LEARNING COLLABORATIVE

RHP 10

Clinical Quality Committee

November 5, 2014
9:00am to 11:00

The Women's Center of Tarrant County
1723 Hemphill, Fort Worth, Texas, 76110

Agenda

9:00 – 9:10	Registration Welcome	*A. Augustus*
9:10 – 9:20	Review of Clinical Quality Committee Charter and Learning Collaborative Goals & Aims	*E. Carter, M.D.*
9:20 – 9:40	Learning Collaborative DY 3 Re-Cap o Webinars and September Learning Session o Feedback	*A. Augustus*
9:40 – 10:00	DY 4 Region 10 – Proposed Topics Care Transitions and Behavioral Health	*W. Young*
10:00 – 10:15	Measurement Update	*V. Do*
10:15 – 10:35	Next Steps • December 5, 2014 Webinar (tentative date) o Region 10 Clinical Quality Committee Update Proposed DY4 Learning Collaborative Activities • January 22, 2015 Learning Session Proposed Agenda	*A. Augustus*
10:35 – 11:00	Questions Meeting Adjourned	

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RHP 10

Clinical Quality Committee

Learning Collaborative Plan Priorities & Focus

Did we realize the goals and objectives established in the learning collaborative plan of 2013?

Clinical Quality Committee Role, Activities and Alignment

Have we met the elements captured in the Charter? Are the elements relevant for DY 4 & 5?

Region 10 Clinical Quality Committee Charter and Learning Collaborative Plan Elements	Yes - No	Comments - Suggestions
Have we provided support to the project owners in meeting their quality standards?		
Have the feedback systems, e.g. measurements been helpful?		
Have there been any recommendations made for utilizing and effectively structuring specialty care, hospital-based, and ancillary service delivery?		
Have we identified and strengthened efforts for the providers to work with advocacy groups and organizations?		
Have we been effective in creating a forum for evaluation of technology to support care coordination and improving outcomes?		
Has the Committee ensured that the collaboratives were aligned with Category 3 DSRIP project goals?		
Did the Committee have a role in improving and/achieving achieve measurable improvement in patient care and clinical operations?		
Has the Committee played a role in developing strategies for engaging senior leadership at provider organizations to support key changes and to regularly monitor the collaborative team's performance?		

Learning Collaborative Plan

Goals

Have we been able to achieve the goals and aims defined for each of the Learning Collaborative tracks?

Learning Collaborative Plan

Goals

Behavioral Health

- Expand Behavioral Health Care Access;
- Integrate Primary & Behavioral Health Care collaborative;
- Provide timely behavioral health care that is integrated with physical health care;
- Identify best practices for better integration of a broader health care continuum by expanding and integrating primary care & behavioral health, sharing information, in addition to collective learning to accelerate improved care and better outcomes.

Learning Collaborative Plan

Goals

Care Transitions and Patient Navigation

- Patients receive effective hospital discharge and primary care follow-up, particularly for those at risk of adverse post-hospital outcomes.

- Expand access to primary care, transform existing care approaches into a patient-centered medical home model of care;

- Implement care transitions or patient navigation programs that provide more proactive and tailored care to patients.

- Provide better care coordination across health care settings and ensuring improved chronic care management for specific disease populations.

Learning Collaborative Aims

Behavioral Health

Learning Collaborative Plan ***Page 2-3***

1. Sharing evidence-based ideas of an integration (or co-location) model based on care improvement programs that are patient-centered such as the Four Quadrant Model for Clinical Integration and the IMPACT Model to provide integrated care for mental and medical needs;

2. Improved processes and workflows, as well as established principles of chronic illness care and collaborative care teams to ensure that professionals with complementary skills work in collaboration to care for a population of patients with mental disorders such as anxiety and depression;

3. Adapt cross-screening practices such as behavioral health screening in primary care settings, e.g. use of the Patient Health Questionnaire (PHQ-9, PHQ-2) and the depression subscale of the Hospital Anxiety and Depression Scale (HADS-D) to screen for depression (i.e. in diabetic patients);

Learning Collaborative Aims

Behavioral Health (continuation)

***Learning Collaborative Plan* Page 3**

4. Based on the ideas of shared models and different approaches used in practice, screening for co-occurring disorders in primary care settings may be applicable in addressing behavioral health issues early, with the potential for improved health outcomes;

5. Improved care coordination by integrated or co-located care team(s);

6. Improved provider-patient communication while integrating patient-centered concepts into a standard of care, as measured through patient feedback tools and measures of shared decision making (SDM); and

7. Improved patient self-management, as evidenced by increased numbers of patients with documented and achieved goals for behavioral and physical health.

Learning Collaborative Aims – Care Transitions & Patient Navigation

Learning Collaborative Plan – Page-3

1. Selection and adoption of support efforts in care improvement models for improving care transitions and patient navigation of care such as Project RED (Re-Engineered Discharge);

2. Improved processes and workflows to make sure patients are receiving right care right setting right time;

3. Reliable and successful hospital-to-primary care transitions;

4. Improved provider-to-provider communication, as measured through patient feedback tools and measures of shared decision-making;

5. Improved self-management of admitting illness(es) by patients and families;

6. Testing and adoption of case management model for higher-risk patients;

7. Reduced readmissions for target patient populations; and

8. Improved outcomes for target patient populations.

LEARNING COLLABORATIVE

RHP 10

DY 3
Learning Collaborative Activities and Topics

Learning Collaborative DY3 Review

Behavioral Health Topics – January – September 2014
Two Region 10 Providers in Addition to Outside Speakers

- The Case for Integrated Behavioral Health and Primary Care (JPS)
- Motivational Interviewing (S. Walters, Ph.D.)
- Defining and Measuring Integration (Dr. Miller)
- Operationalizing Integration (Dr. Miller)
- Role of Integrated Care – Making a Collective Impact (Dr. Miller)
- Site Visit – Integrating BH and PC – JPS Experience (JPS)
- Risk Stratification (JPS)
- Site Visit – Behavioral Health and Primary Care (MHMR)
- Learning Session 2 – Need Topics

Learning Collaborative DY3 Review

Care Transition and Navigation Topics - January – September 2014
Five Region 10 Providers in Addition to Outside Speakers

- Using The Patient's Voice To Guide Our Work (Panel Patients & JPS)
- Motivational Interviewing (S. Walters, Ph.D.)
- Community Based Primary Care For the Elderly (UNTHSC)
- Self Determination in Healthcare Services (MHMR-IDD)
- Healthy Lifestyles Program (THR)
- Primary Care Connection (Baylor)
- Closing the Gap-Personalized Care Transitions(JPS)
- Evolution of Population Management At JPS (JPS)
- Risk Stratification (JPS)
- The Discharge Alternative – A "STEP" in The Right Direction (UNTHSC)
- Learning Session 2 – Need Topics

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Learning Session Two Feedback and Topics

Learning Collaborative

Categorized Topics & Resources Recommended for Care Transitions and Behavioral Health Integration

RHP10 Learning Collaboratives LS2 Care Transitions morning session and CT-BH afternoon panel Sept 24, 2014

1. **<u>Community partnerships for better health for patients</u>**
    - Reach out to Faith Based Community to support patient
    - Geriatric volunteers
    - Meals on Wheels
    - Consider Caregiver as important part of care team, patient supports
    - Community factors contributing to wellness: Transportation, walking paths, caring neighbors
    - Invite Community Resource Partners participate in Learning sessions
    - Community Awareness of the need associated with improving care transitions and of the efforts currently being made by the health system
    - Resource: Caregiver.org

2. **<u>Patient engagement and patient-centeredness</u>**
    - Health is foundation for Achievement
    - Recovery Plan not discharge plan (language matters)
    - Health Literacy needs cross all socio-economic categories
    - Focus Group composed of LTC Residents
    - Respect patient choice
    - Hope is crucial
    - (Health care providers need to) Change culture

Learning Collaborative

Categorized Topics & Resources Recommended for Care Transitions and Behavioral Health Integration

3. **Shared opportunities for improvement, for both inpatient providers and community providers**
    - Know your population →Design team to fit needs; Best Staffing Models: No one fits all
    - "Screen & Intervene," e.g. for older adults: Mild Cognitive Impairment, Geriatric Depression Screen
    - Interdisciplinary Review: Readmits
    - Resource: Project Red (used in LC Change Package and referenced in 2013-14 Prework Packet)
    - Resource: National Transitions of Care Coalition at www.ntocc.org
    - Attach screening protocols to workflows: What do you do when?
    - Workflows needed for roles between staff team members, between inpatient and community providers
    - Clinical Nurse Leader to coordinate care
    - Recommended reading, The Checklist Manifesto
    - BH integration important to achieve CT goals
    - Medication management; Pharmaceuticals/Poly Pharmacy
    - Advanced Nursing Care
    - Providers need sophisticated differential diagnosis in older adults, e.g. Delirium vs Dementia
    - Separate strategies for CT for different populations, e.g. for younger populations (20-40 yrs.): Literacy simplification, care plans use social media

4. **Choosingwisely.org encourage** joint decision-making between providers and patients for 15 specific tests and procedures(Appropriateness of resource utilization)

5. **Palliative care services**: Respect for end of life; Use prediction models for remaining years of life

Learning Collaborative

Categorized Topics & Resources Recommended for Care Transitions and Behavioral Health Integration

6. **Technology** - Alternative visit types in community, using technology: Video visits, Phone visits, Home visits, Use of Avatars in online self-management

7. **Primary care and community providers' role, opportunities for improvement**
   - FY15 Focus on Primary Health Care
   - PCP Accountability
   - Medical Home
   - Expanded Care Transitions team and responsibility to include post-acute care
   - Community PCPs need to improve access to team, PCP visits: "ED is always there"

8. **Payment and overall delivery system supports for CT and BHI improvement**
   - Bundled Payments drive → Health Care
   - There is/are billing code/s for care transitions
   - Innovative sources of payment are important
   - Policy/payment goals use Triple Aim: Better Health of Population, Better Patient Experience, Cost Control
   - "Collaboratory" concept: LC is meant to be a place to experiment with new ways of providing care and measure effectiveness of care
   - Focus on measures for post-acute care


Phone
Hospital
FY15
Wisely
Resource
Dementia
Avatar
Manifesto
populations
Staffing
Leader
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years
Choose
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socio-economic
Neighbors
neighbors
reading
simplification
Technology
NTOC.org
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Reach
coordinate
integration
Achievement
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Primary
Pharmacy
Models
Medical
transition
Cost
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Consider
Video
Know
Clinical
Recommended
Readmits
Bundled
Based
Codes
Checklist
Transition
Depression
vs
Prediction
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Advanced
Geriatric
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Younger
Cognitive
Literacy
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care
Transportation
Accountability
management
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Caregiver.org
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Access
Screen
Faith
BH
crosses
leads
Group
Wheels
Care
post-acute
Plan
Project
Remaining
participate
drive
Paper
one
Focus
Awareness
patient
Nursing
support
Impairment
PCP
Workflow
Learning
Mild
plan
Acute
Measures
Management
ED
factors
fit
Reducing
team
Design
Respecting
Palliative
Pharmaceuticals/Poly
Nurse
Delirium
Respect
Strategies
discharge
Collaboratory
health
volunteers
sources
Community
Home
Visits
outcomes
Walking
change
Hope
fits
contributing
Best
Sobering
choice
Red
innovative
Payments
Partners
Better
life
TOC
condition
Change
Residents
Med
Billing
Health
always
Center
Intervene
Meals
wellness
Caregiver
Improving
media
20-40
social
poor
LTC


poor
Video
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FY15
Plan
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Workflow
Caregiver.org
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Neighbors
Delirium
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Dementia
Payments
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Respect
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Medical
Technology
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Reducing
Staffing
Walking
Accountability
Faith
Codes
Nurse
Transportation
Respecting
discharge
Nursing
Awareness
Pharmacy
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Models
Acute
Project
PCP
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team
wellness
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Hope
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Clinical
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Avatar
Manifesto
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SOBERING
LIFE
LEADS
LEARNING
MEALS
POST-ACUTE
SIMPLIFICATION
PLAN
ED
REACH
PATIENT
MED
FACTORS
POOR
HEALTH
MANAGEMENT
MEDICAL
VISITS
KNOW
SESSIONS
CONDITION
COORDINATE
PROJECT
DELIRIUM
READMITS
WELLNESS
DEMENTIA
BILLING
PAYMENT
AWARENESS
NEEDS
CULTURE
COLLABORATORY
WORKFLOW
NEIGHBORS
FITS
HOPE
CHECKLIST
ACUTE
COGNITIVE
MEASURES
PAPER
TRANSITION
DRIVE
SUPPORT
READING
NTOC.ORG
RESPECT
WALKING
PHARMACEUTICALS/POLY
GROUP
INCLUDE
ALWAYS
ONE
STAFFING
MANIFESTO
CROSSES
MILD
PATHS
CAREGIVER
CONTRIBUTING
BETTER
YOUNGER
SOCIAL
WISELY
CODES
PRIMARY
REDUCING
PAYMENTS
VIDEO
LEADER
FOUNDATION
PREDICTION
NURSING
TOC
VOLUNTEERS
SOURCES
BEST
STRATEGIES
DESIGN
IMPAIRMENT
POPULATIONS
CHOOSE
RESIDENTS
TECHNOLOGY
IMPROVING
PALLIATIVE
AVATAR
ADVANCED
HOME
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FY15
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20-40
CHANGE
SESSIONS
VIDEO
BETTER
HEALTH

Learning Collaborative

Care Transition DY4 Topics

Learning Session Two

- Community and Organization Partnerships
- Patient Centeredness and Engagement – Health Literacy for Select Conditions
- Inpatient and Outpatient Workflows and Partnerships
- Palliative care
- Choosing Wisely – Joint Decision Making (15 tests)
- Primary Care & Community Provider Roles (PCMH)
- Payment & Delivery System Support for CT & BHI
- Behavioral Health Care To Reduce Readmissions

Learning Collaborative
Behavioral Health DY4 Topics

Dr. Miller has agreed to continue to serve as a faculty member for the Behavioral Health Learning Collaborative. This will ensure continuity and the opportunity to further develop concepts introduced. We are currently creating a detailed learning agenda for both the face-to-face sessions with Dr. Miller and other faculty. Additionally, we have invited additional providers to participate in this planning process.

As requested by members in Learning Session 2, DY4 learning is expected to focus heavily on operational themes that will include:

- Standardized work flows
    - From screening to intervention to resolution
- Integrated team member roles
- Required workforce competencies

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RHP 10

Clinical Quality Committee

Measurement Updates

Measures Update

- Care Transition – Outpatient
  - Measures run chart title correction
  - Lagging data for some teams; therefore reporting up to August only
- Progress of the overall LC measures
  - Run chart updates

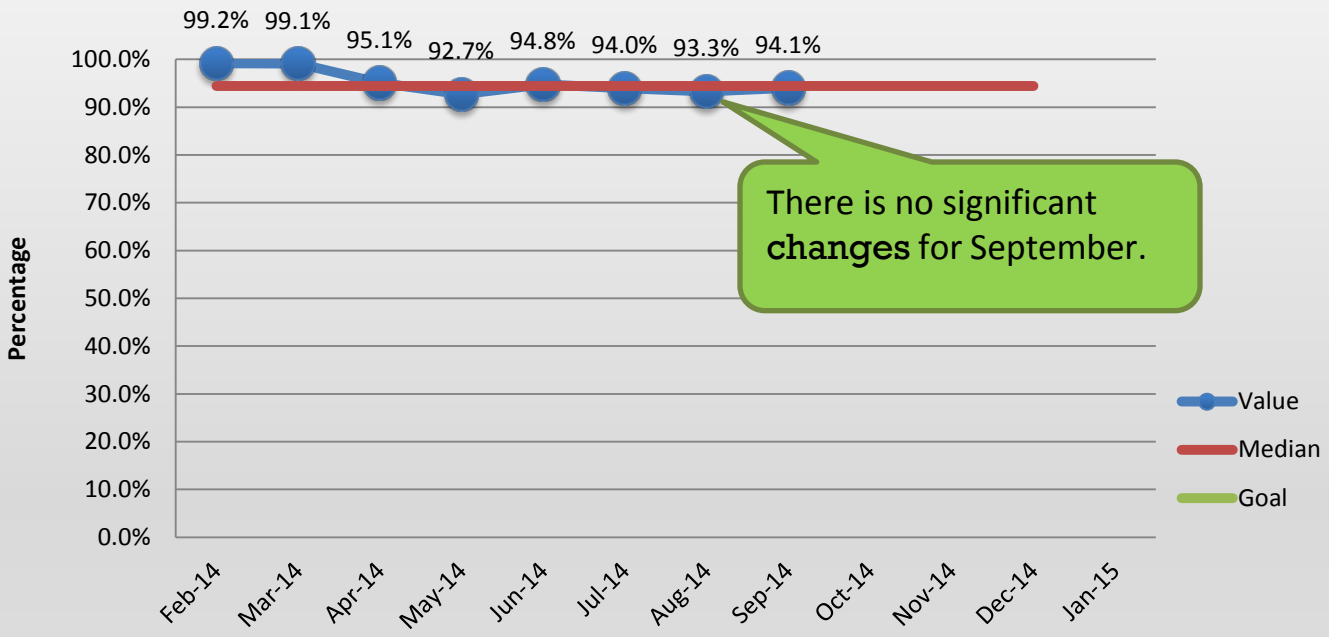
Measures Definition

Care Transition - Outpatient

- Initial title/definition of the two measures were inaccurate on run charts. The following titles have been updated to:
  - Measure 1: **Percentage of individuals who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.**
  - Measure 2: **Percentage of individuals who are provided health education materials related to health condition.**

Care Transition

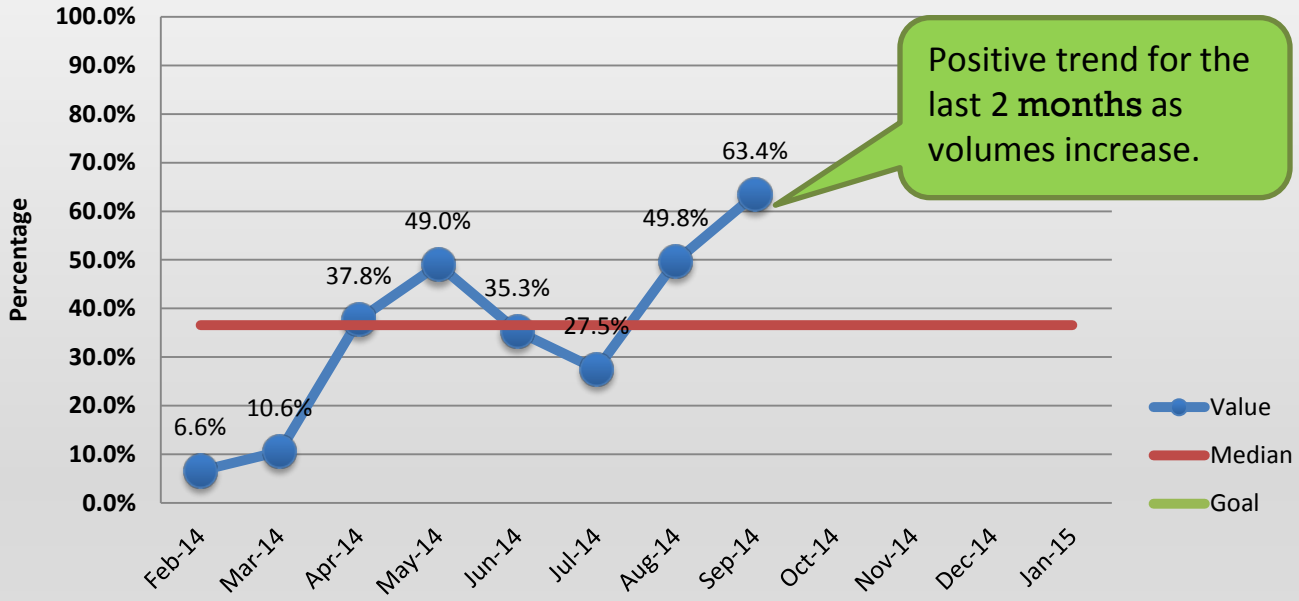
Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	99.2%	99.1%	95.1%	92.7%	94.8%	94.0%	93.3%	94.1%				
Median	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	
Goal												
Numerator:	1722	6461	6333	6706	6681	5152	8887	8841				
Denominator:	1736	6520	6660	7236	7049	5482	9525	9400				

Care Transition

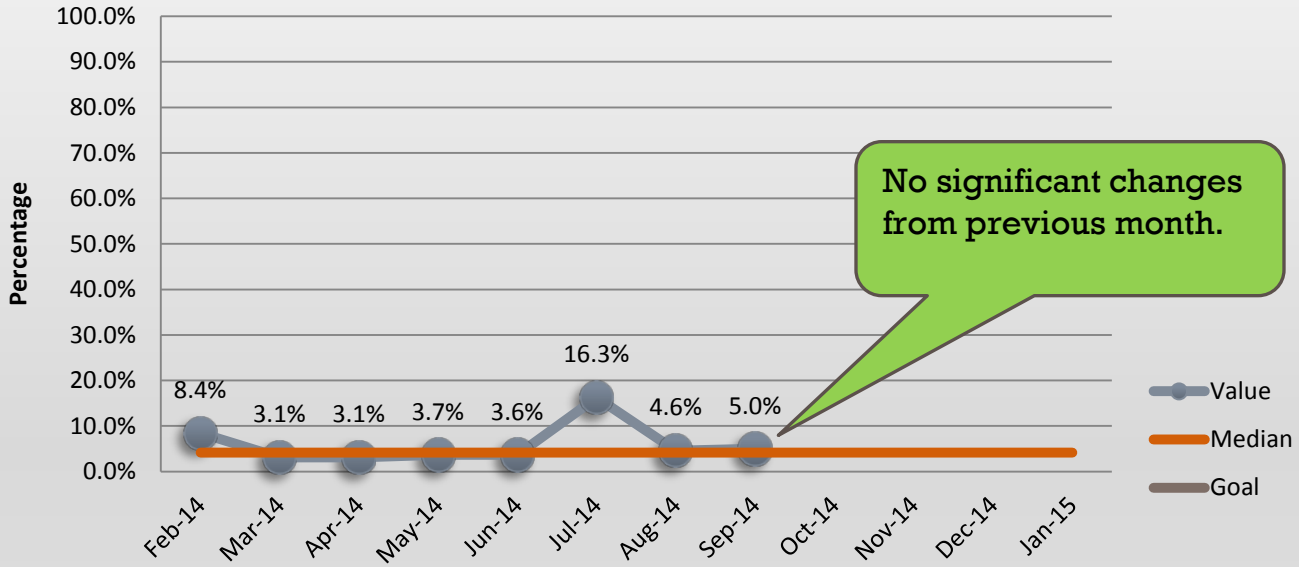
Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	6.6%	10.6%	37.8%	49.0%	35.3%	27.5%	49.8%	63.4%				
Median	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%	36.5%
Goal												
Numerator:	26	52	182	251	135	110	207	298				
Denominator:	391	492	482	512	382	400	416	470				

Care Transition

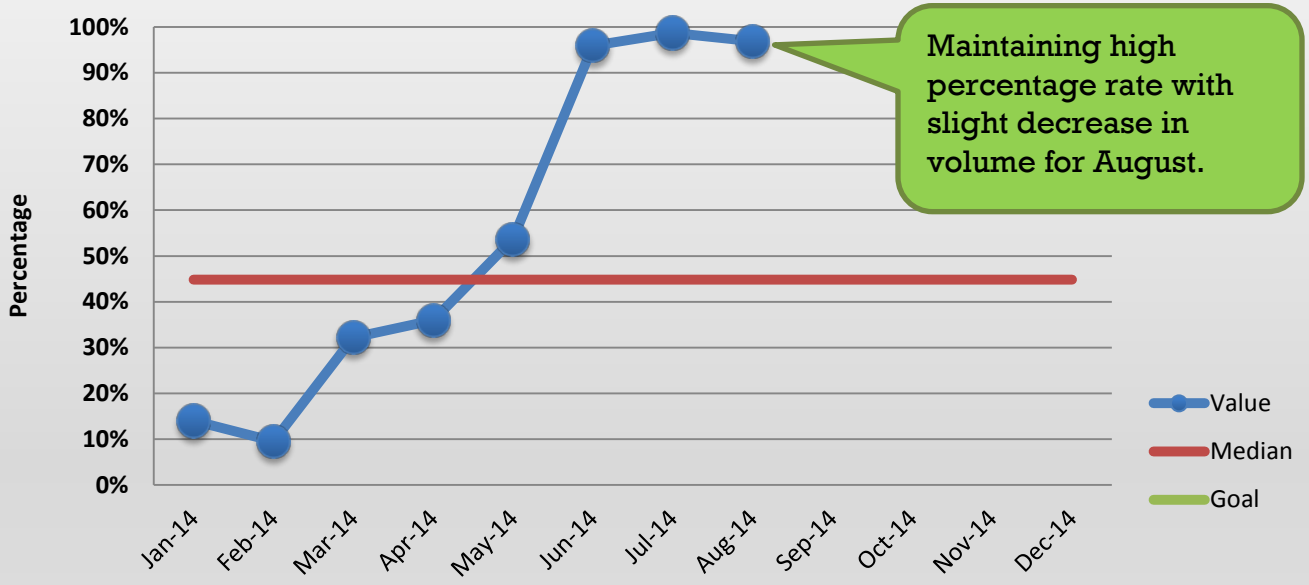
Collaborative (3 of 5 Teams): Percentage discharged patients with community provider contact within 7 days



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	8.4%	3.1%	3.1%	3.7%	3.6%	16.3%	4.6%	5.0%				
Median	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Goal												
Numerator:	150	218	206	268	258	898	443	474				
Denominator:	1778	7011	6694	7257	7074	5514	9595	9468				

Care Transition - Outpatient

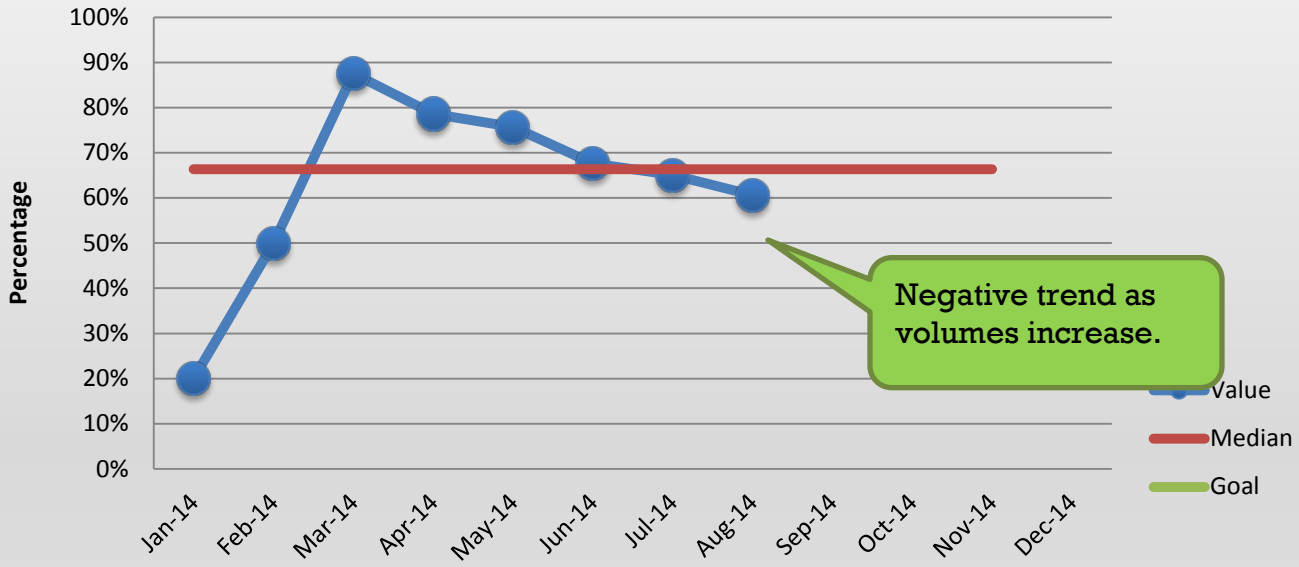
Collaborative (3 Teams): Percentage who are provided health education materials related to health condition.



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Value	14%	10%	32%	36%	54%	96%	99%	97%				
Median	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%
Goal												
Numerator	7	4	19	23	29	71	75	62				
Denominator	50	42	59	64	54	74	76	64				

Care Transition - Outpatient

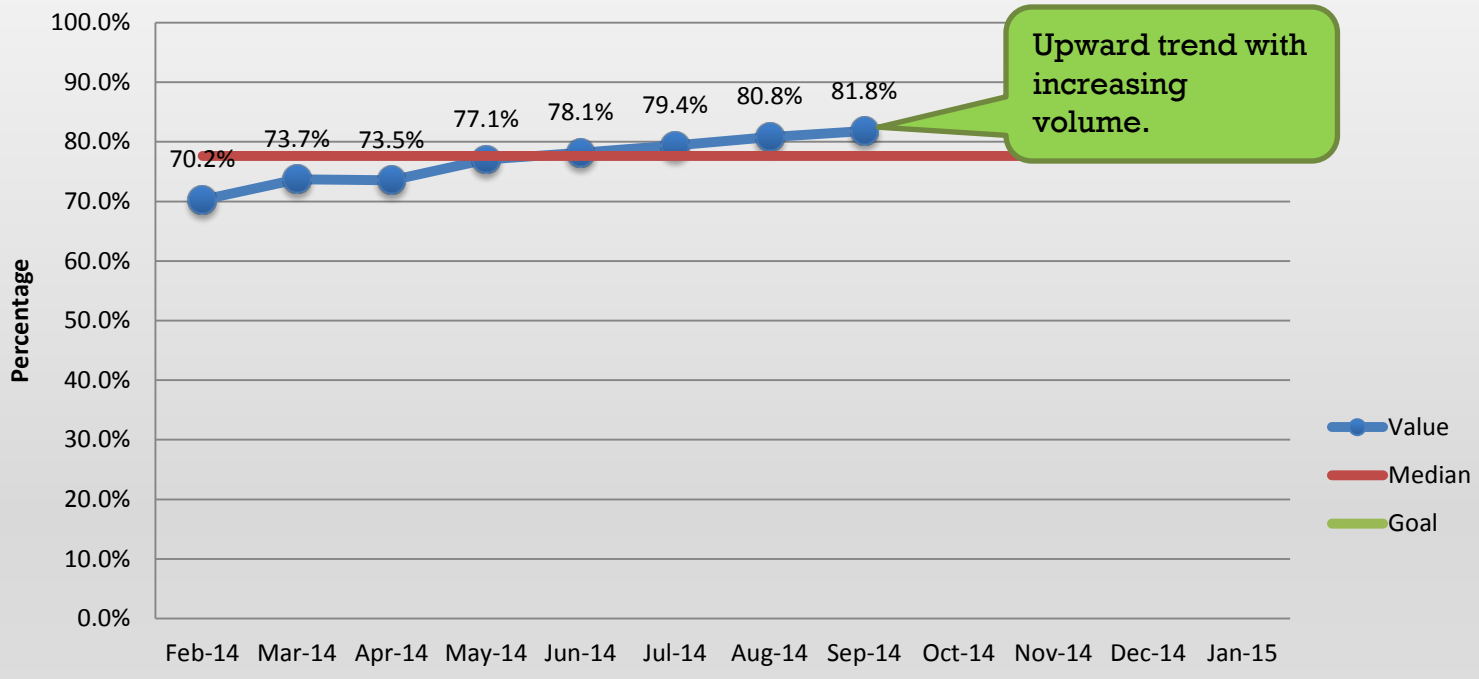
Collaborative (3 Teams): Percentage who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Value	20%	50%	88%	79%	76%	68%	65%	61%				
Median	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	
Goal												
Numerator	1	2	7	11	28	23	54	57				
Denominator	5	4	8	14	37	34	83	94				

Behavioral Health

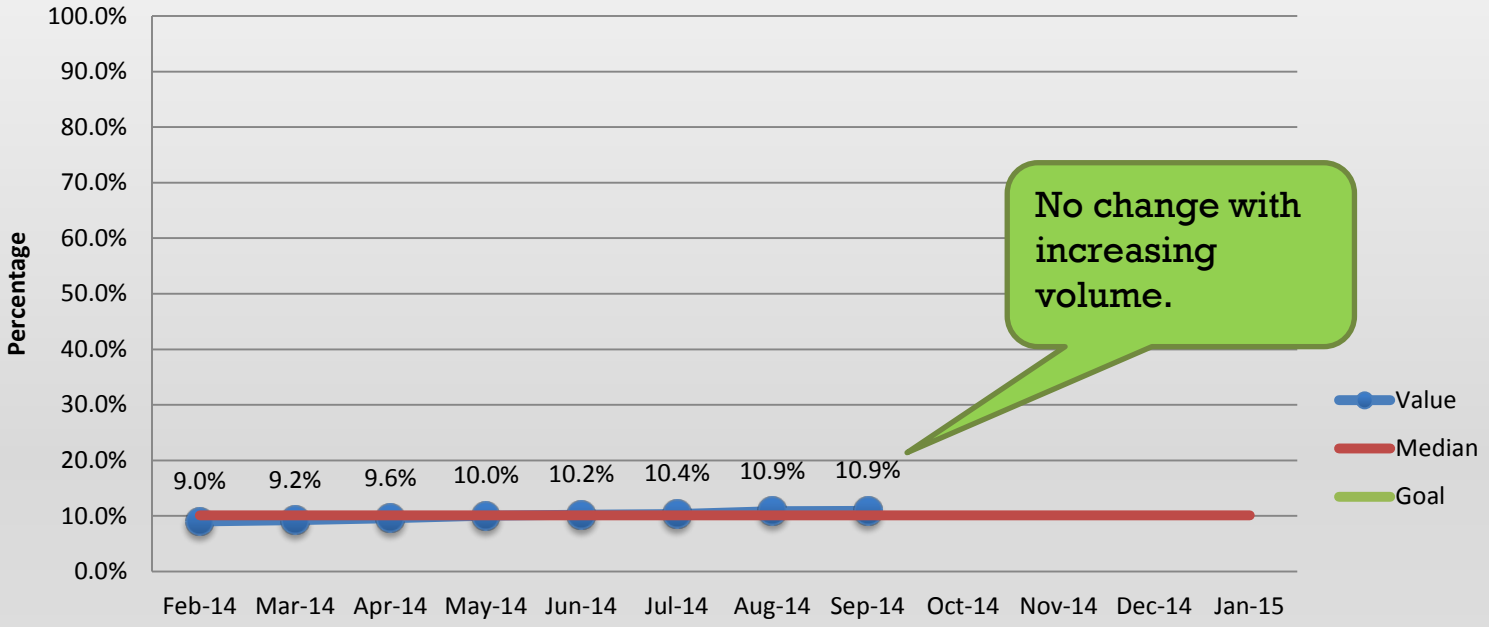
Collaborative (4 Teams): Percentage patients screened with cross-specialty tool



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	70.2%	73.7%	73.5%	77.1%	78.1%	79.4%	80.8%	81.8%				
Median	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%	77.6%
Goal												
Numerator	12744	14529	15455	16781	17957	19084	19939	21052				
Denominator	18142	19713	21016	21778	22979	24028	24672	25736				

Behavioral Health

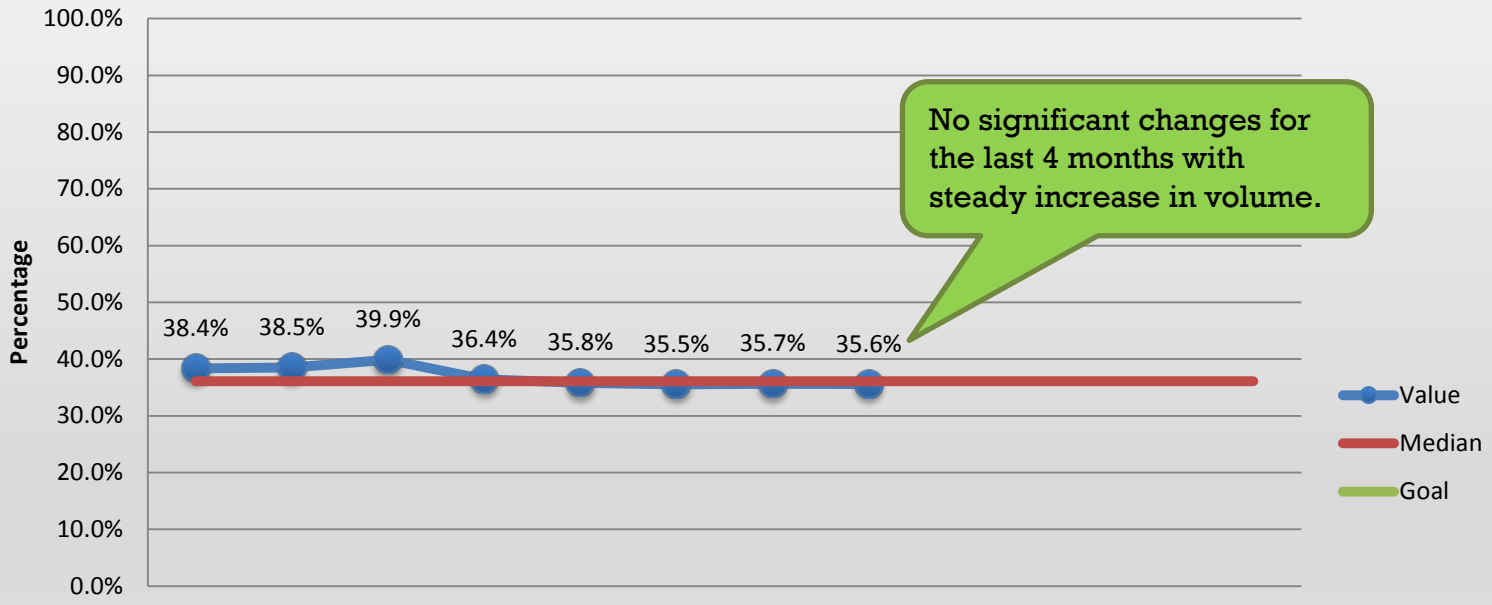
Collaborative (4 Teams): Percentage of patients who received integrated care intervention in past 12 months



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	9.0%	9.2%	9.6%	10.0%	10.2%	10.4%	10.9%	10.9%				
Median	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%	10.1%
Goal												
Numerator	1623	1804	2014	2178	2345	2487	2678	2801				
Denominator	18008	19558	20946	21718	22917	23991	24607	25599				

Behavioral Health

Collaborative (3 Teams): Percentage patients whose condition improved with intervention



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Value	38.4%	38.5%	39.9%	36.4%	35.8%	35.5%	35.7%	35.6%				
Median	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%	36.1%
Goal												
Numerator	6512	6587	6587	6146	6095	6043	6129	6143				
Denominator	16970	17098	16520	16873	17020	16999	17190	17262				

Measures Update

Recognizing Wins!!!

- Care Transition – Inpatient
  - Discharged patients whose follow-up provider received summary within 7 days continue to do well; *going from 27.5% (June) up to 63.4%* in the last 2 months (August and September) as volumes increase during this time frame.
- Care Transition – Outpatient
  - Run chart title corrections
    - Measure 1: **Percentage of individuals who are provided health education materials related to health condition.**
    - Measure 2: **Percentage of individuals who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.**
- Behavioral Health
  - Gradual positive trend for patients screened with cross-specialty tool; going from *70.2% in January to 81.8% for September (11.6% improvement)* as volumes increase (18,142 to 25,736 patients).

LEARNING COLLABORATIVE

RHP 10

Clinical Quality Committee

Planning Calendar

Learning Collaborative Planning Calendar

Seven Webinars – January & September Learning Sessions

Next Steps:

- November 2014 - Survey providers to evaluate:
  - Level of interest in the topics recommended in September
  - Willingness to participate in small group learning and share learnings at a scheduled Webinar
  - Recommendations of Faculty
- December 2014 –
  - Clinical Quality Committee Update On Provider Feedback and Topic Selection
  - January 22nd Learning Session Proposed Agenda

Learning Collaborative

2015 Timeline

Tentative Dates

November - December 2014:

- Clinical Quality Committee Planning – Topics Presented To Providers.

January 2015:

- Learning Session 3: face-to-face training

February-August 2015:

- Action Period: Apply changes, conduct Plan-Do-Study-Act (PDSA) cycles, and collect data to measure impact; each project team at each site should internally convene weekly to review what they are doing (project management, tests of change – PDSAs) and make sure they are on track as a project team.
- Anchor hosts Webinars for shared learning
- Interested providers participate in smaller cohort learning activities

September 2015:

- Learning Session 4 – Share Achievements and Learnings

October – December 2015:

- Clinical Quality Committee Planning

QUESTIONS ???