Category 3: Care Transitions

Data Collection and Management

1. How are you identifying your metrics?

   Normal vs. abnormal labs

   Program for autism, intervention 350 people, age intellectual disability

   Crisis line – referral base, case management

   Care transition program for inpatient discharge pt – reduce readmission

   Identify population/gap analysis

   Reduce ER visits

   Asthma registry, CRD registry

   Data pulling from assessment – RN care management

2. What are key success factors to capturing and meeting your metrics?
3. How can you show for your projects value/ROI?

Cancel Shape Health and wellness. A buffer done side effect of meds. Program is new enough and therefore doesn't have measurements which will calculate ROI.

CET (Cognitive ench. Training) Quality of life measure. Patient satisfaction survey as feedback thus better outcome expected.

4. What have been your greatest challenges in capturing this data, how are you overcoming it?

   A. No tools to collect data
   B. No consistency in how the data is collected and how it is reported
   C. Validity and reliability
   D. Better defined data expectations and Myers and Stauffers/audit expectations
   E. More flexibility in data choice
   F. Total population, not just targeted
   G. You don't own the data, time constraints. Internal and external.
   H. All regulations (HIPPA)
   I. Data goes in but cannot be abstracted or used in a meaningful way
   J. Lack of integration of data/EMR systems
   K. Varied changes
   L. Data collect is varied (manual and electronic)
   M. Common identifiers across EHRs
   N. Understanding DSRIP/Hospital/HHSC language
   O. Determining root cause
   P. Operational definitions

Q. *Data timelines*
R. *Narrowing or enlarging what patients should focus on*
S. *Data standardization*
T. *Data review standardization to ensure "like" comparisons*
U. *Overcoming:*
    Having a data analyst
    Using an access database
    Data collection group
    Data analyst who understands DSRIP

5. What are your thoughts on how this could be measured at a regional or state level?
6. What would you find helpful to know from others on these metrics?

Project Evolution and Expansion

a. How do we start showing the connections we are making? What is the impact? How do we quantify this impact beyond encounters or patients served?
b. How do we start expanding or integrating what we are doing into normal operations to expand beyond 1115 waiver?
c. What can we do to better build political capital? - What type of data would it take?
    A. *Reduce Readmission Data*
    B. *Build long term plans*
    C. *Market programs to payer groups*
    D. *Standardizing data and stories*
    E. *Build partnerships*
    F. *Longitudinal studies*
d. What would it take for your organization to sustain the changes you have made, especially where you have incorporated or partnered with non-healthcare related organizations in order to provide continuity of care for your patients?
    A. *you have to show dollars saved*
    B. *Behaviors changed to show a decline in uninsured and frequent flyers*
    C. *Have to have buy-in*
    D. *Global and community care*
    E. *Wrap-around services/encounters*
    F. *ED Nav. Program partnering with Dallas ED*
        a. *Sustain: Alternate sources of funding. Dallas PD lost funding.*
    G. *Behavioral health partnering with committees reaching out to community/boards. Partnered with schools and promote programs.*
    H. *Increase overall stakeholder "buy-in"*

    a. *Benefit structures*
    b. *Provide incentive (MD)*
    c. *Increase "non-healthcare" partnerships – transportation, grocery stores, gyms*

I. *Increase oversight during processes*
J. *Sustainability Survey*
K. *Business Model*
L. *Dollar value on our services (breast and cervical programs)*
M. *Bill patient's insurance for preventive services for sustainability*
N. *Can't make changes an oversight*