**Community-Based Primary Care for the Elderly (MIGHTY Care) - David Mason, DO, FACOFP**

A community-based model to reach the Medicaid population ages 50 and above through the development and implementation of mobile care teams (consisting of a Physician, NP/PA, PT, MSW/LSW, MA) and community-based clinics in order to increase access to care and improve patient quality of life.

**Training Primary Care Workforce in Evolving Healthcare Delivery Models - Pam McFadden**

Development of the primary care workforce in RHP 10 through providing updated primary care training programs including training on the medical home and chronic care models, disease registry use for population health management, the importance of pneumonia vaccinations in the elderly and other methods to treat diabetes. This project forged relationships with rural providers and partnered with the Cornerstone Charitable Clinic in Fort Worth, part of the Cornerstone Assistance Network.

**Expansion of PLAZA/UNTHSC/TCOM Family Medicine Residency Program - Jon Sivoravong, DO**

Expansion of the 4-4-4 PLAZA/UNTHSC/TCOM Family Medicine Residency Program to a 6-6-6 program. This program focused on promoting careers in Family Medicine in Medically Underserved Areas and Health Professional Shortage Areas.

**Managing Chronically Ill Medicaid Patients using Interventional Telehealth - Brad Cannell, PhD**

Innovative telehealth monitoring system to manage chronically ill adult patients discharged from hospitals in RHP 10. This project utilized the patient monitoring services provided through Care Cycle Solutions (CCS) which developed proprietary software systems to monitor and manage patients, improve care coordination and improve patient recovery and health.

**Discharge Planning and Care Coordination for Medicaid-Eligible Elders (STEP) - Janice Knebl, DO, MBA**

An enhanced transition of care program for discharged Medicaid elders of Tarrant County that included a transition of care coordinator and in home medical care team (consisting of a Physician, NP/PA, PT, MSW/LSW, MA). The team facilitated an enhanced discharge plan, coordinated care, and provided evaluation and treatment. The project fostered collaboration between clinical and administrative representatives from a number of healthcare providers including local hospitals and utilized support services from various community organizations.

**Health Navigation and Incentives for Mental Health Patients (m.chat) - Scott Walters, PhD**

This project, which finished operations in December 2017, utilized a technology-enhanced navigation and incentive program for high-risk mental health patients in Permanent Supportive Housing (PSH) and other low-income housing programs. The project drew on prior research on brief patient navigation systems that utilized motivational interviewing and wellness incentives to specifically target the relationship between substance abuse and mental health in high-risk populations.

**A clinical pharmacist-led medication therapy management (MTM) service for Medicaid-eligible patients with chronic conditions - Katura Bullock, PharmD, BCPS / Cheng Yuet, PharmD**

An innovative primary care model utilizing a clinical pharmacist-led Medication Therapy Management (MTM) model to reach Medicaid persons with chronic diseases. This initiative utilizes the skills of clinical pharmacist services through increasing clinical-pharmacist led encounters, providing written medication management plans, and conducting improved patient education and medication management for patients with at least one chronic disease. This project implemented medication reconciliation which leads to the prevention of medication errors that result in improved outcomes.