**Category 1 Project Narrative**

**St. David’s Round Rock Medical Center – 020957901.1.1**

**Project Area, Option and Title:** 1.1.2Expand Existing Primary Care Capacity

**RHP Project Identification Number:** 020957901.1.1

**Performing Provider Name:** St. David’s Round Rock Medical Center

**Performing Provider TPI #:** 020957901

**Project Summary:**

* **Provider Description:** Round Rock Medical Center (RRMC) is a 173 bed hospital located in Round Rock serving the Williamson and Travis County communities representing approximately 2,100 square miles and a population of approximately 1.5 million.
* **Intervention:** This project entails RRMC expanding the availability of primary care services to a targeted low-income population in Williamson County that does not have existing health coverage, by paying existing local clinics and/or FQHCs to provide services to the population.
* **Project Status:** This project represents a new initiative for RRMC.
* **Project Need:** CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL. In Williamson County, 16.5% of adult residents are uninsured (See Table 3-3). These patients often use hospital emergency departments (EDs) as their primary source for care and, between 2006 and 2010, Williamson County had almost $327 million in charges for Potentially Preventable Admissions (see Table 3-6). Low-income patients in Williamson County have a need for expanded availability of primary care services, which will only occur if primary care physicians are willing to see these patients. The only FQHC in Williamson County that accepts indigent patients currently, Lone Star Circle of Care, is at capacity for adult patients and has a three-four week waitlist for appointments.
* **Target Population:** The target population for this project is Williamson County residents who are uninsured or underinsured, can demonstrate income levels at or below 200% of the Federal Poverty Level, and do not have any source of payment such as existing public assistance programs. RRMC anticipates this will represent approximately 3,000-5,000 individuals, all of whom are low-income. This project will also benefit Medicaid and low-income patients who do not qualify for the program indirectly, by reducing utilization of EDs within the region and thereby increasing access for these other patients. Based on current volumes and patient demographics, RRMC provides between an estimated 40,000 to 45,000 distinct encounters of care in its ED annually, of which an estimated 40% to 45% represent Medicaid or low-income patients, which RRMC expects to increase over time.
* **Category 1 or 2 Expected Project Benefit for Patients:**In DY2, RRMC will establish a baseline for availability of these services and develop an implementation plan regarding eligibility determinations, partnering with local providers, and putting the program into action during DY3. In DY3, this project seeks to increase the number of service hours available in at least one participating clinic by 5 hours per week over DY2, and to implement the primary care expansion program by enrolling eligible patients and providing enrolled patients with at least 3096 primary care visits. During DY4, RRMC expects to provide enrolled patients with at least 3870 visits, and in DY5 RRMC expects to provide enrolled patients with at least 4834 visits (totaling 11,800 visits between DYs 3-5 provided through this project).
* **Category 3 Outcomes:** IT-9.2a: RRMC’s goal is to improve (i.e. decrease) the rate of Emergency Department visits per 100,000 out of all uninsured individuals age 18 years and older eligible for ED encounter to its facility in Region 8, St. David’s Round Rock Medical Center, and RRMC aims to demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5..

**Project Description:**

*Community Clinic Services Project*

RRMC wishes to expand the availability of primary care services to a targeted low income population in the Williamson community that is currently uninsured or underinsured and does not qualify for existing public assistance programs but still meets the following income thresholds: at or below 200% FPL and has no other payment source (“working poor”). RRMC also sees the potential to add specialty physician services, pharmacy services and laboratory services as necessary based on an assessment of the population that utilizes these primary care services. RRMC plans to expand the availability of these primary care services by paying existing local clinics and/or FQHCs in Williamson County to provide services to this population, and potentially by partnering with clinics and FQHCs in other communities to expand their services into Williamson County. A “visit” for the purposes of measuring the success of this project will be defined as: “a face-to-face encounter by an eligible patient with a mid-level provider or physician, resulting in screening, diagnosis and/or treatment, as appropriate.” The Williamson County and Cities Health District (District) will provide infrastructure and resources to assist in the delivery of care to the population RRMC wishes to serve.

**Goals and Relationship to Regional Goals:**

The goal of this project is to improve health outcomes and access for the target population by allowing them to receive the right care in the right setting and to help address the current challenges for these patients. Specifically, these patients often do not receive primary and preventative care from the current health care safety net in Williamson County and, as a result, miss the opportunity to obtain early screening and treatment for conditions that can be managed and/or prevented with proper early intervention. The consequence of this lack of care is that these patients suffer from worse short- and long-term health outcomes and quality of life, while the end cost of treating their conditions to the health care system is increased, as the patients will likely end up in the emergency department (ED) or admitted to the hospital if and when their conditions become acute.

**Specific Project Goals:**

* A 5-hour increase in service hours in at least one participating clinic over the baseline established in DY2 – RRMC believes that increasing the hours of availability will allow local clinics to see new patients, both because some patients cannot access clinics during normal business hours and because some patients cannot obtain appointments due to local clinics being at or above their current capacity. A fivehour increase in available hours per week in at least one clinic is intended to provide meaningful change while being realistic in consideration of the resources available in the community.
* Provide the target population with 3096 primary care visits through participating providers in DY3; 3870 visits in DY4; and 4834 visits in DY5. RRMC is targeting an increase in the volume of uninsured, working-poor patients seen at local clinics because RRMC believes more primary care will result in improved patient outcomes and reduced systemic costs for treating these patients. The targeted increases in patient volume and primary care visits will create a meaningful impact on the community (health- and cost-wise) and is a realistic goal in light of current capacity and resources.

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing the proportion of residents with a regular source of care;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

Expected challenges in implementing and maintaining this project include: identifying providers willing to serve this population on top of the current population they serve; allocation of resources in the most efficient manner to reach the maximum number of underserved patients; patient education on the availability of services; and eligibility screening. RRMC expects to address these challenges by effectively leveraging existing primary care capabilities to create additional capacity to treat a new population of patients.

**5-Year Expected Outcome for Provider and Patients:**

RRMC expects this project to result in increased primary care access for a currently underserved patient population. The increased primary care access should result in increased hours of availability by providers, increased patient encounters, and increased volume of patients, which will ultimately allow providers to more effectively manage and/or prevent the onset of chronic conditions linked to poor lifestyle, lack of medication management, or lack of early intervention. The new patients seen in the existing clinics are expected to experience improved short- and long-term health outcomes, greater satisfaction with the healthcare system, great quality of life when managing chronic diseases, and a reduction in the misuse of the ED for primary care (which will reduce the systemic cost of providing healthcare for the Region).

**Starting Point/Baseline:**

Currently, Williamson County uninsured, indigent patients only have local access to care through Lone Star Circle of Care, which is a local FQHC. Lone Star is currently at capacity for adult patients and has a three to four week waitlist for appointments. The District and other local providers have already screened over 2000 Williamson County residents who may be eligible to enroll in this program, thereby allowing them access to primary care visits with participating providers.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 - Limited access to primary care
* Specific Community Need: CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL.

From a population perspective, 16.5% of Williamson County’s adult residents are uninsured and 10.7% of children are uninsured (RHP Plan, Section III, Table 3-3), 5.5% live below poverty levels (RHP Plan, Section 3, Table 3-1), and 7.4% are unemployed. These groups have very little access to primary and preventative care, especially in circumstances where their household income is slightly above the thresholds for existing public assistance programs in the County.

Between 2006 and 2010, Williamson County had $326,889,520 in charges for Potentially Preventable Admissions Hospitalizations (RHP Plan, Section III, Table 3-6) with especially high rates of PPAs for angina, bacterial pneumonia, COPD, diabetes, and urinary tract infections (RHP Plan, Section III, Table 3-6). Each of those conditions can be either prevented or managed through regular access to primary health care, and avoiding hospitalization will benefit both patient outcomes and systemic healthcare costs. Specifically, these conditions can be prevented or managed with proper screening, intervention, patient education, and monitoring by primary care providers. It is imperative for improving Williamson County’s overall health outcomes that underserved patients have access to primary care services. The District will assist in the provision of care to these patients by working with participating clinics to track the number of targeted patients served by this project, the number of visits provided to targeted patients, and to obtain documentation of increased hours at participating clinics. This project will seek to treat patients who are unable to receive primary care elsewhere, which will improve patient health outcomes and reduce the overall cost of treating these patients.

**Core Project Components:**

Project area 1.1.2 includes three core requirements: a) expand primary care clinic space, b) expand primary care clinic hours, and c) expand primary care clinic staffing. However, Section IV of the CMS-approved Planning Protocol allows providers to exclude core requirements if justified in the project narrative. With this project, RRMC envisions the local clinics with which it partners will necessarily expand their available hours to see additional patients, and RRMC will meet that core requirement with this project. However, RRMC does not intend to expand the physical clinic space available in the community, or to add additional clinical staff as a milestone, but RRMC will require contractors to maintain adequate staff levels in order to meet the needs of the patient population served by this program. This project is intended to make use of existing clinic space and staffing in the community and expand the population treated by the existing staff in the existing space. By using existing primary care clinic settings, the need to achieve the core component of expanding clinic space is unnecessary. Participating clinics will be selected based on the accessibility for population served and willingness to provide an increased number of patient visits annually.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** RRMC does not receive funding from other U.S. Department of Health and Human Services initiatives that would be used for this project.

**Related Category 3 Outcome Measure(s):**

OD – 9: Right Care, Right Setting

* Process Milestones: P1, P2
* Improvement Target: 9.2a – Emergency Department (ED) visits per 100,000

Expanding primary care is intended to improve patient health outcomes and satisfaction and transform the delivery system in a manner that reduces the institutional cost of providing healthcare to the indigent community. A large portion of the high cost of healthcare stem from inappropriate use of the ED, which is often the first and only destination for indigent patients seeking primary care services. RRMC intends for this project to give indigent patients currently unable to afford primary care an easier, earlier, and more appropriate setting in which to obtain the care they need. As a result, RRMC’s goal is to improve (i.e. decrease) the rate of Emergency Department visits per 100,000 out of all uninsured individuals age 18 years and older eligible for ED encounter to its facility in Region 8, St. David’s Round Rock Medical Center, and RRMC aims to demonstrate a 5% improvement over baseline in DY4 and a 10% improvement over baseline in DY5.

The baseline rate established in DY3 was 16.51%. RRMC’s baseline measurement period established in DY3 was 10/01/2012–09/30/2013.

**Relationship to Other Projects:**

Category 4 population focused measures: This project should impact RD1 (Potentially Preventable Admissions), RD2 (30 day readmissions), and RD4 (Patient-centered Healthcare).

**Relationship to Other Performing Providers’ Projects in the RHP and Plan for Learning Collaborative:**

This project relates to other RHP 8 projects performed by the District, including:

* 126936702.1.1 Expanded Capacity to Access to Care;
* 126936702.1.2 Expand Access to Urgent Care and Enhance Urgent Medical Advice;
* 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data; and,
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

Utilizing a multi-disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our service area in the community, we can work to link residents to needed resources (i.e. medical home, programs that will promote a healthy lifestyle), assist with their preventive health needs, and capture the data necessary to identify community needs. Additional access to this type of primary care would reduce the elevated costs associated with urgent and emergent care services by allowing earlier screening, diagnosis, treatment and/or management, before the condition reaches the level that necessitates a higher level of care.

**Project Valuation:**

The valuation of each RRMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. RRMC considers this project as high need because local providers have already screened over 2000 residents in the community who are currently without primary care access and may be eligible for this program—through which these patients will experience improved health outcomes and providers will experience a reduction in the rate of this population misusing emergency departments for primary care services. Assisting this population in navigating the health care system and connecting them to a primary care home rather than utilizing the ED results in significant cost savings to hospitals in the community. In addition, the return on investment for serving this population will also result in fewer number of work hours missed, which in turn increases productivity and economic values. Furthermore, the project seeks to accomplish delivery system reform by understanding that clinical primary care providers are in a shortage in this community, the existing wait time for a primary care visit is more than 9 days, and additional financial support is needed in order to maintain and expand the availability of primary care services. The systemic cost of providing health care to the community will be reduced in the aggregate by making this investment in local primary care access.