Section II
DSRIP Project Summary 8/15/12

Project Title	Brief Project Description	Five-year Goals	Estimated Incentive Amount (DSRIP)
Category 1 Infrastructure Development			
1.1 Expand primary and specialty care access **Collin County Adult Clinic** (more info to come)	To address the needs of the indigent, uninsured and under-insured, Collin County Adult Clinic is making major changes to expand access to primary and specialty care by expanded use of both its existing clinic facilities—East and West.	None given	
1.1 Expand Primary Care Capacity **Plano Children's Medical Clinic** (more info to come)	We would like to employee staff (nurse practitioner, medical assistant and front desk) in order for us to expand our hours of service and offer a medical home to those who are uninsured. Depending on population needs will determine if we expand the hours in the Plano and/or the Wylie offices. Both offices currently see patients 5 days a week with the Plano office having 2 providers everyday and the Wylie office having 1 provider 5 days a week in addition to a provider 3 days a week.	Through the proactive management of referrals and provider panels, patients will have an open provider to accept patients for preventative care as well as urgent care. Emergency Department-based urgent care utilization and associated costs will also decline.	
1.1 Expansion of Project Access-Collin County **Baylor Health Care System**	**Baylor Health Care System** will provide support to Project Access-Collin County through the provision of services in the hospital setting for the underserved population. **Baylor Health Care System** and affiliated physicians will provide labs, diagnostics, minor procedures, imaging, etc. through its hospital in RHP 18 to serve a greater number of patients in the RHP 18 area. In exchange for these services, **Baylor Health Care System** would receive payment at a predetermined rate to fund these hospital based services.	The expansion of Project Access- Collin County would allow a greater number of patients to receive both primary and specialty care services in the RHP 18 region. **Baylor Health Care System** would provide more of the specialty and hospital based ancillary services, as little to no **Baylor** primary care charity capacity exists in RHP 18.	
1.1 Baylor Community Care Clinic Partnership with Douglass Community Clinic **Baylor Regional Medical Center at Plano**	**Baylor Regional Medical Center at Plano** has plans to partner with the Douglass Community Center to establish a clinic for the underserved population in **East Plano**. There is a lack of primary care available in the area and underserved patients have a high prevalence of diabetes and other chronic diseases. **Baylor Regional Medical Center at Plano** would help to develop the operations, processes, protocols and potentially supply providers for this clinic. 21% of the patients with diabetes have Medicaid or are uninsured and are unable to access any primary care.	The goal of this project would be to establish a primary care setting for the underserved population in the Douglass Community area with the potential to expand services depending on need and funding.	

1.1 Open COPCs after hours and on weekends **Centennial Medical Center Frisco**	Adding additional physicians through 501a in order to meet growing community need for OB/GYN, FP, IM and Pediatrics Ensuring that physician placement is based on patient need Developing program to direct from ED settings to appropriate care settings with expanded hours with PCP physicians Expand Urgent Care service hours to meet growing need and re-direct from Emergency Departments Partnership with Frisco Cares Clinic	By expanding the primary care capacity for the community, we are better able to provide the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients	
1.1 Add POPC **Centennial Medical Center Frisco**	Increase the COPC after hours clinic availability Increase the COPC weekend hour availability	By increasing the number of available hours in COPCs, the opportunity for care to be provided at time that is right for patients and communities becomes a priority in the overall plan for care. Increase utilization of ANP's	
1.1 Add COPC and Open COPCs after hours and weekends **Lake Pointe Medical Center Rowlett**	Add PCPs through 501a and recruitment (all will accept Medicaid) in order to meet growing community need for OB/GYN, FP, IM and Pediatrics. Place physicians based on patient/population need. Enhance current efforts to direct patients from ED setting to more appropriate, cost effective care settings with expanded hours and PCP access. Expand Urgent Care Center(s) and COPC(s) service hours (accepting Medicaid) to include evenings and weekends and potentially access points to meet growing need and re-direct from EDs.	By expanding the primary care capacity for the community, we are better able to provide the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients. Additionally, through planned PCP engagement on medical home certification and population health techniques, we anticipate on-going PCP interaction will have long-term positive (reduction) impact on ED and acute care growth trend among targeted populations.	
1.1 Increase Hours and Add Locations for Urgent Care; Subsidize Medicaid/uninsured **Lake Pointe Medical Center Rowlett**	Expand the hours available at urgent care center(s) Expand the COPC slots available to patients for episodic care Document hospital support for additional Medicaid/Uninsured care	Expanding the capacity in hours, clinics, or slots drives the opportunity to improve health care (wellness, appropriate chronic disease management, etc.) and better accommodate the needs of the population and community given increase choice and increase opportunities to choose a secure environment.	
1,1Expand Primary Care Capacity **The Medical Center of Plano**	The Medical Center of Plano will expand a dedicated pediatric provider in an outpatient clinic to see Medicaid and Uninsured pediatric patients and develop a referral process to ensure patients are seen for appropriate follow up but also for preventative and well care.	Through the proactive management of referrals and provider panels, patients will have an open provider to accept patients for preventative care as well as urgent care. Emergency Department-based urgent care utilization and associated costs	

		will also decline.	
1.2 Increase Training of Primary Care Workforce			
1.3 Implement & Utilize Disease Management Registry Functionality			
1.4 Enhance Interpretation Services and Culturally Competent Care			
1.5 Collect Accurate Race, Ethnicity, & Language (REAL) Data to Reduce Disparities			
1.6 Enhance Urgent Medical Advice			
1.7 Expand/establish telemedicine/telehealth program to help fill significant gaps in services. **Lakes Regional MHMR Center**	Lakes Regional MHMR Center proposes to introduce Telemedicine System/Program technology into Rockwall county by implementing high speed data-lines and server based video management technology for a Tele-video/Telemedicine Infrastructure System/Program. The system will provide high definition video/audio transmission between Lakes locations and other provider sites to establish telemedicine/telehealth program to help fill significant gaps in services. The Telemedicine System/Program will enable an expansion of Lakes Regional MHMR Center's capacity to deliver Behavioral Health Services including Psychiatric Service Support to multiple MH and SUD Centers. These capabilities will support the expansion of direct services to individuals served in the mental health programs and introduce new opportunities for clinical supervision; multi-clinic staff collaboration in service delivery. High-speed data-line connectivity and Telemedicine Lab Implementation Sites will include the MH Center in Rockwall, and other participating provider sites as required. Server based telemedicine technology will allow for the management of high speed data-line networked and internet cloud connectivity between multiple Telemedicine Lab sites and mobile devices.	A significant reduction in service gaps and a measurable expansion of capacity to deliver Behavioral Health and Health and Wellness Services through server based, I-cloud capable, high definition telemedicine technology (Telemedicine Infrastructure System/Program). Expansion of access to Specialty Care, specifically Psychiatric Care to underserved populations in rural counties. Through the Telemedicine Program, expand the availability of Behavioral Health Services by other Licensed Providers to underserved populations in rural counties. Expand the capabilities of clinical supervision, training, and mentoring to less credentialed clinicians in remote areas. Enhance the Telemedicine program by creating the capability of consultation with primary care providers andother health professionals according to individual case need.	
1.7 Telemedicine Infrastructure **LifePath Systems**	This project will create the capacity for expanded services in Collin County's rural areas or other special situations where a psychiatrist or medical professional may be required but is not on site.	Collin County currently qualifies as a "Medically Underserved Area" according to the Health Resources and Service Administration (HRSA), a division of the US Department of Health and Human Services. Medically Underserved Areas (MUAs) may be a whole county or a group of contiguous counties, a group of county or civil	

		divisions or a group of urban census tracts in which residents have a shortage of personal health services. Medically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care. Texas Medicaid currently allows & reimburses for telemedicine services in underserved areas. Our goal is to expand access to BH services in Collin County by implementing telemedicine technologies and establishing telemedicine procedures in all BH clinics. This project will enhance service availability to individuals that live in rural areas of the county and who experience difficulty in accessing behavioral health services. By making outpatient BH services available via telemedicine to Collin County's rural areas, LifePath is able to offer expanded behavioral health services to a larger portion of the population, while managing the costs of psychiatric services.	
1.7 Tele-health expansion and coordination in specialty areas **Centennial Medical Center Frisco**	Establish telemedicine program for selected medical service line	By understanding the community needs by assessments, you can expand the most impacted areas for access for patients by teleconferencing.	
1.7 Tele-health Expansion and Coordination in Specialty **Lake Point Medical Center Rowlett**	Establish telemedicine program/access for selected medical service line based on population health needs Create telemedicine access points where there is currently the greatest need as shown by our community need assessment	By better understanding the community needs for specialist care, you can expand the most impacted areas for patients through cost effective use of telemedicine technologies.	
1.7 Introduce, Expand, or Enhance Telmedicine/Telehealth **The Medical Center of Plano**	Providers are not able to obtain timely consults for patients in acute conditions thus delaying care or requiring transfers to other providers resulting in further delays and unnecessary costs. By establishing a telemedicine program, providers and patients will have increased access to specialty care for acute and emergent conditions. Telemedicine will support efforts to enhance, expand and improve the efficiency and timeliness of specialty care services in the community	Increase access and timeliness of access to specialty care and emergency evaluation services will allow patients to be treatment timely and appropriate setting and reduce transfer to other providers	
1.8 Specialty Care Access Expansion **Baylor Health Care System Hospitals**	Create increased capacity for providing specialty care services to a greater number of patients as well as develop a funding mechanism to reimburse/incentivize private practices and hospitals in the **Collin County** area. **Baylor Health Care System hospitals** would provide specialty care services to the uninsured and underinsured populations. Specialty services may include labs, testing, diagnostics, radiology and certain procedures.	The overall goal of this project is to serve a greater number of the uninsured/underserved patient population that exists in the **Collin County** area. By increasing the availability and quantity of specialty care services in the outpatient and inpatient settings, patients will have more options to receive care and do so in a timely manner in	

		order to facilitate improved clinical outcomes and fewer exacerbations of certain conditions. Additionally, this service will also decrease the volumes of specialty care services that would need to be provided by **Collin County and other underserved entities.**	
1.9 Improve & Expand Quality Services through Implementing Electronic Health Record System (EHR) **Texoma Community Center**	Implement an Electronic Health Record System (EHR) that will vastly enhance clinicians' ability to provide collaborative behavioral health treatment and concurrent documentation, and in turn enhance individuals' access to treatment across the service area.	Expand & improve electronic telehealth services to facilitate access, collaborative treatment and concurrent documentation and expand number of patients served by increasing efficiency through implementing EHR in all TCC facilities. This project is essential to improve treatment quality, reduce risk of fraud, improve patient satisfaction, and enhance the quality, efficiency, accuracy, and access to medical and/or treatment data for individuals accessing public mental health in an extremely under-funded rural service area. Developing Texoma Community Center's infrastructure will also increase medical safety for patients by improving efficiency and reducing health disparities	$241,336
1.9 Enhance & Improve Quality Services through Implementing a Comprehensive Telecommunication System **Texhoma Community Center**	Expand & improve service access, facilitate quality patient care and expand number of patients served by implementing an improved Voice-Over-Internet telecommunications system in all TCC facilities. This project is essential to improve treatment quality, reduce risk of hard, and enhance the quality, efficiency, accuracy, and access to medical and/or behavioral health treatment.	Reduce risk to patient care by eliminating disrupted telemedicine patient/psychiatrist visits, dropped and/or fragmented calls, and reduce static overridden telephonic calls by changing from a significantly degraded voice-over-internet system to one that insures patient safety and uninterrupted access to clinicians and staff. Developing Texoma Community Center's infrastructure will increase medical safety for patients by improving efficiency and reducing health disparities	$44202
1.10 Establish Depression/Trama Clinics. **Lakes Regional MHMR Center**	Develop and establish behavioral health clinics for individuals with a primary need for mental health treatment for depression or mental health trauma	Expand the capacity of behavioral health services. Provide treatment to target population. Offer counseling models appropriate to the needs of the target population.	
1.10 Early Intervention Day Treatment and Outreach for Autism Spectrum (ASD) and Related Intellectual Developmental Disabilities (IDD)	The proposed treatment program would be an early intervention center to house a Day Treatment Center for Children with Autism and related Intellectual Developmental Disabilities (IDD), in addition to Applied Behavioral Analysis (ABA) Outreach Services in Rockwall County. The Day Treatment would provide	Expand the capacity of behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better	

Lakes Regional MHMR Center	individualized ABA intervention with a 1:1 ratio. Outreach would consist of interventions for behavior challenges within the Autism Spectrum Disorder/Intellectual Developmental Disabilities (ASD/IDD) population, with a focus on parent training and generalization to the home, community and school environments	outcomes and experience of care.	
1.10 Expansion of BH Services – In SHAPE **Lakes Regional MHMR Center**	Challenge: It has well established that the SPMI population especially those in rural and poverty stricken areas have dramatically shortened life expectancy fraught with physical health difficulties from medication side effects such a morbid obesity, diabetes, and heart disease as well as high instances of preventable diseases from smoking, diet and other life style choices. Solution: Lakes regional proposes to affect this negative trend by implementing the wellness program "Individualized Self Health Action Plan for Empowerment, In SHAPE" promoted by the "Prevention Research Center at Dartmouth" which is part of The Dartmouth Institute. The heart of the program is an individualized physical health care program for people with severe and persistent mental illness developed with a specially trained Health Mentor for one-on-one education, planning, coaching, training and measuring progress toward goals with reflection on the benefits and appreciation of accomplishment. Health Mentor is a designation developed by In SHAPE that requires additional training to that required to be a "Personal Trainer" by the Aerobics and Fitness Association of America, AFAA. One Health Mentor can work with up to 16 individuals at a time for the first 6 months in program; therefore, a six month commitment to the program is desired. The Health Mentor meets with individuals 1 or 2 times per week, but the program is designed to be highly individualized with a focus on designing exercise and nutrition plans that are sustainable in a more health directed lifestyle. It is obvious that community partners are critical in providing these services in the community in sites such as hospital wellness centers, YMCA, and fitness centers. Starting Point: This will be a new addition of a tested and proven program design to the Lakes array of services.	Expand the capacity of behavioral health services to better meet the needs of the patient population and community so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care. The program is aimed directly at improving physical health, personal health knowledge and quality of life of participants thereby reducing the risk of preventable diseases, lowering health care costs and enhancing the life expectancy of individuals with severe and persistent mental illnesses.	
1.10 Expansion of Behavioral Health Services in Collin County **LifePath Systems**	This project will increase the capacity of staff and facility to serve more individuals with mental health, substance abuse and co-occurring disorders (mental health and intellectual disabilities).	Expanding service availability at all BH clinic locations for those individuals that do not meet the clinical &/or financial criteria to access NorthSTAR funded BH services. Currently, only individuals that are diagnosed with a serious	

		mental illness (SMI) and fall below 200% of the poverty level are able to access free or low cost mental health services. Prior to September 2009, Collin County indigent residents with a substance abuse problem had access to Supportive Outpatient Treatment as an entry level of care. In September of 2009, ValueOptions, the BHO for the NorthSTAR population decided to eliminate this option as an entry level of care. All NorthSTAR individuals seeking substance abuse services are required to meet the higher level of care criteria of Intensive Outpatient Treatment. As a result of this restriction of services, LifePath went from serving an average of 85 clients per month in SOP to 10 clients per month, indicating 75 individuals per month are now unable to access any substance abuse services. Expanded Substance Abuse and Mental Health Services will be offered at all current and new locations. In addition specialized therapy and psychiatric care will become available for individuals evidencing both mental health issues and intellectual disabilities. Moving our McKinney BH clinic to a larger office space in McKinney (approximately 8,000 square feet) to serve the growing population in North Central Collin County. For the population of McKinney and the surrounding cities, an estimated 5,975 individuals have a mental illness, no insurance, and need access to care. Currently, less than 600 individuals from this area are able to access low cost services. It is expected that Behavioral Health Services will be expanded to a greater number of Collin County Residents. As a result of this expanded access to appropriate treatment and services, a reduction in the use of local ER's for behavioral health care is expected as is a reduction in the number of	

		interactions with law enforcement. Continuing education for physicians and the establishment of a mentoring program physicians with clinical experience serving individuals with IDD/ASD with increase the pool of available providers to provide behavioral health services in a community setting and decrease the need for more intensive services in an inpatient psychiatric setting and reduce the risk of residential or institutional placement. It would also serve people "in the gap" as many of these individuals have psychiatric diagnoses that are not currently eligible for services in the NorthStar model.	
1.10 Behavioral Health Services for Abused/Neglected Young Children **LifePath Systems**	This project provides home-based mental health counseling focused on parent-child interaction and relationships in homes where abuse or neglect has been confirmed by Texas Child Protective Services.	The goal of this project is to ameliorate the consequences of abuse and neglect. Behavioral Health/Infant Mental Health Services will be expanded to a greater number of Collin and Rockwall County families and young children. The total number served in year two will be 50 children/families and increased by 50 families for year three. The number of children/families served will increase by 20% of the baseline for year four and five, with a minimum of 140 children served at the end of year 5. As a result of this service there will be a reduction in the use of local ER's for both primary and behavioral health services.	
1.10 Expansion of Behavioral Health Services in Southeastern Collin County **LifePath Systems**	This project will establish a Behavioral Health outpatient facility to serve individuals with mental health & substance abuse disorders in an underserved area of Collin County.	Opening a BH clinic in/near Wylie, Texas to serve the growing population of Southeastern Collin County. Access is needed in the Wylie area to serve the existing 336 LifePath clients that must travel 20-35 miles to our nearest clinic location. Additionally, an expanded clinic in this location will provide the opportunity for outreach and identification of individuals needing BH services, but not yet accessing services. For the population of Wylie and the surrounding cities, an estimated 5,975 individuals have a mental illness, no insurance, and need access to care. Currently, less than 600 individuals from this area are able to access low cost services.	

		It is expected that as a result of opening up an additional clinic location, Behavioral Health Services will be expanded to a greater number of Collin County Residents. As a result of this expanded access to appropriate treatment and services, a reduction in the use of local ER's for behavioral health care is expected as is a reduction in the number of interactions with law enforcement.	
1.10 Expansion of Assertive Community Treatment to Criminal Justice Settings **LifePath Systems**	This project will establish a Forensic Assertive Community Treatment (FACT) team to improve access to behavioral health services for individuals being diverted pre- or post-criminal justice setting involvement.	Our goal is to expand access to behavioral health (BH) services for individuals being released from the Collin County Detention Facility or those involved with the Collin County Mental Health or Veterans Courts. The focus is on individuals with serious mental illnesses or veterans with mental health needs by: Establishing a Forensic Assertive Community Treatment (FACT) team to target this population. Potential clients will be identified by the current Collin County Veterans Court or the new court diversion program for individuals with mental illnesses. FACT teams combine behavioral health treatment, rehabilitation, and supportive services in a self-contained clinical team made up of a mix of disciplines including psychiatry, nursing, addiction counseling, and vocational rehabilitation. The team provides intensive services in the community and focuses on 1) preventing arrest and incarceration, 2) preventing psychiatric hospitalization, 3) and accepting the majority of referrals from criminal justice agencies. Recent studies on Forensic Assertive Community Treatment teams have shown a significant reduction in jail days, arrests, hospital days, and an associated reduction in jail and hospital costs for individuals receiving FACT services. It is expected that as a result of immediate access	

		to this intensive level of field-based services, individuals being released or diverted from jail with mental health needs will 1) stabilize rapidly due to the increased effort of a FACT team to bring the services to the client and 2) to reduce the recidivism rate for this population, thereby reducing the costs to the criminal justice system and the county.	
1.11 Increase, Expand, & Enhance Dental Services			
1.12 Expand or Enhance Emergency Medical Transportation Services			
Category 2 Program Innovation and Redesign			
2.1Enhance/Expand Medical Homes **Plano Children's Medical clinic**	We will continue to see patients who are on Medicaid, CHIP or those without insurance. Services and outreach for children in the foster care programs will be maintained and expanded. New requirements by the State of Texas in regards to children under a year of age such as a four day old visit is often difficult financially for the new parents if Medicaid or CHIP has not been established. Contacts with area hospital's newborn nurseries will be made to direct patients to the clinic to establish a medical home and complete the financial process. Each visit cost the clinic $100.00.		
2.2 Redesign the outpatient delivery system to coordinate care for patients with Diabetes Establish Diabetes Management Program (DMP) Expand THR Outpatient Diabetes Education Program **Texas Health Plano** **Texas Health Allen** **Texas Health WNJ**	For diabetes patients identified through the ED, inpatient stays, or community outreach partnerships we will provide them with information about our Diabetes Management program and help them find a Medical Home Evaluate patient progress by utilizing Healthways tools to monitor patients' health status using identified metrics Provide innovative services to manage and monitor patient progress	Increase the number of patients enrolled in the diabetes self-management program by 5% over baseline data.	
2.2 Redesign the outpatient delivery system to coordinate care for patients with Diabetes Establish Diabetes Management Program (DMP)	For diabetes patients identified through the ED, inpatient stays, or community outreach partnerships we will provide them with information about our Diabetes Management program and help them find a Medical Home Evaluate patient progress by utilizing Healthways tools to monitor patients' health status using identified metrics	Increase the number of patients enrolled in the diabetes self-management program by 5% over baseline data	

Expand THR Outpatient Diabetes Education Program **Texas Health Plano** **Texas Health Allen** **Texas Health WNJ**	Provide innovative services to manage and monitor patient progress		
2.3 **Collin County Adult Clinic**	(more information needed)		
2.4 Counseling Service Expansion **Texhoma Community Center**	Enhance Counseling Services to non-target population behavioral health patients by providing office space, furniture, equipment, supplies and a clerical support position for additional licensed staff designated to provide evidenced-based counseling to those who do not meet criteria for TCC's DSHS-funded	Reduce the geographical area's limited access to outpatient counseling opportunities by expanding TCC's counseling services by hiring two (2) licensed clinicians to serve non-target population by providing evidenced-based counseling interventions to those individuals.	$159.060
2.5 Redesign for Cost Containment			
2.6 Establish a medical home for TCC patients who are the most "at risk" due to lack of primary care physician. **Texhoma Community Center**	Enhance Services to include primary medical care for those receiving behavioral health services but who are "at risk" due to a lack of physical health treatment.	Enhance services array by providing physical health care to those receiving behavior health services by contracting with 1 primary care physician and 1 nurse for four hours per week each as well as employ one full-time clerk to manage the PAP medication acquisitions and other related duties. Providing this service will improve outcomes for behavioral health patients who have complications due to chronic conditions and insufficient insurance coverage to meet those physical health needs.	$159,069
2.6 & 1.1 Integrate Primary Care in Mental Health Clinics **Lakes Regional MHMR Center**	Challenge: Primary care in rural areas is sparse and not available to many SPMI patients of Community Centers due to multiple barriers to individual limitations as well as external barriers of poverty, distance and access. Solution: Lakes will survey the client population to establish Primary Care access, barriers, needs and alternatives used. Lakes will survey area resources for Primary Care existing and planned as part of Waiver projects by other entities. Lakes will determine and implement from findings the most effective delivery system(s) to offer individuals enrolled in the behavioral health system for improved access to physical medicine services with a priority on integrating health and behavioral health. While access to Primary Care is a desired underpinning to behavioral health outcomes, cooperation in services and record integration has	Expand capacity of primary care to better accommodate the needs of the patient population so that patients can receive the right care at the right time in the right setting Expand the capacity of behavioral health services so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care. Increase access to physical health services for individuals with a SPMI. Decrease unnecessary emergency department	

	demonstrated substantial advantages for the systems of care and the individual patients. Lakes will explore principal options of creating a Mobile Health Clinic to provide integrated at three rural clinics, linking clients to existing or planned service providers through contractual agreement, and providing coverage for individuals through a managed care entity. Starting point: No baseline data has been collected. Tentative encounters with area health care providers have yielded little information on alternatives. Lakes will be developing much of the relationship, options and infrastructure over the course of the Waiver	usage by individuals enrolled in the behavioral health system.	
2.6 Integrate Physical and Behavioral Health Care **LifePath Systems**	Adding access to primary care in the Behavioral Health clinics for clients who show evidence of developing chronic physical illnesses; and adding access to behavioral health counseling in indigent care clinics for clients who are experiencing depression or other signs of mental health issues.	Our goal is to improve the physical health of individuals with chronic mental illnesses, and to improve the mental health of individuals with chronic physical illnesses. It has been demonstrated that individuals with behavioral health issues have significant chronic physical health conditions that go untreated, and that these individuals suffer increased morbidity, poorer quality of life, and earlier mortality (up to 25 years) than individuals without behavioral diagnoses. Expected results for this project include improving the overall health of the seriously mentally ill population that is served in our BH clinics by offering primary health care services in each BH clinic and by adding behavioral health services in non-profit/indigent Collin County primary care clinics.	
2.7 Expand and Develop ED Liaison Collaboration Provide navigation services to targeted patients who are at a high risk of disconnect from institutionalized health care. **Texas Health Plano** **Texas Health Allen** **Texas Health WNJ**	Implementation of an ED-based case management program to identify patients that are frequent users of the ED and navigate them to area resources or facilitate obtaining a PCP to more effectively manage their disease. Intervene as necessary to provide education and monitor identified patients post discharge to encourage compliance with follow-up plan for receiving ongoing care/support for their healthcare needs. Facilitate arrangements for care, as appropriate, at a lower level, such as an outpatient clinic or skilled facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs	Five-year target goal is to substantially decrease identified population ED utilization by 5%.	
2.7 Identify top 5 PPR admissions within the RHP Identify and Implement Best Practice	Build care teams that are tailored to the patient's health care needs, including non-physician health professionals such as nutritionists offering appropriate education for the disease	By implementing care teams and care management models for these high risk patients, the ability to reduce health care costs and need	

Treatment across Programs to Reduce Re-admissions **Lake Pointe Medical Center Rowlett**	identified; case managers providing care outside the clinic setting via phone, email, and home visits. Apply a care management model to patients identified as having high risk health needs and work with PCPs to ensure consistent implementation of evidence-based protocols Develop tracks for specific diseases that provide consistent, evidence based intervention in health care upon admission and discharge. Measure of readmissions for chronic condition improvement to baseline.	for additional readmissions to ED and inpatient care would be decreased. Additionally, the wellness, quality of life, and productivity of the targeted population should improve.	
2.7 Establish/Expand a Patient Navigation Program **The Medical Center of Plano**	As many providers in Dallas Fort Worth, TMCP sees high utilize patients in the ED and acute care services many with chronic diseases that resources or knowledge of healthcare systems and often with mental and behavioral health issues. TMCP will implement patient care navigation as it has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.	To develop a registry to be able to identify at risk individuals. To engage high-risk patients to participate in prevention activities To implement a series of evidence-based prevention strategies To perform both process and outcome evaluations of this then project to assess improvement and effectiveness of the interventions.	
2.8 Apply Process Improvement Methodology to Improve Quality /Efficiency **The Medical Center of Plano**	In order for healthcare providers to give better care for improved health outcomes in a cost effective manner, organizations needs to adopt tools and methodologies that will facilitate rapid and continuous improvement for efficiencies, improved quality, eliminate waste and redundancies.	TMCP will complete # of Performance/Process Improvement Events in 4 years. Training in LEAN methodologies will be conducted for Executive Management, directors and staff members as process improvement champions in the organization.	
2.9 Apply Process Improvement Methodology to Improve Quality/Efficiency (eg. Rapid Cycle, Management Engineering, Lean Technology			
2.11Implement/Expand Transitions Care Program **The Medical Center of Plano**	Patients face many obstacles once discharged from their acute care hospital to ensure they are complaint. Many patients do not fully understand why they were admitted, what treatments occurred and how to care for themselves once released. A comprehensive care coordination post-discharge from an acute care setting with specific interventions can reduce these factors	Patients will be screened and identified as candidates for transitions care program based on established criteria such as specific chronic diseases, lack of support systems, history of non-compliance and re-admission risk. A transition care plan will be developed for patients and	

	to avoid re-admissions.	intensive case management will be provided for the plan to include medication assistance, medical appointments, self- management of disease and education. The transition care plan is expected to reduce non-compliance and result in better health outcomes to include reduced admissions and appropriate care in appropriate settings at the appropriate time.	
2.12 Community Education in Behavioral Health LifePath Systems	This project will replicate successful community education models of Mental Health First Aid and trained peer counselors to reduce stigma, increase appropriate referrals to mental health treatment, and engage clients in positive, recovery-focused initiatives.	Our goal is to educate members of the public by providing the successful Mental Health First Aid courses to key community members, businesses and organizations. The purpose is to improve the identification and referral of individuals with mental health needs that are not currently receiving adequate levels of care and to recruit, train, and support consumers of behavioral health services to be providers of behavioral health services as volunteers and paraprofessionals. At the same time, the project will incorporate a peer counseling program that will train and use individuals with mental illnesses to advise and counsel others experiencing difficulties. We expect to train at least 160 Collin County individuals during the project period on Mental Health First Aid. Additionally, at least 6 peer providers will be trained and available to provide support to consumers of behavioral health services by the end of the 4th Demonstration year.	
2.12Parner with SNFs to Develop Best Practices **Centennial Medical Center Frisco**	Develop standardized clinical protocols with SNFs Develop scorecards for SNFs with chosen metrics to understand the care that patients will be receiving when leaving the inpatient setting. Improve program opportunities with regular quarterly meetings with all providers to review quality data, protocols, and issues that would drive a return to acute care services within 30 days.	Create smooth transitions of care from inpatient to outpatient settings or to alternative inpatient settings (e.g., skilled nursing facilities) so that patients being discharged (or responsible party, as appropriate) understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.	
2.12 Post-discharge Support for High Risk of Re-admission Patients **Centennial Medical Center Frisco**	Develop protocols for effectively communicating with patients and families during and pos-discharge to improve adherence to discharge and follow up care instructions.	By developing protocols for communicating effectively with patients/families and establishing processes for cases management teams to successfully monitor and transition patients from	

	Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and any additional patient education/coaching as identified in discharge.	inpatient settings will show improvement in patient care and decrease overall cost of readmissions and ED episodes.	
2.12 Develop Registries to Identify High ER Utilizers **Centennial Medical Center Frisco**	Develop and track high ER utilizers with in hospital databases. Review list quarterly to identify opportunities to move these patients/families COPC or other community resources.	By developing options for patients in the community instead of high cost emergency departments, this builds our the patient's relationships with PCP, or community clinics that would improve their overall care and decrease the cost associated with ED care.	
2.12 Partner with SNFs to Develop Best Practices **Lake Pointe Medical Center Rowlett**	Develop standardized clinical protocols with SNFs that integrate with hospital protocols and seek to match formularies, documentation, etc. to aid effective transitions. Develop scorecards for SNFs with chosen metrics to understand the care that patients will be receiving when leaving the inpatient setting. Use scorecards to drive best practices across the region and to quickly share best practices. Improve program opportunities with regular quarterly meetings with all providers to review quality data, protocols, and issues that would drive a return to acute care services within 30 days.	By implementing the improvement in transitions of care from the inpatient to alternative inpatient settings so that patients have fewer disruptions in care which should lead to lower admissions and readmissions to ED/Acute care.	
2.12 Post-discharge Support Program for High Risk of Readmission Patients **Lake Pointe Medical Center Rowlett**	Develop protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow up care instructions. Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and any additional patient education/coaching as identified in discharge. Confirm required PCP and/or home health follow ups are schedule before patient leaves the facility (likely using online scheduling system) and create follow up mechanism to ensure visits are maintained and appropriate interventions are taken based on condition/symptoms.	By developing protocols for communicating effectively with patients/families and establishing processes for cases management teams to successfully monitor and transition patients from inpatient settings will show improvement in patient care and decrease overall cost of readmissions and ED episodes.	
1.12 Develop Registries to	Develop and track high ER utilizers with in hospital data bases.	By developing options for patients in the	

Identify High ER Utilizers **Lake Pointe Medical Center Rowlett**	Review list quarterly to identify opportunities to move these patients/families to COPC or other community resources. Active outreach to engage high ER utilizers in proactive, PCP based interventions to improve wellness and productivity and to reduce the need for high cost ED/acute care interventions.	community instead of high cost emergency departments, we can build stronger patient relationships with PCP or community clinics that would improve their overall care and decrease the cost associated with ED care	

List of Category 3 Project submitted

THR-Category 3.3 Potentially Preventable Readmissions

Title-Congestive Heart Failure Re-admission rate-identification of baseline rate, priority areas, intervention and milestones.

HCA-Category 3: Improvement in Quality and Safety

Intervention 1: Severe Sepsis Resuscitation and Management

Intervention 2: Potentially Preventable Re-admissions – Heart Failure

List of Category 4 Project Submitted

HCA-Category 4: Population-focused Improvements

Domain 1: Potentially Preventable Admissions

Domain 2: 15 Day Re-admissions

Domain 3: Potentially Preventable Complications (PPCs)

Potential DSRIP Project as yet undeveloped

Grayson County

Grayson County is in discussions with the Texas Health Foundation in Grayson to provide a new ER diversion program with a total est. value of $3 mil. For this DSRIP, they would front an est. $2 mil and expect a $3 mil return. They are trying to work out details for this - Judge Bynum and the Foundation and John Teel.

Rockwall County

County meeting with Helping Hands organization

Collin County

2012 DSRIP Plan – Healthcare Collin County C

DY2 (2012-2013)

DSRIP Category 1 – Infrastructure Development –Expanding Health care access (primary and Specialty care, behavioral health/substance abuse).

Project Area: The Medically Underserved Census Tract 309 in McKinney Texas. Located near Webb Elementary and serving the Semaritan Inn homeless shelter, McKinney Independent School District and area senior centers.

Project Goal: To Build Collaborative Partnerships(CP's) that will bring an FQHC – Community Clinic(Project area 1B,1C,2A) to the Medically Underserved Census Tract 309 in McKinney Texas. (ex. of CP's= County Health Dept., Project Access/Specialty Care, FQHC/Primary Care, Behavioral Health). Finalize Needs Assessment.

It is our desire to create a teaching clinic(Project area 1F,2b,2c) to address the need for doctors willing to see patients with low-income no health insurance, Medicaid and Medicare. There are no doctors in this area willing to see these patients and their only source for healthcare is the ER.

Start plans for construction of Clinic mid-late 2013. Engage community support. Research Technologies to support the Clinic(4a, 4b, 5a, 5b)(ex. Electronic Medical Records, Telemedicine, Data recording etc.). Create a Collin County network of social services as a resource to the community and as a way of verifying usage.
Total budget DY2(2012-2013) $125,000 IGT/$50,000

DY3(2013-2014)
DSRIP Category 1 – Infrastructure Development – Expanding Health Care access(primary and Specialty care, behavioral health/Substance Abuse).
Project Area: The Medically Underserved Census Tract 309 in McKinney Texas. Located near Webb Elementary and serving the Samaritan Inn homeless shelter, McKinney Independent School District and area senior centers, County Health Dept./Project Access primary care in greater McKinney area.
Project Goal: Build a "green" FQHC Clinic using Federal FQHC grant funds, community support and local fundraising. Establish staffing requirements and partnerships to provide primary healthcare, behavioral health, Substance Abuse, Prenatal care, dental, vision, hearing, labs, prescriptions etc. Begin work to Develop Patient-Centered Medical home model infrastructure(7a, 7b)
Partner with Project Access to expand Specialty Care(3b, 3c). Relocate to Clinic. Expand Project Access to use Telemedicine for Specialty Care.(3b, 3c). Partner with Teaching Universities to get residents, interns, practicum hours to train and retain professional medical/Behavioral Health staff.
Mid-late 2014 open clinic and begin seeing patients.
DSRIP Category 2 Partner with Hospitals to reduce PPA/PPR(1a, 1b, 1c, 7a, 7b)
Total Budget DY3(2013-14) $250,000 IGT/$100,000

DY4(2014-15)
DSRIP Category 1
Begin looking at locations for satellite clinics. (1F, 2b, 2c)
Plan with the County Health Dept. to address needs in other areas including Farmersville, Waco, Frisco and Allen. Look at Jail Diversion and serving medical/Behavioral Health of Jail population.

DSRIP Category 2
Pilot to develop innovations in Health promotion/Disease Prevention
Begin planning for Wrap-around social service project providing a "green" building and associated services like Community Garden/Food Pantry, Clothing, Housing, Cooking Demonstrations, Lifestyle education/Health coaching, exercise programs/yoga, stress reduction, Obesity/Diabetes support groups, Tobacco use/E-cigs, Addictive Behavior modification, Continuing Education/ESOL/job placement etc. (3a, 3b, 3c, 3d, 3e, 3f, 3g)
Total Budget DY4(2014-15) $1,250,000 IGT/$500,000

DY5(2015-16)
DSRIP Category 1
Open two satellite clinics, Frisco and Allen. Support Farmersville FQHC and begin planning for a satellite in Waco. Contract with County for Indigent Health Care/Behavioral Healthcare/Substance Abuse and Jail Health care/Behavioral Healthcare/Substance Abuse.(1f, 2b, 2c)

DSRIP Category 2
Pilot to develop innovations in Health promotion/Disease Prevention
Begin implementation for Wrap-around social service project building and associated services like Community Garden/Food Pantry, Clothing, Housing, Cooking Demonstrations, Lifestyle education/Health coaching, exercise programs/yoga, stress reduction, Obesity/Diabetes support groups, Tobacco use/E-cigs, Addictive Behavior modification, Continuing Education/ESOL/job placement etc. (3a, 3b, 3c, 3d, 3e, 3f, 3g)
Total Budget DY5(2015-16) $1,250,000 IGT/$500,000