Regional Tools to Share Information about DSRIP Projects

Two examples of regional tools to share information about the projects underway:

- A project map for RHP 3 (Southeast Texas - Houston and surrounding) to find projects by topic area, provider, zip code, Congressional and Legislative Districts. http://www.setexasrhp.com/go/doc/6182/2421626/
- An interactive Powerpoint-based tool for RHP 6 (San Antonio and surrounding) to search for projects by provider, type of provider, project area, Category 3, etc. Download this interactive tool to help you navigate the most current RHP 6 DSRIP Projects. *Posted February 2015.*

Video Examples of DSRIP Projects and Collaboration

- RHP 7 (Austin and surrounding area) - A series of videos that show the impact of a number of DSRIP projects in the region, including related to Assertive Community Treatment for individuals with intellectual and developmental disabilities (IDD), mobile health teams, adult immunizations, mobile crisis outreach services, and veterans' peer support. http://texasregion7rhp.net/

- RHP 12 (Lubbock, Amarillo and surrounding) - A new partnership with other DSRIP providers (University Medical Center Lubbock and Texas Tech) to new offer local chemotherapy to patients at the 39-bed Childress Regional Medical Center. https://www.youtube.com/watch?v=sHp3jKX2GMY&feature=youtu.be

Example of Increased Data Exchange in RHP 19

In RHP 19, all 12 counties are in what we call "white space" in Texas. This means that there is no health information exchange (HIE) in place to cover these areas. This has been an ongoing issue as HIEs have worked to become self-sustainable, but most require an institution of higher education or other system to host them.

With the unique collaborations and regional projects initiated in RHP 19, the major tertiary hospital, United Regional Health Care System, and the RHP anchoring entity, Electra Memorial Hospital, have forged a partnership creating an HIE. United is hosting an HIE powered by Cerner, and Electra is their first integrator. RHP 19 has a vision to create a single HIE for the entire region that would support data sharing, not only between hospitals and physicians, but also across the continuum of care including nursing homes, home health agencies, mental health agencies, and other providers.

To date, RHP 19 has identified the need to better coordinate care from the tertiary center back home to the primary care settings. They currently have a DSRIP project in place using United Regional's Community Partners group, which brings providers across the continuum of care together to discuss the major health issues, as well as quality. It also provides a dashboard measurement back to each

type of provider related to their patients' disposition. These dashboards include patients that were readmitted, so that information can be reviewed and analyzed in hopes of preventing any future adverse results.

This is an environment of cooperation and transparency that could make a real difference in targeting and managing super utilizers. Being able to know what care a patient has received, who and where their primary care and mental health providers are located, and being able to provide real-time information to others, is extremely important in the continuum of care. RHP 19 would like to expand the HIE to include all providers in the region, but cost and technology remain a challenge. Our goal is that the next round of DSRIP will further incentivize these unique collaborative opportunities through regional projects and HIE integration.

Projects Reviewed on CMS Monthly Waiver Monitoring Calls

Below are the summaries of projects reviewed with CMS staff on recent waiver monthly monitoring calls. These are examples of the diversity of Texas DSRIP providers and projects and the early impact of the projects.

- **Bluebonnet Trails Community Center (RHP 6, Guadalupe County**) - In collaboration with the Guadalupe Regional Medical Center, implement a patient navigation project for persons who are frequent users of the Emergency Department due to behavioral health disorders to provide rapid triage, assessment and alternative services to frequent users of the ED. The Patient Navigator has a continuum of care to offer because of expanded Substance Use Disorder Services (supported by DSRIP), Extended Observation Unit (state funded) and the Integrated Health Clinic (HRSA funded). Over time, the goal is to move to a more value-based payment system with the Medicaid managed care plans in this area for this continuum of care, which would include payments and incentives for the Patient Navigation piece, which is critical to appropriate diversion from the ED.

  - Project update at the end of DY 3: 183 unique individuals have been served by 427 encounters in the Patient Navigator Program. Persons who have never used BTCS services have entered services after interaction with the Patient Navigation team, and the project has helped integrate services with other waiver projects (Crisis Respite, Child Crisis Respite, Transitional Housing, Seguin Extended Observation Unit, Georgetown Extended Observation Unit, and Expanded Access Program) and with existing BTCS services (Intellectual and Developmental Disabilities, Mental Health Services).
  - Category 3 outcome measure - IT-3.14 Behavioral Health /Substance Abuse 30-day Readmission Rate

- **Texas Children's Hospital (RHP 3, Houston/Harris County)** - Establish a patient centered medical home for medically fragile children in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes from pediatric providers to a medical home with services provided by adult providers.
  - Project update at the end of DY 3: Our project met its goal of adding 123 new Medicaid patients in DY 3. Other major accomplishments include standardizing a referral process

design to eliminate access barriers, successfully replacing several key staff members, educating community providers to care for complex patients and working with disease specific clinics to develop a defined transition plan.
  o Category 3 outcome measure - IT-10.1.a.i Assessment of Quality of Life (AQoL-4D).

- **Amarillo Public Health Department (RHP 12, Amarillo)** - Expand mobile clinics, which includes the development of an Immunization Program for low income adults 19 years and older, purchase vaccine to immunize targeted adult population ages 19 and older who are indigent or Medicaid, employ staff members to provide adult vaccines, and purchase mobile clinic vehicle to operationalize outreach for adult safety-net vaccination events.

  o Project update at the end of DY 3: The first mobile clinic was held on September 27, 2014 at the Amarillo Civic Center - 167 clients received 436 immunizations.
  o Category 3 outcome measures - IT-12.10 Adults (18+ years) Immunization status, IT-12.4 Pneumonia vaccination status for older adults, IT-12.6 Influenza Immunization -- Ambulatory.

- **Community Care Collaborative (RHP 7, Austin/Travis County)** - Expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and have frequent recent Emergency Department (ED) utilization.

  o Project update at the end of DY 3: The program served 103 new patients due to the DSRIP effort (new staff, an additional vehicle and necessary equipment). These patients are all considered low-income uninsured, have two or more chronic diseases and have been to the ED 2 or more times within a 30 day period. Additionally, the team incorporated data from the patient's 30 day care plan into the CCC health information exchange (HIE), allowing all providers using the HIE to access this information.
  o Category 3 outcome measure - IT-9.2 Reduce ED visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000.