral health, and prevention and wellness services.

Need for the project: People with low-incomes and/or public insurance programs often have to wait four months for a gastroenterology appointment. Wait times for gastroenterology liver services are close to one year. The only clinic option available is located in a hospital in downtown Austin. Among Travis County residents, colon cancer is one of the top two causes of cancer-related deaths. According to analysis of the safety net patient population in Region 7 and surrounding counties, Hepatitis C related visits increased approximately 16% between 2009 and 2010. Data from a recent survey of local safety net providers show that only 34% of needed GI referrals are able to obtain care. Preventive colonoscopies are not available to the target population at this time.

Target population: The target population will be CCC enrollees who need gastroenterology services. All CCC enrollees have incomes under 200% of the Federal Poverty Level and/or have multiple chronic conditions. Over the course of the waiver, this project is expected to serve nearly 1,800 patients. New providers will be located at community based primary care settings whose patient mix includes 90% Medicaid and low income uninsured patients, and all CCC related providers will also serve Medicaid patients as part of their practices. 100% of the QPI for this project will be Medicaid and low-income uninsured.

Category 1 or 2 expected patient benefits: The project seeks to expand the number of gastroenterologists and associated midlevels available to serve 1,800 new patients and offer those services in locations that are better connected with patients' medical homes. This project will also add pulmonology services at the comprehensive health and wellness center located in Southeast Austin, an area consistently identified as high need that will also offer primary care, other specialty care, behavioral health, dental, preventive care, and wellness services.

Category 3 outcomes: 15.18: Hepatitis C Cure Rate

Title of Project: **Expand Specialty Care Capacity for Gastroenterology**

Category / Project Area / Project Option: **1.9.2 Expand Access to Specialty Care**

RHP Project Identification Number: **307459301.1.6 Pass 3**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

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.

This project will expand access to Gastroenterology (GI) services to 1,800 new patients by contracting with and/or hiring additional GI physicians and mid-levels, along with related support staff to serve within the CCC's constellation of community-based primary care settings. . CCC patients will benefit from expanded access to gastroenterology services as described in this project, but also the fourteen other DSRIP projects that the CCC is proposing. These fourteen projects are:

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

GI specialty services for the target population are offered primarily at one hospital-based specialty clinic located at University Medical Center Brackenridge (UMCB) in downtown Austin. A local Federally Qualified Health Center (FQHC) provides a two GI clinic sessions per week at a north Austin site. Even with some GI care available in the community, wait times for GI appointments at the UMCB specialty clinic remain an average 121 days, or approximately four months. Patients who need to see a gastroenterologist for liver disease, including Hepatitis C infection, often have to wait nearly a year for initial care. Data from a recent survey of local safety net providers show that only 34% of patients referred for GI services receive care.

This project will focus on general gastroenterology care and gastroenterology care for chronic liver disease, specifically Hepatitis C.

Long wait times for gastroenterology care are of particular concern given the prevalence of GI related chronic diseases in Region 7 and in Travis County. Among Travis County residents, colon cancer is one of the top two causes of cancer-related deaths. Yet, there are no screening colonoscopies provided for the CCC population, and the existing UMCB facility has no capacity to expand colonoscopy services. This leaves the target population with a significant gap in preventive care designed to address this leading cause of cancer death.

According to projections from the Texas State Data Center, the population in Region 7 grew dramatically between 2000 and 2010. Travis County's population is expected to grow by another 7% during the waiver period. Population growth will place even more demand on already scarce GI resources. Additionally, demand for GI services is expected to increase due to guidelines recently issued by the Centers for Disease Control and Prevention (CDC) that recommend that all people born during 1945-1965 be tested for Hepatitis C. Hepatitis C infection is a growing concern for low-income Travis County residents. According to analysis of the safety net patient population in Region 7 and surrounding counties, Hepatitis C related visits increased approximately 16% between 2009 and 2010. Untreated Hepatitis C infection can result in cirrhosis, hepatocellular carcinoma and increases the risk for liver related death in the infected population. These risks can be mitigated by identifying infected individuals and treating them with FDA approved treatment regimens. This capability is extremely limited currently in Travis County for the safety net population because of provider shortage.

This project addresses current unmet need and anticipated future needs for GI services by expanding GI services into multiple community based primary care clinics that currently serve the target population. It is important to note that we do not believe that utilization of additional GI services beyond meeting the unmet community need will occur. Additional clinic sessions with new GI providers are expected to reduce wait times for care for existing patients. Expansion into community-based primary care settings is expected to transform the health system by offering specialty services in the context of the patient's medical home, minimizing the need to travel to a separate clinic. Care provided in a familiar location that is likely closer to home is expected to achieve better adherence to appointment schedules and treatment plans.

As part of the community-based care expansion for GI services, a new Southeast Health and Wellness Center in southeast Travis County will be developed to provide this care integrated with primary care, other specialty care, behavioral health, dental, preventive care, and wellness services. The site was acquired by Central Health in 2011 to provide a medical home and ancillary services for un and underinsured residents of Austin. Southeast Travis County has consistently been identified as an area with high levels of poverty and limited

healthcare infrastructure. Approximately 270,000 people reside within a 5-mile radius of the proposed Southeast Health and Wellness Center, and 46% live below 200% of the Federal Poverty Level.

Project Goals

- Increase the number of GI providers and associated mid-levels offering services in community-based primary care settings to low-income, uninsured, and publicly insured patients.
- Develop the Southeast Health and Wellness Center to provide community-based GI care
- Provide a cure for Hepatitis C in affected patients

Challenges or Issues Faced by the Performing Provider

Lack of available workforce is a challenge to the implementation of this project because specialty providers are difficult to recruit and retain. Additionally, potential providers must be willing to serve a potentially challenging patient population that will likely suffer from multiple chronic diseases. Integrating specialty care into settings that have traditionally offered primary care may prove to be a challenge at initial implementation.

How the Project Addresses those Challenges

The CCC and its membership organizations have existing relationships with area medical schools and residency programs. We will build on these relationships and aim to retain as many of these providers as we can to provide GI services to our low-income populations. The CCC will also work with the UT-Austin school of nursing to ensure an adequate supply of nurses and other medical support staff that can support the work of expanded specialty care services. To manage care coordination and co-location of primary care and specialty care services, the CCC will develop and implement a standard set of care protocols that will manage the care of the entire target population under a uniform set of guidelines. *How the Project is Related to RHP Goals*

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations. – This project enhances and expands existing specialty care infrastructure to better meet the demand of low-income populations. This infrastructure expansion will allow the target population to access needed preventive screenings and better management of care for GI related chronic conditions.

2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By expanding opportunities to receive gastroenterology services in a timely manner, patients will be able to have their medical concerns addressed more quickly and before problems escalate to more serious issues. Services offered in community-based primary care medical home settings will allow the patient access to care in a more comfortable, appropriate setting.

Five-Year Expected Outcome

By the end of the demonstration period, two additional gastroenterologists and/or skilled midlevel providers will be available to the target population at community-based primary care locations, 1,800 people will receive GI care, and a new comprehensive health and wellness center offering primary care, specialty care, behavioral health, dental, preventive care, and wellness services will be available in a high-need area of Travis County. Among the target population, wait times for general GI care and GI liver care are expected to decrease.

Starting Point/Baseline

Between January and December, 2011, people served in the safety net received 1,343 GI visits at the UMCB Specialty Clinic.

Time Period for Baseline:

January-December, 2011

Rationale

Reason for Selection of Project Options and Components

Project option 1.9.2 – Expand Specialty Care Capacity was chosen to address the extended wait times CCC patients experience when they need to access GI services. Long delays in accessing specialty care result in delayed GI related screenings, such as colonoscopies, which can prevent cancer. Additionally, expansion of GI capacity will allow local providers to enhance screening practices for Hepatitis C. Health screenings that can detect potentially serious health conditions before they worsen could significantly improve patient health outcomes and reduce costs to the health system.

Travis County residents who are low-income, uninsured or have public insurance coverage such as Medicaid, CHIP, or the local Medical Access Program (MAP) struggle with access to specialty care services due to lack of care capacity within the existing provider network serving this population. At the same time, the population in Central Texas is growing dramatically, placing a growing burden on the already strained network of primary and specialty care providers dedicated to providing care to underserved populations.

Option 1.9.2 includes four required components:

a) **Increase service availability with extended hours.** Currently, GI clinic sessions are offered only three days per month to the existing MAP population at the UMCB specialty clinic. A limited number of clinic sessions are offered through a community-based setting. After a series of planning tasks, this project will begin by hiring providers to offer more care in community-based, primary care settings. Hiring of additional providers will allow additional hours of care to be provided beginning in DY 2.
b) **Increase number of specialty clinic locations.** The project will increase the number of specialty clinic locations by placing newly hired providers at existing community-based primary care settings that serve the population but do not yet provide GI services. The project will also develop a portion of the Southeast Health and Wellness Center, under renovation in southeast Austin, which will provide specialty care in the context of a comprehensive medical home offering primary care, specialty care, behavioral health, dental, preventive care, and wellness services. Care offered at the new location will be in addition to care expanded at existing sites.
c) **Implement transparent, standardized referrals across the system.** GI specialty care will be provided within the context of the newly formed Community Care Collaborative (CCC). The CCC's function will be to monitor and coordinate care for the entire covered population. A robust referral system will be developed that will have standard operations across the entire network of care. In DYs 4 and 5, Milestone P-2 will ensure that providers throughout the system receive information and training about referring patients into the GI project.
d) **Conduct quality improvement.** Expanded GI capacity will require careful planning, monitoring, and revision of expansion plans to ensure highest quality care to the patient population. Specialty

providers will conduct continuous quality improvement activities that will be evaluated quarterly. Participation in the RHP7 Learning Collaborative will support these activities.

Reason for Selection of Milestones & Metrics

During DY 2, it is critical for the performing provider to complete a planning process (P-X: Complete a planning process) to understand how much additional capacity is needed and where it should be located to achieve the greatest expansions in care capacity. While this planning is occurring, the performing provider will begin the recruiting and hiring process (I-22: Increase the number of specialty providers) with a goal to provide additional patient visits (I-23: Increase specialty care volume of visits) as early as the second half of DY 2. New providers will be located at existing community-based primary care sites.

In DY 3, to be launched in DY 4, the provider will complete a planning process (P-X: Complete a planning process) to prepare and then work to renovate the Southeast Health and Wellness Center to provide GI specialty care services to the target population. The Southeast Health and Wellness Center will be designed as a comprehensive health and wellness medical home offering primary care, specialty care, behavioral health, dental, preventive care, and wellness services and will be tailored to meet the specific care and cultural needs of the patient population. During this planning process, the CCC will evaluate adding additional capacity for preventive colorectal cancer screenings at the new location. In DY 2, 3, 4, and 5, the provider will hire providers and provide care to additional patients. These milestones will grow over time as care is expanded at existing clinic sites and at the new site to open in DY 4.

Unique Community Need Identification Number

CN.2 Inadequate access to specialty care.

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

GI services are offered to the target population on a limited basis through the UMCB Specialty Clinic (hospital-based) and on a limited basis at a local FQHC. This project will build on and expand GI services offered in community-based primary care settings to increase capacity in this area to benefit the target population.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

N/A

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

15.18: Hepatitis C Cure RateC

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This project reinforces other projects proposed by the CCC, including expanded access to primary and specialty care, and the development of standard protocols for the management of chronic diseases in the CCC population. The following projects are related most directly

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.7: Expanded Specialty Care Services at Community-Based Outpatient Settings: Pulmonary
- 307459301.1.3: Mobile Health Clinics
- 307459301.2.2: Chronic Care Management Protocols

List of Related Category 4 Projects (RHP Project ID Number)

RD-4: Medication management

Relationship to Other Performing Providers' Projects in the RHP

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

176692501.1.1: Expanding Access to Specialty Care

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 other's 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's anchor, will foster the development of topical learning collaboratives – 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. Valuations for Category 3 projects associated with this Category 1 project are weighted according to the number of people expected to benefit from a particular outcome.