University of Texas Rio Grande Valley School of Medicine

Performing Provider Name: University of Texas Rio Grande Valley School of Medicine

IGT Entity Name Supporting Requested Funds (Required): UT Health Rio Grande Valley/University of Texas Rio Grande Valley School of Medicine

Estimated Valuation by Waiver Year:

DY 7 (2017-2018)	Total Amount: $2,500,000	IGT: $1,095,500 (@ 43.82%)
DY 8 (2018-2019)	Total Amount: $2,500,000	IGT: $1,095,500 (@ 43.82%)

Proposed System Definition: UT Health Rio Grande Valley (RGV), the clinical operation for the UTRGV School of Medicine (UTRGVSOM), has multiple clinics and outreach programs to provide integrated, inter-professional, and collaborative care to the underserved. The two sites/systems include the John Austin Pena Clinic (JAPC), a partnership with the Hidalgo County Department of Health and Human Services, Independent School Districts (ISD) (McAllen/Edinburg/PSJA), Juvenile Justice Department (JJD) and the UTRGVSOM and the Integrated Colonia Care System. The Integrated Colonia Care system comprises 6 Hubs. The Hubs include community resource centers and a mobile clinical van located in four counties (Hidalgo, Cameron, Starr, and Willacy)

Medicaid and Low Income or Uninsured Patent Population by Provider (PPP) Estimate: 45% Medicaid and 40% are uninsured and 90% live below 200 % of the poverty level.

Identified Community Needs to be Addressed with Requested Funds:

The RGV is largely an underserved region associated with endemic numbers of obesity, hypertension, diabetes, depression, substance use, and rampant health disparities influenced by social determinants of health (SDH). Patients with hypertension are 10 times more likely to report anxiety and depression. Both depression and obesity greatly affect self-report of social health. Major depressive disorder and overweight patients were 31 times and 18 times more likely, respectively, to rate their physical health status as low. Another group of underserved patients are the triply diagnosed adolescents (mental illness, medical illness and appetitive drive disorder). Eighty two percent of our adolescents are un-insured or underinsured (51% Medicaid/31% no insurance). The average age is 15.6 years, 70% male, 38 % of the clients have had contact with law enforcement and 62% have difficulties in school. Common to our clients include: substance use, children of alcoholics/substance abuse, family violence, foster home placement and child protective services interface. Our program serves the ISD, Juvenile Justice Department (JJD), County, and high-risk adolescents that otherwise would have no treatment options. We focus on relationships with our community partners, integrating care and maximizing interprofessional team-based collaborations. The sites serve as training options for learners, and many continue to find employment in the county (workforce development). We work with families, communities, teachers, social workers, counselors, and the school system to increase community capacity. We partner with the County Judge to provide a drug court for low level offenders. We serve as integrated interprofessional treatment/prevention centers, and address social determinants of health for the group of adolescents served.

The second arm of our community outreach includes the Unimovil that offers primary care, social work, preventive medicine, and Community Health Worker services from learners and faculty, literacy classes from College of Education learners, and psychoeducational classes that focus on exercise and weight loss. Upwards of 60% of our communities have inadequate or no oral health care. Access to mental health services is equally as tenuous, as is the ability to provide eye care including diabetic retinopathy and glaucoma screening.

This proposal will continue/improve services offered to triply diagnosed adolescents/community based-population care and expand services to the community to address oral health needs, ocular healthcare (diabetic retinopathy/glaucoma screening) and mental health screening/treatment by integrating learners and faculty from multiple UTRGV Colleges (Education, Health Affairs, School of Medicine). Integration is addressed by the use of Geographic Information Service (GIS) Mapping, established consortiums and enhanced technology. The community engages learners and are centers for community capacity building, interprofessional training, and focus on social determinants of health (SDH). Faculty provide interprofessional care and education and precept learners, who in turn mentor the following year's cohorts. Centering care at the HUBS provides care in high-need areas, maximizes resources from multiple organizations, and creates early learning opportunities that will expose graduates to pursue a career in community and population based healthcare.

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

Metrics include access to care, PHQ9 results, self-reported substance use, school performance, graduation rates, JJD and school official reports, as well as, screening, school progress, and exercise/diet results. Instruments include Quality of Life (Duke), SDH (SIREN), depression (PHQ) and age specific surveys (RAPPS, CRAFFT, and SASSI) validated in similar populations. HEDIS measures (weight and BMI) and metrics, such as sexual activity, substance use (patient/parents), alcohol/tobacco use, domestic violence in the family, and history of abuse are collected. Adverse Childhood Experiences, and the TRIPOD surveys measure environmental contributors to success and our reliable indicator outcomes for education, home, and community.

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

Improvements include continuity of care, transitions, and care navigation. Partnership with the community organization address prevention/recidivism, shared resources, reduced duplication of services and improved access to care. Training teachers, social workers, providers and other learners for our work-force, produces well-rounded, integrated interprofessional teams and improves community capacity and workforce development. Over 5 years, we expect demonstrable improvement in high school graduation rates, reduced substance use, improved health literacy, and integrated team-based healthcare.

Sustainability Efforts: Partnering with funders/County Commissioners to provide support/low cost clinic space. Creating sites that are patient centered medical homes to provide comprehensive integrated interprofessional collaborative care to reduce cost. Provide learners sites for community capacity building, workforce development and increase access.