DSRIP Update

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Community Care
COLLABORATIVE

October DY5 Reporting Update

Category 1 or 2 Incentives Achieved and Reportable in October	$32,781,061.15
Category 3 Incentives Achieved and Reportable in October	$22,983,552
Category 4 Incentives Achieved and Reportable in October	$1,281,326
	$57,045,939

Total Incentives Reported in April	$6,749,612
Total Incentives Achieved and Reportable in October	$57,045,939
Total Possible Reportable in DY5	$66,629,087
Percentage of DY5 Measures Achieved in DY5	**97%**

Total DY5 Carried Forward into DY6a	$1,764,458

Provider Moments:
- When we heard that one of the moms we provided educational services to was actually teaching her neighbors the information she learned.
Her interactions w/her child were so profoundly different, that people asked her about it. Helping that one family touched the larger community!

Having an abused pregnant & homeless Mother of 1 have a healthy term baby and acquire safe affordable housing. She's now enrolled in College studying Social Work. She wants to help other single moms. Her baby is healthy and walking now.

October DY5 Carry Forward Summary

Project	Metric	Value	Performance	Key Next Steps
1.8 Telepsychiatry Expansion	Patients served	$328,148.60	1550 out of 1800 (86%)	• CUC has initiated tele-BHC encounters to expand services to its patients. • El Buen Samaritano will partner with the CCC in DY6a to bring telepsychiatry services to its patients.
2.4 STI Screening, Treatment and Prevention	Patients who receive STD/HIV tests	$179,398.25	3860 out of 7845 (49%)	• This milestone is a known risk due to error in initial project description.
1.1 Disease Management Registry	Comprehensive Diabetes Care LDL	$448,897.00	80.69% out of 82.61% (-1.92%)	• In DY5, CUC created a custom report to identify diabetics in need of screenings. • In DY6, CUC will evaluate clinic workflow to perform LDL screenings during the patient encounter. This will remove the burden of scheduling a separate appointment for labs.
2.6 System Navigation	ED Visit rate for ACSCs	$808,015.00	36.75% out of 34.17% (-2.58%)	• CCC Medical Management and ATCEMS are collaborating to identify and support high-utilizers in the DSRIP population. • Urgent care and convenient care access will be expanded during DY6a, and a patient and provider engagement strategy will be deployed.
		$1,764,458.85		

Category 1 and 2 Highlights

Project	QPI Performance	Additional Key Accomplishments
Gastroenterology Expansion	**4,558 out of 4,343** additional visits	Since the clinic's launch in DY3, the Hep C clinic has enrolled over 850 patients onto Hep C treatment and cured over 470 of them.
Disease Management Registry	**10,522 out of 7,192** enrolled into the registry	Rolled out a new registry profile for Hepatitis C, which provides automated reminders to screen patients for Hepatitis C if they meet criteria that indicates a higher risk of Hepatitis C.
Pulmonology Expansion	**4,014 out of 3,827** additional visits	Modified clinic workflow to accommodate more walk-in patients as well as scheduling patients for a future appointment upon discharge from their general PCP visit.
PCMH	**55,539 out of 53,153** patients served	15 clinic sites are PCMH recognized and 1 has adopted PCMH principles. Our PCMH partners collectively see an estimated 100,000 patients in Travis County.
Pregnancy Planning	**1,022 out of 932** LARC insertions	Focus groups were held in English and Spanish to improve how services are marketed and delivered to young women.
System Navigation	**1,022 out of 1,000** unique MAP patients receiving call center services	Empaneled 166 patients to a PCP within 72 hours of an ED visit out of a goal of 120 patients. Connected 644 patients to their existing PCP within 72 hours of an ED visit out of a goal of 462.

Category 3 Highlights

Metric	DY5 Cat 3 Performance	Variance to Baseline	Key Accomplishments
Blood pressure control in diabetics	**72.7%** of patients with controlled BP	+2.95%	• Increased provider education
Hepatitis C cure rate	**91.62%** of patients cured	+67.37%	• Initiated services at the ARCH clinic • Utilizing i2i in chart prep for Hep C patients
Diabetes care: retinal eye exam	**53.09%** of patients who received a retinal eye exam	+8.06%	• Redesigned workflow to optimize number of patients appropriately screened • Shared learnings between providers
Gonorrhea follow up three months after treatment	**17.86%** of men and women who undergo follow up testing for uncomplicated Gonorrhea 3-months after treatment	+5.28%	• Tested new patient-centered collection and drop of methods
Tobacco use: screening and cessation	**98.85%** of patients 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.	+18.53%	• Group classes launched in March 2016 at North Central clinic

Questions?