DSRIP at Baylor Scott & White:

Successful Outcome Measurement and Validation

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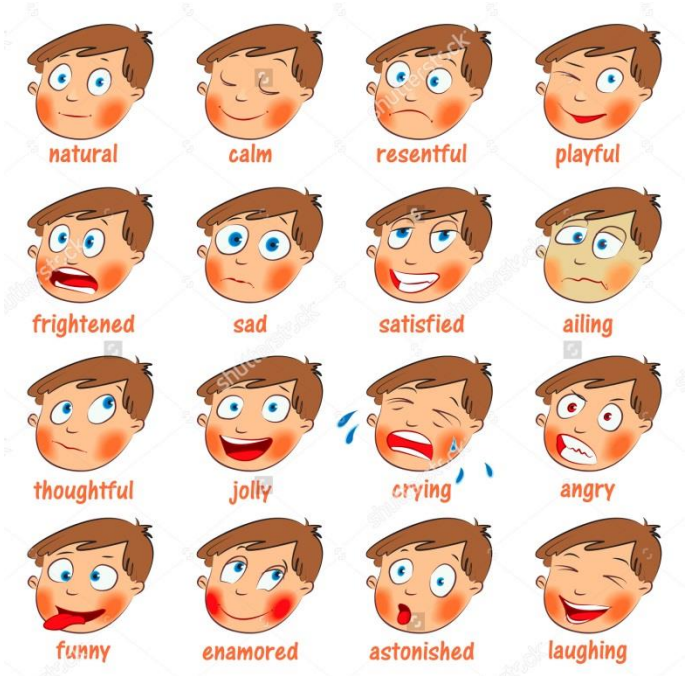
Ryan Pattillo, MBA- Director of Clinic Operations
Niki Shah, MBA, MHSA – System VP Care Redesign & Equitable Care
Jeff Zsohar, MD- President Baylor Community Care Clinics

Goal for Today's Session

Describe the processes, structure, improvement exercises, documentation, internal data validation and audits, communication plans, and continuous operational improvements Baylor Scott & White has implemented to improve outcomes across its multiple RHPs.



DSRIP Project Overview

DSRIP Projects at BSWH

BSWH Enterprise Overview

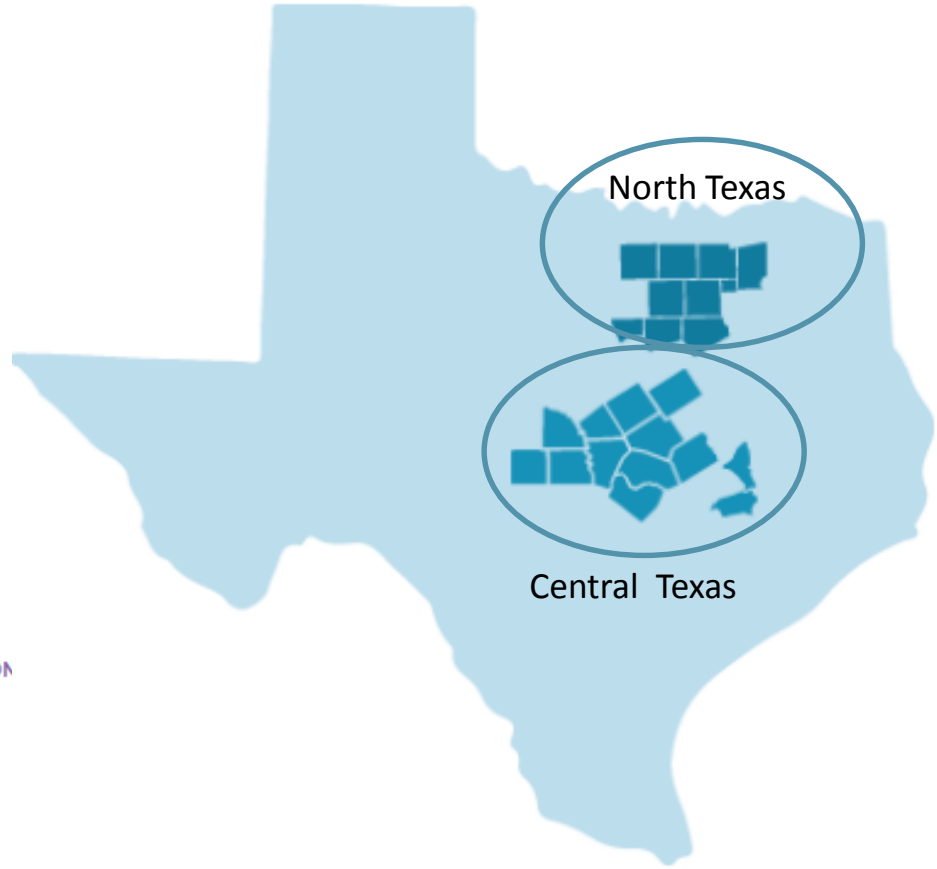
9
BSWH Performing Hospitals

37
DSRIP Projects

95
Quality Measures Tracked

5
RHP Participation

$96.6
Million Dollars Earned To Date



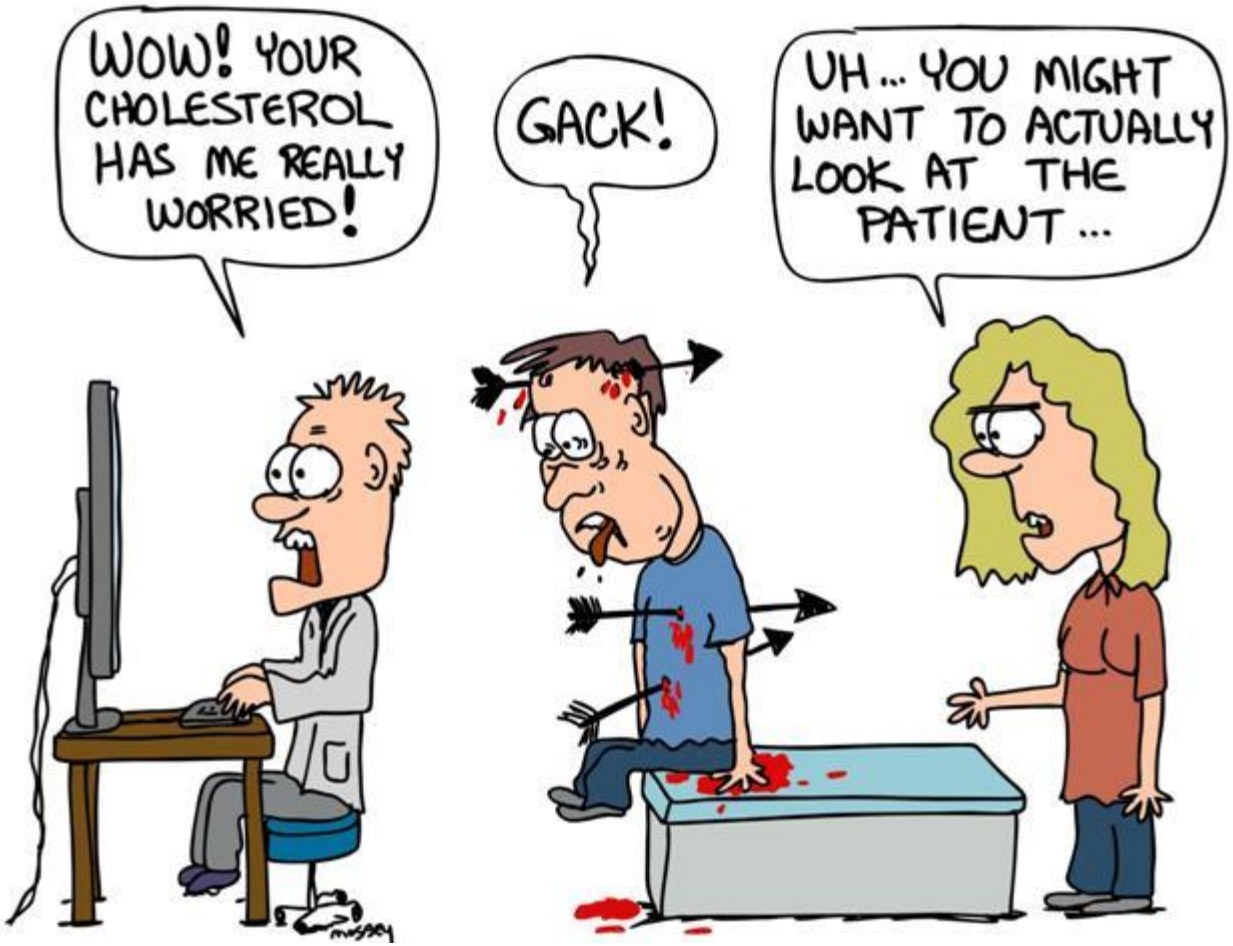
RHPs
8
9
10
16
17

Locations
Dallas
Irving
Garland
Fort Worth
Carrollton
Llano
Brenham
Temple
Waco

DSRIP Projects

Key Points

- DSRIP funding has allowed for the development of:
  - A complete care model that creates cost savings and promotes clinical effectiveness
  - Creation of new partnerships in the community and health systems
  - Innovation and transformation of care through new projects and complementing existing ones
  - Financial sustainability for projects focused on underserved
  - Renewed focus and emphasis on improving quality of care and access for underserved patients

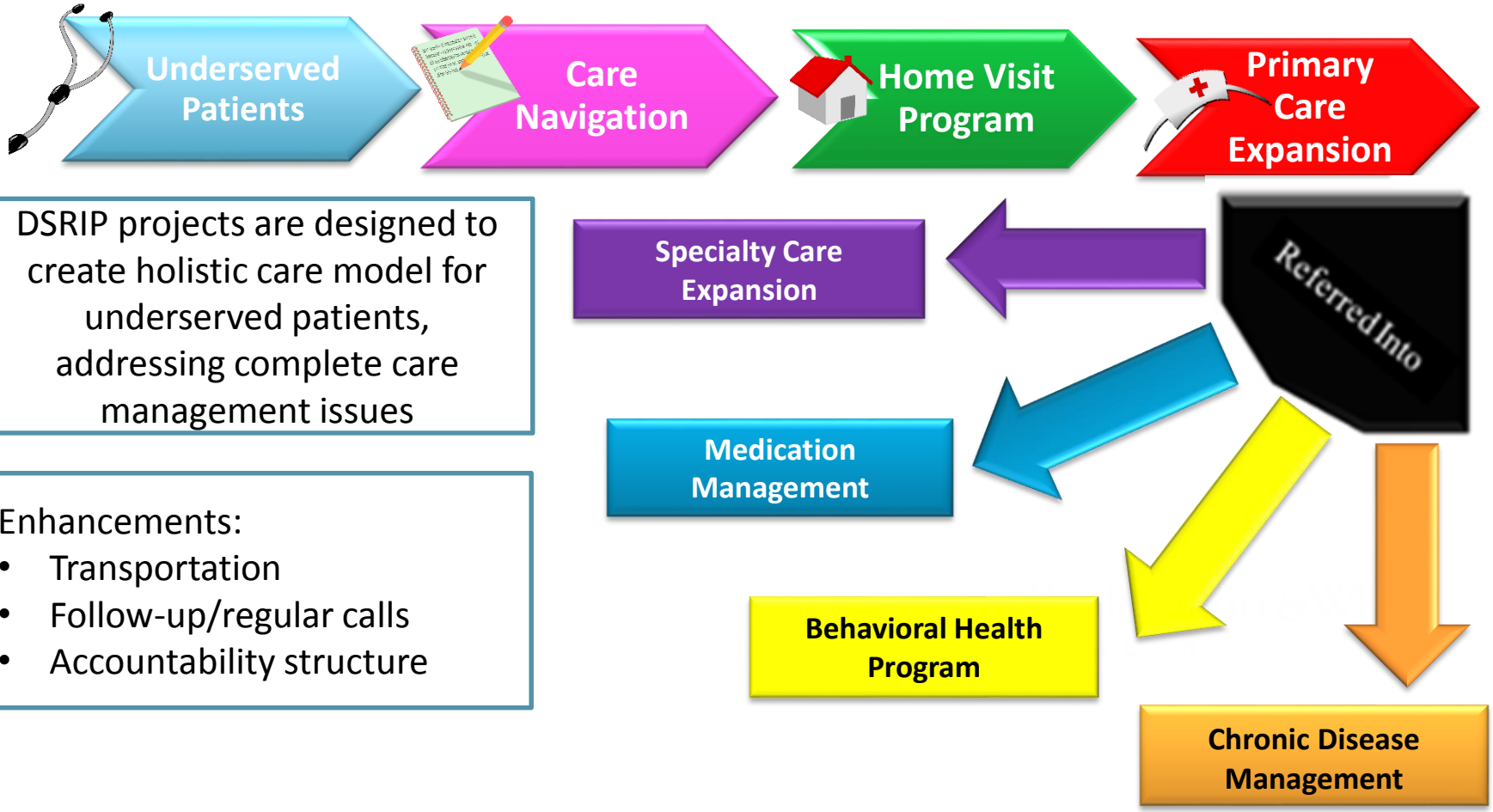

WOW! YOUR CHOLESTEROL HAS ME REALLY WORRIED!
GACK!
UH... YOU MIGHT WANT TO ACTUALLY LOOK AT THE PATIENT...

Clinical Communication & Best Practices

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

North Texas DSRIP Care Management Model

DSRIP Projects = Comprehensive Patient Care



DSRIP projects are designed to create holistic care model for underserved patients, addressing complete care management issues

Enhancements:

- Transportation
- Follow-up/regular calls
- Accountability structure

Clinical Support and Excellence

Expanded Care Team

Physician

Social Worker (LCSW)

- Behavioral Health
- Resource Navigation

Clinical Pharmacist + Pharmacy Tech

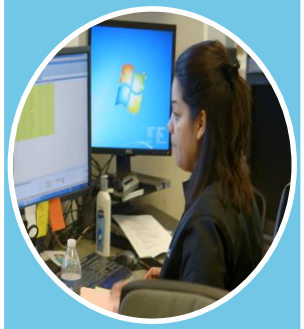
- Med Mgmt
- Tobacco Cess.

Community Health Worker

- Navigation
- Education

RN Care Manager

- Chronic Dx Mgmt



Referral Coordinator

- Coordination

Coordinated | Co-Located | Integrated

Clinical Communication

Metric Definitions

Metric	Numerator	Denominator	Note	Time Period Defined	Measurement Period
DSRIP base population selection criteria for all metrics: all community care clinic patients, who had at least one office visit during one year prior to the report date and were DSRIP eligible (Medicaid, Charity, Self-pay) during that visit. Unless specified otherwise, patients are attributed to the clinics based on their most recent visit location.					
I 12.2	All patients, with DSRIP intake form observations. OBS HDID values: 410650 – chronic disease 410651 – behavioral health 410652 – specialty care 410653 – medication management In order to be included into monthly encounter counts a patient should have at least one 'new patient visit' CPT Code ('99201','99202','99203','99204','99205', '99381','99382','99383','99384','99385','99386','99387') since DSRIP project start date, this encounter becomes first (index) encounter.		Only first DSRIP intake entry is counted for each patient. Patients attributed to the clinics based on the location specified in DSRIP intake form.		
I 15.1	All patients with primary care DSRIP intake form observation (HDID 410647). Referral source is derived from DSRIP referral source observation value.		Patients attributed to the clinics based on the location specified in DSRIP intake form.		
IT 1.7	Patients with last SBP < 140 and DBP < 90 within REPORTING PERIOD	Patients with HT: ICD-9 401.*-405.* and age between 18 and 85	Includes only those patients with recorded BP measurements. Patients with missing BP measurements are treated as 'Not Controlled'.	**Numerator –** The number of pt's in the denominator who's most recent BP is adequately controlled during the REPORTING PERIOD. **Denominator** – Pt's, age 18 to 85 by the last day of the REPORTING PERIOD who had a diagnosis of hypertension during the first six (6) months of REPORTING PERIOD or any time prior to the REPORTING PERIOD and having at least one (1) outpatient encounter during the first six (6) months of REPORTING PERIOD.	**Numerator –** REPORTING PERIOD **Denominator –** Diagnosed Hypertension patients with one (1) outpatient encounter during the first six (6) months of REPORTING PERIOD.

Clinical Review

Performance Evaluation

Summary from Category 3 Metric Data

Primary Care Category 3 Metrics

Specialty Care Category 3 Metrics

Primary Care Volumes

Source: Totals Clinic by	DY4 Actual	DY4 Goal	DY5 Actual	DY5 Goal
BUMC	18727	4400	15162	15316
GAR	1578	1800	730	1800
IRV	6432	2100	5847	4951
BAS	4882	1400	4496	4480
CAR	3068	800	3304	800

Controlling High Blood Pressure

Source: IT-1.7 Tab	Actual	DY4 Goal	Goal DY5
BUMC	68.1%	71.9%	73.4%
GAR	72.9%	72.9%	74.3%
IRV	73.1%	76.1%	77.4%
BAS	66.8%	63.8%	65.7%
CAR	66.3%	63.8%	65.7%

Cervical Cancer Screening

Source: IT-12.1-3 Tab	Actual	DY4 Goal	DY5 Goal
BUMC	72.1%	75.6%	75.9%
GAR	79.1%	80.8%	81.8%
IRV	61.6%	72.4%	73.1%
BAS	77.9%	79.9%	80.9%
CAR	75.1%	61.4%	63.1%

Chronic Disease Program Adherence

Source: IT-21.4 Tab	Actual	DY4 Goal	DY5 Goal
BUMC	31.03%	15%	20%
GAR	33.50%	15%	20%
IRV	28.82%	15%	20%
BAS	33.46%	15%	20%
CAR	22.73%	10%	15%

*will need to pull from most recent month

Breast Cancer Screening

Source: IT-12.1-3 Tab	Actual	DY4 Goal	DY5 Goal
BUMC	54.4%	54.9%	55.8%
GAR	71.3%	52.0%	53.2%
IRV	45.6%	58.9%	59.3%
BAS	52.6%	47.2%	48.9%
CAR	73.7%	44.8%	46.6%

Asthma POA

Source: IT-1.22 Tab	Actual	DY4 Goal	DY5 Goal
BUMC	62.1%	56.6%	58.8%
GAR	74.2%	71.9%	73.4%
IRV	61.1%	50.0%	52.6%
BAS	87.4%	87.0%	87.7%
CAR	73.9%	43.0%	46.0%

Behavioral Health PHQ2 Screening

Source: I-X.1 Tab	Actual	DY4 Goal	Actual	DY5 Goal
BUMC	125%	20%	125%	25%
GAR	124%	20%	124%	25%
IRV	146%	20%	146%	25%
BAS	75%	20%	75%	25%

Colorectal Cancer Screening

Source: IT-12.1-3 Tab	Actual	DY4 Goal	DY5 Goal
BUMC	49.5%	51.0%	53.3%
GAR	48.1%	51.0%	53.3%
IRV	47.1%	51.0%	53.3%
BAS	45.5%	51.0%	53.3%
CAR	60.3%	51.0%	53.3%

Clinical Best Practices

DSRIP Clinic Rankings

Asthma Top 10 Practice Ranking

Rank	Practice Name	N	POA
1	Diabetes Health and Wellness Institute	11	97.73%
2	Baylor Community Care at Garland	18	95.83%
3	Baylor Community Care at Fort Worth	25	93.00%
4	Family Medical Center at Baylor	99	92.42%
5	Colleyville Family Medicine	97	91.24%
6	Baylor Family Health Center at Cityview	116	90.23%
7	Irving Coppell Internal Medicine	29	88.79%
8	Baylor Family Medicine at Coppell	58	87.93%
9	North Texas Health Care Associates - Internal Medicine I/C	37	87.16%
10	Hope Clinic of Garland	15	86.67%

APS Top 10 Practice Ranking

Rank	Practice Name	N	POA
	*Signature Medicine	233	97.24%
1	North Texas Health Care Associates - Internal Medicine I/C	1,226	93.67%
	*Baylor Preferred Health at Park Cities	546	93.52%
2	Irving Coppell Internal Medicine	1,375	92.62%
3	City Square Community Health Services	1,194	91.55%
4	Dallas Diagnostic Association - Park Cities	7,793	89.47%
5	Family Medical Center at North Garland	10,691	89.39%
	*Baylor Preferred Health at Baylor University Medical Center	2,077	88.68%
6	Colleyville Family Medicine	8,496	88.31%
7	Baylor Family Medicine at Cedar Hill	2,496	87.98%

Clinical Communication

Provider Perspective

The benefit of the DSRIP projects is the coordination of care addressing all aspects of a patient's well-being. Simply prescribing a medication for a new and uncontrolled condition is not enough to affect change in our patients. Offering them medication education, medication assistance, disease education, behavioral counseling and access to primary care leads to meaningful change and improvement in our patients' lives.

Shanna Garza, MD *CitySquare Clinic*

I had a patient with precancerous lesion of the cervix and she was able to get in quickly with a GYN specialist potentially saving her life, thanks to the DSRIP funding.

Lydia Best, MD *DHWI*

PDSA & CQI

DSRIP Impact- Quality

Continuous Quality Improvement Activities

Project	CQI
Primary Care	More than 40,000 encounters and patient demographics have been looked into to determine if there are trends with characteristics of patients and their appointment keeping behaviors. These known risk factors allow for the identification of paitents with high probablities of missing appointments. Alternative methodologies to reduce no-shows and increase clinic efficiency are currently being tested.
Behavioral Health	Primary Care providers were asked to complete a pre and post satisfcation survey to see if the implementation of the telephonic psychiatric consultation service inceased their comfort level with treating patients with a behavioral health issue in a primary care setting.
Chronic Disease	The number of referrals to the chronic disease program have increase due to the implementation of standing orders, positioning chronic disease team members at the nurse's station, and participation in pre-visit planning.
Specialty Care	A script was developed for referral coordinators to use when calling patients to remind them of their appointments and the importance of keeping them. Additionally, a $10 processing fee was implemented for scheduling appointments, which helped improve attendance.
Primary Care Connection	Tasks were divided amongst the CHWs to see if they could improve the accuracy of reminder phone calls. This has helped staff feel less overwhelmed, which has increased the percentage of patients who receive their reminder phone calls. The goal was to provide at least 85% of patients with calls.
Medication Management	There is a program implemented in order to identify, resolve and track the adherence barriers for the patients who fail to pick up their medications from the Baylor pharmacies in a timely manner (less than or equal to 7 days from initial fill).
Home Visits	The project was designed to increase referrals from the hospital and Baylor Community Care Clinics to the HomeVisit DSRIP program. To do this we socialized with the CHWs (Navigators and Chronic Disease group) and told them about Housecalls and our DSRIP program and encouraged them to send patients to us that needed home based primary care.

A Colon Cancer screening project 2 clinics have been submitted to the BSWH Quality Awards Summit

PDSA Project Outcomes

Amulya Tatachar, PharmD, BCACP; Cecilia Hui, PharmD; Patricia Whelan, RN, CHC
PJ Pugh, MS, RN, CDE; Marlena Perry, PharmD; Crystal Maturino, CPhT, MA, CHW

Patient Encounters (2/1/16-4/30/16) – 10 patients enrolled in study

First visit: face-to-face (required)	Subsequent visits:	PharmD Visit	RN Health Coach Visit
• Established care and rapport with patient • Discussed patient history of diabetes and/or HTN • Focused on DM education and lifestyle modifications	• Weekly to biweekly telephonic or face-to-face visits • Joint or separate visits with RN Health Coach and PharmD	• Assess medication adherence (including administration technique • Review glucose and BP readings • Physical assessment (vitals) for HTN patients • **Titrate medications*** • Order/update meds, lab values, schedules follow-up appt • Consult provider either verbally or via written documentation to approve medication recommendations	• Review current lifestyle, including diet and exercise • Provide patient-centered lifestyle modifications • Create patient-specific and actionable goals

***Medications titrated according to HTPN Healthcare Provider Guidelines for management of HTN and DM**

Patient Outcomes – 2 Month Mark

*2 A1C labs scheduled in 5/2016

A1C Outcomes	Initial Visit (n = 10)	Last Visit (n = 8)*
A1C (%), mean ± SD	12.1 ± 1.66	9.3 ± 1.2
BP Outcomes	**Initial Visit (n = 7)**	**Last Visit (n = 7)**
Mean baseline BP ± SD , mm Hg Systolic Diastolic	 145 ± 14.1 81 ± 5.1	 126 ± 15.4 81.7 ± 6.5

Patient	A1C (%)	7-Day Average Glucose Reading (mg/dL)
9	10.2	153
10	10.4	132

Conclusion

List of medications adjusted/added: (average 1-2 adjusted/pt)	Time spent with patient (on average):	Positive Findings:	Challenges/areas of improvement:
• Non-insulin (Glipizide, glyburide, januvia, metformin) • Insulin (novolog 70/30, lantus, levemir, toujeo) • Amlodipine, HCTZ	• Face-to-face: 1 hour • Subsequent visit: 40 mins (face-to-face), 25 mins (phone)	• Interdisciplinary approach to chronic disease state management • Improved A1C, improved systolic BP, improved patient satisfaction	• Consistent and frequent follow-up with patients • Telephonic encounters • Logistical challenges with rotating pharmacists

DSRIP Impact- Quality

Continuous Quality Improvement Activities: Palliative Care

- Increased referrals to Hospice Care
- 51% of patients moved to more appropriate level of care within 48 hours of consult
- 100% completion rate on advanced directives, spiritual assessments, and preferences for life sustaining treatment compared to prior baseline closer to 50% amongst chronically ill patients

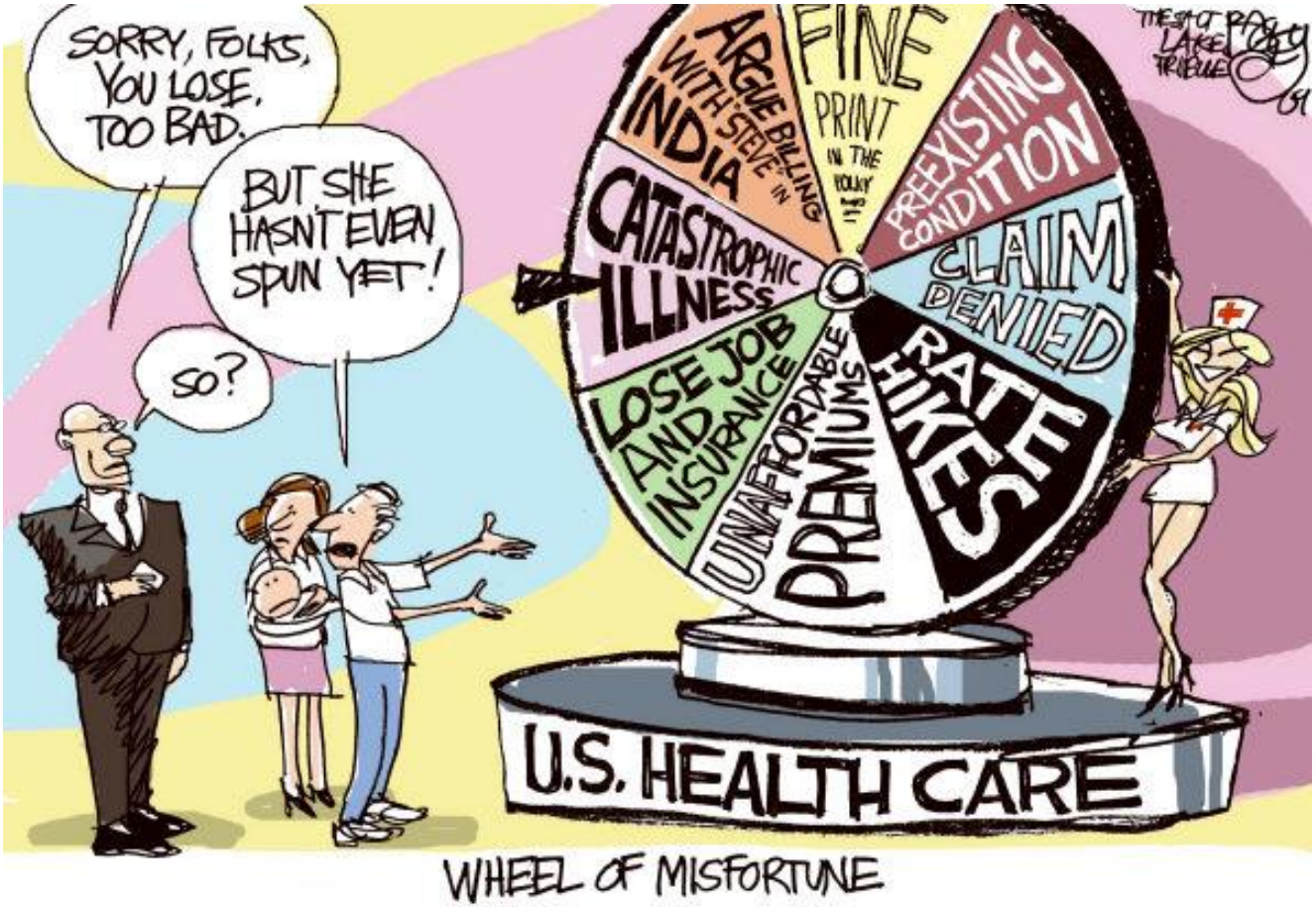
DSRIP Impact- Quality

Continuous Quality Improvement Activities: Palliative Care

- Cost savings for at-risk population
- Daily charges dropped by 80% pre-consult to post-consult
- Expense avoidance estimated at 10% of charges

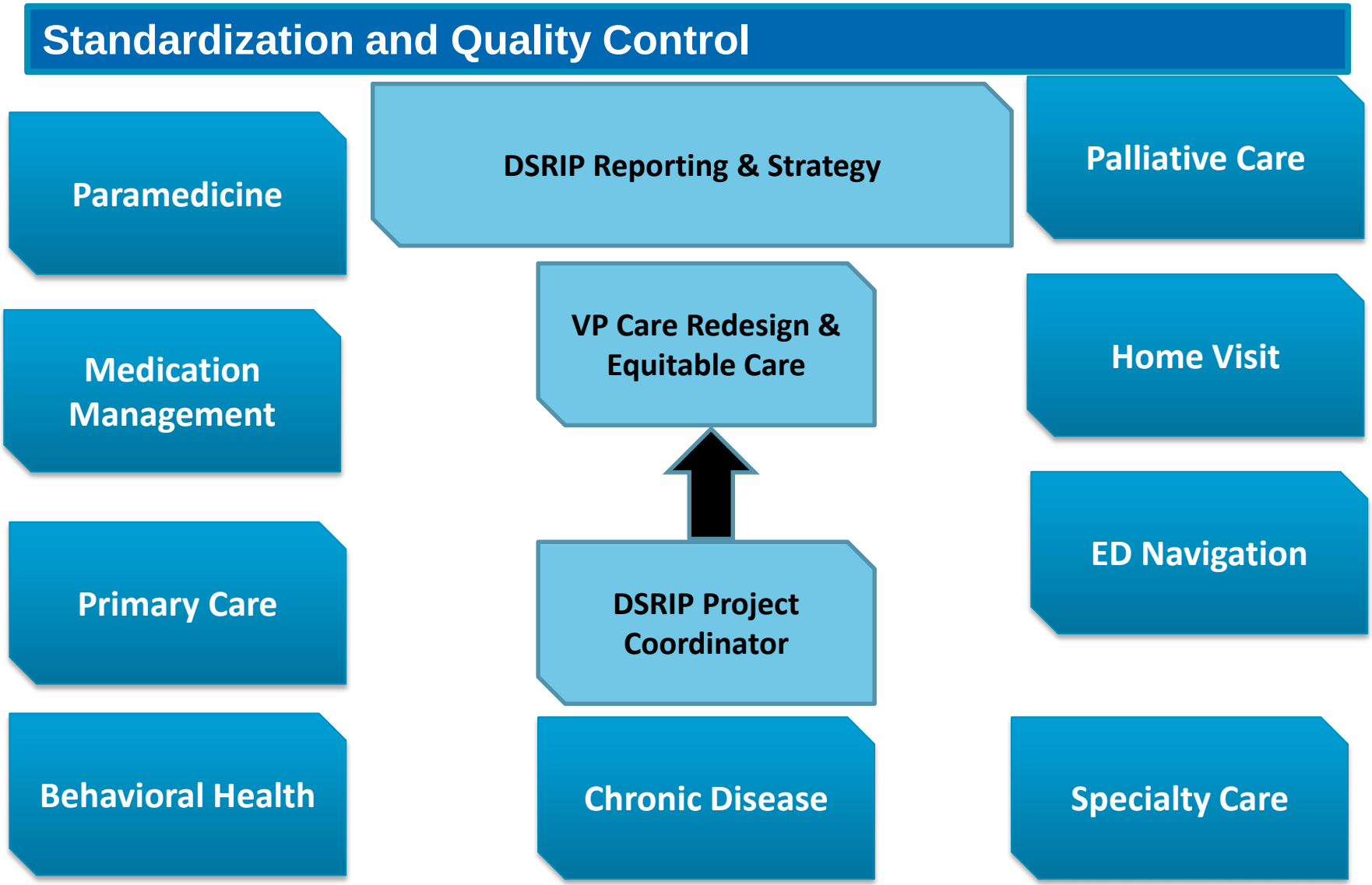
Discharges (est. 10,000 non-OB per year)	Projected Savings
3% - 300	$ 461,550
5% - 500	$ 769,250
7% - 700	$ 1,076,950

Data Governance, EPIC Conversion & State Reporting



WHEEL OF MISFORTUNE

DSRIP Corporate Infrastructure



DSRIP Corporate Infrastructure

Roles and Responsibilities

Reporting	Implementation Support	Data	Finance	Regional Activities/Other
April and October reporting to HHSC-document preparation (templates, write ups, etc)	DSRIP 2.0 Planning	Standardized internal reporting	Budgeting assistance	Coordinate work with community partners
April and October reporting to HHSC-documentation uploads and updates in online reporting tool	Workflow development/mapping	Category 3 data support and validation	Accrual management	
Communication with HHSC	Strategic planning	Monthly internal data audits/checks	Achievement reporting after DSRIP period	Hold quarterly joint project meetings with all facilities
Negotiation of projects with HHSC	Best practice/ideation sharing	Creating input forms and output reports in E.H.R	Point of contact with Finance: CFOs, Finance	Updates on deadlines, policy updates, requirements, HHSC webinars etc.
Plan modifications/project changes with HHSC	Operations support and materials development	Working with EPIC/E.H.R systems to get data into electronic format		Sending consolidated communication about requirements/reporting needs
Audit support (external)	Improvement/modifications to project	Data governance and validation/support		Assist in meeting with IGT entities, other partners as needed
Internal data and progress tracking for metrics	Operations improvement/streamlining	Streamlining data processes and consolidation		Assist with any RHP communication as needed
Quarterly or post reporting metric and financial updates		Dashboard development		
Project Summary development for				

DSRIP Corporate Infrastructure

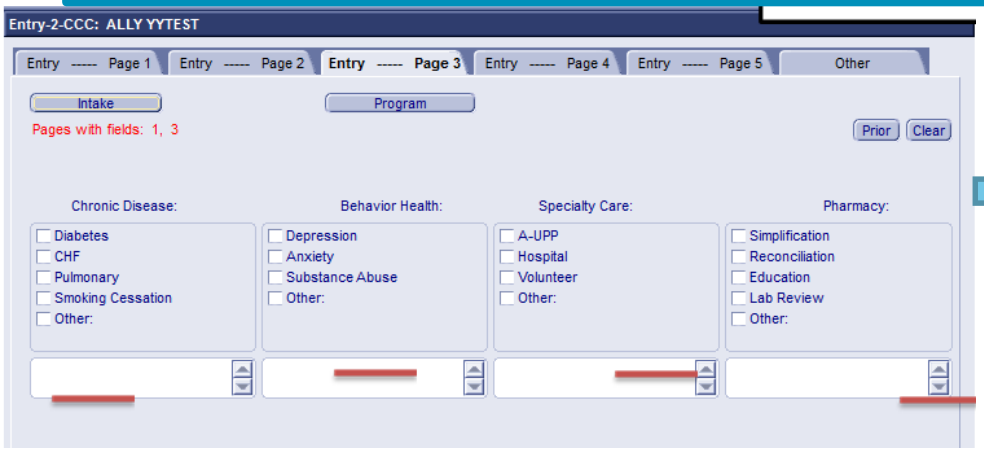
Timeline and Work Management

Executive Dashboard: DSRIP Timeline — On Track
Last Updated: 8/8/2016 — Needs Attention
DSRIP Year: October 1-September 30 — In trouble

Item	Target Date	Owner	Status	Details	October 7	8	12,13,14	15	25	31	November 7	8	12,13,14	15
Dashboards														
Preliminary Dashboards Done	7th/month	Gabby		Dashboards updated minus SC and PCC										
Accruals	8th/month	Niki												
Data for PCC and SC	12-14th/month	Tonya & Cynthia		Dashboards updated with SC and PCC data										
Final Dashboards	15th/month	Gabby		Sent out as pdf internally										
Maintenance Components														
Auditing	All Year	Niki, Gabby, Rustam, Chris		Baseline, Performance review, process review, etc.										
Patient Success Stories/Template	All Year	Project Leads		Documentation of DSRIP Patient Success stories										
Monthly DSRIP Check-In Calls	Every 3rd Thursday/Month	Niki, Gabby, Project Leads		Check in phone calls with project leads for updates on projects and new information from the state										
Mid Year Review	December & June	Niki & Gabby												
Learning Collaboratives-RHP's 8,9,10,16,17	All Year	Niki, Gabby, Project Leads		Attend learning collaboratives for RHP updates, reporting planning, and also requirement of some projects										
Category 3 Internal Audits	8th and 15th/month	Project Leads, Gabby, Rustam		Send out lists to project leads on the 8th of each month and due back for discrepancies by the 15th to discuss with Rustam										
Category 3 Correction Templates	February/July	Niki & Gabby		Baseline/Performance year changes										
Payments Received	July/January	HHSC		Receive payment for projects that have met goals										
State Reporting April & October														
Reporting Planning	March/September	Niki & Gabby												
Project Summaries	All year	Gabby		Accomplishments, Challenges, MLIU reporting, Lessons Learned, Progress on Core Components, Quality Improvement Activities										
Coversheets for all templates	April 25th/Oct 25th	Gabby												
QPI templates	April 25th/Oct 25th	Niki & Gabby												
Category 3 templates	April 25th/Oct 25th	Niki & Gabby												
Category 4 templates	April 25th/Oct 25th	Niki & Gabby												
Summary of CQI Projects	April 25th/Oct 25th	Gabby		Continuous quality improvement summaries										
Final Reporting Due to HHSC	April 30th/Oct 30th	Niki & Gabby		Final reporting submitted to HHSC through website										
NMI templates	June & December	Niki & Gabby		Need more information for projects submitted to HHSC										
DSRIP 2.0														
DY6 Participation Templates	July	Gabby		Finalization of projects, goals, and valuation for DY6										
DY6 Summaries/Specifications	May-September	Niki & Gabby		Inform project leads of DY6 rules/changes										
Sustainability Planning	Ongoing	All		How to sustain current DSRIP programs										

Data Conversion

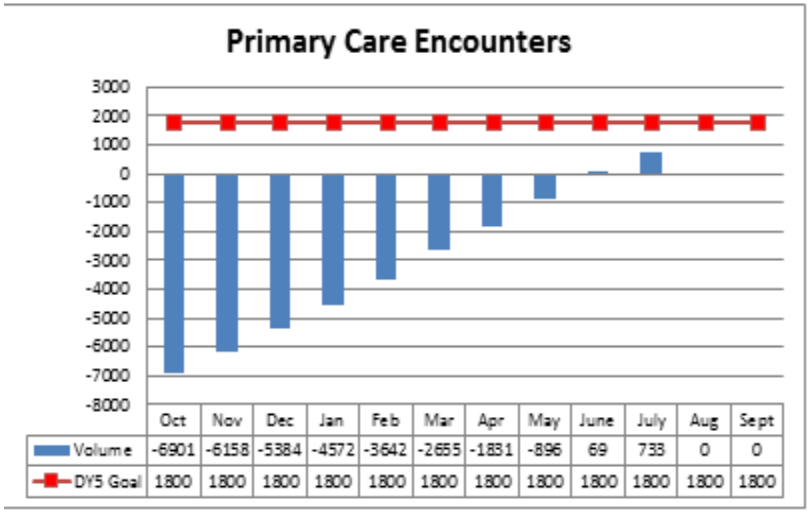
Discrete Fields => Dashboards



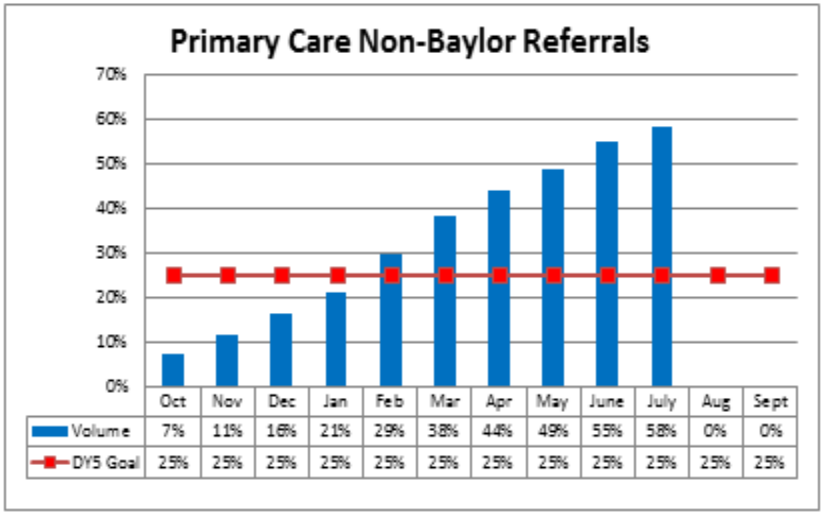
DSRIP Intake Counts by Project Subcategory and Clinic

Clinic Name	Project: Chronic Disease — CHF # of Pts	Diabetes # of Pts	Other # of Pts	Pulmonary # of Pts	Smoking Cessation # of Pts	Behavior Health — Anxiety # of Pts	Depression # of Pts	Other # of Pts	Substance Abuse # of Pts	Total
Baylor Office EHR	0	0	0	1	0	0	0	0	0	1
Health Texas Provider Network	0	0	0	0	0	0	2	0	2	4
Baylor Elder HouseCalls Program and Transitional C	2	1	2	1	0	1	93	0	0	100
Baylor Community Care at Worth Street	83	523	1	84	10	59	290	0	227	1277
Diabetes Health and Wellness Institute	19	399	1	54	4	278	326	3	261	1345
City Square Community Health	14	158	0	87	2	325	610	0	471	1667

DY5 DSRIP Process Metrics
Baylor Garland



Number of encounters (new and existing) for patients enrolled post Dec 1
*included DY2 pre-baseline number (7707)



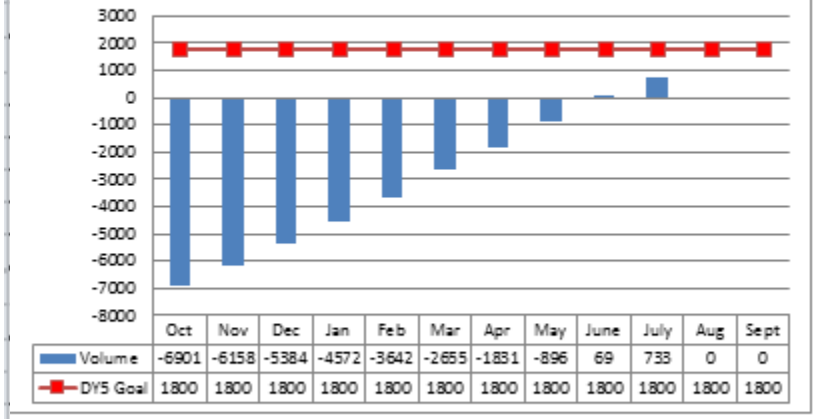
Number of referrals from non-Baylor facility divided by projected patients for DY5

Data Communication

Monthly Dashboards

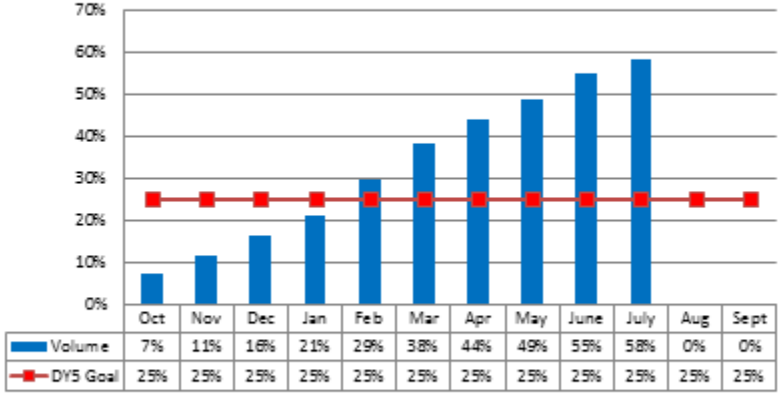
DY5 DSRIP Process Metrics
Baylor Garland

Primary Care Encounters



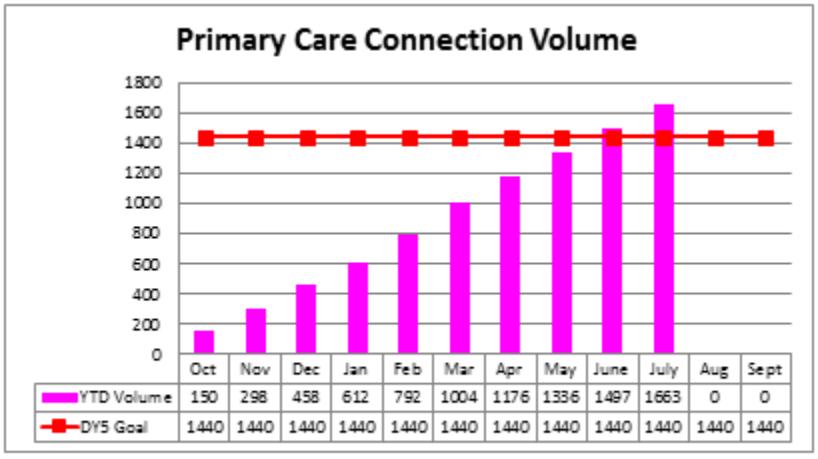
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Volume	-6901	-6158	-5384	-4572	-3642	-2655	-1831	-896	69	733	0	0
DY5 Goal	1800	1800	1800	1800	1800	1800	1800	1800	1800	1800	1800	1800

Primary Care Non-Baylor Referrals



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Volume	7%	11%	16%	21%	29%	38%	44%	49%	55%	58%	0%	0%
DY5 Goal	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%

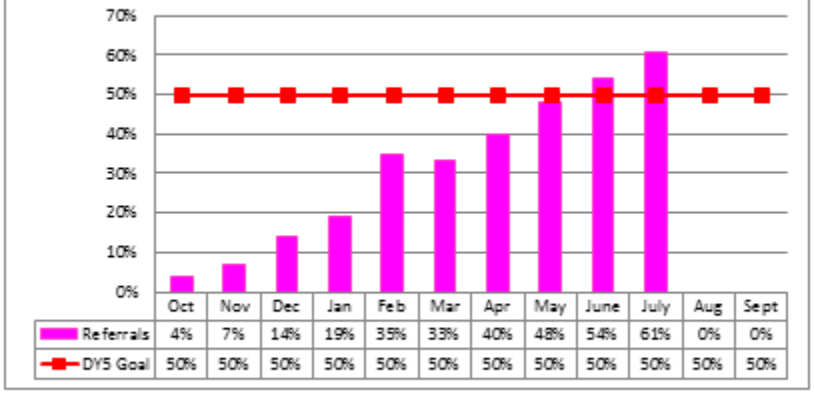
Primary Care Connection Volume



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
YTD Volume	150	298	458	612	792	1004	1176	1336	1497	1663	0	0
DY5 Goal	1440	1440	1440	1440	1440	1440	1440	1440	1440	1440	1440	1440

Number of new patients seen in Primary Care Connection program post October 1, 2014

Primary Care Connection Referrals



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Referrals	4%	7%	14%	19%	35%	33%	40%	48%	54%	61%	0%	0%
DY5 Goal	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

Number of pt's scheduled with appt's divided by Primary Care Connection Volume Projection.

External Audits

Internal Processes

1

Subject: Category 3 DY4 Performance Review of Outcome 195018001.3.1: IT-1.7 Controlling High Blood Pressure

The above project has been selected for DY4 performance review. Please follow the guidelines below for submission of supporting documentation. The deadline for this request is **July 1, 2016**. If you have any questions about the instructions provided for this request, please contact Jeff Wroblewski at jwroblewski@mslc.com or (404) 524-9510.

For the duration of the instructions that follow, the term **Patient Identifier** should be defined as including at least one of the following:

1) Medical Record Number
2) Unique Patient ID
3) Name

Step 1: For all patients included in the denominator, please provide the following data elements

a) Patient Identifier
b) Date of birth
c) Date of patient encounter with a diagnosis of HTN during the first half of the measuremen period
d) Date of the patient encounter in the prior 12 month period (unless waived)
e) Patient diagnosis of one of the following on or before the first half of the measurement pe (diagnosis codes preferred):

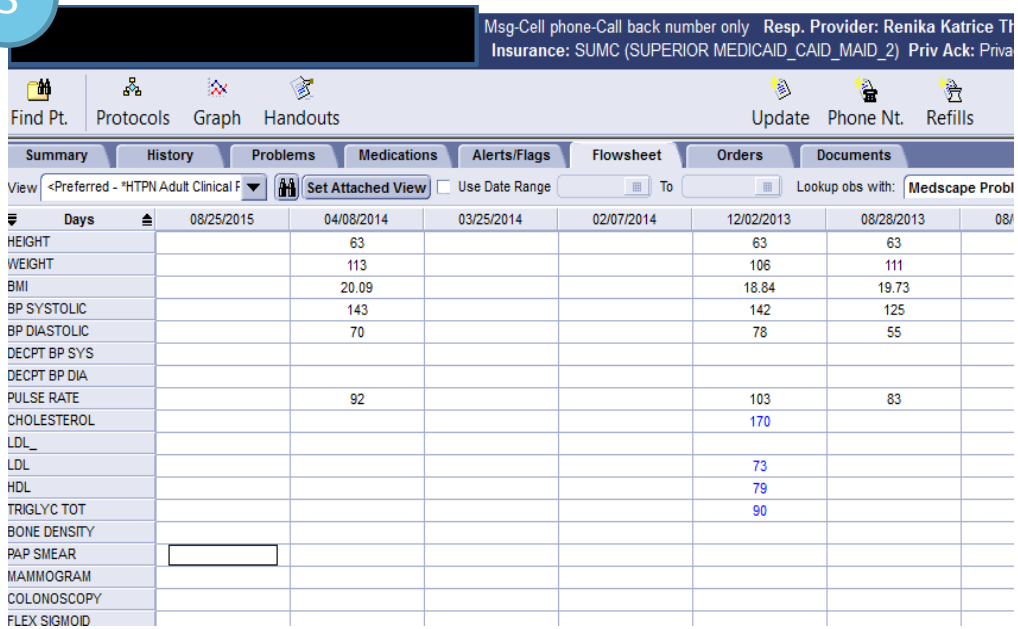
2

PID	DOB	DATE_OF_S	LOCATION_O	PATIENT_	PAYOR_T	obsvalue	obsdate	I
1.481E+15	#######	9/28/2015	BCC Irving	39	Charity	10/22/2011	11/3/2011	I
1.49E+15	#######	9/29/2015	BCC Irving	58	Charity	Not Indicated	9/20/2007	I
1.49E+15	#######	9/29/2015	BCC Irving	58	Charity	not indicated	4/23/2009	I
1.49E+15	#######	9/29/2015	BCC Irving	58	Charity	normal per patient	5/1/2011	I
1.49E+15	#######	9/1/2015	BCC Irving	35	Charity	normal per patient	10/1/2008	`
1.49E+15	#######	9/1/2015	BCC Irving	35	Charity	Normal	12/16/2009	`
1.49E+15	#######	9/1/2015	BCC Irving	35	Charity	normal per patient	9/30/2014	`
1.499E+15	#######	6/26/2015	BCC Irving	64	Charity	normal	6/7/2011	I
1.5E+15	#######	4/10/2015	BCC Irving	54	Charity	normal per patient	7/1/2011	`
1.5E+15	#######	4/10/2015	BCC Irving	54	Charity	normal	12/23/2013	`
1.501E+15	#######	4/2/2015	BCC Irving	45	Charity	normal	10/30/2012	`
1.502E+15	#######	9/16/2015	BCC Irving	45	Charity	normal per patient	5/1/2007	`
1.502E+15	#######	9/16/2015	BCC Irving	45	Charity	normal: NIL-Negative	10/3/2008	`
1.502E+15	#######	9/16/2015	BCC Irving	45	Charity	normal	1/6/2012	`
1.502E+15	#######	9/16/2015	BCC Irving	45	Charity	normal: satisfactory f	8/19/2014	`
1.504E+15	#######	7/20/2015	BCC Irving	33	Charity	Normal per Patient	5/1/2005	`
1.504E+15	#######	7/20/2015	BCC Irving	33	Charity	normal per patient	6/1/2012	`

External Audits

Chart Audits

3



Days	08/25/2015	04/08/2014	03/25/2014	02/07/2014	12/02/2013	08/28/2013	08/
HEIGHT		63			63	63	
WEIGHT		113			106	111	
BMI		20.09			18.84	19.73	
BP SYSTOLIC		143			142	125	
BP DIASTOLIC		70			78	55	
DECPT BP SYS							
DECPT BP DIA							
PULSE RATE		92			103	83	
CHOLESTEROL					170		
LDL_							
LDL					73		
HDL					79		
TRIGLYC TOT					90		
BONE DENSITY							
PAP SMEAR							
MAMMOGRAM							
COLONOSCOPY							
FLEX SIGMOID							

External Audits

Internal Tracking

- Audit Requests
- Chart Audits
- Patient Lists

4

Project ID	Project	Metric	Approv	Year	Document Request Sent	Due Date From Provider	Document Request Received	Completed	Notes
139485012.2.1	I-21.2	Chronic Disease	yes	DY4	6/15/2016	6/22/2016	6/20/2016	yes	pre-DSRIP baseline, MLIU calculation and source, QPI validation- patient lists
139485012.2.1	I-21.2	Chronic Disease	yes	DY3	6/15/2016	6/22/2016	7/6/2016	yes	pre-DSRIP baseline, MLIU calculation and source, QPI validation- patient lists
139485012.2.1	I-21.2	Chronic Disease	yes	DY4	6/20/2016	6/27/2016	6/21/2016	yes	Provide chronic care management program service provided to each patient.
135036506.1.1	I-12.1	Primary Care Encounters	yes	DY4	6/15/2016	6/22/2016	6/17/2016	yes	pre-DSRIP baseline, MLIU calculation and source, QPI validation- patient lists

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BMI Assessment IT-1.21

Campus	DY3 Baseline	DY4 Goal	DY4 Performance October R	DY5 Goal	DY3 Baseline Revised	DY4 Goal Revised	DY4 Performance Re	DY5 Performance	DY5 Goal Revised
BUMC	46.0%	46.9%	77.4%	50.0%	35.6%	46.9%	74.0%	66.7%	49.9%
Irving	51.0%	54.2%	64.8%	56.7%	45.7%	46.9%	64.1%	59.0%	49.9%
Garland	67.0%	67.7%	73.3%	68.1%	46.0%	46.9%	59.7%	54.9%	49.9%
BAS	62.8%	64.2%	83.7%	65.7%	48.6%	51.5%	80.0%	95.5%	54.4%
Carrollton	43.5%	46.9%	79.4%	49.9%	42.6%	46.9%	78.2%	96.1%	49.9%

evised 6.14.16

IT-1.21 was under review by MSLC at a few of our other facilities. Due to the changes we made at the other campuses, in order to be consistent and measure performance using the same methodology approved by MSLC, we are submitting changes for this metric. The changes per MSLC affect both DY3 baseline and DY4 reporting periods. The changes are important to ensure clinical and operational consistency between all of our projects across our campuses and for

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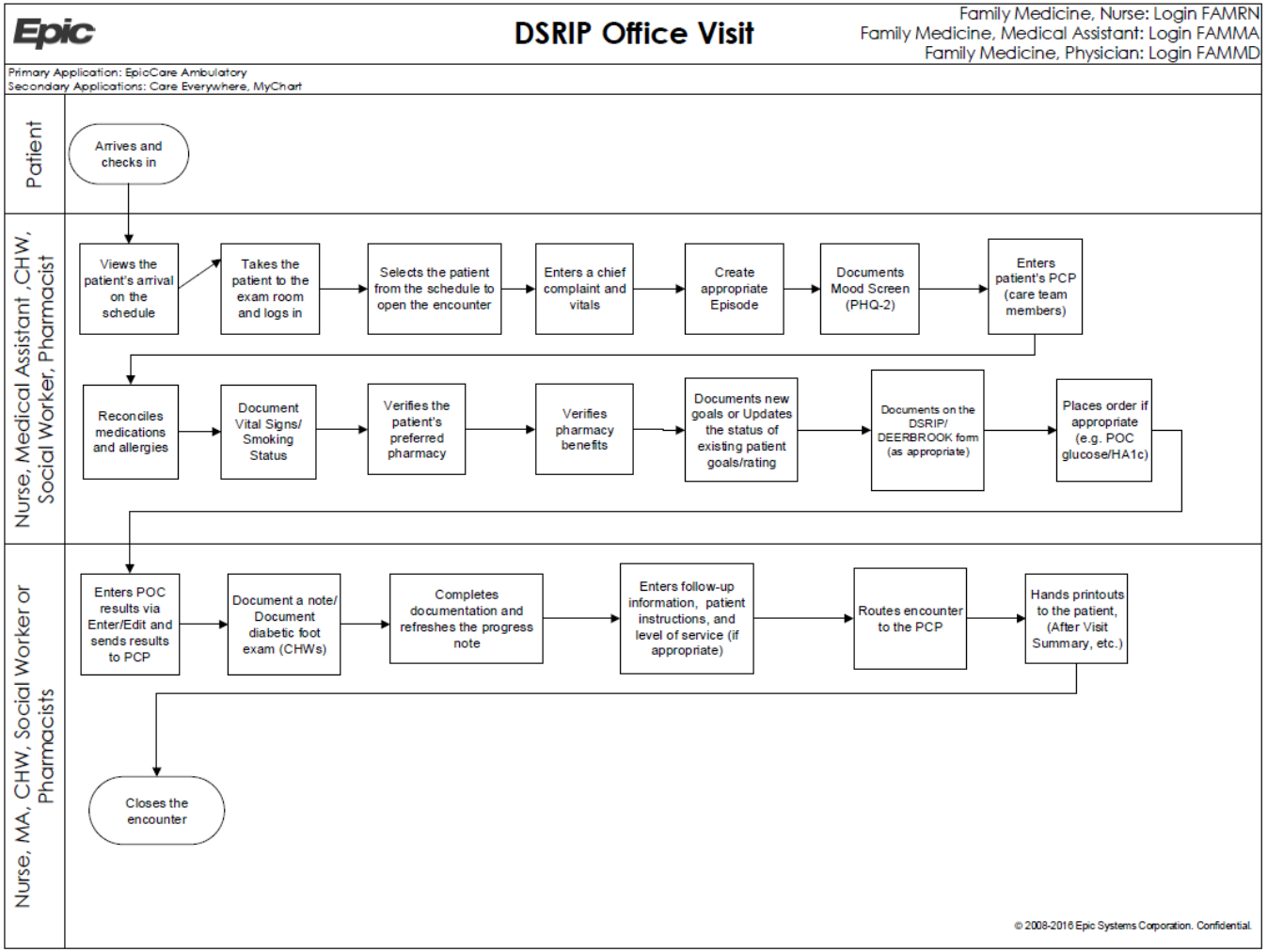
EPIC Conversion

Workflow => Mapping => Testing



EPIC Conversion

Workflow => Mapping => Testing

		Centricity			
Table	**Variable**	Data Type	Definition	**Table**	**Variable**
PERSON	PID*	NUMBER	Person ID for database purposes and report writing. Users see PATIENTID.	PatientDim	PatientKey
	ISPATIENT	VARCHAR2(1)	Indicates if this person is a patient.	PatientDim	Test
	PATIENTID	VARCHAR2(20)	Unique patient ID for a person.	PatientDim	PatientEpicId
	MEDRECNO	VARCHAR2(16)	Medical record identifier.	PatientDim	PrimaryMrn
	SOCSECNO	VARCHAR2(11)	Social security number of the patient.	PatientDim	Ssn
	SEARCHNAME	VARCHAR2(54)	Concatenation of patient's last, first, middle names truncated to fit 52 characters	PatientDim	Name
	LASTNAME	VARCHAR2(25)	Person's last name	PatientDim	LastName
	FIRSTNAME	VARCHAR2(25)	Person's first name	PatientDim	FirstName
	MIDDLENAME	VARCHAR2(25)	Person's middle nan	PatientDim	MiddleName
	DATEOFBIRTH	DATE	Date of birth in the	PatientDim	BirthDate
	SEX	VARCHAR2(1)	Single character tha	PatientDim	Sex
	PSTATUS	VARCHAR2(1)	Patient's status: A, I	PatientDim	Status

ObsTerm	Form	Epic SDE/EHR		Obs Term 03.25.2014
CARDIACEF:mostrecentejectionfraction	CDM	EGG 94.30 (on the problem list)		DSRIP073: yes (03/25/2014 10:56)
DSRIP010:typeofdiabetes	CDM	on the problem list/utilize registries		DSRIP074: no (03/25/2014 10:56)
DSRIP011:dateofdiagnosis(diabetes)	CDM	on the problem list		DSRIP009: dfasdfsa (03/25/2014 10:10)
DSRIP012:monitoringbloodglucose	CDM	BSWH#1035		DSRIP010: Type 1 Diabetes Mellitus (03/25/2014 10:10)
DSRIP013:dailyfootexams	CDM	BSWH#1037		DSRIP011: 03/02/2014 (03/25/2014 10:10)
DSRIP014:asthma	CDM	on the problem list/utilize registries		DSRIP012: Never (03/25/2014 10:10)
DSRIP015:dateofdiagnosis	CDM	on the problem list		DSRIP013: Never (03/25/2014 10:10)
DSRIP016:asthmasymptomfrequency	CDM	BSWH#1038		DSRIP014: yes (03/25/2014 10:10)
DSRIP017:nighttimeawakenings	CDM	BSWH#1039		DSRIP015: 03/02/2014 (03/25/2014 10:10)
DSRIP018:interferwithnormalactivity	CDM	BSWH#1040		DSRIP016: 0-2 days/week (03/25/2014 10:10)
DSRIP020:copd	CDM	on the problem list/utilize registries		DSRIP017: 0-1 nights/month (03/25/2014 10:10)
DSRIP021:dateofdiagnosis(copd)	CDM	on the problem list		DSRIP018: No limitations (03/25/2014 10:10)
DSRIP022:dateofdiagnosis(chf)	CDM	on the problem list		DSRIP020: yes (03/25/2014 10:10)
DSRIP023:monitoringweight	CDM	BSWH#1041		DSRIP021: 03/02/2014 (03/25/2014 10:10)

Successes & Challenges

Medical Afflictions of the Cartoon World


Parkinson's Disease


Anorexia


Amphetamine Addiction


A.D.D.


Gigantism


Senile Agitation


Narcolepsy


Sexual Addiction


Violent Mood Swings


Napoleon Complex


Severe Lisp

DSRIP Impact

Financial

$96.6

MILLION DOLLARS EARNED TO DATE

DSRIP Programs
Transportation
Health and Wellness Institute
Community Partnerships
Home Visits
Equitable Care Initiatives
Texting and Technology
Medications
CHW Expansion
Specialty Care services

DSRIP Impact

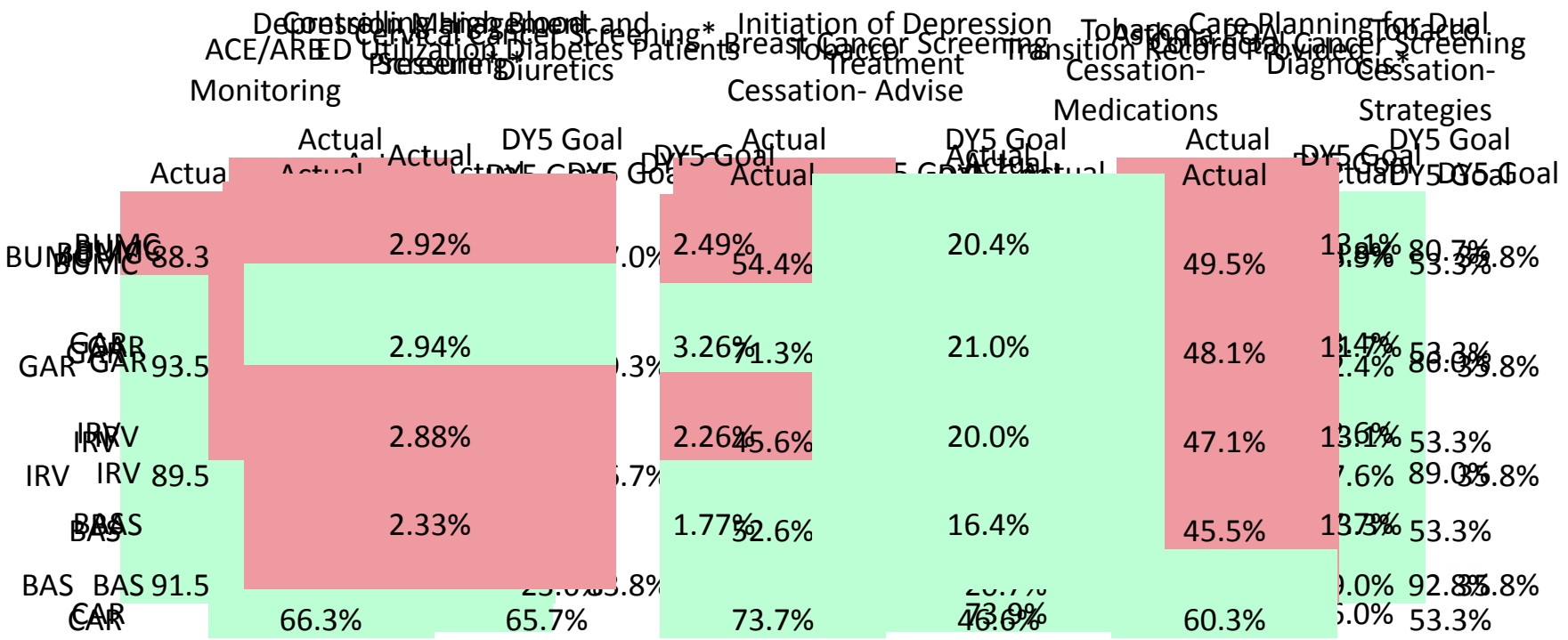
DY3-DY5 Volume Summary

	DY3 Total	DY4 Total	DY5 Total Aug 2016	Total
Primary Care (enc)	35,085	42,792	29,539	107,416
Specialty Care*(enc)	3,610	6,175	4,150	13,935
Chronic Disease*(pts)	2,161	2,856	1,332	6,349
Behavioral Health (pts)	2,459	3,922	3,028	9,409
ED Navigation*(pts)	6,215	9,637	8,455	24,307
Home Visit (pts)	65	259	310	634
Medication Management (pts)	1,910	2,718	3,656	8,284
Palliative Care (pts)	356	973	?	1,329
Totals	**51,861**	**69,332**	**50,470**	**171,663**

DSRIP Impact

DY5 Category 3 Summary

Primary Care Connection- Category 3 Metrics



Patient Impact

Success Story Template & Example

All identities are changed to protect confidentiality.

Hector was a young man with a family which included two small children. When the relationship between he and his wife became estranged, **Hector's long standing depression became too heavy for him**. He walked into his back yard with his shot gun, put it to his chest, and pulled the trigger. He missed his heart by ¼ of an inch. He was brought to Baylor's emergency room and almost didn't pull through the multiple surgeries required to repair extensive damage.

Thanks to Baylor's exceptional doctors and by God's grace, Hector's life was saved and he spent over six weeks recuperating in our ICU and hospital. He came to Worth St Clinic for his follow up care. The doctor was careful to assess Hector for depression and although Hector denied any further suicidal intentions, he was referred to me for follow up assessment, diagnosis and treatment.

When I first saw Hector, he was very sad and depressed. My initial assessment with the PHQ9 revealed a score of 15, but I was sure he was trying to minimize his symptoms. Upon further interview I found that he had a prior attempt at age 21. Hector told me not only did he feel his marriage was over, **but he felt guilty for what he had done to his family and worried about his children** who had witnessed the aftermath of his suicide attempt.

Hector and I began to meet weekly and as I evaluated him, he told a story of his physical abuse by his father since he was eight years old. As he was provided the safety, empathy and medical intervention he needed for his depression, Hector began to get better. **He began to take walks with his children as part of the prescription of exercise. I made a referral for a marriage counselor (not available at Worth St) and they began to work through their problems. His children were also provided play therapy there.**

I spoke with Hector today and was amazed. **The sad, drawn face was gone and in its place was a man who was full of life.** He was smiling frequently and saying hello to everyone. Hector has truly become a symbol of how important it is to make these services accessible. Without help, he would have stayed as he was: depressed and at great risk for a future and potentially fatal suicide attempt.

Hector still has some challenges but he is healing well, both physically and emotionally. **His PHQ9 score today was a five!** I am honored to be a part of Hector's healing and I look forward to his continued success. His story is just one of many success stories I could tell. Hector is why I get up and come to work each day, wondering whose success story will begin. I feel very fortunate to have the privilege to do what I know I am called to do.

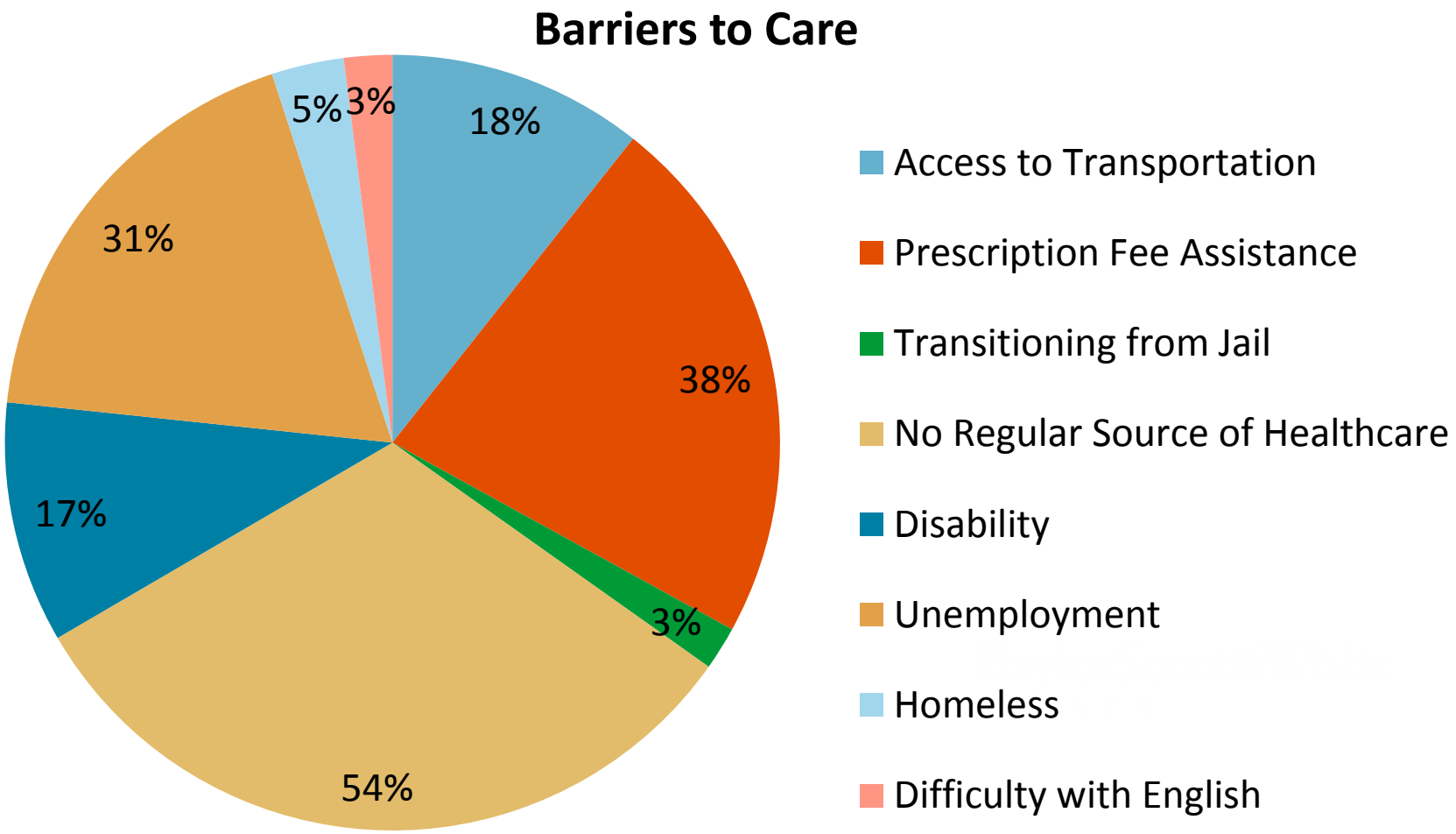
Patient Impact

Success Story Template & Example

DSRIP Project	Increase access to primary care
Location	Brenham
Patient Age	57
Gender	Male
Presenting Diagnoses	Diabetic, post CVA, struggling to walk, dress himself, or lift anything, poor balance.
Success Story	Odis is an African American, diabetic 57 year old male who came to us post CVA as a hospital follow up in January 2016. When he first came to us he was leaning over a walker and had fallen twice at home since his discharge. He was struggling to walk, dress himself, or lift anything without dropping it from his left hand. He had poor balance and his left arm hung flaccidly at his side. After receiving PT here at the clinic from Kat Powers he has gained hand strength, endurance and proprioception. He is now walking with a cane and using his left arm confidently. He also received diabetic education from Becky Kubicek here and his A1C has dropped from 14.6% initially to 6.2% now. He is eating a better diet, exercising regularly and keeping his regular appointments here at the CHC. Odis would not have had access to medical care other than the ER because he has no insurance. DSRIP funds have allowed us to treat this patient and provide allied healthcare services to improve overall health and quality of life.

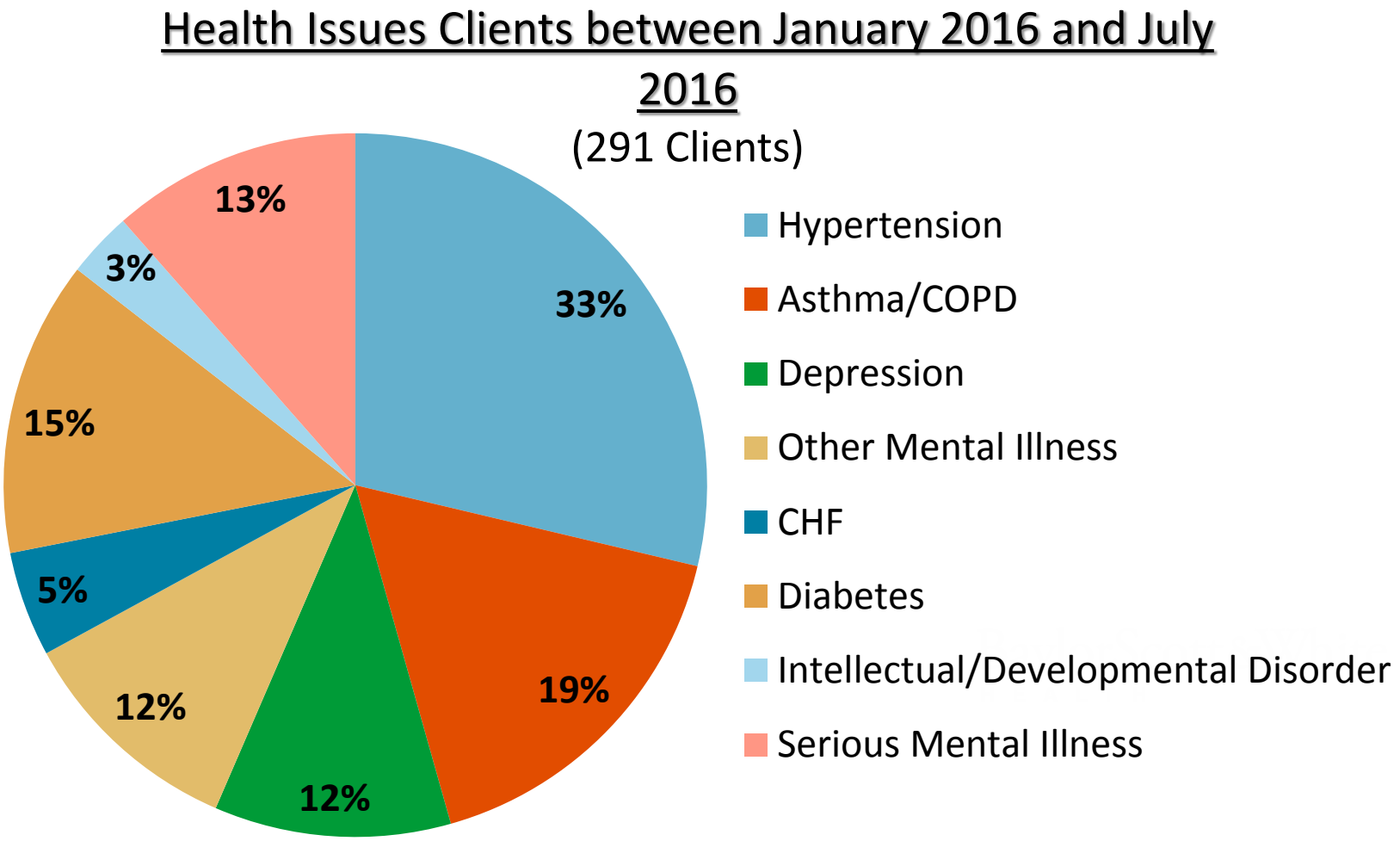
Case Study: Memorial Hospital Care Navigation

Barriers to Care



Case Study: Memorial Hospital Care Navigation

Disease Breakdown of Program



Case Study: Memorial Hospital Care Navigation

Patient Success Story

Bell County Indigent Health Care
Location: Bell County
Patient Age: 62
Gender: Male
Presenting Diagnoses: High Blood pressure

"Jack" was assigned to me from Feed my Sheep, a homeless shelter located in Temple Texas. Mr. Jack was a 62 year old man who had **been homeless for the past 30 plus years**. According to individuals who knew him, **he had made the wilderness his home**. Jack had made a choice to keep minimum contact with civilization itself, but as the years passed by, **his health had began to diminish**. Jack sought assistance from a volunteer at Feed my Sheep; where he was able to get temporary living and medical assistance.

The moment I heard about Jack, I drove to his location to try to gather as much information that I could. Jack had a low tone of voice, but spoke loud enough to feel how humble he was.

I knew I needed to act quickly before his temporary assistance ran out. Jack was in need of many things but my primary concerned was to see if Jack had any family in the area that could take care of him. Jack also had medical necessities, but because he was unable to provide identification, it made his case more difficult to work.

The only thing that Jack remembered was his Social Security number and the names of some family members. **Because of certain tools that we have available, we were able to find his lost brother of over 30 years.**

DSRIP Funded Opportunities

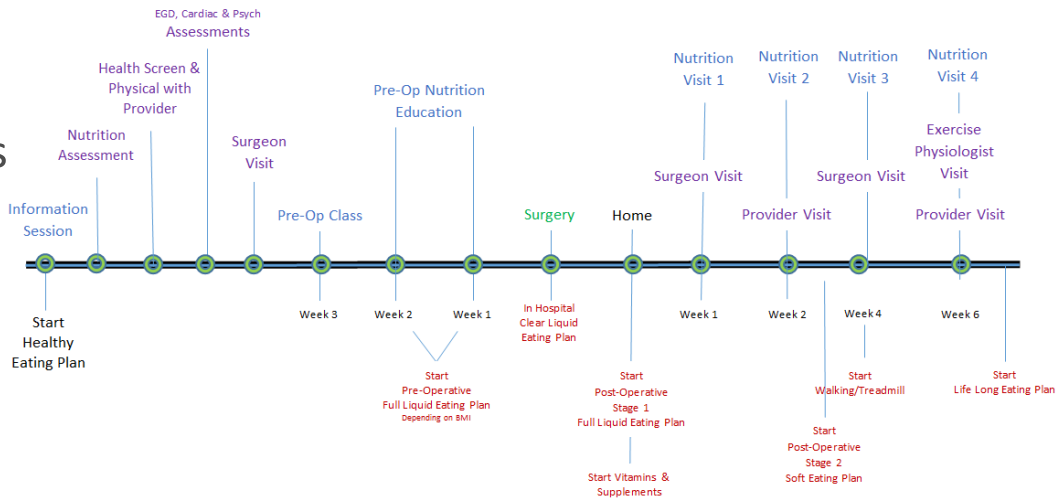
Innovative Bariatrics Surgery Project

- DSRIP specialty care extension projects to provide gastric sleeve surgeries to morbidly obese, Type II diabetic patients (DHWI)
- Creation of comprehensive program with more touchpoints and services than typical bariatrics program
- Utilization of BSWH specialists to provide services
- New initiative, never been done in underserved population

Wave I: 3 patients have completed surgery

Wave II: 3 patients are in queue

Wave III: 4 patients are interested



DSRIP In Review

Challenges/Barriers

- Patient Engagement/Retention
- Transitioning to new E.H.R toward end of a DY
- Staffing and turnover
- M&S baseline changes/corrections to Category 3 metrics
- Developing/redeveloping workflows to address Cat 3 metrics
- Managing patient volumes & balancing quality outcomes
- Finding synergies between DSRIP projects
- Documentation/Data Tracking
- Engaging community partners
- Geographic spread of projects
- Communication and dissemination of information to front line staff

DSRIP In Review

Lessons Learned

- Create programs based on processes, not people
- Leverage technology and digital solutions where possible
- Collaborate and engage with community partners in a formal way, with joint accountability and metrics
- Make every data component reportable- NO FREE TEXT!!!
- Regularly collect patient success stories, pictures and impact analyses
- Keep static patient lists
- Create detailed operational manuals and DSRIP on-boarding guides
- Document all iterative changes to metrics based on HHSC, MSLC, internal changes
- Maintain one corporate structure for all enterprise projects
- Pick metrics that fit into current workflows
- Select the same metrics across similar projects
- Keep EVERYTHING ☺
- Reward and recognize staff regularly, celebrate success
- Get nice presents for data staff

DSRIP 2.0 Planning

DSRIP 2.0 Planning

Identifying and Mitigating Risks

Risk/Requirement	Time Period	Description	Internal v. HHSC	RHP Impact	Mitigating Strategy	Risk Level
EPIC go-live	Transition Year	NTx HTPN go-live on 10/1/16	Internal	9,10	Weekly meetings with front end, back end data reporting; ongoing testing and refinements	Medium
Sustainability/Data Analysis	Transition Year	Required metric for all projects	HHSC	8,9,10,16,17	Create DSRIP core analytics team to provide cost, clinical outcomes and operational analyses	High
Quality Metric Improvement	Transition Year	Threshold of improvement for quality metrics increases significantly, creating risk for not meeting goal due to already high performance levels	HHSC	8,9,10,16,17	Monitor outcomes more closely/regularly, determine operational changes in projects to better match patient outcomes with timing of metrics	Medium
MCO Alignment (Planning)	Transition Year	As part of Sustainability metric (Item #2) showing plan for aligning with local MCOs is requirement	HHSC	8,9,10,16,17	Begin discussions with MCOs to determine what data points, value proposition is for them to fund projects	Med
MCO Alignment (Requirement)	DSRIP 2.0 (DY7-DY10)	HHSC may require some documentation or evidence that some portions of projects will be funded by MCOs. Currently DSRIP projects do not see OB or Children, very limited disabled patients (+/- 20%)	HHSC	8,9,10,16,17	Change project strctures to include peds, pregnant women, disabled so more MCO members are seen in DSRIP projects	High
Performance Bonus Pool Development	DSRIP 2.0 (DY7-DY10)	Creation of regionally based outcome measures which providers must contribute improvement to	HHSC	8,9,10,16,17	Begin conversations with DFWHC and CTx regional entities to understand plans of data aggregation and change BSWH metrics to be more easily measurable	Med-High
Medicaid ID Reporting	DSRIP 2.0 (DY7-DY10)	Requirement to report Medicaid IDs of patients in projects to HHSC and MCOs	HHSC	8,9,10,16,17	Create HTPN carve out for Medicaid patients (26/30 projects in NTX). Remaining NTx projects and CTx projects are hospital based and see Medicaid patients	High
Project Budget Reporting	DSRIP 2.0 (DY7-DY10)	Requirement to publish project costs on annual basis versus valuation of projects	HHSC	8,9,10,16,17	Ensure "next steps" in projects create cost offsets for charity care/uncompensated care activities in hospitals	Medium
Community partner engagement	DSRIP 2.0 (DY7-DY10)	Demonstrate shared outcomes, project plans and patients with community agencies & organizations	HHSC	8,9,10,16,17	Rapid cycle pilots with community partners during DY6 to determine strong partners for DY7-10. Over 16 partnerships already developed and over 10 in the pipeline.	Medium
Project Valuation Changes	DSRIP 2.0 (DY7-DY10)	Potential for re-valuation in DSRIP 2.0 time period based upon provider and project impact	HHSC	8,9,10,16,17	Ensure expenses in projects do not increase until final valuation methodology is determined	Low-Med
Changes to metric and reporting methodologies	DSRIP 2.0 (DY7-DY10)	Volume metrics to change to all or nothing instead of partial payment and potential for no option to carry-forward metrics	HHSC	8,9,10,16,17	1) Adjust reserves to account for increased risk, 2) determine operational improvements to better attain goals	Medium
Patient attribution model to assign patients to providers	DSRIP 2.0 (DY7-DY10)	Possibility for looking at historical utilization to distribute risks between performing providers in a region	HHSC	8,9,10,16,17	Examine potential impact now to determine which new patients may be attributed to BSWH based on model, what risks and costs these patients would bring to BSWH	Med-High

DSRIP 2.0 Planning

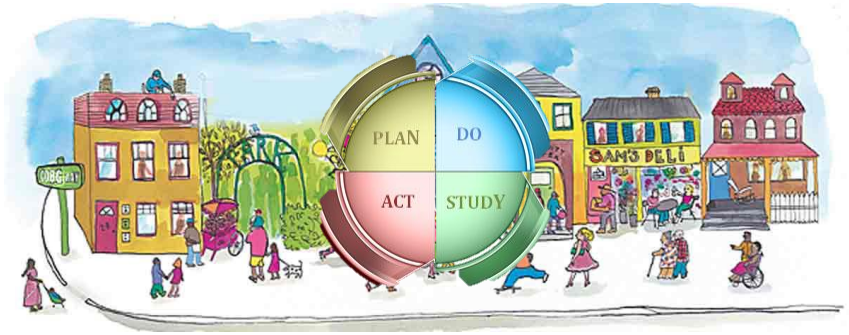
Project Specific Processes

Gaps + Needs

Small ====== Medium ======= **Large**

- Program Enhancements
- Additional Services
- Clinical Augmentation
- Program redesign

Scope

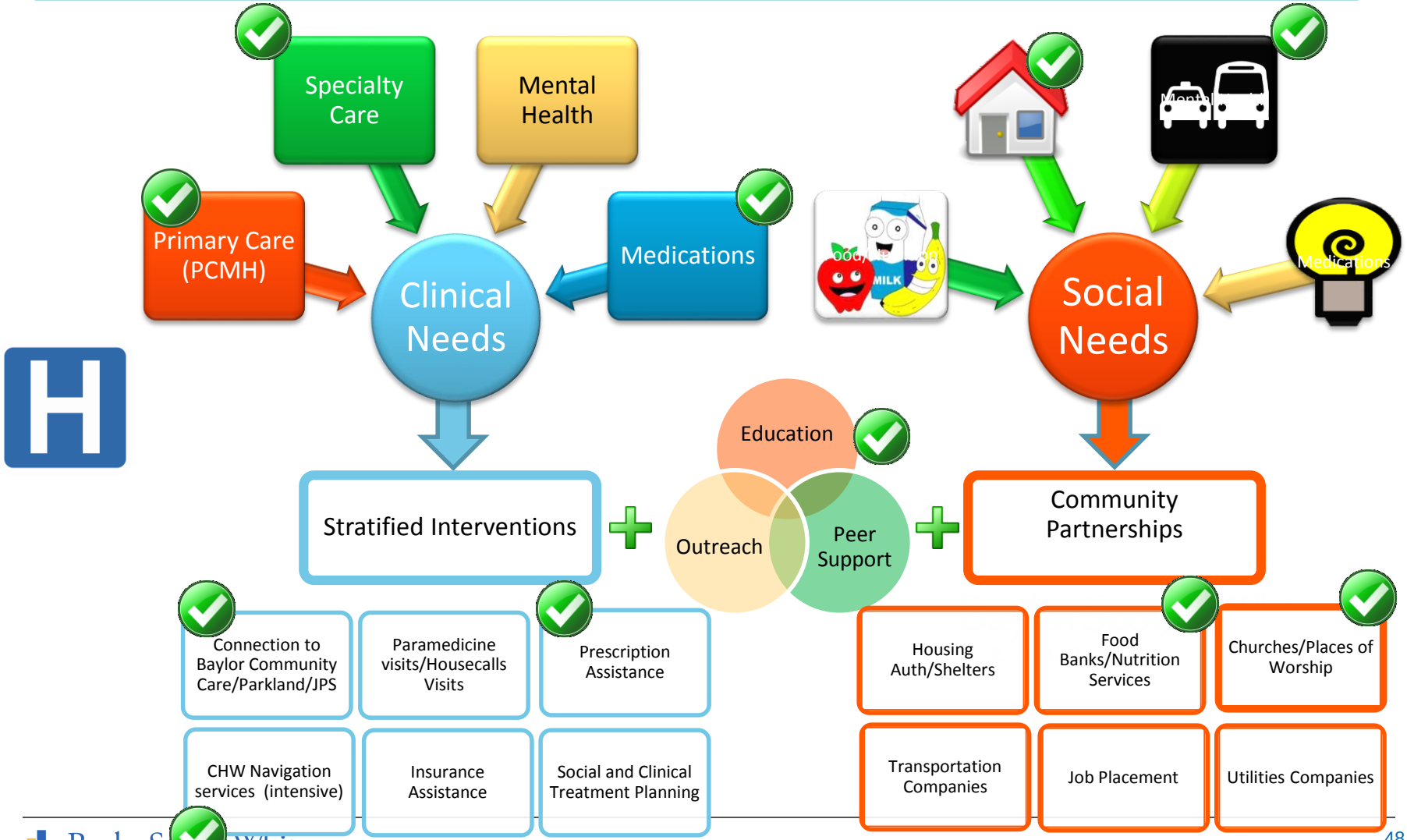


Partners + Innovation

Community Partnerships

Underserved Patient Care Management Model

Future State: Accountable Health Communities (BSWH version)

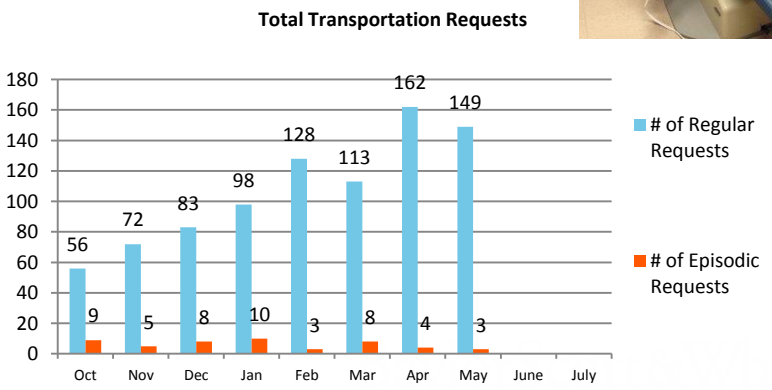


DSRIP Impact- Collaborations

20+ new DSRIP community partnerships

Community Care Partnerships

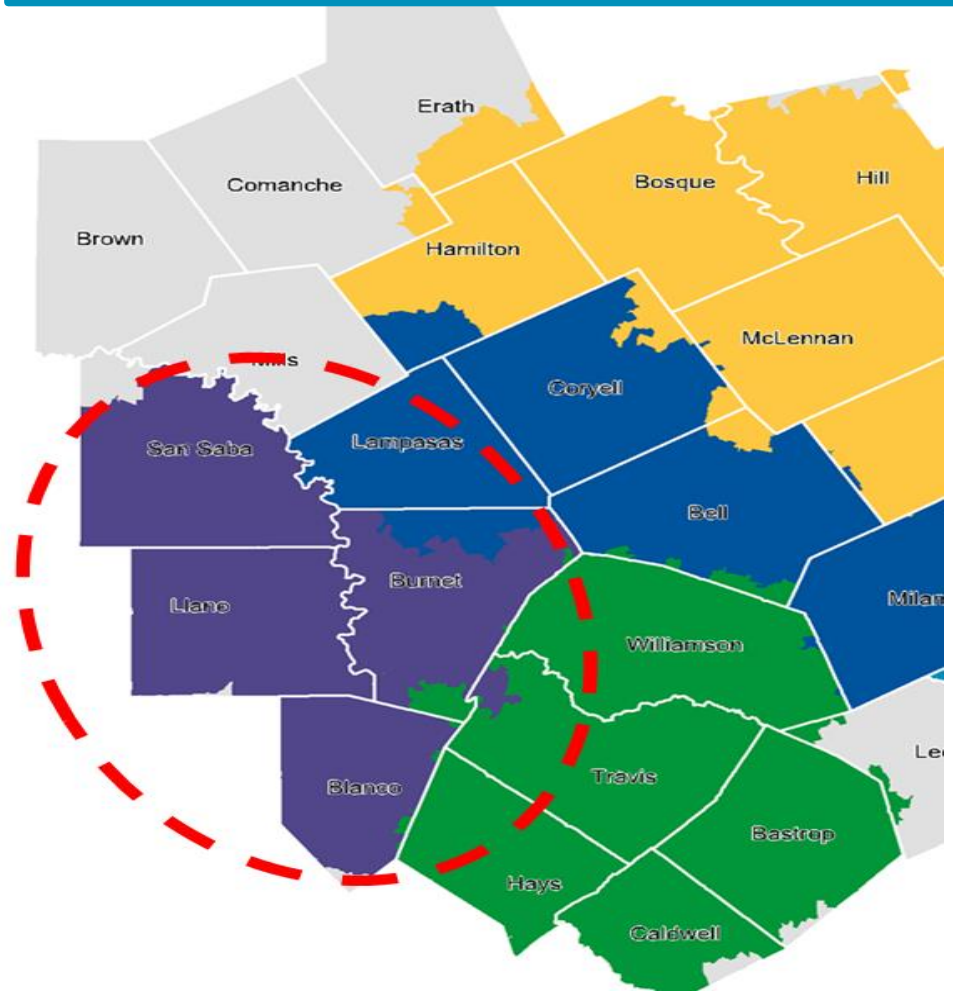
- Jointly operated and funded community care clinics with community based partners
- Transportation program with CitySquare
- Dental Services with Baylor Texas A&M College of Dentistry
- Psychiatric consultations with MetroCare Services and John Peter Smith (County Hospital)
- Primary care patient volume respite relationship with Parkland (County Hospital and JPS)
- Partnership with Mental Health Mental Retardation facilities (MHMR)



Community partnerships help to create relationships and transformation and also help to complement BSWH programs and initiatives

Case Study: Llano County Mental Health

Community Partnership & Collaboration Example

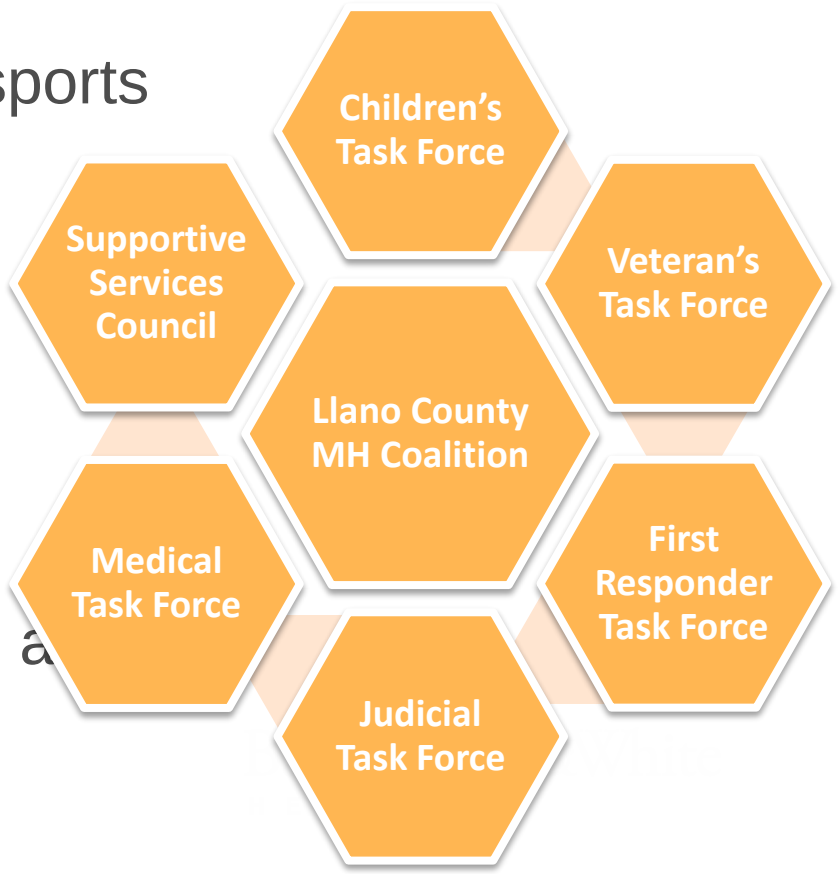


- Llano County
  - Population 19,300
- 8 Zip Codes
- Horseshoe Bay
  - Population 5,500
- Serving 13,800

Case Study: Llano County Mental Health

Community Partnership Successes

- Goal: Reduce Emergency Transports for those with Behavioral Health Needs
- Overutilization of transports
  - EMS
  - Sheriff Department
  - County Resources
- Identification resources a
  not coordinated
- BSWH Llano is integrating
  and bridge organization



Sustainability and Impact Analyses

Program Sustainability

DSRIP Sustainability

Translatable Successes

Integrated Care Model	Ideal Practice Pilot	Roll out to all traditional practices
Expanded Care Team	Ideal practice pilot Grant Opportunity	Roll out to all traditional practices
Shared Metrics btw PCPs and Specialists	Example for ACO physicians	Standard practice for all BSWH practices
Texting/Technology	Roll out to EDs, Remote Care Management Team	Enterprise solution
Community Health Workers	90+ CHWs across enterprise	Roll out to all care settings

Sustainability Assessment

Analytic Design 2.0 (Cohort Comparison Over Time)

Population Based Approach

- All patients included in analysis

Cross Sectional Analysis "Over Time"

- Replaces longitudinal methodology comparing pre / post encounters

Examines Programs Using Compare Groups

- New clinic patients
- Referred but not seen patients

3 Components

- Hospital visits by type - ED / OP / Inpatient

Tracks Both New and Existing Patients

- Engaged / Disengaged

Assumptions & Definitions

Analysis 2.0 (Cohort Comparison Over Time)

Data Sources:

- Community Clinic Data: HTPN Data Warehouse
- Hospital: Trendstar
- Referred Patients: CHW Administration

Data Filters:

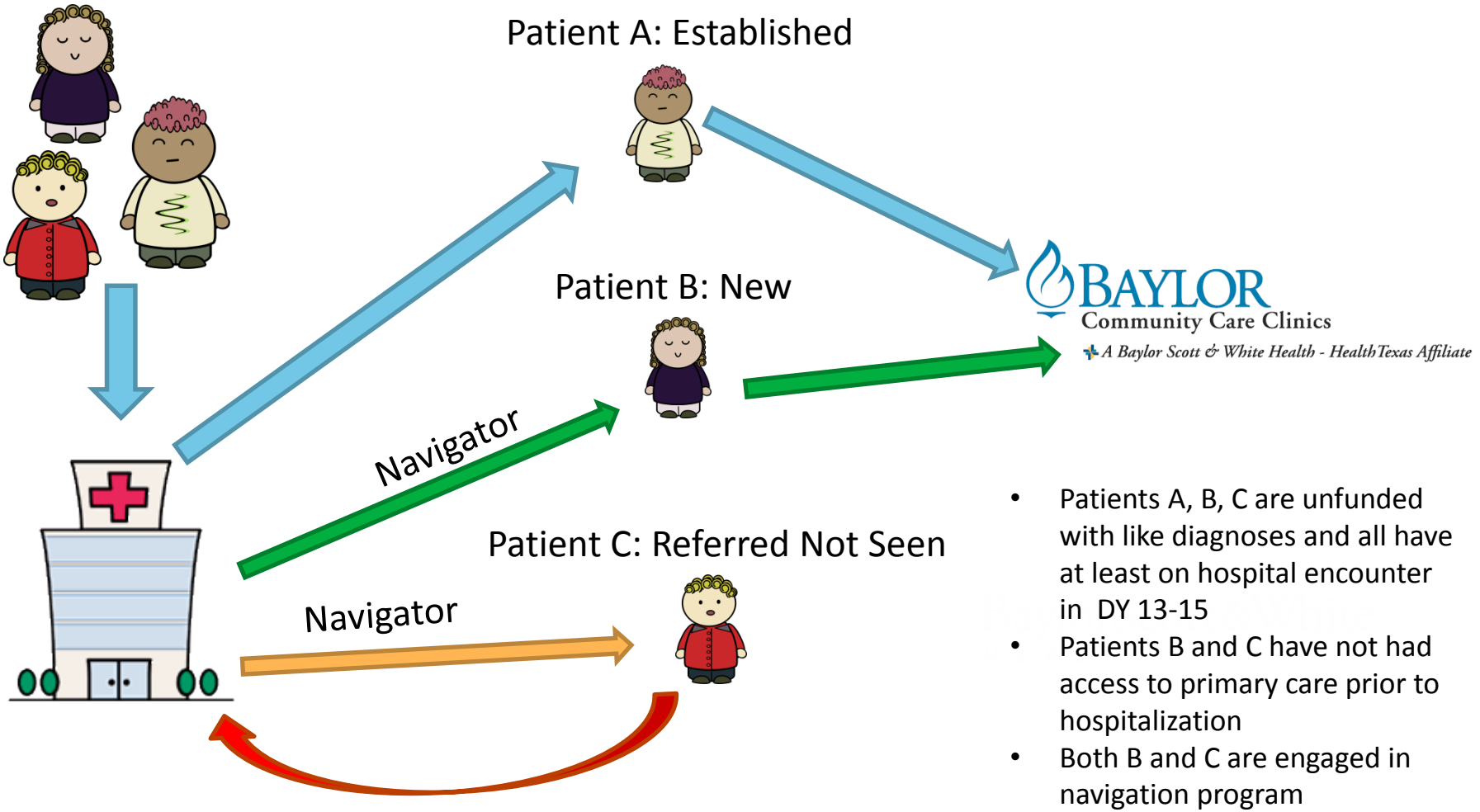
- Hospital MDC: Pre-MDC, Pregnancy, Childbirth; Newborn; Poorly Differentiated Neoplasms; Burns, Multiple Significant Trauma, and HIV Infection
- HTPN Practice ID: Patient seen in community clinic
- EMPI: EMPI populated and<> 0(+98% of patients)

Definitions:

- **Base Year:** Year first seen in community clinic starting with GY 2013
- **GY:** Government Year (October – September)
- **Referred not seen:** patients who were referred but never connected to a clinic
- **Engaged New Patient:** patient who connected with BCC clinic in a given GY
- **Engaged Established Patient:** patient who connected with BCC clinic in a previous GY
- **APR CMI:** Case mix index (acuity)
- **LOS:** length of stay

Analysis 2.0 Illustration

Patient Cohorts (Initial Encounter Point Hospital or ED)



- Patients A, B, C are unfunded with like diagnoses and all have at least on hospital encounter in DY 13-15
- Patients B and C have not had access to primary care prior to hospitalization
- Both B and C are engaged in navigation program

Financial Impact Correlates to Referral Source

Example of Referral Source Tiers

Cohort	% Population	Relative Annual Direct Cost
Hospital Referred (Not Seen)	7%	$$$$
Hospital Referred (Engaged)	10%	$$$
ED Referred (Engaged)	8%	$$
Community Referred	75%	$

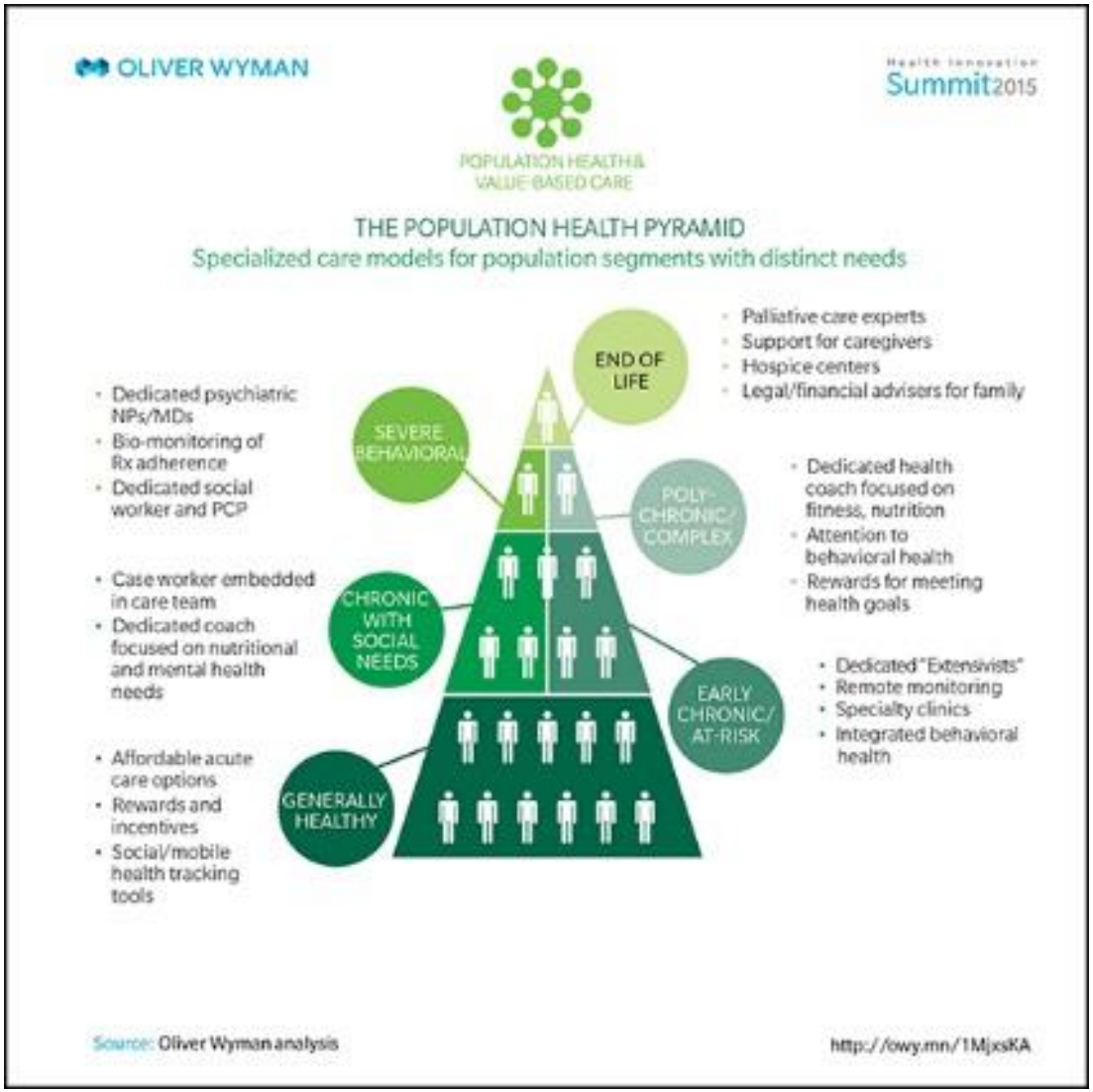
*Visit frequency (≥4 times annually) to the community clinic was associated with higher costs within the engaged tiers

Discussion Points

Factors Impacting Measured Outcomes

- Questions remain about likeness of referred groups: hospital-based vs. community-based
  - Understanding the tracking mechanism for sources of referred patients: inpatient, emergency room, community
- Need to understand nuance: Dating the time of referral in relation to utilization significantly changed the cost savings
  - More appropriate match of first visit date of the engaged clinic patients to the referred not seen patients
  - Based on the average time from referral to first visit date, which better reflected the post utilization for both patient groups.

Looking Forward-Population Health Analysis



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ANALYSIS & COMMENTARY

Patient Segmentation Analysis Offers Significant Benefits For Integrated Care And Support

ABSTRACT Integrated care aims to organize care around the patient instead of the provider. It is therefore crucial to understand differences across patients and their needs. Segmentation analysis that uses big data can help divide a patient population into distinct groups, which can then be targeted with care models and intervention programs tailored to their needs. In this article we explore the potential applications of patient segmentation in integrated care. We propose a framework for population strategies in integrated care—whole populations, subpopulations, and high-risk populations—and show how patient segmentation can support these strategies. Through international case examples, we illustrate practical considerations such as choosing a segmentation logic, accessing data, and tailoring care models. Important issues for policy makers to consider are trade-offs between simplicity and precision, trade-offs between customized and off-the-shelf solutions, and the availability of linked data sets. We conclude that segmentation can provide many benefits to integrated care, and we encourage policy makers to support its use.

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Managing a DSRIP PROGRAM

	TOOLS	ELEMENTS
Making the Case for Funding (Policy)	• DSRIP Success Stories • Example Projects • Example Posters • Infrastructure	• Use market research data to identify uninsured or underinsured populations • Communicate the business case effectively • Explain how funding will improve and expand care in the community • Use testimonials from community members and previous patients to share what is needed to improve the quality of life for the community
Operations	• DSRIP Project Management Guide • Project Plan: Example & Template • Operational Manual: Example & Template • DSRIP Roles & Responsibility • Community Partner Framework • Faith-Based Community Health Framework • Patient Registration Process • Compliance Audit Process	• Identify gaps in care for patients • Determine the appropriate workflow to connect patients to community care resources that they need • Develop a method for project selection and determine clinic capacity • Identify any necessary internal collaborators or external community partners • Implement project initiatives • Evaluate project progress and make any necessary modifications • Develop a financial accrual accounting process and monitor progress
Performance Reporting	• DSRIP Dashboard • Data Management: Criteria, Metric Definitions, & Validation	• Set goals and monitor progress towards metrics • Use analytics and patient data from the EHR to measure progress • Conduct audits and share monthly reports • Set up control processes and validate data
Sustainability	• Sustainability Assessment • Analytical Framework	• Have a strong public relations and marketing team to gain community support • Assign project owners who can advocate for the project • Share success stories with potential partners and the community

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Thank you!