CENTRAL HEALTH

Community Health Champions

Workshop IV

August 16, 2017

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Welcome

Workshop IV

August 16, 2017
Geronimo Rodriguez, Chief Advocacy Officer,
Seton Healthcare Family

Seton PROVIDENCE

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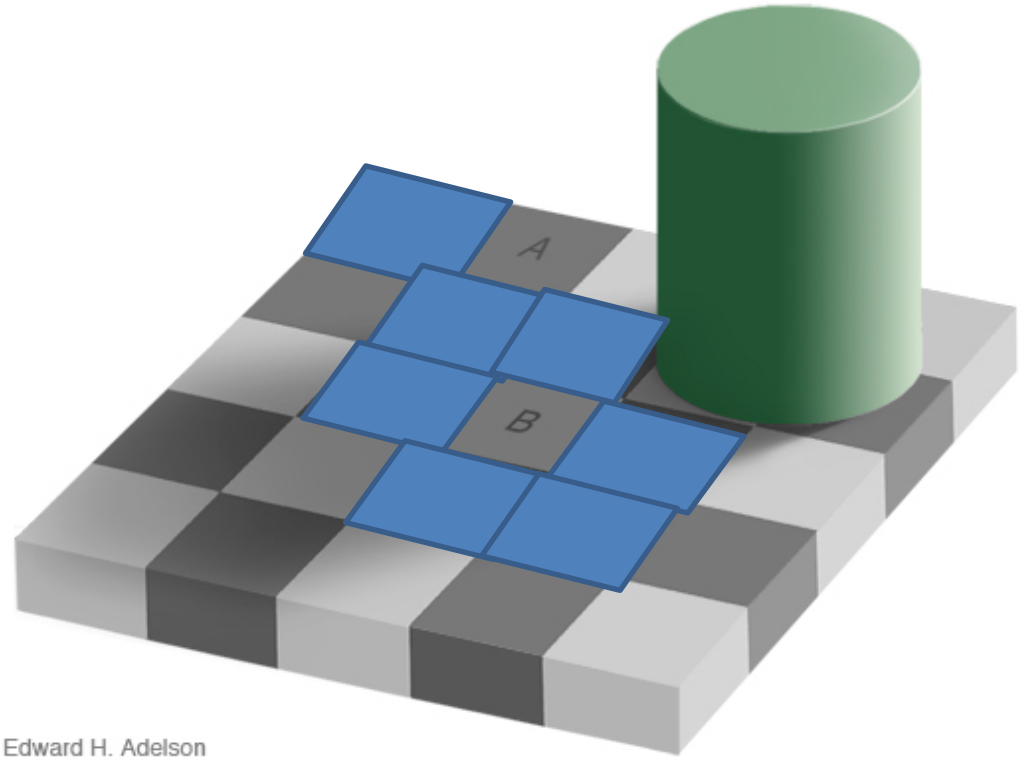
Ascension Texas Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities.

We are advocates for a compassionate and just society through our actions and our words.



Edward H. Adelson

Three Asks

ONE:
Connect to the **Mission** of your organization

TWO:
Get to know each other; have coffee or lunch with someone **different** than you

THREE:
Encourage diversity, inclusion and cultural competence as part of your teams dialogue

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Birth of the Community Care Collaborative

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Christie Garbe, Vice President
and Chief Strategy Officer, Central Health

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History of Local Safety Net Health Care

1884:

- City-County public hospital opens (future site of Brackenridge)

1907:

- Travis County withdraws support; city of Austin takes over operations

1995:

- Seton steps up to operate the city of Austin's public hospital
- Public/private partnership created to deliver safety net health care

2004:

- Voters mandate creation of Travis County Hospital District
- City/county tax rates combined
- Model brings ***value***, but lacks ***connectivity***

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Prior to the CCC— One Safety Net, Two Systems

Clinic/outpatient system

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- Primary care
- Dental/behavioral health
- Medical Access Program(<100% FPL/ sliding fee scale (<200% FPL)

Hospital system

Seton

- Hospital/emergency department
- Inpatient/specialty care
- Seton charity care (<375% FPL)

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Fragmented Health Care

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Central Health focus:

- Public funding
- Financial stewardship
- Primary care-based patient care plans
- Provider data/ patient records

Seton

Seton focus:

- Private funding
- Manage uncapped risk
- Hospital-based patient care plans
- Hospital system data/ patient records

Results of a Fragmented System

- Separate and uncoordinated models for patient care
- Poor communication between hospital/specialty/primary care providers
- Separate financial interests
- Overuse of emergency rooms
- Unwieldy or no sharing of patient records
- No infrastructure/process to collect and analyze patient data across separate systems
- Limited ability to improve patient outcomes

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New Opportunities: The 1115 Medicaid Waiver and Proposition 1

In 2011:

- Texas applies for 1115 Medicaid Waiver
- Hundreds-of-millions of dollars are available to support:
  - Uncompensated hospital care
  - Health care projects demonstrating measurable improvements in patient outcomes (Delivery System Reform Incentive Payment—DSRIP)

In 2012:

- Travis County voters approve increasing property taxes to support Central Health

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A New, Unified System

In 2013:

- Central Health and Seton create the Community Care Collaborative (CCC)
  - 51 percent Central Health/49 percent Seton
  - Both parties agree to provide annual member payments to fund the CCC
  - Creates a mechanism to better unite the safety net health care system

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Maximizing the Opportunity

The CCC creates the opportunity to:

- Align outpatient and hospital-based safety net systems:
  - Shared financial risks
  - Joint planning
  - Improved patient outcomes
- Draw down maximum available 1115 Medicaid Waiver funding

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The CCC Delivers:
New Funding for Expanded Health Care

From 2013-16, the CCC implemented **15** DSRIP programs, achieving **98 percent** of its goals, and earning **$247 million**, which supported:

- New weekend and evening hours at clinics
  - 50,000 additional primary care visits per year
- Specialty care expansion—pulmonology
  - 2,900 additional visits per year; reduced wait from four months to less than 30 days
- Expanded psychiatric services
  - 6,159 telepsychiatry visits; new psychiatric ED
- Expanded women's health services
  - Central Health provides free long-acting reversible contraception for an additional 2,091 women
- New mobile health clinics
  - Three new mobile clinics provided 10,750 primary care appointments and screenings

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The CCC Delivers: System Alignment

Adding specialty care to community clinics
- MAP patients/Seton physicians/CommUnityCare clinics

Expanding primary care
- 19 new urgent/convenient care locations added to MAP network

Improving prenatal care
- Added high and intermediate risk pregnancy care to community-based clinics (Central Health/Seton/Dell Medical School/CommUnityCare partnership)

Sharing patient data
- Collecting/analyzing data from hospital *and* outpatient providers

Shift to value-based-care
- Provider reimbursement based on performance/quality/value, not number of encounters

Improving patient case management
- Hospital-based CCC case managers coordinate care across systems
- Centralized call center providing patients with appointments, referrals and nurse access

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The CCC Delivers: Improved Health Outcomes

Improvements from pre-CCC levels:

- Increased primary care visits by **34,000** per year
- Reduced MAP emergency room admissions by **3,000** per year
- Reduced MAP inpatient hospitalizations by **1,100** per year
- **483** patients cured of Hepatitis C
- Reduced wait time for colonoscopy screenings from four months to less than **14** days
- Increased dental care access by more than **7,000** visits per year
- Provided sexually transmitted infection (STI) treatment to more than **10,000** patients

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The CCC Delivers: New Opportunities

Central Health/Seton investment, and additional dollars earned from DSRIP programs' success is used to fund:

Skilled nursing

- Long and short-term rehabilitation services

Hospice care

- New partnership with Austin Hospice for MAP patients

MAP expansion

- Now available to ***all*** residents at or below 50 percent of the federal poverty level

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A Renewed Vision: The 2018-20 CCC Strategic Plan

Strategic Focus 1	Strategic Focus 2	Strategic Focus 3	Strategic Focus 4
Build an Integrated Delivery System	**Redesign Coverage Programs**	**Improve Value in Care**	**Optimize Health of Covered Population**
Ensure access to appropriate services for enrollees, while enhancing care coordination and continuity of care.	Redesign local coverage programs (Medical Access Program, Sliding Fee Scale, Seton Charity Care), eligibility rules and covered services to better serve residents for whom the CCC is responsible.	Use primary care setting to support value, contracting with partners for better patient outcomes, including maintaining wellness and optimizing the health of chronically ill patients; improve value within specialty care while reducing time to diagnosis and appropriate treatment.	Improve health outcomes for the patients for whom we care.

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The CCC: Looking Forward

- Financially aligned funding model
  - Shared costs
  - Shared risk
  - Joint planning
- Dell Medical School
  - Increasing services
  - Transforming care
- Leverage contracting
  - Best value
  - Most appropriate locations
- Increase transparency
  - Service delivery claims
  - Finances
- Specialty care access
  - Identify need
  - Optimize services
  - Increase provider network

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Transformation vs. Innovation

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August 16, 2017

Dr. Mark Hernandez, Chief Medical Officer,
Community Care Collaborative

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Orthopedics: Reducing Wait Times

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August 16, 2017

Cynthia Gallegos, Project Manager,
Community Care Collaborative
Devin Williams, Nurse Practitioner, Dell Medical School

Overview

- Goal: reduce wait times for MAP & SFS Orthopedic consults from 365+ days to fewer than 60 days by September 30, 2016 by:
  - Increasing access
  - Managing demand
- Initial Pilot Implementation: 4/8/2016
- Service Delivery Implementation: 6/6/2016

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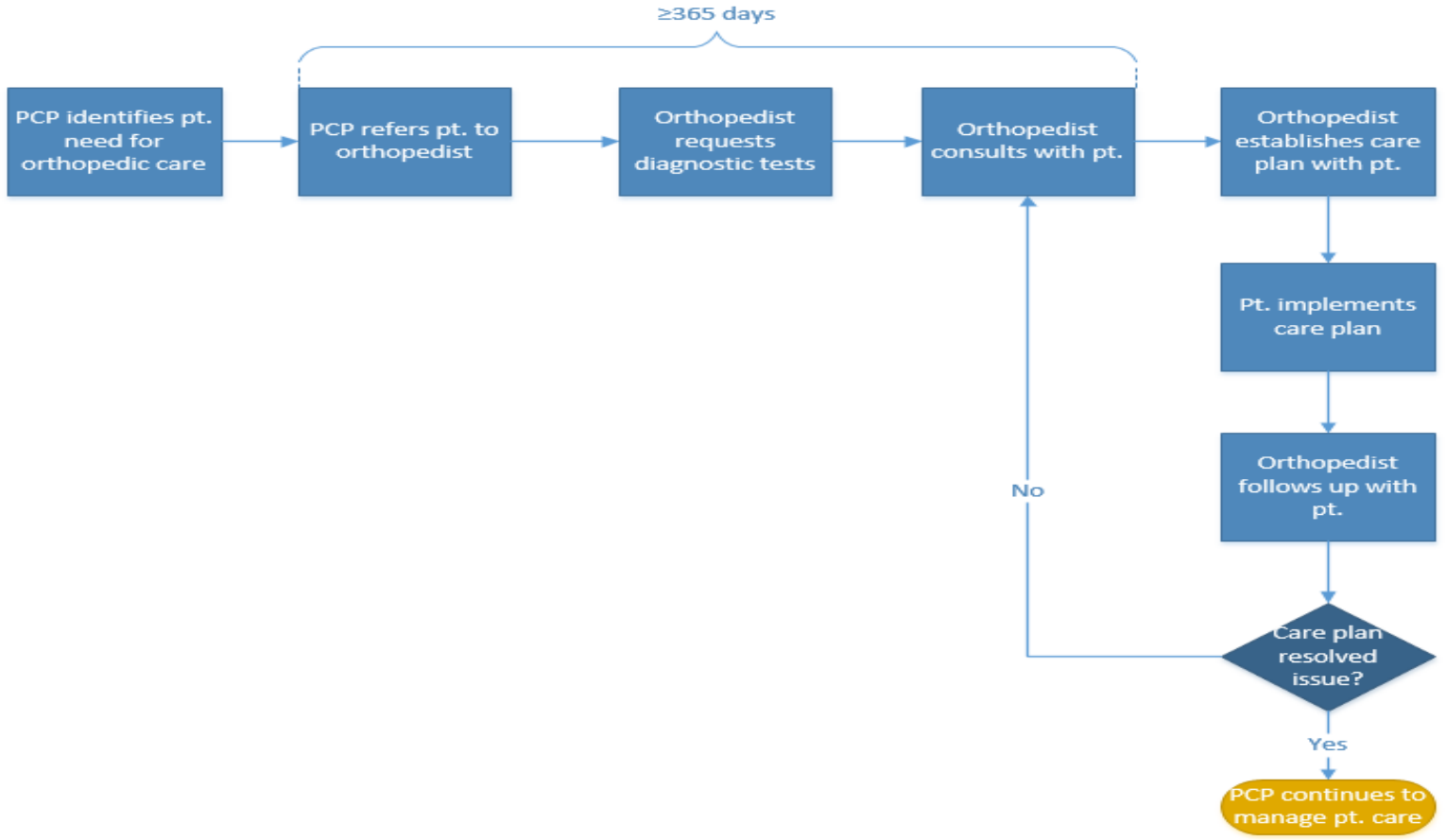
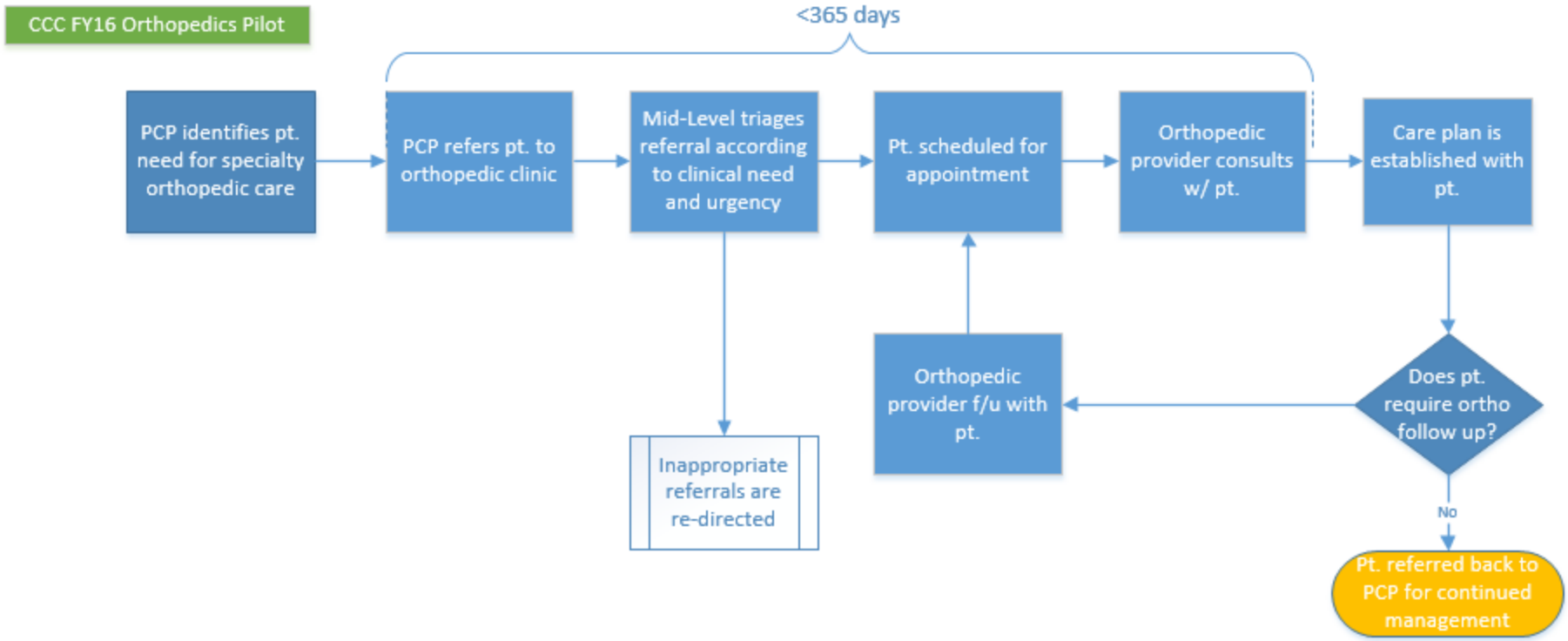
Services Today

- 3 additional half day Orthopedic clinics
- 3 Dell Medical School Providers
- Streamlined referral management process
- <30 day wait time
- No waitlist
- Provider-to-provider feedback loop

Previous State Diagram



Current State Diagram



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Increasing Access

Access

- 3 additional half day clinics
- 5 Dell Medical School Providers
- Provider to Specialist e-Consults
- Protocols to transition patier back to PCP

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Managing Demand

Provider Education

- Revised referral criteria
- Ortho Pilot education session for PCP
- Joint pain management education for PCP
- Provider to specialist e-consults
- Improved referral feedback loop to PCP

Referral Management

- Centralized referral data
- Waitlist oversight
- Provider clinical triage of referrals
- Increased ability to identify urgent referrals
- Refined referral process and protocols

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Orthopedics

		Pre- Pilot	Pilot to date
Access	Clinics/ Providers	• 1 half day clinic/ week provided by Austin Skeletal Trauma (AST)	• 3 additional half day clinics/week provided by DMS • 5 additional orthopedic providers • New partnership with Texas Physical Therapy Specialists for referrals from Ortho providers
Demand Management	Referral Processes	• Process inconsistencies • Low adherence to referral guidelines • Delays in review led to duplicate labs and imaging	• Refined referral process with CUC • Increased adherence to referral guidelines • Provider to provider referral support • Updated referral criteria • More timely referral review for triage
	Waitlist oversight	• 1 RN for multiple specialties • Limited clinical triage • Limited capability to actively identify urgent referrals	• Provider clinical triage • Timely appointments for urgent referrals
	Referral data	• Disparate referral data sources • Limited ability to centralize data	• Manual, centralized report updated weekly • LeadingReach is new referral management system
	Clinical protocols	• No existing protocols to support PCP management of appropriate orthopedic related conditions	• Joint pain protocol in development to support PCP
	Provider education	• Limited resources for provider education	• Orthopedic pilot education sessions provided to CUC providers
	Organization collaboration	• Lack of infrastructure or clear process reduced transparency • Referral follow up inquiries by PCP's submitted as new referrals	• PCP to specialist e-consultation • Timely feedback and recommendations provided to PCP for referrals • Collaboration among CUC, Seton, CCC and DMS • CCC- organized workgroup to exchange ideas with specialty frontline staff • CCC Referral coordinator liaison between partners and clinic
Quality	Right Care, Right Place, Right Time	• 365+ day wait time for ortho services • No protocols in place to release patients to be managed by PCP • Potential gaps in review process created opportunities for delay in patient care • No active review of urgent referrals	• Entire waitlist of 1400+ patients addressed • < 30 day wait time for ortho services • Following best practices for patients with injuries such as meniscus tears by having them seen by physical therapy before considering surgery • Patients released from specialist care and referred back to PCP for continued management • Referrals reviewed and directed to more appropriate setting • Active review of urgent referrals

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Work Involved

- Developed centralized waitlist for referrals
- 1425 Orthopedic referrals to review
- Estimated 160 man hours to fully review and triage initial waitlist
- 3 calls attempted for all waitlist patients

Work Involved Cont.

- Coordination with partners to obtain updated information
- Collaboration with Seton, DMS, CCC & United Way to contact patients and update providers
- Ongoing education sessions with PCP organizations
- Review of referral criteria

Key Challenges

- Lack of infrastructure for referrals
- Manual tracking of progress
- Careful coordination required when collaborating on work
- Difficulty reaching patients
- Breaking old referral habits
- Support staff turnover

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Questions?

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Virtual Care and Telemedicine

Workshop IV

August 16, 2017

Kristi Henderson, Vice President of Innovation and Virtual Care,
Ascension's Texas Ministry

Our Mission

- Committed to serving all persons with special attention to those who are poor & vulnerable
- Dedicated to spiritually centered, holistic care which sustains & improves the health of individuals and their communities
- Advocates for a compassionate and just society through our actions and our words

Today's Challenges

- Traditional healthcare system does not allow us to fulfill our mission
  - Disparities are prevalent
    - Socioeconomic, geographic, cultural
    - Cost containment efforts can further disparities
- Current model is not sustainable
  - Must be good stewards of our resources so we can continue to serve the poor & vulnerable

Solutions Center

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Solutions Center

A Multi Disciplinary Coordination and Care Team

Nurses

Social Workers, Case Managers

Pharmacists

Nurse Practitioners

Registered Dietitians
Certified Diabetes Educators

Respiratory Therapists

Health Promoters

Patient Access Representatives

Monitor Techs

PBX Operators

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What is Virtual Care?

The delivery of patient care, consultations and education supported by telecommunications technologies, via live interactive videoconferencing, store and forward technologies, remote patient monitoring, mHealth

Telemedicine

- Virtual visits, eVisits, Digital Clinics, Direct to Consumer (DTC)

Telehealth-

- Broader term that describes remote healthcare that does not always involve clinical services
- Connected Care, Virtual Care, eHealth, Digital Care,
- OnDemand Care

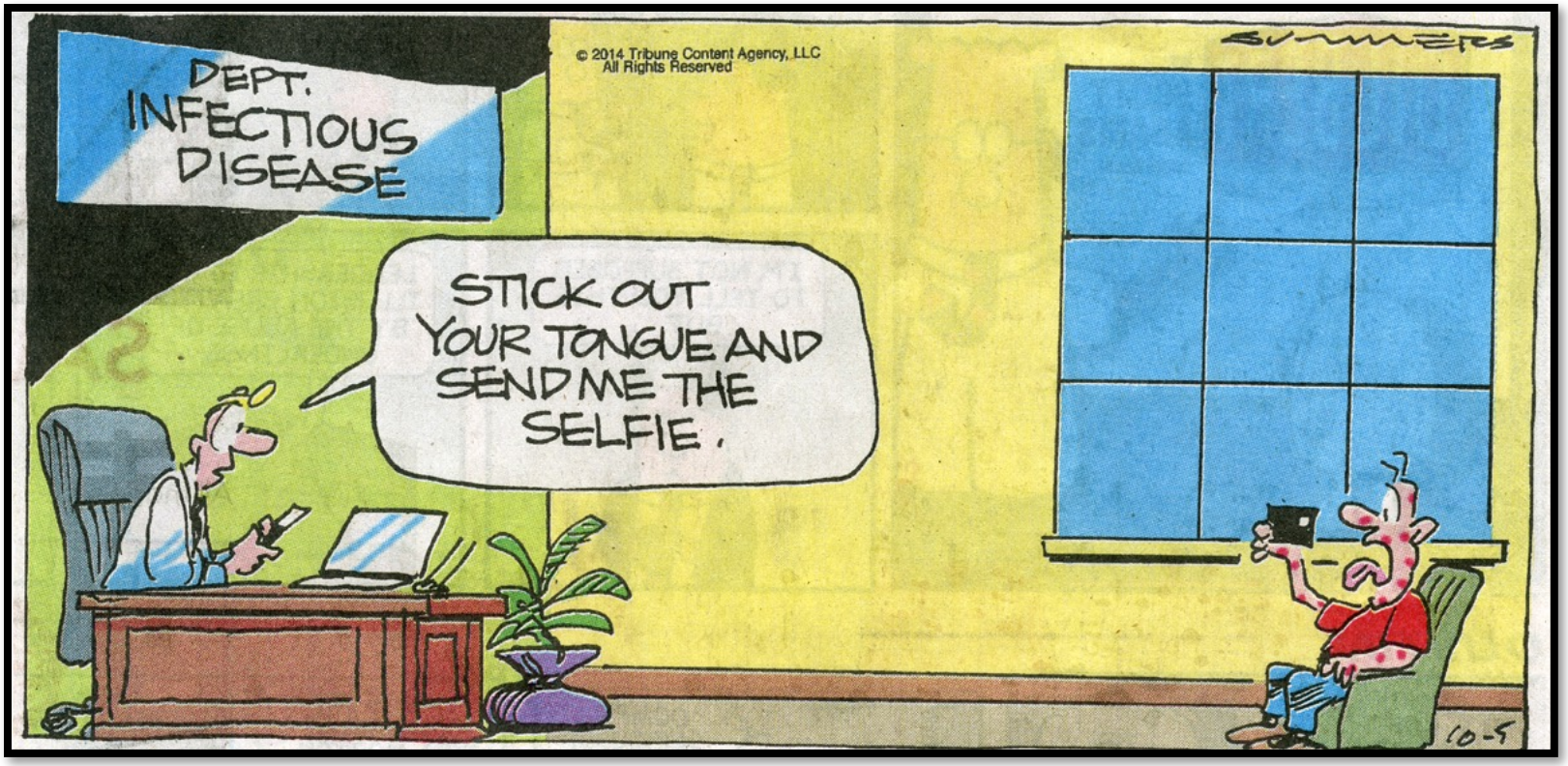
Remote Patient Monitoring (RPM)

- mHealth, Wearables, Sensors, fitness trackers

Store and Forward

How can Virtual Care Help?

- Reduces disparities
  - Geographic, cultural and socioeconomic
- New community based access points
- Shared resources for equal access
- Lower cost options
- Earlier interventions
- Self-empowerment
- Improved health


DEPT. INFECTIOUS DISEASE
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STICK OUT YOUR TONGUE AND SEND ME THE SELFIE.
SUMMERS
10-5

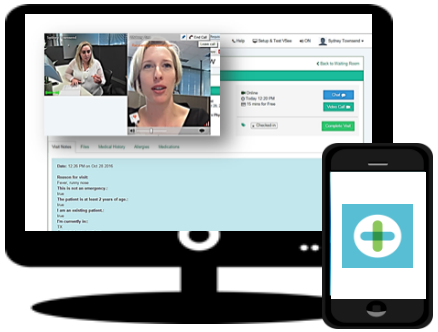
Improve Access to Care

Telehealth brings healthcare to people when & where it's needed

- Local clinic or hospital
- Workplace
- Schools/Colleges
- Nursing Homes/Assisted Living facilities
- Correctional facilities
- Mobile health vans
- Shelters, Group homes…

Virtual Care Services

TELEMEDICINE



DIGITAL CLINICS

REMOTE MONITORING

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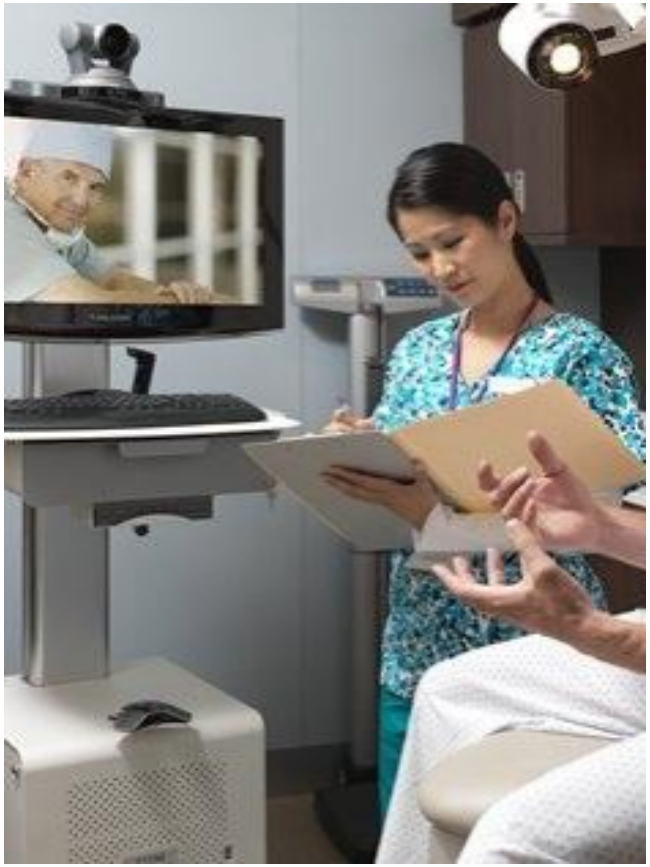

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Seton Healthcare Family

UMCB
Where the specialist is

CommUnity Care Clinic
Where the patient is

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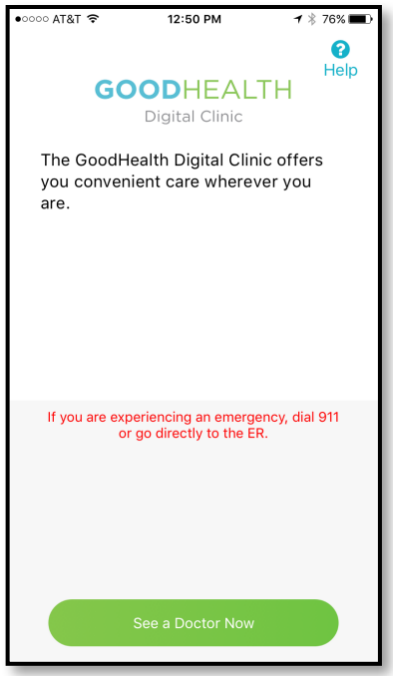

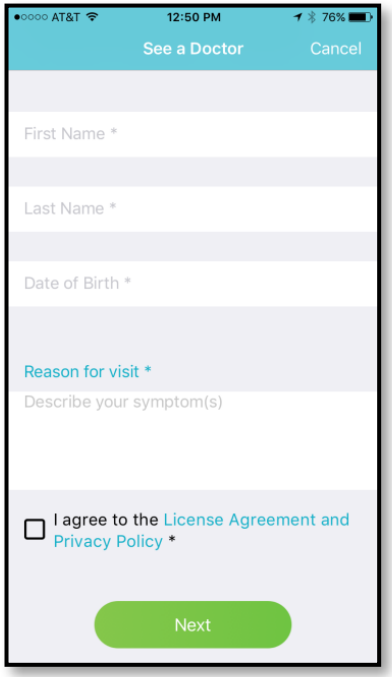

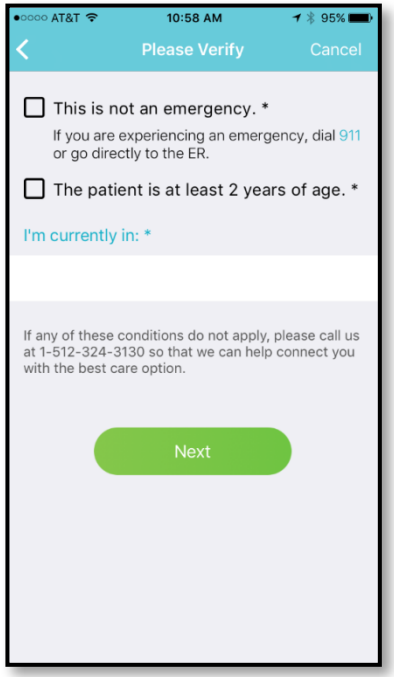

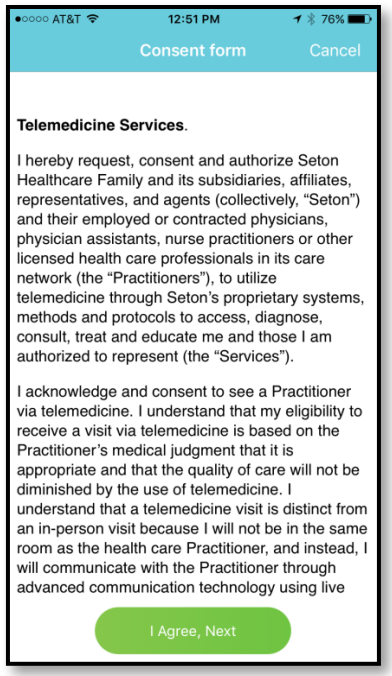

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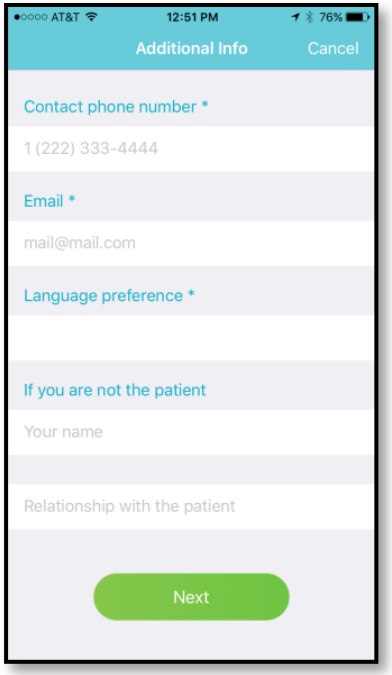

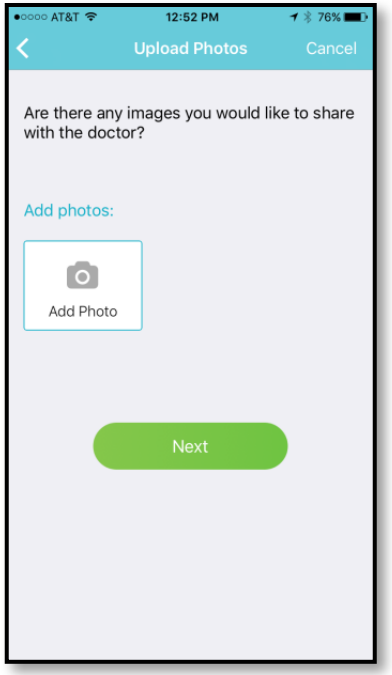

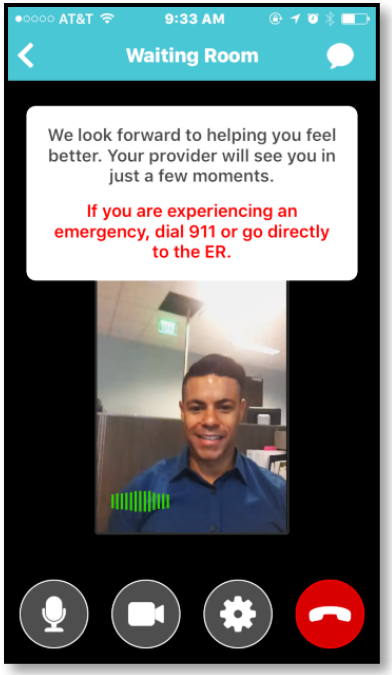

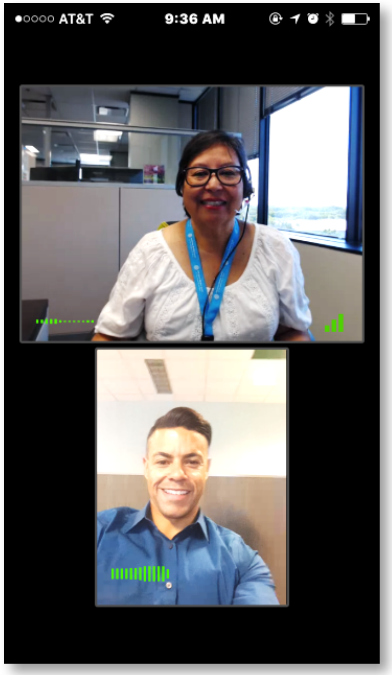

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Remote Monitoring

We provide an easy-to-use kit for patients **to take home**. It allows us to monitor health data for patients remotely, alert physicians when needed, and connect with patients in their homes over video.

Sustaining Health

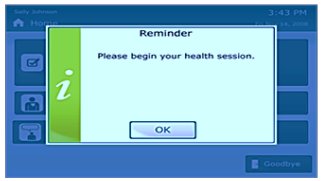
REMOTE CARE MANAGEMENT

Vital Signs and Symptom Monitoring

Engaging Educational Content

Videoconferencing

Reminders



Adherence

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Sustainable Change

Knowledge + Engagement + Support

Phase 1 Monitoring signs and symptoms
Identify resources needed

Phase 2 Learn new medical regimen
Medication management; adherence to orders

Phase 3 Disease process education
Support for changing behavior

Phase 4 Learn and model self-management behaviors
Demonstrate self-monitoring and response

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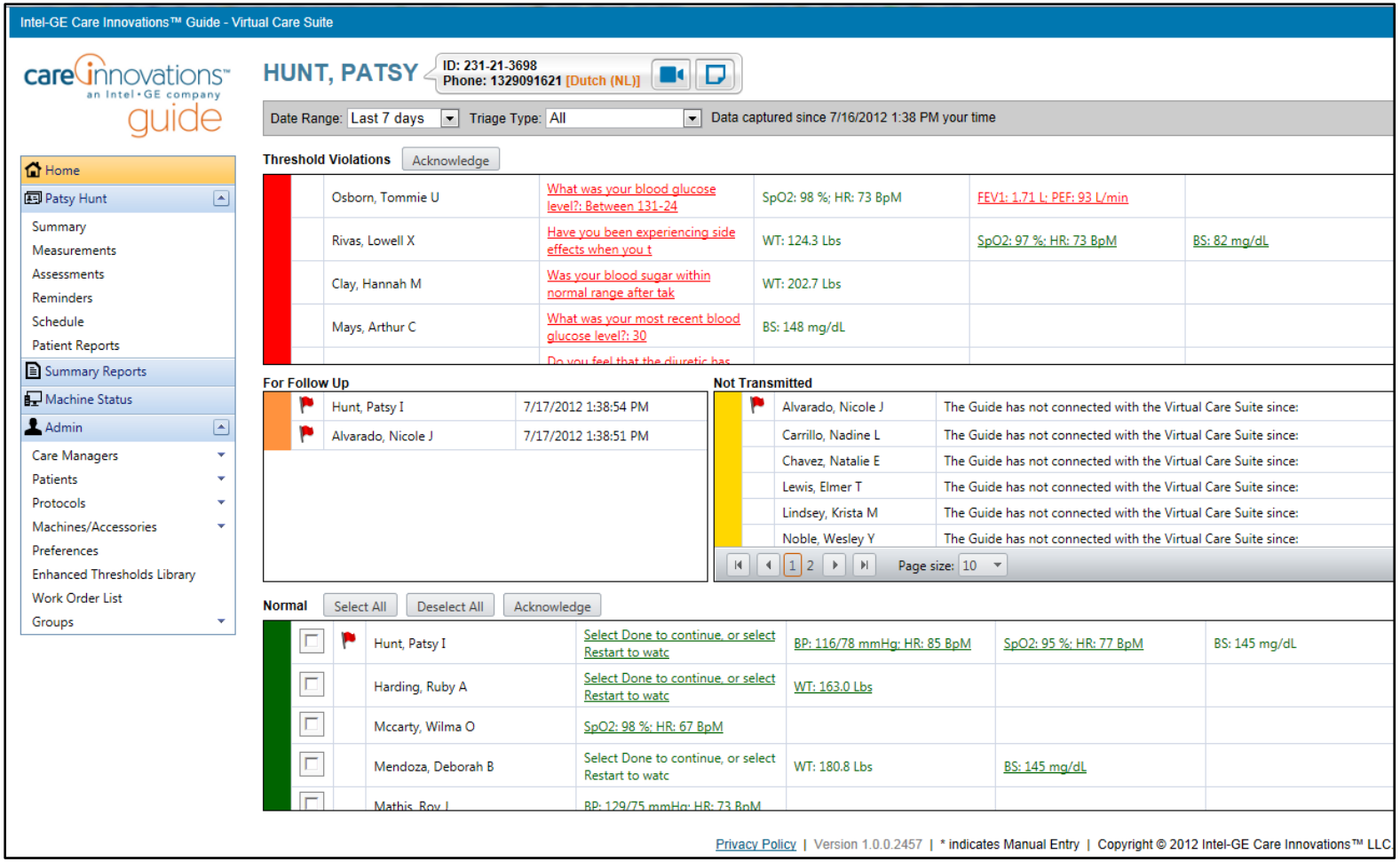

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Patient Testimony

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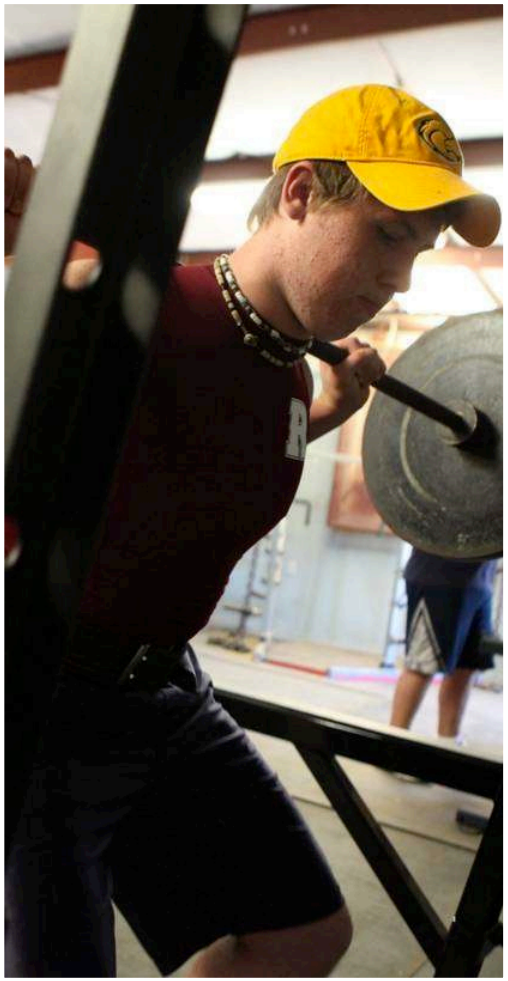
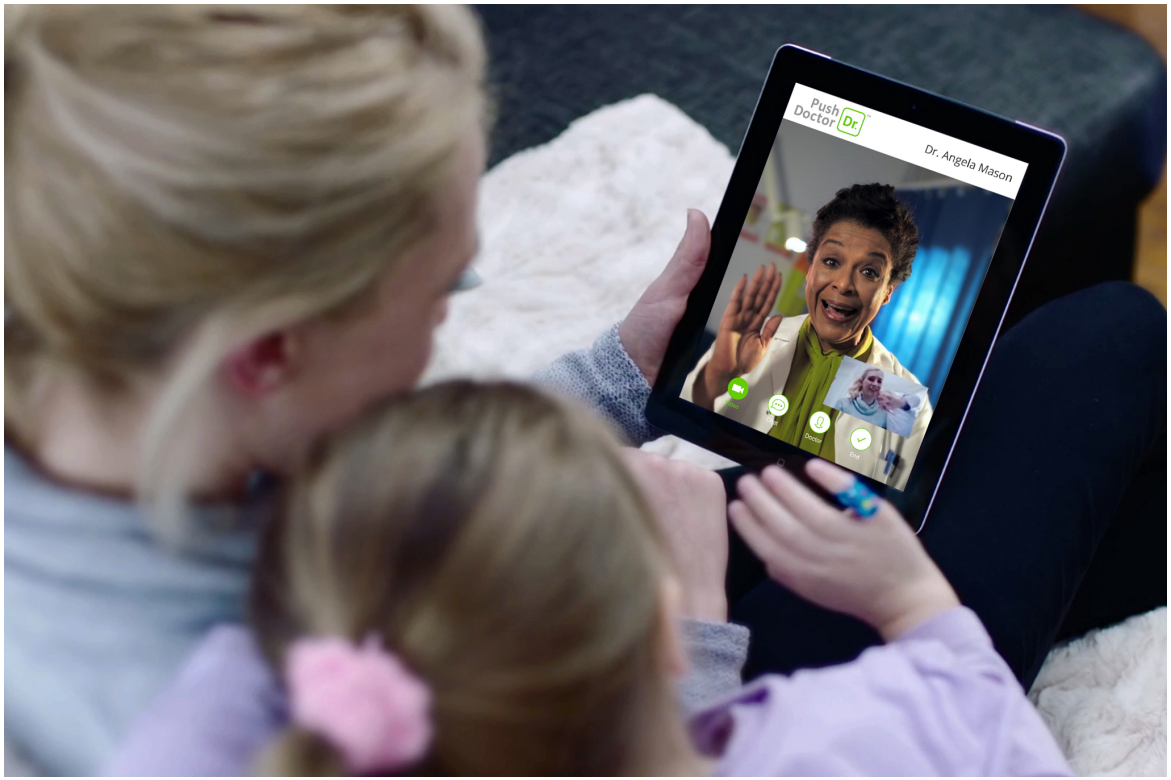


Patient Story: A Child's Laughter



What can this mean for the CCC?

- Patient Centered Medical Home
  - Primary & Specialty Care in one location
  - Multi-disciplinary team approach
  - Coordination of Care
- Personalized Health Care
  - The right level of service when and where its needed
  - Better picture of person's health (more data)
  - Support services in the home for chronic disease management
  - On Demand services
    - Medical and non-medical
- Enhanced Patient Services
  - More frequent interactions with patients with less effort
  - Shared Resources

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Questions?

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Small Group Discussions

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Kristi Henderson, Vice President of Innovation and Virtual Care, Ascension's Texas Ministry

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ANNOUNCEMENTS

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