Performing Provider: Community Care Collaborative
Project Name: Sexually Transmitted Infection Screening, Treatment, and Prevention
Project Identifier: 307459301.2.4 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 provide STI screening and treatment, and HIV testing and referral for positive HIV tests for low-income and Medicaid eligible individuals at risk for STI and HIV transmission. 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 will lead to increased screening and treatment, reduced infection rates, and improved utilization of services in target populations with identified disparities.

Need for the project: Texas has the 3rd highest rate of diagnosed HIV cases in the U.S. and 10th highest rate among teens. Texas teens also rank among the highest rates in the U.S. for syphilis (4th) and gonorrhea (16th). Travis County has significantly higher rates of STI and HIV infection when compared with Texas and U.S. These are significant public health issues with long-term impacts that can be improved through effective evidence-based screenings and treatments. Untreated STIs can lead to negative health outcomes including pelvic inflammatory disease, cancer, and early onset of full blown AIDS, among others.

Target population: The target population for the project is low-income and Medicaid eligible individuals at risk for STI and HIV transmission with an emphasis on individuals under age 25 due to risk factors. The majority of patients will be at or below 200% of the Federal Poverty Level.

Category 1 or 2 expected patient benefits: The project will expand clinic capacity to provide 2000 additional patient visits in DY3, 2,750 patient visits in DY4, and 3,250 patient visits in DY5 for STI screening and HIV tests. An estimated ten percent of all tests are expected to be positive; these individuals will be treated in the clinic for STIs and/or referred out for HIV treatment as appropriate. Patients may receive treatment and referral; however, the need cannot be pre-determined. This information will be included in program evaluations.

Category 3 outcomes:
IT 15.14: The proportion of men and women who undergo follow up testing for uncomplicated Gonorrhea 3-months after treatment.

Title of Project: **Sexually Transmitted Infection Screening, Treatment, and Prevention**
Category / Project Area / Project Option: **2.7.1. Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations to implement evidence-based project to expand capacity for sexually transmitted infection screening, treatment and prevention.**
RHP Project Identification Number: **307459301.2.4 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 expand clinic capacity to provide an increase of 3,250 annual patient visits by DY5 for Sexually Transmitted Infection (STI**) screenings and HIV tests for low-income uninsured or Medicaid eligible individuals.** These patients will benefit from expanded screening and treatment 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
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- Pregnancy Planning
- Community Paramedic Navigator Project
- Comprehensive Patient Navigation
- Centering Pregnancy

Within this project, expanded screening and treatment of the most common STIs will be provided through the medical staff at three Austin health centers, with outreach focused at a clinic located in central East Austin, in particular because this clinic experiences the highest volume for the most at risk populations. These services will be made available to any individual meeting eligibility criteria. According to the Centers for Disease Control (CDC), half of all new infections each year occur among this age group and 1 in 4 are estimated to have an infection by age 24. Within Travis County, males experience higher reported numbers of cases of Gonorrhea, Syphilis and HIV while women have higher numbers of Chlamydia infections. STI rates disproportionately impact African Americans and in the case of Chlamydia Hispanics as well. Austin Travis County Health and Human Services Department (ATCHHSD - local public health department) reported that in 2010 there were approximately 1500 Chlamydia cases reported for women compared to over 4,000 cases among men. The reported number of primary and secondary syphilis cases among men was just over 70 in 2010. In Travis County, Chlamydia, Gonorrhea and Syphilis infection rates per 100,000 are significantly higher rates when compared with Texas and the U.S. For example, the infection rate for Gonorrhea in Travis County in 2010 was 146.3 per 100,000 population as compared with the state rate of 124.0 per 100,000 and national rate of 100.8 per 100,000. According to ATCHHSD, there were 197 newly reported HIV infections in Travis County in 2010 (a number which is probably underreported as it only counts confidential testing, not anonymous). The largest number of infections are among Whites, however, trends indicate that African Americans experience the highest rate of infection in the county.

STIs are preventable and, when undetected and untreated, become a serious public health problem. STI related issues include:

- Transmission to partners thereby increasing total numbers
- Cause other conditions including, pelvic inflammatory disease (PID), cervical cancer, and other Human Papillomavirus (HPV)-related cancers, and sterility
- Cause adverse health conditions in newborns,
- Increase a person's risk for transmitting and acquiring HIV infection

In addition to the serious health consequences of STIs, the CDC reports that STIs drive an estimated $17 billion dollars in healthcare costs each year in the U.S. Prevention programs can help mitigate these costs. According to the CDC's published formulas, the averted sequelae costs associated with treating women for chlamydia, for example, is $1,995 (in 2006 US dollars). *(Cost Effectiveness and Resource Allocations; Formulas for estimating the costs averted by sexually transmitted infection (STI) prevention programs in the United States; Harrell W Chesson*, Dayne Collins and Kathryn Koski; Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, CDC).*

Expanded access to STI screening and treatment services will ensure that more patients receive the right care at the right time in the right setting before STI transmission or adverse health effects from untreated STI occurs. This project will provide easy to access testing and treatment through walk-in hours 6 days per week, allowing patients to come at times that are convenient for them including walk-ins. Same day, on site test results for some STIs will allow clients with identified STIs to receive the initial treatment or medication at the screening visit. Clinic will also provide client delivered partner therapy (per medical

protocol) which allows individuals testing positive in a clinic setting for Chlamydia to receive a prescription for his/her partner. Three month follow-up appointments are scheduled for clients receiving treatment for specific STIs as appropriate.

Existing established clinics will target outreach efforts by utilizing bilingual health staff to engage specific populations and increase referrals through existing clients. Bilingual health educators work with multiple partner agencies such as community colleges, substance abuse treatment centers, nonprofits, and school districts to provide STI health education and referral information. Additionally, health educators will be deployed for specific target populations, such as males, African Americans, and Hispanic who consistently demonstrate the highest rates for STI and HIV infections. The Community Care Collaborative and its network of safety net providers will work together to ensure eligible individuals are aware of the convenient, one stop option being made available.

Project Goals
This DSRIP 2.7.1 project will provide:

- Increased STI and/or HIV screenings
- Increased STI treatment and/or HIV referral for treatment
- Reduced STI infection rates among the targeted population
- Improved utilization of services in target populations with identified disparities

Challenges or Issues Faced by the Performing Provider
A number or issues create barriers and make tackling this health issue a challenge:

- Lack of awareness of STIs (STIs can be asymptomatic, especially in early stages)
- Stigma surrounding STI testing
- Lack of health insurance and ability to pay for STI screenings and treatment
- Creating accessible services to meet clients' needs
- Treatment compliance and partner treatment

How the Project Addresses those Challenges/Issues
This Project will address these challenges by:

- Expanding targeted bilingual outreach, particularly to male, African Americans, and Hispanic clients, that increases awareness of the importance of testing and treatment.
- Providing counseling and testing by trained, experienced, bilingual staff in order to help increase client comfort and reduce stigma for clients seeking testing services.
- Providing services at no cost to the client, eliminating the cost barrier and increasing access to services.
- Providing walk-in appointments and remaining open 6 days per week in order to make services more accessible and flexible for the client.
- Providing onsite same day test results and treatments for appropriate STIs and providing partner-provided treatment prescriptions to infected individuals infected with Chlamydia that they can deliver directly to their partners. Scheduling 3 month follow-up appointments to determine treatment compliance and effectiveness.

How the Project is Related to RHP Goals
This project aligns with Regional Healthcare Partnership 7's Goals 1 and 2:

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

5-Year Expected Outcome for Providers and Patients: This project expects to provide capacity for 2000 additional patient visits in DY3, 2,750 patient visits in DY4, and 3,250 patient visits in DY5 for STI screening and HIV tests. An estimated 10% of screening tests show positive STI results and subsequent STI treatment or referral (for HIV). These individuals will be treated in the clinic for STIs and/or referred out for HIV treatment as appropriate.

Starting Point/Baseline

Baseline Data

Baseline data (current patient visits, STI rates, and HIV rates) for the specific patient population will be established during DY2. Baseline data for community activities attended and at risk individuals reached will be established based on existing standards for bi-lingual community health educators (an average of 4 community activities / month reaching 75 or more people each).

Rationale

Reason for Selection of Project Options and Components

2.7.1 Implement evidenced based strategies to increase appropriate use of technology and testing for targeted populations

This project will improve the reproductive and sexual health of the targeted population who are at risk of STI /HIV infection by providing outreach, testing, treatment and referral. Untreated infections may result in serious health issues including transmission to others, cancers, infertility and negative birth outcomes for newborns. Travis County has a higher rate of infection for some of the most common STIs when compared with the state and the nation. Reproductive and sexual health is one of the seven priorities identified in the National Prevention Strategy published by the National Prevention Counsel and the Office of the Surgeon General. This Project provides services that address two of the four specific recommendations put forth in the strategy: sexual health education; and early detection and treatment of STIs.

Current testing and treatment resources are not sufficient to meet the demand. The project will deploy health educators to educate at risk populations on the risks of exposure and lack of treatment as well as addressing the stigma surrounding testing.

Required Core Component

In addition, a core component of this project will be the use of continuous quality improvement to evaluate and improve upon the effectiveness of this intervention. CQI activities will be integrated into project planning and used for performance improvement opportunities.

Reason for Selection of Milestones & Metrics

The metrics selected reflect salient health needs of the population most at risk for STI and

HIV transmission, including access to outreach, education, counseling, testing and treatment for STIs and HIV. This project will implement an evidence-based intervention, specifically STI screenings and treatment for clients at risk for STI infection and transmission. The project will employ a dedicated Bi-Lingual Community Health Educator (BCHE) who will partner with community based organizations throughout Travis County to outreach to and provide health education information for vulnerable and at risk populations for STIs and HIV. The project will also develop and produce educational materials specific to the project.

Screenings (urine, blood or culture) will be provided to clients at risk for STIs. Treatment for Chlamydia and Gonorrhea will be provided on-site at screening to clients as medically appropriate. Patients will be treated with the recommended regimens, unless therapeutic compliance is in question, symptoms persist, or re-infection is suspected. The provider relies heavily on the efficacy of client education and follow-up program to track clients who have tested positive with an STI. Clients who have tested positive for HIV or Syphilis are referred out for treatment.

DY2 includes P-2 to integrate STI and HIV counseling into visits for clients who are at risk for STI and HIV transmission, P-X to hire 1 Bi-lingual Community Health Educator (BCHE), and P-X to identify a list of key social service agencies that serve men, women, and adolescents at risk for STIs and HIV and create a yearly calendar of targeted community health events to promote STI and HIV testing. During DYs 3 through 5, P-X will be used to document ongoing monthly community health events by the BCHE. Improvement milestones in DYs 3 through 5 will demonstrate increased clinic capacity for patients receiving STI screening and HIV tests (I-5). Additional process milestones include participation in face-to-face learning collaboratives (P-7) and execution of an evaluation process to determine the efficacy of STI/HIV outreach, education, and treatment. (P-4). Data sources to report metrics include EHR, personnel records, scheduling system, and other clinic documentation.

Health centers maintain a process of continuous quality improvement (CQI) through systematic data collection, analysis and assessment, improvement identification, process design, communication, and ongoing evaluation of outcomes to ensure high quality health services. CQI program combines compliance, risk and quality oversight and includes data-driven and data-based performance measurements tracked daily, and weekly. Clinical care is monitored and evaluated through weekly meetings of a clinical core team (VP of Health Services, Chief Medical Officer, CQI staff and health center directors). The committee assesses data obtained from internal and external audits, and formulates plans to ensure continuous quality improvement. All STI medical protocols are updated annually to meet CDC guidelines and are updated more frequently when new CDC guidelines on testing and treatment are issued. For this project, CQI will include a survey of providers, staff, and/or patients to determine efficacy of STI/HIV outreach, education, and treatment and refine future interventions based on results.

Unique Community Need Identification Number
CN.13 - Higher rates of STIs in Travis County than Texas state averages

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

This project significantly enhances the existing delivery system as the expansion of services will improve access to STI/HIV testing and treatment services for at risk populations.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)
There are no related activities funded by DHHS.

Related Category 3 Outcome Measure(s)
Category 3 Outcome Measures(s) Selected
IT 15.14: The proportion of men and women who undergo follow up testing for uncomplicated Gonorrhea 3-months after treatment.

Relationship to Other RHP Projects
How Project Supports, Reinforces, Enables Other Projects
The CCC's fifteen projects (listed within the project description) are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. This project has a similar target population to the CCC's project for Adolescent and Young Adult Pregnancy Prevention (307459301.2.5).

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
This project has a similar target population to the City of Austin Health & Human Services Department project for Adult Immunizations to High Risk Populations (201320302.2.6).

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 collaborative – smaller meetings as 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
Approach and Rationale for Valuing Project

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.