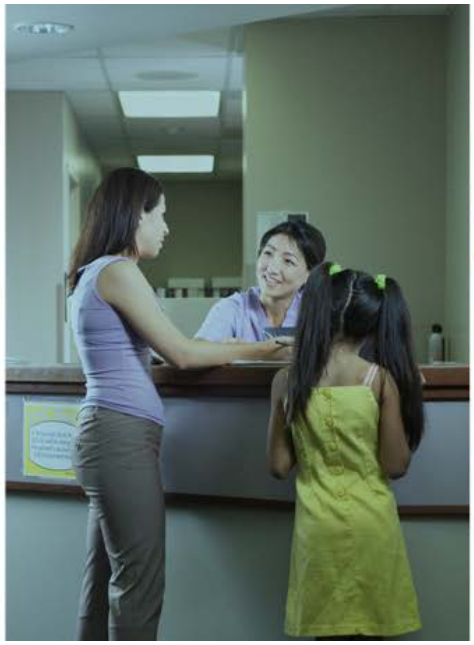





Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

Learning Collaborative Conference

Region 3

June 5th 2014

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

WELCOME!

"We delight in the beauty of the butterfly, but rarely admit the changes it has gone through to achieve that beauty."
— Maya Angelou

OVERVIEW OF THE DAY

- UPDATES
- AGENDA
- PARKING
- COMMITMENTS
- CEU SURVEY
- COMMITMENT TO THE COMMUNITY
- YOUR ANCHOR TEAM

YOUR ANCHOR TEAM

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












RHP UPDATES FROM AROUND THE STATE – RHPS 1, 2, & 6

UT HEALTH NORTHEAST

The Northeast Texas Regional Healthcare Partnership: Working Together to Improve Healthcare

Presented to the RHP 3
Regional Learning Collaborative Meeting

Daniel J. Deslatte, MPA

June 5, 2014

Presentation Outline

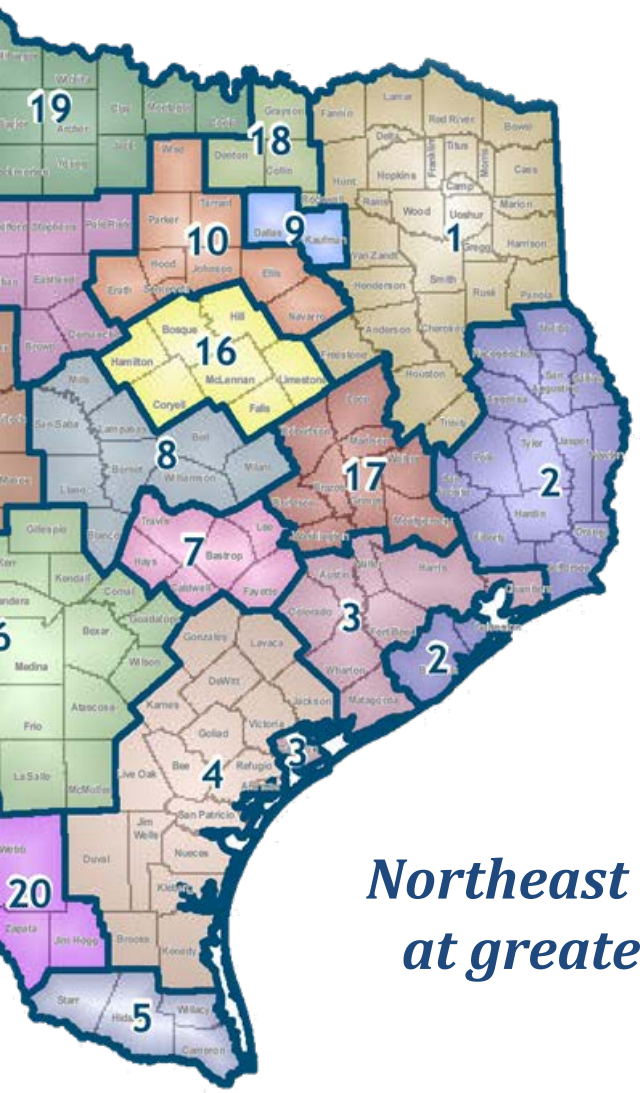
- **The Region:** Highlight of key demographic data, community needs, and health outcomes.

- **The Plan:** Overview of public and stakeholder engagement, summary of projects by provider type and subject, and learning collaboratives.

- **Lessons Learned:** Key challenges and opportunities.

UTHEALTH NORTHEAST

Northeast Texas



	Northeast Texas	Texas
Population	1.3 million	25.1 million
Counties	28	254
Rural Population	53.9%	17.5%
Median Age	41	33.6
Per Capita Income	$19,386	$24,870
Bachelor's Degree	13.2%	25.8%
Minority Population	24.8%	29.6%
Hispanic Origin	13.1%	37.6%

Northeast Texas is older, poorer, less well educated and at greater risk of early death than the state average.

Community Needs Assessment

- **Primary Care Shortages:** All but three counties are medically underserved. In some areas, the ratio of patients to primary care providers is ***five times the statewide average and eight times the national benchmark***.

- **Behavioral Health Professional Shortages:** The ratio of patients to mental health providers in some communities is ***nearly 25,000 to 1, seven times the state average.***

- **Financial Access Challenges:** Approximately 54% of residents are uninsured or on some form of publicly funded insurance.

Community Needs Assessment

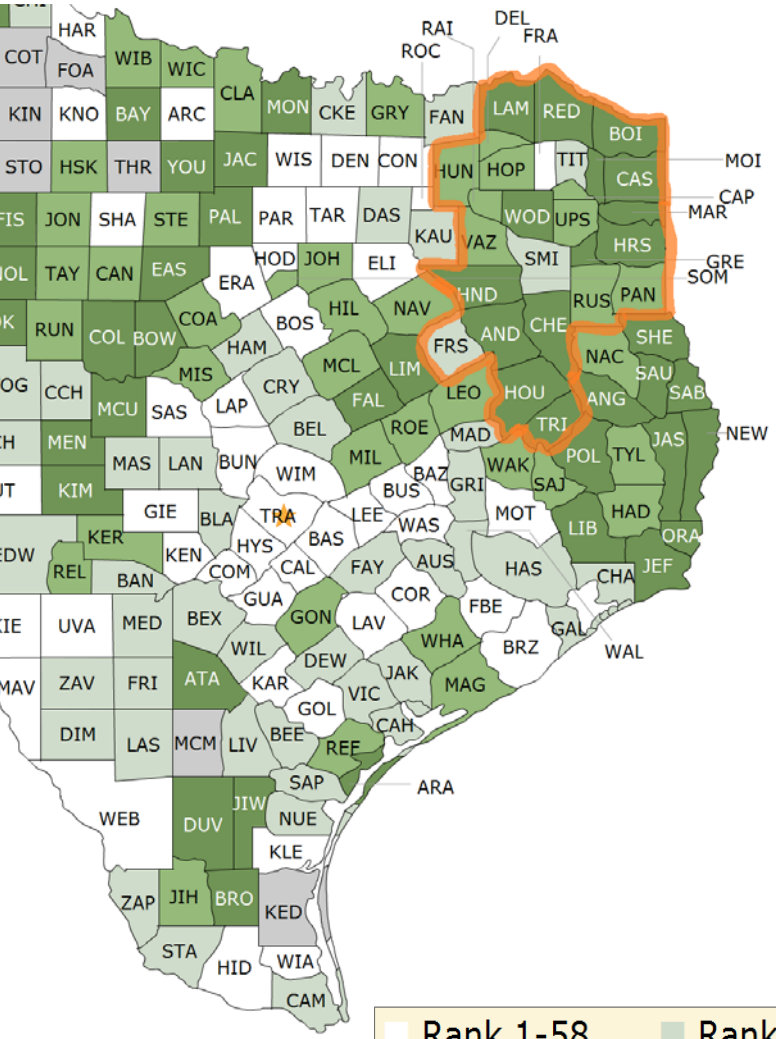
- **Chronic Disease:** The region has higher rates of high blood pressure, lower rates of cholesterol screening, and higher age-adjusted invasive cancer incidence and mortality rates than the state average.

- **Potentially Preventable Hospitalization Rates:** The majority of counties have higher rates for PPH than the state average, resulting in ***$2.8 billion in unnecessary charges from 2005-2010.***

- **Mental/Behavioral Health:** An estimated 85,000 individuals in the region have a serious mental illness and 113,000 need treatment for substance abuse but do not receive it. The region has a suicide rate 65% higher than the rate for Texas.

UTHEALTH NORTHEAST

Health Outcomes & Risk Factors



- **Health Outcomes:** Over half of counties in Northeast Texas are in the bottom quartile of counties in health outcomes.

- **Health Risk Factors:** Over one third of counties in Northeast Texas are in the bottom quartile of counties in health risk factors.

Rank 1-58 | Rank 59-116 | Rank 117-174 | Rank 175-232 | Not Ranked

UTHEALTH NORTHEAST

Plan Development

- Three behavioral health work sessions involving mental health centers, hospitals, and other stakeholders.

- Public process to inform and engage the general public and seek feedback on projects, including 13 meetings with county officials and councils of governments.

- Over three dozen public outreach activities across 15 different communities in Northeast Texas.

- Use of a *National Institutes of Health* scoring tool and external quality reviewers to help providers select the most transformative projects.

Regional Health Plan

- Clear focus of the regional health plan is on addressing the most pressing community needs.

Community Need	Total Projects	% of Plan
Primary & Specialty Care	37	41.99%
Behavioral Health Services	21	17.99%
Care Navigation (ED Use)	13	10.72%
TOP 3 PROJECT AREAS:	**71**	**70.7%**

Projects by Provider Types

• The regional health plan includes projects by a diverse provider base.

Provider Type	Total Projects	% of Plan Projects
Public Hospital or Academic Health Science Center	38	40.0%
Privately Owned or Controlled	37	38.9%
Local Mental Health Authority	18	18.9%
Public Health Department	2	2.1%

- Data does not reflect collaborative relationships.

UTHEALTH NORTHEAST

Sample Projects

- **Primary/Specialty Care:** Creation of medical homes, expanded hour clinics, pediatric obesity interventions, emergency room diversion programs, pediatric asthma.

- **Behavioral Health:** Crisis stabilization centers, jail diversion projects, behavioral-physical health integration projects, technology infrastructure to better coordinate between counties and providers.

- **Other:** Community health worker training, potentially preventable admissions/readmission reduction programs, cancer screening and early detection.

Learning Collaborative Plan

- A learning collaborative is an evidence based process designed to identify, test, and evaluate best practice models in healthcare delivery.

- The region's learning collaborative is guided by a regional advisory committee made up of stakeholders from all DSRIP entities. The advisory committee helps the Anchor select topics and identify clinical experts.

- Focus will always include a behavioral health topic, but the region will also work on potentially preventable admissions/readmission.

Learning Collaborative Plan

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Lessons Learned

- **Challenges:**
  - Very poor health outcomes combined with a time-limited Waiver.
  - Rolling approvals.
  - Changes to outcome and quality measures.
  - Uncertainty of funding.
  - Performance based projects.

- **Opportunities:**
  - Regional approach has led to significant collaboration and partnerships among providers.
  - Learning collaborative offers more opportunity for improvement in quality and cost.

Contact Information

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Progress on the Healthcare Transformation Waiver in RHP 2

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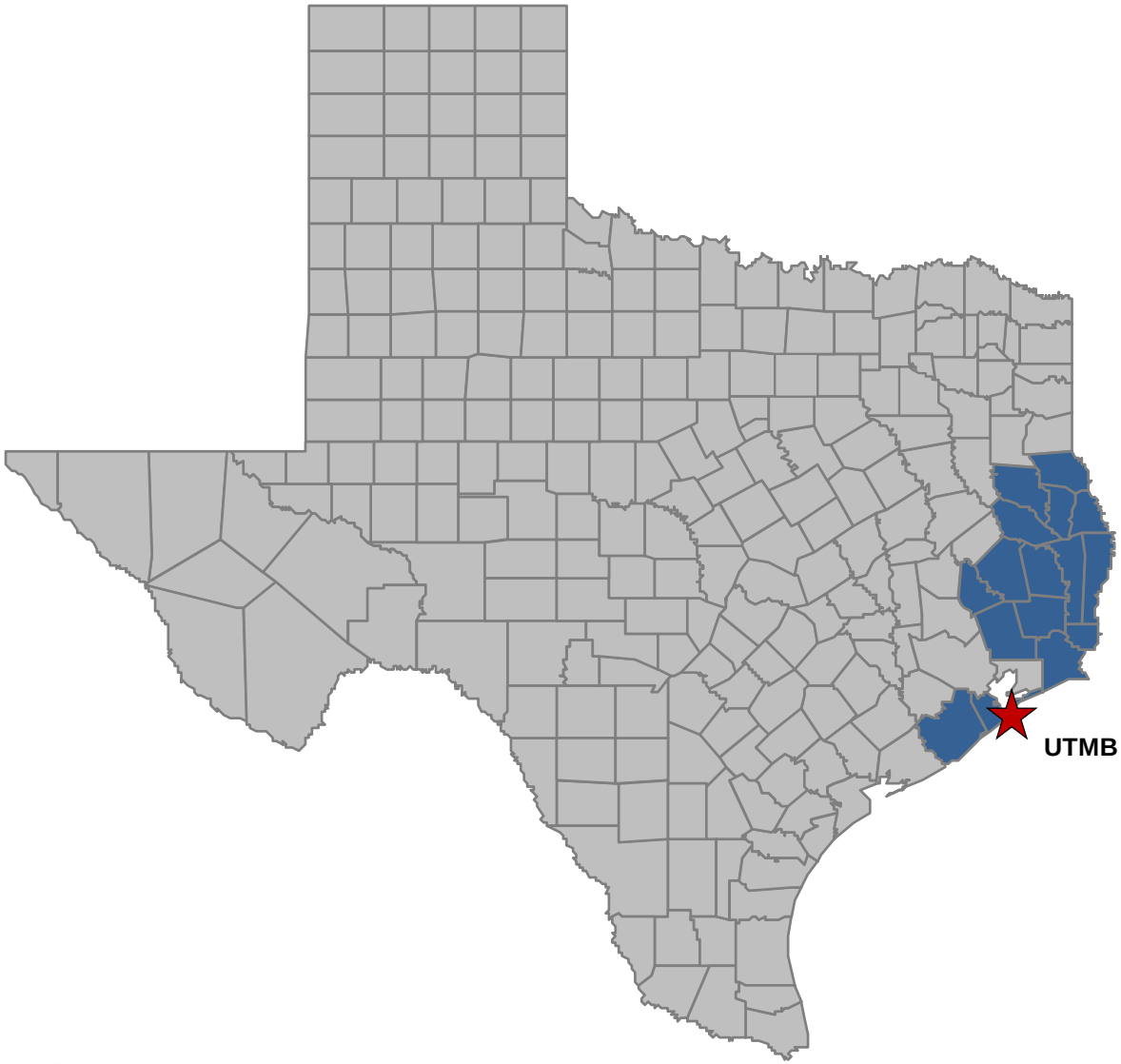
Director, Waiver Quality Operations
Office of the President

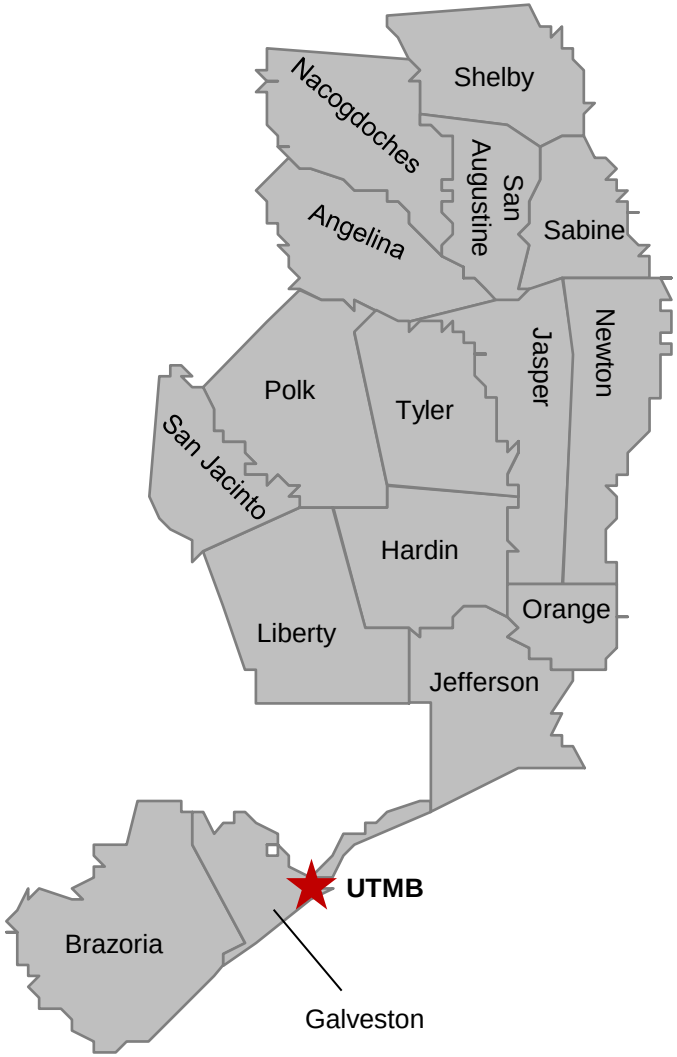
utmb Health

June 5, 2014

Regional Health Partnership: Region 2



Regional Health Partnership: Region 2



- 16 counties
- Population of nearly 1.5 million people
- Covers nearly 14,500 square miles
- Urban and rural with varying infrastructure challenges
- 25% of population is uninsured
- 27% of population is on Medicaid or Medicaid/Medicare (dual eligible)
- More than 50% of the region is designated as Health Professional Shortage Area in Primary Care and/or Mental Health

RHP 2 Community Needs Assessment

- Access barriers
  - Personal resource challenges (i.e. transportation)
  - Lack of insurance coverage
- Health care workforce shortages
  - Physicians (primary and specialty care)
  - Mental/behavioral health providers
  - Allied health professionals (mid-level providers, nurses, etc.)
  - Dentists
  - Community Health Workers/Patient Navigators
- High ED utilization and 30-day readmission rate
- Chronic disease Incidence
  - Diabetes
  - Heart & vascular related diseases
- Mental health related morbidity and mortality

RHP 2 Regional Goals

- Expand access to and coordination of:
  - Patient-centered primary care
  - Behavioral health care services
  - Health promotion and disease prevention
  - Specialty care services
  - Chronic disease management

- Improve quality of care through:
  - Continued process improvements
  - Collaborative learning opportunities
  - Development of innovative solutions

- Grow health system resources by:
  - Expanded and enhanced healthcare workforce training
  - Educate future healthcare professionals through interdisciplinary training that contemplates tomorrow's delivery system

RHP 2 DSRIP Performing Providers

Facility Name	Number of Beds*	Total Discharges*
Angleton-Danbury Medical Center	62	3,460
Baptist Hospitals of Southeast Texas-Beaumont	390	16,475
Brazosport Regional Health System	119	5,100
CHRISTUS Hospital-St. Elizabeth	487	20,501
Nacogdoches Memorial Hospital	142	6,562
Sabine County Hospital	25	305
Tyler County Hospital	25	816
UTMB Hospital	400	22,224
UTMB Physician Group Practice	NA	NA
Spindletop Center	NA	NA
The Gulf Coast Center	NA	NA
The Burke Center	NA	NA
Tri-County Services	NA	NA
Galveston County Health District	NA	NA

RHP 2 Highlighted Projects

Provider Name	Project Description	Target Population
Tri-County Services	Expand access to psychiatry services through proactive medication and care coordination.	Persons with psychiatric conditions that interfere with global functioning.
The Burke Center	Expand access to psychiatry services by expanding the current telemedicine infrastructure.	Persons with significant mental illness unable to access care due to distance or lack of capacity.
Tyler County Hospital	Improve the patient experience and quality of patient care by providing training to all staff in communication and patient satisfaction.	Patients served by Tyler County Hospital.

RHP 2 Highlighted Projects (3-Year)

Provider Name	Project Description	Target Population
UTMB	Expand capacity for Pediatric Specialty care services (such as Cardiology, Endocrinology, etc.)	Children in Jefferson and surrounding counties needing Specialty Care
Gulf Coast Center	Provide Peer Support structure in existing adult mental health clinics.	Persons with severe mental health diagnoses that may improve through non-clinical interventions for wellness.
Nacogdoches Memorial Hospital	Expand capacity and services for expectant mothers.	Maternal patients in Nacogdoches and surrounding counties

RHP 2 Learning Collaborative Efforts

- Reduction in Readmissions Collaborative
  - In person meetings
    - January 23, 2014 (13 organizations participated)
    - May 14, 2014 (12 organizations participated)
  - Utilization of BOOST model (Better Outcomes for Older adults through Safe Transitions) from the Society for Hospital Medicine
- Behavioral Health Collaborative
  - In person meetings
    - March 20, 2014 (21 organizations participated)
    - September 12, 2014 (scheduled)
  - Brainstorm session with key stakeholders in December 2013
  - County-specific meetings held in Brazoria County and Jefferson County to share collaborative plan, current projects and gather feedback on concerns and goals
  - Four topics of focus: integration of primary care and behavioral health, crisis services, substance abuse and peer support services

Challenges/Concerns

- Workforce shortages
  - Multiple projects have expressed difficulty in finding qualified individuals to hire to fulfill project goals
- Intergovernmental Transfer (IGT)
  - Cash flow issues for smaller organizations creates challenges
  - Challenge in funding UC, DSH and DSRIP for greatest participation
- Delays made it difficult for organizations to collaborate on projects
- Competing state and federal programs, such as State Innovation Model (SIM) initiative creates confusion and concern over “double-dipping”
- County government participation

Opportunities

- Development of competencies for new reimbursement models and population health management
- Establishment of new affiliations and community relationships to improve coordination of and access to healthcare services
- Engagement of regional stakeholders, including additional providers, community organizations and patients
- Advancement of the triple aim in Region 2 through enhanced collaboration
  - Improve the patient experience (quality and satisfaction)
  - Improve the health of populations
  - Reduce the per capita cost of care

Questions?

http://www.utmb.edu/1115/

Region 6:
Improving Health and Transforming Care through the Texas 1115 Waiver

RHP 3 Learning Collaborative
June 5, 2014

Carol A. Huber, MBA
Director, Regional Healthcare Partnership Facilitation
University Health System
San Antonio, TX

Presentation Outline

- Overview of Region 6
- Overview of the RHP 6 Plan and project highlights
- Lessons Learned

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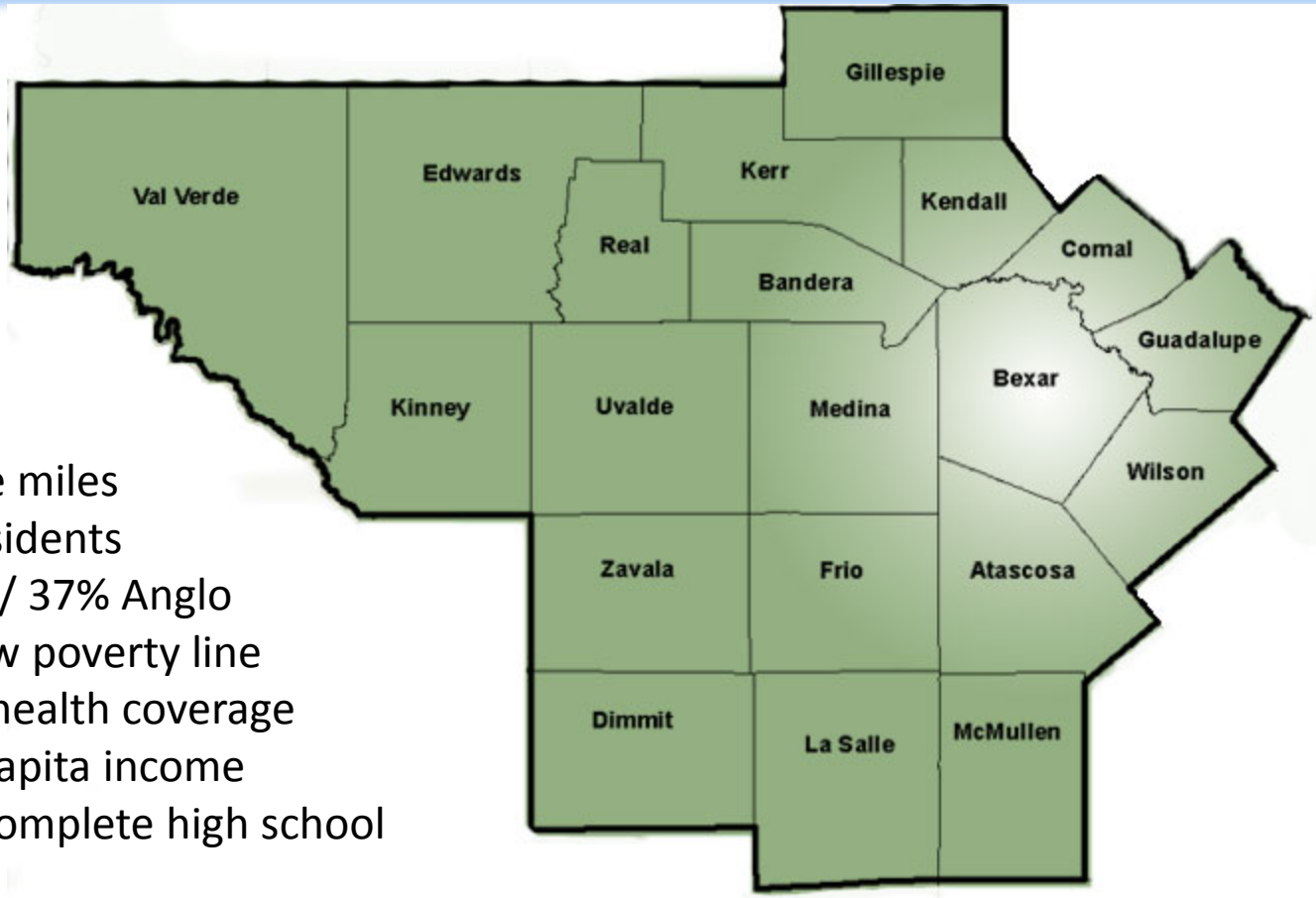
Regional Healthcare Partnership 6



- 20 counties
- 24,734 square miles
- 2.3 million residents
- 54% Hispanic / 37% Anglo
- 16% live below poverty line
- 24% without health coverage
- $36,000 per capita income
- 20% did not complete high school

Source: RHP 6 Plan, submitted to HHSC December 2012

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How does RHP 6 compare to the entire state?

Variable	Texas	RHP 6	RHP 6 Range
Percent Hispanic	38%	54%	17 - 94%
Percent of residents ages 18-64	64%	62%	50 - 64%
Percent of residents with less than high school education	20%	19%	9 – 42%
Percent of deaths due to cardiovascular disease and diabetes	34%	34%	30 - 75%
Percent of mothers under 18 years of age	4.9%	5.5%	3 - 33%
Per capita personal income	$38,609	$35,989	$18K – 50K
Unemployment rate	8.2%	7.4%	5 - 16%
Percent living below poverty	16.5%	16.2%	9 - 35%
Percent uninsured	26%	24%	19 - 37%

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Source: RHP 6 Plan, submitted to HHSC December 2012

Regional Healthcare Partnership 6

Bexar County Hospitals
University Hospital
Baptist Health System
Methodist Hospital
CHRISTUS Santa Rosa Health System
Children's Hospital of San Antonio
Nix Health
Southwest General Hospital
Clarity Child Guidance Center
Texas Center for Infectious Disease
San Antonio State Hospital*

Community Mental Health Centers
Bluebonnet Trails Community Services
Camino Real Community Services
Hill Country MHDD Centers
The Center for Health Care Services

Other Hospitals
South Texas Regional Medical Center* (Atascosa)
Dimmit County Memorial Hospital (Dimmit)
Frio Regional Hospital (Frio)
Hill Country Memorial Hospital (Gillespie)
Guadalupe Regional Medical Center (Guadalupe)
Peterson Regional Medical Center (Kerr)
Medina Healthcare System (Medina)
Uvalde Memorial Hospital (Uvalde)
Val Verde Regional Medical Center (Val Verde)
Connally Memorial Medical Center (Wilson)

University of Texas Health Science Center at San Antonio
Community Medicine Associates
San Antonio Metropolitan Health District

* Participating in the UC Pool only

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RHP 6 Plan

Provider Type	Number of Providers	Number of Projects*
Public Hospitals	10	38
Private Hospitals	8	21
Community Mental Health Centers	4	23
Physician Practices	2	24
Local Health Department	1	6
Total	**25**	**112**

Nine rural hospitals (public and private) have a total of 19 projects

*Does not include new three year projects

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RHP 6 Projects

Project Area	Count of Projects
Behavioral Health	29
Primary Care / Medical Homes	23
Care Mgmt / Care Transitions / Patient Navigation	17
Specialty Care	13
Health Promotion / Disease Prevention	9
Process Improvement	9
Telemedicine	6
Other	6

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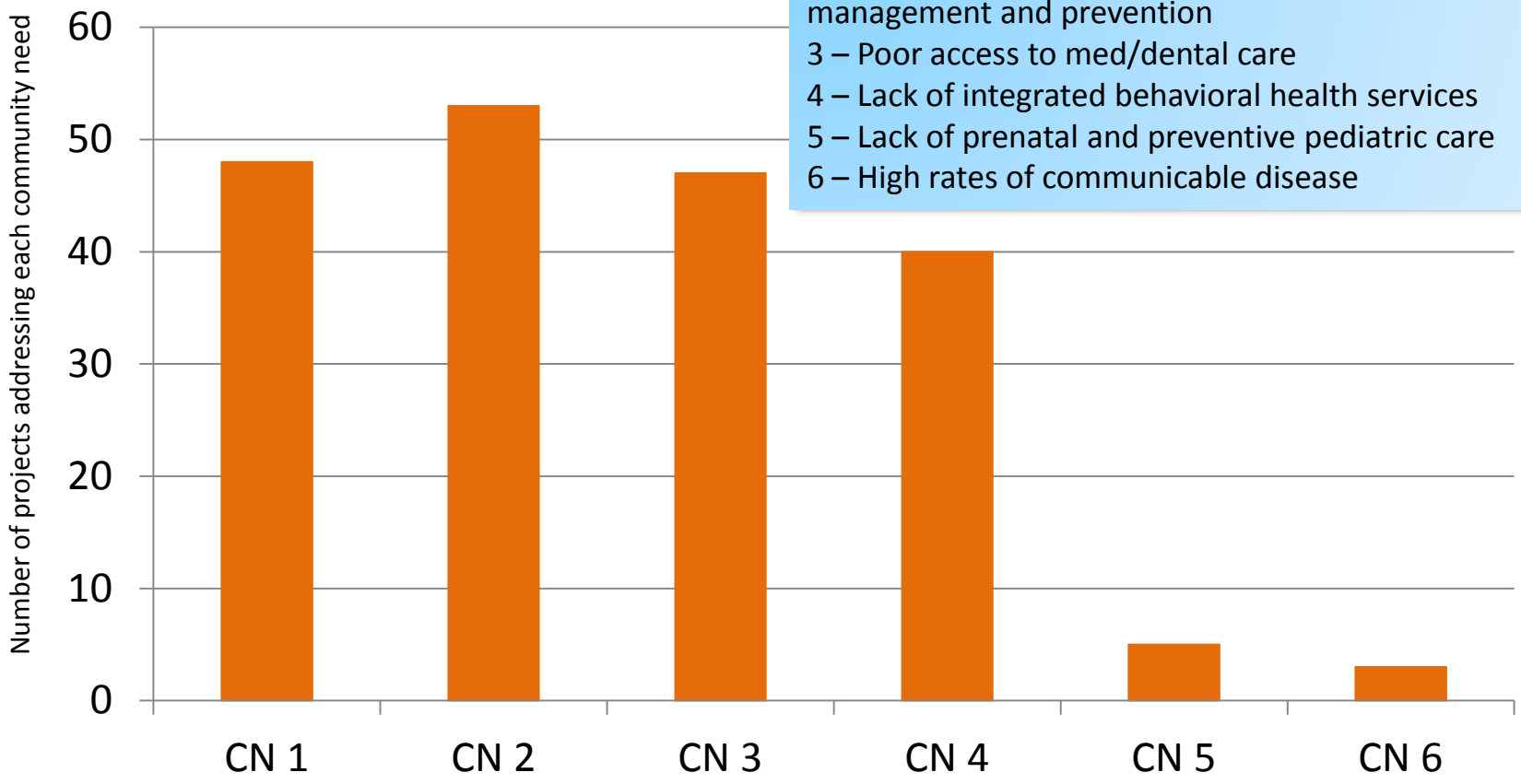
RHP 6 identified six community needs common throughout the region.

Providers identified which needs would be addressed though their proposed projects.

1 – Quality of care in Texas is below the national average
2 – High rates of chronic conditions require improved management and prevention
3 – Poor access to med/dental care
4 – Lack of integrated behavioral health services
5 – Lack of prenatal and preventive pediatric care
6 – High rates of communicable disease



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Training Hill Country educators in mental health first aid

Project Highlights

The need: Low-income victims of past traumas had no access to services that addressed potential mental illness and substance abuse disorders.

The project:

- 200 individuals a year receive trauma counseling
- 1,000 individuals receive mental health first aid training
- Goal is to reduce stigma associated with mental illness
- Collaborate with school districts to train educators, school nurses and administrators

Getting people through the fog of past traumatic experiences and teaching the tools of early detection of mental illness — especially in schools — is underway in 11 rural Texas Hill Country counties

"We saw a great need (to help) individuals with past trauma, they can't recover until they get through that trauma," says David Weden, chief operating officer for the Hill Country Mental Health and Developmental Disabilities in Kerrville.

Facing the past head on can help the person move forward instead of becoming mired in depression or substance and alcohol abuse, according to the organization.

In the second year of the project, Hill Country hired all the staff, developed the trauma counseling plan and set it in motion. The project served 111 people in the first three months of 2014, and the goal is to reach at least 200 by year's end.

Out of the trauma counseling program grew another need to train people through a program known as Mental Health First Aid. Hill Country MHDD has hired four mental health professionals and sent them through extensive training to train others in the community.

More than 50 training sessions have been scheduled through August. Classes include a range of professionals from educators to school nurses in school districts throughout the region. The goal is to reach at least 1,000 people each year to remove the stigma around mental illness and learn the signs and symptoms of early detection so a positive intervention can be made early on.

Mental Health First Aid "is designed to make the ability to respond to a person experiencing mental illness as common as our ability to respond to a person in need of CPR," say MHDD officials.

More beds for children in crisis offers 'right care at the right time and the right place.'

The search for help can be stressful when a child needs emergency psychiatric care. Rachel*, a mother of three children — all of whom receive services at Clarity Children's Guidance Center — recalled when one of them spent seven hours in a local emergency room in need of psychiatric care that the hospital couldn't provide.

"That's not the right place," Rachel said. "They don't have the services."

The addition of 20 new beds to Clarity's 52-bed children's psychiatric hospital will help better address that need — narrowing San Antonio's estimated 65-bed gap for acute crisis psychiatric care for children and adolescents.

Six of the new beds will be reserved for regional psychiatric emergency care, a new program designed to evaluate children in emergency situations to determine their best treatment option.

These 23-hour maximum stay beds will help some of the 1,300 children who go to local emergency rooms each year, where pediatric psychiatric care isn't provided, said Rebecca Helterbrand, vice president of marketing and resource development at Clarity, a nonprofit mental health treatment center for children ages 3 to 17.

Project Highlights

The need: Suicide is the third leading cause of death in youth. City has 65 fewer beds than needed for acute child and adolescent psychiatric care.

The project:

- Clarity Child Guidance Center is a 52 bed psychiatric children's hospital
- 80 percent of patients are at or below the poverty level
- Construction to add 20 psychiatric inpatient and emergency beds in April 2014

The other 14 beds will be used for acute care for children who are at risk of harm to themselves or others.

The new beds will allow an additional 300 children to be assessed and an additional 200 to be treated in the hospital annually, she said. Clarity also offers outpatient care, day treatment and therapy.

"We're going to offer them the right care at the right time and the right place," Helterbrand said, adding that construction should be complete by early 2015.

With one in five children affected by mental illness in the United States, increasing access to mental health treatment will reduce rates of suicide, substance abuse and incarceration among youth, she added.

*Client's name changed for privacy

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Dialing into expert stroke care — a thousand miles away

Curiosity saved William Ashford.

Intrigued by cutting-edge technology, the retired engineer attended a demonstration of the new Tele-Stroke Program at the Medina Regional Hospital in Hondo.

But when the 72-year-old experienced numbness, confusion, difficulty seeing and dizziness – all stroke symptoms — he became one of the first patients to benefit from the Skype-like teleconferencing system that connects the rural hospital in Medina County (pop. 47,000) with a neurologist in Denver.

"If I hadn't wanted to see how it worked, I might not be here," Ashford says. "I remember being strapped to a hospital bed and talking to a doctor on a monitor. He asked me questions that I was barely able to answer. Then they told me I was going to take a helicopter ride to a bigger hospital — scary but exciting."

Billie Bell, Medina Healthcare System quality director, says the high-definition network provides impressive detail, even pupil dilation, so the Denver specialist could examine and speak with Ashford as if they were in the same room.

A web link to monitors in the Medina emergency department permitted the neurologist to review brain scans in real time when minutes mattered.

"With stroke victims, a small window of time exists when we can administer a clot-busting drug called tissue plasminogen activator (tPA) to restore blood flow and prevent disability or even death," Bell says. "That's why an accurate stroke diagnosis is needed as soon as possible."

Project Highlights

The need: Stroke is a major cause of death and disability; minutes count when evaluating patients with stroke symptoms.

The project:

- Medina Regional is a 25-bed critical access hospital serving a rural area
- In DY 2, the Tele-Stroke Network was implemented in the Emergency Department
- Technology allows rapid consults by neurologists across the country

The Tele-Stroke Program gives Medina County's rural residents year-round, 24/7 access to world-class care. It was funded through the Delivery System Reform Incentive Payment Pool of the Texas 1115 Medicaid waiver.

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Taking control; Guadalupe clinic helps low-income patients manage chronic disease

With high blood pressure and diabetes, Alex* has for years had difficulty managing his condition to stay out of the emergency room.

"It's hard to keep things on an even keel with both conditions, and I've been through just a slew of doctors offices," Alex says.

Project Highlights

The need: Poor diabetes management due to limited access to care, costly medicines.

The project:

- In DY 2, GRMC relocated and expanded a clinic for uninsured residents
- A projected 1,100 patient visits in 2014

But after two years of being unable to work — and too young for Medicare — he discovered help through the indigent program at the Guadalupe Clinic for Chronic Disease at Guadalupe Regional Medical Center in Seguin.

"They're nice people. You're not just shuffled in and out," Alex says of the attention to detail with all his conditions.

The rate of diabetes in Guadalupe County is 11.7 percent, compared to the national rate of 8.3 percent. It is largely unmanaged in the area because of limited access to care, the high cost of medications and a lack of education and ability to follow up.

The program relocated from an old house with no air conditioning or wheelchair access to the Guadalupe Regional Medical Center, to be closer to vital services and providers.

In the first four months of 2014, the program has had more than 400 patients and is projecting at least 1,100 for the year, says Lauren Carter, vice president of physician services for GRMC.

"It's made a huge impact on the community so far. They appreciate that have a place to go, that they have an appointment," Carter says. "There are no cancellations. They show up and they are complying with the care plan. I would like to see this program continually grow."

Demonstration Year 2 Results

(October 1, 2012 – September 30, 2013)

- RHP 6 providers achieved 356 of 418 (85%) DY 2 milestones.
  - Included: gap assessments, workforce enhancements, program development and implementation, clinic expansions
- One milestone was not achieved; the rest were "carried forward" to DY3
- Total value of DY 2 milestones: $224 M

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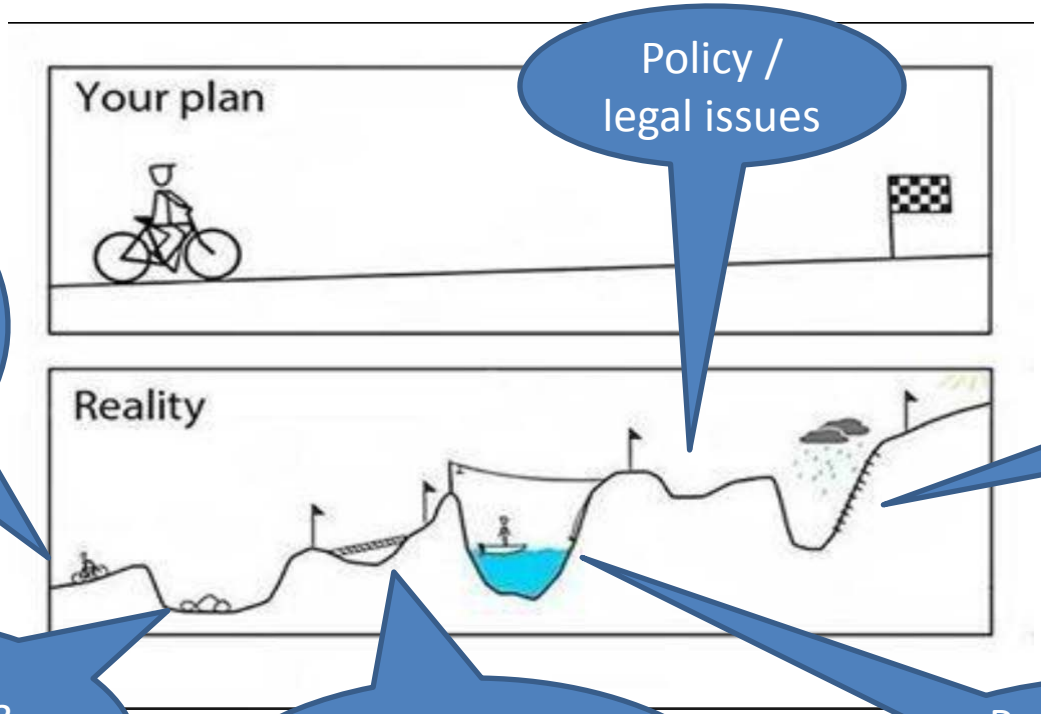
Project Challenges

Common Themes Reported by Providers



Policy / legal issues

Delay in project approval

Data

Securing buy-in & communicating

Limited resources for project administration and reporting

Provider /staff recruitment and retention

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Lessons Learned

Common Themes Reported by Providers

- Value of partnerships and communication
- Importance of planning
- Good use of technology and data systems
- Ability to adapt and use resources efficiently
- How to recruit providers
- Best practices and pitfalls when starting or coordinating new programs

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Lessons Learned & Opportunities
Anchor / Waiver Perspective

We ❤ Performance Logic

We're getting smarter

Collaborations are critical

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RHP 6 Learning Collaborative Plan

- Learning Collaboratives are led by committees of regional volunteers, including DSRIP performing providers and other community stakeholders
- Improvement Collaborative
  - Formal structure based on the Institute for Healthcare Improvement's Model for Improvement
  - Impacts all providers, regardless of type and project
  - DY3 and 4: Reduce Potentially Preventable Readmissions
- Targeted Topics
  - "Organic" model driven by the needs and interests of participants
  - DY2 – Project Management
  - DY3 – Primary care and behavioral health

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Steering Committee Members

Uvalde Memorial Hospital

TRINITY UNIVERSITY

THE CENTER FOR HEALTH CARE SERVICES
Mental Health & Substance Abuse Solutions
Where hope and healing begin.

Bluebonnet Trails Community Services

University Health System
for Bexar County and Beyond

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

CHRISTUS SANTA ROSA Health System

HASA

clarity child guidance center
healing young minds & hearts

Health Collaborative
Bexar County's Community Health Leadership

nix HEALTH
Uncommon Care

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WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER®
SAN ANTONIO

Other Collaborative Opportunities

- Anchors have developed valuable relationships with each other
- Providers are sharing milestone deliverables
- Stakeholder partnerships continue to develop. Examples:
  - Trinity University MHA program
  - Health plans
  - Healthcare Access San Antonio (HASA)
  - Bexar County Community Health Improvement Plan (CHIP)

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http://www.texasrhp6.com/rhp-6-hosts-summit-learning-collaborative/

For more information:

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  www.TexasRHP6.com

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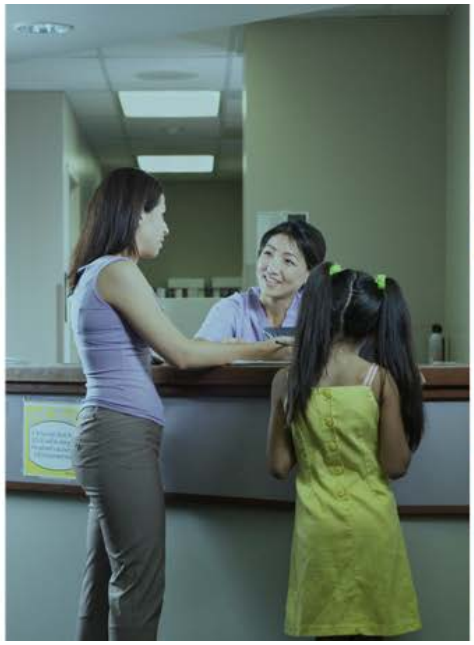
COHORT WORKGROUP UPDATES






Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

Learning Collaborative
Cohort Workgroups Update
Region 3

June 5th 2014

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

Presented by: Margarita Gardea

PRIMARY/SPECIALTY CARE COHORT

COHORT DEMOGRAPHICS

- **Subgroup**
  - Patient Referrals
- **Membership**
  - Leader & Liaison- TBD
  - Participating Organizations
    - Hospitals/Health Systems
    - Community Organizations
    - City and County Health Departments
    - Behavioral Health Organizations

GOAL

- Identify a communication plan for new DSRIP primary care clinics that will assist community organizations in creating appropriate referrals

AIM(s)

- In Development

ACCOMPLISHMENTS & ACTIVITIES

- Kick off meeting
- Development of first subgroup focused on patient referrals and volume metric achievement

NEXT STEPS

- Call to Action
  - Invitation to join Cohort efforts
- Next Meeting Date:
  - To Be Determined

Presented by: Shannon Evans

BEHAVIORAL HEALTH COHORT SUBGROUP

PRIMARY CARE-BEHAVIORAL HEALTH CARE INTEGRATION

COHORT DEMOGRAPHICS

- **Membership**
  - Leader- To Be Determined
  - Liaison- Vaughn O'Neal, St. Joseph Medical Center
  - 25 Participating Organizations
    - Behavioral Health Organizations
    - Mental Health Authorities
    - Individual Hospitals and Health Systems
    - Community Organizations
    - City and County Health Departments
    - Educational Institutions
    - Stakeholders from External Regions

GOAL

- Develop an Integration Assessment Tool that will assist providers in building a common understanding and evaluation of the Center for Integrated Healthcare Solutions (CIHS) six-level framework for integration as it relates to their project.

AIMS

- Establish a baseline for care integration within the region
- Assess the current state of integration
- Assess the desired state of integration
- Assess changes in regional integration as a result of DSRIP projects

LESSONS LEARNED

- Identification of target population for the survey
- Necessity of Subject Matter Expertise Involvement
- Importance of Identification of individual clinic locations
  - 11 Projects
  - 22,762 Individuals

ACCOMPLISHMENTS & ACTIVITIES

- Developed AIMS
- Presentation by Subject Matter Experts
- Established a Work Group to develop assessment tool

NEXT STEPS

- Call to Action
  - Work Group Participation
  - Participation in Assessment Tool Pilot
- Next Meeting
  - Friday, June 27, 2014, 10:00 am – 11:00 am

Presented by: Connie Almeida, PhD, LSSP

BEHAVIORAL HEALTH COHORT SUBGROUP

CARE COORDINATION AND COMMUNICATION POST FOLLOW-UP AND DISCHARGE

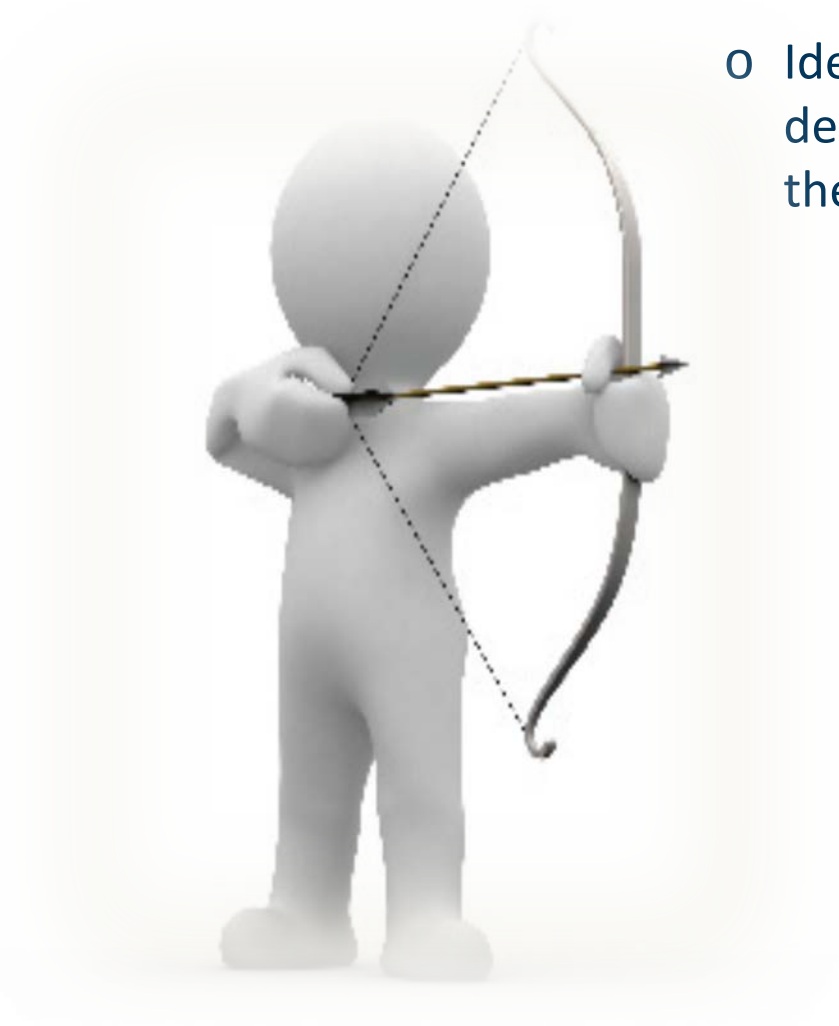
COHORT DEMOGRAPHICS

- **Membership**
  - Leaders – Dr. Connie Almeida, Ft. Bend County; Dr. Scott Hickey, MHMRA; Leonard Kincaid, Houston Recovery Center
  - Liaison - Diane Moore, Memorial Medical Center
  - 24 Participating Organizations
    - Behavioral Healthcare Organizations
    - Mental Health Authorities
    - Individual Hospitals and Health Systems
    - Community Resource Organizations
    - City and County Health Departments
    - Educational Institutions
    - Stakeholders from External Regions
  - 41 Projects – Valued at $396,907,770

GOAL

- Define characteristics of high-risk patients and reasons for readmissions
- Reduce all-cause 30-day readmission rates, to include criminal justice recidivism, by understanding patient characteristics through data analysis.
- Identify gaps in the care delivery system.
- Inform the development of the Patient Navigation Cohort Navigation Tool

AIMS



- Identify, analyze, and summarize patient and delivery factors which lead to readmissions for the purpose of:
  - Performing a gap analysis within RHP 3 to identify available, planned and needed services.
  - Providing the navigation cohort findings to inform the behavioral health component of the patient navigation tool
  - Identifying future (specific) topics and strategies which can become a unique subsequent cohort

LESSONS LEARNED

- Complexity of the system
- Data Provision
  - Identifying the data needed for analysis
    - Individual vs. Summary Information
  - Legal and Compliance Concerns
    - Development of Statement of Purpose
    - Limited Use Agreement

ACCOMPLISHMENTS & ACTIVITIES

- Presentation, 30-day Psychiatric Readmission: Rates, Reasons, Responses
- Internal discussions regarding 30-day Readmissions
- Submission of 30-day Readmissions Data
  - 8 of 14 Organizations with 30-day readmissions outcome measures committed to submission

NEXT STEPS

- Call to Action
  - Refine Name and Aims
  - Discuss data with the internal Compliance and/or Legal departments
  - Submit 30-day readmissions data for analysis
- Next Meeting
  - Friday, June 27, 2014, 8:00 am – 10:00 am

Presented by: Jessica Hall

EMERGENCY CENTER UTILIZATION COHORT

COHORT DEMOGRAPHICS

- **Membership**
  - Leader(s)& Liaison- TBD
  - All interested organizations are welcome to participate

GOAL

- To answer EC utilization-related research questions that are pressing for the region

LESSONS LEARNED

- Necessary to approach EC utilization collaboration from variety of care perspectives

AIMS

- Explore synergies between projects sharing Category 3 measures
- Population and demographic shifts
- How are navigation programs working to reduce inappropriate EC use?
- What are most common PCRED diagnoses? Can education at point of care reduce these visits?
- Frequent fliers

ACCOMPLISHMENTS & ACTIVITIES

- Brainstorming discussions to develop research questions about EC use

NEXT STEPS

- Call to Action:
  - Involvement in brainstorming to ask the right research questions
  - Share data to answer those questions
- Next Meeting Date:
  - Thursday, June 26, 10:00am-11:00am, location TBD

Presented by: Bryan Davis

PATIENT NAVIGATION COHORT

PATIENT NAVIGATION COHORT

Membership

- Leader- Dr. Sandra K. Tyson, UT Physicians
- Liaison- Sahar Qashqai , UT Physicians
- 13 Participating Organizations
  - Physician practices
  - Health Systems
  - Hospitals
  - Behavioral Health Providers
  - Community Organizations
  - FQHCs

NAVIGATION PROJECTS REPRESENTED

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

GOAL

- To reduce the fragmentation of care experienced by the patient to ensure continuity of care
- To provide the patient with the option best suited to them without regard for provider interests

CHALLENGES

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

IMPROVEMENT AREAS

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

AIMS

- **Commitment Statement:**
  - Develop a statement of commitment to our community regarding our collaborative approach to regional navigation and obtain signatures on **June 5th, 2014.**
    - 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 healthcare they need. As partners in healthcare, 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

ACCOMPLISHMENTS

- Creation of Commitment Letter with commitment from 14 organizations
- Signing event with organizational leaders today

AIMS

- **Navigation Tool:**
  - We will identify/develop a navigation tool to be:
    - Web-based
    - User friendly
    - Searchable
    - Contain information organizations are comfortable with providing which could include: providers, specialties, medical services, social services, transportation options, scheduling, etc...
    - Sustainable and secure

ACCOMPLISHMENTS

- Project charter creation
- Engaged vendors that are willing to help maintain environment and code application

LESSONS LEARNED

- Organizations are willing to help provide no cost services, as long as we are willing to ask for help
- It is important to consistently communicate the cohort goals to all organizations to help ensure successful participation and feedback

AIMS

- **Navigation Tool training:**
  - We will arrange for training for RHP3 navigators in the use of the new web-based navigation tool during DY4.

AIMS

- **Community Health Workers Continuing Education Tool:**
  - We will work to develop a tool where health care employers and CHWs can have access to find Texas Certified CEUs available in the Houston area that is based upon provider-identified training needs.

ACCOMPLISHMENTS

- Continuously receiving CEU course objective information from the following Training Centers:
  - UT School of Public Health
  - Harris Health
  - Gateway to Care
  - AHEC East Coastal
  - Houston Community College
- City of Houston - Department of Health and Human Services, obtained verbal approval from University of Houston to provide the creation and on-going maintenance of the tool at no charge to the Cohort
- Once tool is created, training centers will have the ability and be responsible for updating their classes and objectives on the tool.

NEXT STEPS

- Survey will be sent to RHP3 providers to review the tool to determine if there are courses that they do not see represented in the CHW CE Training Tool and would like for the subgroup to work with the training centers to see if they can be developed
- Navigation tool continued development

Presented by: Dr. Stephen Klineberg

THE HEALTH CARE CHALLENGES IN HOUSTON AND TEXAS: TRACKING THE REGION'S ECONOMIC AND DEMOGRAPHIC TRANSFORMATIONS THROUGH 33 YEARS OF HOUSTON SURVEYS

RICE UNIVERSITY
KINDER INSTITUTE
FOR URBAN RESEARCH

The Changing Face of Houston and Texas:

Tracking the Economic and Demographic Transformations; Their Implications for Health Care Policy.

Dr. Stephen Klineberg

Harris Health System Conference: Regional Learning Opportunities, 5 June 2014.

RICE

The Kinder Institute Houston Area Survey (1982-2014)

More than three decades of systematic interviews with representative samples of Harris County residents, focused on three central issues:

RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

The SHEA Surveys on Health, Education and the Arts (2012)

Supported by a grant from Houston Endowment Inc., three focused surveys were developed during 2011 through a series of meetings with local leaders and national experts in the arts, education, and community health.

From November 2011 through July 2012, separate samples of 1,200 scientifically selected Harris County residents were interviewed in three successive surveys, with approximately 65% reached by landline and 35% by cell phone.

Weights were assigned to the data to ensure that the final distributions are in close agreement with the actual Harris County distributions with respect to ethnicity, age, gender, education levels, and home ownership.

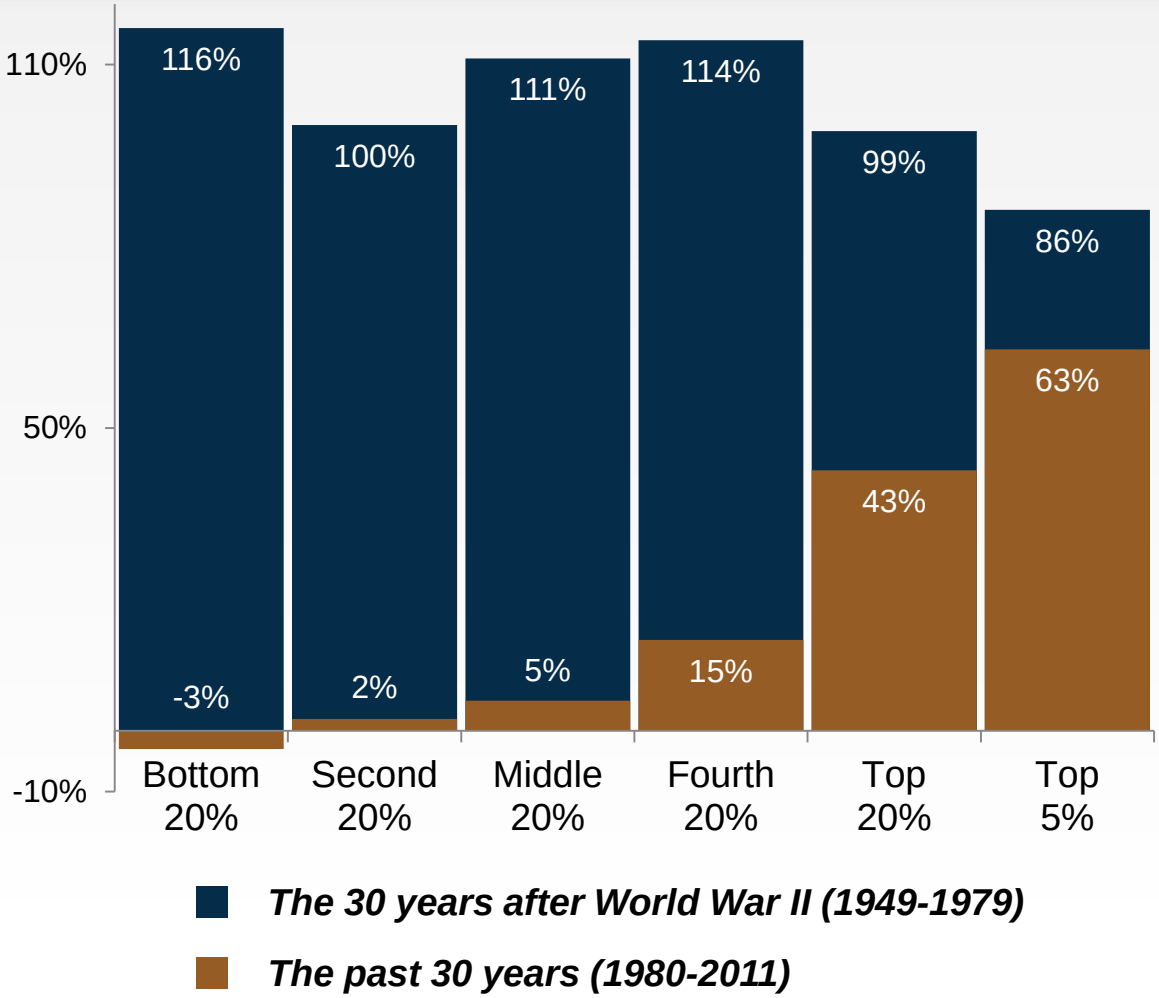
The three printed reports on the most important findings from these separate surveys have now been released to the public and are available from the Kinder Institute web site (at: **kinder.rice.edu/reports**).

Two contrasting economic eras

The 30 years after World War II were a period of broad-based prosperity.

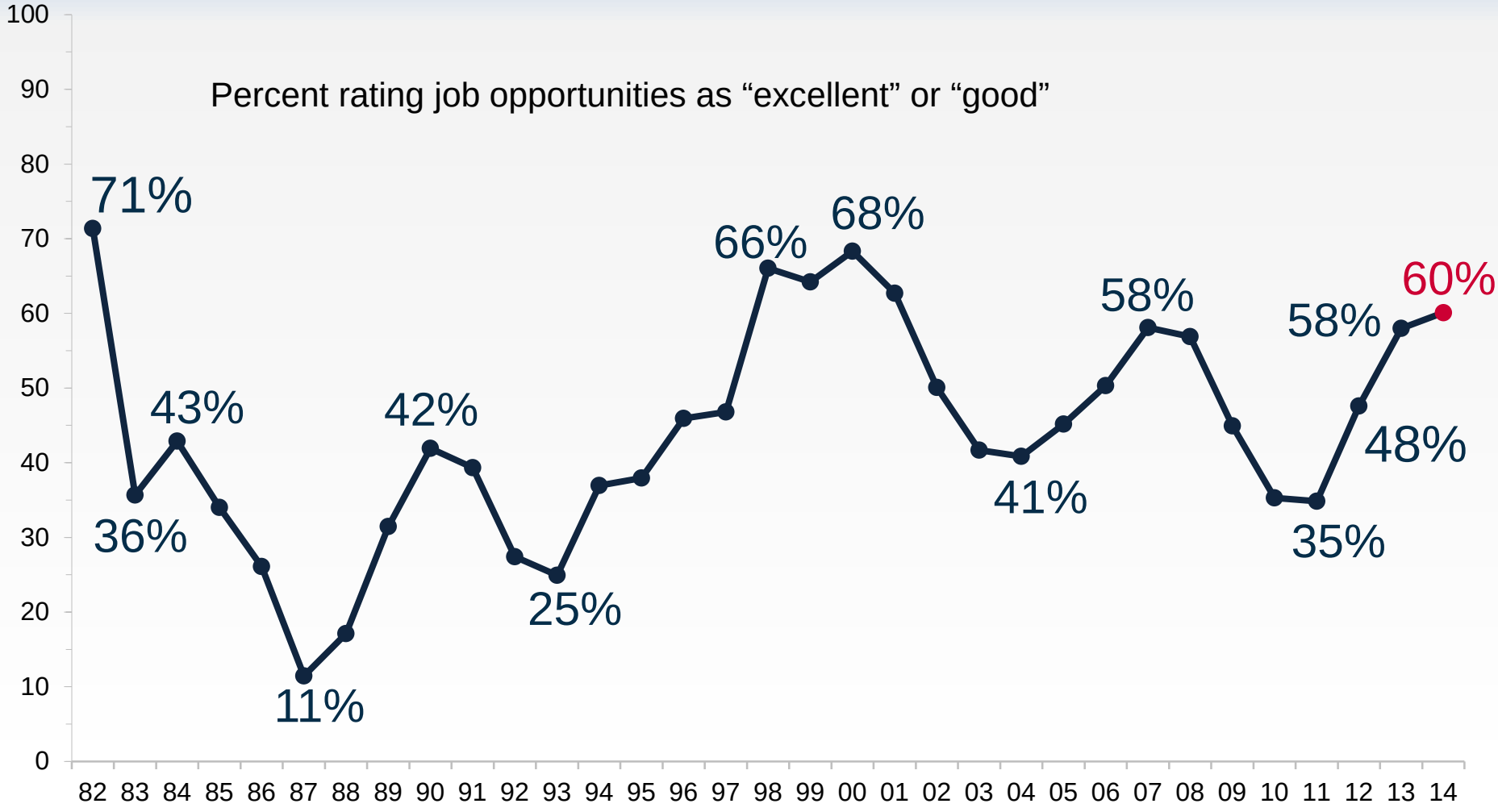
The past 30 years have been marked by growing income inequalities.

Percent increase in before-tax income



U.S. Census Bureau, Current Population Survey, Annual Social And Economic Supplements.
Mean Household Income Received By Each Fifth And The Top 5 Percent, Inflation Adjusted.

Positive evaluations of job opportunities in the Houston area (1982-2014)



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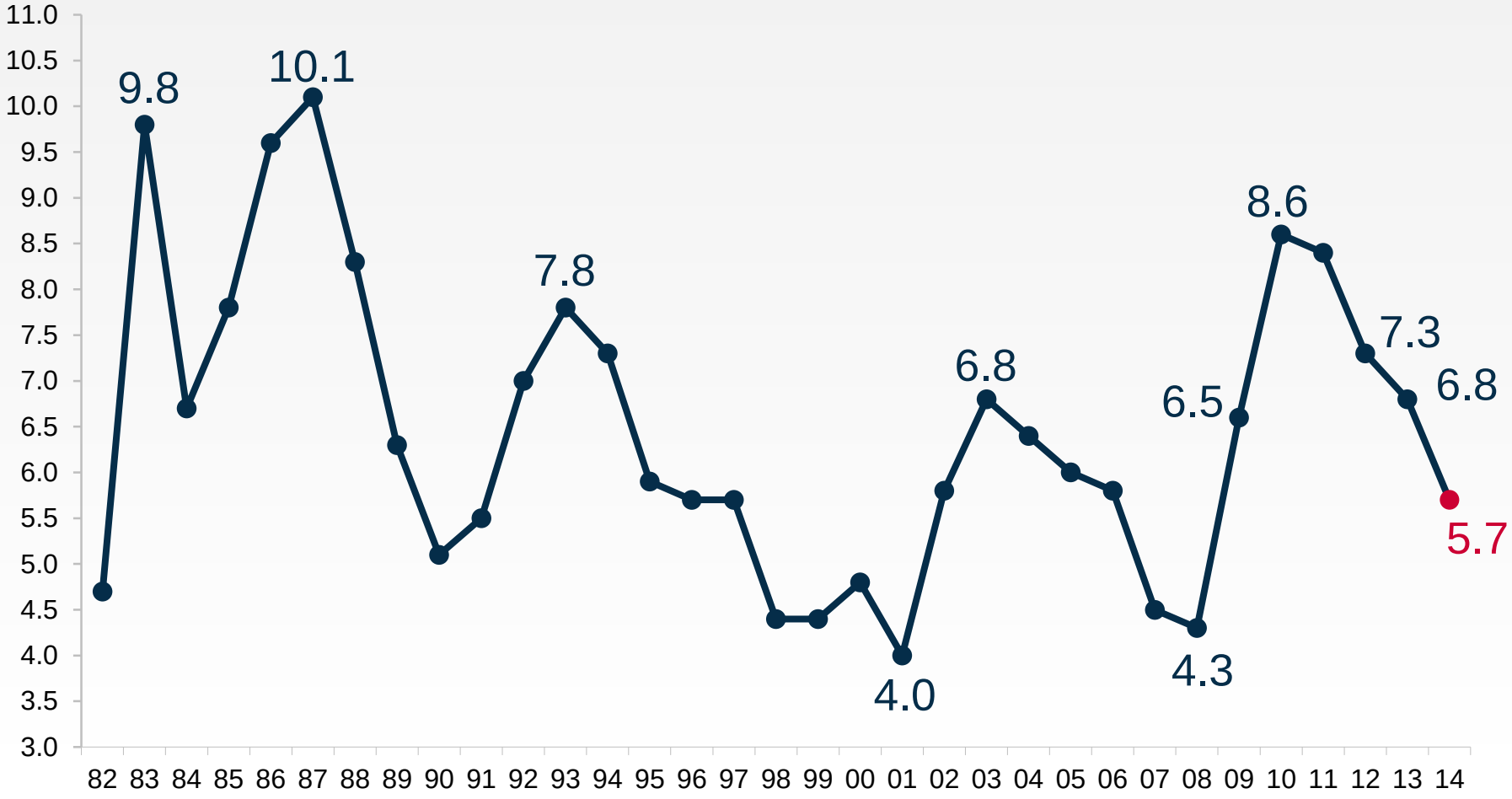
Source: Kinder Houston Area Survey (1982-2014)

The official unemployment rates in Harris County (1982-2014)



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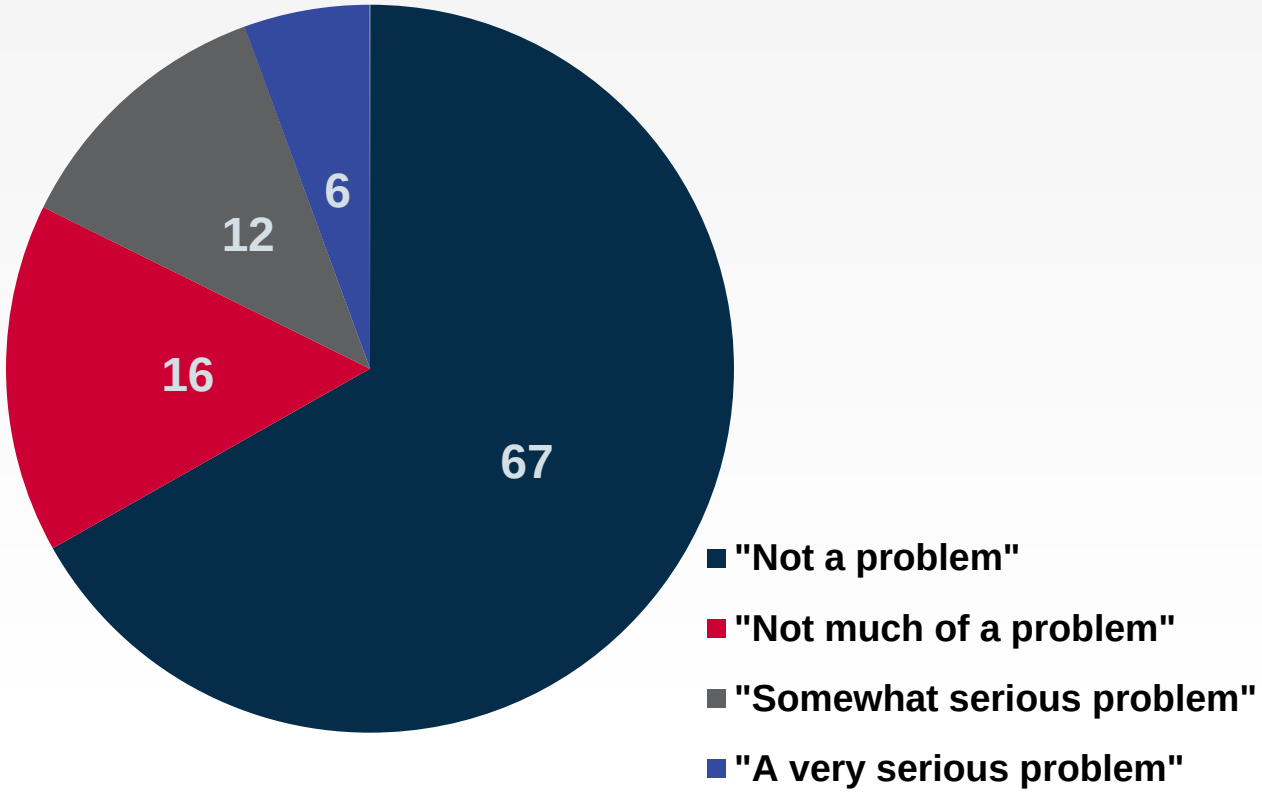
Source: U.S. Department of Labor, Bureau of Labor Statistics. Unemployment rates are not seasonally adjusted.

The prevalence of food insecurity (2014)

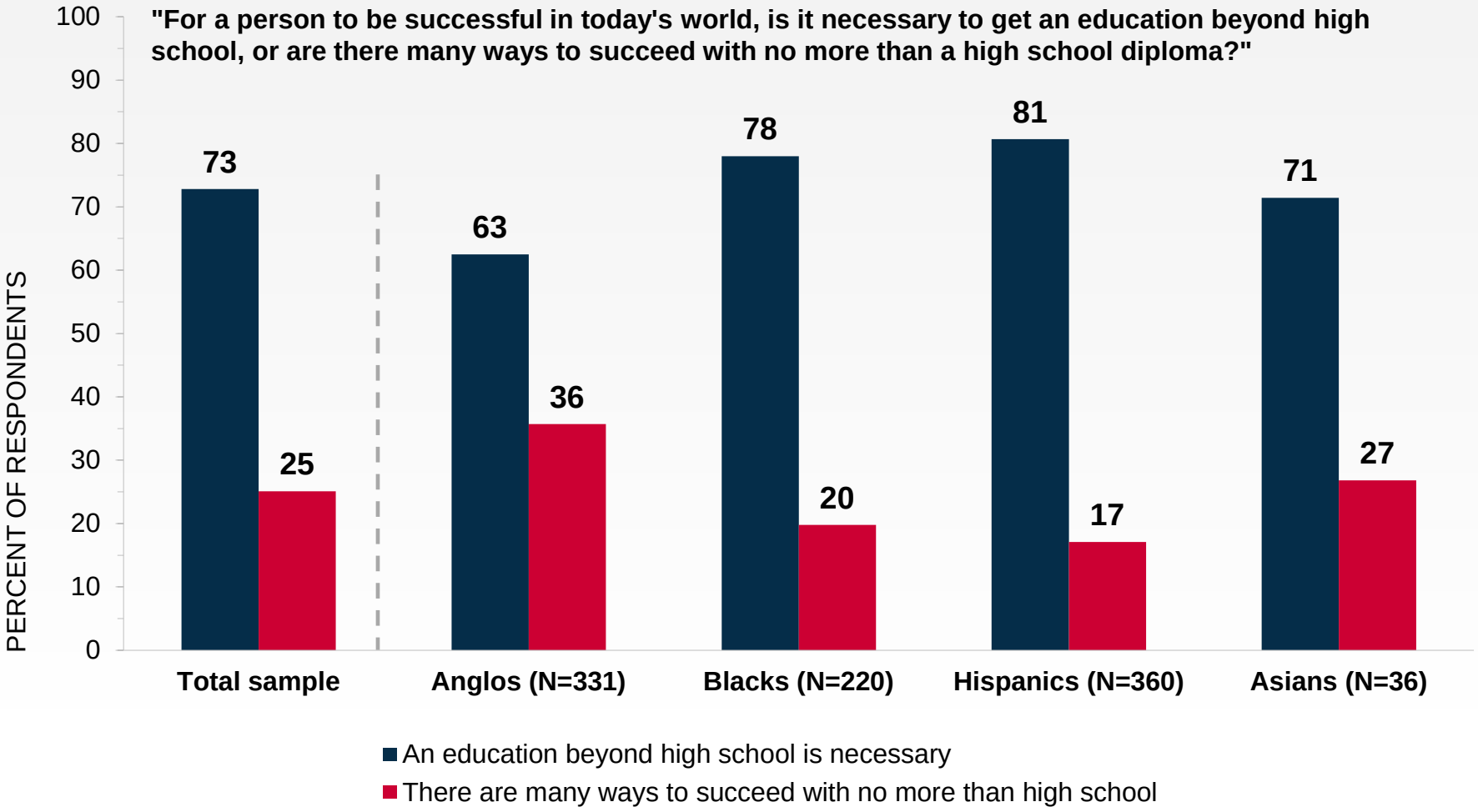
“At any time in the past year, did you have a problem paying for the groceries to feed your household? Has that been a very serious problem for you, somewhat serious, not much of a problem, or not a problem during the past year?”



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: Kinder Institute Houston Area Survey (2014)

The importance of post-secondary education, in the total sample and by ethnicity (2013)



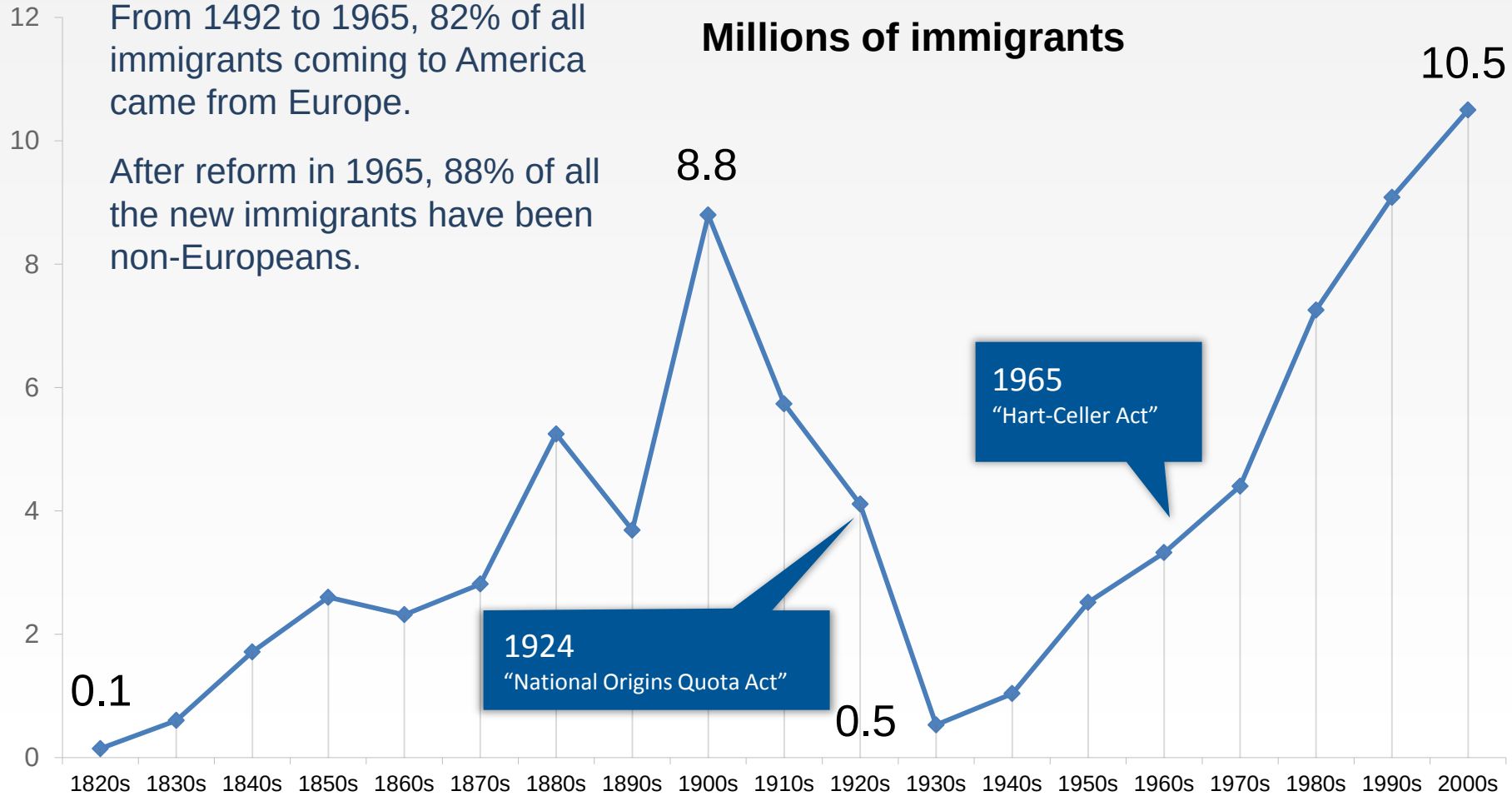
Source: Kinder Institute Houston Area Survey (2013)

The Demographic Revolution

The number of documented U.S. immigrants, by decade (1820-2010)

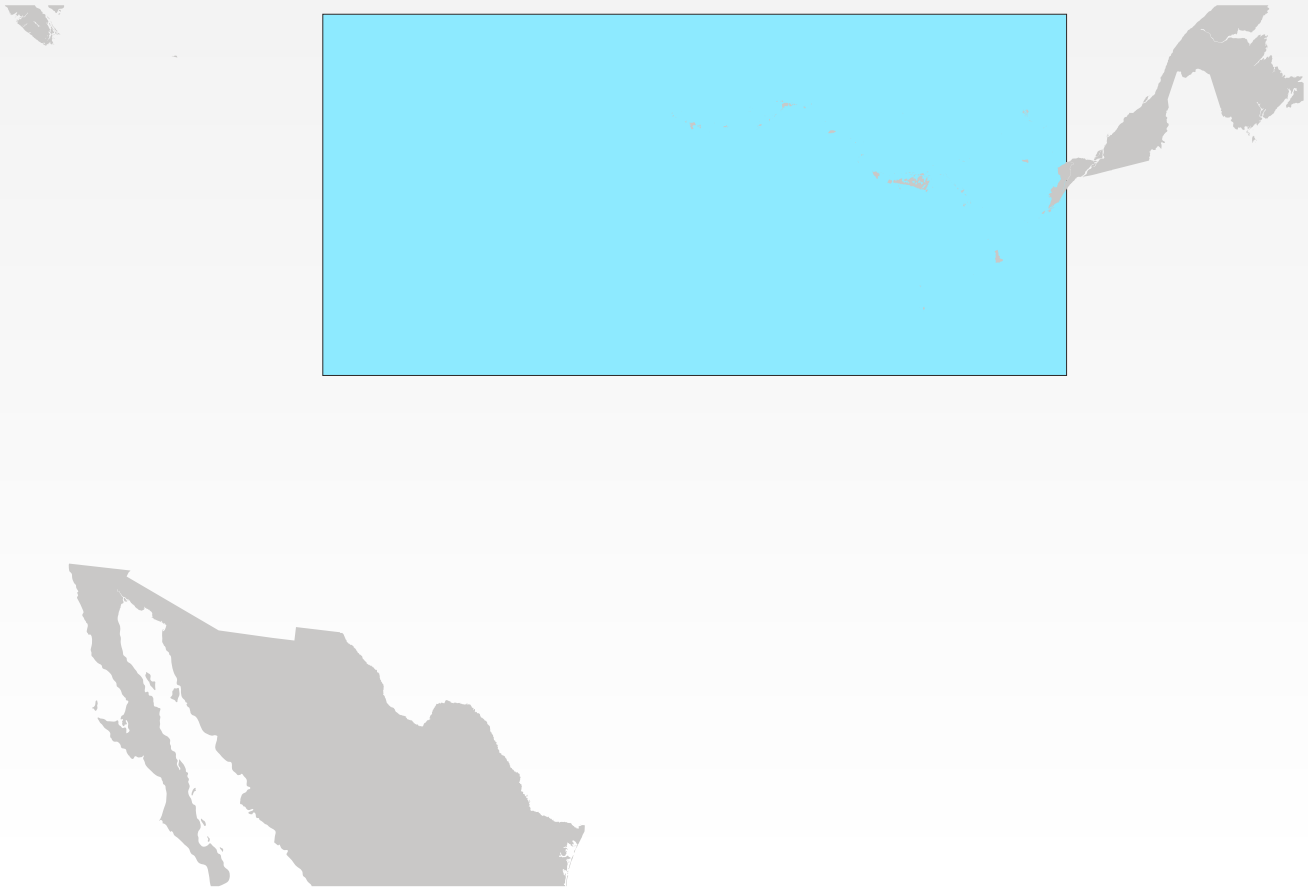
From 1492 to 1965, 82% of all immigrants coming to America came from Europe.

After reform in 1965, 88% of all the new immigrants have been non-Europeans.

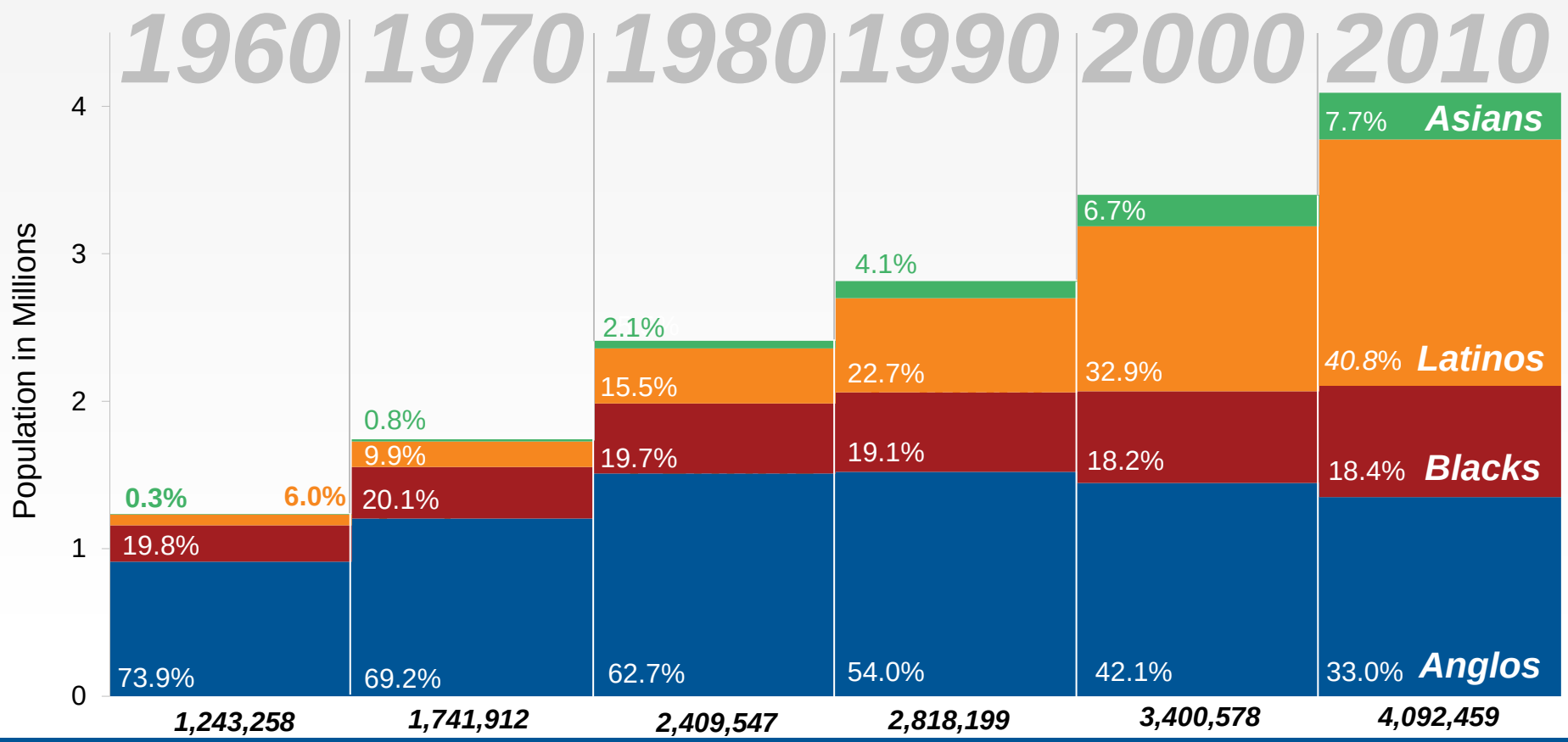


RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Department of Homeland Security. Office of Immigration Statistics.



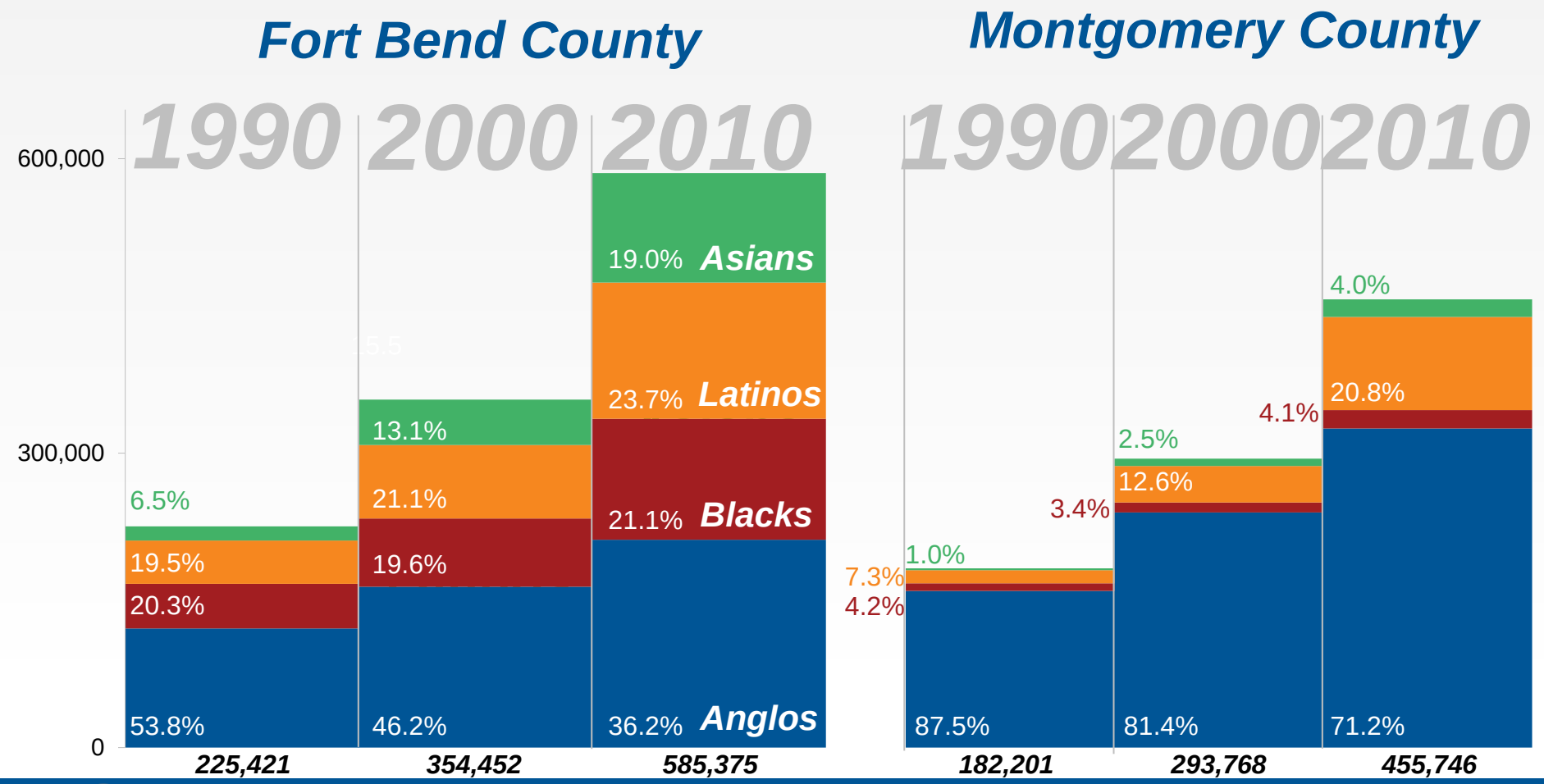
The demographic transformations of Harris County



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census. Classifications based on Texas State Data Center Conventions.

The demographic changes in Fort Bend County and Montgomery County

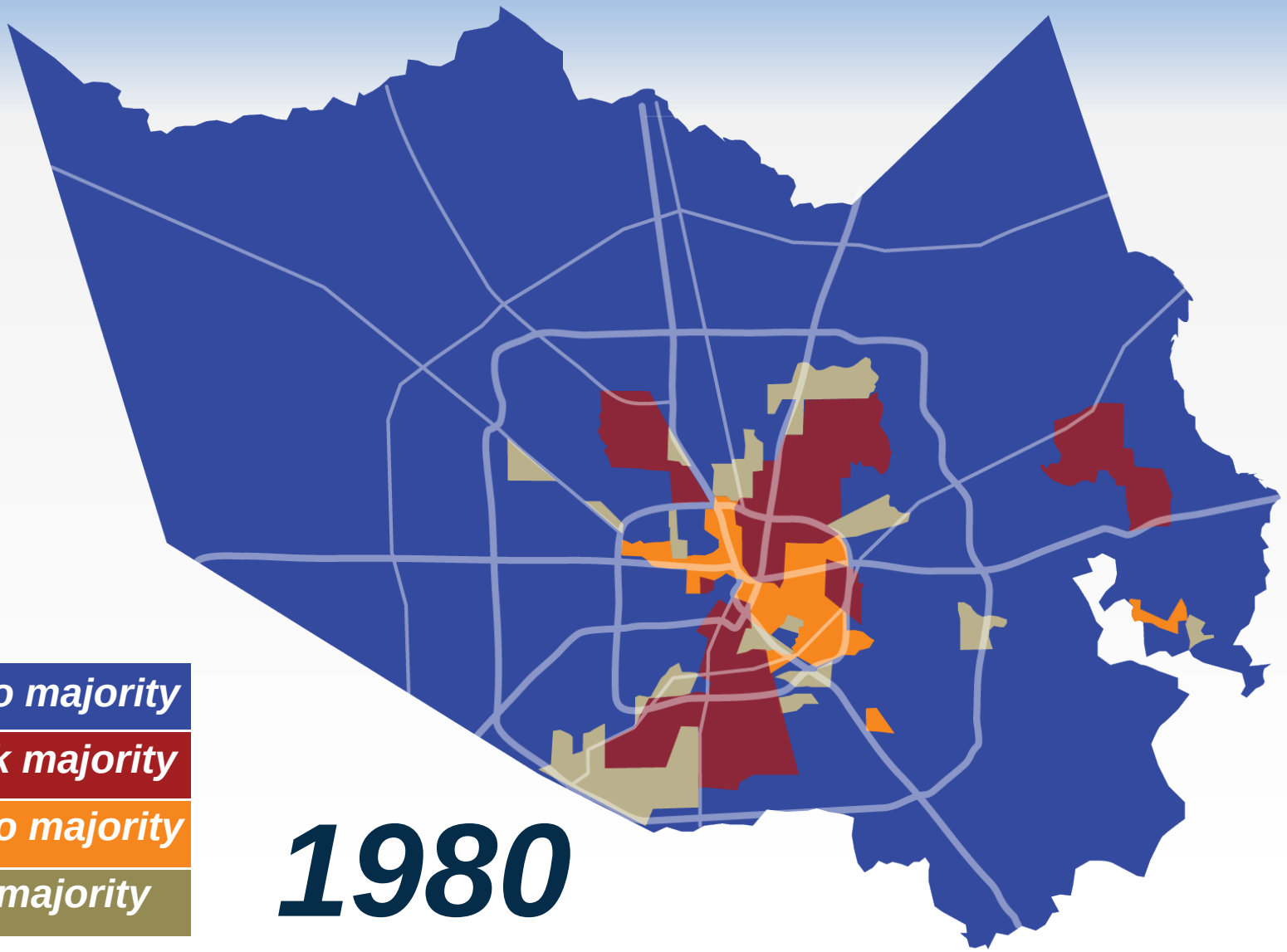


RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census. Classifications based on Texas State Data Center Conventions.

The New Economy

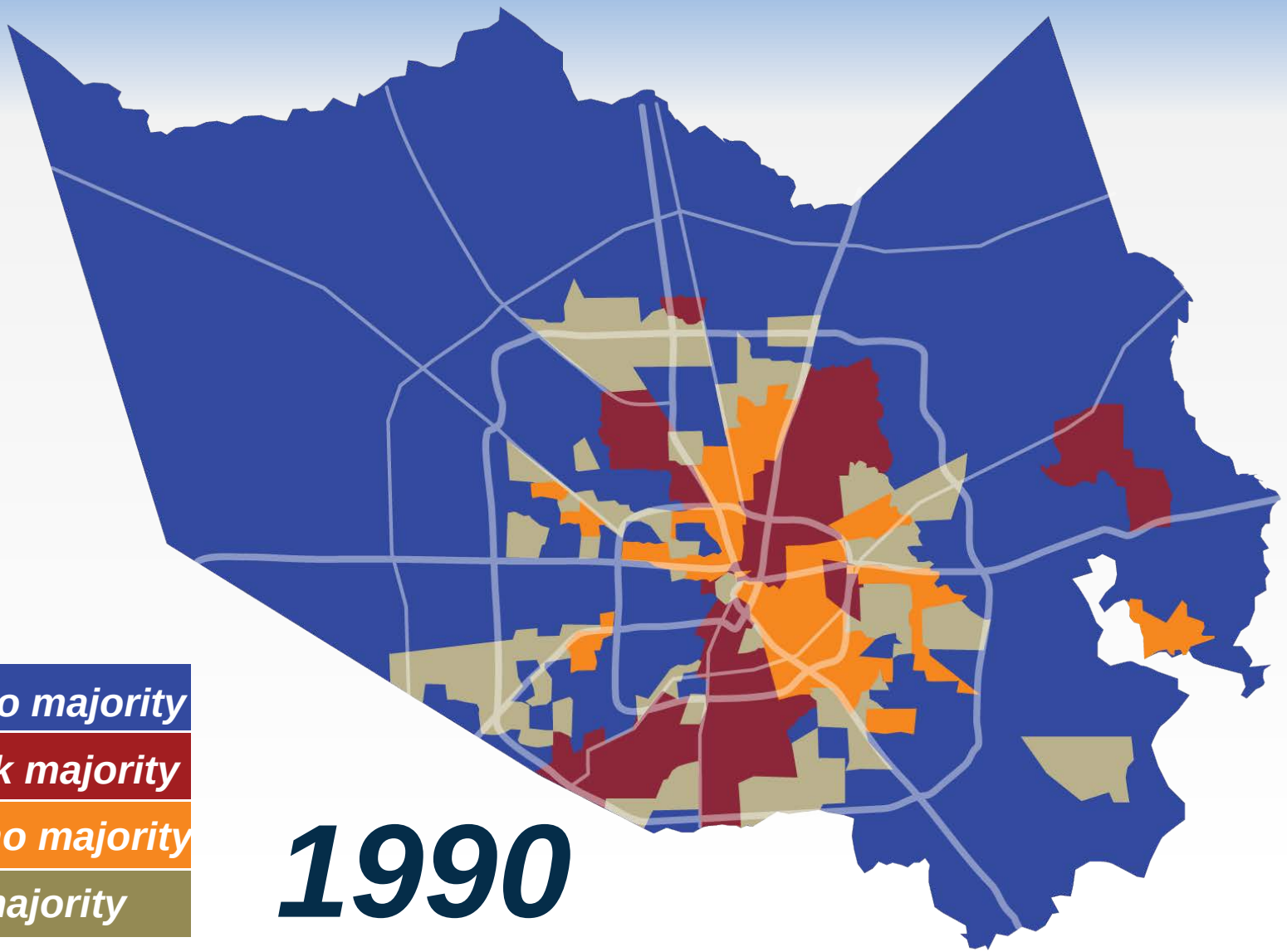
Harris County total population



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Color represents demographic group being a majority in that census tract.
Source: Outreach Strategists, LLC

Harris County total population



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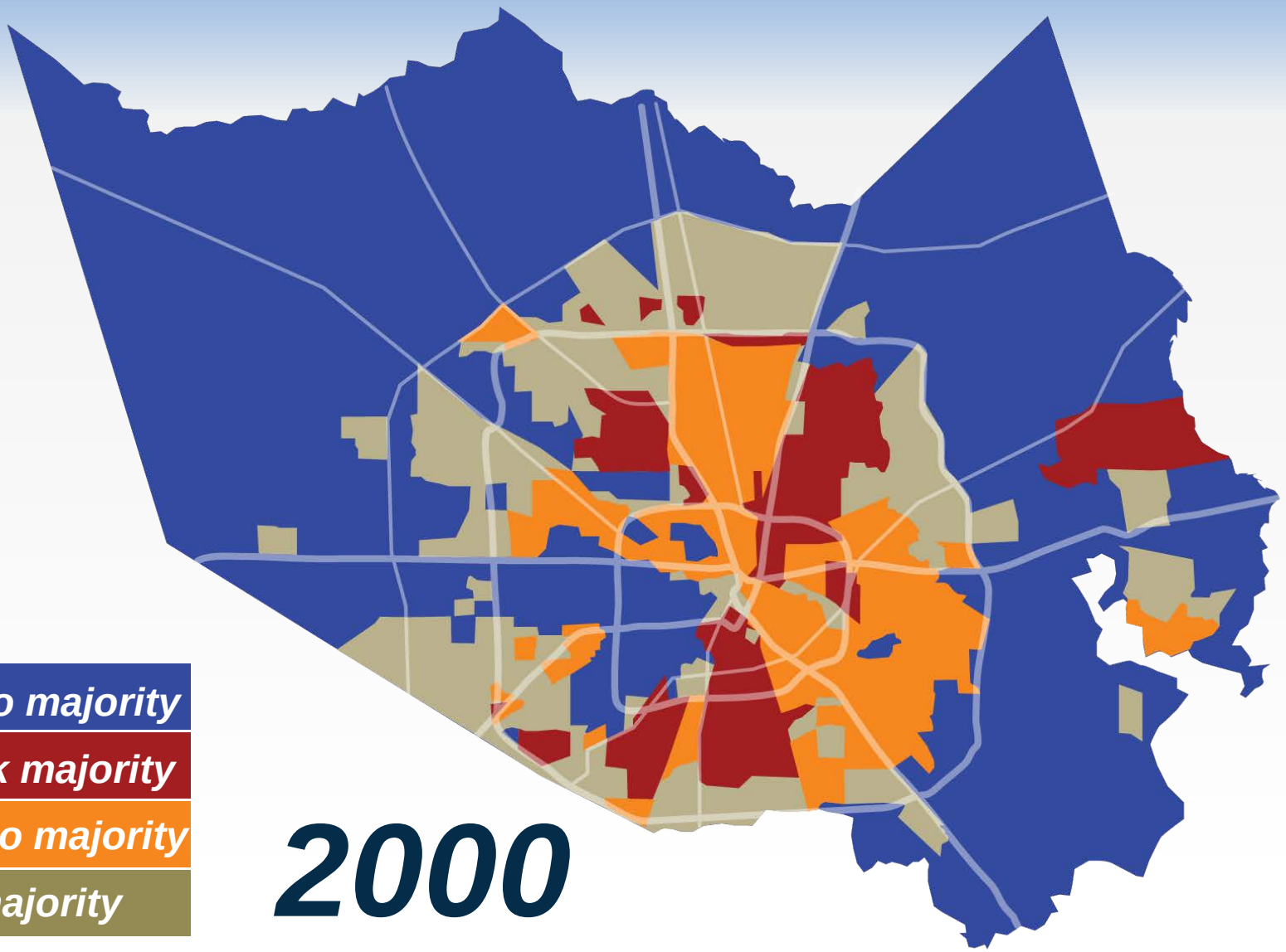
Harris County total population



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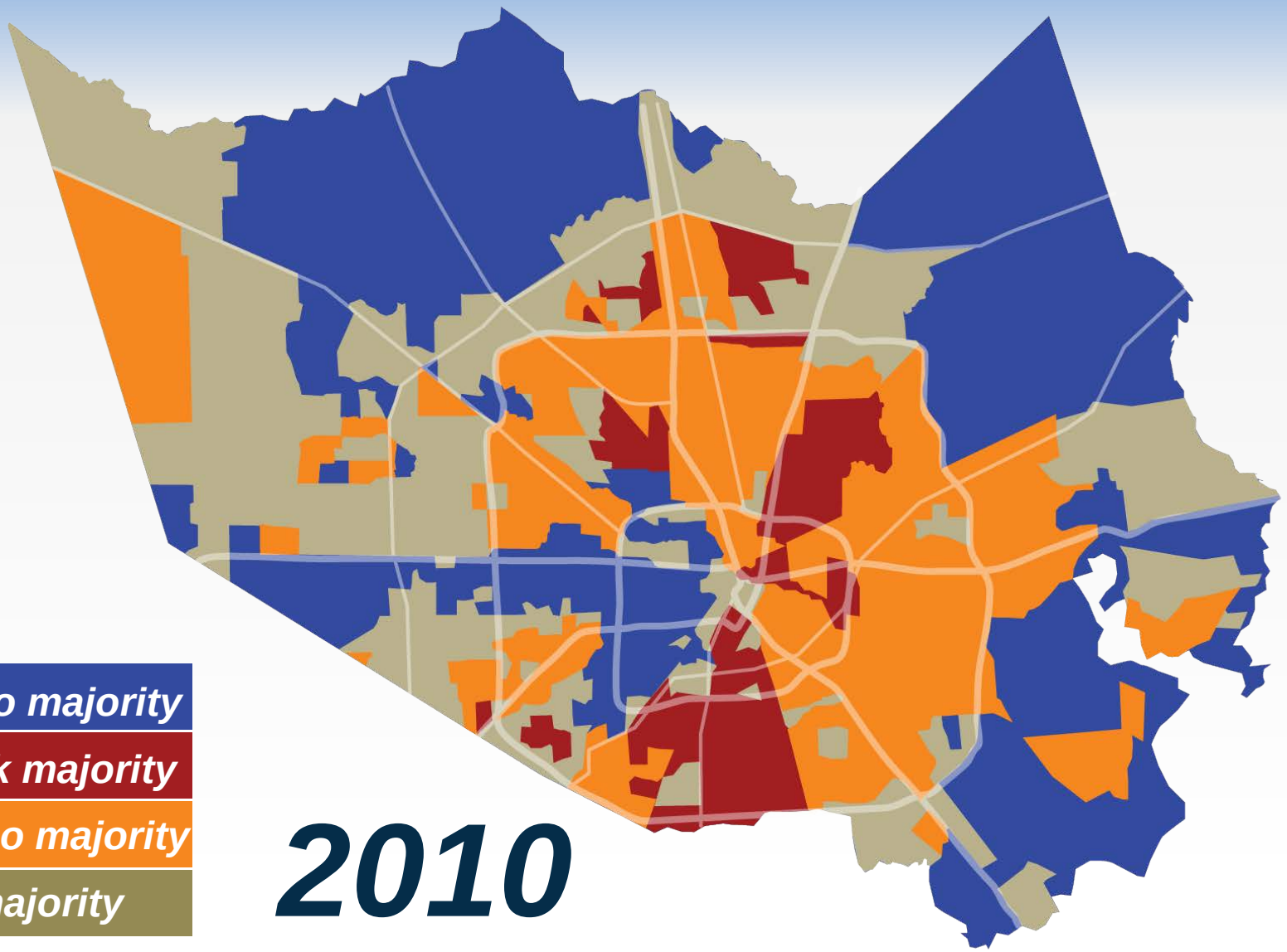
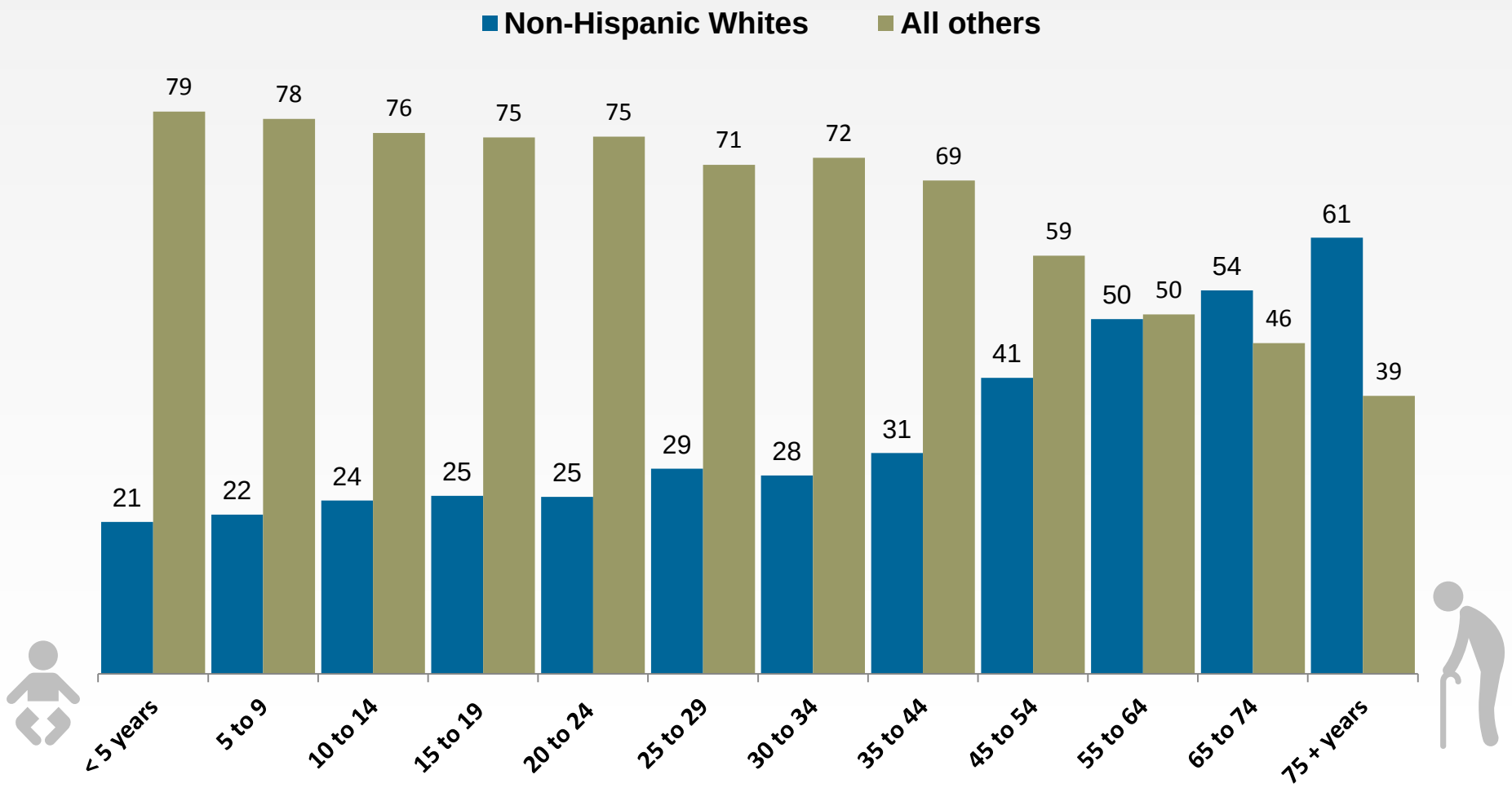
Harris County total population



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Color represents demographic group being a majority in that census tract.
Source: Outreach Strategists, LLC

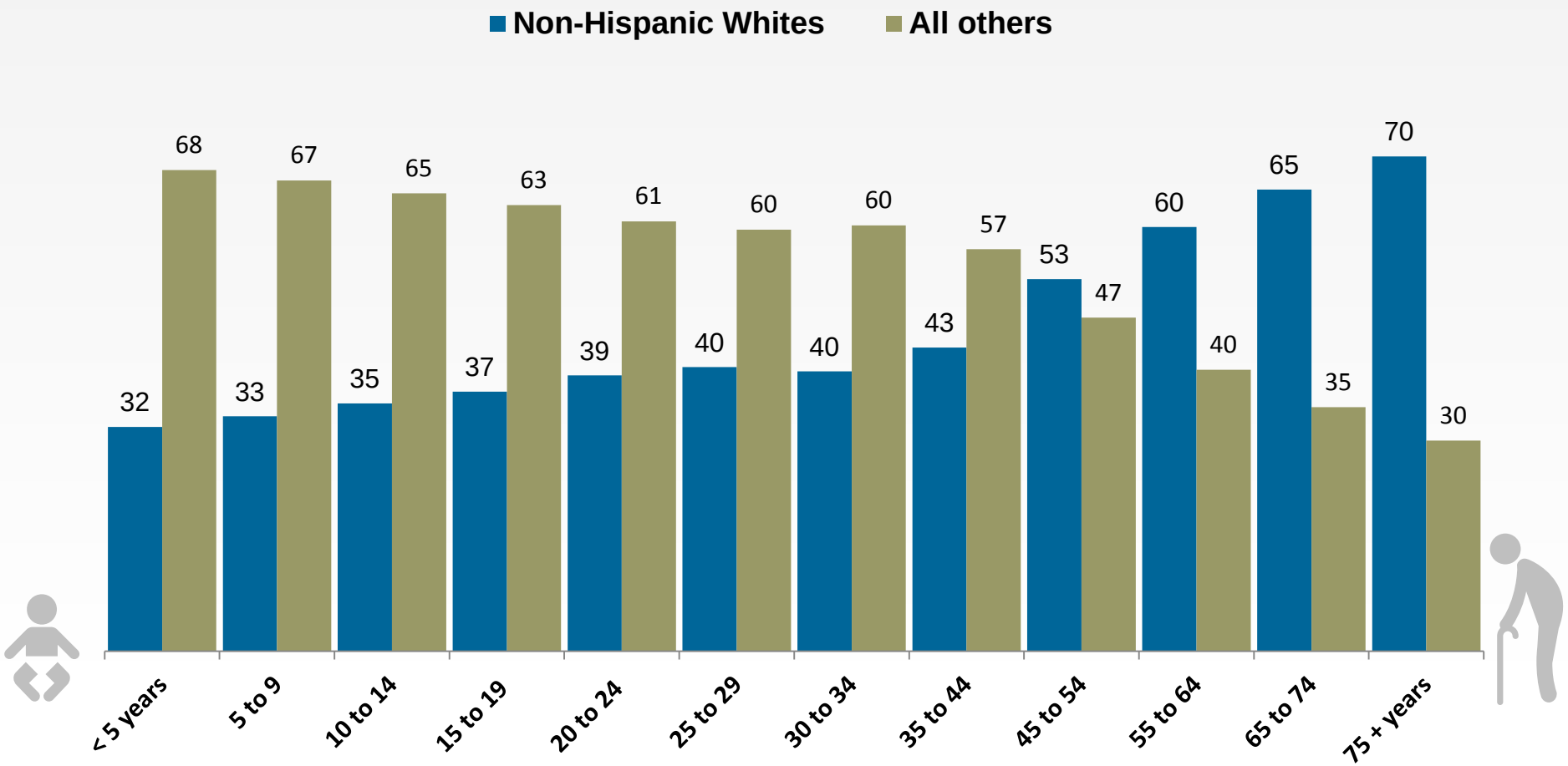
Percent of the population by age group and ethnicity in Harris County in 2012



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census Bureau. 2008-2012 ACS 5-year estimates

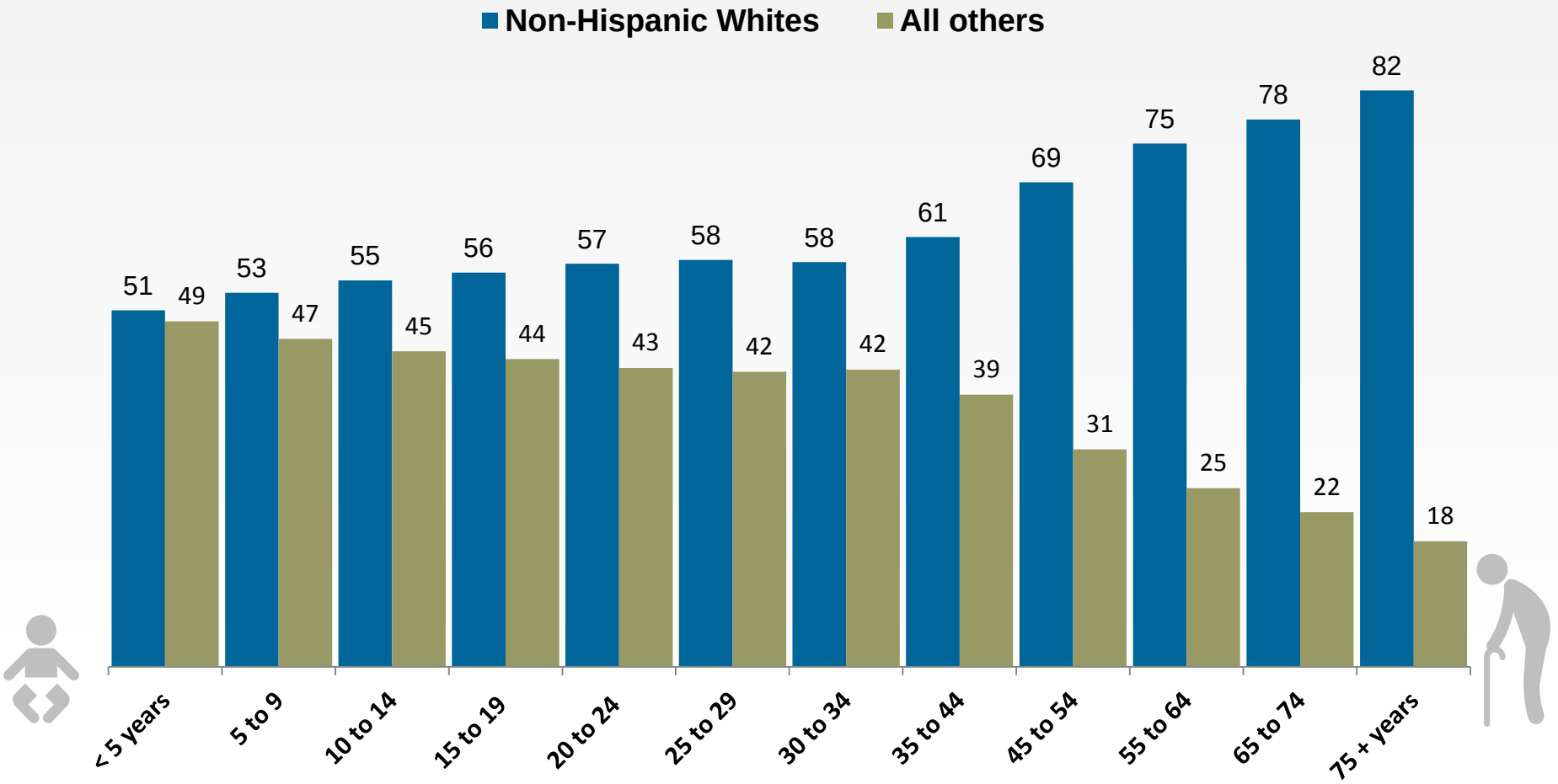
Percent of the population by age group and ethnicity in Texas in 2012



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census Bureau. 2008-2012 ACS 5-year estimates

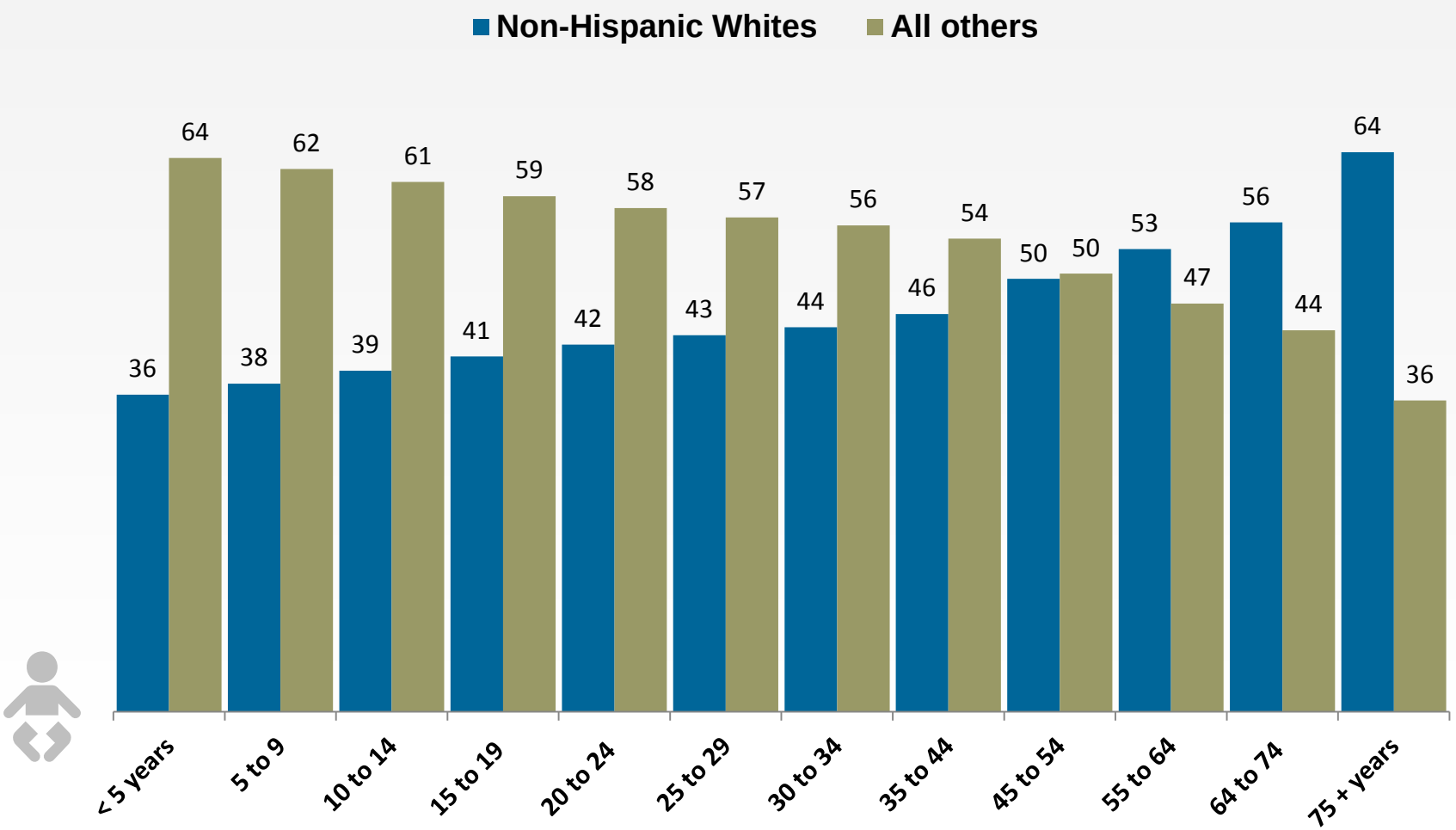
Percent of the population by age group and ethnicity in the United States in 2012



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census Bureau. 2008-2012 ACS 5-year estimates

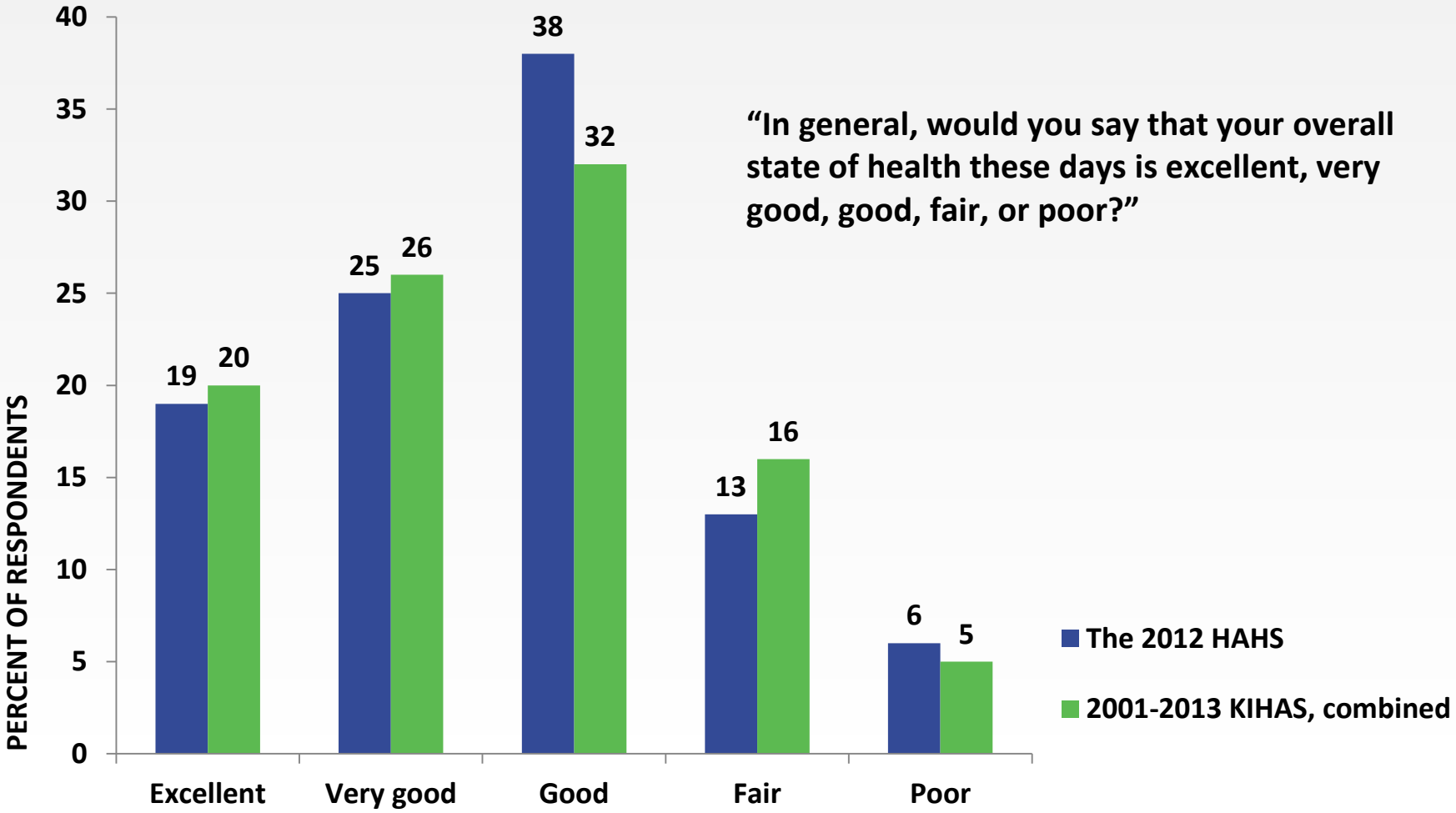
Percent of the population by age group and ethnicity in the United States in 2050



RICE UNIVERSITY KINDER INSTITUTE FOR URBAN RESEARCH

Source: U.S. Census Bureau. 2012 National Population Projections, Alternative Net International Migration Series (Constant Series).

Self-rated health status in Harris County



The structural correlates of self-rated health: The additional importance of health insurance

Respondents who said that their "overall state of health these days" was only "fair" or "poor."

	Model 1 (KHAS 2001-2013)			Model 2 (KHAS 2001-2012)		
Independent Variable	B	SE	OR	B	SE	OR
Sociodemographics						
Age	+.022****	.002	1.022	+.025****	.002	1.025
Female	-.043	.064	.958	-.060	.072	.942
Ethnicity[a]						
Non-Hispanic Whites (Anglos)	-.406****	.072	.666	-.363****	.080	.695
Measures of Socioeconomic Status						
Income[b]						
$35,501 – 50,000	-.459****	.096	.632	-.381****	.108	.683
$50,001 – 75,000	-.631****	.095	.532	-.529****	.107	.589
More than $75,000	-.951****	.093	.387	-.771****	.104	.463
Education[c]						
High School Diploma	-.165	.104	.848	-.053	.122	.948
Some College	-.337***	.103	.714	-.214*	.121	.807
College Degree	-.838****	.113	.432	-.743****	.132	.476
Health Insurance	-----	-----	-----	**-.463**** **	.093	.630
N	6,972			5,435		

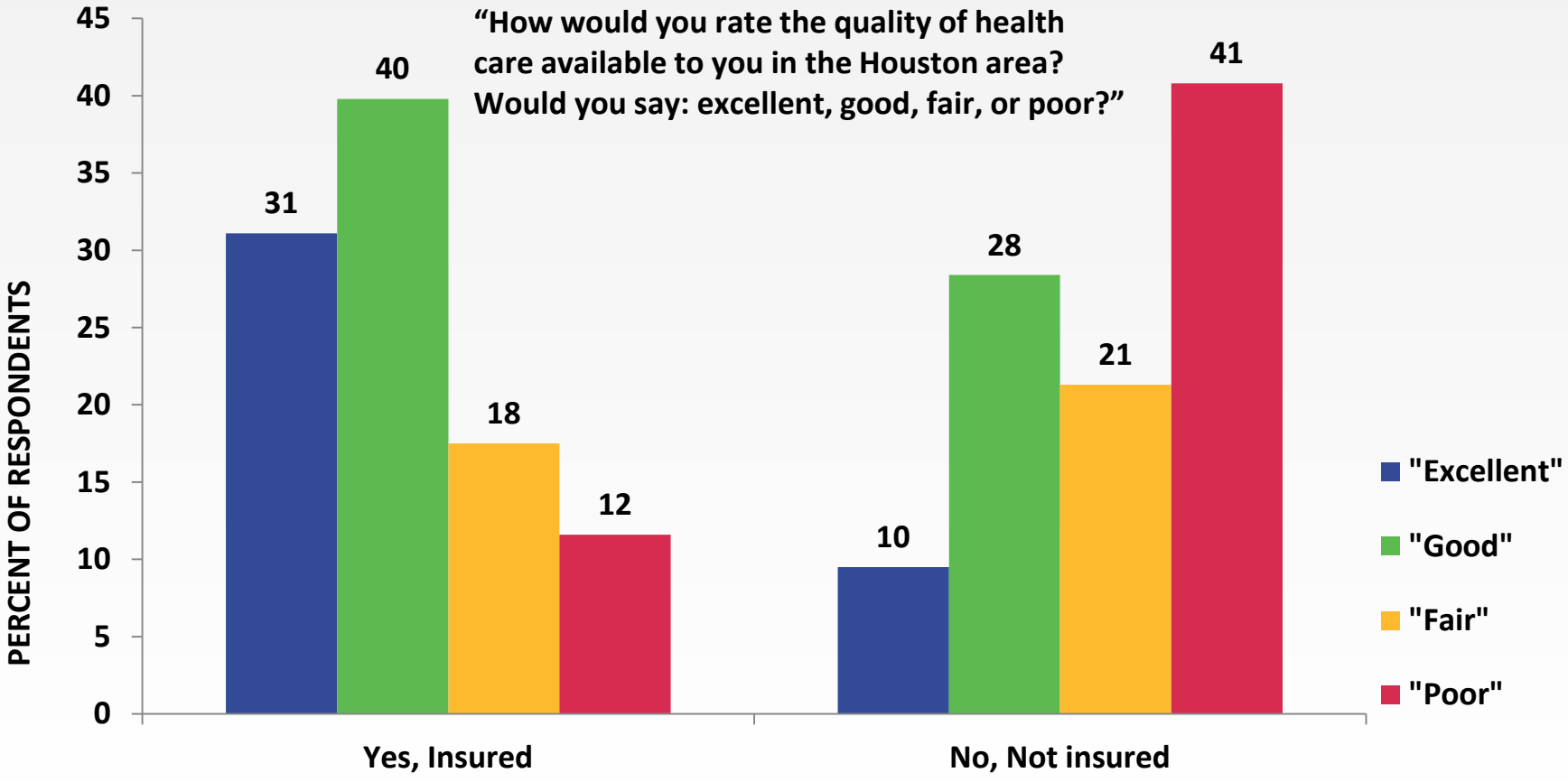
[a]There were no meaningful differences in self-rated health status between blacks, U.S.-born Latinos, and Latino immigrants . Blacks and Latinos make up the reference group. The few Asians and "others" were removed from this analysis.

[b]Reference group: Less than $35,501.

[c]Reference group: Less than high school.

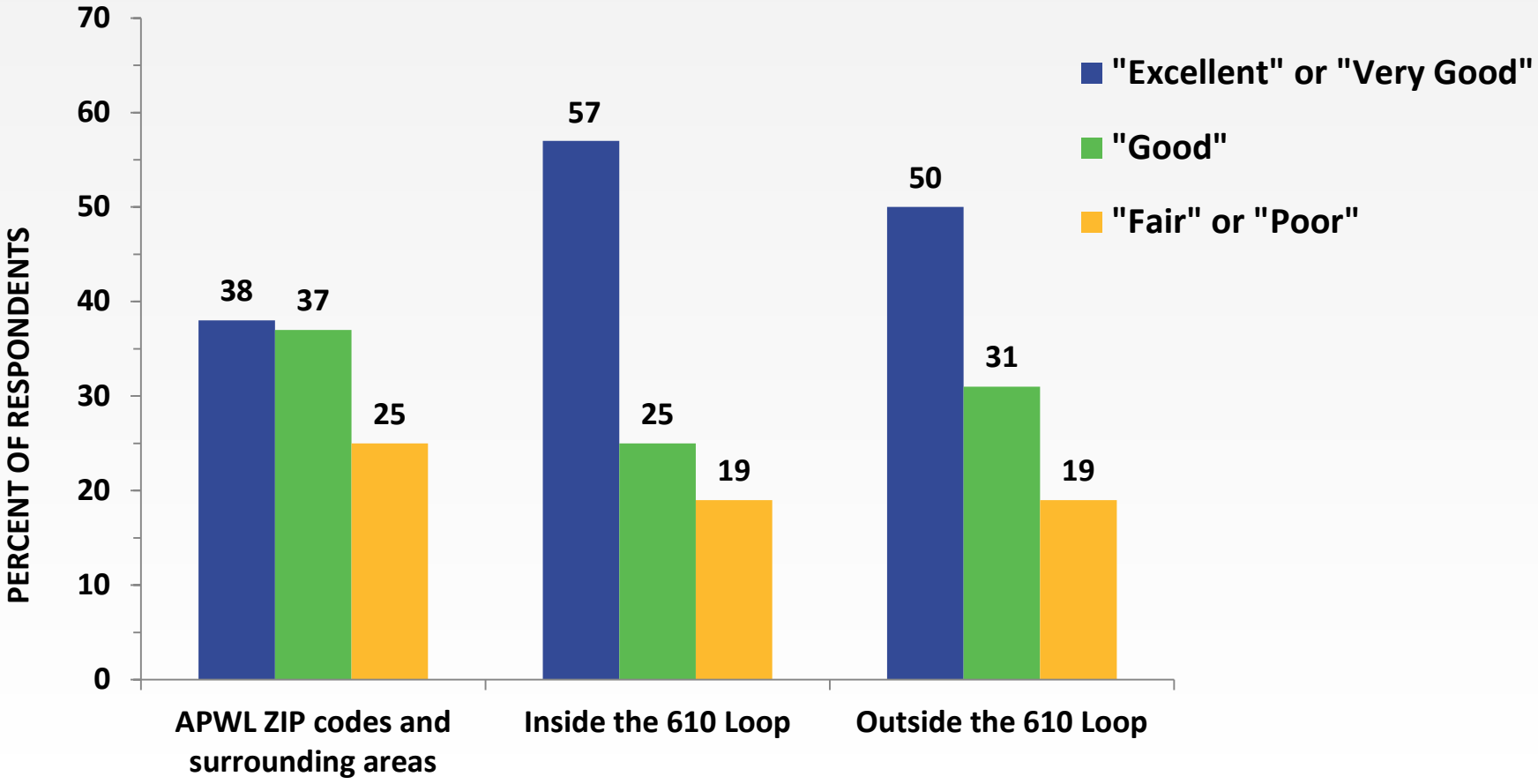
*p < .10, **p < .05, ***p < .01. ****p < .001 (two-tailed tests).

Respondents' ratings of the quality of health care available to them, by insurance coverage (HAHS)



"Are you currently covered by any type of health insurance or health care plan?"

Self-reported health status by proximity to the ten Harris County ZIP codes on the APWL (KIHAS)

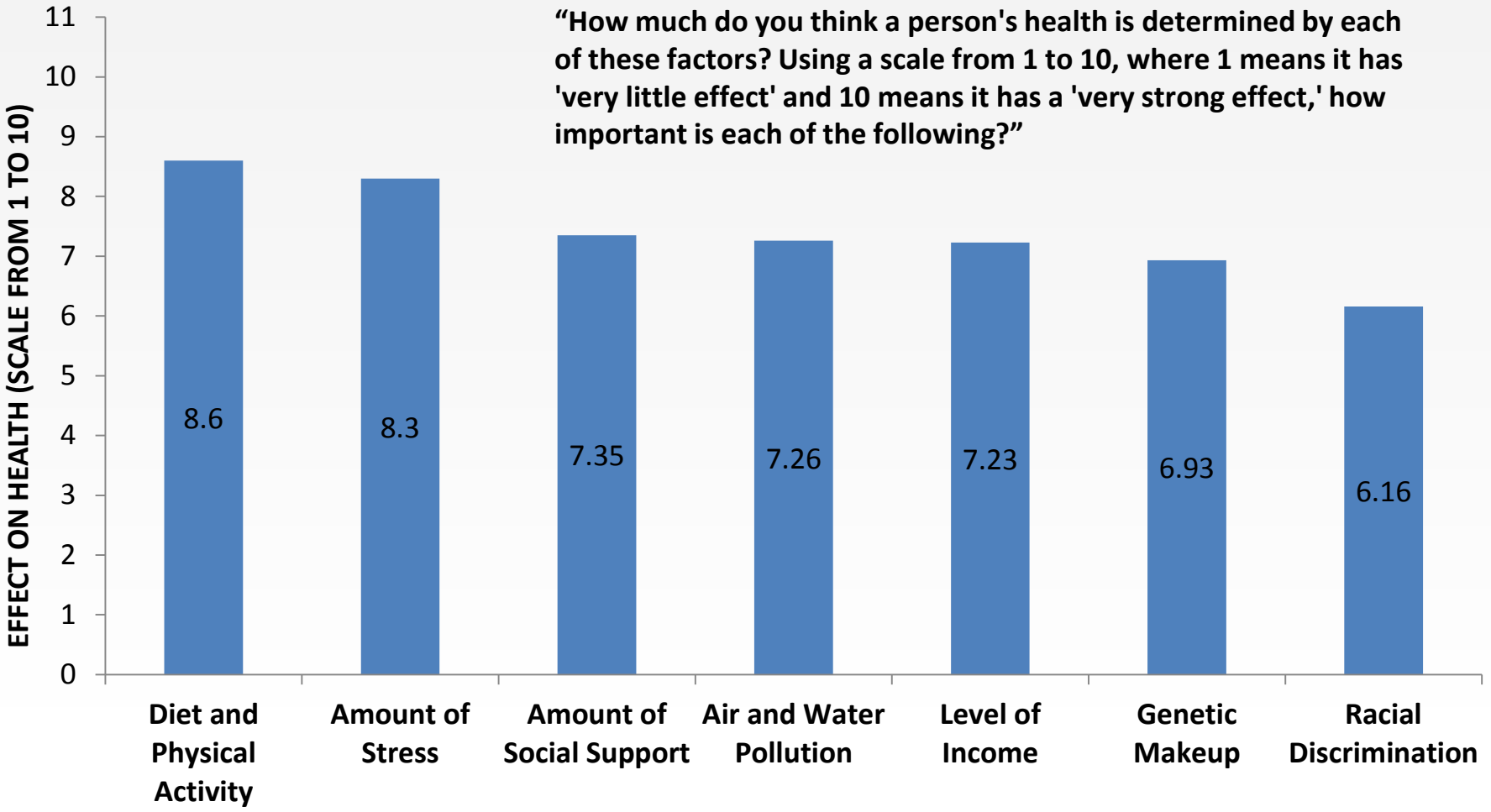


The effects of living in or near the APWL ZIP codes on self-reported health, controlling for the structural variables and for insurance coverage (KIHAS)

Independent Variable	Self-Reported "Fair" or "Poor" Health			
	Coefficient	Standard Error	Odds Ratio (OR)	1-OR
(A) Socioeconomic Status				
(1) Education				
High School Diploma	-.110	.126	.896	-.104
Some College	-.261*	.126	.770	-.230
College Degree	-.781***	.139	.458	-.542
(2) Income				
$35,501 to $50,000	-.449***	.112	.638	-.362
$50,001 to $75,000	-.522***	.109	.593	-.407
More than $75,000	-.776***	.106	.460	-.540
(B) Demographic Characteristics				
(3) Ethnicity				
Black	+.423***	.095	1.526	+.526
Latino	+.195*	.100	1.216	+.216
Asian	+.038	.281	1.039	+.039
(4) Age	+.023***	.002	1.023	+.023
(5) Female	-.101	.073	.904	-.096
(C) Having Health Insurance	-.460***	.096	.631	-.369
(D) Living in or near APWL ZIP Codes	**+.248****	.090	1.281	+.281

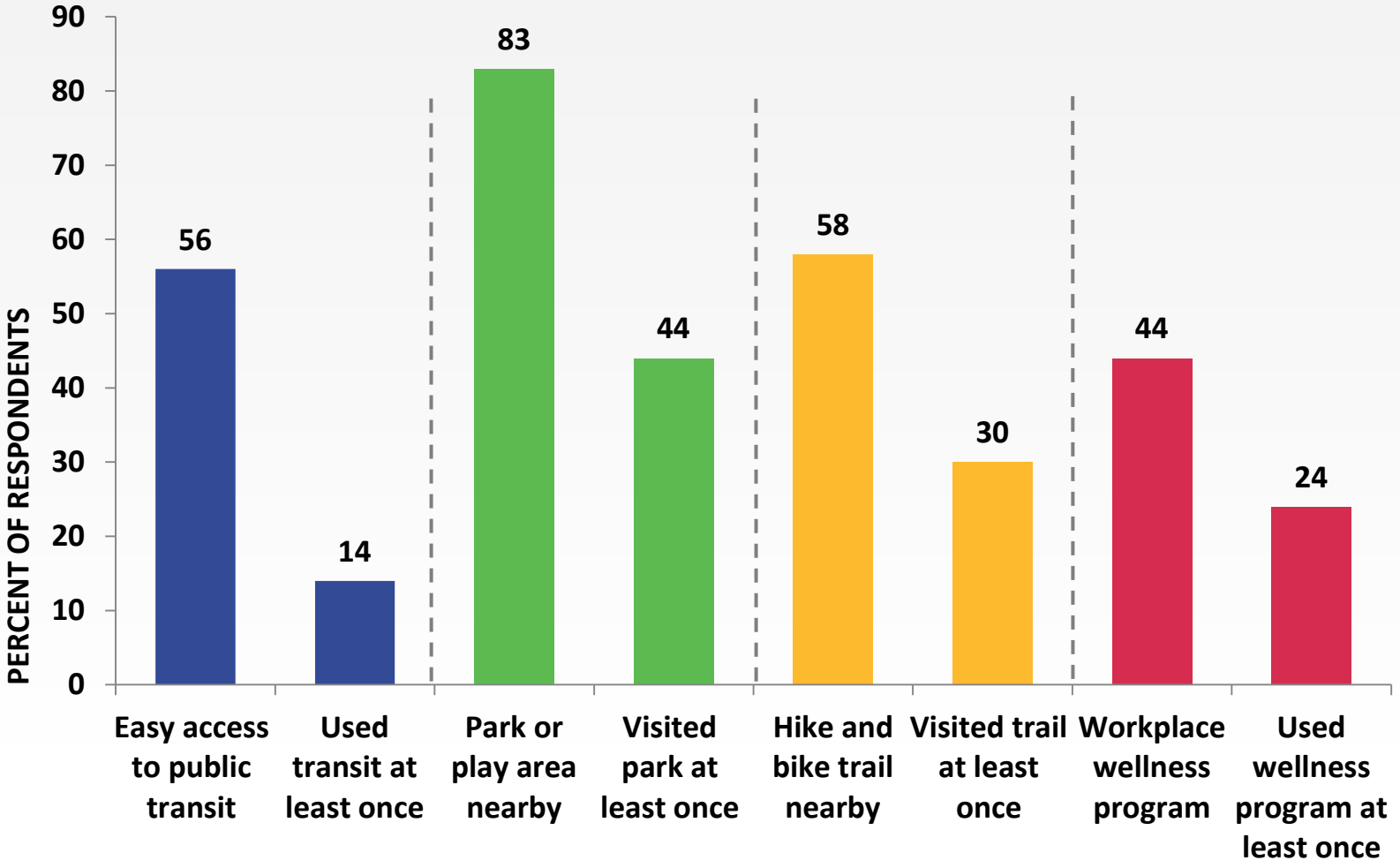
Constant	-.457***	.144	.633	-.367
N	5,275			

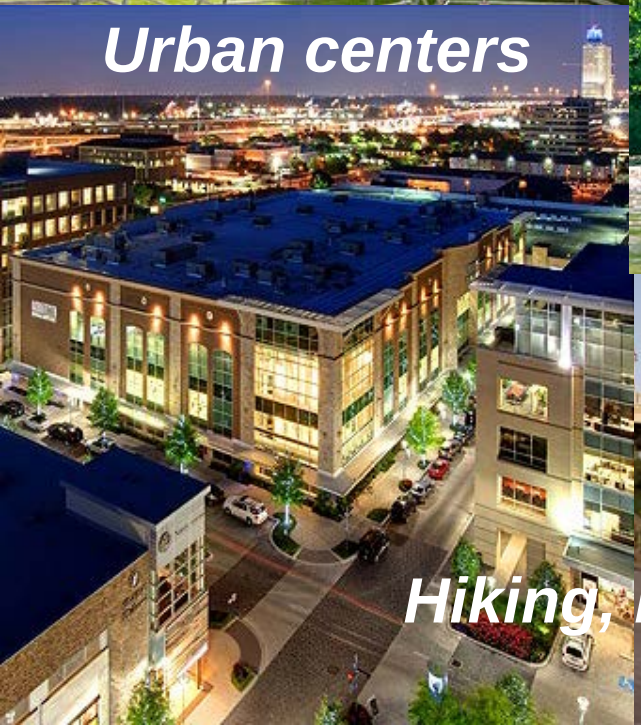
The perceived determinants of a person's health, average ratings (HAHS)



The availability of health-promoting resources compared to their usage during the past year

The availability of health-promoting resources and their usage during the past year (HAHS)





Quality of Place

Houston's urban sprawl

2.1 million
600 sq. mi.

Baltimore
0.6 million
81 sq. mi.

Chicago
2.7 million
228 sq. mi.

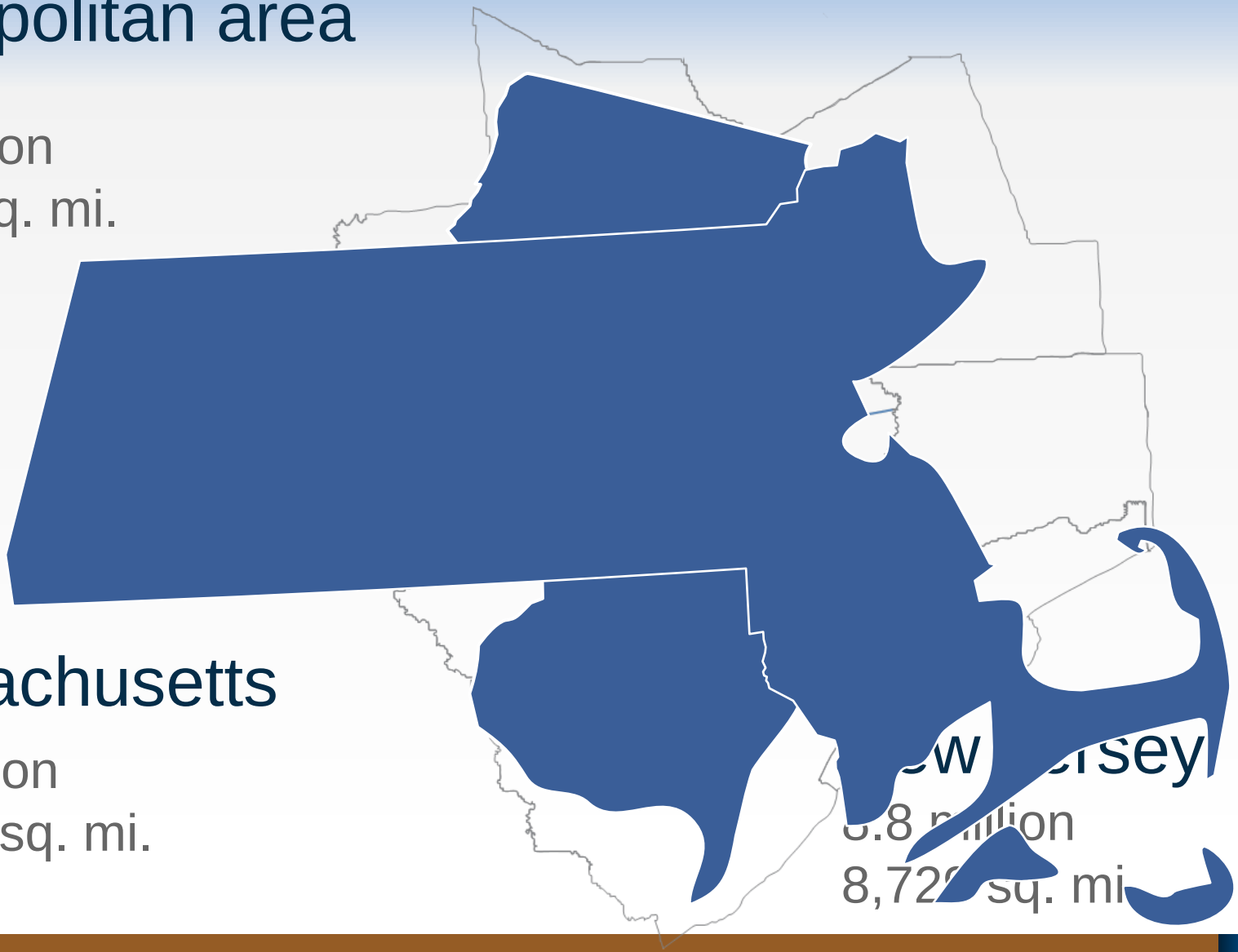
Detroit
0.7 million
139 sq. mi.

Philadelphia
1.5 million
134 sq. mi.

Source: U.S. Census Bureau

The nine-county Houston metropolitan area

5.8 million
9,434 sq. mi.

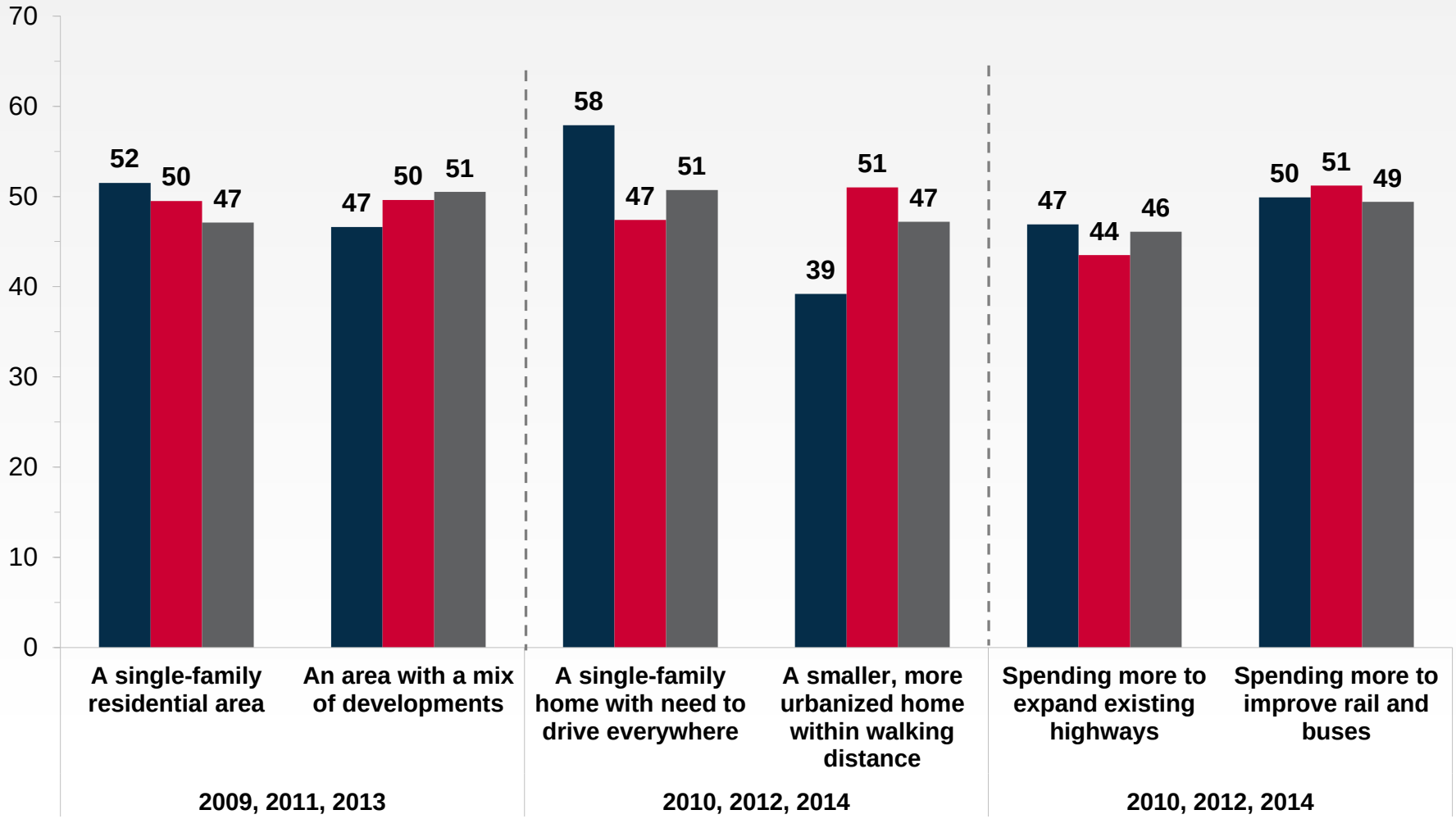


Massachusetts

6.6 million
10,550 sq. mi.

Source: U.S. Census Bureau

The divided preference for car-centered vs. transit-oriented developments (2009-2014)



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Source: Kinder Institute Houston Area Survey (2009-2014)


1978


2011
Hilton
© Ale

Today’s pro-growth agenda

Houston needs to develop into a truly successful multiethnic society, one with equality of opportunity for all communities, where all are encouraged to participate as full partners in shaping the region’s future.

The Houston region needs to nurture a far more educated workforce and develop the research centers that will fuel the new economy.

The Houston region needs to grow into a much more appealing urban destination, while accommodating an expected 3.5 million additional residents in the next 20 years.

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RICE

Presented by: Dr. Lee Revere

RAISE THE FLOOR INITIATIVE – QUALITY IMPROVEMENT METHODOLOGIES

Achieving Continuous Quality Improvement: Region 3 Learning Collaborative

June 5, 2014

Lee Revere, PhD, MHA

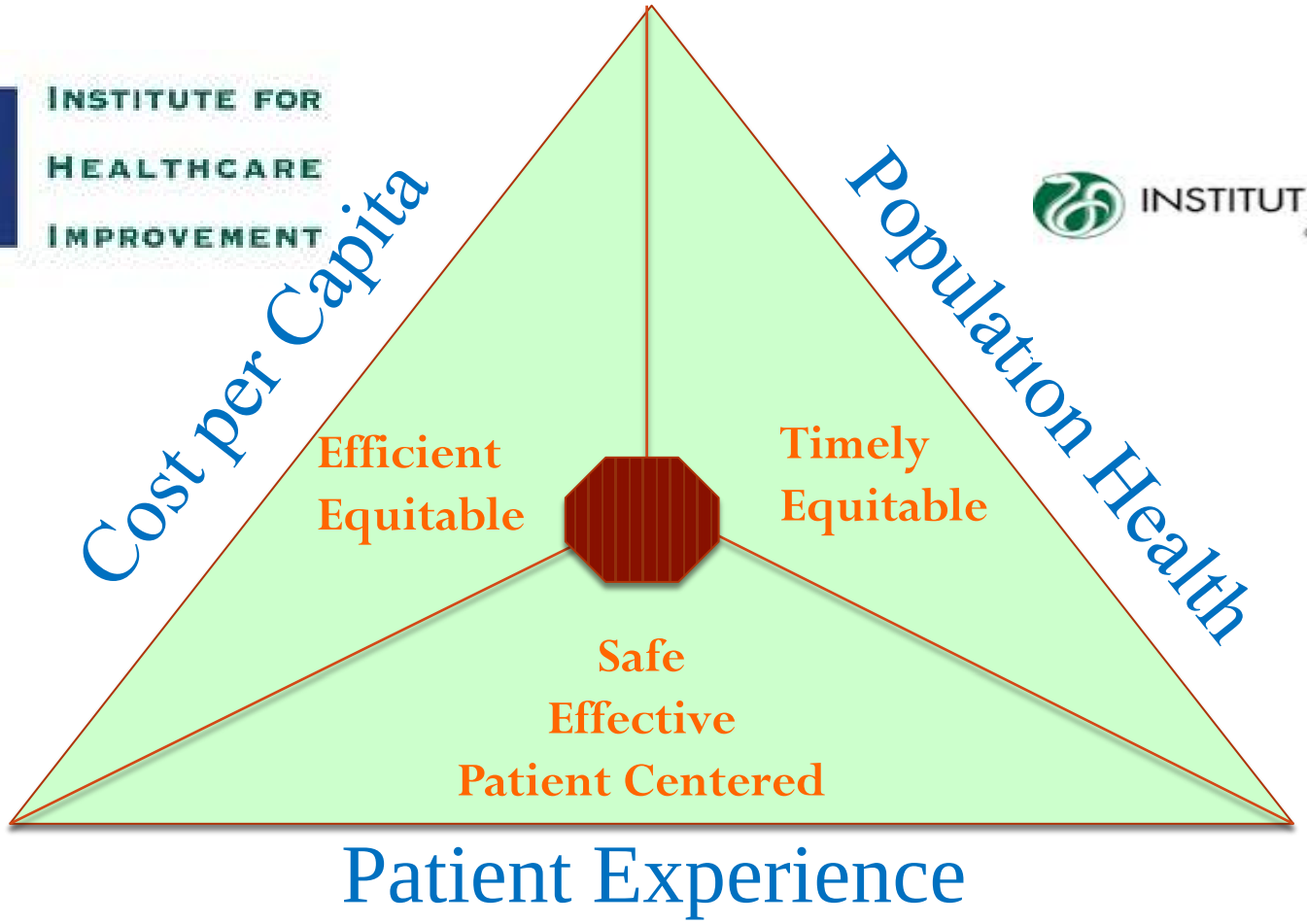
UTHealth | School of Public Health
The University of Texas
Health Science Center at Houston

Learning Objectives

- To explore the definition of "Quality" and "Continuous Quality Improvement" in relationship to 1115 waiver projects;

- To assess and apply (to specific waiver projects) a variety of CQI tools commonly used for process improvement.

Achieving Quality : The 1115 Waiver Perspective



Improving Quality: The Convergence

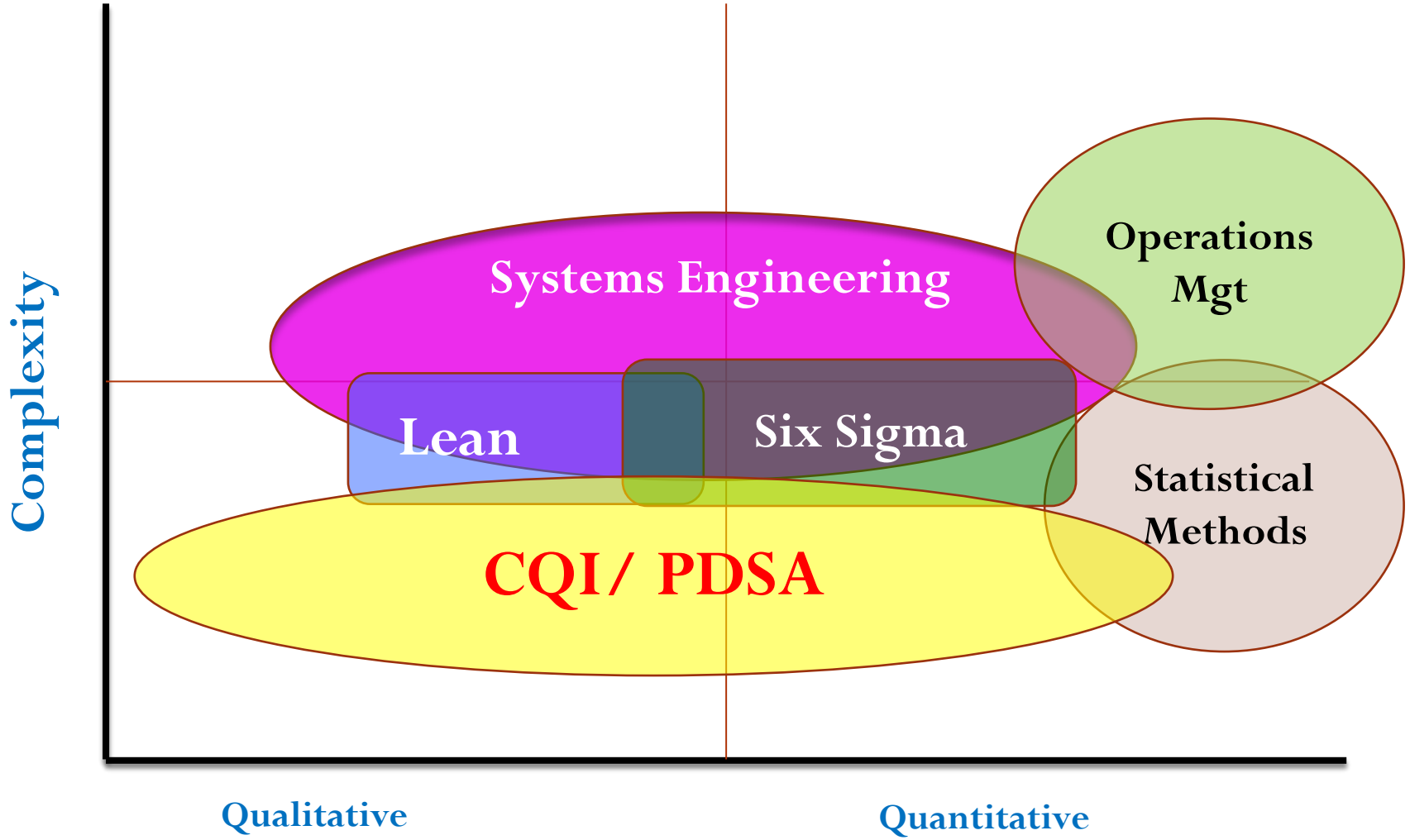
Region 3 Improvement Initiatives

Regional LC Activities

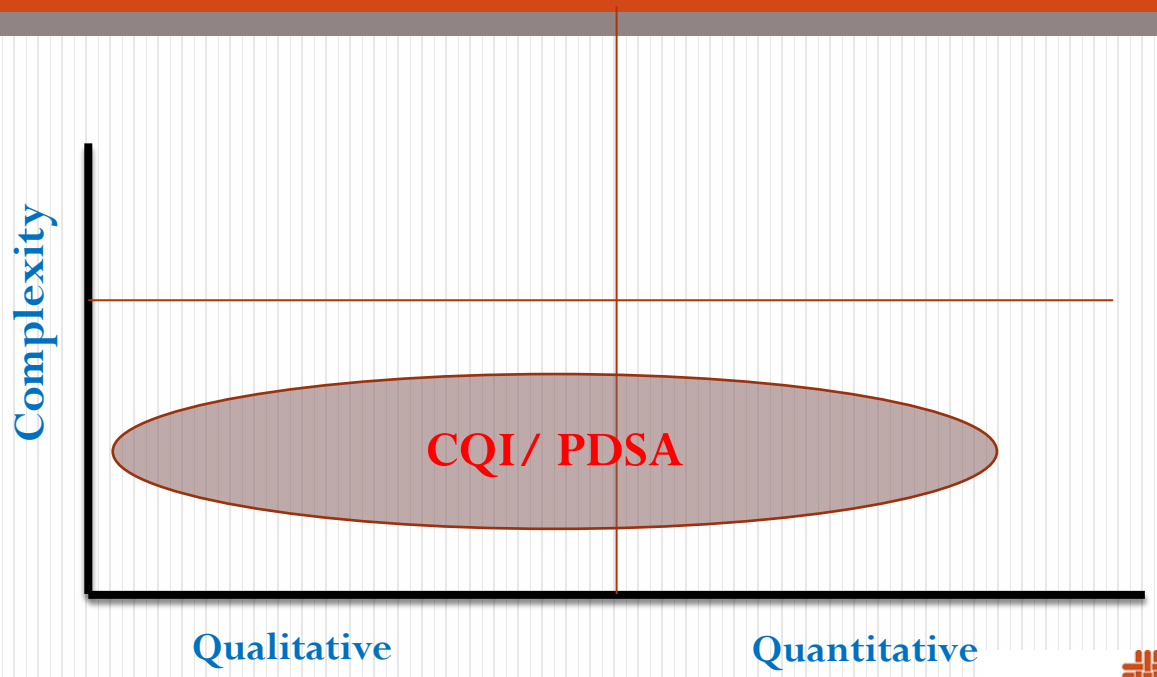
Cohort Workgroups and Sharing

Provider (Waiver) Projects and Organizational Learning

Methodologies for Improvement



Continuous Quality Improvement(CQI)



What Is Continuous Quality Improvement(CQI)?

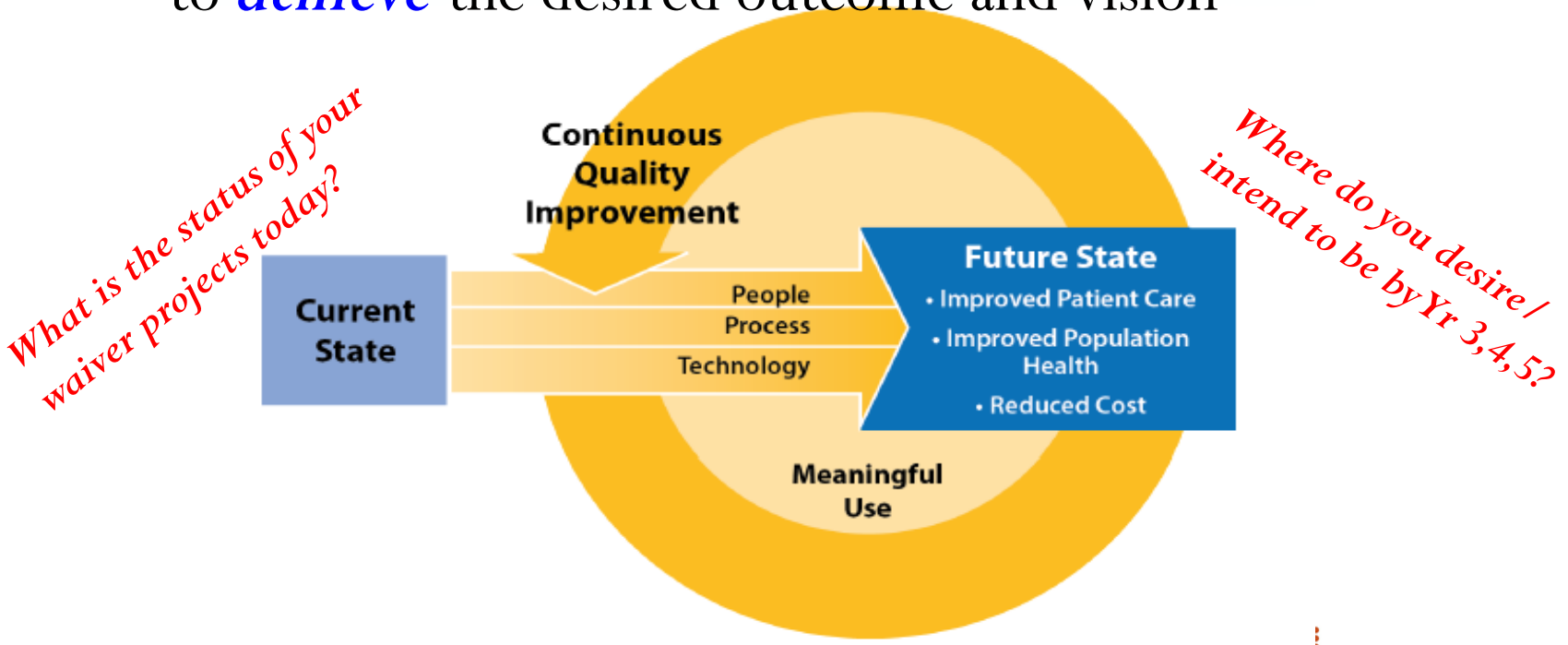
- CQI is a philosophy which aligns teams to ask/ answer:
  "How are we doing?" and *"Can we do it better?"*
  - More ***efficient***?
  - More ***effective***?
  - More ***timely***?

- CQI begins with the culture of improvement for the patient, the practice (*projects*), and the population (*Region 3*).

Reference: (Edwards, 2008); Health Information Technology Research Center (HITRC). 2013. Continuous Quality Improvement (CQI) Strategies to Optimize your Practice

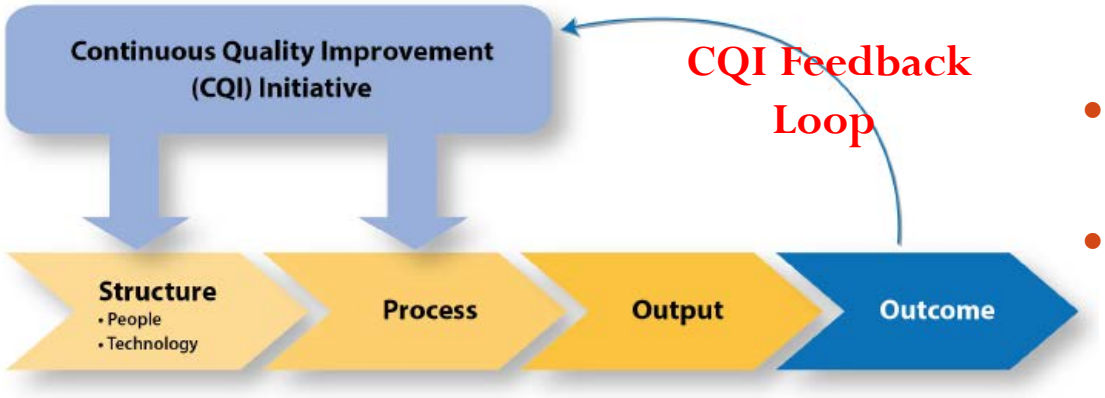
Using CQI to Move From Current to Future State

- A ***structured*** planning approach
  - to ***evaluate*** the current system and processes
  - to ***improve*** the system and processes
  - to ***achieve*** the desired outcome and vision



Reference: Health Information Technology Research Center (HITRC). 2013. Continuous Quality Improvement (CQI) Strategies to Optimize your Practice

The Basic Premise of CQI



CQI Framework Model → Donabedian Model

- **Structure:** technological, human, physical, and financial needed to carry out its work.
- **Process:** activities, workflows, or task(s) necessary to achieve an output or outcome.
- **Output:** immediate predecessor to the change in the patient's status.
- **Outcome:** end result of care (AHRQ, 2009) and a change in the patient's current and future health status due to interventions (Kazley, 2008).
- **Feedback Loop:** once a change to the structure and process is implemented, feedback is needed to determine whether it achieved the intended outcome and, if not, what other changes could be considered.

Reference: Health Information Technology Research Center (HITRC). 2013. Continuous Quality Improvement (CQI) Strategies to Optimize your Practice

The PDSA/PDCA Cycle – The CQI Feedback Look

Plan

- Plan the test or observation, including a plan for collecting data.
- Determine the objectives, questions, and predictions.

Do

- Try out the test on a small scale.
- Document challenges, successes and unexpected results.

Act

- Refine the change, based on what was learned from the test.
- Ensure the next cycle reflects lessons.

Study/Check

- Set aside time to analyze the data and study the results.
- Compare to predictions.
- Summarize what was learned.

Adapted from © 2001 Institute for Healthcare Improvement

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Institute for Healthcare Improvement (IHI) Breakthrough Series Framework and CQI

- A Breakthrough Series Collaborative is *a **short-term learning system*** that brings together a large number of teams ***to seek improvement in a focused topic area***
- Improves ***quality*** while ***reducing costs***
- Collaboratives allow organizations to ***learn from each other*** and ***from experts*** in identified topic areas
- Apply this approach to ***project implementation***
- A Collaborative has three essential characteristics:
  - Implemented in a finite time using a rapid pace
  - Relies on collaboration
  - Grounded in change

INSTITUTE FOR HEALTHCARE IMPROVEMENT

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

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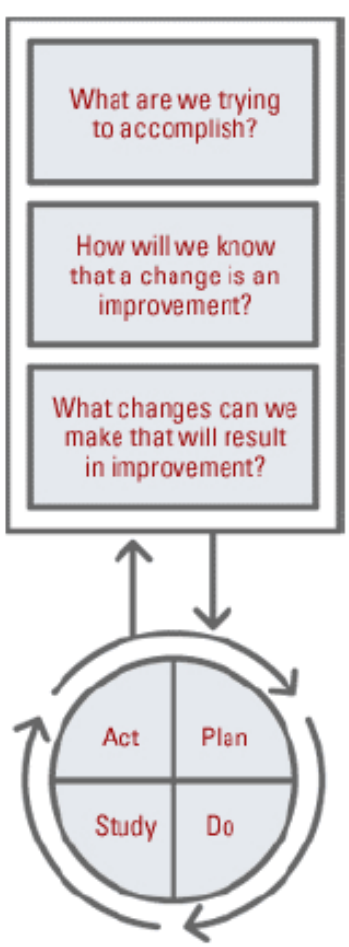
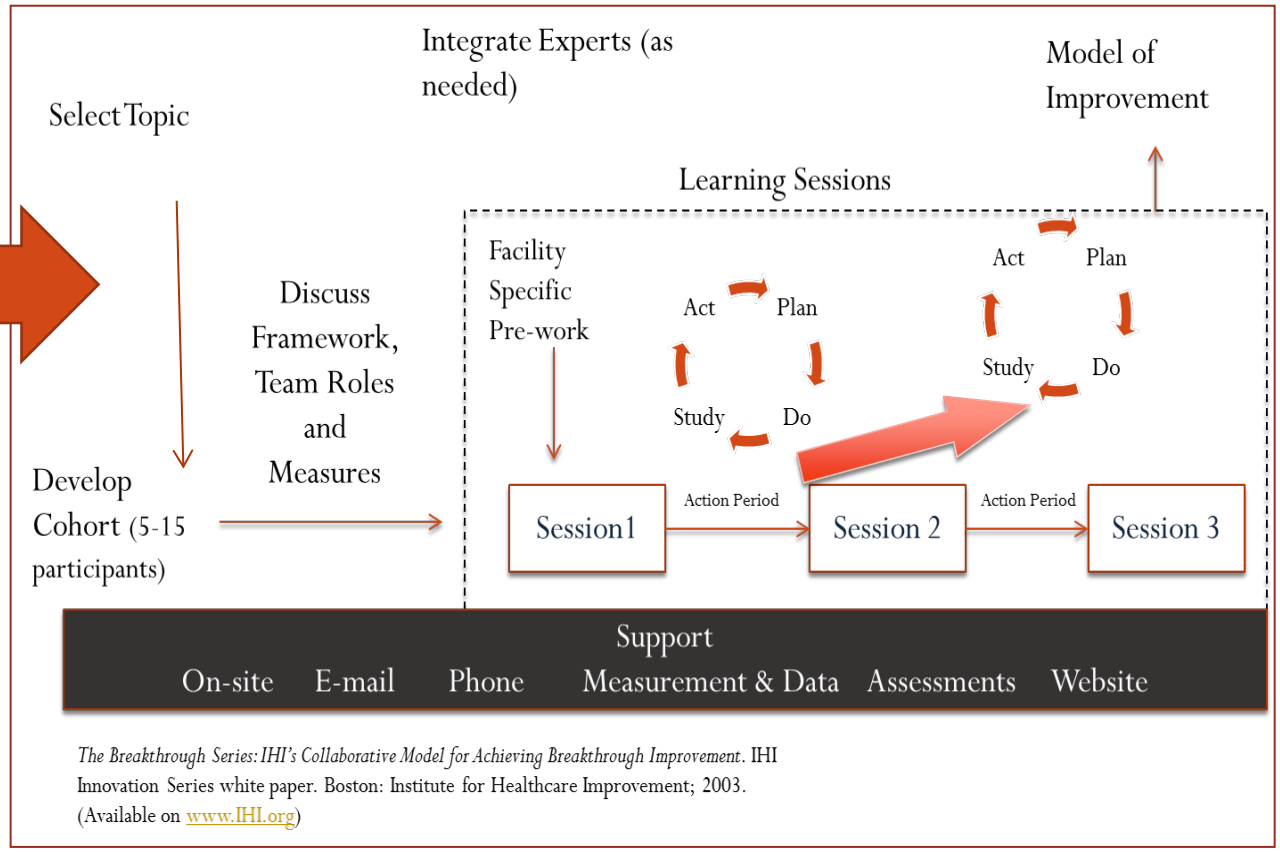
IHI's Strategy for CQI in Health Care

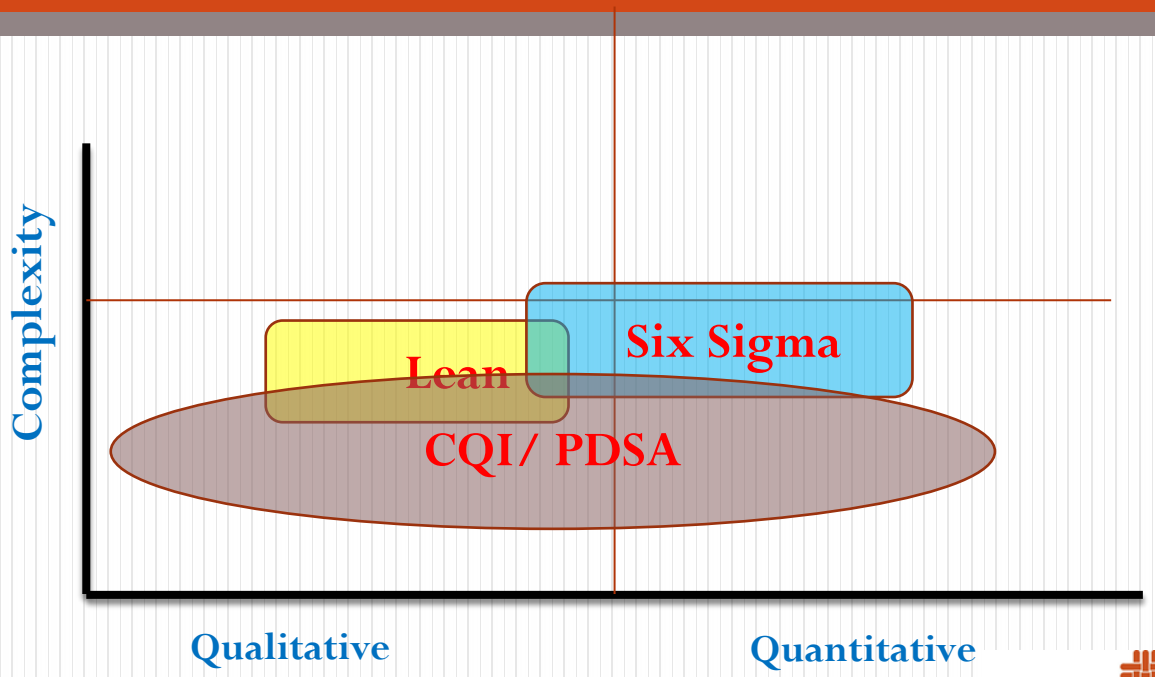
Model for Continuous Quality Improvement





The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

Lean Six Sigma Simplified



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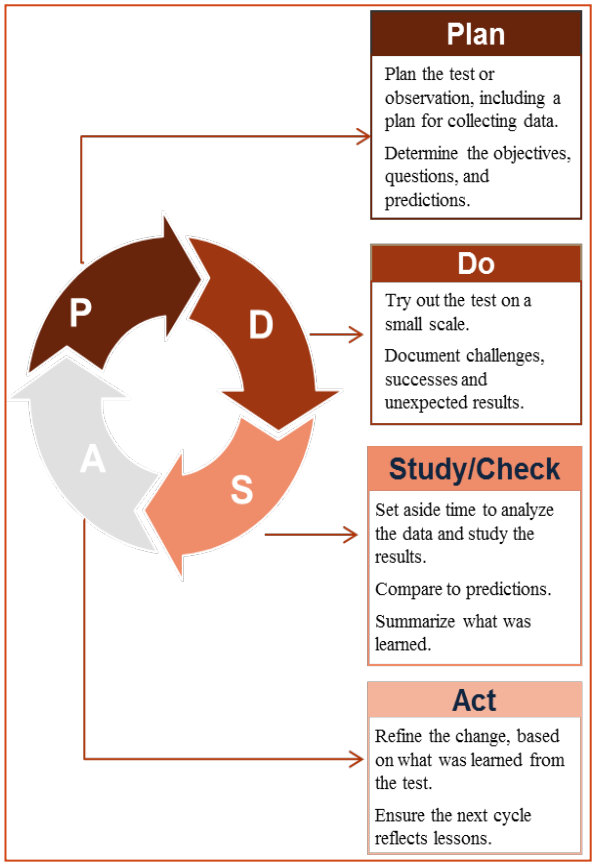
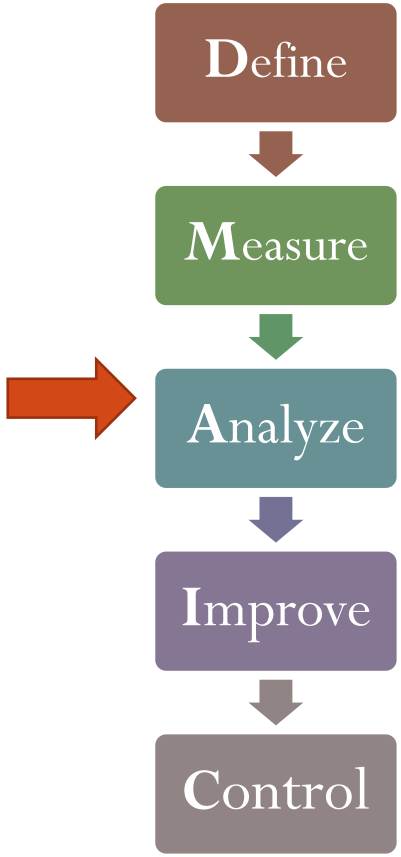
Applying PDSA to Six Sigma DMAIC Framework

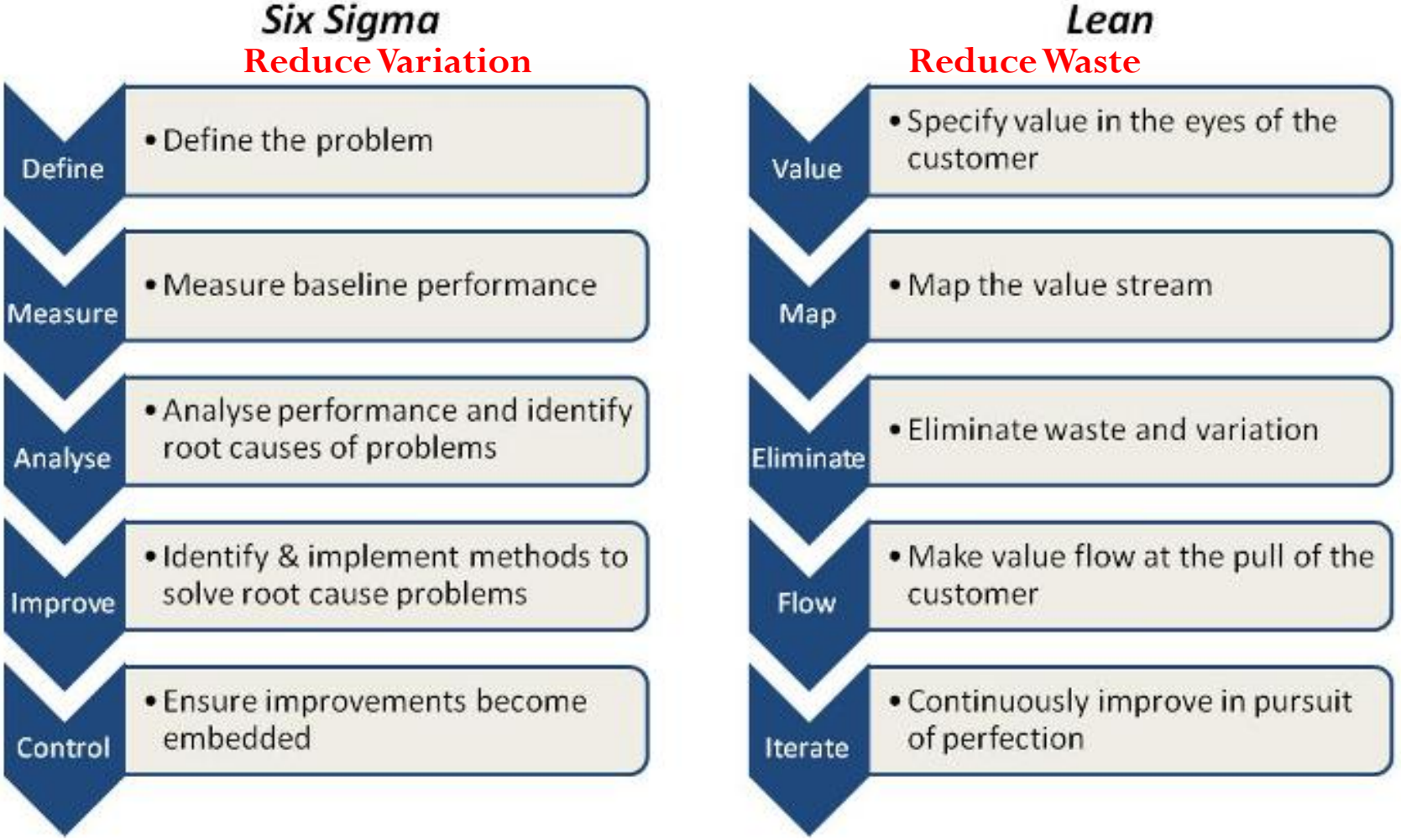




	Step	Tools
D	Select Project	Brainstorming, **VOC Affinity Diagram, Project Charters**
M	Data Collection and Analysis	**SIPOC,** Flow Charts, Checksheets, Histograms, Run Charts, Scatterplots, Pareto Graphs
A	Causal Analysis	**Cause and Effect Diagrams, 5 Whys,** Pareto Charts, Correlation
I	Solution Planning and Implementation	Prioritization Diagrams, Tree Diagrams
C	Evaluation of Effects	Flow charts, Checksheets, Histograms, Run Charts, Scatterplots, Pareto Graphs
C	Standardization	Control / Run Charts

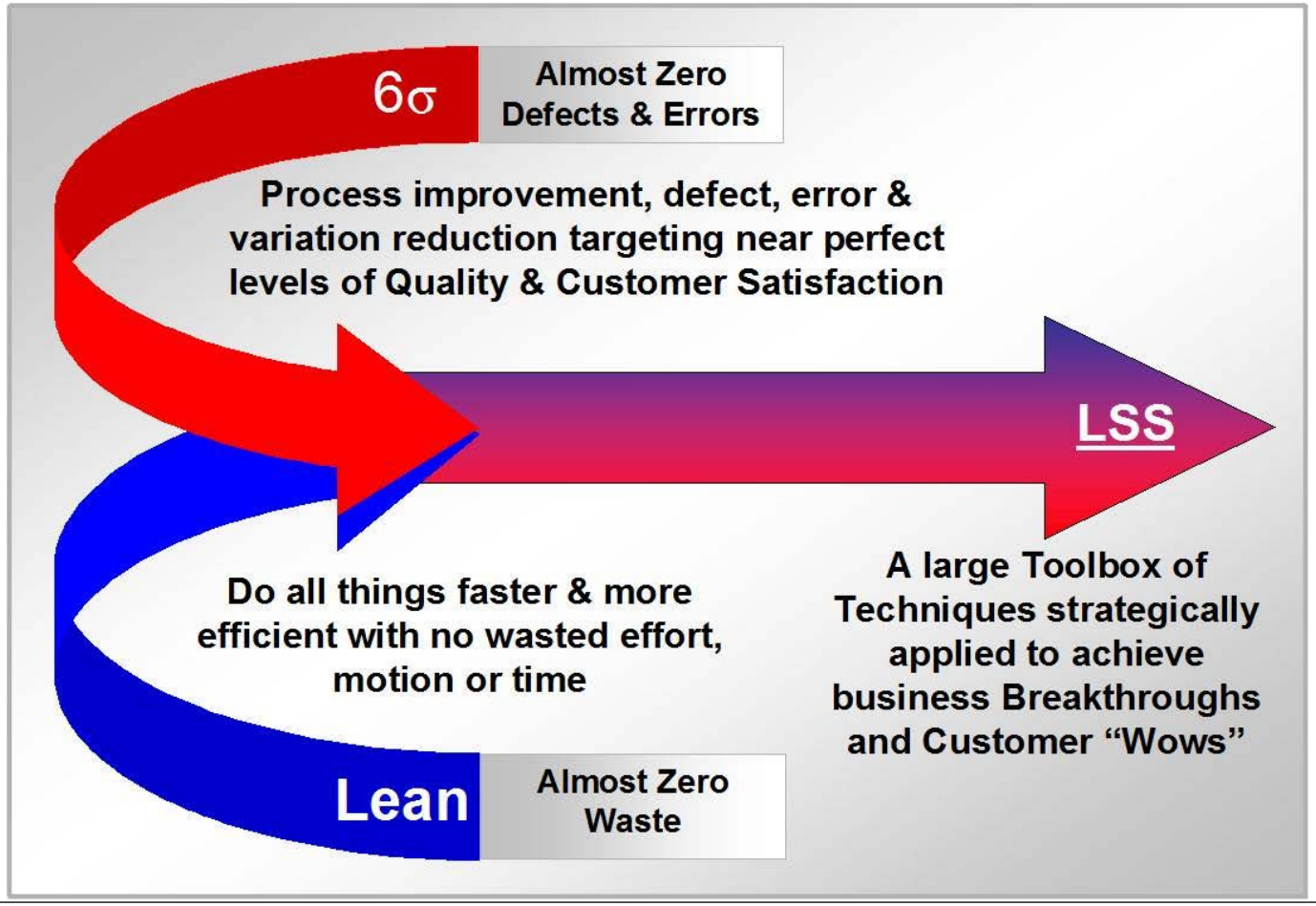
Where is Your Organization on Implementing CQI in Your 1115 Waiver Projects?
Which Tools Does Your 1115 Waiver Project Need?

Six Sigma vs. Lean: *What Method Does Your 1115 Waiver Project Need?*



Where is there Waste in Your Organization?
Are your 1115 Waiver Projects Eliminating Waste??

Six Sigma+ Lean= Lean Six Sigma



Common CQI, Lean, Six Sigma for Process Improvement

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Common Lean Six Sigma Tools for Achieving CQI

Lean

- **VOC**
- **SPIOC**
- **5 Why's / Root Cause Analysis**
- **Flowcharts / Value Stream**
- Spaghetti Diagrams
- 5 S Visual
- Poka-Yoke (error proofing)
- Just-in-Time
- Pull Systems/Leveling
- Kaizen Events
- HFMEA

6σ

- **VOC**
- **Project Charters**
- **Affinity Diagrams**
- **Process Maps/ Flowcharts**
- **Cause & Effect (Fishbone)**
- Check Sheet or Checklist
- Pareto charts
- Correlation/ Hypothesis
- Histogram
- Scatter Chart
- SPC

Voice of Customer

Example:

- Expand primary care
  - "Who is the target population?"
  - "Who is the customer?"
  - "What do they want?"
  - "Will you know they are satisfied?"
  - "What else might they need?"

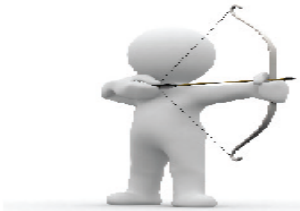
Project Charter

Elements of a Charter

- Problem Statement
- Project Scope
- Measures of Success
- Meeting Expectations
- Identify Team Roles & Responsibility

Adapted from: Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook *Second Edition*

Developing a *SMART* Aim Statement Worksheet

Aim Statement Criteria:	Developmental Questions:
Specific	Who are the target population and persons doing the activity? What is the action or activity?
Measurable	How much change is expected? Will there be an increase or decrease? Can you measure it?
Achievable	Can it be done? Can you accomplish it in the prescribed timeframe? Do you have resources?
Relevant	Does the action relate to what you want to accomplish? Is it important & meaningful? Does it relate to broader program or organizational goals?
Time-Bound	What is the timeline for change? When will this be accomplished? Month, day, time, or year?
Aim Statement 	Write your SMART aim statement below:

Date: 9/23/2013

COHORT GROUP CHARTER

Cohort Group:	Version:	Focus Topic:
EC Utilization (Increased Capacity Subgroup)	1.0	Increased capacity in specialty and primary care setting to help decrease EC volume as necessary.

Problem/Opportunity Statement:

Patients and staff are unaware of the viable alternative resources to emergency care and how to access these alternatives.

Advisory Group Member(s): (specify Data or QI)

QI - Sahar Qcshqai (UTHSC- Houston)	Data and QI - Karen Rose (TCH)

Team Leader: Diane Reidy (Harris Health)

Scribe: Linda Keenan (Harris Health)

Process Improvement Area:

Decreasing clinic type visits to the EC or increasing visits to the area clinics to help decrease visits to the EC.

Initial Aim Statement:

The team will develop a written document that will be designed to inform a patient of the resources available for non-emergent healthcare and initiate use of this document on October 15th and complete pilot on November 30.

Revised Aim Statement (s):

Success Measures:

Number of patients given information about available resources	

Assumptions / Constraints / Obstacles

MeetingTimeline

Meeting:	Date:
Initial Conference Call	9/23/2013
Meeting 1 (in person and conf call available)	9/30/2013

Communication Plan:

Improvement Theories (If…Then):

If		Then	
If		Then	

Project Charter

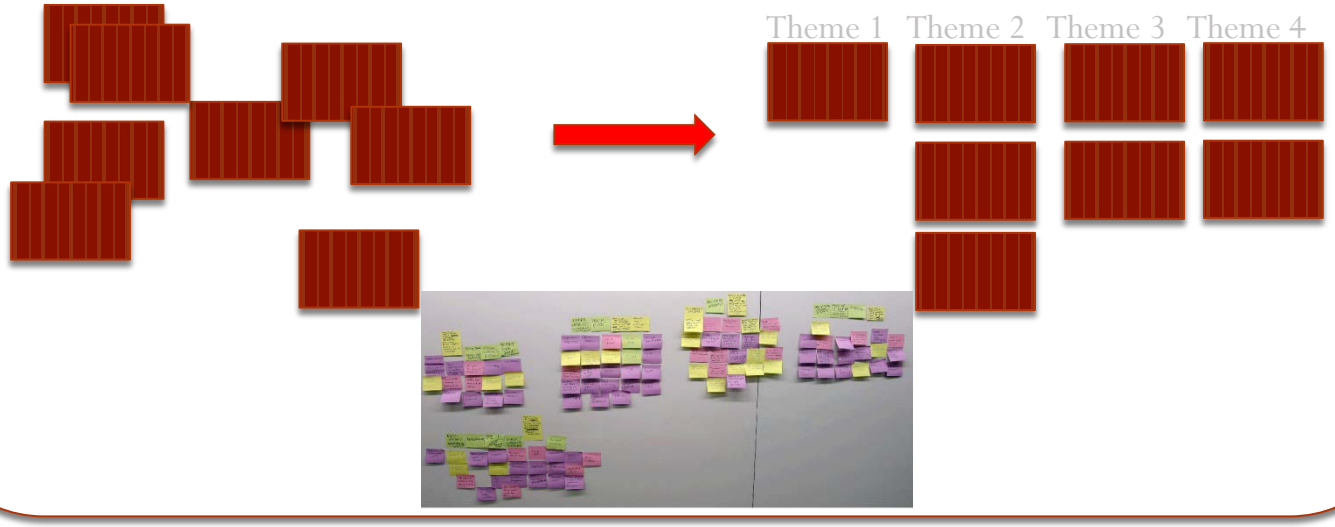
Affinity Diagram

Brainstorm - Organize - Categorize

Affinity diagrams organize ideas and allow groups to make non obvious connections by organizing ideas into themes.

Random Ideas

Affinity Diagram



Example: Patient Navigation

- What is successful patient navigation.

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Affinity Diagram Example:

"What are the challenges for implementing CQI?"

Sources: http://www.conceptdraw.com/solution-park/seven-management-and-planning-tools

5 Why's: Why ask why?

Five Why's Methodology:

- Identifies the root causes of a problems.
- Determines relationships b/t different root causes

"Peeling the onion" and unveiling symptoms to identify the root cause of a problem.

1) *I missed my flight*
2) *I reached airport 30 mins before departure*
3) *I left my house late*
4) *I overslept*
5) *My alarm clock failed to ring*
6) *I forgot to set my alarm clock*

Example: ED utilization

- High readmission rates to ED for patients with chronic (unmanaged) diseases.

Cause and Effect Diagrams are helpful to identify key root causes

5 Why's Example: Root Cause Analysis

1. **Mortality of Pedi CV Surgery is high. WHY?**
2. **Because intra-operative times are too long. WHY?**
3. **Because patients are on bypass too long. WHY?**
4. **Because it takes too long to get the blood we need. WHY?**
5. **Because the Blood Bank doesn't have the blood ready before surgery. WHY?**

Three basic types of causes:

Physical – Tangible, material items failed in some way (example: a car's brakes stop working)

Human – A person/people did something wrong, or did not do something that was needed (example: brakes failed because nobody filled the brake fluid)

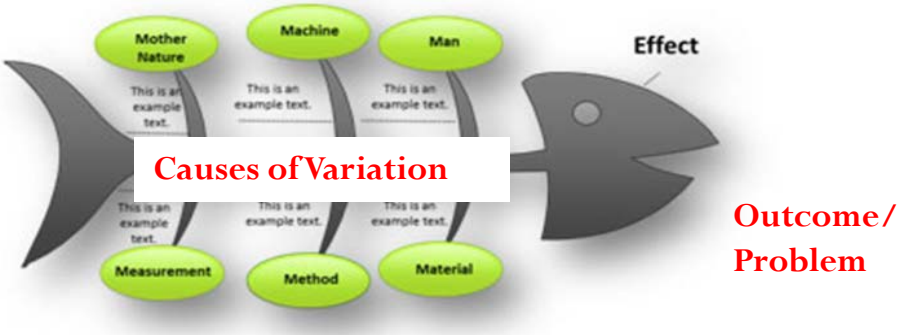
Organizational – A system, process, or policy that people use to make decisions or their work is faulty (example: everyone assumed someone else was taking care of the brake fluid)

What Questions Exist Around Your Waive Projects?

Their Implementation?

Cause-and-Effect Diagram

- AKA Fishbone or Ishikawa Diagram

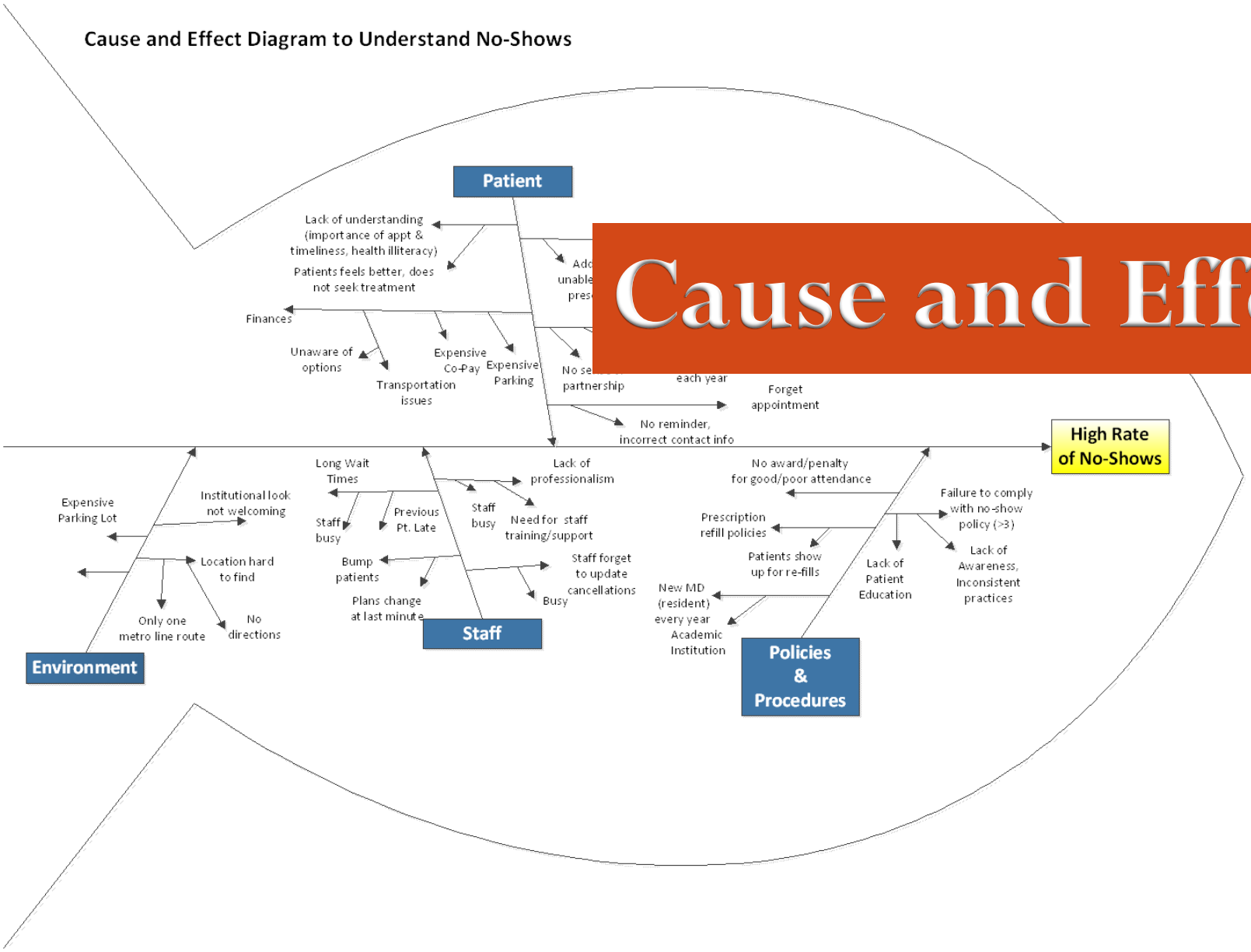


- Tool for identifying "causes" of a problem through brainstorming, observing, surveying, investigating, etc.

Example: Behavioral Health

- Lack of access to behavioral health services.

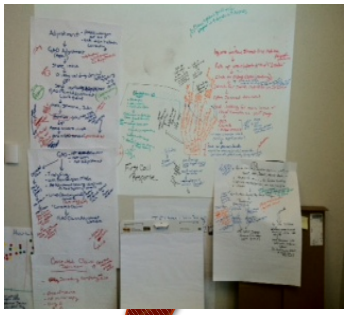
Cause-and-Effect Diagram



SIPOC Diagram

- High-level flowchart
- Includes key elements
- Provides clarity

WHY are we working on this project?
WHO will it impact?
WHAT does our customer want?
HOW can we deliver?

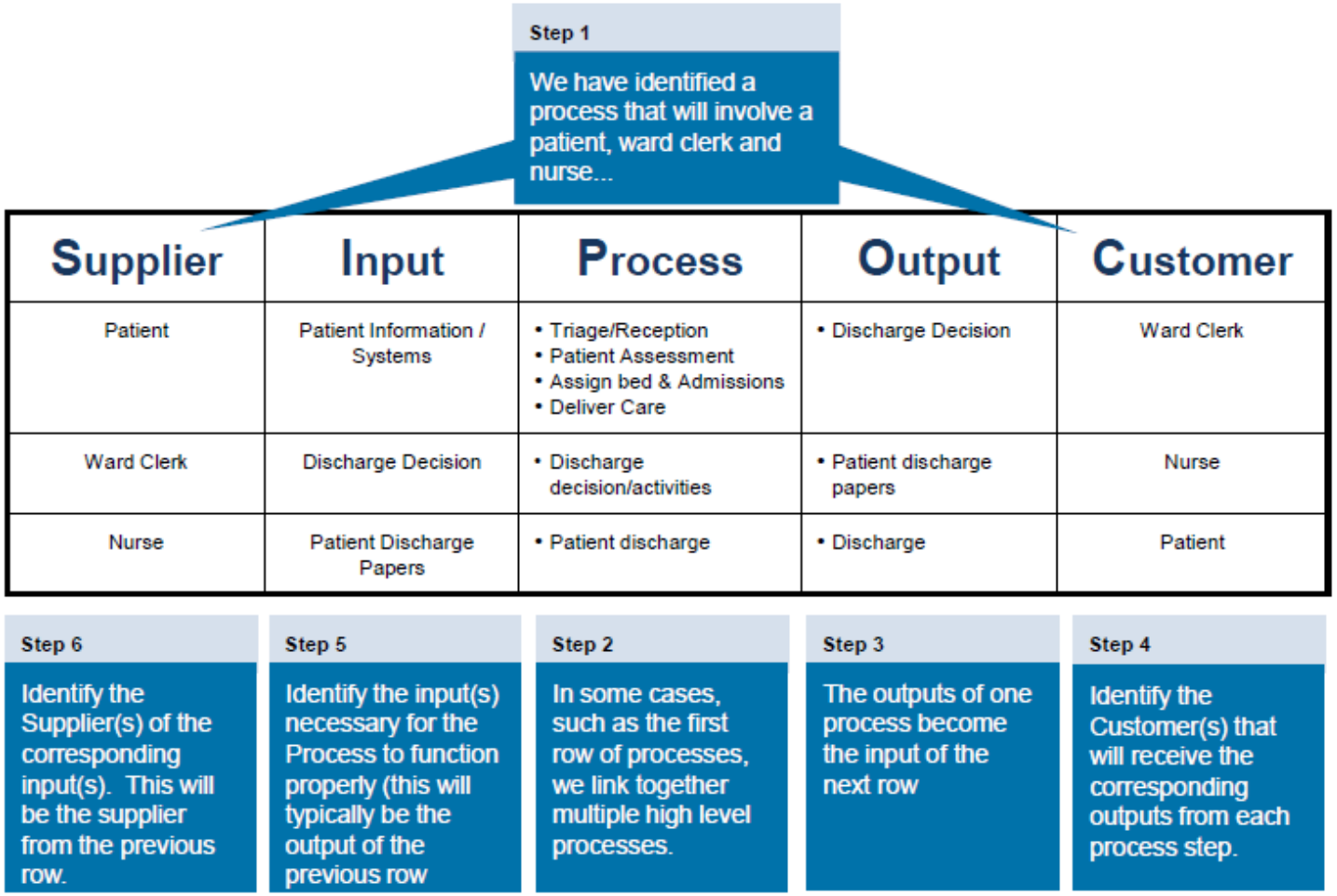


S	I	P	O	C

Example: Primary Care

- Expanding or building primary care clinic.

SIPOC Diagram Example



Source: http://www.patientflowtoolkit.ca/ToolkitDoc/Diagnostic_PDF/Tools/SIPOC.pdf

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SIPOC Worksheet:

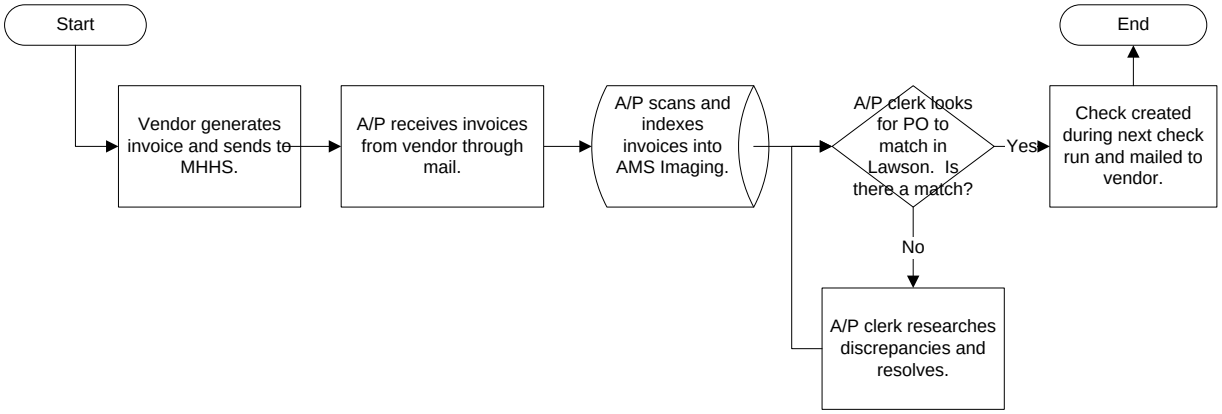
Suppliers	Inputs	Process	Outputs	Customers
Who (internal and/or external supplies the process inputs (i.e. materials, people, information).	What data, supplies, system, tools, or people are required for the process?	What are the steps (high-level) of the process being improved? Usually 4-5 key process points.	What information, data, report, or item is produced from this process?	Who (internal and/or external) receives the output from the process?

What Does a SIPOC Look Like for Expanding Primary Care?

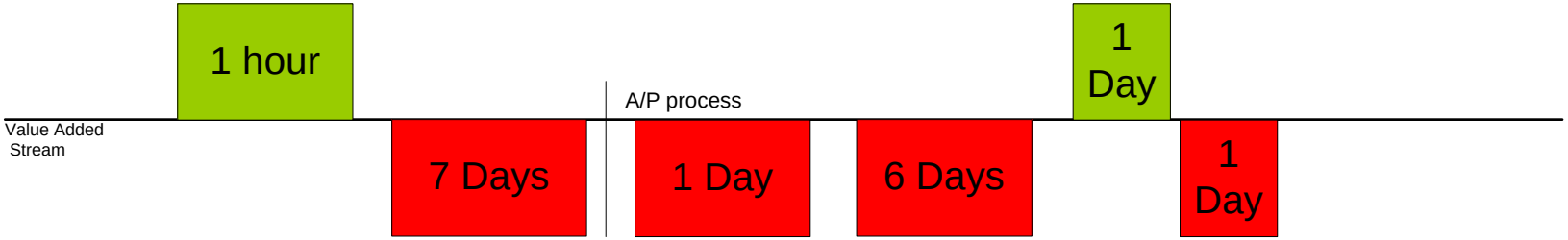
Process Mapping: Value Stream

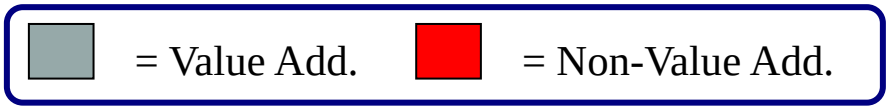
Value Added Activities	Non-Value Added but Necessary Activities	Non-Value Added Activities
<u>Must exhibit three characteristics:</u> 1. The customer cares about it (is willing to pay for it) 2. It changes the item physically, transforming the product or service • Does this step change form, fit or function? • Does it convert input to output? 3. It's done right the first time	• Activities that create no value but which cannot be eliminated based on current state of technology or thinking (Ex: inspection, approvals) • Activities that meet regulatory and legal requirements	• Activities which consume resources but create no value in the eyes of the customer • Waste • Rework

Value Stream Map for AR



14 NON-VALUE ADDED DAYS.





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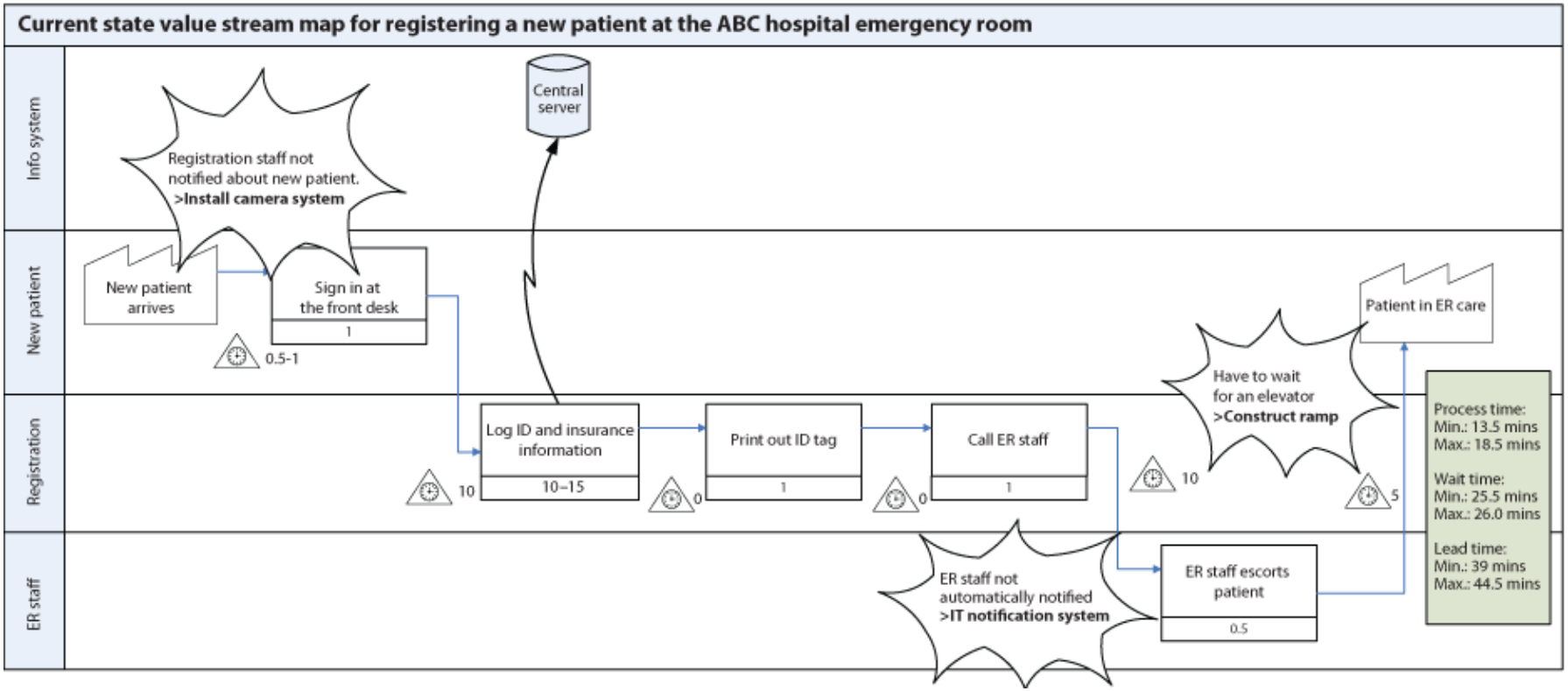
Value Stream Map for ED Registration



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THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Value Stream Map Example

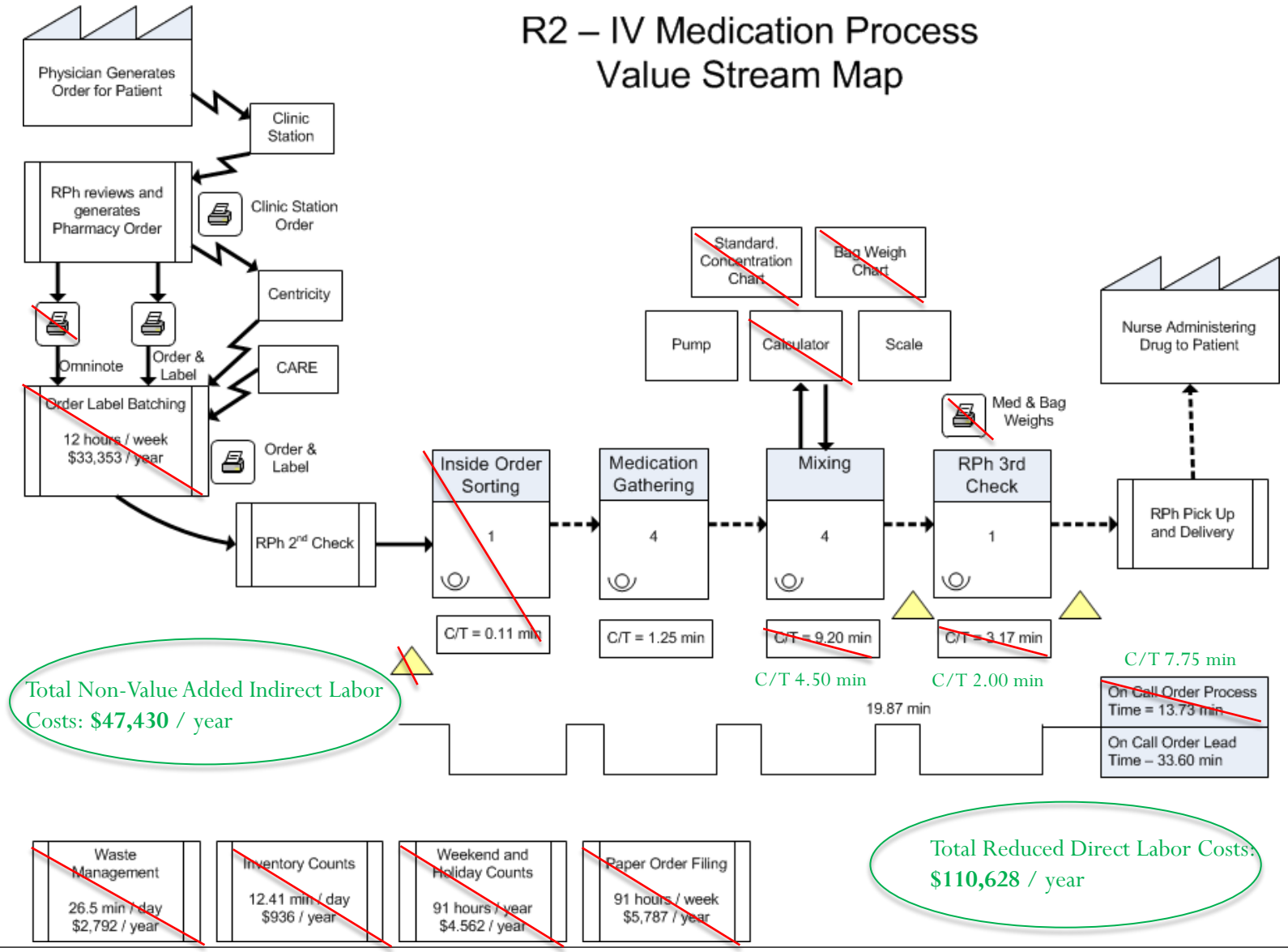


Table Top Exercises: Can you Apply Your Knowledge?

- Select a specific/ unique DSRIP project at your table. Apply the following CQI tools to that project.
  - Voice of Customer
  - Project Charter
  - Affinity Diagram
  - 5 Why's / RCA
  - Cause-and-Effect Diagram
  - SIPOC Diagram

CQI Tools: Reflection, Pair & Share

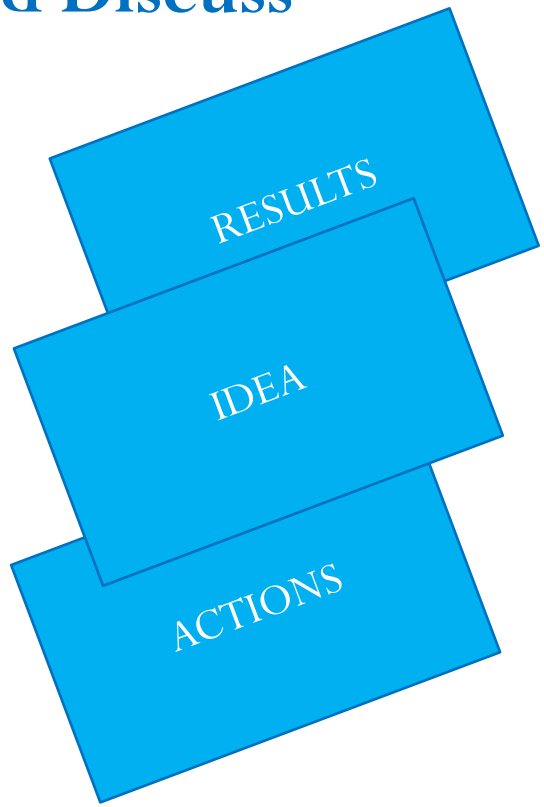
Use Your "Blue Slips" to Answer and Discuss

- What RESULTS did your table achieve?
- What worked WEL in this exercise?

- What did you LIKE?
- What IDEAS did this exercise generate?
- What was the VALUE to you, personally?

- What OPPORTUNITIES do you see?
- What ACTIONS can you take now?

- What didn't you fully understand?
- What additional information do you want/ need?



COMMITMENT TO THE COMMUNITY

Our Commitment to You

We commit to work together to help patients access the healthcare they need. As partners in healthcare, 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**

THANK YOU!
SEE YOU IN THE FALL!