Project Option 2.1.3 Enhance/Expand Medical Homes: C1-2 UT Health Regional Specialty Care Centers

Unique RHP Project Identification Number: 111810101.2.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.1 Enhance/Expand Medical Homes (Options 2.1.3)

The practice at UT Physicians' Clinics serves areas designated as primary care health professional shortage areas (HPSAs), medically underserved areas (MUAs), and medically underserved populations (MUPs). The Bayshore Clinic service area includes several HPSAs (CT 3207, CT 3208, CT 3218, CT 3219, CT 3220, CT 3333). The Bellaire Clinic service area includes several MUPs (CT 4211, CT 4213, CT 4214, CT 4215, CT 4216). Also, the Cinco Ranch Clinic (CT 6731, CT 6733) and the Sienna Clinic (CT 6746) service areas include MUAs. The medical homes will include services in the areas of dentistry, womens' health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosceinces, pediatrics and geriatrics. UT Health already has and/or will establish state-of-the-art top-ranking Regional Centers in Dental Health, Maternal-Fetal Health, Women, Child and Adolescent Health, Healthy Aging, Neurosciences, Sports Medicine, Trauma and Rehabilitation, Behavioral and Mental Health, Heart and Vascular Disorders and Students' Health. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home".

Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians. Members of staff will be placed into multidisciplinary care teams that manage a panel of patients; each with a defined role and tasks would be divided among care team members to reflect the skills, abilities, and credentials of team members. Patients will be linked to a provider and care team so both patients and provider/care team recognizes each other as partners in care. By means of phone, e-mail, or in-person visits, patients will have continuous access to their medical home. This program will rely on the National Committee for Quality Assurance (NCQA) guidelines (http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/PPCPCMH_Training.pdf), which include: 1. improved access and communication, 2. use of data systems to enhance safety and reliability, 3. care management, 4. patient self-management support, 5. electronic prescribing, 6. test tracking, 7. referral tracking, 8. performance reporting and improvement, and 9. advanced electronic communications. (See related project MS1 UT-Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center, and projects C5-C9 and CL3 for chronic disease management programs for asthma, COPD, CHF, diabetes, and hypertension.)

Goal and Relationship to Regional Goals:

To provide a primary care "home base" for patients, who will be assigned a health care team that tailors services to their unique health care needs, effectively coordinates their care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.

Redesigning of the practice at UT Health on the PCMH concept fits right with 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, and builds on the accomplishments of our existing health care system."

Challenges:

Need: 1) Inadequate access to primary care. 2) Insufficient access to care coordination and integrated care treatment programs. 3) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Staff motivation and ability to work as a care team. 2) Availability of manpower to implement staffing plan. With the Medical Homes project patients will have access to comprehensive care in a coordinated manner, including preventive and self-management education programs. Providers will be assembled to work in teams to deliver personalized and effective care to enrolled patients.

5-Year Expected Outcome for Provider and Patients:

Our practice will have been transformed based on the concept of the patient centered medical homes, leading to better coordination of patient care, increased acccess, and improved patient satisfaction.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

A Patient Centred Medical Home is designed to provide a single point of coordination for all health care, including primary care, specialty care, hospital, and post-acute care. Medical Home models provide accessible, continuous, coordinated and comprehensive patient-centered care and are managed centrally by a primary care physician with the active involvement of non-physician practice staff. The model is based on the reasoning that care coordination can reduce fragmentation in patient care in ways that lower costs and lead to better overall patient outcomes. (O'Mallley, A., Peikes, D., & Ginsburg, P. (2008). "Making Medical Homes Work: Moving from Concept to Practice & Qualifying a Physician Practice as a Medical Home." Policy Perspective 1:1-19. Bailit, M. and C. Hughes. "The Patient-Centered Medical Home: A Purchaser Guide." Patient Centered Primary Care Collaborative. 2008. Rosenthal, T. (2008). "The Medical Home: Growing Evidence to Support a New Approach to Primary Care." Journal of the American Board of Family Medicine 21 (5): 427-440.) By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

Project Components:

Through the UTHealth Medical Homes Program, we propose to meet all required project components listed below.

a) Empanelment: Assign all patients to a primary care provider within the medical home. Understand practice supply and demand, and balance patient load accordingly.

b) Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

c) Link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.

d) Assure that patients are able to see their provider or care team whenever possible.

e) Promote and expand access to the medical home by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.

f) Conduct quality improvement for project using methods such as rapid cycle improvement.

For the UTHealth Medical Homes 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-2.]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
Metric 1 [P-2.1.]: UT Physicians policies on medical home
Milestone 2 [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases.
Metric 1 [P-5.1.]: Determine Panel size
Milestone 3 [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.
Metric 1 [P-4.1.]: Expanded primary care team member roles
Milestone 4 [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care.
Metric 1 [P-3.1.]: Primary care team
Milestone 5 [P-9.] : Train medical home personnel on PCMH change concepts.
Metric 1 [P-9.1.]: Number of medical home personnel trained

Improvement Milestones and Metrics:

Milestone 6 [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.
Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the UT Physicians
Milestone 7 [I-16.]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home
Metric 1 [I-16.1.]: Percent of primary care visits at medical home

Unique community need identification numbers the project addresses:

This project addresses community needs CN.1 (Inadequate access to primary care), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), and CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs).

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

This project represents a new initiative. UT Physicians practice is not currently organized to provide medical home service to its patients. In moving to a more patient-centered and team-based model of care, UT Physicians propose to organize to provide medical homes to its patients.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)
Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

Relationship to other Projects:

1.1 (C3) - The expanded capacity to deliver primary care will be necessary for the redesign of the UT Physician practice as patient-centered medical homes, ensuring that there are enough primary care physicians for patient panels.
1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to staff the medical homes.
1.3 (C12) - The disease management registry will be a useful resource for efficient medical home assignment and disease management within the medical homes.
1.7 (A1) - Telemedicine increases the capacity of UT Medical Homes to deliver both primary and specialty care services to patients when and where needed.
1.10 (MS1) - With QI support from project MS1, UT Health will be better equipped to deliver optimum care to patients.
2.2 (CL3, C5 - C9)- A significant number of patients seen regularly in primary care have chronic diseases requiring more effective care for patients enrolled in UT Medical Homes, for which the chronic care model is well suited.
2.9 (A4) - The care navigation project will facilitate the move into a primary care setting for frequent ED users by getting them enrolled in primary care within the UT Medical Homes.
2.11 (C10) - The medication management program will be a useful resource for all care providers in the UT Medical Homes practice.
2.12 (A3, CL1, CL2, MS4) - The various care transitions projects will ensure there is no interruption in the care continuum for patients as they transit from one form of care to the other within the medical homes .

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: 4 X 2 = **8**

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: 5 X 2 = **10**

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: 5 X 2 = **10**

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: **6.8**

111810101.2.1	***OPTION 2.1.3***		***C1-2 UT HEALTH REGIONAL SPECIALTY CARE CENTERS***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.12*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone 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-2.]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their per Metric 1 [P-2.1.]: UT Physicians policies on medical home Baseline/Goal: TBD Data Source: UT Physicians's "Policies and Procedures" documents Milestone 1 Estimated incentive payment: $ 1,067,634 Milestone 2 [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Metric 1 [P-5.1.]: Determine Panel size	Milestone 4 [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care. Metric 1 [P-3.1.]: Primary care team Baseline/Goal: TBD Data Source: UT Physicians staffing records and other program documentation Milestone 4 Estimated incentive payment: $ 1,758,590 Milestone 5 [P-9.] : Train medical home personnel on PCMH change concepts. Metric 1 [P-9.1.]: Number of medical home personnel trained Baseline/Goal: TBD Data Source: Training records and HR documents Milestone 5 Estimated incentive payment: $ 1,758,591		Milestone 6 [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the UT Physicians Goal: TBD Data Source: Practice management system, EHR, or other documentation as designated by UT Physicians Milestone 6 Estimated incentive payment: $ 3,762,565	Milestone 7 [I-16.]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home Metric 1 [I-16.1.]: Percent of primary care visits at medical home Goal: TBD Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider Milestone 7 Estimated incentive payment: $ 3,635,329

111810101.2.1	***OPTION 2.1.3***		***C1-2 UT HEALTH REGIONAL SPECIALTY CARE CENTERS***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.12*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone 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)**
Baseline/Goal: TBD Data Source: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for proactive panel management Milestone 2 Estimated incentive payment: $ 1,067,634 Milestone 3 [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. Metric 1 [P-4.1.]: Expanded primary care team member roles Baseline/Goal: TBD Data Source: Revised job descriptions Milestone 3 Estimated incentive				

111810101.2.1	***OPTION 2.1.3***		***C1-2 UT HEALTH REGIONAL SPECIALTY CARE CENTERS***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.12*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone 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)**
payment: $ 1,607,633				
Year 2 Estimated Milestone Bundle Amount: $3,202,901		Year 3 Estimated Milestone Bundle Amount: $3,517,181	Year 4 Estimated Milestone Bundle Amount: $3,762,565	Year 5 Estimated Milestone Bundle Amount: $3,635,329
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $14,117,976				

Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction

Unique RHP outcome identification number(s): 111810101.3.12

Outcome Measure Description:

IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)
Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

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-6.1 (1) Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.
DY5:
IT-6.1 (1) Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.

Rationale:

The medical home project will provide a primary care "home base" for patients, and they will be assigned a health care team that will effectively coordinate their care across inpatient and outpatient settings, and proactively provide preventive, primary, routine and chronic care to them. This would translate to increased likelihood of getting timely care, ease of setting up appointments and receiving helpful care information. Thus assessing patient satisfaction (for patients of UT Physician clinics, who are not cancer surgery patients and have been assigned to a medical home) in these domains of their care experience, as measured using the adult CG-CAHPS survey for the domain of getting timely care, appointments, and information, will be a good measure of the outcome of this project.

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.

111810101.3.12	*3.IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.1*		
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 Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 168,574	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 195,399 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 195,399	Outcome Improvement Target 1 [IT-6.1 (1)]: Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home. Data Source: Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 418,063	Outcome Improvement Target 2 [IT-6.1 (1)]: Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home. Data Source: Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 908,832
Year 2 Estimated Outcome Amount: $ 168,574	Year 3 Estimated Outcome Amount: $ 390,798	Year 4 Estimated Outcome Amount: $ 418,063	Year 5 Estimated Outcome Amount: $ 908,832
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,886,267			

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