Executive Overview of RHP 4 Plan

Overview of Regional HealthCare Partnership 4/Coastal Bend Region

The 18 counties of Regional Healthcare Partnership (RHP) 4 are Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio and Victoria. This rapidly growing population of the Coastal Bend Region, home to 747,000, is relatively young, predominately Hispanic and is characterized by high poverty rates and high rates of adults without a high school education. The number of people in RHP 4 without health insurance ranges from approximately 19% (Aransas County) to 24% (San Patricio County).

Among the counties of the Coastal Bend Region, about 60% live in two counties – Nueces and Victoria. The municipalities of the Coastal Bend Region are very diverse, including some urban, but many very rural communities and numerous "colonias." Colonias are the unincorporated subdivisions comprised of small housing lots with little or no infrastructure occupied by individuals and families with very low incomes. These "neighborhoods" pose a potentially serious threat to public health and quality of life due primarily to their lack of appropriate infrastructure for wastewater and safe drinking water.

Key Health Challenges Facing RHP 4

The key health challenges of the Coastal Bend Region are rooted in extreme levels of economic and health disparities.

Access Barriers to Care

A lack of access to and utilization of needed health care services—across the region—is exacerbated by low levels of health insurance. In a state with the highest uninsured rate in the country, uninsured rates are even higher in some RHP 4 counties. In Brooks County, 54% of the residents are either uninsured or covered by Medicaid. Additionally, the region faces a shortage of primary care, specialists, behavioral health and dental professionals to serve a growing population, with eight counties in the region having four or fewer PCPs and two counties having none. Residents in rural areas are more likely to perceive barriers to health care access than those who live in urban areas.

These barriers to needed health and behavioral health services limit the capacity of the current delivery system to identify individuals with or at risk for chronic conditions and get them into appropriate programs to help prevent, diagnosis and manage their health conditions.

Chronic Diseases

The extreme levels of economic and health disparities contribute to the unprecedented epidemics of chronic disease—particularly diabetes and related chronic conditions—fueled by high levels of adult and childhood obesity. Federal surveys of the region find that 14.3% of adults have diabetes, compared to 9.7% for the state, and more than 26%[1] are obese. Regional

[1] http://apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?mode=OBS

hospital admissions and related data indicate that the prevalence of these and other chronic conditions including cancer, hypertension and cardiovascular disease lead to preventable hospitalizations.

Mental Health and Substance Abuse

In 2009, RHP 4 hospitals reported that schizoaffective disorder and manic depressive disorder were the third and fourth most common principal admission diagnosis for patients aged 18 to 49 years. About 23% of those responding to a telephone survey of residents stated they had depression, and 12.5 % reported that one of their children needed mental health services. At the same time, the 12 of the 18 counties in the region are a health professional shortage area for mental health professions, in a state that has the lowest per capita spending on mental health services in the country.

RHP 4's Vision for Healthcare Delivery System Transformation

The RHP 4 partners comprise a wide assortment of public and private institutions coming together to address the region's heavy burden of chronic disease and health disparities and its demonstrated need for enhanced access to primary and behavioral health care services. The overarching vision for the region includes the following goals:

- Leverage and improve on existing programs and infrastructure to ensure that the health care delivery system will be adequately developed to meet the primary and specialty care needs of residents throughout a growing, yet historically underserved region.
- Increase access to primary and specialty care services in the short-term, with a focus on individuals with chronic conditions, to ensure they have access to the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Nurture a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.
- Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.

RHP 4 DSRIP Projects to Support Delivery System Transformation

In response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region, RHP 4 has developed DSRIP projects designed to:

1. Expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.

2. Increase the availability of and access to behavioral health services by expanded mental health workforce capacity and the use of technologies to reach patients in rural communities to help prevent admission/readmission to inpatient psychiatric care.

3. Improve the integration of care for people with multiple chronic diseases, including those with co-occurring physical and behavioral health conditions as part of our region's transformation to a quality-based health care system.

4. Increase the capacity of safety net providers in the region to provide patient-centered care and care management, particularly for patients with chronic conditions, to improve health literacy, self-care management skills, and more effectively access or navigate the health care system appropriately.

Four Year Project Summaries

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
CHRISTUS Spohn Hospital Beeville	020811801.1.1	Implement a chronic disease registry to assist Spohn in tracking and managing patient with chronic conditions, with an initial focus on CHF and diabetes.	$860,860	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$232,211
CHRISTUS Spohn Hospital Beeville	020811801.1.2	Implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system	$1,045,330	IT-1.11 Diabetes care: BP control (<140/90mm Hg)	$237,821
CHRISTUS Spohn Hospital Beeville	020811801.1.3	Increase primary care access and capacity in Bee County and neighboring counties. Project goals include the site and space allocation for the proposed FHC and employment of clinic providers and staff to support 5 days/week operation.	$1,932,757	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	$263,729
CHRISTUS Spohn Hospital Beeville	020811801.2.1	Implement Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl) within Spohn's Beeville provider facilities.	$676,391	IT-4.10 Sepsis bundle (NQF 0500)	$226,601
CHRISTUS Spohn Hospital Beeville	020811801.2.2	Implement large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. Integration between Pharmacy, IT and Nursing resulting in all doses of medications given to patients in Spohn's Beeville locations having viable barcodes that are read into the Meditech informatics system.	$430,430	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$219,120
CHRISTUS Spohn Hospital Beeville	020811801.2.3	Implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into the health information system (Meditech) to reduce	$430,430	IT-4.5 Patient Fall Rate	$219,121

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
		process times, improve accuracy, reduce validation/ verification calls to units, and reduce costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.			
CHRISTUS Spohn Hospital Beeville	020811801.2.4	Expand Care Transitions program to focus on preventing readmissions for CHF and diabetes patients.	$922,349	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$234,081
CHRISTUS Spohn Hospital Beeville	020811801.2.5	Implement a screening and treatment protocol in EDs and Family Health Centers to identify patients with dual diagnoses (medical and behavioral health) and assign a case manager to coordinate their care.	$922,349	IT-9.4.b Reduce Emergency Department visits for Diabetes	$234,081
The Corpus Christi Medical Center - Bay Area	020973601.1.1	Expand the number of primary care providers at the Amistad Community Health Center by 2 from the baseline. Amistad Community Health Center is an FQHC.	$4,662,663	IT-1.10 Diabetes care: HbA1c poor control (>9.0%) , IT-1.7 Controlling high blood pressure	$2,493,418
The Corpus Christi Medical Center - Bay Area	020973601.1.2	Expand the existing family practice/ internal medicine residency program by increasing the approved residency positions by 8 and increasing the enrollment by 6. The project will also expand residency coverage to both major campuses and increase the rotations through local continuity of care clinics. Also, develop a community health worker program.	$4,144,589	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$2,324,479
The Corpus Christi Medical Center - Bay Area	020973601.1.3	Expand the existing family practice/ internal medicine residency program to include Fellowship Training in 2 high impact specialties.	$4,144,589	IT-3.17 Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	$3,124,653
The Corpus Christi Medical Center - Bay Area	020973601.1.4	Add a partial hospitalization program (PHP) and additional intensive outpatient programs (IOP) to our existing compliment of behavioral health services	$4,403,626	IT-3.15 Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate	$2,824,795

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
The Corpus Christi Medical Center - Bay Area	020973601.1.5	Implement a chronic disease management registry for one or more targeted chronic diseases.	$3,772,045	IT-3.22 Risk Adjusted All-Cause Readmission	$1,989,260
The Corpus Christi Medical Center - Bay Area	020973601.2.1	Develop evidence based standardized protocols around improving the transition of care from an inpatient hospital to an ambulatory setting. Address effective communication with patient and family, discharge instructions and education, barriers to chronic disease management, and proper identification and placement with a primary care physician	$4,662,663	IT-3.22 Risk Adjusted All-Cause Readmission	$2,509,177
The Corpus Christi Medical Center - Bay Area	020973601.2.2	Implement Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl) within Spohn's Beeville provider facilities.	$4,403,626	IT-4.10 Sepsis bundle (NQF 0500)	$2,809,034
Refugio County Memorial Hospital District	020991801.1.1	Expand the primary care capabilities of the Refugio County Rural Health Clinic. (1) increase the number of hours the clinic will be open; (2) renovate and create space to accommodate additional pts.; and (3) hire an additional physician.	$1,206,513	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	$441,351
Coastal Plains Community Center	080368601.2.1	Partner with 2 non-profit organizations, the FQHC and the Council on Alcohol and Drug Abuse, to integrate primary healthcare and substance abuse services at 5 Behavioral/Mental Health Clinics using the 4-Quadrant Model.	$12,582,690	IT-1.10 Diabetes care: HbA1c poor control (>9.0%) , IT-1.7 Controlling high blood pressure	$1,458,810
DeTar Hospital Navarro	094118902.1.1	Provide the first intensive outpatient program for behavioral health patients in Victoria County.	$3,168,349	IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons, IT-9.4.e Reduce	$1,527,523

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
				Emergency Department visits for Behavioral Health/Substance Abuse	
DeTar Hospital Navarro	094118902.1.3	Implement a family practice residency program in Victoria, TX. These residents and faculty will help fill an existing shortage with clinical rotation requirements.	$5,640,000	IT-14.6 Percent of trainees who have spent at least 5 years living in a health- professional shortage area (HPSA) or medically underserved area , IT-14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey , IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey	$1,344,683
DeTar Hospital Navarro	094118902.2.1	Provide clinics in 5 counties that are Medicaid underserved and/or HPSA/MUAs to increase access to care.	$2,737,752	IT-1.13 Diabetes care: Foot exam , IT-1.21 Adult Body Mass Index (BMI) Assessment , IT-1.23 Tobacco Use: Screening & Cessation , IT-1.7 Controlling high blood pressure	$1,703,730
DeTar Hospital Navarro	094118902.2.2	Provide prenatal clinics in 5 counties that are Medicaid and/or MUAs	$1,445,249	IT-8.1 Timeliness of Prenatal/Postnatal Care, IT-8.2 Percentage of Low Birth- weight births	$1,269,683
CHRISTUS Spohn Hospital Alice	094222902.1.1	Increase the space, hours and staffing of Spohn Alice's primary care clinic currently located in Freer, TX.	$1,039,838	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	$249,011
CHRISTUS Spohn Hospital Alice	094222902.1.2	Implement a Chronic Disease registry to assist Spohn in tracking and managing pts. with chronic conditions.	$1,039,838	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$249,011
CHRISTUS Spohn Hospital Alice	094222902.1.3	Implement a system for early detection and ongoing treatment of peripheral arterial disease (PAD) in Region 4 using a new telemedicine disease management system.	$1,262,661	IT-1.11 Diabetes care: BP control (<140/90mm Hg)	$255,788

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
CHRISTUS Spohn Hospital Alice	094222902.2.1	Implement large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. Integration between Pharmacy, IT and Nursing resulting in all doses of medications given to patients in Spohn's Beeville locations having viable barcodes that are read into the Meditech informatics system.	$519,919	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$233,198
CHRISTUS Spohn Hospital Alice	094222902.2.2	Implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into the health information system (Meditech) to reduce process times, improve accuracy, reduce validation/ verification calls to units, and reduce costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.	$519,919	IT-4.5 Patient Fall Rate	$233,200
CHRISTUS Spohn Hospital Alice	094222902.2.3	Implement Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl) in Spohn's Alice provider facilities.	$817,015	IT-4.10 Sepsis bundle (NQF 0500)	$242,235
CHRISTUS Spohn Hospital Alice	094222902.2.4	Implement a screening and treatment protocol to identify patients with medical (CHF and diabetes) and behavioral health dual diagnoses and assign a case manager to coordinate their care.	$1,188,386	IT-9.4.b Reduce Emergency Department visits for Diabetes	$251,270
CHRISTUS Spohn Hospital Alice	094222902.2.5	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	$1,114,112	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$251,270
CHRISTUS Spohn Hospital Alice	094222902.2.6	Provide licensed mental health provider in the Freer clinic in order to integrate the treatment of physical and behavioral conditions into one location.	$1,114,112	IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse	$253,529

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
Yoakum Community Hospital	112673204.1.1	Create an outpatient clinic and hire primary care physicians and other staff necessary.	$788,887	IT-1.11 Diabetes care: BP control (<140/90mm Hg)	$178,803
Yoakum Community Hospital	112673204.1.2	Increase capacity to provide specialty care services in cardiology, nephrology, gynecology and/or obstetrics.	$664,327	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$175,219
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.1	Increase the space, hours and staffing for Spohn Corpus Christi's primary care clinics in order to serve additional patients.	$7,559,569	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	$1,753,982
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.2	Implement a Chronic Disease registry to assist Spohn in tracking and managing pts. with chronic conditions which will initially focus on pts. with CHF and diabetes.	$6,225,528	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$1,713,411
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.3	Implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in Region 4, using a new telemedicine disease management system that allows specialist input at primary care provider offices.	$7,559,569	IT-1.11 Diabetes care: BP control (<140/90mm Hg)	$1,753,982
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.4	Develop a team of intensivists (physicians with training in critical care medicine) within the hospital to provide care of critically ill patients.	$6,670,209	IT-4.2 Central line-associated bloodstream infections (CLABSI) rates	$1,726,935
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.5	Relocate the Psychiatric Assessment unit currently located at CSHCC-Memorial to its Hector P. Garcia Family Health Center. In addition, the relocated crisis stabilization unit will pool resources with the existing MHMR mobile crisis stabilization team in order to comprehensively redesign the provision of behavioral health care.	$8,448,931	IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse	$1,781,029
CHRISTUS Spohn Hospital Corpus Christi	121775403.1.6	With Texas A&M University's Corpus Christi's College of Nursing, increase the number of psychiatric mental health mid-levels in the	$6,670,209	IT-1.18 Follow-Up After Hospitalization for Mental Illness	$1,726,935

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
		RHP by expanding TAMUCC's existing MSN – NP program to include the Psychiatric Mental Health track.			
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.1	Adapt and disseminate AT&T's mobile application that offers instant feedback via text messaging, coaching, and patient/provider web portals as a patient self-management tool to reduce HbA1c in patients with Type 2 diabetes. Patients using the application will receive quarterly biometric screenings at the clinics (their medical home) as part of the program.	$7,114,889	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$1,740,458
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.10	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	$6,670,209	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$1,726,935
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.11	Transform the CHRISTUS Spohn Health System's ("CSHS") culture of safety and efficiency within its three CSHCC facilities and its three community facilities (Spohn Beeville, Spohn Alice, and Spohn Kleberg).	$13,668,787	IT-4.1 Improvement in risk adjusted Potentially Preventable Complications rate(s)	$1,959,130
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.2	Establish a clinically integrated Hospitalist model through which patients admitted to the hospital as inpatients will be assigned to a multidisciplinary team headed by a hospitalist who will remain the assigned provider for the patient throughout hospitalization and transition the care coordination post-discharge.	$5,336,166	IT-4.2 Central line-associated bloodstream infections (CLABSI) rates	$1,686,364
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.3 updated to 121775403.1.7	Redesign the Family Practice Residency Program to focus less on hospitalist training and instead assign the residents to panels of patients and provider teams, and to provide hands-on care in Spohn's family health centers ("FHCs").	$5,336,166	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$1,686,364

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.4	Work with Nueces MHMR to provide a Licensed Mental Health Provider (LMHP) for at least one of its Family Health Clinics (FHC) in order to integrate the treatment of physical and behavioral conditions into one location.	$7,114,889	IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse	$1,740,458
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.5	Implement a screening and treatment protocol in EDs and Family Health Centers to identify patients with dual diagnoses (medical and behavioral health) and assign a case manager to coordinate their care.	$5,780,847	IT-9.4.b Reduce Emergency Department visits for Diabetes	$1,699,888
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.6	Implement the Medical Home Model in the local community clinic called Hector P. Garcia, where Spohn's physician-residents provide care	$7,114,889	IT-9.4.a Reduce Emergency Department visits for Congestive Heart Failure	$1,740,458
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.7	Implement large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. Integration between Pharmacy, IT and Nursing resulting in all doses of medications given to patients in Spohn's Beeville locations having viable barcodes that are read into the Meditech informatics system.	$3,112,763	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$1,618,747
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.8	Implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into the health information system (Meditech) to reduce process times, improve accuracy, reduce validation/ verification calls to units, and reduce costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.	$3,112,763	IT-4.1 Improvement in risk adjusted Potentially Preventable Complications rate(s)	$1,618,747

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
CHRISTUS Spohn Hospital Corpus Christi	121775403.2.9	Implement Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl) in Spohn's Alice provider facilities.	$4,891,485	IT-4.10 Sepsis bundle (NQF 0500)	$1,672,841
Memorial Hospital	121785303.1.1	increase primary care capacity by expanding the service hours of the Wielder Medical Clinic.	$520,908	IT-9.2.a Emergency Department (ED) visits per 100,000	$89,357
Memorial Hospital	121785303.1.3	Initiate a telemonitoring program for patients with chronic disease using multiple biometric devices to monitor weight, blood pressure, blood glucose, oxygen saturation and/or peak flow.	$347,190	IT-1.7 Controlling high blood pressure	$57,232
Jackson Healthcare Center	121808305.1.1	Expand specialty care capacity by establishing an outpatient pulmonary rehabilitation clinic.	$1,300,000	IT-9.4.f Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease	$575,000
Camino Real Community Services	121990904.1.1	Implement a Mobile Crisis Outreach Team to provide behavioral health crisis intervention services to patients in the Karnes County service area 24/7	$125,339	IT-11.26.d Children and Adolescent Needs and Strengths Assessment	$68,809
Camino Real Community Services	121990904.2.1	Integrate behavioral health and physical health services for clients served in Karnes County.	$877,580	IT-11.14 Annual Physical Exam for Persons with Mental Illness , IT-11.26.e.i Patient Health Questionnaire 9 (PHQ-9)	$68,809
Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services	126844305.2.1	With Gonzales Memorial hospital and FQHC, implement navigation project for ED frequent users	$1,203,064	IT-9.2 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000	$160,738

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
Corpus Christi-Nueces County Public Health District	130958505.1.2	With Diabetes Community Coalition of the Coastal Bend, implement a comprehensive system to include electronic medical records (EMR), an HIE and coordinated care record (CCR) in key community based health clinics and diabetes self-management education and support programs, creating a disease management registry for Nueces County.	$3,118,375	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$411,500
Corpus Christi-Nueces County Public Health District	130958505.2.1	Create Diabetes Care Teams consisting of both Certified Diabetes Educators (CDEs) and Community Health Workers (CHWs) working through community	$2,601,366	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$411,500
Corpus Christi-Nueces County Public Health District	130958505.2.2	Address obesity epidemic in children by applying scientifically sound method (MEND - Mind, Exercise, Nutrition…Do It!) for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits.	$7,401,720	IT-10.1.a.v Pediatric Quality of Life Inventory (PedsQL)	$411,500
Corpus Christi-Nueces County Public Health District	130958505.2.3	Implement the hiring, training and deployment of culturally competent Patient Navigators as patient care coordinators at seven (7) Community Health Centers and/or Public Health Clinics. The Patient Navigator's role will be to work in close collaboration with the staff at the community health centers and public health clinics to refer and connect the target population, individuals at high risk of disconnect from institutionalized health care (i.e., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others), to patient-centered community based support	$1,751,669	IT-1.7 Controlling high blood pressure	$411,500

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
		programs for disease prevention and/or chronic disease management.			
Driscoll Children's Hospital	132812205.1.1	Expand primary care capacity by extending clinic after-hours and increasing the number of patient visits at Driscoll's Urgent Care Center and selected clinics.	$11,242,000	IT-6.1.d.i CG-CAHPS Visit Survey 2.0: Timeliness of Appointments, Care, & Information, IT-9.5 Reduce low acuity ED visits	$1,358,634
Driscoll Children's Hospital	132812205.1.2	Expand an oral health project through which pediatric preventive dental care and education are provided to patients in a primary care provider's office.	$11,272,443	IT-7.12 Oral Evaluation: Children , IT-7.16 Preventive Services for Children at Elevated Caries Risk, IT-7.20 Per Member	$1,202,388
Driscoll Children's Hospital	132812205.1.3	Expand access to pediatric endocrinology services.	$10,474,040	IT-1.1 Third next available appointment , IT-6.1.d.ii CG-CAHPS Visit Survey 2.0: Provider Communication	$989,090
Driscoll Children's Hospital	132812205.1.4	Provide behavioral health services through telemedicine to children and adolescents with limited access to these services.	$4,324,839	IT-1.18 Follow-Up After Hospitalization for Mental Illness	$923,938
Driscoll Children's Hospital	132812205.1.5	The Maternal-Fetal Medicine (MFM) program specializes in the diagnosis and treatment of women with complications of pregnancy; pre-existing medical conditions which may be impacted by pregnancy; and medical conditions which impact the pregnancy itself.	$13,412,500	IT-8.13 NICU days/delivery	$1,376,211
Driscoll Children's Hospital	132812205.2.2	Educate and provide support to low-income women with high-risk pregnancies through "educational" baby showers, nutritional and lactation consultations, and a series of consultation visits after delivery.	$11,502,830	IT-8.12 Pre-term birth rate	$1,298,662
Driscoll Children's Hospital	132812205.2.3	High Risk Infant Follow-up Program to assist pediatricians and families in follow-up care for infants and young children who are at high risk for	$3,925,193	IT-10.5 Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)	$1,084,661
Lavaca Medical Center	135233809.1.1	Provide greater access to primary care services.	$297,532	IT-1.13 Diabetes care: Foot exam , IT-1.21 Adult Body Mass Index (BMI)	$108,844

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
				Assessment , IT-1.23 Tobacco Use: Screening & Cessation	
Gulf Bend Center	135254407.1.2	Expand and enhance the psychiatric and behavioral health telemedicine services already provided by Gulf Bend in its service area in an effort to enhance and improve treatment for individuals with behavioral health conditions.	$1,074,410	IT-6.2.d.xiv PSQ-18 Access, Availability, & Convenience	$465,682
Gulf Bend Center	135254407.2.1	Implement person-centered behavioral health medical home, Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails.	$5,035,400	IT-2.7 Behavioral Health/Substance Abuse (BH/SA) Admission Rate	$508,379
Otto Kaiser Memorial Hospital	136412710.1.1	Implement neuro telemedicine in the ED to provide patient access to neurologists to provide better care and improved outcomes for stroke patients	$517,791	IT-3.12 Stroke (CVA) 30-day Readmission Rate , IT-4.17 Stroke - Thrombolytic Therapy	$267,072
CHRISTUS Spohn Hospital Kleberg	136436606.1.1	Implement a Chronic Disease registry to assist in tracking and managing patients with CHF and diabetes	$901,467	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$207,055
CHRISTUS Spohn Hospital Kleberg	136436606.1.2	Implement a system for early detection and ongoing treatment and management of peripheral arterial disease (PAD) in RHP4, using a new telemedicine disease management system that allows specialist input at PCP offices	$1,094,639	IT-1.11 Diabetes care: BP control (<140/90mm Hg)	$212,930
CHRISTUS Spohn Hospital Kleberg	136436606.2.1	Implement large scale medication management project to improve the delivery of medication to hospital patients, to improve the quality of care and reduce inadvertent errors. Integration between Pharmacy, IT and Nursing resulting in all doses of medications	$450,733	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$193,347

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
		given to patients in Spohn's Beeville locations having viable barcodes that are read into the Meditech informatics system.			
CHRISTUS Spohn Hospital Kleberg	136436606.2.2	Implement Computerized Patient Order Management (CPOM) enabling providers to directly enter orders into the health information system (Meditech) to reduce process times, improve accuracy, reduce validation/ verification calls to units, and reduce costs of healthcare through reduced duplication in tests, labor cost savings, more efficient processes, and earlier patient discharges.	$450,733	IT-4.5 Patient Fall Rate	$193,348
CHRISTUS Spohn Hospital Kleberg	136436606.2.3	Implement Sepsis Resuscitation and Sepsis Management Bundles as treatment for severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl) in Spohn's Alice provider facilities.	$708,295	IT-4.10 Sepsis bundle (NQF 0500)	$201,180
CHRISTUS Spohn Hospital Kleberg	136436606.2.4	Expand care transitions program to focus on preventing readmissions for CHF and diabetes.	$965,857	IT-3.3 Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	$209,013
CHRISTUS Spohn Hospital Kleberg	136436606.2.5	Implement a screening and treatment protocol in EDs and Family Health Centers to identify patients with dual diagnoses (medical and behavioral health)and assign a case manager to coordinate their care.	$965,857	IT-9.4.b Reduce Emergency Department visits for Diabetes	$209,013
Citizens Medical Center	137907508.1.1	Expand primary care capacity in the Victoria area. The Medical Center's collaboration with a recently established FQHC in Victoria will serve to expand overall primary and preventive care capacity.	$4,579,937	IT-12.7 Influenza Immunization-Inpatient, IT-9.10.a Median Time from ED Arrival to ED Departure for Discharged ED Patients, IT-9.10.b Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status, IT-9.10.c Median time from ED arrival to time of departure from the emergency room	$1,334,117

Provider Name	Unique Project ID	Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
				for patients admitted to the facility from the ED	
Citizens Medical Center	137907508.2.1	Deploy LEAN Methodology hospital wide	$6,869,906	IT-4.3 Catheter-associated Urinary Tract Infections (CAUTI) rates , IT-4.8 Sepsis mortality	$1,334,117
MHMR of Nueces County	138305109.2.1	Incorporate primary preventive care into existing behavioral health care system.	$5,478,358	IT-1.25 Adult tobacco use , IT-1.7 Controlling high blood pressure	$1,393,382
MHMR of Nueces County	138305109.2.2	Peer to peer day center program to increase access to peer provided behavioral health services through "drop in" center.	$860,962	IT-11.5 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	$374,761
MHMR of Nueces County	138305109.2.3	Implement innovative system for outreach and education to include website and mobile applications.	$517,956	IT-1.18 Follow-Up After Hospitalization for Mental Illness	$374,761
MHMR of Nueces County	138305109.2.4	Provide a dual diagnosis clinic to provide outpatient crisis prevention and support staff development using National Association of Dual Diagnosis (NADD) direct support certification and clinical competency standards for individuals with a dual diagnosis of intellectual or developmental disability (IDD) and mental health (MH).	$2,372,665	IT-11.26.b Aberrant Behavior Checklist (ABC)	$702,678

Three Year Project Summaries

Performing Provider Name	Project ID	Brief Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
Gonzales Healthcare Systems	121785303.1.100	Implement a continuous glucose monitoring system that will allow providers to discover patterns or trends in diabetic patient glucose control that are not evident by patient self-testing or routine laboratory studies.	$22,671	IT-1.10 Diabetes care: HbA1c poor control (>9.0%)	$48,532
Citizens Medical Center	137907508.1.100	This project will implement an extended behavioral health observation unit in Victoria and the surrounding area of Region 4 to better accommodate the behavioral health and crisis stabilization needs of the regional patient population and community. The Medical Center's collaborative effort with Gulf Bend Center, a Local Mental Health facility, also located in Victoria, TX, will provide a safe and secure environment for short-term stabilization of patients presenting in emergency rooms exhibiting behavioral health symptoms that may or may not require a continued stay in an inpatient care facility.	$2,580,000	IT-9.4.e Reduce Emergency Department visits for Behavioral Health/Substance Abuse	$1,160,013
Citizens Medical Center	137907508.1.101	This project will support improved access to prenatal care in the Victoria area of Region 4 to better accommodate the healthcare needs of the regional patient population and community. The Medical Center's association with a recently established Federally Qualified Health Clinic (FQHC) which opened on 10/01/12, in Victoria will facilitate improved prenatal care access, since the project will include collaboration with surrounding area physicians and the FQHC.	$2,580,000	IT-8.2 Percentage of Low Birth- weight births	$1,160,013
MHMR of Nueces County	138305109.1.100	This project aims to utilize the current service design in an expanded capacity to provide	$1,231,374	IT-11.26.b Aberrant Behavior Checklist (ABC)	$374,762

Performing Provider Name	Project ID	Brief Project Description	Tentative Cat 1-2 Value	Category 3 Selection	Tentative Cat 3 Value
		routine health services to individuals currently on a waiting list for services. The project will enhance service availability to potentially eliminate the waiting list for IDD safety net services by expanding capacity in community based settings to accommodate and eliminate the waiting list.			
MHMR of Nueces County	138305109.2.100	This project aims to utilize community health workers/case managers as patient navigators to provide enhanced social support and culturally competent care to vulnerable/and or high risk patients. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.	$1,304,397	IT-11.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD) , IT-11.13 Assignment of Primary Care Physician to Individuals with Schizophrenia, IT-11.14 Annual Physical Exam for Persons with Mental Illness	$421,607