LEARNING COLLABORATIVE

RHP 10

Welcome and Introduction

Agenda

- Measures progress
- Measures progress for the Learning Collaborative as a whole
- How we did it: Teams describe changes that resulted in improvement
- Story Starters
- Break
- Regional Updates
- Expert Panel: HIE Interoperability
- Lunch
- Keynote Presentation
- Troika activity
- Break
- Sharing your story: Videos
- Wrap-up

LEARNING COLLABORATIVE

RHP 10

Care Transitions and Patient Navigation

RHP 10 Learning Collaborative September 29, 2015

LEARNING COLLABORATIVE

RHP 10

Improvement progress, Care Transitions shared measures

Vincent Do, BSIE, LSSMBB, LBC– *Sensei*
Sr. Performance Improvement Specialist

The role of shared measures reporting

Learning Collaborative

=

Best practices

+

measureable improvement

+

cross-organization learning

What we will cover

- Update on Collaborative teams
- Wins
- Reporting progress of LC overall
- Plan for shared measures

Number of teams reporting

- **Care Transitions - Inpatient** – 5 teams
  - Texas Health Resources - Fort Worth
  - Baylor Health Care System
  - JPS Health Network
  - UNT Health Science Center
  - Wise Regional Health System
- **Care Transitions - Outpatient** – 2 teams
  - MHMR Tarrant County
  - UTSW/Moncrief Cancer Institute

Wins

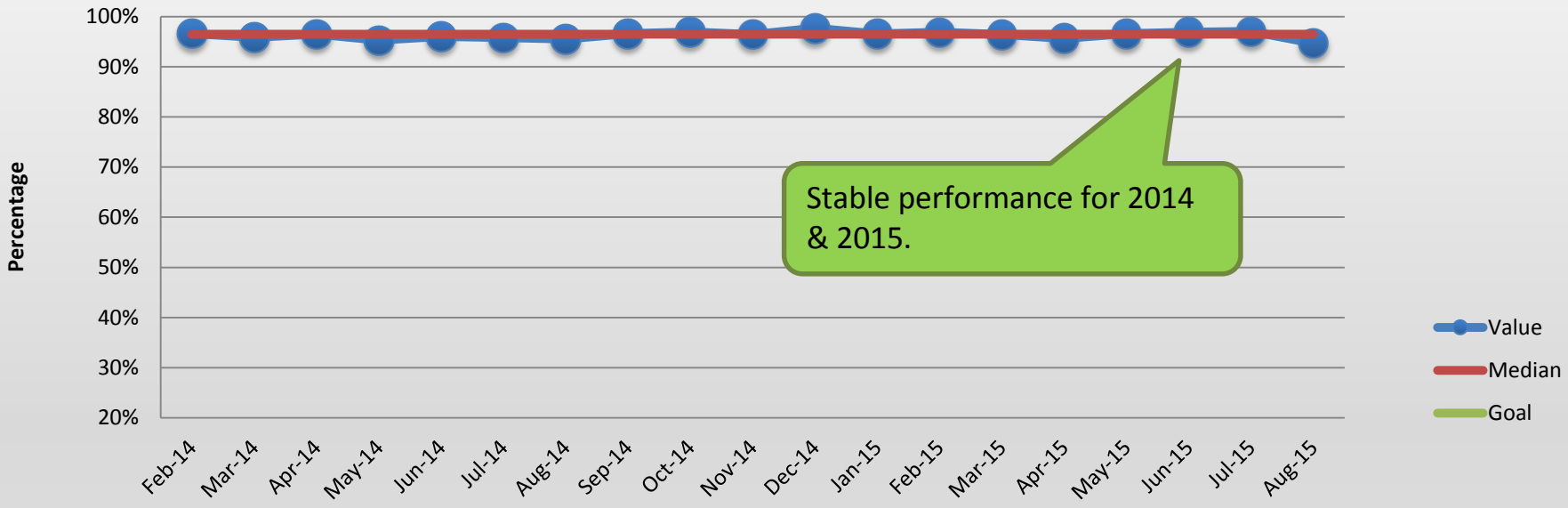
- Total interventions achieved for 2014 and 2015
  - Care Transition: 45,867
  - Care Transition - Outpatient: 1,522

Wins

- Intervention rate for 2014 and 2015
  - Care Transition - Inpatient:
    - Increase from 64% to 70%
  - Care Transition - Outpatient:
    - Increase from 68% to 88%

Care Transitions - Inpatient

Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary

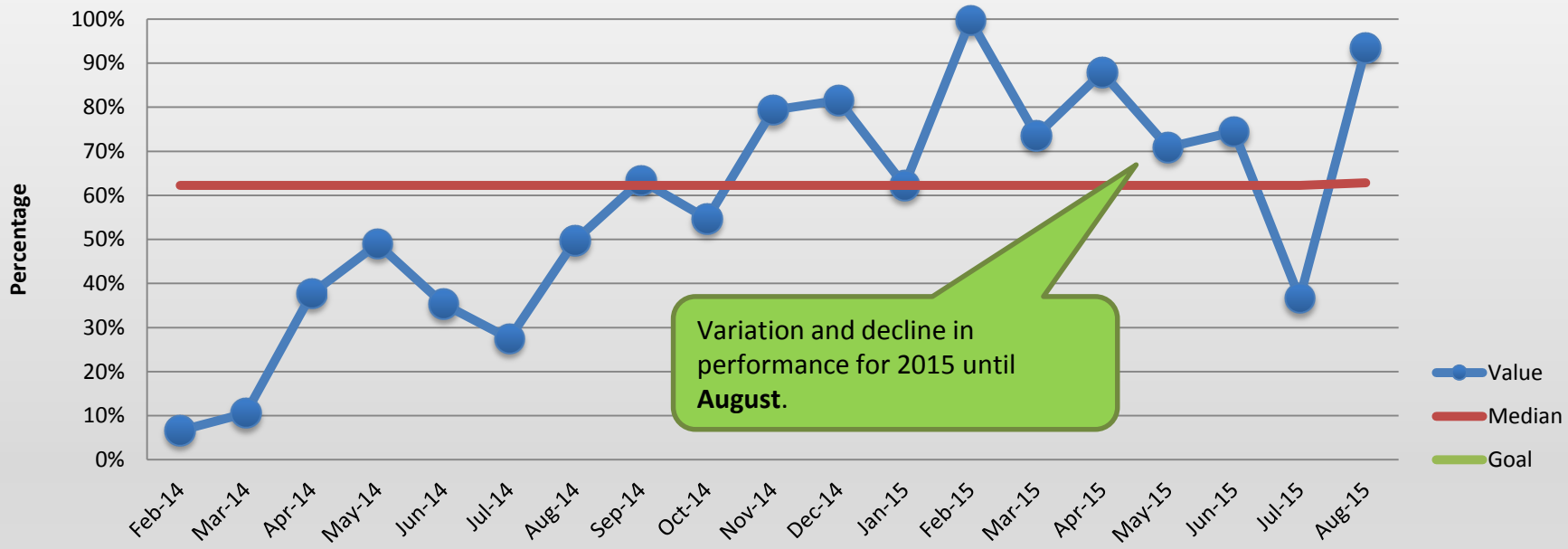


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Value	97%	96%	97%	95%	96%	96%	96%	97%	97%	96%	98%	97%	97%	96%	96%	97%	97%	97%	95%
Median	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
Goal																			
Numerator:	1291	1491	1462	1458	1337	1598	1604	1615	1610	1496	1603	1522	1332	1545	1501	1559	1600	1548	1088
Denominator:	1336	1555	1515	1530	1392	1668	1679	1672	1661	1551	1641	1576	1375	1602	1569	1614	1651	1595	1149

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
96%	96%	16,565	11,695	28,260

Care Transitions - Inpatient

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

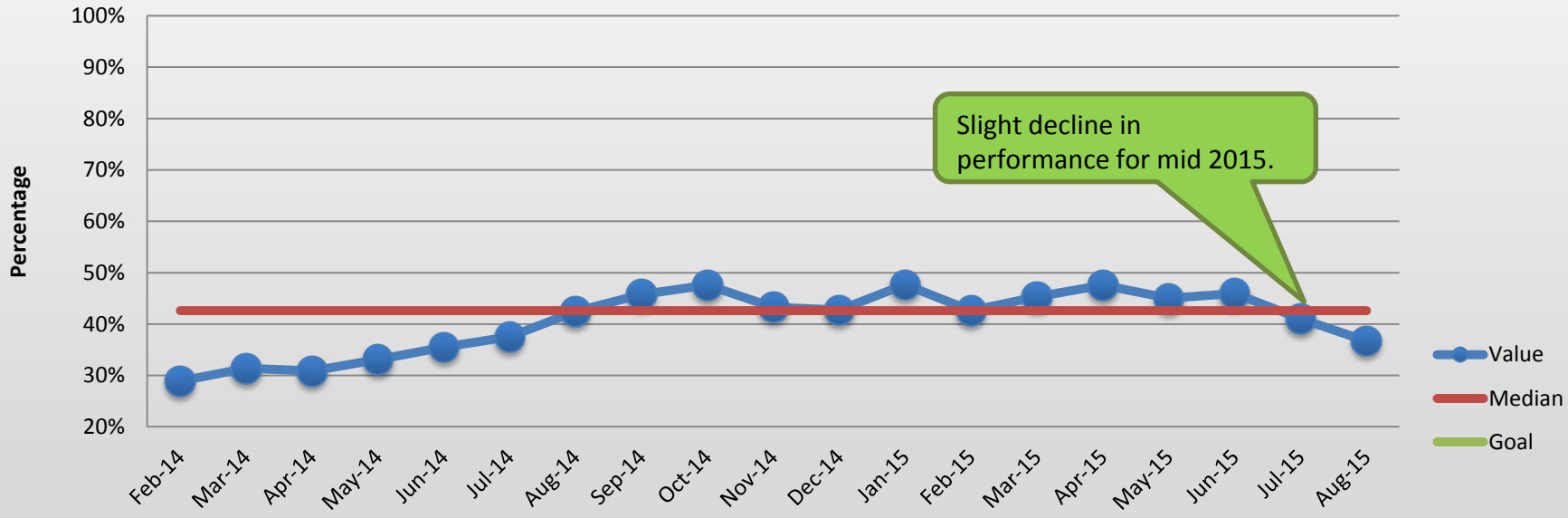


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Value	7%	11%	38%	49%	35%	28%	50%	63%	55%	79%	82%	62%	100%	74%	88%	71%	74%	37%	93%
Median	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	63%
Goal																			
Numerator:	26	52	182	251	135	110	207	298	292	384	425	320	384	384	443	378	413	180	71
Denominator:	391	492	482	512	382	400	416	470	534	484	521	514	385	522	504	533	555	491	76

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
46%	72%	2,362	2,573	4,935

Care Transitions - Inpatient

Collaborative (4 of 5 Teams): Percentage discharged patients with community provider contact within 7 days

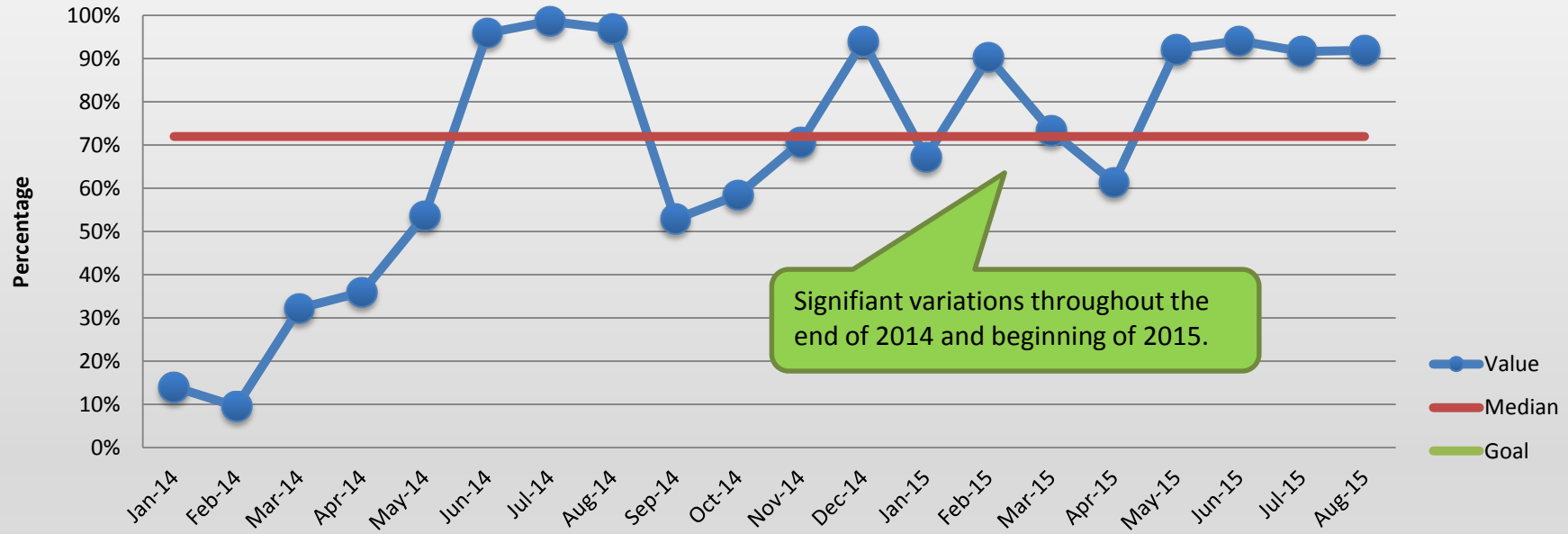


	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Value	29%	31%	31%	33%	35%	38%	42%	46%	48%	43%	43%	48%	43%	45%	48%	45%	46%	41%	37%
Median	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%
Goal																			
Numerator:	398	488	478	513	503	638	742	796	833	711	722	778	652	821	826	785	821	670	497
Denominator:	1378	1555	1549	1551	1417	1700	1749	1740	1751	1642	1690	1632	1530	1811	1737	1743	1786	1633	1354

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
38%	44%	6,822	5,850	12,672

Care Transitions - Outpatient

Collaborative (2 to 3 Teams): Percentage who are provided health education materials related to health condition.

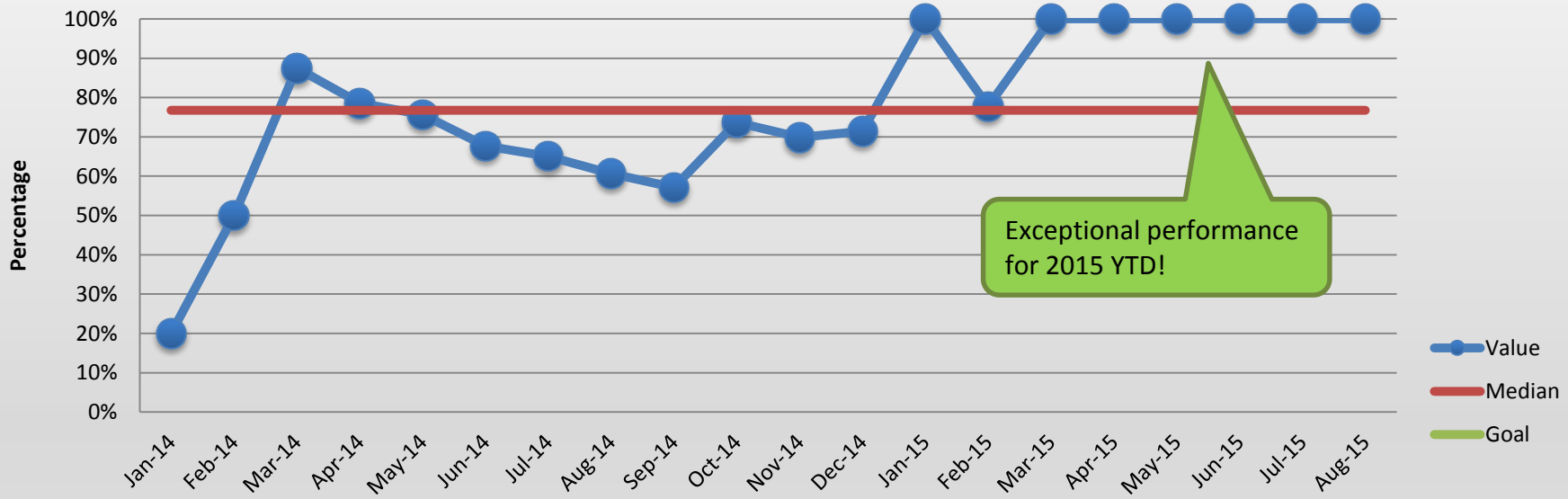


	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Value	14%	10%	32%	36%	54%	96%	99%	97%	53%	58%	71%	94%	67%	90%	73%	61%	92%	94%	92%	92%
Median	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%
Goal																				
Numerator	7	4	19	23	29	71	75	62	37	45	84	78	43	28	22	35	47	32	44	57
Denominator	50	42	59	64	54	74	76	64	70	77	119	83	64	31	30	57	51	34	48	62

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
64%	82%	534	308	842

Care Transitions - Outpatient

Collaborative (2 to 3 Teams): Percentage who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Value	20%	50%	88%	79%	76%	68%	65%	61%	57%	74%	70%	71%	100%	78%	100%	100%	100%	100%	100%	100%
Median	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Goal																				
Numerator	1	2	7	11	28	23	54	57	28	14	44	60	55	21	39	44	37	47	66	42
Denominator	5	4	8	14	37	34	83	94	49	19	63	84	55	27	39	44	37	47	66	42

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
67%	93%	329	351	680

Plan for shared measures

- Continue monthly reporting
- LCC will continue to have 1:1 with collaborative for best practice sharing
- JPS anchor offers data TA as requested

LEARNING COLLABORATIVE

RHP 10

Effective Interventions of RHP 10 Providers

LEARNING COLLABORATIVE RHP 10

Texas Health Resources

Wellness For Life Mobile Health Cancer Screenings

September 29, 2015

Provider Contact for NO PCP Patients within 7 days of Screening Visit

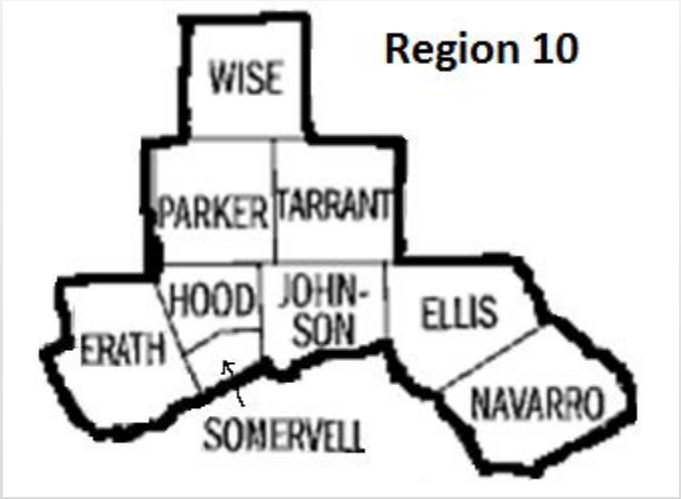
Texas Health Harris Methodist Hospital® FORT WORTH

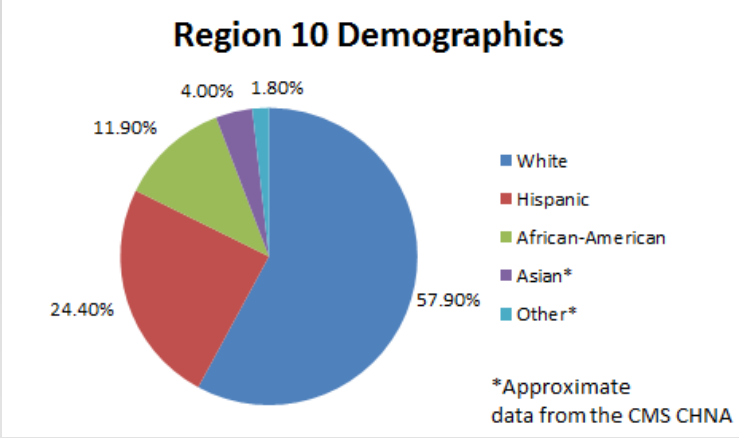
- The current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) has one 40-foot and two 45-foot mobile units that perform cancer screenings:
  - Screening Mammography
  - Cervical Cancer Screening
  - Colon Cancer Screening (Fecal Occult Blood Test)
  - Prostate Cancer Screening
  - Skin Cancer Screening
  - Cardiovascular and Diabetes Screening
- Based out of Texas Health Fort Worth.
- Travels to locations in Tarrant and surrounding counties including Dallas, Denton, Grayson, and many others.

- 1 Manager
- 1 Mobile Operations Coordinator
- 1 Clinical Operations Coordinator
- 1 Administrative Assistant
- 3 Drivers/Admissions Clerks
- 2.5 FTE Family Nurse Practitioners
- 2.8 FTE Mammography Technologists
- 1 RN Patient Navigator
- 1 Community Outreach Coordinator
- 1 Data Analyst
- 1 Fleet Specialist (Engineering Department)
- 1 M.D., Medical Advisor

Wellness for Life: Staff

- RHP 10 encompasses a geographic area of 7,221 square miles.
- Breast Cancer age-adjusted rates for females are some of the highest in RHP 10 counties.
- Cervical cancer death rates for women in Texas are higher than those of the United States overall.
- Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall.





Data Source: CMS CHNA

Table 1: Screen Eligible Population in RHP -10

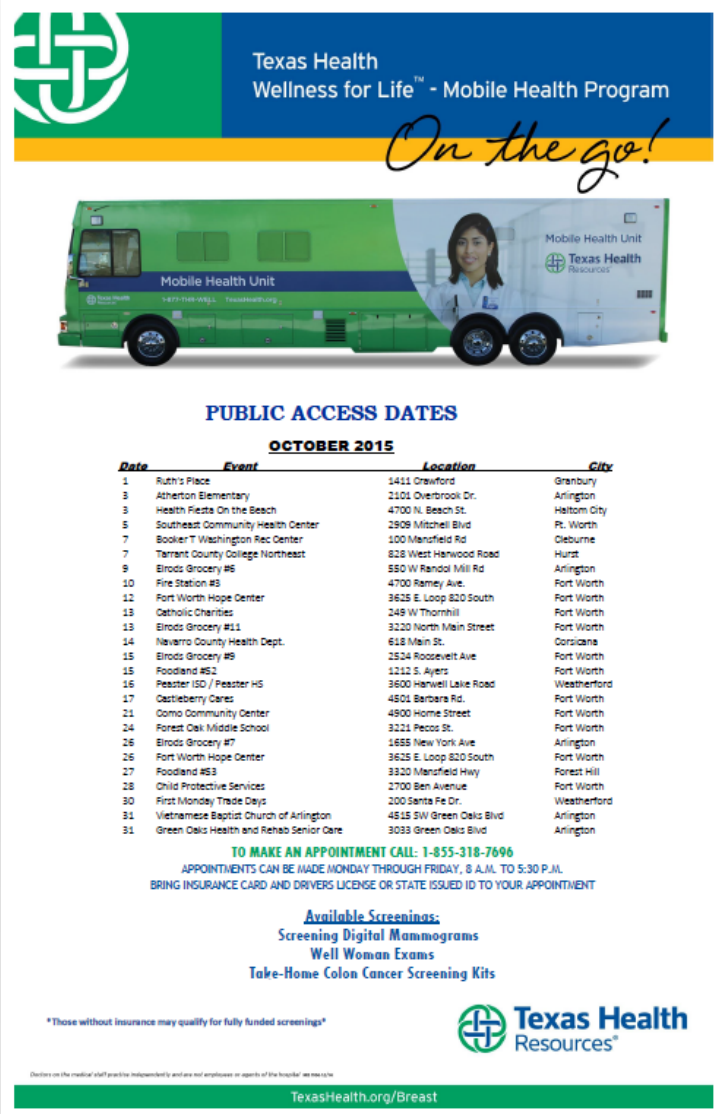
County RHP 10	Medically Underserved Population	2010 Estimated Female Population
Ellis	MUA	28,742
Erath	MUA	6,053
Hood	No MUA	11,224
Johnson	MUA	28,377
Navarro	MUA	8,938
Parker	No MUA	23,718
Somerville	No MUA	1,720
Tarrant	No MUA	921,799
Wise	No MUA	11,805
Total		1,042,376

- There is a lack of awareness of the availability of low-cost or free screenings.
- Transportation, scheduling and availability of screening and care are barriers to screening in rural areas and small towns.
- There is a severe shortage of primary and specialty care available in many rural areas and small towns. Region 10 has very few Texas Breast and Cervical Cancer contractors and Federally Qualified Health Centers.

Data Source: Health Resources and Services Administration & Census Bureau

- Project expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service)
  - To facilitate access to high-quality early cancer detection screening services to medically underserved counties in Region 10 (RHP 10).
- Target DSRIP cancer screenings:
  - Screening Mammography
  - Cervical Cancer Screening
  - Colon Cancer Screening (Fecal Occult Blood Test)
- The project includes follow up for patients to facilitate care transitions into specialty and primary care through our RN patient navigator.

- A network of primary and specialty care providers will be engaged as collaborators in Region 10.
- Patients identified as NO PCP (primary care physician) will be navigated to primary care by the RN Patient Navigator.
  - Approximately 48.65% of our 2,000 patients seen thus far (approx. 973 patients) have identified as NO PCP.
- Patients in need of follow-up as a result of an abnormal cancer screening will be navigated to specialty care by the RN patient navigator.
  - Thereby reducing the time to diagnosis



Texas Health Resources

Need YPO

Catholic Charities Fort Worth

Susan G. Komen GREATER FORT WORTH

Moncrief Cancer Institute
UT Southwestern

Cornerstone Assistance Network

Uniting with others in Christian love to meet the needs of people.

MUSLIM COMMUNITY CENTER FOR HUMAN SERVICE

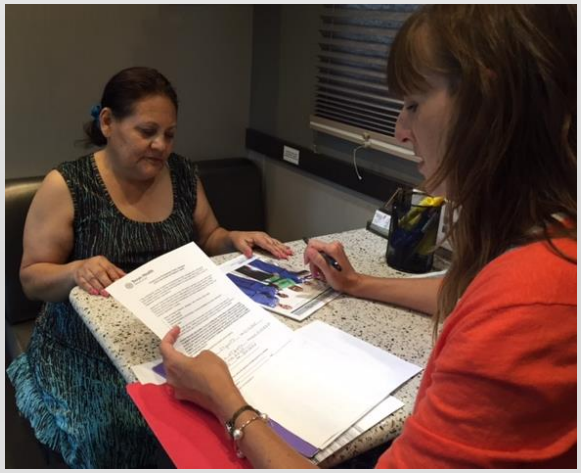
MCCHS

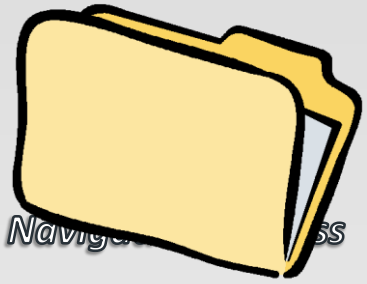
Elrod's Cost Plus Supermarkets

Community Partners

Ruth's Place

- The JPS Learning Collaborative in DY3 established our Care Transitions measure.
- Percentage of NO PCP patients seen on the mobile unit who received contact with his or her follow-up provider team (primary care team or other, including patient navigator) within 7 calendar days of their appointment.
  - Numerator: Number of patients in denominator with contact by follow-up provider within 7 calendar days of discharge.
  - Denominator: Number of NO PCP patients screened on the mobile unit within the defined time period.

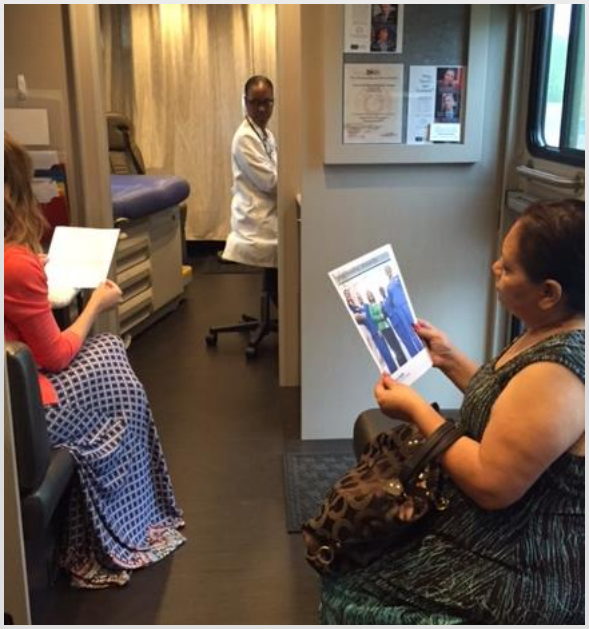




- Patients seen on the mobile unit are identified as NO PCP or having a PCP.
- Patients go through the Admissions Process and an XNET report is generated.
  - The Clinical Outcomes Analyst monitors for the number of NO PCP patients identified.
  - Information is exchanged for Admissions and relevant offices to correctly identify DSRIP patients.
- The Nurse Navigator reviews Patient Records and Provider Notes, if available, to see if the patient really has NO PCP or clinic or other place of care.

» Once a NO PCP patient is identified the Nurse Navigator:

- Prints snapshot and creates a worksheet to work from.
- Documents her contact/calls and activities in CareConnect (electronic health record).
- Prints patient NO PCP letter from Care Connect and adds patient name and appointment date.
  - Letters are sent within 7 days.
  - Letters come in both English and Spanish & include a clinic list for the patient's county.
  - Navigator documents that the letter was sent.



Texas Health Resources

Nurse Navigator Referral Lists for Primary Care

RHP 10 & Tarrant Lists sent with NO PCP Letters

RHP 10 Counties Primary Care Referral List

Ellis County

Hope Clinic
411 East Jefferson
Waxahachie 75165
972-923-2440 phone

Erath County

Cross Timbers Health Center
135 River North Boulevard
Stephenville 76401
254-965-2810

Dublin Family Medicine
305 North Patrick
Dublin 75446
254-445-4900

Hood County

Ruth's Place Clinic
1411 Crawford Avenue
Granbury 76048
817-573-6800

Lake Granbury Medical Center
1310 Paluxy Road
Granbury 76048
817-573-2273

Johnson County

Hope Medical and Dental Clinic
111 Meadow View Drive
Cleburne 76033
817-641-5858

Texas Health Resources Cleburne Mammograms Are A Must
201 Walls Drive
Cleburne 76033
817-556-5400

Texas Health Huguley Hospital
11801 South Freeway
Burleson 76028
817-293-9110

Navarro County

Navarro County Health Department
618 North Main
Corsicana 75110
903-874-6731

Ross Breast Center
901 East Houston, Suite 650
Tyler 75702
903-531-5663

Parker County

Campbell Clinic Health Program
1517 Texas Drive
Weatherford 76086
817-458-3300

Careity Foundation
8713 White Settlement Road
Fort Worth 76108
817-882-4100

Parker County Health Foundation
200 Palo Pinto Highway
Weatherford 76086
817-594-1990

Center of Hope
629 Palo Pinto Highway
Weatherford 76086
817-594-0266

Center of Hope #2
9901 East Bankhead Highway
Aledo 76086
817-441-2242

Somervell County

Glen Rose Medical Center
1021 Holden
Glen Rose 76043
254-897-2215

North Texas Area Wide

Moncrief Cancer Institute
400 West Magnolia Avenue
Fort Worth 76104
1-800-405-7739

Planned Parenthood
Fort Worth, Arlington, Dallas
1-877-855-7526

Wise County

Mary's Gift Clinic
2000 South FM 51
Decatur 76234
940-626-1384

Wise County Community Health Center
2000 South FM 51, Suite D
Decatur 76234
940-393-0100

Tarrant County Primary Care Referral List

Texas Health Resources
Help to Find a Doctor or
Schedule Mobile Appointment
1-855-318-7696

John Peter Smith (JPS)
Many Clinics in Tarrant County
Main Number: 817-921-3431
www.JPSHealthNet.org

JPS Health Center for Women
1201 South Main
Fort Worth 76104
817-702-6500

JPS Medical Home SE Tarrant
1050 West Arkansas Lane
Arlington 76013
817-702-1100

Northside Community Clinic
2106 North Main
Fort Worth 76164
817-625-4254
www.NTACHC.org

SouthEast Community Clinic
2909 Mitchell Boulevard
Fort Worth 76105
817-916-4333

Grand Prairie Community Health Center
405 Stadium Drive
Grand Prairie 75050
214-540-0300

Tarrant County Public Health
1.) 1101 South Main
Fort Worth 76104
817-321-4800 (Infection Screening)
817-321-5327 (Abnormal Pap)
2.) 536 West Randol Mill Road
Arlington 76011
817-321-4724 (Infection Screening)
www.TarrantCounty.com/eHealth

Planned Parenthood of North Texas
Arlington or Dallas (Abnormal Pap)
Main Number: 817-882-1155, #3
www.PPNT.org

Moncrief (Breast Health Program)
1-800-405-7739

Mission Arlington
210 West South Street
Arlington 76010
817-277-9597
www.MissionArlington.org

Cornerstone Medical Clinic
3500 Noble Avenue
Fort Worth 76111
817-632-6000
www.canetwork.org

Mission Fort Worth
4401 Vermont Avenue
Fort Worth 76115
817-207-0229

Al-Shifa Clinic – *Muslim Community Clinic*
7600 Glenview Drive, Suite B
Richland Hills 76180
817-589-9165

Open Arms Health Clinic
3921 West Green Oaks, Suite D
Arlington 76016
817-496-1919

GRACE Community Clinic
(Serves Grapevine, Colleyville, Southlake)
837 East Walnut
Grapevine 76051
817-488-7009 X 147
817-305-4670
www.GraceGrapevine.org

Mercy Medical & Dental Clinic
(Must live in 76110 zip code area)
775 West Bowie
Fort Worth 76110
817-840-3501

Crowley House of Hope Clinic
(Must live in Crowley ISD or 76036 zip code)
216 North Magnolia
Crowley 76036
817-297-6400

The Linda Nix Caring Place Clinic
JPS Children's Clinic
Vision Clinic
901 West Broad
Mansfield 76063
817-473-6611
Dental Clinic 817-473-6611

Hope Medical & Dental Clinic
111 Meadowview Drive
Cleburne 76033
817-641-5858

Baylor Community Care Clinic
1650 West Magnolia, Suite # 207
Fort Worth 76104
817-912-8000

UNT Pediatric Mobile Clinic
Call for appointment in Tarrant County
817-929-5437

Catholic Charities
1.) 249 West Thornhill
Fort Worth 76115
817-534-0814
2.) 917 West Sanford
Arlington 76012
817-274-2560
www.CatholicCharitiesFortWorth.org

Clinica Guadalupe
Alberto Flores M.D.
1220 North Main
Fort Worth 76164
817-378-0777

Community Eye Clinic
(2nd story of First Christian Church)
655 Taylor
Fort Worth 76102
817-289-6800

Bishop Kevin W. Vann Dental Clinic
Provided by Catholic Charities
817-289-3882

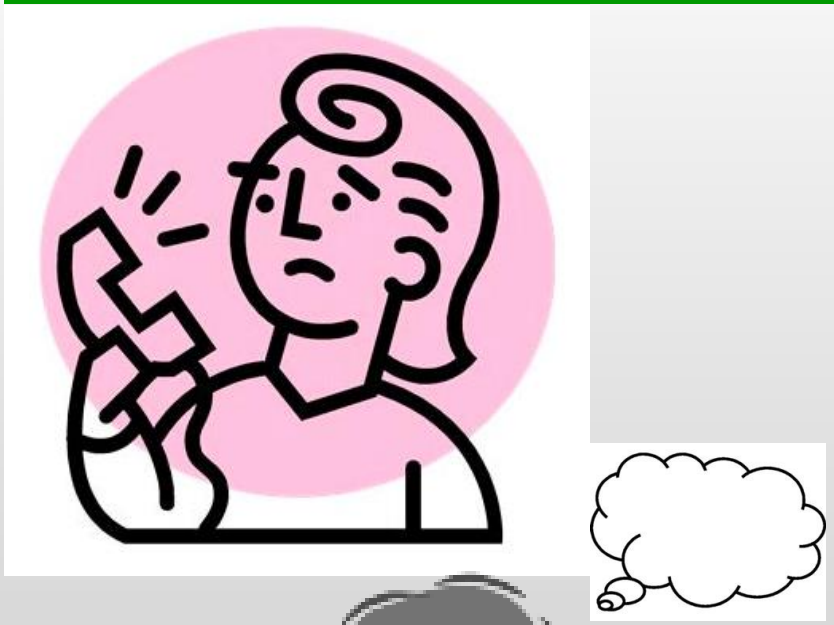
Mission Arlington Dental Clinic
210 West South
Arlington 76010
817-860-4474

- An Interpreter is contacted to make follow-up calls within 2-3 weeks.
  - Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    - Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  - If so: Name of clinic/provider and PCP appointment date (if available) are recorded.
- Information from Interpreter calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.
- Clinical Outcomes Analyst records follow-up notes for outcomes.

Interpreter Calls: high resource cost for low return/effect

12 patients connected to PCP out of 419 NO PCP patients. (less than 3%)

Initial Process



- Calls to all NO PCP patients were time and labor intensive for the Navigator.
  - This took time away from the Navigator to work with patients who had abnormal screening results.
- There was a high proportion of Spanish-only speaking patients which required the use of an interpreter to make most of these calls.
  - The interpreter was needed on a regular basis to make approx. 100 calls a month.
- This process did obtain a lot of information but was cost prohibitive and low impact for patients.
  - Relative cost-to-benefit ratio did not even out when the cost of interpreters was high and for the most part patients were not connecting to a PCP.

- **The Navigator makes the follow-up call via the language line call system utilizing hospital interpreters within 2-3 weeks *for patients with abnormal results*.**
  - > Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    - + Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  - > If so: Name of clinic/provider and PCP appointment date (if available) are recorded.
- Information from these calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.
- Clinical Outcomes Analyst records follow-up notes for outcomes.

All NO PCP patients will still be identified and sent letters with a provider/clinic list.

Patients with an identified health issue determined by screening are more likely to seek care and potentially maintain that relationship and be engaged in their health here-afterward as well.

Improved Process

- Before: Approximately 100 NO PCP calls per month, or more.
  - Time and labor intensive for Navigator
  - Took away from navigation for patients with abnormal results
  - Very few patients actually connected with a medical home
- After: Approximately 20 NO PCP patients with abnormal result calls per month, or more.
  - Navigator has more time to navigate patients with abnormal results
  - Utilizing the hospital interpreters via the language line call system means we can still adequately communicate well with our Spanish-speaking patients
  - Patients with abnormal results are more effectively followed-up on regarding contact with primary and specialty care providers
- All NO PCP patients are still contacted within 7 days by letter with clinic list in patient's county and contact information for navigator.

Improved Changes

Questions?

NO PCP Letter Process

Texas Health Resources

Wellness For Life Mobile Health
Cancer Screenings

September 29, 2015

Provider Contact for NO PCP Patients within 7 days of Screening Visit

Wellness For Life Mobile Health

Texas Health
Harris Methodist Hospital®
FORT WORTH

- The current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) has one 40-foot and two 45-foot mobile units that perform cancer screenings:
  - Screening Mammography
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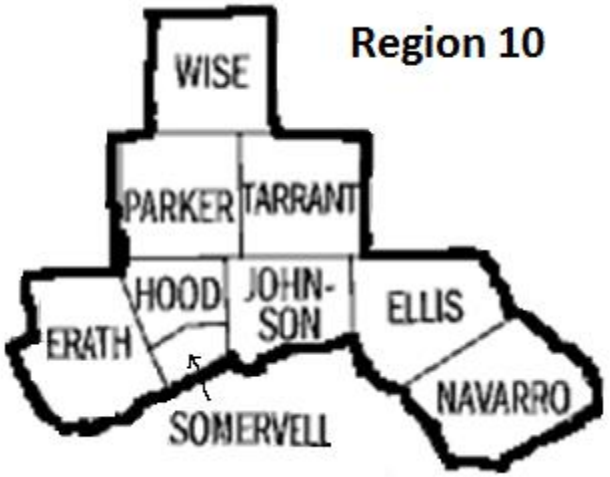
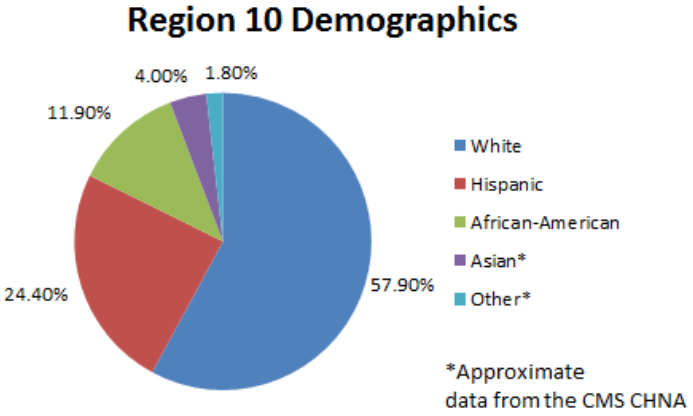
  - Colon Cancer Screening (Fecal Occult Blood Test)
  - Prostate Cancer Screening
  - Skin Cancer Screening
  - Cardiovascular and Diabetes Screening
- Based out of Texas Health Fort Worth.
- Travels to locations in Tarrant and surrounding counties including Dallas, Denton, Grayson, and many others.

- 1 Manager
- 1 Mobile Operations Coordinator
- 1 Clinical Operations Coordinator
- 1 Administrative Assistant
- 3 Drivers/Admissions Clerks
- 2.5 FTE Family Nurse Practitioners
- 2.8 FTE Mammography Technologists
- 1 RN Patient Navigator
- 1 Community Outreach Coordinator
- 1 Data Analyst
- 1 Fleet Specialist (Engineering Department)
- 1 M.D., Medical Advisor

- RHP 10 encompasses a geographic area of 7,221 square miles.
- Breast Cancer age-adjusted rates for females are some of the highest in RHP 10 counties.
- Cervical cancer death rates for women in Texas are higher than those of the United States overall.
- Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall.





Data Source: CMS CHNA

Table 1: Screen Eligible Population in RHP -10

County RHP 10	Medically Underserved Population	2010 Estimated Female Population
Ellis	MUA	28,742
Erath	MUA	6,053
Hood	No MUA	11,224
Johnson	MUA	28,377
Navarro	MUA	8,938
Parker	No MUA	23,718
Somerville	No MUA	1,720
Tarrant	No MUA	921,799
Wise	No MUA	11,805
Total		1,042,376

- There is a lack of awareness of the availability of low-cost or free screenings.
- Transportation, scheduling and availability of screening and care are barriers to screening in rural areas and small towns.
- There is a severe shortage of primary and specialty care available in many rural areas and small towns. Region 10 has very few Texas Breast and Cervical Cancer contractors and Federally Qualified Health Centers.

Data Source: Health Resources and Services Administration & Census Bureau

- Project expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service)
  - To facilitate access to high-quality early cancer detection screening services to medically underserved counties in Region 10 (RHP 10).
- Target DSRIP cancer screenings:
  - Screening Mammography
  - Cervical Cancer Screening
  - Colon Cancer Screening (Fecal Occult Blood Test)
- The project includes follow up for patients to facilitate care transitions into specialty and primary care through our RN patient navigator.

Overview & Background

- A network of primary and specialty care providers will be engaged as collaborators in Region 10.
- Patients identified as NO PCP (primary care physician) will be navigated to primary care by the RN Patient Navigator.
  - Approximately 48.65% of our 2,000 patients seen thus far (approx. 973 patients) have identified as NO PCP.
- Patients in need of follow-up as a result of an abnormal cancer screening will be navigated to specialty care by the RN patient navigator.
  - Thereby reducing the time to diagnosis of cancer.

Texas Health Resources

Community Partners

Need YPO

Catholic Charities Fort Worth

Susan G. Komen GREATER FORT WORTH

Moncrief Cancer Institute
UT Southwestern

Cornerstone Assistance Network

Uniting with others in Christian love to meet the needs of people.

MUSLIM COMMUNITY CENTER FOR HUMAN SERVICE
MCCHS

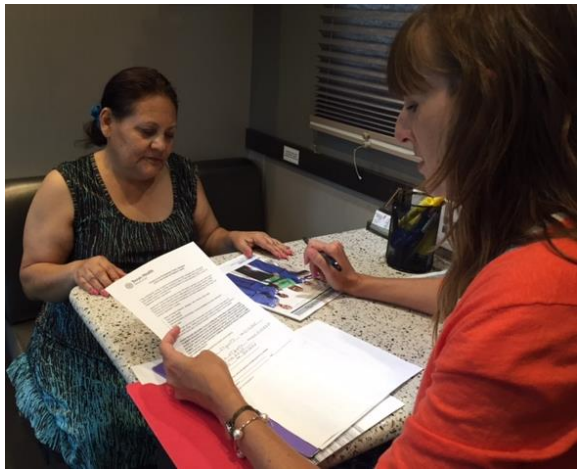
Elrod's COST PLUS SUPERMARKETS

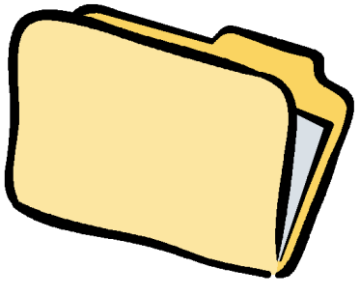
Ruth's Place

Overview & Background: Care Transitions

- The JPS Learning Collaborative in DY3 established our Care Transitions measure.
- Percentage of NO PCP patients seen on the mobile unit who received contact with his or her follow-up provider team (primary care team or other, including patient navigator) within 7 calendar days of their appointment.
  - Numerator: Number of patients in denominator with contact by follow-up provider within 7 calendar days of discharge.
  - Denominator: Number of NO PCP patients screened on the mobile unit within the defined time period.

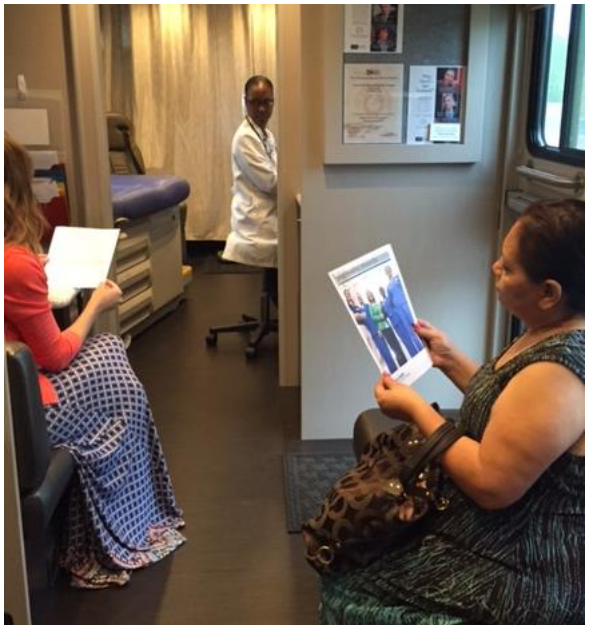
Navigation Process





- Patients seen on the mobile unit are identified as NO PCP or having a PCP.
- Patients go through the Admissions Process and an XNET report is generated.
  - The Clinical Outcomes Analyst monitors for the number of NO PCP patients identified.
  - Information is exchanged for Admissions and relevant offices to correctly identify DSRIP patients.
- The Nurse Navigator reviews Patient Records and Provider Notes, if available, to see if the patient really has NO PCP or clinic or other place of care.

- Once a NO PCP patient is identified the Nurse Navigator:
  - Prints snapshot and creates a worksheet to work from.
  - Documents her contact/calls and activities in CareConnect (electronic health record).
  - Prints patient NO PCP letter from Care Connect and adds patient name and appointment date.
    - Letters are sent within 7 days.
    - Letters come in both English and Spanish & include a clinic list for the patient's county.
    - Navigator documents that the letter was sent.



Nurse Navigator Referral Lists for Primary Care
RHP 10 & Tarrant Lists sent with NO PCP Letters

Texas Health Resources

RHP 10 Counties Primary Care Referral List

Ellis County

Hope Clinic
411 East Jefferson
Waxahachie 75165
972-923-2440 phone

Erath County

Cross Timbers Health Center
135 River North Boulevard
Stephenville 76401
254-965-2810

Dublin Family Medicine
305 North Patrick
Dublin 75446
254-445-4900

Hood County

Ruth's Place Clinic
1411 Crawford Avenue
Granbury 76048
817-573-6800

Lake Granbury Medical Center
1310 Paluxy Road
Granbury 76048
817-573-2273

Johnson County

Hope Medical and Dental Clinic
111 Meadow View Drive
Cleburne 76033
817-641-5858

Texas Health Resources Cleburne Mammograms Are A Must
201 Walls Drive
Cleburne 76033
817-556-5400

Texas Health Huguley Hospital
11801 South Freeway
Burleson 76028
817-293-9110

Navarro County

Navarro County Health Department
618 North Main
Corsicana 75110
903-874-6731

Ross Breast Center
901 East Houston, Suite 650
Tyler 75702
903-531-5663

Parker County

Campbell Clinic Health Program
1517 Texas Drive
Weatherford 76086
817-458-3300

Careity Foundation
8713 White Settlement Road
Fort Worth 76108
817-882-4100

Parker County Health Foundation
200 Palo Pinto Highway
Weatherford 76086
817-594-1990

Center of Hope
629 Palo Pinto Highway
Weatherford 76086
817-594-0266

Center of Hope #2
9901 East Bankhead Highway
Aledo 76086
817-441-2242

Somervell County

Glen Rose Medical Center
1021 Holden
Glen Rose 76043
254-897-2215

North Texas Area Wide

Moncrief Cancer Institute
400 West Magnolia Avenue
Fort Worth 76104
1-800-405-7739

Planned Parenthood
Fort Worth, Arlington, Dallas
1-877-855-7526

Wise County

Mary's Gift Clinic
2000 South FM 51
Decatur 76234
940-626-1384

Wise County Community Health Center
2000 South FM 51, Suite D
Decatur 76234
940-393-0100

Tarrant County Primary Care Referral List

Texas Health Resources
Help to Find a Doctor or
Schedule Mobile Appointment
1-855-318-7696

John Peter Smith (JPS)
Many Clinics in Tarrant County
Main Number: 817-921-3431
www.JPSHealthNet.org

JPS Health Center for Women
1201 South Main
Fort Worth 76104
817-702-6500

JPS Medical Home SE Tarrant
1050 West Arkansas Lane
Arlington 76013
817-702-1100

Northside Community Clinic
2106 North Main
Fort Worth 76164
817-625-4254
www.NTACHC.org

SouthEast Community Clinic
2909 Mitchell Boulevard
Fort Worth 76105
817-916-4333

Grand Prairie Community Health Center
405 Stadium Drive
Grand Prairie 75050
214-540-0300

Tarrant County Public Health
1.) 1101 South Main
Fort Worth 76104
817-321-4800 (Infection Screening)
817-321-5327 (Abnormal Pap)
2.) 536 West Randol Mill Road
Arlington 76011
817-321-4724 (Infection Screening)
www.TarrantCounty.com/eHealth

Planned Parenthood of North Texas
Arlington or Dallas (Abnormal Pap)
Main Number: 817-882-1155, #3
www.PPNT.org

Moncrief (Breast Health Program)
1-800-405-7739

Mission Arlington
210 West South Street
Arlington 76010
817-277-9597
www.MissionArlington.org

Cornerstone Medical Clinic
3500 Noble Avenue
Fort Worth 76111
817-632-6000
www.canetwork.org

Mission Fort Worth
4401 Vermont Avenue
Fort Worth 76115
817-207-0229

Al-Shifa Clinic – *Muslim Community Clinic*
7600 Glenview Drive, Suite B
Richland Hills 76180
817-589-9165

Open Arms Health Clinic
3921 West Green Oaks, Suite D
Arlington 76016
817-496-1919

GRACE Community Clinic
(Serves Grapevine, Colleyville, Southlake)
837 East Walnut
Grapevine 76051
817-488-7009 X 147
817-305-4670
www.GraceGrapevine.org

Mercy Medical & Dental Clinic
(Must live in 76110 zip code area)
775 West Bowie
Fort Worth 76110
817-840-3501

Crowley House of Hope Clinic
(Must live in Crowley ISD or 76036 zip code)
216 North Magnolia
Crowley 76036
817-297-6400

The Linda Nix Caring Place Clinic
JPS Children's Clinic
Vision Clinic
901 West Broad
Mansfield 76063
817-473-6611
Dental Clinic 817-473-6611

Hope Medical & Dental Clinic
111 Meadowview Drive
Cleburne 76033
817-641-5858

Baylor Community Care Clinic
1650 West Magnolia, Suite # 207
Fort Worth 76104
817-912-8000

UNT Pediatric Mobile Clinic
Call for appointment in Tarrant County
817-929-5437

Catholic Charities
1.) 249 West Thornhill
Fort Worth 76115
817-534-0814
2.) 917 West Sanford
Arlington 76012
817-274-2560
www.CatholicCharitiesFortWorth.org

Clinica Guadalupe
Alberto Flores M.D.
1220 North Main
Fort Worth 76164
817-378-0777

Community Eye Clinic
(2nd story of First Christian Church)
655 Taylor
Fort Worth 76102
817-289-6800

Bishop Kevin W. Vann Dental Clinic
Provided by Catholic Charities
817-289-3882

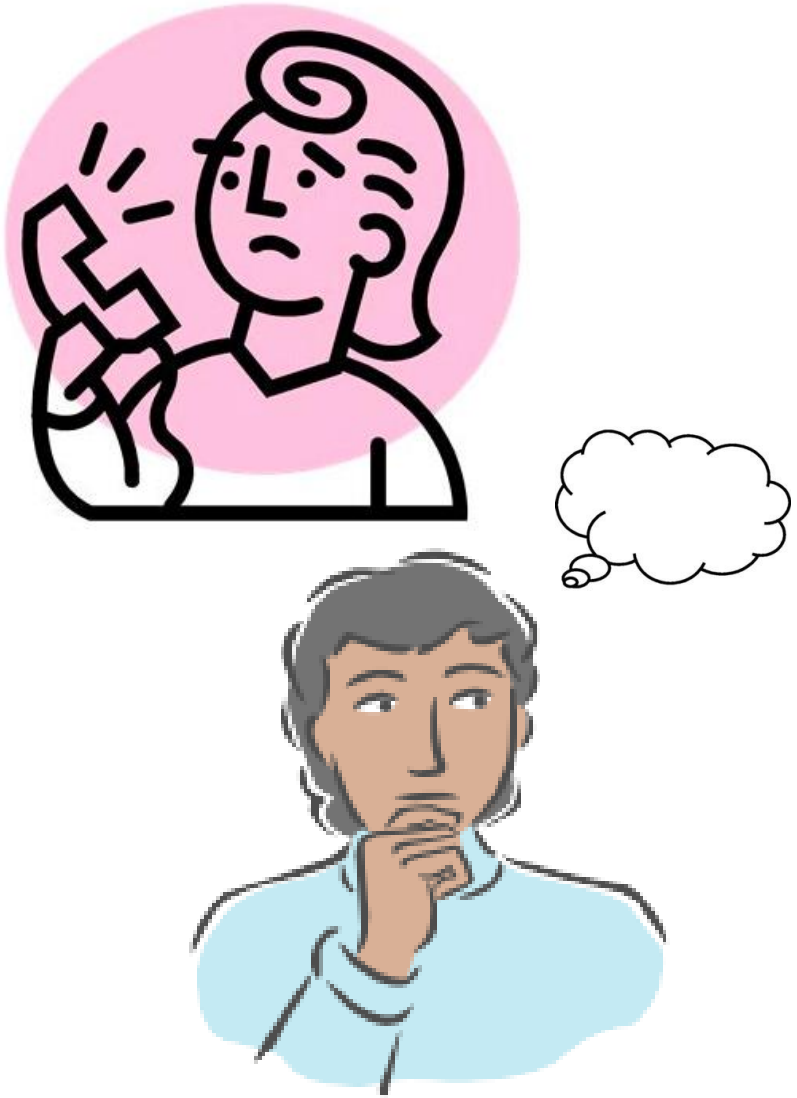
Mission Arlington Dental Clinic
210 West South
Arlington 76010
817-860-4474

Initial Process

- An Interpreter is contacted to make follow-up calls within 2-3 weeks.
  - Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    - Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  - If so: Name of clinic/provider and PCP appointment date (if available) are recorded.
- Information from Interpreter calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.
- Clinical Outcomes Analyst records follow-up notes for outcomes.

Interpreter Calls: high resource cost for low return/effect

12 patients connected to PCP out of 419 NO PCP patients. (less than 3%)



- Calls to all NO PCP patients were time and labor intensive for the Navigator.
  - This took time away from the Navigator to work with patients who had abnormal screening results.
- There was a high proportion of Spanish-only speaking patients which required the use of an interpreter to make most of these calls.
  - The interpreter was needed on a regular basis to make approx. 100 calls a month.
- This process did obtain a lot of information but was cost prohibitive and low impact for patients.
  - Relative cost-to-benefit ratio did not even out when the cost of interpreters was high and for the most part patients were not connecting to a PCP.

Improved Process

- **The Navigator makes the follow-up call via the language line call system utilizing hospital interpreters within 2-3 weeks *for patients with abnormal results*.**
  - Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    - Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  - If so: Name of clinic/provider and PCP appointment date (if available) are recorded.
- Information from these calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.
- Clinical Outcomes Analyst records follow-up notes for outcomes.

All NO PCP patients will still be identified and sent letters with a provider/clinic list.

Patients with an identified health issue determined by screening are more likely to seek care and potentially maintain that relationship and be engaged in their health here-afterward as well.

Improved Changes

- Before: Approximately 100 NO PCP calls per month, or more.
  - Time and labor intensive for Navigator
  - Took away from navigation for patients with abnormal results
  - Very few patients actually connected with a medical home
- After: Approximately 20 NO PCP patients with abnormal result calls per month, or more.
  - Navigator has more time to navigate patients with abnormal results
  - Utilizing the hospital interpreters via the language line call system means we can still adequately communicate well with our Spanish-speaking patients
  - Patients with abnormal results are more effectively followed-up on regarding contact with primary and specialty care providers
- All NO PCP patients are still contacted within 7 days by letter with clinic list in patient's county and contact information for navigator.

Questions?

“Our Success Story”

Care Transitions/CHF360

Shane Jones, MHA

Data Analyst

Wise Regional Health System

Learning Collaborative- September 29, 2015

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Affiliated with, but not controlled by, Baylor Health Care System or its subsidiaries or community medical centers

- 3 Hospitals Locations-Wise and Tarrant Counties
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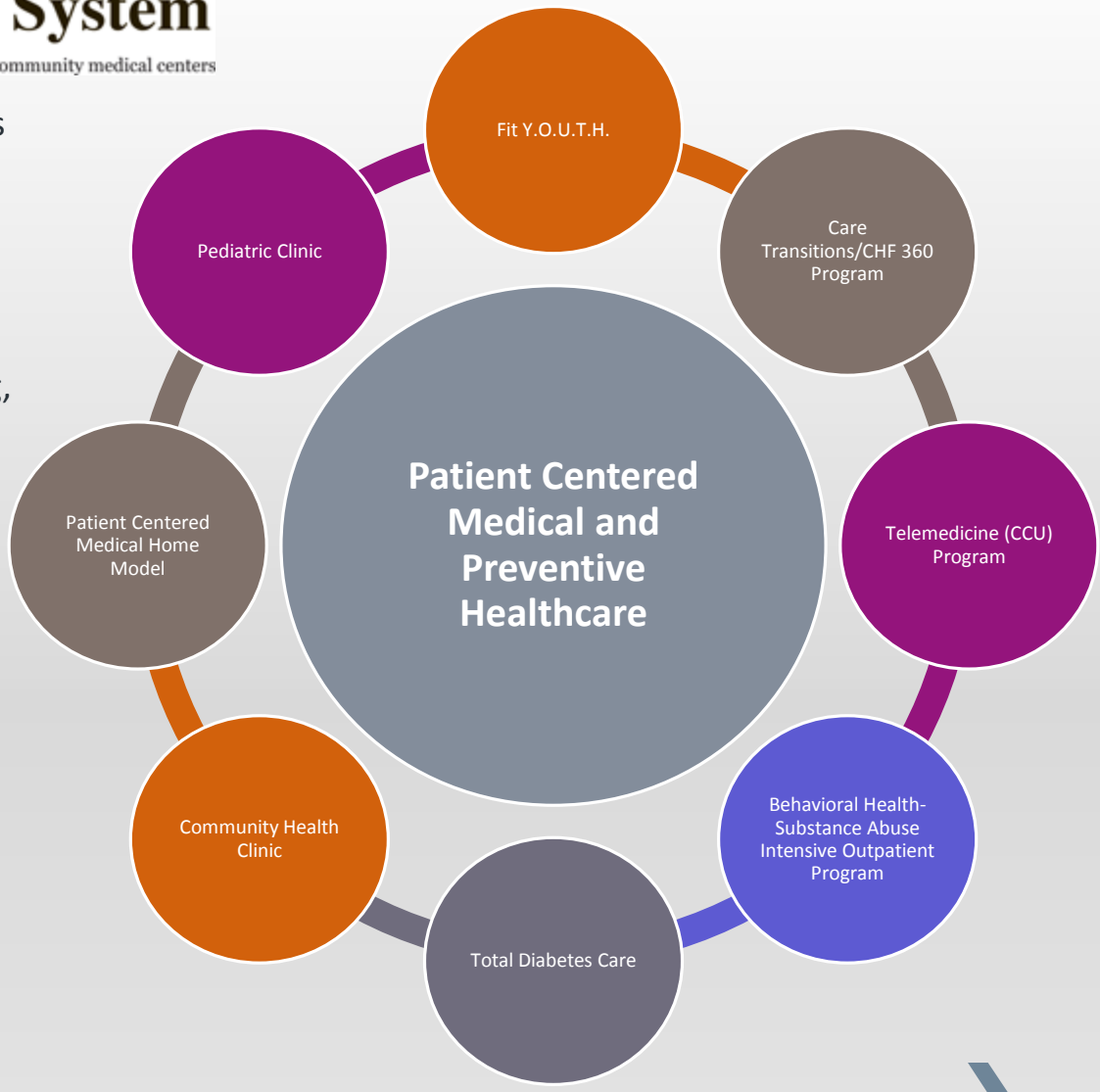

Clinical Care Associates
Wise Regional Health System

- Strategy and Methodology to Project Development
  - DSRIP Structure and Direction
  - Project Champions
  - Utilizing Current Staff Members and Other Resources
  - Hired Nurse Practitioner for CHF360

Early Years

- Multiple Stumbles Along The Way
  - Turnover, Turnover, Turnover
  - Educate and Train New Staff
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  - Policy Changes
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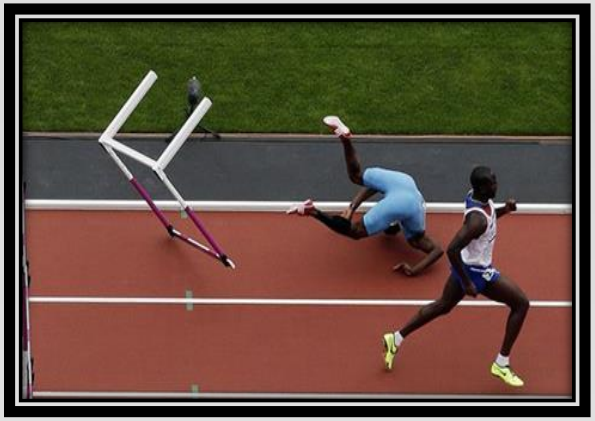
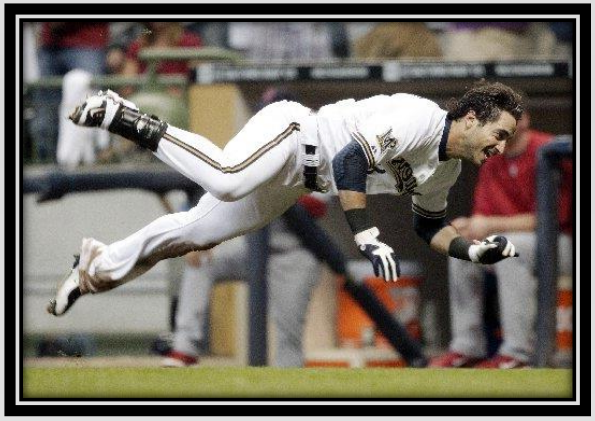
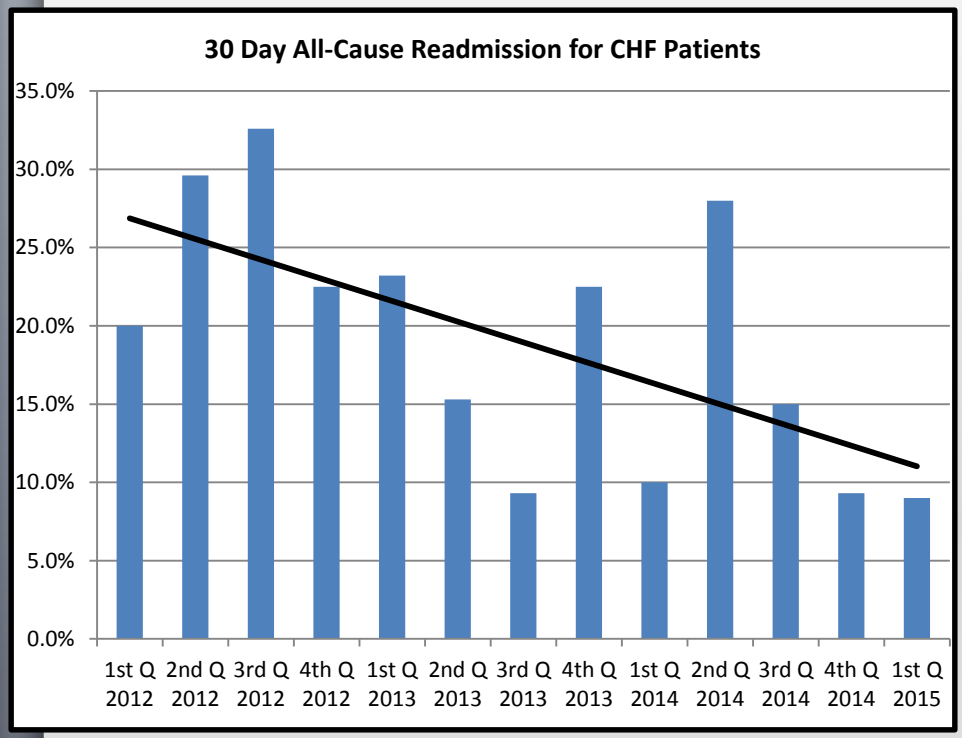



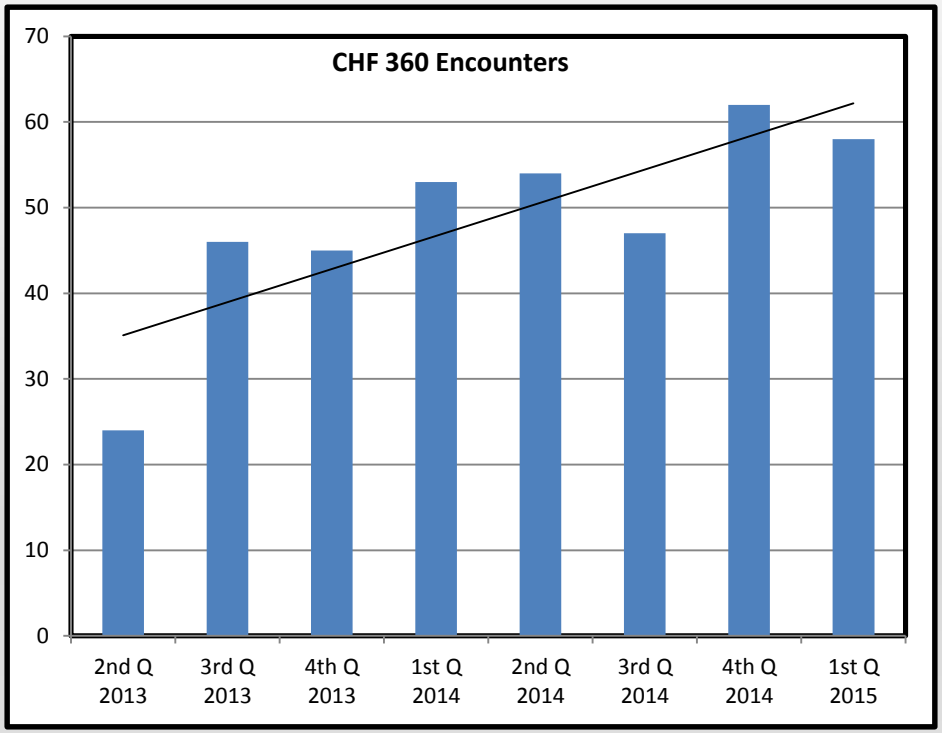
Project Adolescence

- Solid, Motivated Team
- Expand Project Scope to Other Disease Areas
- Working More with Post-Acute Providers in the Area
- Focus on Bigger Picture and Not Just Meeting Milestones

DY5 and Beyond

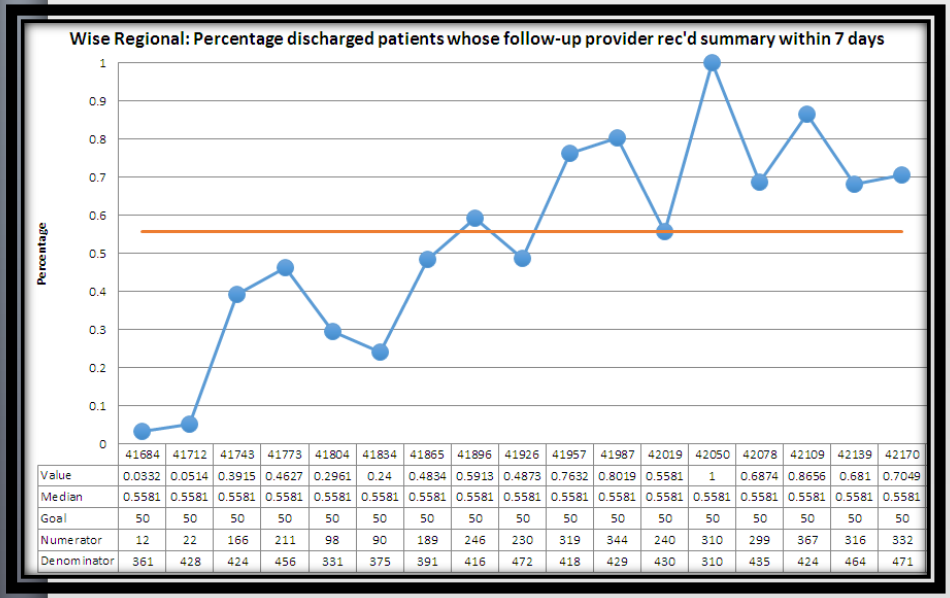
1. Decreased the All-Cause Readmission Rate for CHF Specific Patients by 41%





Major Wins

2. Improvement in the Learning Collaborative Metrics



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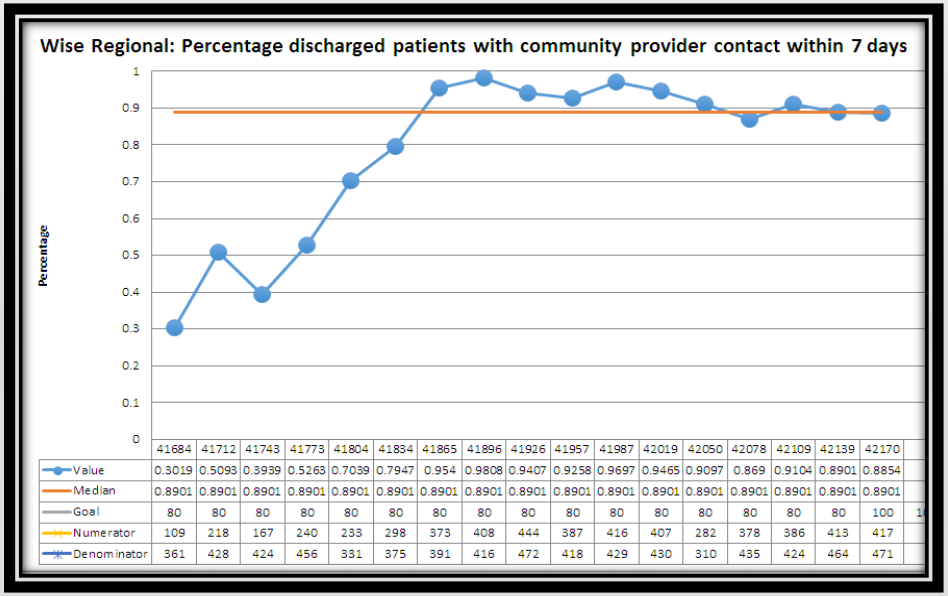
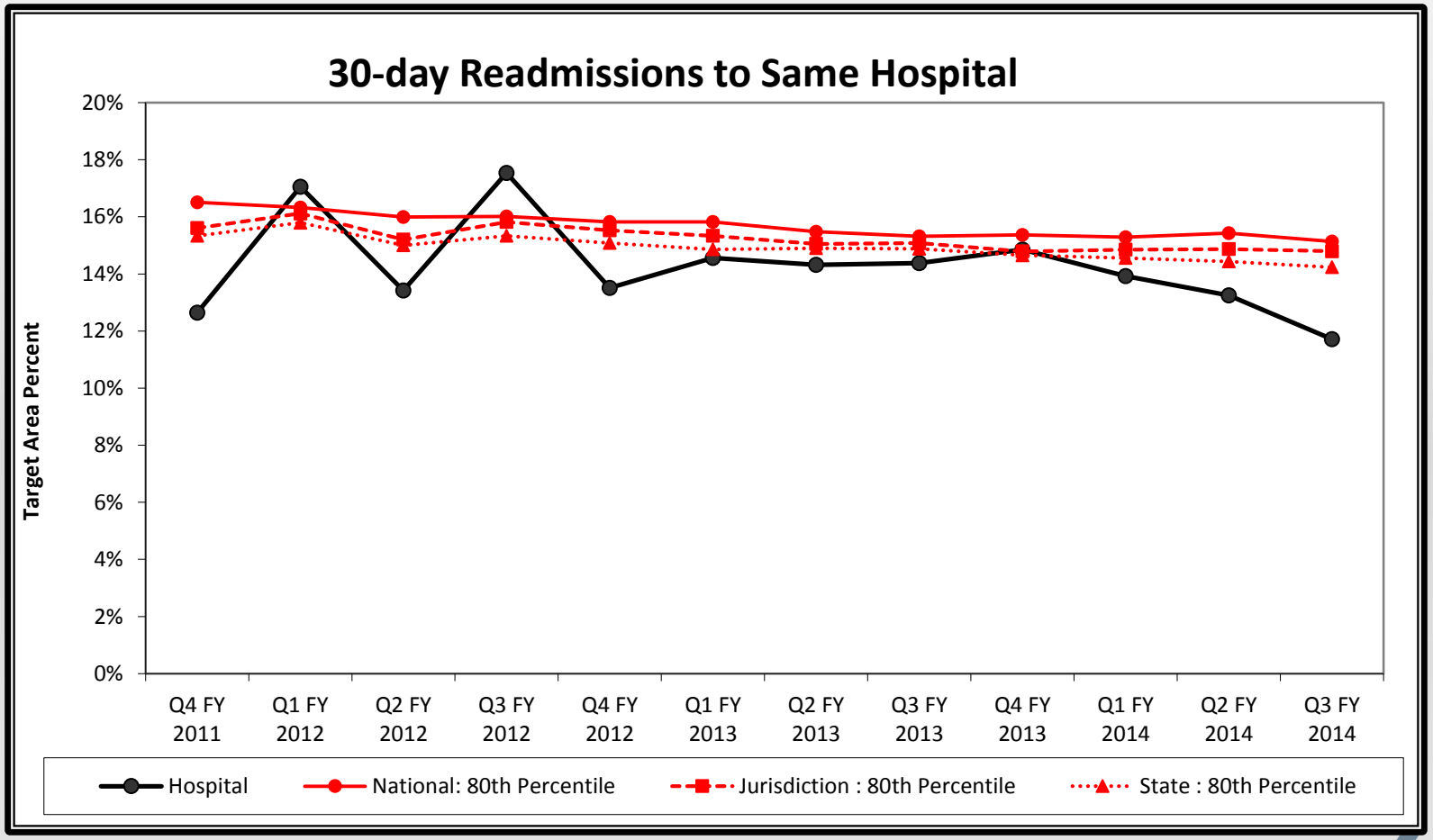
Value	0.0332	0.0514	0.3915	0.4627	0.2961	0.24	0.4834	0.5913	0.4873	0.7632	0.8019	0.5581	1	0.6874	0.8656	0.681	0.7049
Median	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581
Goal	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
Numerator	12	22	166	211	98	90	189	246	230	319	344	240	310	299	367	316	332
Denominator	361	428	424	456	331	375	391	416	472	418	429	430	310	435	424	464	471



	41684	41712	41743	41773	41804	41834	41865	41896	41926	41957	41987	42019	42050	42078	42109	42139	42170
Value	0.3019	0.5093	0.3939	0.5263	0.7039	0.7947	0.954	0.9808	0.9407	0.9258	0.9697	0.9465	0.9097	0.869	0.9104	0.8901	0.8854
Median	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901
Goal	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	100
Numerator	109	218	167	240	233	298	373	408	444	387	416	407	282	378	386	413	417
Denominator	361	428	424	456	331	375	391	416	472	418	429	430	310	435	424	464	471

Major Wins

3. Establishment of the Readmission Reduction Committee and Improvement in All-Cause 30 Day Readmission Rate



Major Wins

- Recommendations Based On Our Experience
  - Build a Strategy Bigger than DSRIP- Create Sustainability
  - Focus on Future Industry Trends- Value Based Purchasing
  - Create More Coordination Between Projects to Build a Continuum of Care
  - Invest in Your People
  - Work with Post-Acute Care Providers Early and Often

Conclusion

Shane Jones, MHA
Data Analyst
Wise Regional Health System
sjones@wiseregional.com
Office: 940-539-2632

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Clinical Care Associates
Wise Regional Health System

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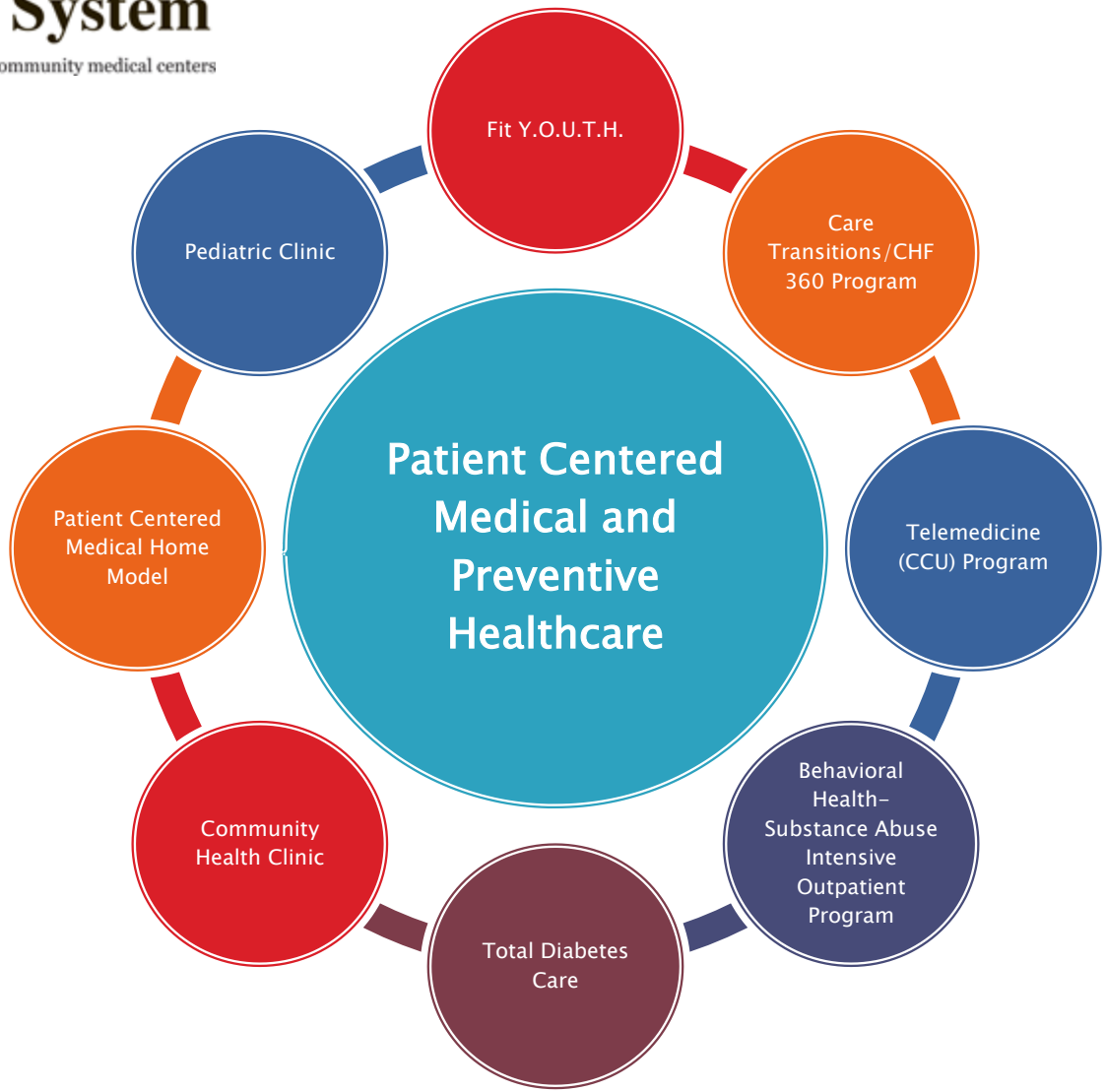

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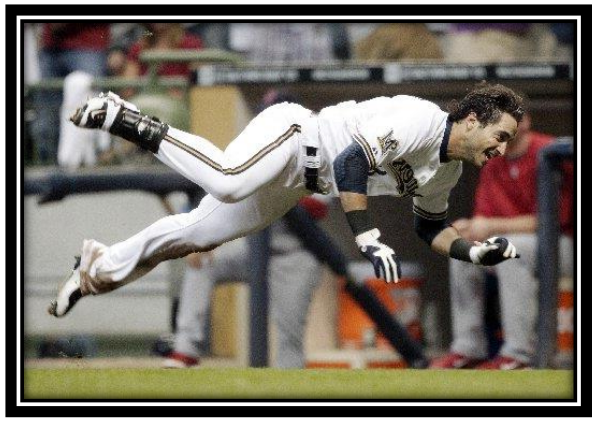

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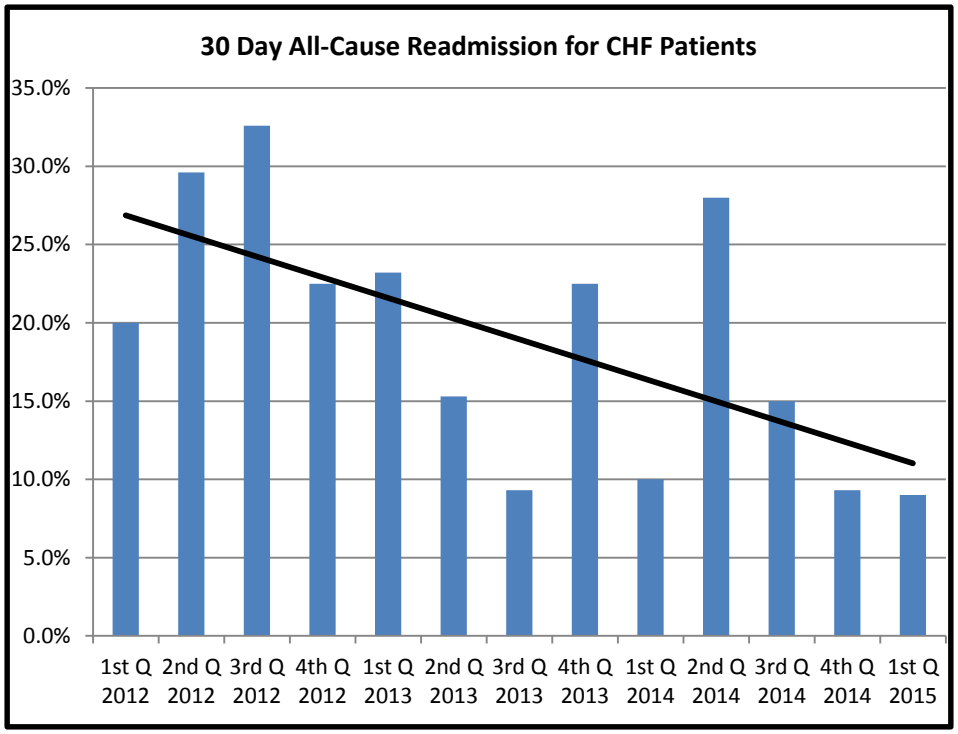
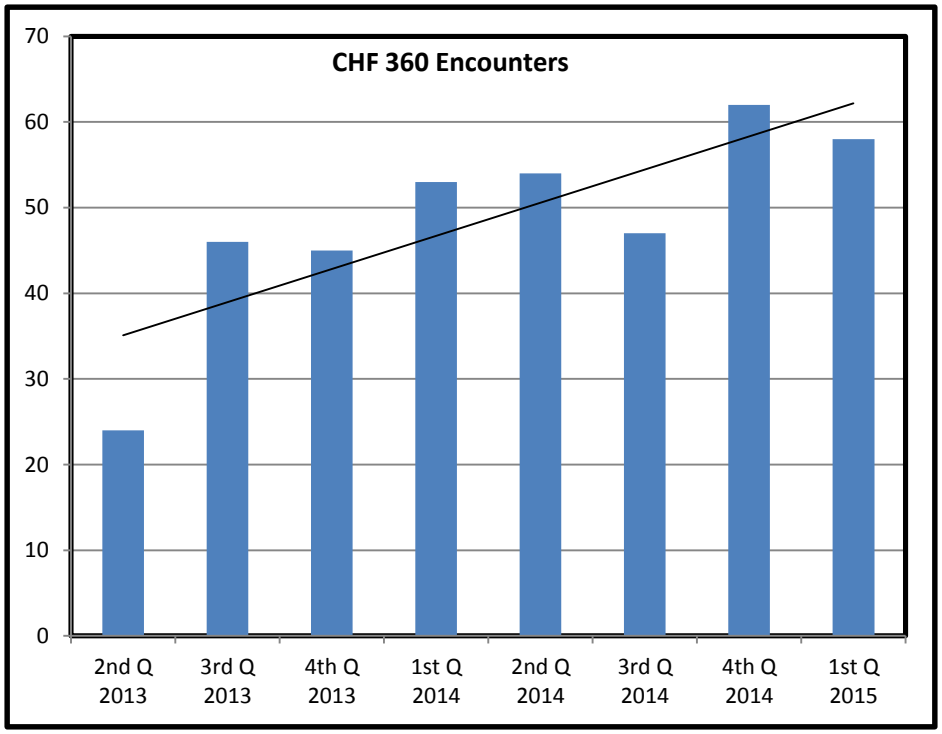
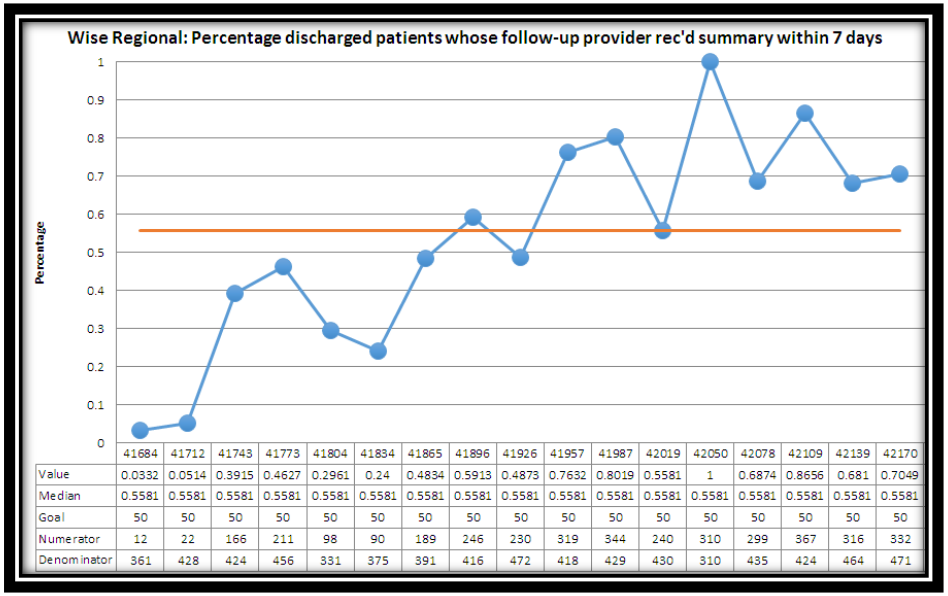


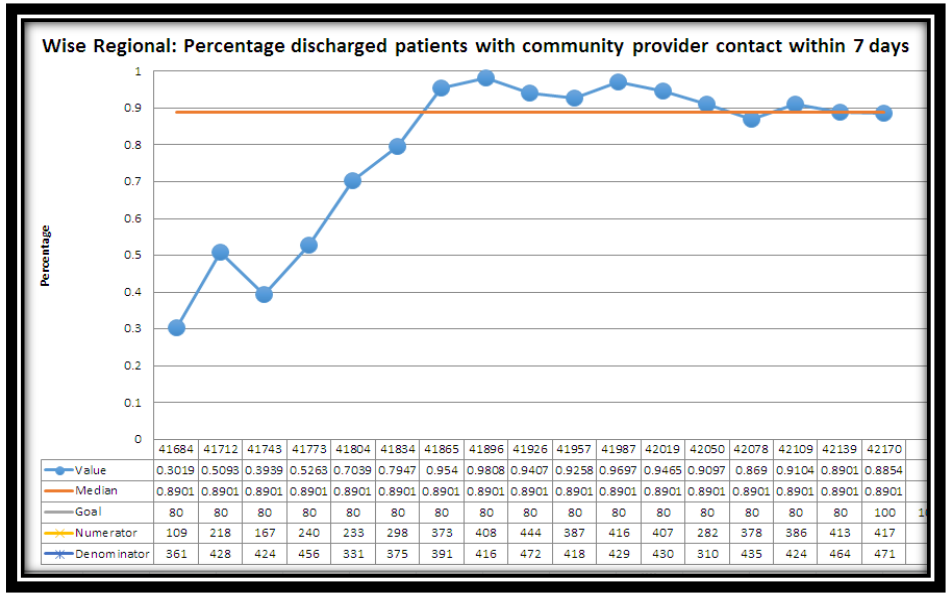


Major Wins

2. Improvement in the Learning Collaborative Metrics



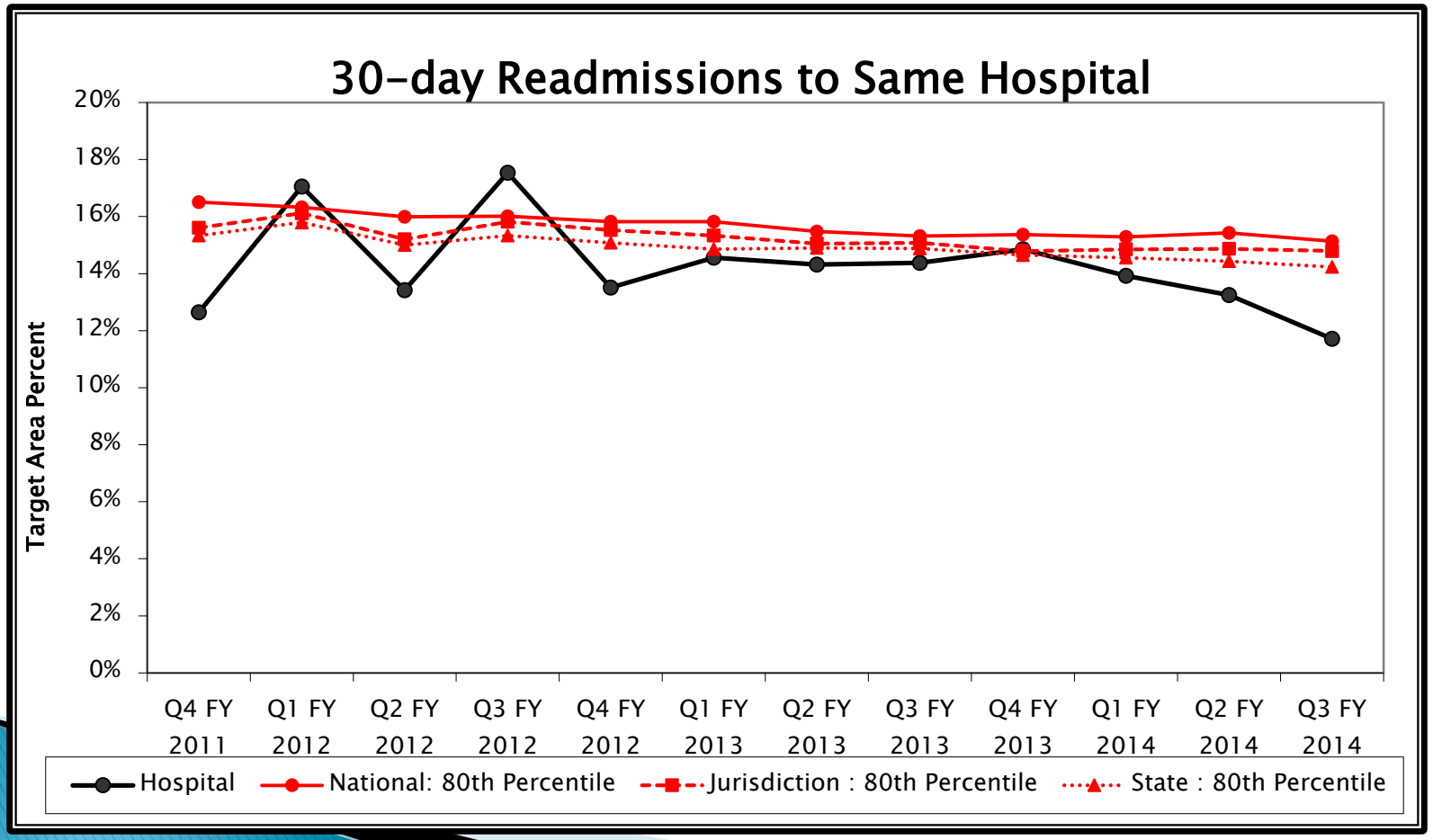
	41684	41712	41743	41773	41804	41834	41865	41896	41926	41957	41987	42019	42050	42078	42109	42139	42170
Value	0.0332	0.0514	0.3915	0.4627	0.2961	0.24	0.4834	0.5913	0.4873	0.7632	0.8019	0.5581	1	0.6874	0.8656	0.681	0.7049
Median	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581	0.5581
Goal	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
Numerator	12	22	166	211	98	90	189	246	230	319	344	240	310	299	367	316	332
Denominator	361	428	424	456	331	375	391	416	472	418	429	430	310	435	424	464	471



	41684	41712	41743	41773	41804	41834	41865	41896	41926	41957	41987	42019	42050	42078	42109	42139	42170
Value	0.3019	0.5093	0.3939	0.5263	0.7039	0.7947	0.954	0.9808	0.9407	0.9258	0.9697	0.9465	0.9097	0.869	0.9104	0.8901	0.8854
Median	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901	0.8901
Goal	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	100
Numerator	109	218	167	240	233	298	373	408	444	387	416	407	282	378	386	413	417
Denominator	361	428	424	456	331	375	391	416	472	418	429	430	310	435	424	464	471

Major Wins

3. Establishment of the Readmission Reduction Committee and Improvement in All-Cause 30 Day Readmission Rate



Conclusion

- Recommendations Based On Our Experience
  - Build a Strategy Bigger than DSRIP- Create Sustainability
  - Focus on Future Industry Trends- Value Based Purchasing
  - Create More Coordination Between Projects to Build a Continuum of Care
  - Invest in Your People
  - Work with Post-Acute Care Providers Early and Often

Questions?

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Wise Regional Health System
Affiliated with, but not controlled by, Baylor Health Care System or its subsidiaries or community medical centers

Clinical Care Associates
Wise Regional Health System

PRIMARY CARE CONNECTION

How We Did It: Changes that Resulted in Improvement

Providing Information to Follow-up Providers

Baylor Scott & White HEALTH

Primary Care Connection (PCC)

BACKGROUND

Goals:

Reduce patient readmissions to the emergency department, improve overall hospital costs and patient outcomes by connecting patients to a medical home

Population of focus :

ED patients who are uninsured or insured through Medicaid with a chronic diagnosis and/or multiple ED visits

Staffing:

Program Director shares time between 4 hospitals

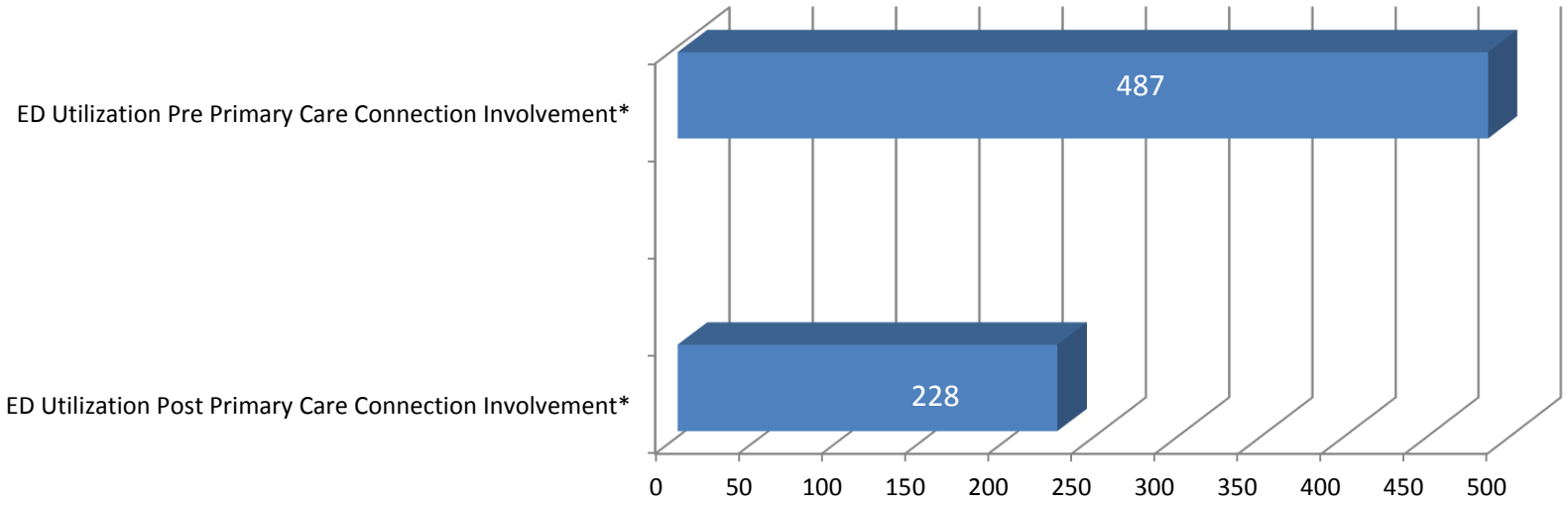
BASMC- 1 Social Work Supervisor; 3 Community Health Workers (CHW's)

Primary Care Connection (PCC)

SERVICES

- Schedule medical home and/or medical specialist appointments
- Address barriers that impact patients' attendance at appointments
- Provide referral to community resources
- Patient education
- Confirm attendance of appointments
- Ensure continuity of follow-up care
- Escalate complex cases to Social Worker
- Care Plan for patients who are identified as high risk based on number of ED visits and chronic illnesses.

BASMC
ED Utilization Among 306 Patients With Confirmed Appointments
August 1, 2013 to November 31, 2014



ED Utilization decreased by 53% after Primary Care Connection Involvement

***Utilization calculated using number of actual patient encounters for identical time periods 90 days before and 90 days after Primary Care Connection involvement.

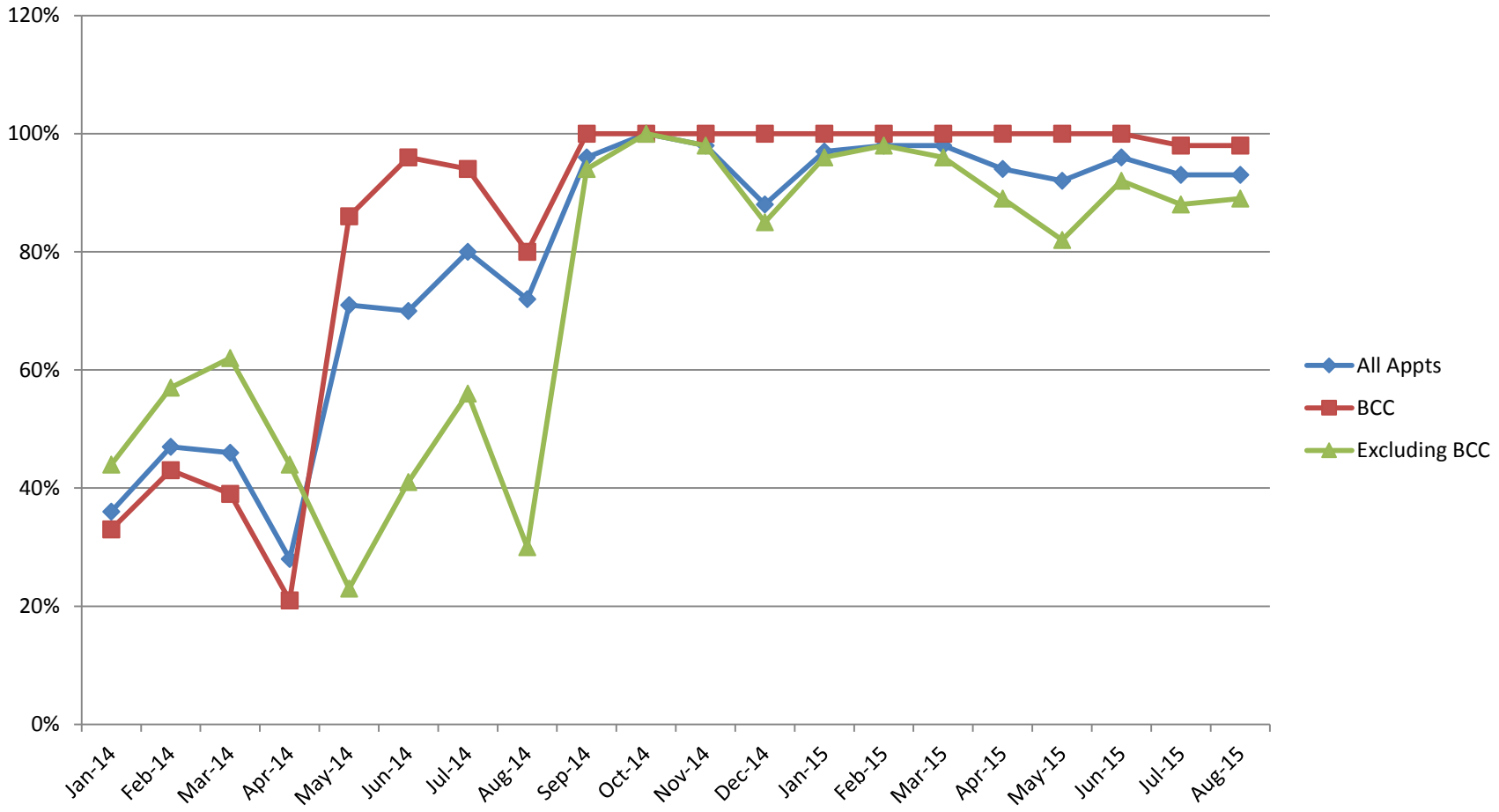
Information Faxed to Provider:

Clinical information faxed to follow-up provider when appointment scheduled by Primary Care Connection

- Numerator: Number of scheduled appointments that have documentation of clinical information being faxed to follow-up provider within 7 days.

- Denominator: All scheduled appointments for Medicaid and Unfunded patients
  - Inclusion criteria: Initial encounter between Primary Care Connection and the patient occurred during the reporting month.

Percentage of Appointments with Clinical Information Faxed to Provider



Current State/Best Practices

- Information faxed via RightFax (electronic fax)
- Information sent when appointment is scheduled
- Documented by staff in a drop down field in documentation template
- Staff is able to select “Provider has access” for those patients scheduled at a Baylor Clinic that is able to access the hospital medical records.
- Process had been integrated in staff workflow/daily process

Barriers

- Providers decline information
- Training new staff
- Integrating other processes, battle of priorities

Where do We go From Here

- EHRs
- Connections and collaborations

Contact Information

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JennifAn@BaylorHealth.edu

Session Objectives

Invite individual reflection and participation

Improve collaboration between projects and organizations

Strengthen relationships & spark partnerships

Share ideas to improve patient engagement

Story Starters

Story starters is a good get-to-know-you icebreaker to help people share interesting stories about themselves, their projects, teams and achievements. This activity works for large and small groups. For very large groups, simply have everyone split into rounds of 8-10 people.

Participants are to complete the following sentences on the cards presented to them:

1. **October begins DY4 reporting, I …..**
2. **My greatest achievement was ….**
3. **One thing I would like to achieve in DY5 is ….**
4. **A best patient story is ….**
5. **The silliest thing I did with my team was….**
6. **If my team were to have a theme song, it would be….**
7. **If my team were to have a mascot, it would be….**
8. **My greatest challenge during my tenure regarding the 1115 Waiver was…**

Take 10 minutes for participants to complete the questions presented and then go around the table and share the results. Answer 1 question at a time going around the table.

Break

10:30-10:45am

LEARNING COLLABORATIVE

RHP 10

Regional Updates

Shelly Corporon, PMP, Director RHP10
Heather Beal, MHA, RHP10 Program Manager

1115 Transformation Waiver Extension & DSRIP Protocols

- Further incentivize transformation and **strengthen healthcare systems** across the state by building on the 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.

1115 Transformation Waiver Renewal Principles

- By September 30, 2015, HHSC must submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend the waiver.
- In September, HHSC plans to request to continue all three components of the waiver for another five years.
- HHSC anticipates a negotiation period with CMS and will plan for a transition period with interim reporting, if necessary.
- Depending on the timeline for negotiations with CMS on waiver extension, propose to continue DY5 QPI in DY6 as a transition year until negotiations are completed.
- All projects from areas included on the 3-year menu may be eligible to continue pending HHSC review of higher risk projects.

»

1115 Transformation Waiver Renewal

» HHSC distributed their initial protocol proposal at the Statewide LC for feedback:

- Metrics for continuing Category 1 & 2 projects
- Extension menu and metrics for Category 1 & 2 replacement projects
- Parameters for combining projects
- Uses for funds not allocated to active projects
- Regional shared bonus pools
- Statewide analysis plan

Waiver Renewal - New Skinny Menu

- 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.
- 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).

Replacement Projects

- There will be fewer metrics to report for achievement, and more standardized metrics.
- QPI milestones will be required each year – 50% of valuation
  - > Request partial achievement of QPI metrics, perhaps with a reduced carryforward window?
- For the other 50% of valuation each year, HHSC is considering two metrics reported via templates.
  - > Reporting on core components, including continuous quality improvement (CQI)
  - > Sustainability planning, including project-level evaluation, health information exchange, and integration with managed care where appropriate
- HHSC is considering changing all QPI metrics to individuals (vs. encounters), though providers will still maintain encounter-level information to support the patient benefit of the project.

- Replacement projects may be submitted for those projects not eligible to continue or withdrawn after June 30, 2014.
- Cross-regional community mental health center projects that are similar may choose to combine into one or more home regions.
- 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.
- The timeline for requesting combining projects is planned to begin in January 2016.

DSRIP Protocols & Replacement Projects

» Assuming most of these providers opt to do replacement projects, HHSC does not anticipate a large amount of leftover DSRIP funds and propose region shared performance bonus pools:

» 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)

Left Over Funds & Regional Performance Bonus Pools

- 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.

Rationale for Switching Cat 3 and Cat 4

- All DSRIP providers will have their Category 3 converted to pay for reporting
- All DSRIP providers will have a portion of their DSRIP valuation converted to their potential earnings from the region's performance bonus pool
  - 5% of DY5 DSRIP funding for smallest providers
  - 10% of DY5 DSRIP funding for larger providers
  - For Category 4 hospitals: The 10% will be taken from these allocated values
- For non-Category 4 participants, the 5% or 10% will be taken proportionately from their Category 1-3 valuation.

Regional Performance Bonus Pools

- State-generated data vs. provider-generated data will be used for the regional shared performance bonus pools.
- There will be some common measures required to be included in the bonus pools for all regions.
- Each region also may select some measures from a list of options for region-specific measures depending on the key community needs and DSRIP areas of focus on in that region.

Regional Performance Bonus Pools

Learning Collaborative Participants

Questions??

LEARNING COLLABORATIVE

RHP 10

Expert Panel: HIE Interoperability

Moderator: Kristin Jenkins, DFWHC President

Panel Members:

Bill Stephens, Tarrant County Public Health

Donna DeBoever, JPS Health System

Debbie Jowers, Texas Health Resources

Tarrant County Public Health

Current Status of PH Meaningful Use Stage 3

- Timing – likely not before late 2016; NPRM underway

Stage 2 Timeline Delayed to 2014

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015											TBD
2016											3
2017											3

HHS had announced in a November 2011 under the "We Can't Wait" announcement, that the Stage 1 has been extended an additional year for providers who attested in 2011 – meaning that these providers will have to attest to Stage 2 in 2014, instead of in 2013.

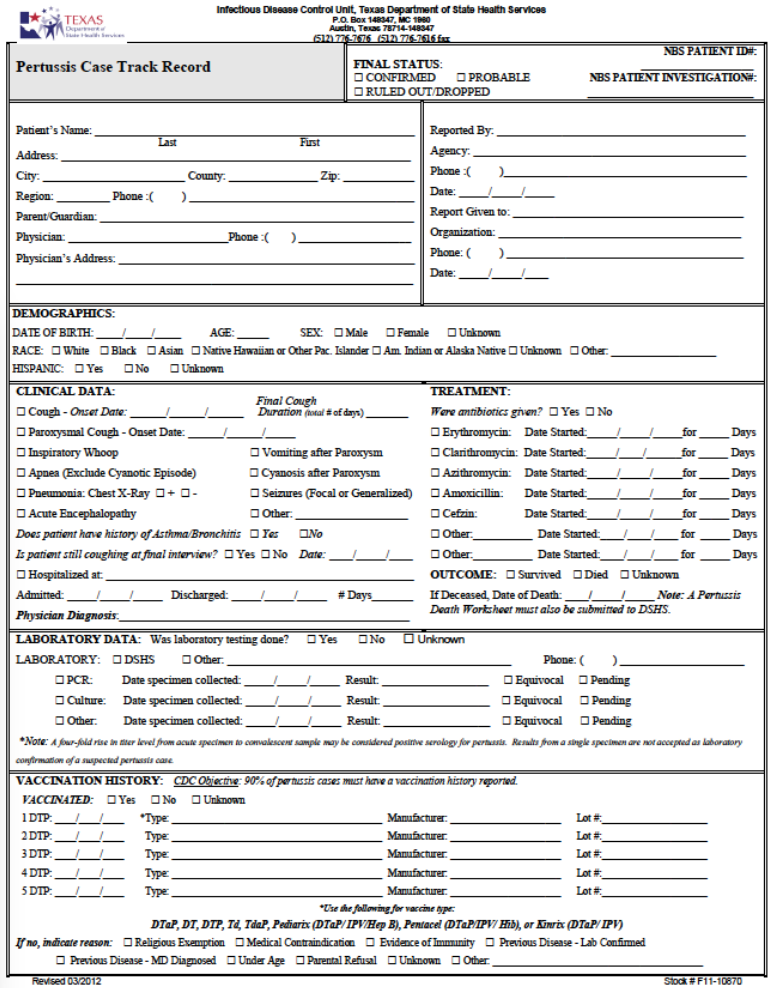
Current Status of PH Meaningful Use Stage 3

- Reportable Conditions Reporting Requirements

Public Health and Clinical Data Registry Reporting	Providers must **attest YES** to three of the following five measures: 1. Immunization Registry Reporting – The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). 2. Syndromic Surveillance Reporting – The EP is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs. 3. Case Reporting – The EP is in active engagement with a public health agency to submit case reporting of reportable conditions. 4. Public Health Registry Reporting – The EP is in active engagement with a public health agency to submit data to public health registries. 5. Clinical Data Registry Reporting – The EP is in active engagement to submit data to a clinical data registry.

Impact of e-Reporting of Reportable Conditions

- Pertussis reporting example
  - Demographics – 16 fields
  - Clinical – 16 fields
  - Treatment – 5 fields
  - Lab tests – 5 fields
  - Immunization – 4 fields
  - **DATA ALREADY PRESENT IN EMRs !**



Infectious Disease Control Unit, Texas Department of State Health Services
P.O. Box 149347, MC 1960
Austin, Texas 78714-149347
(512) 776-7676 (512) 776-7616 fax

Pertussis Case Track Record

NBS PATIENT ID#:

FINAL STATUS: ☐ CONFIRMED ☐ PROBABLE ☐ RULED OUT/DROPPED

NBS PATIENT INVESTIGATION#:

Patient's Name: Last First
Address:
City: County: Zip:
Region: Phone :( )
Parent/Guardian:
Physician: Phone :( )
Physician's Address:

Reported By:
Agency:
Phone :( )
Date: ____/____/____
Report Given to:
Organization:
Phone: ( )
Date: ____/____/____

DEMOGRAPHICS:
DATE OF BIRTH: ____/____/____ AGE: ____ SEX: ☐ Male ☐ Female ☐ Unknown
RACE: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pac. Islander ☐ Am. Indian or Alaska Native ☐ Unknown ☐ Other:
HISPANIC: ☐ Yes ☐ No ☐ Unknown

CLINICAL DATA:
☐ Cough - *Onset Date:* ____/____/____ *Final Cough Duration* (total # of days) ____
☐ Paroxysmal Cough - Onset Date: ____/____/____
☐ Inspiratory Whoop ☐ Vomiting after Paroxysm
☐ Apnea (Exclude Cyanotic Episode) ☐ Cyanosis after Paroxysm
☐ Pneumonia: Chest X-Ray ☐ + ☐ - ☐ Seizures (Focal or Generalized)
☐ Acute Encephalopathy ☐ Other:
Does patient have history of Asthma/Bronchitis ☐ *Yes* ☐*No*
Is patient still coughing at final interview? ☐ Yes ☐ No *Date:* ____/____/____
☐ Hospitalized at:
Admitted: ____/____/____ Discharged: ____/____/____ # Days____
Physician Diagnosis:

TREATMENT:
Were antibiotics given? ☐ Yes ☐ No
☐ Erythromycin: Date Started:____/____/____for ____ Days
☐ Clarithromycin: Date Started:____/____/____for ____ Days
☐ Azithromycin: Date Started:____/____/____for ____ Days
☐ Amoxicillin: Date Started:____/____/____for ____ Days
☐ Cefzin: Date Started:____/____/____for ____ Days
☐ Other:_____ Date Started:____/____/____ for ____ Days
☐ Other:_____ Date Started:____/____/____ for ____ Days
OUTCOME: ☐ Survived ☐ Died ☐ Unknown
If Deceased, Date of Death: ____/____/____ *Note: A Pertussis Death Worksheet must also be submitted to DSHS.*

LABORATORY DATA: Was laboratory testing done? ☐ Yes ☐ No ☐ Unknown
LABORATORY: ☐ DSHS ☐ Other: Phone: ( )
☐ PCR: Date specimen collected: ____/____/____ Result: ☐ Equivocal ☐ Pending
☐ Culture: Date specimen collected: ____/____/____ Result: ☐ Equivocal ☐ Pending
☐ Other: Date specimen collected: ____/____/____ Result: ☐ Equivocal ☐ Pending
**Note: A four-fold rise in titer level from acute specimen to convalescent sample may be considered positive serology for pertussis. Results from a single specimen are not accepted as laboratory confirmation of a suspected pertussis case.*

VACCINATION HISTORY: *CDC Objective: 90% of pertussis cases must have a vaccination history reported.*
VACCINATED: ☐ Yes ☐ No ☐ Unknown
1 DTP: ___/___/___ *Type: Manufacturer: Lot #:
2 DTP: ___/___/___ Type: Manufacturer: Lot #:
3 DTP: ___/___/___ Type: Manufacturer: Lot #:
4 DTP: ___/___/___ Type: Manufacturer: Lot #:
5 DTP: ___/___/___ Type: Manufacturer: Lot #:
**Use the following for vaccine type:*
DTaP, DT, DTP, Td, TdaP, Pediarix (DTaP/ IPV/Hep B), Pentacel (DTaP/IPV/ Hib), or Kinrix (DTaP/ IPV)
If no, indicate reason: ☐ Religious Exemption ☐ Medical Contraindication ☐ Evidence of Immunity ☐ Previous Disease - Lab Confirmed
☐ Previous Disease - MD Diagnosed ☐ Under Age ☐ Parental Refusal ☐ Unknown ☐ Other:

Revised 03/2012 Stock # F11-10870

HIE Activities in Texas to Simplify e-Reporting

- ONC/CDC agency participation – focused on streamlining clinical and public health workflows
- DSRIP HIE project in RHP 10
  - Aggregating clinical data through regional HIE
  - Automatic case detection; confirmed or probable
  - Automatic extraction of clinical data from confirmed/probable cases and reporting to public health within statutory time periods, NOT just ELR results
  - Bidirectional communication in MU stage 3, provider receives full disposition case e-report from local/state public health agency through HIE for final review and report to state health department