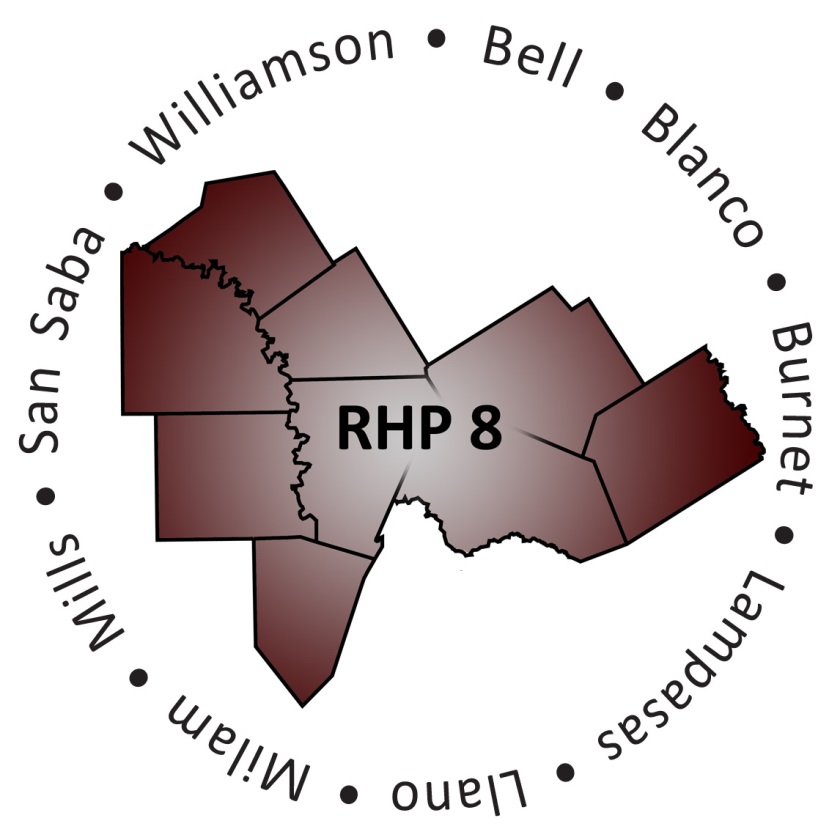
**Regional Health Care Partnership 8 (RHP 8)**

**Overview of 1115 Waiver DSRIP Projects**

**RHP 8 Plan**: <http://www.tamhsc.edu/1115-waiver/resources.html>

**RHP 8 Interactive Tool:** <http://www.tamhsc.edu/1115-waiver/rhp8/index.html>



| **Medicaid Rural Service Area Central (MRSA Central)**  **STAR: Amerigroup, Scott & White Health Plan, Superior**  **STAR+PLUS: Superior, United Healthcare**  **CHIP RSA: Molina, Superior**  **RHP 8 Counties: Bell, Blanco, Lampasas, Llano, Milam, Mills, San Saba**  *\*HHSC Texas Managed Care Service Areas Map Effective Sept 1, 2014* | | | | |
| --- | --- | --- | --- | --- |
| **Organization/Provider Name and**  **Project Lead/Contact Name** | **Project Title** | **Brief Description of Project & Services** | **County(ies) Served** | **Quantifiable Patient Impact (QPI)\***  **DY3, 4, 5** |
| **Baylor Scott & White Medical Center – Llano**  Brian Gregory  810-201-8365  [Brian.Gregory@BSWHealth.org](mailto:Brian.Gregory@BSWHealth.org) | Emergency Services | Apply continuous process improvement strategies guided by the Institute for Healthcare Improvement Model to identify causes of avoidable EMS and ED utilization, prioritize potential solutions, and conduct Plan, Do, Study, Act (PDSA) cycles.  **Service(s)**:   * Reduce inappropriate utilization of emergency medical services (EMS) and emergency department (ED) services by high-utilizers * Allow EMS and ED to be readily available for responding to emergencies and transferring patients to higher levels of care outside the county quickly when needed | Llano | Individuals:  DY3 – 193  DY4 – 151  DY5 – 59  Total: 403 |
| Emergency Services Use by Behavioral Health (BH) Patients | Identify causes of avoidable sheriff department transport of BH patients in crisis, reducing ED use and increasing jail diversion solutions.  **Service(s)**:   * Reduce inappropriate utilization of EMS and ED services by identifying those patients with behavioral health needs and addressing care before crises occur * Reduce need for Sheriff Department deputies to transfer individuals to behavioral health facilities in other counties | Llano | Individuals:  DY3 – 57  DY4 – 102  DY5 – 0  Total: 159 |
| ***Crosswalk Summary:*** *Baylor Scott & White Medical Center - Llano is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable events (admissions, readmissions, ER visits) and reducing behavioral health related admissions/readmissions, via programs that include behavioral health services and health promotion/disease prevention in Llano county.* | | | | |
| **Baylor Scott & White Memorial Hospital – Temple**  MaryEllen Bond  254-724-4071  [MaryEllen.Bond@BSWHealth.org](mailto:MaryEllen.Bond@BSWHealth.org) | Patient Navigation | Provide patient navigation and selected chronic illness supports for a target group of people who are beneficiaries of the Bell County Indigent Care Program, Medicaid, and/or participating hospitals' charity care programs.  **Service(s)**:   * Provide patient navigation services and link patients with the right care, at the right time, in the right setting * Reduce avoidable ED visits | Bell | Encounters:  DY3 – 714  DY4 – 905  DY5 – 0  Total: 1,619 |
| ***Crosswalk Summary:*** *Baylor Scott and White Medical Center - Temple is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable ER visits and access to care, via a patient navigation/coordination program in Bell county.* | | | | |
| **Bell County Public Health District**  Renee Carter  254-778-4766  [rcarter@bellcountyhealth.org](mailto:rcarter@bellcountyhealth.org) | STD Testing for Males | Increase the availability of sexually transmitted disease (STD) testing at Health District clinics for male clients to ultimately decrease the possible harmful related outcomes associated with untreated infections.  **Service(s)**:   * Improve access to timely, high quality care for residents | Bell | Individuals:  DY3 – 729  DY4 – 622  DY5 – 472  Total: 1,823 |
| STD Testing for Females | Increase the availability of STD testing at Health District clinics for female clients to ultimately decrease the possible harmful related outcomes associated with untreated infections.  **Service(s)**:   * Improve access to timely, high quality care for residents | Bell | Individuals:  DY3 – 616  DY4 – 583  DY5 – 360  Total: 1,559 |
| ***Crosswalk Summary:*** *Bell County Public Health District is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable events (admissions, readmissions, ER visits, and complications), access to care and health literacy, via programs that include health promotion/disease prevention in Bell county.* | | | | |
| **Center for Life Resources**  Ranita Oliver  325-646-9574  [Ranita.oliver@cflr.us](mailto:Ranita.oliver@cflr.us) | Telehealth | Implement telemedicine to provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider in rural communities. Thus, reducing unnecessary ED use, and improving consumer satisfaction and access where previously limited or unavailable.  **Service(s):**   * Provide the right care, at the right time, and in the right setting | Mills and San Saba | Encounters:  DY3 – 74  DY4 – 124  DY5 – 72  Total: 270 |
| ***Crosswalk Summary:*** *Center for Life Resources is providing program and/or services that are or could impact areas of interest to MCOs, including anti-depressant medication management and reducing behavioral health related admissions/readmissions through improved care transition/coordination, as well as access to care and quality indicators, via behavioral health programs in Mills and San Saba counties. Center for Life Resources has the ability to report Medicaid IDs for some patients served, is a current contracted/covered provider, and is an EMR/EHR facility.* | | | | |
| **Central Counties Services**  Nicole Williams  254-298-7108  [Nicole.Williams@cccmhmr.org](mailto:Nicole.Williams@cccmhmr.org)  **Central Counties Services**  Nicole Williams  254-298-7108  [Nicole.Williams@cccmhmr.org](mailto:Nicole.Williams@cccmhmr.org)  **Central Counties Services**  Nicole Williams  254-298-7108  [Nicole.Williams@cccmhmr.org](mailto:Nicole.Williams@cccmhmr.org) | School-based Services | Provide school-based BH services for children, kindergarten-5th grade.  **Service(s)**:   * Provide school-based services for children in Kindergarten-5th grade who are poorly adjusted to scholastic achievement due to personal or familial behavioral health problems | Bell | Encounters:  DY3 – 2,747  DY4 – 3,028  DY5 – 2,115  Total: 7,890 |
| Autism Spectrum/  Group Social Skills - *Breakthru Central* | Implement group social skills training for persons diagnosed with high-functioning Autism or Asperger's disorder.  **Service(s)**:   * Enhance the quality of life for persons participating in the “Coffeehouse Model” of social skills training * Transform service delivery system for persons with High-Functioning Autism or Asperger’s Disorder | Bell | Individuals:  DY3 – 30  DY4 – 36  DY5 – 49  Total: 115 |
| Crisis Respite | Provide 24/7 residential-based crisis respite, transitional living, and supportive day services to persons with severe and persistent mental illness (SPMI) who have experienced a crisis.  **Service(s)**:   * Provide successful interventions for persons in early stages of crisis before the crisis situation reaches complexity that institutional level of care becomes the only care option * Establish crisis-responsive residential services that provide a less restrictive/costly level of care for persons in behavior health crisis than admission to the state psychiatric hospitals or jailed for a minor offense * Divert patients from being sent to the state psychiatric hospitals/justice system | Bell, Lampasas, and Milam | Encounters:  DY3 – 700  DY4 – 1,256  DY5 – 0  Total: 1,956 |
| Improve Data Management and Organizational Capacity | Improve the efficiency of clinical service operations through improved technology increasing providers’ capacity.  **Service(s)**:   * Improve data management and organizational processes allowing provider to focus on reducing readmissions to state psychiatric hospital and local jail by improving post discharge follow-up services * Use data to inform and support the Center’s performance and service capacity | Bell, Lampasas, and Milam | Encounters:  DY3 – 115,935  DY4 – 120,201  DY5 – 94,000  Total: 330,136 |
| Chronic Health Management for Persons with SPMI | Provide education, training, and support by a registered nurse to persons with SPMI having chronic health conditions due to prolonged psychiatric medicine use. | Bell | Individuals:  DY3 – 140  DY4 – 179  DY5 – 88  Total: 407 |
| Day Services | Provide supportive day services to adults with SPMI who were recently discharged from a psychiatric hospital or jail, or have recently experienced a crisis.  **Service(s)**:   * Provide skills training activities to patients * Enroll patient in benefit programs he/she may be eligible * Reduce the revolving-door of hospitalizations/incarcerations of chronically and persistently mentally ill persons in the Temple/Belton area | Bell | Individuals:  DY3 – 28  DY4 – 44  DY5 – 44  Total: 116 |
| Autism Spectrum/Work Adjustment – *Breakthru Finishline* | Provide work adjustment training to patients with high-functioning Autism or Asperger's disorder.  **Service(s)**:   * Increase number of persons participating in work adjustment training * Increase participant’s employability skills and behaviors | Bell | Individuals:  DY3 – 8  DY4 – 17  DY5 – 14  Total: 39 |
| Jail Diversion | Provide trained law enforcement officers to assess the BH of someone involved in a minor criminal event, and to direct that person to BH services instead of the criminal justice system.  **Service(s)**:   * Provide law enforcement officers training about how they may assess behavioral health acuity of a person involved in a minor criminal event | Bell | Individuals:  DY3 – 50  DY4 – 70  DY5 – 0  Total: 120 |
| ***Crosswalk Summary:*** *Central Counties Services (CCS) is providing programs/services that are or could impact areas of interest to MCOs, including potentially preventable events (admissions, readmissions, ER visits, complications), reducing behavioral health related admissions/readmissions and access to care, via behavioral health services, chronic care & disease mgmt., workforce development/training, and performance/process improvement programs in Bell, Lampasas, and Milam counties.**CCS is an EMR/EHR facility and can provide Medicaid IDs for some patients served. They are interested in health information exchange and discussing the potential of forming partnerships.* | | | | |
| **Hill Country MHDD Centers**  Kristie Jacoby  830-792-7507  [kjacoby@hillcountry.org](mailto:kjacoby@hillcountry.org)  **Hill Country MHDD Centers**  Kristie Jacoby  830-792-7507  [kjacoby@hillcountry.org](mailto:kjacoby@hillcountry.org) | Co-Occurring Disorders | Implement co-occurring psychiatric and substance use disorder services (COPSD) in order to meet the needs of individuals with psychiatric and substance use issues locally within the community setting; thus, reducing ED utilization, impatient utilization, and incarceration.  **Service(s):**   * Increase coordination of prevention, and care for residents, including those with behavioral and mental health needs * Reduce inappropriate utilization of services | Blanco and Llano | Individuals:  DY3 – 18  DY4 – 33  DY5 – 21  Total: 72 |
| Trauma Informed Care | Provide/implement trauma informed care services to meet the need of individuals who experience trauma that is impacting their behavioral health.  **Service(s)**:   * Increase coordination of prevention, and care for residents, including those with behavioral and mental health needs * Reduce inappropriate utilization of services | Blanco and Llano | Individuals:  DY3 – 8  DY4 – 12  DY5 – 6  Total: 26 |
| Virtual Consultations | Implement psychiatric and clinical guidance 24/7 for primary care physicians and hospitals to help physicians identify and treat BH symptoms earlier to avoid exacerbation of symptoms into a BH crisis.  **Service(s)**:   * Provide primary care providers (PCPs) and hospitals within Blanco and Llano counties with necessary resources and guidance to adequately treat patients who present with behavioral health conditions through virtual, psychiatric consultation | Blanco and Llano | Individuals:  DY3 – 0  DY4 – 0  DY5 – 0  Total: 0 |
| Whole Health Peer Support | Provide Whole Health Peer Support services to meet the overall health needs of individuals who exhibit BH issues.  **Service(s):**   * Identify and train peers of mental health services in the delivery of Whole Health peer support, and integrate their work into the recovery-oriented treatment plan of the individual being served | Blanco and Llano | Individuals:  DY3 – 10  DY4 – 25  DY5 – 56  Total: 91 |
| Veteran Services | Enhance veteran mental health services to meet the overall health needs of veterans dealing with BH issues. Project expands current peer support services for veterans and their family members who need comprehensive, community-based, wrap around BH services.  **Service(s)**:   * Establish veteran peer and mental health services * Reduce ED utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population | Blanco and Llano | Individuals:  DY3 – 14  DY4 – 29  DY5 – 11  Total: 54 |
| ***Crosswalk Summary:*** *Hill Country MHDD Centers is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable events (admissions, readmissions, ER visits), reducing behavioral related admissions/readmissions and access to care, via behavioral health programs in Blanco and Llano counties.* | | | | |
| **Little River Healthcare**  George DeReese  512-430-6475  [gdereese@lrhealthcare.com](mailto:gdereese@lrhealthcare.com)    **Little River Healthcare**  George DeReese  512-430-6475  [gdereese@lrhealthcare.com](mailto:gdereese@lrhealthcare.com) | Primary Care Expansion | Increase primary care access by hiring additional staff, increasing clinic hours and establishing school-based clinics to provide earlier diagnosis of chronic and life-threatening diseases reducing ED visits.  **Service(s):**   * Increase number of primary care physicians in order to increase clinic hours * Expand capacity to care for more children and young adults with Rockdale Independent School District by adding clinics in schools * Reduce inappropriate ED and urgent care utilization, and redirect patients to the primary care clinic | Milam | Encounters:  DY3 – 27,910  DY4 – 24,499  DY5 – 0  Total: 52,409 |
| Specialty Care Expansion | Increase specialty care access by expanding the number of specialty providers, and promoting breast, cervical and colorectal screening and diagnostic services for low income and uninsured individuals.  **Service(s)**:   * Expand number of specialty providers and clinic hours for highest demand specialties (breast, cervical, and colorectal cancers) * Install new specialty diagnostic system * Promote early diagnostic and screening services for at-risk patients | Milam | Encounters:  DY3 – 9,754  DY4 – 12,844  DY5 – 0  Total: 22,598 |
| ***Crosswalk Summary:*** *Little River Healthcare is providing programs and/or services that are or could impact areas of interest to MCOs including, potentially preventable events (admissions, readmissions, ER visits, complications), access to care and quality indicators, via programs that include primary care expansion and specialty care expansion in Milam county.* | | | | |
| **Seton Medical Center – Harker Heights**  Zach Dietze  254-680-6207  [Zach.Dietze@SMCHH.org](mailto:Zach.Dietze@SMCHH.org) | Primary Care Expansion | Expand existing primary care capacity to provide patients with increased access to primary care services by collaborating with the Greater Killeen Free Clinic.  **Service(s):**   * Increase primary care clinic visits by hiring additional primary care providers * Reduce inappropriate utilization of the ED by providing preventive care in the right place, at the right time, in the right setting * Reduce unnecessary healthcare expenses | Bell | Encounters:  DY3 – 832  DY4 – 1,664  DY5 – 168  Total: 2,664 |
| ***Crosswalk Summary:*** *Seton Medical Center – Harker Heights is providing programs and/or services that are or could impact areas of interest to MCOs, including CDC: HbA1c Control <8, potentially preventable events (admissions, readmissions, ER visits, complications), access to care, health literacy and patient retention, via a primary care expansion program in Bell county.* | | | | |

| **Medicaid Managed Care Service Area: Travis**  **STAR: Blue Cross and Blue Shield of Texas, Sendero Health Plans, Seton Health Plan, Superior**  **STAR+PLUS: Amerigroup, United Healthcare**  **CHIP: Blue Cross and Blue Shield of Texas, Sendero Health Plans, Seton Health Plan, Superior**  **RHP 8 Counties: Burnet and Williamson**  *\*HHSC Texas Managed Care Service Areas Map Effective Sept 1, 2014* | | | | |
| --- | --- | --- | --- | --- |
| **Organization/Provider Name and**  **Project Lead/Contact Name** | **Project Title** | **Brief Description of Project & Services** | **County(ies) Served** | **Quantifiable Patient Impact (QPI)\***  **DY3, 4, 5** |
| **Bluebonnet Trails Community Services**  Meghan Nadolski  512-244-8283  [meghan.nadolski@bbtrails.org](mailto:meghan.nadolski@bbtrails.org)  **Bluebonnet Trails Community Services**  Meghan Nadolski  512-244-8283  [meghan.nadolski@bbtrails.org](mailto:meghan.nadolski@bbtrails.org)  **Bluebonnet Trails Community Services**  Meghan Nadolski  512-244-8283  [meghan.nadolski@bbtrails.org](mailto:meghan.nadolski@bbtrails.org) | Expanded Access to Care | Provide expansive array of outpatient behavioral health services to low-income families in rural areas in Williamson and surrounding rural counties.  **Service(s)**:   * Develop robust behavioral health team on site (supported by telemedicine) * Provide behavioral healthcare that is multi‐disciplinary, recovery oriented, and comprehensive * Provide care to those in need regardless of income, insurance status, or diagnosis | Burnet and Williamson | Individuals:  DY3 – 954  DY4 – 1,509  DY5 – 1,118  Total: 3,581 |
| 48-Hour Observation Unit | Implement an involuntary and voluntary 48-Hour Extended Observation Unit in Georgetown for rapid access to stabilizing crisis services and to support involuntary and voluntary admissions.  **Service(s)**:   * Provide emergency and crisis stabilization services in a secure, protected, and clinically/psychiatrically supervised treatment environment * Reduce or eliminate inappropriate utilization of emergency departments, jails, private hospitals, and the State Hospital for short stays by individuals presenting with a mental illness | Burnet and Williamson | Individuals:  DY3 – 254  DY4 – 263  DY5 – 135  Total: 652 |
| Child Crisis Respite | Implement a specialized child crisis respite program to help youth in crisis, diverting them from admission to hospitals or juvenile justice facilities.  **Service(s)**:   * Provide a safe and therapeutic environment linking children and their caregivers with meaningful on-going supports * Divert youth from admission to hospitals or juvenile justice facilities | Williamson | Individuals:  DY3 – 10  DY4 – 16  DY5 – 14  Total: 40 |
| Crisis Expansion | Provide crisis assessment, referral, and short-term stabilization to those needing crisis services.  **Service(s):**   * Establish a crisis assessment and referral unit in Burnet County * Develop a professional and mobile team, including a Mental Health Deputy, to provide assessment of individuals * Reduce or eliminate inappropriate utilization by individuals with mental illness of emergency departments, jails, private hospitals and the State Hospital for short stays | Burnet and Williamson | Individuals:  DY3 – 212  DY4 – 208  DY5 – 284  Total: 704 |
| Outpatient Substance Abuse Treatment | Establish outpatient substance abuse treatment sites in Georgetown, Marble Falls, Round Rock, Taylor and Cedar Park.  **Service(s):**   * Establish intensive outpatient and supportive outpatient substance abuse services in Williamson and Burnet County * Provide a comprehensive service array for persons with co-occurring psychiatric and substance use disorders through a solution-focused and multi-faceted approach to care including psycho-education, peer support groups and motivational interviewing | Burnet and Williamson | Individuals:  DY3 – 212  DY4 – 514  DY5 – 726  Total: 1,452 |
| Transitional Housing | Provide peer-led transitional housing and services to individuals with mental health challenges referred from crisis services, criminal justice system, inpatient settings, and the community who are at risk of homelessness.  **Service(s):**   * Establish a peer-led transitional services program based on recovery principles * Recruit, train, and certify peers to provide services to clients * Provide services to people who have been hospitalized or who have experienced a crisis event and have been in the Crisis Respite facility | Williamson | Individuals:  DY3 – 37  DY4 – 42  DY5 – 52  Total: 131 |
| ED Visit Reduction | Reduce use of emergency services by individuals identified as high utilizers.  **Service(s):**   * Establish a team to provide coordination of care, patient education, and linkage to needed services to prevent unnecessary use of emergency medical services and ED services * Reduce inappropriate emergency transports and ED use * Improve quality of care and access to healthcare for patients with complex medical needs | Williamson | Individuals:  DY3 – 20  DY4 – 45  DY5 – 35  Total: 100 |
| Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Development Disabilities (IDD) | Provide intensive wrap around services for individuals with IDD.  **Service(s):**   * Provide intensive wrap around services for individuals with IDD at the point of crisis and during life transitions * Provide training to law enforcement, emergency room personnel, healthcare providers, psychiatric hospital providers, and community residential and non‐residential providers regarding the project and how to access services * Prevent individuals from inappropriate admissions into institutions and emergency departments through timely and effective delivery of crisis services | Williamson | Individuals:  DY3 – 34  DY4 – 46  DY5 – 52  Total: 132 |
| Jail Diversion | Provide screening, assessment, and case management for youth and adults with a history of criminal justice involvement as well as BH symptoms.  **Service(s):**   * Expand clinical capacity and eligibility criteria for youth and adults arrested or incarcerated in Burnet and Williamson counties * Provide a collaborative approach to screening, assessment, and case management assisting individuals in navigating services in the community while collaborating with local justice systems * Collaborate with juvenile and adult court systems and other components of the justice system | Burnet and Williamson | Individuals:  DY3 – 51  DY4 – 50  DY5 – 59  Total: 160 |
| ***Crosswalk Summary:*** *Bluebonnet Trails Community Services (BTCS) is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable events (admissions, readmissions, ER visits), reducing behavioral health related admissions/readmissions through improved care transition/coordination, access to care, quality indicators, health literacy and patient retention, via programs that include behavioral health services and patient navigation/care coordination in Burnet and Williamson counties. BTCS has the ability to provide Medicaid ID numbers for some patients served and is a current MCO contracted/covered provider with at least one MCO. BTCS is an EHR/EMR facility, and they do have formal data sharing agreements with other providers.* | | | | |
| **St. David’s Round Rock Medical Center**  Michelle Hays  512-341-6404  [michelle.hays@hcahealthcare.com](mailto:michelle.hays@hcahealthcare.com) | Primary Care Expansion | Access2Care Program - Expand availability of primary care services to the low income and uninsured.  **Service(s):**   * Expand availability of primary care services to target low income population that do not have existing health coverage * Educate patients about managing existing chronic conditions * Reduce inappropriate utilization of the ED by providing preventive care * Reduce unnecessary healthcare expenses | Williamson | Encounters:  DY3 – 4,031  DY4 – 7,031  DY5 – 4,002  Total: 15,064 |
| ***Crosswalk Summary:*** *While**St. David’s Round Rock Medical Center has identified that they do provide services in Williamson county via a primary care expansion program, their Access2Care DSRIP Program provides services only to uninsured patients. For that reason, it is felt that the crosswalk initiatives are not applicable at this time due to the target population of the project.* | | | | |
| **Seton Highland Lakes**  Denise Watson  512-715-3100  [ADWatson@seton.org](mailto:ADWatson@seton.org) | Patient Navigation | Implement a patient navigation system to connect indigent and uninsured patients to primary care or medical homes in order to reduce ED utilization and provide cost effective, timely, and site appropriate healthcare services.  **Service(s):**   * Enroll patients in a medical home program with dedicated home health * Manage long-term relationships with patients and their families through care coordinators * Provide patient education about appropriate disease and prescription self-management * Reduce inappropriate utilization of the ED by providing preventive care * Reduce unnecessary healthcare expenses | Burnet | Encounters:  DY3 – 88  DY4 – 172  DY5 – 124  Total: 384 |
| ***Crosswalk Summary:*** *Seton Highland Lakes is providing programs and/or services that are or could impact areas of interest to MCOs, including potentially preventable ER visits and access to care, via a patient navigation/coordination program in Burnet county.* | | | | |
| **Williamson County and Cities Health District**  Matt Richardson  512-943-3639  [marichardson@wcchd.org](mailto:marichardson@wcchd.org)  **Williamson County and Cities Health District**  Matt Richardson  512-943-3639  [marichardson@wcchd.org](mailto:marichardson@wcchd.org) | Primary Care Expansion | Expand capacity of access to preventive clinical care through availability of same day or next day appointments by increasing level of healthcare professionals and extended hours at local health clinics located in Cedar Park, Round Rock, Taylor, and Georgetown.  **Service(s):**   * Increase access points to care * Increase availability of same day and next- day appointments * Offer enhanced level of preventive health services * Provide preventive care in the right place, at the right time, in the right setting | Williamson | Encounters:  DY3 – 0  DY4 – 14,651  DY5 – 15,409  Total: 30,060 |
| Community Paramedicine | Implement community paramedicine in rural communities which will increase access to proactive healthcare and decrease the overuse of EMS for non-emergent events.  **Service(s):**   * Increase number of patients connected to a medical home * Reduce unnecessary ED visits and non-emergency medical service calls | Williamson | Encounters:  DY3 – 0  DY4 – 3,687  DY5 – 1,225  Total: 4,912 |
| REAL Data | Enhance and improve the quality and consistency of public health REAL data (race, ethnicity, gender, and language) client demographic data collection and interpretation ensuring health disparities are addressed appropriately.  **Service(s):**   * Collect and interpret data to inform policy decisions focused on reducing health disparities * Enhance information technology infrastructure for public health system to improve ability to exchange data | Williamson | Individuals:  DY3 – 0  DY4 – 8,719  DY5 – 4,232  Total: 12,951 |
| Patient Navigation | Provide navigation services to under/uninsured persons with targeted chronic conditions or pregnancy to prevent hospital admissions and readmissions.  **Service(s):**   * Increase number of patients establishing a medical home * Increase patient satisfaction with receiving timely care, appointments, and information | Williamson | Individuals:  DY3 – 4,820  DY4 – 4,335  DY5 – 2,751  Total: 11,906 |
| Health Education | Promote preventive health awareness in the community by offering health education classes, eligibility assistance, and case management services, specifically for women of childbearing age, with a high incidence rate of frequent hospitalizations for chronic conditions, and/or in need of prenatal care.  **Service(s):**   * Health education classes, eligibility assistance, case management services | Williamson | Individuals:  DY3 – 180  DY4 – 357  DY5 – 633  Total: 1,170 |
| Childhood Obesity | Implement innovative, evidence-based strategies, to reduce and prevent obesity in children and adolescents (Get Fit, Get Healthy, Get Movin’ program (G3). | Williamson | Encounters:  DY3 – 45,801  DY4 – 65,526  DY5 – 45,056  Total: 156,833 |
| ***Crosswalk Summary:*** *Williamson County & Cities Health District (WCHHD) is providing programs/services that are or could impact areas of interest to MCOs, including access to care and health literacy, via programs that include primary care expansion, health promotion/disease prevention, & performance/process improvement in Williamson County.* *WCHHD is an EMR/EHR facility, and they do have formal data sharing agreements with other providers.**Additionally, WCCHD partners with Williamson County EMS (WilCo EMS) for community paramedicine services, which impacts preventable readmission and ER visits via services that include chronic disease mgmt., eligibility and enrollment assistance, and social service assistance. WilCo EMS has several formal data sharing agreements in place and is heavily involved in data exchange activities.* | | | | |