University of Texas Health Science Center at Houston – RHP 05

IGT Entity Supporting Requested Funds: University of Texas Health Science Center at Houston –RHP 03

DY 7-8 DSRIP Proposal Form Guidelines - Regional Healthcare Partnership 5

PROPOSAL QUESTIONS

Performing Provider Name: University of Texas Health Science Center at Houston-UTHSC Sponsored Projects – RHP 05.

IGT Entity Supporting Requested Funds: (Required): University of Texas Health Science Center at Houston – RHP 03.

Estimated Valuation by Waiver Year:

DY 7 (2017-2018)	Amount: $500,000	IGT: $215,000
DY 8 (2018-2019)	Amount: $500,000	IGT: $215,000
TOTAL REQUEST:	Amount: $1,000,000	IGT: $430,000

Proposed System Definition:
The system definition will include outpatient and maternal services from both Brownsville Community Health Center (BCHC) and Hope Family Health Center (Hope). **1. BCHC patient population** is 20,000; BCHC provides comprehensive primary health care services to the uninsured or underserved populations. **2. Hope Family Health Center (HFHC) patient population** is 3,748 (2965 medical and 783 counseling services); the clinic provides primary and preventative medical services to only the uninsured residents of the Rio Grande Valley.

Counties Served by Provider: Cameron, Hidalgo, and Willacy Counties.

Medicaid and Low Income or Uninsured Patent Population by Provider (PPP) Estimate:
MLIU BCHC: 83%; almost 62% are uninsured, 1.6% are Medicaid/CHIP, 6.4% are Dual Eligible, and 13% are low-income patients. Only 10% have private insurance. The Total % MLIU is 83%. Over 71% of BCHC patients are low-income with 59.5% at or below 100% of Poverty and an additional 12% between 100 and 200% of Poverty. **MLIU Hope:** All patients who are provided medical care and mental health counseling at HFHC are 100% uninsured and do not qualify for any government funded medical assistance.

Identified Community Needs to be addressed with Requested Funds: Based on the Regional Healthcare Partnership (RHP) Plan; December 31, 2012 for RHP 5/South Texas, the list of Community Needs were the following, which we will continue to address with the requested funds:

1. Shortage of primary and specialty care providers and inadequate access to primary or preventive care. Specifically health conditions of obesity, diabetes, depression and high blood pressure will be targeted to improve screening and control. In addition important childhood and adult vaccinations will be emphasized in the primary care programs.

2. Shortage of behavioral health care professionals and inadequate access to behavioral health care. The identification of depression and particularly depression in those with chronic diseases will be emphasized because depression is associated with poor control of many chronic diseases such as diabetes, obesity, heart disease and cancer.
3. Lack of Patient Centered Care.

Outcome Measure(s) Expected to Address Identified Community Needs:

UTHealth has created the Salud y Vida program (Chronic Care Management) which has many collaborators including University of Texas Health Science Center at San Antonio (UTHSCSA). UTHealth has been assigned a Minimum Point Threshold of 22 points. Based on that, below are the Measure Bundles we have reviewed with our clinic partners for selection and that also align with our community needs:

1. Bundle A1: Improved Chronic Disease Management: Diabetes Care
2. Bundle A2: Improved Chronic Disease Management: Heart Disease
3. Bundle C1: Primary Care Prevention - Healthy Texans
4. Bundle C2: Primary Care Prevention - Cancer Screening & Follow-Up
5. Bundle D1: Pediatric Primary Care
6. Bundle D4 Pediatric Chronic Disease Management: Asthma
7. Bundle H1: Integration of Behavioral Health in a Primary Care Setting

We are prepared to select enough bundles to reach the 22 points and additional points if this proposal for additional funds is selected.

Anticipated Core Activities Expected to Impact Identified Outcome Measure(s):

1. Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions (such as cooking classes, DSME classes, and support groups).
2. Improve access to primary or preventive care by ensuring patient's access to the health care team whenever possible and promote and expand access to the medical home.
3. Encourage enrollment and retention for pediatric patients in the DSRIP childhood obesity program by increasing referrals at the selected clinics to the program.
4. Populate the Chronic disease registry with patient data and use the registry to track and follow up with patients and provide reports to providers for better healthcare management development.
5. Emphasize the importance of addressing depression in patients with chronic disease to improve self-management.

   In addition to,
6. Design and implement care teams that are tailored to the patient's health care needs.
7. Patient's accessibility to their care teams in person, by phone or email, or digital applications.
8. Increase patient engagement through digital and motivation.

Sustainability Efforts:

UTHealth works with Federally Qualified Health Clinics and with local community partners to make the proposed program sustainable through its high level of effectiveness thereby improving health of the

population and reducing health care costs. We believe this is the best formula for sustainability and we have demonstrated over the past several years the effectiveness of these approaches. We emphasize the importance of social determinants of health through our community-based components. The combination of the PCMH and community-based combining the PCMH approach with community support programs through community involvement and activities of community health workers we have shown an effective combination that addresses clinical and social determinants of health. We believe this to be a solid combination to insure sustainability. Those sustainability efforts will clearly result in a positive impact; reducing cost and saving money and time. We also are working with partners to create a comprehensive care model where the navigation, outreach and continuity of care services are cost reimbursable.