Community Care Collaborative

The Community Care Collaborative 's Implementation and Enhancement of Chronic Disease Management Registry Functionalities

307459301.1.1 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)3 will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will implement and use chronic disease management registry (DMR) functionalities to alert and inform care teams when patients with one or more chronic diseases require intervention and follow up, according to the CCC's newly formed Chronic Care Management Model (DSRIP Project 307459301.2.2). The DMR functionalities will be one component of an integrated health information technology (HIT) solution for CCC providers that will support analytics, patient care, care management interventions, and disease management. As the HIT captures clinical histories and real values, it will support not only patient management through a medical home but a clinician's next decision at a point of care.

Need for the project: The current system of care has no coordinated Health Information mechanism to track and manage the care that the complexly ill receive. The design of clinically-integrated DMR capabilities across the CCC contracted provider network will help ensure that providers have access to real-time clinical data, reports, reminders, and analytics to better manage care for these patients across the service continuum.

Target population: All care providers within the CCC network will be expected to implement and use the DMR functionalities. Of the 50,000 patients at or below 200% of FPL that the CCC expects to cover initially, an estimated 18,000 have multiple chronic conditions, including heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes; many more have only one chronic condition. In addition, all patients who come into contact with the CCC, regardless of payor, will benefit from DMR functionality. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: The project will add at least twelve thousand patients to the providers' expanded DMR functionalities by DY5: 3000 in DY3, 4000 in DY4, and 5000 in DY5. These patients will benefit, in turn, from the enhanced care that providers will be able to offer through use of the DMR.

Category 3 outcomes:

1.20: Comprehensive Diabetes Care LDL Screening
1.13: Diabetes Care: Foot Exam
1.14: Diabetes care: Nephropathy

Project Title: **The Community Care Collaborative 's Implementation and Enhancement of Chronic Disease Management Registry Functionalities**

Project Option: 1.3.1 – Implement/enhance and use chronic disease management registry functionalities

RHP Project Identification Number: **307459301.1.1 Pass 3**

Performing Provider Name: **Community Care Collaborative (CCC)**

TPI: **307459301**

Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this DSRIP project, the CCC is proposing to implement and use chronic disease management registry (DMR) functionalities to enable a systematic and coordinated approach to caring for its patients with chronic diseases. Of the initial 50,000 patients covered by the CCC, 18,000 (36%) are expected to be patients with two or more chronic conditions. The DMR functionalities will be one component of the expanded health information technology (HIT) solution for CCC providers that will support disease management, analytics, patient care, care management interventions, and disease management. This intervention is one of a package of 15 DSRIP projects that transform the safety net health care system in Travis County, several of which provide clinical services to those with chronic disease. The other projects are:

- Patient Centered Medical Homes
- Chronic Care Management Models
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Telepsychiatry in Community Clinics
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- Community Paramedic Navigator Project
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- STI & HIV Screening and Treatment &

- Pregnancy Planning
- Referrals
    - Comprehensive Patient Navigation
    - Centering Pregnancy

Taken together, all fifteen projects will improve patient health and the experience of care, and control healthcare costs as the CCC launches an ACO-like safety net care system.

Chronic diseases are characterized by gradually worsening symptoms that often do not manifest themselves until they are somewhat progressed. Once diagnosed, the diseases must be managed by the patient and caregiver on a daily basis. Individuals who do not have a medical home, however, are (1) more likely to be unaware of their condition and thus uneducated on the changes they need to make; (2) unlikely to be scheduled for follow-up appointments to monitor their health status; and (3) unlikely to receive referrals for specialty care or other support services. Individuals without a medical home also tend to access services wherever is affordable and convenient, primarily in the emergency department. Care for these individuals is made more difficult for providers unable to access real-time data on any diagnoses or care the individual may have received prior to their visit. Ensuring all patients have a medical home is being addressed by implementation of the Patient Centered Medical Home models, DSRIP project 307459301.2.1. This DSRIP project addresses information for the care teams.

The design of clinically-integrated DMR capabilities across the CCC contracted provider network will capture key administrative and clinical data on that subset of CCC patients with chronic conditions. The DMR capabilities will assist the provider care team to:

- Ensure that these patients receive the proper care at the appropriate time;
- Track the progress and outcomes of care to determine best practices;
- Identify the need for follow-up services;
- Empower patients to take an active role in their treatment; and
- Allow for risk-stratification to identify and target individuals with highest needs.

While the CCC contracted network of primary care provider teams will monitor, update, and evaluate these data on a regular basis, this information will be available to all providers within the CCC delivery network, including those involved in specialty, acute, and emergency care to help better inform treatment throughout the care continuum.

This project will build on the achievements of the Integrated Care Collaboration (ICC), a 501(c)3 non-profit formed by the community's safety net healthcare providers, around HIE design and implementation and care collaboratives. With the DMR functionalities enhanced and implemented throughout the network, the following benefits will be realized:

- There will be enhanced health care outcomes for the targeted patients.
- The patient/provider team encounter improve through use of care standards and access to timely, objective clinical care data.
- The larger community will benefit through more effective use of health care resources based on best care practices.

Goals and Relationship to Regional Goals:

Project Goals

The implementation and enhancement of DMR functions are proposed to help shift the alignment of health care in Travis County from a siloed, sick-care focus to an integrated well-care/prevention focus. The goal of implementing these DMR functions across the CCC network is to enhance the technological infrastructure that will support the management of care of patients with one or more chronic conditions to ensure that they receive the right care at the right time in the right place.

Specifically, the five year goals are to:

1. Roll out the functionalities to CCC providers;
2. Enroll at least 12,000 patients in the registry and generate reports based on their condition, activity, and the CCC's Chronic Care Models.
    - 3. Ensure proper care for patients as enabled by the DMR functions, as demonstrated by increasing rates of critical monitoring & testing of the Category 3 improvement targetsComprehensive Diabetes Care LDL Screening
    - Diabetes Care: Foot Exam
    - Diabetes care: Nephropathy

RHP Goals

This project aims to improve the health of individuals in Travis County with one or more chronic conditions through improved care coordination facilitated by electronic infrastructure development. This project will help meet the following regional goals:

RHP Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 population.

RHP Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.

RHP Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

RHP Goal 4: Bolster individual and population health by improving chronic disease management.

Challenges:

There are a number of potential challenges in the development and implementation of enhanced DMR functions:

1. Registry Design. A number of design factors will need to be agreed-upon, including the initial population of the registry in terms of patients and data markers to be tracked for each chronic disease, where the registry will be housed and managed, the ability to adapt the registry for future needs or in response to lessons learned, legal issues of confidentiality, and frequency/types of system reports.
2. Interoperability with the CCC providers' various clinical information systems. Any DMR functions developed will need to interoperate and exchange data with the different EMR/HIE systems and existing in-house DMR systems to minimize impact to provider care workflow.
3. Data consistency. In order for data to be meaningfully collected and tracked across providers, there must be consistency in the data markers to be collected as well as how the data is measured and reported. This will ensure

objectivity.

4. Maximizing Use of Registry. Consistent utilization of the registry by all CCC providers is key. Some provider teams will need to be convinced that the registry will aid their provision of care, be willing to adopt new care processes as needed, and be able to efficiently obtain and use information from the registry.

How this Project Addresses those Challenges

The resolution of each of these issues will be facilitated by the long history of collaboration among CCC contracted providers through their participation in the Integrated Care Collaborative, described above, which has already resulted in the development of a baseline HIE and some collaborative care programs. It will also be guided by federal meaningful use standards as established by the Office of the National Coordinator for Health Information Technology (ONC) and other identified best practices on DMR implementation.

5-Year Expected Outcome for Provider and Patients:

The 5-Year expected outcome for this project is the implementation of a fully integrated, standardized but flexible DMR which will allow the CCC to adequately aggregate clinical and administrative data on its most high-needs patients, facilitate patient navigation, inform health care treatment, and allow for risk stratification of patients. This project is expected to reduce complications related to chronic diseases for the 12,000 CCC patients with chronic conditions who will be enrolled by DY5. It will reduce complications by providing access to timely, coordinated data to allow for better controlling of health measures such as blood pressure as well as monitoring of successfulness of treatment interventions.

DYs 2 and 3 will be used to identify one or more target populations, determine current technology capabilities for each contracted provider, and identify cross-functional teams to coordinate functionality design and evaluation. The initial roll-out of the DMR functions will occur by the end of DY3. DYs 4 and 5 will expand the implementation and use of registry functionalities throughout the network on a disease-by-disease basis, as CCC-approved protocols are implemented; increase the number of patients in the directory; and enhance reporting capabilities. The CCC plans to implement the registry functionalities in all three Travis County FQHC systems by DY 5.

Starting Point/Baseline:

Currently, system-wide DMR functionalities do not exist within the CCC. Therefore, the number of patients entered into the disease management registry DY2 is 0.

We anticipate entering at least 12,000 individuals into the registry over the DSRIP period.

Rationale

The findings of the Community Needs Assessment for RHP 7 underscore the current and potential future impact of chronic disease on our residents if no changes are made to the current health care system and patient management of health status. The following data is in the CNA:

- Chronic conditions are the current leading causes of death in Region 7, and diabetes rates are rising across most counties.
- The percentage of Hispanics within Region 7 is projected to increase from 34% to approximately 41% in 2016. This demographic typically has higher rates of diabetes, obesity, and physical inactivity compared with Whites.
- The population throughout Region 7 is aging. Two of the fastest growing age groups in Travis County are adults age 45 to 64 and adults 65 and older. Rates of diabetes and other chronic diseases tend to become more prevalent with advancing age, and an older population will contribute to additional demand for healthcare resources.

Further, the Texas Department of State Health Services (DSHS) reports that between 2005 and 2010, there were 35,612 preventable hospitalizations in Travis County, at nearly $1 billion in charges. Most were for related to chronic conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), hypertension, and asthma. *(http://www.dshs.state.tx.us/ph/county.shtm)*

It is clear that a better way to manage the care of these individuals is needed to increase patient quality of life and reduce stress on the health care system through preventive care. The implementation and use of DMR functionalities across the CCC system will allow for more proactive, patient-focused, and collaborative care to help provide the right care, in the right place, at the right time.

Project Components:

The CCC is proposing to implement and enhance DMR functions to manage care for its target population with chronic conditions. This project will include all DSRIP-required core project components.

a) *Entering patient data into a unique chronic disease registry.* The specific conditions and health status markers to be tracked will be defined during the design process in DY2. In demonstration years 3, 4 and 5, as the CCC rolls out protocols related to the management of these specific chronic conditions, providers' patients with the indicated condition will be entered into the registry through creation of a disease profile within the DMR.
b) *Using registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, and family need.* Data will be integrated with the various EHR systems to facilitate access for provider care teams.
c) *Using registry reports to develop and implement targeted QI plans.* Reports will allow for tracking of impact of interventions as well as identification of implementation issues. The CCC will use data from all projects, analyze the effectiveness of interventions, and allocate future resources as needed.
d) *Conducting on-going QI projects by using methods such as rapid cycle improvement, etc.* Lessons learned will be shared and used to improve processes, with all CCC DSRIP projects.

Unique community need identification numbers the project addresses:

CN.7 Lack of coordination of care across settings of care, multiple conditions, and physical and behavioral health

CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions

CN. 9 High rates of chronic disease such as: cardiovascular disease, cancer, diabetes

CN.10 Many residents in Region 7 have multiple chronic conditions

How the project represents a new initiative or significantly enhances and existing delivery system reform initiative:

While Travis County has benefitted greatly from the work of the Integrated Care Collaborative, there remain limitations in the existing HIE system that will be resolved and enhanced through this project as well as through the CCC's Patient-Centered Medical Home project being proposed under Category 2. Limitations of the current system

include –

- The need for providers to log out of their own EHR or other data system to log into the ICC system to access patient data from other providers.
- The limited amount of access to real-time clinical data that could inform the next steps in the care process.
- The need for a higher level of standardization across data systems that would address semantics in text fields, etc. to allow for easier and more accurate reporting.
- An enhanced cross-walking system to allow for greater bi-directionality of data flow.

The work to be done to implement the DMR functionalities and PCMH will address these issues and greatly facilitate the coordination of care across CCC's contracted network continuum.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

The CCC receives no DHHS funding.

Related Category 3 Outcome Measures:

- Comprehensive Diabetes Care LDL Screening
- Diabetes Care: Foot Exam
- Diabetes care: Nephropathy

Relationship to Other RHP Projects

The CCC's 15 projects are all interrelated and will provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC projects most closely related to this project are outlined below.

List of Related Category 1 & 2 Projects

307459301.2.1: Patient-Centered Medical Home Project

307459301.2.3: Integrated Behavioral Health Intervention for Targeted Chronic Disease Patients

307459301.1.8: Telepsychiatry in Federally Qualified Primary Health Clinics

307459301.2.4: Sexually Transmitted Infection Screening, Treatment, and Prevention

List of Related Category 4 Projects

RD-1. Potentially Preventable Admissions (1-8)

RD-2.7. All-Cause: 30-Day Readmissions

RD-4.2. Patient Satisfaction

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

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

137265806.2.6: Chronic Care Management: Adults

137265806.2.9: Adult diabetes inpatient chronic care management

133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models

201320302.2.2: Expansion of Community Diabetes Project

137265806.2.6: Chronic Care Management: Adults

137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will create regular opportunities to share ideas and solve problems, including bi- annual, region-wide meetings, conference calls, on-going use and updating of the RHP 7 website, and smaller, topical meetings as needed to share information, updates and best practices. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Within the CCC, providers will meet at least monthly to discuss implementation and operation issues associated with the DMR project and other data analysis and IT-related projects.

Project Valuation:

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity.

Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.