**Project Option 2.12.2 Implement/Expand Care Transitions Programs: A3 UTHealth General Care Transitions**

**Unique RHP Project Identification Number:** 111810101.2.13
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 2.12 Implement/Expand Care Transitions Programs (Option 2.12.2)

Care transitions refer to the set of interactions necessary to go from one type of care to another. UT Physicians will implement a discharge planning program and post discharge support program that ensures that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with medical and surgical conditions.

**Goal and Relationship to Regional Goals:**

To implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.

Care transitions project will make it easier for patients to access care in a coordinated manner, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

**Challenges:**

Need: 1) High rates of preventable hospital readmissions. 2) Insufficient access to care coordination.

Implementation: 1) Ability to provide culturally appropriate discharge support. 2) 2) Staff recruitment and retention. Patients get unnecessarily readmitted to hospital after a discharge due to avoidable reasons such as failure to adhere to medication regimen, partly due to lack of full understanding of expectations on the part of the patient. With effective culturally sensitive post-discharge support such costly readmissions will be drastically reduced. The program aims to engage CHWs, which have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges they face. Most CHWs come from the local population, are in touch with the community, and are better able to attend to the needs of patients by helping the system to deliver culturally sensitive care and by facilitating their access to health education and support, thereby providing an important and cost effective service to health care teams and to patients. By employing CHWs from within the community and providing competitive compensation/incentives will aid in the recruitment and retention of trained CHWs.

**5-Year Expected Outcome for Provider and Patients:**

The expected outcome of this project will be increased adherence to therapy, increase in number of patients that are followed up in primary care post-discharge from hospital, and a reduction in 30-day hospital readmissions for index admissions of asthma.

**Starting Point/Baseline:**

To be determined during DY3.

**Rationale:**

When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with proactive post-discharge support, can reduce readmission rates and improve health outcomes.

**Project Components:**

Through the UTHealth General Care Transitions Program, we propose to meet all required project components listed below.

a) Use of discharge checklists,
b) Develop post-discharge medication planning,
c) Arrange post-op clinic visit before discharge,
d) Develop "Hand off" communication plans between providers,
e) Provide patient and family recovery education and wellness education, and
f) Conduct follow-up contact using automated flags and reminders.

For the UTHealth General Care Transitions Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

Milestone 1 [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions
Metric 1 [P-1.1.]: Care transitions protocols

Milestone 2 [P-2.]: Implement standardized care transition processes
Metric 1 [P-2.1.]: Care transitions policies and procedures

**Improvement Milestones and Metrics:**

Milestone 3 [I-14]: Milestone: Implement standard care transition processes in specified patient populations.
Metric 1 [I-14.1]: Measure adherence to processes.
Milestone 4 [I-11.]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions
policies
Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and
guidelines

**Unique community need identification numbers the project addresses:**

This project addresses community needs CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs) and CN.9 (High rates of preventable hospital readmissions).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

This project represents a new inititiative. UT Physicians proposes to implement a new care transitions program for general medical and surgical discharges from Memorial Hermann Hospital-TMC with UT Physicians' network of hospitalists with 24/7 management of inpatients with medical and surgical conditions.

**Related Category 3 Outcome Measure(s):**

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs )
IT-3.10 Adult Asthma 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of asthma and with a complete claims history for the 12 months prior to admission.

**Relationship to other Projects:**

1.1 (C3) - The expanded capacity to deliver primary care will ensure that patients without a usual source of care are able to be assigned to a primary care team in the UT medical homes and be given a follow-up appointment prior to discharge.
1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to facilitate the transition of patients from the acute care setting into primary care in a medical home.
1.3 (C12) - The disease management registry will be a useful resource for the primary care team in ensuring that new patients transitioning from the acute care setting are tracked and continuity of care is maintained.
1.7 (A1) - Telemedicine capabilities within the UT Medical Homes will provide increased capacity to deliver both primary and specialty care services to patients when and where needed.
1.9 (C4) - The expansion of specialty care in the primary care setting will provide a greater availability of needed services for new patients transitioning from acute care.
2.1 (C1-2) - The UT Health Multispecialty Physician Group, serving as a Virtual Acountable Care Organization (ACO) provide an extensive network of specialty support centers for primary care providers in advanced medical homes, better equiped to care for new patients transitioning from acute care who have complex needs.
2.2 (CL3, C5 - C9) - The chronic care management models being implemented within the UT Medical Homes will provide improved care for those transitioning from the acute care setting into primary care and must manage a chronic disease. Receiving evidence-based chronic disease management from a primary care team may reduce the patients risk of needing acute care.

**Relationship to Other Performing Providers' Projects in the RHP:**

To be described by RHP Anchor.

**Plan for Learning Collaborative:**

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be rated on a 10-point scale each project. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds available for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of available funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with a couple of exceptions. First, we did not use two of the criteria and second, we began with a 5-point scale for each criteria rated, then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

   This project's score for this criteria: 2 X 2 = **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. If a significant proportion of the target population is uninsured/Medicaid, add 1 additional point.

   This project's score for this criteria: 1 X 2 = **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

   This project's score for this criteria: 2 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

   This project's score for this criteria: 4 X 2 = **8**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth plans to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another, so giving the projects the same, or very similar ratings on this criteria would have again had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.2**

| ***111810101.2.13*** | ***OPTION 2.12.2*** | | ***A3 UTHEALTH GENERAL CARE TRANSITIONS*** | |
|---|---|---|---|---|
| *UTHealth, UTPhysicians* | | | | *111810101* |
| ***Related Category 3 Outcome Measure(s):*** | *111810101.3.28* | *IT-3.10* | *Adult Asthma 30 day readmission rate (Standalone measure)* | |
| **Year 2 (10/1/2012 – 9/30/2013)** | | **Year 3 (10/1/2013 – 9/30/2014)** | **Year 4 (10/1/2014 – 9/30/2015)** | **Year 5 (10/1/2015 – 9/30/2016)** |
| Milestone 1 [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions<br>Metric 1 [P-1.1.]: Care transitions protocols<br>Baseline/Goal: TBD<br>Data Source: Submission of protocols, Care transitions program materials<br><br>Milestone 1 Estimated incentive payment: $ 1,507,247 | | Milestone 2 [P-2.]: Implement standardized care transition processes<br>Metric 1 [P-2.1.]: Care transitions policies and procedures<br>Baseline/Goal: TBD<br>Data Source: Policies and procedures of care transitions program materials<br><br>Milestone 2 Estimated incentive payment: $ 1,655,144 | Milestone 3 [I-14]: Milestone: Implement standard care transition processes in specified patient populations.<br>Metric 1 [I-14.1]: Measure adherence to processes.<br>Goal: TBD<br>Data Source: Hospital administrative data and the patient medical record<br><br>Milestone 3 Estimated incentive payment: $ 1,770,619 | Milestone 4 [I-11.]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies<br>Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines<br>Goal: TBD<br>Data Source: Registry or EMR report/analysis<br><br>Milestone 4 Estimated incentive payment: $ 1,710,743 |
| Year 2 Estimated Milestone Bundle Amount: $1,507,247 | | Year 3 Estimated Milestone Bundle Amount: $1,655,144 | Year 4 Estimated Milestone Bundle Amount: $1,770,619 | Year 5 Estimated Milestone Bundle Amount: $1,710,743 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:*** $6,643,753 | | | | |

**Title of Outcome Measure (Improvement Target)**: OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs )

**Unique RHP outcome identification number(s)**: 111810101.3.28

**Outcome Measure Description:**

IT-3.10 Adult Asthma 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of asthma and with a complete claims history for the 12 months prior to admission.

**Process Milestones:**

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

DY4:
IT-3.10 Decrease by 3% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
DY5:
IT-3.10 Decrease by 5% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

**Rationale:**

When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Patients are likely to have frequent readmissions if they do not get optimal support post discharge. Therefore, 30 day readmission rate for discharges with an index asthma admission will serve a good measure of the program's success.

**Outcome Measure Valuation:**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

| *111810101.3.28* | *3.IT-3.10* | *Adult Asthma 30 day readmission rate (Standalone measure)* | |
|---|---|---|---|
| *UTHealth, UTPhysicians* | | | *111810101* |
| **Related Category 1 or 2 Projects:** | *111810101.2.13* | | |
| **Starting Point/Baseline:** | *To be determined during DY3.* | | |
| **Year 2 (10/1/2012 – 9/30/2013)** | **Year 3 (10/1/2013 – 9/30/2014)** | **Year 4 (10/1/2014 – 9/30/2015)** | **Year 5 (10/1/2015 – 9/30/2016)** |
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans<br>Data Source: Project reports and documents<br><br>Process Milestone 1 Estimated Incentive Payment*:* $ 79,329 | Process Milestone 2 [P-2]: Establish baseline rates<br>Data Source: Provider reports<br><br>Process Milestone 2 Estimated Incentive Payment: $ 91,952<br><br>Process Milestone 3 [P-3]: Develop and test data systems<br>Data Source: Project reports, EMR, claims<br><br>Process Milestone 3 Estimated Incentive Payment: $ 91,953 | Outcome Improvement Target 1 [IT-3.10]: Decrease by 3% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.<br>Data Source: EMR, Claims<br><br>Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 196,735 | Outcome Improvement Target 2 [IT-3.10]: Decrease by 5% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.<br>Data Source: EMR, Claims<br><br>Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 427,686 |
| Year 2 Estimated Outcome Amount: $ 79,329 | Year 3 Estimated Outcome Amount: $ 183,905 | Year 4 Estimated Outcome Amount: $ 196,735 | Year 5 Estimated Outcome Amount: $ 427,686 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:*** $ 887,655 | | | |

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