Community Care Collaborative
The Community Care Collaborative 's Multiple Chronic Disease Management Model
307459301.2.2 Pass 3

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in April 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, 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 research, design and implement Chronic Care Management models to be used across its network of safety net providers. These models will define the clinical protocols, care team staffing, and patient self-management guidelines for the CCC's patients with one chronic condition or Multiple Chronic Conditions. In conjunction with the fourteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this DSRIP will lead to better clinical outcomes for the patient, less reliance on acute and emergency care, and lowered costs of care for the indigent care system in Travis County.

Need for the project: What the CDC has said about the United States is true about Travis County: Chronic diseases are among the most common, costly, and preventable of all health problems here. However, current safety-net health care is fragmented among numerous providers that do not operate under a single standard of care and do not have access to an efficient, shared patient data exchange. This unconnected "system" impedes timely information sharing, best practice implementation, and tracking of the total healthcare-related services received by a particular patient.

Target population: All care providers within the CCC network will be expected to implement the Chronic Care Management Models. 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. The positive impact of the models will not be limited to the CCC's covered population, however; all patients who come into contact with the CCC's provider network, regardless of payor, will benefit from the evidence-based care guidelines and team care approach. This includes thousands of low-income uninsured and Medicaid patients.

Category 1 or 2 expected patient benefits: The project seeks to enroll 13,000 patients with one chronic condition or Multiple Chronic Conditions (MCCs) in the new care model by DY5.

Category 3 outcomes:
1.11: Controlling High Blood Pressure for Diabetics

Title of Project: Expand Chronic Care Management Models: The Community Care Collaborative's Chronic Care Management Model for Individuals with Multiple Chronic Conditions
Category / Project Area / Project Option: 2.2.1

RHP Project Identification Number: 307459301.2.2

Performing Provider Name: Community Care Collaborative

Performing Provider TPI: 307459201

Project Description

Overall 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 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.

The Chronic Care Management Project will result in better health outcomes for the 13,000 patients with one or more chronic conditions who are enrolled through DY5 and who will receive evidence-based, multi-disciplinary care that is standardized across of the CCC's providers. There are an estimated 18,000 persons in the CCC's population with two or more of the following conditions: heart failure, chronic kidney disease, behavioral health issues, COPD, hypertension, malignant neoplasms, and diabetes. These patients will benefit from a robust care protocol as described in this project, but also the fourteen other DSRIP projects that the CCC is proposing. These fourteen projects are:

- Patient Centered Medical Homes
- Disease Management Registry
- 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

The CCC's Chronic Care Management Model will be comprised of:

- *Clinical guidelines* that define standards of care for the assessment, diagnosis, treatment, and pharmacological management for the chronically ill in the CCC. These clinical guidelines will be based on evidence-based best practices, and will be updated accordingly in a process of continuous improvement and refinement.
- *Care team guidelines* that define the composition, function, and tasks of the CCC's Chronic Disease Care Teams. These guidelines will describe the composition of patient care teams and lay out the CCC's approach to ensure effective clinical, pharmacological, nutritional, educational and psychosocial interventions reach the patients who need them. These care team guidelines will emphasize patient-centeredness and culturally and linguistically appropriate care.
- *Education and Self-Management Guidelines* that emphasize increasing patient capacity for self-care through knowledge expansion and behavior change.

As Wagner noted over fifteen years ago, patients with chronic illness have complex needs:

> "[The chronically ill] require planned, regular interactions with their caregivers, with a focus on function and prevention of exacerbations and complications. This interaction includes systematic assessments, attention to treatment guidelines, and behaviorally sophisticated support for the patient's role as self-manager. These interactions must be linked through time by clinically relevant information systems and continuing follow-up initiated by the medical practice."
> (Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract*. 1998 Aug-Sep;1(1):2-4.)

These needs are not currently being met by the safety net system. This DSRIP Project, along with the other CCC DSRIP projects proposed, will give CCC care teams the tools to deliver the right care in the right place.

Patients will be identified as eligible for services through the protocol at many points of care: by their providers; through the Disease Management Registry; through case managers; and at enrollment into the CCC. Multi-disciplinary care teams, staffed by navigators, social workers, nurses and physicians, will provide responsive care with an emphasis on follow-up and also self-management.

Project Goals

The CCC's Chronic Care Management Model project will:

- Design Clinical Care, Care Team, and Education & Self-Management Guidelines for the CCC population with one or more chronic conditions, with disease protocols implemented in every demonstration year;
- Train members of the provider network in operating under the Guidelines;

- Work within the newly launched Disease Management Registry to create protocol-driven care plans and provider reports;
- Implement the Model and consistently improve its operation and design using CQI principles;
- Enroll at least 13,000 patients in the appropriate protocol by DY5;
- Result in improved clinical outcomes for the target population.

Challenges or Issues Faced by the Performing Provider

Because this DSRIP project is proposing that the CCC reconfigure the safety net system to address the needs of patients with multiple chronic diseases, a number of potential obstacles will likely be encountered, including:

- Obtaining the commitment to change and continued willingness to learn from multiple providers across multiple-sized health care organizations;
- Identifying protocols that can be agreed-upon by all entities and that support care for individuals with chronic diseases;
- Ensuring that any protocols and guidelines developed can be absorbed into provider care team work flow; and
- Translating patient education materials into all linguistically and culturally appropriate methods for best transmission and understanding.

How the Project Addresses those Challenges

A challenge-free systems change may not be achievable, but several steps will be taken to aid the transition to the new management model. The CCC's leaders and provider physicians will be recruited to become champions of the change, offering visible support for adoption of the new model. This will be reinforced by the CCC's move to quality-linked payments, through which incentives will be based on quality of care, and shared savings models. Additionally, the CCC will be guided by a panel of physician-leaders that reports to the CCC's Board.

The challenge of drawing up a set of interventions that address patients with chronic conditions will be addressed through a process of continuous engagement and improvement with provider care teams. This complex model will be developed by a dedicated team hired specially for this purpose, and advised by the CCC clinical leadership team that will establish a best practice model of clinical protocols that includes coordination and navigation of patient care.

On-going shared learning opportunities throughout the implementation of the model will also facilitate the transition.

How the Project is Related to RHP Goals

This DSRIP project is related to five of RHP 7's goals:

1. Prepare and develop infrastructure to improve the health of the current and future Region 7 populations.
2. Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.
3. Bolster individual and population health by improving chronic disease management.
4. Support prevention education and healthy lifestyles to improve population health.
5. Improve the patient experience of care by increasing the quality of care and patient safety.

Starting Point/Baseline

There is no standardized Chronic Care Management Model currently used across Travis County's safety net provider system for individuals with one or multiple chronic conditions. Thus, the number of providers using the model is 0 and the number of patients receiving care under the model is also 0.

Rationale

Reason for Selection of Project Options and Components

Chronic diseases are the most common, costly, and preventable of all health problems in the county. Because these diseases are slow to progress and because the CCC serves medically-indigent individuals, many of whom have been out-of-care for many years, a high percentage of the CCC's patient population suffer from one or more chronic diseases. As the Region 7 Community Needs Assessment reports –

> Patients with multiple chronic conditions have a higher risk of potentially preventable hospitalizations, contribute to higher healthcare costs, and are a greater challenge for coordination of care. Among Travis County residents, more than 20% of uninsured and underinsured adults who received care from safety net organizations during 2011 had more than one chronic condition. (pg. 13)

Chronic diseases are characterized by gradually worsening symptoms that often do not manifest themselves until they are somewhat progressed. Once diagnosed, these diseases must be managed by the patient through changes in daily activities. Individuals who do not see a provider on a regular basis, however, are more likely to be unaware of their condition and thus uneducated on the changes they need to make. They do not receive reminders for necessary follow-up assessments or receive "check-ins" by members of a care team who can help them remember to take their medications, assess their blood sugar levels, etc., or make referrals to specialty providers and/or other support services to help ensure that they can successfully care for themselves.

As required, the following components will be implemented:

a) *Design and implement care teams that are tailored to the patient's health care needs.* The composition of these teams will be detailed in the CCC's Care Team Protocols as will the standards for best places/modes for patient engagement, and guidelines for linguistic and cultural sensitivity.
b) *Ensure that patients can access their care teams in person or by phone or email.* The Care Team Protocols will include new standards for increasing patient access to care teams, including web-based patient portals. As a number of the CCC's providers continue to develop their electronic systems to conform to Meaningful Use standards, they will be able to share their experiences with others.
c) *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources*. The CCC will codify its expectations for patient engagement in its Education and Self-Management Guidelines, which will detail roles for all levels of delivery system stakeholders to achieve maximum levels of patient engagement. Participating in RHP 7's learning collaborative, which is focusing on patient engagement, will support this component.
d) *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions.* Chronic Disease Self-Management best practice projects will be identified and implemented in accordance with the Education and Self-Management guidelines. Such projects may include peer supported trainings; community health worker facilitated workshops; and other evidence-based practices.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.* The Chronic Care Management Protocols will be living documents, subject to scrutiny and capable of evolution. Feedback from all stakeholders will be welcome, and the protocols will be constantly evaluated in terms of their ability to improve the patient experience, achieve better clinical outcomes, and lower costs. These evaluation activities will be conducted on an ongoing basis through the CCC's analytics unit, and its Clinical Leadership team, and also through its performance improvement activities.

Unique Community Need Identification Number

- CN.7 Lack of coordination of care across: Settings of care, multiple conditions, 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, & rising rates of diabetes
- CN.10 Many residents in Region 7 have multiple chronic conditions

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative

The Community Care Collaborative is a new delivery system reform initiative for all indigent populations under 200% of FPL living in Travis County. All of the projects represent large-scale attempts to transform the care delivery system.

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

The Community Care Collaborative receives no funds from the US Department of Health and Human Services.

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected

1.11: Controlling High Blood Pressure for Diabetics

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This Chronic Care Management Model Project will go hand-in-hand with two other CCC projects to build critical infrastructure and redesign care for the CCC's target population. The other two CCC projects are the PCMH Project (307459301.2.1) and its Disease Management Registry project (307459301.1.1) All three projects lay the groundwork to enhanced, patient-centered care for CCC's the complexly ill patients. The PCMH project will enable real time clinical data exchange between PCMH-focused providers and hospitals; while the Disease Management Registry project will build analytics capability to inform refinement of treatment approaches such as appear in the Protocols.

List of Related Category 4 Projects (RHP Project ID Number)

RD-1.2. Diabetes Admission Rates
RD-1.4 Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
RD-1.5 Hypertension Admission Rate

RD-2.2 Diabetes: 30-Day Readmissions
RD-2.5 Stroke: 30-Day Readmissions
RD-2.7 All-Cause: 30-Day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects
This project relates most closely to other RHP 7 efforts to enhance services for Travis County indigent adult patients that have complex medical conditions.

133542405.2.5: Implementation of Chronic Disease Prevention/ Management Models: Addressing the Health Promotion and Wellness Needs of Seriously Mentally Ill Adults
201320302.2.2 Expansion of Community Diabetes Project
137265806.2.5: Care Transitions
137265806.2.6: Chronic Care Management: Adults
137265806.2.9: Adult diabetes inpatient chronic care management

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects
RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP's anchor, will foster the development of topical learning collaboratives – smaller meetings as the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. 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.

Project Valuation

Approach for Valuing Project
In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Institute for Healthcare Improvement's Triple Aim framework, supported the 1115 DSRIP Waiver goals and addressed identified 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.