RHP 3 Learning Collaborative – DY5

December 9, 2015

WELCOME!

Overview

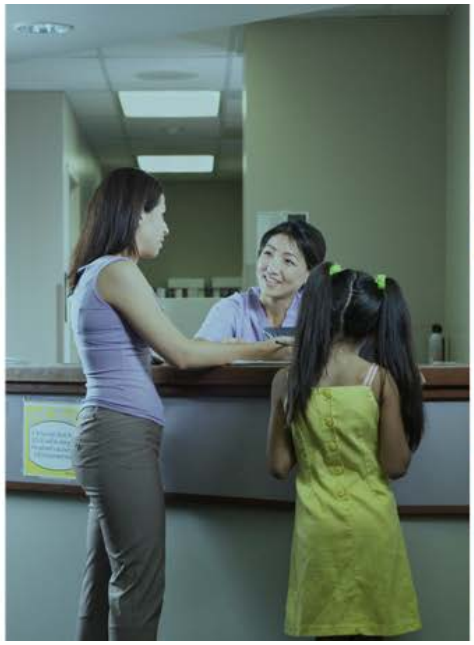
- Welcome
- Cohort Updates-Navigation and Behavioral Health
- Regional Quality Improvement
- Sustainability
- 1115 Waiver Status Update
- DSRIP Perspectives, New York & Other Regions
- Networking, Snacks, & Other Highlights

CHW Tool

Navigation Station

THCIC Behavioral Health 30-Day Readmissions Data

LEARNING COLLABORATIVE COHORT UPDATES



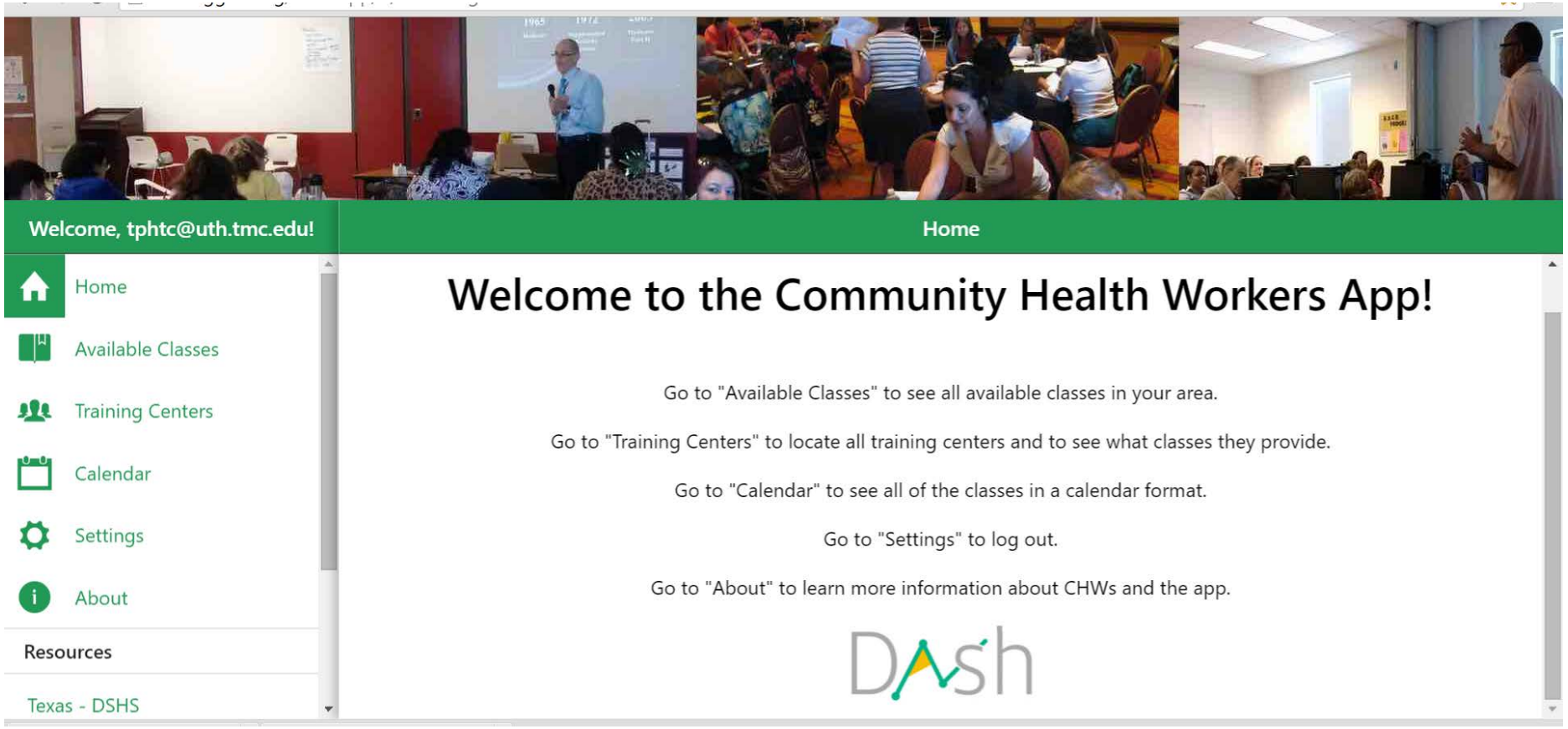
Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

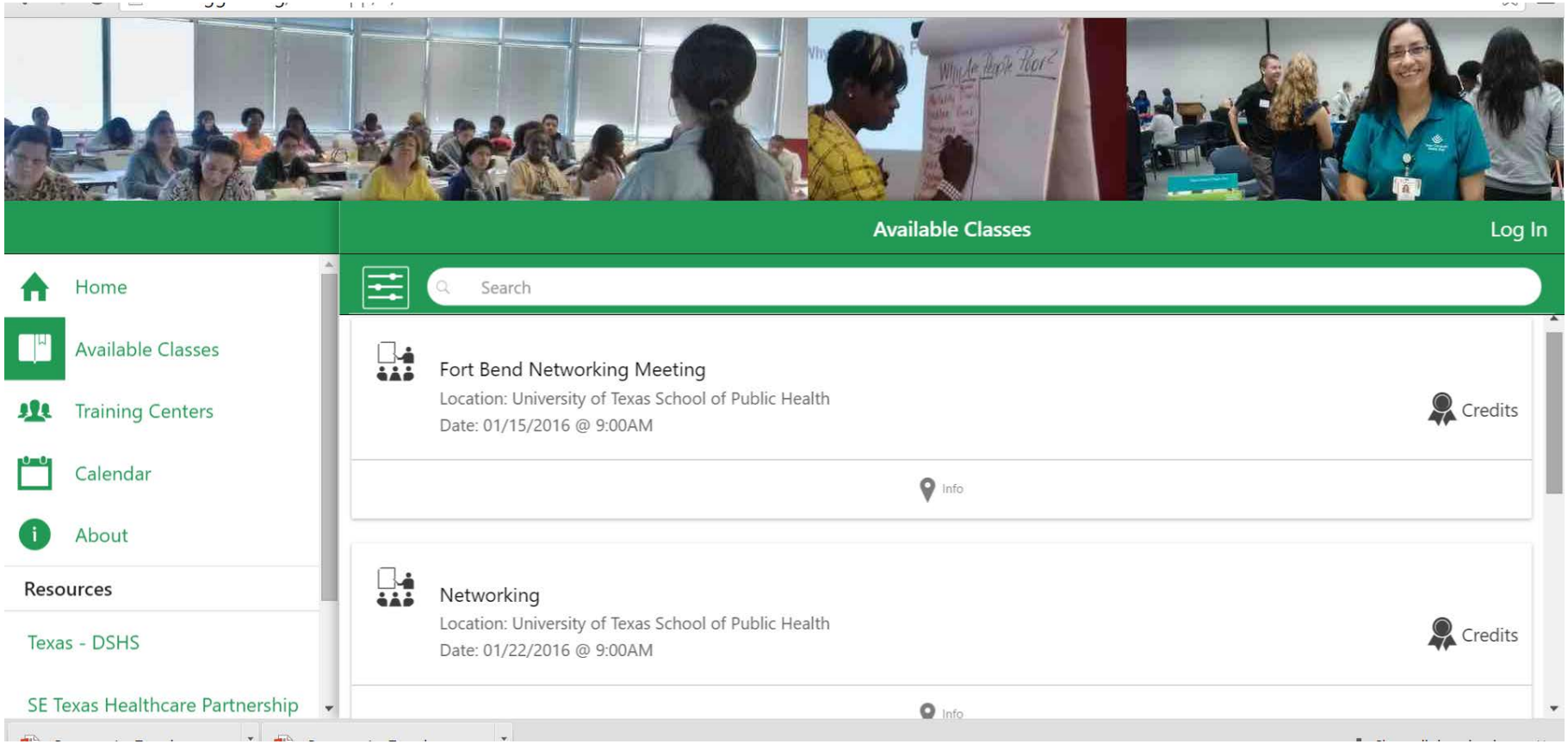
Community Health Worker Continuing Education Web Tool A Project of the Navigation Cohort

Jennifer Bradley, UT Physicians

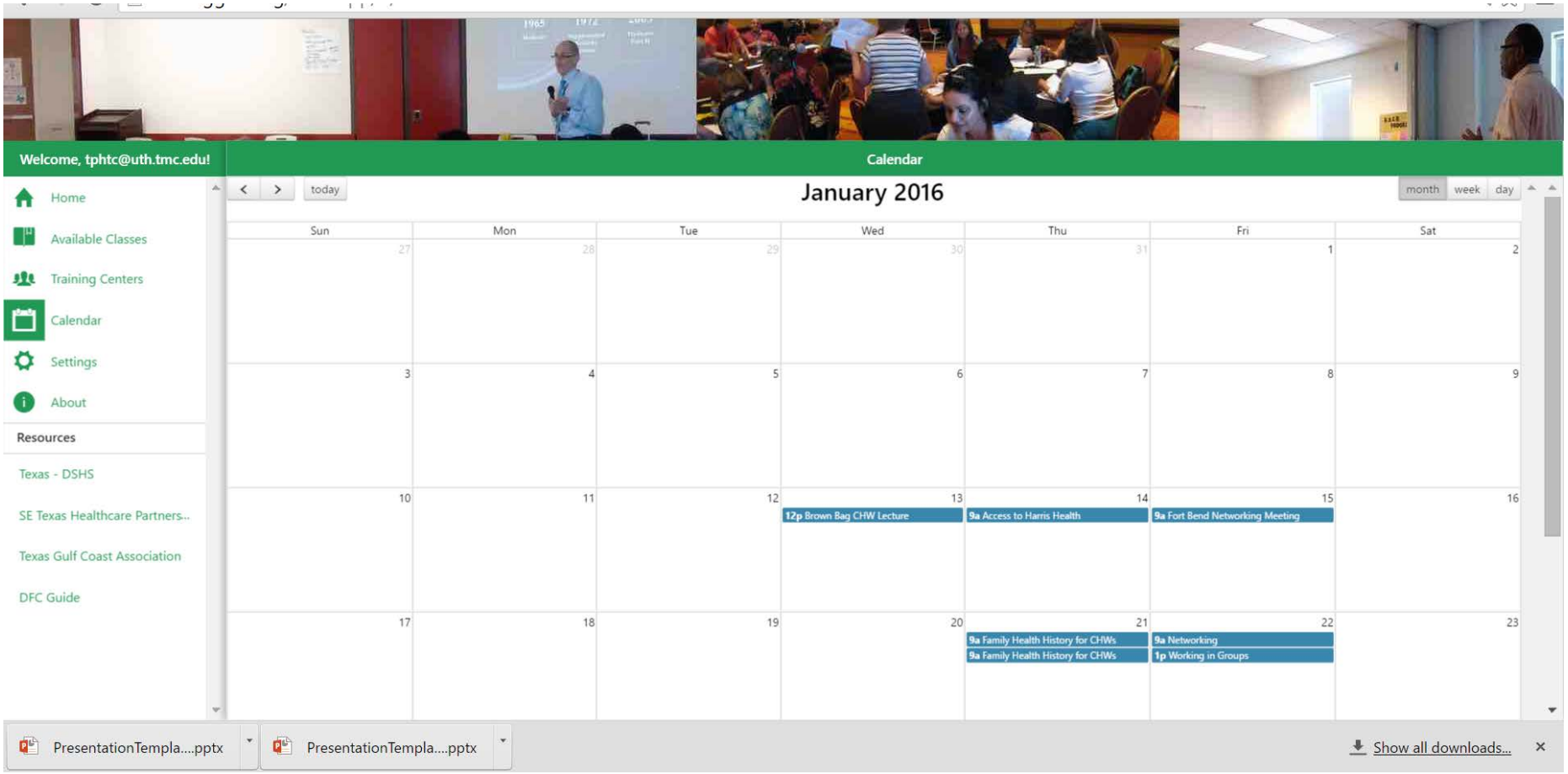
www.CHWceu.com



Finding CHW classes



Calendar


Welcome, tphtc@uth.tmc.edu!
Calendar
Home
Available Classes
Training Centers
Calendar
Settings
About
Resources
Texas - DSHS
SE Texas Healthcare Partners...
Texas Gulf Coast Association
DFC Guide
today
January 2016
month
week
day
Sun
Mon
Tue
Wed
Thu
Fri
Sat
12p Brown Bag CHW Lecture
9a Access to Harris Health
9a Fort Bend Networking Meeting
9a Family Health History for CHWs
9a Family Health History for CHWs
9a Networking
1p Working in Groups
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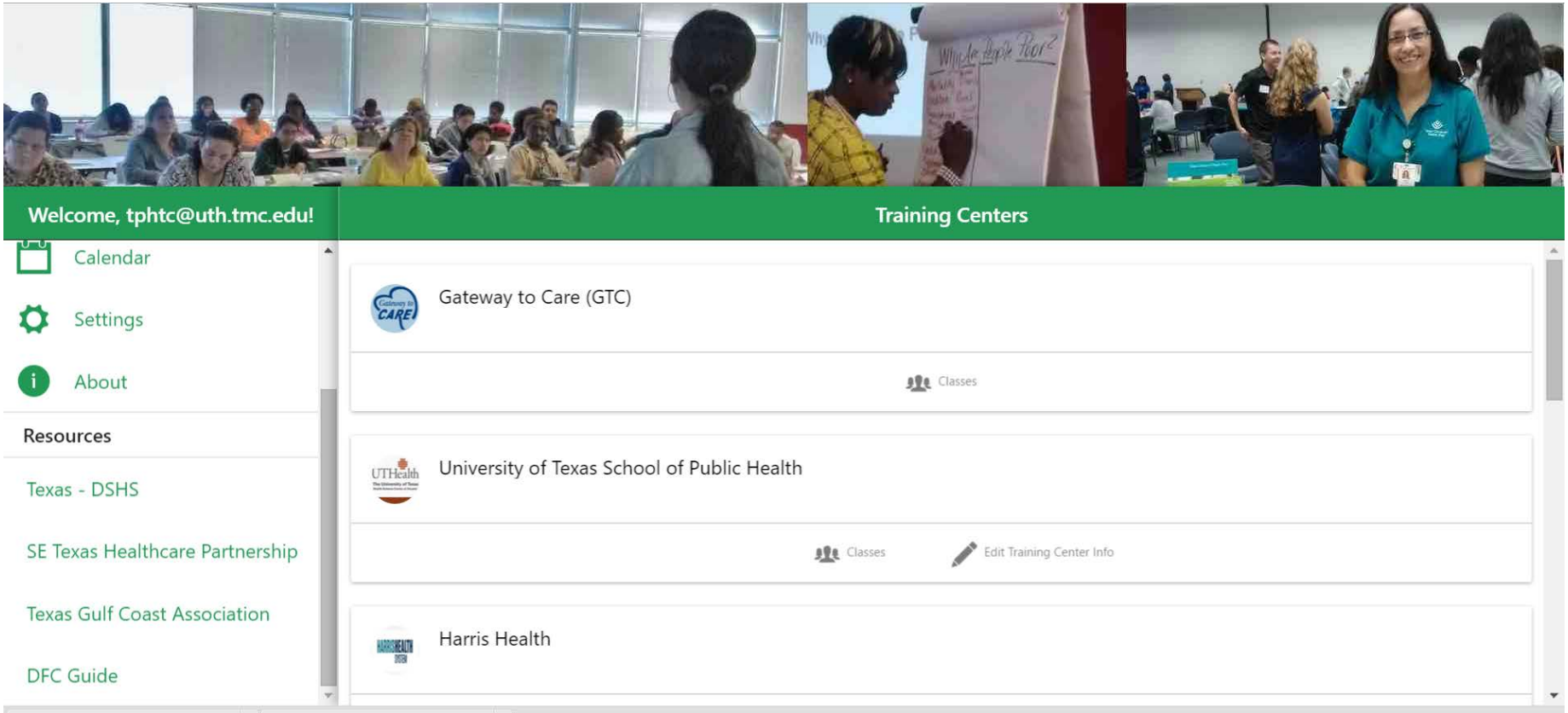
Training Centers



Community Partnership

A million thanks to our community partner!

University of Houston

Bonner leaders Program

Medicine & Society Program

QUESTIONS

setexasrhp@harrishealth.org

Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

Region 3 Health Navigation Station Online Portal

Erin Brackney Kremkus, OneStar Foundation- Navigation Station

texasconnects.org

texas connector
by onestar foundation

Linking Community Needs and Nonprofit Solutions across Texas

LOG IN OR CREATE AN ACCOUNT

Please add me to the Texas Connector mailing list

Home | The Basics | The Buzz | News and Events | Partners | Give Us Feedback | Help

Strengthening Texas Communities

Texas Connector is an online, interactive mapping tool that links needs and nonprofits to strengthen Texas communities. It provides a visual snapshot of social service needs and resources to allow funders, local and state government leaders, research, and the nonprofit community to more effectively meet Texas' growing needs. Texas Connector bridges the information gap between the areas served by nonprofits and the underserved communities of Texas.

Try Texas Connector for free

Region 3 Health Navigation Portal

Region 3 Health Navigation Station

Need an easier, more efficient way to find healthcare services to meet your patient's needs?

Try the Health Navigation Station (HNS) - a collaborative project by the Regional Healthcare Partnership 3 Patient Navigation Cohort and OneStar Foundation.

Region 3 Health Navigation Station

- An online, easy-to-use website specifically designed for patient/client navigation staff, health service providers, and health administrators.
- Contains healthcare services provided by participating Region 3 hospitals, health clinics, and physicians
- Users can search in a patient's neighborhood, according to type of specialty or health service needed, insurances accepted or clinic type.
- Quickly create lists of clinics tailored to your patient's needs to email, print, export results or even view on a map.

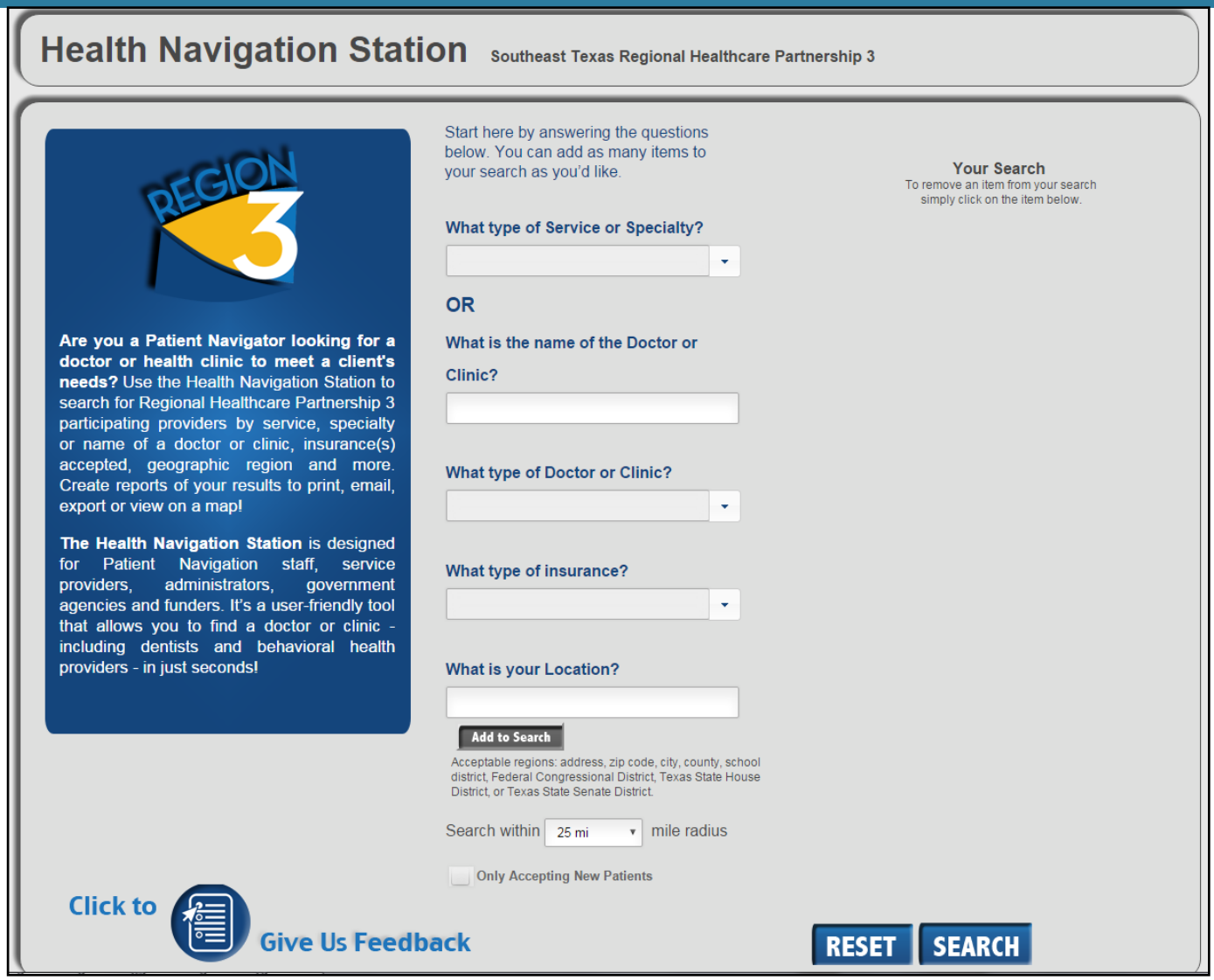
Region 3 Health Navigation Station

- The HNS was designed with you in mind.
- Brings together Region 3 healthcare systems to work in partnership to make services more easily accessed.
- **The HNS is available at no cost for users in Region 3 until September 30, 2016.**
- **Visit www.texasconnects.org and sign up for a free account to try the HNS today.**

Interface Capabilities

- **Search/filter database by:**
  - Type of Service or Specialty or Name
  - Type of Physician or Clinic
  - Insurance Type
  - Geographic area with adjustable distance limit
- **Export and/or print search results**
- **Integrated with Texas Connector features:**
  - Public Transit Visual Layer & Stop-level data

Regional Healthcare Partnership 3 Patient Navigation Tool



Regional Healthcare Partnership 3
Patient Navigation Tool

Health Navigation Station Doctor/Clinic Results

Refine Your Search:

Refresh

Doctor or Clinic Type

Type of Service or Specialty

Service or Specialty: Derm Physician

Insurance Type

Location

Distance: 25 mi of 77020 (Zip)

Export the full results for more details, including: programs, data source, update date, and other service types listed.

Export Data | View on Map | Email Results | Print Results

Show 10 entries | Select All | Deselect All | Delete Selected

Options	Doctor/Clinic Type	Specialty	Doctor/Clinic Name	Clinic Address	Hours	Contact Information	Insurance Accepted	Distance (mi)
Report Incorrect Data View Full Record	Community Clinic	Derm Physician Fam Prac Physician Int Med Nurse Int Med Physician Int Med Resident Neu Physician OBG Dietitian OBG Physician Ped Physician	UTP BELLAIRE MULTI SPECIALTY CLINIC	6700 West Loop South Freeway Bellaire, TX 77401		1-888-488-3627	Life Synch/Corp Health Aetna Alliance AmeriGroup Corporation (Americaid) Beech Street Best Doctors Blue Bell Benefits Trust Blue Cross and Blue Shield of Texas Bravo Healthcare CCN Choice Care Network Cigna Cigna Lifesource Coastal Comp Health Network Community Health Choice CorVel Coventry / Medicare Coventry Healthcare	

Regional Healthcare Partnership 3 Patient Navigation Tool

Health Navigation Station
Southeast Texas Regional Healthcare Partnership 3
Doctor/Clinic Results

Your Search
Doctor/Clinic Type:
Insurance:
Location:

1 of 2 Results

Distance 7.57 mi

Doctor/Clinic Type
Community Clinic

Type of Service or Specialty
Derm Physician
Fam Prac Physician
Int Med Nurse
Int Med Physician
Int Med Resident
Neu Physician
OBG Dietitian
OBG Physician
Ped Physician

Doctor/Clinic Name
UTP BELLAIRE MULTI SPECIALTY CLINIC

Clinic Address
6700 West Loop South Freeway
Bellaire, TX 77401

Hours of Operation

Accepting New Patients: Yes

Contact Information
1-888-488-3627

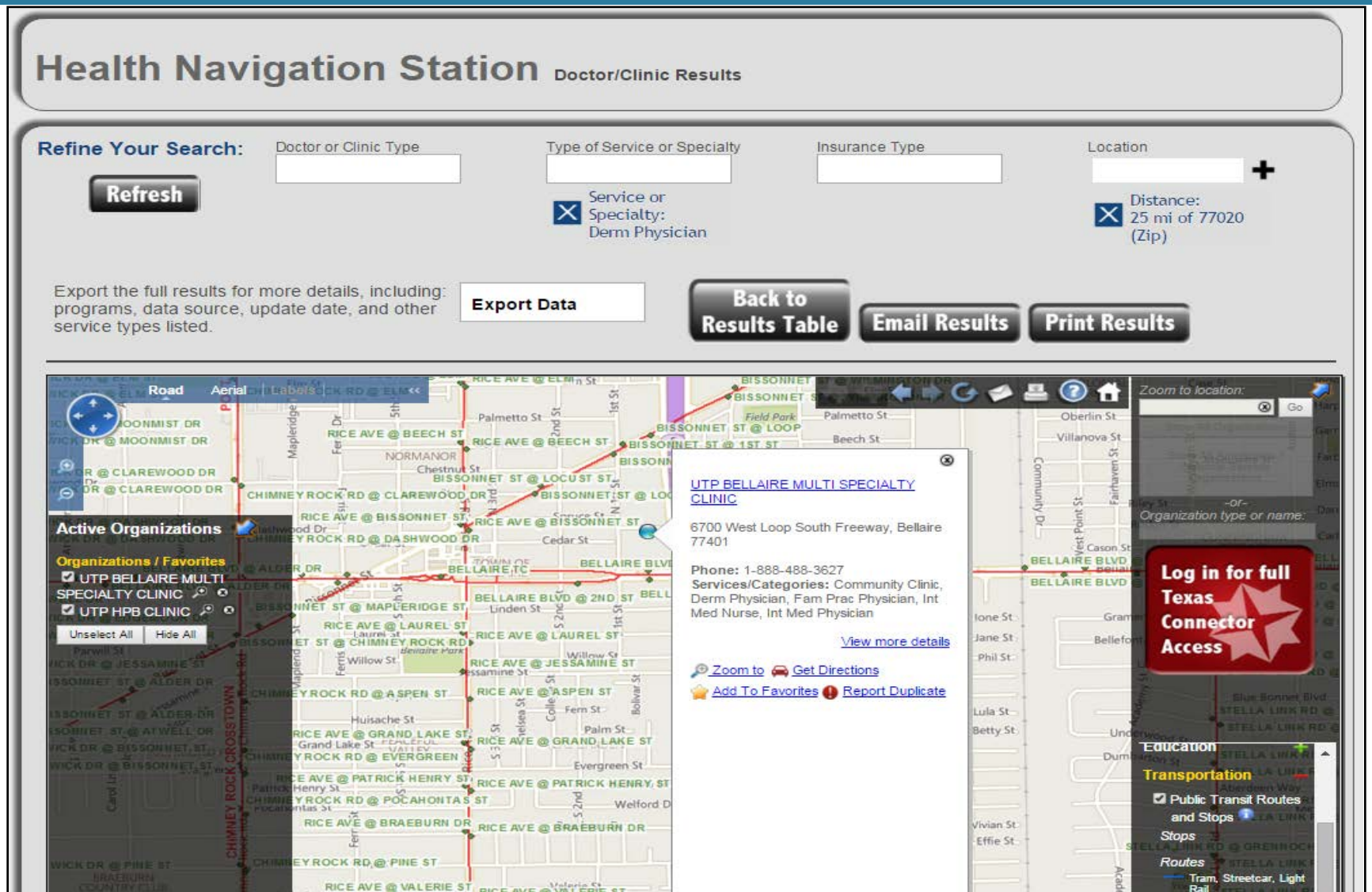
Insurance Accepted
Life Synch/Corp Health
Aetna
Alliance
AmeriGroup Corporation (Americaid)
Beech Street
Best Doctors
Blue Bell Benefits Trust
Blue Cross and Blue Shield of Texas
Bravo Healthcare
CCN
Choice Care Network
Cigna

Data Source & Last Update:
Harris County Health: June 2015

Programs Offered

Other Doctor/Clinic Types

Clinic/Physician Search



Clinic/Physician Details

Organization Details

[Report this organization as a duplicate record]

HOUSTON COMMUNITY HEALTH CENTERS INC (DBA- Denver Harbor Clinic)

Primary Address: 424 Hahlo Street, Houston, TX 77020
Type of Organization: Other
EIN: 76-0622208
Email: mponti.hchc@tachc.org
Contact: Theresa Strong (Development Officer)
Mission Statement: Houston Community Health Centers, Inc. (HCHC) is a private nonprofit Federally Qualified Community Health Center. HCHC provides a full range of medical, dental, and mental health services in medically underserved areas through its two clinics. The organization is also committed to spurring neighborhood economic development through new job creation and improvements in the communities it serves.
Operating Budget: $4,270,658.00
Assets: $3,600,932.00

Programs

Name	Description	Service Area
Medical, Dental, Mental Health, Pediatrics, Ancillary Services Programs	Houston Community Health Centers, Inc. (HCHC) provided first quality medical care to 2,872 unduplicated patients in 2006. As a result of the collaborate partnership between HCHC and the Methodist Hospital, the community health center estimates to provide care to 9,000 patients by the year 2010. The three major operating programs are: 1. Medical 2. Dental(as of January 2008) 3. Mental Health (as of September 2007). This includes medical and dental services at both our family clinic (Denver Harbor) and pediatric clinic (Airline). HCHC offers services to insured (private, Medicaid and Medicare) and uninsured people. HCHC offers ancillary services to assist with Medicaid, CHIP, and CHIP Perinatal enrollment. A sliding fee program is also offered for cash patients. Ophthalmology visits are also held once a month and health education and outreach services are conducted as well. All the doctors at HCHC belong to the Family Medicine Residency Program from the Methodist Hospital. There are currently 4 full time physicians and twelve residents.	

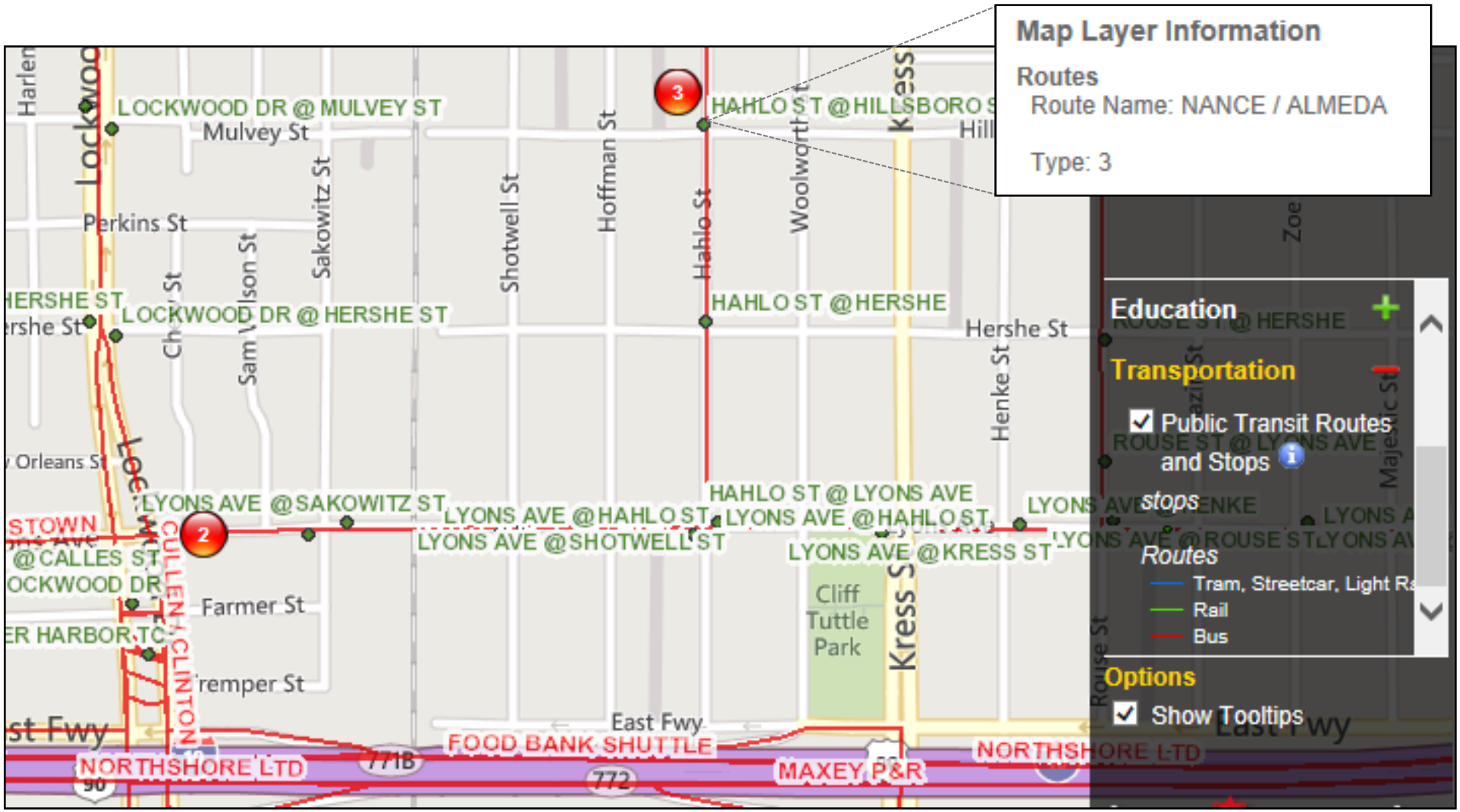
Services and Classification

AIRS: Community Clinics
NTEE: Health Treatment Facilities (Primarily Outpatient)

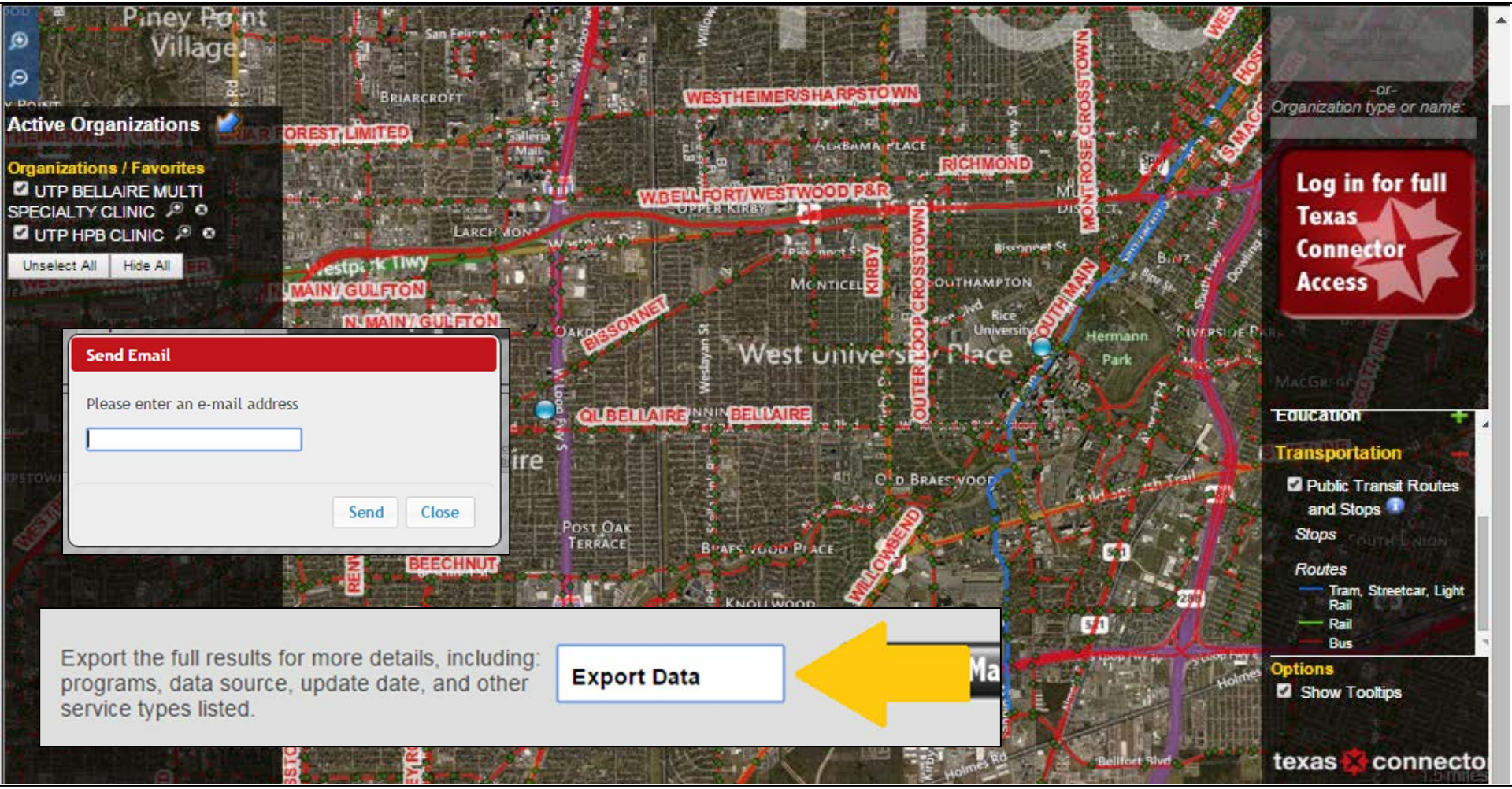
Data Sources

GuideStar - *Last update: 7/23/2013 11:22:22 AM*
User Update - *Last update: 7/28/2014 3:54:07 PM*

Public Transit



Exportable Formats



OneStar Foundation is building a stronger nonprofit sector for a better Texas. We…

CONNECT.

PROMOTE.

CONVENE.

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texas connector™ by onestar foundation

texas connector™

by onestar foundation

QUESTIONS

setexasrhp@harrishealth.org

THCIC Readmission Findings

DSRIP Region 3 Learning Collaborative
December 9, 2015

Our Team

Scott Hickey
Charles Begley
Devika Srivastava
Jessica Hall
Amrita Shenoy
Michelle Eunice
Shannon Evans
Juan Castaneda
Ling-Lun Chien

Goals

1) To describe a baseline for evaluating the impact if DSRIP intervention on 30-day readmission rates

2) To describe demographic and diagnostic characteristics associated with 30-day re-admissions

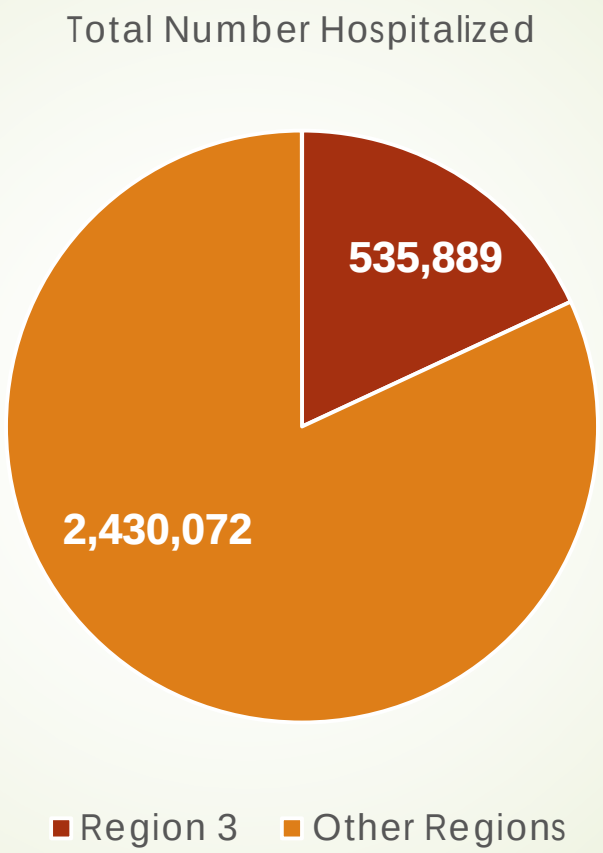
Texas Health Care Information collection (THCIC)

- Charged with collecting data and reporting on health care activity in hospitals and HMO's in Texas
- Goal of enabling consumers to have an impact on the cost and quality of health care
- Maintain a data set of virtually all hospital admissions in Texas
- Thanks to our anchor, Harris Health we have purchased the most recent available year of data, 2012

Advantage of THCIC Dataset

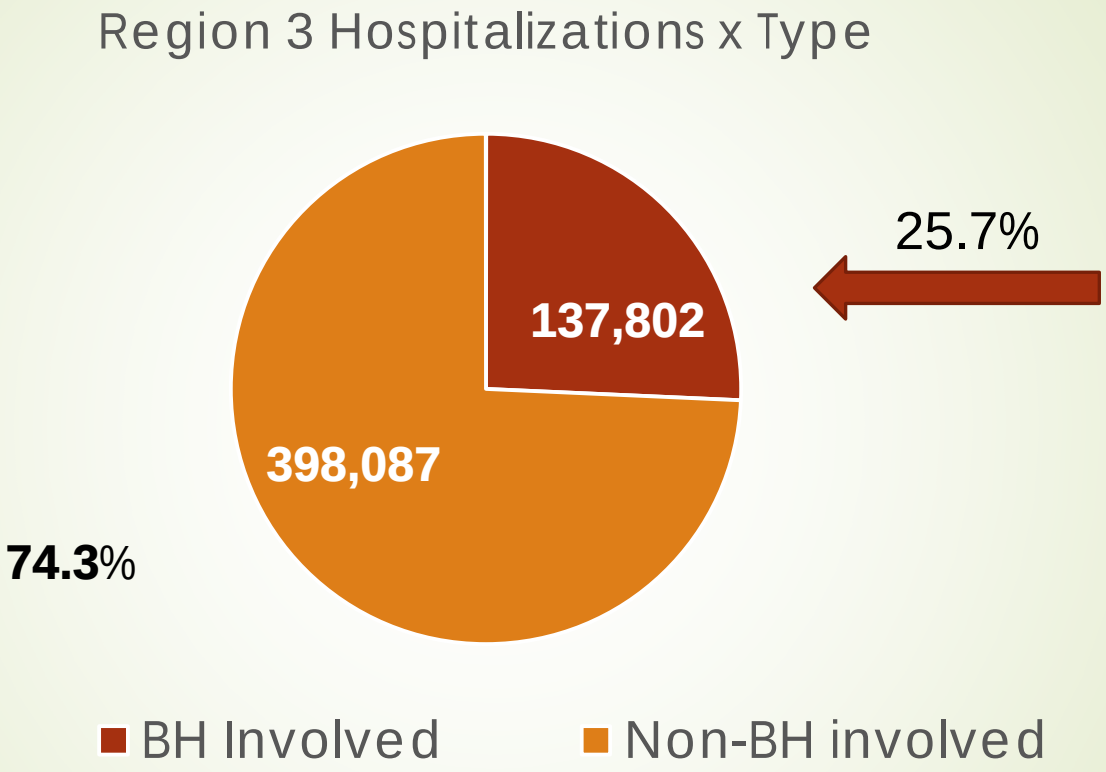
- While other existing data sets are proprietary or are focused on Medicaid, Medicare and SCHIP, THCIC includes all payors as well as the uninsured
- Public agencies including many DSRIP participants serve the low income uninsured often in greater numbers than federally insured
- THCIC may provide a more representative look at re-hospitalizations for especially for these organizations

The 2012 numbers



Region 3 had 18.1% of Texas Hospitalizations

Within Region 3



One fourth of Region 3 Hospitalizations were BH-involved

County of residence

	Frequency	Percent
Harris County	116904	84.8
Fort Bend County	11389	8.3
Matagorda County	1534	1.1
Austin County	1451	1.1
Colorado County	1420	1.0
Wharton County	1380	1.0
Waller County	1314	1.0
Chambers County	1296	.9
Calhoun County	1114	.8
Total	**137802**	**100.0**

Types of admissions

	Frequency	Percent
Index Admit	118621	86.1
Readmit (30 Days)	14058	10.2
Chained Readmit (Following readmit)	5123	3.7
Total	137802	100

Readmission rates

- The published statewide Mental Health/Substance Abuse PPR rate for Texas Medicaid and CHIP adults is 11.81% and for children 9.06%.
- In the Region 3 Sample (including all payors) the 30-day readmission rates were just slightly higher:
  - 12.4% for Adults and 10.0% for Children

Region 3 BH readmission rates are similar to Texas Medicaid rates

Previous findings for Texas Medicaid hospital admission "strings"

- The highest PPR rate is for MH/SA admissions. For adults these admissions have a higher than average number of PPRs per chain (1.38) indicating that patients with MH/SA admissions are more likely to have a string of related admissions.

Schizophrenia & mood disorders

Schizophrenic Disorders produce the longest admission "chains" among BH Diagnostic Groups (1.30 admissions/chain as compared to 1.21 overall)

Behavioral Health Hospital Costs

1) BH-involved admissions in Region 3 rack up **$5B in costs/year**
2) Admissions with **Secondary BH Diagnoses cost the most**
3) **Mood Disorders and Schizophrenic Disorders** add up to be the **most costly BH primary diagnoses**

Texas Medicaid Costs Related to PPR's with Behavioral Health Diagnoses

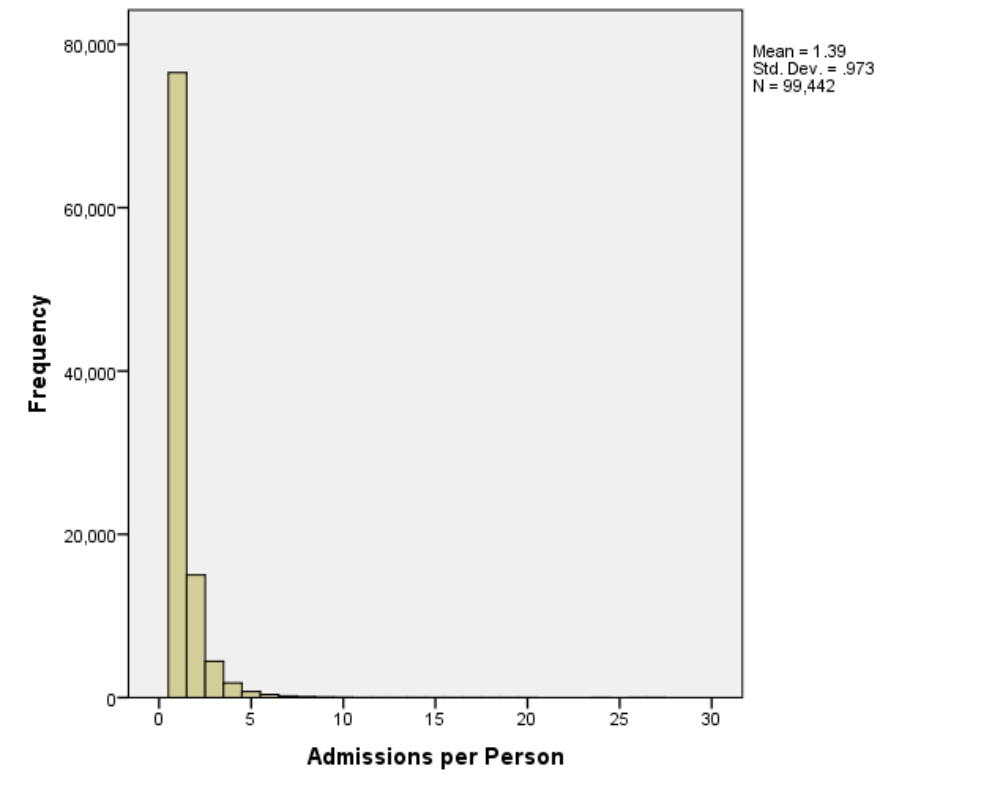
Top three categories were MH/SA related:

1) bipolar disorders with a PPR rate of 9.74 percent, cost of $10,839,063.43,
2) schizophrenia with a rate 14.31%, cost of $5,437,553.45,
3) major depressive disorders & other psychoses with a rate of 9.12%, cost of $4,321,369.13.

The "Big Three" mental health diagnoses are costly

High utilizers: Admissions

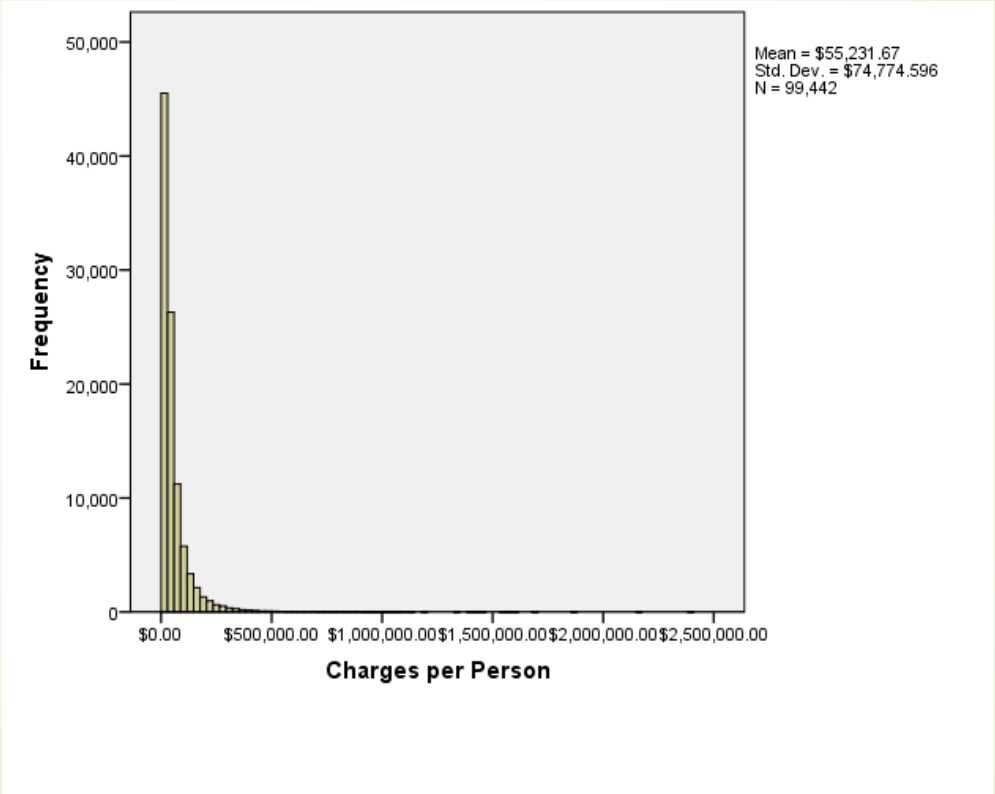
Mean Admissions per Person = 1.39
Range= 1-27 Admissions per Person



16% of readmissions are made by five percent (n=4,972) of BH-involved patients

High utilizers: costs

Mean Cost=$55,232 per person
Range=$0-$2,389,022



5% of patients account for 18% of Charges

Findings Related to Admission Type

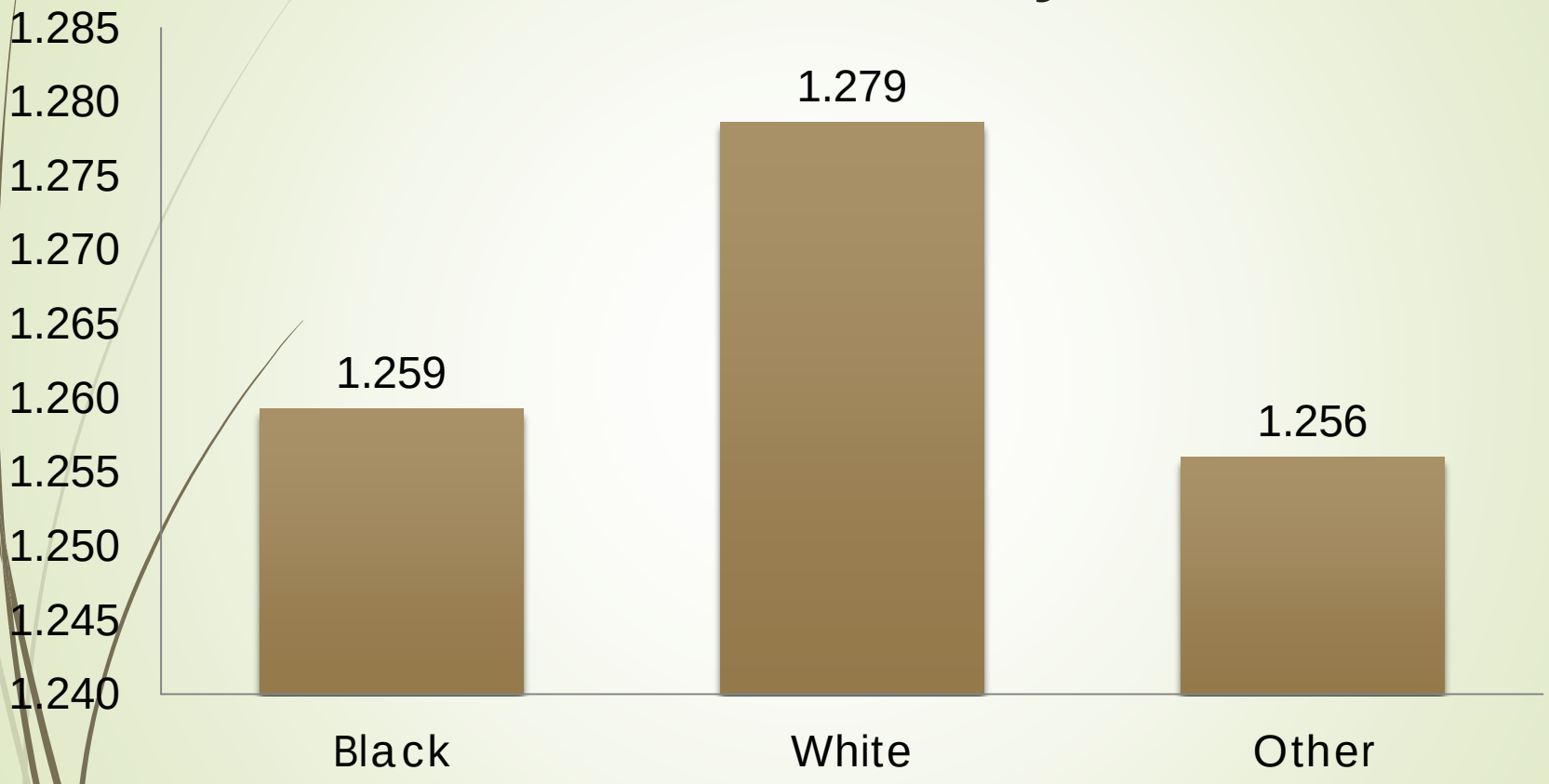
- Associated with higher readmission rates;
  - Secondary BH diagnoses
  - Ethnicity
  - Source of Admission
  - Payor Type
  - Primary BH Diagnostic Group
- Non-psychiatric facilities have more (absolute number) index, readmission, and chained readmission rates.
- AHRQ Primary Diagnostic Group is related to readmission rate with Mood disorders and Schizophrenia being the highest (n) for index, readmission, and chained readmission.

Binary logistic regression

Inputs within the Model
(These red variables are predictive!)

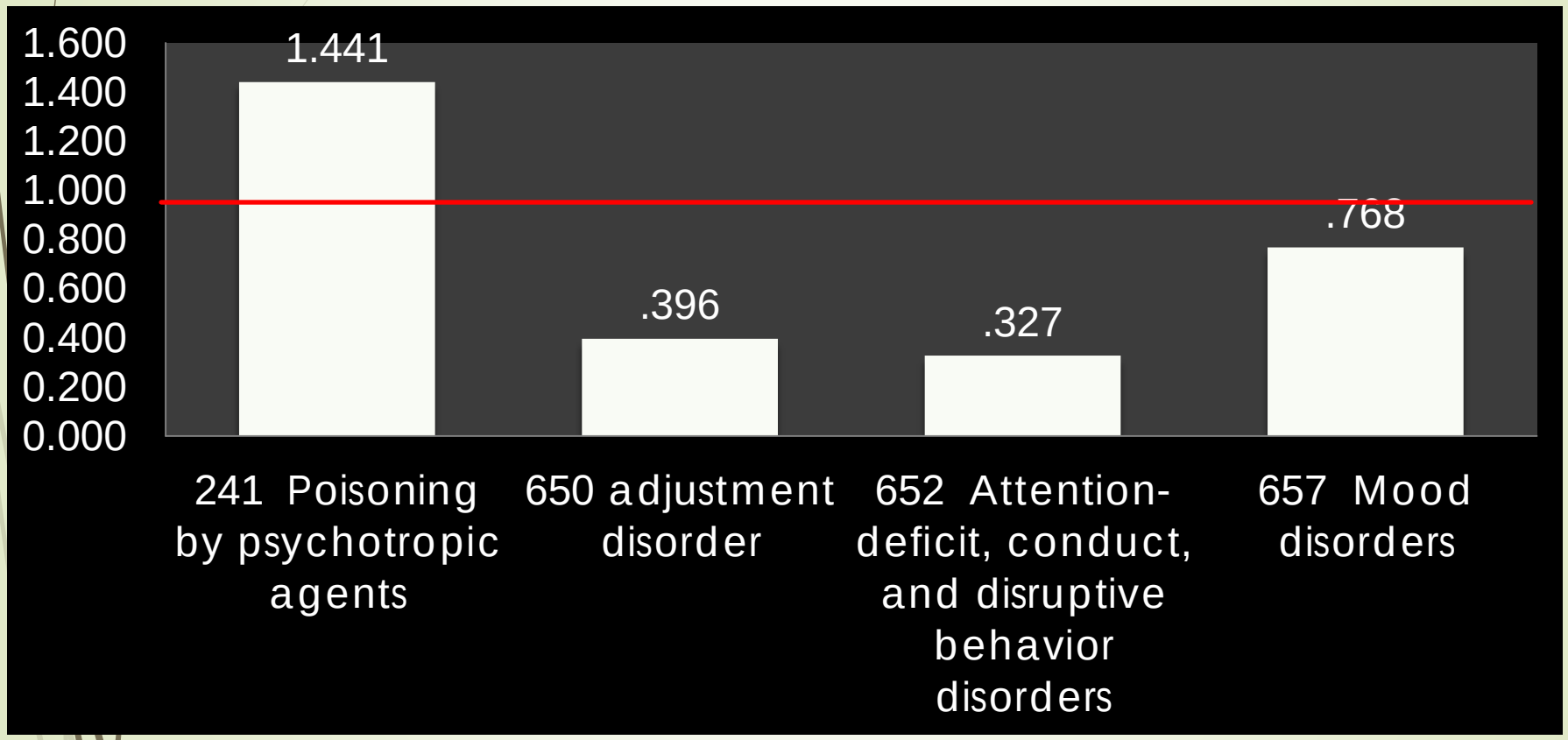
- First-Pay Source (Insurance)
- Principal Diagnostic Group
- Source of Admission
- Ethnicity
- Psychiatric Facility Indicator
- Sex

Significant Odds Ratios For Ethnicity



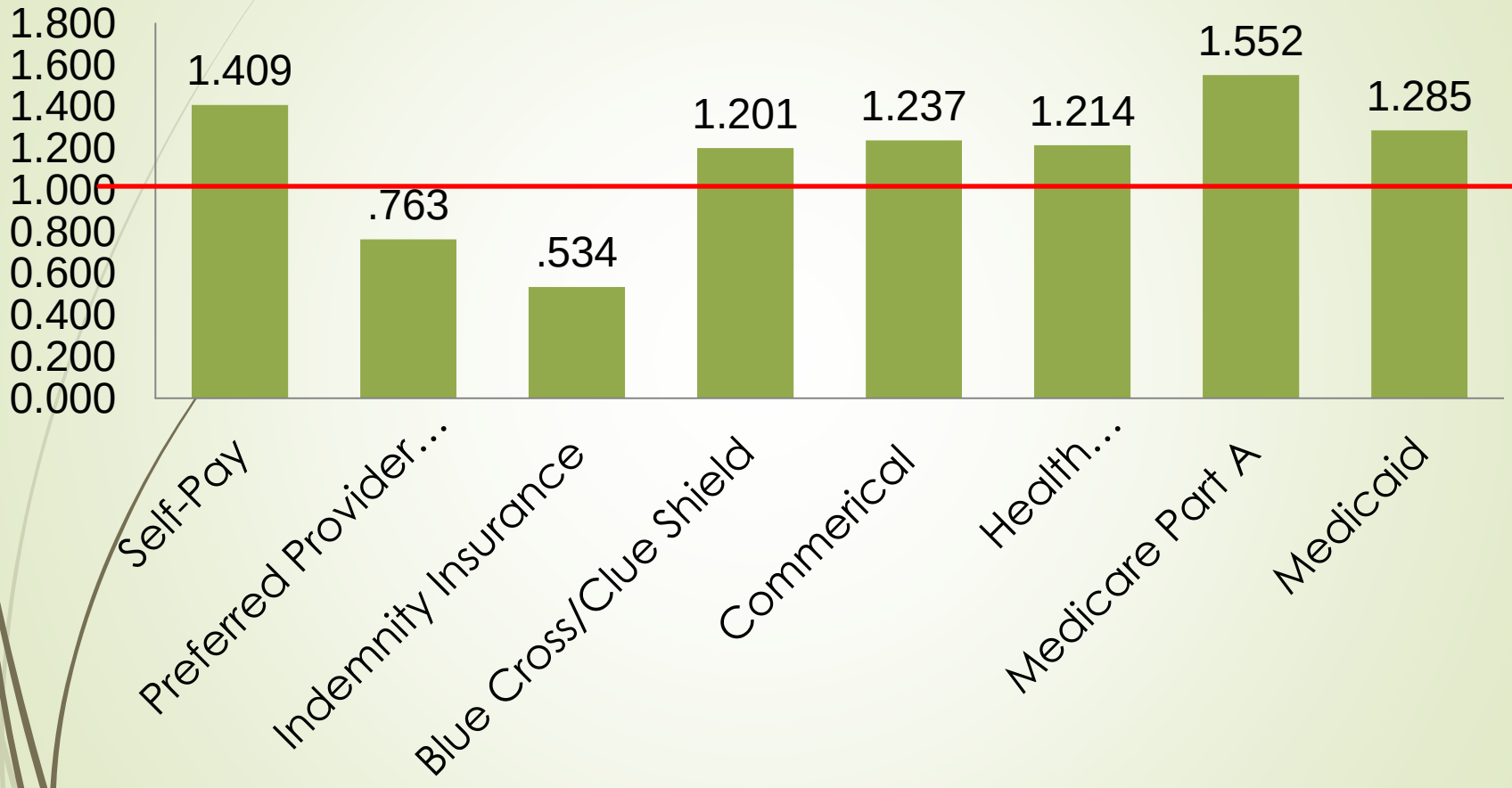
Reference Group: Hispanics
Significant Ethnic Groups for Readmission included Black, White, and Other

Significant Odds ratios for Principal Diagnostic groups



Reference: Screening and History of Mental Health and Substance Abuse Codes

Significant odds ratios for insurance

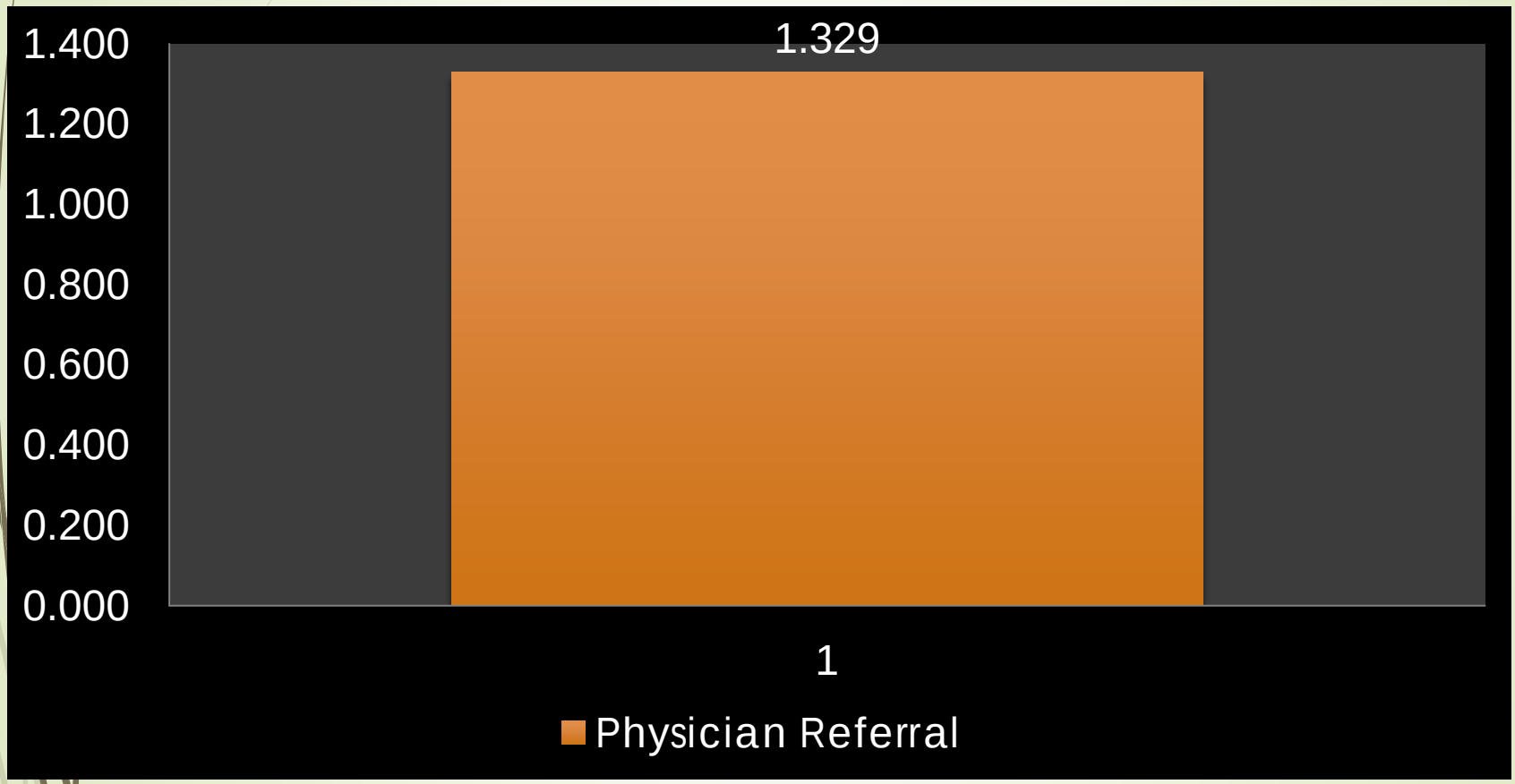


Reference Group: Charity, Indigent, Unknown

Sources of Admission

- Physician Referral
- Clinic Referral
- Transfer from a Hospital
- Transferred from Skilled Nursing Facility
- Transfer from Other Care Facility
- Court Law
- Information NA

Significant odds ratios for Source of Admission



Reference Group: Information Not Available

Implications

- The majority of BH-involved admissions and re-admissions are for secondary BH diagnoses
  - Implication: Collaborative Care is necessary to address co-morbid physical/mental health conditions
- Among BH primary diagnoses, admissions to patients with Mood Disorders and Schizophrenia frequently result in re-admission
- Schizophrenic disorders result in the longest "chains"
  - Implication: a focus on care issues for individuals with major depression, bipolar disorder and schizophrenia might bring payoffs
- Age, diagnosis, ethnicity, insurance status and source of admission influence rehospitalization rates
  - Implication: higher risk patients can be identified for special intervention

RHP 3 programs addressing these issues

- Collaborative Care (26)
- BH Consultation and Liaison within hospitals (7)
- Continuity of Care/Patient Engagement projects (5)
- Expansion of mental health/substance abuse outpatient services (26)

Projects with related Category 3s

RHP3 has 15 projects with Category 3 measures that may reduce 30-day readmissions

Follow-Up After Hospitalization for Mental Illness

- Gulf Bend MHMR Center
- MHMR Authority of Harris County (2)
- Texana Center

Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate

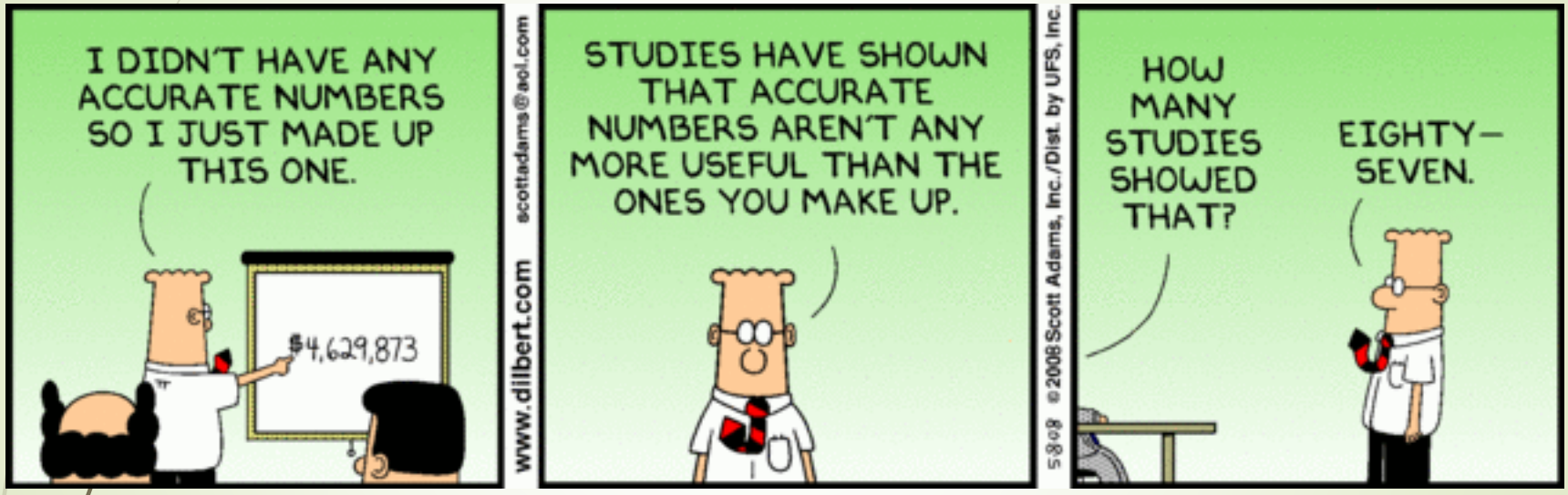
- Bayshore Medical Center
- MHMR Authority of Harris County
- OakBend Medical Center
- OakBend Medical Center

Emergency Department visits for Behavioral Health/ Substance Abuse

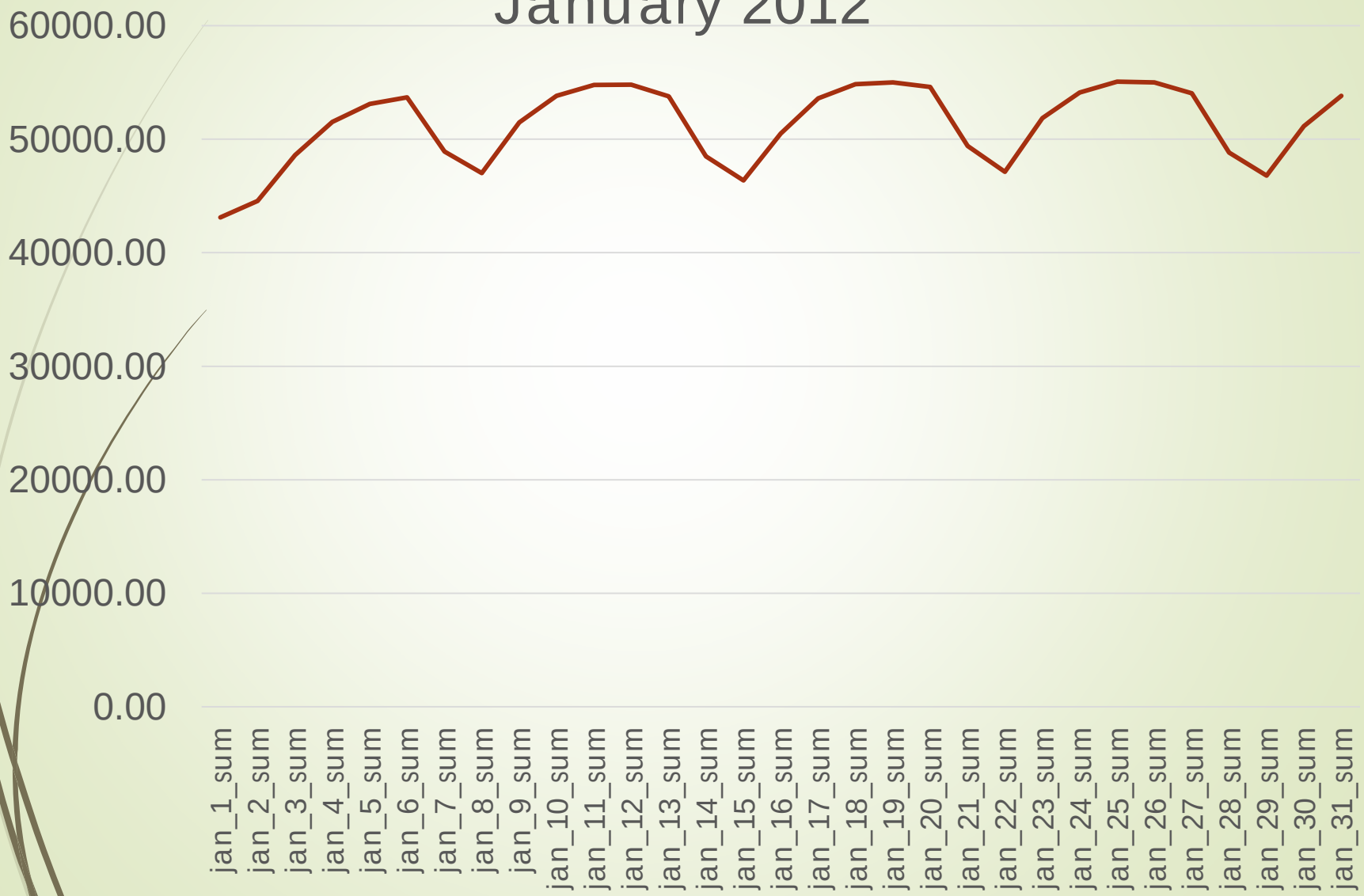
- Fort Bend County Clinical Health Services
- Memorial Hermann (3)
- Methodist Hospital (2)
- St. Joseph's Medical Center

We'll be right back (next year)

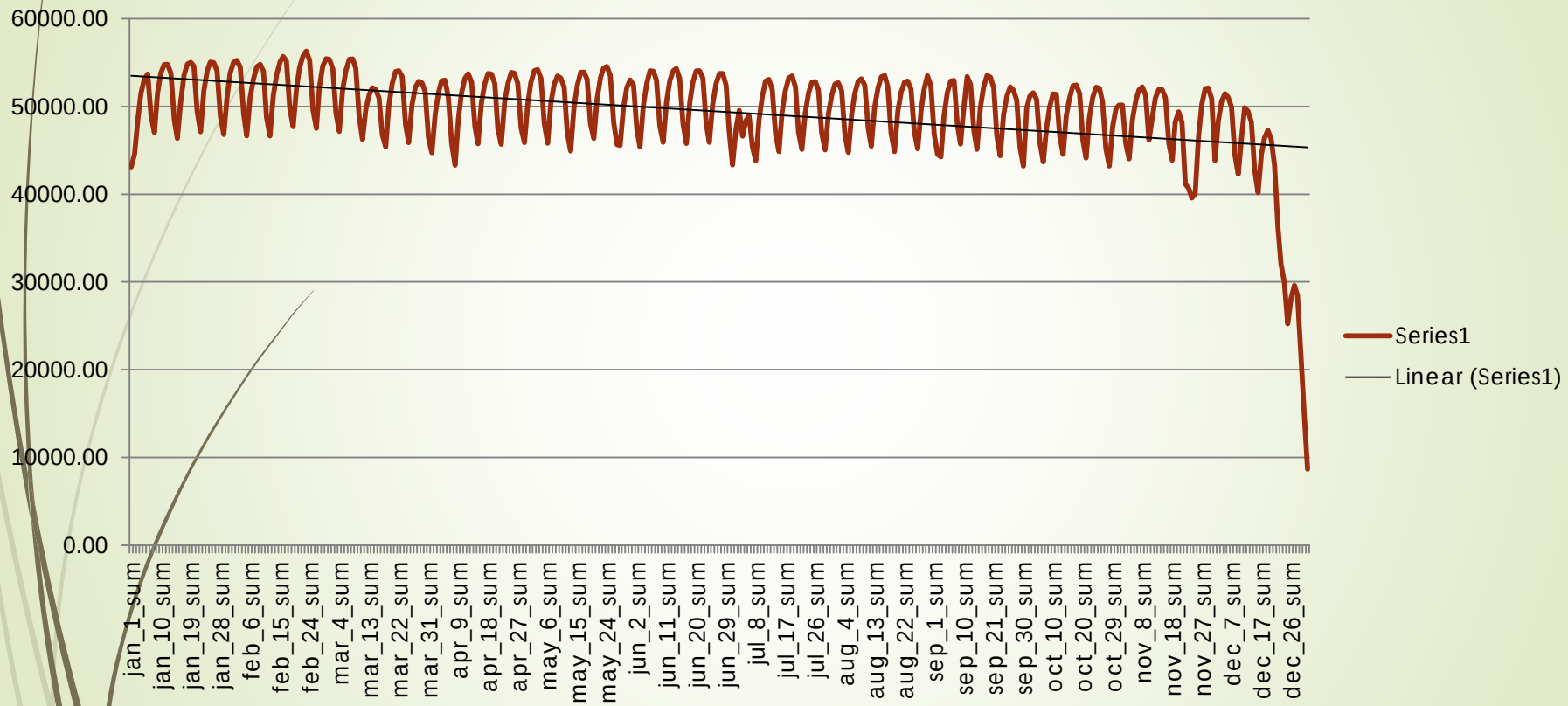
Does it really matter?



Texas Hospitalized Patients x Date: January 2012



Texas hospital census 2012



RHP3
Data Advisory Workgroup
December 2012
questions:
scott.hickey@mhmraharris.org

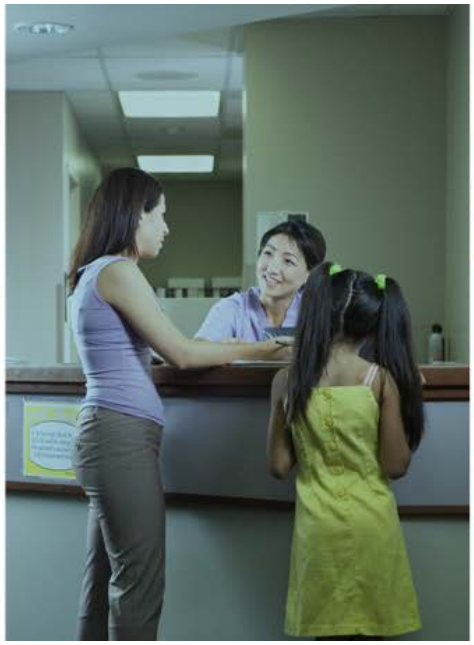
University of Texas School of Public Health

Fort Bend County

Houston Methodist

QUALITY IMPROVEMENT






Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

Using data to inform PDSA and engage stakeholders

Lee Revere, PhD, MHA
Associate Professor and Program Director
Healthcare Management
University of Texas School of Public Health

Marlisa Hardy, DrPH, MPH
Project Manager II
Behavioral Health Transition of Care Program
Houston Methodist Hospital

M. Connie Almeida, PhD, LSSP
Psychologist
Director of Behavioral Health Services
Fort Bend County

Learning Objectives

Review PDSA and the importance of data

Evaluate PDSA in action

Recognize and address data integrity issues

Demonstrate knowledge with a tabletop activity

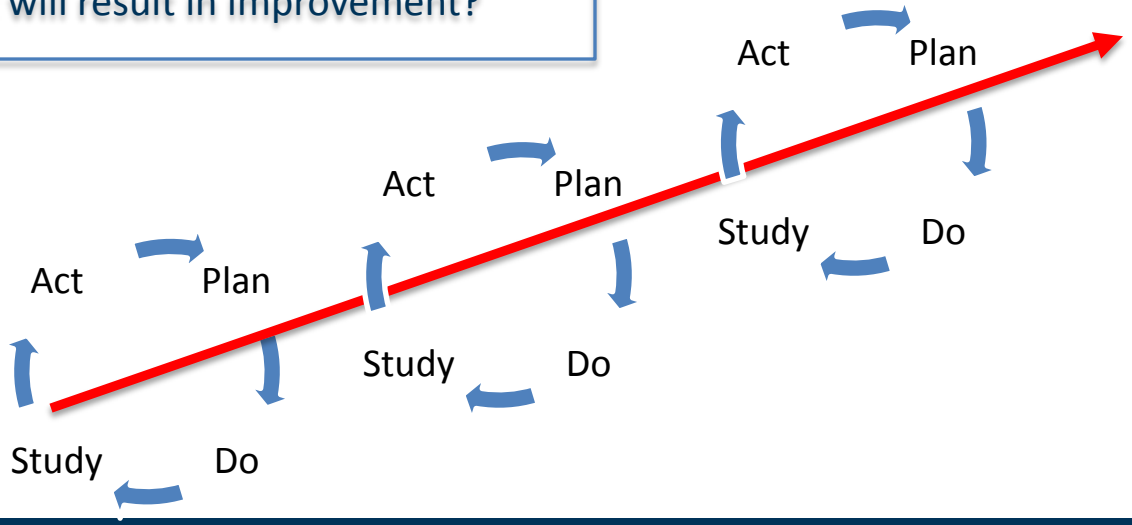
The Model for Improvement

Aim: What are we trying to accomplish?

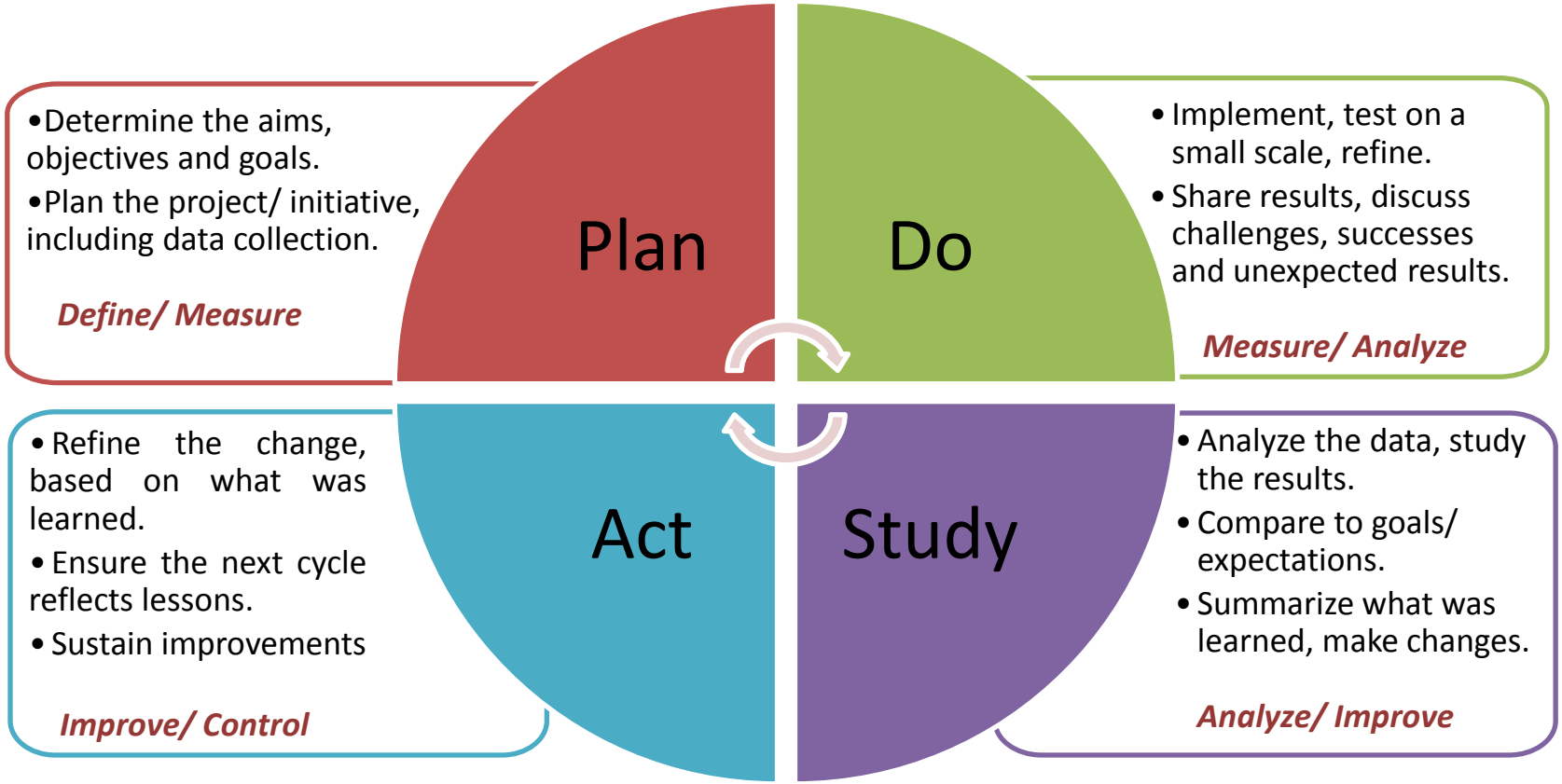
Measure: How will we know that a change is an improvement?

Changes: What changes can we make that will result in improvement?

- The changes are multiple PDSA cycles during the life of the cohort.
- The changes result in improvements at the local facilities and within the region.



The PDSA Cycle



Implementing the PDSA Cycle

- Single department

  Improvements based on data, not opinion

- Office/ Organization

  Stakeholder buy-in; optimize the "system"

- Multi-site

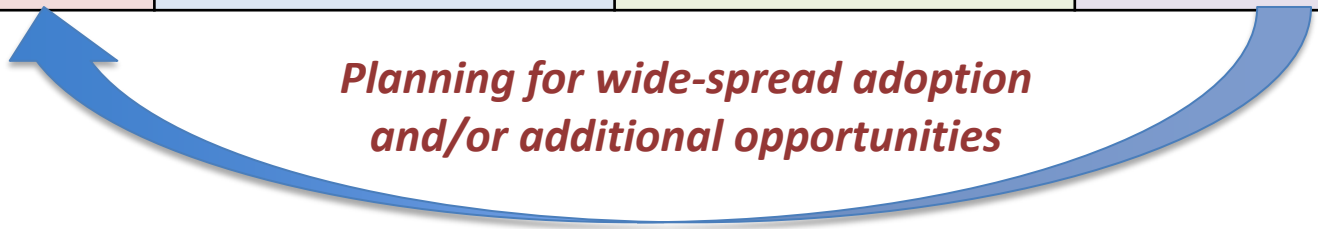
  Benchmark within, internal expertise

DSRIP & Reporting Requires

Not "Required"
Critical to Sustainability

Data applications at every step of the PDSA Cycle

P	D	S	A
Establishing goals Baseline data - where are we - where do we want to be Quantifying Flowcharts - time/ frequency	Evaluating improvements - data reports - time - frequency - quality/ satisfaction	Outcome analysis - comparing data to baseline - assessing goal attainment - Lessons learned	Communicating/ reporting results - storyboarding Sustaining gains - control charts - sampling plan - accountability



PDSA in Action:

FORT BEND COUNTY
HEALTH & HUMAN SERVICES
TRANSFORMING HEALTH CARE
Right Care, Right Place, Right Time

accesshealth™

- Increase accuracy of referral forms

  Referral forms were missing data or had incorrect information

- Reducing no show rates;

  Existing process had a 50% no show rate

Problem: 14% of referral forms have inadequate information

Plan

- Reviewed current referral forms and identified key areas with missing and/or incorrect information by 07/01/2015
- Established a plan to revise the referral form and include stakeholders.

Do

- Revised referral form to decrease missing and/or incorrect information by 08/01/2015
- Disseminated and implemented revised referral form by 08/01/2015

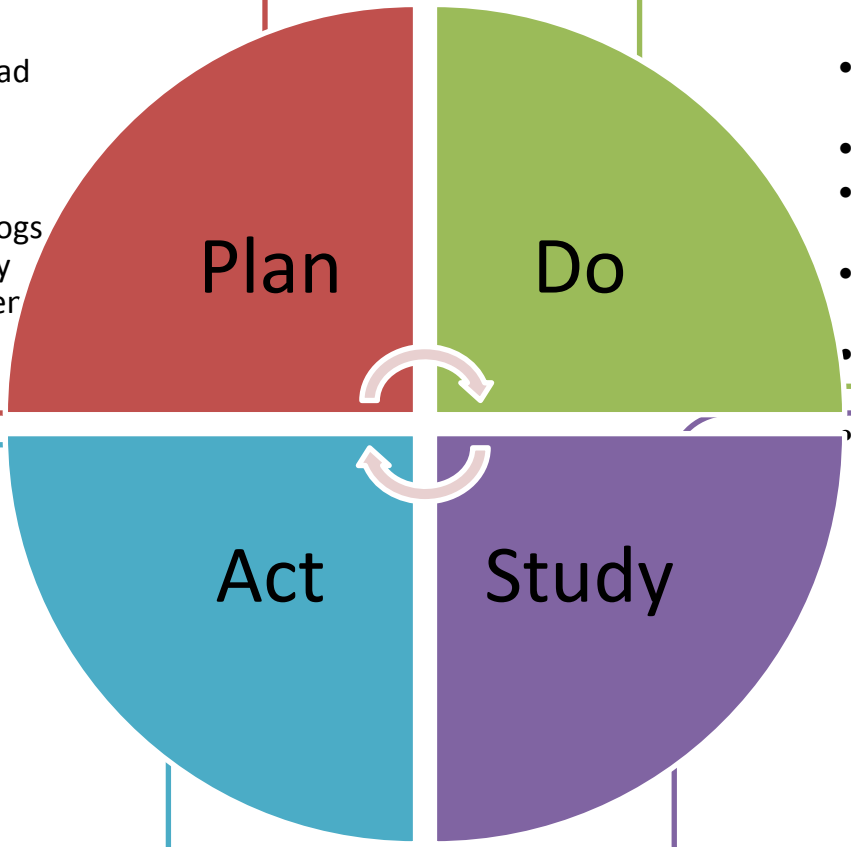
Study

- Evaluated revised referral forms to determine percentage of missing information by 09/30/2015 Missing information decreased to 13%
- Revise referral form to remove item #15

Act

- Further revised form by 10/07/2015 - stakeholders
- Percentage of missing information – 7.8%
- Continue monthly dissemination of data to stakeholders
- Monthly program management reports

PROBLEM: 50% "no show" rate



- In July 2014, patients enrolled CC Program had a 50% "no show" rate to medical appointments, and 100% had at least two visits to the ED over the past year.
- Reviewed EMR, tracking logs and nurses notes to identify patients missing appointmer and reasons.

- Contacted pts to explain importance of keeping/ cancelling appts
- Checked provider schedule for CC patient self-scheduled
- Removed transportation barriers
- Established next-day and same-day reminder calls
- Utilized gas cards, and other transportation "methods"
- Established Pre-appointment planning
- Implemented appointment protocol

- Continued implementation of appointment Protocol
- Continued implementation of Resource Assessment
- Key Performance Indicators (KPI) – program management report - monthly review

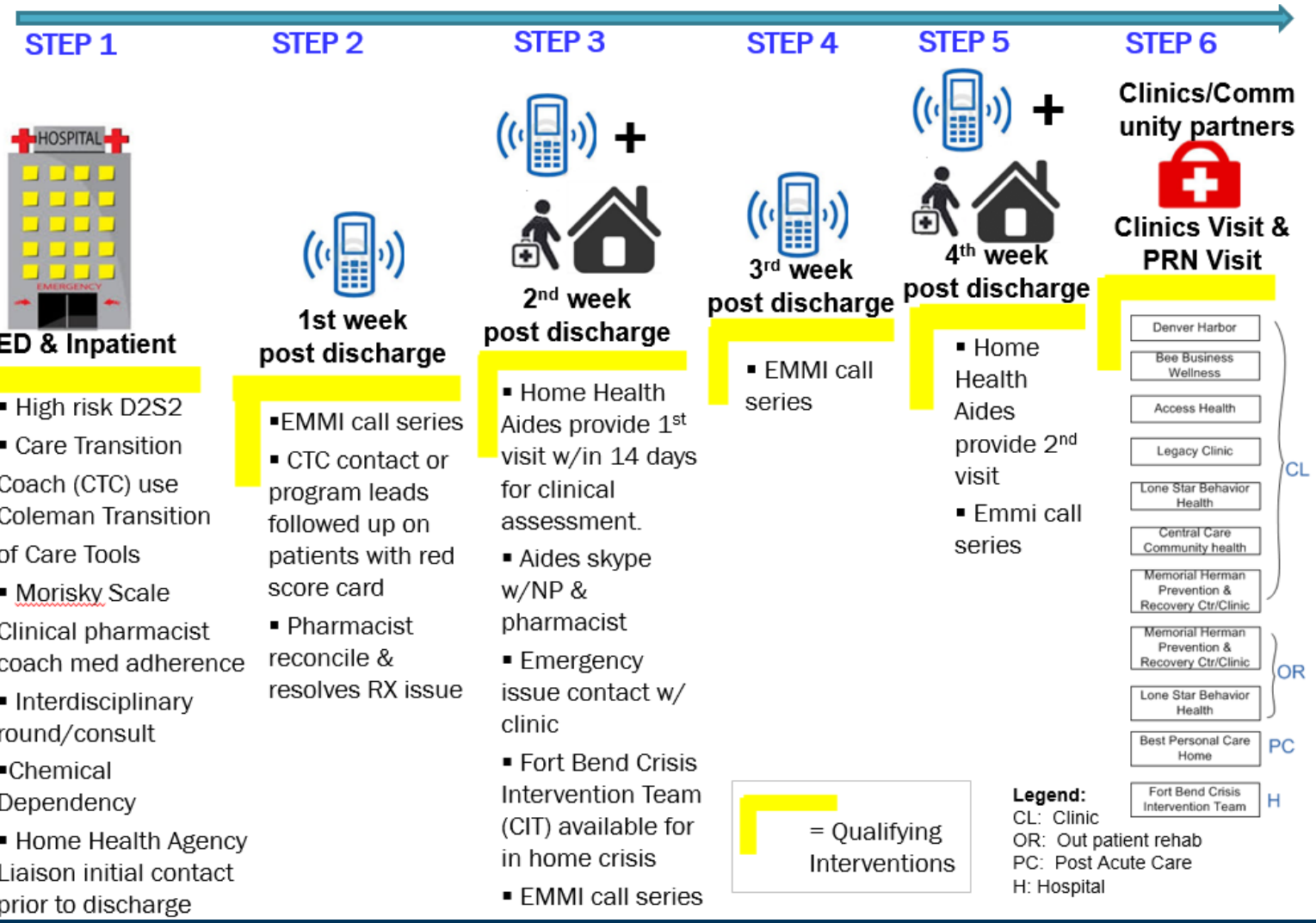
- By January 2015, the "no show" rate had decreased to 24.5% and current rate 10.5%.
- As of June 2015, only 12% of currently enrolled patients have visited the ED
- Reviewed data weekly

Data Integrity and PDSA:

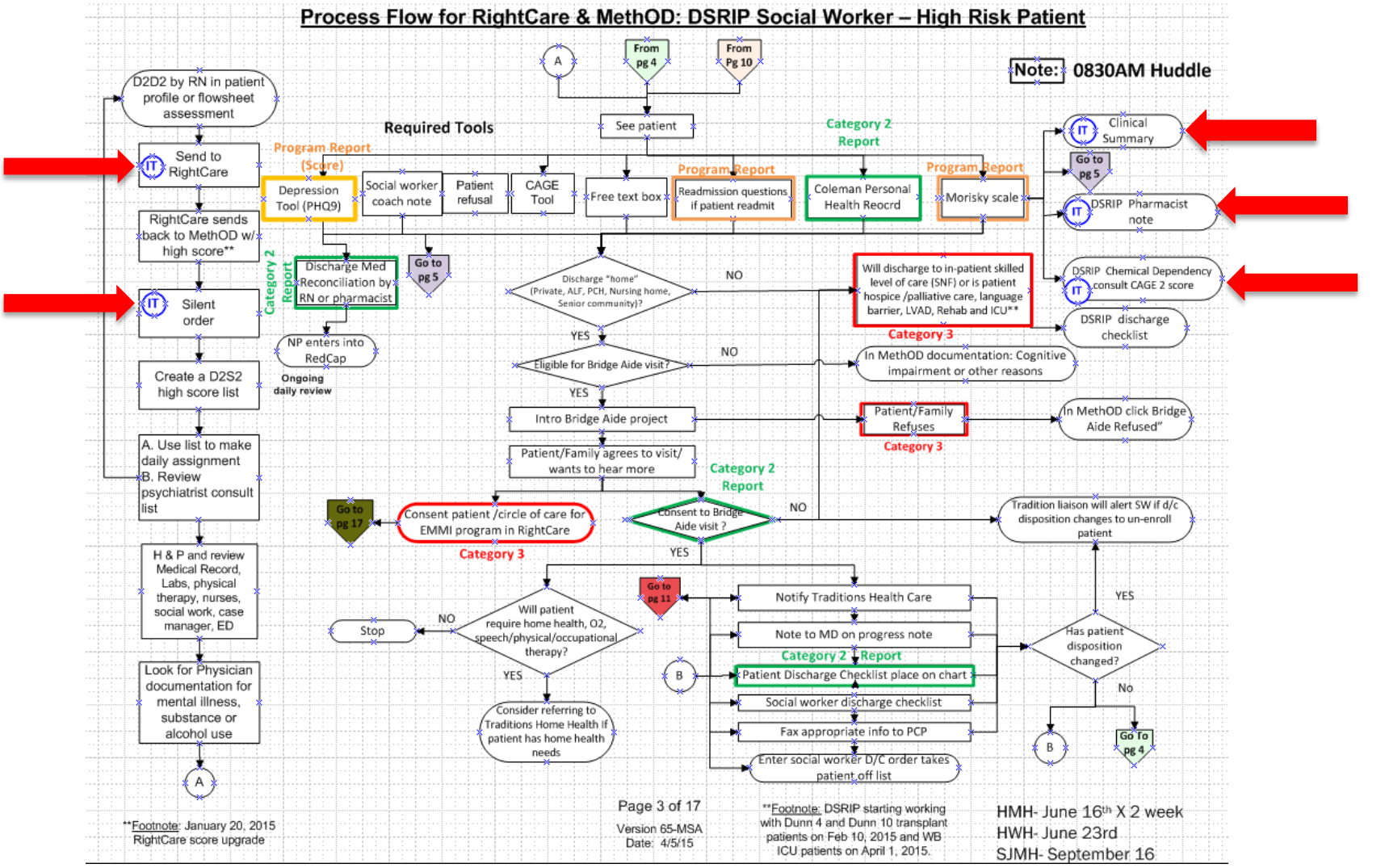
Mission

To reduce hospital readmissions for high risk patients diagnosed with primary or secondary behavioral health and/or substance abuse disorders by increasing access to care and facilitating effective transitions to behavioral health and primary care locations within Harris County.

Project Overview

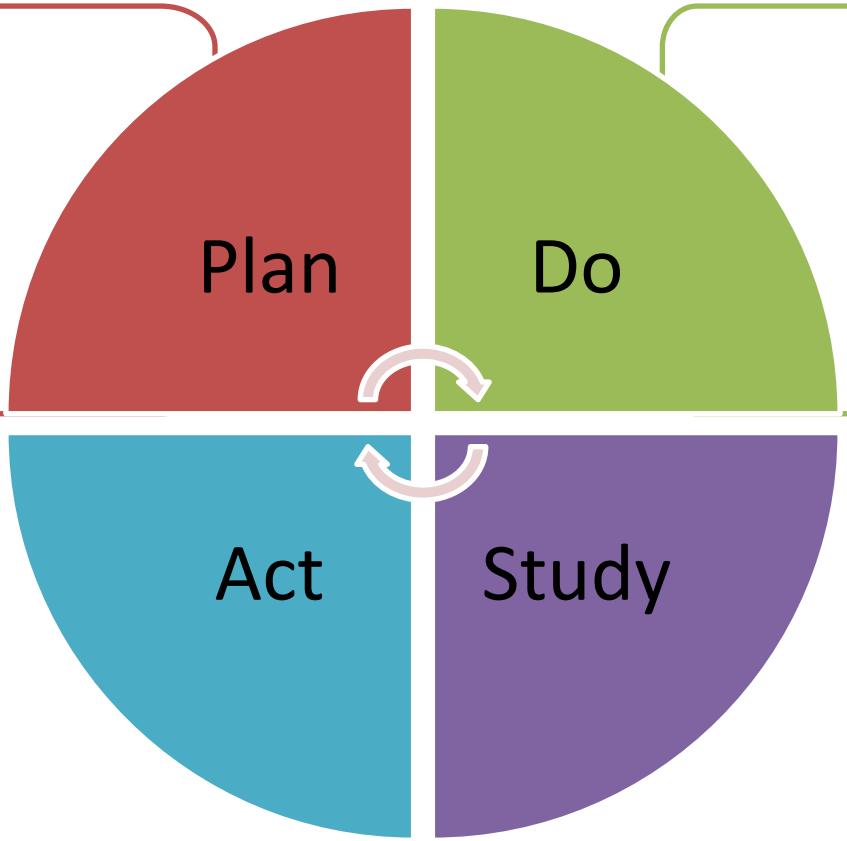


Process Flowchart



Plan - Do

- PDSA meeting with staff (Dec 2014)
- Identified gaps in program delivery



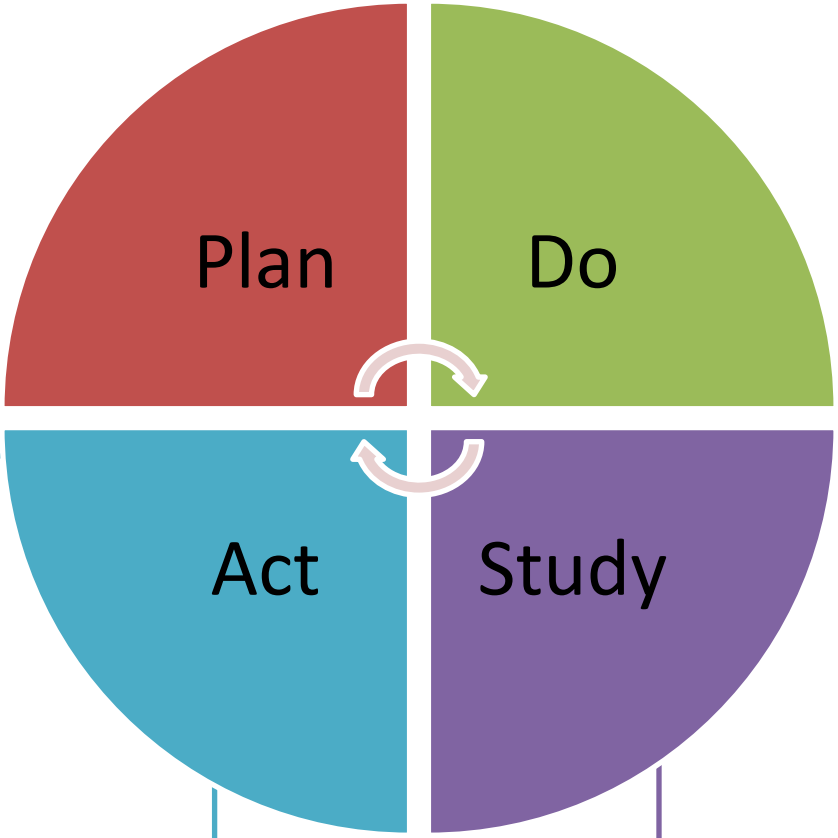
- Case review chart audits
- Monthly PHR reviews
- Weekend work
- Super utilizer meetings

Plan – Do cont'd

Agenda included:

- Reviewing our outcome measures and milestones
- Reviewed patient satisfaction scores across the 3 hospitals
- Focus group data – patient's reason for refusing to enroll in DSRIP program
- Learning techniques to better engage patients and families in post d/c plans of care (ex: Motivational interviewing)

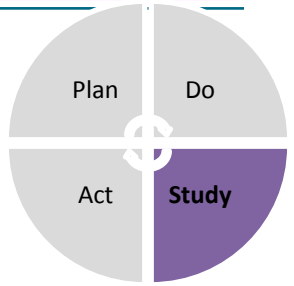
Study - Act

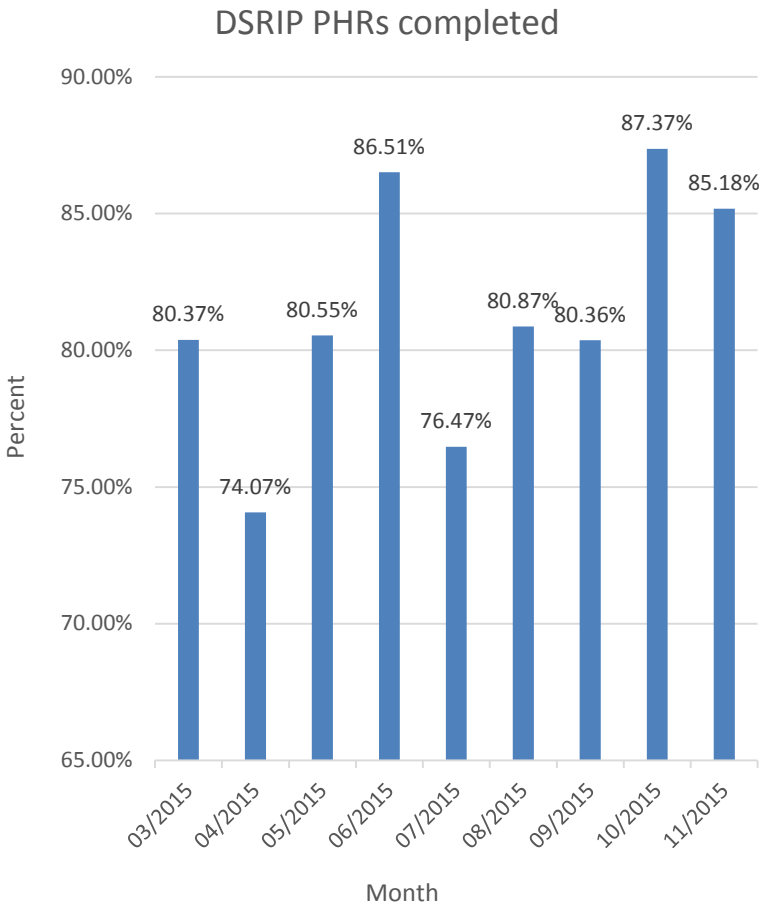


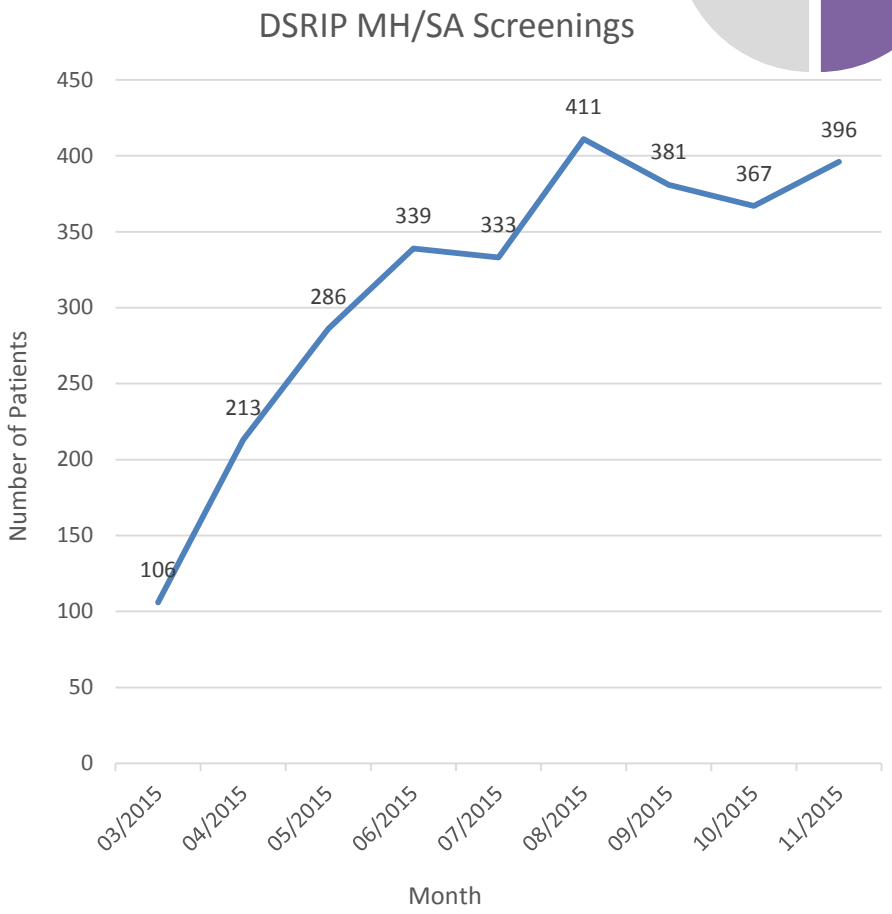
- Changes made based on the data:
  - -Manual checks/Validation
  - -Weekend work/flex schedules
  - -Motivational interviewing 3-day training
  - -Enhanced interventions for super utilizers

- PHR completion
- MH/SA Screening (D2S2)
- N/P home visits
- Patient refusal reasons
- Medication adherence
- Readmissions
- Qualitative patient data

Study

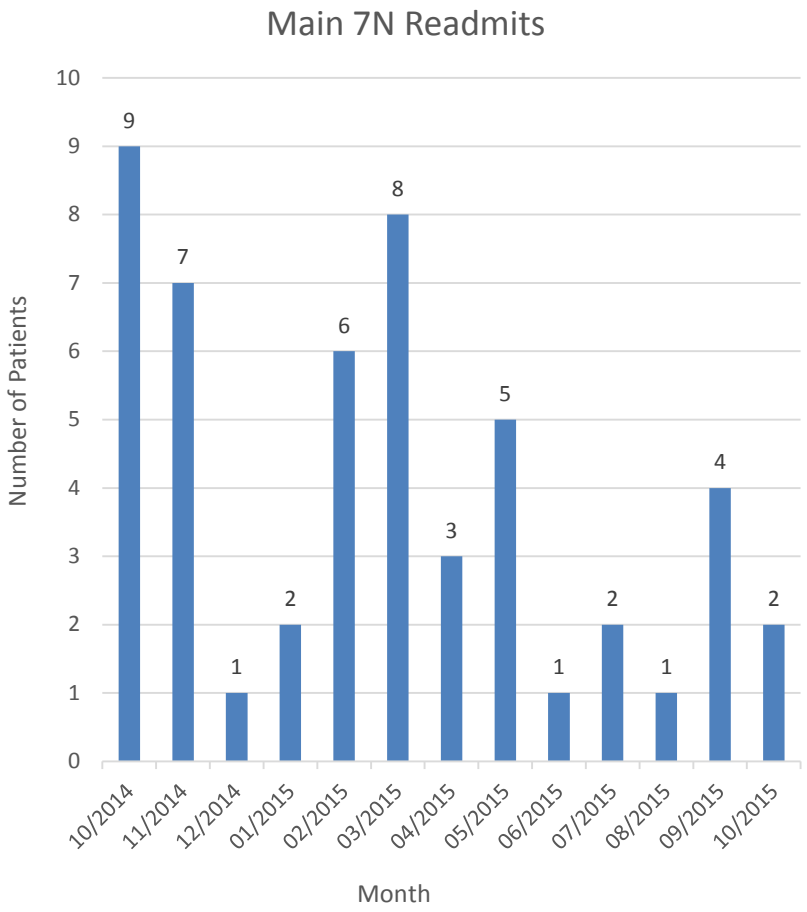

Plan
Do
Act
Study

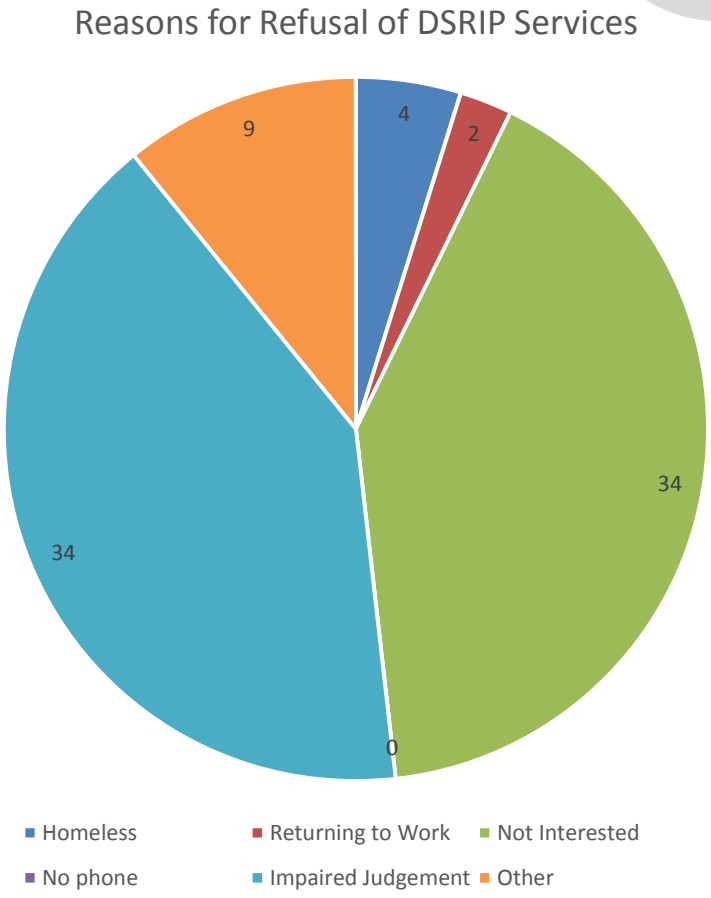

DSRIP PHRs completed
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
Percent
80.37%
74.07%
80.55%
86.51%
76.47%
80.87%
80.36%
87.37%
85.18%
03/2015
04/2015
05/2015
06/2015
07/2015
08/2015
09/2015
10/2015
11/2015
Month


DSRIP MH/SA Screenings
450
400
350
300
250
200
150
100
50
0
Number of Patients
106
213
286
339
333
411
381
367
396
03/2015
04/2015
05/2015
06/2015
07/2015
08/2015
09/2015
10/2015
11/2015
Month

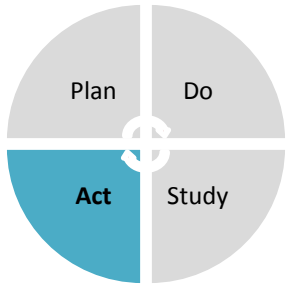
Study – cont'd


Plan
Do
Act
Study


Main 7N Readmits
Number of Patients
Month
10
9
8
7
6
5
4
3
2
1
0
9
7
1
2
6
8
3
5
1
2
1
4
2
10/2014
11/2014
12/2014
01/2015
02/2015
03/2015
04/2015
05/2015
06/2015
07/2015
08/2015
09/2015
10/2015


Reasons for Refusal of DSRIP Services
4
2
34
0
34
9
Homeless
Returning to Work
Not Interested
No phone
Impaired Judgement
Other

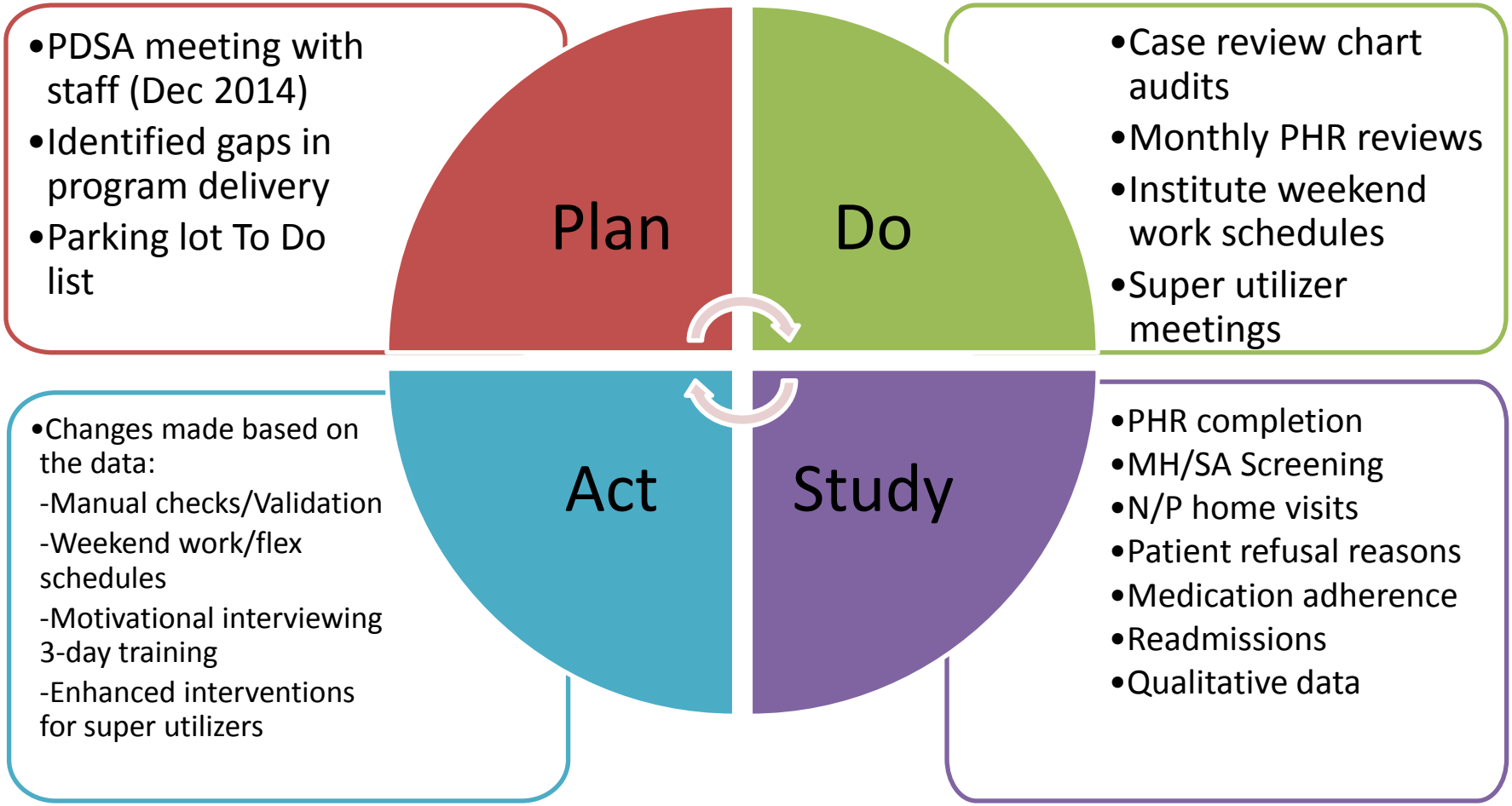
Act



Changes made based on the data:

- Manual checks/validation
- Weekend work/flex schedules
- Motivational interviewing 3-day training
- Enhanced interventions for super utilizers

PDSA


•PDSA meeting with staff (Dec 2014)
•Identified gaps in program delivery
•Parking lot To Do list
Plan
Do
•Case review chart audits
•Monthly PHR reviews
•Institute weekend work schedules
•Super utilizer meetings
•Changes made based on the data:
-Manual checks/Validation
-Weekend work/flex schedules
-Motivational interviewing 3-day training
-Enhanced interventions for super utilizers
Act
Study
•PHR completion
•MH/SA Screening
•N/P home visits
•Patient refusal reasons
•Medication adherence
•Readmissions
•Qualitative data

Data Integrity and Analysis:

➔ Knowing when your data is accurate?

Accountability for accuracy…

➔ When is enough enough when it comes to data?

The cost-effectiveness of data review…

➔ *Data collection for monitoring and sustainability*

Data sampling and tracking...

Using Data Effectively

P Data identifies need

D Data drives assessment of implementation

S Data demonstrates effectiveness

A Data communicates importance, allows wide-spread adoption, ***affords sustainability*** and (ultimately) improves the delivery system

QUESTIONS?
THOUGHTS?
DISCUSSION?

Where are you on the PDSA and data journey…

Raise the Floor Activity

Tabletop Exercise & Discussion

The Crowded Clinic

"Reflexes seem normal. You kept him waiting over two hours."

Drawing and Stretch Time

Central Counties Services, RHP8 & RHP16

SUSTAINABILITY

Sustainability

Dr. Ray Helmcamp, Executive Director, Central Counties Services

Understand Sustainability

Program Sustainability Assessment Tool v2

What is program sustainability capacity?

We define program sustainability capacity as *the ability to maintain programming and its benefits over time*.

Why is program sustainability capacity important?

Programs at all levels and settings struggle with their sustainability capacity. Unfortunately, when programs are forced to shut down, hard won improvements in public health, clinical care, or social service outcomes can dissolve. To maintain these benefits to society, stakeholders must understand all of the factors that contribute to program sustainability. With knowledge of these critical factors, stakeholders can build program *capacity* for sustainability and position their efforts for long term success.

What is the purpose of this tool?

This tool will enable you to assess your program's current capacity for sustainability across a range of specific organizational and contextual factors. Your responses will identify sustainability strengths and challenges. You can then use results to guide sustainability action planning for your program.

Helpful definitions

This tool has been designed for use with a wide variety of programs, both large and small, across different settings. Given this flexibility, it is important for you to think through how you are defining your program, organization, and community before starting the assessment.

Below are a few definitions of terms that are frequently used throughout the tool.

- **Program** refers to the set of formal organized activities that you want to sustain over time. Such activities could occur at the local, state, national, or international level and in a variety of settings.
- **Organization** encompasses all the parent organizations or agencies in which the program is housed. Depending on your program, the organization may refer to a national, state, or local department, a nonprofit organization, a hospital, etc.
- **Community** refers to the stakeholders who may benefit from or who may guide the program. This could include local residents, organizational leaders, decision-makers, etc. Community does not refer to a specific town or neighborhood.

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The name of the program or set of activities I am assessing is:

_____

In the following questions, you will rate your program across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "NA." **For each statement, circle the number that best indicates the extent to which your program has or does the following things.**

Environmental Support: Having a supportive internal and external climate for your program

	To little or no extent					To a very great extent		Not able to answer
1. Champions exist who strongly support the program.	1	2	3	4	5	6	7	NA
2. The program has strong champions with the ability to garner resources.	1	2	3	4	5	6	7	NA
3. The program has leadership support from within the larger organization.	1	2	3	4	5	6	7	NA
4. The program has leadership support from outside of the organization.	1	2	3	4	5	6	7	NA
5. The program has strong public support.	1	2	3	4	5	6	7	NA

Funding Stability: Establishing a consistent financial base for your program

	To little or no extent					To a very great extent		Not able to answer
1. The program exists in a supportive state economic climate.	1	2	3	4	5	6	7	NA
2. The program implements policies to help ensure sustained funding.	1	2	3	4	5	6	7	NA
3. The program is funded through a variety of sources.	1	2	3	4	5	6	7	NA
4. The program has a combination of stable and flexible funding.	1	2	3	4	5	6	7	NA
5. The program has sustained funding.								

For each statement, circle the number that best indicates the extent to which your program has or does the following things.

Partnerships: Cultivating connections between your program and its stakeholders

	To little or no extent					To a very great extent	Not able to answer
1. Diverse community organizations are invested in the success of the program.	1	2	3	4	5	6	7	NA
2. The program communicates with community leaders.	1	2	3	4	5	6	7	NA
3. Community leaders are involved with the program.	1	2	3	4	5	6	7	NA
	1	2	3	4	5	6	7	NA
4. Community members are passionately committed to the program.	1	2	3	4	5	6	7	NA
5. The community is engaged in the development of program goals.								

Organizational Capacity: Having the internal support and resources needed to effectively manage your program and its activities

	To little or no extent					To a very great extent	Not able to answer
1. The program is well integrated into the operations of the organization.	1	2	3	4	5	6	7	NA
2. Organizational systems are in place to support the various program needs.	1	2	3	4	5	6	7	NA
3. Leadership effectively articulates the vision of the program to external partners.	1	2	3	4	5	6	7	NA
4. Leadership efficiently manages staff and other resources.	1	2	3	4	5	6	7	NA
5. The program has adequate staff to complete the program's goals.								

For each statement, circle the number that best indicates the extent to which your program has or does the following things.

Program Evaluation: Assessing your program to inform planning and document results

	To little or no extent					To a very great extent	Not able to answer
1. The program has the capacity for quality program evaluation.	1	2	3	4	5	6	7	NA
2. The program reports short term and intermediate outcomes.	1	2	3	4	5	6	7	NA
3. Evaluation results inform program planning and implementation.	1	2	3	4	5	6	7	NA
4. Program evaluation results are used to demonstrate successes to funders and other key stakeholders.	1	2	3	4	5	6	7	NA
5. The program provides strong evidence to the public that the program works.								

Program Adaptation: Taking actions that adapt your program to ensure its ongoing effectiveness

	To little or no extent					To a very great extent	Not able to answer
1. The program periodically reviews the evidence base.	1	2	3	4	5	6	7	NA
2. The program adapts strategies as needed.	1	2	3	4	5	6	7	NA
3. The program adapts to new science.	1	2	3	4	5	6	7	NA
4. The program proactively adapts to changes in the environment.	1	2	3	4	5	6	7	NA
5. The program makes decisions about which components are ineffective and should not continue.								

For each statement, circle the number that best indicates the extent to which your program has or does the following things.

Communications: Strategic communication with stakeholders and the public about your program

	To little or no extent					To a very great extent	Not able to answer
1. The program has communication strategies to secure and maintain public support.	1	2	3	4	5	6	7	NA
2. Program staff communicate the need for the program to the public.	1	2	3	4	5	6	7	NA
3. The program is marketed in a way that generates interest.	1	2	3	4	5	6	7	NA
4. The program increases community awareness of the issue.	1	2	3	4	5	6	7	NA
5. The program demonstrates its value to the public.								

	To little or no extent					To a very great extent	Not able to answer
1. The program plans for future resource needs.	1	2	3	4	5	6	7	NA
2. The program has a long-term financial plan.	1	2	3	4	5	6	7	NA
3. The program has a sustainability plan.	1	2	3	4	5	6	7	NA
4. The program's goals are understood by all stakeholders.	1	2	3	4	5	6	7	NA
5. The program clearly outlines roles and responsibilities for all stakeholders.								

Program Sustainability Assessment Tool v2

Rating Instructions

Once you have completed the Program Sustainability Assessment Tool, transfer your responses to this rating sheet to calculate your average scores. Please record the score for each item (1-7), or write "NA" if you were not able to answer.

ITEM	Envirmntl. Support	Funding Stability	Partnerships	Organizational Capacity	Program Evaluation	Program Adaptation	Communications	Strategic Planning
1.								
2.								
3.								
4.								
5.								
Domain Total:								
Average Score for Domain:								
Overall Score:								

Add up your scores in each column. Exclude 'NA'

Divide the domain total by the total number of items with a score. Exclude 'NA'

Average together all the domain scores

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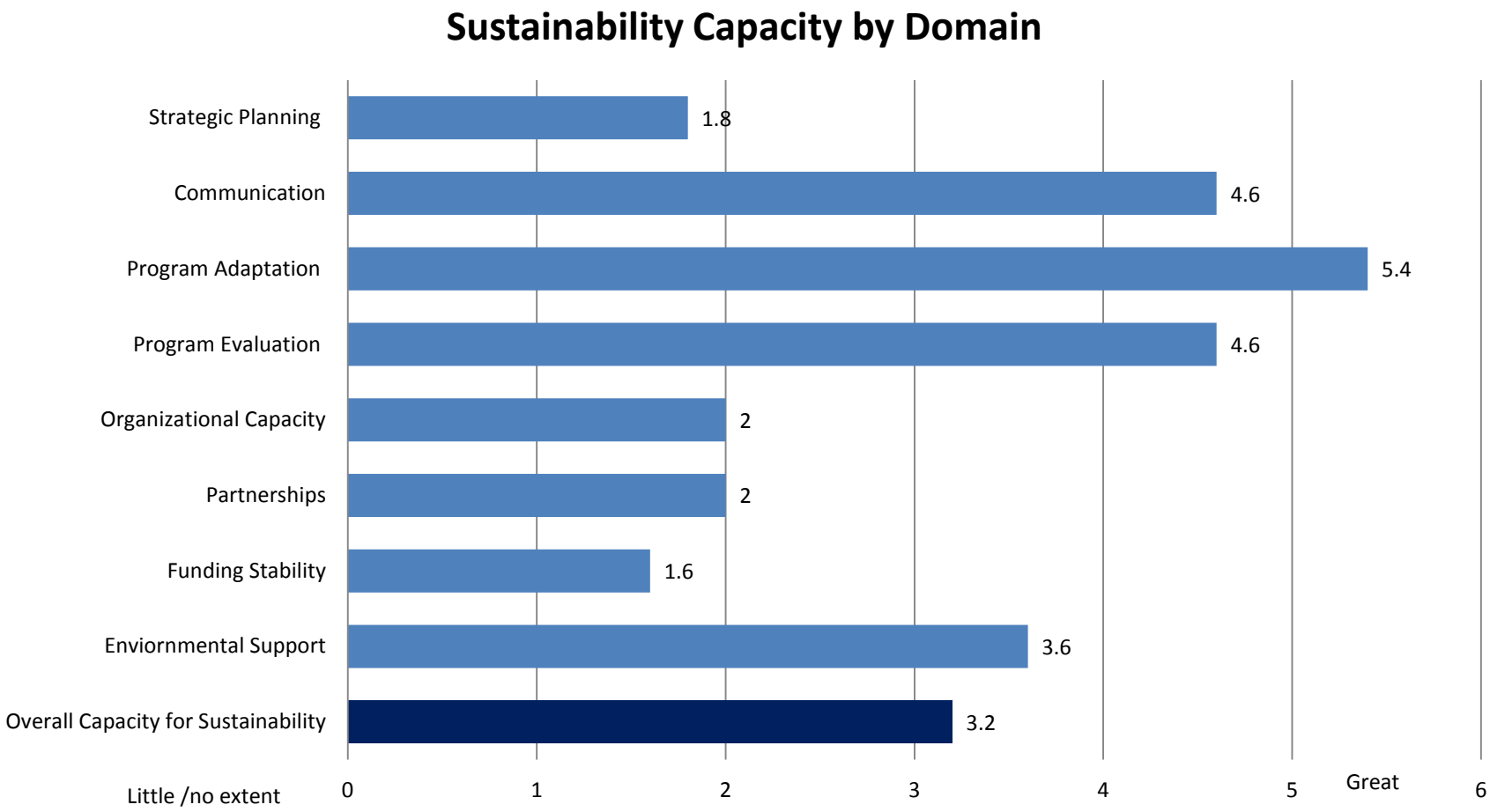
Use these results to guide sustainability action planning for your program. The domains with lower average scores indicate areas where your program's capacity for sustainability could be improved.

BreakThru Central/1115 Waiver Project



Interpreting the Results

- These results can be used to guide sustainability planning for your efforts
  - Indicate room for improvement
  - Address domains that are easily modifiable and have data available to support the needed changes
  - Develop strategies to tackle the domains that may be more difficult to modify
  - Plan to assess sustainability on an ongoing basis to monitor change

Start Exploring Action Steps

- **Develop a sustainability goal for each of the sustainability domains that you have decided to address.**
- **Develop action steps outlining how you will achieve each sustainability goal.**
- **Identify who will need to be involved to make each step successful.**
- **Identify the resources you will need to accomplish each action step.**
- **Develop milestones so you can track your progress.**

Sustainability Action Plan/BreakThru Central

Priority Domain: Funding Stability

Indicator(s) to focus on: Discover alternative funding sources other than 1115 waiver funds

1. What are the next 3 steps to address this domain? {Identify a timeframe for each step and who is responsible.)

Step 1: Meet with IDD Director to determine if the project can be incorporated by the IDD umbrella. If so, develop a picture of what that would look like.
Timeframe: January2016-February 2016
Responsible: Project Manager, Project BCBA, IDD Director, and CEO

Step 2: Search for grants and partnerships that can fund the project. Timeframe:
January2016-February 2016
Responsible: Project Manager, Project BCBA, 1115 Project Manager and CEO

Step 3 Hold a meeting to determine if the excess funds brought in by the project can be used to fund project. Timeframe
: January2016-February 2016
Responsible: Project Manager, Project BCBA, CFO,CEO and Chair of Board of Directors

1. What agencies, organizations, or individuals need to be involved?

Central Counties Services : Project Manager, Project BCBA, CFO,CEO , IDD Director,and Chair of Board of Directors

2. What resources will be needed and how could you obtain these resources? Local and state Grants

Local and State Service Agencies

3. How will you track progress and know you have succeeded?

Sustainability Action Plan/BreakThru Central

Priority Domain: Partnerships

Indicator(s) to focus on: Involvement of diverse community organizations and stockholders

1. What are the next 3 steps to address this domain? (Identify a timeframe for each step and who is responsible.)

Step 1: Hold a brainstorming session to develop a list of organizations and stakeholders that would be good partners for the project.

Timeframe: January2016

Responsible: Project Manager, Project BCBA, 1115 Project Manager

Step 2: Develop a timeline and strategy to approach organizations and stakeholders idenentified during the brainstorming session.

Timeframe: January 2016

Responsible: Project Manager, Project BCBA, 1115 Project Manager

Step 3 Hold meetings with potential community partners to share information about the project to determine if mutual partnerships can be established

Timeframe: February 2016-March 2016

Responsible: Project Manager, Project BCBA, 1115 Project Manager

1. What agencies, organizations, or individuals need to be involved?

Central Counties Services : Project Manager, Project BCBA, 1115 Project Manager

Stakeholders

2. What resources will be needed and how could you obtain these resources? List of

community organizations and how they can be of benefit to the project

Project ID :081771ooi.i.3

Metric Year and ID : DY6 Plan

Do Study Act

Improvement Project Planning Form

Team: Central Counties IDD Services

Project: n15 Coffehouse Social Skills Model _ _ _

Driver-list the drivers you'll be working on	Process measure	90-day Goal	Final Project Goal
1. Meet with IDD Director to determine if project can be absorbed into current programs if 1115 Waiver is not renewed. DECEMBER 2015	Hold meeting in December 2015 to discuss options with Andrea Erskine and Shantia Mays.	Revisit with group to see if waiver has been renewed / if being under JOO umbrella is possible.	Schedule meeting with Administrators to see if this goal will be possible if 1115 waiver is not renewed. Schedule meeting with Administrators to see if this goal will be possible if 1115 waiver is not renewed
2. Apply for grants to assist with the funding of BreakThru Central. JANUARY 2016	Grants : Transportation, Staff, Services	Preliminary results from grants applications/ plan according to outcomes.	
3. Design Plans B & C FEBRUARY 2016	Devise a timeline/framework for both Plans	Plans B & C complete.	Plans B & C are ready to implement pending outcome of Plan A.
4. Meet with DD Director and present Plans B&C .MARCH 2015	Hold meeting in March 2016 to discuss options with Andrea Erskine and Shantia Mays.	Have information from HHSC to determine if the 1115 waiver has been renewed,	Have Plans A,B,C ready to be implemented depending on decision by HHCS.
5 DYS Reporting and Survey of Staff. APRIL 2015	Complete April Reporting. Survey all staff in regards to their plans post DYS.	Develop planning based on staff surveys,	Implement either PAlan A, B, or C.
6 .Summer Recruitment . April2016	Network/Recruit for Sumer DYS	Summer DY5 completed.	

Driver Number (from above)	Change to Test	Tasks to Prepare for Tests	Data Needed to Evaluate Test	Person Responsible	Timeline ('t' = test; 'i=implement,'s' = spread) Week 1	2	2	4	S	6	7	8	9	10	11	12	13	14
1	Met with !DD Director , will IDD have funds to absorb project f 1115 is not renewed,	Graphs, Re-design of how program works		Project Manager, Flanery														
2.	Search for grants and additional funding sources.	Apply for grants and other funding sources.		D.Flanery, N.Williams														
3.	Design Plans B & C	Define components for Plan 8 and Plan C	Present Plans B & C	Project Manager, Flanery BCBA,KZ														

Project Planning Form

Driver Number (from above)	Change to Test	Tasks to Prepare for Tests	Data Needed to Evaluate Test	Person Responsible	TimeLine ('t' =test; 'i'= implement,'s' = spread) Week 1 2 2 4 5 6 7 8 9 10 11 12 13 14
4.	Meet with IDD Director and present Plans B& C	Present Plans to DD Director			
5.	April Reporting/Survey of Staff	Submit reporting data and give surveys to staff.	Analyze data from survey	Project Manager, Flanery	
6.	Summer Recruitment Strategies	Recruit summer attendees		Project Manager, Flanery	

Questions???

Resources

https://sustaintool.org/

LUNCH &
HHSC 1115 WAIVER UPDATE

TEXAS
Health and Human
Services Commission

DSRIP Program Update

December 9, 2015

Lisa Kirsch, Chief Deputy Medicaid/CHIP Director

TEXAS Health and Human Services Commission

Goals of 1115 Transformation Waiver

- Expand Medicaid managed care statewide
- Develop and maintain a coordinated care delivery system
- Improve health outcomes while containing costs
- Protect and leverage federal match dollars to improve the healthcare infrastructure
- Transition to quality-based payment systems across managed care and hospitals

Extension Request for the Pools

- The extension request on the funding pools:
  - To continue the demonstration year (DY) 5 funding level for DSRIP ($3.1 billion annually)
  - An Uncompensated Care (UC) pool equal to the unmet need in Texas, adjusted to remain within budget neutrality each year (ranging from $5.8 billion - $7.4 billion per DY)
- The Centers for Medicare and Medicaid Services (CMS) will require that Texas submit a report next year prior to waiver extension related to how the two pools in the waiver interact with the Medicaid shortfall and what uncompensated care would be if Texas opted to expand Medicaid.
- HHSC anticipates a negotiation period with CMS and will plan for a transition period with interim reporting.

Texas DSRIP Extension Principles

- Further incentivize transformation and **strengthen healthcare systems** across the state by building on the Regional Healthcare Partnership (RHP) structure.
- Maintain **program flexibility** to reflect the diversity of Texas' 254 counties, 20 RHPs, and almost 300 DSRIP providers.
- Further **integrate with Texas Medicaid managed care** quality strategy and value based payment efforts.
- **Streamline** to lesson administrative burden on providers while focusing on collecting the most important information.
- Improve project-level evaluation to **identify the best practices** to be sustained and replicated.
- Continue to **support the healthcare safety net** for Medicaid and low income uninsured Texans.

Evolving Federal Perspective Based on Recent Waivers

- Recent DSRIP programs are more standardized, increasing accountability by incorporating more outcomes-based payments, and operating through community partnerships.
- While each state's DSRIP is different, more recently approved DSRIP programs:
  - Have a more narrowly defined project menu - more prescriptive about project goals and reporting measures
  - Have larger proportions of total DSRIP funding dedicated toward reporting and results.
  - More closely align pay-for-performance (P4P) metrics with their projects.
  - Base project valuation and total per-provider funding allocations on standardized formulas.

Source: NASHP report for MACPAC, March 2015

Evolving Federal Perspective Based on Recent Waivers (cont.)

More recently approved DSRIP programs:

- Have all-or-nothing payment (instead of partial payment).
- Have high performance funds (instead of carry forward).
- Require participating providers to submit project budgets.
- May require providers to report at a high level how incentive payments are spent.
- Use attribution models to assign a large portion of the state's low-income patients to specific participating providers.
- Emphasize the importance of sustainability after quality improvements are achieved.

Source: NASHP report for MACPAC, March 2015

DSRIP Protocols

- Texas indicated to CMS in the extension request that we plan to propose ways to strengthen the DSRIP program in the extension period.
- DSRIP requirements in the extension period will be defined in the revised DSRIP protocols - the Program Funding and Mechanics Protocol (PFM) and the RHP Planning Protocol (DSRIP menu).
- HHSC conducted a webinar on Sep. 30 on initial high-level proposals for the extension period that will be refined in the DSRIP protocols.
- HHSC will consider stakeholder feedback from now through spring 2016 as we work to finalize the protocols for submission to CMS in late spring/early summer 2016.

DSRIP Planning and Negotiations with CMS

- HHSC previously indicated the DSRIP protocols would be submitted to CMS in early 2016. Based on further discussions with CMS, HHSC now plans to:
  - Submit a proposal for a transition year (DY6) in early 2016; and
  - Submit the revised DSRIP protocols in late spring/early summer 2016.
- HHSC will submit high-level proposals to CMS for consideration on an ongoing basis.
  - Based on CMS feedback about the feasibility of various elements, HHSC then will work with stakeholders to develop detailed requirements.
- HHSC will let stakeholders know of items under discussion with CMS and provide opportunities to submit feedback on these proposals through the HHSC website.

DSRIP Protocols

Initial proposals planned:

- Transition year (DY 6 - 10/1/2016 – 9/30/2017)
  - Includes parameters for combining projects
  - Laying the groundwork for performance bonus pools
  - Setting a minimum annual valuation amount per provider
- Revised protocols for extension/renewal (beginning 10/1/2017)
  - Continuing and replacement projects
  - Regional performance bonus pools

Transition Year (DY 6)

- HHSC will propose to CMS that current projects that are eligible to continue or will be replaced be eligible to continue for a transition period of one year (DY 6), including 2.4, 2.5, 2.8 and 1.10 projects.
- HHSC plans to submit proposed transition year parameters to CMS in early 2016.
- In summer 2016, providers submit confirmation of whether they plan to continue/replace current projects or if they plan to withdraw projects.

Transition Year (DY 6) - Statewide Analysis Plan

The extension application includes a proposal to analyze Medicaid data and available all-payer potentially preventable event (PPE) data for managed care service delivery areas and RHPs. HHSC will provide this global trend data to CMS from CY 2013 through the years of the extension period to show whether combined efforts are having an effect on key measures.

- HHSC has been working with Texas Medicaid's external quality review organization, the Institute for Child Health Policy (ICHP), to determine measures ICHP already collects for Medicaid that intersect with DSRIP activities.
- A challenge for statewide analysis of DSRIP results is that HHSC doesn't have access to much data on non-Medicaid populations (including low-income uninsured). HHSC is exploring the use of all-payer data from the Department of State Health Services to add all-payer PPE measures to the statewide analysis.

Transition Year (DY 6) - Statewide Analysis Plan (cont.)

At the DSRIP Statewide Summit in August, the following Medicaid measures were highlighted as possible measures for the statewide analysis plan.

- **Behavioral Health Measures**
  - HEDIS Antidepressant Medication Management (AMM): Acute Phase
  - HEDIS Antidepressant Medication Management (AMM): Continuation Phase
  - HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) within 7 Days
  - HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) within 30 Days
- **Access to Care Measures**
  - HEDIS Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - HEDIS Access to Primary/Preventive Care: Frequency of Ongoing Prenatal Care (FPC)
  - HEDIS Access to Primary/Preventive Care: Postpartum Care (PPC-Postpartum Care)
  - Potentially Preventable Events (PPEs)
- **Potentially Preventable Events**
  - 3M Potentially Preventable Admissions (PPA)
  - 3M Potentially Preventable ED Visits (PPV)
  - AHRQ Pediatric Quality Indicator: Asthma Admission Rate (PDI 14)
  - AHRQ Pediatric Quality Indicator: Diabetes Short-Term Complications Admission Rate (PDI 15)

Performance Bonus Pool
New York Example

NY DSRIP High Performance Fund (HPF)

- There are 10 measures that are part of the NY DSRIP HPF:
  - Potentially Preventable Emergency Department Visits (All Population)
  - Potentially Preventable Readmissions (All Population)
  - Potentially Preventable Emergency Department Visits (BH Population)
  - Potentially Preventable Readmissions (BH Population in SNF)
  - Follow-up for Hospitalization for Mental Illness
  - Antidepressant Medication Management
  - Diabetes Monitoring for People with Diabetes and Schizophrenia
  - Cardiovascular Monitoring for People with CVD and Schizophrenia
  - Controlling Hypertension
  - Tobacco Cessation - Discussion of Cessation Strategies
- Performance goals have been established for these measures and will not be changed throughout the DSRIP demonstration.

Measuring DSRIP Success – Performance Bonus Pools (PBP)

- HHSC will establish the PBP measures that will be required for all regions, and will develop a list of additional potential PBP measures that a region can select based on the key community needs and DSRIP areas of focus in that region.
  - HHSC will consider including the measures in the ICHP statewide analysis plan as PBP measures.
- HHSC will use state-generated data instead of provider-generated data for the PBP measures.
- HHSC will need to ensure that there is no duplication of federal funds (e.g., if PPEs are used for the PBP).
- HHSC seeks stakeholder input on potential Medicaid measures and all-payer measures to help reflect the improvements in healthcare delivery in Texas during the waiver period.

Transition Year (DY 6) - Combining Existing Projects

- The timeline for requesting to combine projects is planned to begin in January 2016.
  - The combined project would begin reporting in the transition year (DY 6).
- Cross-regional community mental health center (CMHC) projects that are similar may choose to combine into one or more home regions.
  - The home region selected must be the region with the highest total valuation.
  - CMHCs will be required to maintain a portion (5-10%) of the original allocation in each of the regions for the regional performance bonus pool.
- Projects from one or multiple providers within an RHP that provide similar services to different populations may combine into one project.
  - e.g., Two similar prevention projects, one targeting females and the other targeting males.

Transition Year (DY 6) - Setting a Minimum Valuation

- HHSC proposes to set a minimum valuation per provider (for Categories 1-4 combined) at $250,000 per demonstration year for the extension period (including the transition year).
  - Impacts 27 providers (24 hospitals, 3 local health departments) and 35 projects.
  - To increase these providers' valuation, HHSC proposes to use approximately $3 million of the current $10.7 million remaining funds not allocated in DY 5 to a region or withdrawn projects.
  - HHSC will review QPI for each of these projects to ensure QPI supports increased valuation.
- Providers may opt out of the increased valuation if intergovernmental transfer (IGT) funds will not be available.

Revised Protocols for DY 7 Forward

The information on the remaining slides is proposed to be effective beginning 10/1/2017 (for DY 7 through DY 10, or for the extension period approved by CMS).

Continuing Category 1 & 2 Projects

All projects from areas included on the 3-year menu may be eligible to continue pending HHSC review of higher risk projects.

- There are many promising projects that need more time to demonstrate outcomes and evaluate best practices.
- Some projects may be required to take a next step and HHSC may propose further standardization of continuing projects (including related to QPI and project intensity).
  - The goal is to further transformation in the extension, including by serving additional Medicaid and low-income individuals where feasible and/or taking next steps on initial projects (e.g., a project established a primary clinic, and now will become a patient centered medical home).
  - HHSC will balance this goal with allowing projects that are on track to further progress and to account for projects that initially set overly aggressive goals.

Continuing Category 1 & 2 Projects (cont.)

- There will be fewer, more standardized milestones/ metrics to report for achievement.
- HHSC is considering the following milestones:
  - 60-70% of Category 1-2 valuation: QPI (one milestone for total QPI and one for MLIU QPI).
  - 30-40% of Category 1-2 valuation:
    - Core components, including CQI
    - Sustainability planning, including health information exchange, integration with managed care, and other community partnerships; and/ or
    - Medicaid ID reporting.

TEXAS Health and Human Services Commission

Replacement Projects

- HHSC identified the projects in July that will be reviewed and may not be eligible to continue (or may require changes to the project scope, milestones/metrics, and/or valuation).
- HHSC will notify projects not eligible to continue in early 2016 to give providers time to plan for replacement projects if needed.
- These providers may propose replacement projects selected from the extension menu.
- Replacement projects would be submitted to HHSC during DY 6 at a date TBD (such as a target date of January 1, 2017) upon CMS approval of the revised RHP Planning Protocol.

Replacement Projects (cont.)

Replacement projects may be submitted in the following circumstances:

- Four-year projects from 2.4, 2.5, 2.8, and 1.10 project areas (except 1.10 for learning collaborative purposes, which may continue)
- Providers of projects withdrawn after June 30, 2014 (so associated funds are not currently allocated to active projects)
- Projects identified from high risk list based on HHSC review
- Providers may also elect to discontinue a current project(s) and propose a replacement
- May be proposed up to the same valuation as original project, not to exceed $5 million per demonstration year

Extension Menu

Replacement projects must use options outlined in the extension menu.

- The Category 1 & 2 draft extension menu is designed to build on the lessons learned from DSRIP in the initial 5-year waiver.
- The extension menu is a streamlined version of the current RHP Planning Protocol - combined similar project options and removed selected project options to keep **the most transformative options** on the menu.
- Opportunities to "hit the ground running" through replication of strong, existing projects with limited or no planning period.
- Project options not included on the extension menu often may be a component of a project in the extension.
- Some project areas and options were consolidated to avoid duplication of options across project areas.

Extension Menu (cont.)

- Input from Clinical Champions was considered during the development of the draft extension menu.
  - Best practices options for some project areas will be identified based on the Transformational Impact Summaries submitted to the Clinical Champions Workgroup.
- Replacement projects and metrics will be more standardized than the current DSRIP menu.
  - HHSC plans to develop templates for submission of replacement projects, including core components.
- Project options included in the draft extension menu are shown in the Summary of the Transformational Extension Protocol (posted on the HHSC waiver renewal webpage).

Switching Category 3 and Category 4

Current

- Category 3, Quality Improvements – Healthcare outcomes that are tied to Category 1 and 2 projects (combination of pay for performance and pay for reporting)
- Category 4, Population-Based Improvements – Hospital-level reporting on data in several domains related to potentially preventable events, patient-centered healthcare, and emergency department care (pay for reporting)

Proposal

- Category 3 – Continue to collect project-related outcome data, but switch to pay for reporting outcomes and building measurement capacity
- Category 4 – Change to pay for performance based on regional performance in improving on a set of key measures (regional shared performance bonus pools using state-generated data)

Switching Category 3 and Category 4 (cont.)

Rationale for Switching Category 3 and Category 4

- Category 3 is extremely complex and many providers, of all types and sizes, are struggling to accurately complete Category 3 reporting and conform to the technical specifications of the measures.
- There is value in building measurement capacity at the provider level and collecting data on the outcomes related to individual DSRIP projects.
- However, given Texas' volume and variety of outcome measures, state-level data may better demonstrate the overall impact of DSRIP, along with Medicaid managed care and other initiatives, on improving healthcare outcomes and population health.

Category 4 –Performance Bonus Pool (PBP)

- HHSC proposes to set aside 5-10% of each provider's total valuation for each DY for the Category 4 performance bonus pool (PBP) to reward high performing regions.
- The same 5% or 10% set aside as DY 6 applies beginning in DY 7 for smaller and larger providers.

Items in Development

- Communications process for stakeholder feedback
- Timelines
- Extension menu – stakeholder feedback is being incorporated
- Replacement project requirements
- QPI requirements for DY 7 forward
- Additional Category 1 or 2 standardized metrics
- Potential changes to Category 3 measures
- Statewide analysis plan
- Regional performance bonus pool measures and funding
- Further uses for funds not allocated to active projects

Waiver Communications

- Find updated materials and outreach details:
  - http://www.hhsc.state.tx.us/1115-waiver.shtml
- Submit questions to:
  - TXHealthcareTransformation@hhsc.state.tx.us

COPE Health Solutions

University Health System, RHP6

Community Care Collaborative, RHP7

DSRIP PERSPECTIVES, NEW YORK & TEXAS REGIONS

New York State DSRIP – Texas Roadmap to an Integrated Delivery System and High Performance Pools

Texas RHP3 Learning Collaborative

December 2015

COPE HEALTH SOLUTIONS

Today's Presenters

Margarita Gardea
Senior Consultant
COPE Health Solutions

Mallory Johnson
Senior Consultant
COPE Health Solutions

COPE Health Solutions – Who We Are

COPE Health Solutions provides our clients with the tools, services and advice they need to be leaders in the health care industry. Focusing on all aspects of strategy, population health management, CMS demonstrations, DSRIP, and workforce development, we help drive our clients' success every step of the way.

COPE's New York DSRIP Experience

Finger Lakes Performing Provider System "FLPPS" (co-owned by UR Medicine & Rochester Regional Health)	• Largest geographic PPS comprised of 13 counties in Western NY • Network Size: ~300 parent level provider organizations across the care continuum • Considered a model for the state, first to launch value based contracting
Mount Sinai Performing Provider System "MSPPS"	• Large PPS with responsibility for implementing DSRIP in NYC across Manhattan, Brooklyn and Queens • Network Size: ~280 parent level provider organizations across the care continuum • Recently purchased large Medicaid hospital system
Montefiore Health System a.k.a. Montefiore Hudson Valley Collaborative Performing Provider System "HVCPPS"	• Led by Montefiore Health System in nine counties of the Hudson Valley (north of the Bronx) • Network Size: ~200 parent level provider organizations across the care continuum • Recognized by CMS as a model health system and Pioneer ACO

Agenda

- New York Waiver at a Glance
  - Compare and Contrast TX and NY DSRIP Waivers
  - NYS Funding Pools
- High Performance Funds
  - DSRIP High Performance Pool
  - Additional High Performance Pools
- Integrated Delivery System Goals and Requirements in New York DSRIP
- Tying It All Together for Success and Sustainability
  - Current Strategies
  - Recommendations
  - Challenges and Lessons Learned
- What Does This Mean for Texas?
- Q&A

New York Waiver at a Glance

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Why talk about NY DSRIP?

- Most recent full DSRIP 1115 Waiver approved by CMS
- Aggressive state goals and expectations that may be seen in Texas Waiver renewal negotiations with CMS
- Focus on creating a fully Integrated Delivery System across the care continuum
- Has similarities to Texas structure for clinical pay for performance outcomes

Texas and New York DSRIP

Common High Level Themes

- Collaboration by providers
- Organization of regional structures to determine priorities and projects at the local level
- Identification of DSRIP funding which bases payment on performance
- Federal, state and local accountability
- Sustainability by establishment of permanent, sustainable delivery system structures and projects
- Regionally developed DSRIP plans

Common DSRIP Program Plan Elements

- Statement of goals
- Identification of participating providers (participation voluntary)
- Performance assessment including community needs assessment, regional planning, and public input
- Detailed milestones and metrics to set achievement expectations
- Governance structure of the regional organization
- Project attestation and certification
- Learning collaborative commitment

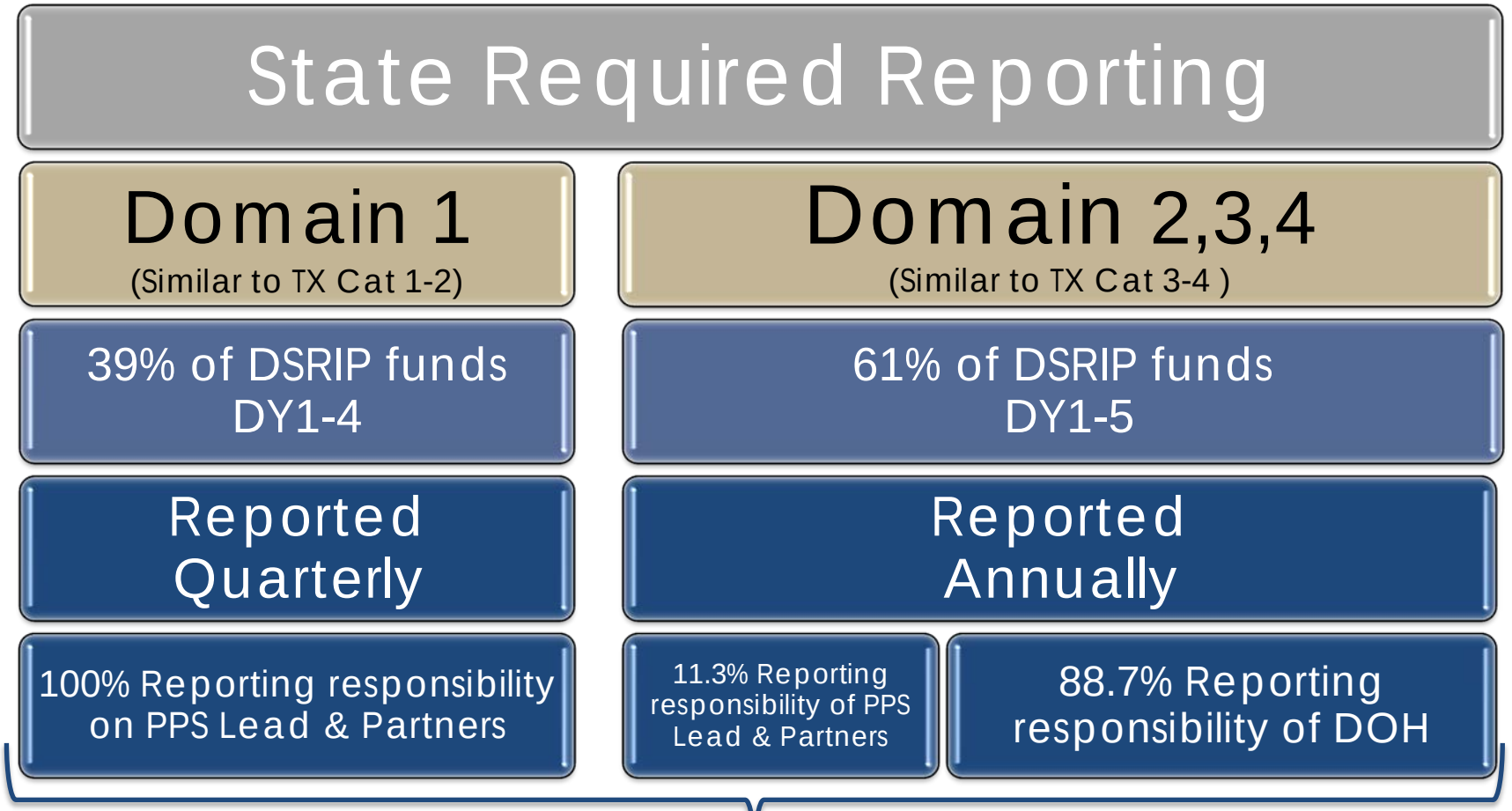
Texas vs. New York DSRIP Structure

Area	NY - PPS	TX - RHP
Startup Investment	$100 million	$500 million
Regionalization	Entire state with 25 self selected - designated regions (PPS)	Entire state with 20 designated regions (RHP)
Target Population	Member attribution at the provider level with most members in MCOs as well as PPS	No member attribution; all population including Medicaid and under/uninsured with specific targets to be met
DSRIP Funds	$6.4 Billion all-funds	$11.1 Billion all-funds
Funding	Joint budgets and funding distribution plan through public hospitals – funds flow to providers unique per PPS structure	Funding dependent upon available IGT funds and commitments from entities

Texas vs. New York DSRIP Structure

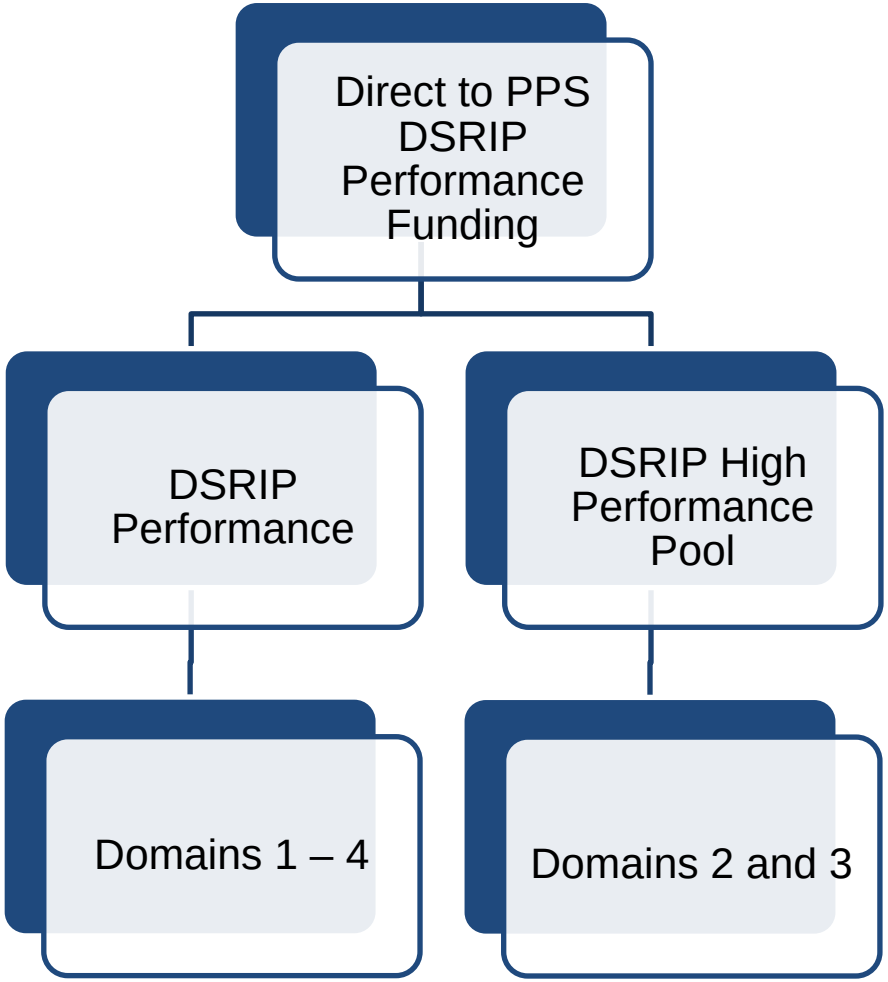
Area	NY – PPS	TX - RHP
Organizational Authority	Formal: Contract for services and drive to System Outcomes	Informal: Administrative and Coordinating
Role/Name	Lead Provider *(Leads had option to develop a New Co)*	Anchor
Eligible Provider Participants	64,099 providers including: hospitals, physicians, medical groups, clinics, mental health and public health agencies, health home/care management agencies, CBOs, BH/SA organizations, SNFs/nursing homes, hospice, pharmacies, and other organizations not fitting into these categories	309 Medicaid providers including: hospitals, medical schools, mental and public health agencies, and physician groups

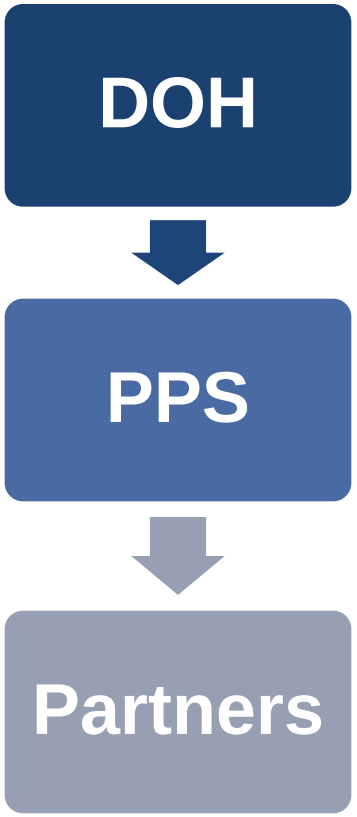
Example NYS PPS Reporting Overview



PPS Partner contracting requirements will enable successful state required reporting & funds flow to partners

New York 1115 Waiver DSRIP Funding





New York 1115 Waiver DSRIP Funding

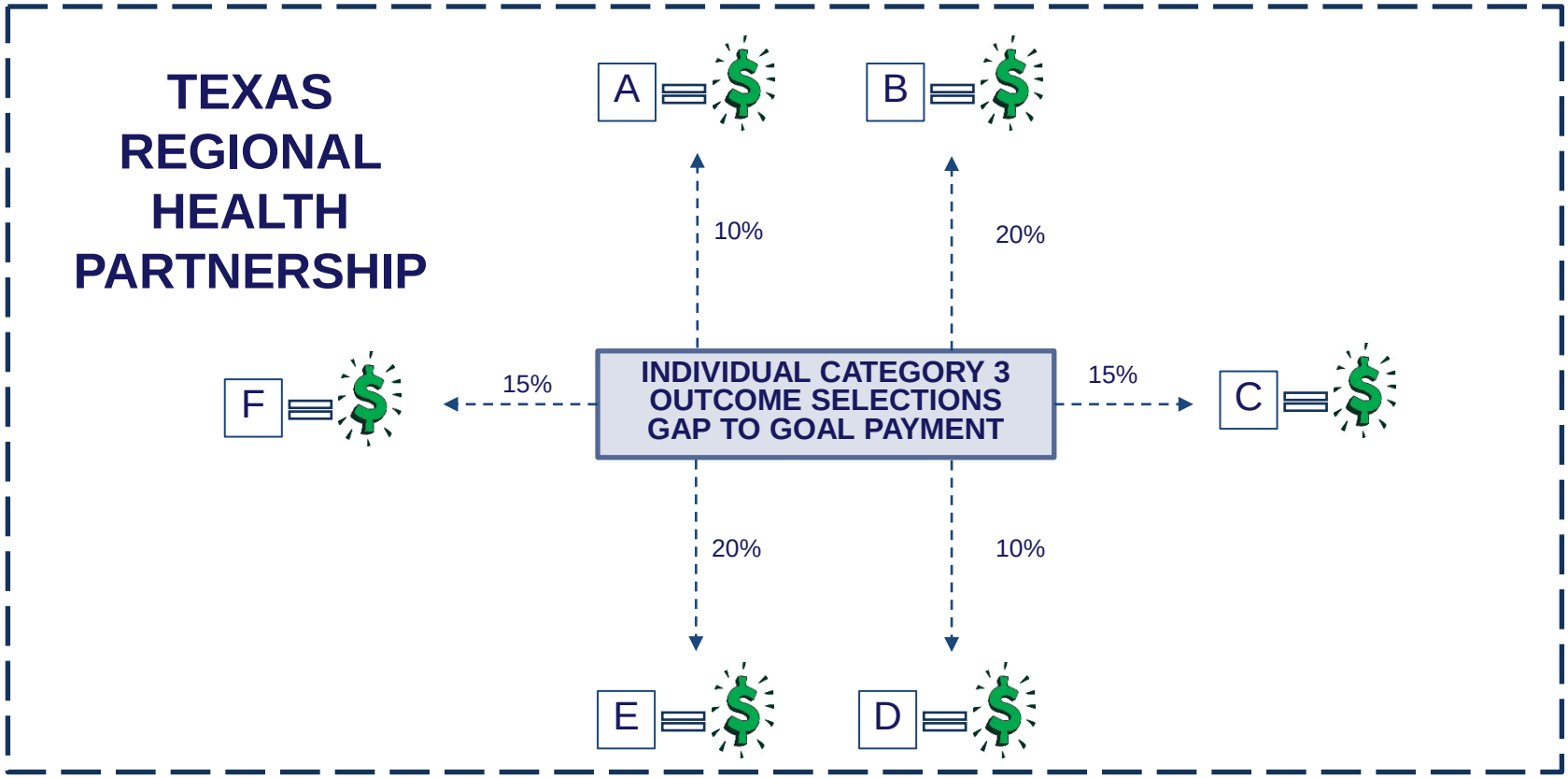
State Guarantee MCO Pass Through Funding

- Additional High Performance Pool*
- Equity Infrastructure
- Equity Performance
- Value Based Payment QIP

*SAME HPF MEASURES AS HPP IN NON MCO DSRIP PERFORMANCE FUNDING

DOH → MCO → PPS → Partners

Performance Achievement & Funds Flow – TX vs. NY

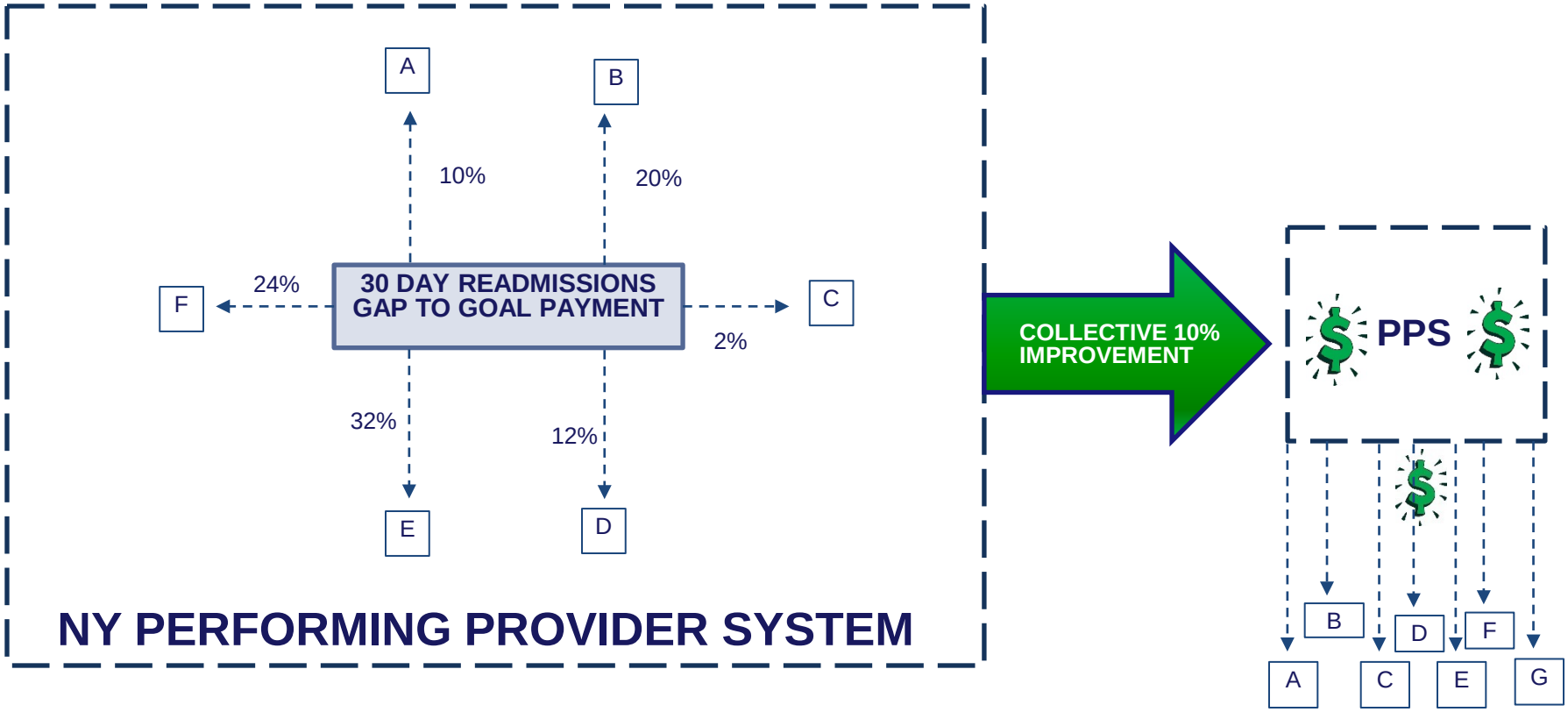


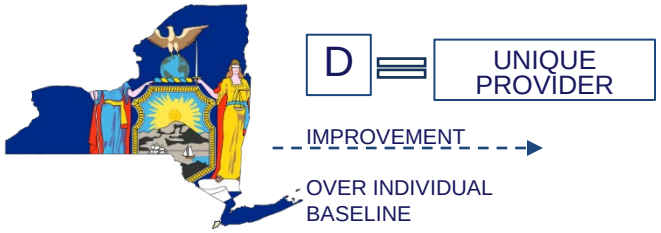
D = UNIQUE PROVIDER

10% IMPROVEMENT

OVER INDIVIDUAL BASELINE

Performance Achievement & Funds Flow – TX vs. NY





High Performance Funds (HPF)

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DSRIP High Performance Pool

- Available for PPS that achieve high performance on HPF eligible measures (P4P transition as early as DY3)
  - 10 eligible measures across Domains 2 and 3
- Total High Performance Fund is split evenly across 2 tiers
  - Tier 1 -Based on 20% gap to goal achievement
  - Tier 2 -Based on exceeding statewide performance targets
- Limited to 30% of PPS project valuation
- Payments will be made once per year coinciding with the second payment periods of DY2 -DY5
- Based on PPS Attribution for Performance (A4P) and the number of projects applicable to high performance chosen by each PPS

Additional High Performance Pool

- Supplemental high performance funding against the same DSRIP measures already identified for high performance payments
- State will pay MCOs and then MCOs are responsible for distributing funds to PPS
  - PPS will be responsible for establishing contracts with MCOs for payment
- Monthly payments from MCOs *are anticipated*
- PPS will need to report out on DSRIP high performance measures as criteria to the MCO, on a monthly basis, *as current guidance stands*

High Performance Eligible Measures

NYS HPF Eligible Measure	Texas Category 3 Measure	Texas Category 4 Measure
Potentially Preventable Emergency Department Visits (All Pop.)		
Potentially Preventable Readmissions (All Pop.)	✓	✓
Antidepressant Medication Management	✓	
Cardiovascular Monitoring for People with CVD and Schizophrenia	✓	
Diabetes Monitoring for People with Diabetes and Schizophrenia	✓	
Follow-up for Hospitalization for Mental Illness	✓	
Potentially Preventable Emergency Department Visits (BH Population)		

Integrated Delivery System (IDS) Goals and Requirements in New York DSRIP

IDS Objectives Defined by NYS DOH

- Create an integrated, collaborative and accountable service delivery structure that incorporates the full continuum of care, eliminating service fragmentation while increasing the opportunity to align provider incentives.
- Incorporation of the medical, behavioral health, post-acute, long term care, social service organizations and payers to transform the current service delivery system from one that is institutionally-based to one that centers around community-based care.
- Each organized integrated delivery system (IDS) will be accountable for delivering accessible evidence-based, high quality care in the right setting, at the right time, at the appropriate cost.
- Organized IDSs will commit to devising and implementing comprehensive population health management strategies and be prepared for active engagement in New York State's payment reform efforts.

IDS and NY DSRIP

- All 25 PPSs in NY required to implement an IDS project
- All providers participating in a PPS MUST be in the IDS project and achieve 100% of applicable requirements
- Participating Provider types in the IDS
  - Primary Care Physicians
  - Non-PCP Practitioners
  - Hospitals / Outpatient Clinics
  - Health Home / Care Management
  - Behavioral Health
  - Substance Abuse
  - Skilled Nursing Facilities / Nursing Homes
  - Pharmacy
  - Hospice
  - Community Based Organizations
  - All Other

IDS Requirements Defined by DOH

Clinical

- Utilize partnering Health Homes and ACO population health management systems and capabilities; demonstrate real service integration which incorporates a population management strategy; develop collaborative care practices.
- PPS has protocols in place for care coordination; PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.
- PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.
- Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.

Technical

- Clinically Interoperable System is in place for all participating providers.
- Connectivity to HIEs, use of EMR alerts and direct messaging, and Stage 3 Meaningful Use achieved for Primary Care Providers, use of registries to track patients.

Financial

- Medicaid Managed Care contract(s) are in place (with PPS or with providers directly) that include value-based payments; meet regularly with MCO to manage utilization trends.
- Providers receive incentive-based compensation consistent with DSRIP goals and objectives; PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation.

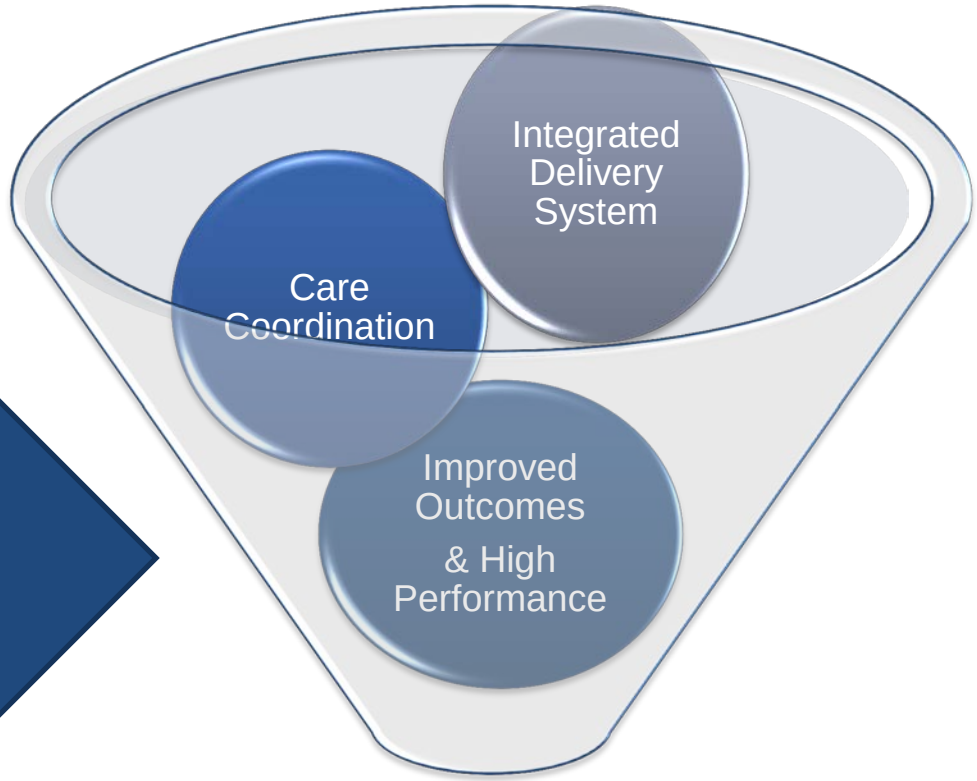
Implementation Planning Observations

- Integrated Delivery System
  - Integration and connectivity across projects and providers is paramount to sustaining the IDS
  - The money (incentive payments to providers) must follow the patient
    - Payment systems must be consistent with quality goals and patient engagement
  - IDS integration must account for and have synergy with MCO contracting approach and MSO services
  - Key to outcome success and attainment of High Performance dollars

Tying It All Together for Success and Sustainability

Ideal State

Providers & MCOs



Transformation and Sustainability

Current Strategies

- Develop a strong network across PPS
- Identify current partner capacity and gaps
- Initial performance based contracts with partners to meet initial goals of PPS
- Identify biggest gaps in Domain 2-4 outcomes for focused interventions and related value
- Early engagement with MCOs
- Early strategic plans to leverage PPS structure post DSRIP

Recommendations for the Future

- Develop strategy for partners to report real time data
- Develop a more robust performance based contracting strategy with specific goals for partners based on contribution to projects
- IPA development strategy for consolidated MCO negotiations and VBP goal achievement
- Collaboration across PPSs to ensure consistency around similar projects in areas that share patients and providers
- Develop strategy for partner draw down of HPP and AHPP dollars

Challenges

- Developing an equitable methodology for funds flow to partners with lack of DOH guidance
- Accessing real time data
- Still dealing with a competitive environment
- Building relationships that may not have existed before
- Lack of adequate resources and staff
- Continuous changes in DSRIP structure and requirements
- MCO strong presence and voiced concerns with future of contracts and VBP strategies

Lessons Learned

- Robust communication strategy is essential
- Early governance structure development is key
- Include partners early on to gain buy-in, especially on sensitive matters like funds flow
- Network development is a continuous cycle, and while not easy, must be done

What Does This Mean for Texas?

Learning Opportunities from NYS Waiver Requirements

- PCMH Certification
  - All safety-net primary care providers participating in DSRIP must achieve 2014 Level 3 NCQA Certification for the PPS to meet requirements
    - Lesson: Providers must be engaged, educated, and incentivized
- Meaningful Use Certification
  - Similar to PCMH, providers must also achieve MU and utilize other technology platforms such as HIEs
    - Lesson: Data will become more easily available and accessible for a streamlined continuum of care
- Value Based Payments and alignment with MCOs
  - Statewide goals of achieving 80% value based payments by the end of the Waiver period
  - Specific project requirements aligned with MCO interaction, coverage for services, incentive based contracts
    - Lesson: Extreme integration and collaboration between providers and MCOs will be required for PPS success and sustainability to prepare organizations to fully integrate DSRIP wins
- Centralized Services/ Support will be offered by PPS Leads in order to support success

High Performance Pools Next Steps

- Opportunity for Texas to learn from challenges and successes as NYS develops strategies to achieve PPS wide goals
- Data sharing opportunities in NYS can be translated into Texas opportunities
- NYS strategies for partner goals and funds flow to partners can inform future bonus fund opportunities in Texas

Q&A

COPE Team Members Currently Engaged in NY DSRIP

- Allen Miller, CEO
- Evan King, Executive Vice President
- Dave Salsberry, (Former Texas Anchor), EVP Consulting
- Wren Keber, VP Consulting
- Sajid Sindha, VP Consulting
- Mallory Johnson, (Former Texas Anchor), Senior Consultant
- Margarita Gardea (Former Texas Anchor), Senior Consultant
- Ragini Sarma, Senior Consultant
- Anush Gevorgyan, Senior Consultant
- Lindsey Wallace, Senior Consultant
- Natalie Chau, Senior Consultant
- Stephanie King, Senior Consultant
- Ray Chang, Senior Consultant & Data Analysis
- Brian Ball, Consultant & Data Analysis

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Thank You!

Regional Healthcare Partnership 6

RHP 3 Learning Collaborative
December 9, 2015

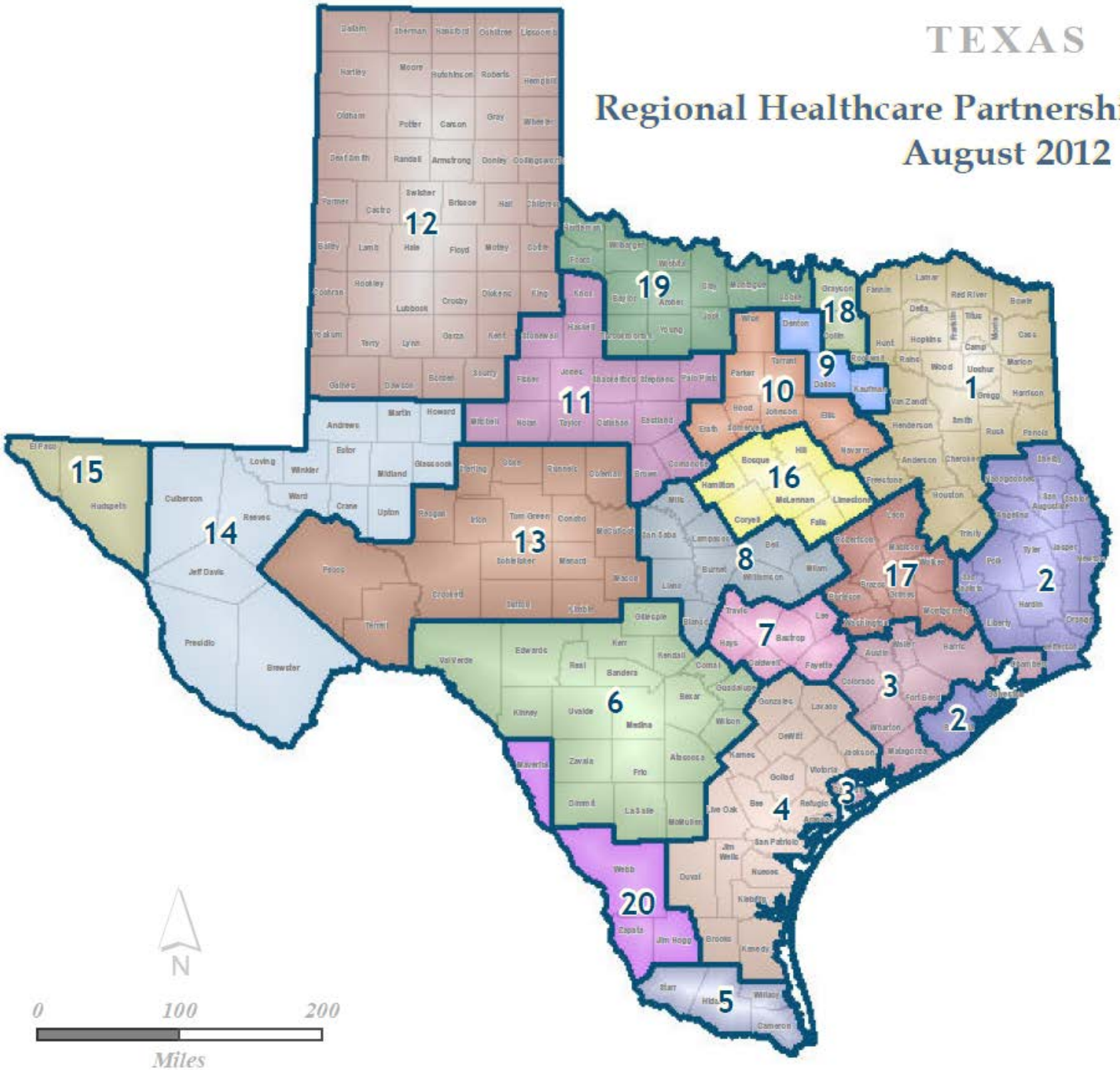
Carol A. Huber, MBA
Director, Regional Healthcare Partnership

RHP6
Texas 1115 Waiver
Improving Health. Transforming Care.

University Health System

TEXAS

Regional Healthcare Partnership (RHP) Regions
August 2012

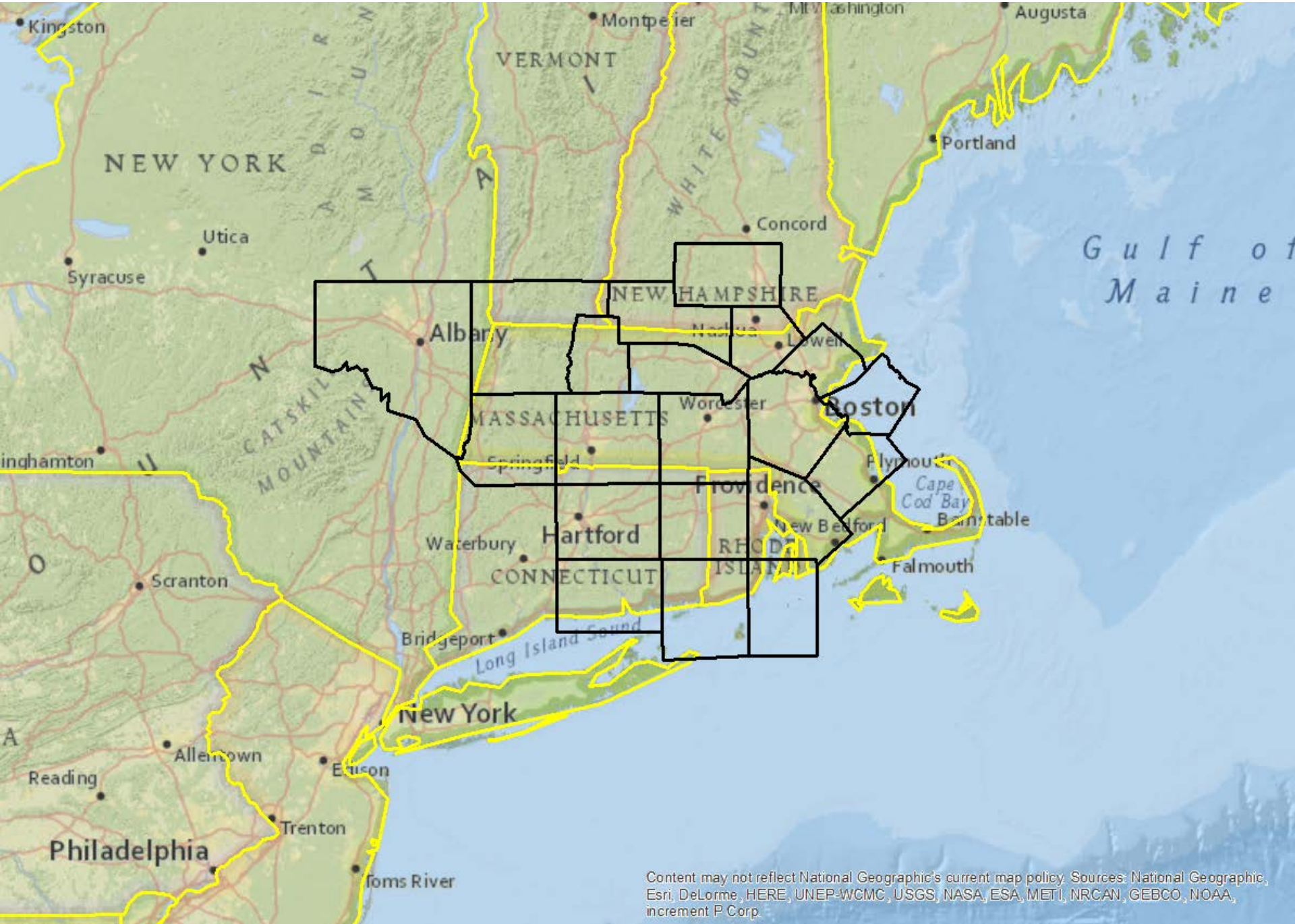


RHP 6

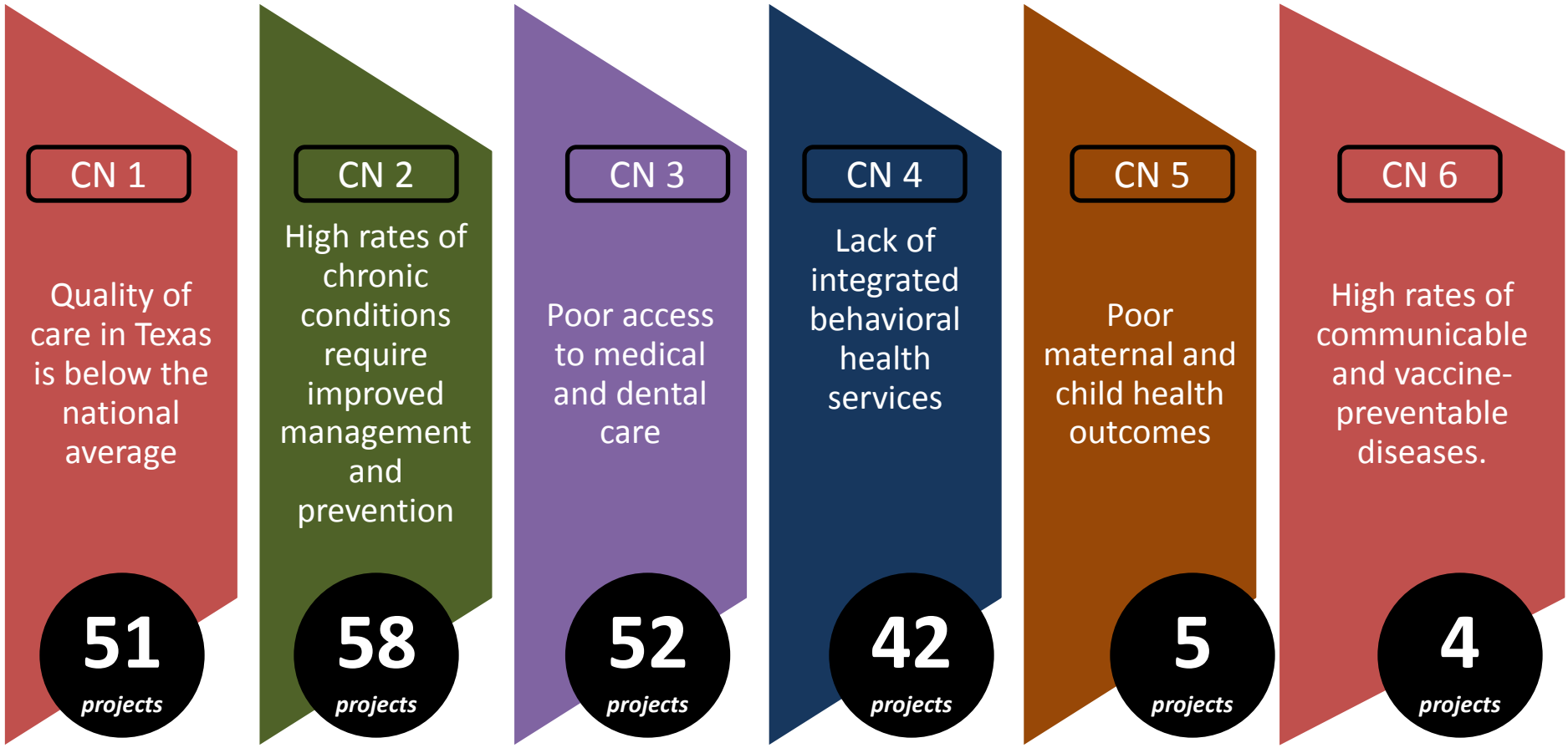
- 20 counties
- 24,734 square miles
- 2.3 million residents
- 54% Hispanic / 37% Anglo
- 16% live below poverty line
- 24% without health coverage
- $36,000 per capita income
- 20% did not complete high school

TEXAS Health and Human Services Commission

Map Prepared by: Strategic Decision Support Department, Texas Health and Human Services Commission. August 7, 2012


Kingston
Montpelier
Mt Washington
Augusta
VERMONT
NEW YORK
ADIRONDACK
WHITE MOUNTAINS
Portland
Concord
Utica
Syracuse
Gulf of Maine
NEW HAMPSHIRE
Albany
Nashua
Lowell
CATSKILL MOUNTAINS
Worcester
Boston
MASSACHUSETTS
Binghamton
Springfield
Plymouth
Providence
Cape Cod Bay
Barnstable
New Bedford
Hartford
Waterbury
RHODE ISLAND
CONNECTICUT
Falmouth
Scranton
Bridgeport
Long Island Sound
New York
Allentown
Reading
Edison
Trenton
Philadelphia
Toms River
Content may not reflect National Geographic's current map policy. Sources: National Geographic, Esri, DeLorme, HERE, UNEP-WCMC, USGS, NASA, ESA, METI, NRCAN, GEBCO, NOAA, increment P Corp.

RHP 6 Community Needs Addressed through DSRIP Projects and Collaboration



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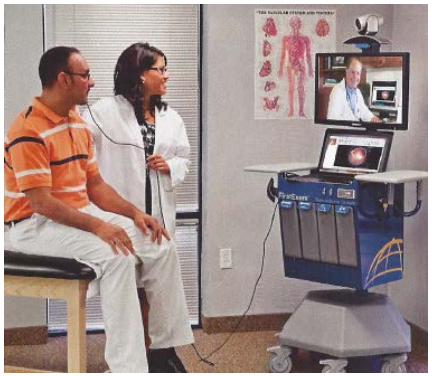

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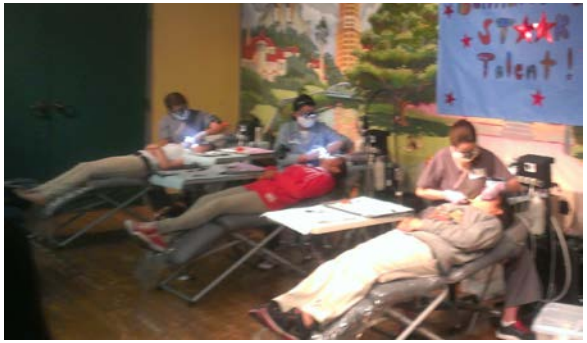
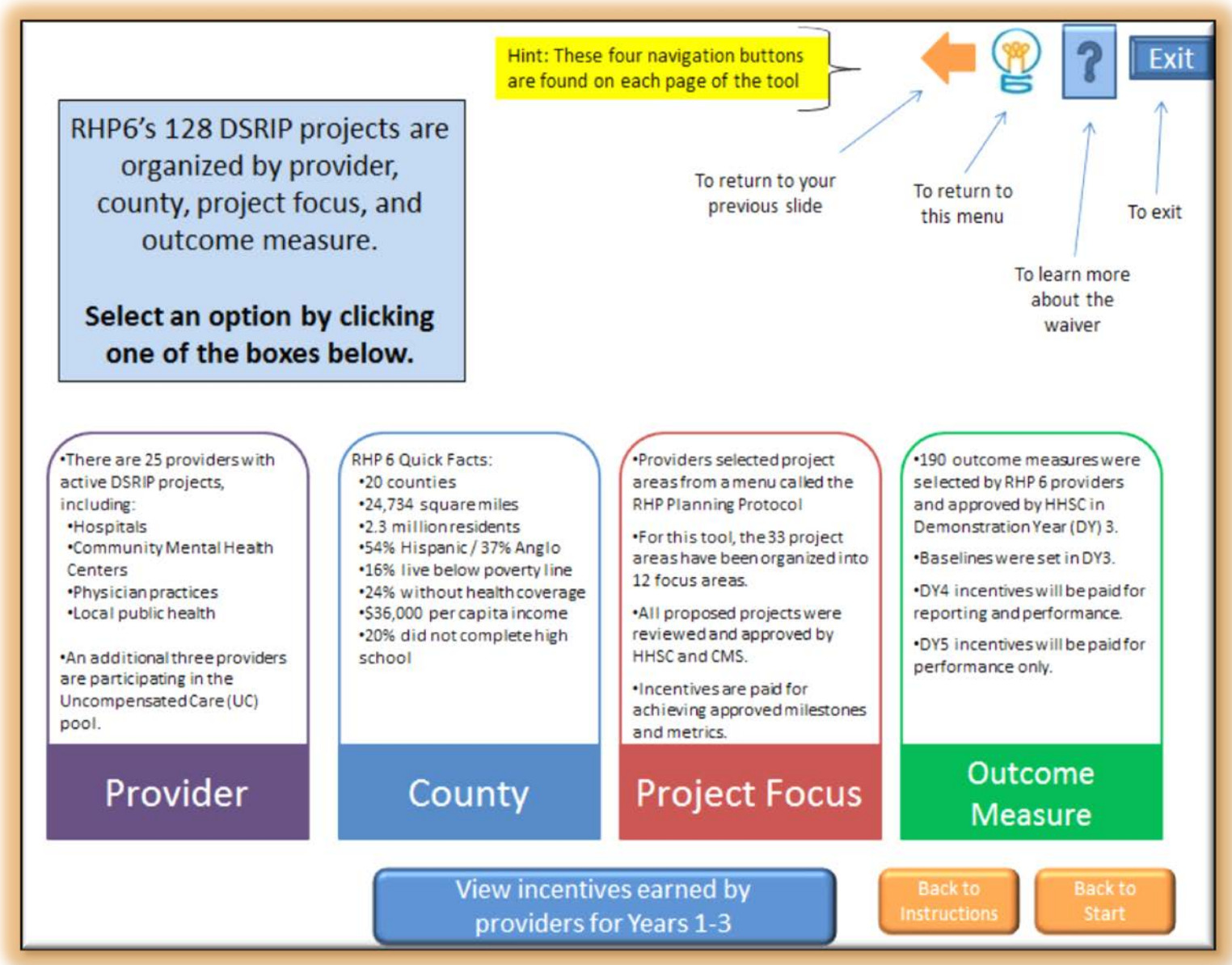
www.TexasRHP6.com



RHP 6 Interactive Tool

http://www.texasrhp6.com/rhp6-public-meeting/



Transformation is…

Collaboration among providers and stakeholders

Common Aim

Address project challenges

"Actionable" Project List

Networking Opportunities

Bexar County Mental Health Consortium

Health Collaborative
Bexar County's Community Health Leadership

Dec 2013 & March 2104 | *June 2014* | *Fall 2014 - 2016*

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Primary Care Learning Collaborative

The RHP 6 Primary Care Learning Collaborative Presents:

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Mark your calendars!

You are invited to visit your colleagues and learn from DSRIP projects in action! Hear from clinicians, patients & staff.

All events will include opportunities for networking and collaboration.

For more information:
Carol.Huber@uhs-sa.com
(210) 358-8792
www.TexasRHP6.com

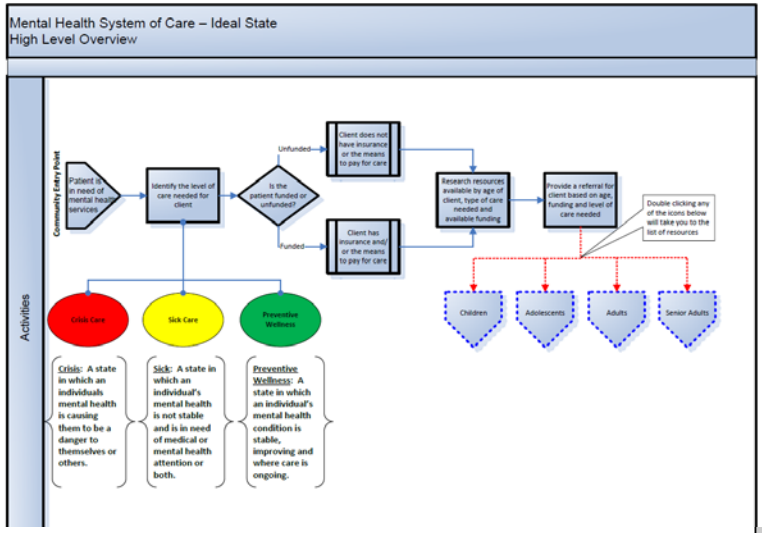
First Stop:
Uvalde Memorial Hospital
Uvalde, Texas

November 19, 2014
10:00 AM—2:00 PM
Register today!

Dr. Rose Garza will introduce you to two of Uvalde Memorial Hospital's newest service lines: the Palliative Care and Community Health Worker (CHW) programs. Informative presentations will give you insight into how the programs were developed, how they are being delivered, and the benefits they provide the community. Meet the teams who are successfully implementing these initiatives. The San Antonio Metropolitan Health District (SAMHD) will also share how it is using CHWs to engage community residents through grassroots strategies to lead the health improvement of ten targeted neighborhoods.

Before you leave Uvalde, check out the Briscoe-Garner Museum which documents the life of John Nance "Cactus Jack" Garner, Vice President to F. D. Roosevelt.

Behavioral Health Learning Collaborative



Provider Name:	**Bluebonnet Trails Community Services**	Project ID:	126844305.1.1
Project Option: *(Ex: 1.13.1)*	1.13.1	Project Title:	**Child Crisis Respite**
Project Description / Summary of Intervention *(50-75 words)*	Check all that apply: ☐ Inpatient ☐ Outpatient ☐ Partial ☒ Other Describe: Implement Treatment Foster Care (TFC) sites in Guadalupe County to provide crisis respite services to youth in psychiatric crisis. Youth will be assessed and if eligible placed in foster homes for an average of 45 days but long enough to resolve the crisis and initiate therapeutic services for youth and family. Admission to TFC will be accessible 8am-5p Monday through Friday.		
Facility Location(s):	Guadalupe County		
Targeted treatment Group	Check all that apply: ☒ Mental Health ☐ Substance Use ☐ Acute mental illness ☒ Intellectual Disabilities ☐ Co-Occuring MH/SA ☐ Integration Behavioral/Physical Health ☐ Serious Mental Illness Post Discharge ☒ Other Specify: Juvenile Justice System		
Targeted non-patient focus, if applicable:	Check all that apply: ☐ Providers ☐ Staff ☐ Students ☐ Community ☐ Other Specify:		
Targeted Ages	Check all that apply: ☒ Children ☒ Adolescents ☐ Adults ☐ Older Adults (65+) If subgroup(s), please specify:		
Targeted Counties:	Check all that apply: ☐ Bexar County ☒ Rural Counties in RHP 6 ☐ Other Counties Specify:		
If other geographical subgroup, please specify: *Ex: zip codes*	N/A		
Targeted % Medicaid and % Low-income Uninsured: *(As submitted to HHSC)*	90%		
Patient financial accommodations:	Check all that apply: ☐ Accepts most insurance ☒ Medicaid enrollment assistance ☒ Free / Low-cost / Charity care / Sliding Scale ☐ Other Specify:		
Describe other sources of funding for your program/organization: (optional)	N/A		
Quantifiable Patient Impact (QPI) Milestone and Target: *(ex: 500 unique patients by DY5):*	49		
Describe the process for referring patients to this program, including exclusion criteria and contact info (phone numbers/website):	During business hours a referral can be made by calling Nina Sullivan at (512-293-6960). In order to be admitted into the program the child and family must be willing to participate in recommended ongoing services. Center website-bbtrails.org		
Identify how your project best aligns with the system of care model:	☒ Crisis Care ☐ Sick Care (but not crisis) ☐ Preventive/Wellness		

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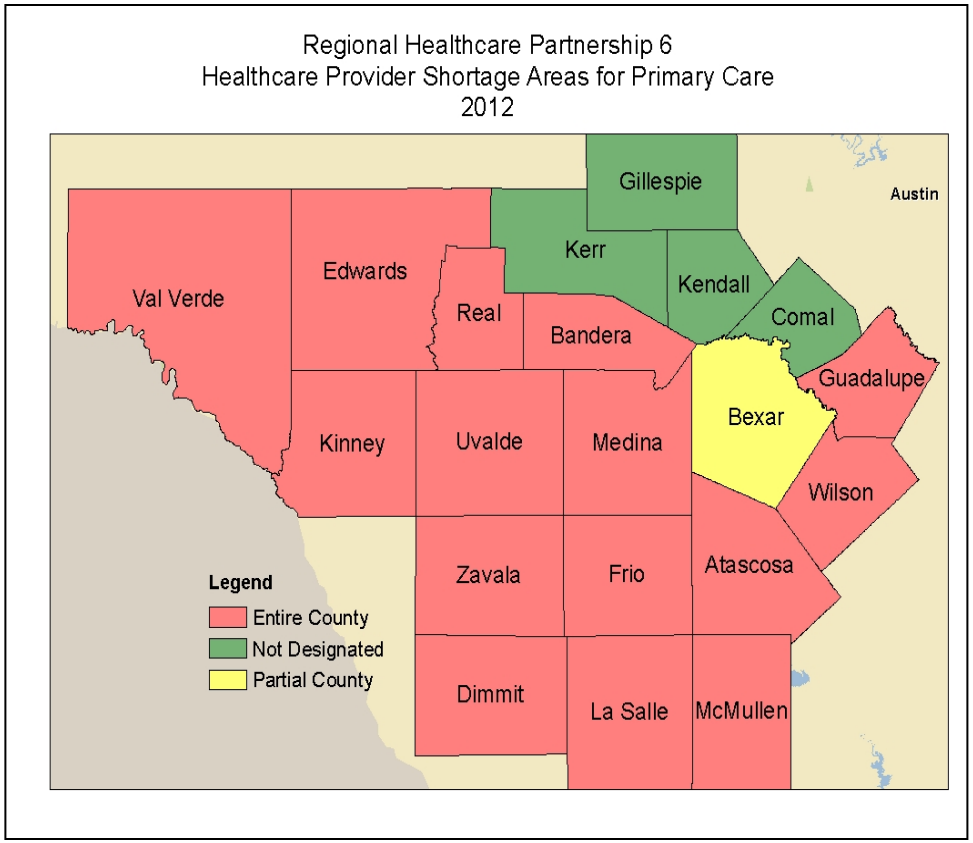
Readmissions Learning Collaborative

- Based on the Institute for Healthcare Improvement Breakthrough Series Model
- Partners in learning with UTMB / RHP 2 and the Improvement Science Research Network
- Engagement from hospitals, community mental health centers, health plans, HASA, academic researchers, and community partners
- **Aim: Reduce readmissions by 5%**
  - 10 hospital teams signed up to participate
  - 7 teams completed the entire process *(attrition due to staffing resources and data issues)*

RHP Plans and DSRIP projects were developed and implemented to address community needs and achieve the Triple Aim

… So are they??

Access to Medical and Dental Care



Primary Care

HPSAs Before DSRIP:
15 Full and 1 Partial

Current HPSAs
12 Full and 1 Partial
Removed from List: Dimmit, Guadalupe, Uvalde

Dental Care

HPSAs Before DSRIP:
11 Full and 1 Partial

Current HPSAs
12 Full and 1 Partial
Added to List: McMullen

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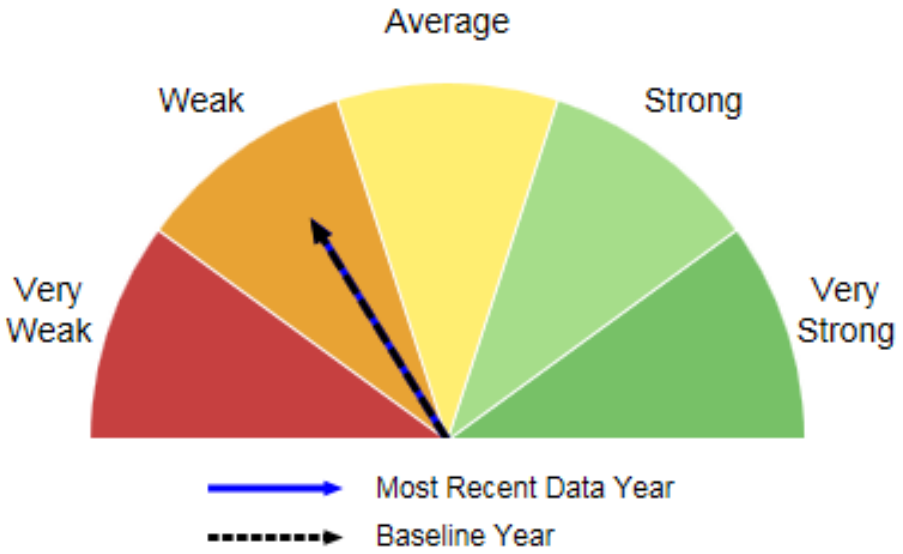
Quality of Care

"According to the Agency for Healthcare Research and Quality's 2011 report, Texas ranks last in the nation on health care quality."

RHP 6 Plan Submission (March 2012)



According to AHRQ's 2013 report, Texas is now ranked 49th of 51 but scores remain weak.

http://nhqrnet.ahrq.gov/inhqrdr/Texas/snapshot/summary/All_Measures/All_Topics

County Health Rankings & Roadmaps

2012
Of 221 counties reviewed,
four RHP 6 counties ranked in the lower half of Texas counties on **Health Outcomes.**

RHP 6 Plan Submission (March 2012)

2015
Of 237 counties reviewed,
six RHP 6 counties ranked in the lower half of Texas counties on **Health Outcomes.**

http://www.countyhealthrankings.org/app/#!/texas/2015/downloads

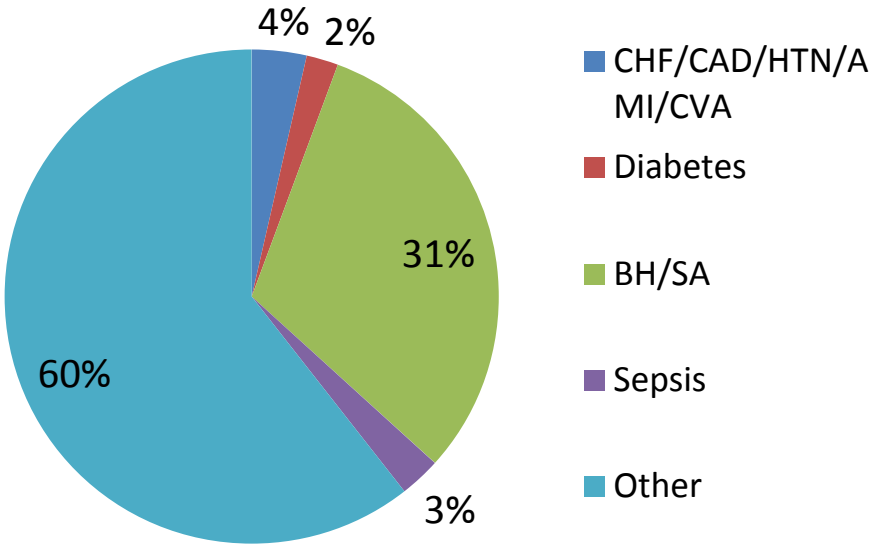
County	2012	2015	2012	2015
	Health Factors Ranking		Health Outcomes Ranking	
Atascosa	178	160	134	157
Bandera	47	52	95	113
Bexar	84	50	73	74
Comal	6	14	7	20
Dimmit	217	213	52	106
Edwards	194	194	105	143
Frio	198	193	64	197
Gillespie	3	8	5	11
Guadalupe	44	20	23	25
Kendall	1	3	6	12
Kerr	59	28	161	140
Kinney	NR	114	NR	40
La Salle	196	172	80	90
McMullen				

Potentially Preventable Readmissions

RHP 6 performs worst in Texas on PPRs (Medicaid and CHIP - CY 2012)

- PPR rate: 5.3%
  - Admissions at risk: 34,391
  - Range: 2.3 – 5.3%
  - State Overall (SFY 2013): 3.7%
  - State Overall - Adults: 8.7% (↑)
- Actual to Expected Ratio: 1.02
- PPR Expenditures: $18,872,000
- Penalties
  - CMS – 9 hospitals
  - HHSC – 2 hospitals

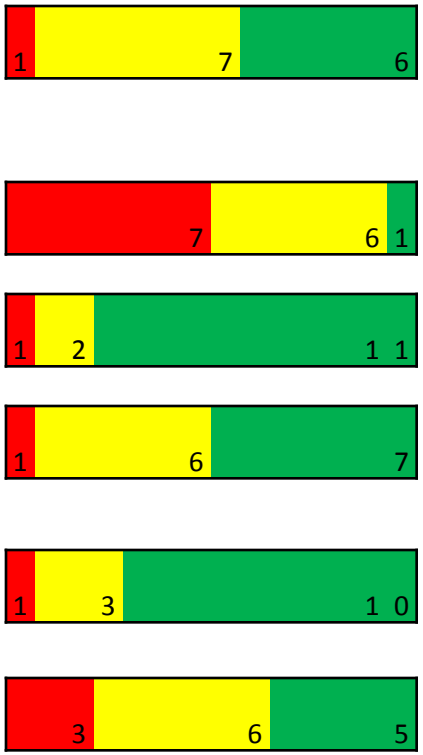
PPR Expenditures by Diagnosis



http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml

Top Ten Evidence-Based Strategies

- Enhanced admission assessment of discharge needs and begin discharge planning upon admission
- Formal assessment of risk of readmission
- Accurate medication reconciliation at admission, at any change in level of care and at discharge
- Patient education
- Identify primary caregiver, if not the patient and include with education and discharge planning
- Use teach-back to validate patient and caregiver's understanding



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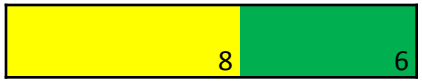
Not Implemented | Partially Implemented | Fully Implemented

Top Ten Evidence-Based Strategies

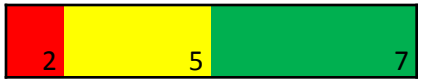
- Send discharge summary and after-hospital care plan to primary care provider (PCP) within 24 to 48 hours of discharge

- Collaborate with post-acute care and community based providers

- Before discharge, schedule follow-up medical appointments and post-discharge tests / labs.



- Conduct post-discharge follow-up calls within 48 hours of discharge



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http://www.patientcarelink.org/uploadDocs/1/Read---Top-Ten-Check-List.pdf

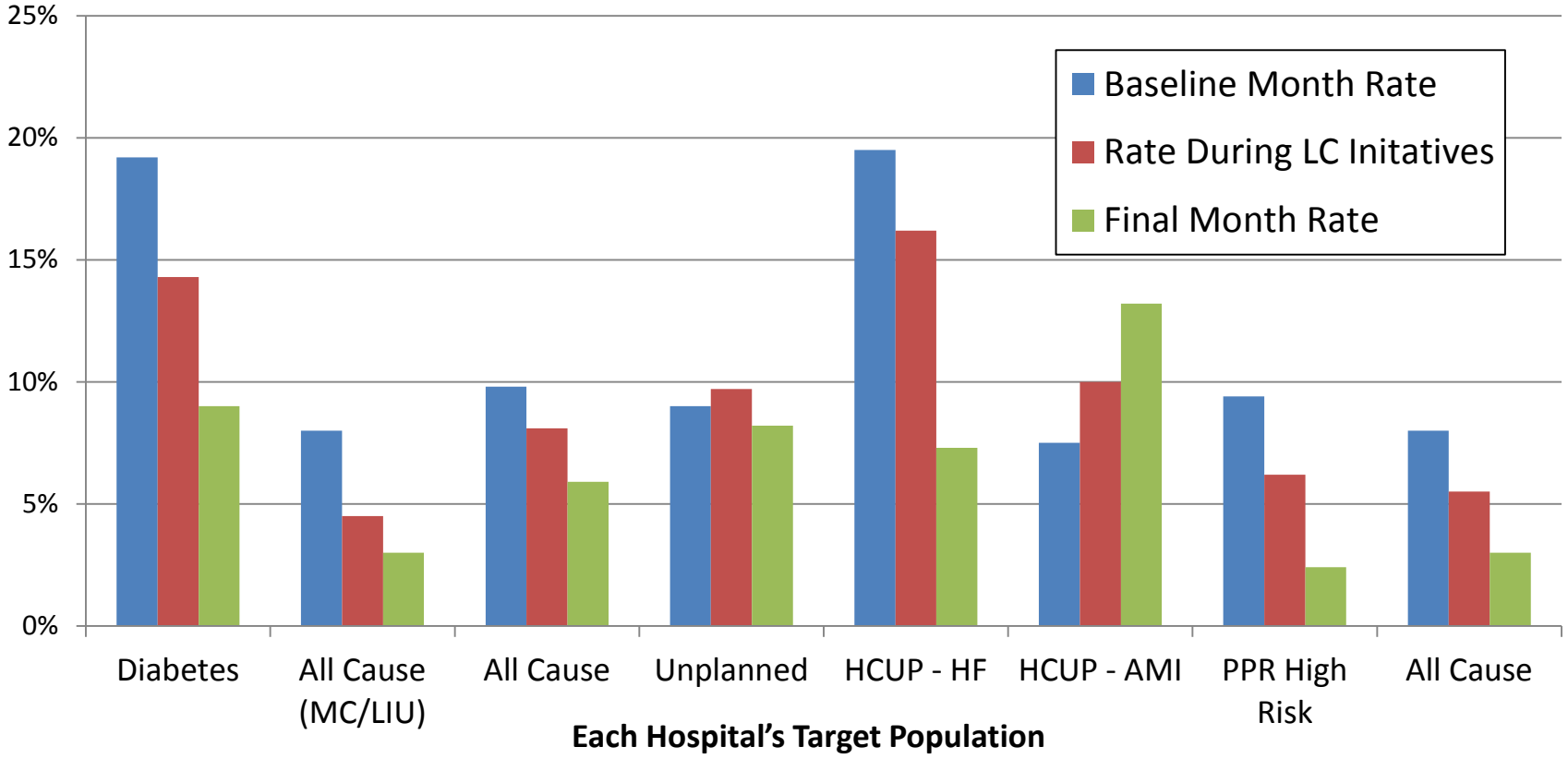
Improvement Strategies and PDSA Cycles

Providers reported testing and/or implementing the following improvement strategies during the Learning Collaborative initiative:

- Discharge process improvements – 4 hospitals
- Post-discharge follow-up – 6 hospitals
- Transition of Care programs – 6 hospitals
- Patient stratification, tracking and reporting – 8 hospitals
- Medication reconciliation – 3 hospitals
- Community partnerships – 9 hospitals and organizations
- Other – 2 hospitals

Readmission Results By Hospital

October 2014 – May 2015



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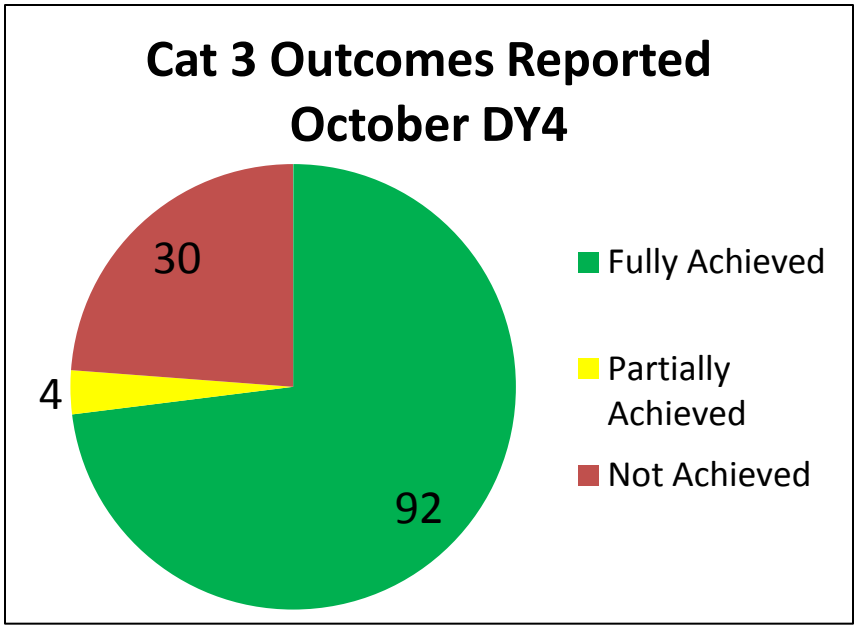
Cat 3 Outcomes… *so far!*



Outcomes Achieved

- Diabetes Care and Control
- Readmissions
- ED Throughput
- Quality (Falls, CAUTI, Stroke)
- Patient Satisfaction
- Low Birth Weight births
- Preventive Care

QPI (October DY4 Reported)	Projects Reporting	DY4 Result	DY4 Target
Patients Served / Positively Impacted	78	197,436	150,173

82% of projects have achieved their DY5 target

... So what's next??

Five Things We Know

- DSRIP is NOT the center of the universe.
- DSRIP incentives WILL end.
- We need more (better?) evaluations.
- Learning Collaborative events are great but…
- The Waiver needs more acronyms.

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ACES

Align * **C**ollaborate * **E**valuate * **S**ustain

- **A**lign
  - Document regional strategies/efforts for addressing community needs.
  - Identify active participants and community stakeholders working on each area of need to better promote and facilitate collaboration among key entities.
- **C**ollaborate and Coordinate - Organize and facilitate meetings targeting relevant and engaged providers and stakeholders to better understand and maximize opportunities for alignment.
- **E**valuate
  - Identify key indicators and assess how DSRIP is improving health and transforming care in RHP 6.
  - Provide program evaluation technical assistance and peer review to DSRIP providers.
  - Aggregate and communicate RHP 6 DSRIP outcomes.
- **S**ustain - Explore and promote strategies and opportunities for sustaining successful DSRIP projects beyond waiver funding.

Why start with sustainability?

Seven Habits of Healthy Kids

- Will DSRIP be renewed?
- For how long?
- Will you continue this project *into* Waiver 2.0?
- Will it continue *after* Waiver 2.0?
- Is the project alive today only because of DSRIP? Only because of YOU?
- Future milestone…
- Assess progress in a year

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What is Sustainability?

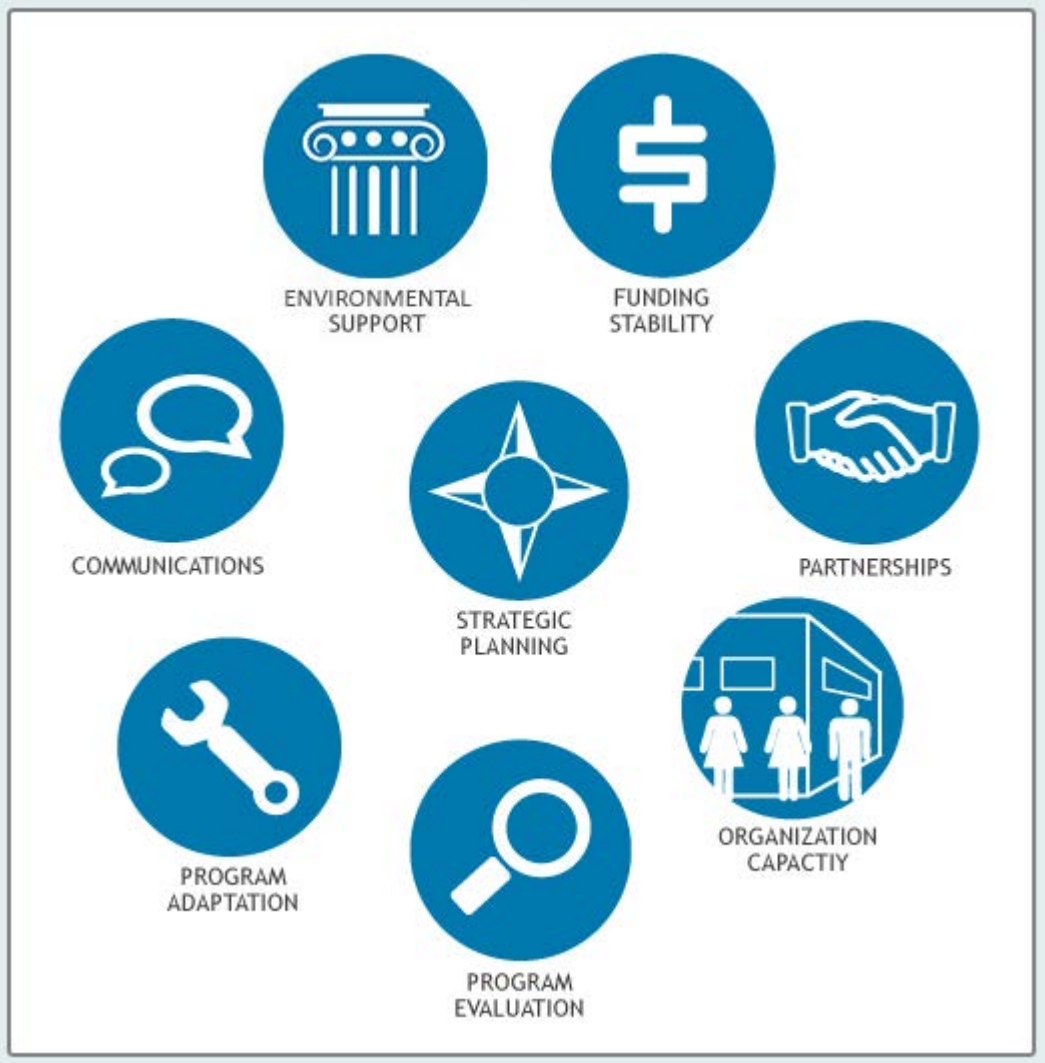
Sustainability
The ability to be sustained, supported, upheld, or confirmed. (www.dictionary.reference.com)

Capacity for sustainability
The ability to maintain programming and its benefits over time. (www.sustaintool.org)

What is required for sustainability?

- It takes more than just

Center for Public Health Systems Science
GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK



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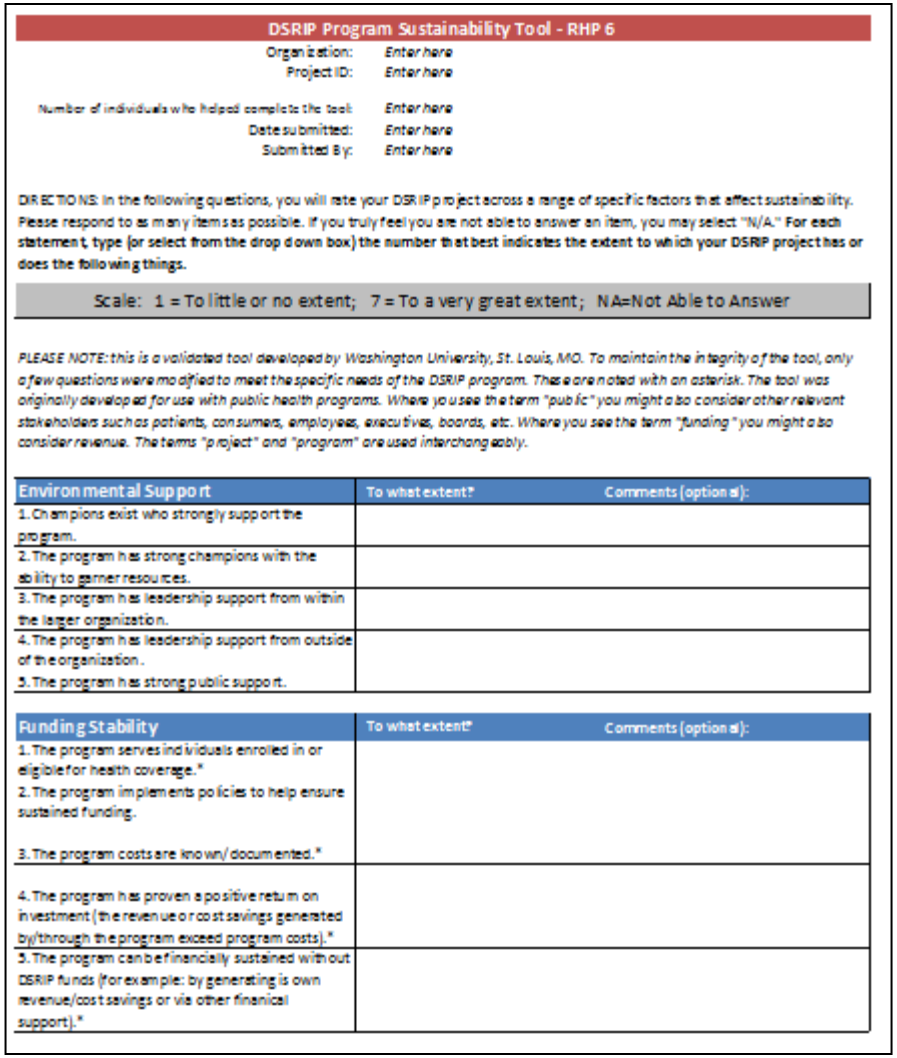
Sustainability Assessment Tool

- Based on the sustaintool.org instrument
- Variances to validated tool are noted with *
- "Public" = _____

  (public, patients, stakeholders, consumers, employees, boards, etc.)
- RHP6 ask: one completed tool PER PROJECT



DSRIP Program Sustainability Tool - RHP 6

Organization: *Enter here*
Project ID: *Enter here*

Number of individuals who helped complete the tool: *Enter here*
Date submitted: *Enter here*
Submitted By: *Enter here*

DIRECTIONS: In the following questions, you will rate your DSRIP project across a range of specific factors that affect sustainability. Please respond to as many items as possible. If you truly feel you are not able to answer an item, you may select "N/A." For each statement, type (or select from the drop down box) the number that best indicates the extent to which your DSRIP project has or does the following things.

Scale: 1 = To little or no extent; 7 = To a very great extent; NA=Not Able to Answer

PLEASE NOTE: this is a validated tool developed by Washington University, St. Louis, MO. To maintain the integrity of the tool, only a few questions were modified to meet the specific needs of the DSRIP program. These are noted with an asterisk. The tool was originally developed for use with public health programs. Where you see the term "public" you might also consider other relevant stakeholders such as patients, consumers, employees, executives, boards, etc. Where you see the term "funding" you might also consider revenue. The terms "project" and "program" are used interchangeably.

Environmental Support	To what extent?	Comments (optional):
1. Champions exist who strongly support the program.		
2. The program has strong champions with the ability to garner resources.		
3. The program has leadership support from within the larger organization.		
4. The program has leadership support from outside of the organization.		
5. The program has strong public support.		

Funding Stability	To what extent?	Comments (optional):
1. The program serves individuals enrolled in or eligible for health coverage.*		
2. The program implements policies to help ensure sustained funding.		
3. The program costs are known/documented.*		
4. The program has proven a positive return on investment (the revenue or cost savings generated by/through the program exceed program costs).*		
5. The program can be financially sustained without DSRIP funds (for example: by generating is own revenue/cost savings or via other financial support).*		

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For more information:

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Director, Regional Healthcare Partnership

University Health System

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210.358.8792

Check out our Interactive Guide to RHP 6 Projects

www.TexasRHP6.com

www.hhsc.state.tx.us

http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml

http://www.hhsc.state.tx.us/1115-docs/websites.pdf

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Dr. Mark Hernandez, Chief Medical Officer

COMMUNITY CARE COLLABORATIVE

Snacks and Networking

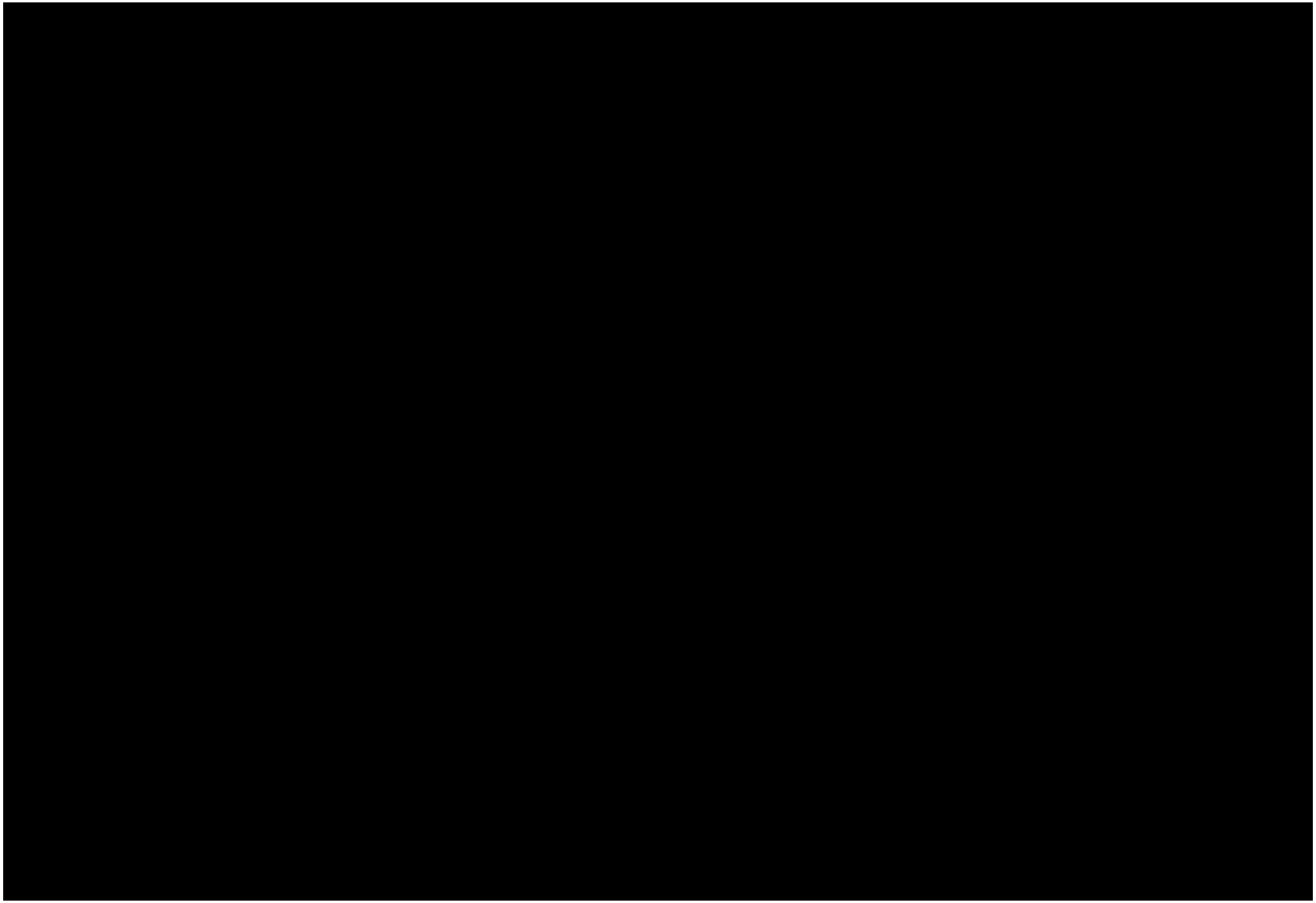
Please take a moment to view the Project Posters!

See you back in the main ballroom at 3:00 p.m. for the final drawing!

Project Spotlight

Shannon Evans, Manager Health System Strategy Operations, Harris Health System-RHP3 Anchor

Project Spotlight Video




THANKS
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BASQUE
TAKK
GRACES
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DANKIE
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SALAMAT
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Баярлалаа
marahaba
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AABHARI
DHANYAVAAD
spelling
mercé
TRAZE
person
BUZNYG
GRATZIAS
Paхмат
akpé
efharisto
aguyjé
woman
KRIO
barka
GRANDMERCÉ
MORÉ
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SAMOAN
kettu
tanemirt
WOLOF
MEANS
ZULU
nanni
multumesc
SAGOLUN
DZIĘKUJĘ
SHEUN
bayarlalaa
ederim
jeboha
waad
SUMANGA
MOTASHAKKERAM
DIOLCH
RESPECTFUL
AGIMUS
XHOSA
STUUTIYI
CÓPS
KAKHULU

Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ☆ Medicaid 1115 Waiver

RHP 3: Category 3 Table Top Activity

Michelle Eunice, DSRIP Regional Operations Liaison , Harris Health System
Jessica Hall, Health System Strategy Analyst, Harris Health System

Introduction

- Category 3
  - Quality outcome measures
  - Required for each project
  - Challenge: Providers must achieve success on measures that have influencers beyond their internal control
- Table Top Exercise
  - Identify best practices
  - Opportunities for improvement
  - Ideas for collaboration

Selection of Category 3 Measures

- Most common measures amongst Providers
- Speak to the biggest challenges in the Region
- Provider questions and feedback around these measures

Each table has a Category 3 topic, please find your table after this presentation

DY5 Achievement - 20 minutes

Please answer the following questions for each organization:

- What is the greatest challenge in achieving your Category 3 goal in DY5?
- What is your greatest Category 3 success to date?
- What areas can be improved?
- What best practices/plans can be implemented to achieve this DY5 goal?

Complete Part I of II: Provider Level Handout

Sample Handout: Part I

Category 3 Outcome: Obstetric

Part I of II: Provider Level

	Organization	Success	Challenge/Improve-ment Opportunity	Improvement Plan/Best Practices
1	Harris Health System	Harris Health System patients show low rates of preterm birth compared to women in studies showing similar risk factors.	Difficult to impact preterm birth rate for project. Most risk factors in our subset are inherent and non-modifiable once the woman is pregnant.	Place a greater focus on interventions for behavioral risk factors in our subset: pregnant women who report they use tobacco, other substances, or that they drink alcohol.
2				

Collaboration – 25 minutes

- How can your table work together to address each organization's challenge and support the improvement plan(s) to meet DY5 goals?

Expected Outcomes

- What outcomes do you expect as a result of collaborating to meet these Category 3 DY5 goals? (e.g. greater physician buy-in, reduction in HbA1c levels)

Complete Part II of II: Regional Level Handout

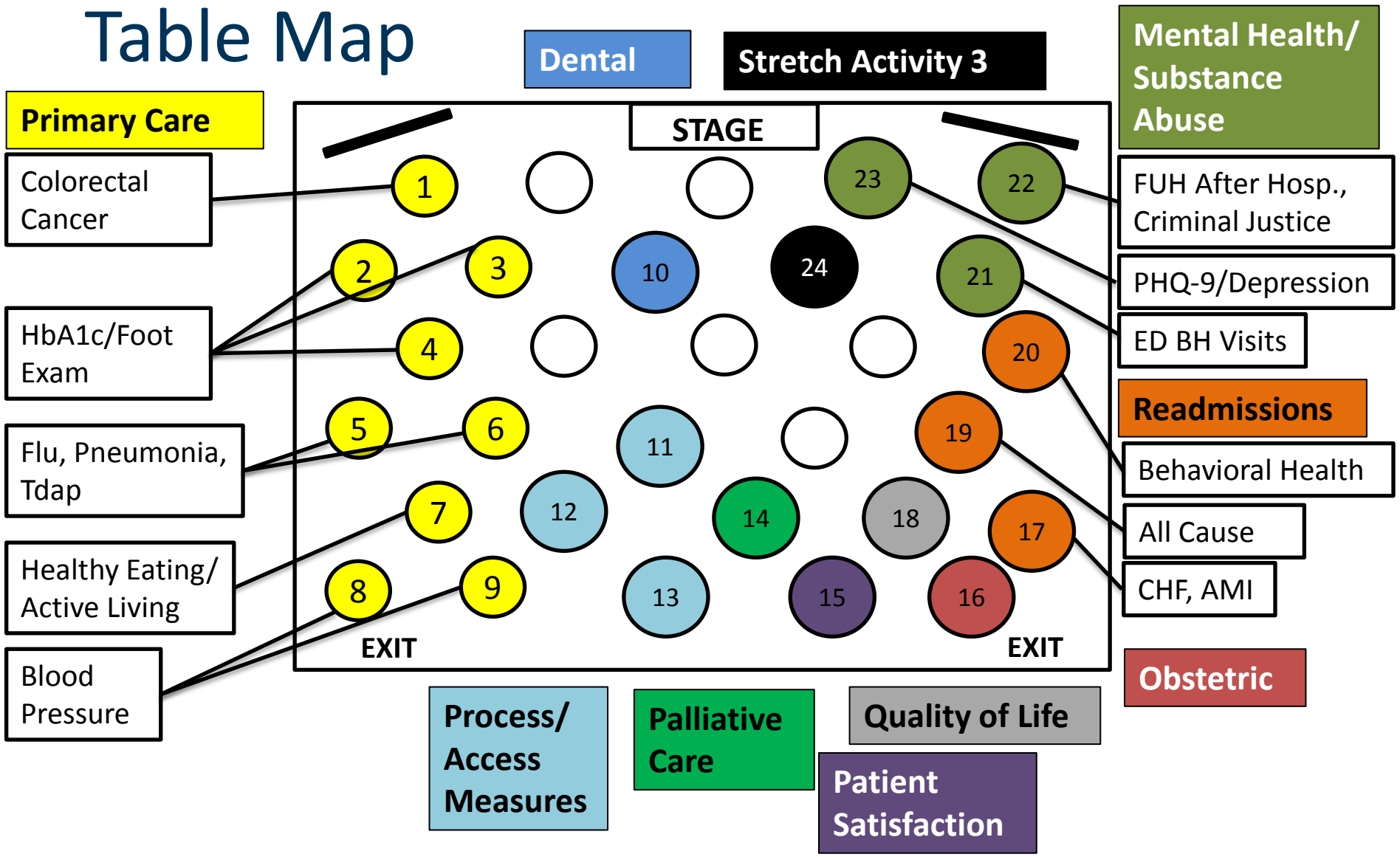
Sample Handout: Part II

Category 3 Outcome: Obstetric

Part II of II: Provider Level

Organization		Collaboration Ideas	Expected Collaboration Outcomes in 6 Months
Providers at your table	1	Collaborate with Providers in the Region and/or State who have successfully reduced their preterm birth rate.	Greater reduction in pre-term birth rate for patients with behavioral health risk factors.
	2		

Table Map


Dental
Stretch Activity 3
Mental Health/ Substance Abuse
Primary Care
STAGE
Colorectal Cancer
HbA1c/Foot Exam
Flu, Pneumonia, Tdap
Healthy Eating/ Active Living
Blood Pressure
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
EXIT
EXIT
FUH After Hosp., Criminal Justice
PHQ-9/Depression
ED BH Visits
Readmissions
Behavioral Health
All Cause
CHF, AMI
Obstetric
Process/ Access Measures
Palliative Care
Quality of Life
Patient Satisfaction

Instructions

- There is a Category 3 topic at the center of each table in the room
- After the instructions, please go to the table of the Category 3 measure related to your project (or of interest to you)
- There is a worksheet at each table – you will have 20 and 25 minutes to complete parts I and II as a group
- Question prompts will be on the screen to help you complete the worksheet
- Wrap-up & report out

Questions?

DY5 Achievement - 20 minutes

Please answer the following questions for each organization:

- What is the greatest challenge in achieving your Category 3 goal in DY5?
- What is your greatest Category 3 success to date?
- What areas can be improved?
- What best practices/plans can be implemented to achieve this DY5 goal?

Complete Part I of II: Provider Level Handout

Collaboration – 25 minutes

- How can your table work together to address each organization's challenge and support the improvement plan(s) to meet DY5 goals?

Expected Outcomes

- What outcomes do you expect as a result of collaborating to meet these Category 3 DY5 goals? (e.g. greater physician buy-in, reduction in HbA1c levels)

Complete Part II of II: Regional Level Handout

Wrap Up & Report Out

CLOSING AND FINAL REMARKS

YOUR ANCHOR TEAM

TIMELINE

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

Dec
- Learning Collaborative – NOW!
- October Reporting Feedback – Dec 9th
- Category 1, 2 & 3 Compliance Monitoring – Ongoing

Jan
- Distribution List Transition- Jan 1st
- October Reporting NMI's Due – an 15th
- Incentive Payments – NLT Jan 31st

Feb
- Category 1 & 2 Compliance Monitoring – Ongoing

Mar
- Category 4 Compliance Monitoring
- Category 1 & 2 Compliance Monitoring –Round 2

Apr
- Round 2, DY5 Reporting – April 30, 2015
- Protocols Submission-TBD

May
- HHSC Uncompensated Care Analysis Report Due to CMS

Reminders

- Event Evaluation
  - Your feedback helps us improve Learning Collaborative activities
    - Event Evaluation
- Distribution List Sign-Up
  - Mass communication will transition from the Anchor mailbox to constant contact on January 1, 2016
    - Distribution List Sign-Up

Commitment to Participate in "Raise the Floor" Initiatives

It is understood that this commitment form is to signify the good and true intent to participate in the following Learning Collaborative activities as presented on December 9, 2015 at the Region 3 Learning Collaborative: (Please check all that apply)

_____ Participate in the Navigation Station Tool by providing requested information
_____ Commit to implementing Quality Improvement approaches learned through group activities
_____ Develop one new collaboration with another provider to be highlighted in Cohort activities and the Region's Newsletter
_____ Complete the Sustainability Assessment and begin developing a long term plan for current DSRIP projects
_____ Utilize the behavioral health THCIC data presented in future program planning
_____ Participate in the following Cohort(s): (Check all that apply)

__EC Utilization
__Behavioral Health
__ Patient Navigation
__Readmissions

Date _____ Organization _____

Name _____ Signature _____

This is a non-binding commitment and serves the purpose of tracking Performing Provider participation intentions as required for Learning Collaborative milestones and metrics reporting. This also allows the Region 3 Anchor to maintain Providers and other Stakeholders actively involved in Learning Collaborative activities.

QUESTIONS?

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