

DSRIP: A Catalyst to Begin Developing Accountable Health Communities

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Introduction

A leader in value-based pediatric population health management, Children's Health was able to accelerate its own system redesign and community integration efforts through the Delivery System Reform Incentive Payment (DSRIP)* program. This five-year funding opportunity has significantly disrupted the clinical system status quo, increased population health capacity for Children's Health and is widening the safety net for vulnerable children living in North Texas — the fastest growing pediatric population in America.¹ Most importantly, it is a major catalyst for developing accountable health communities. This is a new model being advanced by the Centers for Medicare & Medicaid Services (CMS) to address health-related social needs by bridging the divide between the clinical health care delivery system and community service providers.² The DSRIP projects developed by Children's Health establish new links between these entities as the foundation for addressing nonmedical determinants of health.

Background

Jose and Carolina's Dream

Jose and Carolina Gonzales** are hard-working, legal immigrants living in Dallas. Both moved to Texas from Mexico as teens in the 1970s with big dreams of life in America.

Today, Jose and Carolina earn a combined \$55,000 and live with their three children in a run-down rental apartment complex. Jose has limited individual commercial medical insurance through his employer, a freight trucking company. He is struggling to stop smoking and has a chronic cough but finds it hard to stop the smoking habit because of his long days and nights in an 18-wheeler. The Gonzales family has one car, allowing Carolina to work only part time as a housekeeper.

The children are enrolled off and on in the Texas CHIP program but do not have a primary care medical home because there is not one in their neighborhood. Carolina struggles to stay healthy and keep her family healthy, frequently missing work because of respiratory infections, limited medication for quicker recovery or the need to care for her middle child, who often has asthma attacks triggered from secondhand smoke and mold in the apartment. Carolina is grateful for the various hospital emergency rooms that take good care of the family when they get sick.

Carolina and Jose want to offer the "American Dream" to their kids and are grateful to be living in the U.S. However, their life circumstances — low-income jobs, long working days, poor housing conditions, limited transportation and lack of preventive health and wellness opportunities — are making it difficult for them to realize their dreams.

Our Journey to System Transformation

As an organization committed to families like Jose and Carolina's, Children's Health is one of the nation's largest academic pediatric systems. Established in 1913, it is affiliated with UT Southwestern Medical Center and is valued on a local, regional and national level as a provider of choice among physicians, insurance plans, employers and families.

With reform mandates for a value-based payment system on the horizon, Children's Health began in 2010 to build a range of new capabilities to support a population health model within its traditional acute care system.

***Terminology:** DSRIP programs are components of federal funding from Section 1115 demonstrations and are sometimes referred to as "section 1115 waivers." For the purposes of this document, we are using the term DSRIP.

We knew the data concerning our city’s children (49% overweight or obese, 27% with inadequate food and nutrition, and 38% living in poverty³), but we wanted to learn more about the life circumstances of the families we serve. We began a four-year process of deep listening with families to understand their challenges, opportunities and aspirations, as well as their beliefs and attitudes about health and well-being.⁴

From our initial work with families, two guiding principles for system transformation clearly emerged:

- 1) We must view these challenges through the lens of our children and families, engaging them throughout the process.
- 2) We must address both medical and nonmedical determinants of health with community partners that families know and trust.

The Emergence of a New Section 1115 Waiver Program

DSRIP is a component of Section 1115 of the Social Security Act, incentivizing system transformation and quality improvements in hospitals and other providers serving high volumes of low-income patients. It restructures historic Medicaid supplemental payment funding to hospitals caring for underserved patients into a pay-for-performance structure to reward specified delivery system reform metrics.⁵ Its aim is to meet strategic goals through the tenets of the Triple Aim — placing it in natural alignment with the transformational vision of Children’s Health.

The Triple Aim:

- Improving the patient care experience
- Improving the health of populations
- Reducing the per capita cost of health care

Since 2010, nine states (California, Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, Florida and Texas) have negotiated with the federal government to implement DSRIP programs.⁵ Texas’ potential DSRIP pool funding is \$11.4 billion over five years (2011–2016). The state currently has more than 1,450 DSRIP projects distributed through 20 geographic zones, most of which are focused on adult health outcomes.

As the largest pediatric Medicaid provider in the North Texas region and an early adopter of a family population health model, Children’s Health recognized the alignment of DSRIP goals with its own. In 2011, the first year of the DSRIP program in Texas, the Children’s Health population health management team submitted 17 specific funding proposals, followed by two additional project proposals in 2013. We now have 19 programs that are funded and active for first-cycle Texas DSRIPs.

Our DSRIP applications were developed against a backdrop of comprehensive system redesign projects — aimed at the ultimate goal of a healthier community. Our population health capabilities were designed to connect the insurance products, the health care delivery system and the community health support system — as well as the infrastructure and technology capabilities to support the entire ecosystem.

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We knew that by operating independently, none of these systems could create a sufficient tipping point of value for our community — because each system addresses only parts of the Triple Aim. Working effectively together, however, these systems form a distinctive competency that will allow Children’s Health to deliver true value, effectively steward our resources and dramatically scale access for thousands of vulnerable children and families in Texas.



Setting Clear Project Themes

A simple strategy drives all of our DSRIP projects: *If we can measurably improve health and wellness with cross-sector community partners, we will deliver more effectively on our mission promise to make life better for children.*

We will also save money for the health system by averting costly hospital admissions and unnecessary clinical visits.

Our first-cycle projects have been implemented within the following themes and funding levels:

- Expanding primary care access/medical home provision (\$28.3 million)
- Integrating physical and behavioral health (\$8.4 million)
- Improving care transitions (\$6.5 million)
- Helping families manage chronic diseases outside of the care setting (\$18.1 million)
- Implementing telehealth in schools (\$2.9 million)
- Improving care navigation services (\$1.7 million)

How might we gather our clinical, community, family and philanthropic stakeholders to focus on entrenched, complex problems together — and stick together to solve them?

Changing Mindsets

We began to disrupt our approach to activities by setting forth a new emphasis on systems thinking and a family-driven, community focus for every initiative; breaking down traditional clinical and business silos and working toward deep and meaningful service integration; and moving upstream into communities and working with uncommon partners, such as churches, schools, community centers and government entities. We intentionally shifted our focus away from only providing individual, episodic “sick care” treatment to building prevention and wellness opportunities with the community.

Importantly, we became highly intentional in engaging families in this work. We now have families that are community change-agents — having moved from a *recipient mindset* to becoming active *participants* in the long journey to build healthier, better communities. Families have rolled up their sleeves and are committed to helping us better understand their unique needs. Together, we are working to create conditions that will help them create and achieve their best health and well-being.

Internally, a slow, steady and often challenging cultural transition process encouraged key system stakeholders to re-evaluate their day-to-day clinical silos. We asked employees and medical staff at all levels of the organization to reimagine an expanded role for Children’s Health in building a healthier community — and a financially sustainable future for the system itself.

Convening Uncommon Partners

In a seminal step, Children’s Health established the Health and Wellness Alliance for Children (the Alliance) in 2012. We recognized that health care organizations and the broad array of social, education, government, business and faith organizations — while concerned about the same community problems and collaborating from time to time — naturally gravitated back to our own silos of expertise and organizational demands.

Knowing this was the normal tendency, we chartered the Alliance to help pioneer a solution in Dallas, beginning with childhood asthma. How might we gather our clinical, community and philanthropic stakeholders to focus on entrenched, complex problems together — and stick together to solve them?

By adhering closely to the guiding principles of a collective impact organizational model, the Alliance is now comprised of 75 engaged, hands-on member organizations. A small backbone staff, funded by Children’s Health, keeps our clinical experts and community partners at the same table, focused on the same issues and measuring the same indicators for success. The staff also provides critical community linkage for all of our DSRIP-specific projects. We believe we have “proof of concept” that this type of coalition, functioning as a cross-sector “integrator,” is essential to achieve lasting change for our system and our community.

The following examples demonstrate *how* the health care delivery system can link with community organizations to advance health:

“The Health and Wellness Alliance for Children is a shining example of cross-sector organizations coming together with focus, grit and determination to help make Dallas the best city in America for kids to grow up.”

The Honorable Mike Rawlings, Mayor, City of Dallas

Health Care Provider	Linkage	Community
Asthma action plans	Incorporated into	School nurse-driven telehealth program
Asthma clinical guidelines	Informed	Changes to the city housing code
Evidence-based asthma management program	Included	Home visits by AVANCE promotoras

DSRIP Project SPOTLIGHT:

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Connecting Learning and Health Through School-based Telehealth

Schools are highly valued community assets, offering efficient systems for reaching children to provide health services and programs — as approximately 95% of all U.S. children attend school.⁹ Research has validated that closely integrated health and education resources are an untapped opportunity for raising academic achievement and improving learning.⁹

Recognizing the relationship between learning and health, we focused a DSRIP project on integrating and scaling appropriate components of our care system with schools through campus-based telehealth. We staffed the school telehealth services via Children’s Health Pediatric Group, our primary care/medical home network.

Our new school telehealth service has transformed community/clinical relationships and empowered front-line school nurses and teachers. Children are treated and back in class in minutes, instead of hours or days. The program, begun with DSRIP funds awarded in 2013, is now in 284 schools in four counties, impacting more than 250,000 K–12 students — making it the largest and fastest-growing program of its kind in America.

We are especially pleased that our aggressive legislative advocacy in Texas has resulted in school telehealth service reimbursement from both commercial and government payers. This was a significant victory in 2015, as it provides the financial stability to sustain the effort and propel ongoing expansion.

Our service equips school nurses with encrypted telemedicine technology, including high-definition videoconferencing and state-of-the-art digital scopes — connecting children directly to our health care professionals for primary and behavioral health issues. Strep and flu rapid tests are also available to assist with diagnostics alongside the virtual visit.

Through extended technology, we offer after-hours connections for parents to discuss their child’s virtual visit summary, prescriptions and any other requested information.

Early Results: Today, more than 3,000 children have accessed clinical telehealth, with school nurses reporting 72% of these children would otherwise have visited emergency rooms or urgent care centers, costing 88% (\$811) more than the telehealth visit on their school campus.

Incorporating coordinated school health programs with a comprehensive health system for children is scaling effectively and rapidly.

DSRIP Project SPOTLIGHT: Supporting Communities by Expanding Behavioral Health Services

Appropriate, collaborative and family-based support for children and families burdened with behavioral and mental health issues has been a long-standing concern for all medical providers in the North Texas region.

We have implemented DSRIP projects to develop a consistent model in which the behavioral health specialist is an embedded part of the medical home/neighborhood, offering community-based care that addresses the whole family.

Our vision is for full integration of medical and behavioral care teams.

Our specific goal for these projects is to make behavioral health conversations a standard part of every health visit and to ensure that behavioral health referrals are always available — regardless of insurance coverage or a family's ability to pay for services. Staffing includes primary care physicians and specialists within Children's Health, as well as our clinically integrated partners, a charity clinic and other medical systems in North Texas communities.

Our approach is to identify behavioral health needs through screenings that occur normally during age-specific well-child checks in primary care clinics. Patients who require additional assistance are then referred to a behavioral health care manager who determines the additional level of support needed for the patient and family.

Early Results: Since we implemented the DSRIP physical/behavioral integration projects in 2013, more than 2,000 primary care patients have received patient-specific behavioral care management support. Licensed master's-level behavioral health clinicians are now on-site in all 20 Children's Health Pediatric Group clinics throughout the greater Dallas area. Increased professional staffing includes psychiatrists and psychologists to provide higher-level support for children and families who have been identified through the integrated screening process.

Once this new model matures, we will be in a position to influence health care policy and funding through outcomes and legislative advocacy.

Change Is Hard: Project Implementation Challenges

Data Infrastructure

Data collection, both to establish initial baselines of health measures and to improve reportable measures, has been an enormous challenge for us and is an equally daunting challenge for all health care organizations locally and statewide. The data infrastructures necessary for this type of comprehensive integration did not exist at the time of the Texas DSRIP inception or the implementation of our Children's Health DSRIP projects. Consequently, building and re-building IT interoperability continues as a parallel imperative for our overall system transformation and a necessary component to support accurate DSRIP reporting.

Cultural Disruption

The longstanding clinical excellence at Children's Health has been built on our defining affiliation with UT Southwestern Medical Center. This partnership, and the clinical leadership and staffing it embodies, is essential to the system's comprehensive specialty

care delivery and research programs. Significantly, the partnership has also historically represented the cultural identity of the system.

The move upstream into communities, and the expansion of a complex care model to include wellness and primary care — alongside cross-sector community players and families — has created significant cultural disruption. Shifting a large and established faculty of outstanding academic clinicians and caregivers to a new mindset that involves distinctly non-academic, socially driven thinking is an ongoing process.

Conclusion

Our first-cycle DSRIP project results are encouraging. We have been able to expand our primary care network by 233% and integrate behavioral health services into all sites. Further, we have reduced asthma-related emergency department visits by 49% and developed the largest school-based telehealth service in the nation.

While some DSRIP projects have demonstrated more impressive outcomes in the first four years than others have, *all* have measurably improved our ability to better serve populations of families and children and contribute to the social infrastructure of our communities.

Beginning with developing substantive, effective linkages between the health care system and community agencies, DSRIP has been an important catalyst for our system transformation to support an accountable health community. A recent study of hospital leaders noted that lack of financial resources — either through fee-for-service payment or funding for technology and staff infrastructure — was a significant barrier to engaging in community health improvement.¹⁰ Although CMS suggests that DSRIP funding is not intended to be a long-term solution for Medicaid under-reimbursement — nor the sole funding source for system transformation,¹¹ — all indications are that the program will be funded for future cycles, and it is currently expanding into more states.

In our experience, DSRIP funding can and should be pursued as a powerful tool to help hospitals move to a broader and more sustainable approach to improving community health.

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END NOTES

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