Workgroup Session # 1

Meeting Notes – March 20, 2012 (3:00 – 4:45 pm – Health Museum)

Introduction

- The presentation "Regional Healthcare Partnership Planning" was given by HMA, which explained the Waiver in detail. Participants were given the opportunity to ask questions.
- HMA explains that the goal today is to develop an initial brainstorming of potential projects that can be further developed to be included in the Regional Healthcare Partnership Plan that will be submitted to the State for consideration.
- David Lopez presented a brief overview of current issues surrounding the Waiver. He emphasized that workgroups should focus on identifying appropriate, transformational projects and metrics as the final rules of the Waiver are being written. He reviewed the need of IGT entities & the importance of the workgroups & DSRIP plans.

Brainstorming Session + Q/A

- ***Concept: Expand use of chronic case models with a method of reimbursement***
  - Disease management protocols / consistent use of protocols
  - Multiple disease protocols
- ***Concept: Care management expansion***
  - Social support system
  - Collaborative efforts
- ***Concept: Robust disease registry needed***
  - Collaboration of organizations
  - Health information exchange
- ***Concept: Tumor registry updated***
  - To become prospective / real time
  - Additional data elements needed
  - Additional resources needed for data management (personnel)
  - Collaboration & access for all providers
- ***Concept: Health Literacy***
  - Need for patient education & family education

- ***Concept: Mobile technology updates needed***
  - Appointment reminders for patients (texting, etc.)
  - Upgrade of the physician pager system to remove inefficiencies of staff
    - Examples of Perfect Serve & Doc Books given
- ***Concept: Cost of medications increasing***
  - Give diabetic patients free medications if they are compliant (patient incentive)
    - Reduce ER visits
- ***Concept: Access to Clinic visits***
  - Need a larger open access model in the community
  - Need additional physicians to staff open access clinics
- ***Concept: Coordination of behavioral health needs***
  - Collaboration with disease management
- ***Concept: Increase access to mobile services***
  - Lack of reimbursement currently
  - Bring the care to the patient community
- ***Concept: Increase access of Metro to patient base / Region specific transportation needed***
- ***Concept: Re-admission of chronic conditions – prevent with proactive outpatient management***
  - Care managers / case management / navigators
  - Outpatient clinic focus
  - Ensure follow-up appointments are made
- ***Concept: Predictive modeling of disease & patient base needed***
  - Data registries needed (collaborative)
- ***Concept: Discharge planning***
  - Follow-up appointments should be made at the time of discharge
  - Medication management / patient access to cost effective medications
- ***Concept: Community screenings / outreach***
  - Partner with the community
  - Patient education but we must ensure proper access when we educate
- ***Concept: Cultural awareness / competence***

- Social workers / navigators culturally advanced (bilingual, etc.)

- ***Concept: Pediatric childhood chronic conditions***
    - Create medical homes
    - Increase access to specialty care
    - Transitional process for patients (health planning & access)
    - Address funding issues of the patient base
- ***Concept: Obesity***
    - Education needed
    - Partnership with school districts
    - Dietician management (meals on wheels, cooking classes, shopping classes, etc.)
    - Food desert areas – partner with farmer's markets
- ***Concept: Aging population***
    - Education
    - Access to care
    - Palliative care
- ***Concept: Focus to Disease/Condition***
    - Diabetes
    - ESRD
    - HTN
    - CHF
    - COPD
    - Anorexia
- ***Concept: Expand hours of care***
    - Flexibility with schedule
    - Patient centric
    - Nights/Weekends
    - Open access model
- ***Concept: Preventive education model***
    - Community based

- ***Concept: Medical Home expansion***
  - Community based on need
- ***Concept: Linkage to care***
  - Example: patient gets the news of HIV positive – who/how to link them to the care they need
- ***Concept: Length of stay – hospitalization***
  - Discharge planning
  - Patient centered approach versus doctor centered (must have all physicians sign off on patient discharge holding up progress)
  - Incentivize hospitals & providers
- ***Concept: Patient responsibility***
  - Education
  - Link to care coordination
  - Patients need to understand & be responsible
- ***Concept: Partner with insurance companies to get them involved***
  - Insurance carriers need improvements for access, utilization, etc.
  - Accountability for all involved
- ***Concept: Back Pain***
  - Imaging epidemic
  - Prevention of opioid use
  - Preventive approach
- ***Concept: Network of care***
  - Single entity to manage & provide education / continuum of care
- ***Concept: Oral healthcare***
  - Access / Utilization
- ***Concept: Utilization of telemedicine***
  - Expand into community
  - Mental health
  - Low acuity patient interactions
  - Sub-specialty access

- ***Concept: Food sources***
  - Involve grocery stores, schools, employers & farmer's markets in plans to get the community healthy
  - Involvement / education / awareness
- ***Concept: Pediatric utilization***
  - Home visits
  - Expand Ask a Nurse

Conclusion + Q/A

- ***Next Meeting- 4/17/12 at 3PM Health Museum.***
  - We will prioritize our list of potential projects.
  - We will go into further depth on some of the potential projects.
  - We will discuss metrics and outcomes to measure.
  - The HHSC DSRIP menu of projects is due April 1, 2012.
- Remember- We can be paid for expanding programs that currently exist, but we cannot do what we are already doing now.