RHP9 Texas 1115 Waiver
Transforming Healthcare Now

vitalSign6

UTSouthwestern Medical Center

Project Contact: Madhukar H. Trivedi, M.D.
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Background

Depression Remains a Major Health Problem

- 1 in 6 adults will experience depression in their lifetime with the first episode often occurring in childhood/adolescence (Hales *et al.* 2014)
- Diagnostic sensitivity of PCP's for MDD tends to be around 50% (Pence *et al.* 2012).
- Patients do not necessarily present requesting treatment for depression or accurately describe the severity of their symptoms without reference points (Alderson *et al.* 2012).
- Despite our best efforts at treating depression, many patients do not receive adequate treatment. (Kessler *et al.* 2003).
- Despite the reported shortcomings, research from the STAR*D study shows it is possible to provide high quality treatment in primary care setting with outcomes equal to those provided by specialty care (Trivedi *et al.* 2006; Gaynes *et al.* 2009). For these reasons, the MBC approach is highly recommended for primary care settings.

Project Description

VitalSign6: Making Screening for Depression the Sixth Vital Sign is an easy to use, comprehensive program for the identification and treatment of depression in primary care clinics. The program utilizes an innovative web-based iPad application (VS6) to administer the Patient Health Questionnaire (PHQ) to patients. Patients complete the PHQ on an iPad during the triage process, thus making screening for depression the sixth vital sign behind body temperature, blood pressure, heart rate, respiration rate, and oxygenation.

In the first six months of the project, software development and testing, adaptation of the measurement based care (MBC) model for use in primary care settings, and the development of training and support materials were designed, developed, and distributed. Data exchange capabilities between the UT Southwestern Medical Center (UTSW) data warehouse and VS6 clinics were completed, and the first patient was screened in August 2014.

So far eleven primary care clinics have implemented this program. Staff at each clinic has been trained on both depression and Measurement Based Care, and provided with resources supporting the VS6 program. The primary care providers are treating the patients who are diagnosed with depression using the MBC system that supports the use of best practices for the treatment of MDD.

Team

Project Sponsor
Madhukar Trivedi, MD

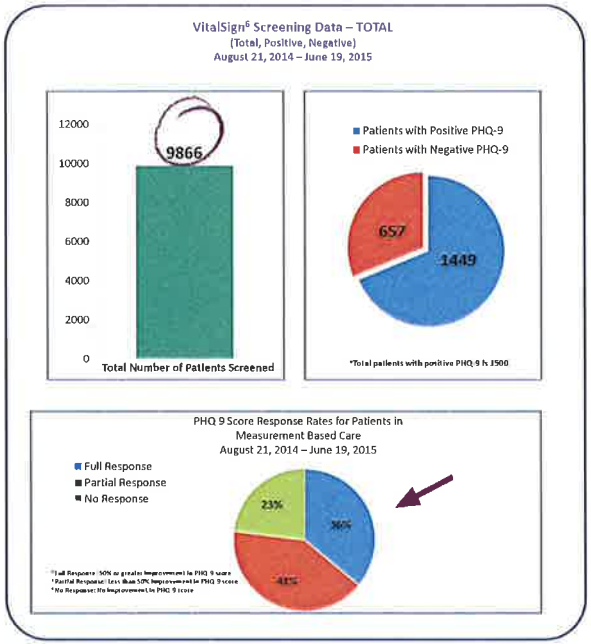
Consulting Clinicians
F. Will Clark, MD - Psychiatrist, Consulting Clinician
Mandeh Jha, MBBS - Psychiatrist, Consulting Clinician
Joseph Trombello, PhD - Consulting Clinician
Katherine Sanchez, LCSW, PhD - Consulting Clinician

Management Team
Charlotte Carito, LPC, LMHC, BC-DMT – Assistant Director DSRIP
Sara Levinson Eidelman, MPH, MSLOC - Project Director
Tiffany Huggins, BSN, RN - Clinical Operations Manager
Paola Rahaiels, MPH, MSSW - Project Manager
Penny Pipes, MA, LPC-S - Software & Application

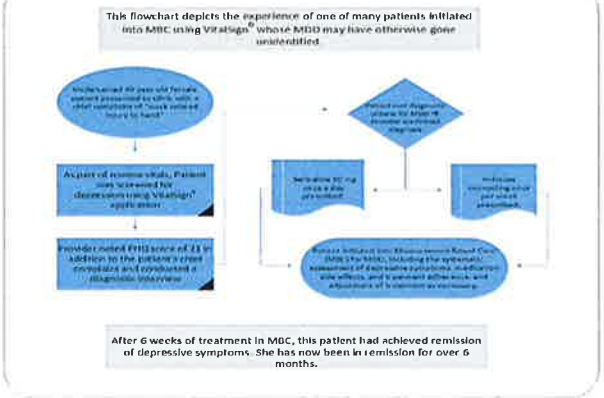
Implementation Team
Valeria Cantu- Project Assistant
Morgan Murray, BSN, RN - Clinical Coordinator
Afsaneh Rezaeiadeh, BSN, RN - Clinical Coordinator
Alma Sanchez, LMSW - Clinical Coordinator
Audrey Cecil - Clinical Coordinator
Felicity Pfaudtsang - Clinical Coordinator
Nancy de la Garza, MD - Clinical Coordinator

Analytics Team
Bruce Gronemann, MA - Evaluation and Reporting
Tom Carmody, PhD - Statistician

Outcomes



Patient Impact



Accomplishments

- Screened over 9,000 patients
- Detected over 600 cases of MDD that would have gone unrecognized
- Provided resources to clinics by developing five online CMEs courses
  - Screening and Monitoring in Primary Care Clinics Treating Underserved Patients
  - Major Depressive Disorder-Remission as a Goal: A measurement-Based Approach
  - Depression Screening Tools and the Basics of Diagnosing
  - Measurement Based Care for Major Depression: Treatment Decisions and Tactics
  - Cases in Measurement Based Care for Major Depression: Treatment Decisions and Tactics
- Launched in eleven primary care clinics

Clinics Actively Screening

Charity clinics
- Agape
- Brother Bill's Helping Hand
- North Dallas Shared Ministries
- Healing Hands Ministry

FQHCs
- HSNT (4 clinics)

UTSCAP/Private Clinics
- Compassion Care Clinic
- Dr. Amanda Perez
- Healthcare Clinics

Next Steps

- In the process of building and designing a Depression Center Network of primary care physicians to implement VitalSign6 beyond DSRIP.
- Establish a system of providing ongoing, real time, quality improvement reporting that will create valuable feedback to manage depression at the clinic level
- Work with Managed Care Plans to support the implementation of VitalSign6 and discuss payment structures for sustainability beyond DSRIP.
- Create an Extract-Transform- Load (ETL) process in efforts to push data to UTSW and generate customized reports for clinics.
- Continue to collaborate with the CME office to train providers in management of MDD in primary care settings.

Medication Management:

Expansion of Medication Management at UT Southwestern

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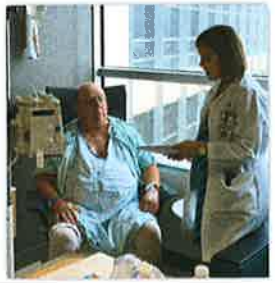
UT Southwestern Medical Center

Project Contact: Dr. Kelly Robinson, Pharm.D., M.B.A.
Contact Email: Kelly.Robinson@UTSouthwestern.edu

Project Description

Before the implementation of this program, in an average month only 43 patients received instructions from a pharmacist before discharge. The Medication Management Project strives to improve medication management for patients by providing counseling from a pharmacist at the time of discharge. By emphasizing medications with a narrow therapeutic window, our team can ensure that patients understand the important dietary and drug interactions that could significantly affect their care.



30 Day Readmission Rates

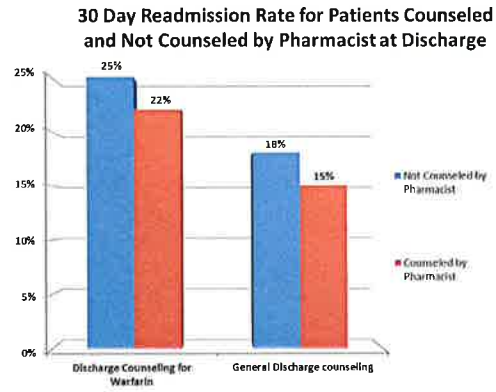
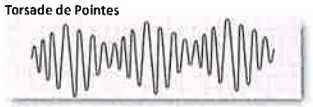


Figure 2 Patients who received counseling by a pharmacist at discharge were less likely to be readmitted during the following 30 days.

Patient Story

In preparing to counsel a patient prior to discharge, one of the discharge pharmacists noticed a patient was prescribed the antibiotic, Levaquin®, for 10 days in combination with Celexa®, which the patient had previously been prescribed. Both Levaquin® and Celexa® can cause QTc prolongation, a change in heartbeat. Patients who experience QTc prolongation are *at risk for developing torsade de pointes, a life-threatening arrhythmia* (below). The patient had a previous EKG with a slightly prolonged QT interval. Thus, the pharmacist notified the physician to order an immediate EKG to evaluate the patient's current status. The medical team determined it was safe to continue both medications for the patient. However, the pharmacist was able to use this opportunity to *extensively educate the patient concerning symptoms the patient should self-monitor* (i.e. chest pain) during their antibiotic treatment.



Number of Patients Impacted

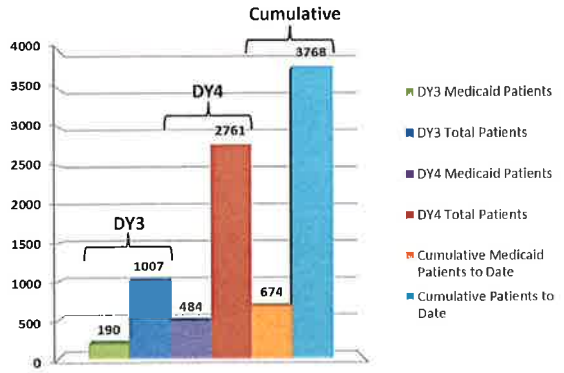


Figure 1 Between DY3 and DY4 our team more than doubled the number of patients counseled by a pharmacist at discharge.

Progress & Accomplishments

- Expanded number of patients who received instruction from a pharmacist prior to discharge
- Streamlined workflows for pharmacists through multiple quality improvement efforts
- Increased percentage of patients who rated their discharge instruction as "excellent" on the Press Ganey survey
- Reduced 30 day readmissions rate for patients who received discharge counseling from a pharmacist (14.95%) compared to those who did not receive counseling from a pharmacist (17.59%) (**Figure 2**)
- Expanded pharmacist discharge counseling in the Emergency Department

Next Steps

- Work with providers to develop their usage of electronic medical record features designed to assist with accurate prescriptions
- Collaborate with UTSCAP Care Coordinators to improve cholesterol and hypertension management
- Actively recruiting pharmacists to expand service
- Develop multiple methods of sustaining project to maintain long term impact

Transitions of Care:

Implementation of a Discharge Risk Assessment System & Transitional Care for Patients of UT Southwestern

RHP9 Texas 1115 Waiver *Transforming Healthcare Now*

UT Southwestern Medical Center

Project Contact: Dr. Kelly Robinson, Pharm.D., M.B.A.
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Project Description

Transitional care programs have been shown to benefit patients and reduce unplanned hospital readmission rates. Our aim is to develop transitional care support services at UT Southwestern Medical Center to assure an efficient continuum of care that will reduce unnecessary readmissions and support better outcomes for patients through discharge risk assessments and discharge summaries.

Discharge Risk Assessment

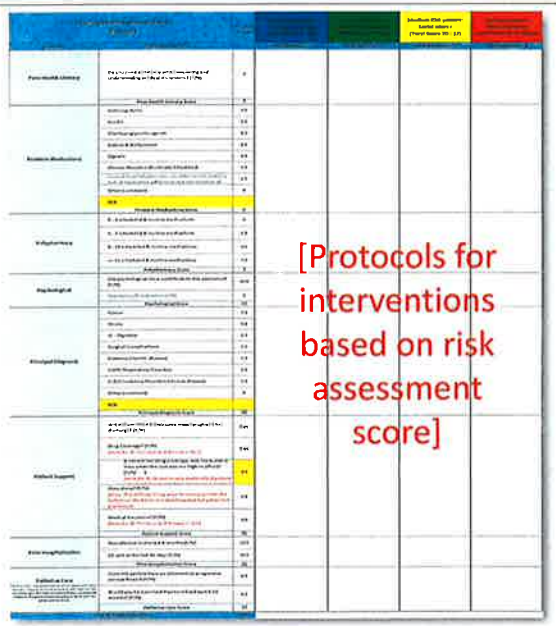

Figure 1 The Discharge Risk Assessment is a robust scoring system within Epic that ties patient readmission risk to protocols for interventions.

Outcomes

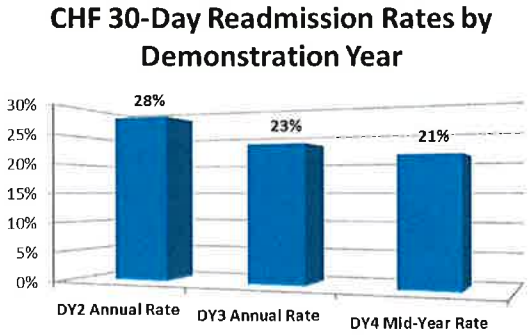

Figure 2 Over the last three demonstration years our team has continued to lower the 30-day readmission rate of patients with chronic heart failure.

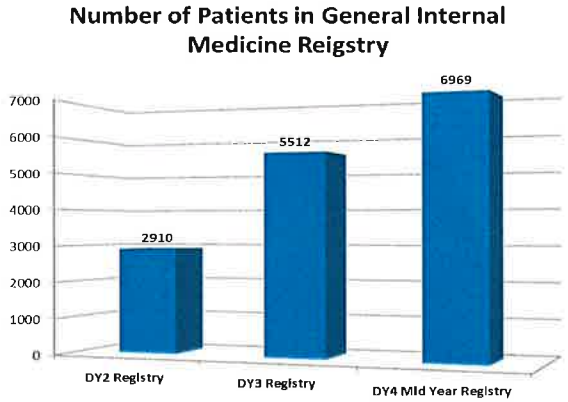

Figure 3 Over the last three demonstration years the general internal medicine registry (excluding cancer and sickle cell diagnosis) has grown. The registry includes data on Discharge Risk Assessment and Interventions as well as readmission data.

Progress & Accomplishments

- Reduced 30-day readmission rates for patients with chronic heart failure
- Adapted Better Outcomes for Older adult Safe Transitions (BOOST) Model to UT Southwestern needs and created Discharge Risk Assessment scoring system (**Figure 1**)
- Identified top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics) or socioeconomic factors that are common causes of avoidable readmission metrics
- Increased registry of patients admitted to General Internal Medicine services (**Figure 3**)
- Identified physicians with highest risk patients and provided them known risk factors
- Improved compliance with discharge risk assessment and discharge summaries protocols

Next Steps

- Continue to evaluate and improve UT Southwestern's Discharge Risk Assessment tool
- Expand more targeted initiatives (like congestive heart failure project)
- Increase project staffing by hiring two additional Transitions of Care Facilitators
- Further develop relationships with providers and community resources
- Increase number of patients receiving transitions of care services in our target population
- Improve discharge summary protocols

Emergency Department Navigation:

Expanding Navigation Services for Patients of William P. Clements Jr. Emergency Department

RHP9 Texas 1115 Waiver Transforming Healthcare Now

UT Southwestern Medical Center

Project Contact: Dr. Kelly Robinson, Pharm.D., M.B.A.
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Background

Emergency department (ED) use is considered one of the most inefficient forms of healthcare delivery. Reduction of preventable or avoidable use of this resource is a priority of many hospital systems, including UT Southwestern. ED navigation projects have been shown to decrease ED readmission rates and improve patient continuity of care through personalized multidisciplinary care plans.

Our ED sees approximately 35,000 visits per year:

- 18% are unfunded
- 31% do not have an identified primary care physician (PCP)
- Patients who have no PCP are frequently seen for episodic care in ED

Providing these patients with a primary care option for routine and urgent care is a viable method to decrease ED utilization for non-emergencies.

Aim Statement

Improve the quality of patient care in our ED while decreasing preventable or avoidable use by deploying innovative healthcare personnel as Patient Navigators. These Patient Navigators will be trained in cultural competency, identifying frequent ED users, referring patients who present to the ED without a primary care physician (PCP) to such a provider, and increasing access to care management.

Outcomes

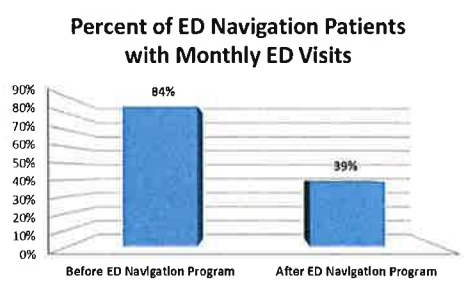

Figure 1 In the "At-Risk" patient cohort identified by our program, 84% on average presented to the ED each month. After Patient Navigation interventions only 39% on average visited the ED each month.

Patient Impact

"The Emergency Department Navigation Program has helped us become more effective in care of our patients in the emergency room, especially with patients that don't have a primary care provider, who are having difficulties knowing what their doctor's recommendations are for them, or who don't have insurance coverage. For patients who are uninsured, we've been able to direct them to medical clinics in their communities that are either free or low cost. In the total care of our patients we have been able to really focus in on specific needs and give recommendations for medical treatment and follow up."

-Terrie Jenkins & Sarah Masih (right), UT Southwestern ED Navigators

Progress & Accomplishments

- Identified patients "At-Risk" for fragmented healthcare and subsequent frequent utilization of ED services and managed their risk (**Figure 1**)
- Implemented multidisciplinary longitudinal patient care plans for "At-Risk" patients
- Referred over 1400 patients to PCPs
- Monitored ED visits for Ambulatory Sensitive Conditions and recorded only 7% ED readmission rate for that cohort
- Developed relationship with Dallas Fire Department Community Program for on-duty staff to conduct at-home visits to patients
- Trained five staff members as knowledgeable Patient Navigators
- Improved electronic health record system to alert navigators and PCP

Next Steps

- Further improve electronic health records
- Recruit additional staff for program growth including a Medical Director, two additional Patient Leads and another Clinical Staff Assistant

Transitions of Cancer Care:

Implementation of a Discharge Risk Assessment System & Expansion of Transitions of Care Services

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UTSouthwestern Medical Center

Project Contact: Dr. Kelly Robinson, Pharm.D., M.B.A.
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Project Description

Our aim is to establish a transitions of care program uniquely aimed at cancer patients—especially those that are at high risk of needing acute care services after discharge—that incorporates a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home providers with the intended purpose of supporting patients and their families.

Discharge Risk Assessment

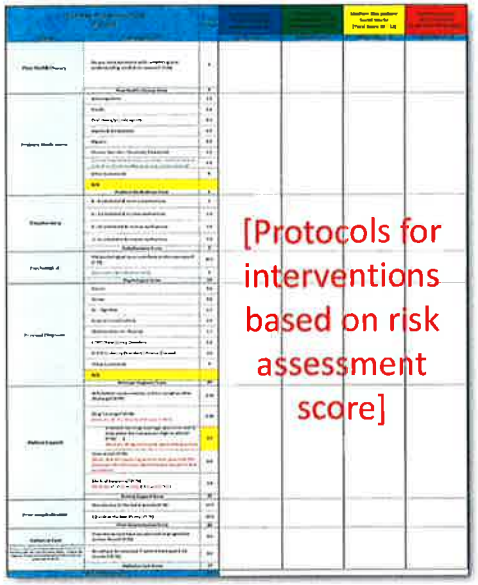

Figure 1 The Discharge Risk Assessment is a robust scoring system within Epic that ties patient readmission risk to protocols for interventions.

Discharge Risk Assessment Accuracy

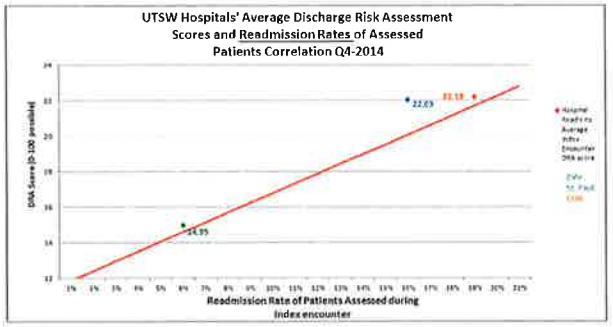

Figure 2 Regression analysis has shown that discharge readmissions rates and our team's Discharge Risk Assessment Score have an $r^2 = 1$. This indicates that our assessments are an accurate tool for evaluating the chance of readmission.

Transmission Records

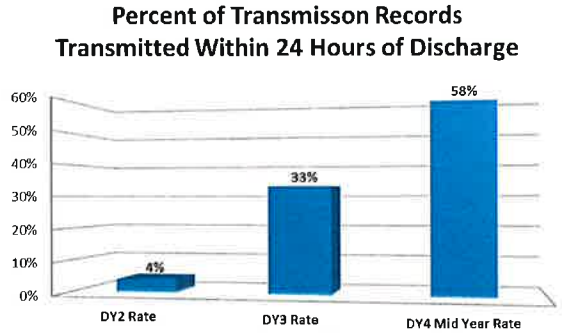

Figure 3 Over the past three demonstration years our team has improved the rate of transmission records transmitted within 24 hours of patient discharge. This is important for tracking metrics and keeping information up to date.

Progress & Accomplishments

- Increased number of patients receiving transitions of cancer care services in our target population
- Improved number of transition records transmitted to PCP or other health care professional within 24 hours of discharge
- Surpassed goal number of patients receiving all recommended education, care and services of transitions of cancer care
- Switched from transitional care Bridge Model to the Better Outcomes for Older adult Safe Transitions (BOOST) Model to create the Discharge Risk Assessment scoring system (**Figure 1**)
- Adapted Discharge Risk Assessment tool to include questions covering issues specific to the oncology population

Next Steps

- Expand project staff by hiring an additional Pharmacist and Inpatient Social Worker
- Increase number of patients receiving transitions of care services in our target population, number of transition records transmitted to PCPs within 24 hours of discharge and number of patients receiving all recommended education, care and services of transitions of cancer care
- Continue to evaluate and improve UT Southwestern Discharge Risk Assessment tool
- Further develop relationships with providers and community resources

Palliative Care:

Expanding Palliative Care at UT Southwestern Medical Center

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UT Southwestern Medical Center

Project Contact: Dr. Kelly Robinson, Pharm.D., M.B.A.
Contact Email: Kelly.Robinson@UTSouthwestern.edu

Background

Palliative care is provided by a team of professionals at UT Southwestern; however, there is an evolving program to ensure that patients receive:

- Dignified and culturally appropriate symptom management, support and education about life threatening disease
- Education and information about options for care
- Care in a manner that prioritizes symptom management and social and spiritual care, that is consistent with patient/family preferences
- Support for families and caregivers of patients

Aim Statement

Implement a multi-disciplinary, patient-centered palliative care service that provides continuity of care across inpatient and ambulatory sites. The service will render care that addresses symptoms, psychosocial and spiritual needs, and takes into consideration cultural preferences.

Palliative Care Team

Steven Leach, MD

From left to right: Chidimma Nguma, NP, Sunitha John, MD, Desi Carozza, MD and Tamara McGregor, MD.

End of Life Treatment Preferences

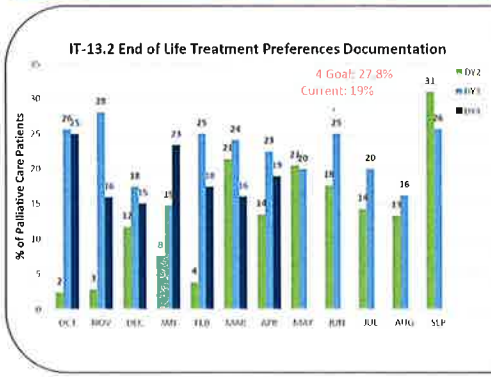

Figure 1 Monthly number of patients for which our team documented end of life treatment preferences.

Patient Impact

"There is no way that I could have made a couple of the decisions I had to make in the last four days of Chase's* life without UTSW Palliative Care" says Mrs. Jones about the recent passing of her husband. Mrs. Jones remembers the palliative care team for their concern with making Chase comfortable as well as their focus on helping and meeting the needs of her and her daughter. Like many patients' spouses, Mrs. Jones had to make difficult decisions about her husband's care, through the ordeal she recalls that "palliative care guided me, told me what to expect and look for. That was one of the only things that got me through—the love, the care of these amazing people." After his passing, Mrs. Jones thanked the UTSW Palliative Care providers (left) for their dedication. Chase was given the nickname "Big Boy" by his young daughter, and that is how his family has asked us to remember him.

*names have been changed for the privacy of the family

Progress & Accomplishments

- Formed strong collaboration with UT Southwestern and Simmons Cancer Center
- Leveraged national expertise with nation's leading palliative care consulting firm
- Implemented numerous Plan-Do-Study-Act (PDSA) Cycles to continuously improve practices
- Improved documentation to capture and report on service delivery and performance
- Engaged Pastoral Care to guide development and implementation of satisfaction survey to address patient and family needs
- Expanded program to provide services in an ambulatory setting
- Successfully recruited additional provider support who matched our cultural fit and passion for developing a stellar Palliative Care Program
- Increased number of patients receiving clinical pain assessment, documented end of life treatment preferences (**Figure 1**) and documented spiritual concerns

Next Steps

- Actively recruit Nurse Care Coordinator to facilitate patient care and support program growth
- Reforecast QPI Impact from 1,050 to 2,050 Palliative Care Consults by DY5
- Continuously improve program through PDSA cycles based on patient/family survey responses and program goals
- Develop multiple methods of sustaining project to create long term impact

Expanding Primary Care Capacity in the UTSCAP Network

UT Southwestern Medical Center

Project Contact: Stephen Prouse

Contact Email: Stephen.Prouse@utsouthwestern.edu

Background

- The UTSCAP Primary Care Network (the "Network") , is a network of affiliated community-based providers that deliver primary care services to the Medicaid/low income/uninsured (MLIU) population.
- The network consists of community-based providers throughout Dallas, Denton, Kaufman and other surrounding Counties.
- The RHP9 Community Needs Assessment indicates further need for access to primary care for the MLIU population in the region.
- This project seeks to meet that need by expanding the UTSCAP network, improving access with additional after-hour and urgent appointments and adding a nurse advice and triage lines to assist patients seeking medial information.

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Project Description

The project will substantially increase the number of patients who have access to high quality, integrated care that has historically been unavailable. Methods will include:

- Adding more primary care physicians to the UTSCAP Network.
- Providing access to more primary care resources through a new nurse advice line
- Increasing office hours, staff hours, & office space.
- Decrease the frequency of use for urgent care or emergency department treatment through enhanced primary care availability and scheduling practices

Challenges

- UTSCAP needs to expand its network to meet QPI goals.
- Network provider schedules need to accommodate after-hour and urgent appointments.
- Standardization is needed for the various electronic medical record systems in use by network providers
- Nurse triage and nurse advice line infrastructure and protocols need to be developed

Progress and Accomplishments

- The network has increased to over 150 community-based providers
- Volume of visit encounters exceeded the goal by over 87,000 visits (35.6% over goal).
- Nearly 75% of all unique patient visits were MLIU encounters
- 28 additional after-hour appointment times were created in provider schedules
- Community Health Workers have been deployed to various provider locations to assist with education linking patients to other community resources.
- Standard electronic medical record software system is being installed at network provider locations

Next Steps

- Continue network provider expansion
- Further increase the available after-hour and urgent appointments.
- Implement nurse advice and triage lines
- Use nurse lines to schedule urgent appointment when appropriate
- Upgrade all network providers with standard electronic medical record software
- Create patient registries to treat and track chronic diseases

Care Coordination

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UT Southwestern Medical Center

Project Description

The Team

UTSCAP is developing a multi-disciplinary workforce to provide care coordination to dually eligible patients who are attributed to the UTSCAP ACO.

The Patients

UTSW Care Coordination leverages two high risk registries (The High Registry and the Higher LOC Registry) to stratify and engage dual eligible patients with the most complex health conditions.

The Intervention

Telephonic and face-to-face care coordination as well as remote patient monitoring and management are employed to reduce ED visits and avoidable inpatient admissions.

The PCP Connection

Care Coordinators will also refer and confirm patients are being seen by their PCP and/or empanelled in an effort to reduce health crisis, avoid complications, and promote disease management.

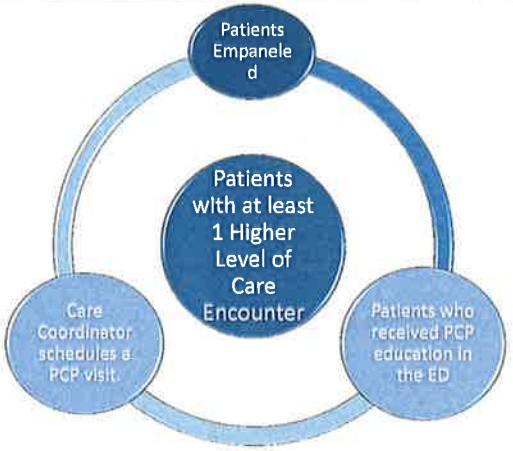
Team

Cathy Bryan, MHA, BSN, RN
Director of Care Coordination
UT Southwestern Accountable Care Network

Nurses
Maria Baxter, RN
Monica Bears, LVN
Sarah Bears, LVN
Annette Mace, LVN
Tinisha Wordlaw, LVN

Community Health Workers
Perce Tate, CCHW
Leonor Castillo, CCHW
Cathy Faz, CCHW
Martha Beshers-Wolfe, CCHW
Rosa Ayala, CHW
Anne Maria Prestipino, CHW
Sandra Juarez, CHW
Maya Casanova, CHW

Patient Registries



Patient Impact

Mrs. K

Mrs. K is a 60 years-old Hispanic female with diabetes, coronary artery disease, hypertension and high cholesterol. An in-home assessment was conducted and medications were reconciled.

Her Story

When we first met Mrs. K her A1C was 12%. By watching her demonstrate a blood sugar check and self-administration of insulin, we learned she had difficulty with her vision leading to improper dosing and administration of her medication. In addition, she was not well educated on the importance of a diabetic diet and did not have a good understanding of the relationship between her blood sugar reading, sliding scale and dose of insulin. Care coordination help her identify the signs of low and high blood sugar and used the Teach-Back method to confirm she understood protocols for addressing outer ranges of her blood sugar. The PCP was asked to provide Mrs. K with a written sliding scale which the care coordinator enlarged it to ensure she could see it. Mrs. K was coached to identify foods that were causing her blood sugars to spike. Soda was identified as a root cause and she set a goal to limit herself to one soda every day. The Coordinator called her every day for a month to remind her to check her blood sugar and communicated with her caregiver on administering the proper amount of insulin.

The Outcome

Through this care coordination strategy, Mrs. K showed significant gains in establishing positive behavior change, self-monitoring, and engaging her caregiver. Her biggest victory was a reduction in her A1C reading from 12% to 9%.

Accomplishments

The development of an ambulatory Care Coordination department within the UTSW Accountable Care Network (ACN) continues to expand and solidify its scope and practice. Below are highlights of recent accomplishments from the first 6 months of DY4.

A Growing Team

Over the past year UTSCAP Care Coordination has grown to include a Care Coordination Director, a Transitional Care Coordinator, a part-time PharmD to assist with medication reconciliation, and are currently pursuing adding 2 new Care Coordination supervisory positions.

Patient Engagement

- Established the referral process for identifying and on-boarding high-risk patients into our Remote Patient Monitoring program.
- Proactive engagement strategies to identify and outreach to patients that could benefit from care coordination services.
- Established systematic workflows to address individual patient needs

Population Management

- Predictive risk modeling is fully integrated into UTSW population management strategies.
- Through collaboration between EPIC builders and Care Coordinators, a more user-friendly system of documentation was implemented.
- Implementation of a new care coordination software platform is in process, scheduled for go live toward the end of DY4.

Increase Training of Primary Care Workforce Community Health Workers

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UT Southwestern Medical Center

Background

Community Health Workers (CHW) are frontline patient advocates who are trusted members of and/or have an unusually close understanding of the community served. This trusted relationship enables CHWS to serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve quality of care.

Project Description

The Community Health Worker project has enabled UT Southwestern Medical Center to implement a training program and expand the utilization of Community Health Workers into the primary care setting. With this implementation, UT Southwestern has the capability of providing outreach educational resources to the patient care community of Dallas, Denton and Kaufman Counties.

Progress & Accomplishments

- The project has integrated trained CHWs into the low-income/uninsured population communities to increase health awareness.
- CHWs have received training on Fall Risk, Breast Screening Prevention, Affordable Care Act, Heart Health, Diabetic Eye education, Transportation Assistance, and help identify future educational criteria based on community needs.
- The Community Health Workers have been trained in Patient Center Medical Home modules which has assisted them with orienting and integrating patients into the primary care setting.

Results and Conclusions

- Successfully recognized community locations that required assistance in bridging these gaps to patient's needs such as Senior Centers, Trans-Gender Communities, Church Organizations, and many other locations.
- The CHWs have Achieved a total of approximately 2,000 plus encounters and continues to increase with the hiring of additional CHWs which has been made possible by the project.

Next Steps

- Finalize and implement program for Community Health Worker certification on site.
- Continue to expand and integrate CHWs into the primary care setting.
- Actively recruit potential candidates for CHW certification.
- Continue to increase encounters and patient impact with community outreach.

Expand Primary Care Services: Collin County

LIFEPATH SYSTEMS

UT Southwestern Medical Center

Project Contact: Stephen Prouse
Contact Email: Stephen.Prouse@utsouthwestern.edu

Background

Lacking a safety net heath care network, Collin County Medicaid and low income residents have limited access to primary care services.

RHP18 Community Needs Assessment:

- CN1-Need for adult primary care services.
- CN5-Treatment for co-morbid medical and behavioral health conditions.
- CN6-Health professions shortage.

Project Description

UT Southwestern's commitment to expand primary care in Collin County with three distinct proposals.

- Establish Primary care services at Richardson/Plano Clinic.
- Affiliation with LifePath Systems behavioral heath clinics.
- Operate a nurse advice line to assist patients.

Challenges

- Richardson/Plano clinic could not complete required MLIU visits without collaboration with LifePath
- Data extraction from LifePath would need to be done manually until an EMR was implemented

Progress and Accomplishments

Primary care services at Richardson/Plano.

- 2 Family Medicine and 2 Ob/Gyn physicians on staff
- Appointments are made Monday through Friday 8:00a.m. to 5:00p.m.
- Services include preventative care, acute illness and injury care, health screenings and chronic disease management

Integration of primary care services imbedded in LifePath System's behavioral health clinics.

- Locum Tenens staff physicians
- 2 Advanced Nurse Practitioners will be assigned to provider primary care are LifePath by 9/30/15
- Collaboration w/mental health providers

Patient Impact

Patient Success Story:

- An 87 year old female LifePath patient was seen by the new primary care physicians at the facility.
- The patient's daughter expressed her gratitude for the new services.
- The daughter explained that her mother had not had a primary physician visit in 20 years.

Results and Conclusions

- Expanded primary care in Collin County with the Richardson/Plano Clinic.
- Expanded further with primary care providers seeing patients at LifePath Systems, a mental health provider for Collin County.
- Provided pneumonia vaccines to seniors and other high risk patients.
- Completed 6,320 primary care visits since 9/30/2014

Next Steps

- On-board 2 ANPs for LifePath
- Establish a nurse advice line
  - Establish/implement protocols
  - Communication plan to advise patients
- Implement an electronic medical records system at LifePath
- Build patient registries for chronic disease management

Establishment of a Sickle Cell Disease Day Treatment Program

RHP9 Texas 1115 Waiver

UT Southwestern Medical Center

Background

Sickle cell disease (SCD) is a blood disorder that can lead to complications of any organ system. One of the most common complaints for adult patients is pain. This population has one of the highest admission and readmission rates as well as Emergency Department (ED) encounters in the country. UT Southwestern Medical Center has not previously addressed the psychological aspects of pain prompting these encounters.

Aim Statement/Project Description

The goals of this project are to build a multidisciplinary team and establish a day treatment program to address these frequent pain exacerbations by providing access to medical treatments as well as psychosocial support to teach patients how to deal with acute/chronic pain while reinforcing self-care to avoid these ED and hospital encounters.

Treatment Focus

- Mood (e.g., depression, anxiety)
- Pain and Stress Management
- Medical Adherence
- Quality of Life Enhancement
- End of Life Concerns
- Sociocultural Factors and Health Wellness

Interventions

- Psychological interventions consist of a **tailored approach** to address patient presenting symptoms, health history, resource access, and sociocultural lifestyle.
- Patients are taught **skill development** based on an integration of solution focused brief therapy, (SFBT), cognitive behavioral therapy (CBT), and acceptance & commitment therapy (ACT) interventions. Research has demonstrated effectiveness of these therapy interventions with chronic pain populations.
- **Psychoeducation** about disease management is provided to patients, families, and friends during quarterly Support Group meetings.
- **Collaboration** with program team and medical providers (e.g., hematology, internal medicine, psychiatry, consult/liaison service, ED, pain management) aids care coordination and facilitates treatment planning.
- **Rapport** development is a key component in service delivery due to cultural and medical stigma associated with seeking psychological support.

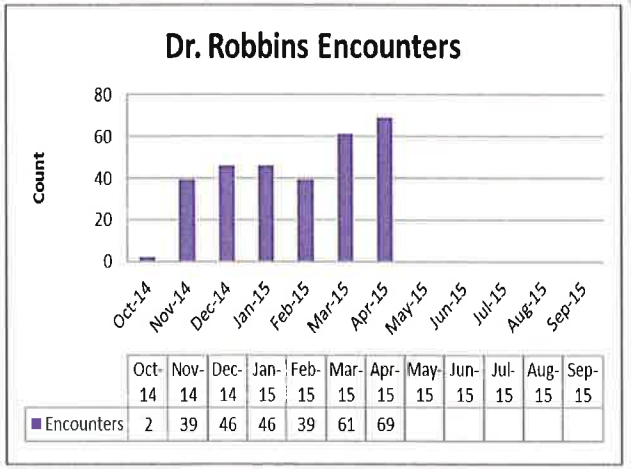
Sickle Cell Psychology Tools & Resources

In addition to her work with individual patients, Dr. Robbins established program-wide resources for SCD patients: clinic screeners for long-term symptom monitoring/interventions; SCD specific crisis resources /referrals; she designed and will implement process group therapy for patients.

Sickle Cell Psychologist

Mona A. Robbins, Ph.D. joined the team as one of few clinical psychologists in the nation with a specific focus in adult SCD. She provides interventions across inpatient and outpatient settings as well as provides support services in the ED.

Patient Impact



	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Encounters	2	39	46	46	39	61	69					

Table. Number of SCD patient encounters with sickle cell psychologist by month across all sites of care.

Implement UT Southwestern Population Management Infrastructure Development

UT Southwestern Medical Center

Project Contact: Stephen Prouse

Contact Email: Stephen.Prouse@utsouthwestern.edu

Background

UT Southwestern did not have the technological capability for predictive modeling, patient risk stratification, or access to point-of-care tools. Thus, the ability to manage and track UTSCAP Network patient outcomes across the Network did not exist, resulting in an inability to provide the most efficient, quality care in the right setting at the right time.

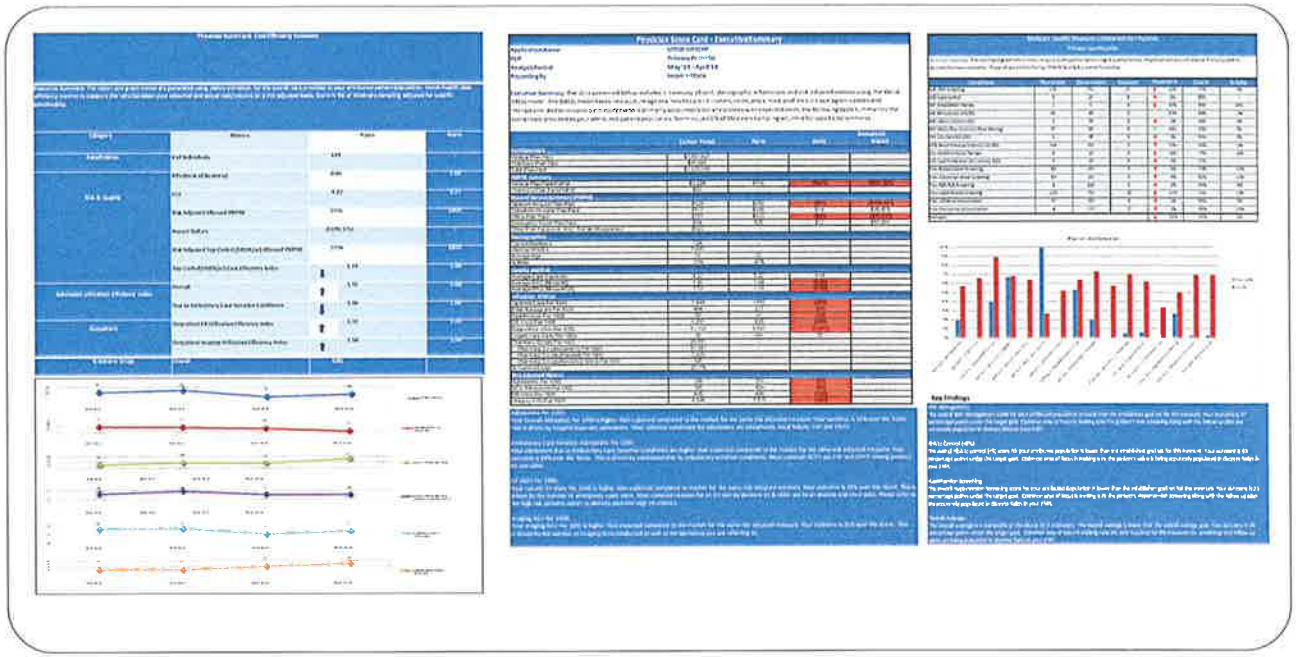
Project Description

This project will create a population management infrastructure that will enhance improvement capacity through technology, and allow the measuring, reporting and driving of quality improvement.

Challenges

The challenge for UT Southwestern was developing an environment where providers recognize the benefits associated with a population management infrastructure and embrace the required changes to improve the quality and cost efficiency for all patient populations.

Reports and Dashboards



Progress and Accomplishments

A comprehensive population management report was developed and began distribution in DY3 which contained the following data:

- Accountable Care Network financial data
- Utilization and efficiency data
- List of high risk patients
- Chronic care quality measures and goals.

Next Steps

- Create a roll-up Network dashboard
- Integrate patient satisfaction data in to the reports and dashboards.
- Distribute to all UTSCAP Network providers
- Develop Continuous Quality Improvement (CQI) strategies with providers to effect positive outcomes.

Family Medicine DSRIP Project

RHP9 Texas 1115 Waiver Transforming Healthcare Now

UT Southwestern Medical Center

Background

In order to address the shortage of primary care physicians, the goal of this project is to graduate Family Medicine physicians who are already trained and committed to applying the principles of patient-centered medical home, chronic disease management and population management to Medicaid and low-income populations.

Aim Statement/Project Description

To better prepare Family Medicine Residents to implement or participate in practice patterns and practice behaviors that will help continue healthcare delivery system reform, they will be provided education and training during their 3-year program that will prepare them to participate in the changes required and implemented.

Team

Amer Shakil, MD Nitin Budhwar, MD Neelima Kale, MD Zaiba Jetpuri, DO

Outcomes

Residents design, implement, and disseminate their own clinical quality improvement projects geared for medically underserved populations.

Additionally, Residency training has been expanded to include:

- Medical home model
- Chronic care models
- Disease registry use
- Patient panel management
- Quality/performance improvement
- Shared medical appointments for chronic disease management
- Practice management

Patient Impact

Specialized training, an expanded curricula, didactic and experiential learning, and a focus on the medical home model, has resulted in:

- Improvement in delivery of services
- Improvement in patient healthcare outcomes
- Improvement in coordination of care
- Improvement in patient safety
- Cost of care reduction for all populations, but especially Medicaid and low-income patients

Progress & Accomplishments

- Implemented patient-centered medical home curricula in Residency clinic
- By project end an estimated 60 quality-improvement projects over 3 year period carried out in Residency clinic
- Almost 50,000 patient encounters by trained Residents during project
- Increased trainees from 28 to 36 over duration of project
- Hired 2 additional full-time Residency Faculty
- Annual improvements in Resident competency with patient-centered medical home model
- Annual measurement of trainee satisfaction

Next Steps

In the final year of the project we will expand the number of trainees enrolled and will measure the impact of the project on their clinical competency and desire to practice in MUAs.

As this project is centered on Resident education and their patients' needs, it will continue to evolve to meet those needs in order to continue improvements in patient outcomes and healthcare delivery.

DSRIP Physician Assistant Project

RHP9 Texas 1115 Waiver — Transforming Healthcare Now

UT Southwestern Medical Center

Background

In the face of immediate challenge by the current and expected future shortage of primary care physicians, the expansion of Medicaid, and the important role Physician Assistants (PAs) play in the delivery of primary care services, expanding the UT Southwestern PA Program is a sound approach to producing more primary care providers in a relatively short time period.

Project Description and Aim

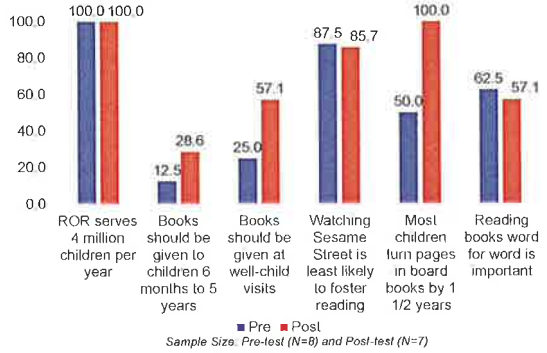
UT Southwestern will increase the class enrollment size and redesign the curriculum of the UT Southwestern Physician Assistant Program in an effort to address the shortage of primary care providers and foster an interest in primary care as a specialty for PA trainees.

Training Primary Care Physician Assistants

Reach Out and Read QI Project

Pre- and Post-Test Knowledge Results (% Correct)

(Survey administered to Center of Hope Student Clinic Managers)



Sample Size: Pre-test (N=8) and Post-test (N=7)

Reach Out and Read Patient Impact

Practice Fusion Documentation

Assessment

Well child examination.

Diagnoses attached to this encounter:

- (V20.2) Routine infant or child health check

Plan Print

ROR - Goodnight Moon, ROR Education provided.

Progress and Accomplishments

- Successfully recruited additional faculty and staff to support program growth and increased enrollment.
- The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved an increase in class size for the program to accept an additional 6 students per year up to a class size of 60, effective May 1, 2015 (42 in 2015, 48 in 2016, 54 in 2017, and 60 in 2018).
- Curriculum on quality improvement and patient safety has been added to two courses (Clinical Prevention and Population Health and Evidence Based Medicine) during the didactic phase of the program.
- In January 2015, the PA Class of 2016 appointed a Community Outreach Chair in order to increase student interest and allow for additional service-learning opportunities in underserved communities.
- PA Class of 2016 students are actively involved in 2 QI projects at Union Gospel Mission homeless shelter clinics
  - Evaluation of the Reach Out and Read Program for pediatric literacy at Center of Hope (COH) for women and children.
  - Evaluation of tobacco screening and cessation at Calvert Place for men.

Next Steps

- Continue recruiting additional faculty and staff members to support program growth.
- Analyze tobacco screening and cessation data from Calvert Place.
- Expand the didactic training PA students receive with additional lectures in the Professional Practice Issues I course.
- Extend the Reach Out and Read QI project to The Family Place and offer more resources to Center of Hope (COH) to include creating a literacy rich environment where patients can read aloud while waiting for appointments and provide patient education for parents.
- Efforts are underway to expand the experiential clinical training PA students receive with a designated clinical course on QI and patient safety and the development of an inter-professional distinction in QI and patient safety with collaboration from the UTSW Office of Quality, Safety and Outcomes Education.

Ambulatory Quality Outcomes and Performance Improvement

RHP9 Texas 1115 Waiver — Transforming Healthcare Now

UT Southwestern Medical Center

Team: Earlene Frink MBA, Meredith Mayo BS, Jacqueline Mutz BSN, MLA, Sherene Philip MHA MBA, Jeremy Reigel, Adrian White RN, MBA
Sponsor: Jason Fish MD, MSHS, MS-MAS

BACKGROUND

Due to the changing landscape of health care, there are renewed efforts to hold institutions accountable for the delivery of high-value care. In order to achieve this, providers are working with advanced technologies such as electronic medical records (EMR) and clinical databases. These tools help in gathering standardized reliable data to create quality metrics and drive delivery system changes impacting all patients, including Medicare/Low Income Uninsured populations.

With the support of executive leadership, the University of Texas Southwestern Medical Center created an ambulatory quality program. The clinic leaders from each of the 41 specialty and sub-specialty ambulatory clinics identified their own measures, resulting in over 100 individual metrics.

PROJECT SCOPE

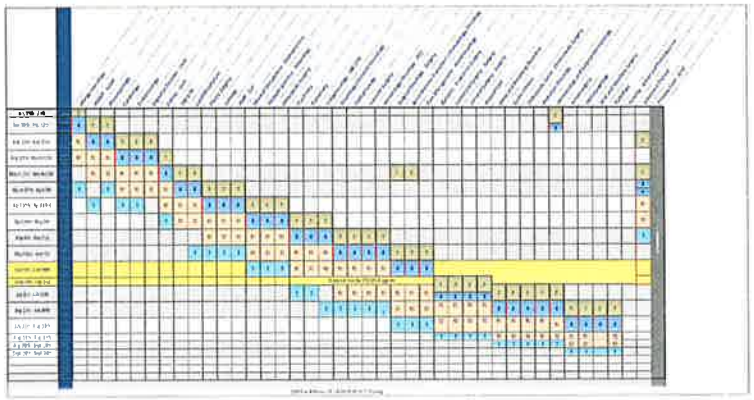
Each individual practice group went through a systematic process in order to:

- Identify factors critical for quality.
- Evaluate care and treatment of a focused population.
- Identify gaps of care and opportunities for performance improvement.
- Optimize use of the EMR.
- Improve healthcare processes that support the delivery of care.

TEAM

Key to success was the establishment of an interdisciplinary team approach with well-defined roles/responsibilities and a tightly managed process and timeline. Members from the offices of Ambulatory Quality Outcomes and Performance Improvement (AQOPI), Information Resources, Data Analytics, and Clinical Operations (aka Quadrad of Success) were assigned and dedicated to each clinic.

TIMELINE BY CLINIC



PROCESS

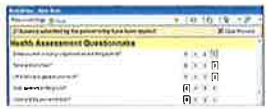
Six Sigma's DMAIC cycle served as the framework for the ten week rapid cycle methodology. Each project was divided into five distinct phases.

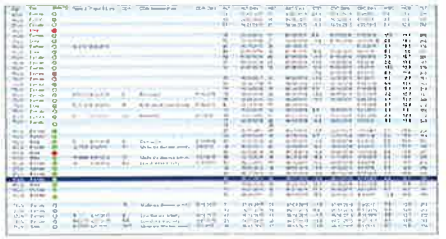
- **DEFINE**: The Define Preparation phase began by identifying and meeting with key stakeholders to define the scope of work and gain a clear understanding of the clinic's objectives.
- **MEASURE**: Define Notes were prepared and shared to confirm "Voice of Customer". Current processes were identified through discussions with clinic leadership, onsite visits, and depicted in workflow diagrams and collateral documents.
- **ANALYZE**: This phase included multiple meetings with clinic leadership and the quadrad team to discuss data collection tools and standardized workflow strategies to address variation and care gaps found in the current processes.
- **IMPROVE**: Improvement activities focused on developing optimized workflow processes, modifying behaviors, and building proven data collection tools. Clinics were supported in these improvement activities through training to ensure a complete and thorough understanding of new operational processes.
- **CONTROL**: Once the project is transferred to the clinic staff for ongoing operational activities, efforts are made to ensure that process improvements are sustained over time through the generation of patient registries and performance measure reports. AQOPI will engage with clinic leadership monthly utilizing a Plan Do Study Act (PDSA) cycle to address any identified variation.

RESULTS

As of June 2015, it is estimated that approximately 11,400 patients will be affected by the six clinics that have gone live with their quality projects. Included in these projects are eight process and two outcome measures generating 57 quality and 22 care gap reports. As a result of these quality projects, data collection tools and patient registries have been created, bringing evidence-based quality metrics directly to the provider. These patient registries are uniquely built within the EMR platform, enabling providers to execute patient-specific actions and orders.

Rheumatology Data Collection Tool





Rheumatology Patient Registry

SUSTAINABILITY

Ongoing collaboration with clinical leadership, supported by the executive leadership team, will ensure the success of the next iteration of the Ambulatory Quality program. The approach will continue to focus on establishing outcome measures across all outpatient care areas with an emphasis on sustaining quality goals, tracking and trending performance measures, and pinpointing areas of improvement over time.

Early Deployment of the AHRQ Team STEPPS Curriculum at UT Southwestern – A pilot project with a Nursing Based Rapid Response Team

Oren Guttman MD, MBA, CHSE , Laura M. Lawson MD, Ravi Bhoja MD, Debra Hogg BS, Julie Earnest, RN, MBA
UTSW Anesthesia Patient Safety and Immersive Learning Simulation Team
University of Texas Southwestern Medical Center at Dallas, Department of Anesthesiology and Pain Management, Dallas, TX

BACKGROUND

The need for crisis resource management skills and interprofessional cooperation is of utmost importance in the setting of acutely ill patients. The Joint Commission states, at the root cause of most sentinel events is not a failure of technical skill, training, or knowledge but interesting enough, but rather, a breakdown in the critical components of team work; namely, in nontechnical skills such as communication, cooperation, coordination, and leadership. Patient outcomes are directly affected by the degree of dysfunction of a care team.

UTSW launched a new, nurse-led rapid response team in one of its campus hospitals in 2014. Experienced nurses were in need of formal training for communication and crisis management. The aim of this project was to provide training for these nurses by utilizing the AHRQ Team STEPPS communication skills as well as simulation, with the goal to increase patient safety. Effectiveness of the course was measured by the attitudes of trainees by utilizing the ISIS Inter-professional Team STEPPS survey both immediately after and remotely after the intervention, as well as video graded assessment of nursing

AGENDA

The class occurred over a one-day, eight hour class, divided into two sessions.

1. AM session:

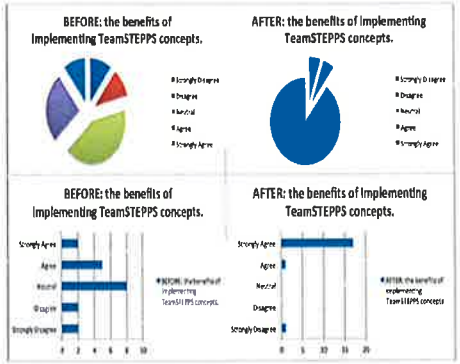
- Forms of disclosures & consents
- ISIS Team STEPPS pre-assessment
- Orientation to the day, the manikin, and to the facility
- Four module instruction, with the incorporation of 2 codes for baseline data
- Lego Drilling

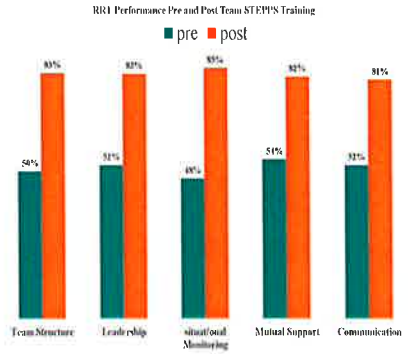
2. PM Session:

- Rapid Response Team Simulations
- 2 final codes with video capture
- ISIS Team STEPPS post assessment survey

Data

1. Immediate pre-course and post-course ISIS Team STEPPS assessment
2. Blinded reviewers to grade video of pre-course and post-course mega-codes
3. Remote survey assessing participant retrospective attitudes on course utility





CONCLUSION

The ability to train for crisis before one arises is critical to good patient outcomes and care. By equipping our rapid-response nurses with hands-on training through an immersive learning course, the nurses reported greatly increased skills in the areas of working as a team member, functioning as leaders, and increased abilities in regards to situational monitoring, mutual support, and communication. Additionally, blinded video grading demonstrated an increase in the areas of team structure, leadership, situational monitoring, mutual support, and communication as well. The course provided the nurses with critical skills to maximize their effectiveness in an expanding clinical role.

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2. Wahr et al, Patient Safety in the Cardiac Operating Room: Human Factors and Teamwork: *Circulation*. 2013; 128: 1139-1169
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Mobile Cancer Survivorship Care:
Improving Surveillance and Quality of Life in Rural Communities

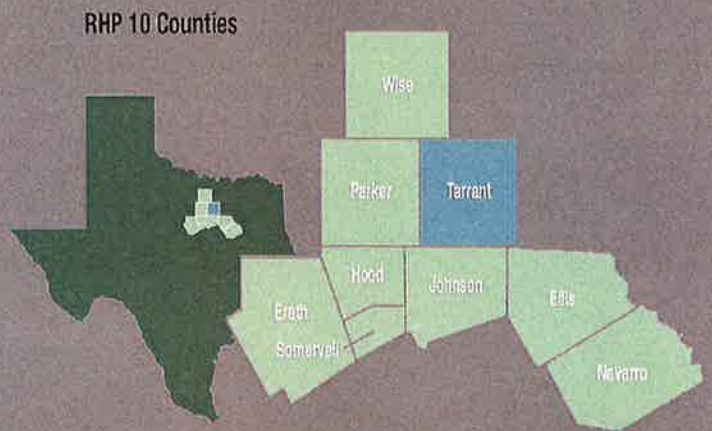
UT Southwestern Medical Center

MONCRIEF CANCER INSTITUTE
UT Southwestern

Keith Argenbright, MD[1,2,3]; Tracy Mazour,RN,MSN,OCN[3]; Emily Berry, MSPH[3]; Bonnie Rose, RN, BSN, OCN[3]; Karen Hatfield, RN[3]; Paula R. Anderson, RN, MN, OCN[3]
[1]Department of Clinical Sciences, UT Southwestern Medical Center; [2]Harold C. Simmons Cancer Center; [3]UT Southwestern Medical Center- Moncrief Cancer Institute

Problem/Evidence

Approximately 15,000 North Texas residents spanning nine North Texas Counties are underserved cancer survivors. Within this 7,000 square mile area, it is estimated that 5,000 uninsured and underinsured cancer survivors are at risk of non-adherence to essential follow-up care due to cost, health professional/facility shortages, lack of reliable transportation and inexperience of navigating a complex medical network. Months and years after surviving the disease, cancer survivors face a range of long term and late treatment effects including pain, difficulties with range of motion, depression, anxiety, fatigue, poor nutrition, and muscle weakness.



Aims

Using an innovative, evidenced-based approach, the program's objectives are to:

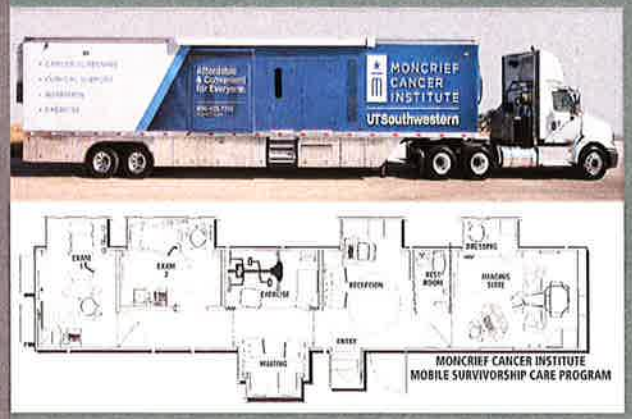
1. Increase adherence to routine cancer screening and surveillance schedules for index cancers.
2. Enhance the experience of care through oncology certified providers and patient navigators.
3. Improve the health of rural populations.
4. Decrease access barriers to care.
5. Reduce the cost of care to the health care system.

Acknowledgements

Program Funding is provided by the Health and Human Services 1115 Waiver, Delivery System Reform Incentive Payment (DSRIP) **Project ID – 126686802.2.1**
Regional Healthcare Partnership (RHP) 10 - Anchor
UT Southwestern IRB Approval # STU 022011-141

Setting

The Mobile Cancer Survivor Clinic, launched in 2015, is a custom-designed, $1.1 million, fully equipped 18-wheeler that delivers multidisciplinary, bilingual follow-up and screening services to cancer survivors within their rural communities. It offers 3-D mammography, as well as colon cancer screenings, 2 private exam rooms, exercise facilities for one-on-one training, and high-speed telemedicine links to cancer experts and counseling services at UT Southwestern Moncrief Cancer Institute in Fort Worth and the Harold C. Simmons Comprehensive Cancer Center in Dallas.



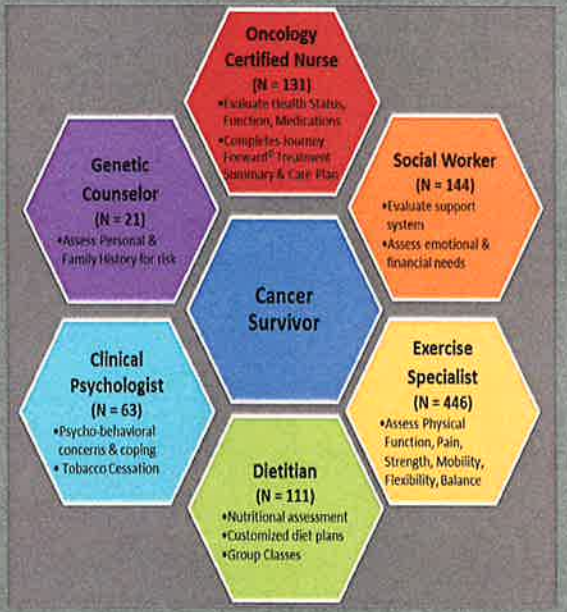
Strategy for Change

Using a mobile delivery system, UTSW-MCI will identify and engage rural uninsured and Medicaid cancer survivors to bring services to patients in rural settings who would otherwise not have access to care. Multidisciplinary clinical assessment, support, cancer screening and surveillance services are provided. The clinic's state-of-the-art telecommunication capability will enable consultations for patients through secure videoconferencing technology, including psychological and genetic counseling, using a telemedicine system. Enabling these disciplines to provide secure videoconferencing and testing using high-speed technology to patients and families in remote and underserved areas, as well as at the in-house clinic, maximizes clinic staff and service utilization.

Outcomes / Results

The Survivorship team provided 941 multidisciplinary survivorship clinical services in year 1. 125 Journey Forward® Treatment Summaries and Survivorship Care Plans competed.

Enrollment will increase 400% to at least 1,750 survivors totaling 4,600 clinical encounters. Research capable data capture including more than 100 demographic, diagnostic and discreet treatment elements for use in future research and program evaluation.



Recommendations

Implementation of the Mobile Cancer Survivor Clinic directly in rural communities removes many barriers to care. The UTSW-MCI mobile survivorship program is a model of how technology can improve healthcare delivery to rural cancer survivors and has the potential to revolutionize survivorship care nationally.

Telemedicine

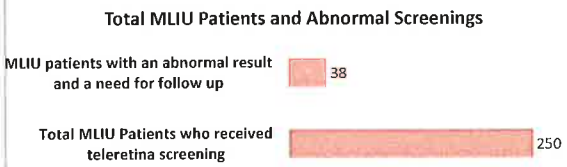
RHP9 Texas 1115 Waiver — Transforming Healthcare Now

UTSouthwestern Medical Center

Ophthalmology Outcomes and Accomplishments

Quantifiable Patient Impact

This project has performed over 250 tele-retinal scans to the MLIU population since August 2014. Of these, 15% resulted in an abnormal result.



Alerting of Abnormal Results

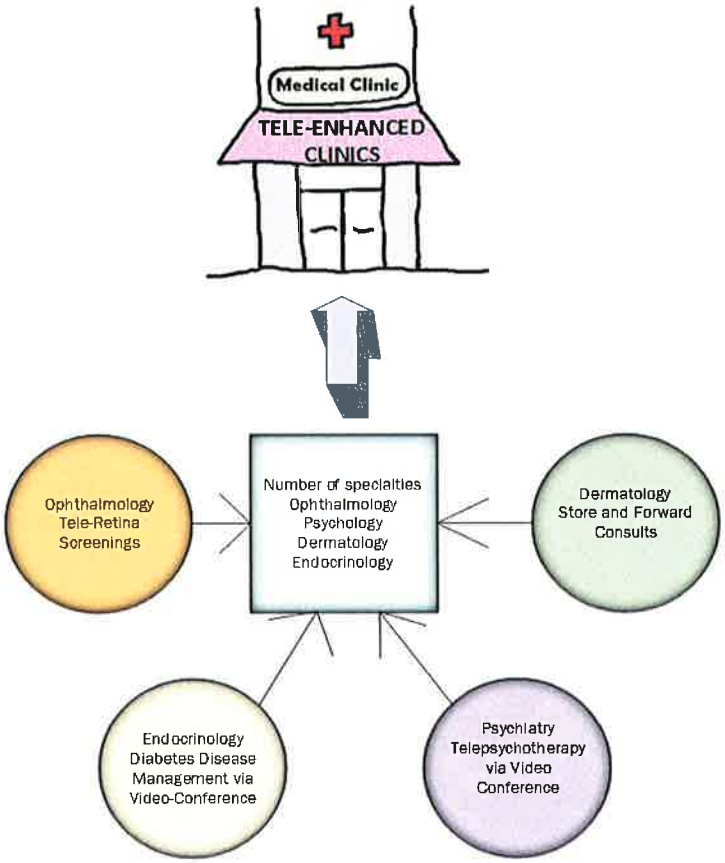
Established workflows are in place to coordinate with patient and their PCP for appropriate follow up based to prevent further retina damage.

Team

Ophthalmology	Dermatology
Gary Pesicka, MD Cathy Bryan, MHA, BSN, RN Director of Care Coordination Perce Tate, CCHW Maria Baxter, RN Cathy Faz, CCHW Leonor Castillo, CCHW	Kim Yancey, MD Priscilla Goode, MAS, Director of ACO
Psychiatry	**Endocrinology**
Madukar H. Trivedi, MD Joseph Trombello, PhD Alma Sanchez, LMSW Audrey Cecil Priscilla Phoutthavong, BS Afsi Rezaeizadeh, RN, BSN	Asra Kermani, MD Cathy Bryan, RN Perce Tate, CCHW Maria Baxter, RN

UTSW Telemedicine Project Design

Establish Tele-Enhanced clinics by implementing telemedicine specialty services to support, consult, and provide direct patient care throughout the UTSCAP Primary Care Network and collaborating Charity clinics in RHP 9.



Overall Project Accomplishments

Telemedicine Summit
A leading expert in the telemedicine field spent 2 days at UTSW to educate, generate interest, and identify telemedicine physician champions.

UTSW Telemedicine Advisory Board
A UTSW Telemedicine Steering Committee has been formed and meets bi-monthly.

Equipment Sublet Agreements
Sublet agreements are in place for ACO community providers perform tele-retinal exams on diabetic patients.

EMR Modifications
EPIC documentation workflows and billing service codes have been created to ensure optimal patient care and satisfaction.

Telemedicine Consent Forms
Consent forms for direct patient service through telemedicine have been approved through legal and translated into Spanish.

Tele-Psychotherapy
Service began 6/17/2015 at Compassion Care Clinic.

Tele-Dermatology and Tele-Endocrinology
Service to begin Mid-Summer.

Quality Improvement Training Program Expansion at UT Southwestern

RHP9 Texas 1115 Waiver Transforming Healthcare Now

UT Southwestern Medical Center

Project Contact: Patrice Griffith
Contact Email: patrice.griffith@utsw.edu

Background

Quality improvement (QI) activities in health care are most successful when done by multidisciplinary teams who are trained in proven quality improvement methodologies and quality tools. The Clinical Safety and Effectiveness (CS&E) course was established at UTSW in 2010 to provide QI training at UT Southwestern (UTSW).

Upon completion of the eight-day course, participants are able to understand the concepts and utilize continuous improvement methods and tools in a practical application. Course attendees are required to work on a healthcare focused improvement project during the course and then present their project outcomes and learnings at the final course meeting.

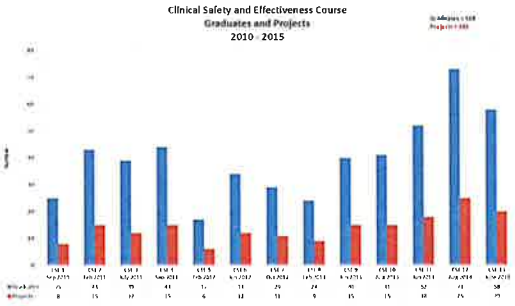
Project Description

This project will expand the existing, successful, advanced quality/process improvement training program, CS&E, beyond UTSW staff and faculty to others in RHP 9 by September 2016.

Team

CSE Steering Committee
Gary Reed , MD, Chief Quality Officer (Interim)
Patrice Griffith, Director, Quality Improvement
Mary Baldwin, Manager Quality Education

Outcomes



Expansion of the CS&E has made it possible for 72 people outside UT Southwestern to attend the course since August 2013:

Institution	Students	Projects
Parkland	47	23
Children's	2	1
VA	2	1

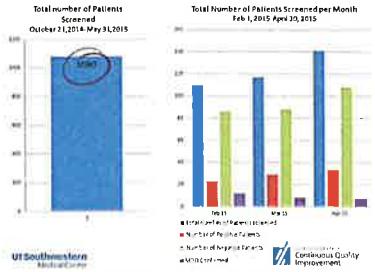
Progress & Accomplishments

Participant projects use systematic methods such as DMAIC or PDSA to structure their projects.
Project topics include:

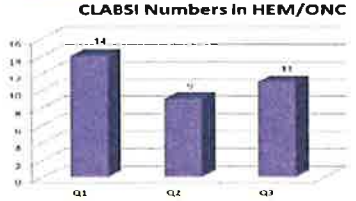
- Improve perioperative glycemic control
- Early Identification of sepsis
- Improve depression screening rates
- Decrease ED wait times at Children's Health
- CLABSI reduction in hematology-oncology
- Reduce specimen labeling errors
- Eliminate C. Diff infections
- Improve radio-ablative iodination therapy

Patient Impact

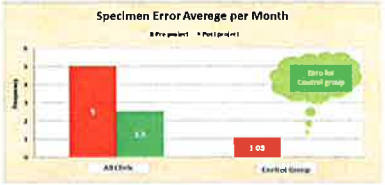
Positive patient outcomes include:



Depression screening rates increased



CLABSIs reduced by 21%



Reduction in specimen errors

Next Steps

- Expand the reach of the CS&E program by targeting organizations such as Texas Health Resources, and continue to support participation by the Dallas VA, Children's Heath and Parkland.

For information about the next CS&E cohort to begin in January 2016, contact: mary.baldwin@utsw.edu.

RHP9 Texas 1115 Waiver
Transforming Healthcare Now

Patient Centered Medical Home:

Expanding the Medical Home Model in the UTSCAP Primary Care Network

UT Southwestern Medical Center

Background

The UTSCAP Primary Care Network (the "Network") is designed to integrate community-based primary care physicians and the faculty physicians of UT Southwestern Medical Center ("UT Southwestern").

As the Network grows through the membership of community-based primary care physicians, this project will develop, implement and evaluate action plans to enhance each practice's delivery of care through the patient centered medical(PCMH) home model.

Outcomes

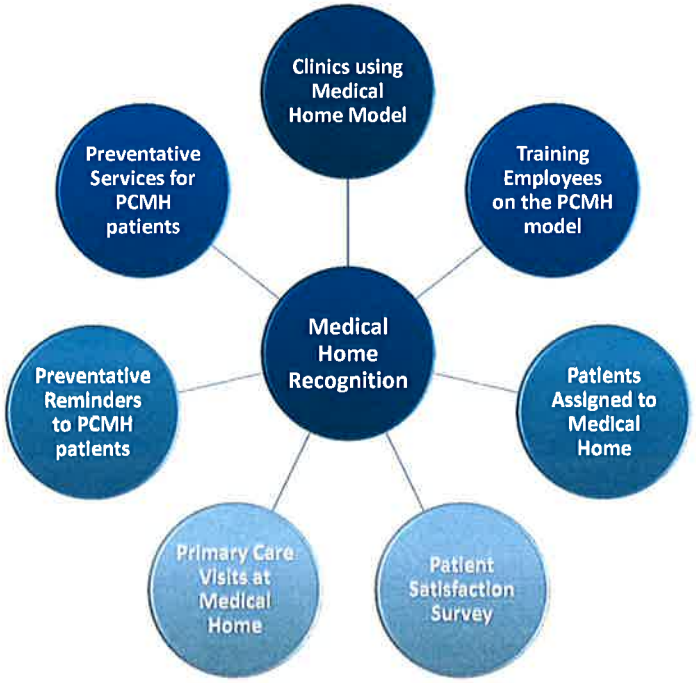
- Over the last six to twelve months we continued to identify UTSCAP community affiliate clinics actively working towards implementing a Patient Centered Medical Home (PCMH) model of care delivery
- Both internal and external workflows have been created to support UTSCAP's efforts to facilitate the full adoption of Medical Home concepts
- Eleven of our community clinics switched from homegrown or highly customized EHR's to UTSW hosted E-ClinicalWorks in order to enhance clinical integration and systemic quality improvements.

Project Description

This project will provide support, resources and expertise in the PCMH model for affiliated community-based primary care physicians and practices to implement this model in their private practice.

One of the key characteristics of the PCMH model is the rigorous measurement and ongoing quality analysis required to prove that appropriate care is being provided, thus reducing avoidable costs and improving patient outcomes.

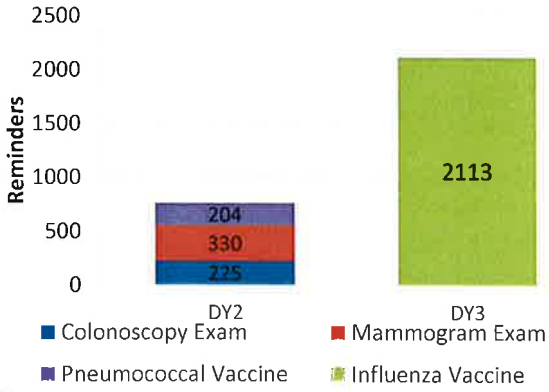
PCMH Project Initiatives



Accomplishments

- PCMH subject matter experts assist with workforce development and shifting the culture of the clinic to a team-based approach.
- Through sub-setting the population we have been able to better identify patient clinical and social determinate issues to support referrals to and alliances with community social service resources for our primary care clinics.

Preventative Service Reminders



Team

- Danny Ireland, FACHE, MBA, Chief Operating Officer, UTSHS
- Joshua Liggin, Director of Clinical Integration
- Joel Estes, NCQA PCMH-CCE, PCMH Consultant
- Bethyln Gerard, CPA, NCQA PCMH-CCE PCMH Consultant