Austin/Travis County Health and Human Services Department

The role of public health is to:

PROMOTE community-wide wellness,

PREVENT disease, and

PROTECT the community from infectious diseases, environmental hazards, and epidemics

1115 Waiver

Public Health and Human Services

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1115 Waiver - Overview

Waiver goals are to:

- Protect hospital supplemental payments (e.g., UPL)
- Expand permitted reimbursement for uncompensated care
- Incentivize delivery system improvements and improve access and system coordination (DSRIP)

City of Austin Waiver Projects:

- Diabetes
- Healthy Families
- Permanent Supportive Housing
- Tobacco Cessation
- Vaccinations
- Maternal Infant Outreach Program
- *Workforce Development* *
- *Teen Pregnancy* *
- *PSH* *
- *Electronic Health Records* *

** three year projects*

1115 Waiver - Region 7 Projects

Dell Children's Hospital

- Care for Chronically Ill Children
- Family-centered Pediatric Obesity
- Counseling on AISD Campuses (AISD funded)

A/TC Integral Care

- MCOT Expansion
- MCOT Telepsychiatry Services
- Crisis Residential program
- Community Behavior Support Team
- Integrated Medical & Behavioral Health Center in Dove Springs
- Chronic Disease Self Management
- Whole Health Peer Support
- Prescriber Expansion
- Mental Health First Aid & Suicide Prevention Training

Community Care

- Disease Management Registry
- Patient Centered Medical Home Model
- Chronic Disease Management Model
- Expanded Hours at Community Clinics
- Mobile Care Vans
- Gastroenterology at Community Clinics
- Musculoskeletal Care at Community Clinics
- Pulmonology at Community Clinics
- Expanded Dental Services
- Integrated Behavioral Health for Diabetes
- Telepsychiatry at Community Clinics
- Pregnancy Reduction Program
- STD/HIV Screening & Treatment
- Community Paramedic Navigation

Brackenridge Hospital

- Psychiatric Emergency Department
- Post-Graduate Training for Psychiatric Specialties
- Psychiatric Telemedicine for Emergency Service
- Substance Abuse Care Connection & Navigation
- Behavioral Health Care Connection & Navigation
- Women's Oncology Care Screening
- Women's Oncology Care Navigation
- Adult Diabetes Care
- Chronic Care Management: Adults
- Language Access & Resource Center
- Culturally Competent Care Training
- Palliative Care Expansion
- OB Navigator Project

Community Diabetes Project

- **Target population**: African American and Hispanic individuals with type 2 diabetes who are medically indigent or Medicaid eligible
- **Strategy:** Increase community health workers (CHWs) & community-based organizations that provide diabetes self-management education, reaching 140 persons with diabetes yearly in Demonstration Years 3-5
- **Successes and Next Steps:**
  - **Pilot:** Tailoring of 6-class diabetes self management curriculum; 7 educators trained, Evaluation of pilot program: curriculum found to be effective in improving quality of life for participants
  - **Full scale implementation**: 2 competitive RFPs issued; 4 class series taught with 16 more class series planned in DY3
  - **Increase in number of CHWs:** 2 new CHWs working in the African American Community trained on diabetes will be certified by August

Healthy Families

- **Target Population**: Expectant families or families with newborns with focus on African-American and Medicaid eligible families
- **Strategy**: Adds an additional unit to Travis County Healthy Families home visiting program
  - National model
  - Intensive child & family services decreasing from Birth to age 3

- **Outcomes**: Establish medical home, early prenatal care, improve birth outcomes, well child checks, parenting skills

ACT Team for PSH Residents

- **Target population** – 15 formerly/currently chronically homeless individuals with tri-morbid health conditions: Chronic Physical Health, Psychiatric, and Substance Use
- **Strategy** - Provide an Assertive Community Treatment (ACT) Team to individuals with tri-morbid conditions residing in Permanent Supportive Housing (PSH). This innovative approach addresses the needs of vulnerable individuals and helps them maintain housing stability and improved quality of life via the medical services provided by the ACT team, which will not only benefit each person but the community at large. This collaborative project engages NHCD and HACA to provide housing.
- **Successes and Next Steps** – Contract was awarded to ATCIC in September of 2013. Their ACT Team now has 4 staff members hired, 3 of whom are actively engaging and working with consumers on a daily basis.
  - Of the consumers engaged in ACT services - 3 are currently housed, 2 are at Safe Haven, 1 is in medical hospital, 1 is at the Inn, and 2 are actively seeking housing while staying at the local shelter.

Tobacco Prevention & Cessation Program

- **Target population**: 18-24 year old tobacco users with a targeted focus on those who are Medicaid-eligible or medically indigent

- **Strategy:** Implement a media campaign focused on tobacco prevention and promotion of cessation services targeting 18-24 year olds. Goal of 150 young adults accessing tobacco cessation services yearly and 5% reduction in prevalence of tobacco use by Demonstration Year 5

- **Successes and Next Steps:**
  - Contract executed for oversampling of 18-24 year olds in Behavior Risk Factor Surveillance System (BRFSS) to monitor the change in prevalence of tobacco use in the target population
  - Digital media buy completed. Ads currently running in online media targeting 18-24 year olds
  - Focus group research will be done to further refine media buys and messaging better influence young adult tobacco users to access cessation services

Vaccinations for High Risk Adults

- **Target population**: Clients seeking care at HHSD STD clinic, day-labor clients, clients seeking substance abuse treatment, adolescent and adult gay and bisexual men (MSM), and homeless populations.
- **Strategy:** Increase vaccination opportunities to at-risk populations to decrease disease morbidity and mortality for vaccine preventable diseases, using client centered outreach (i.e. meeting the client where they are).
- **Successes and Next Steps:**
  - Documented extensive key informant interviews with subject matter experts regarding outreach to target populations
  - Developed vaccine formulary for target populations and purchased necessary vaccines
  - Developed MOU with Front Steps for outreach to homeless clients
  - Hired RN Senior and began orientation and outreach March 24th

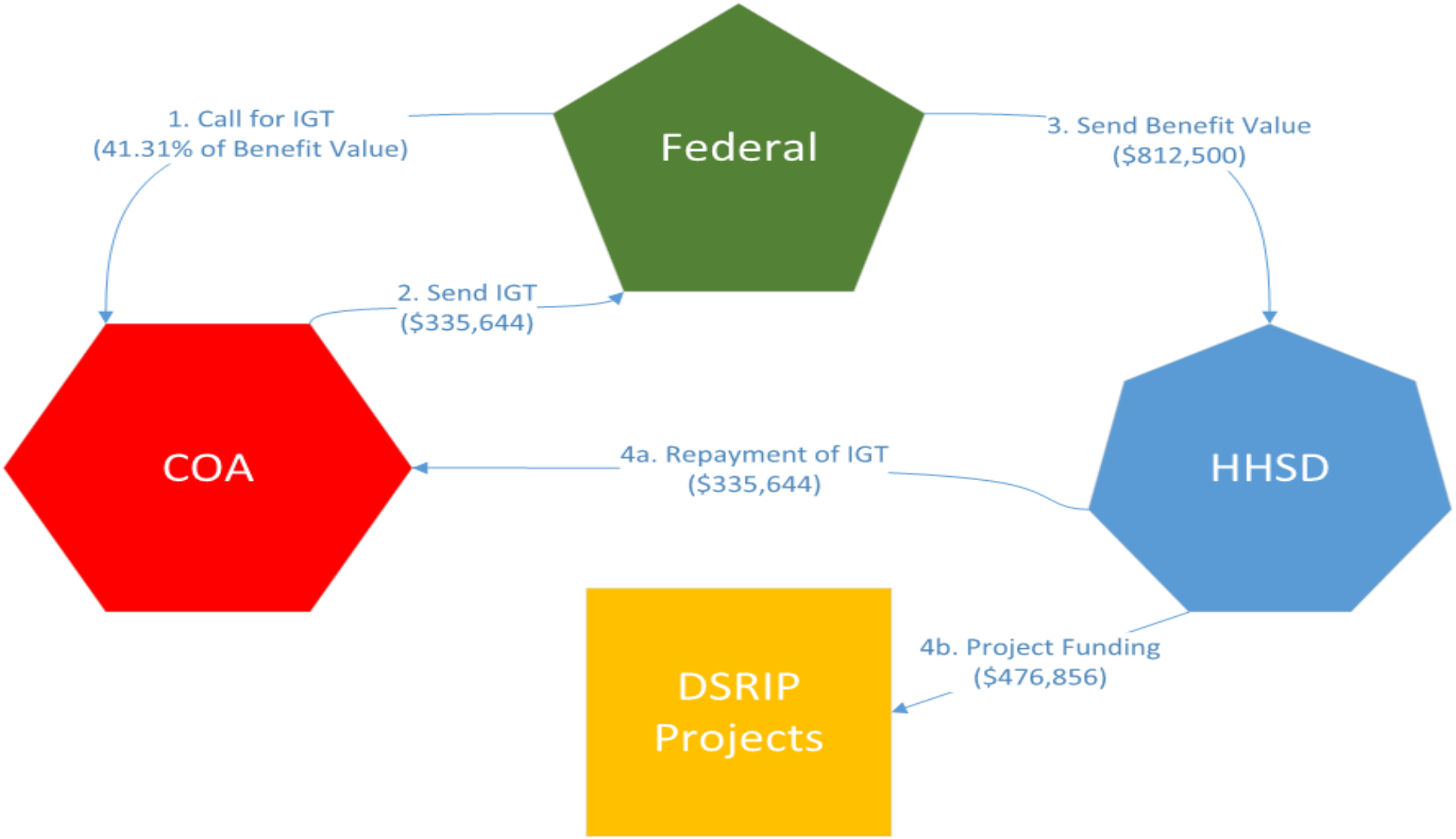
Maternal Infant Outreach Program (MIOP)

- **Target Population** – Low income African-American or Hispanic families that are expecting or planning a pregnancy. It is anticipated that a majority of the families will be Medicaid eligible or uninsured. Outreach will be coordinated with multiple community partners with a focus on recruiting African American Families.
- **Strategy** – This program will use community health workers (CHWs) to improve birth and postnatal outcomes with an emphasis on African-American women in the community with increased access to pre and post natal care and health literacy.
- **Successes and Next Steps** –
  - Conducting two focus groups of approximately 20 African-American local women on their prenatal care and birth experiences.
  - Engaging in on-going conversations with practitioners, community groups, an advisory committee, and other key stakeholders.
  - Identified ten African-American women to serve as CHWs for the project.

New 3 Year Projects

- **Utilization of Peer to Peer (P2P) Health Education Model to address Latina Teen Pregnancy within Austin/Travis County**
  - This model will utilize adolescents as community health workers to improve the sexual and reproductive knowledge of their peers, with a specific focus on Latino youth. As a result of their improved health literacy, it is expected that the prevalence of teen births among Latina females ages 13-19 within Austin/Travis County will decrease.
- **Provide ACT Team to PSH Residents**
  - Provide an Assertive Community Treatment (ACT) team to 60 recently housed individuals (housed through a non-profit housing provider) who were homeless and who have at least two of the three tri-morbid conditions
- **From Patient to Practitioner –**
  - Increase local capacity by preparing 25 low-income, primarily minority, and first-generation-in-college adult students to become Registered Nurses, who will commit to work in community clinics and other settings serving Medicaid and indigent population
- **Clinical Efficiencies for Infectious Disease Management**
  - Implement new clinical protocols and integrate these protocols into electronic medical records to increase efficiencies and decrease duplication of services related to infectious disease management across City of Austin Health and Human Services Department clinics and other point of care locations.

DSRIP - January 2014 Drawdown
$812,500 Benefit Value



Budget

- Maximum potential Benefit Value (before 41% IGT): $31,433,306
- Maximum Value to HHSD (less 41% IGT repayments): $18,545,651
- Benefit Value achieved thru October 2013 reporting
  - Repayment of General Fund to date: $620,375
  - Benefit Value invested back into HHSD projects to date: $891,711

Questions