Community Care Collaborative
The Community Care Collaborative's Patient-Centered Medical Home Model
307459301.2.1 – 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, efficient delivery of services, and lower costs.

Intervention(s): Through this project, the CCC will build a "neighborhood" of patient centered medical homes. All of the providers who work with the CCC to deliver care to safety net populations in Travis County will be expected to achieve certain levels of PCMH practice. The primary care clinics that are part of the CCC will be expected to implement the entire medical home model, and to work towards some level of PCMH recognition. As each provider implements the medical home model, there will be opportunities to share best practices across organizations at frequent "town hall" learning collaborative meetings.

Need for the project: The redesign of the local health care delivery services is needed to address the lack of care coordination and prevalence of high cost incidents, including preventable emergency room visits and hospital admissions within the region. Through the adoption of the PCMH model and the implementation of the CCC's 14 other DSRIP projects, critical infrastructure and services will be developed that will allow for better data exchange between hospitals, medical homes, and patients; shared care standards will be implemented; access to care will expanded, and delivered by a patient-focused, multi-disciplinary care team. The CCC will use this Patient Centered Medical Home project as the true building block for its redesign of the indigent care system as it transitions Travis County to accountable, outcome-based care.

Target population:. The CCC's covered population will initially be around 50,000 persons under 200% of the Federal Poverty Level. All of these patients will be affected by the implementation of PCMH model. In addition, all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from more patient-centered care. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: Through this project, we project that in DY3, 10,000 patients will receive care through clinics adopting the PCMH model; in DY4, 22,500 patients will; in DY5, 37,500 patients will. In total, by the end of DY5, 70,000 patients will receive their care through clinics following the CCC's PCMH principles.

Category 3 outcomes:
1.4 Annual monitoring for patients on diuretics
1.2 Annual monitoring for patients on ACE/ARBs
1.12 Diabetes care: Retinal eye exam

Title of Project: The Community Care Collaborative 's Patient-Centered Medical Home Model
Project Option: **2.1.4 –** Enhance/Expand Medical Homes "Other" project option: Implement other evidence-based project to enhance/expand medical home in an innovative manner not described in the project options above.
Unique Project ID: 307459301.2.1 – 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. 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 align 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) 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.

The Patient Centered Medical Home Project is the centerpiece of the CCC's 15 proposed DSRIP projects. Through the PCMH Project, the CCC will see its entire network of safety net providers adopt core features of patient centered medical homes. All three Federally Qualified Health Center networks – which will together account for over 25 clinic sites in Travis County by DY5 – will achieve system-wide 2011 NCQA PCMH accreditation by DY5. Each year, the number affected by implementation of the medical home model will increase, as changes are implemented through the CCC system. Every patient who receives services at one of the safety net providers within the CCC will benefit from this healthcare practice transformation, whether part of the CCC's covered population or not.

The other DSRIP projects are:

- Disease Management Registry
- Chronic Care Management Models
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- Telepsychiatry in Community Clinics
- STI & HIV Screening and Treatment & Referrals
- Pregnancy Planning
- Community Paramedic Navigator Project
- Comprehensive Patient Navigation
- Centering Pregnancy

These fifteen DSRIP projects, taken together, will transform how indigent care is delivered in Travis County. The breadth of transformation would not be possible without the adoption of a PCMH model of care delivery, creating a neighborhood of medical homes that reflects how care is delivered within the safety net – by multiple providers in multiple locations. By creating better linkages between providers through the PCMH model, which is then undergirded by shared protocols and an integrated disease management registry, the CCC is building a wellness-focused experience for the patient while it improves coordination and reduces costs.

The goals of the CCC align with those of the PCMH model. As stated at its launch, the CCC's "system of care will incorporate new capabilities and services that shift from a focus of treating illness to emphasizing the prevention of illness, management of chronic diseases and the promotion of health. This more effective system will support collaboration among providers, care managers and navigators who will work in partnership with the patient toward a shared goal of improved health. … To accomplish the goals, the new system will have in place appropriate technology that knits together providers, navigators and care managers in multiple locations. This will include a comprehensive patient database and analysis tools that support improved clinical care, patient management and navigation."[1]

This very closely mirrors the principles laid out in the Patient-Centered Primary Collaborative's 2012 report, *Benefits of Implementing the Patient Centered Medical Home: A Review of Cost and Quality Results*:

"The patient-centered medical home is . . . best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality and safety. It is supported by robust health information technology (health IT), provider payment reform focused on patient outcomes and health system efficiencies, and team-based education and training of the health professions workforce." *(p. 3)*

These report further details the benefits of the model as being in alignment with CCC goals:

"Data demonstrates that the PCMH improves health outcomes, enhances the patient and provider experience of care, and reduces expensive, unnecessary hospital and emergency department utilization." *(p.3)*

Even as the patient experience and health outcomes improve, the CCC will launch payment reform pilot programs. To explore different payment options, the CCC will have to have strong primary care as its backbone; a culture that supports and rewards continuous improvement; a clear organizational mission and commitment to quality and collaboration. These three elements are also principles of the PCMH model, which is another reason why its implementation is so important to the CCC.

As the DSRIP project is launched, all of the providers with whom the CCC contracts to provide services will be required to implement the core elements of the PCMH model. The three FQHCs

[1] *http://www.centralhealth.net/file/Community%20Care%20Collaborative%20One%20Page%20Overview.pdf*

that operate in Travis County will be expected to apply for accreditation. All providers will be expected to participate in regular town hall meetings to discuss the challenges and opportunities that PCMH implementation presents.

Goals and Relationship to Regional Goals:

Project Goals

The goal of this project is to establish a patient-centered model of care across all safety net providers and to improve the patient experience of care as measured through patient satisfaction surveys. In addition, patient access to care will improve, as demonstrated through a decrease in time to third next available appointments, and an increased rate of annual screenings for certain conditions.

RHP 7 Goals

This project aims to improve the health of CCC patients in Travis County through improved care coordination facilitated by infrastructure enhancements, maximization of health care resources, and improved patient care experiences. This project meets the following regional goals:

- Goal 1: Prepare and develop infrastructure to improve the health of the current and future Region 7 population.
- Goal 2: Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting.
- Goal 3: Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
- Goal 4: Bolster individual and population health by improving chronic disease management.

Challenges & How the Performing Provider Will Address those Challenges:

While some of the safety net providers have moved towards the PCMH model, there will be challenges to full implementation throughout the network as detailed below.

- Varying Degrees of Readiness/Desire for Change. Some providers will require more changes within their practice to adapt to this new model so may be more resistant to this effort.
- Coordination of Care. Providers must be willing to work collaboratively with other providers and other members of the care team on key care decisions for patients.
- Patient Self-Care. Care teams will need to be trained on the best practices for obtaining patient adoption of recommended self-care management standards.

The resolution of each of these issues will be facilitated by two important factors:

- The availability of PCMH implementation guidelines to assist in planning for and addressing these issues.
- The assistance of peers as presented through learning collaboratives and guided training sessions, not just through implementation but also in steady state of practice.

The CCC will make adequate resources available to its providers to ensure that implementing these models goes smoothly. The CCC will support CQI activities both within provider organizations and among provider organizations.

Starting Point/Baseline:

As it has just been launched, the CCC has not promulgated any PCMH standards for its contracted providers. The number of clinic networks recognized under 2011 PCMH standards in Demonstration Year (DY) 2 is 0.

Rationale

Implementing a village of Patient Centered Medical Homes represents the right choice for the CCC for two reasons: it will improve the care experience & outcomes for the patient, and will lay the foundation for payment reform.

Findings of the RHP7 Community Needs Assessment show that the community is using the most expensive care settings unnecessarily, and that services are being duplicated.

- Lack of Accessible Primary Care: Almost 50% of ED visits in 2011 were for services that could have been provided in a primary care setting. An additional 6% of visits required emergent care that might have been avoided with appropriate ambulatory care.
- Inefficient Use of Resources: Adult residents of RHP 7 have more than 8,500 potentially preventable inpatient hospitalizations per year. These hospitalizations contributed to nearly $1 billion in hospital charges between 2005 and 2010.
- Limited Collaboration and Support Systems: Qualitative regional data indicate a need for better coordination across settings of care. Specific issues include lack of co-located services; separate funding streams, lack of effective IT systems, and providers' historical focus on particular symptoms or disorders.

Through this project, providers will redesign their practice to reduce the system's reliance on these costly and ineffective resources. The PCMH model works to get patients into care when they need it, maximizing access and reducing reliance on expensive points of care and duplicative services.

Further, the CCC will not have a successful ACO-like model without the infrastructure that a neighborhood of medical homes ensures: team-based care with established protocols across multiple points of delivery. This project will build the coordination across providers and the proactive, wellness-focused, patient-centric care that can drive down costs.

Five-Year Expected Outcome for Providers and Patients: At the end of the waiver period, the CCC will have implemented PCMH elements in 100% of the CCC's provider clinics. 70,000 patients will be treated by the provider clinics that have adopted PCMH principles. In addition, 100% of the FQHCs will have achieved PCMH accreditation. Through this project intervention, we expect that patients will see improvements in third next available appointment, annual monitoring for patients on persistent medications, diabetes foot exams and patient satisfaction.

Project Components:

There are no required components associated with this project. However, many of the required core components from Project Option 2.1.2 - *Collaborate with an affiliated Patient Centered Medical Home to integrate care management and coordination for shared, high risk patients* - will be adopted, either through this DSRIP project or other CCC DSRIP projects. These core components are:

a) Improve data exchange between hospitals and affiliated medical home sites;

- This is a key component of the PCMH project. The CCC will improve data exchange between all providers who care for CCC patients by building on the current HIE to add real-time availability to clinical data; standardizing terminology and data-management practices; and facilitating the cross-walking of data among all sites. This builds on years several years of work by the local HIE – the Integrated Care Collaborative (ICC) – to establish a repository of administrative data for all safety net providers in the region.

b) *Develop best practice plans to eliminate gaps in the readiness assessment;*

- The CCC will aid all its providers in assessing and addressing their varied degrees of readiness to implement the PCMH model.

c) *Hiring and training team members to create multidisciplinary teams including social workers, health coaches, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients;*

- As above, the CCC will help its providers identify staff availability as needed to implement the model. At the same time, as the CCC cares for its patients, it will hire social workers, health coaches, care managers, and nurses to provide care management and navigation for patients.

d) *Implementing a comprehensive, multi-disciplinary intervention to address the needs of the shared, high-risk patients in a culturally-sensitive manner;*

- This will be addressed as the CCC develops its Chronic Care Management Care Models through its DSRIP project 307459301.2.2.

e) *Evaluating the success of interventions at decreasing preventable ED and inpatient hospitalization and improving interventions as necessary;*

- The CCC exists to analyze data from all of its projects, to evaluate the effectiveness of interventions, and to allocate future resources to improve the delivery and function of healthcare in Travis County.

f) *Conducting QI processes such as rapid cycle improvement.*
This will be a required activity for all CCC providers, with leadership from the CCC and its commitment to CQI. The CCC will devote ample resources to CQI, through supporting improvement at the clinic level up to the CCC's operations level.

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

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents this first great step towards establishment of an indigent care ACO-like model in Central Texas. It will also significantly enhance the collaborative work of CCC providers around HIE, data analytics, and care collaboration.

The current Indigent Care Collaborative HIE system allows for the sharing of patient administrative data among all participating community safety-net providers. While Travis County has benefitted greatly from the work of the ICC, there remain limitations in the existing HIE system that will be resolved and enhanced through this project. 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.

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

As a new initiative, the Community Care Collaborative receives no funds from the US Department of Health and Human Services. One of its founding partners, the Seton Healthcare Family, is a member of the Pioneer ACO project. There is no overlap in patient population, however, between that project and the CCC's covered population. Additionally, both the safety net providers have received federal HITECH funding. Funds through this PCMH project would not duplicate HITECH awards, as the PCMH funds would work to connect multiple systems into a network of data. We are building on existing HIE and connectivity to collate these data in order to turn it into useful information on the health status of our patients and how we can treat them. Finally, FQHCs receive HRSA funding for operations, and one FQHC is receiving funds through CMS' FQHC Advanced Primary Care Practice Demonstration. This pilot, which will conclude in November 2014, offers the FQHC a monthly care management fee per eligible Medicare beneficiary to implement certain PCMH principles and achieve NCQA Level 3 certification by the end of the project period.

Related Category 3 Outcome Measures:

1.4 Annual monitoring for patients on diuretics
1.2 Annual monitoring for patients on ACE/ARBs
1.12 Diabetes care: Retinal eye exam

Relationship to other Projects:

This PCMH project is inextricably linked to the fourteen other CCC projects listed on page 1. It forms the spine of the new indigent healthcare system that is being launched in Travis County, but all projects are part of this fully integrated system, and each makes sense as part of a larger whole.

Relationship to Other Performing Providers' Projects

The PCMH project relates to other patient-focused care programs being proposed for Travis County, including: 121789503.1.1, Expanding Primary Care Capacity for Low-Income Residents of Hays County, TX, a Pass 1 project submitted by Central Texas Medical Center. This project also is related to many of projects in Region 7 where chronic disease interventions may take place in the PCMH. Projects include:

186599001.2.1: Family and Child Obesity
137265806.2.6: Chronic Care Management: Adults
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative:

RHP 7 DSRIP participants 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 will allow for continuous improvement of regional projects, which will in turn better serve RHP 7's population and transform its healthcare delivery system.

Within the CCC, Learning Collaboratives will play a large role as continuous a means to spread best practices and share innovations. These frequent meetings will serve as reinforcement for providers who are implementing the practice changes and help reinforce patient engagement strategies that support PCMH implementation.

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.