



The health system of tomorrow **NOW.**

Your University Hospital DSRIP Results: Findings from University Health System July 15, 2015



Agenda

- 1. University Health System: Who we are**
- 2. Texas 1115 Waiver Overview**
- 3. University Health System DSRIP Overview**
- 4. Highlighted Projects**
 - Palliative Care**
 - Medication Management**
 - Transitions of Care, Care Model, and Navigation**

Who we are.



- A separate political subdivision of the State of Texas owned by the people of Bexar County
 - 6,000 employees. 1,000 physicians. 700 resident physicians
 - \$1.9 billion annual impact on local economy
- South Texas' Level I Trauma Center since 1994
- South Texas' first Magnet health system (2010)
- Less than 24% of revenue comes from local property taxes.

There is a difference.

- University Hospital has been the primary teaching partner of UT Health Science Center School of Medicine since 1968.
 - Ranked best hospital in San Antonio and #6 in Texas by U.S. News & World Report
 - Clinical Research
 - Innovation
 - Technology
 - Advanced care
 - Level I Trauma Center
 - Pediatric burn program
 - University Transplant Center
 - Level IV Neonatal ICU
 - Heart & Vascular Institute
 - Certified Stroke Center
 - Pediatric Congenital Heart Center
 - Pediatric Hematology & Oncology Clinic



Awards for Organizational Excellence

Nursing Care



Learning Culture



Efficiency



Quality/ Safety/ Outcomes



Community Focus



Business Intelligence





1115 HEALTHCARE TRANSFORMATION WAIVER

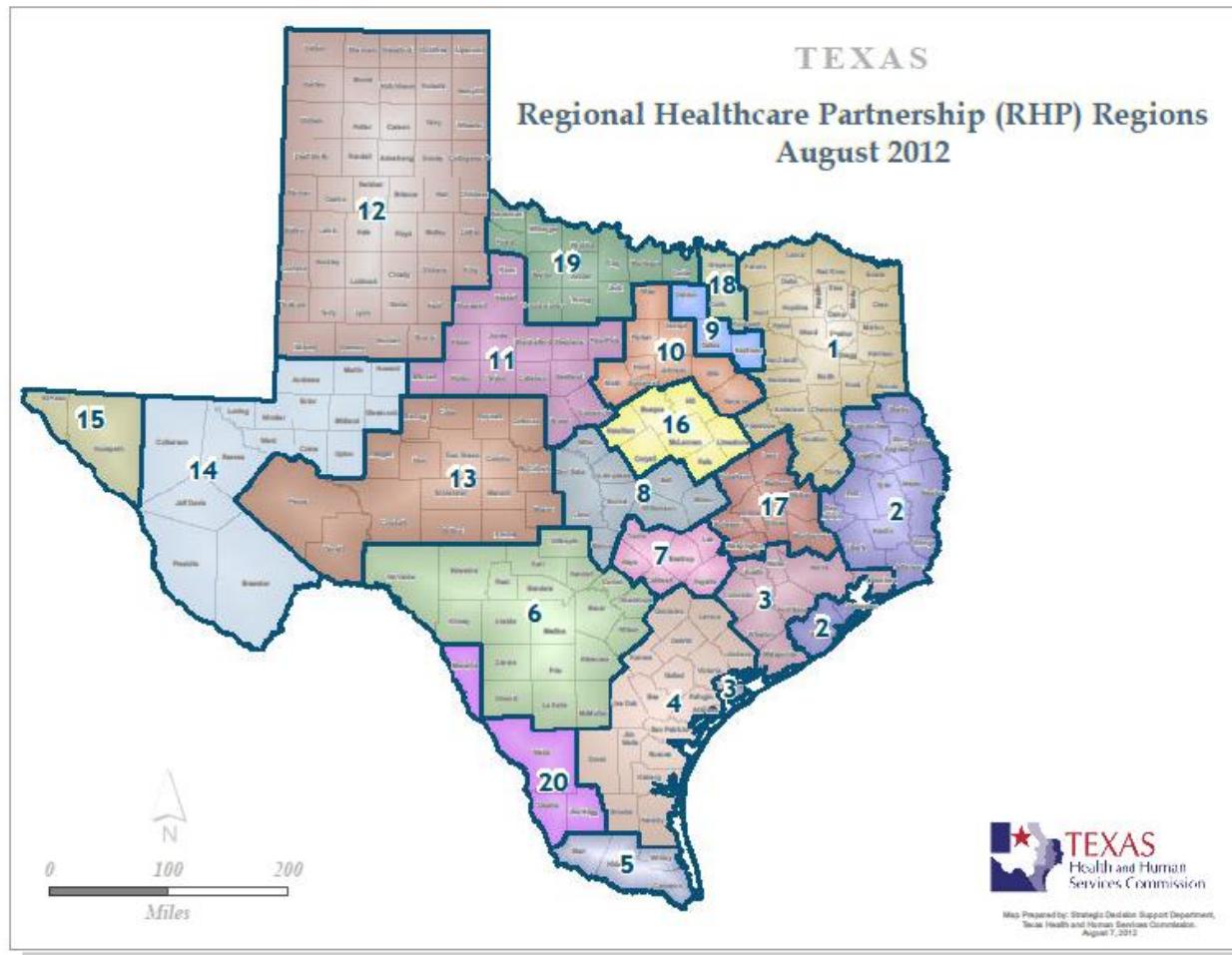
History of 1115 Waiver

- ▶ In December 2011, the Texas Health and Human Services Commission (HHSC) received federal approval of a Medicaid 1115 waiver.
- ▶ The waiver program primarily does two things:
 - ▶ It expands Medicaid managed care to the entire State;
 - ▶ It replaces the upper payment limit program with two new pools of funding:
 - ▶ The Uncompensated Care (UC) pool
 - Reimburses hospitals for the cost of care for Medicaid and uninsured patients for which the hospital does not receive payment.
 - ▶ The Delivery System Reform Incentive Payment (DSRIP) pool
 - Provides payments to hospitals and other providers upon their achieving certain goals that are intended to improve the quality and lower the cost of care.

Regional Healthcare Partnerships

- ▶ HHSC established geographic boundaries for new Regional Healthcare Partnerships (RHP).
- ▶ Each RHP developed a plan that identified the participating partners, community needs and proposed projects.
- ▶ Each RHP is “anchored” by a public hospital or other governmental entity.
- ▶ University Health System is the anchor for RHP 6

Texas HHSC's 20 RHP Regions

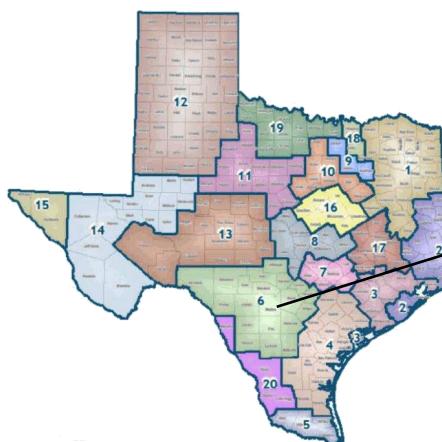
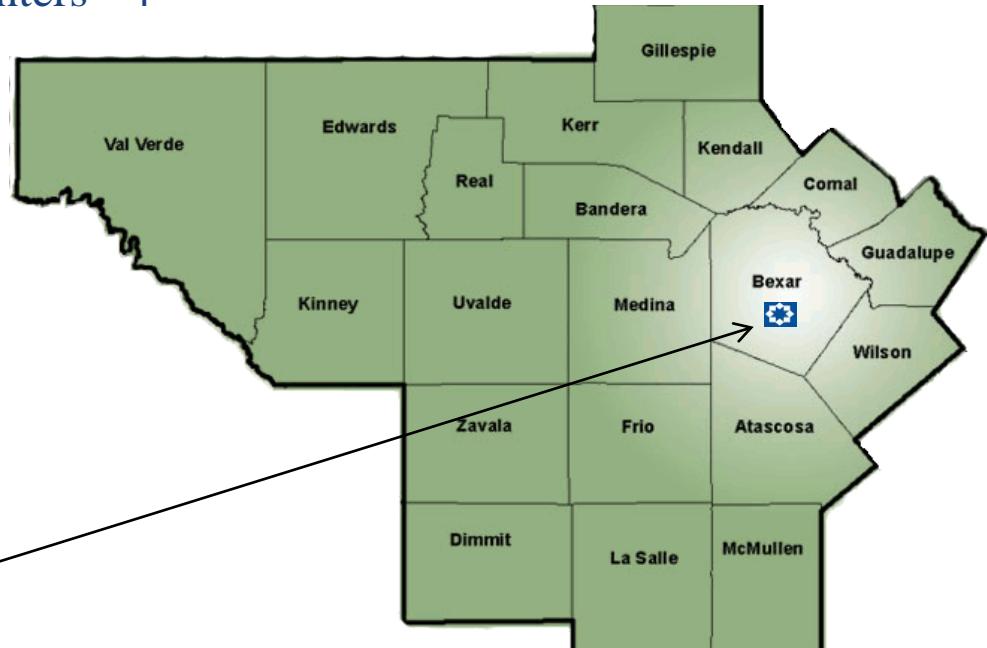


RHP 6

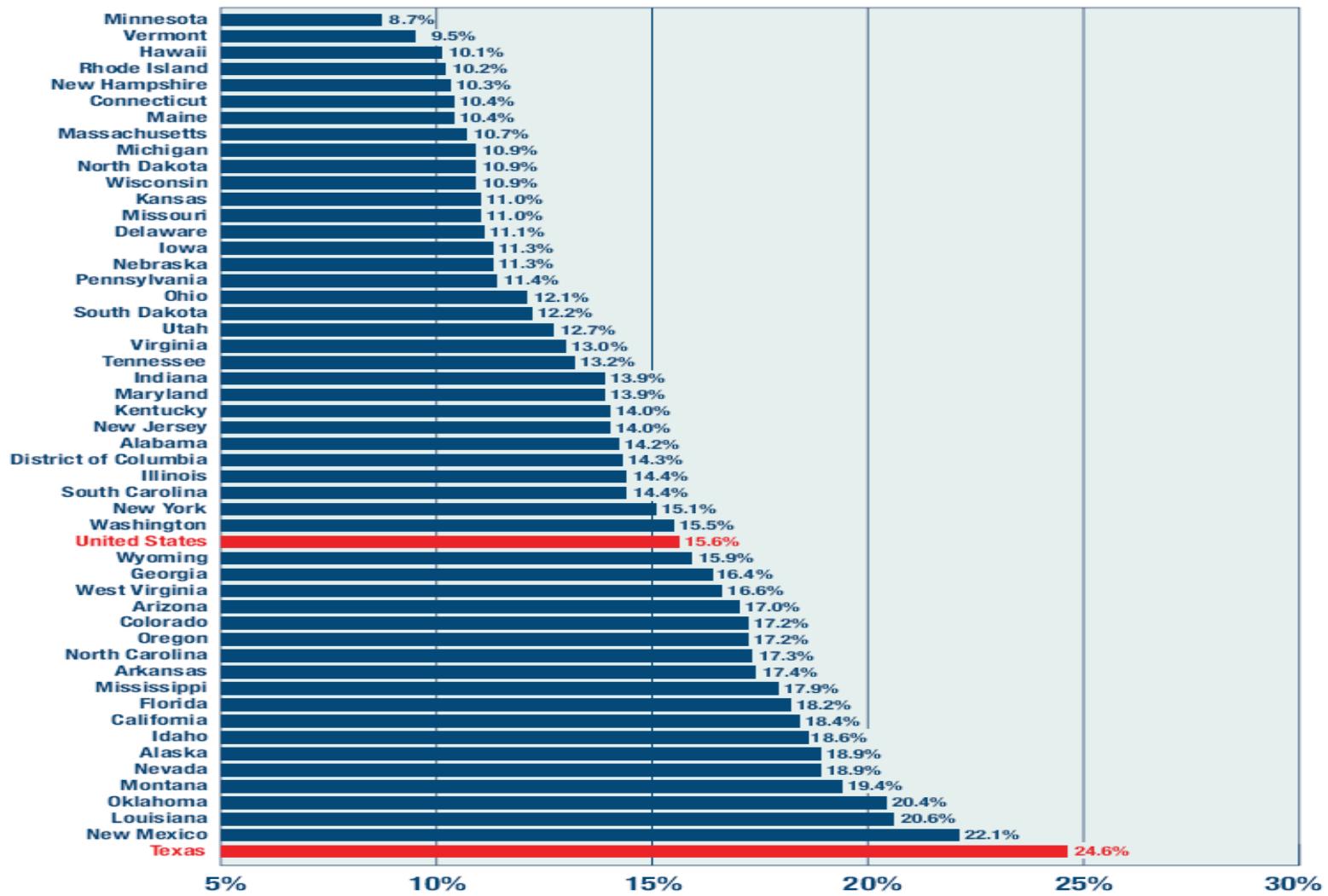
RHP 6

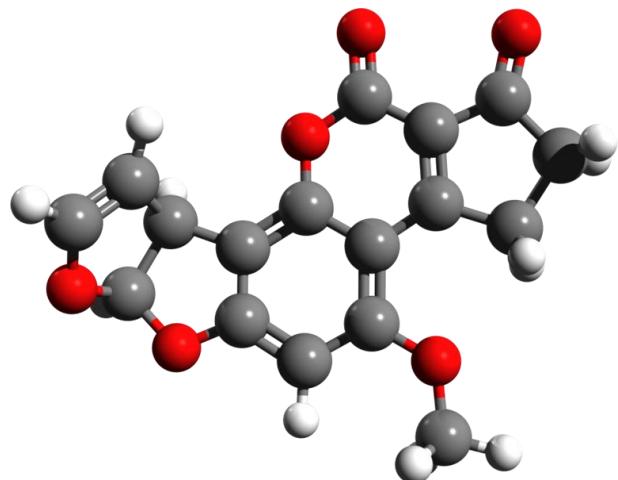
28 Participating Providers:

- ▶ Hospitals - 21
- ▶ Community Mental Health Centers - 4
- ▶ Physician Groups - 2
- ▶ Local Health Department - 1



Texas Ranks 1st in Percentage of Uninsured





DSRIP STRUCTURE

CATEGORY 1 - 4

Planning Protocol Overview

Category 1 and 2: Projects

- ▶ Category 1 projects focus on infrastructure development
 - Category 1 menu contains 14 Project Options
- ▶ Category 2 projects focus on program innovation and redesign
 - Category 2 menu contains 19 Project Options

Category 3: Outcome Measures

- ▶ Each Category 1 or 2 project selected up to three Category 3 Outcome Measures

Category 4: Population-focused Improvements

- ▶ All hospitals must participate and report outcome measures in each of 5 separate reporting domains (RD), reporting domain 6 is optional

Category 1, 2 and 3

Project Type

Category 1 Infrastructure Development

- Investments in technology, tools, and human resources that strengthen ability to improve services.

Category 2 Program Innovation and Redesign

- The piloting, testing, and replicating of evidence based innovative care models.

Outcome Measures

Category 3 Quality Improvement

- Reporting and improvement of clinical outcomes

Category 4

Population-focused Improvements

All hospitals must participate and report outcome measures in each of 5 separate reporting domains (RD), with an optional 6th domain.

RD 1 Potentially Preventable Admissions (PPAs)

RD 2 Potentially Preventable Readmissions (PPRs)

RD 3 Potentially Preventable Complications (PPCs)

RD 4 Patient-centered healthcare

RD 5 Emergency Department - Admit decision time to ED departure time for admitted patients.

Optional RD 6 Initial Core Set of Health Care Quality Measures



**University
Health System**

DSRIP Timeline

DY1

Oct. 1, 2011-
Sept. 30, 2012

- Waiver Approved by CMS
- Menu of Projects Distributed
- Anchors & RHP Regions Selected
- RHP Plans Submitted

DY2

Oct. 1, 2012-
Sept. 30, 2013

- Implement 4-Year Projects
- Achievement and Reporting of Category 1 and 2 Measures

DY3

Oct. 1, 2013-Sept.
30, 2014

- Implement 3-Year Projects
- Achievement and Reporting of Category 1 and 2 Measures
- Report Category 3 Measure Baselines
- Report Category 4 Measures

DY4

Oct. 1, 2014-Sept.
30, 2015

- Achievement and Reporting of Category 1 and 2 Measures
- Report Category 3 Improvement
- Report Category 4 Measures

DY5

Oct. 1, 2015-
Sept. 30, 2016

- Achievement and Reporting of Category 1 and 2 Measures
- Report Category 3 Improvement
- Report Category 4 Measures



UNIVERSITY HEALTH SYSTEM & COMMUNITY MEDICINE ASSOCIATES

DSRIP PROJECTS

DSRIP Projects

26 Projects (23 University Health System and 3 Community Medicine Associates)

Category 1

Infrastructure Development
(13 Projects)

- Increase Primary Care Trainees
- Expand Capacity (5 Projects)
- Implement Disease Registry (2 Projects)
- Interpretation Services
- Telemedicine
- Enhance Oral Health Services
- Develop Behavioral Health Crisis Stabilization Services (2 Projects)

Category 2

Program Innovation &
Redesign
(13 Projects)

- Expand Patient-Centered Medical Home Model
- Expand Chronic Care Management Models (2 Projects)
- Improve Patient Experience
- Preventative Screening
- Process Improvement
- Patient Navigation Program
- Use Of Palliative Care Programs
- Interventions To Avoid Medication Errors
- Expand Transitions Of Care (3 Projects)
- Integrate Primary and Behavioral Health Care Services

DSRIP Coordination and Structure



DSRIP Oversight Team

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**University
Health System**

HIGHLIGHTED PROJECTS

- Palliative Care
- Medication Management
- Transitions of Care, Care Model, and Navigation

Palliative Care



► Purpose

- ▶ To provide access to comprehensive supportive care services for patients who are at risk for serious illnesses.
- ▶ To improve quality of life for patients and families facing serious illness through intensive communication.
- ▶ To provide pain and symptom management, advanced care planning, and coordination of care.

► Accomplishments

- ▶ Developed learning series which has provided education on palliative care to hundreds of health care providers and increased awareness among clinical staff about the service to patients.
- ▶ Has promoted standardization of EMR to better track palliative care patients and ensure all patients receive high quality care that is documented uniformly.

Palliative Care



**Educate 450 Unique Primary Care Specialists in Providing
Palliative Care**

DY	Goal	Achieved
DY2	150	172
DY3	150	167
DY4	90	97
DY5	60	TBD
Total	450	436

Palliative Care

Percent of Palliative Care Patients with a Pain Screening

DY	Goal	Achieved
DY2	25%	99% (10 months)
DY3	50%	96%
DY4	60%	97% (through April)
DY5	75%	TBD

Increase the Number of Palliative Care Consults over the Pre-DSRIP baseline of 277

DY	QPI Goal	Total Goal (QPI + 277 Pre-DSRIP Baseline)	Achieved
DY3	894	1,171	1,259
DY4	913	1,190	859 (through April)
DY5	939	1,216	TBD

Palliative Care



► Project Category 3 Outcomes

- ▶ Increase the percentage of patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
- ▶ Increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns.
- ▶ Increase the percent of patients with documentation that an interdisciplinary family meeting was conducted on or before day five of a medical intensive care unit (MICU) admission.

► Key Collaborations

- ▶ Health Care Providers
- ▶ Patients and Families

Palliative Care



Challenges

- ▶ Outdated data collection mechanisms.
- ▶ Increasing need for palliative care.
- ▶ Number of clergy available to provide spiritual support.
- ▶ Finding times when physicians are available for training.

Lessons Learned

- ▶ Frequent and thorough review of charting by rotating learners helps achieve success by ensuring the learners are being oriented to expected standards of care and documentation.
- ▶ Cooperation with the University Health System Spiritual Care department to support the single team chaplain is essential.
- ▶ The addition of more clinic days has helped increase the number of consults and to increase the quality of care.
- ▶ Utilization of e-learning has facilitated the completion of training of physicians milestones.

Medication Management

Purpose

- ▶ Provide access to a clinical pharmacist in the ambulatory and hospital setting.
- ▶ Educate patients with chronic conditions who are on multiple medications.
- ▶ Provide medication reconciliation to patients.

Accomplishments

- ▶ Encourage patients to be actively engaged in their own health care.
- ▶ Improve medication management and continuity between acute and ambulatory settings.
- ▶ Working with other DSRIP projects to identify high risk patients who may benefit from pharmacy counseling.
- ▶ Have partnered with other health systems for ideas on structure for medication management.



Medication
Management

Medication Management



Manage medications for targeted patients

DY	QPI Goal (Unique Individuals)	Achieved (Unique Individuals)	Achieved (Visits)
DY3	1,500	1,601	2,982
DY4	1,800	1,431 (through April)	3,389 (through April)
DY5	2,160	TBD	TBD

Medication Management

- ▶ Project Category 3 Outcomes
 - ▶ Reduce the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
- ▶ Key Collaborations
 - ▶ Pharmacy leadership
 - ▶ Physicians
 - ▶ Primary Care Medical Home interdisciplinary team members



Medication Management

- ▶ Challenges
 - ▶ Pharmacists need to provide numerous consults with individual patients.
 - ▶ Lack of space for consults to take place.
 - ▶ Recruiting additional pharmacist was a challenge, however, an additional pharmacist will come on board in August 2015.
- ▶ Lessons Learned
 - ▶ The importance of developing a strategy for identifying the patients that will benefit the most from medication management.
 - ▶ Healthcare providers should not assume another provider is teaching a patient about their disease or medication. Each discipline should take ownership in educating patients.



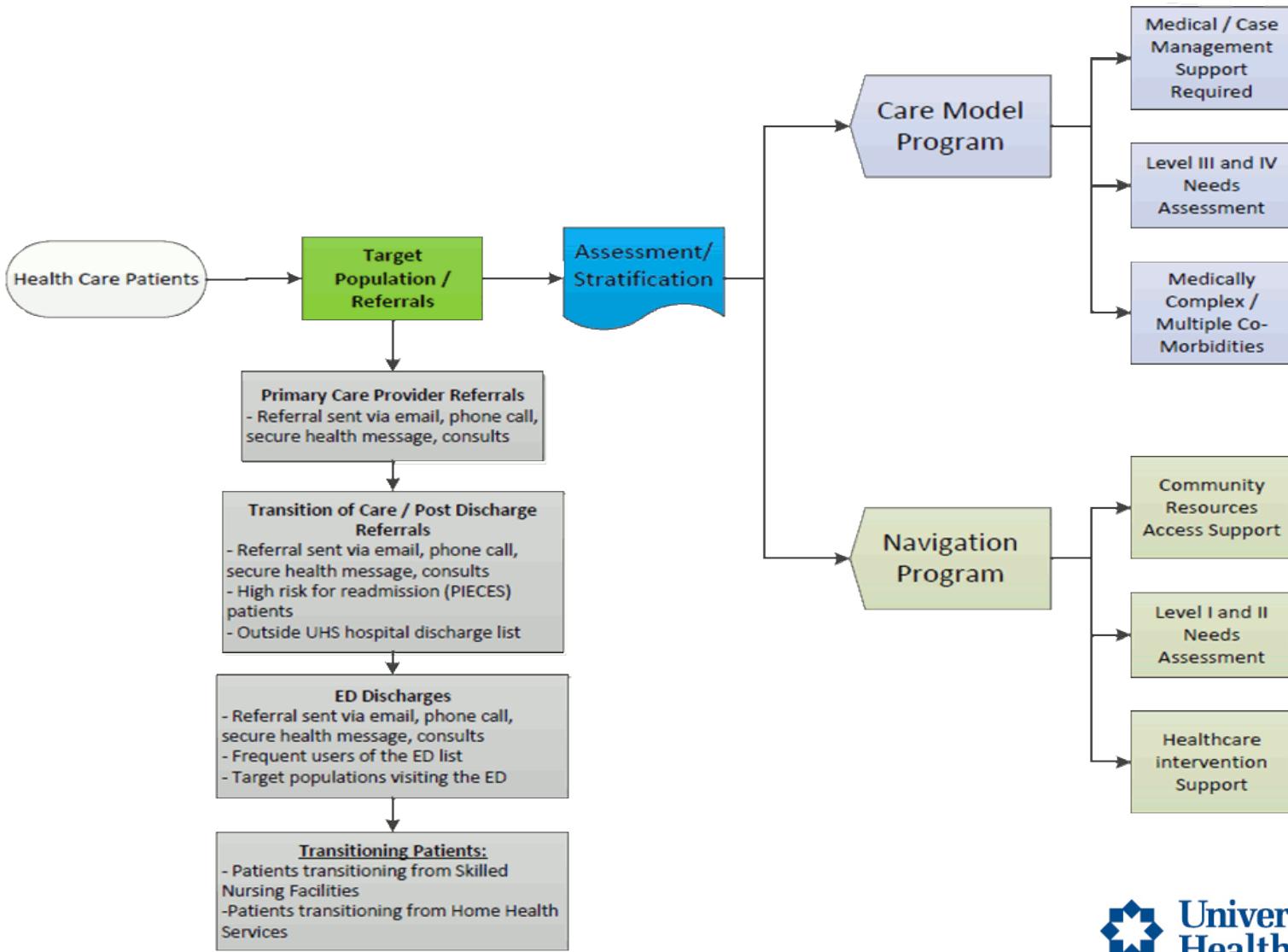
Medication
Management

Care Coordination Projects

Care Model Navigation Transitions of Care



Program Partnership Matrix



Care Model, Navigation, and Transitions of Care

- ▶ Purpose
 - ▶ Establish an interdisciplinary care coordination team within an ambulatory network of care – Care Model
 - ▶ Establish a patient navigation model comprised of social workers and case managers within the ambulatory setting – Navigation
 - ▶ Implement a care transitions program to improve patient engagement after visit– Transition of Care
- ▶ Accomplishments
 - ▶ Expanded services to six clinics from two clinics
 - ▶ Standardized the Care Coordination Process for stratifying patients and for patient support.
 - ▶ Implemented Connect System to follow up with patients who have been recently discharged from the hospital.
 - ▶ Expanded services to the Emergency Room, which more than doubles population that can be reached.
 - ▶ Have acted as a hub for transitioning high risk patients between inpatient and outpatient care.

Care Model, Navigation and Transitions of Care

DY2-DY5 Targets for Care Coordination Projects

Project	DY2	DY3	DY4	DY5	Cumulative* (through April 2015)
Care Model	N/A	600	900	1,150	1,154
Navigation	50	500	800	1,200	2,519
Transitions of Care	N/A	15,000	16,500	18,500	25,097

*Cumulative achieved DOES NOT represent unique patients.
Providers are allowed to count the same patients across years.

Care Model, Navigation and Transitions of Care

Category 3 Outcomes

- Decrease the rate of ED utilization for preventable Diabetes conditions or complications – Care Model and Navigation
- Decrease the risk adjusted rate of hospital admissions (stays) for a subsequent readmission for any reason within 30 days of discharge for patients 18 years of age and older. – Transitions of Care

Key Collaborations

- Social Workers, RN Case Managers, and Patient Navigators
- Medical Providers and other allied health professionals



Care Model, Navigation and Transitions of Care

Challenges

- ▶ Staff turnover.
- ▶ Patients remaining engaged in process.
- ▶ Data collection at the beginning of the projects.

Lessons Learned

- ▶ The need for care coordination services is vast, so finding the patients with the highest needs is important to ensure limited resources are directed at the appropriate patient.
- ▶ Have conducted PDSAs aimed at reducing the gap between discharge from hospital and the outpatient setting.
- ▶ Utilizing the electronic medical record to more accurately track patients by acuity and to stratify patients according to need.





DSRIP Transformation

- ▶ Improve access to care
- ▶ Process improvement
- ▶ Increase collaboration within and outside of the Health System
- ▶ Implement needed programs such as Palliative Care, Medication Management and Transitions of Care
- ▶ Improvement in clinical outcomes



DSRIP Findings: University Health System

Questions

DSRIP Findings: University Health System Presenters

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