# TEXAS
# Managed Care Service Areas
(Effective Fall 2016)

**STAR Health** (statewide) – Superior
**CHIP RSA** (MRSA Service Areas + Hidalgo) – Molina, Superior

**STAR** - *Aetna, Amerigroup, Cook Children's*
**STAR+PLUS** - *Amerigroup, Cigna-HealthSpring*
**STAR Kids** - *Aetna, Cook Children's*
**CHIP** - *Aetna, Amerigroup, Cook Children's*

## LUBBOCK
**STAR** - *Amerigroup, FirstCare, Superior*
**STAR+PLUS** - *Amerigroup, Superior*
**STAR Kids** - *Amerigroup, Superior*
**CHIP** - *FirstCare, Superior*

## MRSA WEST
**STAR** - *Amerigroup, FirstCare, Superior*
**STAR+PLUS** - *Amerigroup, Superior*
**STAR Kids** - *Amerigroup, Superior*

## EL PASO
**STAR** - *El Paso First, Molina, Superior*
**STAR+PLUS** - *Amerigroup, Molina*
**STAR Kids** - *Amerigroup, Superior*
**CHIP** - *El Paso First, Superior*

## TRAVIS
**STAR** - *Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior*
**STAR+PLUS** - *Amerigroup, United*
**STAR Kids** - *Blue Cross and Blue Shield of Texas, Superior*
**CHIP** - *Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior*

## BEXAR
**STAR** - *Aetna, Amerigroup, Community First, Superior*
**STAR+PLUS** - *Amerigroup, Molina, Superior*
**STAR Kids** - *Community First, Superior*
**CHIP** - *Aetna, Amerigroup, Community First, Superior*

## HIDALGO
**STAR** - *Driscoll, Molina, Superior, United*
**STAR+PLUS** - *Cigna-HealthSpring, Molina, Superior*
**STAR Kids** - *Driscoll, Superior, United*

## TARRANT
## DALLAS
**STAR** - *Amerigroup, Molina, Parkland*
**STAR+PLUS** - *Molina, Superior*
**STAR Kids** - *Amerigroup, Children's Medical Center*
**CHIP** - *Amerigroup, Molina, Parkland*

## MRSA NORTHEAST
**STAR** - *Amerigroup, Superior*
**STAR+PLUS** - *Cigna-HealthSpring, United*
**STAR Kids** - *Texas Children's, United*

## MRSA CENTRAL
**STAR** - *Amerigroup, Scott and White, Superior*
**STAR+PLUS** - *Superior, United*
**STAR Kids** - *Blue Cross and Blue Shield of Texas, United*

## JEFFERSON
**STAR** - *Amerigroup, Community Health Choice, Molina, Texas Children's, United*
**STAR+PLUS** - *Amerigroup, Molina, United*
**STAR Kids** - *Texas Children's, United*
**CHIP** - *Amerigroup, Community Health Choice, Molina, Texas Children's, United*

## HARRIS
**STAR** - *Amerigroup, Community Health Choice, Molina, Texas Children's, United*
**STAR+PLUS** - *Amerigroup, Molina, United*
**STAR Kids** - *Amerigroup,Texas Children's, United*
**CHIP** - *Amerigroup, Community Health Choice, Molina, Texas Children's, United*

## NUECES
**STAR** - *Christus, Driscoll, Superior*
**STAR+PLUS** - *Superior, United*
**STAR Kids** - *Driscoll, Superior*
**CHIP** - *Christus, Driscoll, Superior*

**RSA:** Rural Service Area
**MRSA:** Medicaid Rural Service Area

TEXAS Health and Human Services Commission

Map Prepared by: Strategic Decision Support Department, Texas Health and Human Services Commission. MRL. October 1, 2015

# RHP3 Managed Care Service Providers

- Harris & Jefferson
  - Amerigroup
  - Community Health Choice
  - Molina
  - Texas Children's
  - United Healthcare
- MSRA Central
  - Amerigroup
  - Cigna-HealthSpring
  - Scott & White
  - Superior
  - United Healthcare

HHSC MCO Contact Sheet

| Health Plan | Contact | Title | Email | Phone Number | STAR/CHIP Plan Service Areas overlap with RHPs | STAR+PLUS Plan SAs overlap with RHPs |
|---|---|---|---|---|---|---|
| Aetna Better Health | Mary N. Downey | Director, Network Management | DowneyM1@aetna.com | 817-477-9084 | 6, 9, 10 | |
| Amerigroup | Catherine Mitchell | RVP Medicaid Provider Strategy | Catherine.Mitchell@Amerigroup.com | 713-218-5103 | 1, 2, 3, 4, 6, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19 | 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19 |
| Blue Cross and Blue Sheild of Texas | April Beggs | Senior Manager, Government Relations | april_beggs@bcbstx.com | 512-231-7610 | 7, 8 | |
| Christus | Nora Medina | Director of Network Management | nora.medina@christushealth.org | 469-282-3054 | 3, 4 | |
| | Christian Puff | Director of Compliance | Christian.puff@christushealth.org | 469-282-0290 | | |
| | Anita Leal | Executive Director | anita.leal@christushealth.org | 469-282-2585 | | |
| Community First Health Plans | Christine Hollis | Director of Preventative Health and Disease Management | Chollis@cfhp.com | 210-358-6145 | 6 | |
| Community Health Choice | Melanye Otto | | Melanye.Otto@CommunityCares.com | | 2, 3, 17 | |
| Cook Children's Health Plan | Rob Robidou | Director Network Development | Rob.Robidou@cookchildrens.org | 682-885-4485 | 9, 10 | |
| Driscoll Health Plan | Michelle Ramirez | | Michelle.Ramirez@dchstx.org | 361-694-6430 | 3, 4, 5, 6, 20 | |
| El Paso First Response | Janel Luján, LMSW | Senior Director of Operations | jlujan@elpasofirst.com | 915-298-7198 (ext 1090) | 15 | |
| FirstCare Health Plans | Joe Kotlarczyk<br>Dr. Adolfo Valadez | Director, Government Programs, Medicaid<br>Chief Medical Officer | jkotlarczyk@firstcare.com | 512-257-6257 | 6, 11, 12, 13, 14, 19 | |
| Cigna-HealthSpring | Maggie McDowell | | | | | 1, 2, 5, 6, 9, 10, 18, 19, 20 |
| | Robyn Leland | | | | | |
| Molina Healthcare | John J McGuinness | VP Network Management | john.mcguinness@molinahealthcare.com | 972-536-7232 | 1, 2, 3, 5, 9, 10, 15, 17, 18, 20 | 1, 2, 3, 5, 6, 9, 10, 17, 18, 20 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | also cc: DeliveryTX@molinahealth.com | | | |
| Parkland Community Health Plan | Dr. Barry Lachman | | Barry.Lachman@phhs.org | | 1, 9, 10, 18 | |
| Scott & White | Tamara Campbell | | | | 1, 3, 4, 6, 8, 16, 17 | |
| | Cindy Jorgneson | | cjorgensen@sw.org | | | |
| Sendero Health Plan | Pamela Piatt | | Pamela.piatt@senderohealth.com | 512-978-8014 | 7, 8 | |
| Seton | | | | | 7, 8 | |
| Superior Health | Jared Wolfe | | JWOLFE@CENTENE.COM | 512-692-1465 | 1, 2, 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 | 1, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 |
| | Dan Crowe | | dcrowe@centene.com | | | |
| Texas Children's Health Plan | Rosie Valadez<br><br>Rose T. Calhoun | Director of Government Relations<br><br>Director of Quality and Outcomes Management | lrmcstay@texaschildrens.org<br><br>rtcalhou@texaschildrens.org | 832-828-1301<br><br>832-828-1285 | 2, 3, 17 | |
| UnitedHealthcare | Angela Parks | | Angela.Parks@uhc.com | | 2, 3, 5, 6, 17, 20 | 1, 2, 3, 4, 6, 7, 8, 16, 17, 18, 19, |

## PAY-FOR-QUALITY (P4Q) MEASURES

**HEDIS Measures**

- W34: Well-child Visits at 3, 4, 5, & 6 yrs. (STAR, CHIP)
- AWC: Adolescent Well-Care Visits (STAR, CHIP)
- PPC: Prenatal Care and Postpartum Care (STAR only)
- AMM: Anti-depressant Medication Management (STAR+PLUS)
- CDC: HbA1c Control <8 (STAR+PLUS)
- PPE: Potentially Preventable Events
  - PPA: Potentially Preventable Hospital Admissions (STAR, CHIP, STAR+PLUS)
  - PPR: Potentially Preventable Hospital Re-Admissions (STAR, STAR+PLUS)
  - PPV: Potentially Preventable ED visits (STAR, CHIP, STAR+PLUS)
  - PPC: Potentially Preventable Complications (STAR, STAR+PLUS)

*Health plans that excel on meeting the measures are eligible for a bonus of up to 4% of their capitation rate. Health plans that don't meet their measures can lose up to 4% of their capitation rate.*

## PERFORMANCE IMPROVEMENT PROJECT (PIP) TOPICS

- In 2014, HHSC began making PIPs range from 2-3 years in duration rather than annual
- In August 2015, HHSC began allowing MCOs to partner with DSRIP providers on PIPs (can also collaborate with another MCO or DMO)
- All MCOs were required to do a collaborative PIP in 2016 if not already doing one or theirs was expiring
- MCOs with assigned behavioral health topics for 2016 must work with their contracted Behavioral Health Organization (BHO) but doesn't currently count as a "collaborative PIP"

**Assigned 2016 PIP Topics:**

- Increase access to & utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs).
  - **Measure:** URTI PPVs
- Improve care transitions & care coordination to reduce behavioral health-related admissions and readmissions.
  - **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs; BH-Related PPRs; All cause readmissions

## ADDITIONAL HHSC MEDICAID MANAGED CARE QUALITY INITIATIVES

- MCO Report Cards
  - HHSC worked with the Institute for Child Health Policy, the state's external quality review organization, to develop managed care organization report cards to help Medicaid clients select a health plan. The ratings come from a survey from Medicaid MCO members in specific service areas who rank Medicaid MCOs on three topic areas including, getting help from doctors and the health plan, getting checkups and tests, and getting help with health issues.
- HHSC Quality of Care Measures
  - Comprehensive set of measures calculated using National Committee for Quality Assurance-certified software. This data is used to develop reports that are consolidated into a single behavioral report, physical health report, and a dental report.
- Quality Assessment & Performance Improvement Program Summary Reports (QAPI)
  - Each MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement Program that meets state and federal requirements

## OTHER MANAGED CARE QUALITY MEASURES

- Quality Improvement Projects (QIPS/Marketplace)
  - MCOs participating in a Marketplace for two or more consecutive years must implement and report on at least one quality improvement strategy (QIS).
- Accreditation Measures (URAC)
  - Health Plans earn accreditation by the Utilization Review Accreditation Commission. URAC Health Plan Accreditation standards address key issues stated in the ACA requirements, focusing on quality improvement activities that promote patient safety across the continuum of care.
- THSteps/Frew Measures
  - Frew Measures are incentives awarded to MCO HMO and Dental Plans for collaborative efforts with organizations that work with migrant farm workers and outreach efforts. THSteps focuses on the medical, dental, and case management services for age's birth through 20. THSteps generates Checkups Reports annually with data provided by HMOs on members who receive a checkup within 90 days of enrollment and existing member who receive timely checkups. To qualify for an incentive, HMOs must meet minimum requirements determined by HHSC.
- Special Populations/Superuser Report
- Additional internally designated measures/initiatives (e.g., provider/employee incentives, medical costs, QI documentation/evaluation, payment projects)

## FOR ADDITIONAL CONSIDERATION

- Value-added Services

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

**Access to RHP 3 Plan**:
RHP 3 Plan Documents

## Medicaid Rural Service Area Harris (MSRA Central, Harris, Jefferson)

**STAR: Amerigroup, Community Health Choice, Molina, Texas Children's, United**
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**RHP 3 Counties: Austin, Calhoun, Chambers, Colorado, Ft. Bend, Harris, Matagorda, Waller, Wharton**
**HHSC Texas Managed Care Service Areas Map Effective Fall, 2016*

| Organization/Provider Name and Project Lead/Contact Name | Primary Project-Program Type | Project-Program Title | Brief Summary of Project & Services | County(ies) Served | QPI DY3-5 |
|---|---|---|---|---|---|
| **Baylor College of Medicine**<br>**Peggy Smith**<br>**713-873-3601**<br>peggys@bcm.edu | **Primary:**<br>Family Planning | New Baylor Teen Health Clinic at Tejano Center for Community Concerns | Expand Baylor Teen Health Clinic service area by opening a new clinic at the Tejano Center for Community Concerns, which provides transitional housing services for the Houston community. | Harris | 9,000 |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Baylor College of Medicine's Quality Outcomes focus on depression screening by 18 years of age, reducing youth pregnancy rates and HPV vaccinations for adolescents.* | *Medicaid Population Average **25%***<br>*Low Income Uninsured Population Average **75%*** |

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|---|---|---|---|---|---|
| **CHI Baylor St. Luke's Medical Center**<br>**Richelle Dixon**<br>**832-355-7722**<br>rdixon@stlukeshealth.org | **Primary:** Chronic Care | CHF Transitional Care Clinic | Build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend, Calhoun | 1,500 |
| | **Primary:** Chronic Care | Hepatitis C Screening & Project ECHO | Provide screening and treatment for a defined population of patients at risk for and/or diagnosed with Hepatitis C. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend, Calhoun | 6,532 |
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| ***DSRIP Project Quality Outcomes Summary:*** *CHI Baylor St. Luke's Quality Outcomes focus on reducing the risk adjusted congestive heart failure (CHF) 30-day readmission rates and increasing the Hepatitis C cure rate.* | *Medicaid Population Average* ***5.96%***<br>*Low Income Uninsured Population Average* ***41.19%*** |

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|---|---|---|---|---|---|
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| | **Primary:** Chronic Care | Hepatitis C Screening & Project ECHO | Provide screening and treatment for a defined population of patients at risk for and/or diagnosed with Hepatitis C. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend, Calhoun | 6,532 |
| | | | | | |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *CHI Baylor St. Luke's Quality Outcomes focus on reducing the risk adjusted congestive heart failure (CHF) 30-day readmission rates and increasing the Hepatitis C cure rate.* | *Medicaid Population Average* ***5.96%***<br>*Low Income Uninsured Population Average* ***41.19%*** |

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|---|---|---|---|---|---|
| **City of Houston**<br>**William Bryant**<br>**832-393-4626**<br>William.Bryant@houstontx.gov | **Primary:** Oral Health | Oral Health Services for At-Risk Populations | Improve dental health in indigent populations by<br>1) Expanding oral health services for at-risk populations up to age 21 in dental clinics<br>2) Expanding an evidence-base dental sealant program for elementary school children<br>3) Initiating new oral health services for eligible perinatal women. | Harris | 13,198 |
| | **Primary:** Emergency Care/ Navigation | ETHAN-Emergency Telehealth and Navigation | Use telehealth to deter non emergent uses of emergency centers, by connecting clients to a physician at the initial encounter. | Harris | 11,340 |
| | **Primary:** Seniors- Oral Health | Geriatric Oral Health | Improve oral health by providing diagnostic, preventive restorative and surgical oral health services for the elderly to improve the health and quality of life for Houston area at-risk seniors. | Harris | 189 |
| | **Primary:** Substance Abuse/ Behavioral Health | Houston Sobering Center | Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system | Harris | 18,000 |
| | **Primary:** Seniors-Health Education | Healthy Homes - Fall Prevention | Utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety to low income older adults | Harris | 1,575 |

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|---|---|---|---|---|---|
| **City of Houston**<br>**William Bryant**<br>**832-393-4626**<br>William.Bryant@houstontx.gov | **Primary:** Navigation | Care Houston Links | Care Houston Links is a new program that provides care coordination to reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of necessary emergency room care. | Harris | 3,024 |
| | **Primary:** Navigation | HIV Service Linkage | Use patient navigators to connect HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizers. | Harris | 866 |
| | **Primary:** Chronic Care | Tuberculosis Rapid Identification, Treatment, and Recovery Project | Implement interventions to rapidly identify and treat TB to reduce TB morbidity and to shorten recovery time for TB pts by utilizing two testing modalities. | Harris | 726 |
| | **Primary:** Diabetes Management | Diabetes Awareness and Wellness Network Center (DAWN) | Establish self-management programs and wellness using evidence-based designs. | Harris | 1,575 |
| | **Primary:** Family Planning | Nurse Family Partnership (NFP) | Implement innovative evidence-based strategies to reduce low birth weight and preterm birth. | Harris | 630 |
| | **Primary:** Primary & Behavioral Health | Integrated Services for the Homeless | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards integrating health services using the Housing First model. | Harris | 530 |

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|---|---|---|---|---|---|
| **Organization/Provider Name and Project Lead/Contact Name** | **Primary Project/ Program Type** | **Project/ Program Title** | **Brief Summary of Project & Services** | **County Served** | **QPI DY3-5** |
| **City of Houston**<br>**William Bryant**<br>**832-393-4626**<br>William.Bryant@houstontx.gov | **Primary:** Education & Screening | Colorectal Cancer Awareness and Screening (COCAS) | Implement a new colorectal cancer integrated awareness and screening project involving:<br>1) Awareness raising small media campaign<br>2) CRC Education about Screening Guidelines and recommendations<br>3) Access to Community wide Non-invasive FIT testing<br>4) Test taking training<br>5) Testing by nationally accredited laboratory<br>6) Sharing of test results, communication and follow up protocol as appropriate<br>7) Patient Care Navigation for getting individuals situated in a medical home in the targeted zip codes | Harris | 1,080 |
| | **Primary:** Transitional Care | Community Care Transitions Program (CCTP) | Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population. | Harris | 1,440 |
| | **Primary:** Navigation | Houston Health Connect | Houston Health Connect will provide navigation support, case management services and evidenced based chronic disease self-management and health education programming to individuals who are uninsured, disconnected from a medical home, referred for follow-up from a health care provider, disconnected or newly connected to a medical home Additionally, this project ensure children identified by Texas Children's Hospital as disconnected from care are reconnected to care. | Harris | 3,780 |

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|---|---|---|---|---|---|
| **City of Houston**<br>**William Bryant**<br>**832-393-4626**<br>William.Bryant@houstontx.gov | **Primary:**<br>Navigation | Community Re-Entry Network Program | HDHHS will implement a project that provides care management services that integrate primary and behavioral health needs of released ex-offenders, parolees and probationers in Houston, Harris County. The Community Re-Entry Network Program (CRNP), Integrated Health Services Project will provide a multi-dimensional clinical approach to assess and address the mental, physical and psychosocial needs of ex-offenders released from prison and probationers in Houston, Harris County. | Harris | 1,576 |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *City of Houston's Quality Outcomes focus on Oral Health for Children and Adult , Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings Such as Jails or Prisons, Gonorrhea Screening Rates, Reducing the Percentage of Low birth- Weight Births, RAND Short Form 36[1] (SF-36) Health Survey, Congestive Heart Failure (CHF) 30-day Readmission Rate, Colorectal Cancer Screening, Falls: Screening, Adult Immunization status, Screening for High Blood Pressure and Follow-Up Documented, children and Adolescents' Access to Primary Care Practitioners (CAP), Assessment of Quality of Life, Patient Health Questionnaire 9 (PHQ-9), Timeliness of Prenatal/Postnatal Care, Post-Partum Follow-Up and Care Coordination, Influenza Immunization – Ambulatory, Follow-up after Treatment for Primary or Secondary Syphilis, Latent Tuberculosis Infection (LTBI) treatment rate, Diabetes care: HbA1c poor control (>9.0%) and Client and Patient Satisfaction* | *Medicaid Population Average* ***18.21%***<br><br>*Low Income Uninsured Population Average* ***56.95%*** |

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

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|---|---|---|---|---|---|
| **Columbus Community Hospital**<br>**Betty Hajovsky**<br>**979-493-7577**<br>bhajovsky@columbusch.com | **Primary:** Telemedicine/ Pharmacy Services | Implement Telemedicine Program to provide or expand Specialist Referral Services | Implement telemedicine to provide clinical support and patient consultations by a pharmacist after hours and on weekends to reduce medication errors | Colorado | 200 |
| | | | | | |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Columbus Community Hospital's focus is Risk Adjusted All-Cause Readmission* | *Medicaid Population Average **15%***<br><br>*Low Income Uninsured Population Average **5%*** |

# Regional Health Care Partnership (RHP) 3
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**Access to RHP 3 Plan**:
RHP 3 Plan Documents

## Medicaid Rural Service Area Harris (MSRA Central, Harris, Jefferson)

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**HHSC Texas Managed Care Service Areas Map Effective Fall, 2016*

| Organization/Provider Name and Project Lead/Contact Name | Primary Project-Program Type | Project-Program Title | Brief Summary of Project & Services | County(ies) Served | QPI DY3-5 |
|---|---|---|---|---|---|
| **El Campo Memorial Hospital**<br>**Laurie Harvey**<br>**979-578-5254**<br>lharvey@ecmh.org | **Primary:**<br>Quality Improvement | Customer Service Project at El Campo Memorial Hospital | Implement the AIDET Project to improve communication between patients and healthcare providers by providing employees with formal training of how to interact with patients to gain their trust which is essential for obtaining patient compliance and improving clinical outcomes | Wharton | 1,500 |

| | |
|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *El Campo Memorial Hospitals' Quality Outcome is focused on HCAHPS Likelihood to Recommend* | *Medicaid Population Average* ***8.85%***<br><br>*Low Income Uninsured Population Average* ***14.60%*** |

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

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|---|---|---|---|---|---|
| **Organization/Provider Name and Project Lead/Contact Name** | **Primary Project/ Program Type** | **Project/ Program Title** | **Brief Summary of Project & Services** | **County Served** | **QPI DY3-5** |
| **Ft. Bend County**<br>**Kaye Reynolds**<br>**281-238-3519**<br>Kaye.Reynolds@fortbendcountytx.gov | **Primary:** Behavioral Health | Crisis Response Intervention | Develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most appropriate level of care.<br>1) Assessment and enhancement of 911 dispatch system to identify and respond to behavioral health crises,<br>2) Development of specialized crisis intervention team within Fort Bend County Sheriff's Office and<br>3) Implementation of cross systems training and linkages to appropriate services and supports. | Ft. Bend | 3,200 |
| | **Primary:** Primary Care | Expanded Hours at AccessHealth | Expand the hours of operation of the local FQHC to increase access to primary care for the Medicaid, uninsured and underinsured population in the county. | Ft. Bend | 4,500 |
| | **Primary:** Patient Navigation | Care Coordination | Expand patient navigation services to a subset of the uninsured and underinsured population in the county which uses EMS and ED services inappropriately for non-emergent conditions and has no means to pay for the services | Ft. Bend | 94 |
| | **Primary:** Behavioral Health/ Substance Abuse | Screening, Brief Intervention and Referral to Treatment (SBIRT) | The proposed project will enhance the current health care delivery system by adding a Screening, Brief Intervention and Referral to Treatment model (SBIRT) in the Access Health FQHC clinic in Richmond, Texas. This evidence-based model includes: Screening: Universal screening for quickly assessing use and severity of alcohol, illicit drugs, and prescription drug abuse. | Ft. Bend | 675 |

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|---|---|---|---|---|---|
| **Ft. Bend County**<br>**Kaye Reynolds**<br>**281-238-3519**<br>Kaye.Reynolds@fortbendcountytx.gov | **Primary:** Behavioral Health | Recovery & Reintegration | Recovery and reintegration program based on evidence based practices for adults (persons with severe mental illness and/or mental illness and physical health conditions) identified as high risk for recidivism due to homeless/ lack of stable housing, prior history of non-compliance, lack of access to services, complex trauma, substance abuse, lack of family supports and /or lack of integrated care to address complex needs. | Ft. Bend | 50 |
| | **Primary:** Pediatric Behavioral Health | Juvenile Diversion | Design, implement and evaluate a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual development disabilities, substance abuse and physical health issue from initial or further involvement with juvenile. | Ft. Bend | 55 |
| | **Primary:** Primary Care | Community Paramedic | Decrease the number of Uninsured/ under-insured population (Indigent Health Care), Medicaid patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) by providing appropriate care in their home setting using Community Paramedics | Ft. Bend | 225 |
| | **Primary:** Specialty Care Diagnostic Colonoscopy | Colonoscopy Screening - Richmond & Sugarland | In cooperation with local health care providers, provide colonoscopy screening to uninsured and underinsured populations who meet the criteria for this procedure. | Ft. Bend | 200 |

***DSRIP Project Quality Outcomes Summary:*** *Ft. Bend County's Quality Outcomes focus on Reducing Emergency Department visits for Behavioral Health/Substance Abuse, Third next available appointment, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons, Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions , Diabetes care: HbA1c poor control (>9.0%), Decreasing mental health admissions and readmissions to criminal justice settings such as jails or prison, Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000, and High-risk Colorectal Cancer Follow-up rate within one year*

*Medicaid Population Average* ***33.37%***
*Low Income Uninsured Population Average* ***58.55%***

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|---|---|---|---|---|---|
| **Gulfbend Medical Center**<br>**Glenn Zengerle**<br>gzengerle@gulfbend.org | **Primary:** | Integrate primary and behavioral health care services | Develop and implement a Person-Centered Behavioral Health Medical Home in Port Lavaca offering behavioral health services, primary care services, health behavior education and training programs, long and short term, and case management. | Calhoun | 475 |

| | |
|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Gulfbend Medical Center's Quality Outcome is focused on Follow-Up After Hospitalization for Mental Illness* | *Medicaid Population Average* ***53.50%***<br><br>*Low Income Uninsured Population Average -****17.10%*** |

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|---|---|---|---|---|---|
| **The Harris Center for Mental Health & IDD**<br>**Jeanne Wallace**<br>**713-970-3971**<br>jeanne.wallace@mhmraharris.org | **Primary:** Outpatient Behavioral Health | Improve patient satisfaction - Northwest clinic | Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northwest region of the city. | Harris | 1,250 |
| | **Primary:** Outpatient Behavioral Health | Establish new behavioral healthcare clinic at the Lighthouse facility | Establish behavioral healthcare clinic with the Lighthouse facility in order to provide mental health treatment capacity for persons with visual impairment. Project will develop a specialized behavioral health team consisting of mental health, physical health, case management services, wraparound supports, and adaptive technology | Harris | 300 |
| | **Primary:** Behavioral Health Emergency Psychiatric Care | Expand Co-occurring Disorders (COD) Program | The Harris Center will expand its current co-occurring disorders program from a 30 bed to an ultimate 60 bed capacity. In this program, The Harris Center partners with licensed chemical dependency residential treatment providers to offer up to 90 days of integrated co-occurring disorders care. Current research indicates this is a best practice and requires a wide range of collaboration between substance-use and mental health arenas. Integrated treatment providers have a broad knowledge base and are equipped to treat individuals with co-occurring disorders. | Harris | 223 |

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|---|---|---|---|---|---|
| **The Harris Center for Mental Health & IDD**<br>**Jeanne Wallace**<br>**713-970-3971**<br>jeanne.wallace@mhmraharris.org | **Primary:** Behavioral Health Emergency Psychiatric Care | Mobile Crisis Outreach Team (MCOT) | The Harris Center proposes to develop a behavioral health crisis stabilization service as an alternative to hospitalization. The Harris Center Helpline will make follow-up calls and texts to clients who have been released from Psychiatric Emergency Services (PES), Mobile Crisis Outreach Team (MCOT), HCPC and Chronic Consumer Stabilization Initiative (CCSI) to ensure they are following through on their discharge plans, taking medications and getting connected to the next level of care. | Harris | 3,663 |
| | **Primary:** Behavioral Health Emergency Residential Psychiatric Care | Expand Crisis Residential Unit (CRU) | Develop a 24-bed behavioral health crisis stabilization service as an alternative to Hospitalization. | Harris | 642 |
| | **Primary:** Pediatric Behavioral Health Outpatient Services | Improve patient satisfaction - Alice Johnson Junior High - Channelview ISD | Increase outpatient capacity by approximately 400 children and adolescents by implementing 1.5 treatment teams to provide cognitive-behavioral therapy, psychosocial skills training, consultation for school staff and pediatric staff, family interventions, psychiatric assessment, medication management and case-management as needed. | Harris | 810 |
| | **Primary:** Behavioral Health Cognitive Therapy & Psychiatric Services | Expand capacity for people with Intellectual & Developmental Disabilities for Specialized Treatment & rehabilitative services (STARS) | Expand capacity for the current specialized behavioral health services provided to people with Intellectual and Developmental Disabilities (IDD) and/or Autism Spectrum Disorders (ASD) and co-occurring mental illness by adding additional staff. | Harris | 21,250 |
| | **Primary:** Behavioral Health Outpatient | Expand services - Northeast Clinic | Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northeast region of the city. | Harris | 1,250 |
| | **Primary:** Behavioral Health Outpatient | Expand services - Southwest Clinic | Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southwest region of the city. | Harris | 1,250 |

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|---|---|---|---|---|---|
| **The Harris Center for Mental Health & IDD**<br>**Jeanne Wallace**<br>**713-970-3971**<br>jeanne.wallace@mhmraharris.org | **Primary:** Behavioral Health Outpatient | Expand services - Southeast Clinic | Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southeast region of the city. | Harris | 1,250 |
| | **Primary:** Behavioral Health Outpatient | Expand services - Northeast Clinic - | Place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southeast region of the city. | Harris | 1,250 |
| | **Primary:** Behavioral Health-Emergency Psychiatric Care | Interim Care Clinic (ICC) | The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment in a single visit. The clinic will include extended evening hours and availability 7 days a week. | Harris | 5,900 |
| | **Primary:** Behavioral Health Rehabilitation | Clubhouse at Legacy | Implement the ICCD Clubhouse Model, which is a day treatment program for psychosocial rehabilitation of adults diagnosed with a serious and persistent, chronically disabling mental health problem. We will be contracting St. Joseph's House to provide psychosocial rehabilitative services. | Harris | 309 |
| | **Primary:** Behavioral Health Primary Care Integration | Integrate Primary and Behavioral Health Care - Southeast Clinic | Design, implement and evaluate a care management program that integrates primary and behavioral health care services. | Harris | 3,200 |
| | **Primary:** Behavioral Health-Emergency Psychiatric Care | Chronic Consumer Stabilization Initiative (CCSI) | The Harris Center plans to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. The Harris Center provides family and community education about mental illness, outreach and engagement, intensive case management, Mental Health First Aid (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy typically for several months, which is longer than other crisis diversion programs. | Harris | 60 |
| | **Primary:** Behavioral Health-Emergency Psychiatric Care | Mobile Crisis Outreach Team (MCOT) | The Harris Center proposes to expand the current Mobile Crisis Outreach Team which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services. When a consumer initiates an MCOT intervention, two trained MCOT staff responds to the | Harris | 1,179 |

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|---|---|---|---|---|---|
| | | | consumers' needs, meeting them in a variety of settings including in the community, home, or school and provide assessment, intervention, education, and linkage to other services to address identified needs. | | |
| **The Harris Center for Mental Health & IDD**<br>**Jeanne Wallace**<br>**713-970-3971**<br>jeanne.wallace@mhmraharris.org | **Primary:** Behavioral Health-Emergency Psychiatric Care | Critical Time Intervention (CTI) | The Critical Time Intervention Program (CTI) is a nine-month case management model emphasizing developing community linkages and enhancing treatment engagement for mentally ill individuals undergoing transition. | Harris | 129 |
| | **Primary:** Adult & Pediatric Behavioral Health | Harris County Child Protective Services (CPS) Project | Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Preventative mental health care for foster youth. | Harris | 189 |
| | **Primary:** Pediatric Behavioral Health | Juvenile Information System | Implementation of an electronic system that will enable juvenile service providers to work together in a coordinated approach guided by mutually identified goals, shared access to information, and a collaborative treatment and service plan. | Harris | 3,000 |
| | **Primary:** Behavioral Health-Drug Addiction | Santa Maria Hostel Bonita House/Residential Detoxification Program for Women | The proposed project will increase local treatment capacity by adding 8 new residential detoxification beds, with 4 of those beds available to women accompanied by their children. Average length of stay will range from 5-14 days depending on type of substance used and duration of use, severity of co-occurring mental health issues, and pregnancy/health status. | Harris | 450 |
| | **Primary:** Integrate Substance Abuse & Behavioral Health | Integrate substance abuse treatment - Northwest Clinic | Substance abuse treatment services will be integrated and embedded into existing The Harris Center mental health treatment services. | Harris | 3,250 |
| | **Primary:** Behavioral Health Care Transitions | Inpatient to Outpatient Care Transition | The HCPC transition program will hire licensed MH professionals to engage pts pre-discharge from HCPC and assist with successfully linking them to community MH treatment | Harris | 4,650 |
| | **Primary:** Behavioral Health-Emergency Psychiatric Care | Chronic Consumer Stabilization Initiative (CCSI) | Expand the Chronic Consumer Stabilization Initiative (CSSI), an interagency collaboration with the Houston PD. Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. The Harris Center provides family and community education | Harris | 60 |

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| | **Primary:** Behavioral Health-Emergency Psychiatric Care | Crisis Intervention Response Team (CIRT) | Expansion of three additional team of the Crisis Intervention Response Team, which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls. | Harris | 1,800 |
| | **Primary:** Outpatient Rehabilitation & Psych Services | DSRIP Wrap Around Support Services Team | Develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders and their families to avoid utilization of intensive, costlier services. | Harris | 272 |
| | **Primary:** Outpatient Rehabilitation & Psych Services | Intellectual and Developmental Disabilities (IDD) Inpatient Consultation & Liaison project | Expand and further develop the Inpatient Consultation and Liaison (C&L) team that provide consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders. | Harris | 325 |

***DSRIP Project Quality Outcomes Summary:*** *The Harris Center for Mental Health and IDD's Quality Outcomes focus on Patient Health Questionnaire 9 (PHQ-9), Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate, CG-CAHPS 12-month: Provider Communication, Daily Living Activities (DLA-20), Children and Adolescents' Access to Primary Care Practitioners (CAP), Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Behavioral Health /Substance Abuse 30-day Readmission Rate, Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons, Assessment for Psychosocial Issues of Psychiatric Patients, Assessment of Major Depressive Symptoms, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, Adolescent Well-Care Visits (AWC), Adult Needs and Strength Assessment (ANSA), Aberrant Behavior Checklist (ABC), Assessment for Substance Abuse Problems of Psychiatric Patients, Diabetes care: HbA1c poor control (>9.0%), Supports Intensity Scale (SIS), Follow-Up After Hospitalization for Mental Illness, Follow-up Care for Children Prescribed ADHD Medication (ADD), Children and Adolescent Needs and Strengths Assessment, (CANS-MH), Follow-Up After Hospitalization for Mental Illness Controlling high blood pressure and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*

*Medicaid Population Average* ***32.75%***
*Low Income Uninsured Population Average-* ***52.82%***

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| **Harris Health System**<br>**Amanda Callaway**<br>**713-566-6033**<br>Amanda.Callaway@harrishealth.org | **Primary:** Primary Care | Expand Primary Care Access - Monroe Clinic | Expand the capacity of primary care by establishing an adult-focused primary care same day access clinic that offers same day visits during extended hours. | Harris | 31,000 |
| | **Primary:** Adult Behavioral Health | Expansion of Adult Behavioral Health Services | Enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting. | Harris | 9,200 |
| | **Primary:** Chronic Care/ Primary Care | Disease Registry and Disease Management | Develop a disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patients. | Harris | 45,500 |
| | **Primary:** PT/OT | Physical & Occupational Therapy Services Expansion at LBJ Outpatient Rehabilitation Services | Increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics. | Harris | 48,384 |
| | **Primary:** Primary Care | Establish Same Day Clinic - Sunset Heights | Expand the capacity of primary care by establishing an adult-focused primary care that offers same day visits during extended hours. | Harris | 31,000 |

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| **Harris Health System**<br>**Amanda Callaway**<br>**713-566-6033**<br>Amanda.Callaway@harrishealth.org | **Primary:** Adult Oral Health | Expansion of Adult Dental Services | Expand adult dental services by establishing additional sites and expanding services at current sites. Services have been added or expanded at six (6) health centers. | Harris | 11,330 |
| | **Primary:** Primary Care | Expand Primary Care Access - Robindell Clinic | Expand the capacity of primary care by establishing an adult-focused primary care same day access clinic that offers same day visits during extended hours to meet demand. | Harris | 31,000 |
| | **Primary:** Primary Care | System wide Expansion of Primary Care - Additional Providers | Expand the existing capacity of primary care by adding FTE primary care providers to meet the adult primary care demand surround the Health Centers. | Harris | 47,500 |
| | **Primary:** Chronic Care / Behavioral Health | New Health Center – Danny Jackson & Long Point Health Centers | Expand the capacity of primary care by adding the West and Northwest 1 Area Health Centers to the complement of existing health centers to establish Medical Homes primarily for the adult population. | Harris | 25,000 |
| | **Primary:** Chronic Care / Behavioral Health | New Health Center - Cypress Health Center | Expand the capacity of primary care by adding the Northwest 2 Area Health Center to the complement of existing health centers to establish Medical Homes primarily for the adult population. | Harris | 17,500 |
| | **Primary:** Primary Care | Establish 3 Same Day Clinics – Ben Taub Same Day Clinic Margo Hiliard Same Day Clinic Sareen Same Day Clinic | Expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand. | Harris | 55,500 |
| | **Primary:** Primary Care | Expand Partnerships with FQHCs | Develop a seamless referral process by which Harris Health can refer primary care patients to FQHCs. | Harris | 24,500 |
| | **Primary:** Pediatric Behavioral Health | Expansion of Pediatric Mental Health Services - El Franco Lee Health Center | Address the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across nine facilities within the system. Add 3.7 FTE's of psychiatry and 7.6 FTE's of behavioral therapy. | Harris | 9,330 |

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| **Harris Health System**<br>**Amanda Callaway**<br>**713-566-6033**<br>Amanda.Callaway@harrishealth.org | **Primary:** Pharmacy Services | Central Fill Pharmacy | Create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24-hour turnaround time and mail order capability. | Harris | 136,863 |
| | **Primary:** EC Utilization | Reduce Utilization by Top Frequenters | Target ED frequenters and ensure they are managed appropriately through a navigation system. | Harris | 900 |
| | **Primary:** EC Utilization | Emergency Room Advanced Medical Screening | Improve emergency center throughput and reduce inappropriate use of emergency centers in the system through the implementation of a provider-in-triage model. | Harris | 5,000 |
| | **Primary:** Perinatal/ Navigation | OB Navigation Program at Aldine Health Center | Improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy, with a focus on high-risk mothers. | Harris | 2,050 |
| | **Primary:** Chronic Care | System wide Expansion of Point of Care by Clinical Pharmacists | Expand point-of-care services provided by clinic pharmacists for the chronic management of pts receiving anticoagulation therapy and create an educational website. | Harris | 600 |
| | **Primary:** Palliative Care | Palliative Care House Calls Program | Implement a palliative care program to address end-of-life decisions and care needs | Harris | 2,570 |
| | **Primary:** Primary Care/Transitional Care | Chronic Care House Calls Program | Expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients with multiple chronic conditions who are homebound or have extreme difficulties getting to clinic visits due to their health status | Harris | 1,932 |

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|---|---|---|---|---|---|
| **Harris Health System**<br>**Amanda Callaway**<br>**713-566-6033**<br>Amanda.Callaway@harrishealth.org | **Primary:** Quality Improvement – Primary & Specialty Care | Restructure Outpatient Laboratory Medicine | Address the inefficiency of specialty clinics (focusing primarily on diabetes and rheumatology clinics) by making possible ordering best practices diagnostic algorithmic workups and eliminating the current practice of sequential ordering of individual tests. | Harris | 16,500 |
| | **Primary:** Quality Improvement | Innovation Center for Quality | Establish a Center of Innovation to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement. | Harris | 9,200 |

***DSRIP Project Quality Outcomes Summary:*** *Harris Health System's Quality Outcomes focus on Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate, Risk Adjusted All-Cause Readmission, Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Minimization Analysis, Reduce Emergency Department visits for Diabetes, Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care), RAND Short Form 12 (SF-12v2) Health Survey, Chronic Disease Patients Accessing Dental Services Median Time from ED Arrival to ED Departure for Discharged ED Patients, Emergency department (ED) visits where patients left without being seen, Topical Fluoride application, Pre-term birth rate, Adult tobacco use, Hospice and Palliative Care – Proportion admitted to the ICU in the last 30 days of life, Urgent Dental Care Needs in Children: Percentage of children with urgent dental care needs, Pneumonia vaccination status for older adults, Influenza Immunization – Ambulatory, Diabetes care: HbA1c poor control (>9.0%), Diabetes care: Foot exam, Third next available appointment and Patient Health Questionnaire 9 (PHQ-9)*

*Medicaid Population Average* ***14.50%***
*Low Income Uninsured Population Average* ***58.97%***

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

**Access to RHP 3 Plan**:
RHP 3 Plan Documents

## Medicaid Rural Service Area Harris (MRSA Harris)

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**RHP 3 Counties: Austin, Calhoun, Chambers, Colorado, Ft. Bend, Harris, Matagorda, Waller, Wharton**
**HHSC Texas Managed Care Service Areas Map Effective Fall, 2016*

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|---|---|---|---|---|---|
| **HCA -Bayshore Medical Center**<br>**Jeff Sliwinsky**<br>**713-852-1500**<br>Jeff.Sliwinsky@hcahealthcare.com | **Primary:** Family Planning - Perinatal | Expanding the Primary Care Capacity of BMCs Midwife Clinics | Expand OB/GYN care capacity in HCA's OB clinics in East Houston by: 1) recruiting 2 new OB/GYNs; 2) hiring additional support staff; 3) expanding service hours in existing clinics; and 4) relocating a clinic to a larger space that is closer to a Federally Qualified Health Center and public transportation. | Harris | 5,055 |
| | **Primary:** Behavioral Health-Telemedicine | Telemedicine Behavioral Health | Expand existing telemedicine program to establish a 24/7 tele-psychiatry program in HCA's Bayshore ED and implement telemedicine capabilities in HCA's other local hospital EDs. | Harris | 8,259 |
| **HCA -West Houston Medical Center**<br>**Jeff Sliwinsky**<br>**713-852-1500**<br>Jeff.Sliwinsky@hcahealthcare.com | **Primary:** Patient Navigation, Transitional Care- Seniors | The Senior Care Program | Improve the patient throughput, overall experience & quality of care for geriatric patients through a designated "Senior Care Entrance" at hospital & assign special hospital beds to accommodate geriatric population. Train & maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care, assisting seniors in managing appointments, maintaining individual healthcare regimens, & accessing available support through the hospital and the community. | Harris | 6,955 |
| ***DSRIP Project Quality Outcomes Summary:*** *HCA's Quality Outcomes focus on Post-Partum Follow-Up and Care Coordination, Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rates and Risk Adjusted Diabetes 30-day Readmission Rates* | | | | *Medicaid Population Average **33.24%***<br>*Low Income Uninsured Population Average **14.61%*** | |

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

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|---|---|---|---|---|---|
| **Harris County Public Health & Environmental Services**<br>**Will Hudson**<br>**713-439-6092**<br>whudson@hcphes.org | **Primary:** Oral Health | Youth Dental | The project will improve the oral health of indigent school-aged children through collaborations with targeted schools, school districts, Head Start Centers, and communities within Harris County to provide preventive dental screenings and fluoride varnish applications, oral health education, and navigator-assisted referrals to community dental providers, including HCPHES dental services. | Harris | 1,680 |
| | **Primary:** Health Screenings/ Health Education | Expanded Mobile Clinics | The project will improve access to appropriate/affordable prevention, screening and wellness visits for target populations through the provision of community-based mobile health services and will include immunizations, health screenings, health promotion/education, and other established HCPHES public health programming. The project will also feature a robust education/referral program to navigate participants, as appropriate, to additional services such as integrated care programs, primary care providers and treatment programs. | Harris | 4,500 |
| | **Primary:** Primary Care | Obesity Reduction | Harris County Public Health and Environmental Services (HCPHES) will expand its operations and leverage mobile clinic units alongside existing fixed clinics to meet the health needs of low income, indigent and special needs populations, that lack the resources and/or physical mobility to commute to fixed site locations to receive the vital and preventative services necessary to combat and address childhood and adolescent obesity. This expansion will allow for increased accessibility to services, health education programs, and the dissemination of critical health education information to the target communities. | Harris | 872 |

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|---|---|---|---|---|---|
| **Harris County Public Health & Environmental Services**<br>**Will Hudson**<br>**713-439-6092**<br>whudson@hcphes.org | **Primary:** Health Education/ Chronic Care | Tobacco Cessation | Harris County Public Health and Environmental Services (HCPHES) will expand its operations and leverage mobile clinic units alongside existing fixed clinics to meet the health needs of low income, indigent and special needs populations that lack the resources and/or physical mobility to commute to fixed site locations to receive the vital and preventative services necessary to reduce tobacco use. This expansion will allow for increased accessibility to services, health education programs, and the dissemination of critical health education information to the target communities. | Harris | 990 |
| | **Primary:** Chronic Care | Tuberculosis Video Directly Observed Therapy (VDOT) | The project will offer a shortened therapy regimen to qualified patients being treated for latent TB infection (LTBI) by changing the course of medication prescribed. This project will thereby increase the number of patients who are adequately treated for active TB disease and TB infection and ultimately decrease potentially preventable hospitalizations for tuberculosis as well as costs for treating drug-resistant TB. | Harris | 135 |

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| ***DSRIP Project Quality Outcomes Summary:*** *Harris County Public Health and Environmental Services' Quality Outcomes focus on Service Utilization: Children, Influenza Immunization – Ambulatory, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Adolescent tobacco use, Tobacco Use: Screening & Cessation, Latent Tuberculosis Infection (LTBI) treatment rate, Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk, Preventive Services for Children at Elevated Caries Risk, Immunization for Adolescents- Tdap/TD and MCV, HPV vaccine for adolescents, Adult Body Mass Index (BMI) Assessment and Children and Adolescents' Access to Primary Care Practitioners (CAP)* | *Medicaid Population Average* ***29.85%***<br><br>*Low Income Uninsured Population Average* ***63.66%*** |

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

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|---|---|---|---|---|---|
| **Matagorda Regional Medical Center**<br>**Amanda Simmons**<br>**713-859-9683**<br>simmonschiro@yahoo.com | **Primary:** Chronic Disease and Specialty Care | Specialty Care Expansion | Establish the CDSC (Chronic Disease Specialty Clinic) to provide access to specialty services and physicians that support care for a number of key chronic conditions. | Matagorda | 5,000 |
| | **Primary:** Primary Care | MEHOP (Matagorda Episcopal Healthcare Outreach Program - FQHC) | Provide an alternative to care at the right time and right setting primary and urgent care services will be expanded to evenings and weekends through a partnership with our local FQHC (MEHOP) and a new Urgent Care Center owned by MRMC. A nurse advice line manned with RN professionals trained in pediatric as well as adult triage will promote the use of the expanded primary and urgent care services. | Matagorda | 3,250 |
| | **Primary:** Patient Navigation | Patient Navigation | Patient Care Navigation Service will utilize community health workers, case managers and/or other types of health care professionals to provide enhanced social support and culturally competent care for high acuity & high utilizing chronic condition patients identified by a needs assessment. | Matagorda | 380 |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Matagorda Regional Medical Center's Quality Outcomes focus on Ambulatory Care Sensitive Conditions Admissions Rates, Reducing Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000, Diabetes care: BP control (<140/90mm Hg) and Diabetes care: HbA1c poor control (>9.0%)* | *Medicaid Population Average* ***21.81%***<br><br>*Low Income Uninsured Population Average* ***22.89%*** |

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|---|---|---|---|---|---|
| **UT MD Anderson**<br>**Diane M. Benson**<br>**713-745-8370**<br>**dmbenson@mdanderson.org** | **Primary:** Specialty Diagnostic | FIT-Flu Program at Matagorda Episcopal Health Outreach Program | Expand a 2-year Colorectal Cancer (CRC) screening program in Federally Qualified Health Centers in Harris County into other RHP3 counties. This project targets low-income and underinsured populations with the intent of increasing adherence by distributing Fecal Immunochemical Test (FIT) take-home tests at the time of annual flu inoculation. | Austin, Chambers, Colorado, Harris, Ft. Bend, Matagorda, Waller, Wharton | 6,305 |
| | **Primary:** Pediatric Nutritional Services & Chronic Care | We Can! Obesity Prevention at Galena Park ISD | This project will provide an evidence-based childhood obesity prevention program to children and parents of Harris Health System school-based clinics, elementary and middle schools affiliated with the clinics and surrounding communities. There are three components to the proposed evidence-based We Can! Program (1): child, parent and community. Children and parents will receive health promotion programming that will increase knowledge of physical activity and healthy diets and children will engage in physical activity play time. | Harris | 475 |

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|---|---|---|---|---|---|
| **UT MD Anderson**<br>**Diane M. Benson**<br>**713-745-8370**<br>**dmbenson@mdanderson.org** | **Primary:** Chronic Care/Behavioral Health -Smoking | Smoking Cessation Program for HIV/AIDs Patients at Legacy Community Health Services | Implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy Community Health Services sites. | Harris | 1,500 |
| | **Primary:** Behavioral Health- Smoking | ASPIRE Youth Smoking Prevention Program | A Smoking Prevention Interactive Experience (ASPIRE) will be utilized to reach underserved, at-risk youth at various access points in RHP3 counties. | Chambers, Ft. Bend Harris, | 17,650 |
| | **Primary:** Mobile Mammography | Project VALET Mobile Mammography Program | Expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured, low-income, and Medicaid-eligible women ages 40 to 69 in Houston, to the RHP 3 coverage area. | Austin, Colorado, Ft. Bend, Harris, Waller | 3,500 |
| | **Primary:** Chronic Care/Behavioral Health -Smoking | Ask-Advise-Connect Smoking Cessation Program | Ask Advise Connect (AAC) will be delivered to 4 FQHCs in Harris County by implementing clinical practice guidelines and promoting health system supports in electronic health records. Based on questions of adult patients regarding smoking, connections to the Quitline are made by clicking an automated link in the electronic health record (EHR) that sends smokers' names and phone numbers to the Quitline within 24 hours. Patients are contacted by the Quitline within 48 hours of receipt of their contact information. | Harris | 37,554 |
| | **Primary:** Health Education and Screening | Project DERM | This project provides evidence-based, culturally-relevant and literacy-appropriate skin cancer health education to English and Spanish speakers. Skin cancer screenings to those over the age of 20 are provided. For participants who are referred for biopsy of a suspicious lesion, a dermatologist will perform the biopsy on-site or staff will navigate the participant to a biopsy appointment.. | Harris | 570 |

***DSRIP Project Quality Outcomes Summary:*** *UT MD Anderson's Quality Outcomes focus on High-risk Colorectal Cancer Follow-up rate within one year, Mammography follow-up rate, Pediatric Quality of Life Inventory (PedsQL), Client Satisfaction Questionnaire 8 (CSQ-8) and Adult and Adolescent tobacco use and Number of practicing specialty care practitioners per 1000 individuals in HPSA or MUA*

*Medicaid Population Average* ***27.30%***
*Low Income Uninsured Population Average* ***68.31%***

# Regional Health Care Partnership (RHP) 3
# Overview of 1115 Waiver DSRIP Projects

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|---|---|---|---|---|---|
| **Memorial Hermann Northwest**<br>**John Cramer**<br>**713-338-4248**<br>John.Cramer@memorialhermann.org | **Primary:** Primary Care | Health Centers for Schools | Increase number of school-based primary care sites in low-income communities for people with limited access. Expand Memorial Hermann Health Centers for Schools program by 3 opening additional health centers along with a mobile dental van. | Harris | 16,500 |
| | **Primary:** EC Utilization/ Navigation | Nurse Health Line | Implement a region-wide 24-hour nurse health line that will assist patients considering an ER visit in determining what level of care they need to access & and connect them to an appropriate resource. Goal is to ensure efficient use of the system's ED & reduce unnecessary visits. | Harris, Chambers, Waller, Colorado, Austin Ft. Bend, Calhoun, Wharton Matagorda | 104,320 |
| | **Primary:** Home Health/ Behavioral Health | Memorial Hermann Home Health Psych Services | Expand home health service to include psychiatric services, includes specialized training & certifications for nurses & addition of social work services to link clients to additional community care programs. Goal is to provide support of patients with mental health issues, to better manage their care in the home & community, & reduce number of visits to EDs for psychiatric care that could be managed in the home/community environment. | Harris, Chambers, Waller, Austin, Wharton, Colorado | 1,800 |

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|---|---|---|---|---|---|
| **Memorial Hermann Northwest**<br>**John Cramer**<br>**713-338-4248**<br>John.Cramer@memorialhermann.org | **Primary:** Primary Care/ Internal Medicine | Expand Primary Care Capacity | Create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner for the greater Houston MSA. Target population is patients in the greater Houston MSA that would benefit from seeking ambulatory care at ambulatory facility rather than acute care facility. | Harris, Chambers, Waller, Austin, Wharton, Colorado | 24,300 |
| | **Primary:** Navigation/ Behavioral Health | Psych Response Case Management | Provide a 24/7 liaison to act as an adjunct to the Psych Response Team and provide case management of post-discharge behavioral health patients. Case management identifies individuals whose chronic mental illness predicts they will likely have repeat visits to the ER and connect them with case management services for follow-up after discharge. | Harris | 2,050 |
| **Memorial Hermann Hospital**<br>**John Cramer**<br>**713-338-4248**<br>John.Cramer@memorialhermann.org | **Primary:** Primary Care | Physician Network Dev. Internist Associates of Houston | Expand the capacity of primary care through more clinics and available health care professionals to better accommodate the regional patient population and community. Memorial will aim to recruit additional primary care providers and plan to open new primary care locations. | Harris | 504,000 |
| | **Primary:** Behavioral Health | Mental Health Crisis Clinic | Develop a crisis stabilization clinic that would provide rapid access to initial psychiatric treatment and outpatient services. | Harris | 8,500 |
| | **Primary:** Navigation | ER Navigation Memorial Hermann | Expand the current Community Outreach for Person Empowerment (COPE) and ER Navigation programs within all Memorial facilities in RHP3 | Harris | 26,950 |
| | **Primary:** Chronic Care/ Palliative Care | Supportive Medicine Program Memorial Hermann | Implement a comprehensive supportive medicine program that will engage patients with life-threatening, acute or chronic conditions. The program will also educate health care professionals so they can better advise their patients who need end-of-life care outside an acute care setting. | Harris | 5,575 |
| ***DSRIP Project Quality Outcomes Summary:*** *Memorial Hermann's Quality Outcomes focus on Cavities: Children, Reduce Emergency Department visits for Behavioral Health/Substance Abuse, Controlling high blood pressure, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Median Time from ED Arrival to ED Departure for Discharged ED Patients, Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status, Median time from ED arrival to time of departure from the emergency room for patients admitted to the Facility from the ED, Reduce Emergency Department visits for Behavioral Health/Substance Abuse and Hospice and Palliative Care* | | | | *Medicaid Population Average* ***15.84%***<br>*Low Income Uninsured Population Average* ***39.42%*** | |

# Regional Health Care Partnership (RHP) 3
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|---|---|---|---|---|---|
| **Houston Methodist Hospital**<br>**Heather Chung**<br>**713-363-8060**<br>HChung@houstonmethodist.org | **Primary:**<br>Mental Health-Inpatient Psychiatric | Inpatient to Outpatient Behavioral Health Care Transition Program | Facilitate effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians. Leverage community mental health workers to connect patients with existing primary care and mental health resources. | Harris, Chambers | 10,858 |
| **Houston Methodist Willowbrook**<br>**Heather Chung**<br>**713-363-8060**<br>HChung@houstonmethodist.org | **Primary:**<br>Mental Health-Inpatient Psychiatric | Inpatient to Outpatient Behavioral Health Care Transition Program | Facilitate effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians. Leverage community mental health workers to connect patients with existing primary care and mental health resources. | Harris | 1,786 |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Houston Methodist's Quality Outcomes focus on Reducing Emergency Department visits for Behavioral Health/Substance Abuse and Reducing Emergency Department visits for Behavioral Health/Substance Abuse* | *Medicaid Population Average **3.56%***<br>*Low Income Uninsured Population Average **11.89%*** |

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|---|---|---|---|---|---|
| **Oakbend Medical Center**<br>**Ben Steiner**<br>**281-341-3005**<br>bsteiner@obmc.org | **Primary:** Chronic Care | Chronic Disease Registry | Develop a chronic disease registry to use county wide to ensure providers and clinical staff with access to determine clinical outcomes and to identify physician, psychological and emotional needs of the chronically ill patients. | Ft. Bend | 5,196 |
| | **Primary:** Primary Care | Primary Care Expansion | Increase number of Primary Care Physicians (PCPs). | Ft. Bend | 6,100 |
| | **Primary:** Specialty Care | Specialty Care Expansion | Expand the number of Specialty Care Physicians (SCPs) by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services. | Ft. Bend | 2,400 |
| | **Primary:** Patient Experience/ Satisfaction | Redesign to Improve Patient Experience | Establish a patient experience program where patients feel safe, have their voices hear and are empowered. Involve staff education on communication skills. | Ft. Bend | 6,100 |
| | **Primary:** Medication Management-Chronic Care | Medication Management Project | OBMC will educate and train patients and staff on the health benefits of medication management, as well implement evidence-based strategies to enhance the quality of life and the appropriate management. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) and Oak Bend medical group physicians to educate their staff and the community on the importance of medication management, and to assist patients in managing their chronic conditions. | Ft. Bend | 750 |

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|---|---|---|---|---|---|
| **Oakbend Medical Center**<br>**Ben Steiner**<br>**281-341-3005**<br>bsteiner@obmc.org | **Primary:** Navigation | Behavioral Health Navigation Project | Navigators will help to connect and support patients with behavioral health needs to psychiatric treatment and outpatient services who frequently seek treatment in the Emergency Department. | Ft. Bend | 250 |
| | **Primary:** Navigation | Chronic Disease Patient Navigation | Patient Navigators will help and support these patients to navigate through the continuum of health care services. Navigators will ensure that patients receive coordinated, timely and site-appropriate health care services. | Ft. Bend | 222 |
| | **Primary:** Perinatal Health Education | Breastfeeding Health Promotion Program | Educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. | Ft. Bend | 155 |
| | **Primary:** Chronic Care | Self-Management Wellness Program | Finalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, Weight Watchers, OBMC (OakBend Medical Group) and other agencies. | Ft. Bend | 1,760 |

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| ***DSRIP Project Quality Outcomes Summary:*** *Oakbend Medical Center's Quality Outcomes focus on Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate, Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate, Risk Adjusted All-Cause Readmission, Risk Adjusted Stroke (CVA) 30-day Readmission Rate, Risk Adjusted Acute Myocardial Infarction (AMI) 30-day Readmission Rate, HCAHPS Likelihood to Recommend, Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate, Post-Partum Follow-Up and Care Coordination and Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate* | *Medicaid Population Average* ***24.87%***<br>*Low Income Uninsured Population Average* ***24.14%*** |

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| Organization/Provider Name and Project Lead/Contact Name | Primary Project/ Program Type | Project/ Program Title | Brief Summary of Project & Services | County(ies) Served | QPI DY3-5 |
|---|---|---|---|---|---|
| **Rice Medical Center**<br>**JimJanek**<br>**979-232-7061**<br>jdjanek@jdjanek.com | **Primary:** OB services | Women's Health and Obstetrics | Expand the availability of family practice obstetric services in the East Bernard Rural Health Clinic and Rice Medical Center service areas by hiring a family practice obstetrician to work in the clinic. | Colorado, Wharton, Austin, Ft. Bend | 1,400 |
| | **Primary:** Telemedicine Access for Specialty Care Services | Telemedicine Project | Develop the use of telemedicine in Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders. | Wharton, Colorado, Austin | 324 |
| | **Primary:** Primary Care | Wallis Clinic-Primary Care | Establish a primary care clinic in Wallis, TX. This clinic will be operated by a mid-level provider supervised by a physician. | Austin, Wharton, Colorado, Ft. Bend | 3,250 |
| | **Primary:** Urgent Care | Fast Track Clinic-Urgent Care | Enhance the urgent medical advice resources available to pt populations in Colorado County. Establish a new urgent care clinic. This new clinic will be an outpatient clinic and will be physically located in Rice's hospital facility. | Colorado, Wharton, Austin | 2,400 |
| | **Primary:** Expand Primary Care Services | New Clinic with Expanded Hours | Relocate and improve the existing Rural Health Clinic in East Bernard in order to expand access to primary care services in this community. The new clinic will have updated equipment. | Wharton, Colorado, Austin | 1,712 |
| | **Primary:** Immunization Tracking | Systemwide Expansion of ImmTrac to Adults | Implement across-the-board tracking of patients' immunization schedules and completed immunizations in order to avoid duplication and tardiness. | Austin, Wharton, Colorado, Ft. Bend | 900 |

## Medicaid Rural Service Area Harris (MSRA Central, Harris, Jefferson)

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**RHP 3 Counties: Austin, Calhoun, Chambers, Colorado, Ft. Bend, Harris, Matagorda, Waller, Wharton**
**HHSC Texas Managed Care Service Areas Map Effective Fall, 2016*

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|---|---|---|---|---|---|
| **Rice Medical Center**<br>**JimJanek**<br>**979-232-7061**<br>jdjanek@jdjanek.com | **Primary:** Chronic and Long Term Care | Chronic Disease Outreach | Partner with the Colorado County Health Dept. and other local stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction and management using the Care Management Model | Colorado, Wharton, Austin | 1,810 |
| | **Primary:** Chronic Disease Outreach | Establish Diabetes Outpatient Teaching Site | Develop a Certified Diabetes Teaching Center to educate and assist pts with managing their chronic disease. Eduction and management using the Care Management Model | Colorado, Wharton, Austin, Ft. Bend | 1,400 |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Rice Medical Center's Quality Outcomes focus on Post-Partum Follow-Up and Care Coordination, Influenza Immunization – Ambulatory, Immunization for Adolescents- Tdap/TD and MCV, Pneumococcal Immunization- Inpatient, Diabetes care: BP control (<140/90mm Hg), Diabetes care: HbA1c poor control (>9.0%), ED throughput Measure bundle, Pain Assessment and Follow-up, Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented, Adult Body Mass Index (BMI) Assessment, CG-CAHPS 12-month: Timeliness of Appointments, Care, & Information and Diabetes care: HbA1c poor control (>9.0%)* | *Medicaid Population Average* ***9.92%***<br>*Low Income Uninsured Population Average* ***21.81%*** |

# Regional Health Care Partnership (RHP) 3
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|---|---|---|---|---|---|
| **Spindletop Center**<br>**Chalonnes Hoover**<br>**409-784-5668**<br>chalonnes.hoover@stctr.org | **Primary:**<br>Primary Care/ Behavioral Health Integration & Mobile Clinic | Integrate primary and behavioral healthcare services | Co-locate primary care clinics in its buildings to facilitate coordination of primary & behavioral healthcare. A mobile clinic will be acquired to provide physical & behavioral health services for clients in locations other than existing Spindletop clinics. Will also implement Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness | Chambers | 45 |
| | **Primary:**<br>Patient Navigation, Social Work & Health Record Access | Health Information Portal | Develop a web-based portal through which clients can access their health information, implement a system to send reminders and alerts to clients via phone and/or email, and train clients on how to access and use the information to manage their behavioral and physical health care. | Chambers | 22 |

***DSRIP Project Quality Outcomes Summary:*** *Spindletop Center's Quality Outcomes focus on Diabetes care: HbA1c poor control (>9.0%) and Client Satisfaction Questionnaire 8 (CSQ-8)*

*Medicaid Population Average* ***13.03%***

*Low Income Uninsured Population Average* ***77.58%***

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|---|---|---|---|---|---|
| **St. Joseph's Medical Center**<br>**Rick Ford**<br>**615-467-1311**<br>RFord@iasishealthcare.com | **Primary:** Outpatient & Partial Hospitalization Psychiatric Services | Partial Hospitalization Program | Expand services to individuals that have a mental health and/ or other substance abuse disorder through a partial hospitalization program. | Harris, Ft. Bend | 790 |
| | **Primary:** Behavioral & Physical Health Integration | Establish Medi-Psych Unit | The unit will meet the needs of adults (ages 18 and above) who have co-occurring medical and psychiatric diagnoses. These patients are treated on a unit specifically designed to meet both diagnosis within the hospital. It is a separate and distinct unit – comprised of 12 beds | Harris, Ft. Bend | 1,411 |
| | | | | | |

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|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *St. Joseph's Medical Center's Quality Outcomes focus on Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate and Reducing Emergency Department visits for Behavioral Health/Substance Abuse* | *Medicaid Population Average **25.25%***<br>*Low Income Uninsured Population Average **36.13%*** |

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|---|---|---|---|---|---|
| **Texana Center**<br>**Kate Johnson-Patagoc**<br>**281-239-1424**<br>Kate.Johnson@texanacenter.com | **Primary:** Pediatric Mental Health Services | Texana Children's Center for Autism - Sugar Land | Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis, ABA, and speech-language pathology for children diagnosed with autism spectrum disorders, ASD) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. | Harris, Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend | 100 |
| | **Primary:** Emergency Psych Services/ Crisis Stabilization | Texana Center Crisis Center | Develop an 8-bed 48-hour extended observation unit and a 14-bed crisis residential unit where individuals in crisis may go to be assessed and stabilized by providing crisis intervention services. | Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend | 1,872 |
| | **Primary:** Pediatric Behavioral Health –Early Intervention | Texana Therapy for Tots | Implement a system of early identification and delivery of therapeutic services for children with developmental delays that blend the best aspect of private therapy and a natural environment based model and includes social work and/or monitoring by a child development specialist to support parental involvement and supplement the number of clinical hours recommended. | Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend | 11,100 |

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|---|---|---|---|---|---|
| **Texana Center**<br>**Kate Johnson-Patagoc**<br>**281-239-1424**<br>Kate.Johnson@texanacenter.com | **Primary:** Behavioral Health Crisis Intervention | Behavior Stabilization Team | Create a crisis behavioral health care team to intervene to keep individuals in crisis out of the State Support Living Centers, emergency rooms, state mental health hospitals or jail. Individuals dually diagnosed (intellectual and developmental disability, pervasive developmental disorder or mental retardation that have a co-occurring serious and persistent mental illness. | Waller, Austin, Colorado, Wharton, Matagorda, Fort Bend, Harris | 555 |
| | **Primary:** Primary Care | Texana Center Primary Care Integration | This project will hire a primary care physician and other appropriate staff to provide primary care services to the Medicaid and uninsured population currently being served by Texana Center for their mental illness. By providing both services in the same building, by the same performing provider, a "warm" hand off can be made the same day as the visit to the behavioral healthcare provider. The interventions will include screenings, treatment, medication services, education services including disease management and nutrition, exercise and wellness. | Ft. Bend | 308 |

| | |
|---|---|
| ***DSRIP Project Quality Outcomes Summary:*** *Texana Center's Quality Outcomes focus on Developmental Profile 3 (DP-3), Controlling high blood pressure, Follow-Up After Hospitalization for Mental Illness, Vineland Adaptive Behavior Scales, 2nd Edition (VABS II), Aberrant Behavior Checklist (ABC) and the Battelle Development Inventory-2 (BDI-2)* | *Medicaid Population Average* ***61.94%***<br><br>*Low Income Uninsured Population Average* ***30.53%*** |

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|---|---|---|---|---|---|
| **Texas Children's Hospital**<br>**Bethany Lowe**<br>**832-824-1189**<br>bemiller@texaschildrens.org | **Primary:** Pediatric Subspecialty Care- Neurology | Expanding access to subspecialty care | The Neurology Service will focus on provider productivity and hire additional clinical providers in order to expand internal capacity. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 3,004 |
| | **Primary:** Pediatric Subspecialty Care | Expanding access to subspecialty care - The Meyer Center for Developmental Pediatrics | Expand the training of subspecialists, expand the role of a referral center to better allocate children with different needs to a provider that can best suit their needs, refine the role of a Primary Care Pediatrician to help provide long term care, and expand internal provider capacity and hire additional clinical workers. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 356 |
| | **Primary:** Pediatric Subspecialty Care – Allergy & Immunology | Expanding access to subspecialty care - Clinical Care Center - Allergy & Immunology Clinic | Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 2,883 |
| | **Primary:** Pediatric Subspecialty Care - Otolaryngology | Expanding access to subspecialty care - Clinical Care Center | Increase outpatient access for Harris County and surrounding communities to care for pediatric patients with hearing loss to sinus disease and swallowing abnormalities and those patients with disorders of the ear, nose, and/or throat. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 3,352 |

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|---|---|---|---|---|---|
| **Texas Children's Hospital**<br>**Bethany Lowe**<br>**832-824-1189**<br>bemiller@texaschildrens.org | **Primary:** Pediatric Subspecialty Care- Plastic Surgery | Expanding access to subspecialty care - Plastic Surgery Clinic | The Plastic Surgery division has and will continue to add clinic coverage at Texas Children's West Campus and expand its clinical locations. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 753 |
| | **Primary:** Pediatric Subspecialty Care- | Expanding access to subspecialty care | Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the brain and neurological system including neurosurgery, a craniofacial program, TBI clinic and Spina Bifida Clinic | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 1,000 |
| | **Primary:** Pediatric Subspecialty Care- Orthopedics | Expanding access to subspecialty care - Clinical Care Center - Orthopedics | Increase access for children to pediatric subspecialty services in the Orthopedic Surgery clinic at Texas Children's Hospital. Within the next five years the division would like to enhance its sub-specialization in the following areas of Sports Medicine, Orthopedic Oncology, Leg and Limb Deformity, and Hand/Upper Extremity. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 3,864 |
| | **Primary:** Women-Subspecialty Care- Behavioral Health/ Outpatient Psych | Expanding access to subspecialty care - Women | Create access resources which will allow us to diagnosis women quicker and enhance their quality of life. Educating and training obstetricians and pediatricians to improve screening in post-partum depression. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 1,940 |
| | **Primary:** Pediatric Subspecialty Care- Oncology & Cancer Treatment | Expanding access to subspecialty care - Texas Children's Cancer and Hematology Centers | Increase capacity in Texas Children's Cancer and Hematology Clinic | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 8,310 |

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|---|---|---|---|---|---|
| **Texas Children's Hospital**<br>**Bethany Lowe**<br>**832-824-1189**<br>bemiller@texaschildrens.org | **Primary:** Pediatric Subspecialty Care-Rheumatology | Expanding access to subspecialty care - CC Rheumatology Clinic | Increase critical access for the Harris County and surrounding communities to care for pediatric pts with diseases characterized by inflammation of the joints, muscles and/or tendons. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 900 |
| | **Primary:** Pediatric Subspecialty Care- Cardiac Rehabilitation | Expanding access to subspecialty care - Texas Children's Heart Center | Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with congenital heart disease | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 3,594 |
| | **Primary:** Pediatric Subspecialty Care- Pulmonary | Expanding access to subspecialty care - Pulmonary Medicine Clinic | Increase outpatient access for Harris County, specifically North Houston, to care for pediatric patients with conditions affecting the lungs and respiratory tract. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 2,466 |
| | **Primary:** Pediatric Subspecialty Care-Ophthalmology | Expanding access to subspecialty care - Ophthalmology | Increase access to pediatric ophthalmology services provided through Texas Children's Ophthalmology Clinic by: 1) adding an optometrist to see lower acuity pediatric ophthalmology patients, thereby allowing ophthalmic surgeons to see more complex pediatric ophthalmology patients; and 2) expanding services over the next five years with programs such as Ocular Trauma, Ocular Plastics, Pediatric Glaucoma and focus of the Retina can Cornea pediatric patients. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 2,816 |

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|---|---|---|---|---|---|
| **Texas Children's Hospital**<br>**Bethany Lowe**<br>**832-824-1189**<br>bemiller@texaschildrens.org | **Primary:** Pediatric Subspecialty Care- Digestive system | Expanding access to subspecialty care - Gastroenterology, Hepatology & Nutrition Clinic | Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the digestive system. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 9,549 |
| | **Primary:** Pediatric Subspecialty Care Endocrine System | Expanding access to subspecialty care | Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 7,301 |
| | **Primary:** Pediatric Social Work | Expanding access to child abuse examiners- Children's Assessment Center Medical Clinic | Increase the number of children evaluated for abuse and neglect by a child abuse specialist by increasing clinic appointments and the number of providers | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 332 |
| | **Primary:** Adult Primary Care | Expanding access to transitional care for childhood chronic diseases into adulthood - Transition Medicine Clinic | Target adolescents/young adults with significant chronic childhood conditions, define interventions in care transitions from pediatric providers to a medical home with services provided by adult providers, and expand chronic care management model to capture more of the Medicaid population. | Harris, Chambers, Waller, Austin, Colorado, Wharton, Matagorda, Calhoun, Ft. Bend | 549 |

***DSRIP Project Quality Outcomes Summary:*** *Texas Children's Hospital's Quality Outcomes focus on Pediatric Quality of Life Inventory (PedsQL), Asthma Percent of Opportunity Achieved, Diabetes care: HbA1c poor control (>9.0%), Edinburg Postpartum Depression Scale, Assessment of Quality of Life (AQoL-4D), Pain Admission Rate and Third next available appointment*

*Medicaid Population Average **48.13%***

*Low Income Uninsured Population Average **5%***

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| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Adult and Pediatric Primary Care | Expanded Primary Care | Expand primary care capacity at each of its 4 outlying clinics. Space will be acquired for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays. | Harris | 36,459 |
| | **Primary:** Specialty Care | Specialty Care – Pulmonary & Endocrinology | Recruit specialists for the new primary care clinic in North Harris County. This will further enable expansion of UT Health specialty services to another area outside the Texas Medical Center. The new primary care clinic's service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists. | Harris | 19,108 |
| | **Primary:** Medical Education/ Training | Residency Training in the Medical Homes Model | Implement a region-wide 24-hour nurse health line that will assist patients considering an ER visit in determining what level of care they need to access & and connect them to an appropriate resource. Goal is to ensure efficient use of the system's ED & reduce unnecessary visits. | Harris | 21,600 |

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| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Pediatric Behavioral Health | DePelchin & UT Physicians Pediatric Trauma Informed Care Screening and Intervention | Expand capacity and access to Trauma Informed care (TIC) mental health services for children and adolescents and will conduct mental health assessments, and provide a number of interventions with a particular focus on addressing trauma in underserved children. The TIC primary intervention offered will include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based practice and general counseling (such as Cognitive Behavioral Therapy). In order to expand access and capacity, these interventions will be anchored in DePelchin satellite clinics in proximity to several areas of socioeconomic need and will then progressively expand to community settings such as schools and primary care clinics. Developing a telemedicine capability for children in Foster Care. | Harris | 3,200 |
| | **Primary:** Community Health Worker Training | Community Health Worker Training | Expand home health service to include psychiatric services. Includes specialized training & certifications for nurses & addition of social work services to link clients to additional community care programs. Goal is to provide support of patients with mental health issues, to better manage their care in the home & community, & reduce number of visits to EDs for psychiatric care that could be managed in the home/community environment. | Harris, Ft. Bend | 46,000 |
| | **Primary:** Chronic Care | Chronic Disease Registry (services all clinics) | Data entered into a unique chronic disease registry will be used to pro-actively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. Reports drawn from the registry will be used to develop and implement targeted quality improvement plans for diabetes, hypertension, asthma, COPD, and CHF. | Harris, Chambers, Ft. Bend, Waller | 18,060 |
| | **Primary:** Emergency Care Utilization | Nurse Triage Line (services all UTP patients) | Expand access to medical advice and guidance to the appropriate level of care in order to reduce emergency department use for non-emergent conditions, and it will also increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365. | Harris, Chambers, Ft. Bend, Waller | 130,000 |

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| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Adult & Pediatric Primary Care | Heights Clinic (new Primary Care clinic) | Establish a new primary care clinic in the Northwest area of Houston. Space will be acquired for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays. | Harris | 48,936 |
| | **Primary:** Specialty Care - Endocrinology, Chronic care | Specialty Care | Recruit specialists for each of its outlying clinics. Clinic service hours will be extended to provide evening and weekend appointment options. Standardized referral systems will be put in place to ensure access to these specialists. | Harris, Ft. Bend | 66,800 |
| | **Primary:** Quality Improvement | Texas Center for Healthcare Quality Innovation (TCHQI) | Develop a regional systems engineering center, that will recruit systems engineers to integrate with healthcare QI teams to cross train in applying systems engineering science to healthcare processes, and develop interdisciplinary courses for healthcare professionals, students, engineers and administrative healthcare leadership. The project will also develop QI capacity at UT Health by developing specialty-specific QI dashboards that will integrate QI data from various institutions, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements. | Harris | 5,200 |
| | **Primary:** Adult and Pediatric Primary Care | Greens Clinic (New Primary Care clinic) | Establish the North Harris County Primary Care Clinic. Space will be leased to open the clinic, which will include consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to care. Primary care providers and support staff will be recruited to operationalize the project. | Harris | 48,936 |
| | **Primary:** Chronic Care | Coordinated Care Program for Patients with Chronic Diseases at TMC | The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model and using evidence-based standards of care for each of the targeted diseases. | Harris, Ft. Bend | 14,250 |

## Medicaid Rural Service Area Harris (MSRA Central, Harris, Jefferson)

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**CHIP: Amerigroup, Community Health Choice, Molina, Texas Children's, United**
**RHP 3 Counties: Austin, Calhoun, Chambers, Colorado, Ft. Bend, Harris, Matagorda, Waller, Wharton**
**HHSC Texas Managed Care Service Areas Map Effective Fall, 2016*

| Organization/Provider Name and Project Lead/Contact Name | Primary Project-Program Type | Project- Program Title | Brief Summary of Project & Services | County(ies) Served | QPI DY3-5 |
|---|---|---|---|---|---|
| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Primary Care | Patient Centered Medical Homes | The UT medical homes will include services in the areas of dentistry, womens' health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosceinces, pediatrics and geriatrics. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home". Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians. | Harris, Ft. Bend | 15,000 |
| | **Primary:** Specialty Care Obstetrics, Health Education & | Comprehensive Maternal Health Program (THRIVE) | UTP will implement three evidence-based interventions that will ensure that women receive quality preconception, prenatal, intrapartum, postpartum, and interconception care to manage risk factors that lead to adverse pregnancy outcomes. These interventions include: 1) the CHOICES Plus program for women at-risk of alcohol- and/or tobacco-exposed pregnancies and women who are obese, 2) home visits during pregnancy and postpartum period using evidence-based and piloted home visitation program, and 3) nutrition and physical activity promotion programs – A Legacy of Health (Un Legado de Salud) and The Happy Kitchen (La Cocina Alegre®). | Harris | 1,050 |
| | **Primary:** Pediatric Navigation | Teen Health Clinic for At-Risk Youth | The UT medical homes for post-detention adolescents and at-risk youth will provide all medical and psychosocial services for this population. Our innovative program involves facilitating access to the medical home by assisting youths and their guardians in arranging clinic visits, transportation, overcoming language barriers, and other challenges that may interfere with clinic visits. | Harris | 700 |
| | **Primary:** Navigation | Patient Navigation Program at Memorial Hermann TMC | This project targets patients at high risk of disconnect from institutionalized health care; who do not have a primary care provider. Care navigators will support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site-appropriate health care services. | Harris | 37,440 |

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| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Palliative Care | Palliative Care Program at Memorial Hermann TMC | Patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility. | Harris | 8,358 |
| | **Primary:** Chronic Care | Medication Therapy Management Program (for all UTP chronic disease patients) | Implement a technologically driven patient-centered medication therapy management program. The Allscripts analytics tool will enable staff to identify patients at high risk for developing complications and co-morbidities, and patients that have not refilled their medications. Patients will also have access to the patient portal, which will have detailed information on all their medications. Root cause analysis will be used to identify potential medication errors and quality improvement processes will be used to address the causes. | Chambers, Harris, Fort Bend, Waller | 7,500 |
| | **Primary:** Navigation | Transitions of Care Programs at Memorial Hermann TMC | Implement a comprehensive transitions of care program which will ensure that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with specific medical and surgical conditions. | Harris | 2,000 |
| | **Primary:** Integration Adult Behavioral Health and Primary Care | Integrated Behavioral Health and Primary Care Program for Adults-Sienna Village | Design, implement and evaluate a project that will integrate primary and behavioral healthcare services within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A behavioral health provider will be placed in the primary care setting to provide patients with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare. | Harris, Ft. Bend | 2,750 |

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| **UT Physicians**<br>**Sandra Tyson**<br>**713-486-3888**<br>**Sandra.K.Tyson@uth.tmc.edu** | **Primary:** Integration Pediatric Behavioral Health and Primary Care | Integrated Behavioral Health and Primary Care Program for Children & Adolescents-Cinco Ranch | Design, implement and evaluate a project that will integrate primary and behavioral healthcare services for children and adolescents within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A pediatric behavioral health provider will be placed in the primary care setting to children and adolescents with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare. | Harris, Ft. Bend | 2,250 |
| ***DSRIP Project Quality Outcomes Summary:*** *UT Physician's Quality Outcomes focus on Cervical Cancer Screening, Children and Adolescent Needs and Strengths Assessment (CANS-MH, Pneumonia vaccination status for older adults, Influenza Immunization – Ambulatory, Childhood immunization status, Post-Partum Follow-Up and Care Coordination, Chlamydia Screening and Follow up in adolescents, HIV Screening: Patients at High Risk of HIV , Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Breast Cancer Screening, Colorectal Cancer Screening, Cholesterol management for patients with cardiovascular conditions, Sepsis bundle (NQF 0500), Diabetes care: HbA1c poor control (>9.0%), Controlling high blood pressure , Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate, Hospice and Palliative Care – Proportion admitted to the ICU in the last 30 days of life, Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs) Annual monitoring for patients on persistent medications – Digoxin, Annual monitoring for patients on persistent medications- Diuretic, High-risk Colorectal Cancer Follow-up rate within one year, Depression management: Depression Remission at Twelve Months, Pediatric Quality of Life Inventory (PedsQL) Percent of trainees who have spent at least 5 years living in a health- professional shortage area (HPSA) or medically underserved area, Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey, CG-CAHPS Visit Survey 2.0: Timeliness of Appointments, Care, & Information, Depression Screening by 18 years of age, Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment , Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey, Pneumonia vaccination status for older adults and Appropriate Testing for Children With Pharyngitis* | | | | *Medicaid Population Average* ***23.60%***<br><br>*Low Income Uninsured Population Average* ***7.70%*** | |