**Category 1 Project Narrative**

**Williamson County & Cities Health District ‐ 126936702.1.1**

**Project Area, Option and Title:** 1.1.2 Expanded Capacity for Access to Care

**Unique Project ID:** 126936702.1.1

**Performing Provider Name:** Williamson County & Cities Health District (WCCHD)

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description**: Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** This project will expand capacity of access to preventive clinical care through availability of same day or next day appointments by increasing the number of healthcare professionals and extending hours.
* **Project Status:** This project is an expansion of an existing initiative and will add a total of 9,000 encounters in addition to the current 10,000 encounters by the end of DY 5.
* **Project Need:** CN.1.6 – Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County. Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day clinical services refers to those focused services for which access to walk‐in or same day appointments is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: Pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening /immunization. WCCHD currently has one nurse per site, limiting the maximum number of appointments and walk‐in patients able to be seen on any given day. With the limited number of appointments offered and the wait time of 3‐4 weeks for a new patient visit to the local FQHC, patients are using the Emergency Department (ED) for preventable health services.
* **Target Population:** The target population of this project is approximately 80,000 uninsured or underinsured patients in need of preventive clinical services which also includes pregnancy confirmation offered through extended hours with same or next day appointment and/or walk‐in basis. There were approximately 10,000 preventive health services delivered at WCCHD in 2012. Approximately 50% of our current patients are either Medicaid eligible, low income uninsured or indigent, so we expect them to benefit from about half of the proposed project’s services.
* **Category 1 or 2 Expected Project Benefit for Patients:** A pre-DSRIP baseline of 10,000 encounters was established in 2012. By adding additional same or next day appointments and increasing health care personnel, the project seeks to provide 13,000 encounters in DY4 (3,000 over baseline) and 16,000 encounters in DY5 (6,000 over baseline (see Improvement Milestone I‐12.1).
* **Category 3 Outcomes:** The following category 3 measures have been approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-15.6 (Chlamydia screening in women).
	+ IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by clients seen at any one of the WCCHD Public Health Centers (facility subset).
	+ IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years old who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Includes patients seen at any one of the WCCHD Public Health Centers (facility subset).
* **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐ related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐fund the required IGT, could participate in the waiver. Approximately 75,000 individuals are identified as uninsured in Williamson County. Increasing the capacity for access to primary care services where no public transportation is offered, will address a key need that currently exists in the region. Barriers to care lead to delayed care, overutilization of EDs for preventive health needs, and preventable hospitalizations. WCCHD feels that there is a direct correlation between expanded capacity for access to care, improving utilization rates of clinical preventive services, and improved patient satisfaction by having increased capacity to offer an appropriate level of care in at a timely manner, we will be able to improve utilization rates of clinical preventive services in our targeted population. Those patients should be able to report that their needs were met in the primary care setting (not necessitating care at an inappropriate level setting), which will have further positive impact on the medical community by reducing uncompensated care costs.

**Project** **Description:**

*Clinical Prevention Program ‐ WCCHD proposes to expand capacity and access to same day clinical preventive services and care through a) extended service hours and b) enhanced scope of services through expansion of clinic staffing.*

Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day or next day appointments for preventive clinical services refers to those focused services for which access is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening/ immunization. To achieve maximum coordination with medical homes in FQHCs or private practices and benefit appropriate emergency department (ED) utilization, expansion of hours, staff and scope of care is needed, as well as leveraging the IT infrastructure, to allow coordination of this care in and among the medical neighborhood. In contrast to the related St. David’s Medical Center – Round Rock (RRMC) RHP 8 project, our project is focused on preventive health services (i.e. screening, counseling) for any uninsured or underinsured individual, while the RRMC is primarily focused on acute care for individuals under 200% of the FPL. WCCHD will not serve as a medical home; rather, we will complement the continuum of care received in other settings. By offering the availability for same day or next day services that do not require a physician, clients will be diverted to our offices rather than utilizing EDs for these types of services. In addition, women with positive pregnancy tests will also be counseled and connected to a medical home to ensure access to care within the first trimester.

WCCHD currently has one nurse per site, limiting the maximum number of appointed and walk‐in clients able to be seen on any given day. Nursing services are currently available 32 hours per week. With this project, increasing staff will allow us to add nursing services outside of business hours and through the lunch hours, for a total of 40 nursing service hours per site.

This would enable client access to health services through the lunch hour and into the evening. Recent pilots of enhanced weekday hours have documented patient approval because of accessing same day service and/or next day appointments.

We plan to continue our current services (pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; STIs screening and expedited partner therapy and vaccine preventable disease screening/immunization), but also add on new services including well woman exam, adolescent well child care, tobacco cessation counseling, adult physicals, sport physicals, and annual wellness visits. These new services will enhance our scope of services. By expanding our services through employing two nurse practitioners and a physician, the patients will have access to much broader preventative medicine services. These visits will be much more in depth and provide an entry way into our health clinics that was not previously present. The patients will be able to get their full preventative medicine needs met with immunizations, history, physical exam, lab tests, diagnosis and treatment for any newly diagnosed disease states, while also preventing serious disease. We will be able to screen for diabetes, hypertension and cancer using USPTF guidelines. We will be able to identify and treat tobacco addiction. While we do not plan to provide acute care, we will be able to, in most cases, address issues related to a patient’s present medical state without seeking outside care. This will prevent ER visits, by dealing with the issue in the clinic, and avoiding instances where the nurse would need to send the patient to the ER because the issue was beyond what a nurse would be able to handle on his or her own. The nurse practitioner and physician will be able to cover extended hours when appropriate to capture the additional patients who would not normally be able to come in during normal working hours.

In addition to providing clinical preventive services, this project would also offer more same‐ day appointments and walk‐in services for women seeking pregnancy confirmation. In this integrative model, staff will ensure that clients receive coordinated, timely, culturally competent and appropriate health care services and/or referrals, assist in communicating and coordinating health care services with the client’s medical home to avoid inappropriate usage of EDs for primary/preventive health services. Staff will provide care coordination, when applicable, to ensure early entry into prenatal care and establishment of a medical home. Consequently, over the next four project years, it is anticipated that improved access to same‐day or next day services will significantly increase enrollment into prenatal care within the first trimester, and decrease the number of clients seeking to use an ED or urgent care facility for preventive health services.

**Goals and Relationship to Regional Goals:**

In alignment with the regional goals of improving access to timely, high quality care and reducing inappropriate utilization of urgent and emergent services, the goals of this project are:

**Project Goals:**

* Increase access points to care;
* Increase availability of same day and next day appointments;
* Offer enhanced level of preventive health services; and
* Pregnant women accessing care within the first trimester.

**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:**

Health disparities exist in this community, specifically among minority women of child‐bearing age. Recent Williamson County data collected by WCCHD Epidemiology staff suggest that fewer minority women, specifically Hispanic women, seek prenatal care in the first trimester than their non-Hispanic counterparts. From 2009‐2010, for example, 64.3% of Hispanic women were reported to have had prenatal care in the first trimester in contrast to 68.7% Black women and 85.7 % of white non-Hispanic women. Although this is an improvement over the previous two years (51.4% of Hispanic women, 54.6% Black women, and 75.9% of White women are reported to have had prenatal care in the first trimester in 2007‐2008), evidence suggests that women, overall, and specifically Hispanic women, still need better connection to prenatal care. Furthermore, over the past year, financial cutbacks and the subsequent loss of healthcare settings which offered primary women’s health services, have led to further limitations in this area of primary care. Thus, women are seeking care for preventable women’s health services through urgent and emergent care settings.

We realize that one primary reason that people delay accessing care is the difficulty navigating program eligibility. Many clients are overwhelmed with navigating the health care system, thereby giving up or seeking care through an inappropriate level of care (such as an ED). By incorporating a patient navigator in each of our Public Health Centers, clients who access health services at our agency can be directly referred for a quick eligibility screening for internal and external programs and application assistance. Furthermore, in regard to scope of services, our current healthcare professionals on staff, specifically nurses, have a limited scope of practice, limited to screening and treatment under standing delegation orders which precludes them from being able to provide more comprehensive care to symptomatic clients seeking clinical preventive health services.

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

The goal is to consistently define and redefine gaps and needs and increase client access to preventive health services by 10% each project year, beginning DY4.

**Starting Point/Baseline:**

Currently, WCCHD serves as a safety net for the community in the provision of a number of preventive health services. There were approximately 10,000 client encounters for such services in 2012. There are five full‐time nurses and one hourly nurse in the entire health district delivering these types of direct care services.

According to the WCCHD Annual Service Report, from 2009 through 2011, there were an average number of inquiries into the Healthcare Helpline equaling 4,421 contacts by 3,354 persons. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of clients who do not have health insurance coverage, according to the 2012 Community Health Rankings and Roadmaps. This is clear evidence of the need for linkage to healthcare resources through expansion of services within our agency. With the recent loss of some of this county’s Title 10 and Title 20 clinics, the lead time for new patient appointments at the local FQHC is 3‐4 weeks. Clients may not be admitted sooner based on more immediate needs, delaying treatment or leaving no option for them but to seek care at an urgent or emergent care setting.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 ‐ Limited access to primary care
* Specific Community Need: CN.1.6 ‐ Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care or outpatient setting. This often results in more costly, less coordinated care, a lack of appropriate follow‐up care and missed opportunities. Patients who experience barriers in accessing primary care services due to lack of transportation, cost, lack of assigned provider, physical disability, and/or inability to receive appointments in a timely manner are those who benefit from and utilize same day and walk‐in services to greatest advantage. The fact that the local FQHC lead time for new patients is 3‐4 weeks demonstrates that the need for preventive health services exceeds the current capacity for primary care. Many WCCHD clients access services by taking advantage of the flexibility of our walk‐in hours and an increasing number of clients are taking advantage of our extended hours for preventive health services. WCCHD has only been doing evening hours for just over a year and these clinics have been well‐ attended, especially in our high‐volume sites (Round Rock and Cedar Park). Patients relay their gratitude for these services being offered outside of business hours, as it prevents them from having to take time off of work, which is sometimes a luxury they cannot afford. According to data obtained from 30,714 patients surveyed for the Medical Expenditure Panel Survey between 2000 and 2008, patients with access to care during extended hours reported less use and lower associated expenditures for office visits, prescription medications, ED visits, and hospitalizations (10.4% lower for the group with access to extended hours versus the group without such access). This was reported the September 2012 issue of the *Annals of Family Medicine* (*Ann Fam Med*. 2012; 10:388‐395). By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services (see Related Category 3 Outcomes).

**Core Project Components:**

Our goals address two of the three core components of this project: *expansion of primary care clinic hours and expansion of primary care clinic staffing*. With our Public Health Centers located in the heart of four of our major cities in the county, we offer close proximity for our clients that need to access our sites. Health Services, WIC, and social services are co‐located within each of our Public Health Centers. This is designed to allow the clients to access various services at one location, keeping in mind that they are more likely to follow‐through with care/referrals, when related services are more immediately available. Although *expanding outpatient primary care clinic space* is a core component of this project area, WCCHD does not believe expanding physical clinic space is the best use of resources at this time. Instead, the agency will re‐purpose existing space to accommodate increased staff and client volume. Since the goal of the Waiver is to reform health care in a cost‐effective manner, we feel that we can accommodate the increased clinic volume within existing space, and believe our clients are better served by investing project dollars in increased staffing (thereby allowing us to serve our clients more hours each weekday) and enhancing the delivery of care by adding mid‐level providers to our staff.

Clients currently seek services at urgent and emergent care settings, for conditions that could be managed or treated through a primary care setting. Many of these clients presenting to these facilities could have avoided that route, had the client sought access to care sooner. Reasons for this delayed entry into care may include: cost, desire for anonymity, lack of transportation, or the inability to receive appointments in a timely manner. By expanding service hours, increasing staffing, and offering an enhanced level of services at all four Public Health Center sites, clients may have increased access points to care, and become more aware of preventive health services available at an appropriate level of care. Consequently, earlier access to care can prevent inappropriate usage of our hospitals and urgent care settings, thereby decreasing uncompensated care costs.

* Williamson Burnet County Opportunities 2011 Community Needs Assessment:
* <http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf>
* Community Health Profile of Williamson County Precincts (2011)
* <http://www.wcchd.org/statistics_and_reports/>
* Central Texas Sustainability Indicators Project‐2009 Data Report:

http://www.centex‐indicators.org/annual\_rept/ar2009.pdf

* County Health Rankings (2012)
[www.countyhealthrankings.org](http://www.countyhealthrankings.org/)

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** WCCHD does not receive U.S. Department of Health and Human Services program initiative funds which would be associated with this project.

**Related Category 3 Outcome Measure:**

The following category 3 measures have been approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-15.6 (Chlamydia screening in women).

* IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by clients seen at any one of the WCCHD Public Health Centers (facility subset).
* IT-15.6 (Chlamydia screening in women): We will demonstrate improvement by increasing the percentage of women 16-24 years old who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Includes patients seen at anyone of the WCCHD Public Health Centers (facility subset).

Reasons/rationale for selecting the outcome measure:

This particular domain was chosen to help evaluate this project’s interventions. As mentioned above, our goal is expanded capacity to access primary care. By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention, and a positive impact on the community. As we do not currently capture this data on our client survey, we will perform a needs assessment DY2, so we can select a tool that will help us best capture all data in this domain. In DY3, we will be continuing to perform project planning activities, establishing a baseline for patient satisfaction. Simultaneously, we will have had time to increase staff and begin offering an enhanced level of services at all four sites. These interventions will have allowed us to begin increasing service hours, ultimately increasing access points. Meeting the needs of the clients in the primary care setting for preventive health services will decrease the possibility of their needing to seek care at an urgent or emergent care setting. Furthermore, this particular domain is centered on patient satisfaction in getting timely care, appointments, and information. Our second outcome addresses the rate of chlamydia screenings as an indicator of improved access to preventive health services. Once the DY3 baseline is established, we will then set improvement targets based on the QISMC standards.

**Relationship** **to** **Other** **Projects:**

This project relates to all other WCCHD projects, including:

* 126936702.1.2 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 health care;
* 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data;
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
* 126936702.2.2 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

Utilizing a multi‐disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our clinics, and out 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. WCCHD seeks to remain easily identifiable as the local health department, with the understanding that the role of this agency is to protect and promote the health of the community, and prevent illness. The identification of and addressing of health disparities in the community follows the essential public health services that this agency strives to deliver. Conditions that lead to preventable urgent and emergent care utilization are conditions that could be screened, treated, and/or managed by a mid‐level provider in the community (i.e. STIs, pregnancy confirmation). 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.

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

We realize that our community’s needs are not unique. Other communities within the RHP face similar issues in addressing the preventive health needs of their residents. Therefore, we anticipate that other projects will be developed and implemented to address these needs. It is the hope that in collaborating with other performing providers in this region working on similar projects, we can share our ideas, challenges, and successes. Conference calls and periodic meetings will be held, and newsletters will be distributed regularly to share progress of the projects and data related to interventions.

**Project Valuation:**

The valuation of each WCCHD project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. In 2012, 10,000 preventive health services were delivered by WCCHD, with approximately 370 clients presenting for STD services. The cost of treating STDs in EDs can be six times higher than treating in a primary care setting. Hospitalizations from complications of untreated or undertreated infections can cost 12 times higher than if having been identified and treated in a primary care setting. Providing timely, well‐informed care, at the appropriate level and setting for targeted population will redirect them from unnecessary use of urgent and emergent care facilities. The ability to access theses services at an appropriate and affordable level of care will consequently reduce the amount of associated uncompensated care costs encountered through delivery of services to targeted population.

Overall, the project seeks to accomplish delivery system reform by understanding that there is a shortage of clinics that provide preventive health services in this community; that due to this shortage, the average wait time for a new patient can be three weeks or longer; and that in order to fill in this gap in care, additional funding sources and support is needed. Moreover, the diversion of inappropriate non‐emergent care services through urgent and emergent care facilities, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. The value cost of this project, including Category 3, for DYs 2‐5 is estimated at $4,483,549 which is an added savings of over $4,000,000 when compared to the costs of ED visits.