Performing Provider: Community Care Collaborative
Project Name: Expand Specialty Care Capacity for Pulmonology
Project Identifier: 307459301.1.7 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 expand access to pulmonology specialty services for uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring pulmonologists and support staff to serve in community-based primary care settings as part of the CCC's provider network. 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.

Need for the project: Wait times for appointments to see a pulmonologist average four months. The clinic's pulmonologists are contracted to provide sixteen clinic sessions per year and are currently going beyond their contract to provide twenty clinic sessions per year. Even with the additional pro bono services, the pulmonology clinic is not available at all for two and a half months out of the year. If a patient presents in the emergency room with a serious lung disease during the months when the clinic is closed, that patient must be admitted to the hospital to receive services. According to the Texas Department of State Health Services (DSHS), COPD is one of the leading causes of death in Region 7. Not surprisingly, DSHS also finds that COPD is also one of the leading contributors of potentially preventable hospitalization costs in the region between 2005 and 2010.

Target population: The CCC will initially cover 50,000 patients at or below 200% of poverty. This project will provide pulmonary care to an additional 2,400 patients. 100% of patients served in this project are expected to be Medicaid or uninsured under 200% FPL.

Category 1 or 2 expected patient benefits: The project will provide an additional 2,400 underserved people with access to pulmonology specialty care services. The CCC will provide care for uninsured and Medicaid covered Travis County residents. Community-based primary care settings where additional pulmonologists will be stationed served a high percentage of Medicaid patients. Thus, a portion of the benefit of the additional providers will extend to that population as well.

Category 3 outcomes:
1.22: Asthma Percent Opportunity Achieved

Title of Project: **Expand Access to Specialty Care for Pulmonology**
Category / Project Area / Project Option: **1.9.2 Expand Access to Specialty Care**
RHP Project Identification Number: **307459301.1.7**
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 pulmonology specialty services for 2,400 uninsured, underinsured, Medicaid, and Medicare patients by contracting with and/or hiring pulmonologists and support staff to serve in community-based settings as part of the CCC's provider network. This project will also add pulmonology services at the comprehensive health and wellness center located in Southeast Austin and designed to integrate primary care, specialty care, behavioral health, dental, preventive care, and wellness services. The expansion of pulmonology services capacity is expected to reduce hospital admissions for Chronic Obstructive Pulmonary Disorder (COPD) among the target population. These patients will benefit from expanded access to pulmonology services 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
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Gastroenterology 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
- CenteringPregnancy

Currently, pulmonology services are available to the target population primarily at the University Medical Center Brackenridge (UMCB) Specialty Clinic, a hospital-based clinic in downtown Austin. Wait times for appointments to see a pulmonologist average four months. The clinic's pulmonologists are contracted to provide sixteen clinic sessions per year and are currently going beyond their contract to provide twenty clinic sessions per year. Even with the additional pro bono services, the pulmonology clinic is not available at all for two and a half months out of the year. If a patient presents in the emergency room with a serious lung disease during the months when the clinic is closed, that patient must be admitted to the hospital to receive services.

According to the Texas Department of State Health Services (DSHS), COPD is one of the leading causes of death in Region 7. Not surprisingly, DSHS also finds that COPD is also one of the leading contributors of potentially preventable hospitalization costs in the region between 2005 and 2010. According to the City of Austin Health and Human Services Department, tobacco use, a primary contributor to pulmonary diseases, is the leading cause of preventable death in Travis County.

This project will expand the capacity to provide pulmonology services to 2,400 uninsured, underinsured, Medicaid, and Medicare patients by hiring additional providers and support staff to practice in existing community-based primary care clinics within the constellation of the CCC provider network. Pulmonologists will rotate among primary care homes in the CCC network to maximize geographic access to this service. All primary care homes in the CCC provider network will also be equipped to provide spirometry services to assist in diagnosing pulmonary health issues for use by the pulmonologists during their clinics at those locations. By expanding specialty care into community-based primary care clinics that serve as the target population's medical home, care will be more accessible and more likely to be provided in an environment that is more familiar and comfortable to the patient. The project will also support the development of an additional community-based Southeast Health and Wellness Center that will begin operation in southeast Travis County. The site is designed to integrate primary care, specialty care, behavioral health, dental, preventive care, and wellness services. The site was originally acquired by Central Health in 2011 to provide a medical home and ancillary services for uninsured 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. Finally, CCC providers, including pulmonologists will conduct continuous quality improvement that will be evaluated quarterly.

Project Goals

- Expand specialty care capacity in community-based primary care settings for pulmonology services for the target population.
- Increase the number of pulmonologists and associated midlevels offering services to the target population
- Expand the number of primary care sites offering specialty care to the target population by providing pulmonary services at a newly designed clinic in Southeast Austin slated to offer primary care, specialty care, behavioral health, dental, preventive care, and wellness services in one comprehensive location.

Challenges or Issues Faced by the Performing Provider

The performing provider anticipates that provider recruitment in this specialty will be a challenge. Safety net providers frequently struggle to recruit providers to serve their populations because the populations are perceived as challenging in that they may suffer from multiple chronic health conditions.

How the Project Addresses those Challenges

To address the provider recruitment challenge, the CCC will make aggressive efforts to outreach to residency programs that train physicians and other providers to provide these services. We will pay providers at competitive salaries, and, where possible, incorporate their services into local Federally Qualified Health Centers so the providers can access the benefit of Federal Tort Claims Act (FTCA) coverage. The provider will also locate these specialty services in the context of the patient's primary care medical home to make care more accessible, both geographically and in a care environment that is more comfortable and familiar to the patients and their families.

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. Adding new providers, a new service line, and a new comprehensive health and wellness center in community-based settings that provide care to the target population will significantly enhance the healthcare infrastructure available to provide care to low-income, uninsured, and Medicaid covered populations in Travis County.

2. Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting. By providing more pulmonary care options in the outpatient setting, patients and families will have more convenient access to care for their lung diseases. Over time, this additional access will reduce health system costs by treating and managing patients with pulmonary illnesses.

Five Year Expected Outcome

At the end of the demonstration period, two additional pulmonologists or skilled midlevel providerswill be available to the target population, 2,400 additional patients will receive pulmonology services in community-based settings, and a comprehensive, integrated health and wellness center will be functioning in a high need area of the community,

Starting Point/Baseline

Baseline Data

In 2011, there were 136 pulmonary visits to patients seen in the UMCB Specialty Clinic.

Time Period for Baseline

January - December 2011

Rationale

Reason for Selection of Project Options and Components

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. During FY12, more than 13,000 patients served through MAP, nearly a third of total patient served that year, had a diagnosis for a chronic pulmonary disease, including COPD, asthma, emphysema, chronic bronchitis, and others. 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. COPD is one of the leading causes of death in Region 7 and in Travis County and one of the leading causes for potentially preventable hospital admissions, signifying a critical need for additional services to address unmet need for pulmonary care. Therefore, project option 1.9.2 – Expand Specialty Care Capacity - was chosen.

Option 1.9.2 includes four required components:

a) **Increase services availability with extended hours.** Currently, pulmonary clinic sessions are offered only two days per month. During DY 2, the project will implement a comprehensive planning process to identify the optimal scale and locations for pulmonary clinic expansion in the community. This project will begin by hiring providers to offer care in existing community-based, outpatient settings beginning in DY 3. More providers will allow the number of hours to provide care to increase over current levels.
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 outpatient settings that serve the population but do not yet provide this type of service. The project will also develop a portion of a clinic under renovation in southeast Austin that will serve as a new specialty care site. Care offered at the new location will be in addition to care expanded at existing sites.
c) **Implement transparent, standardized referrals across the system.** Pulmonary 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 pulmonology project.
d) **Conduct quality improvement.** Expanded specialty care in pulmonary will require careful planning, monitoring, and revision of expansion plans as providers learn more about providing this service to this population in the context of the medical home. Specialty providers will conduct continuous quality improvement activities and will gather quarterly to discuss lessons learned and revise care delivery strategies. Participation in the RHP7 Learning Collaborative will support these activities.

Reason for Selection of Milestones & Metrics

Because pulmonology service in the primary care setting is in such high demand among the target population, the performing provider will conduct a planning process in DY 2 to determine the optimal scale of the expansion and the locations where services will be provided. This work will be documented in a written expansion plan.

In DY 3, the provider will complete a planning process to prepare and then work to renovate a new comprehensive health and wellness center to provide pulmonary specialty care services to the target population. This work will be documented in a written specialty clinic facility plan. The facility, which will serve as a comprehensive health and wellness center integrating primary care, specialty care, dental, behavioral

health, prevention and wellness services, will be tailored to meet the specific care and cultural needs of the patient population and will be open for services in early DY 4.

In DY 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. Human resource records at CCC provider organizations will document the existence of newly contracted or hired pulmonologists.

Unique Community Need Identification Number

CN.2 Inadequate access to specialty care. This project will expand access to pulmonology services for uninsured, underinsured, Medicaid, and Medicare patients.

CN.18 Tobacco use remains a leading cause of preventable death. This project will increase the capacity of the performing provider to address tobacco related health issues.

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

Pulmonology services for uninsured, underinsured, Medicaid, and Medicare patients are available on an extremely limited basis. This project will expand pulmonologist availability to 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

1.22: Asthma Percent Opportunity Achieved

Final approval for the Category 3 outcome is still pending.

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.

- 307459301.1.2: Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.3: Mobile Health Clinics
- 307459301.1.6: Expanded Specialty Care Services at Community-Based Outpatient Settings: Gastroenterology
- 307459301.2.2: Chronic Care Management Protocols

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

RD-1: Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate

RD-2: Chronic Obstructive Pulmonary Disease: 30 Day Readmissions

RD-2: All Cause – 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

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

This project relates to other projects in the RHP that expand primary and specialty care services (CTMC, St. Marks) in the following projects:

121789503.1.1: Expanding Primary Care

176692501.1.1: Expanding Access to Specialty Care

Within Travis County, the City of Austin's tobacco prevention project addresses the same problem from a different avenue (201320302.2.3).

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.

Potentially preventable hospitalizations for COPD contributed to almost $90 million in hospital charges in Travis County between 2005 and 2010. Based on estimates from the Texas Department of State Health Services, each COPD hospitalization averted through improved outpatient specialty care access could save approximately $27,616 in average hospital charges.