[Draft for Clinical Champion review and feedback]

DSRIP Project Self-Assessment and Peer Review

Instructions to providers here:

Peer reviewers will get information below plus an 'HHSC Coversheet' with summary information of project.

Part 1: Project Summary Information

|  |  |  |
| --- | --- | --- |
| RHP: |  | |
| Performing Provider Name: |  | |
| Healthcare system affiliation, if applicable: |  | |
| Provider Type: | [Drop-down - H, RH, AHSC, CMHC, LHD] | |
| Setting where services are delivered: | [Drop down (non-exclusive)- ambulatory clinic, inpatient setting, community outreach (e.g. school or home based services, long term care facilities] | |
| Counties served by this project: |  | |
| Target Population: | [Drop down -- Medicaid; Low-Income Uninsured; Both] | |
| Contact Name/Email/Phone: |  | |
| Project Title: |  | |
| Category 1 or 2 project ID: |  | |
| Project Type (see key): |  | |
| Secondary Type: | Such as use of Community Health Workers, Peer Supports, etc. | |
| Project Summary: | *Example: Discharge management program. This project was implemented to reduce psychiatric readmission rates by identifying those most at risk for readmission, and providing a targeted discharge program for those most at risk. The project included analysis of readmission data to identify predictors of those most at risk for readmission, and creation of a risk assessment tool. Targeted discharge planning was then provided to those most at risk. The results to date show a two-thirds reduction in readmission rate for those most at risk.* | |
| Q1: Is this project implementing an Evidence Based Model (EBM) for care delivery. If so, please include citations (links) and describe any modifications made to the EBM to provide DSRIP services. |  | |
| Q2: Has this project increased access for individuals not historically receiving services? If so, please describe who is accessing services that previously was not and the how the new access has occurred through the project. |  | |
| Q3: Estimate the number of unique Medicaid and Low Income/ Uninsured individuals served to date (DY1-current) by this DSRIP project? Please estimate the number of unique MLIU individuals to be served by the end of the demonstration? | Medicaid to date | Medicaid by end of demonstration |
| LIU to date | LIU by end of demonstration |
| Q4: Describe any specific outcome improvements achieved? Please include data on numbers and percentages affected, method of measurement, and timeframe as well as other relevant information. If you have any comparative information on potential cost savings, please identify and explain. | *Example: 2/3 reduction in psychiatric readmission rate for those most at risk. Additional data: re: number of people and reduction over what time frame. Any cost savings data.* | |
| Q5: How is this project changing the delivery system within your facility, within your partnering providers, within your region, within TX? | *Example: This project won the Texas Hospital Association’s 2014 Bill Aston Award for quality in recognition of its success in lowering psychiatric hospital readmissions. This project improves care for high risk patients, reduces costs associated with avoided readmissions, and improves the patient experience.* | |
| Q6: Describe key collaborations which are making this project successful. |  | |
| Q7: Is HIE used to support this project? If so, is this new a new agreement or an existing agreement? Please describe organizations that are participating in the HIE. If existing, describe any changes since inception. |  | |
| Q8: Describe any partnerships (contracted or less formal) used in the service delivery to DSRIP eligible patients |  | |
| Q9: Describe any improvements made into your internal data systems |  | |
| Q10: Describe any challenges encountered in program implementation, lessons learned and resolutions (if applicable). |  | |
| Q11: Describe any challenges meeting DSRIP Milestones and Metrics, lessons learned and resolution (if applicable). |  | |
| Q12: Describe how this intervention could inform a Medicaid policy change (if applicable). |  | |
| Q13: Describe any sustainability plan for this project (if applicable). |  | |
| Q14: Describe the potential for replication of this intervention to other provider, regionally and statewide. |  | |
| Other Comments: |  | |

Part 2: Assessment

Provider completes rubric below and subsequently, peers complete rubric (JW recommends blinding between provider and peer assessment -- discuss with CCs).

General (non- project areas specific) assessment - clinical champions to define rubric scores by factor.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Factor | Score 1 | 2 | 3 | 4 | 5 |
| *people* | *Addressing high need population* | {Example of possible rubric structure}- Need is low volume, minimal cost benefit, low efficacy |  | Need is low volume but high cost benefit |  | Need is a high volume, high cost benefit, high rate of disability if not done well |
| *Serves high risk population* |  |  |  |  |  |
| *outcome* | *Demonstrates*  *significant opportunity for cost savings* |  |  |  |  |  |
| *Ability to impact clinical outcomes- demonstrating patient improvement* |  |  |  |  |  |
| *Are outcome(s) selected the most reflective of project goals/activities* |  |  |  |  |  |
| *delivery* | *(CMS 5)- Aligned with evidence based practices for care delivery* |  |  |  |  |  |
| *Addresses critical infrastructure needs* |  |  |  |  |  |
| *Utilizes innovative service delivery design* |  |  |  |  |  |
| *systemness* | *Cohesive with provider level system goals* | Demonstrates improvement in provider systemness |  |  |  |  |
| *Cohesive with regional goals (see RHP plan)* | Demonstrates improvement in regional systemness |  |  |  |  |
| *Demonstrates data transparency (HIE, data sharing, statewide data systems)* |  |  |  |  |  |
| *Services to be considered for MCO integration* | Not applicable to MCO care delivery |  | Minimal benefit to be included with MCO (population covered mismatch) |  | Should be considered for MCO/Medicaid integration |
| *project* | *CMS 5: Ability to show rapid results* |  |  |  |  |  |
| *CMS 5: Addresses front line care delivery* |  |  |  |  |  |
| *CMS 5: Project Sustainability* |  |  |  |  |  |
| *CQI is a primary driver for refining program activities* |  |  |  |  |  |
| *Innovative model and potential for spread* | Not spreadable beyond provider |  |  |  | Very adaptable at large scale |
| *Integrates best practices for project type* |  |  |  |  |  |
| *Overall project transformative value* | Low transformative value |  |  |  | High transformative value |

Any other information to consider that is specific to the project type, please describe.

For example for Patient Navigation:

* Engages traditionally hard to reach patients
* Patient education
* Community Outreach- targets patients in ambulatory setting
* Addresses social determinants of health