LEARNING COLLABORATIVE

RHP 10

Regional Healthcare Partners 3: Harris Health System

Southeast Texas Regional Healthcare Partnership

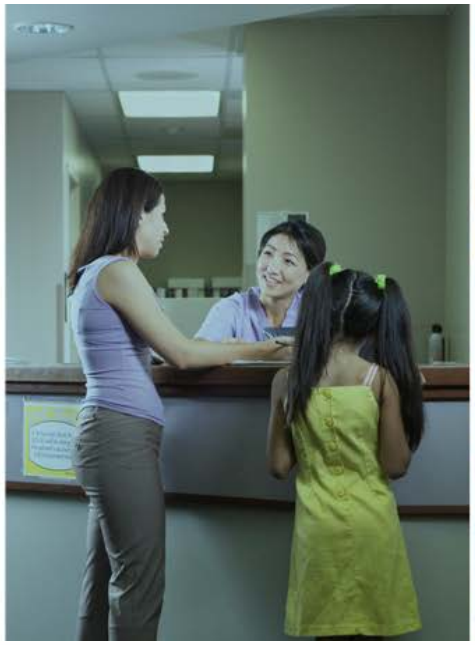
Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

January 21st, 2016

Agenda

Introduction	Meredith Oney
Roll Call	Heather Beal
RHP 8 Learning Collaborative	Michelle Eunice & Nini Lawani
Questions and Answers	All






Southeast Texas Regional Healthcare Partnership

Texas Healthcare Transformation and Quality Improvement Program ✩ Medicaid 1115 Waiver

RHP 10 Learning Collaborative
January 21, 2016

RHP 3

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About Us

- 3 Hospitals
  - Affiliations with Baylor College of Medicine and University of Texas Health Science Center
  - 18 community health centers, including the nation's first free-standing HIV/AIDS treatment center
  - Two large multi-specialty clinics
  - Six same day clinics
  - Five school-based clinics
  - 10 homeless shelter clinics and five homeless eligibility service locations
  - One free-standing dental center
  - One geriatric assessment center
  - Immunization and medical outreach program with mobile health units
- Performing Provider
  - 22 Internal Projects
- RHP 3 Anchor

Regional Health Partnership 3 (RHP3)

Provider

- There are 26 providers with active DSRIP projects, including:
  - Hospitals
  - Academic Health Science Centers
  - Local Public Health Departments
  - Local Mental Health Authorities

County

RHP 3 Quick Facts:

- 9 counties
- 8,580 square miles
- 4.8 million residents
- 51% Anglo/31% Hispanic
- 16.8% live below poverty line
- 8% average unemployment
- 26% without health coverage
- $50,363 per capita income

Project Focus

- Providers selected project areas from a menu called the RHP Planning Protocol
- All proposed projects were reviewed and approved by HHSC and CMS.
- Incentives are paid for achieving approved milestones and metrics.

Outcome Measure

- **190** outcome measures were selected by RHP 3 providers.
- Baselines were set in DY3.
- DY4 incentives will be paid for reporting and performance.
- DY5 incentives will be paid for performance only.

Community Need

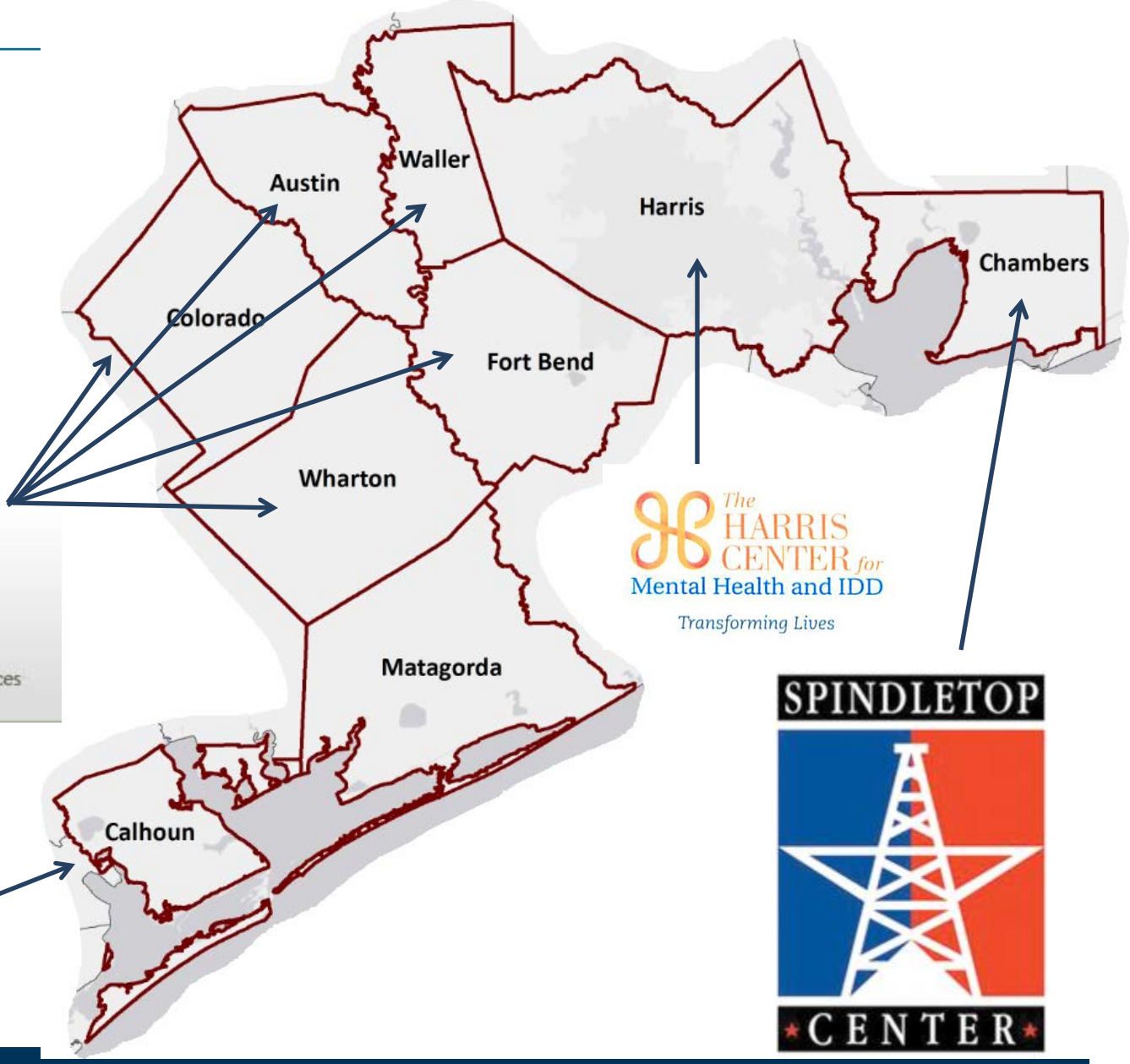
- Providers choose one or more community needs.
- RHP3 includes 25 community needs derived from over 40 community needs assessments throughout the Region

177 Projects worth approximately $1.8 billion in incentive payments

REGION 3

Southeast Texas Regional Healthcare Partnership

Local Mental Health Authorities (LMHAs)



texana
Care | Support | Education
Behavioral Healthcare & Developmental Disabilities Services

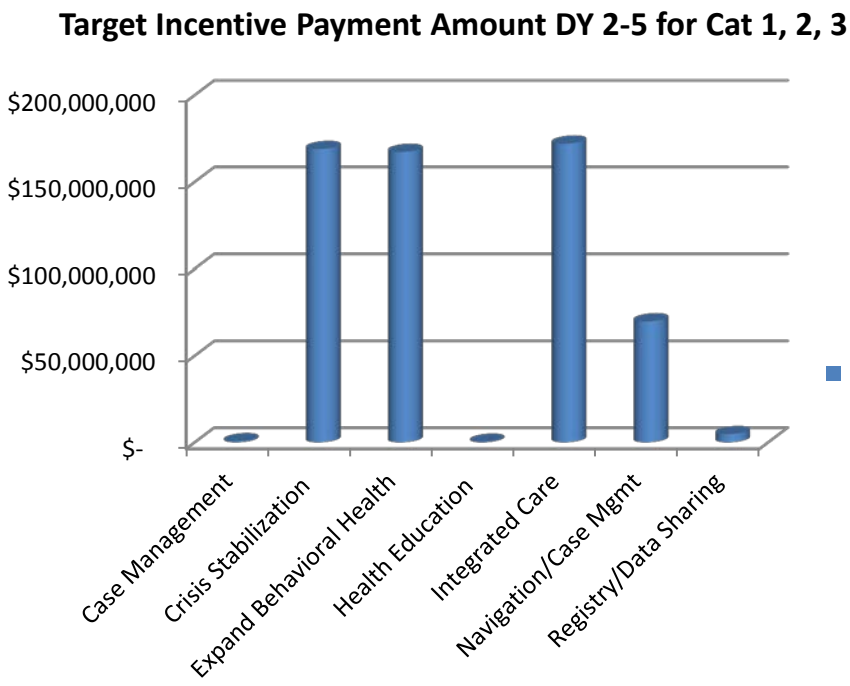
The HARRIS CENTER for Mental Health and IDD
Transforming Lives

SPINDLETOP CENTER

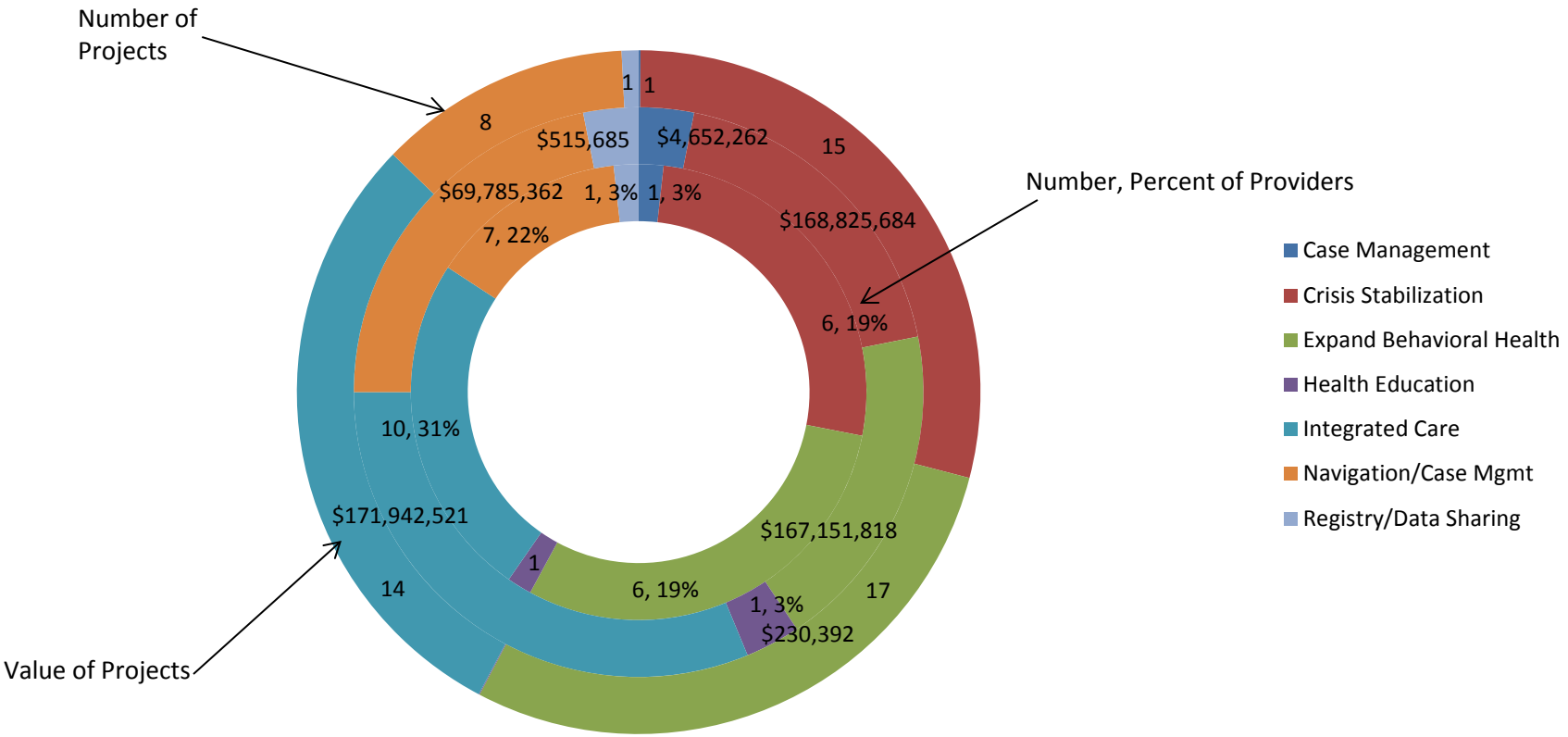
Gulf Bend Center
IMPROVING LIFE THROUGH RECOVERY

RHP 3 Behavioral Health Projects

Project Type	Total Projects	Total Providers	Target Incentive Payment Amount DY 2-5 for Cat 1, 2, 3
Case Management	1	1	$ 515,685
Crisis Stabilization	15	6	$ 168,825,684
Expand Behavioral Health	17	6	$ 167,151,818
Health Education	1	1	$ 230,392
Integrated Care	14	10	$ 171,942,521
Navigation/Case Mgmt	8	7	$ 69,785,362
Registry/Data Sharing	1	1	$ 4,652,262
GRAND TOTAL	**57**	**32**	**$ 583,103,725**



Texas 1115 Waiver Behavioral Health Projects



Cohort Participants

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

Organization Name	Brief Description
Beacon Health Options	CHC's behavioral health vendor
Community Health Choice (CHC)	Health plan carrier
The Harris Center for Mental Health and IDD (formerly MHMRA of Harris County)*	County LMHA/CMHC
Harris Health System – Psychiatry*	County hospital system
Houston Methodist*	Hospital
Houston Recovery Center*	Sobering center
The Lighthouse of Houston	Offers educational programs, community services and outpatient rehabilitation for the blind and visually impaired
Mental Health America of Greater Houston*	Mental health policy, education, and advocacy organization
Memorial Hermann*	Hospital
Network of Behavioral Health Providers*	Behavioral health CEO roundtable (34 members)
Texas Children's Hospital Pavilion for Women	OB/GYN, prenatal care, reproductive psychiatry, labor & delivery, etc.
UT School of Public Health	Academic faculty

*Also a member of the Network of Behavioral Health Providers

Cohort -Integration of Primary and Behavioral Health

- AIMS
  - Assess the current state of integration at a project and regional level
  - Establish baseline for care within the region
  - Assess the desired state of integration
  - Reach desired levels of integration of project and regional integration
  - Assess changes in project and regional integration as a result of DSRIP projects

Cohort -Integration of Primary and Behavioral Health

- Success Measures
  - Development of an Integration Assessment Tool that will assist providers in building a common understanding and evaluation of to measure integration of primary care and behavioral health
  - Improvement of integration of behavioral health and primary care integration within Region 3 with a focus on progression toward the desired state of integration at the provider and regional level
  - Improved health outcomes as a result of improved integration
  - Best Practices implemented at the organizational level

OATI Survey

- What is the OATI?
- Experience with the tool
- Current Participants
  - Texas Children's Hospital
  - Harris Health System
  - Sobering House
  - MHMRA of Greater Houston

Texas Children's Hospital Experience

- Project
- Preparing for discussion
- Conducting the OATI
- Lessons learned and next steps

Harris Health System Experience

- Projects
- Resistance
- Results
- Next Steps

City of Houston

- Project
- Evaluation and Identification
- Results
- Next Steps

Fort Bend County

- Integrated Delivery System
  - Collaborative
  - Multiple Stakeholders
    - EMS
    - Fire
    - County Government
    - FQHC
    - Hospitals
  - Training

Regional Strengths

Program Mission and Vision:

The program welcomes individual with active physical, mental, and substance use conditions, and cognitive disabilities, without discrimination, in all admission areas and waiting areas.

Program Administrative Policies:

The program confidentiality or release of information policies and procedures are written to promote appropriate and routine sharing of necessary information between collaborative mental health providers, substance abuse treatment providers, and medical providers.

Clinical record-keeping policies support integrated documentation (e.g., in assessments, treatment plans, and progress notes) of attention to mental health, physical health, cognitive disability, and substance use issues in a single medical/clinical record or chart.

Quality Improvement and Data:

Program management information systems routinely collect quality improvement data that is used to support progress on specific and measurable quality indicators that represent progress in achieving program-wide integrated physical health/behavioral health capacity.

Regional Strengths cont'd

Access:

Individuals and families receive welcoming access to appropriate care regardless of active issues in any area.

Screening and Identification:

The program's screening policy states that all individuals are to be screened for issues and immediate risk in a welcoming and respectful manner for mental health issues (including trauma), substance use issues, cognitive issues, physical health issues, and basic safety and social needs.

The program has an evidence screening process for identifying and documenting nicotine use/dependence.

Integrated Person-centered Planning:

Treatment/service plans regularly include integrated physical health/behavioral health interventions provided in the program setting, not just outside referrals for specialized care in other settings.

Regional Strengths cont'd

Integrated Treatment/Recovery Programming:

All patients/clients receive basic education and assistance with choices and decisions regarding prevention of physical health and behavioral health conditions and disorders, as appropriate.

The clinic/service setting uses evidence-based protocols to manage and track common physical and behavioral health conditions.

Medication Management:

The organization documents routine communication and facilitates cross consultation between behavioral health and physical health prescribers to ensure quality of care regarding prescribing practices.

All prescribers have knowledge and capability in prescribing practices and medications for treatment of common physical health, mental health, and substance use conditions.

The organization's practice guidelines support access to medication assessment for any condition without requiring a mandatory period of sobriety or symptom remission for another condition.

Common risks associated with all medications, including risks of interaction between behavioral health and physical health medications, are routinely monitored by medical/nursing staff.

Regional Strengths cont'd

Medications with addictive potential are not routinely initiated nor routinely refused in ongoing treatment, including for individuals with substance dependence. Prescription of such medications is individualized based on careful evaluation and consultation, with second opinion when indicated.

***Integrated Discharge/Transition Planning*:**

Discharge plan policies, procedures, and practices address specific matched continuing care needs for all physical health issues, behavioral health issues, and other risk factors.

Discharge summaries integrate attention to physical health and behavioral health concerns and are routinely provided in a timely manner to the receiving providers.

General Staff Competencies and Training:

The organization has written procedures for routinely documenting integrated interventions provided by staff with any level of licensure or training.

The organization has a written plan for integrated competency development for all clinical and support staff.

Regional Strengths cont'd

Specific Staff Competencies:

The staff demonstrate competency to welcome and address the needs of patients/clients with physical health/behavioral health issues who are from different cultures and/or linguistic backgrounds.

The staff demonstrate specific competency in providing education to family members and caregivers regarding physical health and behavioral health issues.

The staff demonstrate specific competency in providing developmentally matched physical health/ behavioral health services to the age-specific populations that are served.

Regional Areas of Improvement

Program Mission and Vision:

The program operates under a written vision, mission, or goal statement that communicates to all staff and stakeholders the goal of becoming an integrated physical health/behavioral health program.

Written program descriptions specifically say that individuals with comorbid physical health and behavioral health conditions are welcomed for care.

Access:

The program has functional policies for facilitating routine (non-emergent) access to integrated primary health and behavioral health assessment and intervention for all individuals who need "same-day" care.

Integrated Assessment:

Assessments document individual and/or family goals for hopeful, meaningful and "happy life" outcomes using the person/family's own words.

Integrated assessments identify specific time periods of recent strength or stability, and skills and supports the individual or family used in order to do relatively well during that time, including those used to manage physical health, mental health, cognitive, substance use issues, and other risk factors.

Integrated assessments document the state of change (i.e., precontemplation, contemplation, preparation, early action, late action, maintenance) the individual is in regarding each disorder, condition or issue.

Regional Areas of Improvement

Integrated Person-centered Planning:

For each of the physical health/behavioral health issues listed in the plan, there is an identified individualized and matched intervention with achievable steps to help the person be successful.

Person-centered (or, if appropriate, family-centered) plans focus on building whole health self-management skills and supports for physical health and behavioral health conditions, using positive rewards for small steps of progress in learning and using the skills and supports.

Integrated Treatment/Recovery Programming:

The program has an organized protocol to address psychosocial issues related to pain management.

Regional Areas of Improvement, cont'd

Integrated Treatment/Recovery Relationships:

Each patient/client has a primary relationship with an individual or an integrated team that integrates attention to physical health and behavioral health issues inside the relationship.

Physical health and behavioral health staff meet regularly as a team to promote routine collaboration in sharing care responsibility for integrating physical health/behavioral health services to clients/patients.

Integrated and Welcoming Program Policies:

Organization policies and procedures are designed to reward and reinforce individuals for making progress in asking for help when they are having difficulty or are beginning to relapse with any issue, rather than focusing on providing "consequences for non-compliance."

Regional Areas of Improvement, cont'd

Medication Management:

The organization has procedures/forms/materials – adapted for individuals who may have cognitive disabilities – to help patients/clients learn about physical health and behavioral health medications, and communicate more easily with prescribers about medications and side effects.

Program/Organizational Collaboration and Partnership:

The program/organization has policies and procedures for documentation of care coordination and collaborative service planning for patients with physical health/behavioral health issues who receive services in collaborative programs.

There is a routine process by which staff provides consultation to a collaborative program delivering complementary services.

There is a routine process by which staff receives consultation from a collaborative program providing complementary services.

Designated staff participate in regularly scheduled physical health/behavioral health interagency care coordination meetings that address the needs of individuals or families with complex issues who use significant levels of service in multiple settings in the community.

What did we do with what we learned?

- Identified common strengths
- Identified common areas of improvement
- Identified partnership opportunities
- Identified a common objective

Lessons Learned

- Celebrate successes—tool completion and strengths identified
- Retell the story of the tool selection/Bring the group back to WIIFM
- Adaption of tool to specific provider environment
- Value of the *process* of tool completion (group participation)
- Factors influencing tool completion

Maintaining Strides

- One on One Consultation
  - Resources and Tools for QI improvement
- Regional Training Opportunities
- Subject Matter Expertise
  - MHA
  - CIHS
  - Guest Speakers

What's Next

- Meeting Schedule
  - For details email setexasrhp@harrishealth.org

QUESTIONS???

Region 10 Learning Collaborative
Care Transitions and Behavioral
Health Combined Monthly Webinar

January 21st, 2016

Provider	Participant
MCA	Kathleen Sweeney, Theresa Guild
Cook Children's	Axel Lewis
TCPH	-
MHMRTC	Melanie Navarro, Mahie Ghoraishi, Camille Patterson, Erin Fogarty, Shantelle Collins, Sheree Abro, Kirk Broome, David Gunter, Marisa Flores, Annette DeJesus Michael Cockerell, Brian Villegas, CJ Flower
NHH	Kathleen Sweeney
PMC	Kathleen Sweeney
Huguley	Jamie Judd, Kevin Blackburn, Kristen Drake
THFW	Jamie Judd
THSW	Jamie Judd, Charisse Huey
THS	Jamie Judd
Ennis Regional	Edwina Henry
Lakes Regional	Kari Rough
JPS Hospital	Lynette Blackwood, Meredith Oney, Faiz Hussain, Heather Beal, Chris Wall, Lara Burnside, Lori Muhr, Karen Goodwin, Brenda Gomez, Jeff Claassen, Gail Warren
UT Southwestern Moncrief Cancer Institute	Emily Berry
THAZ	Jamie Judd
Helen Farabee	-
Wise Regional	Shane Jones, Leah Throckmorton
THAM	Jamie Judd
Pecan Valley	-
THC	Jamie Judd
Baylor	Jennifer Anderson
THHEB	Jamie Judd
Dallas Children's	-
UNTHSC	Andrew Harman
JPS PG	-
Methodist Mansfield	-

Region 10 Learning Collaborative
Care Transitions and Behavioral
Health Combined Monthly Webinar

January 21st, 2016

Wise PG	Shane Jones
Glen Rose	-
Texas Health Alliance	Jamie Judd

Other Stakeholders

Provider	Participant
Grace Bolanos	TMS Health Policy
Michelle Eunice & Nini Lawani	RHP 3
Marie Richards	TMS Health Policy