

Performing Provider	County	Project Title	Description	DY3 Valuation	DY4 Valuation	DY5 Valuation	Project Total
Camino Real Community Services	Maverick	Wrap-Around Intensive Assertive Community Treatment	Provides intensive wrap-around services including medical and behavioral services to 100 patients living in the service area who are the frequent utilizers of emergency crisis services and inpatient hospitalization experiencing behavioral health and substance use/abuse issues in order to reduce expensive inpatient admission or readmission. This team will provide supported housing, supported employment, medical management including education, self-monitoring and medication administration in an effort to improve medical, behavioral, social and substance use/abuse outcomes. IGT used will be State General Revenue from DSHS.	\$650,000	\$715,000	\$786,500	<b>\$2,151,500</b>
Camino Real Community Services	Maverick	Veteran's Services	The emphasis will be upon Vets with chronic and persistent mental health conditions and also upon those with PTSD and other concerns that impede them from more successful readjustment to their lives in local rural communities. It will also capitalize upon the presence of Veteran Organizations as well as upon CRCS history of coordinating with the Veterans Administration Health Care System. IGT used will be State General Revenue from DSHS.	\$320,000	\$352,000	\$387,200	<b>\$1,059,200</b>
Camino Real Community Services	Maverick	Supported Housing and Supported Employment	In Maverick County, there is a critical need for enhanced community based mental health services in the areas of supported housing and supported employment for persons with severe and persistent mental health conditions. IGT used will be State General Revenue from DSHS.	\$150,000	\$1,650,000	\$1,815,000	<b>\$3,615,000</b>
Camino Real Community Services	Maverick	Interventions for Autism Spectrum Disorder / IDD	The proposed day treatment program will provide intensive community based services for individuals with Autism and related Intellectual Developmental Disabilities (IDD) with significant behavioral challenges that interfere with their ability to integrate and function in their natural environments.	\$583,333	\$641,667	\$705,833	<b>\$1,930,833</b>
Laredo Medical Center	Webb	Expand primary care capacity	This project establishes an urgent care clinic to provide a lower cost alternative for those seeking care for illness and minor emergencies in South Central Laredo.	\$1,400,000	\$1,120,021	\$1,120,021	<b>\$3,640,042</b>
Laredo Medical Center	Webb	Expand OB/Gyn Specialty Services	This project increases specialty care capacity to provide Obstetrics/Gynecology specialty services to the underserved areas of South Laredo.	\$1,250,000	\$812,500	\$812,500	<b>\$2,875,000</b>
Laredo Medical Center	Webb	Community Triage Center	This project would establish a Community Triage Center (CTC) in Laredo to serve the community's most vulnerable and often medically-compromised individuals in need of substance abuse and mental health treatment, detoxification, crisis intervention, human services, case management, referral and support through WestCare, a nationally-recognized behavioral health care and human services non-profit organization.	\$1,400,000	\$1,400,000	\$1,400,000	<b>\$4,200,000</b>

Performing Provider	County	Project Title	Description	DY3 Valuation	DY4 Valuation	DY5 Valuation	Project Total
Laredo Medical Center	Webb	Expand telemedicine programs	This project will expand our existing telemedicine programs to include additional specialties: Tele Psychology and Tele ICU. Also, we will continue to expand telemedicine for the specialties currently included in the network: Tele Radiology and Tele Neurology. The expanded telemedicine programs will increase access to specialists for the diagnosis and treatment of conditions that have been identified as an essential need for surrounding communities. The telemedicine network will provide specialty care throughout the facility	\$2,100,000	\$1,862,500	\$1,862,500	<b>\$5,825,000</b>
Doctors Hospital of Laredo	Webb	Expand primary care capacity	Improve access and facilitate prevention of disease. Focus on providing Immunizations, TB Screenings and Flu Shots to reduce non-emergent ER visits.	\$675,000	\$675,000	\$650,000	<b>\$2,000,000</b>
Doctors Hospital of Laredo	Webb	Patient Care Navigation Program	The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. DHL's 3-year goal is to increase the number of primary care provider referrals for patients without a medical home who use the ED.	\$350,000	\$350,000	\$300,000	<b>\$1,000,000</b>
Doctors Hospital of Laredo	Webb	Expand mobile clinics	The Mobile Health Clinic will serve Laredo's primary service area, along with outreaching communities that might not have access to primary care services. DHL will identify a service area in which to deploy the mobile clinic in order to be most effective in reaching a larger population.	\$675,000	\$675,000	\$650,000	<b>\$2,000,000</b>
Driscoll Children's Hospital	Webb	Cadena de Madres program	The goal of this project is to educate and provide support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother	\$800,000	\$750,000	\$570,000	<b>\$2,120,000</b>
Driscoll Children's Hospital	Webb	Oral Health Project	This project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider's (PCP's) office. Target population is infants to children up to age 3.	\$800,000	\$750,000	\$570,000	<b>\$2,120,000</b>
* Project valuations subject to change *			<b>TOTALS</b>	<b>\$11,153,333</b>	<b>\$11,753,688</b>	<b>\$11,629,554</b>	<b>\$34,536,575</b>

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** **Wrap-Around & Assertive Community Treatment**

**Provider Name/TPI:** Camino Real Community Services/121990904

### Project Description

Camino Real Community Services will provide mental health services to the residents of Maverick County and the South Texas Kickapoo Traditional Nation experiencing substance use/abuse and behavioral health crisis. Camino Real Community Services will establish one intensive wrap-around service team (i.e. psychiatrists, nurse practitioners, and licensed clinical staff). Types of services to be provided include supported employment, supported housing, medical management education including self-medication and monitoring, behavioral health counseling and like services for up to 90 days following the crisis and until linkage into community services is complete.

### Intervention(s)

The project is to establish **one Intensive Wrap-Around Assertive Community Treatment team** in the service area to include adults and adolescent and child populations. More specifically, it is the Center's intent to provide intensive wrap-around services including medical and behavioral services up to 30 patients living in the service area including the Kickapoo Nation who are the frequent high utilizers of emergency crisis services, substance abuse services, and inpatient hospitalization. experiencing behavioral health and substance use/abuse issues in order to reduce expensive inpatient admission or readmission. This team will provide supported housing, supported employment, medical management including education, self-monitoring and medication administration in an effort to improve medical, behavioral, social and substance abuse/use interventions

### Need for the project (include RHP 20 Community Need No.)

Camino Real Community Services' area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible intensive wrap-around services including medical, behavioral health, and substance use/abuse interventions. This location has the designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. This is boarder community with small Colonia communities scattered throughout the County. There are no local psychiatric hospitals or crisis stabilization facilities to address the needs of the individuals living in this poverty stricken service area. The center provided 262 crisis assessments (December 2011 – August 2012) to individuals. Of the 262 patients seen in crisis approximately 59 patients were sent to inpatient psychiatric hospitals during this time frame.

### Target population

The target population is individuals of all ages experiencing a medical issues along with psychiatric crisis and substance use/abuse issues requiring frequent intervention services. In Maverick County 25% of the population is living below poverty, 35 % are without medical insurance and 55% are Medicaid eligible. It is anticipated that once the three Intensive Wrap-Around Assertive Community Treatment teams are fully operational, the team will serve 30 persons of which 15 will be Medicaid eligible and 15 will be indigent. There are no federal initiatives addressed/ expanded with these funds.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** **Wrap-Around & Assertive Community Treatment**

**Provider Name/TPI:** Camino Real Community Services/121990904

**Category 1 or 2 expected patient benefits**

The project intends to benefit patients by providing Intensive Wrap-Around Assertive Community Treatment services to include medical follow up, medication management and education, psychiatric and substance use/abuse interventions, 24 hour active treatment by mental health professionals and rehabilitation and education services that enhance patient skills and substance use/abuse counseling by qualified Licensed Chemical Dependency Counselors. It is the performing provider's expectation that this model will improve access to the appropriate level of care for patients addressing the medical, behavioral, social and substance abuse issues of individuals living in a boarder community where these services are lacking. The other benefits include decrease inpatient hospitalization, decrease readmission to inpatient facilities, decrease in emergency room visits, and an increase in medication and treatment compliance.

**Category 3 outcomes expected patient benefits**

OD-9, IT9.2 Decrease Behavioral Health or Substance Abuse admissions and readmissions to institutional facilities including local emergency departments and psychiatric facilities. Patients will benefit from access to crisis services options in lieu of ED usage for related behavioral health or substance abuse issues

**Estimate of Project Valuation for DY 3 – DY 5**

**OPERATIONAL:**

Staffing: Nursing, Specialized Substance Abuse staff, Administrative, Medication Tech; 2 Vehicles; Purchase of Bed Days at Treatment Facilities.

**VALUATION:**

**DY3 \$650,000 DY4 \$715,000 DY5 786,500**

Valuation is based on avoidance of individual's entry into costly criminal justice and inpatient treatment facilities. Significant value will be given to a program that can provide services much more responsive to consumer needs with significantly reduced time frames and efficient use of limited resources!

**IGT Source**

**IGT** used will be State General Revenue from DSHS.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** Veterans Services

**Provider Name/TPI:** Camino Real Community Services/121990904

### Project Description

CRCS proposes to deliver to Maverick County Veterans relevant services that have already proven their worth in other portions of our service area and in other agencies. An expansion and enhancement of our veteran's services will include building Peer-to-Peer counseling and support and other services. We aim to identify motivated veterans who will accept training from CRCS and other Texas Veterans Commission linked resources to enable them to provide quality peer support to their comrades.

During exacerbations of PTSD related symptoms we propose to secure comfortable and safe short term housing alternatives (e.g. hotel room) with some of the allocated funds

### Intervention(s)

The delivery model will include our proven success in other areas with a "Vets-helping-Vets" capability. However, we intend to capitalize upon the presence of traditional Veteran Organizations as well as upon CRCS history of coordinating with the Veterans Administration Health Care System. Peer-to-Peer support counseling by trained veteran outreach workers as well as monthly outreach worker support and coordination meetings. Based upon Peer counseling, referral to more in depth services either via telemedicine capability or face to face with VA, private, or CRCS behavioral health professionals

### Need for the project (include RHP 20 Community Need No.)

State Veteran Commission information resources estimate there are 1,541 veterans in Maverick county. Of that number there are 288 who are known patients for the Veteran's Health Administration. Community based key informant information as well as preliminary Needs Assessment efforts have established a significant need for enhanced Veteran's Service in the area of Region 20 served by Camino Real Community Services as the Local Mental Health Authority. Despite the personal strength and resiliency for stress that is learned and earned by many Veterans, there is appropriate National and State recognition of the unmet need for community based services for recently returning veterans as well as for veterans from earlier conflicts such as Vietnam.

### Target population

Consistent with the CRCS mission and with the aims of the 1115 waiver project generally, the emphasis of the project will be upon homeless, indigent or below the poverty line Vets. Specifically, we will aim to serve Vets with chronic and persistent mental health conditions and also those with PTSD and other service related concerns that impede them from more successful readjustment to productive lives in local rural communities.

Additionally, we will target all Veterans affiliated with traditional veteran's organization for the delivery of behavioral skills and wellness education.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** Veterans Services

**Provider Name/TPI:** Camino Real Community Services/121990904

**Category 1 or 2 expected patient benefits**

Milestone 1: (P-1) assessment of behavioral health and physical health needs of 200 underserved veterans in the region  
Milestone 2: (P-2) identify existing clinics or other settings for improved physical health and behavioral health services in the region  
Milestone 3: (P-4) assess ease of access of potential locations  
Milestone 4: (I-8) provided behavioral health services to 50, 100, 200 veterans over years 1, 2, 3.

**Category 3 outcomes expected patient benefits**

Target: (IT 6.1) an annual 10% increase over baseline of Veterans rating of the access to behavioral health care

**Estimate of Project Valuation for DY 3 – DY 5**

**OPERATIONAL:**

Personnel: 12 part time Peer Counselor Veterans provide an estimated total 80 hours per week; Training: 12 community resident veterans (WACO BETZ training); Travel: Four (4) trips to Maverick County per month; Training Events; 2 Vehicles; Other: Supplementary specialized interventions, education and support equipment.

**VALUATION: DY3 \$320,000, DY4 \$352,000 DY5 387,200**

Valuation is based on avoidance of veteran’s entry into costly criminal justice and inpatient treatment facilities.

**IGT Source**

**IGT** used will be State General Revenue from DSHS.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** Housing and Employment

**Provider Name/TPI:** Camino Real Community Services/121990904

### Project Description

In Maverick County, there is a critical need for enhanced community based mental health services in the areas of supported housing and supported employment for persons with severe and persistent mental health conditions. The project will support the planning, design, procurement (lease or build) of supported housing alternatives for up to 60 persons with severe and persistent mental illness and who are eligible under the priority populations of the 1115 waiver project.

### Intervention(s)

CRCS will provide a range of residential services for the identified population including board and care homes, small group treatment homes, supported living arrangements, supported apartments, family care (foster care) homes, and independent living.

CRCS will develop a range of vocational opportunities including vocational assessments, time-limited job training, special work crews and enclaves tailored to the economic realities of the region, consumer operated vocational alternatives, long term vocational support.

### Need for the project (RHP 20 Community Need No. 2)

This project addresses RHP 20 top Community health Need CN 2: Behavioral Health Services: Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth.

There are essentially no residential alternatives or vocational programs of quality for this entire region for this population in need.

### Target population

Consistent with the CRCS mission and with the aims of the 1115 waiver project generally, the emphasis of the project will be upon homeless, indigent or below the poverty line persons with severe and persistent mental illness. Specifically, we will aim to serve persons with chronic and persistent mental health conditions that impede them from more successful adjustment to productive lives in local rural communities.

### Category 1 or 2 expected patient benefits

Increased numbers of eligible consumers who have satisfactory housing and employment services incorporated into their overall quality of life.

Milestone 1: (P-1) Assessment of housing and employment needs

Milestone 2: Procurement of housing and employment facilities

Milestone 3: We are projecting up to 60 eligible consumers (DY3 20, DY4 40, DY5 60) in appropriate housing and 30 productively engaged in supported employment

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** **Housing and Employment**

**Provider Name/TPI:** Camino Real Community Services/121990904

**Category 3 outcomes expected patient benefits**

Target: Objective measures of patient satisfaction with access to housing and employment in the region 20 area.

**Estimate of Project Valuation for DY 3 – DY 5**

**OPERATIONAL:**

Personnel: 12 full time and 12 part time housing and vocational qualified mental health professionals; Housing Equipment; tools and supplies for Supported Employment; Work Crew Vans; Van annual O&M; Housing Supervision Vehicles; Vehicle O&M; Travel. **VALUE: DY3 \$1,616,667; DY4 \$1,778,333; DY5 \$1,956,167**

How did you determine these values? ANSWER:CRCS examines, analyzes, and predicts reasonably-valued cost avoidance for every service delivery improvement project. CRCS uses reliable information sources for determining cost-avoidance. For example, CRCS considered reports, information, and data from the 2012 National Conference for Community Behavioral Health Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), a report of an HMO claims analysis, the Health Management Associates March 2011 report *Impact of Proposed Budget Cuts to Community-Based Mental Health Services*, and the 2007 Statistical Brief #166 report by the Medical Expenditure Panel Survey.

This CRCS project aims to initiate for the first time in Eagle Pass/Maverick County, an array of community based mental health services that are essential elements to ANY comprehensive and integrated community MH program. It is the existence of such comprehensive and integrated programs that leads to the kinds of enormous cost savings reported by various state and federal agencies. Without the array of services in place, you CANNOT count on the savings being realized! The average per day cost of community based services is \$12 for adults and \$13 for children, as compared to \$401 for a State Hospital bed, \$137 for a jail bed for an inmate with mental illness, and \$986 for an emergency room visit.

**ANNUAL ESTIMATED COSTS FOR COMMUNITY-BASED VERSUS COSTLY CARE**

<b>Adult Community Based Care</b>	<b>Child/Adolescent Community Based Care</b>	<b>CRCS 3 year DSRIP Project</b>	<b>12 Emergency Room Visits</b>	<b>Jail Bed</b>	<b>State Hospital Bed</b>
\$4,380	\$4,745	\$33,000	\$35,496	\$50,005	\$146,365

While this CRCS initial expansion of access to essential community-based mental health care alternatives appears more costly per person than data about community based care, it is still less costly than the inadequate intensive and more restrictive alternatives that have been too long relied upon for this service area. Over time, with CRCS leading creation and expansion of community based services the appropriateness, effectiveness, and costliness of Eagle Pass/Maverick Mental Health services will all improve.

**IGT Source**

IGT used will be State General Revenue from DSHS.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:**

**Project Option: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent cares etc.)**  
**2.13.1 Design, implement, and evaluate research supported and evidence-based interventions tailored towards individuals in the target population.**

**Provider Name/TPI:**

**Camino Real Community Services/121990904**

### Project Description

In Maverick County, there is a critical need for enhanced intervention for children and adults with Autism and related Intellectual Developmental Disabilities. Current funding for IDD services is limited, and has not allowed for the development of the specialized services that maximize functioning level of persons with aberrant behaviors. The proposed day treatment program will provide intensive community based services for individuals with Autism and related Intellectual Developmental Disabilities (IDD) with significant behavioral challenges that interfere with their ability to integrate and function in their natural environments.

### Intervention(s)

Camino Real will provide 1:1 applied behavior analysis (ABA) services to children and adults within the autism spectrum disorders and/or related intellectual and developmental disabilities. The primary focus areas are communication, behavior management, life skills, and social skills. Specialized behavioral Techniques are utilized to teach new appropriate skills, such as communication, as well as, decrease inappropriate skills such as aggressive behavior. Each person's program is individualized to their needs, caregiver receives training, and the programs are supervised by licensed professionals including a Board Certified Applied Behavior Analyst.

The goal is to lead each individual to his or her potential through evidence based therapy. The CRCS Day Treatment Program provides a hands-on approach with assessments, one-to-one therapy, and families and/or provider training to maximize progress and reduce the rate of psychiatric admissions or institutionalization for the target population. The licensed staff will serve as a community expert resource and support to families and providers of individuals with autism/related IDD, as well as a resource to consultants, school districts, and other private or public agencies serving individuals with ASD and IDD.

### Need for the project (include RHP 20 Community Need No.)

CN.2-Currently there is a lack of dedicated services for individuals with Autism Spectrum Disorders or related Intellectual and Developmental Disabilities (IDD) in Maverick county. Medicaid and CHIPS do not cover ABA therapy for Outreach or Day Treatment. Autism-specific treatment in outlying and rural areas to persons of cultural diversity that are low-income and under-insured is often limited, fragmented, costly or inaccessible. Historically, 50-75% of individuals with autism also have some degree of mental retardation (Freeman, 1997; Rapin, 1997). Chasson, Harris and Neely (2007) found that after three years of early intensive behavioral intervention that the state could save on average \$84,300 per child in special education costs. Combined with actual costs incurred by families, this could result in a savings of \$208,500 per child. They also suggest that the up-front costs of implementing ABA programs will be covered within five years.

Lack of ABA services increases the risk for institutionalization, due to inability to manage aberrant behaviors in the community.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** **Project Option: 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent cares etc.) 2.13.1 Design, implement, and evaluate research supported and evidence-based interventions tailored towards individuals in the target population.**

**Provider Name/TPI:** **Camino Real Community Services/121990904**

### Target population

The Target population is 95% Medicaid or uninsured individuals who have Autism Spectrum Disorder or a related Intellectual and Developmental Disability.

### Category 1 or 2 expected patient benefits

The CRCS Day Treatment Program will serve a total of **15 persons over a 3 year** period, decreasing the risk of institutionalization for a potential cost savings of 151,489.60 per person per year.

### Category 3 outcomes expected patient benefits

Functional Status, IT-11.27.c- Aberrant Behavior Checklist (ABC) will be used to assess problem behaviors of children and adults with mental retardation at home, schools, day programs and work training centers.

### Estimate of Project Valuation for DY 3 – DY 5

**VALUATION DY3 \$583,333 DY4 \$641,667 DY5 \$705,833**

CRCS determined the value of each project by comparing the budgeted cost of the specific project against the cost to the community should the services go un-provided. In regards to the Intensive Applied Behavior Analysis program, the significant cost of Special Education services, emergency room visits, and placement in a State Supported Living Facility were used as comparison data against cost for the Intensive Applied Behavior Analysis program. The starting point/baseline for the program is zero, with a total census of 2 at the end of the first year. The total census of those served will increase each year by 3.

Research by (Dawson, Geraldine, 7-13-12) estimates that the cost for treating/providing care for persons with Autism (most of it spent on caring for adults with Autism in institutional settings) is 136 billion annually. In Texas, children and adults with Autism requiring institutionalization cost the state of Texas between \$107.20 per day (\$39,129 annually) and \$415.04 per day (\$151,489.60 annually) (depending on level of need), long term. For a twenty year institutionalization at the highest rate, the state of Texas will pay \$3,029,792.

### IGT Source

Camino Real Community Services will provide IGT total of \$ 772,333 from State DADS GR.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** 162033801.1.2

**Provider Name/TPI:** Laredo Medical Center / 162033801

### Project Description

We propose to create an Urgent Care Clinic in South Central Laredo. This clinic would provide South Central Laredo residents with more accessible and lower cost primary, urgent and minor emergent health care needs so that residents would not need to use the ED for this care. The goal would be to provide increased access to care in the clinic setting for residents of South Central Laredo (approximately 199,000 people).

The clinic would provide the following services, thereby freeing up the ED to focus on true emergencies:

- Primary care services;
- Urgent care services; and
- Minor emergent care.

As a result, patients would have increased access to the care they need in the appropriate setting, with wait times for their care reduced. Right care in the right setting allows for better care at a lower cost. The benefits of this project include:

- Addressing a priority community need for more primary care services, including as a non-ED referral option after normal business hours;
- Providing a lower cost alternative to the ED, thereby helping to reduce ED overcrowding;
- Providing quality health care connected to the ongoing provision of primary care; and
- Lowering overall health care system costs.

### Intervention(s)

We have selected project option **1.1.1 Expand Primary Care Capacity: Establish more primary care clinics**. This project establishes an urgent care clinic to provide a lower cost alternative for those seeking care for illness and minor emergencies.

### Need for the project

The clinic would help a market currently struggling to meet the primary care needs of its population. As sited in the community needs assessment (CN.1), there is a critical shortage of primary care capacity and access. As a result, many residents seek primary care in the ED. In 2012, LMC had 55,512 ED visits, of which the payer mix was: 14.5% Medicare, 8% Managed Care, 39.5% Medicaid, 4% Other Government, 3% Other Private Payer, and 31% Self Pay. Approximately 18% of the visits represented non-emergent care and could have been delivered in a more appropriate, lower cost setting. As a result, average wait times in the ED (door to doctor) last year were 26 minutes. Furthermore, this number of visits represents an increase over the prior year by 2%, demonstrating that costly ED utilization for non-emergent care is on the rise as a result of a shortage of primary care clinic options. This project would provide urgent care resources for residents, thereby reducing non-emergent use of the ED. This project would meet the region's first goal to expand primary care capacity.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** 162033801.1.2

**Provider Name/TPI:** Laredo Medical Center / 162033801

### Target population

The target population is residents of South Central Laredo (our service area is estimated at 199,000 people). We expect to provide 10,137 visits in DYs 4-5, of which we expect approximately 70% will represent low-income (Medicaid, indigent and uninsured) patients.<sup>1</sup>

### Category 1 or 2 expected patient benefits

The project seeks to improve primary care capacity for the 199,000 residents in our South Central Laredo service area, as evidenced by an expected 10,137 in DYs 4-5. Residents will benefit from increased access to primary, urgent and minor emergent care in a clinic setting, thereby also reducing overcrowding and wait times in the ED. Expected patient benefits include:

- Provision of quality care in a clinic setting;
- Reduced wait times for care;
- More patient-centered care; and
- Care coordination with ongoing primary care practitioner.

### Category 3 outcomes expected patient benefits

The related category 3 outcome measure is **IT-9.2.a Reduce total ED visits for all causes (Standalone measure)**. Our goal is to reduce unnecessary ED visits by 5% over baseline as a result of providing access to urgent care as an alternative to the ED.

### Estimate of Project Valuation for DY 3 – DY 5

**DY3: \$1,400,000**

**DY4: \$1,120,021**

**DY5: \$1,120,021**

### IGT Source

Webb County via LPPF

<sup>1</sup> In 2012, LMC had 55,512 ED visits, of which the payer mix was: 14.5% Medicare, 8% Managed Care, 39.5% Medicaid, 4% Other Government, 3% Other Private Payer, and 31% Self Pay

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** 162033801.1.1

**Provider Name/TPI:** Laredo Medical Center / 162033801

### Project Description

This project increases specialty care capacity to provide Obstetrics/Gynecology specialty services to the underserved area of South Laredo. The goal would be to increase access to care in the clinic setting for residents of South Laredo.

### Intervention(s)

We have selected project option 1.9.2 Expand Specialty Care Capacity: Improve access to specialty care. This project increases specialty care capacity to provide Obstetrics/Gynecology specialty services to the underserved areas of South Laredo.

### Need for the project

As cited in the community needs assessment (CN.1), there is a need for specialists to assist in the treatment of chronic diseases. There is currently a significant shortage of Obstetrics/Gynecology specialists in the South Laredo market. This project would increase access to those services.

### Target population

The target population is patients needing Obstetrics/Gynecology services, an estimated 2,300 visits per year, of which 40% represent Medicaid and uninsured.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** 162033801.1.1

**Provider Name/TPI:** Laredo Medical Center / 162033801

**Category 1 or 2 expected patient benefits**

The project seeks to improve access to Obstetrics/Gynecology services in South Laredo, as evidenced by providing a total of 2,300 Obstetrics/Gynecology visits in DYs 4-5. Patients would benefit from timely Obstetrics/Gynecology visits, better diagnoses and treatment plans, and fewer unnecessary tests and transfers. Overall patient care related to Obstetrics/Gynecology health issues would improve as patient access to needed Obstetrics/Gynecology services increases.

**Category 3 outcomes expected patient benefits**

The related category 3 outcome measure is **IT-8.17 Post-Partum Follow-Up and Care Coordination (Standalone measure)**. Our goal: Regardless of age, individuals who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth and who received a breastfeeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning.

**Estimate of Project Valuation for DY 3 – DY 5**

**DY3: \$1,250,000**  
**DY4: \$812,500**  
**DY5: \$812,500**

**IGT Source**

Webb County via LPPF

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** Project Option 2.15.1- Develop and implement an integrated behavioral health and primary care pilot, targeting at-risk populations with mental illness and chronic disease co-morbidity

**Provider Name/TPI:** Laredo Medical Center / 162033801  
WestCare Foundation, Texas, Inc./ 801804885

### Project Description

WestCare Texas proposes to develop and implement a service delivery system know as the Community Triage Center, which will target the identified population through crisis stabilization and treatment services.

### Intervention(s)

**1.13.1** Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

**2.13** Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.)

### Need for the project (include RHP 20 Community Need No.)

WestCare's goals for this initiative are to address several issues noted in the community's Regional Healthcare Partnership Plan 1, Community Needs assessment including:

- Reducing the rate of inappropriate Emergency Department admissions;
- Implementation of a crisis intervention and prevention model of care;
- Implement a model of integrated behavioral health and chronic/ primary health services;
- Expand behavioral health services provided directly to clients by utilizing licensed professional personnel.

### Target population

The Community Triage Centers (CTC) serves the community's most vulnerable and often medically-compromised individuals in need of substance abuse and mental health treatment, detoxification, crisis intervention, human services, case management, referral and support.

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** Project Option 2.15.1- Develop and implement an integrated behavioral health and primary care pilot, targeting at-risk populations with mental illness and chronic disease co-morbidity

**Provider Name/TPI:** Laredo Medical Center / 162033801  
WestCare Foundation, Texas, Inc./ 801804885

### Category 1 or 2 expected patient benefits

CTC outcomes have included reduced costs for local health care and hospitals, more effective coordination of crisis services, reduced non-violent crime and incarceration, and improved behavioral health results for high risk and addicted individuals, their families and the surrounding community.

### Category 3 outcomes expected patient benefits

IT-2.4 Behavioral Health/Substance Abuses Admission Rate  
IT-9.2 ED appropriate utilization  
IT-9.4 Decrease mental health admissions and re-admissions of persons needing crisis stabilization services to institutional facilities

### Estimate of Project Valuation for DY 3 – DY 5

DY 3 - \$1,400,000  
DY 4 - \$1,400,000  
DY 5 - \$1,400,000

### IGT Source

Local Provider Participation Fund

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** 162033801.1.4

**Provider Name/TPI:** Laredo Medical Center / 162033801

### Project Description

This project will expand our existing telemedicine programs to include additional specialties: Tele Psychology and Tele ICU. Also, we will continue to expand telemedicine for the specialties currently included in the network: Tele Radiology and Tele Neurology. The expanded telemedicine programs will increase access to specialists for the diagnosis and treatment of conditions that have been identified as an essential need for surrounding communities. The telemedicine network will provide specialty care throughout the facility.

### Intervention(s)

We have selected Project Option 1.7.1: Introduce, Expand, or Enhance Telemedicine/Telehealth: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region. This project will implement a telemedicine program based on the community demand. Current needs assessment data has revealed the need for an expanded telemedicine program due to the need for timely specialist consults and care.

### Need for the project

As cited in the community needs assessment (CN.1), there is a shortage of specialty care providers: the demand for specialists exceeds available medical physicians in these areas, and prevents adequate access to specialized treatment for prevalent health conditions. There is currently a significant shortage of specialists in the region who are available to consult on and treat patients at Laredo Medical Center sites and those of its partners. Currently, distance is a major barrier in medical treatment for patients experiencing major medical conditions. Additionally, the region suffers from high prevalence of chronic conditions (CN.3), many of which can be better managed with appropriate specialist consultation. Finally, as a result of patients not receiving the care they need in a timely fashion, the region experiences high costs associated with preventable hospitalizations (CN.9).

### Target population

The target population would be patients presenting themselves to Laredo Medical Center or partnering outlying facilities which might need further evaluation by a higher level of care for radiology, neurology, psychiatry, and intensive care related needs. We expect to provide 14,000 to 15,000 consults, interpretations, or Intensive Care Unit patient day monitoring per year via telemedicine in DY 4 and in DY 5, of which an estimated 70% would be for low-income (Medicaid, indigent or uninsured) patients.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** 162033801.1.4

**Provider Name/TPI:** Laredo Medical Center / 162033801

**Category 1 or 2 expected patient benefits**

The project seeks to increase access to specialty services via telemedicine consults, interpretations, and patient monitoring in DY 4. Patients would benefit from:

- Timely specialist consults
- Better diagnoses and treatment plans
- Fewer unnecessary tests, transfers and ED visits
- Improved patient care
- Increased access to specialty services
- Fewer preventable ED visits/hospitalizations resulting from inadequate access to care

**Category 3 outcomes expected patient benefits**

We have selected the following **IT-4.13 Intensive Care: In-hospital mortality rate – (SA)**.

**Estimate of Project Valuation for DY 3 – DY 5**

**DY3: \$2,100,000**

**DY4: \$1,862,500**

**DY5: \$1,862,500**

**IGT Source**

Webb County via the Local Provider Participation Fund

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

**Project Description**

**Expand Primary Care Capacity in North West Laredo. Region is the second fastest growing area in Laredo and currently there are no Family Clinics in operation in immediate vicinity.**

**Intervention(s)**

**Improve access and facilitate prevention of disease. Focus on providing Immunizations, TB Screenings and Flu Shots to reduce non-emergent ER visits.**

**Need for the project (include RHP 20 Community Need No.)**

**NA**

**Target population**

**Clinic will focus on entire family. Target population is all residents in North West quadrant.**

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

**Category 1 or 2 expected patient benefits**

**Patient benefit will center among providing access to preventive care services which currently are not available in area.**

**Category 3 outcomes expected patient benefits**

**Increase number of residents immunized within community and decrease non emergent ER visits.**

**Estimate of Project Valuation for DY 3 – DY 5**

**\$2,000,000**

**IGT Source**

**Webb County via LPPF**

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

### Project Description

The overall goal is to increase the number of patients seen in a more appropriate level of care through implementation of patient navigation services and ED triage protocol. DHL's 3-year goal is to increase the number of primary care provider referrals for patients without a medical home who use the ED.

### Intervention(s)

Establish/Expand a Patient Care Navigation Program: Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care. This project establishes a patient navigator program to track, follow-up on and help manage care for chronically ill patients who have a history of frequently visiting the ED. A team of nurses would connect patients from our hospital to physicians so that patients can receive regular care in the primary care setting. In addition the patient navigator could assist patients without health insurance coverage to acquire appropriate coverage through Medicaid, the federal Health Care Exchange program, and other venues. The patient navigators would remotely monitor patients via frequent telephone check-ups to detect early signs of changes in a patient's condition as well as to make appropriate interventions and referrals to prevent unnecessary and costly ED and/or hospital visits.

### Need for the project (include RHP 20 Community Need No.)

As cited in the community needs assessment, there is a shortage of primary care capacity. As a result, patients tend to over utilize the emergency department for problems that a primary care provider could better treat, which is not desirable and often causes duplicative testing, hinders follow-up, and increases the risk of medical errors.

### Target population

The target population is non-urgent ED patients that do not have sufficient access to primary care. We expect to enroll at least 100 targeted patients in DY 3; 150 patients in DY 4 and 250 targeted patients in DY 5 into the patient navigator program. Of these enrollees, we expect approximately 60% will represent low-income (Medicaid, indigent and uninsured) patients.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

**Category 1 or 2 expected patient benefits**

DHL’s 3-year goal is to increase the number of primary care provider referrals for patients without a medical home who use the ED. We expect to enroll at least 100 targeted patients in DY 3; 150 patients in DY 4 and 250 targeted patients in DY 5 into the patient navigator program. Patients will benefit from access to a primary care provider and follow-up care, resulting in better patient outcomes and the prevention of avoidable ED visits. The expected benefits would include:

- Help patient better navigate the health care system to receive right care, right time, right place;
- Increase patient access to ongoing primary and chronic care;
- Provide care management and coordinated care;
- Provide access to health insurance coverage via Medicaid, Health Insurance Exchanges, etc.
- Improve at-risk patients’ health conditions; and

Reduce preventable ED and/or hospital visits.

**Category 3 outcomes expected patient benefits**

We have selected the following outcome:

Decrease utilization of ED for patients in the navigation program by 65% by helping them receive care through a primary care physician in the appropriate care setting

**Estimate of Project Valuation for DY 3 – DY 5**

**\$1,000,000**

**IGT Source**

**Webb County via LPPF**

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

### Project Description

Through the development of a mobile primary care unit, Laredo and surrounding communities will have the opportunity to access a variety of health resources in a timely and cost effective manner. Specifically, DHL will equip the mobile unit with capabilities that will offer preventive screenings particular to the RHP population. These screenings will begin with cardiac related studies to include: High Blood Pressure, Peripheral Arterial Disease, and Abdominal Aortic Aneurysm screenings. Radiology technicians capable of performing these studies will staff the clinic along with mid-level support. Radius of travel and clinic hours will be dependent on capabilities of the unit. The mobile clinic will look to expanding capabilities once implemented and will look at increasing its primary care capabilities in order to reach a bigger population within RHP 20.

### Intervention(s)

Expand mobile clinics. The Mobile Health Clinic will serve Laredo's primary service area, along with outreaching communities that might not have access to primary care services. DHL will identify a service area in which to deploy the mobile clinic in order to be most effective in reaching a larger population. The clinic will be set up to offer various primary care services, including screenings recommended by the American Heart Association.

### Need for the project (include RHP 20 Community Need No.)

There is inadequate access to primary and preventive care. Many patients have to drive long distances for medical services making distance a barrier. While the supply is lacking, the need is great: Many of the region's adults are overweight or obese. As a result, chronic disease rates are high: heart failure is among the top diseases resulting in hospitalization in RHP 20.

### Target population

The target population will be patients within our primary and secondary services areas that are unable to access appropriate care due to distance. We expect to provide 1,000 encounters through the mobile clinic in DY 3; 1,200 in DY 4 and 1,400 in DY 5; of which we expect approximately 40%, will be Medicaid, indigent or uninsured.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:**

**Provider Name/TPI:**

**Laredo Regional Medical Center, 23-2995413**

**Category 1 or 2 expected patient benefits**

Patients that would otherwise not have access to care due to distance; will now have the opportunity to receive primary care services, as evidenced by 1,000 encounters through the mobile clinic in DY 4 and 1,200 in DY 5. We expect patients to benefit from increased access to preventive and primary care, increased screenings and vaccinations/immunizations, more chronic care, improved health outcomes and fewer hospitalizations.

**Category 3 outcomes expected patient benefits**

We have selected the following outcome:

- IT- 12.6 Influenza Immunization – Ambulatory (NSA)  
Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization.
- IT – 1.21 Comprehensive Diabetes Care Lipid Testing (NSA)  
Percentage of patients 18 – 75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.
- IT – 1.22 Preventive Care & Screening: BMI Screening & Follow Up (NSA)
- 

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.

**Estimate of Project Valuation for DY 3 – DY 5**

**\$2,000,000**

**IGT Source**

**Webb County via LPPF**

## PROPOSED THREE YEAR DSRIP PROJECT

<b>Unique Project Identifier:</b>	<b>2.6.2 – Implement Evidence-based Health Promotion Programs (132812205.2.1)</b>
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<b>Provider Name/TPI:</b>	<b>Driscoll Children’s Hospital – 132812205</b>
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### Project Description

In collaboration with Driscoll Health Plan, Driscoll Hospital plans to expand a highly successful prenatal program that promotes healthy behavior and provides supports to low-income women with high-risk pregnancies. The Project focuses on improving maternity social and healthcare supports available to indigent women during pregnancy. The overall goal of the program is to reduce prematurity and thereby reduce admissions and days in the neonatal intensive care unit (NICU)

The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery. The baby showers focus on encouraging prenatal care, improving nutrition, promoting breast feeding, avoiding dangerous behaviors, and recognizing the signs and symptoms of premature labor. Pregnant women enrolled in Driscoll Children’s Health Plan are mailed an invitation each month of their pregnancy. After attending our baby shower sessions the participant will be educated on how to distinguish healthy choices during their pregnancy and recognize the negative impact of smoking, alcohol, and drugs can have on their health and comprehend the advantages of prenatal care and understand the complications that may occur during their pregnancy. Educational baby showers also recognize signs of preterm labor, and pre labor signs, and understand when medical intervention is needed. Nutritional advice can be reinforced or further advice can be sought from the dietitian, particularly for those with diabetes or gestational diabetes which comprise 13 percent of the population.

The consultation visits encourage postpartum care of the mother, timely infant care, successful breastfeeding, and good nutrition for the mother and the infant, consideration of family planning to gain appropriate birth spacing, and re-enrollment for continuing medical insurance coverage. The consult visitor can also teach important infant safety points like “back to sleep”, the importance of proper car seat use, the appropriate use of the medical office and the emergency room for medical issues. Convincing a mother to breast feed promotes further bonding to the new infant. This can be aided by having consultations with a certified lactation consultant. Breast fed infants have less visits to the physician for medical illness than those that bottle feed. Most mothers will consider delaying the next pregnancy until they wean the current infant.

### Intervention(s)

The goal of this project is to educate and provide support to low income women with high risk pregnancies in order to foster healthy pregnancies and better health outcomes for baby and mother. This goal will be achieved by expanding access to the Cadena de Madres program. The Project has two major components—a set of “educational” baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** 2.6.2 – Implement Evidence-based Health Promotion Programs (132812205.2.1)

**Provider Name/TPI:** Driscoll Children’s Hospital – 132812205

**Need for the project (include RHP 20 Community Need No.)**

Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU). Reduction in NICU inpatient days and pre-term births are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care.

**Target population**

This project will increase community participation and education through these services targeted to serve low-income populations. The program, called Cadena de Madres Project (Mother’s network), seeks to reduce low birth weight and premature deliveries in targeted Texas counties by providing enhanced educational and social support for indigent, predominately Hispanic, women considered to be high risk for adverse birth outcomes.

**Category 1 or 2 expected patient benefits**

This project aims to increase the number of prenatal education sessions (babyshowers), increase the number of plan participants, and increase the number of prenatal and postnatal consultations.

**Category 3 outcomes expected patient benefits**

Data suggest that alcohol, drugs, tobacco use, poor diet, and other chronic diseases like asthma and diabetes have a direct impact on pre-term births resulting in higher Neonatal Intensive Care Unit (NICU) utilization. Reduction in pre-term births with a resultant decrease in NICU days are keys to improving overall health care delivery and health outcomes in the region. This project will grow through community support and recognition for the need of quality information about healthy pregnancies, deliveries, and infant care. This project will increase community participation and education through these services targeted to serve low-income populations.

**Estimate of Project Valuation for DY 3 – DY 5**

**IGT Source**

## PROPOSED THREE YEAR DSRIP PROJECT

**Unique Project Identifier:** 132812205.1.2 (1.8.9 – The implementation or expansion of school-based fluoride varnish programs that provide fluoride varnish applications to otherwise unserved school-aged children

**Provider Name/TPI:** Driscoll Children’s Hospital – 132812205

### Project Description

Today, Driscoll Children’s Hospital collaborates with Driscoll Children’s Health Plan and Primary Care Provider (PCP) to offer dental fluoride varnish treatments to Medicaid-enrolled children in the office of their PCP. These services cannot be a school based intervention since these patients are infants to children up to age 3 years who are the target population. This intervention is designed to be done at the well child visit and in accordance with the American Academy of Pediatrics guidelines. These infants do not typically access a dentist at these young ages, but do see a PCP for immunizations and well child visits. This is the most convenient and cost effective setting for this intervention and does not require separate appointments or travel to another provider, like a dentist. The additional appointments or transportation to another provider would be problematic for this population. The intervention is also less expensive in this setting as an add-on to the well child visit. In addition, Driscoll can site examples of surgery interventions that could have been prevented prior to the school based setting. It is at this critical time that the intervention is most effective. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery.

### Intervention(s)

This project will improve access to oral health services for children by significantly expanding a successful Oral Health project that provides pediatric preventive dental care and education to patients in a primary care provider’s (PCP’s) office. By offering preventive dental care at the PCP office, more children will gain access to crucial preventative oral health care services, thereby reducing the incidence of serious oral health disease that often must be treated with surgery.

### Need for the project (include RHP 20 Community Need No.)

In Texas, less than 1 in 5 children between 6 to 36 months of age who are covered by Medicaid access dental care until dental caries are severe or the child experiences other medical conditions. In Medicaid populations, the incidence of dental caries approaches nearly 80%.

### Target population

The targeted population is 100% Medicaid. The Pediatric Oral Health program provides children in low-income households with a source of preventive and basic dental services while encouraging an ongoing relationship among PCP, parent, child, dentist, and dental program.

**PROPOSED THREE YEAR DSRIP PROJECT**

**Unique Project Identifier:** 132812205.1.2 (1.8.9 – The implementation or expansion of school-based fluoride varnish programs that provide fluoride varnish applications to otherwise unserved school-aged children

**Provider Name/TPI:** Driscoll Children’s Hospital – 132812205

**Category 1 or 2 expected patient benefits**

Increase, expand, and enhance oral health services performed by PCPs in the Driscoll’s delivery service area by percent over the baseline year. This would include but is not limited to increasing the number of participants and increasing the number of fluoride varnish applications.

**Category 3 outcomes expected patient benefits**

The outcomes of Pediatric Oral Health program are evidence that early intervention and education do play a significant role in preventing severe caries and the need for preventable surgeries. Dental cases comprised of approximately 30% of all cases performed in the operating room for Calendar Year 2011. Application of dental education and fluoride varnish treatments will prevent dental operating procedures. The preventive treatment of dental education and fluoride varnish versus dental operating room procedures creates significant value to our community.

**Estimate of Project Valuation for DY 3 – DY 5**

**IGT Source**