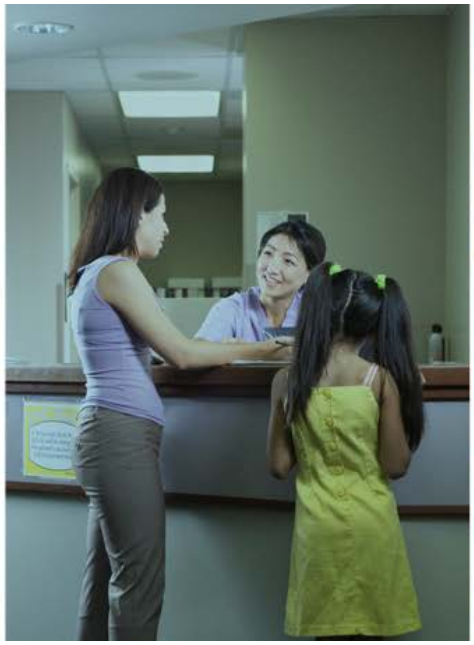





Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

Region 3

Learning Collaborative Conference – DY3

December 4, 2013

Hosted by: Harris Health System – Health System Strategy – Region 3 Anchor

David Lopez/Beth Cloyd

WELCOME

Beth Cloyd

ANCHOR TEAM INTRODUCTIONS

Your Region 3 Anchor Team

Operations

- Policy
- State Protocols
- State Liaison
- Communications

- Reporting
- Data Analysis
- Learning Collaborative

Project Management Office - (PMO)

- Project Support
- PL Implementation
- PL Management and Training

- Performance Measurement and Tracking
- Regional Project Liaisons
- Program Scorecards

Your Region 3 Anchor Team

- Beth Cloyd – EVP and CNE
- Karle Scroggins – Operations Coordinator
- Nicole Lievsay – Director, Operations
- Margarita Gardea – Manager, Operations
- Jennifer Roberts – Strategy Analyst, Operations
- Shannon Evans – Regional Liaison, Operations
- *Open – Regional Liaison, Operations*
- *Open – Director, Project Management Office (PMO)*
- Stephen Orrell – Manager, PMO
- James Conklin – Project Manager, PMO
- Christy Chukwu – Project Manager, PMO
- Swathi Gurjala – Project Manager, PMO

Nicole Lievsay

REGION 3 RHP PLAN UPDATE

Where We've Been…

- Three RHP plan submissions to HHSC
- Full plan submission to CMS on April 11, 2013
- Initial Feedback and Approval from CMS
  - May 2013 and September 2013
- August and October DY2 Reporting
  - Receipt of Approved August DY2 Values – November 2013
- Project Management Software Implementation and Training across Region

Where we are now – RHP Plan

- Completed Phases
  - Phase 1 – Tables 5 & 6 and some of Table 4
  - Phase 2 – Quantifiable Patient Impact Confirmation
  - Phase 3 – DY2 Reporting Metrics Confirmation and Corrections
    - Similar process planned for April DY3 (2014) reporting
  - Phase 4 (In process) – Due 12/6/2013
    - Technical Corrections & Plan modifications
- To Come – Final Approvals of DY4&5 Values

Timeline

Southeast Texas Regional Healthcare Partnership
Texas Healthcare Transformation and Quality Improvement Program ☆ Medicaid 1115 Waiver

Topic	Due to Anchor	Due to HHSC
Learning Collaborative Event	NA	12/4/2013
Phase 4 Submissions	11/29/2013	12/6/2013
Annual Report	12/9/2013 (Start of Day)	12/15/2013
New 3-year Project (Pass 4) Plans	12/11/2013	12/20/2013
Projects still not initially approved from CMS	TBD	TBD
DY4&5 Valuation Feedback from CMS	TBD	TBD
DY2 October Reporting Feedback	TBD	December
IGT Due for October DY2 Reporting	NA	1/3/2014
Incentive Payment for October DY2 Reporting	NA	1/24/2014
April DY3 Reporting (1st Opportunity)	NA	4/30/2014
Final RHP Plan Due to HHSC	TBD	4/2014

Where we are now – Overall for RHP3

- Project Reviews & Approvals
- Annual Report Development and Submission
- New 3-Year Projects (Pass 4) Process Implementation
- Performance Logic Utilization
- Learning Collaborative Activities
- Newsletter Publication
- New Website Development
- GIS/Mapping Tools Discussions
- Regional Recruitment Initiative Discussions

Where we are now – State

- Project Reviews & Approvals
- New Rule related to IGT Funds for State Monitoring
- Mid-Point Assessment Guidance & Planning
- Texas A&M Evaluation Initiation
- Statewide Learning Collaborative Development
- Payment Schedule Implementation
- Uncompensated Care Tool Updates
- Waiver Extension Planning

Nicole Lievsay

EVENT OVERVIEW

AGENDA

- Anchor Team Introductions
- RHP Plan Status Update and Next Steps
- Population Health Analytics & Performance Logic
- Lunch
- Cohort Workgroup Updates
- Data Presentations & Discussion
- Regional Stakeholder Feedback/Q&A
- Next Steps

Goals, Objectives & Activities

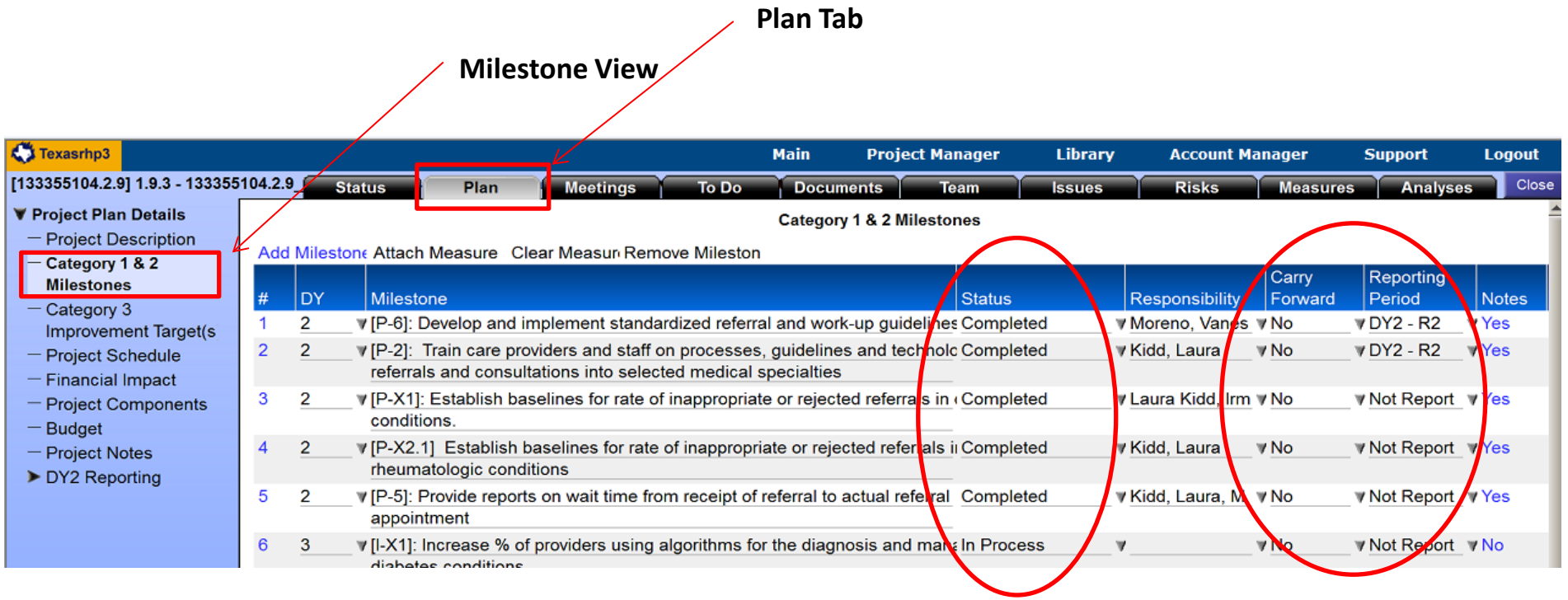
- Something for Everyone
- Learning Collaborative Metrics
  - Raise the Floor Initiatives
  - Participate – Commit – Document
- Celebration of Success
- Newsletter
- Website
- Interviews
- Maps
- Raffle

POPULATION HEALTH ANALYTICS & PERFORMANCE LOGIC

Stephen Orrell

PERFORMANCE LOGIC UPDATES

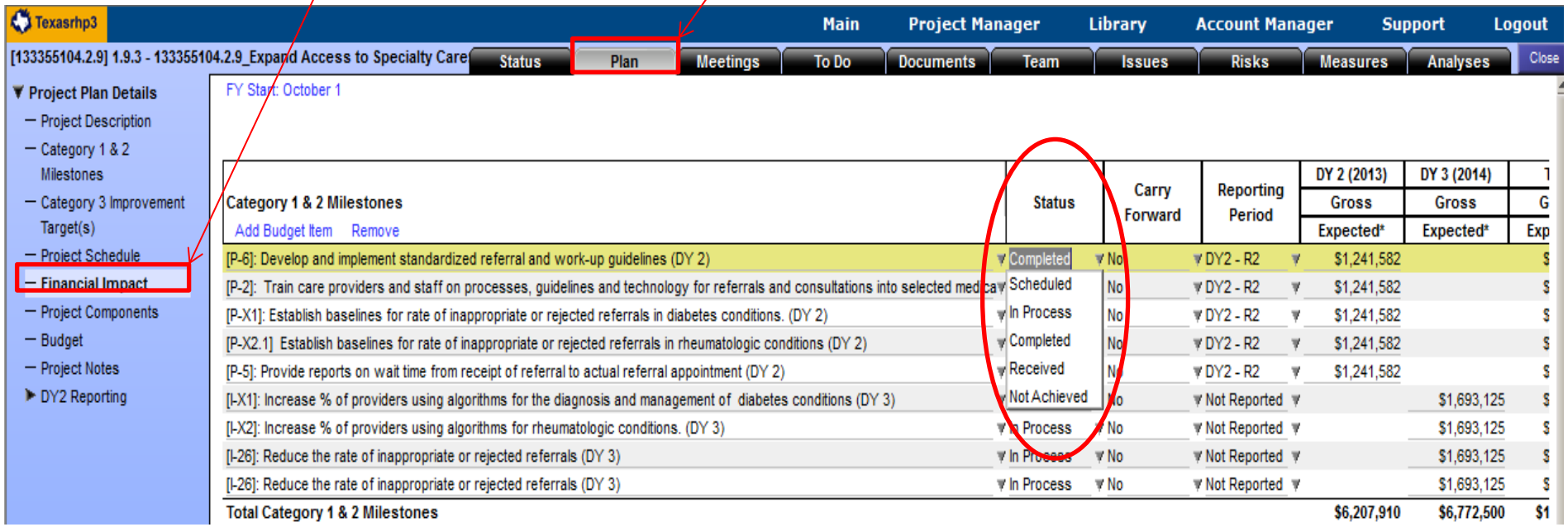
Best Practices – Tracking Milestones



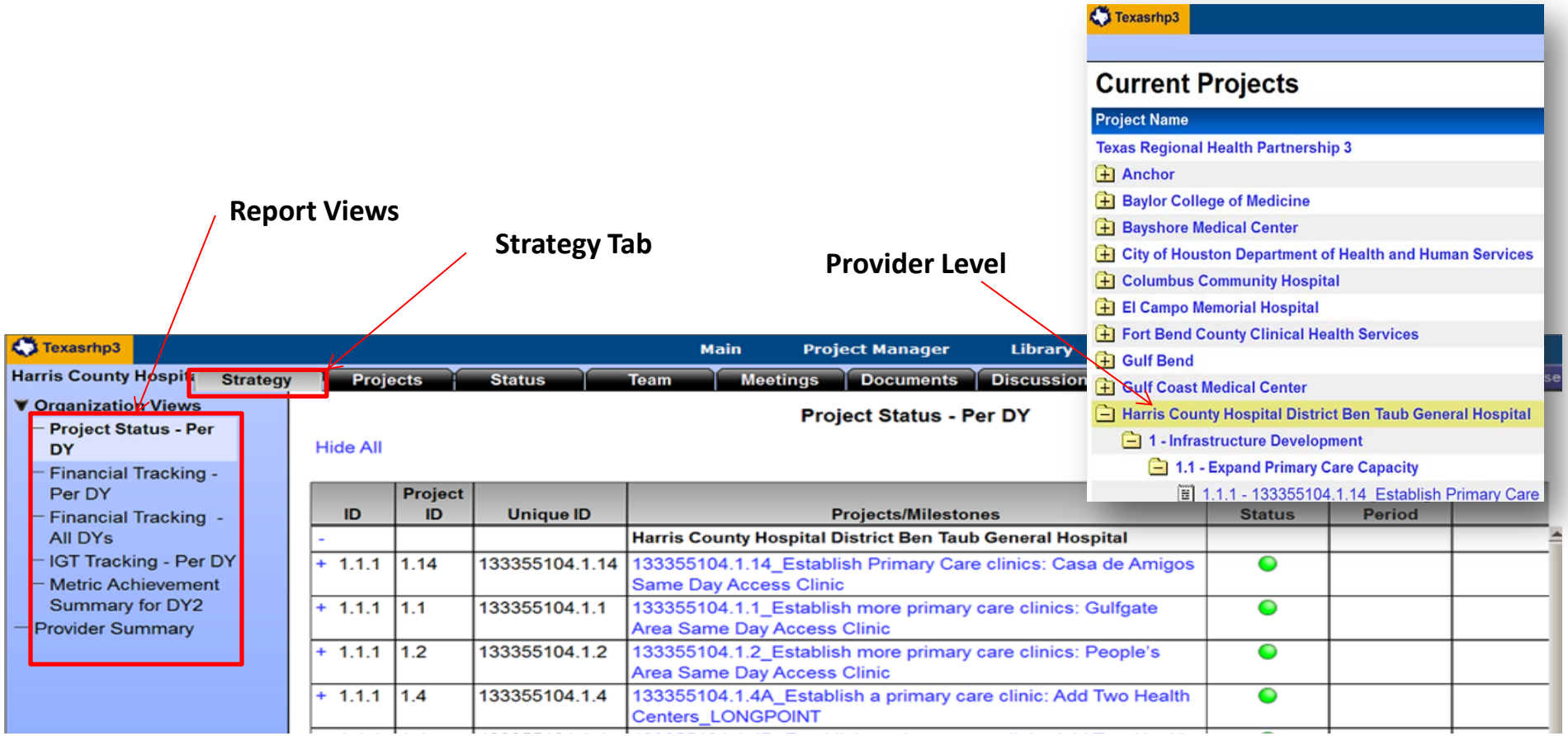
Best Practices – Financial Impact

Plan Tab

Financial Impact View



Best Practices – Project Status Reports



Best Practices – Phase 4

- Existing Fields: Verify/revise the project name, category, intervention, and details
- New Fields: %Medicaid and low income uninsured you expect to serve (from QPI spreadsheet)
- Milestones and Improvement Targets: Verify milestone data are correct
- Financial Impact: Verify the incentive amounts are consistent with your project documents
- Project Components: Add and/or update your core components as specified in the RHP Planning Protocol and project submission
- Measures: Verify the measures are named appropriately
- Issues: Add and/or update issues related to your project

Jennifer Roberts

DATA ADVISORY GROUP UPDATE

Goals:

- Data Advisory Update
- Learn how to use Performance Logic to review regional population health data and improve Category 3 and Category 4 outcomes.

  - Data Advisory Cohort Support
  - Learning Collaborative
  - Annual Report
  - Data Sharing
  - Category 4

Data Advisory Cohort Support

Data Advisory Group Members:

Dr. Connie Almeida-Ft. Bend County
Dr. Deborah Banerjee-COH
Dr. Charles Begley-UTSPH
Joe Dygert-Harris Health System
Scott Hickey-MHMRA
Annie John-Harris Health System
Ed Sturdivant-Ft. Bend County
Karen Rose-Texas Children's
Cherina Thomas-Harris Health System
Dr. Sandra Tyson-UTHSC

EC Regional Hospital Data

Table 7: Hospital Utilization and Financial Experience – 2010

County	# of Hospitals	# of Beds	ER Visits	Outpatient Visits	Inpatient Admissions	Total Uncompensated Care	Total Patient Revenue	Uncomp. Care as % of Total Patient Revenue
Austin	1	23	5,021	63,846	620	$2,234,848	$21,722,744	10.3%
Calhoun	1	25	10,325	26,427	1,321	$6,274,008	$42,694,891	14.7%
Chambers	2	39	5,299	45,164	799	$3,452,446	$20,911,428	16.5%
Colorado	3	73	10,241	101,821	9,012	$5,198,957	$63,496,889	8.2%
Fort Bend	8	771	119,979	294,483	28,743	$116,670,008	$1,995,333,877	5.8%
Harris	59	12,098	1,441,087	7,684,098	476,500	$3,317,319,516	$39,395,686,451	8.4%
Matagorda	2	69	19,368	40,480	3,156	$16,185,582	$108,463,293	14.9%
Waller	0	0	0	0	0	0	0	0
Wharton	2	99	15,530	73,437	2,695	$17,740,547	$149,056,953	11.9%
TOTAL	78	13,197	1,626,850	8,329,756	522,846	$3,485,075,912	$41,797,366,526	8.3%

Emergency Data Sources

- Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals by AHRQ *http://www.ahrq.gov/research/findings/final-reports/ptflow/index.html*
- *Caring for the Cos*tliest by Haydn Bush www.hhnmag.com
- *Better Care for Super-Utilizers* www.rwjf.org
- *Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults* by Sadowski et al.
- *"Because Somebody Cared about Me. That's How It Changed Things'': Homeless, Chronically Ill Patients' Perspectives on Case Management* by Davis et al.
- *Innovation, brainstorming reduce ER wait times* by Ashley Gould www.fiercehealthcare.com

Behavioral Health Data Resources

- TDSHS, Texas Health Care Information Collection, Hospital Discharge Data
- TDSHS, Behavioral Risk Factor Surveillance System
- UTSPH, Harris County Hospital ED Study
- UTSPH, Health of Houston Survey
- HHS http://www.hhs.gov/autism/
- CDC http://www.cdc.gov/mentalhealth/data-stats.htm
- NIH http://www.nimh.nih.gov/statistics/1nhanes.shtml
- SAMHSA http://www.samhsa.gov/data/NSDUH.aspx
- CMS http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/index.html
- Texas Connector http://www.texasconnects.org/

Jennifer Roberts

POPULATION HEALTH ANALYTICS

Category 4 PL Template

	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)
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 1,321,905	$ 3,867,634		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,847
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,581
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$ 4,167,662	$ 4,502,582
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 - Sept. 30	Oct. 1 - Sept. 30	Oct. 1 - Sept. 30
Planned Reporting Period: 1 or 2		2	2	2

Reporting Domains Summary

Providers will submit all Category 4 reporting on a template provided by HHSC. Even for the data made available by HHSC (PPEs), the provider will include this data in the Category 4 reporting template that they submit to HHSC. Providers will report all-payor data and Medicaid only data for RD-4 – RD-6.

RD ID	Domain Name	Measurement Period	Data Source	Required?
RD-1	Potentially Preventable Admissions (PPAs)	Calendar Year	HHSC	Required
RD-2	Potentially Preventable Readmissions (PPR, 30-day)	Calendar Year	HHSC	Required
RD-3	Potentially Preventable Complications (PPCs)	Calendar Year	HHSC	Required
RD-4	Patient-Centered Healthcare	Provider cycle[2]	Provider	Required
RD-5	Emergency Department	Provider cycle[2]	Provider	Required
RD-6[1]	Adult/Child Core set of Health Care Quality Measures	Provider cycle[2]	Provider	Optional

Reporting details RD1

Potentially Preventable Admissions (PPA)

- CHF admit rate
- DM admit rate
- Uncontrolled DM
- DM long-term complications/admit rate
- Behavioral Health/Substance abuse admit rate
- COPD/Adult Asthma admit rate
- HTN admit rate
- Pedi asthma admit rate
- Bacterial pneumonia/flu vax rate

Reporting details RD2

Potentially Preventable 30-Day Readmissions (PPR)

- CHF
- DM
- Behavioral health & Substance abuse
- COPD
- Stroke
- Pedi-asthma
- All cause

*Reporting exceptions (AMA, Cancer, OB, Primary psychiatric, unique populations, new patients <1 yr)

Reporting details RD3

64 Potentially Preventable Complications (PPC)

- stroke, CNS, Pneumonia, pulmonary edema, shock, CHF, Acute MI, ketoacidosis, renal failure, post-op infection, septicemia, accidental puncture/laceration/ hemorrhage during surgery, surgical complications, foreign body, device complications, anesthesia complications, other in-hospital adverse events

Reporting details RD4

Patient-centered Healthcare (PCH)

- In-patient satisfaction
- Medication management
  - Reconciled med list at discharge
    - Meds to be take after discharge
    - Meds continued from in-patient post discharge
    - Discontinued meds (prior to admission)
    - Allergies and adverse reactions to meds

Reporting details RD5

Emergency Department

- Admit decision time to ED departure time (excludes transport time)

Optional Reporting Areas (RD6)

Children

- Percentage of Live Births Weighing less than 2,500 grams
- Cesarean Rate for Nulliparous Singleton Vertex
- Ambulatory Care: Emergency Department Visits
- Pediatric Central Line associated Bloodstream Infections
- Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit

Adult

- All Cause Readmission
- Diabetes, Short term Complications Admission Rate
- COPD Admission Rate
- CHF Admission Rate
- Adult Asthma Admission Rate
- Elective Delivery
- Antenatal Steroids
- Care Transitions


HOW'S THE BIG DATA PROJECT COMING ALONG, HOSKINS?
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THANK YOU!!!

QUESTIONS

LUNCH

Margarita Gardea

COHORT WORKGROUP UPDATES & OPPORTUNITIES

Concept and Structure Overview

- Five (5) Workgroup Opportunities
  - **Emergency Center (EC) Utilization**
  - **Behavioral Health**
  - Navigation
  - Primary Care Access
  - Chronic Care Management
- No deadlines to participate/express interest
- Different levels of commitment
- Purpose and fit into overall structure
- Group Leaders and Advisory Group Liaisons

REGIONAL LEARNING COLLABORATIVE

Identifying Improvement Topics ↓

↑ Disseminating Knowledge

COHORT WORKGROUPS

↓ Identifying discrete improvement areas ↓

COHORT SUBGROUPS

WHO

Performing Providers

Other Community Stakeholders

Experts & Consultants, as needed

WHAT

Developing strategic approaches

Disseminating knowledge gained

WHEN

Workgroup Timeline – as defined by the workgroup (~3 months)

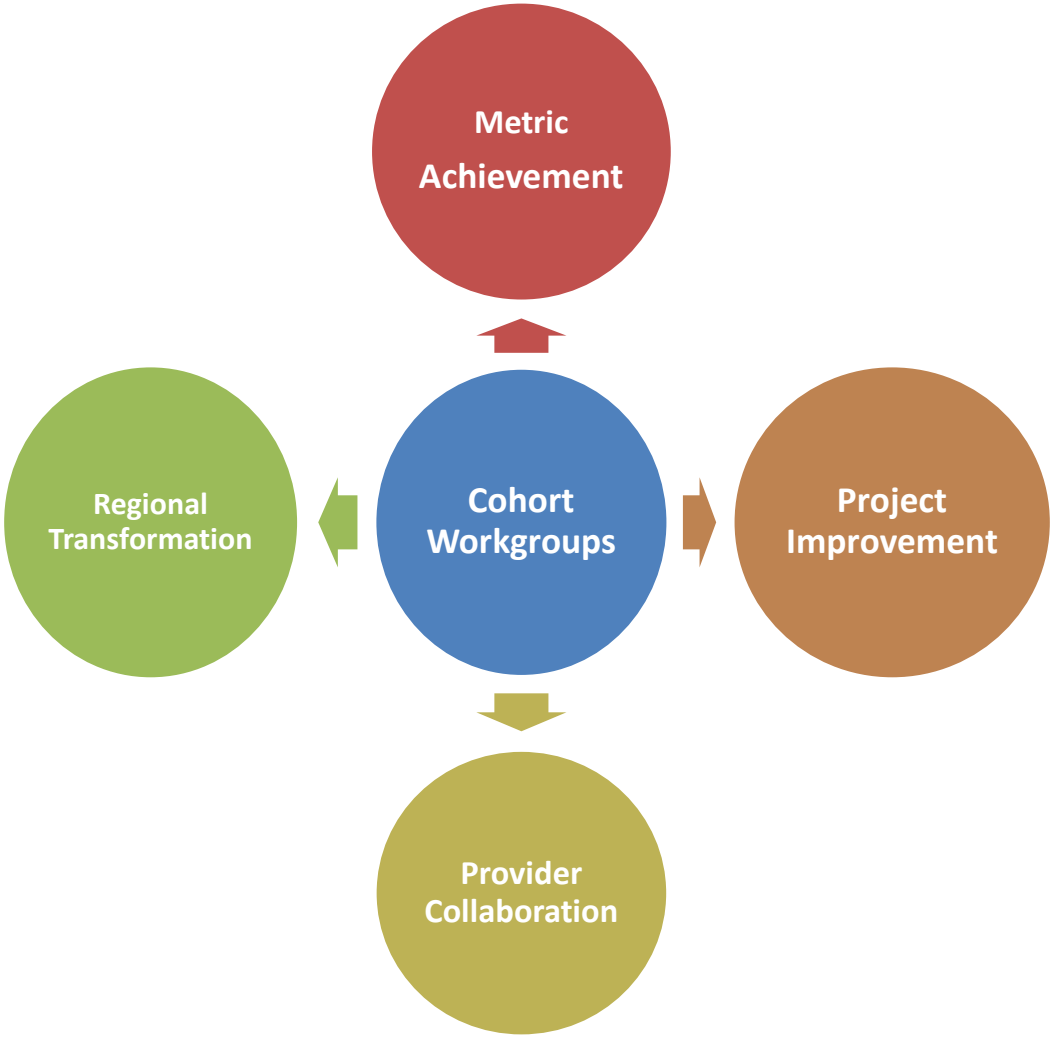
HOW

IHI Model – PDSA Cycles

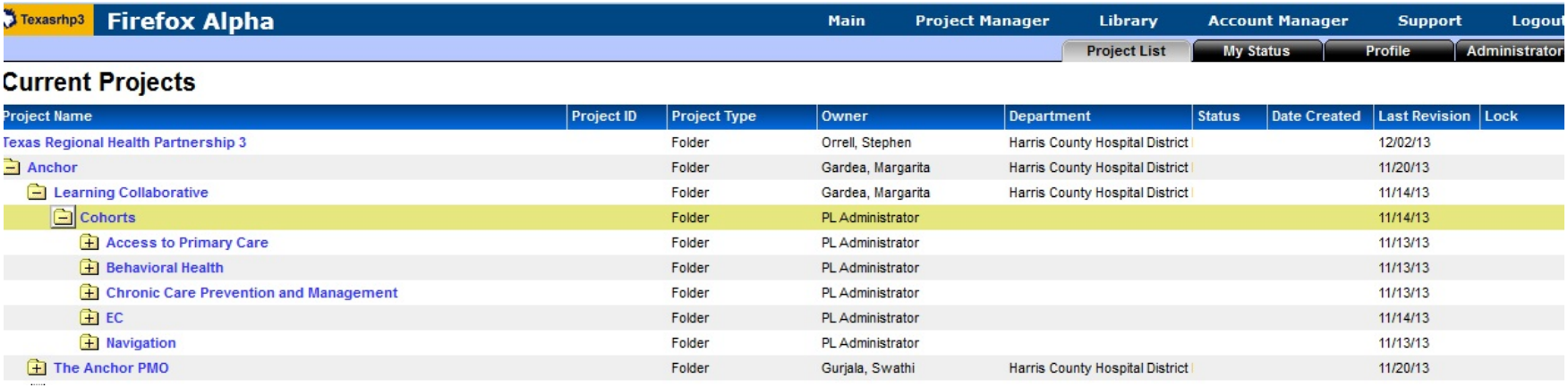
Support from QI and Data Advisory Groups

Documentation Sharing

Cohort Workgroups Outcomes



Learning Collaborative and PL



Current Projects

Project Name	Project ID	Project Type	Owner	Department	Status	Date Created	Last Revision	Lock
Texas Regional Health Partnership 3		Folder	Orrell, Stephen	Harris County Hospital District			12/02/13	
Anchor		Folder	Gardea, Margarita	Harris County Hospital District			11/20/13	
Learning Collaborative		Folder	Gardea, Margarita	Harris County Hospital District			11/14/13	
Cohorts		Folder	PL Administrator				11/14/13	
Access to Primary Care		Folder	PL Administrator				11/13/13	
Behavioral Health		Folder	PL Administrator				11/13/13	
Chronic Care Prevention and Management		Folder	PL Administrator				11/13/13	
EC		Folder	PL Administrator				11/14/13	
Navigation		Folder	PL Administrator				11/13/13	
The Anchor PMO		Folder	Gurjala, Swathi	Harris County Hospital District			11/20/13	

- Project Timelines
- Data Repository
- Goal Setting/Tracking
- Data Sharing

EC Utilization Cohort

- Kickoff Meeting – August 22, 2013
- Subgroups developed from topical interests related to EC Utilization
  - Increased Capacity
  - Navigation
  - Behavioral Health *
- Held meetings with identified group leaders for each subgroup
- Subgroups have developed charters and aims
- Timelines determined by groups

Behavioral Health Cohort

- Kickoff Meeting – November 15,2013
- Group identified challenges and obstacles
- Quality Advisory Group analyzing discussion outcomes for potential subgroups
- Next Step –
  - Set up conference calls to define subgroups
  - Identify group leaders and Advisory Group liaisons
  - Begin developing Charter and Aim Statements

Dr. Charles Begley

EMERGENCY CENTER DATA

Harris County Hospital EC Trends

UT School of Public Health

Houston Health Services Research Collaborative

Charles Begley, Keith Burau,

Pat Courtney, Ibrahim Abbass

Harris County Hospital ED Study

- Since 2002, 11-26 hospitals have shared their ED visit data with the UTSPH
- Data used to:
  - determine trends in number and type of ED visits
  - percent primary care related
  - characteristics of patients
- Today:
  - Recent data points that provide basis for the EC Cohort Subgroups

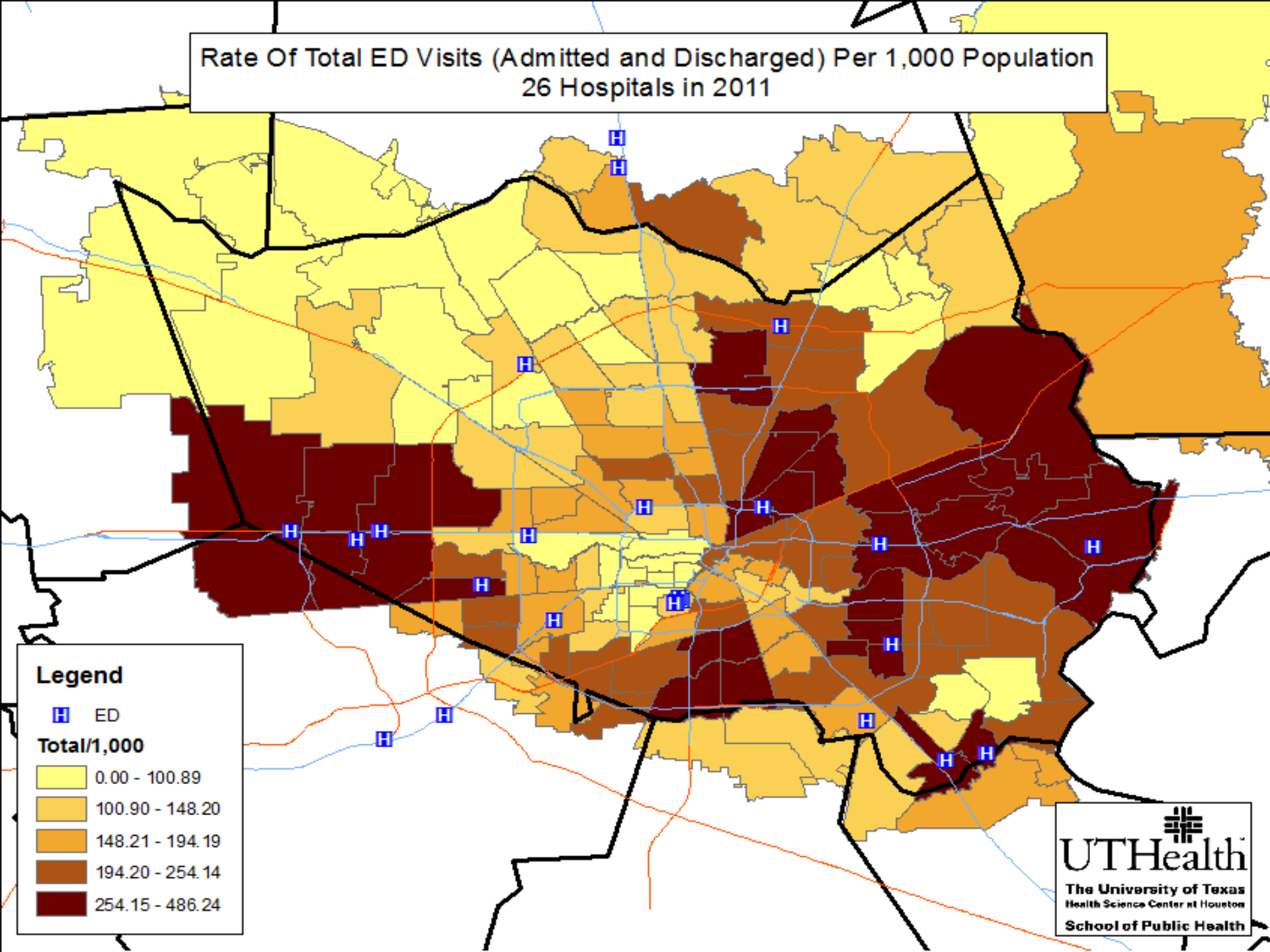
Total ED Visits

- Total ED visits to Harris County Hospitals
  - 1,798,752 in 2011
  - 1,494,120 in 2007
- Percent of total ED visits by Harris County residents
  - 83% 2011
  - 85% 2007
- Harris County population rate of ED visits
  - 314 per 1000 in 2011
  - 326 per 1000 in 2007

Characteristics of Patients

- Female Insured – 250 per 1,000/Uninsured – 311 per 1,000
- Male Insured – 189 per 1,000/Uninsured – 229 per 1,000
- Medicaid/CHIP children – 445 per 1,000
- Highest rates for the very young and very old
- Asian Black Hispanic White

  96 478 242 275

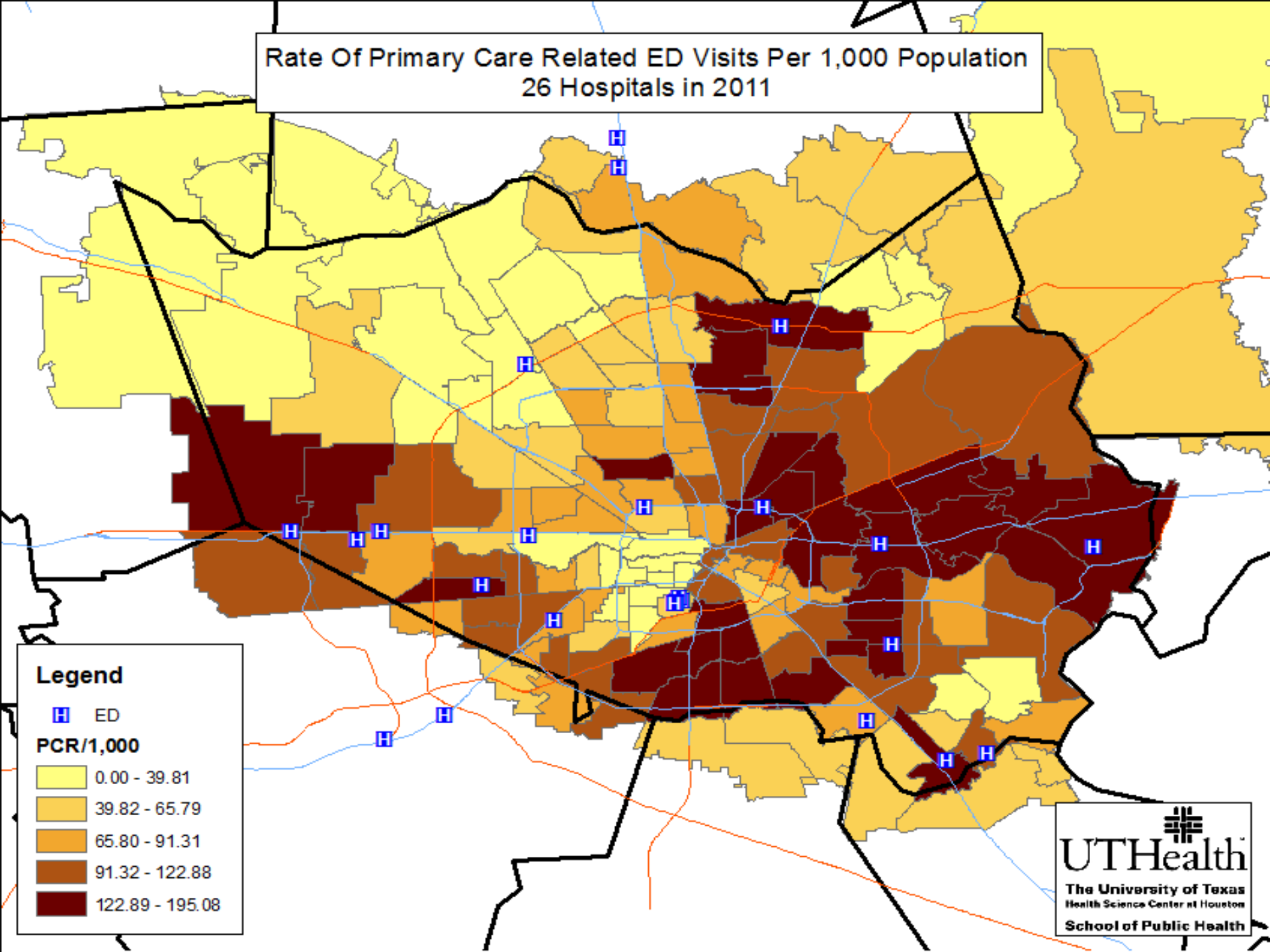

Rate Of Total ED Visits (Admitted and Discharged) Per 1,000 Population
26 Hospitals in 2011
Legend
H ED
Total/1,000
0.00 - 100.89
100.90 - 148.20
148.21 - 194.19
194.20 - 254.14
254.15 - 486.24
UTHealth
The University of Texas
Health Science Center at Houston
School of Public Health

Primary Care Related ED Visits

- 39.7% of all ED visits by Harris County residents were PCR in 2011, slightly lower than in the previous two years
  - 16.9% non-urgent
  - 17.6% primary care treatable
  - 5.2% preventable

Characteristics of Patients with PCR ED Visits

- Same pattern as total ED visits
  - Highest for Medicaid, Medicare
  - Higher for uninsured
  - Higher for very young and elderly
  - Highest for Blacks


Rate Of Primary Care Related ED Visits Per 1,000 Population
26 Hospitals in 2011
Legend
H ED
PCR/1,000
0.00 - 39.81
39.82 - 65.79
65.80 - 91.31
91.32 - 122.88
122.89 - 195.08
UTHealth
The University of Texas
Health Science Center at Houston
School of Public Health

Total and PCR ED Visits by ESI

	Total ED	Pct	PCR ED	Pct
ESI1	3,720	0.86%	170	0.09%
ESI2	64,717	14.81%	16,920	9.11%
ESI3	229,956	52.61%	103,031	54.48%
ESI4	123,876	28.34%	57,027	30.71%
ESI5	14,817	3.39%	8,560	4.61%
	437,086	100.00%	186,708	100.00%

Behavioral Health Related ED Visits

- The percentage of persons with a behavioral health diagnosis was 9.1% in 2011, its highest level in three years.

- The percentage of persons with a primary medical diagnosis as well as a behavioral health diagnosis was 6.9%, its highest level in three years.

2011 Cost of PCR ED Visits

- Total PCR Visits in 26 participating hospitals - 400,070
- Hospital ED Cost - $327,383,128
- Cost if Treated in Community Clinics - $85,098,400
- Difference - $242,284,727

DSRIP Projects Directly Aimed at ED Utilization

- 13 projects with “Appropriate ED Utilization” Category 3 Measure, 9 providers
- 5 behavioral health crisis stabilization projects
- 11 patient navigation projects

Diane Reidy

EC COHORT SUBGROUP – INCREASED CAPACITY

EC Cohort Increase Capacity

Team Members

- Dr. Charles Begley
- Cynthia Lynn
- Dr. Greg Buehler
- Jeffery Johnston
- Linda Keenan
- Dr. Sahar Qashqai
- Dr. Lee Revere
- Diane Waters
- Jannice Phillips
- Karen Rose
- Stephanie Pharr
- Margarita Gardea

EC Cohort Increase Capacity

GOALS

1. Increase the staff knowledge of non-emergent resources
2. Increase the patient's knowledge of non- emergent resources
3. Increase the numbers of patients receiving non-emergent care in a non-emergency setting
4. Decrease the number of patients with non-emergent conditions receiving care in the emergency setting

EC Cohort Increase Capacity

AIM STATEMENT

The team will develop an approved survey to administer to Emergency Department staff. This survey will be used to establish a baseline of the staff's knowledge of community resources for non-emergent care.

EC Cohort Increase Capacity

CURRENT STATUS

We developed a survey that will help us focus on a project that can assist providers in decreasing non-emergent visits.

EC Cohort Increase Capacity

LESSONS LEARNED

- It is much easier to meet by conference call.
- Although we are from different institutions we have many of the same problems
- Had to regroup several times before identifying the appropriate first step

EC Cohort Increase Capacity

NEXT STEPS

- Conduct the Survey
- Analyze the results
- Share the results
- Develop an Action Plan based on the survey results

EC Cohort Increase Capacity

REQUEST FOR COMMITMENT

We would like to request that Performing Providers with Emergency Departments participate in this survey and distribute to appropriate ED Staff.

Dr. Sandra Tyson

EC COHORT SUBGROUP – NAVIGATION

Navigation LC Charter

Leader: Sandra K. Tyson, PhD

Advisory Group Members:

- Karen Rose – QI
- Deborah Banerjee, PhD – Data
- Joe Dygert – Data

Navigation LC Charter

Navigation projects represented

- Emergency Center
- Hospital Admissions with no PCP
- Behavioral Health
- Levels of Care
- Social Services
- Other

Navigation LC Charter

Goal of Navigation

- To reduce the fragmentation of care experienced by the patient to ensure continuity of care

Best Practice for Navigation

- To provide the patient with the option best suited to them without regard for provider interests

Navigation LC Charter

Challenges to meeting this ideal

- Ability to follow patient across provider lines
  - Conflicts of interest
  - Competition
  - Patient confidentiality
- Knowledge of all resources available

Navigation LC Charter

Process Improvement Area

- Continuity of care for patients navigated across organizational lines
- Better navigation tools

Navigation LC Charter

AIM #1

We will develop a statement of commitment to our community regarding our collaborative approach to regional navigation by 12-4-13 and obtain all signatures by 3-31-13.

- Can be used as a framework for building more specific agreements/MOUs between partners.
  - Navigator to patient follow-up
  - Provider to provider follow-up
- Can be posted within our facilities.
- Will be translated into Spanish and other targeted languages.
- Will be shared with the community via various news outlets.

Our Commitment to You

We commit to work together to help patients access the health care they need. As partners in health care, we will:

- Help our patients get timely appointments for care.
- Seek to find the most convenient source of care for our patients.
- Arrange for the type of care that is best for the patient.
- Support our patients in obtaining other needed services.

Your Logo Here

Navigation LC Charter

AIM #2

We will identify/develop a navigation tool by the end of DY3 to be made available to all navigators in RHP3 during DY4.

- Web-based
- Searchable
- Includes providers, specialties, all medical services, social services, transportation options, scheduling, etc.
- Plans for sustainability

Navigation LC Charter

Barriers to achieving:

- *Help our patients get timely appointments for care.*
  14 BARRIERS
- *Seek to find the most convenient source of care for our patients.*
  8 BARRIERS
- *Arrange for the type of care that is best for the patient.*
  13 BARRIERS
- *Support our patients in obtaining other needed services.*
  12 BARRIERS

Potential Solutions—15

Ability to address a solution regionally

Provider Interest

Navigation LC Charter

Training

- AIM #3
  - We will arrange for training for RHP3 navigators in the use of the new web-based navigation tool during DY4.
- AIM #4
  - We will work to develop standardized learning objectives for the development of post, 160-hr CHW training that is based upon provider-identified training needs.

REGIONAL DATA SHARING

Dr. Jim Langabeer

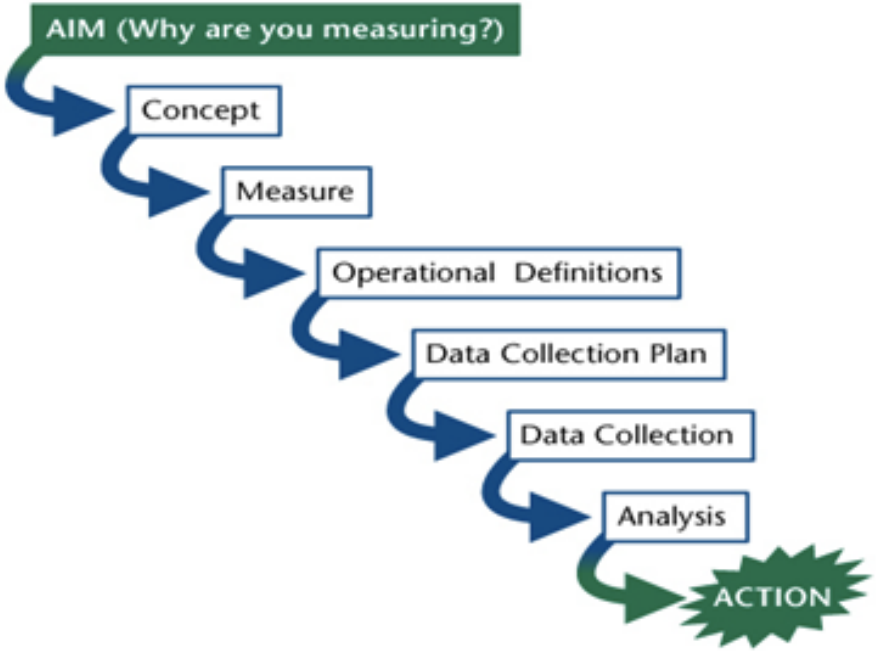
GREATER HOUSTON HEALTHCONNECT

The Regional Health Exchange: Greater Houston Healthconnect

James Langabeer, PhD
CEO, Greater Houston Healthconnect

Greater Houston HEALTHCONNECT

Your DSRIP Project "Measurement Journey"



Source: *Lloyd, R. Quality Health Care: a guide to developing and using indicators. Jones & Bartlett Publishers 2004*

Data Sharing for DSRIP projects

- Measuring outcomes and improving care requires data and information
- Sharing of this information however needs to be well-thought out
- Several ways to get data – fax, email, manual entry, EHR systems, PACS, electronic interfaces between systems, etc.

Data Sharing for DSRIP projects

Greater Houston HEALTHCONNECT

- Peer-to-peer Sharing Limitations
  - Expensive
  - Gets you only certain data fields
  - Is limited to only one or two organization
  - Requires storage of confidential HIPAA data in multiple sources
  - Requires technical resources and knowledge of reporting packages, interfaces, and data models
  - Requires ongoing maintenance overall inefficient
- Need for a better community-based solution

Greater Houston HEALTHCONNECT

Health Information Network (hub)

A health information exchange moves patient information electronically among physician offices, hospitals and other health professionals directly involved in a patient's care, such as pharmacies and labs.

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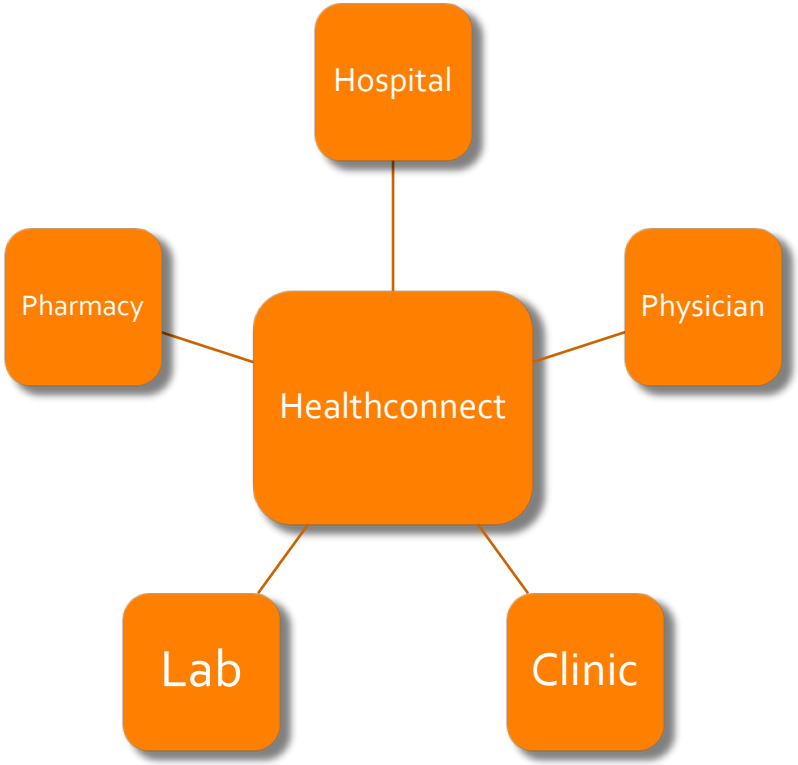
Advantages of a Data Hub

- Many of the major data sources (hospitals, clinics, labs) already connecting
- No need for centralized, redundant data storage
- Proven HIPAA compliance with community standards
- Relatively low cost for participation
- The only way to view broad community-wide data at patient-level
- Very little technical barriers to viewing or sharing
- The solution already exists

The Regional Health Information Exchange



Idea initially developed out of the 2004 Greater Houston Partnership Task Force

- Endorsed by the Harris County Healthcare Alliance
- Harris County Medical Society
- University of Texas SPH Fleming Center for Healthcare Management
- Harris County Academy of Family Physicians
- City of Houston

About Healthconnect

- Independent, non-profit 501c(3) organization, founded in 2012
- Led by a team of seasoned healthcare administrators, researchers, and technology leaders
- Board of directors comprised of the major hospital systems, physician leaders, and business executives
- Partnered with UT School of Public Health
- Funded initially through seed capital from the Department of Health and Human Services Office of the National Coordinator
- Sustained from ongoing participation fees from members

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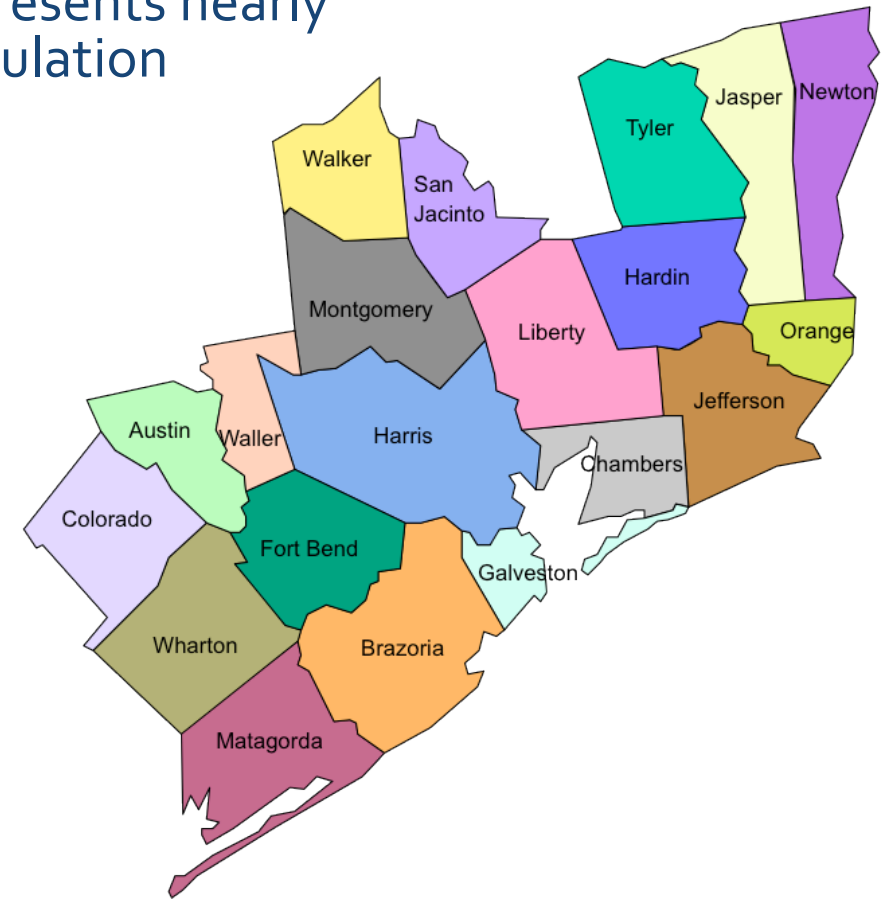
Broad Geographic Reach

- Southeast Texas region represents nearly 25% of the entire Texas population
- 6.9 million population
- 14,000 physicians
- 1,402 pharmacies
- 133 hospitals of all types



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Community Vision of Healthcare in 2017

- Connect 50% of all physicians and 60% of all hospitals
- Eliminate 1,350 adverse drug events totaling $7.9 million for hospitalized patients per year
- Avoid 2,400 readmissions totaling nearly $12 million per year
- Reduce duplicative studies by 80,000 totaling $46 million per year

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Participants

Next Steps

- Determine your specific data requirements, timing, and resources
- Contact Healthconnect to discuss specifics of your project's needs for information sharing
- Think big about possibilities with your projects with broader data access

Your Doctors are Connected, Your Medical Records are Protected

Tim Tindle

MEANINGFUL USE

DATA SHARING TABLETOP ACTIVITY & REPORT OUT

Data Sharing Survey Results

- 48% currently sharing data with other providers
- 22% are not sharing data
- 26% are unsure if they are sharing data
- 4% did not answer

Data Sharing Survey Results

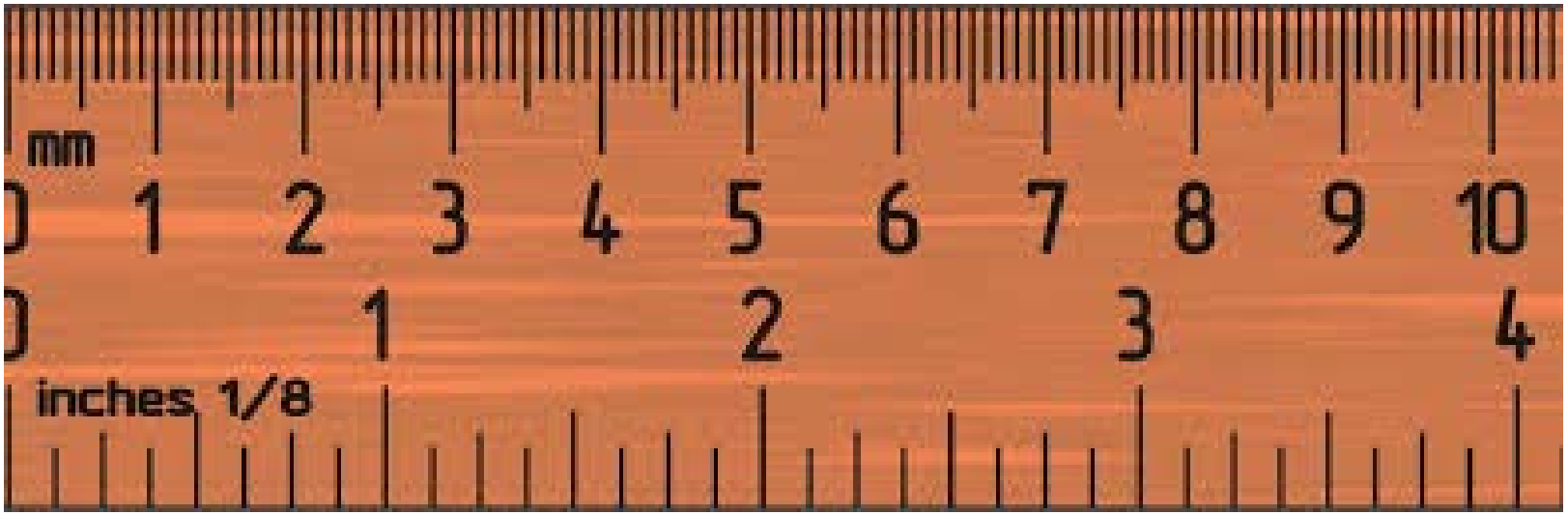
- 74% using EHR
- 42% manual data sharing
- >40% want to share data on: EC, BH, Labs, Primary Care, Specialty Care, Community Needs, Social Services

Instructions

- Identify a table topic you are interested in or is your area of expertise
- Three tables/topic
- Only 2 people from the same organization at each table , *PLEASE!*

Table Tops	
Data Management	Primary Care
Business Office/Finance	Emergency Care
Quality Management	Specialty Care
Navigation	Behavioral Health
Public Health	Disease Management
Social Services/Community Services	Diagnostic Services (Rx, Lab, Imaging, etc…)

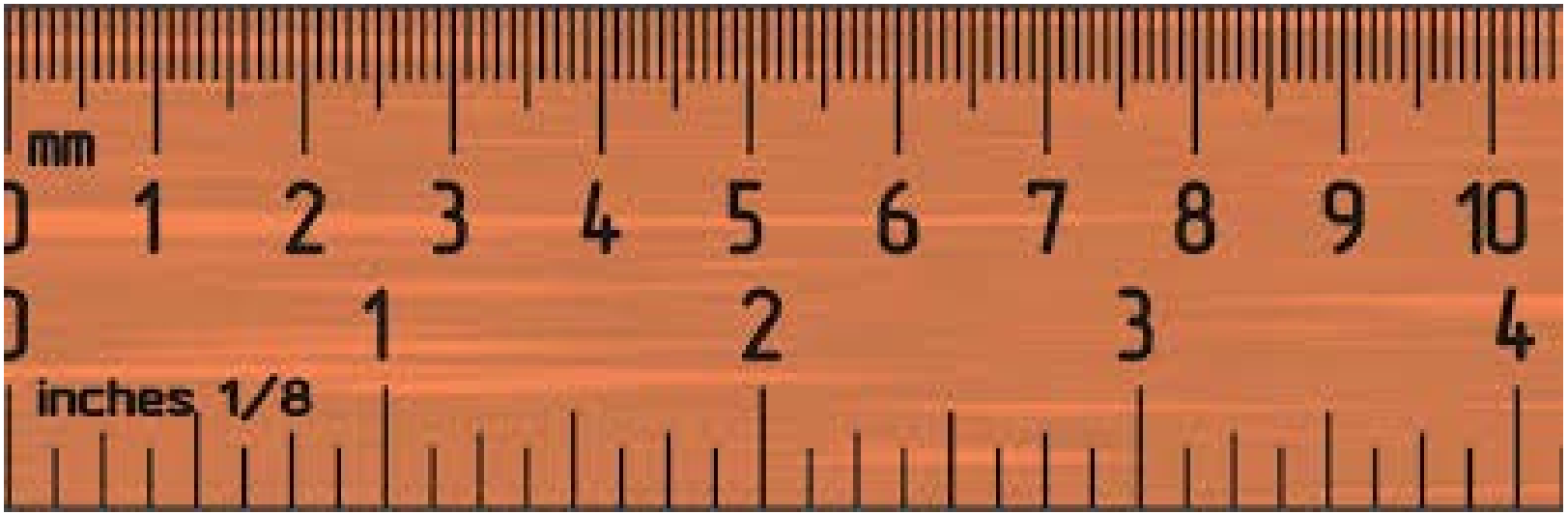
Sharing Data: Where Are We Now



IMPORTANCE

On a scale of 1-10, how <u>important</u> is it for your organization to share data? Discuss…

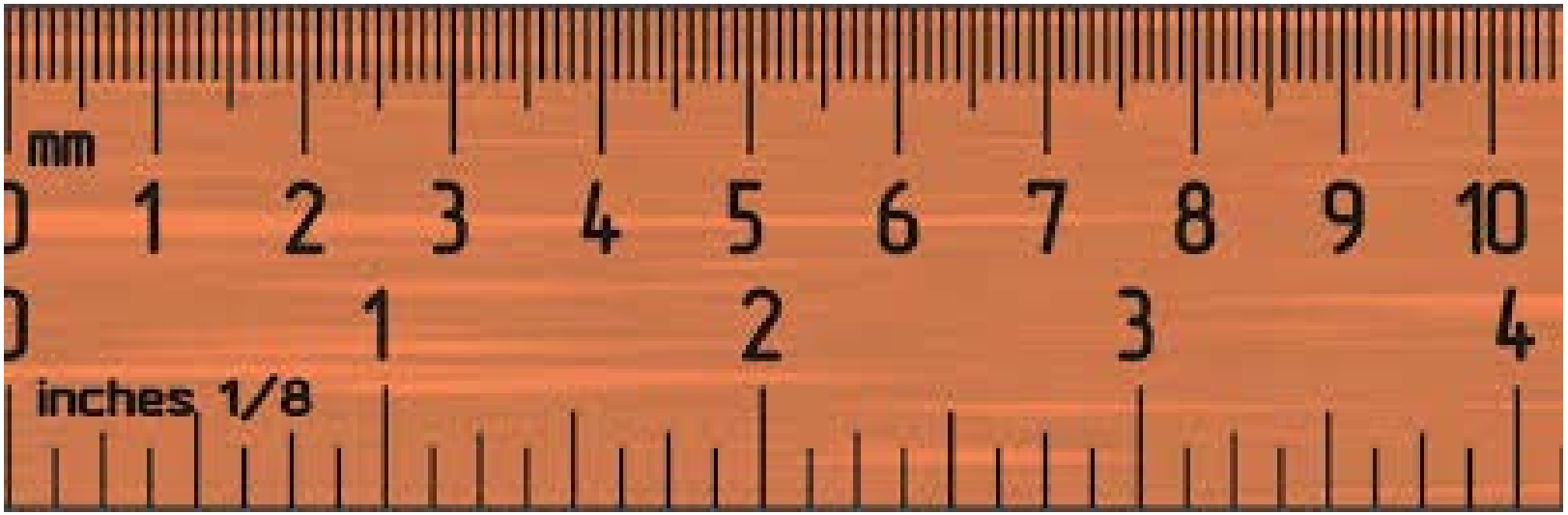
Sharing Data: Where Are We Now



CONFIDENCE

On a scale of 1-10, how confident are you of your organization's ability to share data? Discuss…

Sharing Data: Where Are We Now

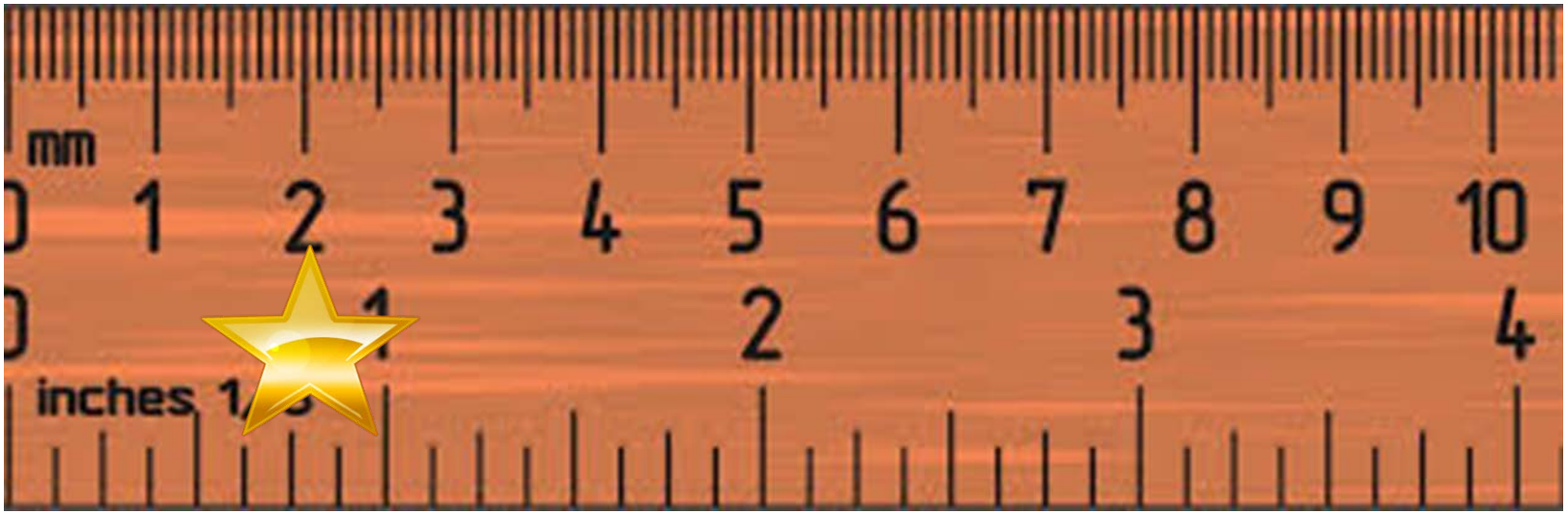


READINESS

On a scale of 1-10, how <u>ready</u> is your organization to share data? Discuss…

Next Steps:

Where Can We Go From Here



What will it take to move your organization closer to a 10 for all three rulers???

READ ALL ABOUT IT!

How will you transform healthcare by sharing data?

Nicole Lievsay

RAISE THE FLOOR INITIATIVES SUMMARY

Commitments & Feedback

- Learning Collaborative Metric Achievement

- Commitments
  - ✓ Participate
  - ✓ Commitment Card
  - ❑ Document Outcomes

- General Feedback

Nicole Lievsay

CLOSING: Q&A AND NEXT STEPS

Next Steps

- Analyze stakeholder feedback from December 4th event
- Identify additional cohort workgroups members
- Schedule other learning opportunities (webinars, newsletters and monthly call topics)
- Schedule next celebratory event – Final Plan
- Develop process for ad hoc learning needs
- Gather and analyze needed and reported data
- Prepare Annual Report
- Prepare for Mid-Point Assessment

Resources

- Ongoing Communications
  - Newsletter
  - Leadership Forums
  - New Website (Planned)
- Region 3 Website: www.setexasrhp.com
- Contact Information:

  setexasrhp@harrishealth.org


preparation
Confirmation
eligible
Initially
Identification
Reporting
Performing Payment
additional
approval
milestone
described
submission
remaining
services
Plan
Innovation
objectives
metrics
process
include
available
Phase
achieving
funding
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reporting
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Waiver
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Uncompensated
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review
Commission
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facilitates
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plan
quality
waiver
RHP
entity
Quality
payments
outcome
plans
including
prior
development
Health
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CMS
Review
UPL
individuals
measures
Redesign
New
targets
participants
Providers
Approved
provider
outlined
milestones
Improvements
allocations
Texas
funds
one
allocation
hospitals
Improvement
participation
Patient
Protocol
time
Program
delivery
Medicare
number
investments
managed
public
healthcare
divided
participating
feedback
within
hospital
Services
required
programs
Provider
Centered
requirements
must
minimum
corresponding
menu
federal
primary
Project
Population-focused
supplemental