Methodist Healthcare Ministries' Social Innovation for a Healthy South Texas:
Transparency Documents

Methodist Healthcare Ministries of South Texas, Inc. (MHM) is committed to transparency in grant-making. This *Plan* includes a description of the application review and selection process. In addition, the following information for new and recompeting applications will be published on www.mhm.org within 90 business days after grants are awarded:

- A list of awarded Sí Texas subgrantees
- The full applications of awarded Sí Texas subgrantees
- A list of all compliant applications submitted
- Executive summaries of all compliant applications as submitted by the applicants
- Summaries of external reviewer comments on successful applications
- A blank template of the external review form
- A description of the grantee selection process
- A list of all external reviewers that completed the review assignment

Publication of this *Plan* does not obligate MHM to award any specific number of grant agreements or to obligate the entire amount of funding available.

Sí Texas Subgrantees

Community Hope Projects, Inc. dba Hope Family Health Center

Mercy Ministries of Laredo

Rural Economic Assistance League (REAL)

Tropical Texas Behavioral Health

Texas A&M International University (TAMIU)

The University of Texas Health Science Center at San Antonio (UTHSCSA)

Lower Rio Grande Valley Community Health Management Corp, Inc. dba El Milagro Clinic

Abstract

Project Name: Si Texas HOPE Integrated Behavioral Health Project
Organization Name: Community Hope Projects, Inc. dba Hope Family Health Center
Address: 2332 Jordan Rd., McAllen, TX 78503
Project Director's Name: Rebecca Stocker
Phone Number: 956-994-3319
E-mail: rramirez.hrhc@gmail.com
Funding requested for first two year period: $500.061

Community Hope Projects, Inc. doing business as Hope Family Health Center (HFHC), located in McAllen, Texas, provides free medical, counseling and case management services to over 2500 uninsured individuals annually in the LRGV. All patients who are provided medical care and mental health counseling at HFHC are 100% uninsured and do not qualify for any government funded medical assistance. The adults and families served at HFHC are low income with a household less than $14,000 for a family of four compared to the state average of $51,704.

HFHC serves the four county area of the LRGV including Starr, Hidalgo, Willacy and Cameron. Although the clinic is located in McAllen, due to its unique model, HFHC annually sees patients from all four counties in the following percentages: 50% from Hidalgo County, 30% from Starr County, 10% from Willacy County and 10% from Cameron County.

Founded by members of Holy Spirit Catholic Parish, the mission of HFHC is to provide patients with quality care for their mind, body and spirit regardless of ability to pay. All services are provided at no cost by medical professionals who volunteer their services either on-site at HFHC or when necessary at the volunteer's private practice.

Knowing that seventeen years of co-located collaborative care at Level 3/4 has proven successful for both patients and medical professionals, HFHC is ready to take strategic steps to move toward Level 5 and ultimately Level 6 in the next five years. HFHC proposes to enhance its current systems by following the Integrated Behavioral Health (IBH) model. IBH is a collaborative care model of identifying and treating mild-to-moderate mental disorders in adults in a primary care setting. HFHC will adapt the model for bilingual (Spanish and English) and monolingual (Spanish speaking) participants.

The ultimate goals of the IBH model are to: 1) More effectively meet the mental health needs of patients; 2) Improve the physical health and functioning of the patients in the program; and 3) Improve the efficiency of clinic operations. Ultimately providing evidence based interventions of health to a community with little to no access.

Narrative

Need:

Community Hope Projects, Inc. doing business as Hope Family Health Center (HFHC), located in McAllen, Texas, provides free medical, counseling and case management services to over 2500 uninsured individuals annually in the LRGV. All patients who are provided medical care and mental health counseling at HFHC are 100% uninsured and do not qualify for any government funded medical assistance.

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Founded by members of Holy Spirit Catholic Parish, the mission of HFHC is to provide quality integrated medical, mental and educational health care services to the poor and indigent living in the LRGV. The organization ensures patients are provided with quality care for their mind, body and spirit regardless of ability to pay. All services are provided at no cost by medical professionals who volunteer their services either on-site at HFHC or when necessary at the volunteer's private practice.

With its faith-based roots, HFHC believes in caring for the poor and indigent. The need for assistance along the Texas/Mexico border community continues to grow. According to the Texas Medical Association (www.texmed.org), poverty and lack of medical insurance and clinical care is dramatically higher in the Lower Rio Grande Valley (LRGV) than in the state as a whole. In 2014, 18% of the total population of Texas lived

in poverty while 37.6% of the total population of the LRGV lived in poverty. In addition, 48% of children in the LRGV live in poverty compared to 34% of children living in poverty in Texas. Since poverty rates and uninsured rates are connected, the LRGV's uninsured rate is 35% compared to 26% at the state level and 15% nationally. The adults and families served at HFHC are low income with a household less than $14,000 for a family of four compared to the state average of $51,704.

Many of HFHC's patients are the working poor – they have jobs but cannot afford health insurance and their salaries are too high to be eligible for public assistance. In other circumstances, patients are unemployed or underemployed and their seasonal income qualifies them for only for insurance though the Affordable Health Care Market Place without any subsidies costing them a monthly premium out of their financial reach. In this situation, families have no option but to go without health insurance. According to the Bureau of Labor Statistics, unemployment rate in 2014 was 4.7 in Texas. The LRGV has the counties with the highest rates including Starr (15.4), Willacy (13.8), and Hidalgo (10.8).

Depression, Diabetes and obesity prevalence data and Hope data:

In 2013, HFHC served 2,012 adults ages 18 and over. In 2014, the number grew close to 2,500 and 2015 numbers are expected to jump to 3,200. The growth has been strategically controlled based on the clinic's capacity and resources. However, it is a commitment of the Board of Directors and clinic leadership that planning for growth is top priority. Although HFHC desires to serve more patients due to the growing need of uninsured and indigent community residents, it also desires to identify the best and appropriate manner in order to plan for and implement that growth.

At HFHC in 2014, 40% of patients suffer with hypertension, 40% of all patients suffer with diabetes and 26% of all patients suffer with both hypertension and diabetes. The rates are alarming given that only 11% of the general population in Texas have diabetes (America's Health Rankings – United Healthcare Foundation 2014).

Unfortunately, obesity rates at HFHC closely match the LRGV regional at 40%. According to the Gallup-Heathway Well-Being Index for 2012, the McAllen-Mission-Edinburg area where HFHC is located is the most obese community in the country. With obesity measured at having a Body Mass Index of 30 or more, the national obesity rate is 28% and Texas has a rate of 30.9% overall. The local LRGV community has a rate of 39%. All according to the 2014, America's Health Rankings – United Health Foundation www.americashealthrankings.org.

The need for HFHC's counseling services are closely tied to the general primary health care need. All patients are screened for depression using the standard depression screening tool during their primary care visits. Those in immediate need for further psychiatric consult are immediately referred to the HOPE counseling services who help them in connect to the appropriate professionals. HFHC employs four full-time professional MSW LPC counselors who annually serve 341 patients. Access and availability for mental health professionals to the uninsured and low-income population is dire in the LRGV. According to the County Health Ranking (www.countyhealthrankings.org) published by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, the ratio for mental health providers to individuals in Texas is 1:1,757. However, in the LRGV the average of the four county area is 1:15,549. The data offers evidence of what HFHC staff and

volunteer physicians see on a daily basis. The lack of mental health providers in the four county region is alarming when combined with other local risk factors such as high obesity rates, high diabetes rates, high poverty rates, high unemployment rates and the rate of new immigrants.

At HFHC, 18% of patients receive both primary care and behavioral health care. In 2014, 9% of patients receiving behavioral health care services have never received primary medical care at HFHC. The primary diagnoses of counseling patients at HFHC have been and continue to be depression and anxiety. In order to meet the needs of the community, the counselors represent the community and all are bilingual in English and Spanish. The Si Texas HOPE project will further measure and analyze counseling services and patient satisfaction in order to build the practice and reach more community residents in need.

It is both an asset and a challenge that the LRGV shares a border with the State of Tamaulipas, Mexico. There are currently nine Texas-Mexico international bridged and border crossings in the LRGV. Despite the danger in northern Mexico and the current border violence issues that South Texas faces, the border still appears to be attractive to migrants. Families longing for safety and opportunity make every effort to join family members in the LRGV.

The majority of those recent immigrants from Mexico and Central America live in poverty in “colonias”. Defined as unincorporated settlements of land providing substandard housing communities lacking most basic living necessities such as drinking water and sewer systems, electricity, paved road and safe and sanitary shelter;

"colonia," in Spanish means a community or neighborhood. In 2014, the Texas Secretary of State identified the LRGV as the area of Texas with the most “colonias” with 1,412 in the four county region. The growing “colonia” problem challenges the already strained local, county and state resources. Therefore, “colonia” residents rely on an episodic system of care depending on funding and strained social progams with limited capacity. The Texas Secretary of State maintains information about “colonias” and more can be found at http://www.sos.state.tx.us/border/colonias/faqs.shtml

Staff training needs:

HFHC staff includes an executive director, medical services coordinator, office manager, office assistant, case manager and four MSW LPC therapists. The executive director spends 70% on administration and 30% of her time as a practicing LCSW Psychotherapist. The staff is minimal for a fully functioning primary care and behavioral care medical clinic serving up to 3,000 patients annually. All physicians and medical professionals who see patients in primary care donate their time as volunteers.

As the small but competent team of staff and volunteers takes on enhancing and expanding the IBH model, additional training and certifications are required. Although the new staff proposed to be hired for Si Texas HOPE will be recruited to be highly qualified to do their jobs, they will also require ongoing training and certifications in a variety of topics directly related to IBH. HFHC expects to send staff to training and conferences, offer on-site training, purchase printed learning materials, and taking advantage of web-based synchronous or asynchronous learning opportunities. The following is a list of subjects that will be considered: FIT Therapy (outcome measurement in therapy practice); trauma, grief & human trafficking; conflict

resolution/domestic violence; Laughter Yoga, IBH cross-discipline training for physicians & behavioral health care providers; diabetes management, obesity interventions, measurement and evaluation; business practice management; federal grants management; and IBH policy and research. Appropriate training expenses have been added to the project budget. HFHC will also engage volunteer local professionals when available to provide on-site presentations and technical assistance.

Project Description

Current stage of behavioral health integration:

Hope Family Health Center has offered both primary and behavioral health care since its creation in 1998. Its collaborative health care model was implemented as a way to provide quality holistic care of the mind, body and spirit to those most in need, bridging the gap between the uninsured population and their ability to receive medical and counseling services.

The last seventeen years has seen HFHC maintain a model of co-located primary and behavioral care. Today, HFHC's 12,000 square foot building allows it to provide all three services – medical, counseling and case management – in one location. Patients receive free medical and counseling services on-site to meet their multiple needs in one location. In addition, a case manager provides social service referrals to patients in need of additional services to support compliment and advocate for their health care needs. Over the past twelve months the case management team of HFHC has held over 3,000 appointments, assessments, and phone calls with patients to help them meet their medical needs and goals.

Meeting multiple needs for each patient in one visit has resulted in satisfaction and better overall outcomes for both the patient and the provider. HFHC leadership including its board of directors remain committed to moving from the current collaborative model where medical and behavioral providers work with each other to a more fully integrated model with shared treatment plans, shared service provision, and shared record keeping. With the Si Texas HOPE project funding, HFHC plans to strengthen its systems, enhance its capacity and expand its services to meet the needs of more patients. The ultimate goal of Si Texas HOPE is to leverage the organization's seventeen years of collaborative care and take a significant jump from Level 3 Basic Collaboration Onsite/Level 4 Close Collaboration with Some System Integration to a fully functioning Level 6 Full Collaboration in Transformed/Merged Integrated Practice as defined by the SAMHSA-HRSA Center for Integrated Practice.

Dedicated to the overall care of the community it serves, HFHC also offers community educational informational and training events on health matters such as influenza, depression, stress management, nutrition and diabetes. The educational series is another way to provide patients with the knowledge needed to self-manage their health. Some of the gatherings are also therapeutic interventions that give potential patients an entry point to services. Such activities currently include Laughter Yoga, a facilitated emotional and physical exercise developed by a physician useful in managing depression, anxiety and blood pressure.

Integrated care model proposed:

Knowing that seventeen years of co-located collaborative care at Level 3/4 has proven

successful for both patients and medical professionals, HFHC is ready to take strategic steps to move toward Level 5 and ultimately Level 6 in the next five years. After research and numerous discussions internally with stakeholders and externally with peer charitable clinics, HFHC has decided to enhance its current systems by following the Integrated Behavioral Health (IBH) model. IBH is a collaborative care model of identifying and treating mild-to-moderate mental disorders in adults in a primary care setting. As done in cited implementation sites, HFHC will adapt the model for bilingual (Spanish and English) and monolingual (Spanish speaking) participants. The model was funded by St. David's Foundation and the Hogg Foundation; and was implemented at People's Community Clinic in Austin, Texas in 2006 and at Lone Star Circle of Care in Georgetown, Texas in 2007. The level of evidence is preliminary since it refers to studies completed on a similar organization at 2 sites with a Quasi Experiential Design. It was evaluated and the outcomes published in two reports cited here and full reports uploaded to FTP site connected with this proposal:

1) Watt T. A. Process and Outcome Evaluation of 2 Integrated Behavioral Health Care Models: People's Community Clinic and Lone Star Circle of Care: Year 3/FinalReport. http://www.austinpcc.org/documents/specialprograms/IBH_year_3_report.pdf. Published 2009. Accessed August 29, 2012.

2) Sanchez K. and Watt T. Collaborative care for the Treatment of Depression in Primary Care With a Low-Income, Spanish-Speaking Populations: Outcomes From a Community-Based Program Evaluation. Prim Care Companion CNS Disord 2012;14(6):doi:10.4088/PCC.12m01385 : 10.4088/PCC.12m01385

In Austin, People's Community Clinic used the IBH model to enable adult clients

diagnosed with depression and anxiety to receive psychiatric medication, counseling and education. The clinic had tremendous success with the program, achieving treatment results typically seen only in controlled clinical trials.

The studies concluded that the IBH model improved primary care patients' mental health outcomes with a minimal investment of resources. Developed originally by researchers at the University of Washington and other universities, the model brings a mental health care manager and consulting psychiatrist into a primary care facility to more effectively serve clients with mental health needs. For this reason HFHC proposes to implement the IBH model for the next five years and rigorously evaluate its effectiveness in the Lower Rio Grande Valley.

Evidence based practice of selected model:

The ultimate goals of the IBH model are to:

1) More effectively meet the mental health needs of patients
2) Improve the physical health and functioning of the patients in the program
3) Improve the efficiency of clinic operations

Keeping with the three major goals, HFHC intends to significantly enhance its care and expand its services to more patients.

For enrollment in the IBH program, the primary care physicians initially identifies the patients in need of mental health services based on the clinical interview and physical evaluation of the patient. While remaining with the physician, the clinical social worker/counselor will interview the patient and if necessary officially screen for level of

mental health and any substance abuser risk or concern. A care manager then conducts a review of both physical care notes and screening outcomes and makes an informed decision about offering the patient enrollment in the program.

The patients are offered up to 6 sessions with the clinical care manager, a Master's-level clinical social worker. The clinical care manager is bilingual when necessary and culturally competent to provide services. The clinical care manager functions as a behavioral care specialist, provides supportive counseling and patient education, systematically follows up with patients for assessment, and tracks patient progress and contacts in a patient registry. The follow-up schedule is established at the first visit with the care manager, during the assessment and enrollment. The care manager can also makes follow-up contact with the patients by telephone.

A consulting psychiatrist with the IBH program provides consultation for 4 hours per week to review cases with the care manager and staff counselors. The psychiatrist evaluates high need patients with diagnostic or treatment concerns and makes treatment recommendations to the clinical care manager, counselor and the primary care physician. If the patient demonstrates low level depression, anxiety or other mental health issue, a staff counselor will make up the trio of care including the care manager and physician. The care manager acts as a liaison between the psychiatrist/counselor and the primary care physician, communicating the psychiatrist's/counselor's recommendations back to the primary care physician. The care manager is a new full-time positions created to successfully implement the IBH model. The primary care physician prescribes all medications to the patients enrolled in the IBH program.

The primary care physicians in the clinic will select a physician “champion” to serve as a liaison between themselves and the program administrators, the clinical care manager, and the psychiatrist/counselor. As part of the IBH program, the clinic will also employ an additional Master’s level social worker licensed professional counselor, and a transitional nurse responsible for delivering a patient centered program for patients with uncontrollable diabetes and/or obesity . The chronic care management program’s goal is to empower each participant, and their families, to understand their diagnosed chronic condition and to bridge the gap from living with uncontrolled diabetes to controlled diabetes.

The transitional nurse will be part of the IBH care team as an additional resource addressing patients’ issues other than their mental health concerns, such as referrals to community resources for nutrition, exercise, smoking cessation, and disease management support groups.

All patients will be informed of the new IBH program objectives. Patients who opt to enroll in the IBH program will be assessed closely for all needs and an IBH care plan will be created. Patients with diagnoses considered beyond the expertise of the clinic staff will be referred to the partner community agencies, Tropical Texas Behavioral Health and Behavioral Health Solutions. These diagnoses may include substance abuse, severe personality disorders, and chronic psychotic disorders such as schizophrenia. However, based on the IBH model, the partner agencies will collaborate with HFHC and share patient progress. Once patients are enrolled in the IBH program and their data is entered into the patient registry, they remain participants in HFHC’s program as long as they remain primary care patients.

Cost-effectiveness:

The studies on the IBH model demonstrate significant reduced costs. Patient primary care visits drop after the first year and then drop significantly during the second year. HFHC expects that the significant funding investment in staffing, technology and professional services will stabilize patient costs in year one, decrease in year 2-3 and then allow for a significant increase in the number of new patients who will be able to access behavioral health care as needed and minimal primary care visits.

HFHC is a no-cost clinic. It currently does not have a system in place to charge patients, collect payment or code services for payment. Therefore, the cost of all services, supplies, facilities and staffing is covered by charitable gifts, grants and fundraising events. Effective stewardship of all funds and resources developed is in the hands of all who serve HFHC. Saving on costs without reducing quality and quantity of services is a core competency of the clinic. However, standardizing the IBH model with systems seamlessly practiced daily by all will only further stretch funds allowing HFHC to do more with funding while also having a successful model to reach new donors.

As an all-volunteer physician and specialist charitable clinic, HFHC depends on the generosity of medical professionals and local medical businesses. Leveraging the donated time, service and supplies of physicians is of great value to the sustainability of the clinic.

The IBH model will include significant recruitment and retention efforts of volunteer medical professionals. A heavy professional education component on the benefits of IBH will be provided and measured. HFHC expects that from year one of the project to

year five, a significant buy-in by volunteers will happen both new and current physicians will find greater satisfaction and patient outcomes. The increase in volunteer engagement and support will also decrease clinic costs.

Five year work plan review:

The five year work plan uploaded as an attachment, clearly identifies four focus areas and six goals based on the preliminary goals of the IBH model.

Focus Area 1: Enhancement and support of current primary and behavioral health care integrations. The goal of this focus area is based on the critical need to engage, inform and reduce all barriers to allow physicians' roles and culture blend and blur as they fully integrate their primary care with behavioral health care. With three action steps that will begin immediately as project begins and then are systemically maintained and continuously improved as needed throughout the five years of the project, it is expected that at least 90% of primary care volunteer providers will incorporate behavioral health assessment into each routine care visits by end of the funding period and as measured by observation, interviews, number of screening tools utilized and percentage of patients referred to IBH program.

Focus Area 2: Collaboration in a fully integrated system. The goal of this focus area corresponds to the original goal of moving from a collaborative model of Level 3/4 to a fully integrated model at Level 6. Based on the current level of system of co-location with limited integration, there are six key steps to achieving the five year goal. It is expected that by identifying barriers and upgrading all information technology; training all staff, volunteers and external partners in use of the patient registry/database;

providing cross-discipline education to all members of the care team; standardizing team communication policies and procedures; finalizing formal agreements with external IBH partners; and finalizing an evaluation plan to measure outcomes; will lead to achieving full collaboration in a practice at Level 6 at the funding period.

Focus Area 3: Patient Primary and Behavioral Health Improvements. This focus area includes two major goals including linking the co-morbidities of obesity, diabetes and behavioral health. HFHC patients who suffer chronic diseases are at most risk of a lifetime of illness and are more likely to present symptoms of depression, anxiety and pain. In order to reach optimal health in patients with a combination of physical and mental illness, key action steps include the following: 1)creating and providing eligible patients access to IBH with culturally-relevant education, training and outreach activities; and 2) dedicated treatment and monitoring of participants by the IBH care team. Specifically the goals are as follows: Goal 1) By the end of the funding period, at least 80% of patients with both 1) obesity and 2)depression, anxiety and/or a substance abuse issue will achieve significant improvements in their health as measured by reducing their BMI, reducing their weight, improving their mental health assessment scores, successfully managing their substance abuse, increasing their satisfaction with clinic visits, lowering their blood pressure and lowering their bad cholesterol levels. Goal 2) By the end of the funding period, at least 80% of patients with both 1) diabetes and 2) depression, anxiety and/or substance abuse issues will achieve significant improvements in their health as measured by reducing their A1C levels, improving their dietary factors, reducing their weight when necessary, improving their mental health

assessment scores, successfully managing their substance abuse, increasing their satisfaction with clinic visits and managing their daily glucose levels.

Focus Area 4: Cost Effectiveness. This focus area corresponds clearly with the original outcomes of the IBH model. In the studies cited, the IBH model significantly reduces patient costs. In the HFHC IBH model, although the patient never bears the cost of care, reducing the cost the clinic to serve patients is critical. The goal for this focus area is as follows: Hope Family Health Center will be able to serve 50% more patients through cost savings and improved stewardship of charitable funding as measured by increase in number of new annual patients at the end of the funding period. Key steps to achieve goal include: establishing data collection and data analysis system in new HIE database to measure frequency of visits, number of new patients, decrease in hospitalizations, and decrease in specialty referrals; and monitor and track project budget, organizational budget and fundraising needs.

Timeline of activities to ramp up to achieve the outcomes:

Once awarded, HFHC plans to immediately recruit and engage the Si Texas HOPE IBH team. Within the first three months all staff and consultants will finalize all details of the five year plan but begin work on the specifics of the first year of the program. This will include selecting all tools including those to measure outcomes. New and current staff will attend trainings and certification programs to elevate their knowledge and skills in IBH. Consultants will implement the information technology systems including all procedures to begin using the EHR and the HIE at its optimal level. Organizational leaders will ensure that all staff and volunteers understand the changes and

improvements happening rapidly at HFHC by spending quality time with all stakeholders and engaging them in the process.

Core competencies:

The IBH program at HFHC will significantly improve and enhance the current operations of the co-located primary and behavioral health care. With additional staffing, enhanced technology, upgraded information management, and new systems for standard operation procedures, the level of core competency to effectively implement the model will be in place in the first six months of the project.

Although already part of a local Health Information Exchange (HIE), the new contract with the regional HIE will not only provide a clinical repository, a health summary exchange, clinical communication solutions and clinical notification solutions; but will also provide analytics. The analytics will include chronic disease dashboards, care management tools, and quality program monitoring. In addition, a consultant will be dedicated to HFHC and responsible for training staff and volunteers in full utilization of the patient registry and all data dashboards. The set up and training will take six months. By the end of the first year, HFHC will be able to create and maintain patient records in the Community Health Record, exchange health summaries including medications, allergies, problems and immunization, etc. with the Community Health Record. Care Managers will have access to hospital notifications to coordinate care with patients post-discharge; at least four volunteer physician practices or external partners not currently using EHRs will be able to access the HIE platform to view clinical data and coordinate care with patients and colleagues; and at least one practice currently

using EHRs will be able to access the HIE platform to view clinical data and coordinate care with patients and colleagues and access result directly in their EHR workflow.

Internally, staff and volunteers will use a new protocol that will streamline patient scheduling and shared treatment planning. Patient records will no longer have two files, one for primary care and one for behavioral health care. The move toward one patient record that includes access to the IBH care team to see relevant information will begin in the first six months. All barriers to a fully integrated record keeping system will be reduced through strategic and continuous improvement. The primary IBH Care Team made up of the physician, care manager, and MSW/LPC will test the new systems and continuously evaluate the process.

Scalability: In year one, the IBH program will build capacity to begin to scale up in year two to serve more patients. In years 2-4, the new systems for streamlining workflow and information management are expected to allow for expansion to open the clinic six days a week with full services and allow for evening hours. By year five and the end of the project funding period, HFHC is expected to offer services in additional space located in the same facility.

Evaluative Measures

Existing evaluation capacity:

With only nine employees and no primary care providers on staff, HFHC operates at an optimal level with minimal resource. In 2014, the clinic served 3,000 unduplicated patients with primary care visits, mental health counseling, and case management. Annual reporting to date has focused on inputs and outputs including utilization of

charitable funding and in-kind donations. The focus has been on maintaining a desirable level of volunteer physicians in order to optimize every hour of every day the clinic is open and mitigating any risk of operating in a medical environment.

However, the 2015 strategic plan includes implementation of a process and an outcome evaluation for the organization and programs. With the 2014 hire of a contract grant writer, and successful awards of larger grants from new funders requiring more reporting; HFHC is at a critical growth crossroads. Choosing to grow, develop and scale up requires a focus on evaluation activities in 2015 and beyond.

Currently, HFHC collects general patient demographics, general diagnostic trends, number of visits, number of missed appointments, number of unexpected closures or volunteer cancelations, volunteer hours, and number of referrals. The data inform decisions for staffing, program improvement needs, and outreach needs.

Theory of Change:

The Si Texas HOPE theory of change is as follows: The use of an IBH model at a charitable clinic, used with collaborative strategies, will lead to Rio Grande Valley wide improvements in chronic disease and behavioral health for the uninsured.

By identifying and removing barriers to full integration of primary and behavioral health care in charitable clinics ultimately leads to significant improvements in obesity, diabetes, and behavioral health such as depression, anxiety and substance abuse for the uninsured served.

Logic Model: With resources and inputs of leadership, current staff, new staff, volunteers, technology, infrastructure and an evidence based IBH Model; HFHC will

implement evidence based activities such as motivational interviewing, depression screening, substance abuse screening, diabetes management, weight management, laughter yoga, grief & trauma counseling, and other activities as needed.

All IBH program assets and activities will be consistent with achieving the near –term goals of achieving a team of primary/behavioral health/care managers who understand and promote and champion team based care management for participating patients; implementation of effective and efficient work flow protocols & processes created and all staff & volt. are knowledgeable in their use; patient information technology systems are robust and data integrity is maintained; and increased, formalized and measurable collaborations with appropriate partners are in place.

Thereby, at the end of the five year funding period, the mid-term goals of increased access and utilization of team approach to primary and behavioral health care services – barriers reduced significantly; improved health and behavioral health care outcomes for patients; increased quality & quantity of IBH treatment services in one location; and significant savings and improved stewardship of charitable funding – increased number of patients served with more services. Please see the attached Logic Model with more details.

Process by which progress toward enhancement and expansion will be tracked:

Based on the urgency to first ramp up all standard operating procedures and tools for measurement and evaluation, an experienced consultant and contractor will assist the project team within the first 90 days. The team will invest in planning time in order to take strategic steps as designed in the initial action plan to enhance capacity. By the

end of the first six months of the project, the Clinical Quality Specialist with the RGV HIE will complete initial training with all staff and volunteers. At the six month mark, project staff will take on the complete responsibly of tracking, measuring, analyzing results and managing for continuous improvement in case of any needed adjustments.

Lead Evaluation Personnel:

As part of the new regional HIE contract, the first two years will include a dedicated clinical analyst who will assist the IBH project team in all process and outcome evaluation activities. The positon requires a professional level analyst and technology specialist able to provide comprehensive services including training administrators, medical staff and volunteers in use of the platform and database for evaluation.

In addition, the IBH project will also contract with an independent evaluation specialist able to focus on building the organization's capacity to integrate rigorous evaluation activities into the standard operations of the clinic. This positon will train others and in year 3-5 will become an employee of HFHC responsible for measurement and evaluation of organizational infrastructure to support IBH, evaluation planning, measurement and evaluation of content and data capacity; building and maintaining measurement and evaluation systems and measurement and evaluation of use and distribution of outcome reports and assessment.

Simultaneously as the contractors are engaged, HFHC staff will be trained to sustain the efforts internally through years three through five.

Collaboration

As a small nonprofit organization and charitable clinic, HFHC is experienced in collaborating with community partners. In need to refer patients to other charitable programs in the LRGV, staff maintains a strong network of positive relationships with decision makers with other clinics, medical practices, medical service businesses, faith-based organizations, churches, government agencies, and individuals.

In particular, HFHC maintains formal agreements with Tropical Texas Behavioral Health and Behavioral Health Solutions. Tropical Texas offers HFHC patients walk-in appointments for severe or emergency mental illness needs. They also bring their mobile unit to the HFHC parking lot on a bi-weekly basis in order to maintain the continuity of care for patients who lack transportation. Behavioral Health Solutions provides licensed chemical dependency counselors (LCDC) for the community and memorandums of understanding are in place to ensure services to HFHC patients are streamlined. As part of the new IBH project, a more formal agreement with both partners will integrate them into the IBH Care Team. Sharing data and tracking patients will make HFHC patients no longer simple referrals to other entities but will remain in the system in order to serve them better. For example, Behavioral Health Solutions will place a LCDC specialist at HOPE on-site with a regular schedule, making it easier for patients who lack transportation and are more comfortable receiving screening and/or counseling at HFHC.

Another new project partner included in this proposal is the formal agreement with Salud y Vida: RGV Chronic Care Management out of the U. T. Health Science Center – Houston operating in Brownsville, Texas. Salud y Vida has a successful reputation in the LRGV. It is an innovative program designed in partnership by local organizations to

transform the delivery of chronic care management for type 2 diabetes in the Rio Grande Valley of Texas (RHP 5). This program identifies participants with uncontrolled diabetes (A1c >9) and recruits them to participate in a structured multi-disciplinary program to promote control and/or improvement in the participants' diabetes and overall health status, resulting in decreased acute care utilization over time.

The many benefits to the participants on the Salud y Vida: RGVCCM program will greatly serve HFHC patients. Participants will benefit from getting a patient-centered approach through education, skills building, and support to help them live a healthy life. More specifically, a transitional specialist who is a registered nurse will be hired by HFHC and will work as the clinic's own employer who will be trained by Salud y Vida in their curriculum and model of support services, self-management education (DSME) classes, every patient receives a glucometer and test strips to monitor diabetes at home, access to exercise classes, home visits by community health workers for education, guidance and support, text message support and a HbA1c exam every 3 months. This program will be a valuable addition to the IBH program activities, goals and outcomes. This partnership between HFHC and UTHSC-Houston will be unique and offer both organizations opportunities for a close partnership throughout the five years of the project. In return UTHSC-Houston will be able to expand their services into Hidalgo County.

In addition, HFHC will also collaborate with UTHSC-San Antonio through another unique opportunity to expand services. UTHSC-SA through its first class of Family Medicine residents program beginning July of 2015, will offer an inter-professional team to HFHC. The team will include two master's level therapists with experience in medical

settings, one PhD level clinician and a consultant psychiatrist. At HFHC, the team will act as trainers and mentors to the clinic's staff and volunteers. Providing on-site continuing education, cross-discipline training, seminars, and updates on latest research. This ongoing education will assist in reaching the IBH goals and outcomes based on staff and volunteers adoption of the full integration Level 6 model. In return, UTHSC-SA residents will have an opportunity to work in a unique setting of a charitable clinic serving a unique population of patients, staff and volunteers.

Current Collaboration Example:

HFHC sees a little more than 2500 patients annually. It expects to see 3500 patients in 2015 and continue the growth at the same pace based on increasing organizational capacity. The controlled growth began in 2014 with the award of the 1115 Health Transformation Waiver Grant to a local hospital who partnered with HFHC to deliver the indigent care. The 1115 Waiver is a Federal waiver preserves the Upper Payment Limit (UPL) funding under a new methodology, but allows for managed care expansion to additional areas of the state. The waiver incentivizes hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

Although HFHC is a private charitable clinic and not a Federally Qualified Health Center, the partnership with Doctor's Renaissance Hospital (DHR)provides a win-win for HFHC and its patients. As part of the Texas 1115 Waiver grant, HFHC does not receive reimbursement for the cost of the patient's care; however, the partnership with Doctor's Renaissance Hospital provided for the placement of a full-time Family Nurse Practitioner and a Medical Assistant at HFHC facility in order to serve additional patients

during additional service hours. The three year partnership will significantly increase the number of patients who can be seen with the addition of the FNP and MA. Without them, HFHC is reliant on volunteer physicians who generously donate their time; however, due to the nature of their busy professions, are sometime unable to serve. HFHC averages 8 volunteer physicians on a monthly basis. The 1115 Waiver partnership team at DHR works closely with HFHC to manage implementation of the project that includes improvements and changes to the operations of the clinic. The changes included adding evening hours and opening on Saturday. The change was a major initiative for HFHC and was executed in January 2015. Although the changes challenged the small and stable clinic staff, HFHC considers the collaboration with DHR successful in making much needed progress toward expanding services.

Resources/Capabilities

HFHC has the experience and expertise to carry out the new Si Texas HOPE IBH project based on its organizational capacity. Opened in 1998 by community members and led by faith-based volunteers, HFHC has grown from an all volunteer organization to a professional organization with nine employees and an average of eight volunteer medical professionals. Together, the Executive Director, Rebecca Stocker and the Board of Directors secure and manage a budget of $1 million dollars. The organization is governed by a diverse board of directors made up of a variety of professionals, faiths, gender, race/ethnicity, and age. The board of directors are committed and involved in the plans for scaling up the organization. After many years of operating solely on private donations and fundraising events, the HFHC leadership took the strategic initiative to accept government and foundation grants. In the last few years, that government and

foundation funding has grown significantly. With the growth, including a recent grant from the Hogg Foundation for Advancing Peer Support in Integrated Behavioral Health Care, the organization has implemented an action plan to ramp up all organizational capacity. The capacity building has taken place through improvement plans for financial management, volunteer recruitment and retention, measurement and evaluation, technology, and communications. An experience grant writer was hired on a part-time basis to search and secure funding for the organizational priorities including improving primary and behavioral health services.

Aware of the needs to increase organizational capacity, HFHC searches for funding that will enhance capacity. All proposals for funding include funds for training staff, improving information technology, and staffing or consultants/contractors with experience to take HFHC to the next level.

Sustainability

Staffing at HFHC has always been carefully considered based on the fluctuations of charitable funding of the clinic. Organizational leadership intentionally keeps staffing to a minimum and controls for salary spending. Continuing to be deliberate about growth is priority for HFHC. Adding grant funded staff members is done with the commitment to sustaining the position as standard component of sustaining services to patients.

Although HFHC is a completely charitable clinic that does not take insurance, government assistance programs or payments of any kind; it does maintain a plan for financial sustainability. Annual budgets are analyzed and subsequent proposed annual budgets are created with a funding diversity plan including grants, individual donations,

events, contracts and planned giving. In 2015, HFHC will begin to ready the land next door for an expansion of both facility and services. Securing funding and organizational growth at HFHC is strategically managed on a multi-year level and not year to year. Thereby, allowing for timely efforts to secure additionally funding for three to five years in the future.

It is not in the growth plan for HFHC to ever become a FQHC or move to a system of taking health insurance or government funded care such as MediCare or Medicaid. Making a change to accepting payments and reimbursements would compromise the mission of the organization to serve the uninsured and the most at-risk of not receiving health care. However, in 2015, the organization will explore a possible addition to a sliding—scale system based on income eligibility. If the system would challenge the current level of service to patients, other ways of enhancing stable funding will be sought. The need for innovation in funding sustainability is clear and HFHC is committed to exploring all methods.

Budget Narrative

a. Personnel: Each staff request is necessary for the operation and optimal outcomes of the project.

Project Manager 1 person @ $50,000 x 100% usage

Transitional Specialist RN 1 person @ $50,000 x 100% usage

MSW/LPC 1 person @ $50,000 x 100% usage

Care Manager 1 person @ x 100% usage

Medical Coordinator 1 person @ x 50% usage of 36,000

Office Manager 1 person @ x 50% usage of 25,000

Finance Administrator 1 person@ x 50% usage of 36,000

A total personnel cost of $248,500. $188,500 is being requested from MHM and $60,000 will be covered by match sources.

b. Fringe Benefits:

Fringe at HFHC includes FICA and health insurance monthly stipends for full-time employees only. Fringe benefits for the salaries of the personnel listed above equal $38,210. The amount of $28,820 is being requested from MHM.

c. Travel: Travel for appropriate staff to attend one national conference, one state conference and one out-of-town education event is calculated as follows:

National Annual IBH Conference 2@ $500 registration= $1,000, flight $700, hotel 120night x 3nightsx1 room= $360, meals $40 x 3 days=150x2= $300; total national=$2360. State Annual Conference 4@ $250 registration=$500, mileage 57.5x800 miles=$460; hotel $85 x 2 nights=$170 x 2 rooms=$340; meals $35 x 2 =$70 x4= $280= total state $2,080. Continuing Ed@ 3 x $200 = $600; mileage 57.5 x 800 miles = $460; hotel $85 x 1 night = $85 x 2 rooms=$170; meals $35 x 1 day = $35 x 3 people = $105 = total state travel for cont. ed = 1,335

A total of $5,775 is requested from MHM.

d. Equipment: No equipment is requested.

e. Supplies:
Supply requests includes general office supplies for use of project team, four computers and software for new staff, program consumable supplies for program participants including take-home materials, and medical supplies specifically for the participants in the project. Medical supplies include all supplies needed for self-care of patients such as glucometers and testing strips.

Consumable office supplies $3000yr, four computers /software for new staff 4 x1500= $6000, medical supplies for participants including A1C analyzer/glucometers/strips = 25,750, program consumable supplies for participants $6000 = total $40,750

A total of $6,000 is requested from MHM. A total of $34,750 is requested from match sources.

f. Contractual:

The following vendor contracts will be secured to assist with the necessary operations of the project.

1 yr contract for capacity building evaluation & evaluation and Federal grants management 80 hrs @ $100 hr = $8000

1 year contract with HIE vendor includes clinical quality specialist, software,licenses & HIE connection $139,200

1 year contract with tech support 135 hrs @$60hr. = $8,100

A total of $12,100 is requested from MHM. A total of $139,200 is requested from match sources.

h. Other – Services:

The training and certifications enhance and expand services to patients and are components of the IBH project.

Laughter Yoga @$500 x 2 staff=$1,000 Trauma & Grief 2000 x 2 therapists=$4000 Phlebotomist cert. $2000 x 1 staff = $2000 Total of $7,000

Criminal background checks $70 x 6 candidates= $420

Upgrade Internet Service necessary to add broadband and speed to new IT systems 12mo x 130 = $1,560

A total of $6,200 is requested from MHM. A total of $2,780 will be secured with match sources.

j. Indirect Charges:

HFHC does not have a negotiated federal indirect rate. Therefore, the request is for the direct cost as an allocated percentage.

Direct cost of A-133 audit allocated at 33% of $8000 total cost = $2666. A total of $2666 is requested from MHM.

HFHC's capability to obtain match:

As a charitable clinic, HFHC maintains relationships with local, state and national private foundations. Securing a 1:1 cash match has been strategically planned with the commitment of the board of directors, the knowledge of the executive director and the skills of the grant writer. Reaching out to the network of relationships within the philanthropic world began in November 2014. Meetings have already taken place with

several potential funders including Valley Baptist Legacy Foundation, RGK Foundation, Michael and Susan Dell Foundation, San Antonio Area Foundation, One Star Foundation, and Astrazeneca Foundation. They all implied an interest in the Si Texas HOPE project and have asked for either full proposal or letters of inquiry based on our full MHM Si Texas proposal once submitted and/or secured.

If funded, HFHC will aggressively distribute requested match proposals and letters of inquiry. Based on their procedures, a match request to Valley Baptist Legacy Foundation has already been submitted.

Internal controls and financial systems:

Due to the small administrative staff at HFHC, internal controls are implemented with the professional assistance of the board of director's treasure who is a bank executive. The board of director's chair is a Certified Professional Accountant and also reviews all financial transactions. The executive director is responsible for day to day financial management including human resource and payroll functions. No part of the financial management is outsources, all checks and book keeping is done in-house. External audits are performed annually and IRS 990 forms are completed timely by an external CPA firm.

The Si Texas HOPE project budget includes additional support of a part-time office manager and financial administrator. The positons will assist the executive director and project director in improving and maintaining additional financial controls based on Federal grant requirements. A capacity building consultant and trainer will also assist project and organizational staff in ensuring adherence to Federal grant laws and regulations.

Organization: Project Title
In the work plan, outline process goals, action steps, and additional required information related to the proposed program. The work plan should span the entire five-year period.

Focus Area 1: Enhancement, replication or support of current primary and behavioral health care integration			
Goal 1: 90% of primary care volunteer providers will incorporate behavioral health assessment into each routine primary care visit by end of funding period.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Provide IBH education & training to all primary care providers and potential volunteer providers	Project Director with input from medical and behavioral health leadership	By June 2015 and then quarterly through end of year 2. Scheduled as needed in years 3-5.	
Select and standardize assessment tools to incorporate into exam visits.	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By August 2015 and then reviewed as needed for continuous improvement	
Identify all barriers and redesign flow and protocols of standard primary care visits to include behavioral health assessments	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By August 2015 and then reviewed as needed for continuous improvement	

Focus Area 2: Collaboration in a fully integrated system			
Goal 1: 95% full collaboration in a transformed/merged integrated practice- Level 6 at the end of the funding period			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Identify barriers and upgrade all technology for patient registry, data collection and data analysis – EMR, HIE and Behavioral Notes	Project team (director, nurse, counselor, care manager) with input from information technology contractor/vendor	By September 2015 Continuously review and make improvements or changes as needed	
Train all staff, volunteers & external partners in full implementation and effective utilization of new patient registry/database	Project team (director, nurse, counselor, care manager) with input from information technology contractor/vendor	By November 2015 and then as needed through end of funding period	
Provide IBH cross-discipline education & training to all primary care and behavioral health providers	Project Director with input from medical and behavioral health leadership	By June 2015 and then quarterly through year 2. As needed in years 3-5	
Create and standardize team communication policies and procedures	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By September 2015 and then reviewed every 6 months or as needed through end of funding period	
Draft & finalize MOUs and formal collaboration agreements with external IBH partners	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By September 2015 and then reviewed as needed through end of funding period	
Create and finalize a project evaluation plan and tools to measure integration process and outcomes	Project team(director, nurse, counselor, care manager) with input from contract trainer & evaluator	By September 2015 and then monitored and reviewed monthly through end of the funding period	

Focus Area 3: Patient Primary and Behavioral Health Improvements			
Goal 1: 80% of patients with both 1) obesity and 2) depression, anxiety and/or substance abuse issues will achieve significant improvements in their health as measured by reducing their BMI, reducing their weight, improving their mental health assessment scores, successfully managing their substance abuse, increasing their satisfaction with clinic visits, lowering their blood pressure and lowering their bad cholesterol levels.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Provide eligible patients access to IBH with culturally-relevant education, training and outreach activities	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By August 2015 and then monthly through year 2. As needed and requested in years 3-5	
Eligible participants treated and monitored by IBH Team	PCP/BHP/Care Manager	By July 2015 then monitored and evaluated at 3, 6 & 12 months.	
Goal 2: 80% of patients with both 1) diabetes and 2) depression, anxiety and/or substance abuse issues will achieve significant improvements in their health as measure by reducing their A1C levels, improving their dietary factors, reducing their weight when necessary, improving their mental health assessment scores, successfully managing their substance abuse, increasing their satisfaction with clinic visits and managing their daily glucose levels.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Provide eligible patients access to IBH with culturally-relevant education, training and outreach activities	Project team (director, nurse, counselor, care manager) with input from medical and behavioral health leadership	By August 2015 and then monthly through year 2. As needed and requested in years 3-5	
Eligible participants treated and monitored by IBH Team	PCP/BHP/Care Manager	By July 2015 then monitored and evaluated at 3, 6 & 12 months.	

Focus Area 4: Cost Effectiveness			
Goal 1: Hope Family Health Center will be able to serve 50% more patients through cost savings and improved stewardship of charitable funding as measured by increase in number of new annual patients at the end of the funding period			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Establish data collection and data analysis system in new HIE database to measure frequency of visits, number of new patients, decrease in hospitalizations, and decrease in specialty referrals	Project Director with input from HIE contractor, evaluator and IT	By November 2015 and then monitored continuously through end of funding period	
Monitor and track project budget, organizational budget and fundraising needs	Project Director with input from Executive Director, Grant Writer and Board of Directors	By November 2015 and then monitored continuously through end of funding period	

ABSTRACT

Project Title:	Sí Three: Integration of 3-D Health Services
Organization:	Mercy Ministries of Laredo
Address:	2500 Zacatecas Street, Laredo Texas 78043
Project Director:	Sister Maria Luisa Vera
Telephone Number:	(956)718-6810 FAX (956)721-7404
Email address:	Maria.Vera@mercy.net
First 2 yr's funding:	$597,327

Mercy Ministries of Laredo (Mercy Clinic) is a primary healthcare clinic located in Webb County, Texas, which provides healthcare and health education to some of the poorest neighborhoods and colonias in the United States. Mercy Clinic serves 2,500 unduplicated patients through 30,000 encounters every year. Of the patients who partner with Mercy Clinic almost 100% are uninsured and 98% fall below the 200% federal poverty guidelines.
The Sí Three: Integration of 3D Health Services proposal is to expand current efforts to integrate more fully the behavioral health and physical health initiatives within the primary care setting, while enhancing overall integration through the innovative addition of spiritual health issues and resources. In keeping with the Mercy tradition of faith-based care, and in accord with the Webb County tradition of inclusive, ecumenical community partnership, the Sí Three project will maximize inclusion of lay and religious support from Laredo's close-knit community.

This conceptual model helps guide the process of diagnosis and treatment, in that a person's health can be affected for better or worse by change in any one of the three dimensions. In addition, the model provides access to a far greater array of support services for the many patients whose behavioral health need is relief of anxiety and/or depression. There is strong research evidence for patients to report equal benefit from faith-based counseling or psychiatry-based counseling, and our community has a rich array of faith-based resources.

To address Focus Area 1 (expansion of services at existing site), in the physical dimension clients with diabetes, obesity and hypertension will be monitored every 3 months using quantitative and qualitative measures (Hbg A1C, weight and blood pressure). Behavioral health measures will include the PHQ-9 for depression, the GAD-7 for anxiety and the CAGE for substance abuse. Spirituality will be measured using the Spirituality Well-Being Index, a nondenominational measure of spiritual awareness. All results will be recorded in Excel format for analysis by the statistician.

To address Focus Area 3 (increasing integration of services), Mercy seeks to move from a current co-located level of collaboration/integration to integrated level 5. Strategies to achieve this goal over the next 3-5 years include more face to face interactions, use of the electronic medical record, closer communication, collaboration as members of a health care team, with scheduled meetings to understand and appreciate the roles and culture of other disciplines within the Laredo community. Significant innovations in meeting this goal are the inclusion of addictions to the evaluation of physical, behavioral and spiritual wellness, in order to better understand the underlying factors impacting a patient's symptoms. Adding the spiritual dimension enhances integration of service by acknowledging and addressing the patient's full spectrum of possible support systems.

Sí Three: Integration of 3D Health Services

I. Need

a. Service area/target population

The first Sisters of Mercy arrived in Laredo in 1894 with $445 and a mission to establish the city's first hospital (Webb County Heritage Foundation). In less than a month, they opened the first Mercy Hospital with 6 rooms and a capacity of 12 patients. In 2003, the Sisters sold the Hospital and founded Mercy Ministries of Laredo to continue their mission of caring for those with unmet health needs in Laredo and the surrounding community.

Mercy, in collaboration with a diverse network of community partners, pursues its mission through two venues, Casa de Misericordia (a shelter for women and children suffering domestic abuse) and Mercy Clinic (a primary health care clinic for uninsured and underinsured residents of Laredo and Webb County).

The importance of Mercy's mission is clear from the one-page Health Facts Profiles provided by the Texas Department of State Health Services (Texas Department of State Health Services). The latest year posted on the DSHS website is 2009, when Webb County's population was estimated at 240,749, with over 95% Hispanic, 36% without health insurance and 31% living below poverty level. Of note are incidence rates of TB (14.3/100,000) and varicella (41.1/100,000) at more than twice the state average and death rates from diabetes (47.1/100,000), influenza/pneumonia (25.2/100,000), septicemia (22.5/100,000) and chronic liver disease/cirrhosis (19.9/100,000), all at 1 ½ - 2 times the state rate, the death rate for diabetes at more at twice the state rate.

b. Access to/utilization of behavioral health care.

Areas of Webb County are classified as a health manpower shortage area and a medically underserved one. In 2011, the UTHSC-SA, the Mid Rio Grande Area Health Education Center and a diverse group of community partners, including Mercy Ministries, conducted a Health Needs Assessment (Mid Rio Grande Area Health Education Center) to identify specific issues of residents of Laredo and Webb County. The Community Health Survey identified lack of insurance and scarcity of providers as the two top issues confronting residents. At that time, 60% of respondents recorded having health insurance coverage, while 40% did not. Scarcity of service providers was recorded as a major issue overall, and a critical issue with respect to behavioral health needs (including mental health, substance abuse, and domestic violence) ; medical needs (particularly chronic illness and support for adults and children with disabilities or special needs); and increased preventive care services and resources.

Data specific to the Mercy Clinic for 2014 highlight the extreme need for affordable health services. The average family size was 4 and their average income was $15,084/year. Of 1,739 applications for service, 77% fell below the 2014 federal poverty level ($23,850 for a family of 4) and qualified for a copay of $10 per visit (HHS). Fourteen percent earned between 100 and

125% and paid $15 per visit. Eight percent earned between 124 and 150% and paid $20/visit. Overall, 99% of clinic patients met guidelines for federal assistance.

c. Training needs of current staff

Current staff are familiar with the tools needed to implement comprehensive integrated care, but will need additional training to add the third dimension (now present, but not formally implemented) of spiritual care to the integration. Other needs are increased skill and comfort in use of the Electronic Medical Record (EPIC) in order to establish closer communication and better understanding of the culture and function of other members of the health care team. Mercy staff will also need training to facilitate utilization of the iNexx referral platform and the HASA (Healthcare Access San Antonio) for communications with Methodist Healthcare Ministries programs.

II. Project Description

a. Current stage of integration of behavioral health services

Mercy Ministries of Laredo (Mercy Clinic) is a primary healthcare clinic located in Webb County, Texas, which provides healthcare and health education to some of the poorest neighborhoods and colonias in the United States. Mercy Clinic serves 2,500 unduplicated patients through 30,000 encounters every year. Of the patients who partner with Mercy Clinic almost 100% are uninsured and 98% fall below the 200% federal poverty guidelines. The communities that will be reached through this project suffer from deep disparities including ethnic composition (essentially 100% of the families served are of Latino origin), per capita income ($10,759), and percentage of families below poverty level (100% of the population served by Mercy, 31% of the population county wide and 40% of those under 18;US Census Bureau, 2006). The extreme poverty, lack of access to basic services including health care, high rates of school dropout, and other demographic indicators show that the needs in these communities are enormous.

Currently, Mercy employs three Family Nurse Practitioners and one Women's Health Nurse Practitioner, along with 2 volunteer Medical Directors, Dr. Rafael Mangual (family practice) and Dr. Dagoberto Gonzalez (women's health). These health care providers provide primary care services for the base clinic and for a mobile clinic that travels to a different site each day throughout Webb County. In addition, there are three financial counselors and one social worker, one part time (28 hours/week) behavioral healthmanager, an LPC (funded by Methodist Ministries for 16 hours/week), two medication assistants that assist patients in obtaining affordable, appropriate medications, one education coordinator (RN and certified diabetic educator), a case manager (RN), and a fulltime clinic director who coordinates the day to day operations.

Because Mercy Clinic's primary focus is on education, prevention and self management for people with chronic illness, approximately 80% of current referrals to the integrated healthcare program are people with diabetes. As reported in a 2013 proposal to the Hogg foundation, under

Mercy's Stage III-IV integrated health program, the following elements are in place on a small scale or in a beginning phase of implementation (Peek; Doherty, et al).

- Some mental health services are co-located in the primary care setting.
- Screening for mental health is being implemented.
- Workflows to enhance care coordination are being strengthened.
- Systematic clinical care management is being provided by a social worker or other licensed mental health provider.
- Communication about the clinical evaluation and treatment plan transpires among health care providers.
- Proactive follow-up and outcome monitoring are being recorded in a patient registry by the care manager.
- Data are being collected to assess health outcomes.

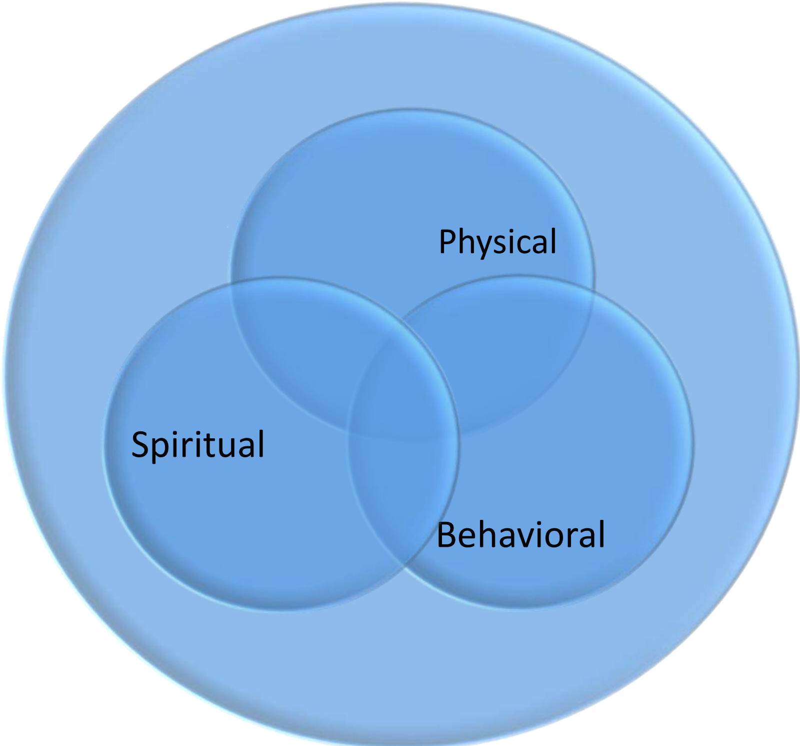
b. Integrated care model.

The Sí Three: Integration of 3D Health Services proposal is to expand current efforts to integrate more fully the behavioral health and physical health initiatives within the primary care setting, while enhancing overall integration through the innovative addition of spiritual health issues and resources. In keeping with the Mercy tradition of faith-based care, and in accord with the Webb County tradition of inclusive, ecumenical community partnership, the Si Three project will maximize inclusion of lay and religious support from Laredo's close-knit community.

In addition to the physical and behavioral aspects, every person has a spiritual side that can strengthen or weaken either or both of the other dimensions of his or her being. The following figure illustrates the underlying conceptualization of the Sí Three project: The outer circle indicates the potential for overall integration, while the three smaller circles inside show different interactions among the three different aspects of the person (represented by the small curvy triangle in the center).

This conceptual model helps guide the process of diagnosis and treatment, in that a person's health can be affected for better or worse by change in any one of the three dimensions. In addition, the model provides access to a far greater array of support services for the many patients whose behavioral health need is relief of anxiety and/or depression. There is strong research evidence that patients report equal benefit from faith-based counseling or psychiatry-based counseling, and our community has a rich array of faith-based resources.

Conceptual Model of 3D Health Care Services Integration



c. Evidence-based practice

Data from the 2007 Texas Behavioral Risk Factor Surveillance System identified uninsured Spanish-speaking Hispanic people as the population group with the lowest prevalence of taking action to control their blood pressure (Ayala). In 2014 JAMA published evidence based guidelines for management of high blood pressure in adults that specified a blood pressure goal of 150/90 for adults age 60 and over, and a goal of 140/90 for adults age 30-59 (James, et al). Out of 1,739 patients seen by Mercy Clinic in 2014, 998 were between the ages of 31-50, with another 411 patients over the age of 50. In consideration of these data, for purposes of the Si Three grant proposal, a target value of 150/90 will be used.

The American Diabetes Association recently published updated guidelines (Standards of Medical Care in Diabetes – 2015) for diagnosis and treatment of diabetes, that includes a recommendation to use the A1C test to diagnose diabetes, using an updated threshold of 7 (rather than 6.5) as a more reachable goal for non-pregnant adults, in consideration of individual differences and variabilities in response. Their guidelines also include recommendations for collaborative management of the disease using an integrated team approach, including patients and families so that individuals take an active role in their health. Mercy Clinic was a partner in a 2009 two year study of the economic impact of lifestyle changes among diabetic patients in Webb and three other Texas counties. The study demonstrated the effectiveness of self management strategies in reducing health care costs (UTCO).

In keeping with recommendations of the U.S. Preventive Services Task Force guidelines for screening and management of obesity in adults, Mercy clinic patients will be screened using weight and waist circumference, found by the Task Force to be as effective and much less cumbersome for providers than BMI . The Task Force also provides evidence for the effectiveness of intensive, multicomponent behavioral interventions to achieve weight loss in obese adults. (See http://www.uspreventiveservicestaskforce.org.)

The PHQ-9 and GAD 7 were developed by Spitzer, Williams, Kroenke and colleagues with an educational grant from Pfizer and are now in the public domain. The PHQ-9 is the most common screening tool available to identify and evaluate depression on the basis of a total possible score of 27 as minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19) and severe (20-27) (Kroenke, et al).

For the GAD 7, of a possible total point value of 21, anxiety is measured as mild (5-9), moderate (10-14) or severe (15 or above) (Spitzer, et al).

The CAGE is an internationally recognized assessment instrument developed by Dr. John Ewing to identify alcoholism. It can be modified or adapted in clinical settings to include a wide range of addictive issues as part of a general health exam (Brown & Rounds). This instrument is also in the public domain, as cited by Ewing. The four items of the CAGE are scored 0 or 1, and a finding of 2 is clinically significant.

All three of these instruments are in the public domain and are available in Spanish.

The Spirituality Index of Wellbeing (SIWB) is a 12-item, bidimensional scale that assesses the effect of spirituality on subjective well-being using two subscales: life scheme and self-efficacy (Daaleman & Frey). Evidence for effectiveness of faith-based counseling for behavioral health issues, particularly anxiety related ones, is supported by clinical research findings of comparable patient outcomes and satisfaction (Hook). The SIWB is offered at no cost and although no Spanish translation has been published, the items are easily converted to Spanish for use with our population. Upon successful completion of the project, our translation will be available for other interested parties.

The elements listed above conform to the framework of The Academy Atlas of Integrated Behavioral Health Care Quality Measures and will support Mercy Clinic's transition from a Level 3-4 to a Level 5 collaboration model as defined by Doherty, et al.

Data will be recorded and stored using EPIC (Electronic Patient Health Record) and evaluated every four months to monitor patients' progress toward achieving better management of their symptoms in any of the dimensions through integration of services for all three areas.

d. Cost effectiveness

The key to cost effectiveness of the Sí Three project is the addition of the third dimension, spiritual well being, highlighting the original mission of the Sisters of Mercy and energizing the strong faith-based caring tradition of the Laredo and Webb county community. Laredo has a strong religious community that provides support and comfort for a broad spectrum of the underserved population. Individual and family counseling, as well as peer group support, will complement those services available through the secular behavioral health resources. In addition, religious organizations in the community host many of the available self help groups for persons with addictive conditions, concerning alcohol, drug, smoking, food or other substance. These resources will help offset the cost of contracted psychiatric services that will include telemedicine and referral services. Partnership with religious groups also will provide access to adequate facilities for food preparation, exercise and nutrition classes.

e. Comprehensive 5 year work plan (uploaded as instructed)

Mercy's comprehensive 5 year work plan (uploaded) specifies how Mercy's services will be expanded utilizing the integrated 3D model, to include physical, behavioral, and spiritual dimensions of health. Specifically, the objectives establish the benchmarks to be met during the first two years, and the activities and personnel required to achieve these outcomes.

To address Focus Area 1 (expansion of services at existing site), in the physical dimension clients with diabetes, obesity and hypertension will be monitored every 3 months using quantitative and qualitative measures (Hbg A1C, weight and blood pressure. Behavioral health measures will include the PHQ-9 for depression, the GAD-7 for anxiety and the CAGE for substance abuse. Spirituality will be measured using the Spirituality Well-Being Index, a nondenominational measure of spiritual awareness. All results will be recorded in Excel format for analysis by the statistician.

To address Focus Area 3 (increasing integration of services), Mercy seeks to move from a current co-located level of collaboration/integration (between levels 3 & 4 on Heath, et al, Scale of Integration) to integrated level 5. Strategies to achieve this goal over the next 3-5 years include more face to face interactions, closer communication, collaboration as members of a health care team, with scheduled meetings to understand and appreciate the roles and culture of other disciplines within the Laredo community. Significant innovations in meeting this goal are the inclusion of addictions to the evaluation of physical, behavioral and spiritual wellness, in order to better understand the underlying factors impacting a patient's symptoms. Adding the spiritual dimension enhances integration of service by acknowledging and addressing the patient's full spectrum of possible support systems.

f. Preparatory steps

During the first 3-6 months of the project period, necessary staff will be hired, including a project manager, a navigator, a tracker, and a data entry clerk. Services will also be contracted with a psychiatrist (using telemedicine from Houston Texas), a part time dietician, an exercise coach, a statistician (see Memorandum of Understanding with Texas A&M International University for services of Dr. Fernando Quintana), and a research design consultant. During the first three months, the project manager will establish relationships with community groups (most likely churches) who agree to participate with the project team by providing suitable meeting space for integrated care provider meetings as well as educational and supportive activities for patients in the program. One example of this partnership will be access to church kitchens and fellowship halls for cooking classes, exercise activities and educational opportunities.

Clearly, a critical area to address is data collection and management. In the first quarter, project staff will develop specific templates for data entry and review these with providers and other staff to modify as needed to make them as user-friendly as possible. Time lines will be set for completion and the project manager will review forms and give feedback to the team on any issues that need to be addressed.

In the first months, necessary equipment and supplies will also be purchased, including those needed for education, exercise, cooking classes, and patient self-management.

g. Core competencies

Through use of the Electronic Health Record (EPIC) system used throughout Mercy Health Systems, shared patient scheduling, shared treatment planning, shared service provision, and shared record keeping will be facilitated. Project activities that include increased face to face meetings and inclusion in case management conferences will promote increasing use of EPIC and allow participants to assist each other in maximizing benefits from these shared electronic health records.

Mercy Clinic converted to electronic health records in October 2013. EPIC software was installed by Mercy Health, the parent company of Mercy Ministries of Laredo and is the software used throughout the Mercy Health system. Mercy Health provides all the support required to maintain the system including hardware, software upgrades, interfaces, security, training and

reporting. All staff members are required to complete appropriate training before being granted access to the system. EPIC is used for registration, scheduling and billing as well as the clinical record. Non Mercy employees can be granted access to a patient's medical record after completing an on-boarding process at the corporate level and completing the appropriate training for their role. All members of the team will be able to access patient care data utilizing the EPIC system. Any documents obtained from outside the EPIC system can be scanned for all members to have access.

h. Scalability

As described in the Logic Model and Work Plan, the Sí Three project envisions a wide community investment in enhancing, replicating, and integrating services that promote patient awareness and self care in addressing their primary care health needs through self monitoring, behavior change and lifestyle choices. The inclusion of the spiritual dimension resonates with the Laredo community, in that many existing wellness initiatives are linked to recreational opportunities and hosted by religious groups through ―jamaicas" (health fairs) that fill the grounds of churches with educational, recreational, and food booths and provide outlets for family diversion as well as opportunities for intervention by health care providers.

Laredo has a long tradition of partnership across health care organizations. The inclusion of addiction as a focus will bring several of these groups into closer collaboration with the Clinic, including SCAN (Serving Children and Adolescents with Need), Alcoholics Anonymous, the Area Health Education Coalition (AHEC), City of Laredo Health Department, and Webb County. Other partners will be more closely involved through the evaluation activities, including Texas A&M International University and The University of Texas Health Science Center San Antonio, Laredo campus. Telemedicine arrangements to supplement mental health services available in Laredo are under discussion with JSA Health Telepsychiatry, based in Houston, Texas. At the present time, there are extremely limited psychiatric physicians in Laredo.

II. Evaluative Measures

a. Evaluation capacity

A recently completed grant (ending in December 2014) provides evidence of data management, analysis, and reporting in response to grant requirements. The goal of Mercy's Diabetes Program (funded by Methodist Health Ministries) is to develop diabetes self care skills (to improve eating habits and maintain good nutrition, to increase physical activity and to prevent diabetic complications). The program consists of initial evaluation to customize a care plan by a certified diabetic instructor. We offer a six week course, exercise classes, and home visits, as well as collaborating with local providers who provide eye exams, foot exams, dental screenings and fillings and oral health education to patients free of charge. In 2014, 25 newly diagnosed diabetic patients were enrolled in the program. Six of these patients were enrolled in the final quarter, so no terminal data are available yet for them. Of the 19 who completed the 6 month program, six reduced their A1C to below 7, four more reduced their A1C by 2 points, even though it still remained between 7.1 and 8, and nine patients showed no improvement. Overall, the project was a success, given that over 50% achieved positive results. It would be interesting

to know more about the factors that made a difference in whether or not patients were able to improve their A1C scores.

In addition, the data collection helped uncover unexpected issues with use of EPIC for an outpatient setting rather than a hospital. Excellent IT services from St. Louis have assisted in resolving the issues as they have arisen, and the experience is reassuring in light of the need to orient and train many more team members to use the system to record data for the Si Texas project.

Mercy Clinic has developed and established the trust and practice models that are culturally appropriate for this vastly underserved population. Therefore, to serve the local community, Mercy Clinic providers are bilingual (Spanish and English) and bicultural (natives of Laredo or Nuevo Laredo, Mexico). Trust is created in that the promotoras (community healthcare workers) live and work in the underserved areas where the patients reside. Efforts to increase the number of women who come for screenings have been successful due to these factors. However, efforts to encourage patients to return for screenings have failed in spite of mailed reminders and phone calls from the registration clerks.

A grant from the Cancer Prevention and Research Institute of Texas, titled ―Loteria de Comadres Contra el Cancer (CPRIT) is now in its third and final year. Literature clearly indicates that early detection and diagnosis are essential to decreasing the mortality and morbidity rates associated with breast and cervical cancer. The literature also illustrates that compliance is related to convenience of service, trust or the healthcare provider and culturally competent providers. The goals of the project were to (1) increase awareness and knowledge of breast, cervical, and colorectal cancer prevention, (2) refer patients for cancer screening, and (3) establish trust among program beneficiaries. (Project reports are attached in ―Evaluation Measures".) In year one, it is estimated that over 1 million persons were exposed to the educational content through media. Person to person contacts through loterias and platicas totaled 1,130. Referred for screening were 372, and those who kept appointments were 59 (32%). In year two, over 1million were again reached through media and made aware of breast cancer. Person-to-person contacts totaled 1,100, and 214 were referred for screening. Appointments kept were 55 (38.23%).

It is important to note that the patient population at Mercy is transitory and without regular or consistent phone numbers. In fact, reminder calls made by a patient representative to 211 patients between June 18 and July 3 of this year proved to have 30 phone numbers which were no longer in service. Also, 50 messages were left on voice mail or with family and those calls have yet to be returned.

A behavioral health manager was hired 6 months ago to provide integration of behavioral health services, and maintain records using the EPIC system. During the past quarter, 27 patients have been referred for behavioral health services and are being seen by the behavioral health manager and the LPC. Of these 27, pre treatment and mid or post treatment data are available for 7 although the first reportable data will be available in March 2015.

b. Logic model and theory of change

The logic model of Sí Three: Integration of 3D Health Services (see attached Logic Model) with respect to Focus 1 (expansion of services at existing site) is based on the Theory of Change that if healthcare providers refer patients to appropriate integrated services and track their participation and progress then patients will improve their overall health status in all three dimensions of health (physical health, behavior health and spiritual well being). This will ultimately lead to better health outcomes for the underserved indigent population here in Laredo. Using resources that include existing staff, new hires funded through the grant, and collaboration with a wider range of community resources, Mercy clinic will be able to expand behavioral health and add spiritual wellness services along with better monitoring and data management.

To address Focus 3 (progress toward Level 5 Integrated Practice), the Logic Model is based on the Theory of Change that if the health care team moves from a Level 3-4 to a Level 5 Integrated Practice, providers will gain an indepth understanding of the roles of other team members and the culture of the clinic patients; patients will in turn express greater satisfaction with the team and will achieve their goals in all three health dimensions. (See attached Logic Model).

c. Lead evaluation personnel

Lead evaluation personnel will include the project manager, supported by a contracted statistician (see Memorandum of Understanding with Texas A&M International University for services of Dr. Fernando Quintana), and a research design consultant (Dr. Susan Walker). The project manager will be a nurse practitioner (family and/or mental health), bilingual, community-oriented, who will supervise overall project activities and establish relationships with community groups (most likely churches) who agree to participate with the project team by providing suitable meeting space for integrated care provider meetings as well as educational and supportive activities for patients in the program. Dr. Quintana is an Associate Professor of Biology and Statistics at Texas A&M International University. He also serves as an Associate Professor of Statistics at Texas A&M Health Science Center, College Station, Texas. His publications and research are detailed in his Curriculum Vitae, upon request. He is an active participant in community health research projects in the Laredo community and is currently working with a local pediatrician on a study of BMI in children. He will provide statistical analysis as well as guidance in data collection. Dr. Walker is a Professor Emerita of Nursing, Texas A&M International University. Although she retired from her position as Dean and Professor of Community Mental Health Nursing in 2007, she remains active in the community through the Area Health Education Center, Mercy Ministries and consultation with the School of Nursing and Texas A&M International University. Her special interests include grant writing, accreditation reporting, and writing about ethical and legal issues in community health and end of life. Her contribution to the Sí Three grant project will include review of data collection, interface with Dr. Quintana, interpretation of outcome data for reporting, presentations and publication. Curriculum Vitae are available on request.

d. Tracking progress

Clearly, a critical area to address is data collection and management. In the first quarter, project staff will develop specific templates for data entry and review these with providers and other staff to modify as needed to make them as user-friendly as possible. Time lines will be set for completion and the project manager will review forms and give feedback to the team on any issues that need to be addressed. The hiring of a data entry clerk through project funding will facilitate accomplishment of this goal, as will ongoing training and support for all staff and partners involved in use of the templates and EPIC.

e. Data collection and use

For one year patient data have been stored using EPIC (Electronic Patient Health Record) and evaluated on a quarterly basis to monitor diabetic patients' progress toward achieving better management of their symptoms and during the past six months a behavioral health navigator was hired to provide integration of behavioral health services for these patients. With limited resources and only a part time behavioral health manager and LPC, these data are at a preliminary level.

(Note: HIMSS Delta and CCAT still pending.)

III. Collaboration

a. Formal and informal collaborations

Mercy Clinic collaborates with Methodist Healthcare Ministries (MHM) and St. Mary's University in San Antonio, Texas. Methodist provides a Licensed Professional Counselor (LPC) at Mercy Clinic two days a week. This marks the third year of this partnership. She counsels 40 patients a year. The LPC will treat patients who have more moderate to serious depression. Mercy Clinic has collaborated with St. Mary's University in San Antonio and Texas A&M International University in Laredo (TAMIU) in providing student opportunities for clinical practice in pastoral counseling and counseling psychology. TAMIU Family Nurse Practitioner students are precepted at Mercy Clinic by the three FNPs and one WHNP. Because of the lack of psychiatry services available in the community, Mercy Clinic will continue its current practice of referring patients whose needs are beyond our scope of services to our community's only behavioral services provider, Border Region Behavioral Center. In addition, volunteer physicians and dentists provide services on a monthly basis—for example, the epilepsy clinic from San Antonio holds clinic at Mercy each month, Dr. Wells (podiatrist) offers clinic services quarterly and Dr. Hochman (retinal specialist) holds clinic for Mercy clients twice a year. Many other providers offer specialty services as well.

b. Collaborative community projects

Organization	Time Frame	Project	Impact
UT Medical Branch, Galveston	2009-2011	UTCO Community outreach diabetes program	Measure economic impact of lifestyle and self management skills training
UT Health Science Center San Antonio	2011	Laredo/Webb County Community Health and Workforce Assessment	Data analysis and publication of needs of Laredo community; ongoing task forces and work groups
Webb County Food Bank	2014	Health fair	Flu shots
Area Health Education Center	2003 - present	Collaboration on various health events and research	Information on health careers; health services for indigent

IV. Resources/capabilities

a. Experience and expertise of organization

Because Mercy Clinic's primary focus is on education, prevention and self management for people with chronic illness, approximately 80% of current referrals to the integrated healthcare program are people with diabetes. As reported in a 2013 proposal to the Hogg foundation, under Mercy's Stage III-IV integrated health program, the following elements are in place on a small scale or in a beginning phase of implementation.

- Some mental health services are co-located in the primary care setting.
- Screening for mental health is being implemented.
- Workflows to enhance care coordination are being strengthened.
- Systematic clinical care management is being provided by a social worker or other licensed mental health provider.
- Communication about the clinical evaluation and treatment plan transpires among health care providers.
- Proactive follow-up and outcome monitoring are being recorded in a patient registry by the care manager.
- Data are being collected to assess health outcomes.

b. Organizational structure

The capability and commitment of administration, management, and the governing board and their support for the Si Three project are evident from the previous projects described above, as well as the attached letters of support from administration and board members.

c. Governing Board

The Board of Directors of Mercy Ministries of Laredo is comprised of 17 members, including four Sisters of Mercy (only one is from Laredo), 14 women and 3 men, 11 Hispanic. Six members work in the health care arena (one is a physician), three are in public health, two in banking and two community at large. Four members are from the Mercy system outside of Laredo and Texas. The Board meets quarterly. All are in support of the project; for evidence, see Letters of Support (Appendix A).

d. Current or proposed systems to:

i. Ensure single integrated medical and behavioral health care record thru use of EMR

Mercy Clinic converted to electronic health records in October 2013. EPIC software was installed by Mercy Health, the parent company of Mercy Ministries of Laredo and is the software used throughout the Mercy Health system. Mercy Health provides all the support required to maintain the system including hardware, software upgrades, interfaces, security, training and reporting. All staff members are required to complete appropriate training before being granted access to the system. EPIC is used for registration, scheduling and billing as well as the clinical record. Non Mercy employees can be granted access to a patient's medical record after completing an on-boarding process at the corporate level and completing the appropriate training for their role. All members of the team will be able to access patient care data utilizing the EPIC system. Any documents obtained from outside the EPIC system can be scanned for all members to have access.

ii. Engage in local or regional health information exchange (HIE)

The Laredo health care community is actively engaged in communicating with each other, through meetings, email, telephone or informal channels. See above discussion of collaborative projects, in particular those facilitated by the Area Health Education Center. The advent of the Electronic Medical Record (EPIC) has brought information exchange to a much deeper level. In addition, some Mercy staff are already utilizing the iNexx referral platform and the HASA (Healthcare Access San Antonio) for communications with Methodist Healthcare Ministries programs.

iii. Track patients referred for complex/specialty BHC to ensure continuity of care

The primary care provider (who also serves as a navigator in this grant) initiates the visit and makes referrals to behavioral health or any specialized referral. When patients are sent for specialty consultation, the consultant records his recommendation and returns it to the clinic with the patient or by FAX. The note is then scanned into the Electronic Medical Record. The referral stays open in the medical record until it is replaced by the note. This establishes a tracking mechanism for better follow up.

iv. Make BHS available through tele-behavioral health

Due to the lack of psychiatrists available in Laredo, a conference call was initiated with JSA Health Telepsychiatry in Houston, Texas, to explore availability and appropriateness of

telepsychiatry services. The outcome of the conference was highly encouraging, with the Houston group offering a choice of on demand or block time, as well as emergency availability for consult. They also offer consultative support to primary care providers, including the Medical Director. They employ three bilingual psychiatrists and are aware of the Clinic's need for a bilingual psychiatrist. The costs will be discussed in the budget narrative, but seem reasonable. In Laredo, there are two mental health nurse practitioners that would also complement the group in consultation.

V. Sustainability

a. Recruitment and retention plan

Informally, inquiries have been made with several individuals regarding interest in the proposed project. Officially, recruitment cannot begin until there has been a notice of grant award. Activities in the first quarter of the grant will be focused on recruitment, training and equipping necessary personnel. We will post job descriptions in local media, electronic media and actively pursue persons who would meet the qualifications and be an asset to our clinic.

b. Behavioral health reimbursement environment

There are essentially no formal behavioral health services available in the Laredo area for low income individuals, except on a severe emergency basis involving either a commitment to the state facility (MHMR) or an encounter with law enforcement. Because of the desperate need of services, the Mercy clinic chooses not to charge a fee for behavioral health encounters, fearing that the fee will discourage participation. Behavioral health intervention is facilitated by the providers' assessing the patient's mental health status using the GAD-7 and PHQ-9 and then, if warranted, contacting the behavioral health navigator to counsel the patient and schedule a visit with a counselor or the LPC funded by Methodist Health Ministries.

c. Plans to maximize collections and reimbursement

Because of Mercy's philosophical position on behavioral health and because Mercy clinic patients do not have health insurance of any kind, the sustainability of behavioral health integration is going to be greatly augmented by increased referral into self help and support groups whenever possible and expanding the pool of counselors to include faith-based counseling. In the meantime, while building collaborative relationships to facilitate these resources, the Sí Three grant funding allocated for 1.5 FTE of LPC services will alleviate the scarcity considerably.

VI. Budget Narrative

a.first year funding

In the first year of funding, overall expenses will total $599,741, of which $295,767 will be requested from the Sí Texas grant and which will be matched by $303,974 with funds from community foundations and other philanthropic entities.

The greatest portion of first year expenses will be allocated for personnel, including project manager ($125,000/year), navigator services (25% time for 3 currently employed nurse practitioners and 25% time for one currently employed spiritual navigator) = $84,030), a tracker ($37,440), a part time data entry clerk 50% ($15,600), a part time dietician 50% ($27,040), a part time exercise coach 50% ($19,760), an educator 50% ($31,200), 1.5 FTE licensed professional counselor services ($81,120). Project related employee benefits add $90,035. Overall personnel expenses in the first year, including both salary and benefits, will total $511,225.

Ideally the Project Manager will be a Family Nurse Practitioner and/or a Mental Health Nurse Practitioner, in order to best facilitate the integration of behavioral health with physical health services. There are two advanced practice nurses currently in Laredo who hold both these credentials.

The navigators (currently employed by Mercy Clinic as Family Nurse Practitioners) will devote 25% of their time to navigation services appropriate to their expertise. They will assure that all patients are screened for diabetes, obesity, hypertension, substance abuse, anxiety, depression, and spiritual wellbeing, and referred to appropriate resources. They will enter their findings into the Electronic Medical Record, in order to facilitate access by the whole team as well as outside consultants. The tracker will follow up on navigator findings by assisting patients to identify and overcome barriers in participating in their own care, with patient follow up, making phone calls and home visits as necessary to improve patient participation over levels achieved in previous projects that relied on telephone contact. Many of the indigent people in Laredo have short term telephones only, with no consistent contact number available.

The dietician, under direct supervision of the Project Manager will counsel individuals and groups on basic principles of healthy nutrition, as well as adaptations for diabetic, hypertensive, and obese patients, to include cooking classes for families or groups to help promote dietary change. Under direct supervision of the Project Manager, the Exercise Coach provides group fitness instruction, monitors and educates patients and families on fitness and safety, and maintains a safe and enjoyable atmosphere for class participants.

A Registered Nurse, who is also a certified diabetic educator, is already employed by Mercy Clinic; however, due to the very large diabetic clinic population, a part time educator is needed to address the needs of persons with hypertension, obesity, and for behavioral health concerns. The additional LPC services will essentially quadruple the counseling hours available and allow many more patients to be treated for behavioral health concerns. The lack of professional counselors is currently one of the greatest barriers we have in providing integrated services.

Contractual and consultative services necessary to meet data and reporting requirements of the grant optimize effectiveness of salaried personnel include two evaluators, one statistician and one research designer ($20,000/year). A telemedicine psychiatrist will be contracted for on demand services ($21,000 for the first year) to provide a resource for psychiatric referral due to the lack of psychiatrists in Laredo and Webb County.

Other first year expenses include travel ($7,684) to professional conferences for nurse practitioners, counselors and diabetic educators and $270 for training meetings at the beginning of the project year for all clinic staff to orient them to the project and their role in it. As the project moves toward increased integration, team meetings across all three dimensions will be added to develop and support greater communication and understanding among disciplines.

b. Capability to obtain matching funds

Mercy Ministries of Laredo has a fulltime Director of Development, who will be responsible to search for and find the resources necessary to meet matching requirements. Although there are a couple of leads, there is no firm agreement until a grant is awarded and then it can be marketed to the appropriate foundation or individuals.

c. Internal controls and financial systems.

Mercy Ministries of Laredo uses the accrual basis of accounting with a fiscal year end of June 30th. The organization's financial statements are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and Financial Accounting Standards Board (FASB) No. 117, Financial Statements of Not-For-Profit Organizations. QuickBooks for Non-Profits software is used.

The Chief Financial Officer is responsible for closing the books by the 5th business day each month. Monthly financial statements are reviewed by management and reported to Mercy Health (corporate member of Mercy Ministries of Laredo). All bank accounts are reconciled as part of the monthly closing procedure. Actual to budget comparisons are made each month and significant variances noted. On a quarterly basis financial statements along with actual to budget comparisons are presented by the Chief Financial Officer to the Board of Directors for review and approval.

The organization's annual budget is prepared and approved annually. The budget is prepared by the Chief Financial Officer in conjunction with the administrative team of Mercy Ministries (the President, Clinic Director, Development Director and Outreach Director). The budget is presented to the Board of Directors for approval at the March board meeting prior to the start of each fiscal year.

Yearend financial statements are audited annually by Certified Public Accountants. The audit is completed by September 1st each year and presented to the Board of Directors of Mercy Ministries at the September board meeting by the managing partner of the CPA firm.

Policies and Procedures are in place for the control of cash, cash disbursements, purchasing and payroll.

Mercy Ministries of Laredo has experience working with federal, state, local government and multiple foundation grants. In 2009 Mercy received a HRSA grant for the purchase of a mobile clinic. In 2010 Mercy was awarded a Cancer Prevention and Research Institute of Texas (CPRIT) grant for $300,000 over a two year period. This grant was audited in March 2012 by CPRIT with no findings. In 2012 Mercy was awarded a three year CPRIT grant. An award by MHM would not put Mercy Ministries of Laredo over the threshold for an A-133 audit. However, as a member of Mercy Health, Mercy Ministries of Laredo would report any federal dollars to our corporate Grant Department and would include those grants in the corporate Schedule of Expenditures of Federal Awards (SEFA). The corporate grant department monitors federal awards and periodically tests expenditures.

Mercy Ministries of Laredo has been a partner with MHM since 2007. Every year since, Mercy has received multiple grants totaling over $1,951,000 helping fund Mercy's Dental Program, Women's Comprehensive Health Program and Diabetic Program.

d. Key financial personnelElizabeth Casso is the Chief Financial Officer of Mercy Ministries and reports directly to the President. She is responsible for preparation of all financial statements and operating reports for regulatory compliance and fiscal requirements, directs the development of financial and operational policies and procedures oversees the preparation of annual budgets and monitors operating costs and expenditures to ensure budgetary compliance. Ms. Casso oversees the patient accounting department including manager and three cashiers. Ms. Casso also oversees the financial reporting and coordination of annual audit for Casa De Misericordia an affiliate organization. Ms. Casso has a bachelors degree in Accounting and over 11 years experience in non-profit financial management. In 2013 Ms. Casso coordinated the conversion of Mercy Clinic to electronic health records.

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Appendix A

January 27, 2015

Rafael Mangual, M.D.
Mercy Ministries of Laredo
2500 Zacatecas Street
Laredo, TX 78046

Sister Maria Luisa Vera
Mercy Ministries of Laredo
2500 Zacatecas Street
Laredo, TX 78046

Dear Sister Maria Luisa:

It is my pleasure to write a letter in support of the Mercy Ministries of Laredo's "Si Three: Integration of 3D Health Services" proposal being submitted to the Si Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

I have served Mercy Ministries as Medical Director for six years now, although I have served as a service provider. I have known of their important work for many years. I share the mission of the Sisters of Mercy/Mercy Ministries of Laredo to provide quality healthcare for the underserved of our community. We are doing well with few resources to address priority physical needs of our clients with regard to diabetes, hypertension and obesity. However, we are hard pressed to address the behavioral health needs of our clients and have given limited attention to their spiritual needs.

The Si Three project envisions a coherent, integrated, individualized approach to optimizing the health of our client population.

I fully support the efforts of Mercy Ministries of Laredo in seeking external funding to support a program designed to promote integrated care by maximizing use of our human and fiscal resources.

Please feel free to contact me if any further information is needed.

Respectfully,

Rafael Mangual, M.D.
Medical Director

January 28, 2015

Natalie Burkhalter, F.N.P., A.C.N.P.
Ana Laura Garza, F.N.P.
María Hernández, F.N.P., W.H.N.P.

Sister Maria Luisa Vera
Mercy Ministries of Laredo
2500 Zacatecas Street
Laredo, TX 78046

Dear Sister María Luisa:

We who serve as family nurse practitioners for Mercy Ministries of Laredo (Mercy) came to minister with the Sisters of Mercy after many years of nursing and nurse practitioner experience. Over those years we have enjoyed working with the Sisters on a variety of community health initiatives.

We share their passion for the mission of the Sisters of providing quality healthcare for the underserved of our community. Mercy Clinic does well with its limited resources in addressing priority physical needs of our clients with regard to diabetes, hypertension and obesity. However, we are hard pressed to address the behavioral health needs of our clients and have given limited attention to their spiritual needs.

The Si Three project submitted by our Mercy Ministries of Laredo envisions a primary healthcare clinic where a coherent, integrated, individualized approach to optimizing the health of our client population. We see this as a logical next step for the future of Mercy Clinic.

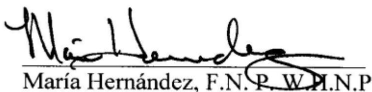
We fully support Mercy's efforts to seek external funding to support a program designed to promote integrated care by maximizing use of our human and fiscal resources in caring for the whole person.

Please feel free to contact any one of us if any further information is needed.

Respectfully,

Natalie Burkhalter, F.N.P., A.C.N.P.

Ana Laura Garza, F.N.P



María Hernández, F.N.P., W.H.N.P

Webb County Indigent Health Care Services Department

Nancy Cadena-Salinas, Director
1620 Santa Ursula Avenue
Office (956) 523-4747 / Fax (956) 523-4748

January 27, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

On behalf of the Webb County Indigent Health Care Services Department, it is my privilege to write this letter in support of the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

Over the past several years, we have worked closely with the Sisters of Mercy and know of the importance of their work. The Sisters of Mercy, through Mercy Ministries of Laredo, are committed and dedicated to serving those most in need and we appreciate their efforts to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address priority physical needs of their clients with regard to diabetes, hypertension, and obesity. They are now looking for ways to better address the behavioral health needs of clients and to include spiritual care. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the physical, behavioral, and spiritual dimensions of the whole person.

Please feel free to contact me at (956) 523-4741 if any further information is needed.

Respectfully,

Nancy Cadena Salinas

Nancy Cadena-Salinas,
Webb County Indigent Health Care Director

cc: Tano E. Tijerina, Webb County Judge
Frank Sciaraffa, County Commissioner Precinct 1
Rosaura "Wawi" Tijerina, County Commissioner Precinct 2
John C. Galo, County Commissioner Precinct 3
Jaime Canales, County Commissioner Precinct 4

SCAN

Serving Children and Adults In Need, Inc.

Our Passion is Helping People

2347 E. SAUNDERS, STE B • LAREDO, TX 78041 • PH. (956) 724-5111 • FAX (956) 725-8367 • 1-800-355-7226 • www.scan-inc.org

January 27, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

Serving Children and Adults in Need (SCAN), Inc. supports the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

SCAN is keenly aware of the important work the Sisters of Mercy do through Mercy Ministries of Laredo (Mercy) in Laredo and the surrounding area. SCAN is mindful of their mission to serve those most in need and the efforts Mercy makes to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address the urgent physical needs of their clients with regard to diabetes, hypertension and obesity. At the present they are seeking for ways to better address the behavioral health needs of their clients and to include spiritual care. The Sí Three Project that Mercy Ministries of Laredo envisions will be a coherent, integrated, individualized approach to optimizing the health of their client population.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care that addresses the physical, behavioral and spiritual dimensions of the whole person.

Please feel free to contact me if any further information is needed.

Respectfully,

Isela Dabdoub, CEO
Serving Children and Adults in Need, Inc.

Laredo

January 27, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

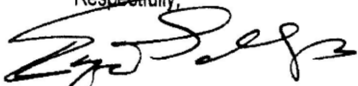
It is my pleasure to write a letter in support of the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

In a short time, I have come to know of the important work of the Sisters of Mercy through Mercy Ministries of Laredo (Mercy) over the years. I admire their passion for serving those most in need and appreciate the efforts Mercy makes to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address priority physical needs of their clients with regard to diabetes, hypertension and obesity. Now they are looking for ways to better address the behavioral health needs of clients and to include spiritual care. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the physical, behavioral and spiritual dimensions of the whole person.

Please feel free to contact me if any further information is needed.

Respectfully,



Enrique Gallegos, FACHE
Chief Executive Officer
Laredo Medical Center

1700 E. SAUNDERS ST. ▪ P.O. BOX 2068 ▪ LAREDO, TEXAS 78044-2068

(956) 796-5000 ph.

2600 Cedar Ave., P.O. Box 2337, Laredo, TX 78044
Tel. (956) 795-4900 Fax. (956) 726-2632

February 3, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa

Re: Letter of Support-Texas Si Grant

This is in support of Mercy Ministries of Laredo (MML) in their application for a total integration project for healthcare services to our community. We are an underserved area with as much as 40% of the population uninsured. Recently, we helped enroll persons in ACA (160) and most of them had one person employed and insured but the family was not insured. When the screening was done most did not qualify for a reduced policy or a subsidy consequently they did not enroll. From our public health responsibility this action further promotes persons seeking health care only when they have to. Preventive care and early detection therefore is not accessed causing person to complicate and wind up in the emergency room. This is a serious concern to us and as well means behavioral health will not be provided adding to the healthcare burden.

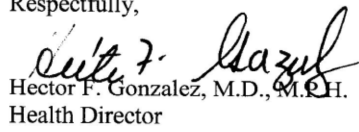
For more than 30 years MML has partnered with the City of Laredo Health Department (CLHD) in many health care activities, they provide the best healthcare service to the needier population, the medically indigent. As health director we know of their commitment to serve and care for persons highly vulnerable and susceptible to disease. Their proposal to the Texas Si Grant, "Sí Three: Integration of 3D Health Services" is considered an enhancement for the delivery of the most needed to access healthcare services especially to address the epidemic in South Texas, diabetes, obesity, and hypertension. We know from experience that disease self management that integrates behavioral health works, we have done so for 3 years now with case management and peer social psycho-support. MML of Laredo is expanding this model in all their services and delivery programs and we applaud them as this is the way to the future, as all clinical cases need this essential commodity.

During the past three years, MML together with the CLHD have screened more than 3,000 men, and women for breast, colon, and cervical cancer. Detecting more than 100 people with early cancer and all have received followed up care through our social worker system. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population.

We fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the

physical, behavioral and spiritual dimensions of the whole person. Please feel free to contact me if any further information is needed.

Respectfully,



Hector F. Gonzalez, M.D., M.P.H.
Health Director

TEXAS A&M INTERNATIONAL UNIVERSITY
A Member of The Texas A&M University System

Office of the Dean
College of Nursing and Health Sciences
Dr. F.M. Canseco School of Nursing

January 27, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

It is my pleasure to write a letter in support of the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

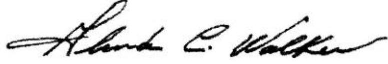
I have come to known of the important work of the Sisters of Mercy through Mercy Ministries of Laredo (Mercy) in a few short months. I share their in their mission for serving those most in need and appreciate the efforts Mercy makes to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address priority physical needs of their clients with regard to diabetes, hypertension and obesity. Now they are looking for ways to better address the behavioral health needs of clients and to include spiritual care. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population. It is my hope that this awarding this grant to Mercy will provide additional opportunities for clinical experience for some of my students.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the physical, behavioral and spiritual dimensions of the whole person.

5201 University Boulevard, Laredo, Texas 78041-1900 • (956) 326-2450 • Fax (956) 326-2449 • www.tamiu.edu

Please feel free to contact me if any further information is needed.

Respectfully,



Glenda C. Walker, PhD, RN
Dean

5201 University Boulevard, Laredo, Texas 78041-1900 • (956)326-2450 • Fax (956)326-2449 • www.tamiu.edu

January 27, 2015

Rene Lopez, CEO
Doctors Hospital of Laredo
10700 McPherson Road
Laredo, Texas 78045

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

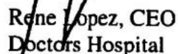
It is my pleasure to write a letter in support of the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

I have come to known of the important work of the Sisters of Mercy through Mercy Ministries of Laredo (Mercy) in a few short years. I share their in their mission for serving those most in need and appreciate the efforts Mercy makes to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address priority physical needs of their clients with regard to diabetes, hypertension and obesity. Now they are looking for ways to better address the behavioral health needs of clients and to include spiritual care. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the physical, behavioral and spiritual dimensions of the whole person.

Please feel free to contact me if any further information is needed.

Respectfully,



Rene Lopez, CEO
Doctors Hospital

Border Region Behavioral Health Center

Daniel G. Castillon
Executive Director

January 27, 2015

Sister María Luisa Vera, RSM
President
Mercy Ministries of Laredo
2500 Zacatecas St.
Laredo, Texas 78046

Dear Sister María Luisa:

It is my pleasure to write a letter in support of the Mercy Ministries of Laredo's "Sí Three: Integration of 3D Health Services" proposal being submitted to the Sí Texas program at Methodist Healthcare Ministries by Mercy Ministries of Laredo/Mercy Clinic.

As Executive Director of Border Region Behavioral Health Center I have come to known of the important work of the Sisters of Mercy through Mercy Ministries of Laredo (Mercy) over the years. I share their in their mission for serving those most in need and appreciate the efforts Mercy makes to provide quality healthcare for those who are underserved in our community. They work hard within the limitation of human and fiscal resources to address priority physical needs of their clients with regard to diabetes, hypertension and obesity. Now they are looking for ways to better address the behavioral health needs of clients and to include spiritual care. The Sí Three project envisions a coherent, integrated, individualized approach to optimizing the health of their client population.

I fully support the efforts of Mercy Ministries of Laredo/Mercy Clinic in seeking external funding to support a program designed to promote integrated care with a project that addresses the physical, behavioral and spiritual dimensions of the whole person.

Please feel free to contact me if any further information is needed.

Respectfully,

Daniel G. Castillon
Executive Director

1500 Pappas P.O. Box 1835 Laredo, TX 78044-1835 (956) 794-3000 (956) 794-3575 (fax)

Work Plan
Mercy Ministries Si Three: Integration of 3D Health Services

Focus Area A: Expand services at existing site (Physical)			
Goal #1 100% of obese, diabetic and hypertension patients will be screened by HCP using empirical assessments during initial/yearly/follow-up visits and results recorded. 45% of screened patients will meet their (a) HbG A1C, (b) Blood Pressure, and/or (c) weight-loss/waist circumference goal by April 2017 as measured by monthly and 3-month measurements.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
1A Diabetic: HCP Training/Orientation to Project All Patients will be screened to determine Hbg A1C levels greater than or equal to 7.0. All Patients will be screened to determine Hbg A1C levels higher than 7.0 that would benefit from education, diet and exercise programs being offered. 1B Obese: All Patients will be screened to determine if their weight exceeds 30 pounds over their ideal body weight using the same electronic scale and a waist circumference that is greater than 35 in women and 40 in men using a tape measure (will develop short and long term goals for each patient) and would benefit from education, diet and exercise programs offered at the clinic.	PI Project Manager (PM) HCP-screen/refer/Navigator (NN) Behavioral Navigator (BN) Spiritual Navigator (SN) Tracker (T) Dependent on Patient Needs: Education (Ed) Dietitian (D) Exercise (E) Integrated Services will be included: LPC (LPC) Counselor (C) Self Help/Support Groups/Group Therapy/Family Counseling, Psychiatrist (Contractual), SCAN of Laredo, City of Laredo Health Dept STD/HIV/AIDS or clergy Data Entry (DE) Evaluator (EV)	(Year One) *Hire a FT project manager (PI) *Hire, navigator, tracker and PT educator, dietician, and exercise coach. (PM) *Purchase equipment, office materials, patient information, etc. (PM) *Re-locate office personnel to accommodate new hires (PI, PM) *Train HCP in the referral protocol for diabetic education classes, family education, cooking classes, exercise programs along with integration of behavioral health services and spiritual health. (PM) *Orient HCP's in the standardized assessment protocols, electronic medical records, data collection and recording (PM, Ed) *Develop pathway with project manager, navigator, tracker, data entry staff and evaluator. (PI, PM) *Develop and have printed all of the questionnaires and educational materials in both English and Spanish. (Ed) *Purchase the items for class participants, ie. Blood pressure machines, weight scales, tape measures, diabetic strips for the glucometer, tote bags and journals. (Ed, PM)	The first 3-6 months would include hiring all personnel for the project and orientation of all key providers.

1C Hypertension: All Patients will be screened to determine B/P levels greater than 150/90 that would benefit from educational, diet and exercise programs offered at the clinic.		*Offer educational classes on a weekly basis for diabetes, hypertension and obesity along with diet and exercise and monitor the patient's progress and attendance. (Ed) *Integrate tracker services for all patients especially the ones that skip or do not overcome barriers of attendance and integration of activities. (PM, T) *Navigate with the patients for all services (N) *Complete 100 standardized assessments and integrate patients in the 3D design (N, LPC) *Review data for completeness and accuracy and counsel or mentor as necessary (PM, EV) *Establish clinical partnerships and seek funding partners (PI, PM) *Develop and administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete annual report and submit (PI, PM) (Year Two) *****Continue the assessment **process** and add an additional 100 new standardized assessments and increase cohort to 200 in year two. (PM, all N) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries (PI, EV,PM) *Review data for completeness and accuracy and counsel or mentor as necessary (PM, EV) *Establish clinical partnerships and continue to seek funding partners (PI, PM) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Meet with community partners to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN)	

		(Year Three) *****Continue the assessment process and add an additional 100 new standardized assessments and increase cohort to 300 in year three. (NN) *Focus Groups on the Integration of behavioral health and spiritual health (PM) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(EV, PM) *Review data for completeness and accuracy and counsel or mentor as necessary (PM, EV) *Establish clinical partnerships and continue to seek funding partners (PI, PM) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Analyze data from years one and two and plan Quasi experimental study to evaluate the effect of integrated services on one or more physical outcomes (PI, EV, PM) *Evaluate project outcomes and make corrective action plans if needed (PM, EV) Year Four *Continue the assessment and integration process (N) *Enroll 50 new patients for Quasi experimental study to evaluate the effect of integrated services on one or more physical outcomes (EV, PM) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Continue monitoring and data collection with all patients as in year three (PM,EV, N) *Conduct the Quasi experimental study (PI,EV,PM)	

		*Complete annual report and submit Year Five *Continue the assessment and integration process (N) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete the Quasi experimental study, analyze results, and generate a report and article for publication (PI, PM, EV) *Complete project and present findings at a local, regional, and system levels (PI,PM,EV) *Complete annual report and submit to Methodist and Mercy Ministries	

Focus Area A: Expand services at existing site (Behavioral)			
Goal #2 All patients seen by primary providers for diabetes, obesity, and/or hypertension will complete standardized assessments (PHQ-9 , GAD-7 and CAGE) on each initial visit and results recorded: anyone with depression and anxiety will be re-assessed and referred to behavioral health navigator and re-assessed at least quarterly.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Depression : 100% of patients will be screened using the PHQ-9 and patients who score greater than 5 will be referred for behavioral services Anxiety: 100% of patients will be screened using the GAD-7 and patients who score greater than 5 will be referred for behavioral services Substance: 100% of patients will be screened using the CAGE score and patients who score greater than 2 will be referred for behavioral services.	PI HCP-screen and refer (NN) Project Manager Navigator Tracker Dependent on Patient Needs: Educator LPC Self Help/Support Groups Group Therapy Family Counseling Social Worker (SW) Counselor (C) Psychiatrist Contractual SCAN City of Laredo Health Dept STD/HIV/AIDS Faith-based Counselor	(Year One) *Hire Behavioral Health Navigator (PI) *Orient HCP in the referral protocol for integration of behavioral health services and spiritual health (PI, PM) *Hire the LPC(s), Sign a contract with a telemedicine Psychiatrist Group (PI, PM) *Orientation for Medical Director and HCP's on process and treatment plans and integration of behavioral services. (PM) *Contact community self-help and support groups and develop referral services.(PI, PM) *Develop and have printed all of the questionnaires and educational materials.(Ed) *Purchase the items for participants, tote bag with a journal.(PM, Ed) *Offer educational classes, group therapy and family counseling and monitor the patient's progress and attendance of sessions.(PM, LPC, C) *Integrate tracker services for all patient especially the ones that skip or do not overcome barriers of attendance and integration of activities. (N, T) *Navigate with the patients for all services. (PM, T) *Re-evaluate patients with positive scores to determine the need for continued services *Integrate documentation of behavioral health services in the medical record using EPIC. (NN,BN, T) *Review data for completeness and accuracy, and	(Year One) *The Ideal plan is that the Behavioral Navigator will serve as the project manager * Contractual agreement for Telemedicine Psychiatry (on Demand) (PI)

		counsel and mentor as necessary (PM, EV) *Develop and administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete annual report (BN, PM) (Year Two) **Continue the assessment process** and integrate additional community outreach services (PM, SW) *Prepare annual report and evaluate outcomes along with the physical outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PI,EV, PM) *Re-evaluate patients with positive scores to determine the need for continued services *Integrate documentation of behavioral health services in the medical record using EPIC. (NN,BN, T) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Meet with community partners to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) (Year Three) * Continue the assessment process and integrate additional community outreach services(PM, BN) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Analyze data from years one and two and plan Quasi experimental study to evaluate the effect of integrated services (PI, EV, PM) *Integrate data into experimental study design	(Year Two) Expand contractual services to include time slot appointments on a scheduled basis and on demand Evaluation activities including satisfaction surveys, annual report and Quasi experimental study itemized and integrated with Goal 1

		*Evaluate project outcomes and make corrective action plans if needed (PM, EV) (Year Four) * **Continue the assessment process** and integrate additional community outreach services(PM, BN) *Integrate documentation of behavioral health services in the medical record using EPIC.(NN,BN, T) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Meet with community partners to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Conduct Quasi experimental study to evaluate the effect of integrated services (PI, EV, PM) *Evaluate project outcomes and make corrective action plans if needed (PM, EV) (Year Five) *Continue assessment and integration process (N) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete the Quasi experimental study, analyze results, and generate a report and article for publication (PI, PM, EV) *Complete and submit annual report. *Complete project and present findings at a local, regional, and system levels (PI,PM,EV)	
Focus Area A: Expand services at existing site (Spiritual)			

Goal #3 All patients seen by primary providers for diabetes, obesity, and/or hypertension will be administered a standardize assessment of spiritual well being and record results.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Well Being: 100% of patients will be screened using the Spirituality-Well Being Index score and patients with PHQ-9, and GAD-7 scores of greater than 5 and 50 or greater on the Spirituality Index will be offered the faith-based behavioral health services.	PI HCP Project Manager (PM) Navigator (N) Tracker (T) Dependent on Patient Needs: Educator (Ed) Faith-based Counselor (FBC)	(Year One) *Orient HCP's in the referral protocol for integration of behavioral health services and spiritual health (PI, PM) *Identify community faith-based congregations that will provide a location for groups, self-help/support groups and develop referral services. (PI, PM, T) *Contact local faith-based leaders for use of kitchens and possible classroom for patient education and support groups.(PM, N) *Integrate dietary cooking classes using faith-based kitchens throughout Webb County (D) *Contact community self-help and support groups and develop referral services.(PI, PM) *Develop and have printed all of the questionnaires and educational materials.(Ed) *Purchase the items for participants, tote bag with a journal.(PM, Ed) *Offer educational classes, group therapy and family counseling and monitor the patient's progress and attendance of sessions.(PM, SN, C) *Integrate tracker services for all patient especially the ones that skip or do not overcome barriers of attendance and integration of activities. (SN, T) *Navigate with the patients for all services. (PM,SN, T) *Re-evaluate patients with positive scores to determine the need for continued	The local food bank and grocery stores will be utilized in purchasing the food that will be cooked during the classes as this is where the majority of our patients receive their staples.

		services(EV,PM) *Integrate documentation of spiritual health services in the medical record using EPIC. (NN,BN,SN, T) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Develop and administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete annual report (BN, PM) (Year Two) Continue the assessment process and data recording (SN, PM, SW) *Add 5 additional faith-based groups to be used throughout the county (PI,PM) *Prepare annual report and evaluate outcomes along with the physical outcomes and provide a summary to Methodist Healthcare Ministries(PI,EV, PM) *Re-evaluate patients with positive scores to determine the need for continued services *Integrate documentation of spiritual health services in the medical record using EPIC. (NN,BN, T) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Meet with community partners to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete and submit annual report. (EV,PM)	

		(Year Three) * Continue the assessment process and integrate additional faith-based community outreach services(PM, BN) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Analyze data from years one and two and plan Quasi experimental study to evaluate the effect of integrated services (PI, EV, PM) *Integrate data into experimental study design (EV, PM) *Evaluate project outcomes and make corrective action plans if needed (PM, EV) *Complete and submit annual report (EV,PM) (Year Four) * Continue the assessment process and integrate additional community outreach services(PM, BN) *Integrate documentation of spiritual health services in the medical record using EPIC.(NN,BN,FBC, T) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Meet with faith-based community partners to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN,FBC) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Conduct Quasi experimental study to evaluate the effect of integrated services (PI, EV, PM) *Evaluate project outcomes and make	

		corrective action plans if needed (PM, EV) *Complete and submit annual report (EV,PM) (Year Five) *Continue the assessment and integration process (N) *Administer satisfaction survey to monitor the quality of services provided (PM,ED) *Complete the Quasi experimental study, analyze results, and generate a report and article for publication (PI, PM, EV) *Complete project and present findings at a local, regional, and system levels (PI,PM,EV) *Complete and submit annual report (EV,PM)	

Focus Area B: Enhance effectiveness by increasing integration of services			
Goal #1 85% of the healthcare team will move from a Level 3-4 to a Level 5 integrated practice over the first two years of the project and 100% over the remaining three years of the project period: 85% of providers and staff will rate satisfaction with integrated services as 4-5 at end of year two and 100% at the end of year five.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
*Diabetic, Obese, and Hypertensive patients will communicate in person and schedule visits as needed throughout the project. *Collaboration driven by need for consultation and coordinated plans for the more difficult patients in order to facilitate the desire to be a member of the team. *Have regular face-to-face interactions with the healthcare team about patient progress and actively seek solutions together as a healthcare team. *All members will work toward an in- depth understanding of the roles and culture of our patients.	PI HCP-screen and refer(NN) Project Manager(PM) Navigator (N) Tracker (T) Dependent on Patient Needs: Education (Ed) Dietitian Exercise Integrated Services will be included: LPC, Self Help/Support Groups/Group Therapy/Family Counseling, Psychiatrist (Contractual), SCAN, City of Laredo Health Dept STD/HIV/AIDS or faith-based providers	Year One *Develop and implement case conferences and consultations across the three dimensions.(PM, N, HCP) *Identify community support self-help groups and their locations while using the mobile clinic services throughout Webb County.(PI,PM, BN) *Schedule meetings with the sponsors of groups to discuss the 3D model (EV, PM, BN) *Develop, administer, and record satisfaction surveys to monitor quality of services provided(BN, PM) *Develop satisfaction surveys focused on attitudes toward integrated services(PM) *Develop a data sheet to monitor collaborative interactions and meetings(EV) *Prepare annual report(PI,PM, EV) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Meet with the 3 dimensions to review project and plan for continuation of the integrated partnership. (PM, EV, NN, SN, BN, T, LPC, FBC, ALL) *Evaluate progress toward level 5 integration (PM, EV)	Currently working toward a Level 4 integrated practice model and this opportunity would expand services to a Level 5 Satisfaction surveys will be given throughout the process and to evaluate the interventions.

		(Year Two) *Continue year one plan and evaluate progress (PM, EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV) (Year Three) *Evaluate year two plan and evaluate progress toward level 5 completion(PM,EV) *Analyze data and any barriers to integration of providers and staff.(EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PI,PM,EV) (Year Four) *Revise plan to address barriers identified in year three.(PM, EV) Evaluate response to satisfaction surveys and prepare integrated report (PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(EV, PM) (Year Five) *Continue year four plan and evaluate final project outcomes and integrate into the report of Quasi experimental study.(PIPM, EV) *Prepare annual report and evaluate	

		outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(EV,PM)	

<table>
<tr><td colspan="4">Focus Area B: Enhance effectiveness by increasing integration of services</td></tr>
<tr><td colspan="4">Goal #2 100% of patients seen by primary providers with diabetes, obesity and/or hypertension will be screened, results recorded, and referred if needed for addiction services using the modified CAGE screening questionnaire. 85% of the patients referred to substance abuse therapy will rate their experience as helpful (4) or most helpful (5) on the satisfaction survey(given quarterly) in years one and two; 90% in years three to five.</td></tr>
<tr><th>Key Action Steps</th><th>Person/Area Responsible</th><th>Time Frame</th><th>Comments</th></tr>
<tr>
<td>Addiction
*Patients identified with substance abuse or addictions will be referred to appropriate service provider.
*Collaboration driven by need for consultation and coordinated plans for the more difficult patients in order to facilitate the desire to receive help and become a member of the team.
*Have regular face-to-face interactions with the healthcare team about patient progress and actively seek solutions together as a healthcare team.
*All members will work toward an in- depth understanding of the roles and culture of our patients.</td>
<td>HCP-screen and refer
Project Manager
Navigator
Tracker
Dependent on Patient Needs:
Education
Dietitian
Exercise
Integrated Services will be included:

LPC, Self Help/Support Groups/Group Therapy/Family Counseling, Psychiatrist (Contractual), SCAN, City of Laredo Health Dept STD/HIV/AIDS Faith-based Counselor</td>
<td>(Year One)
*Develop and implement case conferences and consultations across the three dimensions.(PM,BN,)
*Identify community support self-help groups and their locations while using the mobile van services throughout Webb County.(PM, BN)
*Schedule meetings with the sponsors of the groups to discuss the 3D model (PM)
*Develop and administer satisfaction survey quarterly to monitor quality of services provided(EV,PM)
*Record data for completeness and accuracy, and counsel and mentor as necessary (PM, EV)
*Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV)

(Year Two)
*Have team meetings to better understand the roles and culture of the group and patient population(PM)
*Administer satisfaction survey quarterly to monitor quality of services provided(PM,EV)
*Record treatment plan modification made as a result of patient feed-back on</td>
<td>Satisfaction surveys will be given quaterly throughout the process and to evaluate the interventions

Patients may require short or long term treatment or may need to change modalities for best results.</td>
</tr>
</table>

		satisfaction surveys or other communication (T, BN) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,BN) (Year Three) *Have team meetings to better understand the roles and culture of the group and patient population(PM) *Administer satisfaction survey quarterly to monitor quality of services provided(PM,EV) *Record treatment plan modification made as a result of patient feed-back on satisfaction surveys or other communication (T, BN, PM) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) *Analyze data and any barriers to integration of services. (EV, BN) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(EV, PM) (Year Four) *Revise plan to address barriers identified in year three.(PM,EV) *Evaluate response to satisfaction surveys	

		and prepare integrated report (PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM, EV) (Year Five) *Continue year four plan and evaluate final project outcomes and integrate into the report of Quasi experimental study.(PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM, EV)	

Focus Area B: Enhance effectiveness by increasing integration of services

Goal #3 100% of patients identified with depression and anxiety will be referred to a LPC, telemedicine psychiatry, mentor, group therapy, self-help and/or support group and progress monitored: 85% of those patients that attend will rate the service four to five on the quarterly satisfaction survey years one and two; 90% in years three to five.

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Depression and Anxiety: *Patients identified with depression and anxiety will be referred to appropriate service provider. *Collaboration driven by need for consultation and coordinated plans in order to facilitate the desire to receive help and become a member of the team. *Have regular face-to-face interactions with the healthcare team about patient progress and actively seek solutions together as a healthcare team. *All members will work toward an in- depth understanding of the roles and culture of our patients.	HCP-screen and refer Project Manager Navigator Tracker Dependent on Patient Needs: Education Dietitian Exercise Integrated Services will be included: LPC, Self Help/Support Groups/Group Therapy/Family Counseling, Psychiatrist (Contractual), SCAN, City of Laredo Health Dept STD/HIV/AIDS Faith-based Counselor	*Identify providers for behavioral health services and provide navigation assistance throughout the process.(PM, BN) *Develop and implement case conferences and consultations across the three dimensions.(PM) *Identify community support self-help groups and their locations while using the mobile clinic services throughout Webb County.(PI,PM,BN) *Schedule meetings with the sponsors of the groups to discuss the 3D model(PM) *Develop and implement satisfaction survey to monitor quality of services provided(PM,EV) *Record data and prepare annual report for MHM and Mercy Ministries(PM,EV) *Administer satisfaction survey quarterly to monitor quality of services provided(PM) *Record treatment plan modification made as a result of patient feed-back on satisfaction surveys or other communication (PM,T, BN) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) Year Two	Satisfaction surveys will be given throughout the process and to evaluate the interventions

		*Organize meetings to educate and facilitate the understanding of the roles and culture of patients in the group(PM, Ed) *Expand telemedicine psychiatry to include time slot appointments and on demand visits(PI,PM) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV) *Record data and prepare annual report for MHM and Mercy Ministries(PM,EV) *Administer satisfaction survey quarterly to monitor quality of services provided(PM) *Record treatment plan modification made as a result of patient feed-back on satisfaction surveys or other communication (PM,T, BN,EV) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) Year Three *Organize meetings to educate and facilitate the understanding of the roles and culture of patients in the group and re-evaluate the project and time-lines(PM) *Possible Expansion of telemedicine psychiatry to include more time slot appointments and on demand visits(PI,PM) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV)	

		*Acquire additional clinic space to accommodate new programs and expanded services(PI,PM) (Year Four) *Revise plan to address barriers identified in year three.(PM,EV) *Evaluate response to satisfaction surveys and prepare integrated report (EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries(PM,EV) (Year Five) *Continue year four plan and evaluate final project outcomes and integrate into the report of quasi experimental study.(PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV)	Possible expansion project in the third year

Focus Area 3: Enhance effectiveness by increasing integration of services (Spiritual)			
Goal #4 100% of patients who present with anxiety and/or depression and identify spirituality as a means of support are referred to a faith-based counselor and progress monitored;: 85% of patients who attend faith-based counseling will rate the services four to five on quarterly satisfaction surveys in years one and two, 90% in years three to five.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Spiritual: Patients identifying spirituality as a means of support and maintaining their well-being will be referred to appropriate faith-based counselor for assistance. *Collaboration driven by need for consultation and coordinated plans in order to facilitate the desire to receive help and become a member of the team. *Have regular face-to-face interactions with the healthcare team about patient progress and actively seek solutions together as a healthcare team. *All members will work toward an in- depth understanding of the roles and culture of our patients.	HCP Project Manager Navigator Tracker Dependent on Patient Needs: Counselor Faith-based Counselor	*Identify partners for faith-based behavioral health services and provide navigation assistance throughout the process.(PI,PM) *Develop and implement case conferences and consultations across the three dimensions.(PM) *Identify community support faith-based self-help groups and their locations while using the mobile clinic services throughout Webb County.(PI, PM) *Schedule meetings with the sponsors of the faith-based groups to discuss the 3D model(PM) *Develop and implement satisfaction survey to monitor quality of services provided (PM,EV) *Record data and prepare annual report for MHM and Mercy Ministries (PM,EV) *Administer satisfaction survey quarterly to monitor quality of services provided(PM) *Record treatment plan modification made as a result of patient feed-back on satisfaction surveys or other communication (T, BN) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) Year Two	Satisfaction surveys will be given throughout the process and to evaluate the interventions

		*Organize meetings to educate and facilitate the understanding of the roles and culture of patients in the group(PM) *Enlist 3 additional faith-based resources within the communities(PI,PM) *Record data and prepare annual report for MHM and Mercy Ministries(PM,EV) *Administer satisfaction survey quarterly to monitor quality of services provided(PM) *Record treatment plan modification made as a result of patient feed-back on satisfaction surveys or other communication (T, BN) *Review data for completeness and accuracy, and counsel and mentor as necessary (PM, EV) Year Three *Review all data from years one and two and modify as necessary(PM,EV) *Organize meetings to educate and facilitate the understanding of the roles and culture of patients in the group and re-evaluate the project and time-lines(PI,PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PM,EV) (Year Four) *Revise plan to address barriers identified in year three.(PM,T) *Evaluate response to satisfaction surveys	

		and prepare integrated report (PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PI,PM,EV) (Year Five) *Continue year four plan and evaluate final project outcomes and integrate into the report of quasi experimental study.(PM,EV) *Prepare annual report and evaluate outcomes and provide a summary to Methodist Healthcare Ministries and Mercy Ministries(PI, PM,EV)	

Project Narrative

Abstract

Community Healthcare InveSted in keeping Patients Active (CHISPA):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

Lower Rio Grande Valley Community Health Management Corporation, Inc.
(El Milagro Clinic)
Address: 901 East Vermont Ave., McAllen, TX 78503
Project Director: Isidore Flores, Ph.D., Project Manager
Phone numbers: (956) 648-0543 (voice)
e-mail address: iflores@ivhiinc.org
Funding request for the first 2-year budget period: $651,844 (to have equal be match)

CHISPA will address a critical need and potentially save lives of obese, diabetic and depressed patients of El Milagro Clinic in Hidalgo County, Texas. The goal of the proposed project is to integrate behavioral health services more fully into primary care of the clinic population's large population of patients with chronic disease and co-morbidities. El Milagro Clinic has begun to work toward integrated behavioral health with a wellness center and a co-located behavioral health partner, Life Center. Founded in 1976, El Milagro Clinic provides a medical safety net for the low-income, mostly Hispanic patient population in the City of McAllen and surrounding areas in the lower Rio Grande Valley including Hidalgo County. The county lies on the U.S.-Mexico border with a rapidly growing population of 815,996; the population includes immigrants of all income levels, retirees from all parts of the United States, a growing manufacturing sector, tourism, and extensive international commerce in manufactured goods and fresh produce. Clinic patients who lack medical insurance, Medicaid, or Medicare total 90%. Adults in the region have a type 2 diabetes prevalence of 30.7%; 39% of local diabetic patients have symptoms of depression. Adults in Hidalgo County have an obesity rate of 42.9%.

At the clinic, integration of behavioral health with primary healthcare has begun through two initiatives: an immediate, short behavioral health intervention at a primary care visit and groups activities at the clinic's wellness center. The proposed project will increase the effectiveness of existing services through greater integration of behavioral health services. The project will screen patients for depression, extend the immediate behavioral health intervention to more patients, provide holistic plans of care for diabetic, obese, and depressed patients, and implement an evidence-based program to prevent diabetes. Plans of care, negotiated by an occupational therapist with each patient, will have realistic goals and be re-evaluated periodically. More intensive interventions will address uncontrolled diabetic and clinically depressed patients.

The evidence-based prevention program involves group-based empowerment, education, and physical activity weekly for 6 months with monthly followup for 18 months. Among program participants, 33% are expected to meet their weight loss goals in the first six months, and 33% of those with depressive symptoms are expected to improve significantly in one year. The involvement of community health workers will be crucial to engaging the low-income patient population, sustaining involvement in group activities, and keeping program costs low. The project will better inform and empower patients and their families through more coordinated and targeted clinical care, ultimately strengthening the region's culture of health.

Narrative

Community Healthcare InveSted in keeping Patients Active (CHISPA) will address a critical need and potentially save lives of obese, diabetic and depressed patients of El Milagro Clinic in Hidalgo County. The clinic will improve the health of the patient population and their families through integrated behavioral health and primary care. The project uses the Methodist Healthcare Ministries theory of change, that "integrated behavioral health models, used with collaborative strategies," will improve behavioral health and decrease chronic disease. The clinic will employ a team approach with community health workers, licensed professional counselors, an occupational therapist, and a nutritionist working with the clinic's medical personnel including physicians, nurses, and physician's assistants. Key activities of the project, explained in detail below, will include systematic depression screening of patients; initiation of a behavioral health intervention during a primary care visit; social support and education by community health workers; and group-based empowerment, education, and exercise sessions at the wellness center and in the community.

Need

Hidalgo County has a growing population of 815,996 and one of the largest medically uninsured populations (36.4%) in the country (United States Census Bureau, 2013). Health problems related to high rates of diabetes, obesity, and depression are exacerbated by limited access to healthcare in the region. People of all economic levels ask public health professionals and medical providers to assist the community to prevent diabetes. Local people experience diabetes as a heavy burden of care because they see the disease as a one-way path to amputations, blindness, kidney dialysis, prolonged suffering, and early death.

According to a 2014 CDC report, 42.9% of Hidalgo County adults are obese (analytic

methods by Zhang et al. 2014). The problem is worse among the low-income population according to a recent program addressing that target population. The program was explicitly focused on improving health, not on preventing obesity; nonetheless, 58% of participants were obese (BMI ≥ 30) and 13% were categorized as extremely obese (BMI ≥ 40; Millard et al. 2011).

A recent, scientifically rigorous study found that the prevalence of diabetes in the region is 30.7% (Fisher-Hoch et al., 2012). This extremely high prevalence of diabetes can only be lowered by transformation in the region toward a stronger culture of health; hence the proposed project will target not only diabetics but also those at risk of developing diabetes because they are obese or have primary relatives with diabetes. The county has diabetes hospitalization rates that are among the highest in Texas (Millard et al. 2011). The diabetes mortality rate in Hidalgo County was 24.0 per 100,000 population in 2009, compared with the Texas average of 23.1 per 100,000 population (Texas Department of State Health Services, 2009).

Hidalgo County has a shortage of behavioral health providers. The ratio of population to behavioral health providers is 4,609 to 1, which is extremely high in comparison to the Texas ratio of 1,757 to 1 (University of Wisconsin, 2014). The Health Resources and Services Administration (2015) has designated Hidalgo County as a Health Professional Shortage Area (HPSA) for mental health.

In a recent survey of Texas Prevention Resource Center (PRC) 11, which encompasses a geographic area that includes Hidalgo County, 39% of respondents reported that they had experienced symptoms of chronic depression and 11.2% were clinically diagnosed with major depression (Professional Research Consultants, 2011). The same rate of clinical depression symptoms appeared in a study of diabetic patients in the area (Mier et al., 2008). Hidalgo County had the second highest percentage of deaths due to suicide, 26.1%, in PRC 11 (Prevention

Resource Center, 2014).

Unique characteristics that impact access to and use of behavioral health care

Lack of health information and a shortage of behavioral health services contribute to poor utilization of behavioral health services and delayed diagnosis of type 2 diabetes in the region. The regional cultural landscape heavily influences negative perceptions of mental illness in the region (Barrera, Gonzalez, & Jordan, 2013). Behavioral health practitioners in the region reported that the stigma associated with mental illness was a major fear for patients struggling to admit and accept their illness (Barrera, Gonzalez, & Jordan, 2013). Hispanic patients in the Rio Grande Valley relate their views of mental distress through culturally shaped negative terms and descriptions that tend to exaggerate the threat of behavioral health problems (Barrera, Gonzalez, & Jordan, 2013); thus culturally reinforced stigma and fear tend to reduce the utilization of behavioral health services in Hispanic populations (Ruiz, 1995). Careful use of terminology in the clinical setting can help to break down some of these barriers. For example, "stress" is a socially acceptable form of mental distress, whereas "mental health illness" is not.

Further barriers to this project come from culturally embedded ideas that type 2 diabetes is determined by genetics and that it is a death sentence. A 10-year-old girl expressed considerable sadness because she assumed she would have diabetes as an adult, as her grandparents have the disease. An employee of a local business remarked, referring to the local population, "We're Hispanic. We all have diabetes!" Regarding obesity, chubby babies and children are favored and viewed as healthy, whereas those with age-appropriate slenderness are seen as sickly. Several medical groups offer bariatric surgery, and their information sessions are filled with potential patients, many of whom go on weight gaining binges to qualify for the surgery, which too often leads to further hospitalizations and a return to obesity after an initial

abrupt loss of weight. The proposed project can address the major problems created by the lack of information on early type 2 diabetes prevention in the local community.

The clinic staff will need training in several areas to work with this project. In preparation to facilitate the group sessions, community health workers (*promotoras de salud*, or "promotoras") will require training in experiential learning, didactic instruction, peer mentoring, and observation following the HELP PD protocols (Katula et al. 2010). Clinic staff will require training in the Patient Health Questionnaire depression screening tool (PHQ-9); it is designed to be self-administered, but some clinic patients are likely to need assistance with it, as with any written questions. Staff will need training in the use of non-stigmatizing terminology for mental illness and behavioral healthcare. Staff will also need training on the general goals and procedures of the project to contribute to a smooth flow of patients and family members through the various activities and phases of the program.

Project Description

a. Stage of behavioral health integration

El Milagro Clinic will use Sí Texas funding to increase the effectiveness of existing medical and wellness services through greater integration of behavioral health services. The clinic has a Level of Behavioral Health Integration of 3, "Basic Collaboration Onsite" (see Table 1, call for proposals). The bases for this classification are that the clinic has co-located behavioral health services through Life Center, a behavioral health provider, with collaboration on some cases, but separate case records and no regular meetings to coordinate care. With support from Sí Texas, the clinic will improve the integration and quality of services to reach the Integrated Care Level of 5 or 6.

El Milagro Clinic currently provides a "warm handoff" to some patients at primary care

appointments who need behavioral health services. That is, the primary care provider directly introduces the patient to the behavioral health provider during a medical visit. The behavioral health provider is a licensed professional counselor (LPC) who is a partner in Life Center, an organization co-located at the clinic. The counselor meets the patient immediately and provides a brief behavioral health intervention. This process initiates a needed behavioral health intervention immediately, breaks through the barrier of stigma against behavioral health services, and allows the counselor to develop rapport, thus encouraging the patient to have confidence in the services offered. After conducting a formative evaluation of warm handoffs, the project partner Nuestra Clinica del Valle (a federally qualified health center) found that warm handoffs provide the added benefits of saving time for primary care physicians and relieves one of the pressures of providing primary care services. Physicians find behavioral health issues difficult to accommodate in a primary care visit and are relieved to know that the patient is receiving appropriate care.

In addition to the warm handoff approach, El Milagro will implement an evidence-based program named the Healthy Living Partnerships to Prevent Diabetes (HELP PD, Katula et al. 2013). HELP PD is a community-based program that will be adapted by CHISPA to include activities in the clinic and in the community. The program will make intervention activities available near their homes for patients with transportation problems. This extension from clinic into the community is an innovative aspect of the program which will rely on community centers, churches, and possibly daycare centers as intervention sites. Other innovative aspects of the program include the integration of an Occupational Therapist as part of the care-giving team to address issues of both mind and body in formulating a plan of care with the patient and to contribute to the program’s work with groups of patients and their family members. The

Occupational Therapist will develop plans of care with all depressed, diabetic, or obese patients with periodic re-evaluations to assist in the coordination of care and communication with patients. Depressed, diabetic, and obese patients who are ineligible for the HELP PD program will be included in plans of care.

b. The integrated care model

i. Integration of primary medical and behavioral health care

Behavioral healthcare services will be integrated into clinic procedures in several ways involving all the staff at El Milagro Clinic. Physicians will assess patients' need for behavioral health care and refer the milder cases to the proposed program, patients with greater symptoms to the professional counselors co-located at Life Center, and those with major depression symptoms to a psychiatrist off site. Licensed professional counselors will meet primary care patients through warm handoff introductions by physicians. The counselors will provide a brief behavioral health intervention and arrange ongoing treatment when warranted as well as contribute to the design of holistic group-based lifestyle intervention activities and caregiver team meetings.

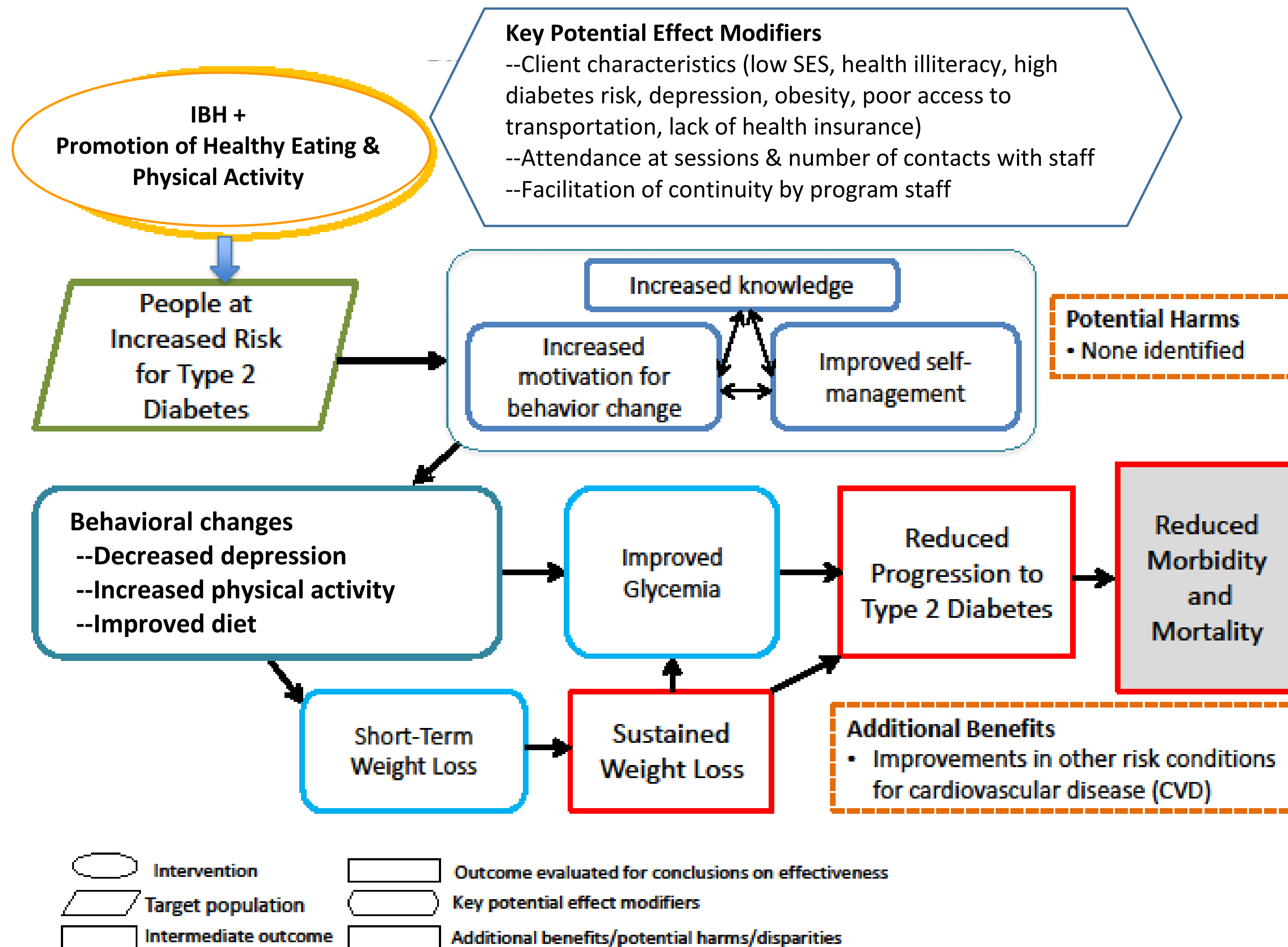
Community health workers who are controlled diabetics, Hispanic, and suited to positions of leadership and program facilitation will be trained to meet patients in the waiting room, gather data on patients' problems and coping skills, and assist patients to fill out the a PHQ-9 self-report depression assessment tool. The community health workers will also coordinate group-based lifestyle intervention activities to educate patients on healthy eating, increasing physical activity, and developing their coping skills. The HELP PD program involves trained community health workers coordinating weekly group meetings for the first six months of the program, followed by monthly meetings for the next eighteen months. At each meeting,

the workers weigh participants, record measurements and other information, and follow up no-shows through with program delivery by phone when necessary. The community health workers will gather information for behavioral health assessment by the physician and will encourage the lifestyle intervention groups to provide social support for the participants. These activities constitute the contribution of the community health workers to the behavioral health component of the project in addition to the health education and physical activity components.

The CHISPA project will utilize a planned system of operations beginning from the moment after a patient signs into the front desk of the primary health clinic. A promotora (community health worker) will greet each patient in a professional, sincere and welcoming manner within a semi-private area of the waiting room to initiate a discussion allowing the patient to identify problems in general health, family structure, home environment, and socialization patterns. The promotora will also elicit general information about nutritional needs and pursuits in work, leisure, and physical activity. The patient will then be asked to answer the first two questions from a depression screening tool (PHQ-9, to be applied to all adolescent and adult patients). If the responses indicate depressive symptoms, the patient will be asked to complete the screening questions. This process will indicate whether the patient needs a behavioral health referral. The patient's responses to the questions will be scored by a qualified clinician, and results will be entered into the patient's chart before the primary care visit. A PHQ-9 score of 10 will serve to identify the patient as a possible candidate for behavioral health treatment. Using this information, the physician will further assess the patient and will be better prepared to decide whether additional referrals to other professionals on site and off are needed.

The program will implement a stepped-care approach to address patients with different levels of need for medical and behavioral health treatment. Patients who are referred to HELP

CHISPA Analytic Framework: Combined Programs with Integrated Behavioral Health (IBH) and Promotion of Healthy Eating and Physical Activity to Prevent and Control Type 2 Diabetes
(Adapted by CHISPA from The Community Guide, 2015)



PD will be invited to group sessions at the wellness center or, if they face transportation difficulties, a location in the community near their homes. Before they join HELP PD, the patients will be screened to make sure they are healthy and able to participate without harming themselves. They will be screened for "any comorbid conditions that would make physical activity unsafe," including "recent history of an acute cardiovascular disease event, uncontrolled hypertension (blood pressure ≥ 160/100), cancer, or other conditions limiting life expectancy," and "major psychiatric or cognitive problems" including major depression syndrome (Katula et al. 2010, Katula et al. 2011:1452). Patients who are ineligible for HELP PD will still be offered integrated behavioral health care and the opportunity to participate in the HELP PD groups later if they become eligible.

HELP PD will provide weekly group sessions for six months (Phase 1) and monthly sessions for the last eighteen months (Phase 2). Trained promotoras will coordinate the sessions, keep attendance, take weight measurements, and record data. Participants will have a personalized consultation with a registered dietitian in months 1, 3, and 6 of Phase 1, and the program will follow the lifestyle intervention session schedule of HELP PD (Katula et al. 2010). The CHISPA analytic framework on the previous page shows the flow of causes of change that can reduce obesity, diabetes and depression in the target population. The project team will adapt the educational contents of HELP PD to make it culturally congruent for the people of South Texas; that is, educational materials will be available in English and Spanish and will emphasize aspects of local culture that support healthy eating and increased physical activity. Educational DVDs, designed, recorded, and tested by Peña-Purcell et al. (2011) will be used in the program on a trial basis. They include video episodes in a telenovela (soap opera) format and other culturally familiar materials developed for communities in the region. Peña-Purcell et al. (2011)

developed the materials for a quazi-experimental diabetes self-management pilot program for Hispanics, which included an element of randomization, and found it effective in reducing HbA_{1c} values and increasing self-efficacy and self-care scores. Additional educational materials are available from a program developed by Millard et al. (2011) for early diabetes prevention in the low-income population of the region. These materials were adapted from the Diabetes Empowerment and Education Program, developed for the Hispanic population in Chicago.

ii. Use of a team-based, integrated model of care that incorporates behavioral health services and primary care

CHISPA will integrate behavioral health care services in a primary healthcare setting with a multidisciplinary team approach. Physicians will provide referrals to counseling, occupational therapy, and if warranted, for psychiatric consultation. Trained nursing staff together with promotoras, an occupational therapist, and a nutritionist will provide education in the self-management of diabetes and healthy lifestyles.

Since co-morbidities frequently exist in patients with depression (Katon et al. 2004, Mier et al. 2008), patients would benefit from education in diabetic self-care management, obesity, nutritional intake and physical exercise, provided by an occupational therapist, nursing staff and physicians. Furthermore, patients receiving occupational therapy would engage in group exercise to take advantage of the social interaction offered in their group of peers.

iii. Innovative components

This project has several innovative components. First, an occupational therapist (OT) will be integrated into the team to develop a plan of care in negotiation with the patient at the request of a physician. Occupational therapy provides a useful component in planning because of the field's integration of mind and body in treatment and the tradition of a team approach to

enhancing patient health, defined holistically. The American Occupational Therapy Association (AOTA) has recognized the importance of addressing the chronic disease epidemic in the United States. AOTA has developed documents and practice guidelines noting the roles that occupational therapists can play in health and wellness, diabetes self-management, and obesity or bariatric care, areas of practice are deemed as emerging (AOTA, 2007, 2011, 2012)..

OTs have expertise in analyzing performance skills and patterns required by daily activities or occupations. Using a client-centered approach, they will work with patients to identify desired changes, to access relevant information and instruction, and to set measureable and attainable self-management goals necessary for living healthier lives with the chronic conditions CHISPA addresses. Some examples of OT interventions relevant to this project's target populations include assisting individuals to prioritize and simplify daily tasks, to break down exercise and dietary changes into manageable parts, to make needed adaptations to their environment, to access transportation resources, and to identify healthy food choices and simplify cooking tasks.

OTs also address changes in a person's self-image and psychosocial aspects of living with a chronic condition (Crist and Mosley 2010). Examples of interventions specific to diabetic patients include assistance in organizing and tracking medications, instruction in compensatory or protective ways to handle hot, cold or sharp objects by persons with peripheral sensory loss, proper use of medical equipment and instruction in therapeutic exercise. OTs can assist persons with depression to build a sense of accomplishment by helping them determine how to adapt behaviors in order to take part in activities meaningful to them (Sokol-McKay, 2010). Using the recovery model identified in the National Consensus Statement on Mental Health Recovery (Opp n.d.; Williams et al., 2009), occupational therapists assist depressed persons to build hope,

motivation and empowerment by instructing them in coping strategies to better manage the effects of depression on their lives. They also identify and help implement healthy routines and habits for wellness, increase awareness of community resources and assist with creating budgets when appropriate.

A second innovative component is to bring community health workers (promotoras) into the clinic setting with responsibilities to patients throughout their primary care visit. Usually promotoras are limited to outreach, attending booths at health fairs, and providing limited health education. In the clinic, they may take a role in directing patients to various offices and waiting rooms. In this project, the community health workers will meet patients in the reception area and accompany them through the visit, beginning a conversation in the waiting room, assisting the patient with a self-administered depression screening tool (PHQ-9), and meeting the patient after the physical examination for an introduction to the wellness center and, for eligible patients, an introduction to the occupational therapist to develop a plan of care.

A third innovative component is to have parts of the program occurring in the clinic and wellness center, and other parts in community centers and churches close to neighborhoods where some patients live. The latter will be used as sites for wellness lessons and activities for those patients who have difficulties in traveling to the clinic for the Phase 1 and 2 lifestyle intervention sessions.

c. Describe the evidence based practices on which the IBH interventions are based.

This program will implement the intervention of Katula et al. (2013), Healthy Living Partnerships to Prevent Diabetes (HELP PD; see references uploaded in evidence section). HELP PD addressed overweight and obese prediabetic patients through a translation of the Diabetes Prevention Program Lifestyle Weight Loss intervention, with a Diabetes Education Program

delivered by community health workers, participation by health experts in some group education sessions, and one-on-one meetings with dietitians. Compared with patients receiving the usual kind of medical care, participants in HELP PD achieved statistically significant reductions in blood glucose levels, insulin, weight, body mass index, and waist circumference.

HELP PD was studied over a two-year period in a randomized controlled trial. The Guide to Community Preventive Services (2014a, 2014b) found that the program used scientific standards of the highest quality regarding low risk of sampling bias, low dropout rate, outcome measures that were reliable and valid, and other variables. The Guide published a major review of combined diet and physical activity programs to prevent type 2 diabetes, and Katula et al. (2013) was among the few peer-reviewed published studies with no faults in quality assessment. In general, the review found strong evidence of effectiveness in reducing new-onset diabetes through combined diet and physical activity promotion programs for those at risk of type 2 diabetes. Such programs also were found to increase the likelihood of improving diabetes and cardiovascular risk factors, including overweight and high blood glucose; they also increased the likelihood of reverting to normoglycemia (Guide to Community Preventive Sevices 2014c)

Regarding the program of Katula et al. (2013) specifically, the evidence in support is strong on several bases. It is strong in that there is more than one study of the program (Katula et al. 2011 and 2013) and of its cost-effectiveness (Lawlor et al. 2013). These outcome evaluations were done by external evaluators, i.e., researchers, who were not involved in implementing the program. The studies belonged to a randomized controlled trial with high internal validity and 301 patients who were white (73.3%) or African American (24.7%), men and women; very few were Hispanic (1.3%). Most had at least a high school education (72.1%; Blackwell et al. 2011). The program was carried out in 14 sites.

The proposed implementation of HELP PD at El Milagro Clinic would address a largely Hispanic patient population, most of whom have less than a high school education. The educational level would not be a barrier, however, because the lessons in nutrition, physical activity, and coping skills to be conveyed to the patients do not require a high level of education. The project team will adapt HELP PD by incorporating educational materials from other evidence-based programs that are available in Spanish and been used with the regional population (Peña-Purcell et al. 2011, Millard et al. 2011). This program is feasible for implementation with El Milagro patients because they are familiar with community health workers, whom they trust as peers and members of their own communities, and because they value group-oriented programs. They are aware of the dangers of diabetes and express the need to prevent it as much as possible; however, they lack information about prevention and self-care. HELP PD emphasizes problem-solving for members of each group as they strive for weight loss, in contrast to programs emphasizing didactic activities without an empowerment emphasis (Katula et al. 2013).

d. Cost-effectiveness

HELP PD is a translation from the Diabetes Prevention Program, which used a lifestyle management approach to reduce the incidence of diabetes by 58% compared to 0% in a control group (Blackwell et al. 2011). According to the Guide to Community Preventive Services (2014c), combined diet and physical activity promotion programs for those at risk of type 2 diabetes have proved cost-effective in numerous studies. Group-based programs have a lower cost per participant than individual sessions, and programs staffed by trained laypeople have lower costs than those staffed by health professionals. As implemented by Katula et al. (2013), the care provided by HELP PD cost $850 per person for two years as opposed to $2,631 per

person for two years in the Diabetes Prevention Program (DPP). The cost of the latter was already considered reasonable by many in the diabetes prevention community because of much greater costs of diabetes care in the latter stages of the disease.

The current scenario for low-income patients in Hidalgo County is both gloomy and expensive. Typically, they are diagnosed late in the progression of type 2 diabetes, when their care is expensive. For lack of medications and ongoing continuity of care, patients take on a pattern of visiting the hospital emergency department in diabetic crisis, resulting in costs of $0.5 million annually for kidney dialysis (report from local primary care clinic; aside from amputations and blindness care). El Milagro Clinic will offer much earlier care at the cost of $850 for two years, which will allow patients to avoid severely disabling symptoms of the disease.

As noted below under **h**, El Milagro Clinic expects to be able to expand the patient base to include more people with health insurance to assist in funding care for those with scarce resources.

e. Provide a comprehensive five-year work plan (see Appendix A).
The work plan should
be detailed and logical, and describe how integrated behavioral health services will be responsive to the needs of the target population, including timeframes for the accomplishment of key tasks. Address how the following will be accomplished:

- *Enhancement of primary and behavioral health care integration: describe whether the organization intends on 1) expansion of services to more clients and/or 2) replication of the program to additional sites and/or 3) increasing the level/effectiveness of integration of services.*
- *Close collaboration in a fully integrated system (refer to the Integration Model and Appendix B: Integrated Behavioral Health Model).*

The Work Plan shows that the project will advance integrated behavioral healthcare (IBH) and collaboration in an increasingly integrated system in a stepwise manner. Over the

course of training and implementation, clinic providers and other staff will be included with project staff in decisions about how to bring the clinic through the necessary transitions. Every effort will be made to give ownership to providers and other healthcare staff at the clinic, and to make sure all staff are informed about the intent and clinic practices of the project.

f. Describe how the organization will ramp up to achieve the outcomes. Provide a timeline.

El Milagro Clinic will ramp up through trainings, meetings, and increased ownership by the staff of integrated behavioral health and collaboration. Participation in design of patient flows and the development of training will be open to primary care physicians and other caregivers. Staff of Nuestra Clinica del Valle will contribute from their experience and expertise in integrated

TIME LINE

Year 1	M	J	J	A	S	O	N	D	J	F	M	A
Weekly project meetings	x	x	x	x	x	x	x	x	x	x	x	x
Project and clinic staff meetings	x	x	x			x			x			x
Hiring & training personnel in IBH	x	x	x									
Roll out IBH increasingly			x	x	x	x	x	x	x	x	x	x
Train staff in collaboration				x	x	x	x	x	x	x	x	
Increase collaboration						x	x	x	x	x	x	x
HELP PD activities					x	x	x	x	x	x	x	x
Ongoing process & outcome evaluation	x	x	x	x	x	x	x	x	x	x	x	x
Years 2-5												
Weekly project meetings	x	x	x	x	x	x	x	x	x	x	x	x
Project and clinic staff meetings			x			x			x			x
Increase IBH availability to pts	x	x	x	x	x	x	x	x	x	x	x	x
Increase collaboration	x	x	x	x	x	x	x	x	x	x	x	x
HELP PD activities	x	x	x	x	x	x	x	x	x	x	x	x
Ongoing training in EBPs	x						x					
Ongoing process & outcome evaluation	x	x	x	x	x	x	x	x	x	x	x	x

behavioral healthcare and working with patients on diabetes self-care. The work plan and time line show the schedule for training and rolling out different parts of the project. Generally, training and implementation on IBH will precede training and implementation of increased collaboration by sharing an EMR system and sharing responsibilities for patients. El Milagro Clinic expects to have its EMR system functioning in September 2015; therefore, it makes sense to attend to aspects of the project first that are less dependent on an EMR.

g. Describe how IBH core competencies will be achieved by the end of the five-year period

The inception of the EMR will ease the sharing of patient scheduling, treatment planning, providing services, and keeping records. The training provided by the proposed project will encourage the staff to enter into closer collaboration in all these processes. The more difficult areas will be treatment planning and providing services, which is likely to occur only with very difficult cases, even though other patients could benefit as well. Record keeping for an EMR is considered overly burdensome by some physicians and may present obstacles to implementation as well because of the time demands inherent in more comprehensive records.

h. Describe any current or future scalability possibilities.

The project team expects that the success of CHISPA will lead to increased numbers of patients seeking care at El Milagro Clinic and its partner, Nuestra Clinica del Valle. El Milagro Clinic will try to diversify its patient mix to include more patients covered by medical insurance, Medicaid, and Medicare. An increase in patient numbers can be accommodated more easily when the demand for intensive patient care decreases, as is expected in this project over the long term. The team expects that the effect of increased healthy eating and physical activity among patients will contribute to broader patterns of population health improvement in the region, and the same approach may be appropriate in other areas of the state and nation.

Evaluative Measures

a. El Milagro Clinic's evaluative capacity and the team's experience in evaluation

El Milagro Clinic has excellent potential to build evaluation capacity, and Sí Texas funding would allow it to make major strides in that regard. The clinic has a devoted staff and systematic record-keeping practices. The project team is interested in working with staff to upgrade their evaluation activities, especially with advice from project partner Nuestra Clinica del Valle (a federally qualified health center), which has well established evaluation routines, partly because of expertise and interest on the part of the current and former medical directors, and partly because of the demands of reporting to federal authorities. Additionally, Texas A&M-McAllen Campus has a faculty member with strong evaluation skills and access to the university's Institutional Review Board for review and approval of research ethics.

Past evaluation experience at the clinic includes an El Milagro Clinic cancer prevention project that was evaluated by Dr. Millard of Texas A&M School of Public Health-McAllen Campus. The program recruited mothers and daughters to visit the clinic together for a half-day program in cancer prevention education and screening in a pleasant atmosphere with activities such as fingernail painting and lunch. The program ran monthly for six months, involving about 35 people monthly. The evaluation involved process and outcome variables as well as ethnographic analysis of qualitative data. Pre- and post-tests were used to evaluate education sessions; they were successful in reinforcing the content of the lessons but not useful for evaluation because all the participants helped one another with the answers. Any pre- and post-test evaluation with the clinic population would require that participants respond to test questions in isolation or individual interviews, and this arrangement would have to be made in a diplomatic and non-threatening way. Additional evaluation of the education sessions was implemented

through ethnographic observation and by collection of questions asked by participants. The formative evaluation was useful to assist the project in refining the educational content of ensuing sessions. This evaluation method will be useful in the proposed project as well.

Although El Milagro Clinic has little experience with program evaluation, the project team has much more experience and is well prepared to implement data collection for the proposed project. Dr. Millard has experience in teaching program evaluation in public health and in evaluating several projects in the region dealing with obesity prevention and early diabetes prevention. One of the projects was a quasi-experimental pilot project with an element of randomization and intervention and comparison groups. Process and outcome evaluations were implemented; decline in body mass index was the lone outcome variable. The program evaluated resembled HELP PD on a smaller scale, and the result was a statistically significant decline in BMI in the intervention but not the comparison groups (Millard et al. 2011).

Other evaluation experience of Dr. Millard includes a cancer prevention project of Mercy Ministries of Laredo, and several school-based obesity prevention projects with Edinburg Consolidated Independent School District. All project evaluations involve process and outcome variables. In the school-based programs, pre- and post-data on body mass index were collected on two intervention schools and a comparison school. The intervention involved increased activities at gym class, during recess, and in the classroom, plus an upgrade of the school playground to include a walking trail and new playground equipment. For all of these projects, Millard assisted in writing the proposals, designing the evaluation, and implementing it. Additional evaluation experience of Dr. Millard and the International Valley Health Institute involved a program to educate low-income parents on the benefits of physical activity for the health of their children and the dangers of obesity for the population. A process evaluation was

implemented for that project as well as a qualitative outcome evaluation. These experiences provide a valuable foundation for the proposed project.

b. Theory of change, logic model, and SMART goals

Our theory of change is that combined programs with integrated behavioral health and promotion of healthy eating and physical activity can decrease depression, obesity, and type 2 diabetes. Improvement in physical and mental health will be achieved over 5 years in measureable outcomes in depressive symptoms, obesity rates, and HbA_{1c} levels among program participants. The logic model shows the resources at El Milagro Clinic, including staff to be provided by the proposed program, including a nutritionist, an occupational therapist for developing plans of care, and promotoras. Activities of the project are the warm handoff and other behavioral health services for patients, a plan of care for each program participant, and the HELP PD lifestyle modification program to be pursued by each participant for two years. El Milagro Clinic will better integrate behavioral health into patient care and deliver a higher quality of care to patients who are depressed, obese, or diabetic. The project will provide opportunities for educating families, aiming to spread as completely as possible, a culture of health in combating diabetes. In a county of 850,000 people, however, we do not expect that this one program will make a large change, even if it does so for at least one-third of the participants.

The SMART goals are as follows:

At least 33% of obese, depressed, or diabetic patients will have a decline of 4 points in depressive symptoms on the PHQ-9 in one year if they participate in project activities (behavioral health care, HELP PD, or both). [We will work with 910 people per year, and at least 33%, or 303, will achieve this change.]

At least 33% of obese or overweight patients will meet their weight loss goals in six

months if they participate in HELP PD, as measured by weekly weigh-ins. [We will work with 910 people per year and we expect at least 303, or 33%, to meet their weight-loss goals in their first six months of participation in HELP PD.]

At least 33% of prediabetic patients will lower their HbA_{1c} level by a statistically significant amount within two years of beginning participation in HELP PD. [We will work with 720 participants in the first 2 years of operation of HELP PD, and we expect at least 33% of those with prediabetes will lower their HbA_{1c} levels by a statistically significant amount within two years.

c. Lead evaluation personnel

The lead evaluation staff member is Ann Millard, Ph.D., Associate Professor, School of Public Health –McAllen Campus, Texas A&M University Health Science Center. She has taught public health program evaluation in the Master of Public Health program at the McAllen Campus in Hidalgo County for twelve years and has worked as an evaluator on a dozen programs in the South Texas region during that time. Sources of funding included the CDC, which funded the Texas Department of State Health Services- Nutrition Physical Activity and Obesity Prevention Program. Several funding sources required online data entry in complex data collection systems.

Dr. Millard is bilingual in English and Spanish, trained in qualitative and quantitative analysis, and has experience in research in Mexico, with Hispanic/Latino migrant farm workers and rural communities in the Midwestern U.S., and Hidalgo County where she has focused on primary prevention of diabetes. She has been trained in team-based empowerment of low literacy communities and has found those skills crucial in working with South Texas communities.

This project is particularly interesting to her because it deals with type 2 diabetes prevention, especially at the primary and secondary levels. Dr. Millard promotes the idea that

type 2 diabetes is preventable because this understanding is crucial to reversing the course of the regional diabetes epidemic, in which 30.7% of adults are diabetic. The proposed project will take that message as a basic lesson to be transmitted in disseminating information. Dr. Millard's supervisory roles have included hiring, training, and overseeing the work of promotoras, undergraduate students, and graduate students for many years. The number of staff she has directed at any one time have ranged from one to ten. International Valley Health Institute and has collaborated with Dr. Millard on several projects involving obesity prevention in low-income communities; they were funded by the Texas Department of State Health Services and the American Heart Association. Dr. Millard works well with project teams because she welcomes team members to contribute solutions to problems and creative ideas, while still maintaining high standards for accuracy in data collection, recording and analysis.

d. **Process for tracking progress toward enhancement of IBH and related programs**

Process evaluation will be ongoing throughout the project to deal with any problems as they arise and to ensure a high quality of data collection. Quantitative aspects of process evaluation will involve counts of patient encounters by promotoras, counts of warm handoffs, counts of patients enrolled in HELP PD, and attendance at group and individualized sessions. Progress in enhancement of IBH will be tracked through these counts and through interviews with clinic staff about their perceptions of the push toward integration.

Another evaluation avenue in tracking progress will be changes in patients' health status. We expect the health of at least one third of participants in the HELP PD program as measured by the SMART goals. We also will record basic sociodemographic information about the participants (age, education, and so on) to use in analyzing responses to the integrated behavioral health program components. Additional measures would be interesting (see for example Katon et

al. 2004; Peña-Purcell et al. 2011); however, with a low-literacy population, we try to keep questionnaires as short and few as possible because they are difficult, tiring, and anxiety-inducing for people who are not used to the format and nature of questionnaires.

e. Current process of data collection and use

The current process of data collection at El Milagro clinic is to keep a count of patients, their medical insurance, Medicaid, and Medicare status, and their eligibility for the funding of their care by the various program grants secured by the clinic. The clinic keeps careful track of expenditures on grant-funded categories and other clinic operational categories, including various aspects of maintenance. When a grant calls for evaluation, data collection on patients is done for that purpose. Otherwise, patient care is not routinely evaluated because of a shortage of funds and trained personnel. The proposed project is an opportunity to institute regular evaluation of patient care, which will be facilitated by the use of the new EMR system. On the basis of grant management by the clinic and the skills and experience of the project team, it is apparent that the clinic is well prepared to implement the evaluative activities required by Sí Texas.

Collaboration

Local project partners include Life Center, the co-located behavioral health partnership at El Milagro Clinic. Life Center will provide patient services, including receiving clients through a warm handoff. Nuestra Clinica del Valle (a federally qualified health center) will provide consultation on the warm handoff process, educational approaches with diabetic patients, and clinic evaluation. International Valley Health Institute will recruit, ensure training, and direct promotoras de salud (community health workers), identify a registered dietitian and an occupational therapist to hire and provide management for the program; and Texas A&M

University Health Science Center-McAllen Campus will work on the evaluation.

El Milagro has a history of successful collaboration with the partners, and this project will strengthen these relationships. Life Center is currently providing services to a few of the clinic's patients, and this project will increase and regularize that function. International Valley Health Institute collaborated with El Milagro Clinic in a smoking cessation program (2013-14) with weekly meetings of small groups, many of whose members successfully quit according to a quantitative evaluation. Nuestra Clinica del Valle, El Milagro Clinic and Texas A&M-McAllen Campus collaborated in a four-year study of community health workers funded by Robert Wood Johnson Foundation (2001-2005). Also, the Texas A&M faculty member who will evaluate the proposed program is a former member of Nuestra Clinica del Valle's Board of Trustees. The project partners thus have a history of working smoothly and productively together. The organizations have successfully collaborated to complete project activities, submit required reports, and meet deadlines. In addition, El Milagro Clinic has many other partner organizations in the region and is known for actively seeking partnerships to benefit patients.

Resources/Capabilities

a. Experience and expertise to carry out the proposed five-year plan

El Milagro Clinic is now completing its fourth decade of serving the working poor of McAllen and surrounding areas of Hidalgo County. The clinic is largely funded through grants and, with the help of the project team, has the capacity to implement the proposed program. The clinic is clearly ready to implement integrated care, as it has already begun to do so with co-located Life Center professional counselors through the warm handoff process. In addition, the clinic has a wellness center on site providing behavioral health services, group-based physical activity, health education, and social support. Wellness center activities include journaling,

Zumba, and other physical activities. The clinic director highly values efforts to improve services for patients with depression, diabetes, and obesity because of high prevalence of these three conditions.

Regarding the ability to carry out a five-year plan, the clinic is also capable in that area. For the clinic, the five-year program would be welcome as a way to provide intensive services to patients in great need, and simultaneously improve clinic functioning to meet the needs of the patient population generally.

***b.* Organizational structure and operational and oversight needs**

The clinic administration is stable and committed to improve patient care as much as possible. The board is composed of knowledgeable community members including doctors and other leaders who understand the importance of behavioral health integration and also of diabetes prevention.

c. Governing board and willingness and ability to support program expansion.

The El Milagro Board of Trustees meets every other month and includes seven members who are committed to supporting the clinic expansion. The Board includes two physicians, a chiropractor, businesspeople, and a former state congressman who has long been involved in efforts to expand medical safety net and behavioral health care in the region. Board members differ by ethnicity and gender, representing the local population.

d. Current and planned systems as applicable: i. Electronic medical records (EMR)

El Milagro Clinic has plans and funding to install World Vista as the EMR. The program manager of the proposed project has been assisting the clinic director with information on the options available and planning for installation. The concept is to develop a single integrated medical and behavioral health record for use with clinic patients.

ii. Engage in a local or regional health information exchange (HIE). The clinic does not currently plan to participate in an HIE; the EMR has to come first.

iii. Track patients referred for complex/specialty behavioral health care to ensure continuity of care. The clinic does not currently plan to track such patients other than through the EMR.

iv. If applicable, make behavioral health services available through telebehavioral-health. The clinic does serve patients who have transportation problems; however there are no current plans to communicate through telebehavioral health technology. Internet-based communication is difficult in many low-income and rural areas of the region.

Sustainability after the grant period

In the proposed project, El Milagro Clinic will consult with Nuestra Clinica del Valle, the federally qualified health center in the county and will ask for advice on staffing, reimbursement, and financing integrated behavioral health services. Facing much the same environment and potential philanthropic sources of funding as El Milagro, Nuestra Clinica can explain some of the options. Another local clinic that provides more behavioral health services for a low-income client population is Hope Clinic, and El Milagro will also seek their advice. Certainly, grant support will be sought as a normal process of the clinic to secure funding for many of its programs in addition to assistance with personnel as described below.

a. Describe the recruitment and retention plan for staff

The budget covers new professional staff and community health workers to be hired to support the project. Recruitment of professional staff will be through advertisement and through networks of medical and public health professionals. Recruitment of community health workers will also be through advertisement and additionally, through the South Texas Promotoras

Association, located in Hidalgo County, with over 200 members. Additional behavioral health staffing can be obtained through the University of Texas Pan American (soon to become the University of Texas Rio Grande Valley) School of Social Work, which already places students at El Milagro Clinic as part of their training. The university's CAMP program is willing to recruit some undergraduate students in migrant farmworker families to work serving communities in need. The students will potentially be able to take on some of the work of the promotoras.

b. ***Describe the behavioral health care reimbursement environment***

Currently, the partner clinic, Nuestra Clinica del Valle, offers behavioral health care at the main clinic without reimbursement. Support for an LPC is provided through other income streams. Part of the rationale for this arrangement is that the warm handoff makes the primary care physician's use of time more efficient. Whether the warm handoff pays for itself in this way is unknown.

c. How the applicant proposes to maximize collections and reimbursement

El Milagro will try to diversify the patient population to generate more program income. As the community realizes the value of the services offered, patients with private insurance, Medicare, and Medicaid can be expected to seek services there. Adolescents and adults in the region seek ways to prevent diabetes and to reduce obesity, and they have proved able to secure payment for such services as bariatric surgery. The potential paying patient population is likely to seek services at El Milagro Clinic as soon as the clinic is recognized for its services.

Budget narrative

As vendors, partners have entries beginning in Contractual/Consultant Services.

The International Valley Health Institute (IVHI) will manage the project, including hiring personnel, meeting the criminal background check requirement, and managing all aspects of the

project. Pay rates of unidentified professionals are taken from the CareerOneStop web page (US Department of Labor, Employment and Training Administration).

The Project Manager, a Ph.D. Ecological Psychologist with extensive grants experience, will have primary responsibility for the project; he will devote 50% of his time to the task.

An Occupational Therapist (@ $90,000/yr.) will develop and re-evaluate plans of care with clients and manage each case with help from the healthcare team.

A Registered Dietician (@ $40,000/yr.) will contribute to all dietary aspects.

Promotoras de Salud (Community Health Workers) will work at the clinic with patients and will implement HELP PD programs in the community. (6FTEs x $22,000/yr. = $132,000/yr.)

A Certified Medical Assistant and Certified Promotora (@ $37,000) will manage the promotora team in scheduling, coordinating training, day-to-day activities.

A Bookkeeper (@ $32,000/yr.) will use Quickbooks to manage the day-to-day fiscal business of the project and will contribute to data entry for the project evaluation.

Fringe Benefits include the basics required by government ($31,162) plus Health Insurance for full time staff hired onto the project (4 @ $400/mon. x 12mons. = $19,200).

The travel budget includes attendance at the annual American Public Health Association meeting for the Program Manager and the Evaluator (2 x $1,500): $3,000; and local travel to the community program sites for promotoras (6 x 50 miles/wk x 50 wks. x $0.55/mile): $8,250.

The supplies budget includes educational materials (504 clients x $25/client = $12,600; 6 scales to determine client weight: $480; a copy machine: $400; copier paper and Toner: $200; posters for the community sites (6 sites, including the clinic site, x $100): $600; and computer equipment (6 sets x $900): $5,400.

The IBH expansion will involve greater responsibilities of the physician, necessitating a 1

hr. per day increase of his time (1hr/day x 250 days x $100 = $24,000).

NCDV, a Federally Qualified Health Center, will provide advice (Director: $5,000; MD: $10,000; Behavioral Health Specialist: $5,000; Health Educator: $5,000).

A Professional Health Educator will train the trainers (i.e. the promotoras) and provide education at some group meetings (1 person @ $48,000 x 50% = $24,000).

The local evaluation component will be headed by a PhD. Medical Anthropologist and Public Health Evaluation university professor (1 person @$101,473 x 30% = $30,442 + university determined fringes on 30% time = $7,809).

Other Costs involve Criminal History Checks (20 people x $50 = $1,000); and Community Program Maintenance Charges (5 sites x 4 days/wk x 50 wks = 1,000 days @ $25 = $25,000).

In addition, portions of El Milagro's insurance, utilities, janitorial and maintenance, and CPA accounting services are included in the budget.

Lower Rio Grande Valley Community Health Management Corporation, Inc. (El Milagro Clinic):
Community Healthcare InveSted in keeping Patients Active (CHISPA):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

Focus Area 1: Enhancement of current primary and behavioral health integration			
Goal 1: 75% of primary care providers will incorporate behavioral health assessments into each routine primary care visit by the end of the five year funding period.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Advertise positions & hire staff	Program Manager	Months 1-2	
Weekly project meetings	All project staff	Throughout the 5 year project	
Project and El Milagro Clinic staff meetings	All staff	Months 1, 2, 3, and quarterly thereafter throughout the 5 year project	
Train all healthcare staff & promotoras in PHQ-9 depression scale administration	Program Manager and Nuestra Clinica del Valle (NCDV) consultant M.D. & Behavioral Health specialist	Initial training with return demonstration and initial efforts with patients: first 3 months	Input: advice from Nuestra Clinica Program Manager to oversee training Training & implementation evaluation through questionnaire
Train all healthcare staff & promotoras in de-stigmatizing mental illness	Program Manager and NCDV consultant Behavioral Health specialist	Initial training with role playing: first 3 months	Training will be ongoing throughout this part of the project to refresh knowledge, update procedures, and take care of any promotora turnover

EMR planning and training	Program Manager to communicate with El Milagro IT for training	Initial training for all project staff as soon as EMR is available, Sept. 2015	
Train promotoras in record keeping on data for behavioral health assessment	Program Manager and Evaluator	First 3 months; train with return demonstration	Team building exercises to be included. Training implementation evaluation through questionnaire
Roll out IBH increasingly and begin HELP PD activities	El Milagro Clinic staff and project staff	Months 3 and through the end of the 5 year project.	Track progress in IBH and Lifestyle Interventions
Collect evaluation data on % of providers who incorporate behavioral health assessments	Evaluator and staff	Ongoing for the remainder of project, every 3 months	Data collection on medical records & in interviews with providers & observations in the clinic
Retrain on all trainings to date as necessary	Program Manager and Evaluator and others as needed	Ongoing for the remainder of the project, at least every 6 months	Train 100% of new hires within 1 week Training & implementation evaluation through questionnaire

Focus Area 2: Collaboration in a fully integrated system			
Goal 1: 75% of patients will be receiving integrated health care by the end of the 5 year funding period			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Weekly project meetings	All project staff	Throughout the 5 year project	
Project and El Milagro Clinic staff meetings	All staff	Months 1, 2, 3, and quarterly thereafter throughout the 5 year project	
Train staff in shared patient scheduling	Program Manager with Nuestra Clinica Consultants	Months 4-5: training 90% By month 7, 80% of appointments will be shared	Training & implementation evaluation through questionnaire

Train staff in shared treatment planning	Program Manager with Nuestra Clinica Consultants	Months 6-7: training 90% By month 9, 80% of appointments will have shared treatment available	Training & implementation evaluation through questionnaire
Train staff in shared service provision	Program Manager with Nuestra Clinica Consultants	Months 8-9: training 90% By month 11, 80% of patients will have shared service provision available	Training & implementation evaluation through questionnaire
Train staff in shared record keeping	Program Manager with Nuestra Clinica Consultants	Months 10-11: training 90% By month 13, 80% of records will be available for sharing	Training & implementation evaluation through questionnaire.
Increase collaboration	El Milagro Clinic staff	Month 6 – end of 5 yr project	
Ongoing training in Evidence Based Practices	Program Manager and Project and Clinic Staff	May and November, yrs 2 – 5.	
Fully implement EMR with IBH	Program Manager and IT staff	Month 18	80% of caregivers will be exclusively using EMR
Measure level of health care integration and respond as necessary	Program Manager and Evaluator	Month 19 and every six months thereafter	

ABSTRACT

Project Title: **TRIP** for Salud y Vida (***T**ransportation for **R**ural **I**ntegrated health **P**artnership)*

Organizational Name: Rural Economic Assistance League, Inc. (REAL, Inc.)

Address: 301 Lucero Street, Alice, TX 78332

Project Director: Martín Ornelas **Phone:** 361-664-7826 (voice); 361-664-4554 (fax)

Email: martin.ornelas@tcncb.org **2 Year Funding Request:** $1,608,604

REAL, Inc. has over 42 years experience in administering state, local and federal grants in the Coastal Bend area. The grants awarded have funded housing for low income elderly and persons with disabilities, adult day care centers, home health care services and public transportation. REAL Transit is a Rural Transit District that provides demand response services to the general public, seniors, and Persons with Disabilities in Aransas, Bee, Brooks, Duval, Jim Wells, Live Oak, Refugio and San Patricio Counties. The demand response services are offered Monday through Friday, 8:00 a.m. to 5:00 p.m. using a 24 hour call system which allows for scheduling trips.

The rural counties of Brooks, Jim Wells, Kenedy and Kleberg have a combined population of over 81,400 people with an average of 11% are persons with disabilities and an average of 23.2% are persons in poverty. The proposed project will target adult consumers with Mental Illness that are being served by Coastal Plains Community Center and that are registered in their Integrated Behavioral Health model, Project Salud Y Vida.

REAL, Inc. is partnering with the Transportation Coordination Network of the Coastal Bend (TCN), Coastal Plains Community Center (CPCC), Community Action Corporation of South TX (CACOST), South Coastal Area Health Education Center (SCAHEC), and Kleberg County Human Services – Paisano Transit, to increase the level of effectiveness of the existing Integrated Behavioral Health Program, Project Salud Y Vida, throughout the five rural counties of Brooks, Duval, Jim Wells, Kenedy and Kleberg counties.

Coastal Plains Community Center is the Mental Health Authority in the rural counties of the Coastal Bend and manages Project Salud Y Vida which is at Level 4 of the IBH framework (Co-Located) and is the primary care clinic operated by Community Action Corporation of South TX. There are four (4) Salud Y Vida primary clinics co-located within Coastal Plains' facilities that have been operating for the past two years.

The proposed project ***TRIP for Salud y Vida*** will increase the effectiveness of the existing IBH services by heightening the level of integration through the systematic integration of transportation and Enhanced Integrated Services (EIS) at the individual and community level in the four existing clinics.

TRIP for Salud y Vida consumers will enjoy increased health benefits by participating in primary and behavioral health clinics by eliminating transportation as the obstacle in accessing both existing Salud Y Vida services and the EIS services to be provided. The tangible benefits that low income consumers in the rural communities will derive will be increased access to individual and community level services including: Diabetes Education, Chronic Disease Self Management Education, Exercise Classes, Physical and Behavioral Health Screenings, Healthy Cooking classes, Healthy eating classes, Travel Training, Smoking Cessation, Consumer Empowerment Education, Health Fairs, Outreach and Education.

Need

The five (5) county service area to be covered includes Brooks, Duval, Jim Wells, Kenedy and Kleberg counties. The proposed service area covers a geographical area over 5,941 square miles, and has a population over 93,000 according to the US Census 2013, with an average of with 15.4% being 65 or older, and 12.4% being persons with disabilities. The service area is rural and densely populated with vast open space between the various small cities with the three largest being Alice (19,104), Kingsville (26,213) and Falfurrias (4,981). In 2010, 68.9 % of the South TX population was estimated to be Hispanic, 25.2 % was non-Hispanic white. The Bureau of Economic Analysis and the Census Bureau (Small area income and poverty estimates, 2012) cites that South TX residents' per capita personal income in 2010 was lower than for all of TX, and the poverty rate in South TX was higher. In 2010, 8.9% of the South TX population was unemployed, and 23.6% lived below the poverty level. During this same time period, TX' unemployment rate was 8.2% and the poverty rate was 17.9%. Overall the residents in the five county service area are predominantly Hispanic, struggle with lower educational levels, have less income and less access to health care, which in turn increases their risk for negative health outcomes.

The TX Behavioral Risk Factor Surveillance System Combined Year Data Set indicates that 32.7% of adults who lived in South TX were obese, a higher prevalence for obesity than the rest of TX (29.1%) or the nation (27%). In addition, Hispanics from nonmetropolitan counties had a higher obesity rate at 47%, than Hispanics in metropolitan counties at 36%.

According to the TX Diabetes Council, in 2009 1.7 million adults were living with diagnosed diabetes. CDC's Diabetes at a glance, 2011, estimates 1.9 million new cases of diabetes were diagnosed in people aged 20 or older. South TX has an 11.6% prevalence rate of diabetes as compared to the rest of TX (9.3%) and the rest of the nation (8.9%). Hispanics in South TX had a prevalence of diabetes at 13% which is higher than Hispanics in the rest of TX and non-Hispanic whites in South TX.

According to the CDC's MMWR October, 2010, 8.4% to 9.1% of the adults in TX meet criteria for current depression. In TX, the US 2006 Behavioral Risk Factor Surveillance System, found that Adults aged 18≥ had a prevalence rate of greater than 8% for depression, and greater than 5% prevalence of a serious psychological distresses.

Coastal Plains Community Center (CPCC) provides services to 2,100 adults per month of which 53% are female, 47% are male, 74% are not in the labor force, and 43% have Medicaid or Medicare coverage.

The IBH Model being used is called "Project Salud Y Vida" and is operated in partnership with Community Action Corporation of South TX (CACOST). The goal of Project Salud Y Vida is to provide primary care, primary care related medication, substance abuse services, preventative health care and care management/health navigation services to their consumers, in a culturally, linguistically and mental health "stigma-free" environment.

The Salud Y Vida clinics served 857 consumers from October 2012 to September 2013, and had a no show rate to Salud Y Vida clinic appointments over 22%. The CPCC Navigators have indicated the greatest factor impacting the high no show rate is the lack

of available transportation. Many consumers live in the various rural and remote locations of the various counties and unmet transportation needs severely impacts consumer increased participation in the available services.

Even though the primary health services provided are currently meeting existing consumer needs, CACOST has identified the need to create a Dedicated Integrated Behavioral Health Unit (DIBH). The DIBH unit would consist of a Provider, a Care Coordinator, two (2) MA's and a Clerk. CACOST has identified that through a DIBH unit; it would address having a rotating team throughout the project's service area and reduce the impact on having multiple personnel from the various CACOST clinics. The level of consistency and increased continuum of care would result in increased effectiveness of the Salud Y Vida Project as well as ultimately improve and enhance the intended health outcomes of this project.

The current staff and Navigators are trained in providing integrated care as they are well into their fourth demonstration year. Through staff formalized case conferences, the personnel has effectively responded to the identified capacity needs and have instituted staff development trainings, in-services and other capacity building activities.

Project Description

Project Salud Y Vida offers primary care services. The current Salud Y Vida program is undergoing internal changes to be at Level 4 of Integration by the end of their demonstration year four (September 30, 2015). The program is operated in a Co-located facility and has separate systems of scheduling and medical records. The close proximity of the clinics facilitates face to face interaction between primary care clinic

staff and behavioral health staff. During clinic days the on-going communication assists collaboration and consultation regarding consumer health needs and improves basic understanding of the respective roles and cultures of each organization.

At the patient level, the integration currently allows for smooth referral processes, but the health and mental health clinic remain separate services. The steps being taken to move toward a Level 4 Close Collaboration with Some System Integration includes development of a consultation form that is used to open communications between the medical clinic staff and the Navigator regarding consumer's health needs. In addition to regularly scheduled case consultations, trainings have been implemented for medical clinic staff. Various information sharing methods are being developed to provide access to medical records by the providers of both systems and allows them to discuss # of clients served, average number of contacts per client, and medication costs during monthly Utilization Management meetings. Enhancement to the care the consumers are receiving at the primary care clinic will be improved by having a Dedicated IBH Unit consisting of dedicated clinical staff that will rotate throughout the project's service area.

With the established integrated primary and behavioral health care in place, the partnership established by the ***TRIP for Salud Y Vida*** program will allow systematic integration of transit services and improvements that will increase the level of consumer health literacy and navigation of the health care system through empowerment gained by participation in trainings that will encourage the consumer's use of information in decision making and self-management.

The teams involved in the proposed project are the Enhanced Integrated Services (EIS) Unit, The Dedicated IBH (DIBH) Unit, and the Community Level Integration (CLI) Unit. The EIS Unit will include administration and project staff who will work collaboratively with the DIBH Unit and CPCC to enhance the services offered to consumers through mobility management strategies that will provide transportation and skills building trainings for consumers.

The CLI Unit will include trainers, and outreach workers working collaboratively with the EIS Unit, DIBH Unit, CPCC and consumers to offer skills building trainings and educational opportunities that will increase effective communication between all levels of the care teams and consumers. The CLI Unit will conduct outreach and health screenings for the general public that will reach at least 100 individuals at 10 health fairs in the project service area, and work in close contact with the EIS Unit to develop a training calendar to include such topics as travel, transportation technology, and skills building training in support of the Navigators functions. As an accredited CME provider, the CLI Unit will assist the project with an educational program for medical clinic staff that will increase provider cultural sensitivity, effective communication skills, promote patient centered care and engagement in planning and decision making regarding their care. Through joint trainings and a Capacity Team Building Workshop (retreat) the EIS Unit, DIBH Unit, CLI Unit and CPCC project staff will strengthen the essential personal relationships, and develop a sense of team unity that will facilitate a greater understanding of each other's systems and processes and enhance team communication which will lead to a greater ability of the partnership to reach a higher

level of integration that will benefit the Salud Y Vida clinic, the ***TRIP for Salud Y Vida*** project and the consumer.

At the individual level, CPCC Navigators will have the ability assist the consumer by scheduling transportation to and from medical and mental health clinic visits and offering enhanced integration services, marketing materials, and training calendars to provide consumers with skills building trainings on Diabetes education, chronic disease self-management, exercise classes, healthy eating and cooking classes, travel training, transportation technology training, smoking cessation, and general wellness classes. For those consumers that would benefit from individualize trainings will be scheduled by the Navigator and provided by a REAL nurse from the EIS unit. The REAL nurse will work one on one with the consumer or in a family setting such as the consumer's home or adult day care facility. According to the consumer needs, their provider, family member/caregiver or any combination that is comfortable to the consumer can be included in the health education to facilitate the consumers understanding and comfort with the skills building training. Community partners AgriLife Extension and Wesley Nurses in the region offer Diabetes education that can be included on the calendar developed as an additional resource for consumer skills building opportunities.

The systematic integration of transportation services in the ***TRIP for Salud Y Vida*** project is both innovative and unprecedented as it includes the use of state of the art technology in the transportation industry. Through the mobility management efforts of TCN, both REAL and Paisano Transit, were successful in leveraging a $269,000 federal investment that upgraded their operational capacity with the purchase of software and

hardware. The investment resulted in the purchase of a portion of a comprehensive, web-based transportation management system (New Gen). Current modules purchased include Trip Optimization, on-vehicle tablets and integration software, AVL vehicle tracking locators, fare card integration and bar code scanner. The results of this investment is improved safety for the passengers, greater convenience for the traveling public and improved efficiencies for the transit districts by better management of their fleet, assets (vehicles) and services through a state of the art transportation management package.

An unprecedented investment in rural public transit will position both REAL and Paisano Transit to elevate their responses to the needs of consumer that have lacked adequate access to public transportation. Through ***TRIP for Salud Y Vida***, the innovation in the use of transportation technology to decimate the transportation barrier is attainable. The proposed modules are: web based ride request that will be at the fingertips of any unit within the ***TRIP for Salud Y Vida*** project. Whether it's while the nurse is giving the Doctor's follow up instructions, or while scheduling a follow up appointment, or at a health fair, or a Navigator confirming attendance for a walking or cooking demonstration class; <u>any of the team members can make the reservation on the spot</u>. The trip request will automatically be entered into the reservations system of the respective transit provider. If the transit provider cannot accommodate the trip, another new module will send the request to a cloud based bulletin board for the other transit provider to accommodate. The inherent ease of transportation integration will be seamless.

Once the reservation has been made, through another new module, the consumer will receive an automatic call back confirming reservation (and potentially the navigator or someone else). A second automatic call back will occur the night or two nights before the scheduled trip. Furthermore, because both REAL and Paisano Transit already have the AVL vehicle locator, through a new module the consumer will receive real time text of the approximate time of vehicle arrival. ***TRIP for Salud Y Vida*** will also integrate a new consumer controlled application "Locate my bus," which gives consumers the ability to see in real time when to go out their door when the bus is around the corner.

The ***TRIP for Salud Y Vida*** project's technological enhancements are the cornerstone of this program's innovation along with the purchase of dedicated vehicle(s) and three (3) dedicated drivers to accommodate the multiple transportation requests. As proposed, the vehicles will be rotating based on scheduling needs between the small vehicle(s), medium vehicle(s) and large vehicle. It is anticipated that on Salud Y Vida clinic days, there may be 10 consumer in one site that will be transported in the afternoon, so the scheduling (that is done through the Optimization program that the transit districts previously purchased) dictates which vehicle is to be used where. The state of the art vehicles will all be ADA compliant and will have low floor entry ramps to assure that consumer with limited mobility in or in wheelchairs can comfortably board and unboard any of the vehicles.

Through the investment of capital in rural communities' assets and ability to systematically integrate transportation will without any doubt impact both the reduction of the no show rates, but also the consumers' ability to further engage and

integrate themselves in the various other enhancement activities that will support overall health outcome improvements.

Through increased collaboration, team communication, monthly meetings, data collection and reporting and annual reviews of focus areas the enhanced integration teams in this project can continuously evaluate and adjust the enhancement services being provided by a highly trained, culturally sensitive team that will transform the primary and preventative health care received by consumers. With the transportation barrier removed, the Navigators will have more time to dedicate to case management efforts and one on one patient education and assistance and will support the adherence to appointments and quality of the care received in the Salud Y Vida clinic.

Preliminary to Moderate Evidence for IBH Service Delivery in Area. The Salud y Vida clinic currently has preliminary to moderate evidence. As part of the Salud Y Vida program, clinical health metrics collected are systematically measured and recorded by the health clinic staff. These assessments have been used to establish a baseline.

The proposed project will expand our current evaluation to include assessment of behavioral and clinical health metrics over time following participation in the intervention. Given our focus on improvement and access to transportation we will assess baseline transportation needs at the four sites and determine the impact of the program on increasing access to 1) regular medical, 2) mental health, 3) preventative health clinic appointments and 4) health related educational classes by September 30, 2015. The proposed addition to the initial evaluation of health metrics will move us from a limited assessment to a more robust quasi-experimental design by using a

comparative interrupted time series to show the change in health metrics. The revised evaluation plan will allow us to assess the influence of transportation on health related outcomes through the removal of currently experienced transportation barriers in the consumer population.

Although current evaluation methods are meeting the requirements that the Salud Y Vida clinic needs for billing and reporting purposes, it does not provide a method for tracking of participant health metrics over time or the evaluation of other programs and barriers. The proposed evaluation will be enhanced in a manner that will allow for measurement of the effectiveness of the proposed intervention and provide a plan that is easily replicated in any integrated primary care and behavioral health setting.

CPCC established that there is annual cost savings of $2040 per patient served by the primary care/behavioral health integration. Because Project Salud Y Vida is an established IBH clinic and the proposed intervention is enhancing services provided by allowing for a DIBH Unit of clinic staff that will be consistent and familiar with the consumers and project partners, and the EIS and CLI Units will be providing services to enhance the consumer experience through the IBH clinic and provide for consistent reliable transportation to and from appointments and consumer skills building training opportunities, the cost benefit received by the proposed project could be greater than that number established by CPCC. Additionally, in Project Salud Y Vida there is a plan in place to move stable consumers in the future from the care of psychiatrist to the primary care settings as deemed appropriate by the care team and through the consistent and enhanced care provided for consumers through this partnership, the

number of stable consumers moved to the primary care setting could further increase the cost savings of this program.

Evaluative Measures

The ***TRIP for Salud Y Vida*** project partners all have existing evaluation capacity that is primarily focus on both qualitative and quantitative measures through the collection of health data and on-going face to face or group discussions consultations. However, under the ***TRIP for Salud Y Vida*** project, we will elevate the capacity of each respective organization as we will increase the collective capacity through a more rigorous and systematic evaluation under the leadership of Dr. Melissa Valerio.

Dr. Melissa A. Valerio, PhD, MPH will be responsible for all evaluation activities in direct relation to the ***TRIP for Salud Y Vida*** Project Director, in close collaboration with all the representatives of the partnering agencies. Dr. Valerio's credentials include her current appointment as an Associate Professor of Health Promotion and Behavioral Sciences at the University of TX School of Public Health. Her ongoing research is in the design and evaluation of interventions to address functional health literacy, disease prevention and self-management, and the underlying theme of her research is addressing chronic disease management and health outcomes. Her experience in the past six years in this area of research includes serving as PI and Co-I on various studies to evaluate interventions in asthma, patient-provider communication, and type 2 diabetes.

The evaluation health metrics data collected on current and future patients in the Salud Y Vida clinic is collected by the medical clinic staff and entered into Sevocity EMR, Electronic Health Record System for data sharing. Those enrolled in Salud Y Vida clinics

have demographic data, lab readings and attendance and participation metrics for preventative services offered and used; these will all be used for evaluation. Upon request from CPCC, CACOST provides information by consumer that includes the number of visits to the clinic, lab readings including blood sugar level (Hemoglobin A1c) and blood pressure to CPCC and are scanned into each consumer file and used for CPCC reporting purposes. The data received improves CPCC programming by providing a method to track the use of the primary care clinic by the consumers, and lab results are reviewed by the staff behavioral health Psychiatrists before they prescribe psychiatric medication; allowing for understanding of consumer needs as well as needs of the community and clinic services.

The evaluation design follows two approaches: principles of Community Based Participatory Research (CBPR) and the Empowerment Evaluation (EE) ***(1-3).*** The approach allows for the ownership of the program and evaluation by the community partners and fosters empowerment and use of the information to improve services provided to community consumers. The goal is to improve program success through development of buy-in, capacity and ongoing promotion of quality improvement to expand reach as well as program efficacy.

Figure 1: CDC Framework for Public Health Program Evaluation

The evaluation design allows for greater understanding of impact for ***TRIP for Salud Y Vida*** program goals. We will 1) maximize the use of existing data collection efforts, 2) organize and structure a data sharing collaborative in the rural area to promote

evaluation across disciplines and partners, 3) determine best methods and approaches to collect evaluation data that will allow for assessment of our SMART Goals ***(4)*** and 4) use the data collected to maximize collaboration and focus on quality improvement ***(3).*** These steps in the evaluation follow the CDC's recommended standards for conduct of "good" evaluation (See Figure 1).

For the evaluation we will conduct a 1) a process evaluation and 2) an impact evaluation using a pre/post-test quasi-experimental design to maximize understanding of the fidelity, reach and impact of the ***TRIP for Salud Y Vida*** program. The approach will allow us to better use findings for improvement of IBH based programs, sustainability and replication as well as dissemination. The Evaluator will also promote ongoing collaboration and use of evaluation data over the 5 year period to build organizational capacity.

Consumer Data Collection. Consumers in the ***TRIP for Salud Y Vida*** program will be asked to enroll in the evaluation. We expect that over 90% of consumers will enroll in the program and its evaluation. All consumers will receive invitations to join the program and enroll in the evaluation. Any survey data will be collected in both English and Spanish per the consumer's preference. Assessment data will be collected at enrollment (Baseline) at 6, 12, 18 and 24 months. Retrospective data from EHRs and clinical records will be extracted and used to assess each consumer enrolled in the program as their own comparison. Given potential difficulties or missing data we will also identify a delayed program group that will serve as a comparison group. We will collect data from enrolled consumers and offer all services to them through their Salud

Y Vida clinic and will also use a delayed-control group design (6 months) that will allow us to collect baseline data from participants and introduce the program at different sites across a period of time that will serve as a comparison group for evaluation of the program's impact. The delayed program comparison group format will provide us with data at sites that we can then use for comparison as control groups over time. This design also promotes feasibility of introduction and "roll out" of the program across the rural area.

Rationale for Hypotheses - Hypothesis 1: ***TRIP for Salud y Vida*** consumers will have significantly improved A1c, lipid, and BP values and levels of self-management behaviors (i.e., daily level of physical activity, daily dietary composition, and adherence) compared to delayed-program comparison group.We expect all consumers receiving services at the program partner organizations will demonstrate some initial improvement in metabolic indices such as A1c, lipids, and BP over the delayed-program group sites. However, we expect the improvements in the ***TRIP for Salud y Vida*** consumers will be greater in degree and duration than those seen in the delayed-program comparison group. We believe that access to information about diabetes and its self-management and transportation mobility management, motivation, and problem solving strategies through the Enhanced Integrated services will have a greater and more lasting impact on behavior, quality of life, and metabolic indices of health than access to publicly available services and provision of metabolic data to patients and their physicians.

Hypothesis 2: ***TRIP for Salud y Vida*** consumers will have improved levels of quality of life compared to the delayed-program comparison group. **Through the *TRIP for***

Salud y Vida, we hypothesize that participants will have a greater understanding of navigation of the health care system, which will lead to improved overall quality of life than individuals in the delayed-program group. The empowerment and health literacy focused ***TRIP for Salud y Vida*** provides cognitive and process skill training program begins with asking patients to identify the aspect of living in a rural area that is causing them the most difficulty or is most frustrating regarding access to care. The three remaining steps of the process are intended to facilitate problem exploration, goal setting, choosing a problem-solving approach, and self-evaluation of outcomes. This model provides tools for increasing consumer autonomy, improving care management through navigation of the health care system, and more effective coping with psychosocial issues that will result in reduced stress and less negative impact on quality of life.

Hypothesis 3: ***TRIP for Salud y Vida*** intervention will be cost-effective given improvements in behavioral and clinical outcomes compared to the delayed-program comparison group. We hypothesize that several factors will contribute to the effectiveness and cost-effectiveness of the training program. First, access to dependable transportation and the EIS means that consumers can access preventive, clinical and educational programming for health care on a regular basis. Second, the EIS contacts will encourage patients to keep their list of priorities over the short and long term. Third, participants will have a greater understanding of how to effectively use the transportation and health care resources available to them. And fourth, over the long term EIS will have costs that are lower than medical professionals.

Process Evaluation. A limitation of many evaluations is that they focus exclusively on internal validity and efficacy, rather than on equally important determinants of successful implementation in other settings. We will use the RE-AIM framework to systematically consider the strengths and weaknesses of our SMART program goals to better guide planning ***(5-8)***. The goal of the RE-AIM framework of program evaluation is to broaden the focus of programs to include dimensions critical to an intervention's translation into usual clinical care delivery ***(9-12)***. Our process evaluation will address each of the RE-AIM dimensions of Reach, Efficacy, Adoption, Implementation, and Maintenance.

Reach: We will evaluate Reach by determining the enrollment rate among eligible consumers invited to participate, and comparing the characteristics of enrollees with those of other potential enrollees in the partner sites

Efficacy: Primary analyses of intervention efficacy have been described above. We will conduct extensive exploratory analyses to identify the characteristics of participants associated with intervention efficacy and the specific intermediate outcomes most associated with impacts on participants' physiologic health. Subgroup analyses will focus on differential impacts across groups defined by indicators of illness severity.

Adoption: Adoption is defined as the proportion of settings or practices who adopt an intervention, and their representativeness. We will monitor adoption of our program through various ways.

Implementation is the extent to which the intervention is implemented as intended. Using data captured through the ***TRIP for Salud y Vida*** program and partner databases,

we are able to assess number and duration of contacts, the nature of the contacts, attendance at community-level educational events, and feedback about the intervention. In our analyses, we will examine implementation as a function of consumers' characteristics, community characteristics, and the health care system site. We also will examine variation in outcomes as a function of the extent to which elements of the program were implemented as planned.

Maintenance will be evaluated by examining factors predicting drop-out from the ***TRIP for Salud y Vida*** and whether drop-out is differential across the consumer characteristics. We also will conduct time-trend analyses to determine whether consumers' willingness to participate in ***TRIP for Salud y Vida*** changes are maintained throughout the program period. To assess maintenance or sustainability at the system level, we will meet with participating partners on an ongoing basis. Since an important goal of MHM is the translation of funded programs to system approaches and practice, it is important to assess the feasibility of this program for this rural population. To accomplish this, we will conduct a qualitative and quantitative process evaluation throughout the project period (baseline, 6 and 24 months).

Questions pertaining to fidelity and acceptability will be included in brief phone interviews conducted by the evaluator. For individuals who dropped out of the program, we will ask questions including initial reasons for choosing to participate, reasons for withdrawing, and aspects that affected their interest in the project or their ability to participate. Analyses of quantitative measures will be similar to those described above, and will include descriptive statistics (frequency distributions and

comparisons of means), and multivariate OLS regression or logistic regression, depending on the outcome variable of interest.

Finally, qualitative analyses will be used to examine data from interviews, focus groups, and field notes. Qualitative data will be analyzed using a grounded-theory, a method for analyzing qualitative data that is reproducible and scientifically rigorous (13-14). The results of the qualitative data analysis will be stratified by location to identify similarities and differences in results across the rural area. Reports on the evaluation data will be developed and disseminated to partners, consumers and MHM.

The ***TRIP for Salud y Vida*** program also marks a significant innovation. Not only is it culturally tailored and provided in both English and Spanish, but it is also theory-based and experiential in nature to promote health literacy related skills, specifically navigation of the health care system.

Collaboration

One of the benefits of rural communities is the existing formal and informal collaborations between the various community organizations. REAL, Inc. has been the Rural Public Transit provider for more than 28 years and has contractual relationships with both CPCC and CACOST to provide transportation services to some of the clientele such as seniors or individuals on wheelchairs. In the same way, CPCC and CACOST have had long standing formal and informal collaborations for numerous years from informal referrals of clients for years, to the more current formalized IBH project of Salud Y Vida. In fact, the various participating organizations all have working relationships with each

other which facilitated the discussions that have led to existing collaboration being proposed under this project.

Examples of these collaborations include the following: REAL has an executed Inter Local Agreement with Paisano Transit and TCN; REAL, Paisano Transit, SCAHEC and TCN collaborate on an annual Public Service Academy that transports youth to the community college (Del Mar) in the urbanized area; CPCC and REAL have a contractual relationship to provide limited transit services (particularly in the larger facilities in locations outside the service area in this proposal); TCN, SCAHEC, REAL and Paisano Transit submitted a joint proposal to develop a rural Promotora Travel Training Program.

REAL as the lead applicant agency has extensive experience in working on collaborative project, with the most recent notable project being a current 3 to five year project to construct a Multi Modal Regional Transit Facility (M2TF) in the City of Alice to increase rural transportation infrastructure and enhance the mobility of the public by connecting them to local, regional and national transportation systems. During the first year, REAL and TCN worked collaboratively with the City of Alice, and Jim Wells County which resulted in a joint inter local agreement allowing for the submission of three (3) funding proposals in support of the planning of the M2TF to The TX Department of Transportation (TxDOT), Federal Transit Authority (FTA), and the Community Transportation Association of America (CTAA). The later was awarded and we are currently in the first quarter of a one year long term technical assistance project being funded by CTAA to advance the planning of the M2TF. The most recent meeting

concerning this facility took place January 8, 2015 and a collective panel of representatives from REAL, CTAA, TCN, City of Alice, Jim Wells County, Christus Spohn Hospital, Jim Wells County Economic Development Corporation, Alice Chamber of Commerce, TxDOT, and LSC Consulting met to gather information and discuss plans and needs for the M2TF. This example clearly demonstrates REAL's and TCN's ability to work collaboratively with other organizations and develop a shared goal, maintain ongoing communication and subsequent reinforcing activities.

Additional informal relationships exist that through this project will increase, specifically as SCAHEC will lead the efforts of community level enhancement activities and outreach which is one of their many strengths, as well as being the only Promotora Training Center in the Coastal Bend and a CEU, CME and CHW provider. SCAHEC, CACOST, TCN and CPCC all have a developing informal relationship Wesley Nurses in the region that will certainly flourish. In addition SCAHEC has ongoing formal communication with CACOST to assist in their provider recruitment, as SCAHEC is currently contracted to manage the medical rotation of residents in the Coastal Bend. This will provide assistance to CACOST in the recruitment of the medical provider under the DIBH Unit.

The combination of formal and informal collaborations between all the partner organizations will facilitate the ongoing structured communication that is integrated in the program plan through monthly and quarterly structured meetings, joint trainings as well as the ongoing monitoring that will take place, will result in increased effectiveness of the respective roles of each partner organization as well as the collective

strengthening of the entire approach. As a result of the on-going relationships will ultimately increase the effectiveness of the desired health improvement outcomes as well as the desired reduction in the no show rates.

In addition, the strength of the collaboration is deeply rooted in that each partnering organization brings forward their particular strength in collectively working toward achieving the same desired outcome: improved health outcomes and reduction of no show rates. The historical joint ventures are indicative of the inevitable success of the overall project. It is clear that personal relationships that bring the various organizations under this joint venture will continue to strengthen over time due to the project partners increased level of understanding of operations of the systems of each entity involved in the partnership gained through travel training, mental health trainings, effective communications trainings and information exchange planning involved in the implementation of this project.

Resources/Capabilities

REAL is governed by a 13 member Board of Directors who has delegated authority to the Executive Director to provide oversight and management to its multiple programs. Furthermore, the REAL Board of Directors demonstrated a strong commitment and support through their approval for the formal collaboration being developed by REAL and TCN through the development of this effort. The REAL diverse Board of Directors is made up representatives from the counties served by REAL's various programs, elected officials (current and past), business owners and community leaders. They meet on a monthly basis which serves as a formal mechanism to stay informed, updated and

engaged in the overall direction of the organization. Through their formal support for submission of the grant to MHM, demonstrates their willingness and commitment to support the existing IBH program and the proposed expansion through the systematic integration of transportation services.

REAL, Inc. has over 42 years experience in administering state, local and federal grants in the Coastal Bend area. REAL Transit is a Rural Transit District that provides demand response services to the general public, seniors, and persons with disabilities in Aransas, Bee, Brooks, Duval, Jim Wells, Live Oak, Refugio and San Patricio Counties. REAL's Board of Directors at its meeting of December 29, 2014 enthusiastically supported the submission of the proposed proposal and authorized the Executive Director to submit with their approval. In turn, REAL's management in partnership with TCN began the efforts to bring together all the players to successfully expand the proposed project. With the long history of REAL's legacy, staff has clearly demonstrated their experience and expertise to manage the proposed project over the anticipated 5 years of the grants.

The Executive Director of REAL, Inc., Gloria Ramos, RN has an understanding of the importance of coordinated care, and unique insight and understanding of patient needs and patient/provider interaction, vital in this project and reflected in all the programs that REAL, Inc. offers the communities of the Coastal Bend. The transportation component that this program will bring to the current integrated care model will utilize the expertise of REAL Transit in providing transportation services to the residents of the Coastal Bend and the training provided to the transit employees by the mental health

authority will increase sensitivity to and understanding of those with mental health conditions and allow for a better transportation experience. Coastal Plains Community Center is the local Mental Health Authority and has been existence since 1996. CACOST is a nonprofit corporation that has been in existence since 1967. REAL, CACOST, CPCC and TCN together have over 117 years of combined experience in managing complex, multi-year, collaborative projects and grants that uniquely positions ***TRIP for Salud Y Vida*** for success.

The expertise, readiness and commitment to the success of this project is evidenced through the various operational units that will in close coordination and communication will implement the proposed project. The project oversight will be provided by TCN, under the direction of TCN's Director, Martín Ornelas, who will have overall day to day management responsibilities. Previously, Mr. Ornelas served as Director of the Coastal Bend Rural Health Partnership which brought together CACOST, CPCC and consumer of mental health services under the rubric of a consumer led group called Voices Leadership Group, to develop and secure funding under the TX Mental Health Transformation State Incentive Grant in 2004. This collaborative lead by Mr. Ornelas resulted in a year-long planning process that resulted in the formalized establishment of Salud Y Vida by CACOST and CPCC. Additional evaluation and research expertise of Mr. Ornelas includes positions as Coordinator of Research & Evaluation for a California based National organization and as Field Director for a seven state regional KABB (Knowledge, Attitudes, Belief and Behaviors) survey funded by the Dept. of Health and Human Services through the CDC. In addition, Mr. Ornelas was instrumental in the

completion of the region's Coordinated Transportation Plan under a contract with TX Department of Transportation. Mr. Ornelas has extensive planning experience and has successfully managed numerous Planning Projects under contract with TxDOT. Notably, Mr. Ornelas has been successful in creating extensive partnerships that result in increased focus and attention on innovative solutions to the rural communities' transportation challenges. Mr. Ornelas has extensive experience with Contracts, Project Management, Evaluation and Planning.

The Salud Y Vida project currently operates through two non-integrated medical and behavioral health care record EMR systems. While this is case, in 2015 the plan is to have some system integration by allowing each other to view each other's EMR systems. While still not integrated it is a step in that direction. The current primary care EMR system used by CACOST is Sevocity while CPCC utilizes Anasazi. The Salud Y Vida program is currently developing a plan to track referrals of patients to preventative health care to include dental and women's health care covered for enrolled consumers through the Salud Y Vida program, thereby insuring a stronger continuum of care for consumer.

Sustainability

The Salud Y Vida project has been in operation for several years and has been providing integrated behavioral health services. As such, the Behavioral Health Unit operated by CPCC is fully staffed and will continue providing services upon notification without any interruption. CACOST on the other hand, has identified the need to have a Dedicated Integrated Behavioral Health Unit that will be rotating throughout the

project's service area. This in turn will require having a full time Provider rather than the current staffing pattern that has multiple mid-level providers. The recruitment of a full time provider will be supported through the efforts of the SCAHEC who is contracted to coordinated medical residents in the Coastal Bend, which will ultimately be of benefit and secure a Provider at the earliest opportunity. In the interim, services will continue with the current configuration until the full DIBH Unit is fully staffed to insure that there is no interruption of services. Other staff to be hired will immediately initiate in the Enhanced Integration Services Unit (EIS). In the startup phase, existing staff will be available so as to insure a smooth ramp up period. Thus, while there may be staff needed it will not adversely impact the start of the project.

The current environment for behavioral health integration is extremely positive as demonstrated through the commitment of both CPCC and CACOST in implementing the Salud Y Vida project. The Medicaid 1115 waiver program has resulted in a sustainable funding stream to support existing service levels which is indicated by the lack of financial need of CPCC. In addition, the future environment is beginning to look as it can sustain the program after funding has ended. In addition, through the integration of systematic transportation, the biggest hurdle in the startup of new service is the lack of capital to invest in the service. However, with startup costs including the assets to be used, it allows for REAL's transportation services under TxDOT funding to identify and integrate the transportation services to be provided beyond the period of the grant. While public transportation is not fully funded, the potential five year period of the

project would provide ample time to identify future ways to meet the operating transportation costs.

Budget Narrative

The ***TRIP for Salud Y Vida*** program's budget is broken down by the various operational units. The Administration Unit consists of four positions that will have the overall responsibility for the grants management including executive level oversight, fiscal oversight and disbursement, payroll and human resource functions and all accounts payables and receivables. This unit will insure all expenses and contractual obligations are adequately tracked, recorded and reported as required, as well as maintaining adequate financial systems and internal controls. The Executive Director is responsible for maintaining the Board of Directors engaged and informed.

The Enhanced Integrated Services Unit consists of the programmatic oversight and all day to day operations of the ***TRIP for Salud Y Vida*** program. The Director will provide the necessary leadership to convene and advance the overall goals of the program with the support of a full time Manager and a full time Administrative Assistant. In addition, there is a 30% FTE administrative coordinator responsible for tracking and reporting and a 50% FTE nurse that will provide one-on-one education as well as conduct all home visits for patient/family/provider education in support of the program. The EIS unit will be responsible for all program reporting (internal and external); partner agencies engagement; consumer engagement; mobility management; contracts management and adherence of the CLI and Evaluator; procurement of the five vehicles and the Shah software modules; supervision of EIS staff; consultants; and will be the direct liaison to

MHM. The EIS unit will be responsible for the development, lay out, production and dissemination of marketing materials as well as for coordinating the Integrated Capacity team building "retreat." The mobility management includes the oversight of the drivers, scheduling and their operations. The EIS unit will be responsible for working with the other units in providing the logistical support in coordinating the skills building training throughout the service area. Some of which will require space rental, speaker(s), materials and general training supplies. Other costs that the EIS unit will be directly responsible are the basic operational costs including rent, utilities and all other communication means.

The CLI unit is contracted to South Coastal Area Health Education Center and will conduct outreach, organize and attend health fairs, conduct trainings, health literacy trainings and conduct individual and group Enhanced intervention activities that meet the needs of consumers.

The dedicated Integrated Behavioral Health Unit (IBH) is a direct contract for CACOST to provide the primary care and all associated costs in the Salud Y Vida Clinic. All costs are detailed at 80% as the IBH unit will only be under this program that percentage of time. Other personnel related costs include staff training and Continuing Education. In addition, the budget reflects operational costs: travel, office supplies, telephone, marketing, printing, and membership dues. Other associated costs for the IBH Unit are lab service costs, medical supplies, pharmaceutical, EMR system, and clinical disposal costs. The dedicated IBH unit budget also includes acquisition of a vehicle to assist in the rotating team between the various clinical sites.

The Evaluator is retained under contract at 10% of the program budget and is responsible for the development and adherence to evaluation strategies identified. For documentation, analysis and appropriate evaluative reporting to the Director, Executive Director, partnering organizations and MHM as required.

Other costs included in the budget are pre-employment training costs, criminal history checks and pre-employment drug screening for all units participating in the ***TRIP for Salud Y Vida*** program.

REAL in conjunction with TCN's Director will be responsible to work alongside MHM in actively and tirelessly at pursuing all possibilities at securing the required match. Unequivocally, we agree to seek through all means possible the required match to insure the success of the ***TRIP for Salud Y Vida*** program. The track record within the Transportation industry has yielded success, and with the brokering of new relationships with national foundations by MHM will create opportunities for the dissemination of innovative and state of the art approaches that will improve IBH outcomes. The unprecedented opportunity is welcomed and all assistance provided will without a doubt insure that the match requirements are met.

REAL, Inc's Board of Director formulates financial policies and delegates administration of the financial policies to the Executive Director and reviews operations and activities. The ED has responsibilities for all operations including financial management. The Finance Coordinator is responsible to the ED for all financial operations. The A/P and R clerk respond to the Finance Coordinator. REAL's separates financial duties and responsibilities among various staff so that no staff member has

sole control over receipts, payroll, bank reconciliations, account payable or other accounting functions. The MIP accounting software system uses the Accrual basis of accounting and maintains separate General Ledger accounts as required by funding source regulations. REAL accounting policies and procedures are consistent with GAAP, OMB Circular A-122, OMB Circular A-110, and OMB Circular A-133. No previous funding has been received by MHM.

The Finance Coordinator (FC) oversees financial operations and fiscal reporting to the Executive Director. The FC has over 20 years of finance experience, the last 12 in a non-profit setting. Their education experience was completed in 1989 from Del Mar College in Computer Science. For the past 12 years she has managed the finance duties in various state and federal programs in accordance with FASB accounting standards. The Finance Coordination and the Finance Department has been a part of REAL's growth with the expansion of the Transportation Department and the growth of the Health Services Department.

Focus Area 1: Increase the effectiveness of Project Salud Y Vida by a 2% decrease in the "no show" appointments in the medical clinic and mental health clinic as measured by the number of Salud Y Vida consumers scheduled, transported to and from the clinic, and seen in each clinic compared to baseline data.			
Goal: 25% of Salud Y Vida consumers participating in year one of the ***TRIP for Salud Y Vida*** program for 6 months will decrease their no show rate in the medical and mental health clinic by April 2016, as measured by CPCC attendance records.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Purchase vehicles to have readily available transportation for Salud Y Vida consumers	REAL, Inc.	By July 2015	
Hire drivers to accommodate the trips created by serving the Salud Y Vida clinic consumers	REAL, Inc., Paisano Transit	By July 2015	
Train drivers to have an understanding of and sensitivity to the diverse needs of the Salud y Vida clinic consumers	REAL, Inc., Paisano Transit , TCN, CPCC	Starting July 2015 and ongoing throughout grant period	
Develop training calendar and marketing documents for transportation technology training for Navigators and consumers	REAL, Inc.	By October 2015	
Develop a transportation coordination scheduling plan for Navigators to assist consumers with transportation arrangements	REAL, Inc., Paisano Transit, TCN	By October 2015	

Provide travel training for consumers so that consumers can schedule their own trips and use public transportation for all their transit needs	REAL, Inc., Paisano Transit, TCN, SCAHEC	Starting July 2015 and ongoing throughout grant period (April 2020)	
Monthly meetings, Data Collection and Reporting	REAL, Inc., Paisano Transit TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Bi-monthly meetings and Reporting	REAL, Inc., Paisano Transit TCN, SCAHEC CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Quarterly Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Semi Annual Data Analysis	REAL, Inc.	October 2016, April 2017, October 2017, April 2018, October 2018, April 2019, October 2019, April 2020	
Annual Review of Focus Area	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	
Goal Evaluation, Adjust Goal as needed, Adjust Work Plan for new Goal if needed	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	

Focus Area 2: Increase the level of effectiveness in Project Salud Y Vida by a 10% increase in positive results of health metrics of the Salud Y Vida consumers from baseline data by providing transportation and supporting the clinic with Enhanced Integration Services (EIS) including Diabetes Education, Chronic Disease Self Management Education, Healthy Eating & Cooking Classes, Exercise Classes, Smoking Cessation Education, and General Wellness Classes as measured by clinic lab readings.

Goal: 30% of Salud Y Vida consumers who participate in the ***TRIP for Salud Y Vida*** program for 12 months will have a 10% increase in positive results in health metrics (HbA1C, Blood pressure, BMI, Cholesterol) from baseline by April 2017 as measured by regular clinic lab readings.

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Contract with area health education providers to provide consumer skills building trainings	REAL, Inc.	By October 2015	

Develop a calendar and marketing documents of group consumer skills building trainings in the areas of each Salud y Vida clinic	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	By December 2015	
Develop a plan for at personalized visits for one on one consumer skills building trainings	REAL, Inc., TCN, SCAHEC, CPCC, CACOST	By December 2015	
Provide travel training for consumers so that consumers can schedule their own trips and use public transportation for all their transit needs	REAL, Inc., Paisano Transit, TCN, SCAHEC	Starting July 2015 and ongoing throughout grant period	
Develop a transportation coordination scheduling plan for Navigators to assist consumers with transportation arrangements	REAL, Inc., Paisano Transit, TCN	By October 2015	
Monthly Meetings, Data Collection and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Bi-Monthly Meetings and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Quarterly Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Semi Annual Data Analysis	REAL, Inc.	April 2017, October 2017, April 2018, October 2018, April 2019, October 2019, April 2020	
Annual Review of Focus Area	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	
Goal Evaluation, Adjust Goal as needed, Adjust Work Plan for new Goal if needed	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	

Focus Area 3: Increase the level of effectiveness of Project Salud Y Vida by an increase the number of preventative health care (Women's Health and Dental) appointments as measured by the number of scheduled and transported through participation in the ***TRIP for Salud y Vida*** program.

Goal: 25% of Salud Y Vida consumers participating in the ***TRIP for Salud Y Vida*** program for 12 months will utilize a form of preventative health care (Women's Health and Dental)by April 2017 as measured by CPCC attendance records.

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Enhance and adjust the transportation scheduling plan to allow for preventative health care appointments to be easily scheduled by Navigators and consumers	REAL, Inc., Paisano Transit, TCN, CPCC, CACOST	By October 2015	
Develop training calendar and marketing documents for transportation technology training for Navigators and consumers	REAL, Inc.	By October 2015	
Provide travel training for consumers so that consumers can schedule their own trips and use public transportation for all their transit needs	REAL, Inc., Paisano Transit, TCN, SCAHEC	Starting July 2015 and ongoing throughout grant period (April 2020)	
Develop a transportation coordination scheduling plan for Navigators to assist consumers with transportation arrangements	REAL, Inc., Paisano Transit, TCN	By October 2015	
Monthly Meetings, Data Collection and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Bi-Monthly Meetings and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	
Quarterly Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period (April 2020)	

Semi Annual Data Analysis	REAL, Inc.	April 2017, October 2017, April 2018, October 2018, April 2019, October 2019, April 2020	
Annual Review of Focus Area	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	
Goal Evaluation, Adjust Goal as needed, Adjust Work Plan for new Goal if needed	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	

Focus Area 4: Increase the level of consumer health literacy and navigation of the health care system through empowerment as measured by participation in trainings which will encourage the consumer use information in decision making and self management.

Goal: 25% of Salud Y Vida consumers participating in the ***TRIP for Salud Y Vida*** program for 12 months will use information obtained in consumer skills building trainings in decision making and self management by April 2017 as measured by phone interview of Salud Y Vida consumer.

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Provide travel training for consumers so that consumers can schedule their own trips and use public transportation for all their transit needs	REAL, Inc., Paisano Transit, TCN, SCAHEC	Starting July 2015 and ongoing throughout grant period (April 2020)	
Develop training calendar and marketing documents for transportation technology training for Navigators and consumers	REAL, Inc.	By October 2015	
Provide consumer trainings that offer health literacy skills building in the areas of communication, navigation of the health care system and self-advocacy.	REAL, Inc., SCAHEC	Planning June 2015 to December 2015, and classes quarterly beginning January 2016 throughout grant period April 2020	
Provide health provider trainings that increases provider cultural sensitivity, effective communication skills and promote patient centered care and engagement in planning and decision making regarding their care.	REAL, Inc., SCAHEC	Planning June 2015 to December 2015, and classes quarterly beginning January 2016 throughout grant period April 2020	

Monthly Meetings, Data Collection and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period	
Bi-Monthly Meetings and Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period	
Quarterly Reporting	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	Starting July 2015 and ongoing throughout grant period	
Semi Annual Data Analysis	REAL, Inc.	April 2017, October 2017, April 2018, October 2018, April 2019, October 2019, April 2020	
Annual Review of Focus Area	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	
Goal Evaluation, Adjust Goal as needed, Adjust Work Plan for new Goal if needed	REAL, Inc., Paisano Transit, TCN, SCAHEC, CPCC, CACOST	April 2016, April 2017, April 2018, April 2019, April 2020	
Annual Phone interview with Salud Y Vida Consumers	REAL, Inc.	April 2016, April 2017, April 2018, April 2019, April 2020	

ABSTRACT

Juntos for Better Health
Texas A&M International University
5201 University Boulevard - Laredo, TX 78041-1900
Project Director: Dr. Glenda Walker
(956) 326-2574 // FAX (956) 326-2449// glenda.walker@tamiu.edu

Amount Requested for Two Year Period: $5,410,607

Juntos for Better Health is a partnership of nine community health care service providers developing the first fully coordinated comprehensive health care delivery system among multiple partners in Laredo. The word Juntos means "together." Texas A&M International University and the Canseco School of Nursing and Health Sciences will serve as the lead agency on this innovative and collaborative grant. For purposes of this study, we will focus on the system of health care in Webb, Zapata, and Jim Hogg Counties. The various partners are all experienced in some form of primary, secondary and/or tertiary health care provision, but have decided to come together to pool resources and improve the effectiveness of their services to the community. Most of these organizations operate quite independently and have very limited communication and collaboration with each other. Because of this, many clients receive piece meal care and lack an actual medical home. As one specific agency attempts to address all needs, they find themselves stretched for resources and lacking the competency to address all client concerns. We are proposing a system of Integrated Behavioral Health which provides a continuum of care for those with obesity, diabetes and depression. Following successful efforts documented in the professional health care literature, we offer a plan that focuses on *prevention* and *compliance.* The primary goal of this specific project is to increase effectiveness of existing services by heightening the level of integration of behavioral health from prevention to compliance with their health treatment plans.

Juntos for Better Health will carefully follow the Dartmouth Prevention Management Model to evaluate the effectiveness of the model in increasing follow-up compliance with health treatment plans for diabetes and mental health disorders and the *Juntos* Transformational Care Model. Members of these low-income communities will receive culturally competent education about Prevention Care.

1) The general public will be better informed about health care services in the region.
2) The health screenings will be more thorough in terms of offering a more comprehensive Integrated Behavioral Health Care Services system of delivery with better coordination of care.
3) An integration of services will lead to greater sense of team service delivery among health care providers in the region.
4) In addition to these measures leading to greater adherence to their treatment plans, clients will receive follow-up care through a Prevention Care Model Unit to increase the probabilities that they make their appointments, take their medication and follow their treatment plan.
5) Through this system of integrated behavioral health, an electronic database of health information will be developed to benefit both clients and the coordination of activities between health care providers.

PROJECT NARRATIVE

I. NEED

The *2011 Laredo/Webb County Workforce and Needs Assessment* identified that access to affordable health care is one of the most significant concerns for residents of this region. As Table 1 illustrates, the residents of Jim Hogg, Webb and Zapata Counties are more likely to live below the poverty level, be medically uninsured, and lack the ability to speak English well.

Table 1. Local Demographics

Location (Counties or State)	Webb	Jim Hogg	Zapata	Texas
Uninsured	36%	28%	35%	26%
Primary Care Physicians *(Physicians to Patient Ratio)*	3,288 : 1	2,633 : 1	7,141 : 1	1,743 : 1
Mental Health Providers *(Physicians to Patient Ratio)*	6,479 : 1	Not Available	Not Available	1,757 : 1
Living Below Poverty Level	28.1%	20.7%	34.7%	15.7%
Spanish Speakers 5-yrs-old & older not able to speak English well	46.9%	22.9%	39.0%	12.3%

In addition, the *2011 Laredo/Webb County Community Health and Workforce Needs Assessment* showed that one out of four Webb County respondents reported lack of transportation as a barrier to going to a clinic or hospital, to work, and to the grocery store. Therefore, many of the clients we serve face significant barriers to care because they are poor, uninsured, have limited English ability and lack accessibility. Additionally, the 2011 Community Household Survey, found that 47.3% of respondents visit a doctor only when there is a problem. Approximately 30% see a physician every 6 months; and, four out of ten seek medical help in Mexico. Currently, obtaining medical care in Mexico is problematic due to border violence. Health disparities include lack of access to health care services, a shortage of health care providers, and increased rates of certain infectious diseases, such as tuberculosis. Challenges for many rural residents are exacerbated by other factors, including weak environmental

infrastructure, dilapidated homes, a lack of potable water and sewer and drainage systems, fear of losing wages for time spent away from work, and lack of awareness of available health care programs. Mobile units that offer intermittent and limited services to this population may serve as the only option. Actual statistical data are not current or available.

As an underserved community, no recent clinical studies have been performed with any academic rigor, nor is there data that reports preventive measures, attendance at health screenings, or compliance with treatment plans. A follow-up convenience sample of Laredo residents was asked to describe their health care experiences and concerns. The preliminary draft was reported at the January 2015 *Laredo of Tomorrow Health Task Force*. Some of the major responses applicable to this project are: 1) most residents seek medical care from medical clinics, 2) most seek services due to illness; 3) the sites most listed for annual checkups are the school districts; and 4) the major health care concerns are diabetes first and cancer second. The number of responses for the study was 1,285 with 924 coming from the United Independent School District which provides for the educational needs of all children who reside in the Colonias.

This region faces a significant shortage of physician capacity for both primary care and specialty areas such as mental health care. According to the Robert Wood Johnson and University of Wisconsin Population Health Institute's County Health Rankings & Roadmaps (2014), Texas has one mental health provider for 1,757 residents. Webb County has one provider for every 6,479 residents! This shortage of behavioral health providers demands the most efficient use of offering services throughout the region. The current delivery model is designed to *react* to clients with chronic conditions at the hospital and then to treat in the hospital setting.

There is a need for greater connectivity and coordination among hospital and primary care providers and community based chronic disease management resources so that clients are able to

learn and have support for creating lifestyle changes to effectively improve client outcomes. In terms of specific disease prevalence in this community, Gateway Community Health Center reports that 16% (4,209 clients) of their adult population has diabetes (http://www.diabetesinitiative.org/programs/DIGateway.html). The 2012 Texas Healthcare Transformation and Quality Improvement Program Regional Healthcare Partnership (RHP) 20 Plan for Webb, Jim Hogg, Zapata and Maverick counties (Cadena, 2012), states that 70% of the population has at least one chronic condition, caused in part by the high rates of obesity and overweight problems. For example, 36% are overweight and 16% of the school age population has abnormal glucose levels. The 2009 Texas Department of State Health Services Health Facts Profile shows the diabetes mortality in Webb County to be *more than twice* the rate of the State of Texas (47.1 per 100,000 v. 23.1 per 100,000).

The problem of diabetes is a serious one in Texas. Adult diabetes prevalence has grown from 6.2% of the adult population in 1999 to 9.7% of the adult population in 2010, and the South Texas region that we are covering has among the highest incidence rates in the state, as well as the highest Diabetes Crude Adjusted Hospitalization rates, and Diabetes Age-Adjusted Mortality Rate by County (Texas State Department of Health Services, 2013). The age-adjusted mortality rates for diabetes was substantially higher than residents in Bexar County, other South Texas locations and the Lower Rio Grande Valley (http://soupfin.tdh.state.tx.us/birth.htm).

All project staff will first need training in the development of teamwork and collaboration in order to eliminate any sense of territorial issues related to client care. Workshops will be conducted which focus on team building, trust, communication and collaboration. After the team building foundation has been established, the first priority will be to develop a common vocabulary and definitions for treatment protocols related to assessment, referral and

compliance. Secondly, the partners must actively engage in conversations in order to develop a comprehensive tracking system that communicates across agency information platforms. And thirdly, all staff will need extensive training in the information platforms utilized in the project to ensure compliance with HIPPA, while allowing for the sharing and coordination of information.

The 9 *Juntos for Better Health* Partners will:

1. Share definitions and terminology
2. Share a tracking system
3. Share health medical information, especially those pertaining to:
   (a) Compliance and interventions
   (b) Primary prevention
   (c) Health Care Teams
   (d) Referrals to partners for specialized services
4. Share resources for primary prevention including best practice protocols and personnel
5. Implement a common prevention care management protocol for non-compliant clients
6. Implement a traveling health care team (i.e., FNP, LPC) to partner with facilities
7. Coordinate referrals to partners for specialized services

Webb County (2013 population, 262,495), is the largest county in the South Texas area and the 6th largest county in the state of Texas (United States Census Bureau, 2013). It is comprised by El Cenizo, Rio Bravo, and Laredo. Webb County has high rates of poverty and low levels of education. Many constituents in the Rio Bravo and El Cenizo municipalities are not fully bilingual and the main language spoken is Spanish. The education, economic and language disparities leave a segment of these populations with restricted access to understanding how local, state and federal governments operate and support their communities. In Webb County, there are also 62 colonias with over 25,000 residents. Over half of these residents are living below the poverty level and half of the population is without health insurance of any kind.

The 2013 U.S. Census American Community Survey shows Zapata County to have a population of 14,390 94% are Hispanic/Latino, and over one-third of the population lives below the poverty level (U.S. Census American Community Survey, 2013). This population also faces

serious changes as it is the sometimes home of migrant farm workers. While there are some ranches with affluent owners, there is also great poverty.

The 2013 U.S. Census American Community Survey shows Jim Hogg County to have a population of 5,245, 92.1% are Hispanic/Latino and while only 14.7% of the population live below the poverty level, the median household income is ($ 36,121); substantially lower than the Texas median. Also, 81.9% of the population speak a language other than English at home.

All regions in this project face significant problems related to a lack of access to health care. The use of preventive health care services is low among the general Mexican American population, and Laredo/Webb County is not the exception (Laredo/Webb County Community Needs and Workforce Assessment, 2011). One of the primary barriers to health care for South Texas are the residents' perceptions that they cannot afford health care, and accessibility to transportation. These factors may contribute to a feeling of learned helplessness by community residents.

One of the outcomes for the *Juntos for Better Health* will be to the development of best practice plans of care including client education, referrals and compliance to facilitate better health care in these communities. In many cases, residents are diagnosed through community health screenings events held by various agencies. Therefore it is essential that medical home between partners be addressed and specialty care be coordinated with the medical home.

II. PROJECT DESCRIPTION

The primary goal of the proposal is to develop a coordinated and integrated health care network. Nine partner agencies will collaborate to provide a continuum of care beginning with health education for obesity, to management of chronic conditions (i.e., diabetes and mental health). The proposal will target primary, secondary and tertiary care services related to diabetes

and mental health issues. The project uses a multi-prong approach (Table 2 and see Figure 1 on page 11) to achieve the end goal which is a coordinated and integrated system of health care. Each prong (P) represents a different level of integration:

Table #2. Multi-Prong Approach
P1: Proposals and services used by all partners of the project (prevention care management unit); Represents level 4 close collaboration on-site with some system integration.
P2: Protocols and services used by selected partners based upon a gap in service (1. traveling health care teams to Holding Institute and other agencies and 2. use of Doctors Hospital's mobile van for health education and screenings); Represents level 3 basic collaboration on-site.
P3: Increased personnel by specific agencies to increase access and/or specialty care (i.e., nutritionist for Border Region Behavioral Health Care (BRBHC) Represents level 2 basic collaboration at a distance.

The prevention care management unit (PCMU) will be used by all partners to increase client compliance. One of the first activities of the *Juntos* projects staff will be to develop a shared definition and protocol for determining and tracking compliance. The PCMU is based on the Dartmouth Model and the research conducted by Dietrich et al., 2006, which tested the effectiveness of the model in increasing cancer screening compliance. The Dartmouth Model correlates with the *Juntos* Transformational Change model with both models placing empowerment of clients and communities at the core. Table 3 presents an overview of project objectives, activities, measures and responsible parties. For a detailed analysis of the goals of the proposal please see the Five Year Work Plan.

Table #3. Objectives per Prong	
Prong 1	**Objective 1 – Establish a PCMU based on the Dartmouth model. It is hypothesized that the clients that participate in the PCMU intervention groups will have significantly higher compliance rates than the control (normal) treatment group** **Activities:** Implement a quasi-experimental study which has three groups, normal treatment, intervention group one - phone call follow-ups, intervention group two - phone calls plus home visits. **Measures:** Three way analysis of variance, and covariance plus other statistical tests as appropriate. **Responsible Party:** Partner working team, Program, Research and Data Manager

Table #3. Objectives per Prong	
Prong 1	**Objective 2 – Establish health education protocols for all partnering agencies including information and pre-and-post questionnaires. The health education information presented in the *Juntos* project will focus on obesity, diabetes and mental health** **Activities:** 500 participants in a health promotion sessions. Development of protocols and brochures related to obesity, diabetes and mental health **Measures:** Logs of number of participants and t-test of knowledge based pre- and post-test **Responsible Party:** CONHS Nusing Faculty, Graduates and Undergraduates, Co-PI
	Objective 3 – Establish a shared health information system for partners to coordinate and share plans of care and referrals **Activities:** (1) Establish affiliation agreement for use of shared health information, (2) Establish with partners the parameters for the health information system, (3) Work with TAMIU IT department to establish specifications for health information system, (4) Negotiate contract for the development of health information system. **Measures:** (1) Deployment of health information system, (2) Users of health information system will evaluate ease and efficacy of system as related to components of collaboration and communication of client information. Correlational models will be used to assess efficacy of the health information system based on user surveys. **Responsible Party:** Project PI, Co-PI, Program, Research and Data Manager
Prong 2	**Objective 1 – Establish traveling health care teams (THCT) that move to agencies in need of primary/psychiatric services. It is hypothesized that the client seen by the THCT will have increased compliance and positive outcomes compared to clients referred through the normal agency protocol** **Activities:** (1) Post position for two FNP's and two LPC's which will comprise the two traveling teams, (2) Hire personnel, (3) Deploy personnel THCT to Holding Institute, Serving Children & Adults in Need (SCAN), Casa Ortiz and other agencies as requested. **Measures:** (1) Track number of clients seen for services by the THCT, (2) Assessment of client satisfaction using standardized survey, (3) Track number of referrals, (4) Track compliance rate for referrals, (5) Compare compliance rates for THCT for standard referral. **Responsible Party:** PI & Co-PIs, THCT teams, Program, Research and Data Manager
	Objective 2 – Establish screening and referral protocols for the mobile health van **Activities:** (1) Coordinate with Doctor's Hospital needs, and schedule for traveling team to use van, (2) Match needs of beneficiaries [i.e. schools and churches to mobile van schedule], (3) Develop screening protocols for Doctor's Hospital, (4) Develop referral protocol for agencies other than Doctor's Hospital, (5) Develop health education information that is congruent with other health information. **Measures:** (1) Track number of clients seen by THCT, (2) Assessment of client satisfaction survey, (3) Assessment of knowledge gain related to obesity, diabetes, mental health issues using the pre-and-post test, (4) Track number of referrals, (5) Track compliance rates for referrals **Responsible Party:** Partners Working Teams, THCT, Progam, Research and Data Manager

Table #3. Objectives per Prong	
Prong 3	**Objective 1: Develop best practice referral protocols which will be used among the partnering agencies** **Activities:** (1) Conduct review of literature to establish best practice protocol, (2) Utilized literature to develop best practice referral protocols, (3) Review and approval of best practice protocols by partners, (4) Implementation of best practice protocols. **Measures:** Assessment by partners of the effectiveness of referral process according to new protocol as compared to pre-*Juntos* protocols **Responsible Party:** Program Manager, Research Manager, CONHS Nursing Faculty
	Objective 2: Provide partners with requested resources (as determined by each partner) which will increase their capacity **Activities:** (1) Assessment of partner assets and resources which could be shared among the partners, (2) Implement partner budget request as per this proposal **Measures:** (1) Each partner will establish baseline data related to access to care and availability of specialized services [i.e., nutritionist], (2) Each partner will track the additional client contacts as the results of the additional resources provide by the grant **Responsible Party:** Program Manager
	Objective 3: Provide partners with requested resources (as determined by each partner) which will increase the integration of primary health and mental health services **Activities:** (1) Implement partner budget request as per this proposal, (2) Track number of clients with a treatment plan which includes both primary health and mental health services **Measures:** Each partner will track the additional treatment plans which incorporate primary health and mental health as the results of the additional resources provide by the grant. 2) Agency's partner staff will be asked to assess pre-post *Juntos* level of integration of primary health and mental health services **Responsible Party:** ProgramManager, PI and Co-PIs

Partners for the *Si Texas; Juntos for Better Health* proposal will not have to receive training in cultural competence, but will need training on working together in the development of an Integrated Behavioral Health Team. While many providers have worked for various agencies in this region, there is a critical need for collaboration improvement; therefore, the current level of collaboration for this project is considered level one on the (Heath et al. 2013) Levels of Collaboration/Integration Scale.

In the development of this proposal, the CFOs from the majority of health care agencies in Laredo were invited to a preliminary meeting to discuss collaboration on the *Si Texas* grant RFA. As a result of the meeting and subsequent one-on-one meetings with agencies, nine partners were

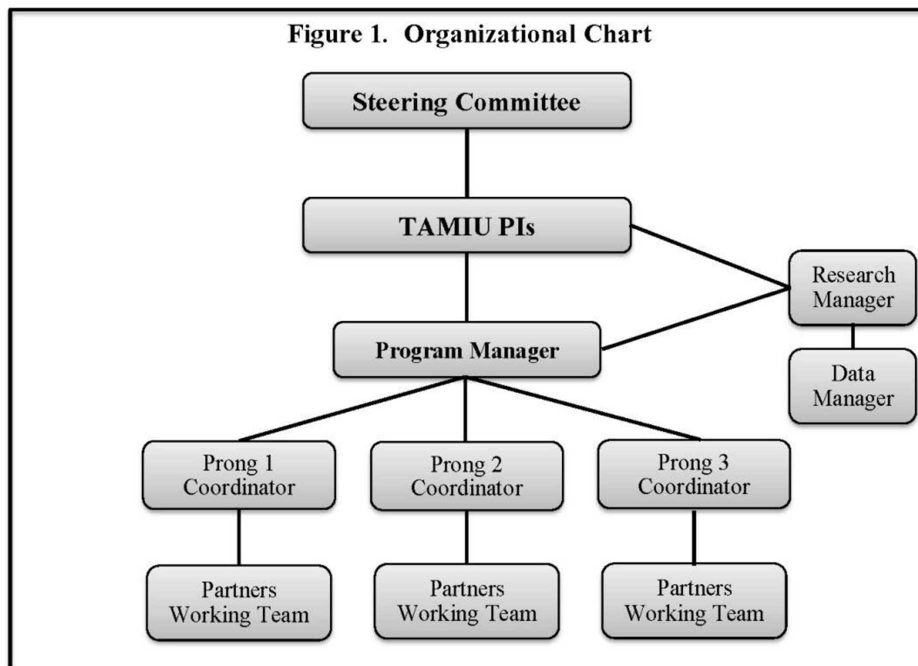
identified and committed to participate in the project, (AHEC, Border Region Behavioral Health Care, City of Laredo Health Department, Doctors Hospital of Laredo, Gateway Community Health Center, Holding Institute Community Center, Office of Border Affairs, SCAN and TAMIU). All of the partnering institutions have committed to providing cash match to the project as identified in the budget. Additional beneficiaries will also include United Independent School District, Laredo Independent School District and County of Webb Indigent Services. To date, Laredo Medical Center (LMC) has requested to join the project in future years. LMC has requested a psychiatric social worker to coordinate psychiatric and primary care within their hospital. Beneficiaries are agencies with clients participating in health care education and/or early screenings such as in the two local school districts.

Each partner was asked to identify both their level of financial commitment and their level of commitment to project goals. In addition partners were asked to complete an inventory of services and gaps in services. Based on this inventory of services, partners provided TAMIU with their budget request which would facilitate increased capacity and integration of primary health and mental health services. As the project evolved, it became apparent that the *Juntos* project would have the three prongs or levels of collaboration as identified above.

It is clear that we have to move systematically through stages of partnership building. First of all, there is little systematic data collection and analysis of data for this region. Therefore a priority for this grant is partner participation and establishing a protocol for the systematic collection and analysis of project data in order to evaluate project goals and objectives.

Each system will clearly be operating independently but they will communicate about shared clients, best practice protocols and referrals. For example, co-occurring treatment related to diabetes and mental health between partners SCAN and GCHC and any other partner will be

quickly worked into the development of a comprehensive patient plan of care. In addition the partners have identified other needs which will be addressed by this project. For example, Holding Institue Community Center (Holding Institute) has identified the need for primary health and mental health care services at their agency. The THCT which constitutes prong two of the grant will meet this need. Another example includes, the need for extra space for Border Region Behavioral Health Center (BRBHC) and the surplus of space at Holding Institute which may lead to leveraging space with additional access for mental health services provided by BRBHC.



The organization structure for the project is illustrated in Figure 1. Unlike other organizational structures partnership is at the core of this project. Therefore, the first tier in the organization structure is the Executive Steering Council which consists of the each agency's designated representative for the partnership and the grant. Under the Executive Steering Committee there is a direct line to the principal investigator and the two Co-PIs who report directly to the Executive Steering Committee. A Program Manager reports to the project principal investigators. Additional direct lines of reporting include the Data Manager and Research Manager who report both to the Program Manager and the principal investigators. By consensus of the partners, prong

coordinators will be assigned to the *Juntos* project by their respective agencies to monitor primary, secondary and tertiary levels of prevention. In addition, there will be working teams comprised of personnel from all partnering agencies.

Level of Evidence and Research for Best Practices of the Juntos Model

This proposal uses two frameworks the Dartmouth Prevention Care Management Model (Figure 2) and the Laredo *Juntos* Transformational Change Model to achieve the objectives in the above narrative. The Prevention Care Management Unit (PCMU) (P1) will be integrated throughout the partner agencies. The Dartmouth Model serves as the research model that interfaces and compliments the client and community change model. Both are described below.

The PCMU approach is focused on educating clients about the value of screening tests and their benefits, and motivating (activating) clients to take action on the information and follow up with their health care appointments and treatment plan. The Preventative Care Management (PCM) approach was developed to improve the cancer screening rates for ethnically diverse women (Hispanic) of Community Health Centers in New York City. According to the model the patient support and educational material can be particularly effective at increasing awareness and subsequently compliance with screening in primary care settings. This knowledge helps develop a sense of self-empowerment regarding the clients health care.

Figure 3 shows the components of the model as modified for the *Juntos for Better Health* project. As shown in Figure 3, the PCMU staff, first identifies clients who are overdue for follow-up or not following their treatment plans, and then contacts each overdue patient to determine the specific types of support needed. The PCMU staff then provides telephone support along with patient educational materials, PCM tools, and appointment reminders. The PCMU staff continues to call the patient until fully up-to-date for all appointments and in compliance

with their treatment plan. If follow-up phone calls are not successful, then TAMIU nursing students will make a home visit if permitted by the client. Once fully up-to-date, the patient is moved to the bottom of the list, and contacted only if s/he becomes noncompliant.

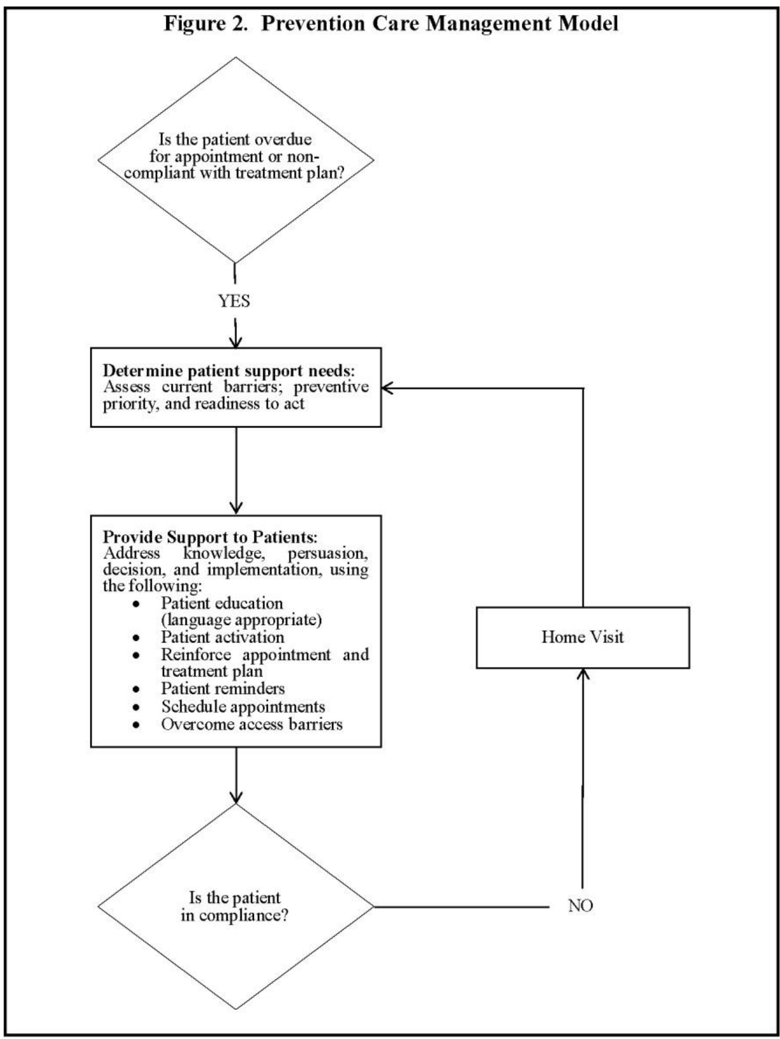
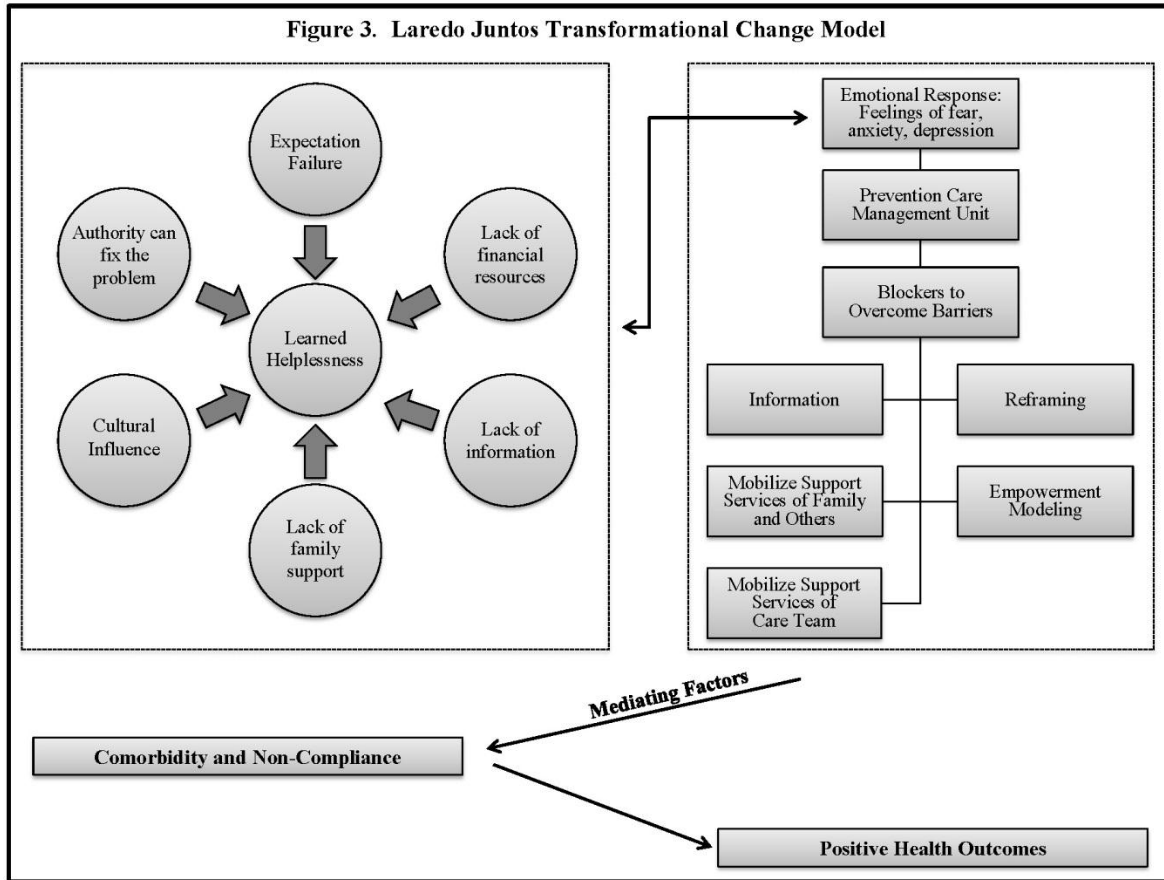


Figure 3 illustrates, the Laredo Project Juntos Transformational Change Model. Clients often operate from a starting point of helplessness. The belief that one's actions does not directly impact outcomes is multifactored and variables such as lack of family support, lack of information, and lack of financial resources contribute to a belief that chance, rather than one's actions or lack of actions, influences outcomes. This leads to emotional responses such as feelings of fear, anger, anxiety and depression. If these feelings are not dealt with, they will feed back into the helpless cycle and will exacerbate any physical and/or mental health problems. The PCM approach is the bridge to blocking the emotional response, stopping the continuous cycle of helplessness, and achieving the goal of effective use of health care services.



The PCM approach will be used in all the partnering agencies providing secondary and tertiary services related to diabetes and mental health. To test the effectiveness of the Dartmouth Model, an experimental study was conducted in 11 community and migrant health centers in New York (Dietrich et al., 2006). In the Dietrich study, eligible consenting women were randomly assigned to the control or intervention group using a computer-based random-number generator. 1413 women overdue for cancer screening were randomly assigned to receive a telephone based intervention (delivered by 8 PCM Managers) or usual care. The intervention included information about breast, cervical and colorectal cancers, and provided motivational and logistical support for obtaining the screening and other preventive services. The usual care group received statndard services wth answers to questions the women may have had. The

women in the intervention group received a series of telephone support calls from a prevention care manager. The data were drawn from these contact logs.

The Dietrich study found that nearly 63% of women identified their primary language as Spanish and most were insured by Medicaid or Medicare. Over two thirds of the subjects had been receiving their health care from their health centers for at least three years. Many of the women had chronic diseases and more than half were obese. Between baseline and follow-up, screening rates in the intervention group increased by 17% for mammography ($p< 0.001$), by 10% for Papanicolaou testing ($p< 0.001$) and by >60% for any colorectal screening ($p< 0.001$). The proportions of women who were up to date for all three forms of screening increased by 105% in the intervention group ($p< 0.001$). There was no evidence that the interventions' effect varied by site. This study's findings have important implications for the *Juntos* project. Even a modest intervention can increase screening rates. Telephonic support is especially effective and may be used to address multiple issues at once.

The Dartmouth PCM Model will be implemented with all partners with clients who are being treated for diabetes and mental health problems. The majority of partners could not provide estimates for noncompliance. According to partner data the rate of noncompliance for GCHC was 30% with 4209 diabetics this equals a possible sample of 1262. According to the CLHD 33% of their patients have abnormal glucose readings and their noncompliance rate is 29%; however, the serve basis for the CLHD is unknown. For BRBHC the number of clients seen in FY 2014 was 6573 with a noncompliance rate of 15% which provides a possible sample of 986 for the PCMU. During the FY 2014 the HICC saw 2800 and SCAN saw 804 clients; however, the noncompliance rate is unknown. Since baseline compliance rates and population served are

only available for GCHC and BRBHC these two partners will serve as the primary sites for the replication study of the PCMU; however, any partner agency may refer clients to the PCMU.

The protocol for inclusion in the *Juntos* study will include consent of the client. Definitions for non-compliance will be developed by the partners and a tracking form developed using the Dartmouth forms as the template. The client sample from GCHC, BRBHC, and other partners will be assigned to three groups. Group one will be the control who will receive an information session as per their treatment plan and a one-time mailing of information about the importance of keeping follow-up appointments and information related to following their treatment plan. Group two will be the first of two intervention groups. Group two will receive follow up phone calls reminding them of their appointment and accessing any barriers to compliance with the follow-up. Phone calls will continue each week for three weeks. If the client fails to make the follow-up after three weeks then the client will be placed in the second intervention group. The intervention includes a home visit from project staff and/or TAMIU nursing students and Wesley nurses if the client agrees to a home visit. During the home visit, a basic assessment will be conducted such as vital signs, glucose assessments and any barriers to making follow-up appointment. Any negative finding will be immediately reported to the partner PCMU and TAMIU faculty. The appropriate parametric and non-parametric statistical tests will be used to determine the effectiveness of the research interventions. Various tests will be used to control for possible confounding variables such as age, sex, and chronicity of disease.

The travelling health care team (THCT) is a modification based upon the house call methodology used with diabetic clients as described in the research study conducted by Cohen et al. (2012). In this study, 36,000 Medicare clients with diabetes were divided into two groups and the rates of hospitalization, readmission, outpatient hospital visits and physician office visits

were compared between the two groups. The two groups consisted of the Chronic Conditions Special Needs Plans (C-SNPs) a type of Medicare authorized by the 2003 Medicare Modernization Act to provide coordinated health care to people with selected chronic health conditions and the traditional fee-for-service Medicare plan.

A central part of the C-SNPs program is a coordinated plan for client improvement using outreach programs. A key component of the model is the HouseCalls program, which send specially trained nurse practitioners and physicians to enrollee's homes. In 2010 XLHealth performed more than 82,000 HouseCalls home visits across all of its operations. The study found that "special-needs plan enrollees had lower admission rates, shorter average lengths-of-stay in the hospital, lower readmission rates, slightly lower rates of hospital outpatient visits, and slightly higher rate of physician office visits than their fee-for-service counterparts. In all five states combined, special-needs plan enrollees averaged 2.8 hospital days, 4.8 hospital outpatient visits, and 9.0 physician office visits per year. Fee-for-service enrollees in the comparison sample averaged 3.5 days in the hospital, 5.4 outpatient hospital visits, and 8.5 physician office visits." The authors believe that "the strategies used by the special-needs plan to enhance primary care – including in-home visits, medication reconciliation, improved care transitions, and care coordination are effective in reducing hospitalization and readmission rates for Medicare beneficiaries with diabetes in the five states."

(P2) is the THCT, which will consist of a FNP and a LCP. The teams will rotate between the, SCAN, the Holding Institute and Casa Ortiz. In addition the THCT will be used to increase access to health care with the mobile van. The THCT will participate and expand the health screening conducted by the partners. Primary health assessments including mental health initial screenings will be conducted at SCAN, the Holding Institute and Casa Ortiz on a set schedule as

determined by the partners. Once the initial intake is conducted by the THCT, the patient will be referred to a medical home and an appointment arranged at the time of intake. The rate of compliance with the follow up appointment will be monitored. If the follow-up appointment is missed one of the intake team members will contact the client and assess the barriers to follow-up and develop a barrier intervention plan (BIP). If the BIP is unsuccessful, then the client will be referred to the PCMU. Tracking data will be used to assess the health problems identified and the follow-up compliance rate. Statistical analysis will be used to assess the effectiveness of the follow-up phone calls, BIPS, and video conference hand off in improved compliance rates.

(P3) initiatives and activities are based on partner budget requests. The budget narrative includes the individual request for partnering organization which will facilitate access and capacity building in addition to more holistic services for the proposed project. These requests are mainly focused on two areas: 1) additional personnel to increase access and capacity and 2) additional personnel to expand the services offered such as an additional Licensed Professional for the Healing Arts (LPHA) and a nutritionist to provide more integrated holistic services at BRBHC. The LPHA in the Adult Behavioral Health Unit would offer counseling sessions to clients that are afflicted with depression. If hired, this would mean that the BRBHC would be able to serve 130 more clients per month or 1560 additional clients per year. The nutritionist would be able to see 160 clients a month or 1920 additional clients per year. Additional supervising staff with the TAMIU Stress Center will allow Master of Arts Counseling and Psychology students to provide support services for veterans' families and support groups for 200 stroke survivors in Laredo area.

III. EVALUATIVE MEASURES

As described in the above narrative the *Juntos* project uses three levels of collaboration (prongs) to achieve the goal of a coordinated and integrated comprehensive delivery systems with multiple health partners in Laredo. Each prong (P1, P2, & P3) has activities, measurements and responsible parties defined in the narrative. Included in this description are the various statistical tests that will be used to determine effectiveness of the activities. For example, evaluation of the effectiveness of P3 activities which include additional services to increase access and capacity will be tracked using a systematic tracking system developed by the partners. In addition to tracking the number of clients seen and type of services, evaluation forms will include a section completed by both the client and provider which ranks the outcome effectiveness of the treatment. When possible pre-post tests of knowledge will be used to assess the effectiveness of interventions such as nutritional counseling. Standardized tests such as the SCL90 will be used to assess changes in psychological symptoms pre and post health arts interventions. Statistical analyses will include the use of t-tests when pre and post tests are used, and correlational tests will be used to assess client and providers assessment of outcomes.

The *Juntos* project uses a transformational change theory, which is also identified and described extensively in the narrative. In addition the PCM model correlates with the *Juntos* transformational model and is a major construct in the transformational change model. The PCM model is a major component of the logic model which has been uploaded separately. Examples of two specific SMART goals for this project are included in the narrative (Table 4). The five year work plan identifies all the major goals using the SMART format:

Table #4. SMART Goals for PCM Model
Goal 1: The PCMU will increase compliance rates by 10% (126 clients) for clients at GCHC who are diabetic and identified as noncompliant by May 2016 as measured by maintaining follow-up appointments consistently for three months and HgbA1c 6.5 or below.
Goal 2: The PCMU will increase compliance rates by 10% (98 clients) for clients at BRBHC who have a primary mental health diagnosis of depression by May 2016 as measured by maintaining follow-up appointments consistently for three months and medication compliance.

Since there are nine partnering institutions, TAMIU will lead and monitor the evaluation activities of the project. TAMIU has extensive experience in evaluation and has numerous statistical experts in all types of parametric and nonparametric tests. Several of the statisticians on campus are sought out as experts in the statistical analysis of health care data (NIH & NSF funded). One TAMIU faculty, Dr. Ned Kock, has consulted on international health care research studies and has developed three dimensional regression models for health care problems such as obesity and nutrition. Dr. Kock will be used as a consultant throughout the project.

TAMIU nursing faculty and students are experts in Hispanic competencies related to health care issues. The principal investigator, Dr. Glenda Walker, has extensive experience in two areas applicable to this project: 1) Partnership development 2) management of large multi-site research grants. Dr. Walker developed the East Texas Nursing Consortium (NEC4) which consisted of nine nursing programs in the East Texas region. The consortium was responsible for the development and impementation of two major multi-site studies which focused on the identification and intervention with nursing students at risk for attrition. Based on the success of the East Texas research grants the Texas Higher Education Coordinating Board (THECB) funded a three million dollar replication study for the State of Texas, which included 27 nursing programs, over 9,000 students and 880,000 data points. The Co-PIs for the project are Rose Saldivar and Gwendolyn George both nursing faculty in the CONHS. Rose Saldivar is a FNP and PMNNP and bring over 15 years experience in nursing education. Prior to joining the

CONHS faculty Ms. Saldivar was the Program Coordinator of a multi-site mobile unit which provided services to the colonias of Webb County. Part of her responsibilities included evaluation of patient outcomes. Dr. Gwendolyn George in an FNP, DNP who provided coordination and evaluation of mobile health care services to the 9th Ward after Hurricane Katrina.

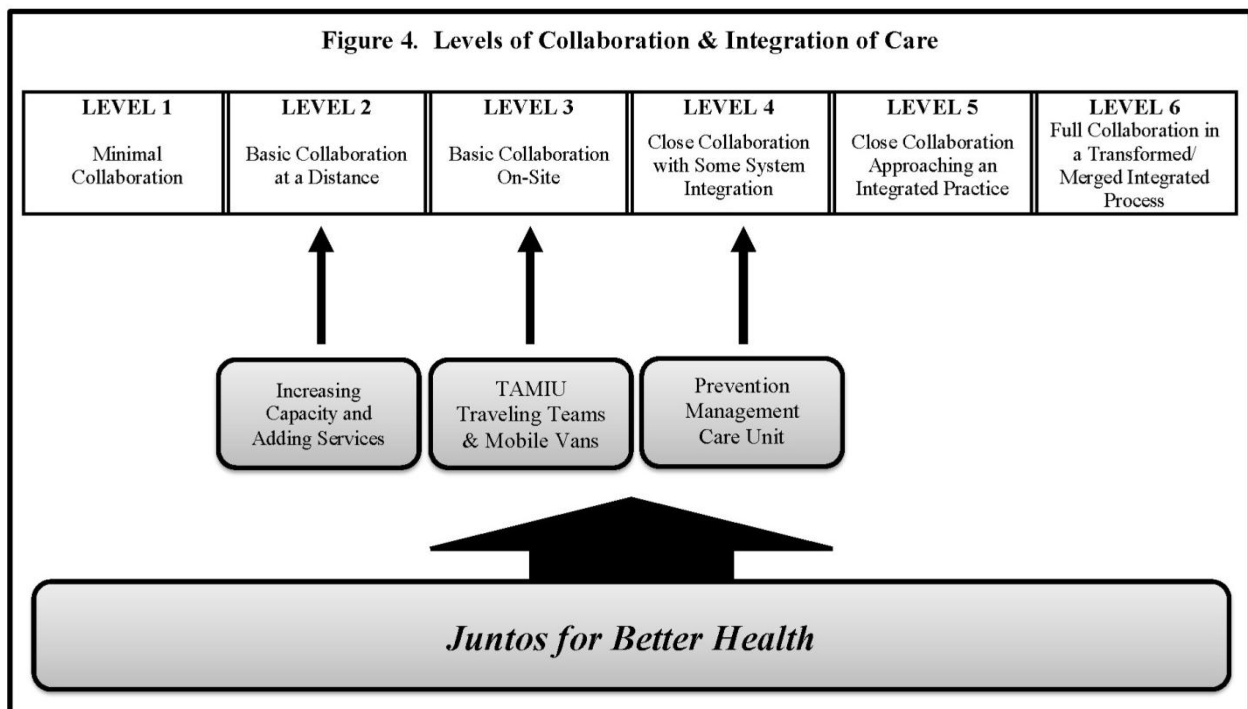
We believe that long-term success of project involves the recruitment and retention of staff who are culturally competent. It is essential that staff have the trust of the partners to develop a truly functional and integerated health care team. Therefore, additional key personnel will include a **Program Manager** who must have experience working with the health care community in the Laredo area. The Program Manager must have exception interpersonal and team building skills and feel comfortable working with many stakeholders with multiple interests. One of the important requirements is the ability to lead and guide others, while empowering them be successful. The **Research Manager** position must have extensive experience in health care with a focus in public health. This individual must have extensive experience in managing and tracking large data sets and must have excellent personnel and team building skills. The Research Manager must have experience as a research director, as this position also requires experience in research and data analysis. The **Data Manager**, who would ideally have a Ph.D., must have exceptional experience in health care research, preferably in health behaviors evaluation research.

IV. COLLABORATION

Numerous short-term projects have taken place among the partners (See Figure #4) For example, in a project funded by the DSHS-OBH, the TAMIU Community Stress Center worked in collaboration with the Health & Human Services Commission – Office of Border Affairs, and

the TAMU-Colonias program to provide group counselling sessions in Webb County Community Centers or churches embedded in the Colonias. If serious mental health issues were discovered in group sessions, an appointment was made with TAMIU counselor interns and resident for a one on one consultation to discuss local mental health resources. In addition, TAMIU faculty members have done community outreach activities and student interns have been involved with each of the Juntos for Better Health partners. One example is the Laredo/Webb County Workforce and Health Study, in which GCHC and the City of Laredo Health Department were among the grantees for this study. They contracted with TAMIU students and faculty to design the study, gather data, analyze it and draft the report.

Figure 4. Levels of Collaboration & Integration of Care



The TAMIU CONHS will provide the necessary hands (undergraduate nursing students and graduate nurse practitioner students) to reach out to the community to bring clients into the project network by providing health education and primary health screenings, especially as it relates to diabetes, obesity and mental health issues. Faculty and students from other departments

at TAMIU will also contribute to the project with data entry and data analysis. The Texas A&M University Community Stress Center (CSC) has the dual purpose of providing counseling services in the Laredo area to low income and underserved persons, and providing the required training hours and professional supervision to graduate students in the Master's Counseling Psychology Program. In the last three years, 15 CSC graduate students have served 225 individuals ranging from children to aging adults at Casa Ortiz and TAMIU. Students treated clients who report having issues related to stress, anxiety, depression, family conflict, and low academic performance. ***Casa Ortiz*** is a building managed by TAMIU, and the building will be renovated as a: 1) screening service site for SI Texas clients, 2) satellite site for the Prevention Care Management Unit and 3) site to expand on the number of clients seen at the CSC.

The Mid Rio Grande Border Area Health Education Center addresses the region's need for health education (offering workshops on depression, obesity, diabetes, and mental health) and focuses on the growing need for healthcare and academic resources in this region.

The Border Region Behavioral Health Center serves individuals with psychiatric, behavioral and developmental disabilities. The Center served 6,573 clients in the last fiscal year and because 20% of their youth clients (1,275) are obese and an additional 60% are overweight, they feel an integrated health plan with a nutritional dimension would greatly benefit this region.

The City of Laredo Health Department has extensive data on obesity, diabetes, with 1 in 3 adults having abnormal glucose levels, 30% of school children are overweight with abnormal glucose levels. Great improvement has been seen in all 600 persons who have participated in the Health Department program, Healthy Living/Viviendo Mejor.

Doctors Hospital of Laredo provides high quality medical services to the following numbers of patients from Laredo and surrounding communities in calendar year 2013: 29,386

emergency room visits, 96,738 outpatient visits, and 8,532 admissions in calendar year 2013. Doctors Hospital is a for-profit facility with a network of 5 outpatient clinics in Laredo.

Gateway Community Health Center, Inc. is a non-profit corporation funded by the U.S. Department of Health and Human Services, serving all residents in Webb, Zapata, and Jim Hogg counties. The Center offers primary and mental health care, and provides many preventive health services, including prenatal care, immunizations, diabetes awareness/education programs, cancer screening programs, worksite wellness, family planning services and self-management classes for diabetic clients taught by certified promotoras (outreach workers). Annual eye exams, eye surgeries and diabetic supplies are provided through a grant from the Methodist Healthcare Ministries. In calendar year 2013, 26,307 clients were provided with 123,219 medical, dental, and special clinical client visits. Most GCHC clients fall below federal poverty guidelines and no one is denied services because of inability to pay.

Holding Institute Community Center offers various services to the underserved populations in the region (2,800 people in FY 2013-14), such as food distribution and various forms of adult education and counseling. Holding Institute is requesting a Wesley nurse be stationed within their facility, to offer diabetes monitoring, nutrition and fitness programming, facilitate individual and family counseling, and be a liaison to the other health programs such as the THCT and the PCMU.

The Human Services Commission – Office of Border Affairs has facilitated numerous outreach programs to underserved communities, such as a collaboration with the Christian Medical & Dental Association, which is comprised of 60 – 80 dental and medical students from the University of Texas Health Science Center at San Antonio and pharmacy students from Texas State University at San Marcos.

Serving Children & Adults in Need is a non-profit organization and is a community leader in both residential and outpatient substance abuse treatment services, Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) and Case Management Services. In the past fiscal year, SCAN served 804 outpatient, 402 inpatient and 270 clients diagnosed with COPSD.

VI. SUSTAINABILITY

A business plan will be developed for financial sustainability based on the following revenue sources: Medicaid, Medicare, private insurance and a fee-for-service. Each partner has existing reimbursement systems in effect. Payment for services will be provided by Medicaid, Medicare and health insurance companies. There will be an increase in revenue as a result of increased service encounters, which will offset personnel costs in the future. Based on the evaluation data of the THCT, one of the potential outcomes of the project is the development of a true Housecalls approach for discharged patients. Local hospitals and Blue Cross Blue Shield will be approached for contractual funding for both the THCT, PCMU and Housecalls. By decreasing readmission to the hospital and emergency room visits due to noncompliance in treatment plans, for newly discharged patients, the cost savings will offset the personnel cost for the above units.

All partner agencies will be asked to share their billing processes, which will maximize billing codes to capture all potential billable integrated mental health services into primary care. This will include an evaluation of all billable mental health and primary care services such as navigation services. In addition the project team will attempt to determine if the interventions in the PCMU would qualify under the navigator billing code.

VII. BUDGET NARRATIVE

A. Budget Narrative for Year 1		
Expenses and Justification	**Sí Texas**	**Matching**
PROJECT PERSONNEL EXPENSES		
Sr. Personnel: Dr. Glenda Walker, PD/PI (35%); Co-PIs: Ms. Rose Saldivar Prong 1 Coor. (50%); Dr. Gwendolyn George, Prong 2 Coor. (25%); Mr. Michael Smith Prong 3 Coor. (100%); Dr. Sara Castro-Olivo TAMIU Stress Ctr. Dir. (12%); Mr. Jaime Arizpe Program Manager (100%); Research Manager (100%); Data Manager (100%); **Other Personnel:** FNP Stress Ctr. Student Supervisor (100%); 2 LPC Stress Ctr. Student Supervisors (100%); Project Admin. Assistant (100%); 4 graduate students (75%); **Holding Inst.:** Director of Operation (70%); Director of Administration & Finance (70%); Administrative Assistant (70%); **AHEC:** Prevention Management Model staff (100%); **Border Region Behavioral Health Ctr.:** 2 Licensed Professionals for the Healing Arts unit for CAPS unit (100%); 2 Licensed Professional for the Healing Arts for ABHU unit (100%); 2 Nutritionists for CAPS unit (100%); 2 Nutritionists for ABHU unit (100%); **Gateway Community Health Ctr.:** Dr. Derly Hinojosa & 1 other medical doctor (100%); 2 Nutritionists (100%); 2 Medical Assistants (100%); 2 Patient Navigators (100%); **SCAN:** Clinical Director (15%); Substance Abuse Counselors (22%); Project Supervisor (22%); COPSD Case Manager/Navigator (100%); Outreach Worker (50%); **City of Laredo Health:** LVN III (100%)**;** Case Manager (100%); 2 LPCs (100%); FNP (100%)	$1,438,615	$859,299
SCAN Personnel Fringe Benefits **-** FICA: 7.65%, Health Insurance: $3,150/year x 100% FTEs (five & one .87/FTE match); Retirement 2%, SUTA 3%, Worker's comp. 2%	$43,292	$8,016
City of Laredo Health Fringe Benefits - FICA: 7.65%, Health & Dental Insurance: $885.97; Retirement 20.65%, Unemployment $9,000 x 2.3%, Worker's comp. 0.0032 x 90.63% x FNP salary; .0120 x 90,63% x LVN III salary; .0067 x 90.63% x LPC salary; .0067 x 90.63% x case manager salary	$77,279	$73,031
Personnel Fringe Benefits (all others) - FICA: 7.65%, Health Insurance: $647/month x 100% FTEs; $315/month < 100% FTE; Retirement 8.5%, Unemploy.: 0.40%, Worker's comp. 0.95%, Students: worker's comp. 0.95%, unemployment 0.4%, Health Insurance $150/month	$315,217	$193,985

Expenses and Justification	Sí Texas	Matching
TRAVEL		
Includes all partners–Local Travel per person ~$1,870/traveler/year: Local: $0.55 per mile x ~850 miles per month x 12 months x 9 partners for local travel to deliver services to colonias, clinics in outlying counties, etc. for ~3 travelers per partner	$50,490	
Project staff to regional meeting in SA-12 people @ $635/trip/person: Ground (fuel & rental) @ $500/vehicle x 2; Lodging @ $115 x 3 nights x 10 rooms; M&IE @ $66 x 4 days x 12	$7,618	
National conference travel for 2 project staff (6 total) per trip for professional development - for 3 trips @ $1,515/person: Airfare $675 x 2 travelers; Lodging @ $150/night x 3 nights x 2 travelers; M&IE 3 days @ $85/day x 4 days x 2 travelers; ground transportation @ $100 per trip = $3,030/trip x 3 trips	$9,090	
SUPPLIES		
Consumable office supplies for clinics & expanding services & for mental health & substance abuse symposium & other events @ $3,500 per partner (AHEC cash match for $25,000)	$6,500	$25,000
Desktop computers for new project personnel @ $1,800/each plus software @ $600/each for 12 project personnel; 16 iPads w/123GB @ 699/each for field work; additional iPads, laptops, & other supplies for setting up clinics at Casa Ortiz, Holding & other partnering agencies to be paid with match from AHEC @ $25,000 in total	$39,984	$25,000
SCAN Other Supplies-drug tests @ 12,750; incentives @ $2,000	$14,750	
AHEC Other Supplies: 1 Portable projector @ $800; 1 cell phone package @ $2,000 per year; 2 prepaid cell phones - 2 @ $600; Folding chairs & tables @ $300 total; Refreshments for student trainings @ $34/meeting x 50	$6,000	
CONTRACTUAL/CONSULTANT SERVICES		
Medical Clinic Professional Consultant - 1 Consultant with an expertise on development of nurse-managed clinics at partner sites @ $167 per hour for 120 hours for a total of $20,000	$20,000	
City of Laredo Health to contract - Dr. Erika Juarez, MD @ $200 per hour for 100 hours for Diagnostic & Statistical Manual-evidenced based disease self-management with understanding disease, psycho-social support, healthier cooking, low impact exercise & lab pre/post testing		$20,000
Juntos mental health & substance abuse symposium/Juntos Staff Development - 2 symposiums w/1 speaker each: airfare $635; hotel 98 x 2 nights; per diem $56 x 3 days; ground $100 per trip; and honoraium $1,000 (~125 per hour for 8 hours) x 2	$4,198	

Expenses and Justification	Sí Texas	Matching
In Conjunction w/HHSC: Hands and Feet Medical Missions-FTEs ~45 UTMB-Galveston volunteers, equipment, medical supplies & travel; Christian Medical & Dental Assoc. 60-80 dental & medical students from the UTHSC- SA & pharmacy students from Texas State University for 4 health fairs annually in colonia of Webb Co. for 30K in dental services/ trip; $16,000 in free medical services/trip		$55,000
HHSC Follow-up of direct services health provider stakeholders - ~$37.50 per patient x 320	$12,000	
Holding Facilities Super. @ $5,400; Facilities Asst. @ $4,200; 3 ESL Instructors @ $4,320; 3 Computer Lit. Instructors @ $4,320	$6,384	$6,384
TRAINING		
SCAN Training - Staff Training on Trauma		$2,034
EVALUATION		
Standardized Tests - SCL-90 Q software-based Profile in Eng. & Span. @ ~$15 for each patient for 500 patients; Use of CATI Lab at TAMIU for $5,000 per full survey; Evaluation expenses for on-site activities - Pre and post-tests & materials (TAMUS Match)	$12,500	$30,000
OTHER COSTS		
Criminal History Checks-$50 per background check x 45 personnel	$2,250	
Promotional costs (includes AHEC match)-$3,889 per partner x 9 agencies for project dissemination & project identification in the community: flyers, brochures, T-shirts for staff; giveaways at health fairs; student ID cards, etc. for a total of $35,000	$10,000	$ 25,000
Juntos mental health & substance abuse symposium/Juntos Staff Development - Room rental @ $1,500 x 2; Refreshments/lunch @ $12 per participant x 150 participants x 2	$6,600	
Holding Expenses - Telephone $2,411 per year for services x 70%; Alarm $583 per year for services x 70%; water $5,825 per year for services x 100%; sanitation $2,214 per year for services x 100%; elec. $34,952 per year for services x 100%; internet $6,268 per year for services x 100%	$25,677	$25,677
SCAN Expenses - Utilities $4,500/month x 12/mos. x 6% usage; communication $2,000/ month. x 12/mos. x 6% usage; maintenance $1,500/ month. x 12/mos. 6% usage; insurance $45,000/year x 5% allocation based on staff & office content; copier lease $800/ month x 12/mos. x 15% usage	$9,450	
Federally approved indirect cost rate - DHHS negotiated Pre-determined rate of MTDC	$211,789	$1,140,076
TOTAL EXPENSES – Year 1	**$2,329,684**	**$2,488,503**

B. University Capacity to Obtain Match

TAMIU has secured matching funds in the amount of **$2,488,503** (52%) as detailed above. The cash amounts are $50,000 from AHEC and $30,000 from Texas A&M University System. TAMIU will continue to seek matching funds to augment the project efforts.

C. Current Internal Controls and Financial Systems

The Office of Research and Sponsored Projects (ORSP) and the Office of Grants and Contracts (OGAC) have 3 staff members who are Certified Research Administrators. These offices provide hands-on support to Principle Investigators (PIs) on expenditures, compliance with federal laws and regulations, as well as reporting requirements. ORSP helps find funding opportunities and provides hands'-on support to university faculty and staff developing grant applications. The OGAC is headed by a director and an associate director with over 10 years' experience each managing federal, state, local, and private awards, including a massive Department of Education grant to serve over 8,000 high school students in 10 surrounding counties. TAMIU is already over the threshold for A-133 audits. TAMIU received notice of grant funding from MHM for Building Nursing Capacity on the Border on December 4, 2014. All grant applications and funded projects are routed for internal approval and administered through Maestro, a Texas A&M University System-wide integrated research information system.

D. Description of Key Financial Personnel

Juan Cisneros, III, the Director of OGAC has an MBA and is responsible for the administration, management, and supervision of the office staff. Mr. Cisneros works directly under the VP for Finance and Administration. He 1) meets with PIs at the start of projects, 2) responds PI inquiries on project administration, 3) reviews all grant agreements and contracts related to the sponsored award 4) reviews and approves: requisitions, service contracts, requests for new positions for sponsored program accounts; 5) monitors financial reporting deadlines to ensure the university complies with sponsored agreements, prepares and reviews financial reports to grant agencies, and approves invoices submitted to agencies for reimbursement of program expenses, 6) prepares state, federal and internal reports, develops and implements department policies, manages the department budget, manages the department and program specific audits, participates on university committees and attends conferences for professional development, 7) compiles sponsored program reports for the annual budget process. *Julio Medina*, the Associate Director of OGAC, has an MBA and he 1) provides responsible administrative support to Mr. Cisneros for the fiscal administration of sponsored awards and contracts, 2) monitors revenues and helps review requisitions to ensure expenditures are in compliance with approved budget and sponsor guidelines, 3) provides direct oversight of Gear-Up programs and their matching funds, 4) helps submit sponsored program budget reports to PI's, 5) helps prepare financial reports, 6) requests reimbursement of funds from agencies, 7) reviews the monthly indirect cost reports, 8) and reviews monthly invoices prior to submission to funding agencies. The Office of Institutional Advancement works to secure local funds from private donors in order to expand or sustain TAMIU projects.

VIII. References

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WORK PLAN

FOCUS AREA 1: Replication of best practice using Dartmouth Model of Prevention Care Management Unit (PCMU)			
Goal 1 - The Prevention Care Management Unit (PCMU) will increase compliance rates by 10% for clients at Gateway Community Health Center (GCHC) who are diabetics (primary health) and identified as non-compliant, as measured by maintaining follow-up appointments consistently for three months and maintain and HgbA1c of 6.5 or below			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Modify the Dartmouth manual and forms for diabetic clients.	Partners Working Team	November *(six months after start date)*	Includes procedures for informed consent and approval by IRB.
2. Develop procedure for identifying non-compliant clients.	Partners Working Team	November *(six months after start date)*	After initial one year pilot with GCHC additional partners may be added as requested
3. Conduct training of PCMU staff and nursing students.	Partners Working Team/CONHS Nursing Faculty	February 2016	Initial training
4. Role-play phone calls to clients by PCMU and nursing students.	CONHS Faculty/Graduate and Undergraduate	February 2016	
5. Place non-compliant diabetic clients into control and intervention group (phone calls)	Partners Working Team/CONHS Nursing Faculty/GCHC	March 2016 and Ongoing	
6. Implement PCMU protocol with pilot group of diabetic clients and GCHC.	Partners Working Team/CONHS Nursing Faculty/GCHC	March 2016 and Ongoing	
7. Continue with phone calls (three phone calls)	Partners Working Team/CONHS Nursing Faculty/GCHC	March 2016 and Ongoing	
8. If non-compliant after three phone call refer for home visit.	Partners Working Team/CONHS Nursing Faculty/GCHC	March 2016 and Ongoing	
9. Implement data entry of variables.	Partners Working Team/Data Manager/Research Specialist	March 2016 and Ongoing	
10. Track compliance rates	Partners Working Team/CONHS Nursing Faculty/GCHC	March 2016 and Ongoing	

FOCUS AREA 1: Replication of best practice using Dartmouth Model of Prevention Care Management Unit (PCMU)			
Goal 1 - The Prevention Care Management Unit (PCMU) will increase compliance rates by 10% for clients at Gateway Community Health Center (GCHC) who are diabetics (primary health) and identified as non-compliant, as measured by maintaining follow-up appointments consistently for three months and maintain and HgbA1c of 6.5 or below			
11. Analyze compliance rates between groups yearly.	Partners Working Team/Data Manager/Research Specialist	June 2016 and Ongoing	
12. Analyze compliance rates after five years.	Partners Working Team/Data Manager/Research Specialist	June 2021	
13. Analyze barriers to compliance based on phone calls yearly and at five years (qualitative and quantitative).	Partners Working Team/Data Manager/Research Specialist	June 2016 and 2021	Annual and five year reports of data analysis of PCMU effectiveness
Goal 2 - The PCMU will increase compliance rates by 10% for clients at Border Region Behavioral Health Center (BRBHC) who have a primary mental health diagnosis of depression as measure by maintaining follow-up appointments for three months and medication compliance			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Modify the Dartmouth manual and forms for depression	Partners Working Team	November *(six months after start date)*	Includes procedures for informed consent and approval by IRB
2. Develop procedures for identifying non-compliance with partners	Partners Working Team	June 2016	
3. Conduct training of PCMU staff, nursing students and other partners	Partners Working Team/CONHS Nursing Faculty	February and September 2016	February (Initial training for new partners and protocols) and September (refresher)
4. Role play phone calls to clients by PCMU staff and nursing students	CONHS Faculty/Graduate and Undergraduate	September 2016	
5. Place non-compliance depressed clients into control and intervention groups (phone calls)	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2016 and ongoing	
6. Implement PCMU protocol with pilot group at BRBHC	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2016 and ongoing	
7. Continue with phone calls (three phone calls)	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2016 and ongoing	

FOCUS AREA 1: Replication of best practice using Dartmouth Model of Prevention Care Management Unit (PCMU)			
Goal 2 - The PCMU will increase compliance rates by 10% for clients at Border Region Behavioral Health Center (BRBHC) who have a primary mental health diagnosis of depression as measure by maintaining follow-up appointments for three months and medication compliance			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
8. If non-compliant after three phone call refer for home visits	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2016 and ongoing	
9. Implement PCMU protocols with other partners	Partners Working Team/CONHS Nursing Faculty/Other partners	November 2016 and ongoing	
10. Implement data entry of variables	Partners Working Team/Data Manager/Research Specialist	November 2016 and ongoing	
11. Track compliance rates	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2016 and ongoing	
12. Analyze compliance rates between groups yearly	Partners Working Team/Data Manager/Research Specialist	November 2016 and ongoing	
13. Analyze compliance rates after five years	Partners Working Team/Data Manager/Research Specialist	November 2021 and ongoing	
14. Analyze barriers to compliance based on phone calls yearly and at five years (qualitative and quantitative)	Partners Working Team/Data Manager/Research Specialist	May 2017 and 2021	Annual and five year reports of data analysis of PCMU effectiveness

FOCUS AREA 1: Replication of best practice using Dartmouth Model of Prevention Care Management Unit (PCMU)			
Goal 3 - The PCMU will increase compliance rates by 10% for clients at both GCHC and BRBHC who have a coexisting diagnosis of depression and diabetes as measure by maintaining follow-up appointments for three months, medication compliance and maintenance of a HgbA1c of 6.5 or below			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Modify the Dartmouth manual and forms for depression	Partners Working Team	November *(six months after start date)*	Includes procedures for informed consent and approval by IRB.
2. Develop procedures for identifying non-compliance with partners	Partners Working Team	June 2016	
3. Conduct training of PCMU staff, nursing students and other partners	Partners Working Team/CONHS Nursing Faculty	September 2017	February (Initial training for new partners and protocols) and September (Refresher for returning nursing students or new employees)
4. Role play phone calls to clients by PCMU staff and nursing students.	CONHS Faculty/Graduate and Undergraduate	September 2017	
5. Place non-compliance depressed clients into control and intervention groups (phone calls)	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2017 and ongoing	
6. Implement PCMU protocol with pilot group at BRBHC.	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2017 and ongoing	
7. Continue with phone calls (three phone calls).	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2017 and ongoing	
8. If non-compliant after three phone call refer for home visits.	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2017 and ongoing	
9. Implement PCMU protocols with other partners.	Partners Working Team/CONHS Nursing Faculty/Other partners	November 2017 and ongoing	
10. Implement data entry of variables.	Partners Working Team/Data Manager/Research Specialist	November 2017 and ongoing	

FOCUS AREA 1: Replication of best practice using Dartmouth Model of Prevention Care Management Unit (PCMU)			
Goal 3 - The PCMU will increase compliance rates by 10% for clients at both GCHC and BRBHC who have a coexisting diagnosis of depression and diabetes as measure by maintaining follow-up appointments for three months, medication compliance and maintenance of a HgbA1c of 6.5 or below			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
11. Track compliance rates.	Partners Working Team/CONHS Nursing Faculty/GCHC	November 2017 and ongoing	
12. Analyze compliance rates between groups yearly.	Partners Working Team/Data Manager/Research Specialist	November 2017 and ongoing	
13. Analyze compliance rates after five years.	Partners Working Team/Data Manager/Research Specialist	November 2021 and ongoing	
14. Analyze barriers to compliance based on phone calls yearly and at five years (qualitative and quantitative).	Partners Working Team/Data Manager/Research Specialist	May 2018 and 2021	Annual and five year reports of data analysis of PCMU effectiveness

FOCUS AREA 2: Enhancement of Primary Health Care Education to Mitigate the Occurrence of Obesity, Diabetes and Depression			
Goal 4: Health education sessions will be provided to a minimum 500 participants per year using the mobile van and /or other outreach methods with a significant increase in knowledge related to the prevention of obesity, diabetes and /or depression measured by a pre-post survey			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Identify or develop health education material related obesity, diabetes and /or depression	Partners Working Team/CONHS Nursing Faculty	November 2015 *(six months after start date)*	Includes procedures for informed consent and approval by IRB. Educational material will be bilingual (English/Spanish).
2. Negotiate with Doctor's Hospital of Laredo mobile van schedule	PI and Co-PI	November 2015 *(six months after start date)*	Every attempt will be made to accommodate evening hours for the community (i.e., schools, churches, entertainment events, etc.)
3. Train nursing students and mobile van personnel on the implementation of training modules and how to conduct pre-post- test	Partners Working Team/CONHS Nursing Faculty	February 2016	
4. Training by *Juntos* research specialist and data manager for nursing students regarding reliability of pre-post- testing procedure	Partners Working Team/Data Manager/Research Specialist	February 2016	
5. Implement health education sessions	CONHS Nursing Faculty/Nursing Students	February 2016 and Ongoing	
6. Implement data entry of variables	Partners Working Team/Data Manager/Research Specialist	May 2016 and Ongoing	
7. Data analysis	Data Manager/Research Specialist	May 2016 and Ongoing	Annually and throughout the five years of the project
8. Identify or develop health education material related obesity, diabetes and /or depression.	Partners Working Team/CONHS Nursing Faculty	November 2015 *(six months after start date)*	Includes procedures for informed consent and approval by IRB. Educational material will be bilingual (English/Spanish).
9. Negotiate with Doctor's Hospital of Laredo mobile van schedule.	PI and Co-PI	November 2015 *(six months after start date)*	Every attempt will be made to accommodate evening hours for the community (i.e., schools, churches, entertainment events, etc.)

FOCUS AREA 2: Enhancement of Primary Health Care Education to Mitigate the Occurrence of Obesity, Diabetes and Depression			
Goal 4: Health education sessions will be provided to a minimum 500 participants per year using the mobile van and /or other outreach methods with a significant increase in knowledge related to the prevention of obesity, diabetes and /or depression measured by a pre-post survey			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
10. Train nursing students and mobile van personnel on the implementation of training modules and how to conduct pre-post- test.	Partners Working Team/CONHS Nursing Faculty	February 2016	
11. Training by *Juntos* research specialist and data manager for nursing students regarding reliability of pre-post- testing procedure.	PI and Co-PI /Research Specialist	February 2016	
12. Implement health education sessions	CONHS Nursing Faculty/Nursing Students	February 2016 and Ongoing	
13. Implement data entry of variables.	Partners Working Team/Data Manager/Research Specialist	May 2016 and Ongoing	
14. Data analysis.	Data Manager/Research Specialist	May 2016 and Ongoing	Annually and throughout the five years of the project

FOCUS AREA 3: Enhance and Increase the Level and Effectiveness of Primary and Behavioral Healh Care Integration in the Sites (Holding Institute, SCAN, and Casa Ortiz)			
Goal 5: Provide traveling health care teams (THCT) which consist of an FNP and LPC which will rotate among the following agencies Holding Institute Community Center (Holding Institute), Serving Children and Adults in Need (SCAN) and Casa Ortiz thereby increasing the number of clients receiving both primary and mental health integrated services by 250 clients per year.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Work with partner agencies to identify client needs and partner resources.	Program Manager	November 2015 *(six months after start date*)	
2. Establish memorandums of understanding (MOU) which outlines roles and functions of THCT.	PI and Co-PI	November 2015 *(six months after start date)*	
3. Approval of MOU from Texas A&M general council.	PI and Co-PI	November 2015 *(six months after start date)*	
4. Hire consultant to help in the development of the physical structures for the clinics, billing and billing procedures and screening protocols	PI and Co-PI	November 2015 *(six months after start date)*	
5. Identify practice referral protocols and agencies for medical home and specialty services.	Partners Working Team/CONHS Nursing Faculty	November 2015 *(six months after start date)*	
6. Contract with billing services for reimbursement (Medicare, Medicaid, health insurance, etc.)	Texas A&M System	February 2016	
7. Obtain medical equipment and consumable suppliers	PI and Co-PI	May 2016	
8. Post position and hire FNPs and LPCs who will comprise the THCT.	PI and Co-PI/Juntos Executive Steering Committee	May 2016	
9. Implement THCT at Holding Institute.	Project Manager	Fall 2016	
10. Implement THCT at SCAN.	Project Manager	Spring 2017	
11. Implement THCT at Casa Ortiz.	Project Manager	Fall 2017	
12. Track number of client seen for	Partners Working Team/Data	Fall 2016	

FOCUS AREA 3: Enhance and Increase the Level and Effectiveness of Primary and Behavioral Healh Care Integration in the Sites (Holding Institute, SCAN, and Casa Ortiz)			
Goal 5: Provide traveling health care teams (THCT) which consist of an FNP and LPC which will rotate among the following agencies Holding Institute Community Center (Holding Institute), Serving Children and Adults in Need (SCAN) and Casa Ortiz thereby increasing the number of clients receiving both primary and mental health integrated services by 250 clients per year.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
services by the THCT unit at Holding Institute, SCAN and Casa Ortiz.	Manager/Research Specialist	and Ongoing	
13. Assess client satisfaction of services provide by the THCT at each site.	THCT/Partners Working Team/Data Manager/Research Specialist	Fall 2016 and Ongoing	
14. Track number of referral	Partners Working Team/Data Manager/Research Specialist	Fall 2016 and Ongoing	
15. Track compliance rate of referrals.	Partners Working Team/Data Manager/Research Specialist	Fall 2016 and Ongoing	
16. Track compliance rates for TCHT versus standardized referral	Partners Working Team/Data Manager/Research Specialist	Fall 2016 and Ongoing	

FOCUS AREA 4: Enhance the Effectiveness of Partner Agencies to Deliver Primary Health Care and Behavioral Care			
Goal 6: The capacity of partner agencies to provide additional primary health services and behavioral health service in a more comprehensive manner will be increased by 25% above baseline 2015 data			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Establish baseline data for number of clients seen and type of services for FY 2014.	Partners Working Team/Data Manager/Research Specialist	June 2016	Baseline data limited and must be determined at beginning of grant by Data Specialist.
2. Assess partner's assets and resources which can be shared among partners.	Project Manager	June 2016	
3. Negotiate sharing of resources to avoid duplication of services.	Project Manager/PIs and Co-PIs	November 2015 (six months after start date)	
4. Implement partner budgets request as per this proposal.	Project Manager/PIs and Co-PIs	November 2015 (six months after start date)	
5. Each partner with track additional client contacts and types of services that are a direct result of their grant budget.	Partners Working Team/Data Manager/Research Specialist	November 2015 and ongoing	i.e., BRBHC will track nutritionist and healing art encounters based on additional personnel. In addition SCL-90 will be used to assess the effectiveness of the healing art intervention pre- and post-.

FOCUS AREA 5: Develop Fully Integrated Health Information Systems for all Partner Agencies			
Goal 6: Increase by 25% the coordination and sharing of client care plans by partners and agencies by year 5 of this grant as assessed by an agency assessment of level of coordinate survey pre- post- grant			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
1. Work with partner agency to identify existing EMR systems and their health information sharing needs.	Project Manager/Data Manager/Research Specialist	Fall 2016	
2. Work with Texas A&M system to identify a health care information system that meets systems requirements for confidentiality and state and federal guidelines	PIs and Co-PIs	Fall 2016	
3. Establish affiliation agreement for use of sharing health information	PIs and Co-PIs	Fall 2016	
4. Conduct pre-level of coordination survey	Project Manager/Data Manager/Research Specialist	Fall 2016	
5. Negotiate contract for the development of a health information system.	Texas A&M System	Fall 2017	
6. Train partnering agencies and THCT on the health information system	Project Manager/Data Manager/Research Specialist	Spring 2018	
7. Implement health information system	Project Manager/Data Manager/Research Specialist	Spring 2018 and Ongoing	
8. Assess effectiveness of health information system pre-post-	Project Manager/Data Manager/Research Specialist	Fall 2021	

Project Title: Improving Access to Integrated Care for Rio Grande Valley Residents with Severe and Persistent Mental Illness
Organization Name: Tropical Texas Behavioral Health
Address: 1901 S. 24th Avenue, Edinburg, TX 78539
Project Director Name: Diana Maldonado, Director of Primary Care Services
Phone Numbers: Voice: (956) 316-3037, Fax: (956) 316-3028
E-Mail Address: dmaldonado@ttbh.org
Funding Requested in this Application for the first two year budget period: $1,569,995

Abstract

Tropical Texas Behavioral Health (TTBH) is one of the first Local Mental Health Authorities (LMHAs) established in Texas as a result of the 1967 enactment of House Bill 3, and is currently the 5th largest LMHA in the state. With more than 700 employees operating from behavioral health clinics in Edinburg, Weslaco, Harlingen and Brownsville, TTBH makes an extensive array of evidence-based behavioral health services accessible to low income and uninsured residents of the Lower Rio Grande Valley (RGV or The Valley) diagnosed with Severe and Persistent Mental Illness (SPMI), Co-Occurring Psychiatric and Substance use Disorders (COPSD) and/or Intellectual and Developmental Disabilities (IDD). Located on the most Southern border between Texas and Mexico, the RGV has a population of more than 1.2 million predominantly Hispanic residents that has grown faster and had higher poverty rates than most areas of the country since the year 2000[1]. Communities in the RGV contend with higher rates of chronic disease and substantial disparities in the availability of quality healthcare in comparison to other parts of the state and the country[2]. Studies have established that individuals with SPMI face a unique set of added challenges to accessing primary care[3]. These factors combine to make it especially difficult for our clients and their families to obtain critical preventive primary care services. This project will support TTBH's efforts to diminish obstacles to care by expanding access for more people in the RGV living with SPMI to primary care integrated into the familiar setting of the behavioral health clinic.

TTBH will hire, train and equip a team of medical professionals and care coordinators to deliver primary care services to 500 unduplicated adult clients from the Brownsville area per year for the first two years of the grant term. Without this intervention, these clients likely would not receive timely integrated care due to barriers including fearfulness and apprehension, poverty, lack of transportation and provider resource limitations. The project will increase the effectiveness of our primary care services by funding a care coordinator positon at each of our co-located clinics, to improve opportunities for clients with especially complicated healthcare issues to achieve the health outcomes and quality of life they desire. The project will also innovate the delivery of integrated care by allowing for in-house completion of medical clearance evaluations of persons in need of psychiatric hospitalization, reducing utilization of emergency department resources to do so. Primary care will be delivered from a co-located clinic currently under construction at our Brownsville outpatient clinic. TTBH successfully co-located primary care within our Edinburg and Harlingen facilities in 2014, gaining valuable experience addressing the many challenges associated with reverse co-location of integrated care. Standardized instruments will be used to measure behavioral and physical health outcomes and to demonstrate the benefit of this intervention to those served, and by extension, to their families and communities.

Need

TTBH is the LMHA for the more than 1.2 million residents of Hidalgo, Cameron and Willacy counties in Texas, a 3,100 square mile area along the Southern Texas Gulf Coast and the border with Mexico. U.S. Census Bureau data indicate that from 2000-2010, the McAllen-Edinburg-Mission (Hidalgo County) and Brownsville-Harlingen (Cameron County) Metropolitan Statistical Areas (MSAs) experienced the 11th and 60th highest growth rates of the 381 MSAs in the U.S., respectively. The population of the RGV is predominantly Hispanic/Latino, making up 91%, 89% and 87% of the populations of Hidalgo, Cameron and Willacy Counties, respectively, in 2013. Persons of Hispanic/Latino decent also comprise the predominant racial/ethnic group served by TTBH, accounting for 95% of persons served by the center in State Fiscal Year 2014 (SFY14).

TTBH serves a predominantly indigent population. According to the U.S. Census Bureau, from 2011-2013, the McAllen/Edinburg/Mission MSA had the lowest per capita personal income of the 381 MSAs in the country, and the Brownsville-Harlingen MSA the second lowest. In 2013, median household incomes and the percentages of persons below the poverty level were $53,046 and 15.4% for the U.S.; $51,900 and 17.6% for the state of Texas; $34,146 and 34.8% in Hidalgo County; $33,179 and 34.8% in Cameron County, and $25,886 and 40% in Willacy County (U.S. Census Bureau, 2013). The disabling effects of poverty are exacerbated by the deficiencies of local public transit services including inadequate service coverage areas and schedules that limit users' ability to get where they need to go when they choose. Individuals with mental illness often don't know about available transportation opportunities or how to use them, and low income and uninsured residents with mental illness aren't eligible to participate in transportation programs that are limited to people with Medicaid or other insurance. In July 2012, more than

two thousand adults served by TTBH responded to survey questions concerning patterns of health care use and the ability to access care. Forty three percent (43%) reported that they lacked health insurance; more than 25% indicated their home was 10 or more miles from the nearest medical facility; 30% reported that they had only occasionally reliable transportation or none at all; only 3% reported using public transportation to get to their appointments; and although a majority of respondents said they relied on personal vehicles or the support of family or friends to get to their appointments, nearly half (48%) indicated they did not seek routine checkups or preventative care on a regular basis.

Rates of chronic disease and related mortality among the general population of the RGV exceed those in most other regions of the state and the nation. Heart disease, stroke and diabetes are the 1st, 3rd and 7th leading causes of death in the United States, respectively[4]. In the RGV, heart disease, stroke and diabetes are the 1st, 3rd and 4th leading causes of death, respectively[5]. According to the 2014 Regional Needs Assessment (RNA) compiled by the Texas Department of State Health Services (DSHS)-funded Prevention Resource Center in Region 11 (PRC 11), heart disease and stroke are among the most widespread and costly health problems currently facing the United States, accounting for more than $500 billion in health care expenditures and related expenses in 2010 alone[6]. The leading modifiable (controllable) risk factors for heart disease and stroke have been identified as: high blood pressure; high cholesterol; cigarette smoking; diabetes; poor diet and physical inactivity; and overweight and obesity.

In 2010, approximately 8.3 percent of adult Texans 18 years or older reported they had been diagnosed with heart disease or stroke, and roughly 1.5 million Texans were living with cardiovascular disease (CVD)[7]. In 2011, of the 2,847 heart disease-related deaths in the 19 counties in Southmost Texas served by PRC 11, half (50%) were from Hidalgo and Cameron

Counties alone[8]. In 2012, the mortality rate for the Texas border counties was 28.6 deaths per 100,000 population, higher than the combined mortality rate for all non-border counties of 21.0 per 100,000[9]. Of the 11 Public Health regions (PHRs) in Texas, PHR 11 (Southmost Texas) had the highest age-adjusted prevalence of diabetes (13.7% - 19.0%) and high blood pressure (47.1% - 55.7%), and was one of the two highest PHRs for age-adjusted prevalence of adults with no leisure time physical activity (31.5% - 34.4%), obese adults (37.5% - 44.3%) and prevalence of "Physical Health Not Good 5+ Days" (21.8% - 24.7%).

Based on a study of 2,000 Mexican American adults from 2003 to 2008 called the Cameron County Hispanic Cohort (CCHC), researchers at the University of Texas School of Public Health at Brownsville found that 31% of participants had diabetes and 81% were either obese (49%) or overweight (32%)[10]. The study results also pointed to the existence of significant number of cases of undiagnosed diabetes in the RGV in comparison to lower self-reported prevalence rates identified by the Centers for Disease Control's (CDC) 2010 Behavioral Risk Factor Surveillance System (BRFSS)[11].

In 2012, the prevalence of adult smokers in Texas (18%) equaled that of the nation, and although over 80% of individuals who smoke express a desire to stop smoking and 35% try to stop each year, less than 5% are successful in unaided attempts to quit[12,13]. While BRFSS data indicated that only 14% of persons from Region 11 self-reported to be current smokers at risk[14], self-report data of this kind tend to underrepresent actual usage. Nonetheless, youth and adults in the RGV who use tobacco are at significantly increased risk of heart disease, stroke and a number of other chronic diseases[15].

In 2013, just over 1,222 tuberculosis (TB) cases were reported in Texas. The U.S. national TB infection rate in 2013 was 3.0 cases per 100,000 population with 9,582 cases reported. Texas

reported 12.7% of the total 2013 cases, with a TB infection rate of 4.6 cases per 100,000 population. In 2013, the Texas counties with the highest incidence rates of TB were the counties on the border with Mexico, with Willacy and Cameron Counties among the highest of those[16].

Cameron, Willacy, Hidalgo and Starr Counties comprise the Texas Health and Human Services Commission's (HHSC) Regional Healthcare Partnership 5 (RHP 5). In 2011, self-reported prevalence rates of fair or poor mental health in RHP 5 were much higher than rates nationally (20% v. 12%), as were rates of chronic depression in the region compared to national prevalence rates (40% v. 27%)[17]. Worse still, the entire region continues to endure a shortage of mental health professionals, in a state that has historically had the lowest per capita spending on mental health services in the country[18]. Individuals with SPMI living in regions throughout Texas are eight times more likely to be incarcerated than treated in hospitals, at tremendous public and personal cost[19].

While some of the highest morbidity and mortality rates due to chronic disease persist in Texas, and in particular along the state's southern border with Mexico, the situation is worse still for residents with Severe and Persistent Mental Illness (SPMI), including the full range of schizophrenia and other psychotic disorders, and mood disorders including major depressive disorders and bipolar disorders. The even higher rates of co-morbid chronic medical illness in people with SPMI, the unique challenges they face managing their illnesses, and their disproportionately high rates of premature death relative to the general population are well documented. In their 2006 technical report: Morbidity and Mortality in People with Serious Mental Illness, the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) cited data from studies in a number of U.S. states demonstrating that on average, people with SPMI have a higher risk of death and die at much

younger ages than individuals from their cohorts in the general population. Moreover, their data demonstrated that individuals with SPMI died an average 1 to 10 years earlier than persons diagnosed with a "non-major" mental illness. The report indicated the increased mortality and morbidity rates were largely due to preventable conditions including cardiovascular disease, diabetes (including related conditions such as kidney failure), respiratory disease (including pneumonia and influenza) and infectious diseases (including HIV/AIDS). The researchers argued that having SPMI is a risk factor for problems accessing health care due to the lack of motivation, fearfulness, and social instability experienced by persons with SPMI, and the fragmented behavioral and primary healthcare service systems.

Factors identified as placing people with SPMI at higher risk of morbidity and mortality included higher rates of smoking, drug and alcohol use, obesity and poor nutrition, lack of exercise, unsafe sexual behavior, exposure to infectious diseases, as well as homelessness, victimization/trauma, unemployment, poverty, incarceration, and social isolation. The report also cited research suggesting the population of people with SPMI had high use of medical emergency services, fewer preventive services, lower rates of cardiovascular procedures and worse diabetes care[20]. In addition to being a mental health care Health Professional Shortage Area (HPSA), RHP 5 has long been a primary care HPSA as well, with difficulty recruiting and retaining primary care and specialist physicians and nurses[21]. The disparate impact of chronic physical illnesses in the general population of the Valley is compounded for those with SPMI due to an even greater likelihood of being poor and/or uninsured, and the functional impairments caused by their mental illness. Evidence of the benefits of integrating primary care into outpatient behavioral health settings in terms of patient health outcomes and the cost of care is limited but growing.

A 2001 study involving the integration of primary care services within a mental health clinic treating veterans with mental illness reported that "enrollment in a co-located, integrated clinic was associated with increased primary care use and improved attainment of some cardiovascular risk goals"[22]. The study found that the veterans who received primary care services co-located within the mental health setting realized "significantly improved goal attainment for blood pressure, low-density lipoprotein cholesterol, triglycerides, and BMI." For persons served in community mental health centers, research has also shown the implementation of care management delivered in an integrated primary care setting can result in sustainable improvements in physical health outcomes (e.g. cardiovascular risk, physical functioning and pain) and patient and provider satisfaction, as well as significant potential cost savings to health care systems relative to care as usual (i.e., simple referral to a primary care provider)[23].

Co-location and integration of primary care services within behavioral health settings improves access to routine primary care for persons with SPMI given that their "primary point of contact with the health care system is through public-sector mental health programs rather than primary medical care"[24]. Co-location also reduces the cost and inconvenience to persons served of traveling to multiple locations in order to receive behavioral and physical healthcare.

This project will support TTBH's efforts to reduce key obstacles to accessing primary care faced by clients in Brownsville by hiring, training and equipping a dedicated team of medical professionals to make a medical home in the community available to individuals currently without one. The project will also increase the effectiveness of our primary care services by funding a care coordinator at each of our co-located clinics to improve opportunities for clients with particularly challenging healthcare issues to achieve the outcomes they desire. Without this intervention it is likely the clients who will benefit would not receive timely integrated care due

to regional healthcare disparities, barriers to care due to the symptoms of their mental illness, the reluctance of many physicians to treat person with mental illness, and provider resource limitations.

Project Description

If funded, this project will support TTBH to hire, train and equip a treatment team consisting of one full-time equivalent (1 FTE) primary care physician (PCP), physician assistant or nurse practitioner; 1 FTE licensed vocational nurse; 1 FTE registered dietician; and 1 FTE care coordinator to deliver co-located, preventive primary care to TTBH clients receiving ongoing behavioral health services at our Brownsville outpatient clinic. Funding for an additional 2 FTE care coordinator positions is included in the proposal; one for each of our existing primary care clinics in Harlingen and Edinburg to enhance the effectiveness of the services currently delivered there.

Primary care services from the Brownsville primary care clinic will be available 40 hours per week, Monday through Friday, from 8:00 a.m. to 5:00 p.m. Persons eligible to receive primary care services from this clinic will be individuals from Cameron County, specifically Brownsville and the surrounding communities, who are actively receiving behavioral health services from TTBH.

Integrated medical and behavioral health services will be provided in accordance with generally accepted standards of medical practice and will be individualized according to the specific strengths, needs, abilities and preferences of the person and family served. The scope of services will be limited to the training and expertise of the clinical professional involved and/or by the complexity or severity of the case. Primary care services will be provided under the supervision

of the TTBH Chief Medical Officer and Director of Primary Care, will utilize evidence-based and best practices, and will include:

- Physician Services: Delivered by a licensed family practice physician/physician assistant/nurse practitioner. Services will include: diagnosis and treatment of chronic diseases including but not limited to diabetes, hypertension, hypercholesterolemia, obesity, asthma and heart disease; acute conditions such as colds and flu; treatment of minor injuries; routine check-ups; immunizations and injections; and specified preventive screenings;
- Chronic Care Management: Services will be delivered by an experienced registered nurse to individuals at elevated risk due to their chronic illnesses. Chronic care services will include: regular patient assessment; development of well-defined and individualized treatment objectives; patient education; and collaborative goal-setting, action planning and problem solving to promote achievement of optimal health outcomes as identified by the client/patient. *Note:* These services are currently in place with funding assistance obtained through the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver (1115 Waiver);
- Nursing Services: Delivered by a licensed vocational nurse (LVN). The LVN will provide medication training, educating the client and family on the individual's chronic condition, the symptoms of the illness, the intended and side effects of prescribed medications, and interactions with their co-occurring mental illness and the medications to treat the illness. The LVN will also be responsible for incidental services including, but not limited to, taking and monitoring vital signs, processing orders for labs, injection administration and assisting with minor procedures;

- Care Coordination: Services will be delivered by an appropriately qualified and experienced bachelor's level professional. Care coordinators will provide services that will enhance the effectiveness of integrated care at all of our primary care clinics through the identification/designation of a single position responsible for coordinating internal and external components of the individual's behavioral and primary health care. Services will include: assisting with the development of medical care plans and monitoring progress with the achievement of treatment goals; participating as a member of the integrated care team to support the delivery of collaborative care; facilitating access to care from internal and external providers and specialists when indicated; ensuring implementation of evidence-based treatment protocols; educating clients/patients on diet, exercise and other healthy lifestyle choices; provision of training and support to increase the individual's confidence and skills in self-managing their chronic condition(s); provision of education and support to family members; regular monitoring of health outcomes and treatment adherence; facilitating revision of the care plan as indicated; and active scheduling and monitoring of compliance with follow-up appointments;
- Dietary Services: Services will be delivered by a registered dietician to support effective management of chronic conditions. Services will include, but are not limited to, nutritional education; menu/meal planning; nutritional counseling; body composition analysis and recipe modification;
- Basic Laboratory Services: Services will include: urinalysis; glucose and lipid levels; thyroid panels; and testing/screening for HIV, pregnancy, tuberculosis, streptococcus, influenza, H Pylori, occult blood, and STDs. Specialty lab services will be referred out to a contracted lab service;

- Pharmacy Services: Services to eligible TTBH clients delivered by a contracted pharmacy benefits manager to facilitate access to affordable, quality medications. TTBH's Patient Assistance Program (PAP) provides quality medication to eligible clients at no cost. Administrative staff will assist clients to obtain and complete the paperwork required by the respective pharmaceutical company. Sample medications, donated to TTBH by pharmaceutical companies, will also be made available to clients without insurance coverage at no cost; and
- Medical Clearances: During normal business hours, the PCP/physician assistant/nurse practitioner assigned to the Brownsville clinic will complete in-house medical evaluations often needed to clear individuals experiencing psychiatric crisis for admission to an inpatient psychiatric hospital to stabilize the crisis event. This will reduce costly and unnecessary utilization of local law enforcement and hospital emergency department resources to accomplish the service.

Evidence-Based Practices (EBPs) available through our behavioral health clinics include, but are not limited to: Cognitive Behavioral Therapy (CBT) to treat major depression and anxiety; Cognitive Processing Therapy (CPT) to treat traumatic stress; integrated COPSD services to address co-morbid substance use; Motivational Interviewing; Assertive Community Treatment; Illness Management and Recovery; Individual Placement and Supports for Supported Employment; Permanent Supportive Housing services; and Peer Support services.

Integrated primary care services will accomplish the key elements of Wagner's model for effective chronic illness care, namely, an organized delivery system linked with complementary community resources, sustained by productive interactions between multidisciplinary care teams and "activated" or educated patients and their families[25]. Evidence-based practices for the

delivery primary care will include screening for indicators of chronic disease, counseling and education, preventive medications and care coordination services. The clinic will provide screening for HbA1c and glucose levels, lipid and thyroid panels, other screening and laboratory testing, and referrals for specialty primary care. Using education curricula developed by the Centers for Disease Control and Prevention (CDC), American Diabetes Association, Substance Abuse and Mental Health Services Administration (SAMHSA), American College of Physicians and other nationally recognized organizations, the primary care team will provide counseling and education on preventive health and chronic disease management topics including: risk factors for chronic disease; diet, nutrition and exercise; cessation of tobacco, alcohol and other drug use; reproductive and sexual health; and the importance of routine primary and dental care. The PCP/physician assistant/nurse practitioner will prescribe medication with a focus on promoting health, preventing disease, and managing the health of individuals with SPMI and co-morbid chronic health issues. Care coordination services will be provided to clients identified at high risk due to an especially complex combination of health, functional, and social problems. The care coordinator will facilitate access to resources necessary to meet the client's diverse needs, monitor the quality of services delivered, and advocate on the client's behalf when necessary. The care coordinator will track the continuity of care delivered to clients referred for complex or specialty treatment and ensure the appropriate exchange of information between providers responsible for different aspects of care, to promote quality outcomes[26].

Behavioral and primary healthcare services delivered from our Edinburg and Harlingen outpatient clinics are currently operating at Level 5 on the Integrated Health Continuum endorsed by the SAMHSA-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions. Both service types are delivered from the same facility; "warm

hand-offs" of clients referred to primary care are occurring, and integrated treatment teams, involving primary care and behavioral health clinicians, meet monthly to review shared cases, discuss concerns and identify necessary changes to the plan of care. As needed, clinicians also communicate in person or by telephone, email, or teleconferencing equipment. The primary care professionals hired by TTBH have enthusiastically accepted the challenge of assimilating into a behavioral health milieu and providing culturally competent care in a unique region of the state and the country. Clinicians from both disciplines have demonstrated genuine investment in collaborating for the benefit of persons served, as evidenced by their ability to promptly and professionally resolve differing opinions and understanding of roles and culture. (See Attachment B: TTBH Integrated Care Team Meeting Documents 11.21.14.pdf).

The lack of research providing specific support for the benefit of reverse co-location of integrated primary care services within a community-based outpatient behavioral health setting serving a predominantly low income Hispanic population supports the innovative quality of our plan to do so in Brownsville. There is, however, a growing body of quasi-experimental preliminary evidence supporting key elements of our proposed intervention. Research has shown that integrated primary care, made available to individuals with co-morbid SPMI and chronic physical illness through reverse co-location of primary care within a behavioral health setting can significantly improve rates at which patients with SPMI access preventive primary care services, and can result in greater improvement of mental health, physical health and quality of life compared to usual care. Evidence also suggests this model of integrated care has the potential to reduce healthcare costs in comparison to fragmented or "siloed" care.

A 2001 study at a Veterans Affairs (VA) mental health clinic randomized 120 enrolled patients into an intervention group receiving integrated primary care that emphasized case management,

preventive medical care, patient education and close collaboration between mental health and primary care providers, and a control group receiving care as usual, i.e., referral to the VA general medical clinic in the adjacent building. The study found that individuals who received the integrated care intervention were significantly more likely to have made a primary care visit; had a greater mea number of primary care visits; were more likely to have received 15 of the 17 preventive measures from the clinical practice guidelines involved; and had significantly greater improvement in health as measured the physical component of the 36-item Short-Form Health Survey than those in the usual care group[27]. In 2003, a group of 500 persons with SPMI receiving care from an outpatient mental health services provider in Massachusetts were randomly assigned to an experimental group that received routine primary care from a nurse practitioner in the behavioral health setting including physical exams, diagnostic tests, specialty referrals and ongoing follow-up. The control group received treatment as usual, i.e., referral to their existing PCP if they had one. Among the findings: emergency department visits for patients in the experimental group were 43% lower than in the control group; routine contact with a PCP was 50% greater in the experimental group, with a 70% greater incidence of physical examinations; the experimental group experienced a 44% rate of access to health care screens for hypertension and diabetes compared to 0% in the control group; 23% of the patients in the experimental group received nutrition counseling compared to 0% in the control group; 15% agreed to discuss strategies for tobacco and drug use cessation compared with 0% in the control group; and overall inpatient medical hospitalization charges for patients in the experimental group were $55,000 less than those for the patients in the control group[28]. The researcher suggested this may have been due to better management of the health of patients in the

experimental group before illnesses manifest acutely and required hospitalization, as compared to the control group.

In 2011, 407 psychiatric outpatients with SPMI were randomly assigned to an intervention group that received care coordination and health education services from a medical care manager, or to a group that received usual care, in this case, patients received a list with contact information for local PCPs accepting uninsured and Medicaid patients. Study participants were followed over a two-year period. The two-year findings indicated: patients in the experimental group received 56% of the preventive services that they were eligible for as compared to 17% in the control group; the proportion of patients in the experimental with diagnoses of diabetes, hypertension and/or heart disease who received care in accordance with accepted guidelines increased from 28% to 43%, while falling from 31% to 28% in the control group; there was a significantly greater improvement in the mental component of the 36-Item Short-Form Health Survey for the intervention group compared to the usual care group; and the mean per-patient total costs for the intervention group were $932 less than for the usual care group, with a 92.3% probability that intervention care was associated with lower costs than usual care[29,30].

Evaluative Measures

TTBH Integrated primary care services, delivered to adult clients with SPMI and co-morbid chronic illness from a clinic co-located within the outpatient behavioral health clinic where they receive community-based behavioral health services, will lead to improved physical health and mental health for an increasing proportion of clients served.

TTBH is well positioned to participate in the internal and external evaluation of the proposed project. The center's capacity for quality oversight has expanded in response to sizeable growth

of both our service array and the volume of clients served in recent years. Quality assurance activities are directed by Stella Bryan, Manager of the Planning and Evaluation Department. Ms. Bryan holds a Bachelor's degree in Criminal Justice from the University of Texas Pan-American, and more than 18 years of progressive supervisory experience with TTBH, much of it for the center's IDD services, a program scrutinized rigorously by the Texas Department of Aging and Disability Services (DADS). Stella has successfully managed the center's quality assurance program during the period of the most rapid expansion in the agency's history. She reports directly to the Chief Administrative Officer.

The staff of our Planning and Evaluation Department regularly review a range of performance indicators using a variety of internally and externally developed tools. Findings are supplied to the center's performance improvement oversight committees from which recommendations for improvement are forwarded to executive management for determination of appropriate actions. TTBH's participation in the 1115 Waiver has necessitated evaluation of our 15 healthcare transformation projects using standardized measures to evaluate outcomes. While this is a learning process at this time, we have chosen two of these measures to evaluate this project. Physical health benefits of the intervention will be measured using National Quality Forum (NQF) measure 0018: Controlling High Blood Pressure. Mental health benefits will be evaluated using the Adult Needs and Strengths Assessment or ANSA.

As reflected in our logic model, and based on the accompanying preliminary evidence, we believe the delivery of evidence-based primary care, integrated into the familiar environment of the community behavioral health setting, using an integrated care team approach, and the effective coordination of diverse support resources, will result in measurable mental health and physical health benefits to our clients that would not be realized in the absence of this

intervention. The evidence supports the potential for this reverse co-location project to produce annual increases in the proportion of adult clients with SPMI and cardiometabolic co-morbidities served annually whose blood pressure in good control (<140/90) and who demonstrate improvements in one or more of the functioning domains assessed by the ANSA.

We will obtain baseline measures of the proportion of all adult clients served by TTBH in Year 1 (May 1, 2015 through April 30, 2016) with blood pressure (BP) values indicating good control, and who demonstrate improvement in at least 1 functioning domain in the ANSA. Our proposed five-year physical health outcome goals are:

- By April 30, 2017, the % of patients served in primary care during the period from May 1, 2016 through April 30, 2017, who evidence BP in good control will increase by an amount equal to the Year 1 baseline + [5%*(High Performance Level - baseline)];
- By April 30, 2018, the % of patients served in primary care during the period from May 1, 2017 through April 30, 2018, who evidence BP in good control will increase by an amount equal to the Year 1 baseline + [10%*(HPL - baseline)];
- By April 30, 2019, the % of patients served in primary care during the period from May 1, 2018 through April 30, 2019, who evidence BP in good control will increase by an amount equal to the Year 1 baseline + [15%*(HPL - baseline)]; and
- By April 30, 2020, the % of patients served in primary care during the period from May 1, 2019 through April 30, 2020, who evidence BP in good control will increase by an amount equal to the Year 1 baseline + [20%*(HPL - baseline)].

Proposed five-year mental health outcome goals are:

- By April 30, 2017, the % of patients served in primary care during the period from May 1, 2016 through April 30, 2017, evidencing improved functioning on at least one domain of the ANSA will increase by an amount equal to the Year 1 baseline + 2%;
- By April 30, 2018, the % of patients served in primary care during the period from May 1, 2016 through April 30, 2017, evidencing improved functioning on at least one domain of the ANSA will increase by an amount equal to the Year 1 baseline + 2%;
- By April 30, 2019, the % of patients served in primary care during the period from May 1, 2016 through April 30, 2017, evidencing improved functioning on at least one domain of the ANSA will increase by an amount equal to the Year 1 baseline + 2%; and
- By April 30, 2020, the % of patients served in primary care during the period from May 1, 2016 through April 30, 2017, evidencing improved functioning on at least one domain of the ANSA will increase by an amount equal to the Year 1 baseline + 2%.

The data for each measure is currently captured in assessments within our EHR, facilitating easy retrieval and reporting of outcomes and results.

Collaboration

Among the collaborative efforts TTBH is involved in addressing the expansion of primary care access to indigent clients and families in the RGV is our partnership with elements of the Valley Baptist Hospital (VBH) system. TTBH and the VBH Indigent Care Program have informally agreed to set up a mutual referral arrangement whereby VBH Indigent Care will refer indigent clients who have a major mental illness and potentially need integrated primary care, to TTBH. In turn, TTBH will refer indigent clients in need of specialty care to VBH Indigent Care. TTBH has also been encouraged by the Hospital's Legacy Foundation (VBLF) to submit this project

proposal for consideration of funding through their upcoming May 2015 grant cycle. If awarded to TTBH, the funds would support the sustainability of this integrated care project as a source of local match for the Si Texas grant.

TTBH is exploring potential partnerships involving enhanced access to medical and mental health doctoral students. Conversations between TTBH and representatives of the new University of Texas Rio Grande Valley (UTRGV) Medical School have focused on opportunities for residents to be able to complete rotations through our primary care clinics at a contractually agreed upon reduced rate of compensation. This would provide a unique community-based training venue for the medical school, a source of treatment providers and local match dollars for TTBH, and could have an impact on influencing future physicians to stay in the RGV to care for historically undeserved communities. TTBH has been in similar discussions with the Lone Star Psychology Internship Consortium (LSPIC) around the use of TTBH clinics as potential placement sites (residency) for psychology doctoral students. TTBH is also looking at potential cost savings through pro-bono contracts with local specialty providers (e.g., neurology, cardiology, ophthalmology).

Through the 1115 waiver, TTBH is participating in several integrated care learning collaboratives with other LMHAs and providers from RHPs around the state. We have hosted several LMHAs requesting to tour our Harlingen and Edinburg clinics, and shared policies, forms and other information concerning our reverse co-location projects. The waiver has also resulted in a local collaboration between TTBH and the Cameron County Department of Health (CCDH). We serve as the source of Inter-Governmental Transfer (IGT) funds supporting two mental health care navigation projects operated by CCDH through a subcontract with TTBH; one

serving the mental health needs of medically fragile children, and the other women at risk for postpartum depression.

Resources/Capabilities

In 2014, TTBH successfully co-located primary care clinics within our behavioral health outpatient clinics in Harlingen and Edinburg. In doing so, we gained valuable experience in addressing the challenges associated with reverse co-location and integration of primary care into the culture and operations of a community-based behavioral health setting, among them, the allocation of required clinic space; acquiring necessary supplies and equipment; establishing referral processes; development and modification of necessary consents and other forms; maintenance of a single electronic health record; establishing integrated treatment team meetings and other mechanisms for effective communication between behavioral and physical health disciplines; etc. This was accomplished using a Rapid Cycle Change Plan (RCCP). The RCCP allowed us to systematically identify key task areas (e.g., construction and design, staffing, training, equipment, policies, licenses and regulations, contracting, etc.) necessary to accomplish the final objective, the constituent actions steps needed to complete each task area, timelines for the completion of the action steps, and the staff responsible for completion of each action step (See Attachment C: TTBH Primary Care RCCP 12.12.14.pdf).

Since the opening of our co-located primary care clinics in 2014, TTBH has provided integrated primary care services to 803 unduplicated clients from our Edinburg clinic. An unduplicated count of 287 clients identified with elevated risk of poor outcomes due their co-morbid chronic illnesses have also received chronic care management services in Edinburg. In Harlingen, 629 unduplicated clients have received primary care services, and 221 of those clients have received chronic care management. Although implementation of the Brownsville primary care clinic is

pending completion of construction currently underway, 79 unduplicated clients from the Brownsville area have received primary and chronic care management services provided from the Harlingen clinic location. Unfortunately this has required the clients to travel 50 miles roundtrip to access the services. With the experience of having successfully co-located primary care within two of our outpatient behavioral health operations, and having identified the tasks and timelines required to replicate the program in Brownsville through the RCCP process, TTBH is well positioned to implement and expand access to this innovative and evidence-based model of care for the clients and families we serve in that part of the Valley.

Over the past twelve years, TTBH's Executive Management Team (EMT) has been the driving force behind the center's improved capacity to grow the array of healthcare services made available to residents of the RGV, expand service access to more Valley residents in need, and improve the quality of the services delivered, while ensuring the continued enhancement of the agency's financial positon. Beginning in 2011, the EMT championed the development and implementation of the fifteen (15) healthcare innovation and infrastructure development projects approved and partially funded by the Centers for Medicare and Medicaid Services (CMS) through the 1115 Waiver. Two of the 15 projects target treatment concerns involving the integration of primary care services for our clients with serious medical co-morbidities. The number and scope of the projects TTBH is operating through the 1115 Waiver are unique among participating providers of all types throughout the state, and reflect the EMT's exceptional commitment to improving health outcomes in the communities we serve.

The accomplishments of the EMT and the center on behalf of our clients are not possible without the dedicated support and oversight of our Board of Trustees. The nine members of the Board are appointed based on their community standing and professional achievements in fields

including local government, education, healthcare and social services. TTBH ensures that all of the counties we serve are represented on the Board, and that Board membership is reflective of the demographic composition of the Valley.

Evidence of the effective leadership of the EMT and governance of our Board is demonstrated bin the results of the center's 2014 accreditation survey by the Commission on the Accreditation of Rehabilitation Facilities (CARF International). Since 2008, TTBH has received three consecutive 3-year accreditations (the highest level of accreditation possible) for an increasing number of direct care and administrative programs. Since 2011, TTBH has been the only LMHA in Texas with a crisis intervention program accredited by CARF. In 2014, TTBH included governance standards in our survey request for the first time. We received full accreditation (i.e., without recommendations) for all leadership and governance standards. In their survey summary CARF surveyors reported, "The leadership of the organization is professional, visionary, and outstanding in its efforts to contribute to the community. Its vision is imparted to the operations of the organization and is reflected in a very detailed, comprehensive, and thorough set of policies and procedures. A dedicated and active board of directors effectively carries out the mission of the organization." (See Attachment D: CARF Survey Report Summary for TTBH - 2014.pdf)

In 2009, TTBH completed the transition from a hard copy medical record, to a paperless Electronic Health Record (EHR) run on Cerner-Anasazi software. In 2014, the functionalities necessary to record primary care services were integrated into the EHR, resulting in a single, integrated EHR. During a recent visit to TTBH under their contract with HHSC to evaluate implementation of the 1115 Waiver, the evaluator from the Texas A&M University School of Public Health cited our execution of an integrated EHR as an emerging best practice in the state.

TTBH implemented the use of telemedicine technology to deliver remote psychiatry services in 2002, and is currently able to bill for the delivery of telehealth services. Use of telemedicine technology to deliver primary care services has not begun at this time, but we are considering the procedural and regulatory requirements implications of doing so. TTBH is not currently part of a health information exchange (HIE) network, but we are reviewing available options with local HIE service providers and healthcare providers in RHP 5. Currently, the responsibility for tracking patients referred for complex or specialty health services is accomplished by our case management and continuity of care staff, and documented in our EHR. If funded, responsibility for ensuring continuity of necessary medical health care will be the responsibility of the care coordinator. Mechanisms through which this will be documented external or in addition to our EHR are under consideration at this time.

Sustainability

TTBH has implemented a number of strategies to enhance employee recruitment and retention. Strategies to recruit applicants include: internal job postings and external mailings; competitive hiring and salary structures based on years of experience; recruitment incentives made available through our partnership with the National Health Service Corps; sign-on bonuses; relocation allowances: advertising in local newspapers; position postings through the Work In Texas and other online resources; and use of locum tenens and retained firm searches for qualified applicants when necessary. Retention strategies utilized include: advancement opportunities for all positions through a structured career ladder process; opportunities for earned productivity incentives; performance awards; low-cost individual and family health insurance benefits; exceptional matching retirement contributions; tuition, continuing education certification and license renewal reimbursement; a comprehensive employee assistance program; a fully

electronic medical record; and paid training and education opportunities to enhance staff competencies and promote professional development.

The center's capacity needs are managed through the structures within TTBH's Human Resources (HR) Department and program. The HR program is responsible for the development and maintenance of an effective management team and maintenance of staffing levels that ensure appropriate quality of services and the safety of persons served by providing an effective mechanism for staff orientation and ongoing training and development. Training and education made available through, and training records maintained by, the HR program ensure that a positive and growth-oriented system of employee performance and evaluation is in place. The effective management of TTBH's human resources is one of the key areas of the agency's performance reviewed regularly throughout the fiscal year by the EMT and evaluated annually by the Board of Trustees, using benchmarks revised annually and documented in the center's strategic plan (see Attachment E: FY15 Strategic Plan - Management of Human Resources - FINAL 12 11 2014.pdf).

In 2014, TTBH successfully recruited an experienced and qualified individual to direct our primary care service programs as well as a family practice physician, nurse practitioner, three registered nurses and a registered dietician to deliver direct primary care and chronic care management services to eligible clients Valleywide. To date, however, receipt of primary care by eligible clients from the Brownsville area has required that they travel from Brownsville to our Harlingen clinic, approximately 50 miles roundtrip, as a source to fund a dedicated primary care team for the Brownsville clinic has not been finalized.

This project to integrate primary and behavioral health care will serve a predominantly low income/indigent patient population. In 2014, an internal TTBH review of the household income

information in the financial assessments of more than 11,000 clients indicated that 91% were living below federal poverty levels and did not have the ability to pay for the behavioral health services they received. To date, TTBH has not experienced an increase in patients attributable to the Affordable Care Act. Our patients are not likely to gain a funding source unless they become eligible for Medicaid or federal funding programs to assist with healthcare are expanded in Texas.

Because individuals receiving newly expanded primary care services from the Brownsville clinic will be active TTBH clients, each will complete a "Monthly Ability to Pay" (MAP) assessment upon admission to behavioral health services and will benefit from the sliding pay scale determined as a result of the assessment. Indigent clients will be charged a $5.00 copay for physician follow-up visits, and $3.00 each for up to five (5) prescriptions per month. Individuals whose MAP indicates no ability to pay may have copays waived. TTBH will also utilize a generic formulary and pharmaceutical Patient Assistance Programs to offset the cost of prescription medications.

Going forward, as contracts with managed care organizations can be amended to include reimbursement for primary care provided to individuals with Medicaid and Medicare coverage, TTBH will do so to obtain reimbursement for covered services. We will also review the payor mix for persons served to determine if a break-even point is achievable in terms of the number of clients with a third-party payor source that would have to be served to cover the costs of services to the many without a pay source. TTBH is seeking 501(c) 3 status to enhance our ability to deliver care to our clients at the lowest costs possible.

TTBH has successfully administered, delivered and reported grant-funded services for many years. We currently have six programs operating with the assistance of grants, funding targeted

mental health services for veterans and their families in the RGV; services to transition homeless persons with SPMI into treatment and housing and to train them in the skills needed to maintain stable housing; substance abuse aftercare services for individuals in the federal Bureau of Prisons system; and the delivery of Mental Health First Aid training to local educators. The earliest of these 6 programs was first funded in 2002, and five of the six have been renewed repeatedly.

As with other grant-funded programs, sustainability or growth of the proposed integrated care project beyond the term of the grant will be accomplished through regular review of operating efficiencies to identify opportunities to contain costs; through exploration of all options to generate revenue through the program including assisting persons served to apply for and obtain applicable benefits; and through continual research of alternative financial support through public, private, local and national funding sources that share our vision for enhancing access to, and the quality of, integrated primary care services to persons with SPMI in our region. A number of funding drives are also planned in 2015 to generate revenues to support greatly expanded operations in response to the escalated pace of change in the local healthcare delivery system.

To ensure that all of our services are accountable to the persons served and our communities, TTBH regularly solicits recommendations and feedback from a variety of stakeholder groups including persons served and family members; our Board; our employees; and local advisory groups, healthcare providers and government officials. Stakeholder input is carefully considered and used to inform the agency's strategic goals and initiatives and to ensure that healthcare imperatives identified by our communities are prioritized for funding.

Budget Narrative

Our budgeted salaries consist of one PCP's annual salary of $302,466; one licensed vocational nurse's annual salary of $43,202; one registered dietician's annual salary of $61,206; and three care coordinators with an annual salary of $46,204 each. Budgets are based on our current annual salary rates for existing employees.

The budget for fringe benefits reflect the Center's current total rate of 25.49%. The current budget consists of FICA tax benefit of 5.87%; Medicare tax of 1.45%; health insurance at 12.33%; retirement at 3.54%; life insurance benefit of .24%; workers compensation coverage of 1.52%; unemployment benefit of .48%; and Employee Assistance Program at .06%.

Travel costs include local mileage reimbursement budgeted at the Center's average rate of $350 per employee per year. Also included in the travel costs are expenses for the registered dietician to attend Texas Department of State Health Services (DSHS) DEEP training in Austin. The costs consist of hotel costs of $417 for 3 nights, airfare costs of $550 and meal expenses of $144 for 4 nights.

The supplies budget is based on a $300 average cost per each full time equivalent. This includes supplies, paper and toner. In addition, startup expenses have been included, namely, a budget for computers of $3,500 per full time equivalent, a budget for desks of $400 per full time equivalent, a budget for chairs of $110 per full time equivalent, a budget for book shelves of $100 per full time equivalent, and a budget for telephones of $464 per full time equivalent.

Our contractual and consultation services budget consists of estimated costs for referrals to specialty therapy. This includes occupational therapy, dental services, physical therapy, cardiologist services, endocrinologist services and other specialty services that our clients may need. Our estimated costs for these specialty therapies is budgeted at $15,000 per year.

Other costs include those for criminal history checks, utilities, telephone; licenses, electronic home page; medications, lab expenses, building maintenance, insurance, advertising, and training. The costs for criminal history checks are budgeted at $50 per full time equivalent. Utilities and building maintenance costs are based on square footage with both budgeted at $12,260. For this expense we multiplied the current utility and building cost per square foot by the square footage allocation determined using one of our existing primary care clinics. TTBH budgeted telephone utility expenses at $1,089 per full time equivalent. Our licenses are budgeted at $856.50 per full time equivalent and includes necessary licenses for Microsoft, Adobe Acrobat, Office 365 and antivirus software. Included in other operating costs is $10,000 for electronic health record software for each of our PCPs. Our medication costs were calculated by taking the estimated additional unduplicated clients we would serve and our estimated monthly cost of medications per client of $98.61 for an estimated total of $591,672. Our laboratory expenses were also calculated by multiplying the number of estimated additional clients by the average cost per lab for an estimated total of $45,552. The insurance line item budget includes professional liability insurance for the PCP in the amount of $15,387. In addition, we budgeted for the building property and flood insurance along with vehicle insurance and general liability for a total cost of $33,285. Our advertising and training costs expense is budgeted per full time equivalent. The advertising budget per full time equivalent is $654 and our estimated budgeted training cost per full time equivalent is $239.

Indirect costs were allocated at 10% of the total costs. TTBH currently has an audited indirect rate of 10.34% but to comply with the amount allowed per MHM we have allocated only 10% of indirect cost. Our cost allocation plan reflects the 10.34% audited percentage.

At this time, TTBH will use current cash reserves as the source of match for 100% of requested Si Texas grant funds. We intend to submit an application for grant funding through the Valley Baptist Legacy Foundation. If approved, those funds would also be used as a match source for MHM grant funding. In the budget table section for "Other Federal Sources of Funding" we have listed funding TTBH is eligible to earn through a project operating with financial assistance from the 1115 Waiver. The registered nurse who will deliver chronic care management services from the Brownsville primary care clinic will work in the same proximity and serve the same clients that the employees funded through the Si Texas grant will potentially serve. TTBH is aware that the federal funds listed in this section of the budget table are not eligible for use as match for this grant. The funds are listed for informational purposes only.

Financial oversight of TTBH operations is the responsibility of Beatriz Trejo, Chief Financial Officer (CFO). Ms. Trejo has been the center's CFO since 2009, and has more than 16 years' experience as a financial executive in the healthcare industry of the RGV. She is a member of the TTBH Executive Management Team, is principally responsible for preparing monthly and year-end financial reports to the center's Board and oversees all systems involved in financial audits of the agency. She directs the center's finance and information systems departments. Ms. Trejo earned a Bachelor's degree in Business Administration from the University of Texas Pan American, and is a Certified Public Accountant. She reports directly to the Chief Executive Officer.

The mechanisms for accurately evaluating and determining operating costs reflected in TTBH's cost allocation plan have been developed in compliance with state and federal guidelines and cost accounting methodologies applicable to the agency's various funding sources. Adherence to our cost allocation and business plans has resulted in the agency's strong financial position and

will support our capacity to carry out the proposed project and comply with MHM and federal reporting requirements.

The center has internal control policies and procedures that are followed to prevent bankruptcy and incapacitation including the regular monitoring of contract target limits. Related performance measures are reviewed monthly by the center's Utilization Management Committee. Operations and liquidity ratios are reported to the Board of Trustees monthly. Independent auditors' reports on the agency's internal controls for financial reporting, compliance and other matters based on audits of financial statements performed in accordance with Government Auditing Standards have consistently resulted in findings of no deficiencies over the past several years. The results have qualified TTBH for designation as a low risk auditee.

TTBH complies with the Uniform Grant Management Standards (UGMS) and is required to have an annual audit. Results of financial audits are reported to TTBH's Board of Trustees and State Granting Agencies. UGMS also dictates filing requirements to granting agencies. As a measure of the accuracy of its financial reporting, in FY 2014, TTBH was awarded a Certificate of Achievement for Excellence in Financial Reporting for the fiscal year ended August 31, 2013, from the Government Finance Officers Association of the United States and Canada. The award recognizes government units and public employee retirement systems whose Comprehensive Annual Financial Reports achieve the highest standards in government accounting and financial reporting. TTBH has received this award each of the last three years.

WORK PLAN

Tropical Texas Behavioral Health: Improving Access to Integrated Care for Rio Grande Valley Residents with Severe and Persistent Mental Illness

<table>
<tr><td colspan="4">Focus Area 1: (1) Expand access to integrated primary care services by (2) replicating the implementation of primary care services co-located at Harlingen and Edinburg outpatient behavioral health clinics.</td></tr>
<tr><td colspan="4">Goal: By July 1, 2015, TTBH will begin operation of a primary care clinic co-located within our Brownsville outpatient behavioral health clinic. Goal attainment will be demonstrated by documented evidence of completed construction and equipping of the co-located clinic; hiring and training 1 full-time equivalent (FTE) physician/physician assistant/nurse practitioner 1 FTE licensed vocational nurse and 1 FTE care coordinator to staff the clinic; and the initiation of service delivery by staff hired into the new positions.</td></tr>
<tr><td>Key Action Steps</td><td>Person/Area Responsible</td><td>Time Frame</td><td>Comments</td></tr>
<tr><td>Construction of co-located primary care clinic in Brownsville</td><td>High Mark Construction, LLC</td><td>By May 31, 2015</td><td>Underway.</td></tr>
<tr><td>Staffing: Post new positions, screen applicants, schedule interviews, select and hire, new employee orientation</td><td>CMO, Primary Care Services Director, HR Director, HR Department</td><td>By June 1, 2015</td><td>Salary structure, job descriptions, board approval for new positions, and recruitment strategies already in place.</td></tr>
<tr><td>Identify and purchase necessary equipment and supplies</td><td>Primary Care Services Director, Purchasing Manager</td><td>By May1, 2015</td><td>Underway.</td></tr>
<tr><td>Training primary care staff on topics specific to delivery of integrated care at TTBH</td><td>Primary Care Services Director, CMO</td><td>By June 1, 2015</td><td></td></tr>
<tr><td>Service documentation, forms development, data entry and data reporting</td><td>Primary Care Services Director, COO, Management of Information Systems (MIS) Director, Revenue Enhancement Services Manager</td><td>Completed</td><td>Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics.</td></tr>
</table>

Program Description, Policies and Procedures	Primary Care Services Director, CMO, COO, CAO	Completed	Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics.
Technology	MIS Director, COO, Primary Care Services Director, Revenue Enhancement Services Manager	Completed	Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics.
Regulatory	Planning and Evaluation Department, CAO, CFO, COO	Completed	Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics.
Billing	Revenue Enhancement Services Manager, COO, Primary Care Services Director	Completed	Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics. Pending amendments to existing managed care contracts for reimbursement of Medicaid/Medicare billable services.
Contracted Services (pharmacy benefits, lab services, after-hour consultation services)	Contracts Manager	By June 1, 2015	Required contracts in place for Harlingen and Edinburg clinic programs.
Integration of Care (integration of EHR, integrated care team meetings)	Primary Care Services Director, Program Services Director CMO, MIS Director, COO	Completed	Completed with co-location of primary care services at Harlingen and Edinburg outpatient clinics.

Focus Area 2: Improve the effectiveness of existing primary care services.

Goal: By June 1, 2015 will improve the effectiveness of existing primary care services by adding medical care coordination services to high risk clients served at our co-located clinics in Harlingen and Edinburg. Goal attainment will be demonstrated by documented evidence of hiring and training 1 full-time equivalent (FTE) care coordinator for the Harlingen primary care clinic and 1 FTE care coordinator for the Edinburg clinic.

Key Action Steps	Person/Area Responsible	Time Frame	Comments

Set salary structure for new positions	COO, CFO, Primary Care Services Director, HR Director	By March 1, 2015	
Develop job descriptions for new positions	Primary Care Services Director, Brownsville Service Center Manager	By April 1, 2015	
Post new positions	HR Department	By April 1, 2015	
Develop interview questions	Primary Care Services Director	By April 15, 2015	
Screen applicants	HR Department	By April 30, 2015	
Schedule interviews	HR Department	By May 15, 2015	
Select and hire	HR Department, Primary Care Services Director	By June 1, 2015	
Complete New Employee Orientation	HR Department	By June 26, 2015	

Focus Area 3: Collaboration in a fully integrated system.			
Goal: By November 30, 2015, TTBH will achieve implementation of collaboration/integration at Level 5 of the IBH continuum as demonstrated by documented evidence of (1) the operating of a co-located primary care clinic at the Brownsville outpatient clinic, and (2) participation of Brownsville primary care medical staff in at least three (3) monthly integrated treatment team meetings (i.e., sign-in sheets, agendas and minutes of three monthly integrated team meetings).			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Begin delivery of primary care services staffed by dedicated clinic team.	Brownsville Primary Care Clinic Staff, Primary Care Director	By July 1, 2015	
Participation in three (3) integrated care team meetings	Brownsville clinic physician, LVN, care coordinator, Primary Care Services Director	By November 30, 2015	Monthly integrated care team meetings have been taking place since April 2014.

Focus Area 4: Expand access to integrated primary care services			
Goal: By April 30, 2020 TTBH increase the number of unduplicated clients receiving behavioral health services at our Brownsville outpatient clinic who also receive integrated primary care services from a physician/physician assistant/nurse practitioner at our co-located clinic annually to 650 by the year ending April 30, 2020.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Deliver integrated primary care services by a physician to 500 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2015 - April 30, 2016	
Deliver integrated primary care services by a physician to 500 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2016 - April 30, 2017	
Deliver integrated primary care services by a physician to 550 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2017 - April 30, 2018	
Deliver integrated primary care services by a physician to 600 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2018 - April 30, 2019	
Deliver integrated primary care services by a physician to 650 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2019 - April 30, 2020	

Focus Area 5: Expand access to integrated primary care services			
Goal: By April 30, 2020 TTBH increase the number of unduplicated clients receiving behavioral health services at our Brownsville outpatient clinic who also receive integrated primary care services from a chronic care nurse at our co-located clinic annually to 200 by the year ending April 30, 2020.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Deliver integrated primary care services by a chronic care nurse to 100 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2015 - April 30, 2016	
Deliver integrated primary care services by a chronic care nurse to 125 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2016 - April 30, 2017	
Deliver integrated primary care services by a chronic care nurse to150 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2017 - April 30, 2018	
Deliver integrated primary care services by a chronic care nurse to 175 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2018 - April 30, 2019	
Deliver integrated primary care services by a chronic care nurse to 200 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2019 - April 30, 2020	

Focus Area 6: Expand access to integrated primary care services			
Goal: By April 30, 2020 TTBH increase the number of unduplicated clients receiving behavioral health services at our Brownsville outpatient clinic who also receive integrated primary care services from a medical care coordinator at our co-located clinic annually to 200 by the year ending April 30, 2020.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Deliver integrated primary care services by a medical care coordinator to 100 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2015 - April 30, 2016	
Deliver integrated primary care services by a medical care coordinator to 125 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2016 - April 30, 2017	
Deliver integrated primary care services by a medical care coordinator to150 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2017 - April 30, 2018	
Deliver integrated primary care services by a medical care coordinator to 175 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2018 - April 30, 2019	
Deliver integrated primary care services by a medical care coordinator to 200 unduplicated clients receiving behavioral health services at the Brownsville outpatient behavioral health clinic.	Primary Care Services Director	May 1, 2019 - April 30, 2020	

Focus Area 7: Expand access to integrated primary care services			
Goal: By April 30, 2020 TTBH increase the number of unduplicated individuals presenting at our Brownsville outpatient clinic during normal business hours who are experiencing a psychiatric crisis requiring inpatient hospitalization who receive an in-house medical clearance evaluation from the clinic physician/physician assistant/nurse practitioner annually to 100 by the year ending April 30, 2020.			
Key Action Steps	Person/Area Responsible	Time Frame	Comments
Provide medical clearance evaluations to at least 100 individuals presenting to the Brownsville outpatient behavioral health clinic during business hours experiencing psychiatric crisis and requiring inpatient hospitalization services.	Primary Care Services Director	May 1, 2015 - April 30, 2016	
Provide medical clearance evaluations to at least 100 individuals presenting to the Brownsville outpatient behavioral health clinic during business hours experiencing psychiatric crisis and requiring inpatient hospitalization services.	Primary Care Services Director	May 1, 2016 - April 30, 2017	
Provide medical clearance evaluations to at least 100 individuals presenting to the Brownsville outpatient behavioral health clinic during business hours experiencing psychiatric crisis and requiring inpatient hospitalization services.	Primary Care Services Director	May 1, 2017 - April 30, 2018	
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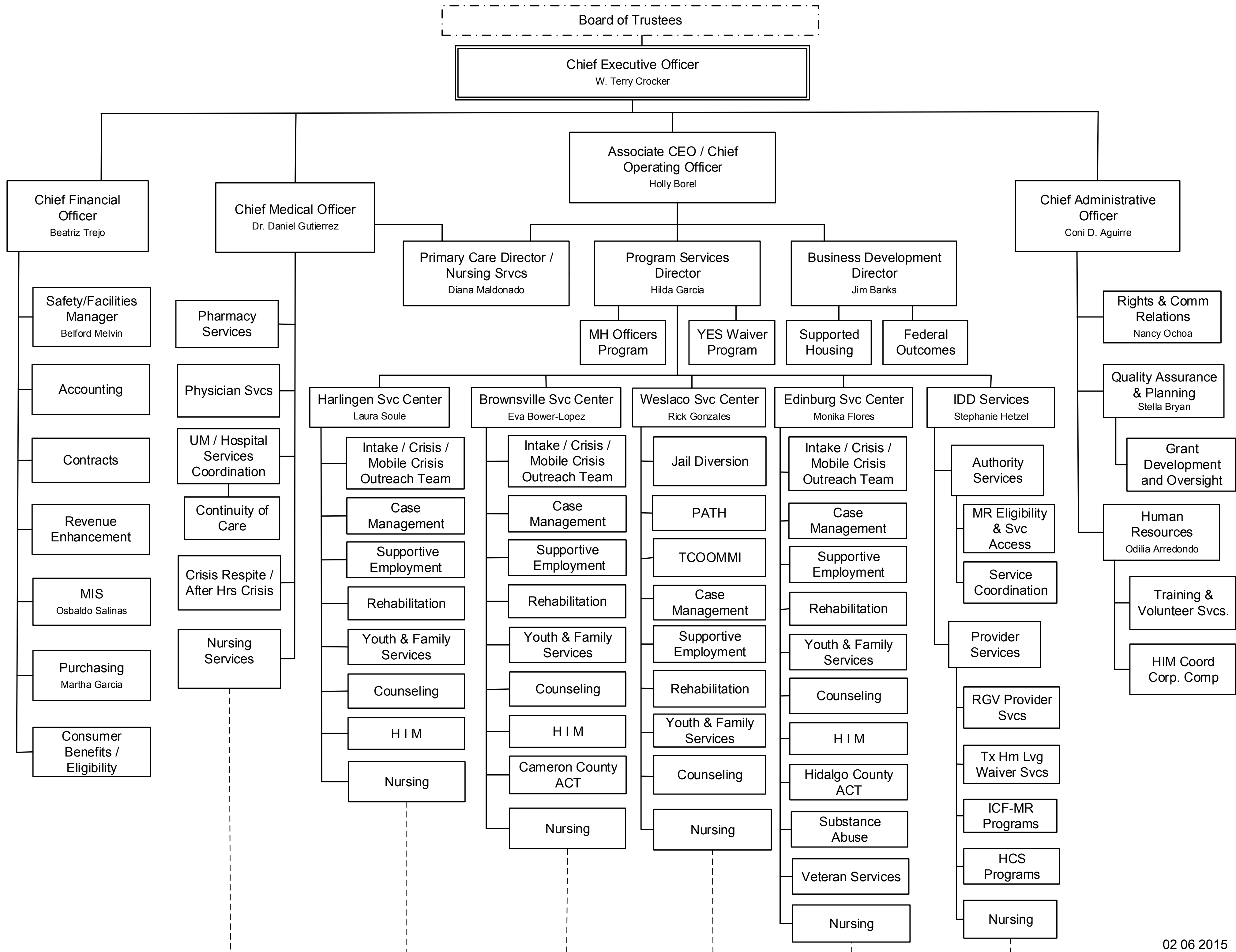

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HIM Coord Corp. Comp
02 06 2015

Abstract

Project Title: Primary Care Behavior Health (PCBH) Implementation
Organization name: University of Texas Health Science Center at San Antonio
Address: Family Health Center, 2821 Michealangelo Dr, Suite 400, Edinburg, TX 78539
Project Director: Deepu George, PhD
Phone number: 956-362-3524
E-mail: georgedv@uthscsa.edu
Funding requested: 691,733 (for 2 years, inclusive of approved indirect costs)

The University of Texas Health Sciences Center at San Antonio presence in the valley was formally established in 2002 with the inauguration of the Regional Academic Health Center (RAHC), contributing to medical education and residency training to retain physicians in Rio Grande Valley as well as the Texas. The associated Family Medicine residencies (FMR) at Edinburg and McAllen work together to prepare physicians to serve the underserved communities with team-based inter-professional and integrated care.

The proposed integrated behavioral health care services will replicate the successful Primary Care Behavioral Health (PCBH) championed by Dr. Kirk Strosahl and Dr. Patricia Robinson of Mountainview Consulting group. In partnership with them, we will implement both onsite and offsite training to help both programs achieve PRACTICE CHANGE to move to a Level 5 of integrated behavioral health. Additional plans for expansion and collaboration with local organizations are outlined in the proposal.

Both Family Medicine Residency programs already provide care to low income members of Hidalgo county. Additionally, some faculty already work with Hope Clinic in McAllen, a free clinic for uninsured, underserved population for the area. Residents will rotate through Hope Clinic to provide care. We will also provide Hope clinic with training, guidance, and tools to increase their level of integration as part of our collaboration with the community.

The purpose of this grant is three-fold: to provide a model for best practices, increase access to care, and by implementing an integrated behavioral health model, prepare young physicians to think about health care of tomorrow as an integrated, inter-professional endeavor.

Need

The target service area is Hidalgo County with a **total population of 811,904** in 2012 and is projected to be **918,291 in 2015** (Regional Healthcare Partnership (RHP) Plan, 2012). Majority of the population **(44%) fall between the ages of 26-64** median age being 32.1, with ages 0-18 at second place (36%). With **91% self-reporting as Hispanic**, the **median household income is $33,218** with a **poverty rate of 34.2%** across all ages (Davila, Rodriguez, Urbina, & Nino, 2104). With over 30% of households living in poverty, 16.9% of children uninsured, the Hidalgo County is a major site for concentrated effects of poverty. Residents living in high-poverty areas deal with higher rates of crime and other structural deficits along with stressful effects of being poor and marginalized without access to resources. They are also less likely to have completed high school, have higher unemployment, and often live below the poverty line. They are more likely to be exposed to environmental hazards and have higher rates of chronic physical as well as mental health concerns (Cohen et al., 2003; Diez-Roux et al., 2001; Quercia & Bates, 2002). For example, rates of depression, asthma, diabetes, and heart ailments are higher. In the Rio Grande Valley/Lower South Texas, **20.4% of respondents** reported **depressive episodes**. These same respondents had an **education that was less than high school** and 16.7% had an income of less that $25,000 (Davila et al., 2104).

Hidalgo County is home to *colonias*, which is defined as an unincorporated settlement of land along Texas-Mexico border that may lack some of the most basic living necessisites, such as drinking water and sewer systems, electricity, paved roads, and safe and sanitary housing. In the 19 counties that make up Rio Grande Valley / Lower South Texas, there are a **total of 1902 *colonias* of which 943 are located in Hidalgo County**(Davila et al., 2104).

The presence of risk factors stemming from concentration of poverty, highest concentration of *colonias*, and additional pressures of being a border town, Hidalgo County presents meaningful opportunities to intervene for several unmet health (physical and behavioral) and substance abuse challenges. The health (physical and behavioral) challenges in this county are therefore multi-factorial; the **challenge of primary care** is to have resources within clinic to address a range of **bio-psycho-socio-cultural problems** and develop **a culture of working in inter-professional teams** to address the vast array of challenges.

Of all the counties in the Rio Grande Valley, **Hidalgo** county has the **second highest rate of suicide (26.9%)** and was **third in rate of overdose death (8.8%) in the year 2011**. Hidalgo county also has the highest rate of drug and alcohol related fatalities (36.9%). These statistics are further compounded by high number of high school dropouts and low college enrolment. Hidalgo also **leads the valley in sexually transmitted diseases**. From a 2012 survey of Texas Department of State and Human Services, the county had the highest reported cases in Chlamydia (N=3172 out of 10,185), Gonorrhea (N=527 out of 1,846), HIV (N=68 out of 188), and AIDS (N=41 out of 20). Closely related sexual behavior reports were teenage pregnancies, with Hidalgo county having the highest reported teenage pregnancies in all categories (Under 14=48, 15-17yrs=993, 18-19yrs=1642).

Hidalgo county has the second **highest adolescent referrals for substance abuse (31.7%)** according to a report in 2013. Out of the 31.7%, only 21.7% received any treatment in Hidalgo county. In the state of Texas, average lifetime alcohol use by secondary students is 58% and in

the Rio Grande Valley/Lower South Texas, respondents aged between 18-19 years of hage had a behavioral risk factor of 27.3%. Similar to Alcohol, the region also has challenges of marijuana, prescription drug abuse and other illicit drugs. This does not include the **19.7% of males and 9.4% of females** who are active smokers. Below are other facts about the healthcare needs of Hidaglo County (Regional Healthcare Partnership (RHP) Plan, 2012):

1. **Only 25%** is covered by **Medicaid**
2. 38% of non-elderly are uninsured
3. Hidalgo County is a **designated Health Professional Shortage Area for mental health**
4. Available mental health care is described as "crisis care only"
5. **31.58 per 100,000 deaths are due to Diabetes**. Diabetes is ranked as the 10th leading cause for Mortality
6. Prevalence of diabetes for adults: 31% in the Lower Rio Grande Valley Region
7. 76% of adults in the region are obese
8. 39% of adults in the Lower Rio Grande Valley reported experiencing chronic depression (depressive symptoms 2 or more years)

These cited needs are compounded further by **lack of appropriate access to healthcare**, especially for those residents who are poor and are uninsured. In the Rio Grande Valley, there are only **15.5 family physicians per 100,000**. There are even fewer behavioral health providers. In 2010, there were 37 psychiatrists in this area and 119 psychologists. Psychiatrists and psychologists often see mental health conditions once they are fully developed or at times are unbearable. This is important especially when physical health conditions co-exist with mental health conditions. In a community mental health survey, patients in a community mental health center had the following rates of chronic physical health conditions:

- 33% had chest pain
- 29% had high blood pressure
- 16% had diabetes
- 10% had seizures

However, with appropriate integration of behavioral health providers in primary care alongside physicians, many mental health conditions can be addressed and prevented from becoming lifelong disabilities. The Regional Health Partnership (2012) identifies "integrating behavioral health services with physical health service is an important priority for improving the coordination and quality of care for individuals with co-occcurring conditions".

Training needs of current staff in preparation for providing integrated care:
Nearly 70% of all healthcare visits are psychosocial and 50% of behavioral health care in the US is provided by primary care physicians (California Primary Care Association, 2007; Strosahl, 2002). Family medicine residencies therefore have a commitment to training residents on behavioral health and psychosocial aspects of healthcare. Both sites currently have varying degrees of training for physicians on behavioral health issues with the Edinburg program having one provider providing basic psychotherapy services. The grant will help both programs scale up to a higher level of integration.

Project Description

Stage of behavioral health integration, how that was determined, and discussion of expanding, enhancing, or replicating and why your approach is innovative.

Levels of integration: The McAllen FMR program serving the area for 30+ years has minimal integration of behavioral health services. Based on practice history and referral patterns, the program is COORDINATED at LEVEL 2 (Basic collaboration at a distance). Physicians (7 faculty and 18 residents) will refer patients out to psychiatrists or other mental health providers, communicate based on referral notes and some phone consults, and rely on each other to provide necessary behavioral health care. The Edinburg FMR program is welcoming its first class of 6 residents has a Behavioral Scientist located in the family medicine clinic. The program at the moment – has 3 faculty physicians seeing patients and 1 behavioral science faculty providing brief consults and psychotherapy as necessary – functions as CO-LOCATED at LEVEL3 (Basic collaboration onsite). Currently, physician notes are electronic while behavioral health notes are based on paper charts (plan for integrated EMR will launch in May). Providers communicate often with behavioral health provider, with no predictable patterns or established work-flow for referrals. Two providers at this site (Deepu George and Eron Manusov) worked previously in an integrated behavioral health system that emphasized an inter-professional model of care.
With a strong team of primary care providers, both programs, aligned with MHM theory of change aim to achieve PRACTICE CHANGE by becoming a fully INTEGRATED (LEVEL 5) behavioral health system – with goals of addressing population based needs, provide evidence based care, reduce the burden on PCP through creation of integrated team, and better appreciation of different professions as part of the team.

In partnership with Mountainview Consulting group, we will replicate the evidence based Primary Care Behavioral Health model (PCBH) at UTHSCSA (UT-RGV) Family Medicine Residency (FMR) Programs at Edinburg and McAllen. Mountainview Consulting Group (MCG), Inc. is a consultation firm that specializes in design, implementation and evaluation of integrated primary care behavioral health programs. The two principal owners of the company are Patricia Robinson, Ph.D., Director of Training and Program Evaluation, and Kirk Strosahl, Ph.D., President. Both Dr. Robinson and Dr. Strosahl are licensed Psychologists in Washington. MCG was incorporated in the state of Washington in 1999. Dr. Robinson and Strosahl have been instrumental in training and implementing the Primary Care Behavioral Health (PCBH) model in several national and international health systems including prominent institutions such as the U.S. Air Force (Air Force Medical Operations Agency (AFMOA), 2011), the Department of Defense (Department of Defense, 2013) University of Arkansas Medical Systems' Family practice residency programs. Deepu George PhD (Behavioral science faculty from Edinburg FMR) and Eron Manusov MD (Program director for Edinburg FMR) has experience in developing and formalizing an integrated behavioral health model (a partial implementation of the PCBH model) previously at the Due/Southern Regional Area Health Education Center (Duke/SR-AHEC) FMR. To respond comprehensively to the needs of our population in Hidalgo County and to increase population based care delivery, we (both programs) have decided to implement and train our staff and providers in the PCBH model – an integrated behavioral health model.

Describe the integrated care model including: Integration of primary medical and behavioral health care; Use of team-based integrated model of care that incorporates behavioral health services and primary care and Any innovative components

Scope of PCBH model: The PCBH model integrates a Behavioral Health Consultant (BHC) as part of the primary care team and works in close proximity with the Primary Care Provider (PCP). Trained to function as a generalist consultant in for PCP, the BHC addresses life-style based somatic complaints (headaches, irritable bowel syndrome, obesity, psychosomatic manifestations), sub-threshold syndromes (martial conflict, intimate partner violence), preventive care (behavior activation, adopting healthy behavior), and chronic diseases (diabetes, hypertension, depression). The PCBH model understands the busy and fast pace nature of primary care (PC) and focuses attempts at integration to reduce the burden on the PC system. The model not only responds to time crunch many PCPs experience with heavy, complex patient loads but also strengthens the lack of behavioral health and psychosocial management skills many PCPs do not receive in training. The most common response behavioral health issues is to prescribe an SSRI while a reasonable alternative to medication would be a strong dose of behavioral interventions. With increasing challenges of patient care in PC and the presence of an underserved population with several unmet health (behavioral and physical) needs in Hidalgo County, a sensible integration should be able to do the following (P. Robinson & Reiter, In press)

1. Integration must improve identification of undiagnosed problems
2. Integration must help with ALL behaviorally influenced conditions
3. Integration must subtract from, not add to, the workload of PCPs
4. Integration must help PCPs improve behavior change skills
5. Integration must improve care outcomes in PC
6. Integration must help decrease the medication culture of PC
7. Integrated care must be accessible
8. Patients must perceive integrated care as routine care
9. Long visits and frequent followups must be avoided to enable access

The PCBH model therefore is patient centered, population-based, evidence based integrated behavioral health approach that has the capacity to respond to needs of a population. This model mirrors the MHM theory of change to improve physical and mental health conditions in the valley with measurable outcomes as well as place an emphasis on sustainability. By implementing this model at two FMR programs, we not only increase access to needed behavioral health services in the area but also affords new roles, responsibilities, and learning opportunities for the primary care physicians of tomorrow for the Rio Grande Valley.

The PCBH Model Description: The behavioral health provider is referred to as a Behavioral Health Consultant (BHC) – distinct from a traditional *therapist* role, which are more common in the co-located, coordinated levels of integration. For the BHC, the primary customer or referral source is the PCP rather than the patient/client in the traditional mental health model. A great deal of communication occurs between PCP and BHC, especially to follow-up on treatment plan and patient progress. BHC functions as a team member and is highly accessible (on-demand access) as compared to a therapist who functions autonomously and sees patients based on schedule. Because primary care (PC) is a team based environment, the BHC should mimic this behavior and become part of the coordinated team. This involves the BHC being located within

the workspace, having fluid schedule to increase accessibility, and helping out as needed (providing a follow up plan, calling a patient in crisis, review of psychiatric history, meeting patient). The BHC maintains high accessibility with the capacity to meet patients same day with a standard meeting of 30 minutes (usually shorter), ensuring that PCPs and patients can receive immediate attention. A typical BHC schedule can accommodate about 14 patients (30 minutes per visit), maintain the practice pace of a typical PC. And because PCPs often have a wide problem scope (knows little about a lot), the fit of the BHC as a team member is dependent on their generalist skills. In the PCBH model, the BHC utilizes a consultant approach in which he sees any behavioral problem the PCP sees. The BHC will help with all ages, all manner of psychiatric and substance abuse problems, behavioral medicine conditions, preventive care, and any other problem that is behaviorally driven. Thus, a BHC must have a broad knowledge base and solid generalist skills that enable him to take all comers.
In this model, the ownership of mental health care is still led by the PCP as the BHC join forces with PCP to help as needed. This not only helps the patient feel connected to the PCP but will experience the BHC as a team member. Working as a regular PC team member alongside the PCP often allows a BHC to inherit the PCP's "halo," which allows for building rapport in much less time. Thus, in the PCBH model, the BHC must be effective with patients and PCPs alike. The BHC must provide concise and relevant recommendations to the PCP, so as not to slow her down, and look for ways to share some of the PCP's workload. The BHC must also always develop a clear *patient change plan* (i.e., a printed or written plan concerning one or more specific behavior changes to improve patient functioning), based on empirically supported interventions for both the patient and PCP to follow.

PCBH and population health The American Medical Association notes that community or population interventions succeed by making small changes in a large number of people rather than large changes in a small number of people. Mirroring this perspective, the PCBH model aims to make general behavior change services more accessible, with the goal of improving the health of the general population. Being located in PC, where care is provided across the lifespan, the BHC is offered numerous opportunities to encourage small lifestyle changes or coping practices over time; the BHC is also able to help with prevention, as well as treatment of acute and chronic conditions. Based in public health and epidemiology, the BHC (and the PCBH model) therefore strives to:

- Focus on raising health of the population
- Emphasis on early identification and prevention
- Designed to serve high percentage of population
- Provide triage and clinical services in stepped care fashion
- Use "panels" instead of "clinical case" model
- Provide measurement based care

For example, every time a patient visits a primary care clinic someone takes their blood pressure. The PCBH model will use a similar strategy to identify behavioral health indicators to track outcomes for treatments of various behavioral health conditions. Tracking how well the patient improves overtime not only helps the provider make appropriate adjustments, it also helps the patient recognize that when they engaged with the PC Team (PCP and BHC) and followed through on appointments, they felt and performed better. This is called measurement based care.

More broadly than the individual patient, a BHC is conceptually concerned with: reaching the population with a certain condition, teaching effective behavior change strategies to PCP to increase their effectiveness, or identifying education gaps (health literacy challenges) about disease conditions. When such broad based ideas are implemented into specific plans (establishing a screening for depression, developing a class on parenting for families with adolescents, or holding afternoon lectures to teach PCPs motivational interviewing), many in the population can benefit even without the BHC being always present. (See attached figure of workflow at the end of document).

Innovative components: To ensure full implementation and ensure success of moving to a Level 5, we will have direct support from Dr. Robinson and Strosahl through onsite and off-site support. They have expertise in implementing such a model in several FMR settings. In addition to receiving direct training from the authors of this model to ensure high fidelity, we are developing a web-based patient registry in partnership with UTHSCSA Department of Epidemiology and Biostatistics. Population-based care, measurement-based care, and measurements-based treatment to target (for example, a 20% reduction in PHQ9 score) are important notions in integrated care and helpful in managing chronic conditions. A web-based registry is recommended (Unutzer, Choi, Cook, & Oishi, 2002) to structure encounter with patients, identifying those who are not improving, prompting changes in treatment, and tracking effectiveness across providers and caseloads. This registry will better manage population health, ensure sustainability for our implementation, make data informed treatment decisions and feedback on our performance. The registry will also serve as a main data source for evaluation of effectiveness of the implementation and impact of this replication for both FMR sites. The registry can serve as a model for future replications locally and act as an infrastructure for data collection and management.

Describe evidence based practices on which the IBH interventions are based. Be sure to include the level of evidence and how the level was determined. Describe how you are tracking outcomes and their results.

The PCBH model is a well-known, widely practiced, nationally and internationally implemented model. Several major health systems such as the Department of Defense's primary care clinics (Department of Defense, 2013) and the United States Air Force (Air Force Medical Operations Agency (AFMOA), 2011) have implemented the model. In the report titled *Evolving models of behavioral health integration in primary care* by the Millbank Foundation (Collins, Hewson, Munger, & Wade, 2010), the PCBH model was designated as a fully integrated model.

The model began with the work and writings of Kirk Strohsal (Strosahl, 1998), a clinical psychologist and one of the founders of the trans-diagnostic, third-wave behavior therapy known as Acceptance and Commitment therapy (talked about later). Patricia Robinson and Jeff Reiter completed the first edition of the book titled "Behavioral health consultation and primary care: A guide to integrating services" (2007; In press) and is working on the second edition. Based on the following studies, the PCBH has MODERATE EVIDENCE. All studies use a BHC, a core component of the PCBH model.

Impact of behavioral health consultant interventions on patient symptoms and functioning in an integrated family medicine clinic (Bryan, Morrow, & Appolonio, 2009)
Abstract: Patterns of symptomatic and functional change associated with behavioral health consultant (BHC) intervention in an integrated family medicine clinic were investigated among 338 primary care patients under routine conditions without exclusion. Patients were referred to the BHC by primary care providers (PCPs) and participated in one to four brief, behaviorally oriented appointments in primary care. The Behavioral Health Measure-20 (BHM) was completed at each appointment. Results indicated that higher levels of distress at baseline were associated with more follow-up appointments, and that patients demonstrated simultaneous, clinically meaningful improvement in well-being, symptoms, and functioning in as few as two to three BHC appointments. Patterns of clinical improvement support the effectiveness of BHC interventions, but contradict the phase model of psychotherapy (Howard, Lueger, Maling, & Martinovich, 1993)

Using behavioral health consultant to treat insomnia in primary care: A clinical case series (Goodie, Isler, Hunter, & Peterson, 2009)
Abstract: Cognitive–behavioral treatments for insomnia are as effective as medications and have longer lasting effects. The current study used a clinical case series design to evaluate the effectiveness of a brief behavioral intervention for insomnia delivered in a non-research, real-world family medicine clinical setting. Participants included 29 sleep impaired patients who were seen regardless of their comorbid conditions. The treatment included three brief visits with a behavioral health consultant (BHC), plus the provision of a self-help insomnia treatment book. At post treatment 83% of participants achieved a mean sleep efficiency 485%, as compared to only 14% at baseline. Limited-contact behavioral treatment of insomnia delivered by BHCs within a collaborative care family medicine clinic effectively reduced symptoms of insomnia, regardless of comorbid medical diagnoses.

Longitudinal outcomes after brief behavioral health intervention in an integrated primary care clinic (Ray-Sannerud et al., 2012)
Abstract: The primary aim of the current study was to obtain information about the longitudinal clinical functioning of primary care patients who had received care from behavioral health consultants (BHCs) integrated into a large family medicine clinic. Global mental health functioning was measured with the 20-item self-report Behavioral Health Measure (BHM), which was completed by patients at all appointments with the BHC. The BHM was then mailed to 664 patients 1.5 to 3 years after receipt of intervention from BHCs in primary care, of which 70 (10.5%) were completed and returned (62.9% female; mean age 43.1 12.7 years; 48.6% Caucasian, 12.9% African American, 21.4% Hispanic/Latino, 2.9% Asian/Pacific Islander, 10.0% Other, 4.3% no response). Mixed effects modeling revealed that patients improved from their first to last BHC appointment, with gains being maintained an average of 2 years after intervention. Patterns of results remained significant even when accounting for the receipt of additional mental health treatment subsequent to BHC intervention. Findings suggest that clinical gains achieved by this subset of primary care patients that were associated with brief BHC intervention were maintained approximately 2 years after the final appointment.

As mentioned earlier, PCBH interventions are based on a trans-diagnostic, third-wave behavior therapy known as Acceptance and Commitment Therapy (ACT). In her latest writing, Robinson

(2015) makes a case that primary care is the setting where most people seek relief from suffering and the PCBH model offers a platform for ACT. According to one of the founders Steven C Hayes, the core of ACT can be stated simply as: make room for difficult thoughts and feelings without entanglement or avoidance; learn to come into the present moment consciously and to attend more flexibly to what is important; link this emotional, cognitive, and attentional flexibility to values-based choices; build these choices out into larger and larger patterns of committed action (https://www.psychologytoday.com/blog/get-out-your-mind/20140/behavioral-science-and-local-empowerment). Since 1986, there have been 110 randomized clinical trials of ACT and its impact on various behavioral health and psychosocial concerns. ACT have been found to significantly improve a wide range of primary care conditions such as depression, tobacco cessation, chronic pain experiences, anxiety, diabetes, parent-child outcomes, aggressive behavior, emotional dysregulation and other conditions. Several of the studies reported are from primary care settings. Due to limited space, I have attached the list of randomized clinical trials of ACT along with the levels of evidence for PCBH. I have also attached Robinson (P. J. Robinson, 2015) manuscript (directly from author) reflecting the latest evolution of PCBH and ACT.

As mentioned in the previous section, through the use of a patient registry system, we will keep track of all implementation processes and outcomes of the replication.

Describe how the proposed IBH project is a cost-effective approach for meeting the behavioral health needs of the target population given the level of behavioral health care resources currently in the service area. Include information on community return on investment, if known. Explain why the cost per patient is reasonable.

Unmet behavioral health needs not only cost suffering for individual, but is a burden on the economic, social, healthcare systems. The Patient Centered Primary Care Collaborative released two slide Decks in 2014 (https://www.pcpcc.org/resource/behavioral-health-integration-pcmh) on “Why integration is critical” and “Where and how integration is happening?” Key points from their work shows that:

- PC is burdened with behavioral health needs, which often go undetected or untreated
- As physical health worsens, the odds of having mental illness increase
- Depression and Anxiety are among the Top 5 conditions that drive overall healthcare cost
- Depression leads the pack in the top 10 costliest conditions for employers
- Additionally, people who are depressed, anxious, and experiencing other stressors, are likely to use the healthcare system twice as much making costs high.
- Untreated mental disorders in chronic illness are projected to cost commercial and Medicare purchasers between $130 and $350 billion annually

Thus the socio-economic benefits from improving care for behavioral health conditions and improving access can reduce overall health expenditures, especially for unnecessary usage; decrease turnover from employment and days lost at work; and reduce indirect cost on providers, family members, and larger healthcare system who are involved in caring individuals with depression or other behavioral health experiences.

The report from Patient Centered Primary Care Collaborative also noted that:

- Medical use decreased by 15.7% for individual receiving behavioral health treatment, but increase by 12.3% for those who did not receive any treatment
- Treatment provided to diabetics with depression resulted in $896.00 lower total health care cost over 24 months.
- Depression treatment in primary care resulted in $3,300 lower total healthcare cost over 48 months.
- Multi-condition collaborative care for depression and diabetes saved $594 per patient over 24 months.

Hidalgo County is a region concentrated in poverty, low access to healthcare, and a designated health professional shortage area. The UTHSCSA presence in the valley (and soon to be established University of Texas Rio Grande Valley School of Medicine) has historical commitment to increasing access to medical care in the valley. The implementation of PCBH model increases our capacity to respond comprehensively to the needs of the population in a cost-effective manner in the long run and train family physicians who understand the importance of such integrated models of care for their future practice. Based on above evidence and reviews, increasing access to behavioral health through PC and integration has better outcomes and impact than usual care for behavioral health. In planning for the implementation, we will explore methodological ways to measure the impact on cost savings and return on investment.

A) **Provide a comprehensive work plan.** (See Work plan attachment)

B) **Describe how the organization will ramp up to achieve the outcomes. Provide a time line**

With direct collaboration (both onsite and offsite) with Dr. Robinson and Dr. Strosahl, both FMR sites will plan, train, and implement the model (pre-launch assessment, hiring of personnel, core competency training for BHCs, development of protocol, consultation process, and population based screening) by January 2016. With program monitoring, implementation of patient registry to track outcomes, and support from Dr. Robinson and Dr. Strosahl, we will evaluate our fidelity to the PCBH model. Using the PCBH Tool Kit (https://www.dropbox.com/sh/zgbqw40g8b79nk0/AADNSHFixerMpvGsCOcX3RgNa), we will track our organizational levels of integration and develop various other elements to create a "PRACTICE CHANGE" to reflect a LEVEL 5 of Integration. Dr. Matiana Gonzalez-Wright will lead team meetings identify opportunities for quality and process improvements to ensure our shift to a fully integrated care PC. By the end of year 1, our aim is to function at LEVEL 5 of integration reflecting practice change.

The Edinburg FMR program is currently in the process of getting certified as Patient Centered Medical Home (PCMH). PCMH standards (http://www.annfammed.org/content/12/2/183.2) call for integrated services, which includes provisions for direct behavioral health services in primary care, whole person orientation, coordinated and integrated care, enhanced access and physician directed care. The Edinburg FMR therefore has an emphasis on inter-professional care in an established PCMH. With additional resources like PharmD training, medical student education, the program is committed to planning, executing and evaluating a complex integrated care program. The PCMH certification processes directly influences practice change in the system

and therefore will ramp up the implementation and acceptance of the PCBH model. Additional details are provided in the work plan.

C) Describe how the following competencies of behavioral health integration will be achieved by the end of the 5 year period: shared patient scheduling, shared treatment planning, shared service provision, and shared record keeping.

(See work plan for details)

D) Describe any current or future scalability possibilities. Include information about support from key program stakeholders for expansion of services to more clients, replication of the program in additional sites and/or increasing the level of integration of their services.

Once both the sites are fully functioning on the PCBH model, we will partner with other Graduate Medical Education program primary care clinics to increase integrated behavioral health solutions. For example, the internal medicine residency program has expressed interest in having an integrated behavioral health program in their site. Similarly, we will partner with the Psychiatry residency program (to be established in 2 years by University of Texas – Rio Grande Valley) in the future to involve the role of a consultant psychiatrist as part of our PCBH personnel. The collective experience of implementing the PCBH model will have direct implications for two community wide projects in the valley aimed at reducing healthcare disparities and increase access to integrated, inter-professional services. The Valley Inter-professional Development and Services (VIDAS) program, recently funded by United Health Foundation seeks to unite the region by building a consortium of integrated inter-professional collaborative to create a sustainable model for health care to the most vulnerable populations in the region. The VIDAS program will utilize mobile health clinics and tele-health to promote integrated and inter-professional care to meet physical and behavioral health needs in areas with poor and underserved populations of the region. A second project focuses on providing integrated primary and behavioral health care to triply diagnosed adolescents in the valley. This intervention project focuses adolescents who have three major diagnoses: a chronic disease, a diagnosed/diagnosable mental health condition, and an appetitive drive disorder (any form of addictive behavior). The project site is the John Austin Pena clinic in Edinburg, TX. The collective experience of implementing PCBH model at two FMR sites, use of the patient registry, and evaluative measures to ensure fidelity will prepare the faculty and residents from both programs to share insights to these projects to increase integrated behavioral health options. Eron Manusov MD, the program director of the Edinburg FMR is the Co-PI on both of these projects. Curtis Galke DO, Deepu George PhD, and Marcela Riojas MD from the Edinburg Program and Eric Peterson MD and Maria Colon-Gonzalez MD from the McAllen program are all involved in the triply diagnosed project.

Evaluative Measures

Please describe organization's existing evaluation capacity. You may include a past evaluation as an example of evaluation experience. Samples might include recent program evaluations, statistical reports with recommendations on how to address the findings in

program operations, etc. What are the key elements of the evaluation? Did it include process measures? Outcome measures? How were data collected and validated?

Existing Evaluation Capacity
The University of Texas Health Science Center at San Antonio has a historical commitment to the Lower Rio Grande Valley evidenced by the presence of Regional Academic Health Centers (RAHC) in Harlingen (established in 2002) and Edinburg (established 2006). The RAHC's strength lies in community-based teaching approach which attracts students. To date over 1000 medical students have completed their portion of training in the Valley. The RAHC has also successfully started and maintained an Internal Medicine Residency program since 2002. The RAHC has a two research units – the Medical Research Division (http://www.rahc.uthscsa.edu/MRD/index.aspx) and the Clinical Research Unit (http://www.rahc.uthscsa.edu/CRU/index.aspx). The Clinical Research Unit has helped manage and support research initiatives that directly impact health care information and services. For example, the South Texas Environmental Education and Research (STEER) provides training for health professionals of all levels (physicians to promotoras/community health workers) to address environmental and public health concerns that affecting South Texas, the Texas-Mexico Border and the Nation (Report attached).

Other than the institutional capacity to implement health care delivery, knowledge, and training, each of our programs remain committed to improving quality of our services. All FMR faculty in Edinburg and some faculty at McAllen FMR have completed a UTHSCSA led Clinical Safety and Effectiveness certificate program focused on quality improvement and patient safety. Dr. Gonzalez-Wright is a certified Six Sigma Master Black Belt. Under her guidance she has developed the following curriculum for the McAllen FMR.

Quality Improvement Curriculum: Beginning in January 2014, a 6-month quality improvement curriculum for the McAllen Family Medicine Residency Program was designed around the data-driven Six Sigma improvement cycle of DMAIC, reserving 1 month for each of the steps in the process: Define, Measure, Analyze, Improve, Control, and 1 month for conclusions and final presentations. This consisted of a combination of weekly lectures and opportunities for team time.

Two projects, with one focused on compliance with medication reconciliation and another focused on reducing patient visit turnaround time, were launched in January 2014, run and lead by faculty. Projects were led by faculty and included dividing our 18 residents into 2 groups, consisting of 3 PGY1, 3 PGY2, and 3 PGY3, with increasing responsibility for upper levels, as well as any other clinic staff members involved in the process. These efforts were met with the successful completion of both projects, with 1 of the them winning the 1st place award for 'New Projects' at the 2014 UT Shared Visions: Improving Systems to Improve Lives Conference. Both projects have showed significant improvements in their intended outcomes and this curriculum was adapted and appropriate changes were made for the 2nd semester which began in July 2014. Two additional projects have successfully embarked while the previous 2 are being monitored and addressed via a monthly dashboard

This curriculum has provided educational opportunities for residents and faculty to look at medicine and patient care from different perspectives, improving the overall delivery of health care and the quality of graduate medical education at the UTHSCSA McAllen Family Medicine Residency Program. Faculty, residents, and clinic staff have become very engaged and have taken much interest in improving various aspects of the program's patient care and operational efficiency. The McAllen FMR has also completed a process improvement project to improve physician documentation for coding and billing. The aim of the project was to improve CPT coding accuracy supported by three key components: History, Exam, & Decision-making from a baseline of 20% to 100% as well as the timely completion of resident documentation of outpatient visits within 12 hours from a baseline of 79% to 100% by June 2015. The Edinburg FMR has launched a project on patient throughput to improve overall cycle time and time with physician. Dr. Gonzalez-Wright continues to provide leadership and consultations on these projects.

Recent evaluation project attached separately

Lead evaluation personnel:

Matiana Gonzalez-Wright, EdD, MeD
Assistant Professor
Department of Family & Community Medicine – UTHSCSA
McAllen Family Medicine Residency Program

Dr. Gonzalez-Wright has experience in the oversight and management of the collection, analysis, and reporting of data necessary for institutional policy analysis, strategic planning, and decision making in healthcare and academic settings. She also has evaluated institutional effectiveness in accordance with the accrediting bodies of healthcare institutions and universities. She is a GE Healthcare Certified Six Sigma Master Black Belt with multiple project successes. Dr. Gonzalez-Wright holds Masters of Education and Doctorate of Education degrees from The University of Texas at Austin. She completed a National Cancer Institute post-doctoral fellowship researching breast cancer and obesity prevention among minority populations. She has also practiced as a community and clinical Registered Dietitian.

Deepu George, PhD, LMFT-A
Assistant Professor
Department of Family & Community Medicine – UTHSCSA
Edinburg Family Medicine Residency Program
Dr. George completed his doctoral work in Human Development & Family Science and specialized in Family Therapy. He completed a yearlong residency training in Medical Family Therapy & Integrated Care at the Duke/SR-AHEC Family Medicine Residency in Fayetteville, NC. He has experience working in an integrated behavioral health model by directly providing clinical services with primary care physicians (residents and faculty), providing lectures on behavioral science topics to residents (Family medicine and pharmacy). His focus as the behavioral science faculty is to promote an integrated behavioral health clinic as well as education. He worked as a Graduate Research Assistant with Dr. Jay A. Mancini on several Department of Defense and Army projects focused on program development, evaluation, and

basic research on issues related to effects of community programs, deployment, and re-integration on military families.

Mountainview Consulting Group – Patricia Robinson PhD, Kirk Strosahl PhD, Jeff Reiter PhD

Founders of PCBH Model - http://www.mtnviewconsulting.com/#!about2/c4nz

Kirk Strosahl, PhD, is a cofounder of Acceptance and Commitment Therapy, a cognitive behavioral therapy that has gained widespread adoption in the mental health and substance abuse community. He is the author of numerous articles on the subjects of primary care behavioral health integration, using outcome assessment to guide practice and strategies for working with challenging, high-risk, and suicidal clients. He is well-known nationally for his innovative approach to the integration of behavioral health and primary care services.

Patricia Robinson, PhD, is a pioneer in the use of Acceptance and Commitment Therapy in primary care and other brief intervention settings. She participated in several of the initial studies documenting improved outcomes with integration of behavioral health services into primary care. She is the author of numerous articles, book chapters and books on primary care behavioral health integration and brief interventions. She has also authored several self-help books. She trains for health care systems, large and small, all over the world.

Dr. Jeff Reiter, PhD is co-author of the book Behavioral Consultation and Primary Care: A Guide to Integrating Services and is co-director of primary care behavioral health services for Healthpoint Community Health Centers, near Seattle, Washington. In 2008, he was one of three consultants contracted by the US Air Force to help them implement integrated care services throughout their bases worldwide.

Jay A. Mancini, PhD

Anne Montgomery Haltiwanger Distinguished Professor
Department of Human Development & Family Science
Director, Family & Community Resilience Laboratory
The University of Georgia

Jay A. Mancini is the Haltiwanger Distinguished Professor at The University of Georgia and head of the Department of Human Development and Family Science. He is also Emeritus Professor of Human Development at Virginia Polytechnic Institute and State University (Virginia Tech). Dr. Mancini's work has focused on lifespan human development, community systems, building community capacity, military family support systems, time-use and families, and psychological well-being. Throughout his career the focus has been on resilience and vulnerabilities of individuals, families, and communities, and their multiple intersections. His program development and evaluation research has been funded by Andrus Foundation, the National Institute on Aging (NIH), U.S. Department of Agriculture, Virginia Department of Mental Health, U.S. Department of the Air Force, U.S. Department of the Army, and U.S. Department of Defense (Military Community and Family Policy Directorate), totaling more than $15M. He has been a consultant with Oak Ridge National Laboratory (TN), America's Promise Alliance (D.C.), Caliber Associates (Fairfax, VA), Family Research and Analysis (Greensboro, NC), Social Research Applications Corporation (D.C.), and the Human Services Research and Design Laboratory (UNC-Chapel Hill). He has also been a consulting Research Sociologist to the National Park Service, U.S. Department of the Interior.

Dr. Mancini researches the intersections of resilience and vulnerabilities within family and community contexts. Active research projects included quantitative studies on adolescents in military families, as well as whole-family research, also focused on military families. Dr. Mancini's theorizing focuses on families within the context of communities.

Describe the process by which progress toward enhancement, replication or expansion of the IBH project will be tracked and any measures that will be utilized in these assessments. Refer to your logic model as needed.

Effective management of chronic health conditions requires a coordinated team and shared information. Biostatisticians at UTHSC San Antonio School of Medicine's Department of Epidemiology & Biostatistics (DEB) will work with us to create a web-based registry. The DEB is closely involved in numerous interdisciplinary research activities throughout UTHSCSA and has assisted investigators in conducting high quality clinical and translational research. The department provides the methodological and biostatistical support throughout all stages of the research process, including protocol review, protocol development and methodological consultation on study design, statistical consultation, and provision of exploratory and sophisticated data analysis.

This web-based registry will help facilitate a shared care plan to collaboratively treat medical and behavioral health conditions. In addition, it track patient progress and goals, identify patients who need more help, and share this information with the care team. The registry will support the core principles of effective integrated care resulting in better clinical outcomes and will provide information to help us determine if and when we achieve our target to treatment goals. Other indicators including quality of life, hospital admissions and readmissions, patient satisfaction, cost of service, patient clinical assessments (Duke Health Profile, PHQ-9, GAD 7), utilization patterns (i.e. ER room use), and BMI metrics will help to determine the effectiveness of the program.

Throughout implementation, we will also be checking internal consistency of provider behavior (BHC and PCP) and other system factors / behaviors in ensuring a shift to LEVEL 5. For example, we will look at short term outcomes such as regular use of population based screening tools, percentage of same day consults, provider and patient satisfaction, number of consults averaged by the BHC, and billing practices. Mountainview Consulting group will provide off-site distance consultations on sharpening BHC skills in primary care, targeting specific disease conditions, developing and sustaining "pathway" protocols to address conditions (chronic pain pathway, relational distress pathway, substance use pathway, smoking cessation pathway etc.,).

Describe your current process of data collection and use. Describe what types of data are currently collected and how that informs the objective, outcomes and improves programming.

Currently, in order to sustain improvements and track performance of quality improvement initiatives that have been conducted at the MFMRC, monthly metrics are collected and tracked on a dashboard. Data can be collected using various sources including the EMR, patient tracking logs, manual data collection tools, and REDCap – a self-managed, secure, web-based system that is designed to support data collection strategies for research studies. These metrics are reviewed by key stakeholders and compared to program goals and performance specifications. Each

project is assigned an owner who is responsible sustaining the improvements made and making further improvements if necessary. If data indicate that performance is not meeting the project goal, the owner is held accountable for making improvements through the use of team meetings and various performance improvement tools. A quality improvement expert is available at all times to guide owners on making and sustaining the improvements made.

Quality Improvement initiatives completed and tracked to-date include Patient Throughput, Medication Reconciliation, Patient Satisfaction and Improving Physician Documentation for Coding and Billing. Plans are to incorporate a similar tracking infrastructure at the Edinburg Family Medicine clinic.

Collaboration

Formal and Informal Collaborations with community organizations/providers and how these collaborations support the proposed project and increase the overall behavioral health of the target population. Describe how the collaborations will be strengthened, if needed in support of the proposed project.

Tropical Texas

In January 2015, the McAllen program has recently launched a collaboration with Tropical Texas Behavioral Health Center in Edinburg, a community mental health and mental retardation center in the State of Texas established under House Bill 3. Tropical Texas Center is dedicated to providing person centered mental health, intellectual and developmental disabilities and substance abuse services for individuals of Cameron, Hidalgo and Willacy Counties. Senior residents rotate at Center one full day a week, dividing their time shadowing the center's psychiatrist and working with the family medicine clinic physician to treat psychiatric patients with co-morbid conditions including diabetes.

In 2008, the following programs at Tropical Texas Behavioral Health received a three year accreditation from the Commission on the Accreditation of Rehabilitation Facilities (CARF) International: Assertive Community Treatment: Mental Health (Adults); Outpatient Treatment: Mental Health (Adults); Outpatient Treatment: Mental Health (Children and Adolescents); and Residential Treatment: Integrated DD/Mental Health (Adults). As a result of the 2011 CARF survey, TTBH added Case Management (MH) and Crisis Services to the list of CARF accredited programs.

The Valley Inter-professional Development and Services (VIDAS) program recently funded by United Health Foundation seeks to unite the region by building a consortium of integrated inter-professional collaborative to create a sustainable model for health care to the most vulnerable populations in the region. The VIDAS program will utilize mobile health clinics and tele-health to promote integrated and inter-professional care to meet physical and behavioral health needs in areas with poor and underserved populations of the region. The collaborative care model will prove useful to manage population level outcomes and will be implemented as seen fit in the future. A second project focuses on providing integrated primary and behavioral health care to triply diagnosed adolescents in the valley. This intervention project focuses adolescents who have three major diagnoses: a chronic disease, a diagnosed/diagnosable mental health condition, and an appetitive drive disorder (any form of addictive behavior). The project site is the John

Austin Pena clinic in Edinburg, TX. The collective experience of implementing collaborative care at two FMR sites, use of the patient registry, and evaluative measures to ensure fidelity will prepare the faculty from both programs to share insights to these projects to increase integrated behavioral health options. Eron Manusov MD, the program director of the Edinburg FMR is the Co-PI on both of these projects. Curtis Galke DO, Deepu George PhD, and Marcela Riojas MD from the Edinburg Program and Eric Peterson MD and Maria Colon-Gonzalez MD from the McAllen program are all involved in the Triply diagnosed project.

The Post-Partum Project: Pain Control, C-Section and Breastfeeding (2014-2105)
The McAllen FMR is in collaboration with Universal Health Services Facilities McAllen Medical Center and The Women's Corner at Edinburg Regional Medical Center to conduct a prospective randomized controlled study comparing oral ibuprofen provided around the clock versus PRN for postoperative pain control after elective cesarean delivery and their effects on breastfeeding. Objectives are to help understand postoperative pain management in elective cesarean section patients to improve patient satisfaction and select safer analgesia; to assess the influence of post-operative pain control using these two analgesic regimens on breastfeeding; and to assess the cost difference between these two analgesic regimens and determine which is more cost effective. The aim of the study is to examine the current practice for post-cesarean section analgesia at McAllen Medical Center and determine whether there is an advantage of using Motrin versus Acetaminophen. Outcomes will focus on patients' perspective of pain control and their success with breastfeeding efforts and hypothesis is that inadequate patient pain relief may hinder breastfeeding efforts. Cristella Hernandez, MD, Assistant Clinical Professor faculty at the McAllen FMR is the Principal Investigator with Salvador Elizarraraz, MD, third-year resident at the McAllen FMR as Sub-Investor. Matiana Gonzalez-Wright, EdD, Assistant Clinical Professor at McAllen FMR is also involved in the study.

Salud y Vida: The Rio Grande Valley Chronic Care Management (RGVCCM) Program Implementation Guide (Upper Valley) (2014-2015)
Salud y Vida, the Rio Grande Valley Chronic Care Management Program, is an innovative program developed by local organizations to transform the delivery of chronic care management in the Rio Grande Valley. This program identifies participants with uncontrolled diabetes and invites them to participate in a structured program to ensure stabilization and/or improvement in the participants' health status, leading to decreased acute care utilization.

Salud y Vida is a partnership between a number of hospitals, primary care entities, health care providers, universities, health information management organizations and outreach organizations to insure participants achieve control of their diabetes. Those organizations include UTHSCSA/UT School of Public Health, South Texas Health System, the McAllen FMR, and other surrounding health systems and community health centers in the RGV.

The Salud y Vida program holds as its vision that vulnerable participants with diabetes mellitus will achieve improved health after participation in the Chronic Care Management Program. The goal is to empower each participant, and their families, to understand their diagnosed chronic condition. The intention of the program is to bridge the gap from living with uncontrolled diabetes to controlled diabetes by providing participant centered comprehensive care utilizing a multi-disciplinary delivery method and medical treatment coordinated with primary care.

Since spring of 2014, faculty and residents at the McAllen FMR have referred patients to this program.

Residency Research Network of Texas (RRNeT)
In 1997, the Residency Research Network of Texas (RRNeST), a group of UTHSCSA family medicine residency programs, was established. With funding from the Health Services and Resources Administration (HRSA), UTHSCSA Department of Family and Community Medicine linked four family medicine residency programs including the McAllen FMR with research. This collaboration provided hands-on research training and experience to family medicine faculty and residents as they studied important health concerns in their practices. Additionally, for academicians, the collaboration provided practice-savvy collaborators and unique patient populations to study. At its inception RRNeT also included residency programs in San Antonio, Corpus Christi, Harlingen, and a private practice in Laredo. Sunand Kallumadanda, MD, Assistant Clinical Faculty at the McAllen FMR is a steering committee member of the RRNeT and Matiana Gonzalez-Wright, EdD and Deepu George, PhD are RRNeT members.

In 2004, RRNeT opened its doors to additional Texas family medicine residency programs, enlarging the community of collaborators, diversifying the patient populations, and expanding the list of researchable questions. Now known as RRNeT - the Residency Research Network of Texas - ten residency programs spread from Dallas, Fort Worth and Garland in the North, to Austin and San Antonio in the Center, to Lubbock in the West, and Corpus Christi, Harlingen, and McAllen in the South. RRNeT represents 100 family physician faculty and 300 family medicine residents who see 300,000 patient visits per year.

RRNeT research interests include barriers to care for diabetes, alternative medicine use, medication adherence, firearm safety, adolescent preventive care, obesity prevention and pain management. RRNeT seeks to improve health care and access to minority populations, with the intent to eliminate health disparities that affect our communities.

RRNeT completed research projects in which the Dr. Kallumadanda and Dr. Gonzalez-Wright at the McAllen FMR have participated include:

A Longitudinal Study of Low Back Pain (2008)
Purpose: RRNeT has identified and enrolled 258 family medicine patients with chronic low back pain into a longitudinal study. Over four years, we will examine changes in use of opioid medicines, pain severity, health outcomes, and disability.
Study Aims: (1) examining changes in opioid dose from 2008 to 2009; and assessing whether these changes are associated with changes in pain, functioning, and health status; (2) examining the natural history of procedural interventions, and the resulting long-term impact on pain, functioning, health outcomes, and opioid dosing. 3) examining the dynamics by which patients initiate, escalate, or withdraw from prescribed opioids;
Subjects: are 258 adults with chronic low back pain of greater than 3 months duration, who have visited the clinic more than one time.
Outcome Measures: include change in opioid dose (primary outcome) and pain severity, health, and functional status, as measured by the MOS Short-Form-36 (secondary outcomes).

Design: Investigators initiated a prospective cohort study of patients with chronic low back pain in 2008 and enlisted student research assistants to administer surveys and review medical records in seven RRNeT practices in Texas. This project will continue to collect data from patients who agreed to be followed longitudinally over five years. The participating residency programs will each maintain contact with their study subjects, administer brief surveys, and examine subjects' medical records.
To date: Medical students collected information from 228 back patients and researched topics ranging from impact of procedures to alleviate pain, opiod use and health outcomes, substance abuse, mental health and pain among diverse back pain patients.

Patients Understanding of Their Disease (2014)
Funded by the Texas Academy of Family Physicians Foundation, this study was conducted to examine the correlations between patients' understanding of their disease, their readiness of motivation to self-manage their disease, their self-management behaviors (adherence and activation), and their disease outcomes, including blood pressure, BMI, and A1c. Subjects were 675 adult outpatients with type 2 diabetes or hypertension. Medical student research assistants administered patient surveys that measured patients' knowledge of their disease, health literacy, readiness and motivation to manage their disease, medication adherence, patient activation, and patient demographics. Students asked patient's physician to complete a checklist that recorded patient's blood pressure, BMI, and A1c (when applicable). Data analysis correlated these outcomes with knowledge, literacy, motivation adherence activation while controlling for patient characteristics. Findings helped inform clinical interventions to enhance health outcomes in patients with chronic disease, including patient education programs, counseling approaches or pharmacy/medication coaching.

The McAllen FMR's extensive experience in working in partnership with university, health and community systems to conduct programs as well as launch and complete research studies shows a proven track record of collaborative success.

Resources/capabilities

Describe any past, current, proposed work the organization has engaged in whereby you were working with other organizations on a shared goal, shared measurements were continuous communication and reinforcing activities are evident.
The previous mentioned projects and evaluations are examples of our commitment to working with broader coalitions. Faculty and residents from our program provide services at HOPE Clinic in McAllen. The Hope clinic is a free healthcare clinic for uninsured and underserved members of the community. As we implement the PCBH model, we will provide Hope with necessary guidance, training, and strategies for full integration.

In particular, we will be interested to partner with MHM and other grantees to specifically focus on improving integrated behavioral health in the valley and to usher in an era of patient centered medical homes in the valley.

Describe the experience and expertise that qualify the organization to carry out the proposed five year plan, including readiness to implement integrated care.

The University of Texas Health Science Center at San Antonio has a historical commitment to the Lower Rio Grande Valley evidenced by the presence of Regional Academic Health Centers (RAHC) in Harlingen (established in 2002) and Edinburg (established 2006). The RAHC's strength lies in community-based teaching approach which attracts students. To date, over 1000 medical students have completed their portion of training in the Rio Grande Valley (the Valley). The RAHC has also successfully started and maintained an Internal Medicine Residency program since 2002. The RAHC has a two research units – the Medical Research Division (http://www.rahc.uthscsa.edu/MRD/index.aspx) and the Clinical Research Unit (http://www.rahc.uthscsa.edu/CRU/index.aspx). The Clinical Research Unit has helped manage and support research initiatives that directly impact health care information and services. For example, the South Texas Environmental Education and Research (STEER) provides training for Health professionals of all levels (physicians to promotoras/community health workers) to address environmental and public health concerns that affect South Texas, the Texas-Mexico Border and the Nation (Report attached).

The family medicine programs represent UTHSCSA's increasing commitment to providing needed healthcare in the valley. The FMR in McAllen (MFM) has served the community for 36 years and the UT DHR FMR will increase the reach of our organization to address healthcare needs and reduce disparities. Soon, our transition to UT-Rio Grande Valley School of Medicine not only increases our educational programs to increase health professionals in the valley, but will also exponentially increase the number of providers in the valley. Health disparities are greatly magnified in Hispanic populations and greater than 80 percent of the Valley is Hispanic. Mental illness and substance abuse are in particular more prevalent in this population. The new existing (Family Medicine, Internal Medicine, Surgery, OB/GYN) and proposed expansions (Preventive Medicine, Psychiatry, Pediatrics) for residency programs in the valley increases opportunities for collaborations to increase behavioral health integration into other primary care settings in this vulnerable population.

Eron Manusov MD (Program Director) and Deepu George PhD (Behavioral Science faculty(for UT DHR FMR) have experience in designing and implementing an integrated behavioral health model in Duke/SR-AHEC FMR in Fayetteville, NC. Matiana Gonzalez-Wright EdD (Behavioral Science and Research faculty for MFM) has extensive experience in public health initiatives and quality improvement with certification Six Sigma Master Black Belt certification.

Describe how the organizational structure, including the capability and commitment of administration, management and governing board, is appropriate for the operational and oversight needs necessary to implement onsite integrated services.

The proposed integrated behavioral health model replication will occur at two FMR sites. Deepu George PhD and Matiana Gonzalez-Wright EdD are the lead behavioral science faculty. Deepu George will lead the behavioral science integration process in consultation with our partners in Mountainview Consulting group. Matiana Gonzalez-Wright will monitor project implementation, evaluation, and quality improvement processes. The Edinburg FMR will begin with 6 residents and the McAllen FMR has 18 residents. There are 12.5 clinical faculty physician FTEs between the two programs who lead education, evaluation of progress for residents, and provide feedback on their performance and progress. The PCBH model integrates behavioral

health with clinical practice, education and administration. The family medicine residents, faculty and curriculum are evaluated in a competency based system. A similar evaluation process (this is also part of the PCBH model) will be used to monitor the progress of integration of Behavioral Health team with the primary care team. As mentioned previously, the Edinburg FMR will achieve certification in PCMH by the time the grant announcement is scheduled. Additionally, the institutional commitment to providing integrated behavioral health in primary care is evidenced by the VIDAS and Triply Diagnosed Adolescents projects mentioned earilier.

Describe the make-up of the governing board including number of members, number of meetings, diversity, and willingness and ability to support program expansion.

FMR programs already have committees and processes in place for appraising clinical and educational practices. Faculty meetings are held weekly to monthly to discuss program and resident performance, schedules, clinic operations that directly affect program performance, and receive updates on any research and quality improvement related efforts. Faculty meetings emphasize collaboration and inter-professional processes. Members review over 15 evaluation tools that tract and improve clinical care, education, research and administration

The FMR Clinical Competency Committees, a group of members from teaching faculty, meets semi-annually to review the milestone and competency-based progress of each resident in the program. The provision of direct, feedback by the CCC to the program director is an important process for determining whether the resident's performance is accurately revealed in the rotational evaluations. The CCC discussion and recommendations are communicated to the program director for feedback to the resident, and are considered equal in weight to written evaluations.

The Program Evaluation Committees composed of faculty members and at least one resident meets annually. Faculty members assigned to this committee by the residency program director are involved in planning, developing, implementing, and evaluating educational activities of the program; reviewing and making recommendations for revision of competency-based curriculum goals and objectives; addressing areas of non-compliance with ACGME standards; and reviewing the program annually using evaluations of faculty, residents, and others.

A quality improvement and patient safety curriculum for the FMR is designed around the data-driven Six Sigma improvement cycle of DMAIC, reserving 1 month for each of the steps in the process: Define, Measure, Analyze, Improve, Control, and 1 month for conclusions and final presentations. The curriculum includes weekly learning and opportunities for teams to apply concepts and ideas to quality improvement initiatives important to the quality, safety and efficiency of patient care.

Describe current or proposed systems to do the following and how they support program replication as applicable:

Single integrated medical and behavioral health EMR: Both FMR use Cerner Ambulatory electronic medical record. Edinburg FMR is in the process of building enhancements in the system for behavioral health information, taking care to build in the essential safeguards to

maintain patient confidentiality. These enhancements will be deployed at both residency sites and used in clinical care sites external to the FMR.

HIE capability: We currently do not participate in any local and regional HIE. As part of MHM's commitment to influencing health outcomes in the valley and theory of change, we are ready to partner to improve such capability in the region.

Track patients referred for complex/specialty: A coordinated team and shared information is essential to effectively manage chronic health conditions such as depression and diabetes. Biostatisticians from the UTHSCSA Department of Epidemiology and Biostatistics will assist in developing a web-based registry that will help facilitate a shared care plan to collaboratively treat these medical and behavioral health conditions. This registry will track patient progress and goals, identify patients who need more help, and share information among the entire care team.

Tele-behavioral health: Currently, neither FRM offers tele-behavioral health services. However, the school of medicine was awarded a large grant that will fund design and deployment of a tele-behavioral service. This grant is based on integrated behavioral health and the collaborative care unit and will interweave with the FMR clinical, educational, research and administrative functions.

Sustainability

Describe recruitment and retention plan for staff, including any new professional.

We will recruit 3 behavioral health providers to be shared between two sites to implement the PCBH model (included in the grant). In the future, with educational programs such Social Work and Clinical Psychology in the local universities, we will form strategic partnerships for student placement. We also hope to initiate positions in the future for training final year family therapy students in integrated care and behavioral science.

Describe the behavioral health care reimbursement environment in your service area. What is the environment? Is payment available or likely to be available for the proposed services? At what percent of cost?

Doctors Hospital at Renaissance, the physician owned hospital affiliated with University of Texas (site of the Edinburg Program) has developed a robust and successful environment for billing and collections. The MMC FMR has been in the region for greater than 26 years. Both programs will utilize the University of Texas physician plan to bill and collect based on information provided by successful providers/hospital systems in the region. We are also in the process of identifying and increasing opportunities for using behavioral health codes in primary care at the Edinburg program. With a full implementation, our goal is to better understand billable opportunities and become efficient in behavioral health coding. Additionally, our training with Mountainview Consulting group will focus on coding strategies in PC.

A portion of the patients are non-insured, and therefore do not represent financially viable populations. The University and the two systems, however, aided by 1115 waiver projects are committed to providing care to this vulnerable population. The School of Medicine and granting organizations are extremely active in supporting care and designing sustainable projects for care of the region.

Highlight plans for how the applicant proposes to maximize collections and reimbursement for providing integrated health care services consistent with its sliding fee and billings and collections policies and procedures.

The UT Practice Plan in development has taken advantage of the success of the systems in the region to maximize billing, reimbursement and collection. Dr. Deepu George and Dr Eron Manusov have experience in monitoring billing and collection on a monthly basis to maximize income generation. Patients screened with instruments will be billed accordingly and patients seen in consultation with an integrated medical diagnosis will be billed appropriately. Sliding fee and charity care are monitored and are calculated into income generation to maintain sustainability. Additionally, while the benefits of integrated behavioral health care are clearly documented, the current payment system is still lacking in appropriate incentives for such programs. As a program, we will continue to seek other opportunities for funding to sustain this program in addition to income generated.

Budget Narrative

A	**Salary** **Total: $214,750.00**
	Behavioral health providers (3 persons) will be hired to provide direct behavioral health services and to function as a primary care team member. The proposed salary per individual is $55,000. For 3 providers - $165,000
	Research assistant (1 person) will be hired part time for year 1 to manage various aspects of the grant to support data collection and implementation. The proposed salary for this individual is $17,500
	Program directors (2 persons) are current employees who will commit 2.5% effort for the project in year 1. The proposed grant contribution to their salary is $12,250.
	Behavioral scientists (2 persons) are current employees, lead investigators, who will commit 10% effort for the project in year 1. The proposed grant contribution to their salary is $20,000.
B	**Personnel Fringe Benefits** **Total: $ 63,135**
	FICA 7.65% all employees = $16,428 **Health Insurance** 8% faculty, 10% for staff = $20,830 **Retirement** 8% for faculty, 10% for staff = $20,830 **Workers compensation** 0.60% (all employees) = $1,289 **Terminated accrued leave** 1.7% (all employees) = $3,758
C	**Equipment** **Total: $4,500**
	Computers (3) will be purchased to help behavioral health providers integrate with primary care physicians to enter notes in electronic medical record. Each one is estimated at $1,500.
D	**Computer Programs** **Total: $975**
	Microsoft Suite (3 licenses) will be purchased to provide basic computing capabilities for personnel to work with data, create presentations, and assist in research projects. They will also use it for online trainings, literature searches, and updating evidence based practices. Estimated at $100 per license
	SPSS (3 licenses) will be purchased to facilitate statistical analysis of project data for evaluation and research purposes. Estimated cost is $225
E	**Supplies** **Total: $500**

	Printing of patient handouts for education and treatment facilitation in clinic. Several handouts will be printed. Estimated cost is $500	
F	**Contractual / Consultant Services**	**Total: 47,980**
	Mountainview Consulting group will provide necessary training in PCBH model to meet LEVEL 5 of Integrated Behavioral Health. They will provide offsite and onsite training. Total cost for year 1 is $30,480	
	Evaluation consultant (1 person) is an external consultant with years of experience in evaluation and project management. Estimated cost for him in year 1 $10,000	
	Methodologist / statistician (1 person) is an external consultant on analysis and methods for research. Estimated cost for year 1 is $7,500.	
G	**Other costs**	**Total: 12,980**
	Criminal history checks (3 persons) is required by the university to hire 3 behavioral health providers. Estimated cost for year 1 is $210	
	Reference books for PCBH (6 books for both sites) is an essential training and implementation that is not available elsewhere. Estimated cost for year 1 is $360	
	Development of registry – the registry is a critical component for evaluation and management of population based care. The total cost for development and maintenance by UTHSCSA Dept of Epidemiology and Biostatistics is $12,320.	
H	**Indirect costs**	**Total: 34,473**
	Federally approved indirect cost rate	
	TOTAL for YEAR 1 = $379,203	

Capability to match

We have reached out to The Valley Baptist Legacy Foundation, a local organization that is looking for partnerships for the Si Texas grant. We will pursue other local and national foundations involved in healthcare improvement.

Describe current internal controls and financial systems

The Health Science Center utilizes PeopleSoft enterprise financial system for its general ledger and the accounting for its sponsored award activities. There are automated controls in PeopleSoft for the project setup process. The account setup is first prepared by the Office of Sponsored Programs staff member in accordance with the terms and conditions of the award document. All charges and costs are assigned to a combination PGid, department id, fund group, and account that identify funding sources and other classification information (budget categories, department, etc). The last two digits of the fund group number designate the funding source, which distinguishes between federal and non-federal sources. Programs are assigned PGids so that expenses can be accounted for by program.

Expenditures are initiated by the PI and routed to the Office of Accounting. Supporting documentation, including detailed information regarding the nature of the expense, is required before payment is approved. Transactions are routed within the system through several levels. A requisition is initiated by the department administrator, routed to the project manager, and finally, routed to the Office of Accounting before payment can be made. Approvals for Purchase Orders and Requisitions are electronically provided. Expenditures cannot process within PeopleSoft without these approvals. When an invoice is received, the invoice is entered into

PeopleSoft by an Office of Accounting staff member. The System checks the information entered against the requisition and receiving information for the procured goods and services. It will not allow a payment to process which has a higher amount than the amount on the Purchase. The Health Science Center Office of Sponsored Programs administers over $120m in federal awards each year. In addition, the Health Science Center is subject to an A-133 audit each fiscal year. The institution currently has five active MHM awards that total $3.1 million.

Provide a description of key financial personnel

The Office of Sponsored Programs (OSP) Director Chris G Green is a licensed Certified Public Accountant (CPA) in the State of Texas and has worked at The University of Texas Health Science Center at San Antonio for over twenty years. His office handles both pre- and post-award sponsored programs administration including negotiation of clinical study and other agreements, effort certification, and F&A rate proposal preparation and negotiation. Mr. Green is also staff to the institution's Research Strategic Advisory Committee. Over $200m in sponsored awards is administered by the Office of Sponsored Programs staff.

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Work plan

Focus Area 1: Implementation of PCBH Model to increase level of current primary and behavioral health care integration			
Goal: We will achieve at least a 60% increase from our base line of "Levels of integration" by July 2017 as measured by the "Implementing primary care behavioral health service: Organizational status tool" (a tool provided by the PCBH authors).			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Develop job descriptions for BHCs; formulate interview questions	Deepu George, Mountain View Consulting (MCG), and respective leadership of programs	By May 31 2015	Hiring / recruiting is the first to in increasing access behavioral health in primary care
Hire a BHC	Faculty and residents from both programs	By July 2015	
Develop PCBH manual and tool kit	Deepu George, MCG, Matiana Gonzalez-Wright and respective leadership	By June 2015	Manual spells out responsibilities, roles, workflows, pahway programs – all elements of integration
Set dates for onsite training and recruit partipants	MCG and both FMR programs	By July 2015	
Assessment of core competency of PCP and BHC	MCG during training	During training	
Test, develop and deploy charting for BHC in EMR	Deepu George, Cerner IT team DHR	May 2015	This is already in process for our clinic, will have to share with
Test and institute registry for tracking patients	Both clinics; have one person be good at entering data	June 2015	
Introduce appropriate screening tools for PC visits	Redesign workflow to introduce screeners	July 2015	
Introduce BHC to daily clinic	Hired BHCs,	August 2015 (beginning of integration)	
Monthly calls with MCG	BHCs and project leaders	Through out the two years,	For close monitoring of data collection
Increase patient contact for BHC up to 6 – 8 aday	BHCs, PCPs, - the healthcare team	December 2015	
Monitor BH billing; strategic use of billing to maximize	BHCs, PCPs, billing team	Throughout the program	

Use of registry to develop population based approach for psychological problems	BHCs, health care team	Throughout the program	
Regularly holds training for staff, PCPs, and special classes for patients	BHCs and faculty	Starting January 2016 and throughout the program	
Evaluation of in-clinic behaviors and numbers (based on patient registry and other means)	The healthcare team	Every 6 months of the program	To ensure fidelity and productivity and monitor progress to Level 5
Implementation of system wide behavioral health education	Deepu George & BHCs	July 2015 through months to follow	Behavioral science is a core component of family medicine residency education, training, and evaluation. Every resident will be trained in Acceptance and Commitment Therapy (ACT) – the core frame work of PCBH.

Focus Area 2: Collaboration in a fully integrated system

Goal: At least 33% of patients who receive care at our clinics by the end of June 2016 will have met with a BHC one or more times as measured by the number of patients with a BHC note.

Key Action Steps	Person/Area Responsible	Time Frame	Comments
Development of a work flow to easily integrate BHC with PCP	Program staff, MCG, and healthcare team	By August – September 2015	
BHC has access to PCP notes and have specialized templates to enter consult notes for BH visits	Program IT and EMR; facilitated by program leadership	Fully implemented by September 2015	The project team will continue to develop templates to better address practice needs

PCP facilitates same day consults, communication, and works with the BHC	PCP – BHC	Start from August 2015	
Focus Area 3: Access to care			
Goal: Both clinics will achieve 100% access to care criteria by the end of January 2016 as measured by one reception area, one health record, typically one visit to address all needs, integrated provider model.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Have a BHC hired	Faculty and residents from both programs	BY July 2015	
Implement desired changes to waiting area to facilitate BH appointments	Matiana Gonzalez-Wright and healthcare workers in the clinic	By August 2015	Periodically review patient experiences for improving one reception area (the HER, typical one visit to address needs are covered above in Focus area 2)
Focus Area 4: Clinical service provision			
Goal: Both clinics will achieve 100% clinical service provision by July of 2016 as evidenced by one treatment plan in notes, all services provided onsite, ongoing consultation and involvement ins services, one prescribing provider, and one set of lab work.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Regular conversations about pathways established in clinic between PCP and BHC for effective implementation	The healthcare team	From August 2015 onwards	We will periodically bring this up in huddles, during didactics, and reviews of residents
Implementing BHC tabs outside of exam rooms to indicate BHC engagement and BHC status as a team member	The healthcare team	Bu July 2015 in both clinics	
Steady increase in the use of BHC by the PCP reflected in increasing patient contact by BHC	The healthcare team (BHC, PCP, faculty, MAs)	Throughout the program	Keep close monitoring of number of contacts and troubleshoot when numbers are low

Focus Area: Funding			
Goal: At least 75% of one BHCs salary is generated every year that by 2018, both programs can support their BHC independent of external funds as measured by income generated through BHC services			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Increasing coding accuracy in BHC	MCG and BHC; billing staff from UT Medicine	Starting in August 2015	MCG will train BHCs in the beginning
Develop a relationship with UT Billing	BHC and program	Starting August 2015	Keep in touch with them regarding updates, new codes, new incident to coding guidelines, to increase coding accuracy
Zero incomplete charts by every Friday – weekly clearance by BHC	BHC	Starting August 2015	No late notes
Establish protocol for re-submitting rejected reimbursements	BHC, program leadership, UT billing	Starting August 2015	Develop ways to resubmit claims and learn from mistakes
Developing alternative methods of payment	BHC, program leadership	Starting February 2016	Developing ideas like parenting classes, sleep hygiene, and have individual rates for such group classes
Applying for additional funds to make up for lost revenue	Program leadership	July 2016	Search out funds and partnership opportunities
Provide consultation to other organizations on PCBH model	BHC; program leadership	July 2017	With 2 years of implementation, the BH team can promote training for fees – the received funds will directly support BHC salaries and benefits

Focus Area: Use of Evidence based practices			
Goal: 80% of all consults and services provided in both sites by December of 2016 will be evidence based as measured by qualitative review of consult notes.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Complete core competency training in PCBH and Functional Acceptance and Commitment Therapy (FACT)	MCG and BHCs	During training with MCG	
Utilize off-site consultation with MCG for supervision of using evidenced based strategies	MCG and BHCs	From September 2015 onwards	
Develop journal club for BHCs and PCPs	Any member of the healthcare team	From February 2016 onwards	Increase learning, discussion, and familiarity on these practices across the board
Develop presentations for didactics and group learning	BHC	From July 2016 onwards	After nearly an year of implementation, BHCs should begin teaching skills and evidence to all staff during different meetings
Development of pocket cards as tools for intervention	The program leadership and healthcare team	From July 2016 onwards	Develop small cards, wall posters of motivational interviewing, functional assessment acronyms etc.,
Developing competency to specify type of treatment offered	BHC; consultation with MCG	From July 2016	BHC should be able to identify his / her interventions as they are used

Focus Area: Data / Information technology			
Goal: 100% fully integrated EMR access fro BHCs and PCPs by August 2016 as measured by ease of access to gather information by a provider (PCP or BHC).			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Development of templates in Cerner and testing them	Deepu George – with DHR team; then sharing with McAllen	To be completed by May 2015	Will continue to improve template to better reflect PCBH and ACT frameworks

Developing a MOU with McAllen EMR system regarding sharing BH templates (not health information – just templates for notes)	Program leadership and IT from both programs	Establish protocol by the end of the year	This will improve innovation
Receive inputs from MCG and update templates by implementation	Deepu George to review templates with MCG	By July 2015	
Have templates for common measurements (Duke health profile, pain assessment, etc.,)	IT Teams in both programs	Bu August 2015	Ongoing project – to update with new tools
Goal: 100% percent implementation of registry with full functions by 18 months into the program, as measured by presence of an active registry and the use of the registry.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Implementation of registry in partnership with UTHSCSA Department of Ep and Biostats	UTHSCSA Epi and Bio stats department and programs	September 2015	Establish a time for trial and feedback with the developers
Weekly monitoring of registry by BHC or Research assistant to check progress	BHC or Research assistant	Through out the program	Performance below the previous baseline should trigger a meeting to improve registry usage; this should be documented carefully
Document clinical decisions made from the registry	BHC PCP and healthcare team members	Starting January 2016	
Use registry to establish PCMH standards	PCMH team for both programs	Starting July 2016	

Focus Area: Development of a behavioral health consultant workforce			
Goal: to have 6 behavioral health consultants between the two programs by August 2018 as measured by 3 more hires by the programs.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Use data every year to show effectiveness of the PCBH model	BHC and healthcare team	Every year end review	Develop a strong report for both the programs and share with leadership – with graphs,

			testimonies, and satisfaction ratings from providers and patients
Use data to show the key tasks BHC performs and how such functioning increases efficiency	BHC and healthcare team; quality improvement team / projects	Periodically	Discuss with MCG on ways to provide feedback to the system regarding its use of BHC and show critical value
Develop metrics on money saved and return on investment and potential reduction in healthcare expenditure	Healthcare team, program leadership, stakeholders in the area	Start collecting data; have a report ready in 1.5 years to show pilot data	Use this to hire other BHCs because of cost-saving

Focus Area: Scaling services and replicating			
Goal: Train, consult and implement PCBH in at least 2 clinics by 2019 as evidenced by providing consults, presentations, and support given to implement their PCBH model.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Develop repository of knowledge regarding implementation	BHCs, research assistant, evaluation consultants	End of 2 years	
Develop and submit manuscripts on the process of implementing PCBH	Program leadership, healthcare team	Periodically	Encourage active scholarship; provide time for such developments
Present in local conferences and meetings to share stories of success and challenges	The healthcare team	As opportunities arise (local conferences; press releases)	
Collect, develop, and curate videos, books, recording, transcripts of sessions for training	The healthcare team	As opportunities arise	Developing podcasts, you tube videos and other mediums to share stories to establish expertise in the model
Develop expertise in PCBH model and South Texas	Healthcare team		Develop manuscripts, qualitative studies
Identify potential clinics to expand	BHC team		Internal medicine, Hope Clinic

Focus Area: Consortium and strategic partnership			
Goal: Establish a MHM Si Texas learning collaborative with other grantees by January 2018 as evidenced by a MOU between integrated behavioral health providers.			
Key Action Steps	**Person/Area Responsible**	**Time Frame**	**Comments**
Develop early learning processes from other programs	Grantees network; facilitated by MHM	From July 2016 onwards	Share results; success stories; strategies; make integrated care culturally relevant to South Texas
Develop an online platform to share ideas and resources	Grantees network	From July 2016	

All compliant applications submitted:

Community Hope Projects, Inc. dba Hope Family Health Center

Mercy Ministries of Laredo

Rural Economic Assistance League (REAL)

Tropical Texas Behavioral Health

Texas A&M International University (TAMIU)

The University of Texas Health Science Center at San Antonio (UTHSCSA)

Lower Rio Grande Valley Community Health Management Corp, Inc. dba El Milagro Clinic

The Boys and Girls Club of Pharr

Executive summaries of all compliant applications as submitted by the applicants

Project Title: Healthy Teens Project

Organization Name: Boys and Girls Club of Pharr

Address: 1026 South Fir St. Pharr, TX. 78577

Project Director Name: Alfredo Mata, Jr.

Phone Number: (956) 781-5437

Email Address: fmata@pharrkids.org

Amount of Funding Requested: $500,000

ABSTRACT

Boys and Girls Clubs are autonomous, non-profit, youth development organizations; facility based and strategically housed within the communities they serve. They provide programs to young people within five (5) areas of programming. These include; Sports Fitness & Recreation, Character & Leadership Development, Education & Career Development, Health and Life Skills, and the Arts. Programs are traditionally offered afterschool and during the summer months. In Hidalgo County, the largest of four counties that make up the Rio Grande Valley of South Texas, there are six (6) Boys & Girls Club organizations. These include: The Boys and Girls Club of Alamo-San Juan, the Boys and Girls Clubs of Edinburg RGV., the Boys and Girls Club of Pharr, the Boys and Girls Club of McAllen, the Boys and Girls Club of Mission, and the Boys and Girls Club of Weslaco. At times working together to address the negative socio-economic issues that affect young people in the region, they collectively serve an estimated 30,000 youth each year. Due to who they are, and where they are located, Boys and Girls Clubs of Hidalgo County are the ideal organization to provide health education and prevention programs to a captive audience.

The Healthy Teens Project, a comprehensive sex education/pregnancy prevention program for at risk youth ages 12-18, integrates physical and behavioral health services into current sex education efforts provided by clubs. Utilizing the evidence based **Children's Aid Society-Carrera Program Model for Pregnancy Prevention** (CAS-Carrera Program) as the guiding intervention; the Healthy Teens Project consists of two components: 1. Group Based Sex Education in the context of a comprehensive youth development setting, and 2. an integrated Health Service Component. While Boys and Girls Club programs already promote the social-emotional health of adolescents, strengthening their current sex education component, and integrating a health service component, will enhance the overall program. This in turn will address the physical and behavioral co-morbidities that result from the early initiation of teen sex and improve the overall health and wellbeing of participants, creating substantial and measurable benefits to the region.

Abstract

Project Name: Si Texas HOPE Integrated Behavioral Health Project
Organization Name: Community Hope Projects, Inc. dba Hope Family Health Center
Address: 2332 Jordan Rd., McAllen, TX 78503
Project Director's Name: Rebecca Stocker
Phone Number: 956-994-3319
E-mail: rramirez.hrhc@gmail.com
Funding requested for first two year period: $500.061

Community Hope Projects, Inc. doing business as Hope Family Health Center (HFHC), located in McAllen, Texas, provides free medical, counseling and case management services to over 2500 uninsured individuals annually in the LRGV. All patients who are provided medical care and mental health counseling at HFHC are 100% uninsured and do not qualify for any government funded medical assistance. The adults and families served at HFHC are low income with a household less than $14,000 for a family of four compared to the state average of $51,704.

HFHC serves the four county area of the LRGV including Starr, Hidalgo, Willacy and Cameron. Although the clinic is located in McAllen, due to its unique model, HFHC annually sees patients from all four counties in the following percentages: 50% from Hidalgo County, 30% from Starr County, 10% from Willacy County and 10% from Cameron County.

Founded by members of Holy Spirit Catholic Parish, the mission of HFHC is to provide patients with quality care for their mind, body and spirit regardless of ability to pay. All services are provided at no cost by medical professionals who volunteer their services either on-site at HFHC or when necessary at the volunteer's private practice.

Knowing that seventeen years of co-located collaborative care at Level 3/4 has proven successful for both patients and medical professionals, HFHC is ready to take strategic steps to move toward Level 5 and ultimately Level 6 in the next five years. HFHC proposes to enhance its current systems by following the Integrated Behavioral Health (IBH) model. IBH is a collaborative care model of identifying and treating mild-to-moderate mental disorders in adults in a primary care setting. HFHC will adapt the model for bilingual (Spanish and English) and monolingual (Spanish speaking) participants.

The ultimate goals of the IBH model are to: 1) More effectively meet the mental health needs of patients; 2) Improve the physical health and functioning of the patients in the program; and 3) Improve the efficiency of clinic operations. Ultimately providing evidence based interventions of health to a community with little to no access.

ABSTRACT

Project Title:	Sí Three: Integration of 3-D Health Services
Organization:	Mercy Ministries of Laredo
Address:	2500 Zacatecas Street, Laredo Texas 78043
Project Director:	Sister Maria Luisa Vera
Telephone Number:	(956)718-6810 FAX (956)721-7404
Email address:	Maria.Vera@mercy.net
First 2 yr's funding:	$597,327

Mercy Ministries of Laredo (Mercy Clinic) is a primary healthcare clinic located in Webb County, Texas, which provides healthcare and health education to some of the poorest neighborhoods and colonias in the United States. Mercy Clinic serves 2,500 unduplicated patients through 30,000 encounters every year. Of the patients who partner with Mercy Clinic almost 100% are uninsured and 98% fall below the 200% federal poverty guidelines.
The Sí Three: Integration of 3D Health Services proposal is to expand current efforts to integrate more fully the behavioral health and physical health initiatives within the primary care setting, while enhancing overall integration through the innovative addition of spiritual health issues and resources. In keeping with the Mercy tradition of faith-based care, and in accord with the Webb County tradition of inclusive, ecumenical community partnership, the Sí Three project will maximize inclusion of lay and religious support from Laredo's close-knit community.

This conceptual model helps guide the process of diagnosis and treatment, in that a person's health can be affected for better or worse by change in any one of the three dimensions. In addition, the model provides access to a far greater array of support services for the many patients whose behavioral health need is relief of anxiety and/or depression. There is strong research evidence for patients to report equal benefit from faith-based counseling or psychiatry-based counseling, and our community has a rich array of faith-based resources.

To address Focus Area 1 (expansion of services at existing site), in the physical dimension clients with diabetes, obesity and hypertension will be monitored every 3 months using quantitative and qualitative measures (Hbg A1C, weight and blood pressure). Behavioral health measures will include the PHQ-9 for depression, the GAD-7 for anxiety and the CAGE for substance abuse. Spirituality will be measured using the Spirituality Well-Being Index, a nondenominational measure of spiritual awareness. All results will be recorded in Excel format for analysis by the statistician.

To address Focus Area 3 (increasing integration of services), Mercy seeks to move from a current co-located level of collaboration/integration to integrated level 5. Strategies to achieve this goal over the next 3-5 years include more face to face interactions, use of the electronic medical record, closer communication, collaboration as members of a health care team, with scheduled meetings to understand and appreciate the roles and culture of other disciplines within the Laredo community. Significant innovations in meeting this goal are the inclusion of addictions to the evaluation of physical, behavioral and spiritual wellness, in order to better understand the underlying factors impacting a patient's symptoms. Adding the spiritual dimension enhances integration of service by acknowledging and addressing the patient's full spectrum of possible support systems.

Project Narrative

Abstract

Community Healthcare InveSted in keeping Patients Active (CHISPA):
Integrated Behavioral Health Reducing Diabetes, Obesity, & Depression

Lower Rio Grande Valley Community Health Management Corporation, Inc.
(El Milagro Clinic)
Address: 901 East Vermont Ave., McAllen, TX 78503
Project Director: Isidore Flores, Ph.D., Project Manager
Phone numbers: (956) 648-0543 (voice)
e-mail address: iflores@ivhiinc.org
Funding request for the first 2-year budget period: $651,844 (to have equal be match)

CHISPA will address a critical need and potentially save lives of obese, diabetic and depressed patients of El Milagro Clinic in Hidalgo County, Texas. The goal of the proposed project is to integrate behavioral health services more fully into primary care of the clinic population's large population of patients with chronic disease and co-morbidities. El Milagro Clinic has begun to work toward integrated behavioral health with a wellness center and a co-located behavioral health partner, Life Center. Founded in 1976, El Milagro Clinic provides a medical safety net for the low-income, mostly Hispanic patient population in the City of McAllen and surrounding areas in the lower Rio Grande Valley including Hidalgo County. The county lies on the U.S.-Mexico border with a rapidly growing population of 815,996; the population includes immigrants of all income levels, retirees from all parts of the United States, a growing manufacturing sector, tourism, and extensive international commerce in manufactured goods and fresh produce. Clinic patients who lack medical insurance, Medicaid, or Medicare total 90%. Adults in the region have a type 2 diabetes prevalence of 30.7%; 39% of local diabetic patients have symptoms of depression. Adults in Hidalgo County have an obesity rate of 42.9%.

At the clinic, integration of behavioral health with primary healthcare has begun through two initiatives: an immediate, short behavioral health intervention at a primary care visit and groups activities at the clinic's wellness center. The proposed project will increase the effectiveness of existing services through greater integration of behavioral health services. The project will screen patients for depression, extend the immediate behavioral health intervention to more patients, provide holistic plans of care for diabetic, obese, and depressed patients, and implement an evidence-based program to prevent diabetes. Plans of care, negotiated by an occupational therapist with each patient, will have realistic goals and be re-evaluated periodically. More intensive interventions will address uncontrolled diabetic and clinically depressed patients.

The evidence-based prevention program involves group-based empowerment, education, and physical activity weekly for 6 months with monthly followup for 18 months. Among program participants, 33% are expected to meet their weight loss goals in the first six months, and 33% of those with depressive symptoms are expected to improve significantly in one year. The involvement of community health workers will be crucial to engaging the low-income patient population, sustaining involvement in group activities, and keeping program costs low. The project will better inform and empower patients and their families through more coordinated and targeted clinical care, ultimately strengthening the region's culture of health.

ABSTRACT

Project Title: **TRIP** for Salud y Vida (***T****ransportation for* ***R****ural* ***I****ntegrated health* ***P****artnership)*

Organizational Name: Rural Economic Assistance League, Inc. (REAL, Inc.)

Address: 301 Lucero Street, Alice, TX 78332

Project Director: Martín Ornelas **Phone:** 361-664-7826 (voice); 361-664-4554 (fax)

Email: martin.ornelas@tcncb.org **2 Year Funding Request:** $1,608,604

REAL, Inc. has over 42 years experience in administering state, local and federal grants in the Coastal Bend area. The grants awarded have funded housing for low income elderly and persons with disabilities, adult day care centers, home health care services and public transportation. REAL Transit is a Rural Transit District that provides demand response services to the general public, seniors, and Persons with Disabilities in Aransas, Bee, Brooks, Duval, Jim Wells, Live Oak, Refugio and San Patricio Counties. The demand response services are offered Monday through Friday, 8:00 a.m. to 5:00 p.m. using a 24 hour call system which allows for scheduling trips.

The rural counties of Brooks, Jim Wells, Kenedy and Kleberg have a combined population of over 81,400 people with an average of 11% are persons with disabilities and an average of 23.2% are persons in poverty. The proposed project will target adult consumers with Mental Illness that are being served by Coastal Plains Community Center and that are registered in their Integrated Behavioral Health model, Project Salud Y Vida.

REAL, Inc. is partnering with the Transportation Coordination Network of the Coastal Bend (TCN), Coastal Plains Community Center (CPCC), Community Action Corporation of South TX (CACOST), South Coastal Area Health Education Center (SCAHEC), and Kleberg County Human Services – Paisano Transit, to increase the level of effectiveness of the existing Integrated Behavioral Health Program, Project Salud Y Vida, throughout the five rural counties of Brooks, Duval, Jim Wells, Kenedy and Kleberg counties.

Coastal Plains Community Center is the Mental Health Authority in the rural counties of the Coastal Bend and manages Project Salud Y Vida which is at Level 4 of the IBH framework (Co-Located) and is the primary care clinic operated by Community Action Corporation of South TX. There are four (4) Salud Y Vida primary clinics co-located within Coastal Plains' facilities that have been operating for the past two years.

The proposed project ***TRIP for Salud y Vida*** will increase the effectiveness of the existing IBH services by heightening the level of integration through the systematic integration of transportation and Enhanced Integrated Services (EIS) at the individual and community level in the four existing clinics.

TRIP for Salud y Vida consumers will enjoy increased health benefits by participating in primary and behavioral health clinics by eliminating transportation as the obstacle in accessing both existing Salud Y Vida services and the EIS services to be provided. The tangible benefits that low income consumers in the rural communities will derive will be increased access to individual and community level services including: Diabetes Education, Chronic Disease Self Management Education, Exercise Classes, Physical and Behavioral Health Screenings, Healthy Cooking classes, Healthy eating classes, Travel Training, Smoking Cessation, Consumer Empowerment Education, Health Fairs, Outreach and Education.

ABSTRACT

Juntos for Better Health
Texas A&M International University
5201 University Boulevard - Laredo, TX 78041-1900
Project Director: Dr. Glenda Walker
(956) 326-2574 // FAX (956) 326-2449// glenda.walker@tamiu.edu

Amount Requested for Two Year Period: $5,410,607

Juntos for Better Health is a partnership of nine community health care service providers developing the first fully coordinated comprehensive health care delivery system among multiple partners in Laredo. The word Juntos means "together." Texas A&M International University and the Canseco School of Nursing and Health Sciences will serve as the lead agency on this innovative and collaborative grant. For purposes of this study, we will focus on the system of health care in Webb, Zapata, and Jim Hogg Counties. The various partners are all experienced in some form of primary, secondary and/or tertiary health care provision, but have decided to come together to pool resources and improve the effectiveness of their services to the community. Most of these organizations operate quite independently and have very limited communication and collaboration with each other. Because of this, many clients receive piece meal care and lack an actual medical home. As one specific agency attempts to address all needs, they find themselves stretched for resources and lacking the competency to address all client concerns. We are proposing a system of Integrated Behavioral Health which provides a continuum of care for those with obesity, diabetes and depression. Following successful efforts documented in the professional health care literature, we offer a plan that focuses on *prevention* and *compliance.* The primary goal of this specific project is to increase effectiveness of existing services by heightening the level of integration of behavioral health from prevention to compliance with their health treatment plans.

Juntos for Better Health will carefully follow the Dartmouth Prevention Management Model to evaluate the effectiveness of the model in increasing follow-up compliance with health treatment plans for diabetes and mental health disorders and the *Juntos* Transformational Care Model. Members of these low-income communities will receive culturally competent education about Prevention Care.

1) The general public will be better informed about health care services in the region.
2) The health screenings will be more thorough in terms of offering a more comprehensive Integrated Behavioral Health Care Services system of delivery with better coordination of care.
3) An integration of services will lead to greater sense of team service delivery among health care providers in the region.
4) In addition to these measures leading to greater adherence to their treatment plans, clients will receive follow-up care through a Prevention Care Model Unit to increase the probabilities that they make their appointments, take their medication and follow their treatment plan.
5) Through this system of integrated behavioral health, an electronic database of health information will be developed to benefit both clients and the coordination of activities between health care providers.

Project Title: Improving Access to Integrated Care for Rio Grande Valley Residents with Severe and Persistent Mental Illness
Organization Name: Tropical Texas Behavioral Health
Address: 1901 S. 24th Avenue, Edinburg, TX 78539
Project Director Name: Diana Maldonado, Director of Primary Care Services
Phone Numbers: Voice: (956) 316-3037, Fax: (956) 316-3028
E-Mail Address: dmaldonado@ttbh.org
Funding Requested in this Application for the first two year budget period: $1,569,995

Abstract

Tropical Texas Behavioral Health (TTBH) is one of the first Local Mental Health Authorities (LMHAs) established in Texas as a result of the 1967 enactment of House Bill 3, and is currently the 5th largest LMHA in the state. With more than 700 employees operating from behavioral health clinics in Edinburg, Weslaco, Harlingen and Brownsville, TTBH makes an extensive array of evidence-based behavioral health services accessible to low income and uninsured residents of the Lower Rio Grande Valley (RGV or The Valley) diagnosed with Severe and Persistent Mental Illness (SPMI), Co-Occurring Psychiatric and Substance use Disorders (COPSD) and/or Intellectual and Developmental Disabilities (IDD). Located on the most Southern border between Texas and Mexico, the RGV has a population of more than 1.2 million predominantly Hispanic residents that has grown faster and had higher poverty rates than most areas of the country since the year 2000[1]. Communities in the RGV contend with higher rates of chronic disease and substantial disparities in the availability of quality healthcare in comparison to other parts of the state and the country[2]. Studies have established that individuals with SPMI face a unique set of added challenges to accessing primary care[3]. These factors combine to make it especially difficult for our clients and their families to obtain critical preventive primary care services. This project will support TTBH's efforts to diminish obstacles to care by expanding access for more people in the RGV living with SPMI to primary care integrated into the familiar setting of the behavioral health clinic.

TTBH will hire, train and equip a team of medical professionals and care coordinators to deliver primary care services to 500 unduplicated adult clients from the Brownsville area per year for the first two years of the grant term. Without this intervention, these clients likely would not receive timely integrated care due to barriers including fearfulness and apprehension, poverty, lack of transportation and provider resource limitations. The project will increase the effectiveness of our primary care services by funding a care coordinator positon at each of our co-located clinics, to improve opportunities for clients with especially complicated healthcare issues to achieve the health outcomes and quality of life they desire. The project will also innovate the delivery of integrated care by allowing for in-house completion of medical clearance evaluations of persons in need of psychiatric hospitalization, reducing utilization of emergency department resources to do so. Primary care will be delivered from a co-located clinic currently under construction at our Brownsville outpatient clinic. TTBH successfully co-located primary care within our Edinburg and Harlingen facilities in 2014, gaining valuable experience addressing the many challenges associated with reverse co-location of integrated care. Standardized instruments will be used to measure behavioral and physical health outcomes and to demonstrate the benefit of this intervention to those served, and by extension, to their families and communities.

Abstract

Project Title: Primary Care Behavior Health (PCBH) Implementation
Organization name: University of Texas Health Science Center at San Antonio
Address: Family Health Center, 2821 Michealangelo Dr, Suite 400, Edinburg, TX 78539
Project Director: Deepu George, PhD
Phone number: 956-362-3524
E-mail: georgedv@uthscsa.edu
Funding requested: 691,733 (for 2 years, inclusive of approved indirect costs)

The University of Texas Health Sciences Center at San Antonio presence in the valley was formally established in 2002 with the inauguration of the Regional Academic Health Center (RAHC), contributing to medical education and residency training to retain physicians in Rio Grande Valley as well as the Texas. The associated Family Medicine residencies (FMR) at Edinburg and McAllen work together to prepare physicians to serve the underserved communities with team-based inter-professional and integrated care.

The proposed integrated behavioral health care services will replicate the successful Primary Care Behavioral Health (PCBH) championed by Dr. Kirk Strosahl and Dr. Patricia Robinson of Mountainview Consulting group. In partnership with them, we will implement both onsite and offsite training to help both programs achieve PRACTICE CHANGE to move to a Level 5 of integrated behavioral health. Additional plans for expansion and collaboration with local organizations are outlined in the proposal.

Both Family Medicine Residency programs already provide care to low income members of Hidalgo county. Additionally, some faculty already work with Hope Clinic in McAllen, a free clinic for uninsured, underserved population for the area. Residents will rotate through Hope Clinic to provide care. We will also provide Hope clinic with training, guidance, and tools to increase their level of integration as part of our collaboration with the community.

The purpose of this grant is three-fold: to provide a model for best practices, increase access to care, and by implementing an integrated behavioral health model, prepare young physicians to think about health care of tomorrow as an integrated, inter-professional endeavor.

Sí Texas Application Scoring Rubric

1. Introduction

Please provide your Reviewer ID and the applicant's organization name.

***1. Please select your Reviewer ID from the dropdown below. (Find your Reviewer ID in your Sí Texas External Review packet).**

***2. Please select the applicant's organization name:**

To access the web-based scoring rubric in Survey Monkey and submit your scores and comments, use this link: https://www.surveymonkey.com/s/SiTexas

2. NEED: 5 points

***3. Applicant will provide services in the eligible target counties to a low-income population.**
(Eligible target counties include the following Texas counties: Webb, Zapata, Duval, Jim Hogg, Starr, Brooks, Jim Wells, Kleberg, Kenedy, Hidalgo, Willacy, Cameron).

- Yes
- No
- Unclear

<u>Additional review criteria for "Need":</u>

- Applicant's description of service area/target population demonstrates a clear need for integrated primary health care/behavioral health services. (At a minimum, prevalence data on depression, obesity and diabetes in their target area/population is provided).
- Applicant describes the unique characteristics of the service area/target population that impact access to or utilization of behavioral health care.
- Applicant's training needs (organizational capacity) are described.

***4. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Need" review criteria, out of a possible 5 points.**

Please comment on the score you selected.

***5. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Need" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

3. PROJECT DESCRIPTION: 40 Points

***6. Please rate the applicant's current stage of integrated behavioral health according to the SAMSHA-HRSA IBH continuum (provided in your reviewer packet).**

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
○	○	○	○	○	○

***7. Please rate the applicant's proposed intervention's stage of integrated behavioral health according to the SAMSHA-HRSA IBH continuum (provided in your reviewer packet).**

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
○	○	○	○	○	○

8. Please comment on your selections in questions 6 and 7.

***9. The Work Plan describes plans to (*check all that applicant has included*):**

- ☐ Expand services to more clients
- ☐ Replicate the program to additional sites
- ☐ Increase the level of integration of services
- ☐ None of the above

Please comment on quality of applicant's plan to accomplish these tasks:

***10. Based on the applicant's description of their proposed intervention and the evidence described, please rate the level of evidence of effectiveness of the proposed intervention, according to the definitions below.**

- **STRONG**: Strong evidence means evidence from previous studies on the program, the designs of which can support causal conclusions (i.e., studies with high internal validity), and that, in total, include enough of the range of participants and settings to support scaling up to the state, regional, or national level (i.e., studies with high external validity). The following are examples of strong evidence: (1) more than one well-designed and well-implemented experimental study or well-designed and well-implemented quasi-experimental study that supports the effectiveness of the practice, strategy, or program; or (2) one large, well-designed and well-implemented randomized controlled, multisite trial that supports the effectiveness of the practice, strategy, or program.

- **MODERATE:** Moderate evidence means evidence from previous studies on the program, the designs of which can support causal conclusions (i.e., studies with high internal validity) but have limited generalizability (i.e., moderate external validity) or viceversa - studies that only support moderate causal conclusions but have broad general applicability. Examples of studies that would constitute moderate evidence include: (1) at least one well-designed and well-implemented experimental or quasiexperimental study supporting the effectiveness of the practice strategy, or program, with small sample sizes or other conditions of implementation or analysis that limit generalizability; or (2) correlational research with strong statistical controls for selection bias and for discerning the influence of internal factors.

- **PRELIMINARY:** Preliminary evidence means the model has evidence based on a reasonable hypothesis and supported by credible research findings. Examples of research that meet the standards include: 1) outcome studies that track participants through a program and measure participants' responses at the end of the program; and 2) third-party pre- and post-test research that determines whether participants have improved on an intended outcome.

- **NOT YET PRELIMINARY:** Insufficient evidence exists of the effectiveness of the proposed intervention.

Please comment on your selection:

Additional review criteria for "Project Description":

- Applicant has proposed an integrated care model, including components such as: integration of primary medical and behavioral health care, use of a team-based, integrated model of care that incorporates behavioral health services within the primary care delivery system, and use of evidence-based practices to support the interventions.
- Applicant describes a realistic process for ensuring that shared systems (such as *patient/client scheduling, treatment planning, service provision, record keeping*) will be achieved through the five-year project.
- Applicant describes evidence of potential for scalability (such as: *support from key program stakeholders, expansion of services to more clients/patients, replication of their program in additional sites and/or increasing the level of integration of their services*).
- Applicant's proposed intervention is realistic, attainable, innovative, likely to make an impact within a 5-year time frame, and a cost-effective approach to meeting the behavioral health needs of the target population.
- Applicant describes innovative components of their proposed intervention.
- Applicant provided a 5-year Work Plan that is detailed, realistic, logical and responsive to the needs of the target population.

***11. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Project Description" review criteria, out of a possible 40 points.**

Please comment on the score you selected.

***12. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Project Description" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

4. EVALUATIVE MEASURES: 15 points

13. Based on your review of the *Monitoring & Evaluation Capacity Assessment, Logic Model, Past Evaluation Samples (if provided) and Narrative*, please indicate how much you agree/disagree with the following statement:

The applicant has the capacity to participate in evaluation and assessment (including capable staff identified to participate in the evaluation).

Strongly Agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree

Please comment on your selection:

Additional review criteria for "Evaluative Measures":

- Data collection, data use and analysis inform the applicant's objective and outcomes and are used to improve the organization's programming.
- Applicant is capable of tracking progress (and has listed process measures that will be used, separate from the required outcome measures).
- Applicant presents a strong theory of change and logic model (including inputs, activities and outcomes) that is aligned with MHM's Theory of Change and likely to produce results.
- Applicant's proposed outcome measures are sound and conform to SMART goal criteria.
- Applicant proposes an adequate budget to create a robust evaluation in cooperation with the MHM-funded external evaluator.

***14. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Evaluative Measures" review criteria, out of a possible 15 points.**

Please comment on the score you selected.

Sí Texas Application Scoring Rubric

***15. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Evaluative Measures" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

5. COLLABORATION: 10 points

Review criteria for "Collaboration":

- The proposed formal and informal collaborations will support the proposed project and will increase the overall behavioral health of the target population.
- If needed, the applicant has adequately described how collaborations will be strengthened in support of the proposed project.
- Applicant describes past, current or future work with other organizations on a shared goal where shared measurements, continuous communication and reinforcing activities were evident.
- Applicant demonstrates experience and/or readiness to work collectively with other organizations/stakeholders.

***16. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Collaboration" review criteria, out of a possible 10 points.**

Please comment on the score you selected.

***17. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Collaboration" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

6. RESOURCES/CAPABILITIES: 10 points

18. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates that current or proposed systems will support program expansion, replication or enhancement (such as: *ensuring a single integrated medical and behavioral health care record through use of electronic medical records - EMR, engaging in a local or regional health information exchange - HIE, tracking patients referred for complex/specialty behavioral health care, and/or making behavioral health services available through telebehavioral health*).

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please explain your selection:

Additional review criteria for "Resources/Capabilities":

- The experience and expertise described in the proposal qualify the applicant to carry out the proposed five-year plan, including readiness to replicate, support or enhance integrated care.
- The applicant's organizational infrastructure (*including IT and financial systems, fundraising processes, commitment of administration, management and the governing board*) is appropriate for the operations and oversight necessary to implement the project.
- The applicant has provided adequate evidence of effective board governance and of a diverse, qualified board that will help to support program expansion.

***19. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Resources/Capabilities" review criteria, out of a possible 10 points.**

Please comment on the score you selected.

***20. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Resources/Capabilities" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

7. SUSTAINABILITY: 5 points

21. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates ability to sustain the project after the grant period.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please comment on your selection

Additional review criteria for "Sustainability":

- *If applicable*, the applicant has described a sound recruitment and retention plan for behavioral health staff.
- *If applicable,* the applicant has demonstrated a sound plan for a health care reimbursement environment that will sustain the program.

***22. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Sustainability" review criteria, out of a possible 5 points.**

Please comment on the score you selected.

***23. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Sustainability" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

8. COST EFFECTIVENESS & BUDGET ADEQUACY: 15 points

24. Please indicate how much you agree/disagree with the following statement:

The applicant demonstrates the ability to seek a match or has secured a match.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Please comment on your selection

Additional review criteria for "Cost Effectiveness & Budget Adequacy":

- The applicant demonstrates, with consistent and complete information, a detailed and appropriate Budget with justification that is supportive of the Budget Narrative and is consistent with the Project Description section of the Narrative.
- The applicant has a strong financial team in place, enabling potential growth.

***25. Based on your review of the application and consideration of the questions and criteria above, please score the applicant on the "Cost Effectiveness and Budget Adequacy" review criteria out of a possible 15 points.**

Please comment on the score you selected.

***26. Please comment on this proposal's strengths, weaknesses, opportunities and threats in relation to the "Cost Effectiveness and Budget Adequacy" review criteria.**

Strengths

Weaknesses

Opportunities

Threats

A description of the subgrantee selection process

Goal of the Competition:

To select high-performing organizations that offer effective IBH interventions, with adequate integration of care and at least preliminary evidence of effectiveness, to participate in Sí Texas: Social Innovation for a Healthy South Texas.

Eligibility Criteria

- Phase 1 review criteria: Application review to ensure eligibility with RFP requirements including but not limited to: serving low income populations, amount requested in proportion to organizational budget, financial controls, commitment to seek match, and all submitted requirements are in place.
- Phase 2 review or selection criteria: Review of the application's project description, need, evaluative measures, collaboration, resources and capabilities, sustainability, and support requested.
- Phase 3 review criteria: Level of Evidence, IBH integration, scaling potential, financial maturity and capacity, capacity to match, long-term sustainability, and evaluation capabilities are assessed to determine value of award.

Review Process

- Key subgrant eligibility criteria required by the Statute are assessed to ensure compliance.
- MHM will ensure that: nonprofits with preliminary levels of evidence will receive less funding than nonprofits with higher levels of evidence, subgrantees have the information to develop adequate evaluation budgets, and have addressed long-term sustainability. MHM will use evaluations to inform subgrantee organizations as they improve levels of evidence, organization capacity, and evaluation capacity.
- Teams of three reviewers per team will include at least one person from each category: Evaluation, Other Funders, and IBH Providers.

Evaluation Considerations and the Award Process:

- Relationship between interventions and evaluation: Subgrantees will be implementing more than one intervention across multiple subgrantees, and will participate in the same evaluation.
- Clear descriptions of evaluation expectations and how this will be communicated: MHM will communicate evaluation expectations to subgrantees (a) in the RFP instructions; (b) through applicant workshops and webinars; (c) through group TA calls and webinars; (d) through one-on-one coaching; (e) through group e-mails to the subgrantee cohort. Subgrantees are expected to: have the infrastructure to track outcomes, track shared metrics for the project, continuously

improve and build the strength of their evidence, cooperate with the external evaluator and build their own capacity for evaluation.

- When and how evaluation plans, evaluation capacity, and budget will be considered as part of the overall review. Involvement of qualified evaluator(s) in the review process: Evaluation plans, capacity, and budgets will be considered during **Phase 2** of the review, which is review and scoring by external evaluators
- Who makes the final decision: The fully informed Sí Texas team recommends subgrant amounts and recipients, which are submitted to SIF for review. A committee of the MHM Board makes the final determination for subgrant awards.

External reviewers that completed the review assignment:

Atkins, Abigail

Davis, Mary

Fernandez, Kandyce

Hanson, Wendy

Harrison, Celeste

McPherson, Kimberly

Nelson, Heather

Quisenberry, Judy

Salas, Henry

Small, Monty

Watt, Toni Terling

Wells, Rebecca

Wolff, Lisa

Ybarra, Rick

Zahniser, Jim

External Reviewer Comment Summaries

El Milagro Clinic

The external reviewers made the following remarks about El Milagro's application: demonstrated clear understanding of community needs, innovative use of promotoras, increases access to care with community programs, intervention can be replicated, experienced evaluation lead, strong existing partnerships, a competent and representative board, history in the community, realistic staffing and appropriate budget.

Hope Family Health Center

External reviewers had favorable opinions about the application submitted by Hope Family Health Center. Comments by the reviewers include: community understanding, clear plans and explanations, a sound model of integration, evaluation capabilities including data collection procedures, strong partnerships and collaboration, leadership support, mission driven, project can be replicated, ability to seek match, and a strong financial team.

Mercy Ministries of Laredo

External reviewers voiced positive opinions of the innovative proposal submitted by Mercy Ministries. External reviewer comments include: cultural sensitivity, an innovative project, developed strategies, strong evaluation components and resources, good supporting evidence of the counseling component, developed community partnerships, history in the community, good staff credentials, previous grant experience, board oversight and support, and a realistic budget.

Rural Economic Assistance League

The external reviewers acknowledged several exciting opportunities within the REAL proposal and commented on the following: provided a clear description of community needs, addresses barriers to care, has good evaluation resources, well planned services, strong collaborative relationships, leadership experience, board dedication, and organization and partnership commitment.

Texas A&M International University

External reviewers had a positive response to the creation of a coordinated system of care in the TAMIU proposal. External reviewer comments include: demonstrated an understanding of community need, using a good intervention model, developed unique strategies, development of a coordinated system of care, experienced evaluation staff, collaboration with established organizations in pursuit of a common goal, many available resources, and a capable financial team.

The University of Texas Health Science Center at San Antonio

The external reviewers expressed confidence in The University of Texas Health Science Center at San Antonio's ability to implement the proposed project and evaluation. Reviewers commented on the following aspects: UTHSCSA provided a clear demonstration of community need and supporting evidence, detailed work plan and strategies, proposed use of consultants, available evaluation expertise, adequate organizational capacity and internal resources, history of collaborative work, developed infrastructure, organizational support, and appropriate budget.

Tropical Texas Behavioral Health

External reviewers had favorable comments regarding the proposal submitted by Tropical Texas Behavioral Health which focused on replicating a successful IBH model in a new location. The reviewer comments emphasized: a clear understanding of the exceptionally high need in the region, understanding of best practices, using integrated EMR, replication of an existing model, use of a Planning and Evaluation Department, SMART goals with valid measures, good collaboration, available resources, good leadership and financial management, and ability to secure a match.