

DSRIP Projects: Developing Systems of Care

Ben Raimer, MD, FAAP

Professor, UTMB School of Medicine
Senior Vice President, Health Policy and Legislative Affairs
University of Texas Medical Branch

Craig Kovacevich, MA

Associate Vice President, Waiver Operations & Community Health Plans
Office of the President
University of Texas Medical Branch

HHSC Statewide Learning Collaborative Summit
August 27, 2015

What are Systems of Care?

- ❖ Concept rooted in Behavioral Health:
 - Organizational philosophy and framework
 - Involves collaboration across agencies, families, and youth
 - Purpose of improving services and access
 - Core values:
 - Family driven and youth guided
 - Community based
 - Culturally and linguistically competent

Integrated Systems of Care

❖ Integrated systems of care:

- Enhance linkages between primary care, specialty care, and inpatient settings
 - Chronic disease management programs
 - Engaging patients in how to improve care delivery and coordination across the system
 - Piloting targeted approaches for particularly vulnerable patients who are frequent utilizers of the Emergency Department
- Invest in building blocks of patient engagement, data analytic infrastructure, performance improvement strategy and performance management systems, and workforce capacity

Integrated Systems of Care (cont'd)

- ❖ Vulnerable populations targeted:
 - Behavioral health
 - Medicaid, low-income uninsured (MLIU)
- ❖ Collaboration achieved:
 - Diverse organizations brought together in a new atmosphere
 - Primary care teams working with behavioral health teams
 - Providers collaborating amongst one another to provide patient-centered care
 - Collaboration and team-based approach to care in order to provide quality health care services

Integrated Systems of Care (cont'd)



Source: <http://exhibitionfloor.himss.org/himss14/public/Booth.aspx?IndexInList=&Upgrade=&FromPage=&BoothID=135110&Task=ProductsDetails&PROID=250>

Systems of Care: Application to DSRIP

- ❖ DSRIP is a vehicle for transitioning from fragmented systems of care to increasingly integrated systems of patient-centered care that are better equipped to manage population health
- ❖ DSRIP projects may incorporate milestones that seek to increase integration and improve patient care
- ❖ DSRIP activities focusing on:
 - Transforming the delivery infrastructure to enhance provider-patient communication and clinical outcomes
 - Recalibrating the workforce to maximize individual skill sets
 - Building bridges to population health management
 - Accelerating patient safety and quality initiatives

Systems of Care: Care Coordination

- ❖ Patient navigation and care transitions DSRIP projects
 - Coordinates, guides, and navigates patients through the entire health care continuum
 - Seeks to eliminate barriers to health care (access, financial, cultural, psychological, etc...)
- ❖ Advantages:
 - Patients receive more timely and improved access to care
 - Promotes use of Community Health Workers (CHWs)
 - Useful for coordination and management of chronic diseases
 - Facilitates appropriate delivery and use of health care services
 - Improves outcomes and reduces costs by ensuring “right care, right setting”

Systems of Care: Patient-Centered Medical Home

- ❖ Patient-centered medical home DSRIP projects
 - Restructures the clinic model into a multidisciplinary care team that manages a panel of patients
 - Expands and coordinates access to more comprehensive health care services

- ❖ Advantages:
 - Reduces system costs associated with hospital readmissions and/or Emergency Department visits
 - Emphasis on patient-centered care and population health management
 - Care coordination through team-based model
 - Improves care quality and patient experience

Systems of Care: Telemedicine

❖ Telemedicine DSRIP projects

- Virtual embedment of health care provider via telemedicine
- Telepsychiatry often used to incorporate behavioral health provider team for a more concerted approach to care

❖ Advantages:

- Eliminates distance and transportation barriers
- Greater convenience for patients and providers
- Useful alternative if there is a lack of resources/expertise
- Potential to improve cost, access, quality, efficiency, patient satisfaction, and no-show rates
- Increases collaboration among providers, community health clinics, hospitals, mental health authorities, etc...

Systems of Care in Action:

The Story of Childress Regional Medical Center and the Power of Transformation through Collaboration



The Future of Systems of Care

- ❖ Integrated systems of care are a powerful source for healthcare transformation
- ❖ DSRIP projects that focus on building systems of care have resulted in increased collaboration, improved population health, and quality care for vulnerable populations
- ❖ Continued support from the 1115 Healthcare Transformation Waiver will positively impact the overall health of those served in Texas and further promote the Triple Aim of Healthcare:
 - Improving the patient experience of care
 - Improving the health of populations
 - Reducing the per capita cost of health care

Panelists



Alison Glendenning-Napoli, MSN, RN-BC, CCP
Director, Outpatient Care Management
Community Health Program
University of Texas Medical Branch
alglende@utmb.edu

Bio:

Ms. Glendenning-Napoli is the Director of Outpatient Care Management at UTMB Health where she directs the Community Health Program and the Transitions of Care program. She has been a nurse for 28 years including experience in hospital, home health, and the insurance industry with a focus in case management, utilization management, and underserved populations spanning several states as well as U.S. outlying islands in the Pacific. She is board certified in case management.

Project Description:

The Transitions of Care DSRIP project, is a readmissions prevention program specifically targeting patients with the diagnoses of CHF, AMI, and pneumonia. The goal of this program is to make contact with patients while hospitalized and follow-up at home within 48 hours of discharge. Home visits focus on medication reconciliation, access to post-acute follow-up care, and education regarding red flags. The Community Health Program is a case management/disease management program for patients with chronic disease. RN Care Managers, Social Workers, and Community Health Workers connect with patients at home, telephonically, and at clinic visits to establish and access primary care, obtain required medications, supplies, and community resources, and learn chronic disease self-management skills to improve health outcomes and quality of life.

UTMB Community Health Program

Coordinated, Patient-Centered Care

Alison Glendenning-Napoli, MSN, RN-BC, CCP

Director, Outpatient Care Management

Community Health Program

University of Texas Medical Branch

HHSC Statewide Learning Collaborative Summit

August 27, 2015

System of Care

- Identified increased health system use and readmission rates in patients with chronic disease; higher in uninsured and underinsured
- 90% of chronic disease management occurs outside the traditional health system encounter
- Developed system of coordinated care delivered to the patient

System Interventions

- Connecting with patients prior to discharge, involvement in discharge planning
- Home visit follow-up within 48 hours of acute care discharge
- Continue home visits, clinic co-visits, and telephone follow-up
- Patient education on disease self-management, health system navigation, and community resources
- Intensive access to case management staff, averaging 4.1 encounters per patient, per month

Mary

Mary is a 64-year-old diabetic who had been in and out of the ED with severe hyperglycemia. Mary reported that she had been “sick” for years but didn’t really understand what was wrong with her. Some difficult, life-changing, personal events had also taken a toll on Mary and she found herself nearly confined to her home. We visited Mary at her home and began working with her to understand her disease.

Mary and Vicki

(and Joshalyn, and Sarah, and Dr. Mercantante...)



Impact of System

- 55% of patients have improved blood pressure
- 67% of patients have improved HgbA1C levels
- 36% of those with no PCP are able to establish care with a PCP within 30 days (55% within 90 days)
- 23% reduction in inpatient utilization
- 17% reduction in overall health system costs

*All data is preliminary and not validated at this writing

Summary

- Striving for the Triple Aim...
- Improved efficiencies in care coordination among internal and external entities
- Improved access to care for low-income, uninsured, and underinsured patients
- Improved clinical and health outcomes
- Improved utilization and cost of care outcomes
- System-wide review of care management and development of new inter-disciplinary care model



Mark S. Hernandez, MD
Chief Medical Officer, Community Care Collaborative
Executive Director, Clinic Integration
Seton Healthcare Family
Mark.Hernandez@CCC-ids.org

Bio:

Mark Hernandez, Chief Medical Officer for the Community Care Collaborative, works with multiple clinicians and service organizations throughout Travis County to fulfill the goals of the Collaborative, which include transforming the delivery of care into an integrated system. Dr. Hernandez is board-certified in Internal Medicine. He holds academic appointments with the University of Texas Southwestern University and the University of Texas Medical Branch and is adjunct faculty with the University of Texas at Austin School of Nursing and active in advanced practice nursing student education.

Project Description:

The Community Care Collaborative (CCC)'s Patient Centered Medical Home project seeks to build a "neighborhood" of patient centered medical homes. The primary care clinics that are part of the CCC will be expected to implement the entire medical home model. CCC's Chronic Disease Management project implements chronic care management models for CCC's network of safety net providers. These models will define the clinical protocols, care team staffing, and patient self-management guidelines for the CCC's patient population.

The Community Care Collaborative Plan for Healthcare Transformation in Travis County



MARK HERNANDEZ, MD
CHIEF MEDICAL OFFICER



First Thought



“Change is hard because people overestimate the value of what they have--- and underestimate the value of what they may gain by giving that up.”

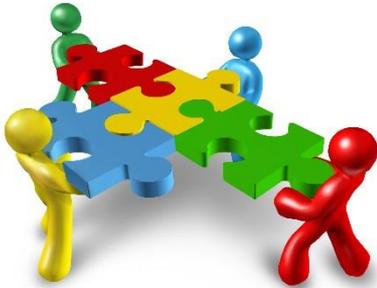
- James Belasco and Ralph Stayer Flight of the Buffalo 1994



What is the Community Care Collaborative?



The Community Care Collaborative is a non-profit organization developed by Central Health and Seton Health Care Family with the purpose of advancing the health of identified vulnerable populations in Travis County through high-quality, cost-effective, person-centered care.



High Quality Care requires System Integration:

- Integrated data through HIE
- Consistency of Quality
- Navigation Services
- Measurement of Outcomes



Cost Effective Care

- Preventative Health
- Innovation

- Use of Federal Funding
- Upstream Case Management



Person Centered Care

- Medical Home
- “No Wrong Door”
- Seamless to user
- Health Education
- Improved Access
- Integration of Behavioral Health

The Problem



- Almost 21% of all Travis County Residents under the age of 65 are without health insurance.
- Of these uninsured, almost 6 of every 10 have family members who are employed.
- Out of 211,000 uninsured, approximately 136,000 live below 200% of FPL.
- 35,000 uninsured patients utilized inpatient or emergency services without receiving any outpatient clinical care.
- There is little coordination of the care delivered by safety net providers in Travis County.
- Connecting patients to appropriate care is a difficult process.
- Quality improvement activities for the safety net population are uncoordinated.

What do we need to do?



- Transform the delivery system in order to provide more effective and efficient care as evidenced by improved patient outcomes
- Eliminate inappropriate utilization of the healthcare system and increase care in the most appropriate settings
- Provide non-clinical services (e.g. patient navigation) to strengthen continuum of services
- Develop metrics to measure the effectiveness of the new system and to create continuous quality improvement
- Use assets of the CCC to serve the safety net and the general population in a financially responsible manner
- Develop a mutually agreed upon benefit plan for safety net population based upon actuarial data

CCC Essential Elements



- Patient Centered Medical Homes
- Health Information Exchange
- Selected Population Management, including Chronic Disease, High Risk, Transition care, along with others
- Pharmacy Management
- Integrated Outpatient/Inpatient Care Protocols
- Transitional Care
- Outcome Measurement and Analytics
- Process Improvement and Innovation
- Outreach and Engagement



Dawn Zieger
Executive Director of Access & Integration
JPS Health Network
DZieger@jpshealth.org

Bio:

Dawn Zieger is a passionate and transformational leader who inspires others to broaden their vision for what's possible. She joined JPS Health Network in 2013 and is currently Executive Director of Access and Integration for the Community Health division, overseeing 4 Medicaid waiver innovation programs to transform healthcare delivery. Dawn is responsible for over 150 staff who work to connect patients to care in the right setting at the right time. Most recently, Dawn is a contributor to August 2015 Journal of Emergency Medicine article evaluating The Role of Charity Care and Primary Care Physician Assignment on ED Use in Homeless Patients.

Project Description:

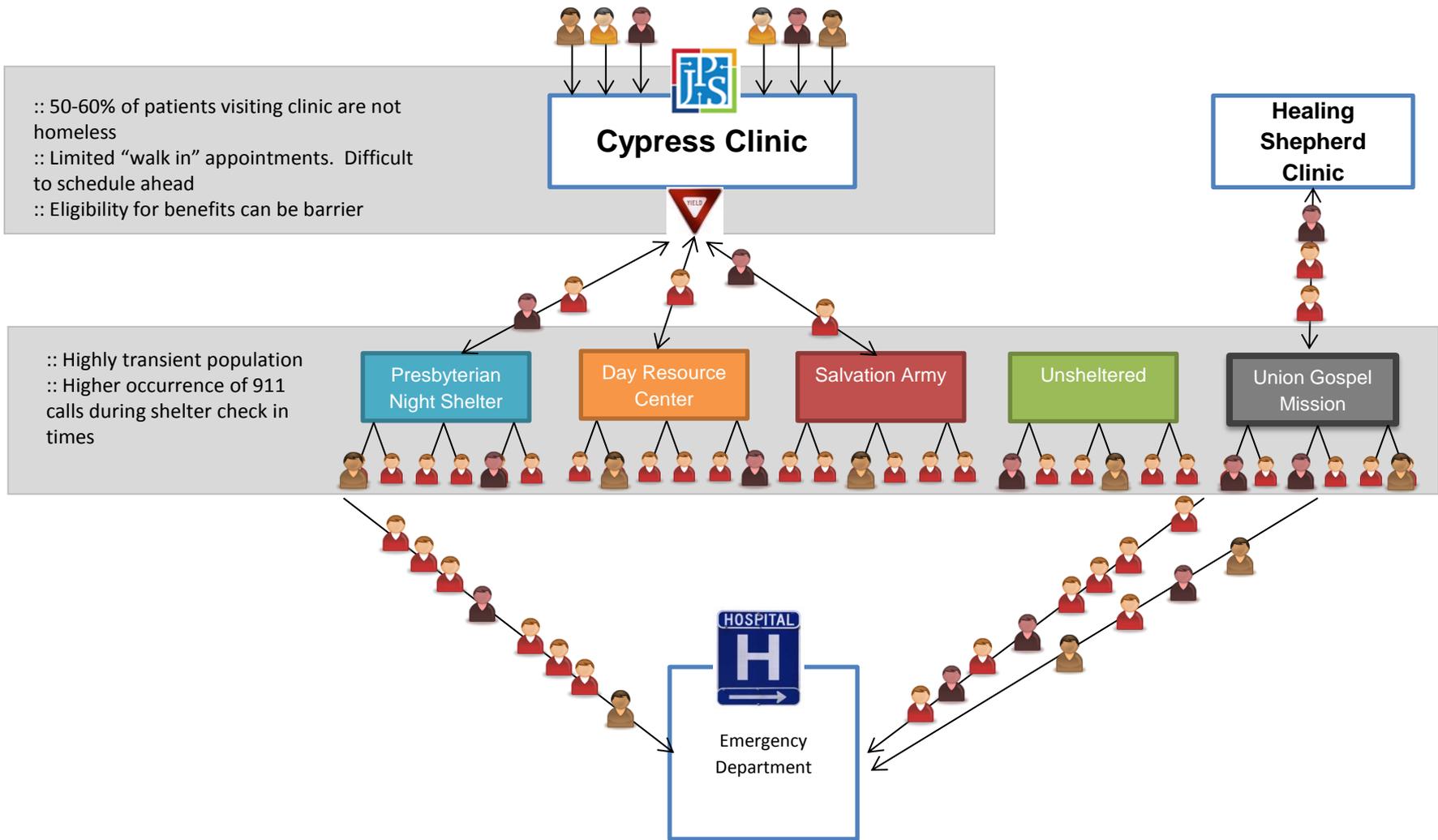
Care Connections for the Homeless improves care transition and health outcomes for the Tarrant County Homeless population by deploying multi-disciplinary teams to provide services to individuals living on the streets, shelters, or in supportive housing. The MedStar Patient Navigation Program navigates patients at risk for potentially preventable ED visits and hospital admissions to more safe and effective settings for their healthcare needs. Community Connect increases access to primary care for the residually uninsured Tarrant County residents through care coordinators, expanded primary care and specialty services, and improved information sharing with JPS Health Network collaborative partners.



Transforming Systems of Care – Care Connections for the Homeless

Dawn Zieger, Executive Director of Access & Integration
August 27, 2015

Current State



Care Connections for the Homeless Focus Areas



Adapt Clinic Practices

- New provider and care team focused on homeless patient population
- Adapted PCMH practices to achieve level 3 certification

Deploy Outreach

- Integrate medical personnel with shelters
- Partner with outreach services to identify campers in need of medical services
- Coordinate outreach care with existing Cypress clinic

Care Coordination Integration

- Implement daily hospital rounding with homeless patients
- Educate Inpatient case management and social workers on challenges facing homeless
- Implement ED based transitional care coordinators

Final Clinic Model

- Walk in access to care
- Case management & JPS eligibility integrated with social service case managers
- Additional staffing in clinic
- Integration of medication delivery solution

Coming soon! New Resource Center

NEWS > LOCAL > COMMUNITY > FORT WORTH



\$10 million health, resource center for homeless coming to Fort Worth

BY CATY HIRST - CHIRST@STAR-TELEGRAM.COM

02/06/2015 3:53 PM | Updated: 02/09/2015 4:19 PM



But..... We still have work to do!

-Housing

- Can we create alternative funding streams with managed care?

-Benefits

- Only 13% of Care connections patients on Medicaid. Opportunity exists!

-Respite care

- After hours emergency room discharges
- Inpatient, Outpatient surgery recovery



Landon Sturdivant, MPA, LBSW
Chief Operating Officer
West Texas Centers
Landon.Sturdivant@wtcmhmr.org

Bio:

Landon Sturdivant serves as the Chief Operating Officer for West Texas Centers. Sturdivant has over 28 years experience in community behavioral health. He has experience serving in various capacities including Case Management, Human Resources, Management and Support, Information Technology, and Executive Management. He has served in his current capacity as the Chief Operating Officer of West Texas Centers since 1997. Sturdivant obtained his Bachelor Degree in Social Work from East Central University in Ada, Oklahoma and his Masters of Public Administration from Angelo State University in San Angelo, Texas.

Project Description:

Expand the current telepsychiatry program by installing telemedicine equipment in additional remote locations. Telemedicine offers a wide array of services to include 24-hour crisis intervention, psychiatric evaluation, consultation and rehabilitation, medication management, and case management. These services are intended to assist in transforming the health care delivery system to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.



2015 Statewide Learning Collaborative Summit
Systems of Care In Rural/Frontier Texas

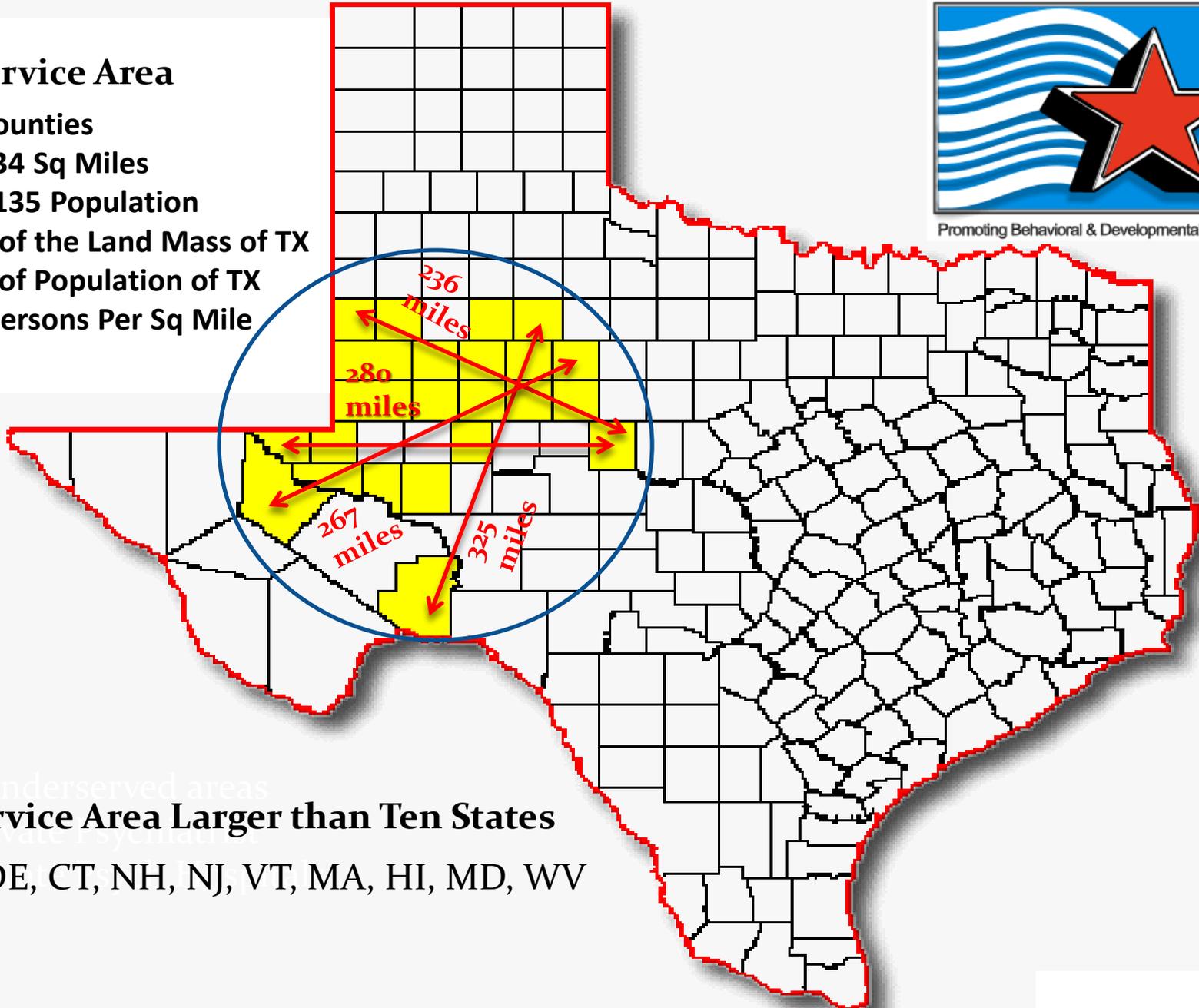
Telemedicine A Tool for Expanding Systems of Care

Landon Sturdivant, MPA
Chief Operating Officer
West Texas Centers
Landon.Sturdivant@wtcmhmr.org



Service Area

- 23 Counties
- 25,034 Sq Miles
- 217,135 Population
- 11% of the Land Mass of TX
- <1% of Population of TX
- 8.7 Persons Per Sq Mile



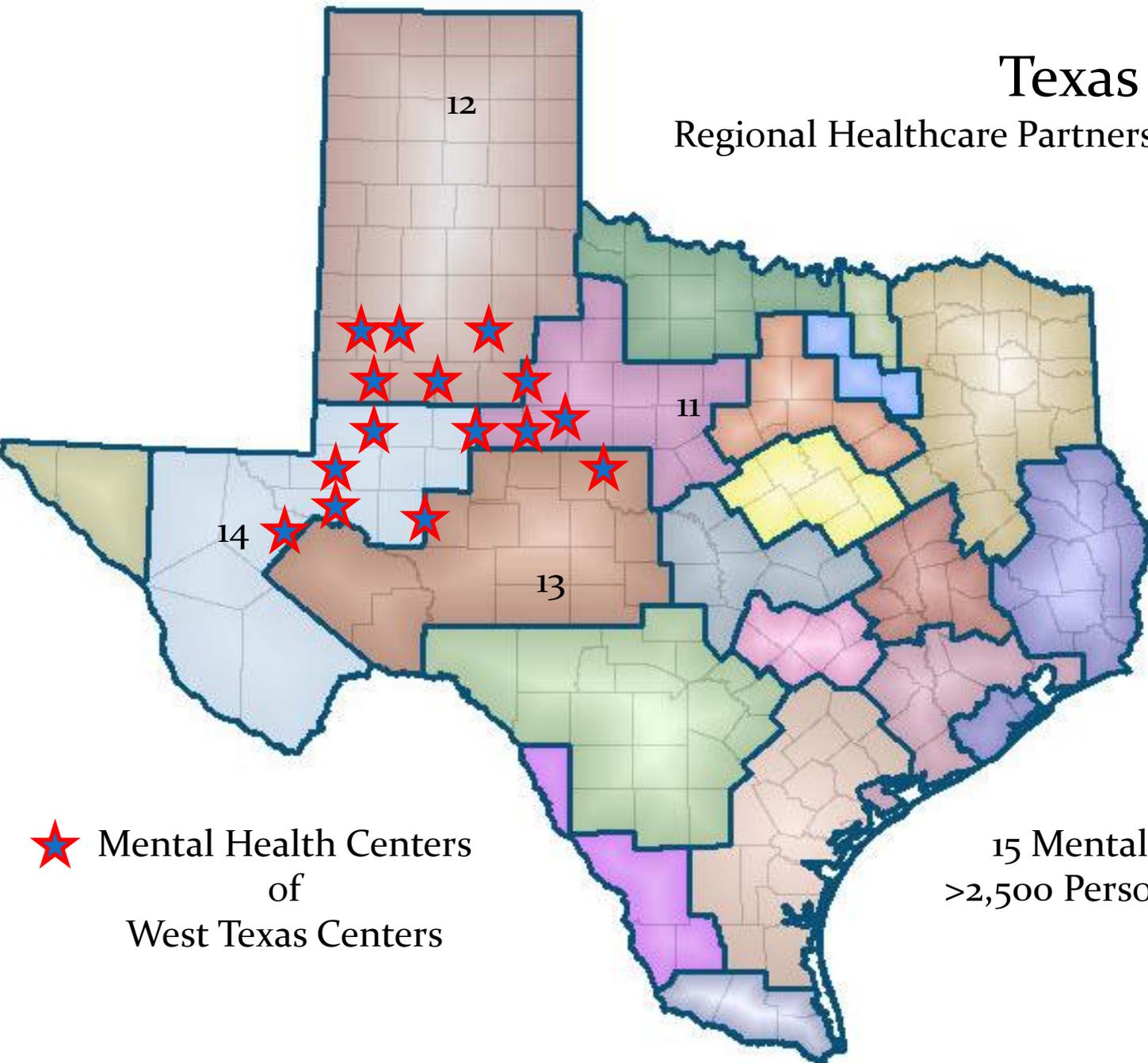
All underserved areas
of private psychiatric

Service Area Larger than Ten States

RI, DE, CT, NH, NJ, VT, MA, HI, MD, WV

Texas

Regional Healthcare Partnerships (RHP) Regions



★ Mental Health Centers
of
West Texas Centers

15 Mental Health Centers
>2,500 Persons Served Per Month

Challenges

Large Geographical Service Area
Limited or No Local Providers
Limited or No Public Transportation

Solution

Develop a Tele-psychiatry System of Care

Initial Experimentation

March 2000 West Texas Centers Purchased First Telemedicine Equipment

DSRIP - Telemedicine Expansion Project

Expand Network IT Connections

Purchase Hardware-Laptops, Switches, Routers, Cameras

Purchase Software - Lifesize ClearSea

Contract Additional Providers

Increase Access to Care

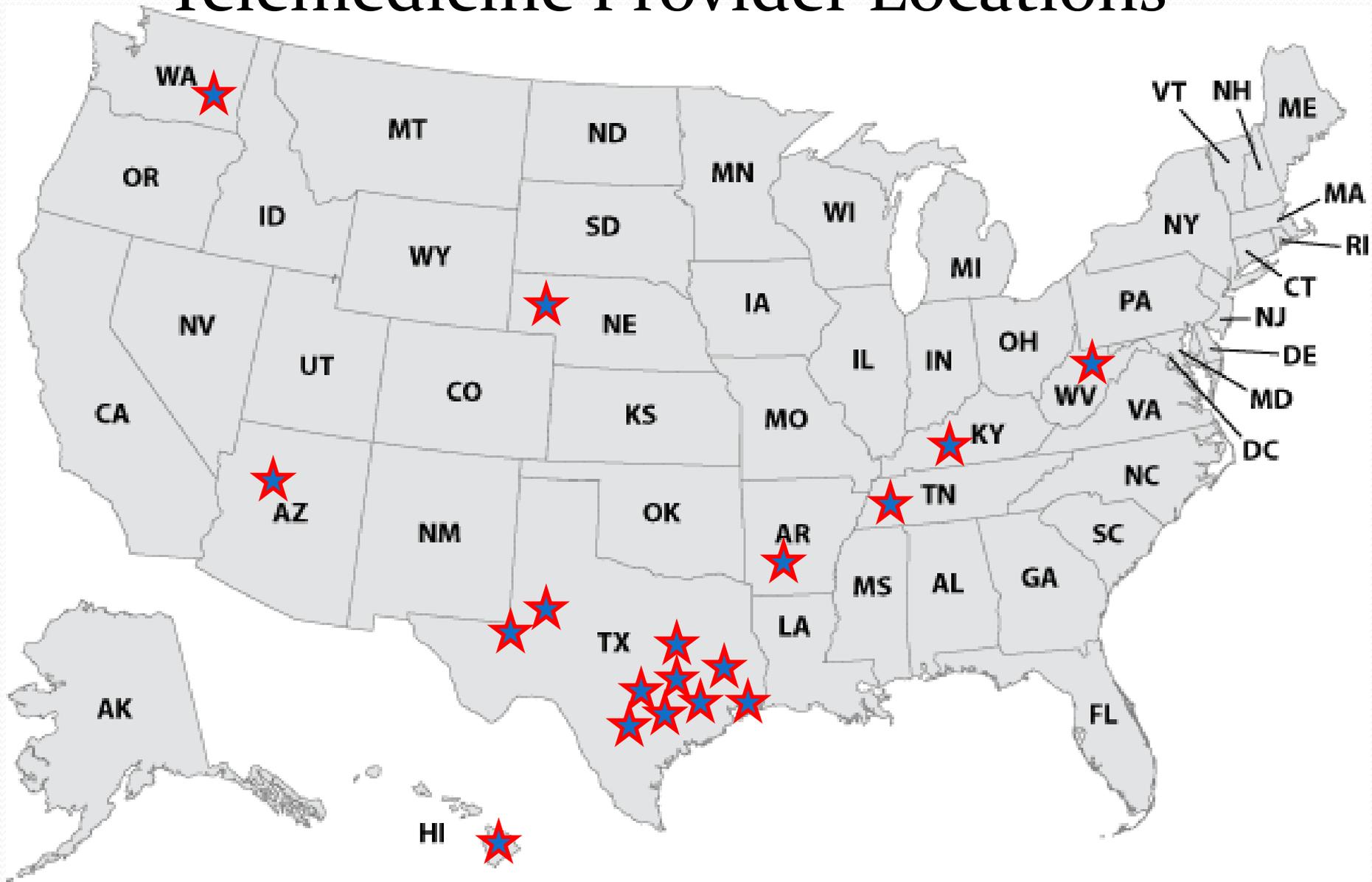


**TELEHEALTH
is not new**

1879

(Aronson, 1977; Backhaus et al., 2012; IOM, 2012; Wittson et al., 1961; Wittson & Benschoter, 1972)

West Texas Centers Telemedicine Provider Locations



Benefits

- ★ Eliminated Waiting List
- ★ Expanded Services within the Local Jails
- ★ Expanded System of Providers Across the Nation
- ★ Increased Access to Psychiatric Care
- ★ **Decreased Time and Cost of Arrest, ER Visit and Hospital Admissions**

Next Steps

- **Expand Tele-Psychiatry into Local Emergency Rooms**
- **Expand Tele-Psychiatry Services with Community Partners**
- **Expand Contracts with MCOs for Tele-Psychiatry**
- **Expand Tele-Psychiatry Services in Jails**
- **Expand Primary/Behavioral Healthcare Integration through Tele-Psychiatry**

Telemedicine is Today's Reality



Doctor's visit by videophone in the Jetson home (1962)



Karla Blaine, BSN, RN, CPHQ
Brazos Valley Post-Discharge Care Coordination Program
Rural and Community Health Institute, College of Medicine
Texas A&M Health Science Center
blaine@tamhsc.edu

Bio:

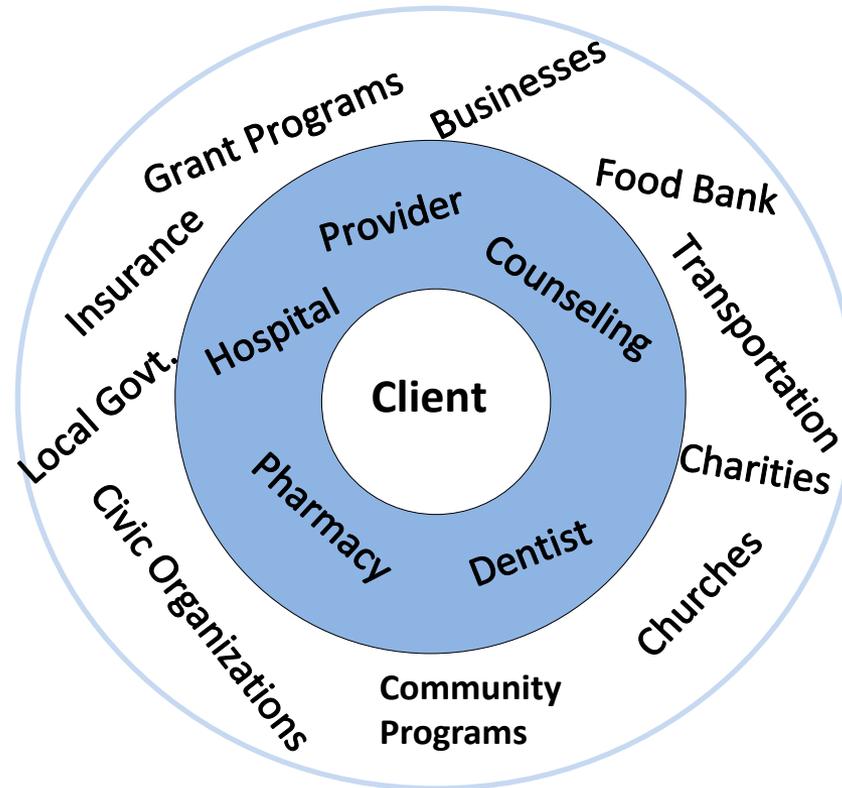
Ms. Blaine is an RN at the Texas A&M Health Science Center, Rural and Community Health Institute. Presently she is the program manager for the Brazos Valley Post-Discharge Care Coordination Program. She has been a nurse for more than 30 years including experience in hospital, home health and the insurance industry with a focus in case management, utilization management and quality management. She is currently a Certified Professional in Healthcare Quality (CPHQ).

Project Description:

Our DSRIP project, the Brazos Valley Post-Discharge Care Coordination Program (BVCCP) is an ED diversion project. The goal of our program is to identify frequent ED users who do not have a regular source of primary care, and post-discharge from the ED; to assign these clients to a care coordinator/navigator. We have state certified Community Health Workers (CHWs) who work with the clients by providing options for accessing regular primary care as well as other health resources to help the clients achieve and maintain positive health outcomes.



Brazos Valley Post-Discharge Care Coordination Program



- ▶ A Client centered and dynamic system
- ▶ Individualized to the clients' needs and priorities

Moderated Panel Discussion

Questions