# Section II. Executive Overview of RHP

Regional Healthcare Partnership 8 (RHP 8) is a nine-county partnership that consists of: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson counties, and it is contained within Health Service Region 7 as defined by the Texas Department of State Health Services (DSHS). Formed in June 2012, RHP 8 is located in Central Texas with a regional population close to 860,803 (based on 2010 US Census). The Texas A&M University Health Science Center (TAMHSC) is the Anchor institution. The region is composed of the following: 14 Intergovernmental Transfer (IGT) Entities that support Uncompensated Care (UC) and/or Delivery System Reform Incentive Payment (DSRIP), and 18 Providers (six UC-Only and 12 DSRIP). Providers implementing DSRIP projects in RHP 8 include: six hospitals, two health districts, and four local mental health authorities (LMHAs). Links to Supplementary RHP 8 Data for addenda referenced in Sections II and III are found in Addendum 1A.

RHP 8 is a large area, covering 8,547 square miles, and has a population density of 100.73 residents per square mile[[1]](#footnote-1) compared to a statewide density of 95.92. A map of the region is included in Addendum 1B.

### Patient Population

The total population for RHP 8 was 860,803 with Bell and Williamson Counties consisting of about 85% of RHP 8’s residents according to the 2010 Census. These two counties are similar to Texas in terms of age distributions. However, the other counties in RHP 8 tend to have older populations, with Blanco, Burnet, Lampasas, Milam and Mills counties all having almost twice the Texas average for residents over 65 years of age. Over 31% of Llano County’s population is over 65. A large percentage of RHP 8 is uninsured. According to County Health Rankings (2010), only Bell, Llano, and Williamson Counties are below Texas’ rate of 26%. Mills (30.5%) and San Saba (34.5%) Counties have the highest percentages of uninsured adults. These two counties also have higher rates than the Texas average of uninsured children. Burnet, Llano, and San Saba Counties all had higher percentages of children participating in the Children’s Health Insurance Program (CHIP) than the State of Texas as seen in Table 3-3.

### Health Systems and Providers

RHP 8 has the benefit of several large hospital systems: Seton Healthcare Family, St. David’s Healthcare, Baylor Scott & White Health, and Community Health Systems. These systems have their largest hospitals in RHP 8 in Williamson and Bell Counties. There also are several smaller hospitals, primarily in Burnet, Llano, and Milam counties. There are numerous primary care clinics (see Table 1-1) and four LMHAs within RHP 8.

RHP 8 has a full continuum of care, which includes health promotion, primary care, specialty care, chronic disease management, labor and delivery, general and specialty surgery, intensive care, behavioral healthcare services, rehabilitation, emergency care, and many others. RHP 8 also has a large number of health professionals. However, the most comprehensive services are available through the hospital systems in the more populous Bell and Williamson counties. Healthcare resources are less abundant in the rural counties of RHP 8.

In most cases, limited primary care can be obtained locally but more preventative screenings and specialty care must be accessed in the more populous areas or other regions. This can create transportation issues for many residents in RHP 8, resulting in long waits to access certain types of care, and causing some residents to not receive the necessary healthcare.

### Changes in DSRIP Performing Providers after Waiver Initially Approved

In April 2012, the building of Seton Medical Center Harker Heights was completed, and the 83-bed hospital opened its doors June 2012. During demonstration year 3 (DY3), Seton Medical Center Harker Heights joined RHP 8 as a Performing Provider (participating in both the UC and DSRIP programs). Seton Medical Center Harker Heights proposed, and received approval, to implement a three-year project to expand primary care. The hospital has participated and contributed to RHP 8 learning collaborative face-to-face events and conference calls, and they have collaborated with other stakeholders in the region to share best practices.

Additionally, in October 2013, RHP 8 saw two of our DSRIP Providers undergo the merger between Baylor Healthcare System, based in Dallas, and Scott & White Healthcare, based in Temple, as they formed a new organization that combined their nationally recognized health systems. The newly created system commonly referred to as Baylor Scott & White, merged the hospital's adjacent markets to create Texas' largest, nonprofit system, with 43 hospitals, and a combined 2013 revenue of $5.9 billion and assets of $8.3 billion. During 2013, it was the biggest healthcare merger of the year in Texas, and one of the biggest in the nation.

## Key Health Challenges

Much like the United States and the State of Texas, there are health challenges present in RHP 8 that can only be addressed successfully through broad system transformation and collaboration among healthcare Providers and organizations. The challenges outlined for this region are closely related with the proposed DSRIP projects as well as the interests of RHP 8 hospitals, LMHAs, local health departments, and other stakeholders.

The broad key health challenges being addressed in RHP 8 by Providers implementing DSRIP projects include:

* Limited access to primary care,
* Limited access to behavioral/mental health services, and
* Lack of coordinated care, especially for those with multiple needs.

**Poor Access to Primary Care**

As seen earlier in this section, there are fewer Providers located in the more rural counties of RHP 8, particularly in Blanco, Mills and San Saba Counties. Except for nurses, these three counties have seven or fewer of all other healthcare professionals represented in Table 3-4. Expanding primary and specialty care services is an essential component of transforming and integrating the healthcare system in RHP 8.

Transportation is a common barrier to accessing care in RHP 8 that spans across all key health challenges. There is difficulty in supporting services in areas with low population density. However, RHP 8 is growing tremendously in population and needs, and the current healthcare infrastructure and capacity will not be able to keep up without adequate programs and projects to expand in these areas. In many cases, successful outcomes are directly related to the amount of time required to access healthcare. Long distances between healthcare Providers, much less specialty care, can inhibit positive health outcomes.

In many cases, providers are not available in some areas. In addition to the health provider shortage in several RHP 8 counties, access to care is also influenced by health coverage; as has been illustrated in this section, a significant proportion of RHP 8 residents are uninsured (see Table 3-3). A small number of these individuals in each county qualify for the County Indigent Healthcare Program. Medically indigent is defined as county residents that are at or below 21% of the federal poverty limit (FPL). These residents use disproportionate amounts of resources from their local healthcare and social services providers and often lack access to care coordination and a medical home. In RHP 8, there is a need for additional support services such as patient education and transportation services to assist these residents in navigating the healthcare system and seeking care before there is an emergency.

Other service needs in RHP 8 within the primary care spectrum are preventive services, including routine preventive screenings and treatment related to women’s health and reproductive health. Bell County is repeatedly among the highest Chlamydia and Gonorrhea rates in the state with each of these disease rates being approximately three times the rate in Texas in 2011[[2]](#footnote-2).

* Gonorrhea – 362.4/100,000 (Texas = 117.8/100,000)
* Chlamydia – 1,325.7/100,000 (Texas = 473.0/100,000)

Bell County also reports over 586 clients were seen in sexually transmitted disease (STD) clinics in 2011 and 618 in 2010. According to the Centers for Disease Control (CDC), the reported number of cases is often significantly lower than the actual number of cases because many infected people are often unaware of or do not seek treatment for their infections. In many clinical settings, routine testing is not practiced. Undetected and untreated STDs can result in health issues such as poor pregnancy outcomes, ectopic pregnancy, neonatal infections, and sterility. Bell County Public Health District is addressing this issue by implementing two transformational DSRIP projects in Bell County.

**Poor Access to Behavioral/Mental Health Services**

Although RHP 8 is served by four LMHAs, the behavioral health needs of the region exceed the capacity of these organizations to provide adequate care to many who may need services. This is not uncommon as mental and behavioral resources and services are often overburdened and lack the resources necessary to meet the needs. Persons experiencing symptoms of a mental illness often are transported to EDs and then to psychiatric facilities or jail. Crisis stabilization and respite services being offered through DSRIP projects provide an opportunity for patients to received needed services in more appropriate settings, and allow law enforcement officers and ED personnel to focus on other duties.

Adults who have not been able to avoid psychiatric hospitalization or incarceration often need skills training on managing stress, medications, and daily life successfully. This may also include a transportation component to enable patients to see their healthcare providers or education on how to utilize the public transportation systems available in the area. Because transportation is often a huge issue in rural counties, telepsychiatry programs being implemented in RHP 8 are showing promise to overcome this barrier. In many cases, care coordination and integration of support services is essential in assisting individuals in managing their chronic or persistent mental illnesses.

**Lack of Coordinated Care, Especially for Those with Multiple Needs**

Chronic diseases are an acknowledged health challenge in RHP 8, much like the rest of the state and country. Many counties in the region had rates of chronic disease deaths that were similar or higher when compared to the rates for the State as a whole at the onset of the waiver. As seen in Table 3-6, chronic diseases account for many preventable hospitalizations that use a considerable amount of time and resources that should be spent on other hospital functions. RHP 8 Providers implementing DSRIP projects aimed at addressing this population are finding the effects of chronic diseases can be controlled, reduced, or eliminated by programs that encourage people to make healthier lifestyle choices and offer appropriate chronic disease management resources.

If the existing recipe of poor access to services and uncoordinated care compound each other, the end result is growing health disparities, particularly among those who are lower income, live in more rural areas of the region, have mental health issues or intellectual disabilities, or have multiple needs. This drives up healthcare costs by increasing inappropriate use of the ED and potentially preventable hospital admissions. Through the implementation of more than 40 DSRIP projects in this region, these issues are being addressed and mitigated.

In 2010, there were 318,220 visits to ED across RHP 8.15 Non-trauma emergency room visits are one of the most costly ways to access the healthcare system and are often avoidable when residents have access to education about healthy living, adequate primary care, and prevention resources. Individuals with IDD often disproportionately use the emergency room to access care and may be in need of other wrap-around behavioral health and crisis intervention services. Appropriate identification of these individuals and tailoring services through the DSRIP projects underway in our region are helping to eliminate some of the burden on EDs.

In addition to inappropriate ED use, many conditions that could be managed through adequate primary care go untreated, resulting in avoidable hospitalization, costing RHP 8 upwards of $738,375,609 in the five-year period between 2005 and 2010 (see Table 3-6). The improved and strengthened healthcare delivery system with enhanced access and coordination of a broad range of services is truly transforming the health outcomes and quality of life for residents in RHP 8.

## RHP Goals and Vision, and Plans for Achievement

The goal of RHP 8 is to transform the local and regional healthcare delivery systems to improve access to care, efficiency, and effectiveness. Specifically, RHP 8 began addressing the key challenges during DY3 through the implementation of over 40 DSRIP projects in the region. Providers in RHP 8 are addressing the three key areas through the following methods:

1. **Improving access to timely, high quality care for residents, including those with multiple needs;**

Providers in RHP 8 have implemented multiple DSRIP projects aimed at expanding the availability and capacity of primary care in the region, as well as expanding services available through primary care providers. In addition to new primary care sites and expanded clinic hours, providers target disparity groups with evidence-based health promotion, disease prevention, and chronic care management. Many of these new services aim to improve patient satisfaction, an indicator of quality of care.

1. **Increasing the proportion of residents with a regular source of care;**

The expansion of primary care capacity in RHP 8 has provided opportunities for residents to establish a regular source of care, or medical home. By enhancing the availability of urgent medical advice, patients seek assistance from their medical home rather than the ED. As well, new patient navigation programs assist patients without a medical home to available providers, and establish and maintain contact with the patient and his/her medical team throughout their care process.

1. **Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and**

The coordination of care in RHP 8 is being addressed by Providers who are integrating primary and behavioral health services, as well as integrating behavioral health services for those with IDD needs. Providers have created patient navigation programs to ensure residents who tend to access inappropriate care settings more frequently access a regular source of care (the right care at the right time in the right setting). Innovational telemedicine projects have impacted behavioral health in RHP 8 communities as well.

1. **Reducing inappropriate utilization of services.**

Given the largely rural nature of RHP 8, inappropriate utilization of services is a critical issue as many needed services simply are not available locally. All of the activities described under methods 1, 2 and 3 above, work together to reduce inappropriate utilization of the ED, the Justice System, and EMS. The expansion of primary care availability and accessibility, care coordination through patient navigation, targeted behavioral health services, and evidence-based health promotion/disease prevention targeting high risk and disparities populations, all serve to get people into the right care at the right time.

| **Table 2-1. RHP CATEGORY 1 and 2 PROJECTS** |
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| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
| ***Category 1: Infrastructure Development*** |
| 126844305.1.1 Bluebonnet Trails Community Services | 1.12.2 | Expand the number of community based settings where behavioral health services may be delivered in underserved areas | * OD 10, IT-10.1.b.ii – RAND Short Form 12 (SF12v2) Health Survey
 |
| 126844305.1.2 Bluebonnet Trails Community Services | 1.13.1 | Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system | * OD 3, IT-3.14 - BH/SA 30-Day Readmission Rates
 |
| 126844305.1.3 Bluebonnet Trails Community Services | 1.13.1 | Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system | * OD 9, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice settings such as jails or prisons
 |
| 126844305.1.4(PASS 2)Bluebonnet Trails Community Services | 1.13.1 | Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system | * OD 3, IT-3.14 - BH/SA 30-Day Readmission Rates
 |
| 126844305.1.5(PASS 2)Bluebonnet Trails Community Services | 1.12.2 | Expand the number of community based settings where behavioral health services may be delivered in underserved areas | * OD 11, IT-11.8 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
 |
| 133339505.1.1Center for Life Resources | 1.11.1 | Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state | * OD 11, IT-11.26.e.i - Patient Health Questionnaire 9 (PHQ-9)
 |
| 081771001.1.1Central Counties Services | 1.1.1 | Establish More Primary Care Clinics | * OD 11, IT-11.26.d - Children and adolescent needs and strengths assessment (CANS-MH)
 |
| ~~081771001.1.2Central Counties Services~~ | ~~1.11.2~~ | ~~Implement technology‐assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified Providers.~~ | * ~~OD 3, IT-3.14 - BH/SA 30-day readmission rates~~

**\*\*Project Withdrawn by Provider – April 2015\*\*** |
| 081771001.1.3Central Counties Services | 1.12.2 | Expand the number of community based settings where behavioral health services may be delivered in underserved areas | * OD 10, IT-10.1.a.iv - Assessment of Quality of Life (AQoL-8D)
 |

| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
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| 081771001.1.4 (PASS 2)Central Counties Services | 1.13.1 | Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system | * OD 9, IT-9.1 - Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons
 |
| 081771001.1.5(PASS 2)Central Counties Services | 1.10.2 | Enhance improvement capacity through technology | * OD 3, IT-3.14 - BH/SA 30-day readmission rates
 |
| 081771001.1.100(3-YEAR PROJECT)Central Counties Services | 1.12.2 | Expand the number of community based setting where behavioral health services may be delivered in underserved areas. Title: Model of Work Adjustment Training | * OD 10, IT-10.1.a.iv - Assessment of Quality of Life (AQoL-8D)
 |
| 183086102.1.1(PASS 2)Little River Healthcare | 1.1.2 | Expand existing primary care capacity | * OD 9, IT-9.2.a - ED visits per 100,000
 |
| 183086102.1.2(PASS 2)Little River Healthcare | 1.9.2 | Improve Access to Specialty Care | * OD 12, IT-12.1 - Breast Cancer Screening
* OD 12, IT-12.2 - Cervical Cancer Screening
* OD 12, IT-12.3 - Colorectal Cancer Screening
 |
| 013122392.1.100(3-YEAR PROJECT)Seton Medical Center Harker Heights | 1.1.2 | Expand Existing Primary Care Capacity | * OD 1, IT-1.11 - Diabetes care: BP control (140/90mm Hg)
 |
| 020957901.1.1St. David's Round Rock Medical Center | 1.1.2 | Expand existing primary care capacity | * OD 9, IT-9.2.a - Emergency Department (ED) visits per 100,000
 |
| 126936702.1.1Williamson County and Cities Health District | 1.1.2 | Expand existing primary care capacity | * OD 6, IT-6.2.a - OD Client Satisfaction Questionnaire 8 (CSQ-8)
* OD 15, IT-15.6 - Chlamydia screening in women
 |
| 126936702.1.2Williamson County and Cities Health District | 1.6.2 | Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to healthcare. | * OD 3, IT-3.2 - CHF 30-day readmission rate
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| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
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| 126936702.1.3Williamson County and Cities Health District | 1.5.3 | Implement project to enhance collection, interpretation, and / or use of REAL data. Providers may select one or more of the following project components, as appropriate for the provider’s starting point in collection and use of REAL data: | * OD 1, IT-1.29 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
* OD 15, IT-15.6 - Chlamydia screening in women
* OD 12, IT-12.11 - Percentage of adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday
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| ***Category 2: Program Innovation and Redesign*** |
| 088334001.2.1Bell County Public Health District | 2.7.1 | Implement innovative evidence‐based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) | * OD 6, IT-6.2.b - Visit-Specific Satisfaction Instrument (VSQ-9)
 |
| 088334001.2.2(PASS 2)Bell County Public Health District | 2.7.1 | Implement innovative evidence‐based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) | * OD 6, IT-6.2.b - Visit-Specific Satisfaction Instrument (VSQ-9)
 |
| 126844305.2.1 Bluebonnet Trails Community Services | 2.13.2 | In an innovative manner not described above, implement other evidence-based project for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones. | * OD 11, IT-11.26.c - Adult Needs and Strength Assessment (ANSA)
 |
| 126844305.2.2Bluebonnet Trails Community Services | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 9, IT- 9.4.e - Reduce Emergency Department (ED) visits for Behavioral Health/Substance Abuse
 |
| 126844305.2.3(PASS 2)Bluebonnet Trails Community Services | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 11, IT-11.26.b - Aberrant Behavior Checklist (ABC)
 |
| 126844305.2.4(PASS 2)Bluebonnet Trails Community Services  | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 9, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice settings such as jails or prisons
 |
| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
| 081771001.2.1Central Counties Services | 2.2.2 | Apply evidence-based care management model to patients identified as having high-risk healthcare needs | * OD 1, IT-1.11 - Diabetes care: BP control (140/90mm Hg)
 |
| 081771001.2.2Central Counties Services | 2.7.1 | Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) | * OD 15, IT-15.6 - Chlamydia screening in women
* OD 15, IT-15.9 - Syphilis screening
* OD 15, IT-15.12 - Gonorrhea screening rates
 |
| 081771001.2.3Central Counties Services | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 9, IT-9.1 - Decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons
 |
| 081771001.2.100(3-YEAR PROJECT)Central Counties Services | 2.13.1 | Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e. criminal justice system, ER, urgent care) | * OD 09, IT-9.1 - Decrease in MH admissions and readmissions to criminal justice setting such as jails or prisons
 |
| 133340307.2.1Hill Country MHDD | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 11, IT-11.25 – Daily Living Activities DLA-20
 |
| 133340307.2.2Hill Country MHDD | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 11, IT-11.25 – Daily Living Activities DLA-20
 |
| 133340307.2.3Hill Country MHDD | 2.16.1 | Design, implement, and evaluate a program to provide remote psychiatric consultative services to all participating primary care providers delivering services to patients with mental illness or substance abuse disorders | * OD 11, IT-11.16 – Assessment for Substance Abuse Problems of Psychiatric Patients
* OD 11, IT-11.19 - Assessment for Psychosocial Issues of Psychiatric Patients
* OD 11, IT-11.21 - Assessment of Major Depressive Symptoms
 |
| 133340307.2.4(PASS 2)Hill Country MHDD | 2.18.1 | 2.18.1 - Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders. | * OD 11, IT-11.25 – Daily Living Activities DLA-20
 |

| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
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| 133340307.2.5(PASS 2)Hill Country MHDD | 2.13.1 | Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. | * OD 11, IT-11.25 – Daily Living Activities DLA-20
 |
| 220798701.2.1Scott & White Hospital—Llano | 2.8.1 | Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency. | * OD 9, IT-9.2.a - ED visits per 100,000
 |
| 220798701.2.2(PASS 2)Scott & White Hospital—Llano | 2.8.1 | Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency. | * OD 9, IT-9.2.a - ED visits per 100,000
 |
| 137249208.2.1Scott & White Memorial Hospital  | 2.9.1 | Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized healthcare (for example, 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) | * OD 9, IT-9.2.a - ED visits per 100,000
 |
| 094151004.2.1(PASS 2)Seton Highland Lakes | 2.9.1 | Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized healthcare (for example, 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) | * OD 6, IT-6.1.a.v - HCAHPS communication about medicine
* OD 9, IT-9.5 - Reduce low acuity ED visits
 |
| 126936702.2.1 Williamson County and Cities Health District | 2.9.1 | Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized healthcare (for example, 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) | * OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
* OD 1, IT-1.7 - The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
 |

| **Project Title (include unique RHP project ID number)** | **Project Area** | **Brief Project Description** | **Related Category 3 Outcome Measures** |
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| 126936702.2.2(PASS 2)Williamson County and Cities Health District | 2.6.1 | Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population. | * OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
* OD 1, IT-1.7 - The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
 |
| 126936702.2.100(3-YEAR PROJECT)Williamson County and Cities Health District | 2.7.5 | Implement innovative evidence‐based strategies to reduce and prevent obesity in children and adolescents | * OD 6, IT-6.2.a - Client Satisfaction Questionnaire 8 (CSQ-8)
* OD 1, IT-1.29 - Weight assessment and counseling for nutrition and physical activity for children/adolescents
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1. Texas Workforce Commission County Narrative Profiles <http://www.texasindustryprofiles.com/apps/cnp/index.asp> [↑](#footnote-ref-1)
2. Texas Department of State Health Services – Texas STD Surveillance Report (2011) <http://www.dshs.state.tx.us/hivstd/reports/> [↑](#footnote-ref-2)