Region 10

Regional Healthcare Partnership

Clinical & Quality Committee

June 14, 2012

Table of Contents

June 14, 2012

Contents

Tab 1

Minutes

MEETING OF THE
REGION 10 REGIONAL HEALTHCARE PARTNERSHIP
CLINICAL & QUALITY COMMITTEE
THURSDAY, MAY 24, 2012

Members Present:

Beatty, Coke	Pecan Valley Centers	Erath, Somervell, Hood, Parker, Johnson
Clauson, Todd	Parker County Hospital District	Parker
Floyd, Gary MD	JPS Health Network	Tarrant
Gilmore, Donna	Pecan Valley Centers	Erath, Somervell, Hood, Parker, Johnson
McClammy, Lisa	Glen Rose Medical Center	Somervell
Nati, Carol MD	Tarrant County MHMR	Tarrant
Noble, Tyna	Parker County Hospital District	Parker
Parker, Sandra MD	Tarrant County Public Health	Tarrant
Robins, Scott MD	Health Care Association	Tarrant
Sherman, Lynn	Wise Regional Medical Center	Wise
Stroud, David	Tarrant County MHMR	Tarrant
Wallace, Lindsey	JPS Health Network	Tarrant
Wayland, Larry	Wise Regional Medical Center	Wise
Young, Wayne	JPS Health Network	Tarrant
Carter, Elizabeth MD	JPS Health Network	Tarrant
Rule, Scott	JPS Health Network	Tarrant

Region 10 RHP Team Present:

King, Evan	COPE Health Solutions
Miller, Allen	COPE Health Solutions

I. Welcome and Introductions

Dr. Elizabeth Carter, Sr. VP of Population Health, JPS Health Network, the anchor facility for Region 10 opened the meeting by welcoming all present and thanking them for their attendance. Introduction of those present followed.

II. Overview of Waiver 1115

Allen Miller, Region 10 consultant, provided the committee members a brief overview of the 1115 Waiver. While patterned after the California Waiver, the Texas Waiver includes notable differences, including the use of Regional Healthcare Partnerships across multiple counties with a single anchor facility to coordinate development and submission of a proposal to HHSC for performing providers, both public and private.

The Waiver is not a "Block Grant" and will only “pay for performance” once the benchmarks and metrics are met. Performing providers will not be able to draw down DSRIP funds for

projects that are not able to show measurable data and/or metrics so it is important to focus on projects that are achievable and for which meaningful data can be provided.

DSRIP projects should provide value to the community, correlate with the Community Needs Assessment, and be Best Practice or Evidence Based when possible. DSRIP projects should also be achievable, measurable, and sustainable while providing new or additional/expanded services to the community. These should be new projects/programs or the expansion of services, access or improved quality of existing programs. Best practices and planning resources can be found at the "Partnership for Patients" website:

Category 1 and 2 DSRIP projects should provide the groundwork and should generally relate to projects in Categories 3 and 4. Projects can be completed by one entity, jointly (multi-provider) or regionally (across multiple counties/region).

It is still being determined at the state level what the DSRIP project requirements (number of projects and category) will be for each County/Provider.

III. Review: RHP Charter

Draft Charter of the RHP Planning Committee was reviewed. The Purpose of the Committee will be to ensure that appropriate clinical and quality metrics and outcomes are considered in (i) the selection of Delivery System Reform Incentive Payment (DSRIP) projects, and (ii) the measurement and reporting for the DSRIP projects consistent with the requirements of the 1115 Waiver Standard Terms & Conditions and the needs of the respective communities of Region 10.

The committee will work in conjunction with the other RHP committees to provide guidance, oversight and implementation of the DSRIP plan and ensure that projects meet all applicable protocols in addition to the fulfilling the requirements of the Waiver Standard Terms and Conditions.

IV. Region 10 Planning and Timelines

- August 17, 2012 – Completion of Region 10 plan for public comment
- August 31, 2012 - Submission of Region 10 plan to HHSC

V. Report Out and Discussion

General Stakeholder Survey: In order to have sufficient feedback, the goal is to receive at least 15 general stakeholder survey responses per county. The deadline for responses has been extended to June 1, 2012.

DSRIP Worksheets will be provided to allow performing providers and County Judges to begin discussing and planning for DSRIP projects. Completed Worksheets should be returned to rhp@jpshealth.org no later than June 8, 2012. Once the Regional Plan has been made available and submitted to HHSC the final Plan will be sent to CMS for review. CMS will provide feedback and recommendations to the Regions on their plans by December 12, 2012

and Committee members should anticipate that finalized plans will be due to CMS by January 15, 2013.

COPE team members will be available for support and committee members are encouraged to contact them with any potential questions or concerns.

VI. Meeting Dates

The Clinical & Quality Committee will meet on the 2nd and 4th Thursday of each month from 9:00am – 10:30am at the Riley Center. Members are welcome to attend the RHP Region 10 DSRIP and Planning Committee which meets directly following the Clinical & Quality Committee.

VII. Action Items & Follow-up

a. Share ACO Quality Metrics
b. Share DSRIP Category 3 & 4
c. Share Los Angeles County and Alameda County DSRIP proposal from California
d. Share Example DSRIP menu project
e. Develop and disseminate Population Health Metrics Survey
f. Share Partnership for Patients resource (website) - http://www.healthcare.gov/compare/partnership-for-patients/
g. Members to review and provide feedback regarding draft charter within two weeks (by June 7, 2012); charter will be adopted at next committee meeting on June 14, 2012
h. Members to work with respective organization to complete and return DSRIP planning worksheets by June 8, 2012
i. Webinar regarding DSRIP planning tools will be scheduled for week of May 28, 2012
j. Members to complete general stakeholder survey

Tab 2

Charter

Charter
Adopted by RHP Clinical & Quality Committee on [Date]

I. Overview

The primary goal of the Clinical & Quality Committee is to ensure that appropriate clinical and quality metrics and outcomes are considered in (i) the selection of Delivery System Reform Incentive Payment (DSRIP) projects, and (ii) the measurement and reporting for the DSRIP projects consistent with the requirements of the 1115 Waiver Standard Terms & Conditions and the needs of the respective communities of Region 10.

II. Purpose

A. List of objectives and major activities of the committee - The Clinical & Quality Committee's core focus will be to select and apply appropriate clinical and quality outcomes and metrics related to the Region 10 plan as required by the terms of the Waiver. This will require focus in, but may not be limited to, the following areas:
   1. Input to HHSC on DSRIP project menu
   2. DSRIP project clinical and quality evaluation – Develop methodologies, guiding principles and protocols for evaluating DSRIP projects to (i) ensure prompt acceptance by HHSC and CMS, (ii) enable reporting and measurement, and (iii) improve access, quality and outcomes to the betterment of the region. This will require education and coordination with participating members, other Region 10 committees, HHSC and CMS.
   3. Analysis of proposed outcomes and metrics associated with proposed DSRIP projects

B. Overview of deliverables, milestones and deadlines (timeline) – The deliverables for the Clinical & Quality Committee for Region 10 include:
   1. Comments to HHSC on DSRIP menu
   2. Coordinate with other RHP committees to complete the Region 10 plan
   3. Completion of position papers and other policies necessary for promoting Region 10 requirements and for guiding member participation (as needed)

III. Membership

A. Membership Qualification – Each provider organization that participates in Region 10, as memorialized by an executed affiliation agreement, may participate in the committee's meetings and agendas. Meetings will be open to the public.

B. List of committee members, titles and organizational affiliation – The committee shall consist of:
   1. List of members to be finalized after HHSC makes final determination of Region 10 counties and map.

C. Chair – Name, title and organizational affiliation – Elizabeth Carter, MD, Senior Vice President – Population Health of the anchor organization will chair meetings. The committee shall determine a back-up co-chair.

D. Voting & decision-making process – Each participating organization will be required to designate one voting member for matters that require a vote for approval. Decision-making will be by majority vote when required.

IV. Roles and Responsibilities

A. The RHP Clinical & Quality Committee is charged with the following responsibilities during the initial RHP plan development and the four year performance period:

1. Community Health Needs Assessments: Inform development of community and provider readiness assessments.
2. DSRIP projects: Support Planning committee in development and selection of appropriate DSRIP projects that reflect local and regional provider vision and address healthcare delivery system gaps; including development of milestones, metrics and clinical outcome measures.
3. DSRIP project valuation – With Planning and Finance committees, develop methodologies and protocols for assigning values to DSRIP projects; including education and coordination with participating providers, HHSC and CMS.
4. Coordinate with Planning Committee to develop RHP processes, protocols and standards for data collection, reporting, performance management (post implementation).
5. Discuss and disseminate new developments and updates from HHSC.

V. Meetings

A. Meeting Schedule
   1. 2nd & 4th Thursday of each month
   2. Time: 9:00am-10:30am
   3. Location: The Riley Center - Southwestern Baptist Theological Seminary, Conference RC - 237

B. Meeting Agenda
   1. Outline of agenda template and content - The attached agenda format will be used.

   2. Process for developing, approving agenda with Chair and timeline for dissemination with committee members – Agenda items for each meeting will be developed in each preceding meeting. Requests for additional agenda items may be made and can be made by a participating member one week prior to a regularly scheduled meeting.

   3. Process for developing, approving and disseminating materials to committee members – Agenda's and materials will be distributed by e-mail on the Monday before each meeting.

Tab 3

Powerpoint

REGION 10
RHP CLINICAL & QUALITY COMMITTEE

June 14, 2012

Introductions

- Facilitators
- Members of Clinical & Quality Committee

Today's Agenda

- Review and approve minutes from May 24th
- Review and ratify committee charter
- Community health needs assessment
- DSRIP Projects
  - Partner comparisons
  - Summary of regional DSRIP project ideas
  - How to develop DSRIP projects - Tool
- Agenda for next meeting
- Q&A

MINUTES AND CHARTER

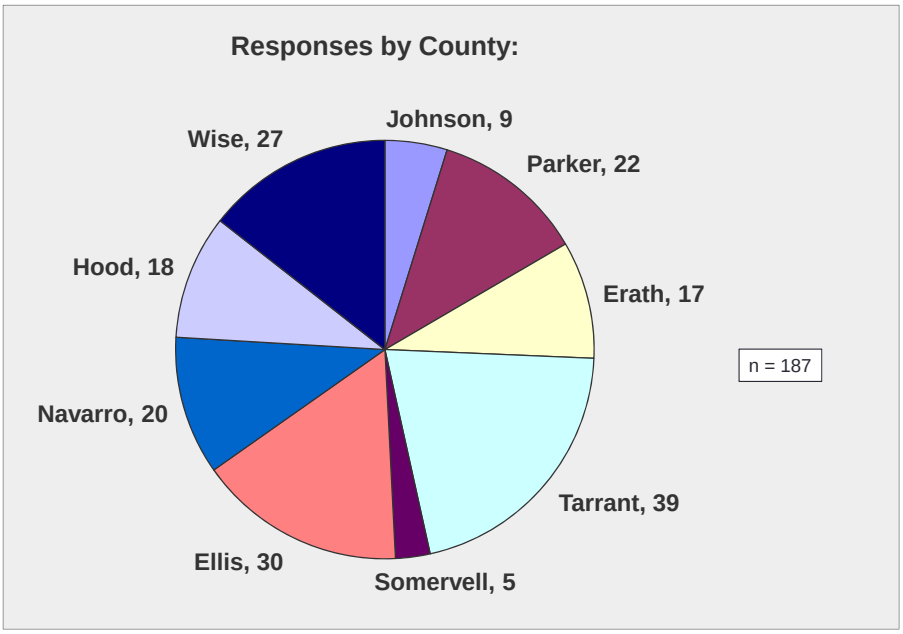
Refer to Handout

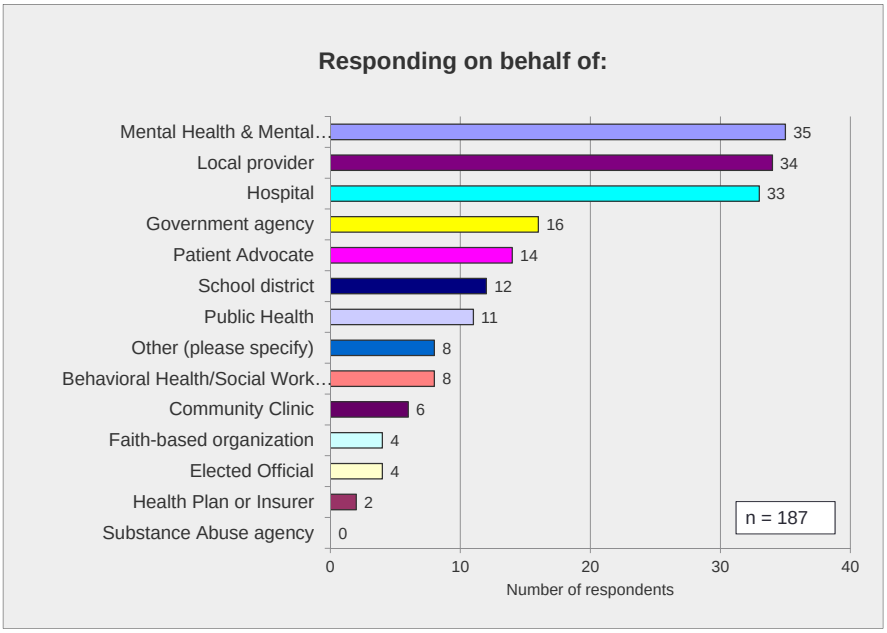
COMMUNITY HEALTH NEEDS ASSESSMENT

Stakeholder Survey – Key Findings

Stakeholder Survey Results

- Regional summary completed (provided via email)
- County summaries with regional comparisons will be distributed this week





Access to Care: Key Takeaways

- The top three barriers for access to all types of care:
  - Lack of coverage/financial hardship (#1 for all types)
  - Difficulty navigating the system/lack of awareness of available resources
  - Lack of capacity (e.g. insufficient number of providers, extended wait times, etc.)

Access to Care: Key Takeaways

- For routine care (hospital, primary/preventive and specialty care), the majority of respondents rated them as “difficult” to access
- For Mental/behavioral health care the majority of respondents rated it as “very difficult” to access
- Emergency care was rated by most respondents as “easy” to access

Care Coordination: Key Takeaways

- In general, respondents did not feel that there was effective care coordination among providers.
- Respondents also agreed that there was a lack of coordination with mental health providers.
- However, respondents agreed that care coordination for chronically-ill patients between primary and specialty care providers was somewhat effective.

Community Health: Key Takeaways

- The top health conditions affecting Region 10 patients were diabetes, obesity, hypertension, COPD and congestive heart failure.
- Patients mostly get their health education from friends, family, the internet and their doctor.
- Behavioral health and substance abuse were the top two issues impacting patient health.

PERFORMING PROVIDER READINESS ASSESSMENT

Performing Provider Readiness Assessment

- *Basic Services, Capacity and Capabilities* – Assessment of core services provided and basic provider organization, key gaps in relation to demand for services, market demand or changing health care environment.
- *Integrated Care Delivery* – The level of "system-ness" and coordination maintained by an organization both internally and with other providers (e.g., information sharing, care coordination, data collection and reporting across providers/network).
- *Population Health Management* – [Health care delivery and/or] interventions designed to maintain and improve people's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.

REGIONAL & MULTI-PROVIDER DSRIP PROJECT IDEAS

Refer to Handouts

HOW TO DEVELOP DSRIP PROJECTS

Overview

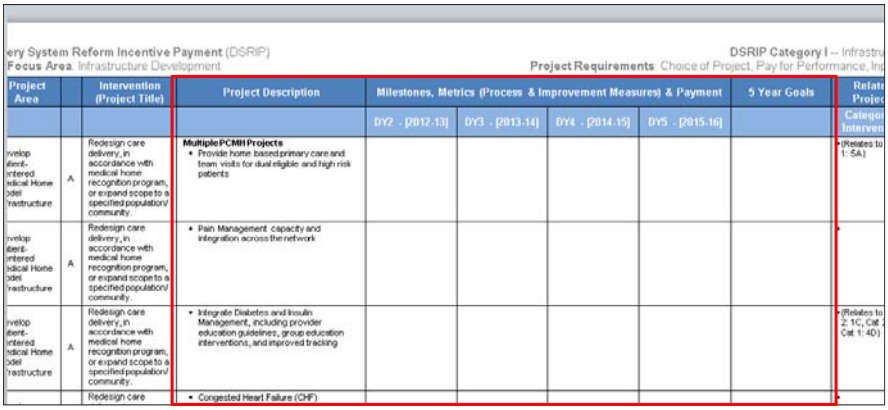
- Project champions are responsible for developing and fleshing out potential DSRIP projects.
- DSRIP projects should be feasible, but also work toward improving the current health care infrastructure.
- All DSRIP projects must have an impact, specific metrics, volume and outcome measures while also balancing the resources needed for each intervention.

HHSC definitions

Delivery System Reform Incentive Payment (DSRIP)
Pool Focus Area: Infrastructure Development

	Project Area		Intervention (Project Title)	Project Description	Milestones, Metrics (Process &	
					DY2 - [2012-13]	DY3 - [2013-1
7	Develop Patient-Centered Medical Home Model Infrastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/ community.	**Multiple PCMH Projects** • Provide home based primary care and team visits for dual eligible and high risk patients		
7	Develop Patient-Centered Medical Home Model Infrastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/ community.	• Pain Management capacity and integration across the network		
	Develop Patient-		Redesign care delivery, in accordance with	• Integrate Diabetes and Insulin Management, including provider education guidelines, group education		

Project Development

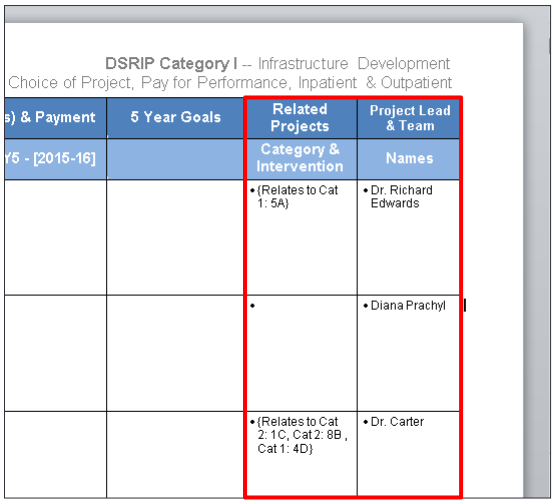


ery System Reform Incentive Payment (DSRIP)
Focus Area: Infrastructure Development

DSRIP Category I -- Infrastru
Project Requirements: Choice of Project, Pay for Performance, Inp

Project Area		Intervention (Project Title)	Project Description	Milestones, Metrics (Process & Improvement Measures) & Payment				5 Year Goals	Relate Projec
				DY2 - [2012-13]	DY3 - [2013-14]	DY4 - [2014-15]	DY5 - [2015-16]		Categor Interven
ivelop dient-intered dical Home odel frastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/ community	**Multiple PCMH Projects** • Provide home based primary care and team visits for dual eligible and high risk patients						• (Relates to 1: 5A)
ivelop dient-intered dical Home odel frastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/ community	• Pain Management capacity and integration across the network						•
ivelop dient-intered dical Home odel frastructure	A	Redesign care delivery, in accordance with medical home recognition program, or expand scope to a specified population/ community	• Integrate Diabetes and Insulin Management, including provider education guidelines, group education interventions, and improved tracking						• (Relates to 2: 1C, Cat 2 Cat 1: 4D)
		Redesign care	• Congested Heart Failure (CHF)						•

Resources



DSRIP Category I -- Infrastructure Development
Choice of Project, Pay for Performance, Inpatient & Outpatient

s) & Payment	5 Year Goals	Related Projects	Project Lead & Team
Y5 - [2015-16]		Category & Intervention	Names
		• (Relates to Cat 1: 5A)	• Dr. Richard Edwards
		•	• Diana Prachyl
		• (Relates to Cat 2: 1C, Cat 2: 8B , Cat 1: 4D)	• Dr. Carter

DEVELOPING DSRIP PROJECTS

Key players

- Consider the other key leaders, staff and physicians and/or any external partner(s) who will need to be involved to ensure success.

Example: Project area is "Expand primary care access," Category 1, Project area 2.

Key leaders include Dr. X, primary care staff and patient advocates for primary care.

Project description

- Provide a basic description of the project activities, including clarification as to whether planning, implementation of a new service(s), and/or expansion of existing services will be involved.

Example: Expand primary care access

Project description: Coordinate with non-hospital Clinics to expand Primary Care Access, assist them in becoming PCMH and coordinate care across continuum.

Factors of success

- Consider the key factors for success with the project. Examples include:
  - Hiring a new leader with expertise in "X,"
  - Gaining buy-in from private physicians,
  - Garnering support of "X" community organizations,
  - Garnering support and engagement from health plan, etc.

Example: Expand primary care access

Factors of success include developing working relationships with non-hospital clinics to move toward PCMH and sufficient enrollment of patients who would use PCMH.

Roles

- Understand the key roles of organizational and partner resources for the project, including:
  - Role of Administrative/Analytical Staff.
  - Role of clinicians and allied professionals.
  - Role of Partner resources.

Example: Expand primary care access

Key roles of staff include:
-Developing strategy to implement PMCH
-Identifying patients to enroll in PMCH
-Maintenance

Existing resources

- Estimate how many existing staff and physicians will be assigned, either in current or new roles.
- How many new people for each role will need to be hired?
- What other resources are needed to support staff?

Example: Expand primary care access

Will need:
-X number of physicians
-X number of administrators
-X additional facilities

Impact

- Identify the expected impacts of the project on patients (satisfaction, health outcomes, quality of life/ADLs), staff, clinicians or cost.

Example: Expand primary care access

Impact includes improved health outcomes, improved care navigation, savings from preventive care, etc.

Metrics

- What metrics would you use to measure the impacts?
- How is that metric defined?
- Define the evidence base for the metric

See examples in DSRIP tables provided

Example: Expand primary care access at three clinic sites in southeastern region

HHSC will provide further guidance on how to develop detailed metrics for each intervention.

Data

- Are you able to identify a source for baseline data?
  - If so, what and where is the source?
  - If not, is this data being collected at all now, or is there a plan to collect the data soon?
- How will the data be collected and reported?
  - If electronic, through what source (software, database, etc.) will the data be collected from?
  - If not electronic, through what source and process, and by whom?

Example: Expand primary care access

Measurable data is number of primary care visits per demonstration year and length of time to third available routine appointment.

Data will be collected from PCMHs.

NEXT STEPS

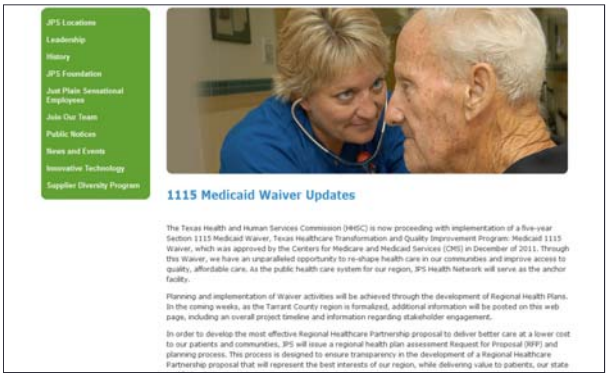
Next Agenda & Meeting Schedule

- Homework to complete:
  - Performing Provider Readiness Assessment
  - Regional DSRIP voting assignment
- Draft Agenda for Next Meeting (June 28th)
  - Review Regional DSRIP voting summary
  - Review PPRA Summary
- Meeting Schedule
  - 2nd & 4th Thursday of each month
  - Time: 9:00am-10:30am
  - Location: The Riley Center - Southwestern Baptist Theological Seminary, Conference RC - 237

QUESTIONS

Contact information

- **Email:** rhp@jpshealth.org
- **Website:** http://www.jpshealthnet.org/rhp.aspx



Tab 4

Regional Stakeholder Survey Summary

The Region 10 RHP Stakeholder Survey is intended to collect qualitative data and feedback in the following three areas of focus: access to care, care coordination and community health. Surveys were collected over a period of one month via a web-based survey tool. A total of 191 responses were received in this timeframe.

Area of Focus One: Access to Care

The majority of survey respondents felt that routine hospital services, routine primary/preventive care and routine specialty care were "difficult" to access. Mental/behavioral health care services were the most difficult for low-income patients to access, while emergency services were least difficult to access.

All types of care had the same identified top barriers to access:

- Lack of coverage/financial hardship (Consistently the number one barrier)
- Difficulty navigating system/lack of awareness of available resources
- Lack of provider capacity

Area of Focus Two: Care Coordination

The majority of the respondents said they **did not believe that** low-income patients could:

- Choose and establish a relationship with a primary care provider
- Access private primary care providers
- Access community health centers, free clinics or public clinics
- Access behavioral/mental health providers

The top barriers to effective care coordination (between providers and systems) were the complexity of coordination, lack of staff, lack of financial integration, fragmented service systems and practice norms that allow providers to work in silos.

Area of Focus Three: Community Health

The top five conditions rated as most prevalent in Region 10 were diabetes, obesity, hypertension, heart failure and chronic obstructive pulmonary disease (COPD), in decreasing order. On the other hand, the top five conditions rated as contributing most to preventable hospitalizations were hypertension, uncontrolled diabetes, COPD, congestive heart failure and diabetes short-term complications in decreasing order.

Respondents felt that behavioral health, substance abuse and insufficient access to care were the top issues affecting population health. In addition, they listed friends and family, the internet and their doctor as the main places where patients were getting health education.

Key Takeaways

Respondents overwhelmingly listed a lack of coverage/financial hardship as a barrier to care for low-income patients. Write-in comments in the survey indicated an overuse of the emergency department services and an inability for patients to access primary/preventive care (due to difficulty navigating the system and a lack of capacity, according to responses). In general, respondents did not feel that there was strong care coordination between primary care providers, hospitals and specialists.

Tab 5

Regional DSRIP Project Ideas

Tab 6

Multi-Provider DSRIP Project Ideas