Collaborative Connections Impacting Care – Day 2
Thursday, May 28, 2015
Introduction

Fred Cerise, MD, MPH
President and CEO
Parkland Health & Hospital System
An ACA Progress Report

May 28, 2015

Fred Cerise
Parkland Health & Hospital System
RHP 9 Anchor
ACA Update

- Coverage/Access
- Cost
- Quality
Medicaid Expansion

Current Status of State Medicaid Expansion Decisions

Adopted (30 States including DC)
Adoption under discussion (4 States)
Not Adopting At This Time (17 States)

NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

# Coverage in Expansion and Non-Expansion States

**HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT**  
**May 5, 2015**

<table>
<thead>
<tr>
<th>Non-expansion</th>
<th>Baseline Uninsured Rate</th>
<th>Q1 2014</th>
<th>Q3 2014</th>
<th>Q1 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;138% of FPL</td>
<td>61.8</td>
<td>-2.5</td>
<td>-4.5</td>
<td>-6.9</td>
</tr>
<tr>
<td>139-400% of FPL</td>
<td>22.2</td>
<td>-4.7</td>
<td>-7.3</td>
<td>-10.1</td>
</tr>
<tr>
<td>&gt;400% of FPL</td>
<td>1.9</td>
<td>0.4</td>
<td>-0.6</td>
<td>-1.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expansion</th>
<th>Baseline Uninsured Rate</th>
<th>Q1 2014</th>
<th>Q3 2014</th>
<th>Q1 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;138% of FPL</td>
<td>55.0</td>
<td>-2.7</td>
<td>-5.5</td>
<td>-13</td>
</tr>
<tr>
<td>139-400% of FPL</td>
<td>18.1</td>
<td>-4.1</td>
<td>-8.3</td>
<td>-9.5</td>
</tr>
<tr>
<td>&gt;400% of FPL</td>
<td>1.8</td>
<td>-0.4</td>
<td>-1.3</td>
<td>-1.3</td>
</tr>
</tbody>
</table>

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 3/4/15. All models update the analysis from Sommers et al, N Eng J Med 2014. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, household income, state of residence, +/- a linear time trend; *ASPE defines states that expanded their Medicaid programs as of February 1, 2015. States include AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV.
### Health Insurance Coverage and the Affordable Care Act
May 5, 2015

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Baseline Uninsured Rate</th>
<th>Q1 2014</th>
<th>Q3 2014</th>
<th>Q1 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whites</td>
<td>14.3</td>
<td>-1.7</td>
<td>-4.7</td>
<td>-5.3</td>
</tr>
<tr>
<td>African Americans</td>
<td>22.4</td>
<td>-4.5</td>
<td>-7.2</td>
<td>-9.2</td>
</tr>
<tr>
<td>Latinos</td>
<td>41.8</td>
<td>-4.1</td>
<td>-5.9</td>
<td>-12.3</td>
</tr>
</tbody>
</table>

Change in Percentage Points from Baseline Trend

Quarterly estimates of the Uninsured Rate
Gallup-Healthways Well-Being Index, 2012-2015

<table>
<thead>
<tr>
<th></th>
<th>Q1 2014</th>
<th>Q3 2014</th>
<th>Q1 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number gained</td>
<td>5,200,000</td>
<td>10,700,000</td>
<td>14,100,000</td>
</tr>
<tr>
<td>coverage since baseline (Q1 2012-Q3 2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 3/4/15. All models update the analysis from Sommers et al, NEnglJMed 2014. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, household income, state of residence, +/- a linear time trend.
Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?
Among adults aged 18 and older

% Uninsured

Quarter 1 2008-Quarter 1 2015
Gallup-Healthways Well-Being Index

Gallup
Health Spending as Share of GDP

Source: Health Affairs, January 2015
### National health spending and gross domestic product (GDP)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP</td>
<td>16.42</td>
<td>17.09</td>
<td>17.71</td>
<td>17.74</td>
</tr>
<tr>
<td>National Health Spending (HS)</td>
<td>2.86</td>
<td>2.99</td>
<td>3.14</td>
<td>3.15</td>
</tr>
<tr>
<td>HS Share of GDP</td>
<td>17.4%</td>
<td>17.5%</td>
<td>17.7%</td>
<td>17.8%</td>
</tr>
<tr>
<td>HS Share of PGDP</td>
<td>16.5%</td>
<td>16.7%</td>
<td>17.1%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Growth from Prior 12 Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS</td>
<td>3.3%</td>
<td>4.5%</td>
<td>5.2%</td>
<td>5.6%</td>
</tr>
<tr>
<td>GDP</td>
<td>4.3%</td>
<td>4.1%</td>
<td>3.4%</td>
<td>3.8%</td>
</tr>
<tr>
<td>HS Minus GDP</td>
<td>-1.0%</td>
<td>0.4%</td>
<td>1.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>HS Minus PGDP</td>
<td>-0.2%</td>
<td>1.2%</td>
<td>2.2%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

Source: Altarum monthly health spending estimates (see Methods on page 4); monthly GDP is from Macroeconomic Advisers and Altarum estimates; potential GDP (PGDP), defined as what GDP would be at full employment, is from the quarterly Congressional Budget Office estimates, converted to monthly by Altarum.

*Spending is trillions of dollars, seasonally adjusted annual rate.
Exhibit 4. Health Spending Year-Over-Year Growth for Selected Categories

Source: Altarum monthly national health spending estimates
Specialty Drugs Spending

Growth in Spending on Prescription Drugs

Source: Unpublished data from Altarum Health Sector Economic Indicators™.
EXHIBIT 1

Annual Cost Of Oncologic Drugs Approved By The Food And Drug Administration In 2012

- Afinitor (everolimus)
- Bosulif (bosutinib)
- Cometriq (cabozantinib)
- Erivedge (vismodegib)
- Iclusig (ponatinib)
- Inlyta (axitinib)
- Kyprolis (carfilzomib)
- Perjeta (pertuzumab)
- Stivarga (regorafenib)
- Votrient (pazopanib)
- Xtandi (enzalutamide)
- Zaltrap (ziv-aflibercept)

SOURCE: Authors' analysis.

Hirsch, Balu, Schulman. Health Affairs, October 2014
Many Non-Group Enrollees Report Feeling Vulnerable To High Medical Bills

In general, do you feel well-protected by your health insurance plan, or do you feel vulnerable to high medical bills?

- Feel vulnerable to high medical bills
- Feel well-protected by your health insurance plan

Non-group enrollees with ACA-compliant plans: 38% vs. 57%
Non-group enrollees with non-ACA-compliant plans: 34% vs. 64%
Employer-sponsored insurance: 28% vs. 71%

NOTE: Don’t know/Refused and Just got my plan/too soon to tell (Vol.) responses not shown
SOURCE: Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees, Wave 2 (conducted February 18-April 5, 2015); Kaiser Family Foundation Health Tracking Poll (conducted March 6-12, 2015)
Earnings vs. Health Expenses

Out-of-Pocket Pain
Cumulative Growth in Worker Health Expenses vs. Earnings

- Single Deductible: 108%
- Single Premium Contribution: 72%
- Workers’ Earnings: 23%

Source: Analysis of Kaiser/HRET Employer Health Benefits Survey and BLS data.
Coverage Doesn’t Translate to Care

1 in 4 adults with non-group coverage went without some needed health care because they could not afford the cost.

Types of health care that adults with non-group coverage went without (by percent of adults)*

- Tests, treatment, or follow-up care: 15%
- Prescription drugs: 14%
- Medical care: 12%
- General doctor: 12%
- Specialist: 11%

*Adults who bought non-group health insurance in 2014 and who were insured for the past 12 months.

Source: Urban Institute, 2014
Quality of Care is Improving… but not very fast

Average proportion of recommended care across a panel of quality care metrics 2006-2010

Source: AHRQ Quality Report, 2013
New Models of Care

CMS Innovations Portfolio: Testing New Models to Improve Quality

**Accountable Care Organizations (ACOs)**
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ERSD Care Initiative

**Primary Care Transformation**
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

**Bundled Payment for Care Improvement**
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

**Capacity to Spread Innovation**
- Partnership for Patients
- Community-Based Care Transitions
- Million Hearts

**Health Care Innovation Awards**

**State Innovation Models Initiative**

**Initiatives Focused on the Medicaid Population**
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

**Medicare-Medicaid Enrollees**
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
## Four of the 26 Models Launched by the CMS Innovation Center.

<table>
<thead>
<tr>
<th>Model Name</th>
<th>Start Date</th>
<th>Description</th>
<th>Early Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bundled Payments for Care Improvement</td>
<td>April 1, 2013</td>
<td>Composed of four broadly defined models of care, which link payments for multiple clinical services during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial accountability for episodes of care.</td>
<td>Within orthopedic surgery episodes that include acute and post-acute care (Model 2), participating hospitals in the fourth quarter of 2013 had significantly lower episode payments for patients who used post-acute care services ($3,724 savings on average for a 90-day episode).</td>
</tr>
<tr>
<td>Comprehensive Primary Care Initiative</td>
<td>January 1, 2013</td>
<td>Multipayer model in seven U.S. regions to support primary care practice transformation through enhanced, non-visit-based payments (care management fees and shared savings), data feedback, and learning systems.</td>
<td>In its first year, the model produced 2% gross savings (nearly enough to offset care management fees), including reductions in hospitalizations, emergency department visits, and 30-day readmissions.</td>
</tr>
<tr>
<td>Pioneer Accountable Care Organization (ACO) Model</td>
<td>January 1, 2012</td>
<td>Designed to show how particular ACO payment arrangements can best improve care and generate savings for Medicare and to test alternative program designs to inform future policy for the Medicare Shared Savings Program.</td>
<td>In the model’s first 2 years, actuarial savings were $184 million (according to the independent evaluation, $385 million in risk-adjusted savings as compared with preceding and local market trends).</td>
</tr>
<tr>
<td>Partnership for Patients</td>
<td>December 1, 2011</td>
<td>Engages leadership of more than 3700 acute care hospitals to align with the model goals of 40% reduction in all-cause preventable harm and 20% reduction in all-cause 30-day readmissions.</td>
<td>Through 2013, a total of 1.3 million harms were prevented and up to $12 billion and an estimated 50,000 lives were saved, owing to model and other synergistic efforts.</td>
</tr>
</tbody>
</table>
Medicare Spending per Beneficiary
Overlaid with BPCI Phase II Participant Locations
Expected and Actual Expenditures (per Beneficiary) for Pioneer Accountable Care Organizations (ACO) with and without Shared Savings, in First and Second Years

Source: GAO analysis of CMS data. | GAO-15-401
Table 4: Count of Pioneer ACOs with Higher, Lower, and No Significant Spending Growth between 2011 and 2012 Relative to Local FFS Market, by Service Type (N = 32)

<table>
<thead>
<tr>
<th>Service</th>
<th>Significantly Faster Growth</th>
<th>Significantly Slower Growth</th>
<th>No Significant Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>4</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>SNF</td>
<td>9</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Home Health</td>
<td>9</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Inpatient</td>
<td>2</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Physician</td>
<td>4</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Hospice</td>
<td>7</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>4</td>
<td>2</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: Analysis of Medicare claims data from the Chronic Condition Warehouse Master Beneficiary Summary File
Pioneer ACO Savings and Losses: 2012 & 2013

Year 1 (2012)
- Shared losses: 1
- Shared savings: 13
- No shared savings or losses: 18

Year 2 (2013)
- Shared losses: 6
- Shared savings: 11
- No shared savings or losses: 6
Changes in Average Scores for Quality Measure Domains for 23 Pioneer ACOs that Participated in 2012 and 2013

Note: GAO-15-401-Pioneer ACO Model
### Table ES.2. Early CPC outcomes on Medicare FFS health care cost and service use show promise in first 12 months of CPC (October 2012–September 2013)

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>AR</th>
<th>CO</th>
<th>NJ</th>
<th>NY</th>
<th>OH/KY</th>
<th>OK</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare expenditures and service use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditures without fees</td>
<td>-2%**</td>
<td>0%</td>
<td>1%</td>
<td>-5%***</td>
<td>-2%</td>
<td>4%*</td>
<td>-7%***</td>
<td>-2%</td>
</tr>
<tr>
<td>Expenditures with fees</td>
<td>1%</td>
<td>3%*</td>
<td>4%</td>
<td>-3%</td>
<td>0%</td>
<td>6%***</td>
<td>-5%***</td>
<td>1%</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>-2%*</td>
<td>2%</td>
<td>3%</td>
<td>-5%*</td>
<td>-6%**</td>
<td>4%</td>
<td>-7%***</td>
<td>-5%</td>
</tr>
<tr>
<td>Outpatient ED visits</td>
<td>-3%***</td>
<td>-3%</td>
<td>-1%</td>
<td>-4%</td>
<td>2%</td>
<td>-1%</td>
<td>-7%***</td>
<td>-6%*</td>
</tr>
</tbody>
</table>

Note: Negative, statistically significant estimates (in green) are favorable, implying reductions in service use and/or costs, while positive, statistically significant estimates (in red) are unfavorable, implying increases in service use and costs. Impact estimates are based on a difference-in-differences analysis that adjusts for baseline patient characteristics (including HCC scores) and baseline practice characteristics.

*//*** Statistically significant at the 10%/5%/1% level, two-tailed test.

### Table ES.3. Very few early changes in CPC outcomes on Medicare FFS claims-based quality of care in first 12 months of CPC (October 2012–September 2013)

<table>
<thead>
<tr>
<th>Quality-of-care process measures</th>
<th>All</th>
<th>AR</th>
<th>CO</th>
<th>NJ</th>
<th>NY</th>
<th>OH/KY</th>
<th>OK</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with all 4 diabetes measures</td>
<td>3%</td>
<td>12%</td>
<td>8%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>-21%***</td>
<td>11%*</td>
</tr>
<tr>
<td>Continuity of care:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of primary care visits at attributed practice</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
<td>-1%</td>
<td>-1%</td>
<td>2%</td>
<td>-2%</td>
</tr>
<tr>
<td>Transitional care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-day follow-up to hospitalization</td>
<td>0%</td>
<td>-4%</td>
<td>3%</td>
<td>0%</td>
<td>4%**</td>
<td>-2%</td>
<td>-2%</td>
<td>2%</td>
</tr>
<tr>
<td>Quality-of-care outcome measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACSC admissions</td>
<td>1%</td>
<td>7%</td>
<td>-4%</td>
<td>-1%</td>
<td>-6%</td>
<td>8%</td>
<td>-5%</td>
<td>3%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>-4%</td>
<td>1%</td>
<td>-2%</td>
<td>-6%</td>
<td>-1%</td>
<td>8%</td>
<td>-7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Note: Positive, statistically significant, estimates (in green) are favorable, implying improvement in care quality, and negative, statistically significant estimates (in red) are unfavorable, implying a deterioration in care quality. Impact estimates are based on a difference-in-differences analysis that adjusts for baseline patient characteristics (including HCC scores) and baseline practice characteristics.

*//*** Statistically significant at the 10%/5%/1% level, two-tailed test.
Readmission Rates

EXHIBIT 1

All-Condition Thirty-Day Hospital Readmission Rates For Medicare Beneficiaries, By Month, 2007-13

Source: Authors’ analysis of data from the Centers for Medicare and Medicaid Services.

Scale not yet achieved

- Just over 300 Medicare Shared Savings Accountable Care Organizations, 23 Pioneer ACOs; 287 Commercial and 34 Medicaid
- 7,000 NCQA recognized PCMHs (roughly 10%)
- Comprehensive Primary Care Initiative has 492 practices; 2,158 providers and 2.5 million patients
- Bundled Payments for Care Improvement focuses on 48 episodes of care
- 8 states in Multi-payer Advanced Primary Care Practice Demonstration

Payers are not yet ready to engage, enable, share data
Value-Based Payment Goals

Source: Burwell, NEJM, March 5, 2015
Value-Based Payment Strategies

**Incentives**
ACOs, advanced primary care medical homes, bundled payments, dual eligible demos, specialty care payment models, care coordination payments

**Improve care delivery**
Partnership for Patients, transitional care coordination to reduce readmissions, Transforming Clinical Practice Initiative, Medicaid Health Homes

**Accelerate availability of information to guide decision making**
Meaningful use, Hospital Compare, PCORI

Source: Burwell, NEJM, March 5, 2015
Current Status of State Medicaid Expansion Decisions

- **Adopted (30 States including DC)**
- **Adoption under discussion (4 States)**
- **Not Adopting At This Time (17 States)**

NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT** has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Past State Decisions on Implementation

Figure 1
State Implementation of Medicaid by State

- Number of states that newly implemented Medicaid
- Number of states that previously implemented Medicaid programs

Jan 1967: 26 states
Jan 1968: 37 states
Jan 1969: 41 states
Jan 1970: 8 states
Sept 1972: 50 states
Oct 1982: 1 state


Figure 2
State Implementation of CHIP by Date

- Number of states that newly implemented CHIP
- Number of states that previously implemented CHIP programs

Oct 1998: 45 states
Oct 1999: 45 states
Oct 2000: 49 states

Questions?
Telling Your Project’s Story

Suzanne Smith, MBA
Founder & Managing Director
Social Impact Architects
Teach  Entertain
Mediate
Teach
Cohesion
Communicate
Recordkeeping
Why?
Scrambled Sentences  Story  Why?
Whatever you call it, the “new economy” is at its core, a storytelling economy.”

- Frank A. Mills
TODAY, AROUND 35,000 PEOPLE WILL PASS BY THIS POSTER.

11,600 OF THEM WILL GET CANCER.

Silence is deadly.
Those who tell the stories rule society.

- Plato
You can’t connect the dots looking forward; you can only connect them looking backwards.

-Steve Jobs

Why should I care?
Why should I care now?
What can I do?

How do you impact human life?
To what end?

Who are you?
DATA
EXECUTION
CONCEPT
THE BIG IDEA
MADE to STICK

SUCCESs Model

A sticky idea is understood, it’s remembered, and it changes something. Sticky ideas of all kinds—ranging from the “kidney thieves” urban legend to JFK’s “Man on the Moon” speech—have six traits in common. If you make use of these traits in your communication, you’ll make your ideas stickier. (You don’t need all 6 to have a sticky idea, but it’s fair to say the more, the better!)

**PRINCIPLE 1**

**SIMPLE**

Simplicity isn’t about dumbing down; it’s about prioritizing. (Southwest will be THE low-fare airline.) What’s the core of your message? Can you communicate it with an analogy or high-concept pitch?

**PRINCIPLE 2**

**UNEXPECTED**

To get attention, violate a schema. (The Nordie who ironed a shirt...) To hold attention, use curiosity gaps. (What are Saturn’s rings made of?) Before your message can stick, your audience has to want it.

**PRINCIPLE 3**

**CONCRETE**

To be concrete, use sensory language. (Think Aesop’s fables.) Paint a mental picture. (“A man on the moon...”) Remember the Velcro theory of memory—try to hook into multiple types of memory.

**PRINCIPLE 4**

**CREDIBLE**

Ideas can get credibility from outside (authorities or anti-authorities) or from within, using human-scale statistics or vivid details. Let people “try before they buy.” (“Where’s the Beef?”)

**PRINCIPLE 5**

**EMOTIONAL**

People care about people, not numbers. (Remember Iroka.) Don’t forget the WIIFY (What’s In It For You). But identity appeals can often trump self-interest. (“Don’t Mess With Texas” spoke to Bubba’s identity.)

**PRINCIPLE 6**

**STORIES**

Stories drive action through simulation (what to do) and inspiration (the motivation to do it). Think Jared. Springboard stories (See Denning’s World Bank tale) help people see how an existing problem might change.

www.MADEtoSTICK.com

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Post-Test
Suzanne Smith, MBA
Founder & Managing Director, Social Impact Architects

National Member
• Senior Policy Advisor, Social Enterprise Alliance
• Consultant Member, Society for Organizational Learning
• Research Fellow, Center for the Advancement of Social Entrepreneurship at Duke University (CASE)
• Alumni Council, Fuqua School of Business at Duke University

Local Leader
• Adjunct Professor – University of North Texas
• Dallas, Texas – South Dallas/Fair Park Trust, Mayor’s Task Force on Poverty, Dallas Business Club, Entrepreneurs for North Texas, Leadership Dallas, Leadership North Texas & Junior League
• Cincinnati, Ohio – Flywheel: Social Enterprise Hub

Awards & Honors
• Dallas Regional Chamber, Young ATHENA Award, 2014
• Huffington Post’s Top 10 Social Sector Blog, 2014
• Dallas Business Journal’s 40 Under 40 Award, 2012
• Next Generation Social Entrepreneurs Award, 2010
BREAK
Madhukar Trivedi, MD
Professor and Chief of the Division of Mood Disorders, Department of Psychiatry
The University of Texas Southwestern Medical Center
LUNCH

Return to Main Room
Integrated Behavioral Health from Concept to Reality

Alan L. Podawiltz, DO, MS, FAPA
Chair of Psychiatry University North Texas Health Science Center Texas College of Osteopathic Medicine
Chair of Psychiatry JPS Health Network

Wayne Young
Senior Vice President, Operations & Administrator
JPS Health Network
Presenters

Alan Podawiltz, DO, MS, FAPA
- Chair of Psychiatry, University of North Texas Health Sciences Center
- Chair of Psychiatry, JPS Health Network

Wayne Young, M.Ed., MBA, LPC, FACHE
- Senior Vice President, Behavioral Health
- Administrator, Trinity Springs Pavilion
JPS Health Network

The $950 million tax-supported healthcare system serving residents of Fort Worth and surrounding communities in Tarrant County, Texas.

John Peter Smith Hospital
- 537 acute-care beds
- Tarrant County’s only Level I Trauma Center
- 110,000+ emergency room visits annually

Patient Care Pavilion at John Peter Smith Hospital

- 30 primary care and specialty clinics
- 20 school-based health centers
- 1.1 million patient encounters annually

Nine residency programs, including the nation’s largest hospital-based family medicine residency
JPS Behavioral Health

JPS Health Network has a robust Behavioral Health Service Line

- 19,000+ emergency visits
- 30,000+ outpatient visits
- 30,000+ inpatient days

Trinity Springs Pavilion
JPS Health Network Locations

= JPS Behavioral Health Location

Tarrant County Population = 1.9M
Psychiatric Emergency Center

Emergency Psychiatric Services:

- 24 hours a day, seven days a week
- Psychiatrist on-site at all times
- Voluntary and involuntary patients
- Psychiatric evaluation
- Short-term interventions including observation, stabilization, and monitoring
- Admission to JPS inpatient services
- Referral services

Psychiatric Emergency Center Triages

<table>
<thead>
<tr>
<th>Year</th>
<th>Triages</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>15,997</td>
</tr>
<tr>
<td>2009</td>
<td>17,546</td>
</tr>
<tr>
<td>2010</td>
<td>19,413</td>
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<td>20,074</td>
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<td>2012</td>
<td>21,919</td>
</tr>
<tr>
<td>2013</td>
<td>20,285</td>
</tr>
<tr>
<td>2014</td>
<td>19,532</td>
</tr>
<tr>
<td>2015</td>
<td>18,356</td>
</tr>
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</table>
Adult Inpatient Services

Crisis intervention and individualized, structured treatment are provided to patients in need of an intensive and safe setting.

Two units totaling 60 acute adult beds.
Adolescent Inpatient Services

The Adolescent Inpatient Unit is a 16 bed acute care unit.
Local Commitment Alternative

JPS opened 20 beds under contract with MHMR/DSHS for to offset the reduction in NTSH beds available in Tarrant County.
Peer Support Specialists

Peer Support Specialists are increasingly involved in our system. We hired two as a pilot effort 18 months ago and today we have 8 with a 9th position posted for a “Family Partner”

- Psychiatric Emergency Center
- Trinity Springs - Adult Inpatient
- Psychiatric Day Rehab
- Central BH Assessment Center
The JPS Patient and Family Advisory Council is a group of 12-14 people who express interest in helping JPS improve our services.

- Dedicated to Behavioral Health Services
- Includes patients and family members of those who received or have received behavioral health services at JPS
- Assist with identifying priority areas for us to address
- Partner in Performance Improvement Projects
- Assist in setting policy and giving input into the impact current policies have on patients and families.
We started a risk stratified readmission assessment tool to inform our discharge management program which connects with people after they leave the hospital to promote continued recovery.
Mental Health Court is held in TSP twice weekly.

MHMR staff serve as court liaisons between TSP, MHMR, and North Texas State Hospital.

98% of those who go to NTSH from Tarrant County depart from Trinity Springs Pavilion.
Most JPS outpatient behavioral health services are integrated into strategically located JPS Health Centers.

<table>
<thead>
<tr>
<th>Locations</th>
<th>Partial Hospitalization</th>
<th>Med Mgmt</th>
<th>Assessment</th>
<th>Psychological Testing</th>
<th>Psychology</th>
<th>Counseling</th>
<th>Vocational Rehab</th>
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<tr>
<td>Central Arlington</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
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<tr>
<td>Northeast</td>
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<td>YES</td>
<td>-</td>
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<tr>
<td>Stop Six</td>
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<td>YES</td>
<td>YES</td>
<td>-</td>
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<tr>
<td>Viola Pitts</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
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<tr>
<td>Northeast SBC</td>
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<td>-</td>
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<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
</tr>
<tr>
<td>HEB BH Clinic</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Psych Day Rehab</td>
<td>&quot;YES&quot;</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
<td>-</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Healing Wings</td>
<td>-</td>
<td>-</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>-</td>
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<tr>
<td>SE Tarrant Co MH</td>
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<td>YES</td>
<td>-</td>
<td>YES</td>
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<table>
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<tr>
<th>Year</th>
<th>Outpatient Visits</th>
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<tr>
<td>2013</td>
<td>17,875</td>
</tr>
<tr>
<td>2014</td>
<td>32,980</td>
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<tr>
<td>*2015</td>
<td>40,334</td>
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</table>

*Projected
- Does not include Virtual Guidance Patients
The Case for Integrated Care

US Adults Meeting BH Diagnostic Criteria

- Anxiety Disorder: 19% (19%) - 31% (31%)
- Mood Disorder: 10% (10%) - 21% (21%)
- Impulse Control Disorder: 11% (11%) - 25% (25%)
- Substance Use Disorder: 13% (13%) - 35% (35%)
- Any Disorder: 32% (32%) - 57% (57%)

Within Past 12 Months
Every in Lifetime
The Case for Integrated Care

- **Adults with Mental Health Conditions, 25%**
- **Adults with Medical Conditions, 58%**
- **29% of Adults with Medical Conditions Also Have Mental Health Conditions**
- **68% of Adults with Mental Health Conditions Also Have Medical Conditions**

The Case for Integrated Care

Total Healthcare Costs of Patients with and without Depression

<table>
<thead>
<tr>
<th>Condition</th>
<th>PMPM - Without Depression</th>
<th>PMPM - With Depression</th>
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<tbody>
<tr>
<td>Hypertension</td>
<td>$639</td>
<td>$1,132</td>
</tr>
<tr>
<td>Arthritis</td>
<td>$623</td>
<td>$1,262</td>
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<tr>
<td>Diabetes</td>
<td>$789</td>
<td>$1,341</td>
</tr>
<tr>
<td>Asthma</td>
<td>$1,175</td>
<td>$1,303</td>
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<tr>
<td>Heart Disease</td>
<td>$1,101</td>
<td>$1,811</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Mean Age at Time of Death</th>
<th>Mean Years of Life Lost Per Client</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Clients Who Died During Year</td>
<td>Male Clients Who Died During Year</td>
</tr>
<tr>
<td>1997</td>
<td>55.0</td>
<td>52.4</td>
</tr>
<tr>
<td>1998</td>
<td>55.0</td>
<td>53.3</td>
</tr>
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<td>1999</td>
<td>54.0</td>
<td>50.8</td>
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# The Case for Integrated Care

<table>
<thead>
<tr>
<th>MINIMAL COLLABORATION</th>
<th>BASIC COLLABORATION FROM A DISTANCE</th>
<th>BASIC COLLABORATION ONSITE</th>
<th>CLOSE COLLABORATION/PARTLY COLLABORATED</th>
<th>FULLY INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Separate systems</td>
<td>➢ Separate systems</td>
<td>➢ Separate systems</td>
<td>➢ Some shared systems</td>
<td>➢ Shared systems and facilities in seamless bio-psychosocial web</td>
</tr>
<tr>
<td>➢ Separate facilities</td>
<td>➢ Separate facilities</td>
<td>➢ Same facilities</td>
<td>➢ Same facilities</td>
<td>➢ Consumers and providers have same expectations of system</td>
</tr>
<tr>
<td>➢ Communication is rare</td>
<td>➢ Periodic focused communication; most written</td>
<td>➢ Regular communication, occasionally face-to-face</td>
<td>➢ Face-to-face consultation; coordinated treatment plans</td>
<td>➢ In-depth appreciation of roles and culture</td>
</tr>
<tr>
<td>➢ Little appreciation of each other's culture</td>
<td>➢ View each other as outside resources</td>
<td>➢ Some appreciation of each other's role and general sense of large picture</td>
<td>➢ Basic appreciation of each other's role and cultures</td>
<td>➢ Collaborative routines are regular and smooth</td>
</tr>
<tr>
<td>➢</td>
<td>➢ Mental health usually has more influence</td>
<td>➢ Collaborative routines difficult; time and operation barriers</td>
<td>➢ Influence sharing</td>
<td>➢ Conscious influence sharing based on situation and expertise</td>
</tr>
</tbody>
</table>

"Nobody knows my name. Who are you?"

"I help your consumers."

"I am your consultant."

"We are a team in the care of consumers."

"Together, we teach others how to be a team in care of consumers and design a care system."

Source: SAMHSA: A standard framework for levels of integrated healthcare
Behavioral Health DSRIP at JPS

- Discharge Management Program
- Partial Hospitalization Program
- Extended Clinic Hours
- Integrated Care
- Virtual Psychiatric and Clinical Guidance
- Central Assessment and Referral Center
- Psych Day Rehab for Homeless
JPS Behavioral Health Integration Model

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

Information Sharing

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

Integrated Planning

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL

Bi-Directional Screening

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

Integrated Service Delivery
Physician Engagement and Barriers

• Perception of Time

• Understanding the purpose of integration and its value

• Organizational culture and sensitivity

• Practice agreements and standardization of care
Information Sharing

- Monthly Information Packets
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- Best Practice Advisories
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- Evidence based library

Integrated Planning
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Integrated Service Delivery
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Bi-Directional Screening
- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL

Evidence based library
Information Sharing
- Practice Agreements

• Negotiated with primary care physician leaders and medical directors
• Documented in written agreement
• Approved by Med Executive Committee
Information Sharing
- Practice Agreements

Core Elements of our Practice Agreements

- Statement of Purpose
- Roles and Responsibilities
- Screening Process
- Referral Protocols
- Communication Standards
- Patient Interventions and Transitions
- Strategies for Patients in Crisis
Information Sharing - Practice Agreements (1 of 3)

Clinical Practice Agreement

Coordination of Services between Behavioral Health and Primary Care in the Outpatient Setting

The goal of this agreement is to enhance the coordination of patient care services between Primary Care and Behavioral Health. This agreement will help ensure appropriate levels of care for the patient. The overall goal of specialty behavioral health services is to help the patient attain the highest level of independent function. To this end, these services and interventions will, for the most part, be targeted and time limited to maximize patient stability. The intent is to return the patient to on-going treatment in the medical home once appropriate.

Virtual Behavioral Health Consultation

If the Primary Care Provider desires a Behavioral Health consult, the Virtual Behavioral Health Clinical Guidance Service is available to outpatient Primary Care Providers on a 24/7 basis. The clinical guidance team will offer the first line of assistance to Primary Care Providers with patients that present signs and symptoms of mental illness. The team will have the ability to assist in directing referrals for Behavioral Health to appropriate areas and will provide support to Primary Care Providers with resources and guidance to adequately treat patients who present with behavioral health conditions. This support will include:

- Information and referral assistance
- General information about various mental illnesses and tools to assist with determining an appropriate diagnosis
- An evidence based resource with literature and evidence based practices from multiple sources on behavioral health disorders and topics to be available to medical professionals including guidelines for psychotropic medication indications, diagnosis and symptomology, psychotropic medication administration and monitoring, and appropriate screening, prevention, and interventions in community settings
- Webinar types of education and training for primary care providers focused on improved identification, diagnosis, and treatment of common behavioral health conditions
- Virtual behavioral health guidance consisting of an interdisciplinary consultative team comprised by a psychiatrist, a master’s level psychiatric social worker and a psychiatric nurse who will ensure virtual psychiatric guidance services are available within 30 minutes on a 24-hour basis to primary care providers.

Standardized Screening

Behavioral Health will provide Primary Care with standardized screening tools to assist with diagnosing individuals with behavioral health issues as well as early detection and intervention. A standardized treatment protocol will be provided to Primary Care providers to begin first line treatment to uncomplicated or mild psychiatric illnesses. The tools used can also help guide physicians to the next level in the referral process.
Clinical Practice Agreement (Cont.)

Embedded Behavioral Health Specialists

Behavioral health will provide primary care with a behavioral health specialist at each of the integrated sites where behavioral health services are currently located. The general behavioral health specialist is typically a social worker or a psychiatric nurse. They will be located within the primary care setting and function as part of the primary care team as well as the behavioral health team. The specialist’s role is to provide support and assistance to both PCPs and their patients without engaging in any form of extended specialty behavioral health care. The role of the behavioral health specialist is to coordinate care and communication between behavioral health and primary care.

Their responsibilities are as follows:

- Integrate treatment plan to include behavioral health goals and education for patients with behavioral health issues.
- Follow up with providers and patients being referred to behavioral health and being referred back into primary care.
- Provide immediate access to a behavioral health provider by delivering behavioral health services and interventions in the primary care setting on a stat basis.
- Provide brief, solution focused counseling services in primary care settings as needed.
- Manage the referral process and case load balance between primary care referrals and stable BH patients transitioning back to primary care providers.
- Initiate treatment planning related to behavioral health issues for patients psychiatric illness.

Referrals to Behavioral Health

The following unstable conditions of patients would be appropriate for primary care providers to request consultation and/or refer to behavioral health providers:

- Schizophrenia
- Bipolar spectrum disorders
- Major Depressive disorder with psychosis
- Treatment resistant depression as defined by failure of at least one antidepressant trial at appropriate dosage for 6-8 weeks.
- Newly diagnosed or untreated/unremitting Post Traumatic Stress Disorder
- Borderline Personality Disorder with self-injurious behavior
- Suicidal or homicidal patients (w/o intent or plan)
- Psychiatric Evaluation for ADD/ADHD and medication recommendations
- Any patient insisting upon seeing a mental health professional
- Need for consultation to support on-going medical counseling and/or behavior management in the primary care setting
- Patient experiencing significant acute physical and/or emotional distress as a result of life events (e.g., death, divorce, etc.) and the patient’s usual coping skills and resources are overwhelmed.
- Patients with primary medical conditions with evidence or diagnosis of comorbid psychiatric illness.
- Psychotherapy, requested by the physician and/or the patient, to address specific emotional/behavioral problems and needs.

Other psychiatric conditions not listed above may be referred at the primary care provider's discretion. Uncomplicated depressive or anxiety disorders should initially be treated by the primary care provider with an adequate (6-8 weeks at an adequate dose) trial of a selective serotonin reuptake inhibitor or other appropriate medication of the primary care provider’s choice. Patients referred for depression should be seen by their primary care provider at the recommended intervals until their first behavioral health
Clinical Practice Agreement (Cont.)

In response to a physician referral or a patient initiated request for services the patient will be evaluated by licensed clinician member of Behavioral Health Team. This will include initial telephone screening, triage and referral as well as face-to-face evaluation as indicated. Recommendations for specialty mental health services will be made based upon established medical necessity criteria and then prioritized based on availability and need.

Emergent Situations
Emergency situations in which the patient presents in a crisis as a danger to self or others with a plan or intention to act should be taken seriously. The patient should not be left alone and staff should contact 911 to ensure the patient is evaluated for safety. NOTE: an emergency in the outpatient setting should never rely on consultative process.

Case Review/Conference Consult
Behavioral health outpatient consult services will be available for difficult case review and/or integrated service case conferencing on an as needed basis. The intent of this service is to increase effective communication and hand off for cases shared between behavioral health and primary care as well as to provide case review for challenging patient issues related to behavioral health. Patients who may not be appropriate for outpatient behavioral health consultation include:

- Patient needing emergent care (e.g., suicidal or homicidal ideations)
- Patients on pain medications without comorbid psychiatric illness
- Patients with a primary diagnosis of substance dependence for the purpose of detoxification, substance abuse rehabilitation, or withdrawal management.
- Patients stable on benzodiazepines for sedative or hypnotic benefits
- Patients stable on antidepressant medication for depression or anxiety disorders
- Patients with uncomplicated depression prior to at least one (1) antidepressant trial for a 6-8 week period at an appropriate dosage.
- Patients with only a positive depression screen without further evaluation by the primary care provider establishing a diagnosis of depression
- Vascular Cognitive Disorders

Informing Patients of Need for Consult
Patients referred to behavioral health services need to be informed of the need for specialty consultation by the Primary Care Provider. The patient’s agreement with the consultation is essential for successful patient engagement in their health care plan.

Return of Patients to Primary Care
Once a patient is determined to be stable on commonly prescribed psychiatric medications without need for other behavioral health interventions, the patient will be referred back to a primary care provider for continued medication management. A stable psychiatric patient is defined as one of the following:

- A patient on no more than two psychotropic medications
- A patient who has had no change in medication during the past six months
- Able to self-manage mental health treatment needs without requiring on-going multidisciplinary/team-based mental health services
- A patient that meets criteria within Quadrant I and Quadrant III of the Four Quadrant Model.

Behavioral health providers, with concurrence from the patient, will contact the primary care provider to discuss the transfer of care and follow-up recommendation for continued monitoring. Behavioral health will retain responsibility for care of patients with unstable psychiatric conditions.

A formal agreement regarding the coordination of care between primary care and behavioral health was implemented on ______.
Information Sharing
- Monthly Information Packets

October 2013 - Depression
November 2013 - Anxiety
December 2013 - Insomnia
January 2014 - Bipolar
February 2014 - Schizophrenia
March 2014 - PTSD
April 2014 - Integrated Healthcare
May 2014 - Psych Meds and Pregnancy
June 2014 - Metabolic Side Effects from Antipsychotics
July 2014 - Domestic Violence
August 2014 - Substance Abuse
September 2014 - Antidepressant-Anticonvulsants for Chronic Pain
October 2014 - Prescribing and Tapering Benzodiazepines
November 2014 - Importance of Integrated Healthcare
December 2014 - Insomnia & Sleep Hygiene
January 2015 - Eating Disorders
February 2015 - E-Consults
March 2015 - Depression
Information Sharing
- Best Practice Advisory

Staff trained on screening tool

Automated alert in EMR prompts providers to document follow-up plan for scores > 9

Results monitored

Physician Documentation of Follow-Up Plan

Among individuals with PHQ-9 score >9

Before "Best Practice Advisory" 46.8%  

After "Best Practice Advisory" 89.4%
Information Sharing
- Best Practice Advisory

1. Patient record in EMR prompts depression screening with PHQ-9. After all questions are answered, a total score will populate and assign a severity risk.

2. If the score is >9, the screening creates a “Best Practice Advisory.”

3. If the provider chooses to take action and evaluate further, a smart order set automatically populates (e.g., referrals, medications, follow-up).

4. “Best Practice Advisory” additionally presents recommended intervention based on PHQ-9 Score.

5. The system will remind staff/providers to screen for depression using the PHQ-9 if the patient has not been screened within the past 12 months.
Two presentations each year focusing on common behavioral health issues found in Primary Care. Both are done in person and streamed on the internet

- Management of Anxiety in Primary Care
- Management of Depression in Primary Care
- Benzodiazepine Prescribing and Tapering Guidelines in Primary Care

These are also made available on our Virtual Guidance Provider Resource Page
Information Sharing
- Evidenced Based Library

Clinical Guidance at Your Fingertips

BEHAVIORAL HEALTH VIRTUAL RESOURCE
Information Sharing  
- Evidenced Based Library

Research Library

- Anxiety Disorders
- Best Practice Guidelines for Behavioral Health
- Bipolar Disorder
- Depression
- Insomnia
- Personality Disorders
- Schizophrenia
- Substance Abuse
- Virtual Website Links

Anxiety Disorders

<table>
<thead>
<tr>
<th>Screening Tools</th>
<th>Treatment Guidelines</th>
<th>Patient Resources</th>
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<tbody>
<tr>
<td>Generalized Anxiety Disorder Screening Scale (.pdf)</td>
<td>Clinical Guidelines for the Management of Anxiety (.pdf)</td>
<td>Anxiety Patient Instructions (Adult)</td>
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<tr>
<td>GAD-7 Anxiety Scale (.pdf)</td>
<td>Management of Anxiety in Adults (NHS) (.pdf)</td>
<td>Instructions (Child) (.pdf)</td>
</tr>
<tr>
<td></td>
<td>Drug Treatment Guidelines for Anxiety Disorders (.pdf)</td>
<td>Relaxation (.pdf)</td>
</tr>
<tr>
<td></td>
<td>Management of Generalized Anxiety Disorder (.pdf)</td>
<td>Unhelpful Thinking Styles (.pdf)</td>
</tr>
<tr>
<td></td>
<td>Treatment Guidelines for Generalized Anxiety Disorder (.pdf)</td>
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</table>
Integrated Planning

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

- PHQ-9
- SBIRT
- Tobacco Use
- HbA1c
- LDL
Integrated Planning
- Shared Care Plans

Our system is transitioning to shared care plans as a way to improve coordination and integration of care

• Work in progress
• Broader than Behavioral Health and Primary Care
• Allows all specialties and primary care to see, edit and document problems, goals, interventions, and outcomes.
• Seen in the same format from the same screen for all disciplines involved.
Integrated Planning
- Shared Patient Lists

Our Shared Patient Lists were created to identify patients shared between a behavioral health provider and primary care provider at the same location

- Identifies key metrics:
  - BP
  - HbA1c
  - PHQ-9
  - Diagnoses
  - Medications
  - # of ED Visits in past 6 months
  - # of Hospitalizations in past 6 months

- Embedded Specialists summarize key points from previous visits and reports to providers.

- Drives recommendations for transitioning level of specialty involvement and care
Multidisciplinary Case Conference occur at the request of the patient and/or the providers.

These typically involve the most complex patients.
Bi-Directional Screening

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME's
- Evidence based library

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- PHQ-9
- SBIRT
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- HbA1c
- LDL
Bi-Directional Screening  
- PHQ-9

- Standardize screening administration and follow-up processes across primary care practices
- Train staff on how to use screening and how to escalate
- Work with IT to develop MER reporting specs and create reports
- Automate alerts in EMR prompting providers to screen patients at routine intervals
- Include recommended guidelines in EMR for provider action
- Monitor and share results to inform quality improvement
Bi-Directional Screening - PHQ-9

Over 100,000 primary care screenings for depression

Patients Screened for Depression in Primary Care

<table>
<thead>
<tr>
<th>Month</th>
<th>Patients Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-13</td>
<td>255</td>
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<tr>
<td>May-13</td>
<td>7184</td>
</tr>
<tr>
<td>Jun-13</td>
<td>6171</td>
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<tr>
<td>Jul-13</td>
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<td>Aug-13</td>
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<td>Sep-13</td>
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<tr>
<td>Nov-13</td>
<td>2120</td>
</tr>
<tr>
<td>Dec-13</td>
<td>2341</td>
</tr>
<tr>
<td>Jan-14</td>
<td>4636</td>
</tr>
<tr>
<td>Feb-14</td>
<td>4435</td>
</tr>
<tr>
<td>Mar-14</td>
<td>5234</td>
</tr>
<tr>
<td>Apr-14</td>
<td>6113</td>
</tr>
<tr>
<td>May-14</td>
<td>5819</td>
</tr>
<tr>
<td>Jun-14</td>
<td>6004</td>
</tr>
<tr>
<td>Jul-14</td>
<td>5949</td>
</tr>
<tr>
<td>Aug-14</td>
<td>6853</td>
</tr>
<tr>
<td>Sep-14</td>
<td>6111</td>
</tr>
<tr>
<td>Oct-14</td>
<td>6328</td>
</tr>
<tr>
<td>Nov-14</td>
<td>5914</td>
</tr>
<tr>
<td>Dec-14</td>
<td>6153</td>
</tr>
<tr>
<td>Jan-15</td>
<td>6009</td>
</tr>
<tr>
<td>Feb-15</td>
<td>6593</td>
</tr>
<tr>
<td>Mar-15</td>
<td></td>
</tr>
</tbody>
</table>
## Bi-Directional Screening - PHQ-9

<table>
<thead>
<tr>
<th>Score:</th>
<th>Interpretation:</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>Mild to Minimal Risk</td>
<td>• Support, educate to call if worsens, follow up as needed.</td>
</tr>
</tbody>
</table>
| 10-14      | Moderate Risk            | • Antidepressant therapy and/or psychotherapy  
• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed  
• Conduct suicide risk assessment  
• Virtual Psychiatric Guidance  
• Follow up in 4-8 weeks |
| 15-19      | Moderately Severe Risk   | • Antidepressant and/or psychotherapy  
• Behavioral health specialist provides resources, initiates treatment planning and motivational therapy as needed  
• Conduct suicide risk assessment  
• Virtual Psychiatric Guidance  
• Referral to Psychiatry if warranted  
• Follow up in 2-4 weeks |
| 20 or higher | Severe Risk             | • Antidepressant, Possible augmentation  
• BH specialist provides resources, initiates treatment planning and follows up with patient.  
• Conduct Suicide risk assessment  
• Follow up in 2-4 weeks  
• Referral to Psychiatry |
Bi-Directional Screening
- 12 Month Remission Rates

12 Month Depression Remission Rate

<table>
<thead>
<tr>
<th>Month</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>11.1%</td>
</tr>
<tr>
<td>Jul-14</td>
<td>51.7%</td>
</tr>
<tr>
<td>Aug-14</td>
<td>32.4%</td>
</tr>
<tr>
<td>Sep-14</td>
<td>32.7%</td>
</tr>
<tr>
<td>Oct-14</td>
<td>33.3%</td>
</tr>
<tr>
<td>Nov-14</td>
<td>47.2%</td>
</tr>
<tr>
<td>Dec-14</td>
<td>23.3%</td>
</tr>
<tr>
<td>Jan-15</td>
<td>30.1%</td>
</tr>
<tr>
<td>Feb-15</td>
<td>25.0%</td>
</tr>
<tr>
<td>Mar-15</td>
<td>28.4%</td>
</tr>
</tbody>
</table>
Approximately 500 trauma patients are positive for alcohol on arrival. Our Behavioral Health team engages them utilizing SBIRT.
Bi-Directional Screening - Tobacco Use

Tobacco Use Screening (Inpatient Psych)

<table>
<thead>
<tr>
<th></th>
<th>Tobacco Screening</th>
<th>Tobacco Use Treatment Provided/Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-15</td>
<td>85%</td>
<td>13%</td>
</tr>
<tr>
<td>Feb-15</td>
<td>93%</td>
<td>38%</td>
</tr>
<tr>
<td>Mar-15</td>
<td>98%</td>
<td>76%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>98%</td>
<td>57%</td>
</tr>
</tbody>
</table>
Bi-Directional Screening - HbA1c

HbA1c >9.0 (lower is better)

Started piloting screening for substance abuse, diabetes and heart disease in people with schizophrenia

Bi-Directional Screening
- LDL

Pilot Cardiovascular Screening (LDL) and Diabetes (HbA1c) in Day Rehab
*Will go live in all behavioral health clinics once IT build is complete
Integrated Service Delivery

- Monthly Information Packets
- Practice Agreements
- Best Practice Advisories
- Face-to-Face CME’s
- Evidence based library

- Shared care plan
- Multidisciplinary Case Conference
- Shared Patient Lists

- Group Visits
- Embedded BH Specialists
- Virtual Psychiatric and Clinical Guidance
- Diabetes Education Classes

- PHQ-9
- SBIRT
- Tobacco Use
- Hba1c
- LDL
Integrated Service Delivery
- Group Visits

At several primary care clinics, we have quarterly Co-Facilitated Medical Groups with the Primary Care Physician and Embedded Specialists.
Co-location of primary care within a MHMR behavioral health setting for the homeless population to provide convenience for target population of a “one stop shop”.

- Improved access to primary care for individuals with behavioral health conditions and vice versa.
- Provide service coordination to assure seamless level of care between BH and PC
- Reduce cost of care by diverting individuals out of the ED.

Role collaboration plays

Collaboration, coordination, communication and consultation on the integrated care team have been crucial for the successful outcome for individuals.

- Coordination of information sharing
- Coordination of appointment scheduling
- Coordination of appropriate level of care
- Coordination of needed resources
- Direct face-to-face communication & consultation regarding critical cases
Integrated Service Delivery
- Embedded BH Specialists

We currently have embedded behavioral health expertise into multiple settings:

- Primary Care Clinics
- Trauma Services
- AIDS/HIV Medical Home
- Diabetes Groups
- Co-Facilitating General Medical Condition Groups Throughout System
Integrated Service Delivery
- Virtual Psychiatric & Clinical Guidance

• Education

• Evidence base practice

• Case specific consultation
Integrated Service Delivery
- Virtual Psychiatric & Clinical Guidance

Virtual Services by Month


Values:
- Aug-13: 35
- Sep-13: 69
- Oct-13: 78
- Nov-13: 91
- Dec-13: 139
- Jan-14: 170
- Feb-14: 178
- Mar-14: 135
- Apr-14: 146
- May-14: 151
- Jun-14: 168
- Jul-14: 181
- Aug-14: 264
- Sep-14: 194
- Oct-14: 248
- Nov-14: 432
- Dec-14: 293
- Jan-15: 312
- Feb-15: 140
Integrated Service Delivery
- Virtual Psychiatric & Clinical Guidance

Virtual Website Visits

- Jul-13: 453
- Aug-13: 658
- Sep-13: 576
- Oct-13: 538
- Nov-13: 677
- Dec-13: 100
- Jan-14: 712
- Feb-14: 735
- Mar-14: 819
- Apr-14: 850
- May-14: 891
- Jun-14: 842
- Jul-14: 914
- Aug-14: 900
- Sep-14: 927
- Oct-14: 782
- Nov-14: 804
- Dec-14: 719
- Jan-15: 719
- Feb-15: 612
- Mar-15:
Integrated Service Delivery
- Virtual Psychiatric & Clinical Guidance

Primary care providers can speak with a psychiatrist about evidence based and best practice medication algorithms within 30 minutes.
We have eight Diabetic Education Groups at various locations in both English and Spanish. Each of the group cohorts meet for eight weeks.

Embedded specialists lead the 8th group to discuss depression, coping skills, and stress management related to their medical conditions and lifestyle changes.
Integrated Service Delivery - Clinical Pharmacist

- Review patients’ medications and make recommendations for psychotropic and non-psychotropic medications
- Support for patients with medication related questions or problems
- Facilitate inpatient groups on medication-related topics (3 x/week)
- Soon to see patients receiving care in our HIV+/AIDS Clinic with complex medication regimens
- Teach psychopharmacology lectures for the Psychiatry, Emergency, & Family Medicine Residents
Learning Collaborative

We currently have seven organizations operating in the nine Texas counties of RHP 10 that are participating in the Integrated Care Learning Collaborative.

- Baylor Health Care System
- Helen Farabee Center
- JPS Health Network
- Lake Regional MHMR Center
- MHMR of Tarrant County
- Pecan Valley Centers
- Wise Regional Health System

http://rhp10txlc.com/
## Improve Screening Rates

<table>
<thead>
<tr>
<th>Percentage of patients screened with team’s selected cross-specialty screening</th>
<th><strong>Numerator</strong>: Total number of patients in the population of focus who have received screening with the selected screening tool within the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Denominator</strong>: Total patient population of focus for improved care integration at your site.</td>
</tr>
</tbody>
</table>

### Behavioral health screenings for primary care settings
- PHQ2/PHQ9
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Tobacco use screening
- Alcohol abuse screening (audit), MAST
- Drug abuse screening (DAST)
- Screening for risk of harm to self or others

### Physical health screenings commonly done in behavioral health settings
- Diabetes screening
- Hypertension Screening
- BMI Calculation
- COPD Screening
- Cardiovascular disease screening
- HIV, STD, hepatitis
Improve Coordination

<table>
<thead>
<tr>
<th>Percentage of patients who received the teams’ selected integrated care intervention in past 12 months.</th>
<th><strong>Numerator:</strong> Number of patients in the population of focus who have received the selected integrated care intervention in the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> Total patient population of focus for improved care integration at your site.</td>
<td></td>
</tr>
</tbody>
</table>

- Patients with a shared care plan documented at both the PC Provider site and the BH Provider site
- Patients whose treatment plans include goals for both PC and BH
- Patients whose care was covered in Care Coordination Conferences with PC and BH Providers in the past 12 months (Note: Teams focusing on more complex patients may want to track patients covered in coordination conferences at more frequent interval. They could use the different interval in addition to or instead of the 12-month interval.)
- Patients receive a visit with both their PC Provider and BH Provider within a set time period (e.g. past 60 days for more complex patients)
## Improve Outcomes

<table>
<thead>
<tr>
<th>Percentage of patients receiving integrated care whose condition improved.</th>
<th><strong>Numerator:</strong> Number of patients in population of focus whose condition has been documented as improved in past 12 months, as measured by selected indicator.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Denominator:</strong> Total patient population of focus for improved care integration at your site.</td>
</tr>
</tbody>
</table>

### Examples of improvement in behavioral health conditions in primary care settings
- Screening results no longer positive
- Adherence to medication for behavioral health condition (in DSRIP category 3)
- Completion of counseling for behavioral health condition, based on documented achievement of 1+ treatment plan goals
- Reduced PHQ-9 score for all patients with initial scores over 10, to less than 10
- Reduced PHQ-9 score for all patients with initial scores over 10, to less than 5
- Behavioral health condition in remission
- Abstinence from alcohol or other drug use
- Reduced alcohol or other drug use

### Examples of improvement in primary care conditions in behavioral health settings
- Screening results no longer positive
- Reduced tobacco use
- Discontinued tobacco use
- HbA1c less than 9%
- BP to <140/90
- LDL-C control
- Patients engaged in or received treatment for STD, HIV, hepatitis
Integrated Care

Success

what people think it looks like

what it really looks like
QUESTIONS?
Results, Outcomes and the Real Impact of the Transformation Waiver

Noelle Gaughen  
Medicaid/CHIP Transformation Waiver  
Texas Health and Human Services Commission

Christina Mintner  
Vice President Waiver Operations  
Parkland Health & Hospital System
Demonstrating the Impact of the Texas Transformation Waiver

Noelle Gaughen
Senior Policy Advisor
Health and Human Services Commission
Medicaid/CHIP Transformation Waiver
Waiver Renewal Ask

“HHSC proposes that the majority of the current 1458 active DSRIP projects be eligible to continue into the extension period in order to give projects more time to demonstrate outcomes.”
How do we demonstrate outcomes?

- Project Level Outcomes
  - Mid Point Assessment
  - Operational data from QPI, Category 3, and qualitative reporting
  - Clinical Champions
  - Stretch Activity 3
  - MCO Alignment
- Statewide DSRIP Evaluation
- National DSRIP Evaluation
Challenges

• Data availability, standardization, and timeliness
• Complex objectives
• Changing populations
• Changing measurement resources
<table>
<thead>
<tr>
<th>QPI Measurement Type</th>
<th>Sum of all DY3 QPI Goals</th>
<th>DY3 QPI Achieved (from 10/2013 - 09/2014)</th>
<th>% of total DY3 QPI Goals Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters</td>
<td>1,201,060</td>
<td>2,057,326</td>
<td>171%</td>
</tr>
<tr>
<td>Individuals</td>
<td>706,046</td>
<td>956,811</td>
<td>136%</td>
</tr>
</tbody>
</table>
Category 3 Performance

- 249 Category 3 outcomes reported DY4 achievement in April
  - XX% reported an improvement over their baseline.
  - XX% fully achieved or exceeded their DY4 goal.
Qualitative Reporting

Common Challenges & Lessons Learned identified in Semi-Annual Reporting:
- Patient Recruitment/Participation
- Administrative Capacity
- Provider recruitment & retention
- Changing organizational structure
Stretch Activity 3: Alternative Approaches to Program and Outcome Linkages

• 96 Cat 1 or 2 projects are required to conduct a program evaluation as part of their Category 3 stretch Activity, making it the second most common Cat 3 outcome.

• HHSC plans to have training and support for providers conducting a program evaluation at the 2015 SLC
Clinical Champions

- A workgroup made up of clinical, quality and operational experts, who will help HHSC to:
  - Assess the transformational potential and impact of active DSRIP projects
  - Identify best practices by project area
  - Support HHSC in discussions of waiver renewal/extension and inform the clinical and quality aspects of future DSRIP protocol development.

- Clinical Champions nominations were solicited from Executive Waiver Committee member entities and other stakeholders, and began meeting monthly in January 2015 with support from HHSC staff.
Sent to Anchors and Providers week of May 11th:

- Identify and share promising practices with like projects around the state
- Develop content for the 2015 Statewide Learning Collaborative
- Support Waiver extension/renewal efforts with CMS
- Inform ways to better evaluate projects in the next phase of the Waiver

1st Batch deadline: May 31st
2nd Batch review deadline: June 15th
Transformational Impact Summary

• Intent is to identify information that demonstrates the early success of projects.
• Not intended to be a formal peer-review or determine which projects are eligible for continuation beyond DY5.
The Impact Summary asks if providers are able to provide Medicaid IDs for patients served through DSRIP projects. This is intended to determine capacity for future analysis.
• HHSC is encouraging coordination between DSRIP projects and MCO performance improvement projects (PIPs).
• Best practices and lessons learned from DSRIP will inform Medicaid benefits and program design.
DSRIP and Managed Care

- HHSC Quality Analytics team will be setting up quarterly one-on-one calls with MCOs to discuss, among other topics, progress on payment reform and moving successful DSRIP projects into Medicaid managed care.

- HHSC is working with some DSRIP providers that serve Medicaid patients to develop a model for creating value-based purchasing arrangements with MCOs. Specifically, HHSC is looking at:
  - Services provided by these DSRIP projects (those that are both covered and not covered by Medicaid)
  - Reimbursement and/or costs of those services,
  - Outcomes for the patients being served – both the quality of care outcomes and the cost/savings metrics.
Formal Waiver Evaluation

Evaluation Goals:

• Measure changes to quality, health outcomes, and cost as a result of DSRIP
• Measure changes in collaboration among organizations as a result of DSRIP
• Assess stakeholder perceptions and recommendations
Formal Waiver Evaluation Questions

• What are stakeholders’ perceptions of Program implementation and effectiveness? What are their recommendations for future improvement?
• Did the Program increase collaboration among RHP participants?
• Did DSRIP projects improve cost, quality, and health outcomes?
• Did participation in DSRIP projects change trends in Uncompensated Care claims?
<table>
<thead>
<tr>
<th>Question</th>
<th>Sample Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders’ perceptions</td>
<td>All participating organizations in all 20 RHPs</td>
</tr>
<tr>
<td>Overall effects of Program on <strong>collaboration</strong> among RHP participants</td>
<td>All DSRIP participants in all 20 RHPs</td>
</tr>
<tr>
<td>DSRIP project effects on <strong>cost, quality, and health</strong> outcomes</td>
<td>10 DSRIP ED care navigation project sites and 10 comparison sites</td>
</tr>
<tr>
<td>Trends in <strong>Uncompensated Care</strong> claims</td>
<td>All hospitals submitting UC claims</td>
</tr>
</tbody>
</table>
Stakeholder Findings

DSRIP Strengths

- Resources to serve more patients/clients
- Opportunity to design innovative projects
- Collaboration with other organizations in area/community
- Access to health services program
- Opportunity for system reform
CMS Led Nationwide DSRIP Evaluation Questions

• What is the effect of the DSRIP demonstration funding paid to provider systems on the transformation of the delivery system, clinical quality, population health, use of value based payments, and per capita costs?

• Have DSRIP programs led to:
  • Transformation of the delivery system?
  • Improved clinical care at the individual level?
  • Improved health of low-income populations?
  • Value-based payment among safety-net providers?
  • Lower growth in Medicaid costs?
  • Sustained changes in any or all of the areas above?

• How are outcomes associated with program characteristics?
Waiver Renewal Updates
Pool Transition Plan

• STC 48 – HHSC was required to submit by March 31, 2015, a pool transition plan that addressed the following:
  - Experience with the DSRIP pools,
  - Actual uncompensated care trends in the State, and
  - Investment in value based purchasing or other reform options.

• HHSC submitted the transition plan March 24, 2015.

• When Texas submits its renewal/extension request in September 2015, HHSC plans to request:
  - to continue at least the demonstration year (DY) 5 funding level for DSRIP ($3.1 billion annually) and
  - a UC pool equal to the unmet UC need in Texas.
Pool Transition Plan

State goals for the pools for the extension period:

• Continue to support the healthcare safety net for MLIU Texans.
• Further incentivize transformation and strengthen healthcare systems across the state by building on the RHP structure.
• Maintain program flexibility to reflect the diversity of Texas' 254 counties, 20 RHPs, and over 300 DSRIP providers.
• Improve project-level evaluation to identify the best practices in DSRIP to be sustained and replicated.
• Further integrate DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
• Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.
Timeline to Develop Renewal Request

• HHSC staff is working to develop the draft renewal packet for public stakeholder meetings in July.
  – The renewal packet will include continuation of the managed care programs in the 1115 waiver, as well as the UC and DSRIP pools.

• RHP 9 / 10 Public Stakeholder Meeting:
  • Tuesday, July 21
  • Old Red Museum of Dallas County Culture and History
  • 10am to 12pm

• HHSC will review comments and finalize the renewal packet in August and then get State Leadership signoff to submit by September 30, 2015.
Timeline to Develop Renewal Request

• The renewal packet does not need to have the protocol revisions, although CMS would like to get them as soon as possible. HHSC plans to make changes to the two DSRIP protocols – the RHP Planning Protocol and Program Funding and Mechanics (PFM) Protocol for submission to CMS in late 2015 – early 2016.

• Many of the specific programmatic details around project continuation, requirements and funding will be included in the protocols rather than in the renewal packet.

• HHSC tentatively plans to hold a webinar on the proposed changes to the DSRIP protocols in early August and also will discuss these changes at the Statewide Learning Collaborative Summit in Austin on August 27-28, 2015.
Renewal Request

• CMS has indicated that changes will be required to the waiver Special Terms and Conditions in order to extend the pools.

• HHSC is certain CMS will want additional changes to the waiver.

• While HHSC understands from CMS is that extensions typically are for 3 years (and sometimes 1 year), HHSC is going to request a 5 year extension to see if that might be possible.
DSRIP Renewal Request

• HHSC plans to propose the following for DSRIP:
• Continue with the existing DSRIP program administrative structure, including the 20 RHPs and role of the anchoring entities to provide regional coordination and technical assistance.
• The majority of the current 1400+ active DSRIP projects will be eligible to continue into the extension period in order to give projects more time to demonstrate outcomes.
  • These projects may be required or encouraged to take a logical next step toward further transformation.
  • Some projects will not be eligible to continue based on review of the independent assessor and HHSC.
DSRIP Renewal Request

• What to do with funds from the DSRIP pool not allocated to continuing projects?
• Propose alternate transformative projects from narrower menu based on lessons learned,
• Bring smallest projects up to a minimum valuation level, and/or
• Establish a shared performance bonus pool for regions that make improvements on key measures.
DSRIP Renewal Request

• Work to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information.
• Allow certain projects to be combined into a single project to reduce reporting burden (ex – providers who are in multiple regions with same project)
• Reduce and standardize the number of metrics reported
  – Cat 1-2: QPI milestones required each year – overall QPI and one specific to Medicaid/low income uninsured
  – Cat 1-2: Optional milestones such as related to increased data exchange and project-level evaluation/sustainability planning
  – Cat 3 TBD - HHSC continues to review the Category 3 methodologies and how outcomes align with projects.
• Eliminate achievement carry forward, or possibly extend to just one reporting period beyond the DY (vs. 2), but allow for partial achievement for QPI similar to what's allowed for Cat 3 now
DSRIP Results & Alignment with Managed Care

- Further integrate DSRIP efforts with Texas' Medicaid managed care quality strategy and other value based payment efforts.
- Develop a value based purchasing roadmap by late 2016/early 2017 for the extension period.
- Further align DSRIP and managed care quality measures where possible (e.g. consider some managed care P4Q measures for DSRIP shared performance bonus pool).
- HHSC will provide CMS Medicaid and inpatient all-payer global trend data such as PPEs from 2012 through the extension period (by managed care plans/areas and RHP) to help show whether combined efforts are having an effect on key measures.
DSRIP Results & Alignment with Managed Care

• Other ideas to help evaluate the Medicaid impact of DSRIP projects and to further data exchange to support care coordination and systems of care
• Along with QPI information, require DSRIP projects to report Medicaid IDs of patients served by the project.
• Require all DSRIP and UC hospitals to provide admission, discharge, and transfer (ADT) information either to their regional HIE or a State-level HIE. HHSC could provide Medicaid ADT information to Medicaid MCOs for them to share with providers to improve care coordination.
RHP 9 / 10 Public Meeting

Old Red Museum of Dallas County
Culture & History
Tuesday, July 21
10am to 12pm
QUESTIONS????
BREAK & BREAKOUT SESSIONS

Fan Fare
Day 2 – Category 3
• Go to Breakout Session Rooms after Break – 2:15 P.M.
• After Breakout Sessions Return to Main Room
Breakout by Category 3

• Table Discussion
  • How are you identifying your metrics?
  • How often are you measuring?
  • What are key success factors to capturing and meeting your metrics?
  • What have been your greatest challenges in capturing your data, how are you overcoming these challenges?

• Report Out
  • Some tables will share their discussion outcomes with the rest of the group in the room
Mobile Health to Engage Medicaid Participants

Jay Bernhardt, PhD, MPH
Founding Director Center for Health Communications
University of Texas at Austin
Mobile Health to Engage Medicaid Participants

Jay M. Bernhardt, PhD, MPH
Professor and Director, Center for Health Communication
Everett D. Collier Centennial Chair in Communication

The University of Texas at Austin
Center for Health Communication
Moody College of Communication
Mission:
To improve health in Texas, the United States, and globally through leadership and excellence in health communication research, education, programs, and partnerships.

http://moody.utexas.edu/healthcomm
Health IT and Health Disparities

Health Information Technology (HIT) “…provides an opportunity for engaging populations not historically well served by the traditional health community… The impact of facilitating patient and population contribution to, and control of, their health information has the potential to provide further insights into, and opportunities to address, disparities in underserved populations”

Adult Gadget Ownership (2002-2014)
Mobile Only Households

- Hispanic adults (51%) more likely than non-Hispanic white adults (33%) or non-Hispanic black adults (39%) to be mobile only.
- Renters (54%) more mobile only than home owners (25%).
- People in mobile-only households exhibit more risk behaviors.

Smartphone Ownership Patterns

% of U.S. adults in each group who own a smartphone:

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults</td>
<td>64%</td>
</tr>
<tr>
<td>Male</td>
<td>66%</td>
</tr>
<tr>
<td>Female</td>
<td>63%</td>
</tr>
<tr>
<td>18-29</td>
<td>85%</td>
</tr>
<tr>
<td>30-49</td>
<td>79%</td>
</tr>
<tr>
<td>50-64</td>
<td>54%</td>
</tr>
<tr>
<td>65+</td>
<td>27%</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>61%</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>70%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>71%</td>
</tr>
<tr>
<td>HS grad or less</td>
<td>52%</td>
</tr>
<tr>
<td>Some college</td>
<td>69%</td>
</tr>
<tr>
<td>College+</td>
<td>78%</td>
</tr>
<tr>
<td>Less than $30,000/yr</td>
<td>50%</td>
</tr>
<tr>
<td>$30,000-$49,999</td>
<td>71%</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>72%</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>84%</td>
</tr>
<tr>
<td>Urban</td>
<td>68%</td>
</tr>
<tr>
<td>Suburban</td>
<td>66%</td>
</tr>
<tr>
<td>Rural</td>
<td>52%</td>
</tr>
</tbody>
</table>

Lower-income and Minority Smartphone Owners are Especially Likely to Have Canceled or Cut Off Service:

% of smartphone owners who have canceled or cut off service for a period of time because maintaining their service was a financial burden:

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>23%</td>
</tr>
<tr>
<td>18-29</td>
<td>32%</td>
</tr>
<tr>
<td>30-49</td>
<td>25%</td>
</tr>
<tr>
<td>50-64</td>
<td>17%</td>
</tr>
<tr>
<td>65+</td>
<td>5%</td>
</tr>
<tr>
<td>White</td>
<td>17%</td>
</tr>
<tr>
<td>Black</td>
<td>42%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>36%</td>
</tr>
<tr>
<td>HH Income $75k+</td>
<td>10%</td>
</tr>
<tr>
<td>HH Income $30k-$75k</td>
<td>20%</td>
</tr>
<tr>
<td>HH Income &lt;$30k</td>
<td>44%</td>
</tr>
</tbody>
</table>

Combined analysis of Pew Research Center surveys conducted December 4-17 and 12-21, 2014.
Daily SMS Use (2011)

- Almost 10 trillion SMS messages sent in 2012
  - 80% of all US cell phone owners text
  - 92% of US smart phone owners text
  - US SMS users average 35 texts per day
- 99% of received SMS are opened and 90% read within 3 minutes of being received
- Messaging Apps growing while SMS very slightly declining (but still very high)
  - Kik, WhatsApp, SnapChat

<table>
<thead>
<tr>
<th>All text messaging users</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>All text messaging users</td>
<td>41.5</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>40.9</td>
<td>10</td>
</tr>
<tr>
<td>Women</td>
<td>42.0</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>87.7</td>
<td>40</td>
</tr>
<tr>
<td>30-49</td>
<td>27.0</td>
<td>10</td>
</tr>
<tr>
<td>50-64</td>
<td>11.4</td>
<td>3</td>
</tr>
<tr>
<td>65+</td>
<td>4.7</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>31.2</td>
<td>10</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>70.1</td>
<td>20</td>
</tr>
<tr>
<td>Hispanic</td>
<td>48.9</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $30,000</td>
<td>58.7</td>
<td>20</td>
</tr>
<tr>
<td>$30,000-$49,999</td>
<td>40.2</td>
<td>15</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>25.9</td>
<td>10</td>
</tr>
<tr>
<td>$75,000+</td>
<td>31.9</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education level</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>69.4</td>
<td>20</td>
</tr>
<tr>
<td>High School diploma</td>
<td>45.4</td>
<td>15</td>
</tr>
<tr>
<td>Some College</td>
<td>53.0</td>
<td>15</td>
</tr>
<tr>
<td>College+</td>
<td>23.8</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: The Pew Research Center's Internet & American Life Project, April 26 – May 22, 2011 Spring Tracking Survey. n=2,277 adult internet users ages 18 and older, including 755 cell phone interviews. Interviews were conducted in English and Spanish.

http://www.factbrowser.com/tags/sms
Almost two-thirds of cell owners go online using their phones
Among cell phone owners, the % who use the internet or email on their phone

Demographics of cell-mostly internet users
Among cell internet users, the % who mostly use their phone to go online

<table>
<thead>
<tr>
<th>All cell internet users (n=1,185)</th>
<th>% who mostly go online using their cell phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men (n=388)</td>
<td>34%</td>
</tr>
<tr>
<td>Women (n=567)</td>
<td>34%</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White, Non-Hispanic (n=762)</td>
<td>27%</td>
</tr>
<tr>
<td>Black, Non-Hispanic (n=158)</td>
<td>43%</td>
</tr>
<tr>
<td>Hispanic (n=157)</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>18-29 (n=338)</td>
<td>50%</td>
</tr>
<tr>
<td>30-49 (n=303)</td>
<td>35%</td>
</tr>
<tr>
<td>50-64 (n=304)</td>
<td>14%</td>
</tr>
<tr>
<td>65+ (n=109)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Education attainment</strong></td>
<td></td>
</tr>
<tr>
<td>Less than high school/high school grad (n=338)</td>
<td>45%</td>
</tr>
<tr>
<td>Some College (n=306)</td>
<td>34%</td>
</tr>
<tr>
<td>College + (n=541)</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Household income</strong></td>
<td></td>
</tr>
<tr>
<td>Less than $30,000/yr (n=236)</td>
<td>45%</td>
</tr>
<tr>
<td>$30,000-$44,999 (n=175)</td>
<td>39%</td>
</tr>
<tr>
<td>$50,000-$74,999 (n=171)</td>
<td>30%</td>
</tr>
<tr>
<td>$75,000+ (n=219)</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Urbanity</strong></td>
<td></td>
</tr>
<tr>
<td>Urban (n=430)</td>
<td>33%</td>
</tr>
<tr>
<td>Suburban (n=571)</td>
<td>35%</td>
</tr>
<tr>
<td>Rural (n=176)</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: Pew Internet & American Life Project Spring Tracking Survey, April 17-May 19, 2013. N=1,185 cell internet users ages 18+. Interviews were conducted in English and Spanish and on landline and cell phones. The margin of error for results based on cell internet users is +/- 2.4 percentage points.

Note: Percentages marked with a superscript letter (e.g., *) indicate a statistically significant difference between that row and the row designated by that superscript letter, among categories of each demographic characteristic (e.g. age).
Mobile Use Summary

• Mobile phone access is ubiquitous, even among lower income and minority populations
• Texting and mobile web access is highest among minority and lower income populations
• Smartphones are rapidly replacing feature phones among all population groups
mHealth vs. eHealth

• **mHealth** (aka m-health or mobile health)
  – Application of mobile devices including phones, tablets, and integrated monitoring devices to support all aspects of healthcare and public health

• **eHealth** (aka health information technology [HIT], health or medical informatics)
  – Application of information technology to health systems including electronic health records, information management systems, surveillance
Taxonomy of mHealth Applications

**SYSTEMS:**
- Data collection tools
- Medical records
- Test results notification
- Appointment reminders

**MEDICAL CARE:**
- Clinical decision support systems
- Medical education
- Disease monitoring
- Acute disease management

**PREVENTION/HEALTH PROMOTION:**
- Treatment programs
- Chronic disease management
- Medication adherence
- Health behavior change programs
- Untargeted mass health promotion
mHealth and Apps

• > 100,000 health-related apps available
• Spending at $4B/year
• $25B+ by 2017?

Source: research2guidance, 808 apps from Apple App Store, Google Play, BlackBerry App World and Windows Phone Store (March 2014)
Who Uses mHealth apps?

- Chronically ill people: 31%
- Health and fitness interested people: 28%
- Physicians: 14%
- Temporarily ill people: 8%
- Hospitals: 7%
- Others: 12%

Source: research2guidance mHealth App Developer Economics survey 2014, n=2032
Why Don’t Health Apps Work?

- The fatal flaw of health apps is not the design, accessibility, functionality, interoperability, etc.

The fatal flaw of health apps is the user!
mHealth via Mobile Web (mWeb)

- Almost two-thirds of mobile phone owners go online
- Few health sites have a mobile optimized websites
- Requires “responsive design” or create a mobile layer of critical content
Why is healthcare behind on mWeb?

• Lack of expertise and cost for CMS, SEO, and responsive design has not exceeded benefits
• More search and access from mobile than PC
• Major opportunities for impact using mWeb
• Every organization needs a mWeb strategy!
mHealth via SMS

Don’t forget your multivitamin! Baby’s spine and brain are developing now. Getting 400 micrograms of folic acid daily is key to help prevent birth defects.

Reply Back

@UTHealthComm
@jaybernhardt
mHealth for Patient Reminders

• Reviewed 29 studies with 33 interventions
  – Study sizes: n=325-2864
  – Study durations: 2-7 months
• 32 of 33 interventions showed benefits of sending reminders prior to appointments
  – Manual calls more effective than automated reminders (39% vs. 29%) but at higher cost
  – No differences on reminder timing

mHealth for Type 2 Diabetes

• Reviewed 13 telehealth interventions for T2
  – 4 studies showed improved glycemic control
  – 5 of 8 showed improved dietary adherence
  – 5 of 8 showed improved physical activity
  – 3 of 8 showed improved blood glucose monitoring
  – 3 of 8 showed improved medication adherence
• Conclusion: Behavioral telehealth has promise

SMS-Based mHealth Findings

• Reviewed 12 studies (17 articles) using SMS
  – Intervention length ranged from 3-12 months
  – Sample sizes (n=16-126, + 1,705)
  – Disease management: Diabetes, Asthma
  – Disease prevention: Medication adherence, Weight loss, Physical activity, Smoking cessation
  – 8 of 9 powered studies found evidence of significant behavior change

SMS Systematic Review of Reviews

• Reviewed 15 systematic reviews and meta-analyses
  – Explored 89 individual studies using SMS for public health
  – SMS-based interventions were effective for diabetes self-management, weight loss and physical activity, smoking cessation, medication adherence for antiretroviral therapy
  – Limited consistent evidence across the studies and reviews to inform recommended intervention characteristics.
  – Additional research needed to establish longer-term intervention effects, identify recommended intervention characteristics, and explore issues of cost-effectiveness.

SMS Example: text4baby

- **Goal:** To reach women at high risk of having poor birth outcomes
- Free program from National Healthy Mothers, Healthy Babies Coalition with J&J and 900+ partners
- Over 475,000 mothers since 2010
- Three free text messages per week
- Health tips timed to due/birth date
- Available in both English and Spanish

Adapted from Bushar & Kendrick (2013). Text4baby Just Turned Three! What Have We Learned? DHCX 2013 Presentation.
SMS Example: text4baby

- **Process Evaluations**
  - Users: 53% pregnant, 46% delivered
  - Referrals 23% MD/RN, 23% media, 16% HD
  - Good at reaching moderately low income
- **Outcome Evaluations**
  - Increases self efficacy among moms
  - Helps remind about vaccines
- **Program Improvements**
  - More 2-part (longer) messages
  - Links to mWeb sites

Don’t forget your multivitamin! Baby’s spine and brain are developing now. Getting 400 micrograms of folic acid daily is key to help prevent birth defects.
SMS Pilots Focused on Health Disparities

- Formative research on SMS for health (Kharbanda et al, 2009)
  - SMS immunization reminders were OK among urban parents
- SMS Pilot on Diabetes Self Management (Dick et al, 2011)
  - Older adult urban African American population (n=18)
  - Although ½ of respondents were initially uncomfortable with SMS messages, treatment adherence and self-care confidence improved
- SMS on influenza vaccine (Stockwell et al, 2012)
  - SMS increased vaccine uptake urban, low income pediatric patients
- Despite the potential, limited mHealth research focused on underserved patients and populations has been published
Wearables for Medicaid Participants?

• Rapid sales growth
• Frequent innovation
• Crowdfunding success
  – Kickstarter/Indiegogo
• CES 2014 & 2015
Use Cases for Health Wearables

• Fitness and Wellness
  – Steps, speed, and distance traveled (calories burned)
  – Heart rate and recovery
  – Skin and body temperature
  – Posture and body position
  – Sleep patterns and quality
  – Sun/UV ray exposure

• Chronic Disease Self-Management
  – Obesity and Overweight (Fitness and calories)
  – Arthritis (Gate and steps)
  – Diabetes (Blood glucose)
  – Epilepsy (Seizure sensor)
  – Dementia (Memory aids)
Research on Self Monitoring

• **Weight Loss**
  – Consistent significant association between self-monitoring (diet, weight, exercise) and weight loss (Burke et al., JADA, 2011)

• **Diabetes**
  – Self-monitoring of blood glucose may lead to improvements in diabetes self management (McAndrew et al., The Diabetes Educator, 2007)

• **Physical Activity**
  – 12 of 14 studies showed increased activity among youth wearing pedometers (Lubans et al., Prev Med, 2009)
Wearable Game Changer?

“…the most personal device we’ve ever created.” – Tim Cook

@UTHealthComm @jaybernhardt
Microsoft Band
What Did We Learn Today?
mHealth for Medicaid Participants

- High access among hard-to-reach patients
- Facilitates accessible, sustainable, sharable, social, multimedia, multi-directional, personalized, and engaging messages
- Relatively low cost for high reach and impact
- Potential for EHR interoperability/integration
- SMS has strongest evidence of efficacy
mHealth for Medicaid Participants

- Few studies of mHealth use mobile web or apps
- Mostly pilot studies using SMS or mHealth with underserved (except for Text4Baby)
- Programs should be targeted and customized for patient and community needs
- Privacy and HIPAA rules must be considered
- Research on cost and sustainability needed
“We will soon be saying ‘mHealth is dead’ because all healthcare and public health functions will use mobile technologies!”

- @jaybernhardt
THANK YOU

Jay M. Bernhardt, PhD, MPH

jay.bernhardt@austin.utexas.edu

moody.utexas.edu/healthcomm
Collaborative Connections
Improving Care

Day 2 - Final Thoughts