FORT BEND COUNTY

HEALTH & HUMAN SERVICES

TRANSFORMING HEALTH CARE

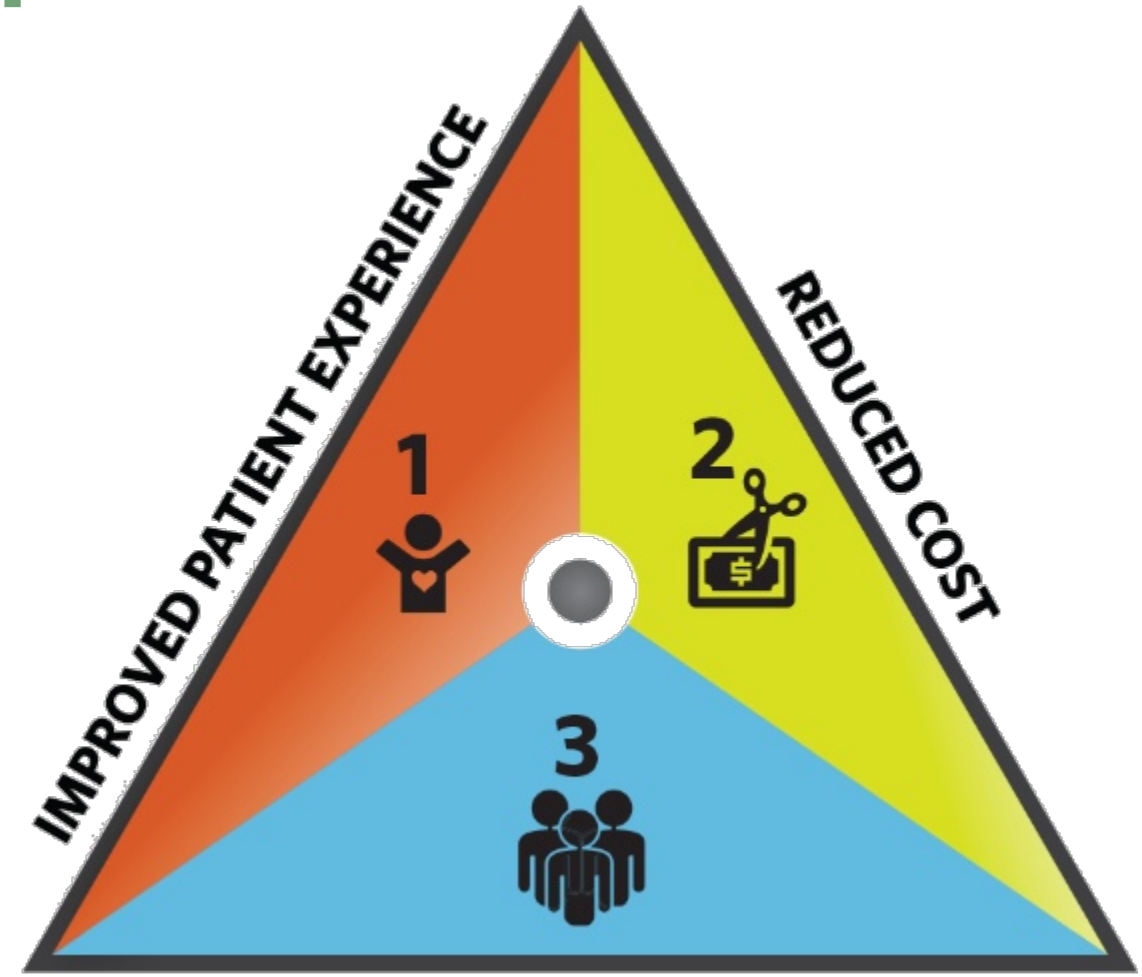
Right Care, Right Place, Right Time

Fort Bend County 1115 Waiver

Commissioners Court

December 6, 2016

Purpose of the 1115 Waiver



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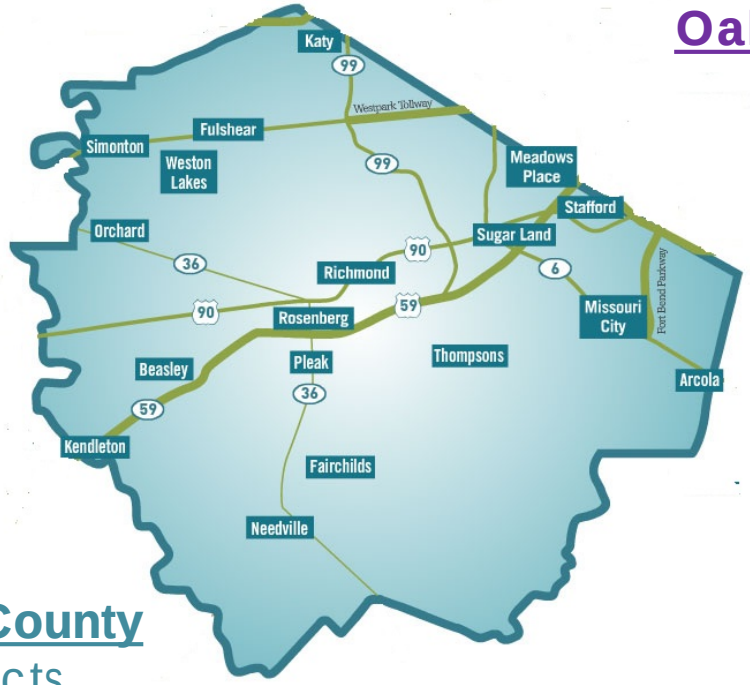
DSRIP Projects in Fort Bend County



OakBend Medical Center

9 Projects
9 Outcome Measures
$51,290,674

Texana Center

5 Projects
6 Outcome Measures
$39,583,241

Fort Bend County

8 Projects
9 Outcome Measures
$24,995,237

Memorial Hermann

8 Projects
8 Outcome Measures
$24,601,150

*Estimated impact to Fort Bend County

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Project Improvement Areas

Improve Quality of Life

HEALTH OUTCOMES

Care Coordination – Fort Bend County
Community Paramedic – Fort Bend County
Chronic Disease Patient Navigation – OakBend Medical Center
Behavioral Health Patient Navigation – OakBend Medical Center
Medication Management – OakBend Medical Center
Chronic Disease Registry– OakBend Medical Center
Breastfeeding Program – OakBend Medical Center
Wellness/Self-Management– OakBend Medical Center
Patient Experience – OakBend Medical Center
Primary Care Integration into BH Clinic – Texana Center
24-Hour Nurse Triage Line – Memorial Hermann
Home Health Psychiatric Program – Memorial Hermann
ER Navigation – Memorial Hermann

IMPLEMENTING EVIDENCE BASED PREVENTION

Colonoscopy Screening– Fort Bend County
SBIRT (Screening, Brief Intervention, Referral to Treatment) – Fort Bend County

Reduce Unnecessary Utilization of Health Care Resources

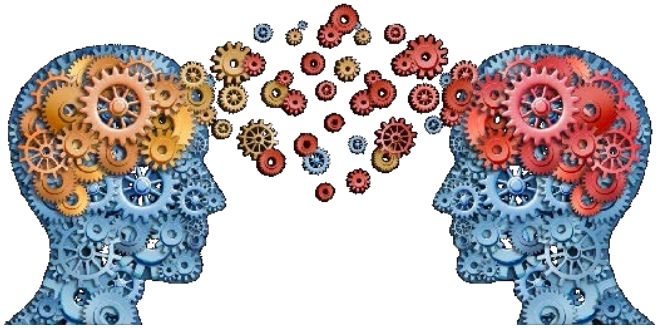
INTERVENTION / DIVERSION

Behavioral Health Crisis Center– Texana Center
Juvenile Diversion – Fort Bend County
Crisis Response and Intervention – Fort Bend County
Recovery & Reintegration – Fort Bend County
Behavior Stabilization Project – Texana Center
Psych Response Team Case Management – Memorial Hermann
Mental Health Crisis Clinics – Memorial Hermann

INCREASE CAPACITY

Primary Care Expansion – OakBend Medical Center
Specialty Care Expansion – OakBend Medical Center
Expanded Hours – Fort Bend County
Therapy for Tots – Texana Center
Children's Center for Autism – Texana Center
School Based Expansion – Memorial Hermann
Convenient Care Centers – Memorial Hermann
Physician Network Development – Memorial Hermann

DSRIP Projects



DSRIP funding allowed for the development of:

- Creation of new partnerships in the community and health systems
- Innovation and transformation of care through new projects and enhancements
- Renewed focus and emphasis on improving quality of care and access for underserved patients
- Navigation care model for patients with chronic disease
- Enhanced response and care for individuals in mental health crisis

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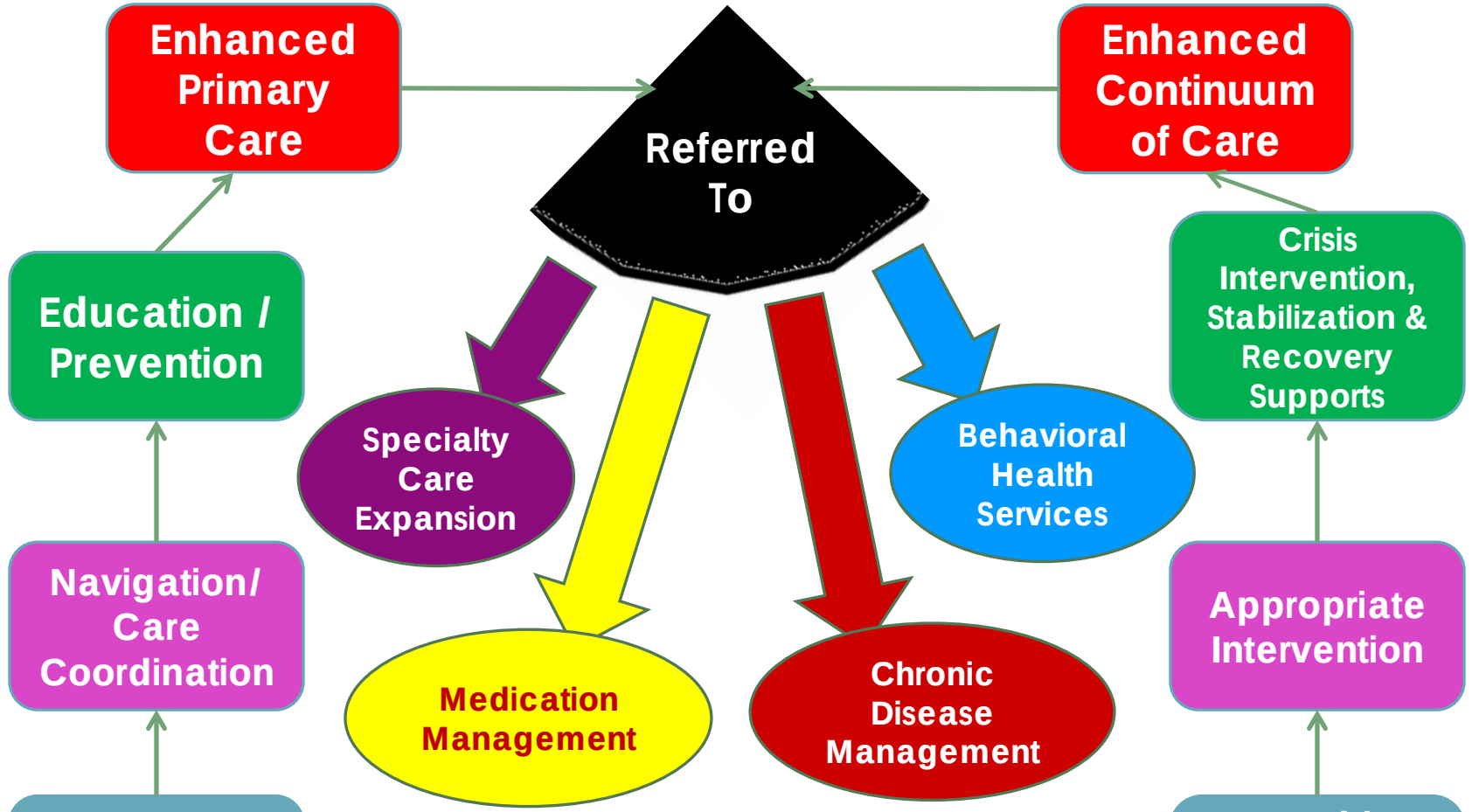
DSRIP Projects



Building partnerships: patients, practitioners, community agencies and the private sector
Enhancements: transportation, employment, education, food, housing, and increased access and accessibility to services

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Expanded Care Teams

Physicians
Nurses

Medical First Responders

Dieticians
Patient Educators

Navigators
CHWs

Behavioral Health Providers

Law Enforcement

Management Administration

Data Managers

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Provider Perspective

"The 1115 Waiver Program provides increased access to quality healthcare for our community. Prior to coming to AccessHealth, many did not have a place, other than the emergency room, to receive their primary healthcare. This program provides them access to hope and better health for themselves and their families."
- David Krusleski, M.D.

"Texana Center's specialized programs, through the 1115 Waiver, provide needed intervention for children birth through three with a developmental delay, children with an Autism diagnosis, and children and adults with intellectual and developmental disabilities. Because of this intervention, clients increase skills and have improved quality of life that otherwise would not have been available to them. It is vital to our community that these projects continue."
- Kate Johnson-Patagoc, MS, BCBA, Texana Center
Director of Specialized Services

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Patient Perspective

- "Thank you for your time, influence, and effort to give me a sense of belonging. To make my life better. Your expertise has given me a new chapter, new future, new direction, and new goals." (Recovery and Reintegration Client)

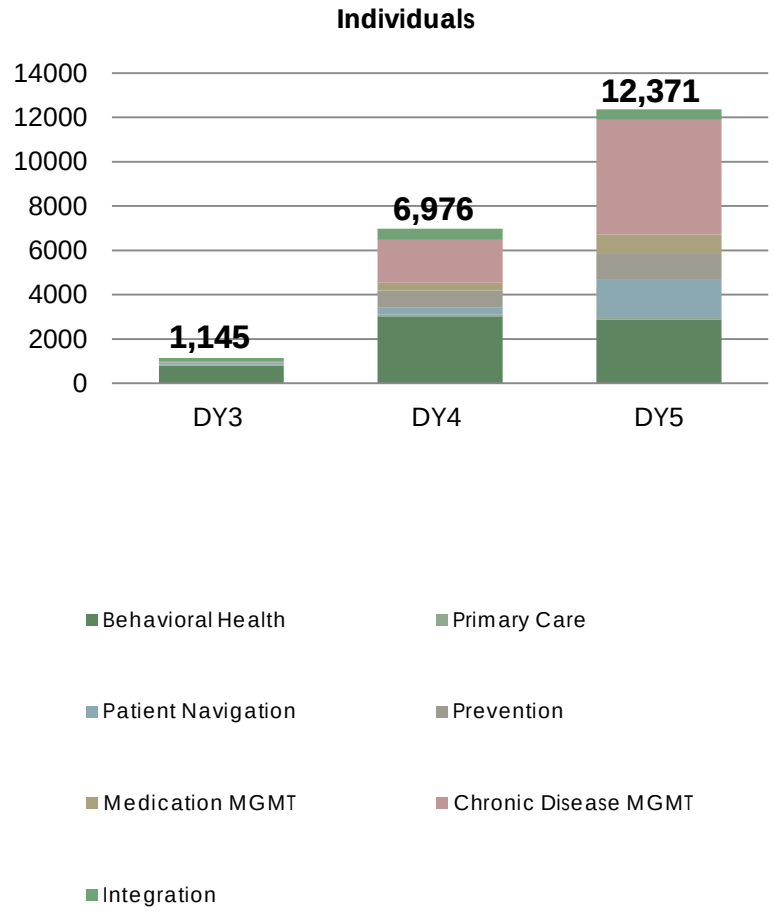
- "The CIT Division of Fort Bend County Sheriff's Office saved my life because I wouldn't have been able to continue life without the help and concern for me and my family's well-being from the CIT Deputy." (CIT client)

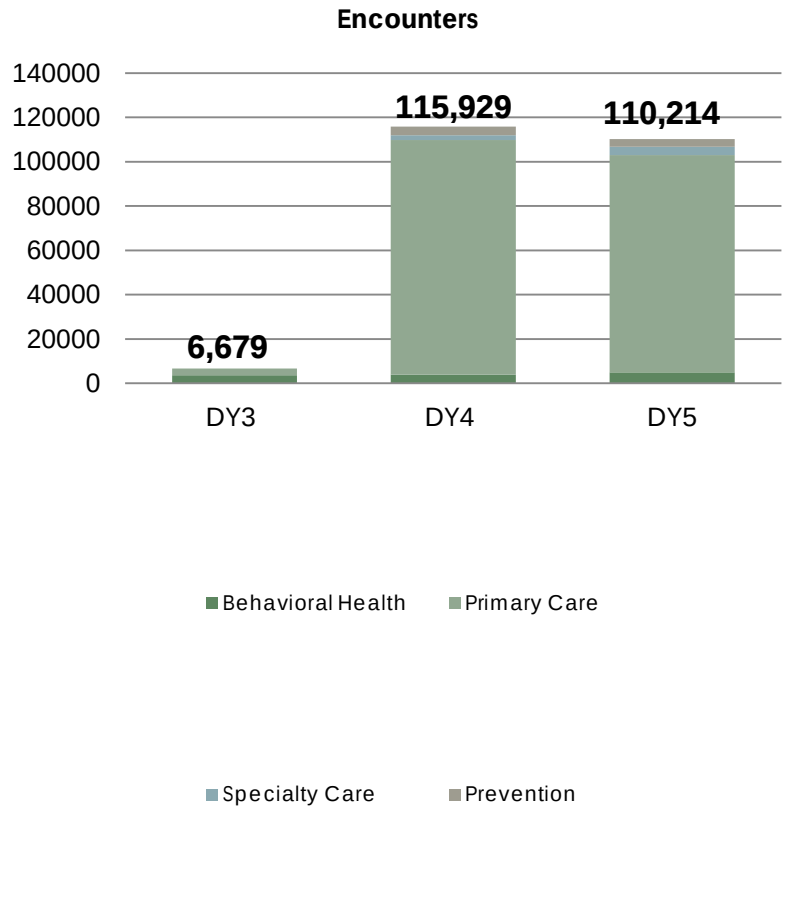
Patient Perspective

- "I feel like I have control again and a huge part of that has to do with the work you took time to do with me." (Memorial Hermann's Mental Health Crisis Clinics)

- "I was scared and didn't know what to do or where to turn. I had no idea a program like this existed and I am so glad I was able to get the help." (Memorial Hermann's Psych Response Team Case Management Program)

Impact – The Numbers





Impact – the numbers

individuals

Project Type	DY3	DY4	DY5	Total
Behavioral Health - 8	792	3,025	2,865	**6,682**
Primary Care - 1	50	75	83	**208**
Patient Navigation - 4	103	315	1,714	**2,132**
Prevention - 2	50	781	1,170	**2,001**
Medication Mgmt - 1	-	344	885	**1,229**
Chronic Disease Mgmt - 1	-	1,926	5,179	**7,105**
Integration - 3	150	510	475	**1,135**
Total	**1,145**	**6,976**	**12,371**	**20,492**

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Impact – the numbers

encounters

Project Type	DY3	DY4	DY5	Total
Behavioral Health - 2	3,600	3,907	4,876	**12,383**
Primary Care - 5	3,079	105,853	98,180	**207,112**
Specialty Care - 1	-	2,276	3,650	**5,926**
Prevention - 2	-	3,893	3,508	**7,401**
Total	**6,679**	**115,929**	**110,214**	**232,822**

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Impact – the outcomes

- Increased percentage of hypertensive patients with blood pressure under control from 55.2% to 63%
- Reduced the percentage of untreated dental caries in student patients from 40% to 25%
- Increased the percentage of student patients receiving Physical Activity, Weight, and Nutritional Counseling from 15% to over 80%
- Readmission rates for CHF, BH, and All-Cause reduced yearly from the baseline year
- Reduced incarceration and emergency room utilization for mental health patients
- Decrease in admissions and readmissions to criminal justice
- Reduced HbA1C >9% levels in diabetic patients
- Reduced emergency room visits in high utilizers

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Initiatives Highlights

- Fort Bend County Crisis Intervention Team
- Improved communication between law enforcement, community and providers
- Home-Based Behavioral Health Services
- Mental Health Peace Officer training
- Expanded care team
- Expanded medical care to the home
- Diabetic education class
- Community Health Worker certification
- Tobacco cessation education class

Enhanced Partnerships

- Transportation
- Social Service Agencies
- MD Anderson Cancer Center Colorectal Cancer Education Trainings
- Specialty Care Providers
- Local Fire Departments
- Fort Bend County criminal justice system, including the courts

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Impact – the stories

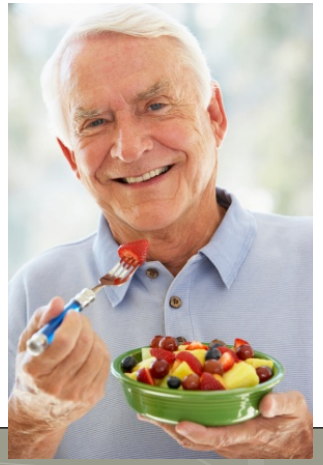
DSRIP Project: Care Coordination
Patient Age: 58 year old male
Presenting Diagnoses: Diabetes type II, hypertension, right big toe amputation due to chronic foot ulcers and gangrene

Before:

- Client was the sole provider for his wife and grandchildren
- Several hospitalizations prevented him from working full time job to support his family.

Program:

- Referred from **OakBend Medical Center** to Care Coordination at **AccessHealth**
- Nurse reviewed medications with the client to
  - ensure understanding of his medication regimen and lab results
  - provided wound care supplies
  - provided a gas voucher.
- Registered Dietician consulted with the patient to
  - educate on nutrition
  - provide sample menus and grocery suggestions
- CHW referred patient to the following agencies for assistance:
  - ***Fort Bend United Way, Fort Bend County Emergency Management & Fort Bend Habitat for Humanity RESTORE*** who helped to provide a refrigerator for client
  - ***Catholic Charities*** who provided gift cards for food and gifts for grandchildren



Results:

- Patient's HbA1c shows his diabetes to be under control since enrollment.
- Now discharged from Care Coordination
- Patient has a positive outlook on life, works a few hours a day, continues to have hope and has not been back to the hospital.

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Impact – the stories

DSRIP Project: Memorial Hermann Psych Response Team Case Management Program and Memorial Hermann Mental Health Crisis Clinics
Patient Age: 58 year old female
Presenting Diagnoses: Bipolar Disorder with Psychotic Features with a history of poly-substance abuse and trauma; Renal Failure

Before:

- Patient frequented Sugar Land campus ED on 17 separate occasions and had multiple visits from the Psych Response Team,

Program:

- Patient was enrolled in the **Psych Response Team Case Management (PRCM) Program** to
  - assist with stabilization and connections to outpatient care as the patient did not meet criteria for admittance into an inpatient psychiatric hospital
  - serious concern for the quality of care provided by the patient's caregiver (daughter)
  - PRCM team continued to meet with the patient at the home, connect the patient to psychiatric care, and attend patient appointments to ensure continuity of care.
  - PRCM team quickly became more concerned when observations of neglect from the caregiver became apparent:
    - caregiver continuously disregarded medication regimen education
    - did not offer encouragement/assistance, and
    - stopped all medications against medical advice to the patient
  - during this lapse of treatment, the patient visited the Mental Health Crisis Clinics on two separate occasions
  - patient's overall health still continued to decline rapidly due to lack of engagement from the caregiver
  - after continued denial for any assistance from outside support group or respite care, intervention from Adult Protective Services and the police occurred.
  - Since then the PRCM team, has worked diligently with the patient for over a year

Results:

- patient living with another daughter who offered support and commitment to the patient's physical and mental health
- client now connected to ongoing outpatient psychiatric treatment, regular dialysis, and physical therapy which has rekindled her ability to walk and dance.
- patient's overall wellbeing is more stable and her mood, appearance, and activity has flourished. I
- November 2016, the patient was successfully discharge from the PRCM program as she continues her care in her home and community.

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Cost Savings / Avoidance

- DY4 Cost per jail stay per inmate with Mental Health condition
  - $4,825
  - *Average # of days = 38.6
  - Cost per day = $125
- Jail Diversions x cost per inmate
  - 200 diversions
  - $965,000 saved

- DY5 Cost per jail stay per inmate with Mental Health condition
  - $4,825
  - *Average # of days = 38.6
  - Cost per day = $125
- Jail Diversions x cost per inmate
  - 254 diversions
  - $1,225,550 saved

*38.6 days average is based on persons with mental illness represented by the Mental Health Public Defenders Office

Total Jail Diversion Savings for DY4 & DY5=

$2,190,550

Cost Savings / Avoidance

- FBC Cost of an Ambulance Transport
  - $839
- Number of EMS Transports in Community Paramedic patients prior to enrollment
  - 220
- Number of EMS transports during enrollment
  - 131
  - 40% decrease
  - $74,671

- Average Cost of ED visit
  - $1,200
  - Number of ED Visits in Community Paramedic patients prior to enrollment
  - 220
- Number of ED visits during enrollment
  - 131
  - 40% decrease
  - $157,200

Total EMS/ED Savings DY4 = **$231,871***

Performed during DY5 (carried over)

*Each EMS transport results in an ED visit

IGT and Draw Down (FBC)

as of August 31,2016

- The County has sent in IGT amounts totaling $5,700,029 and has received $13,514,821 in incentive payments. The net amount is $7,814,792. Since we have spent $7,481,259 to date, the County has a current positive cash flow of $333,533

- Most recent achievements were reported in October 2016

- The IGT due to HHSC and DSRIP payments from HHSC depends on the percent completion reported on each achievement

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Cumulative Budget

as of August 31,2016

Description	Budget	Actual	Encumbered	Balance
Administration	792,938	741,467	328	51,143
CIT	3,353,542	3,130,220	4,874	218,448
Juvenile	292,957	237,726	4,457	50,774
Recovery & Reintegration	302,173	201,637	1,708	98,828
Care Coordination	980,258	779,930	147,377	52,951
Community Paramedic	802,354	699,153	15,031	88,170
Colonoscopy Screening	342,800	178,292	95,900	68,608
Expand Primary Care	1,622,899	1,366,497	200,429	55,973
SBIRT	194,954	146,336	28,933	19,685
Contingency	2,597,050			2,597,050
Balance	$11,281,925	$7,481,259	$499,036	$3,301,630

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Challenges

- Transportation
- Colonoscopy Uptake
- Specialty Care
- Uncertainty of future 1115 Waiver funding
- Integration of care
- Co-occurring substance abuse disorders
- Safe and stable housing
- Employment opportunities
- Sharing of information and communication about patient needs

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Moving Forward

- DY6 – 15 Month through December 2017
- Negotiations are ongoing for DY7 and beyond
- Program Sustainability Planning
- Enhance Community Partnerships
- Innovative Approaches To Medical Care
- Integration of Medical and Behavioral Health
- Continuous Quality Improvement
- Explore MCO Collaboration
- Explore data information systems to effectively manage care transitions between emergency department visits, first responders, behavioral health providers and detention settings

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Questions?

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