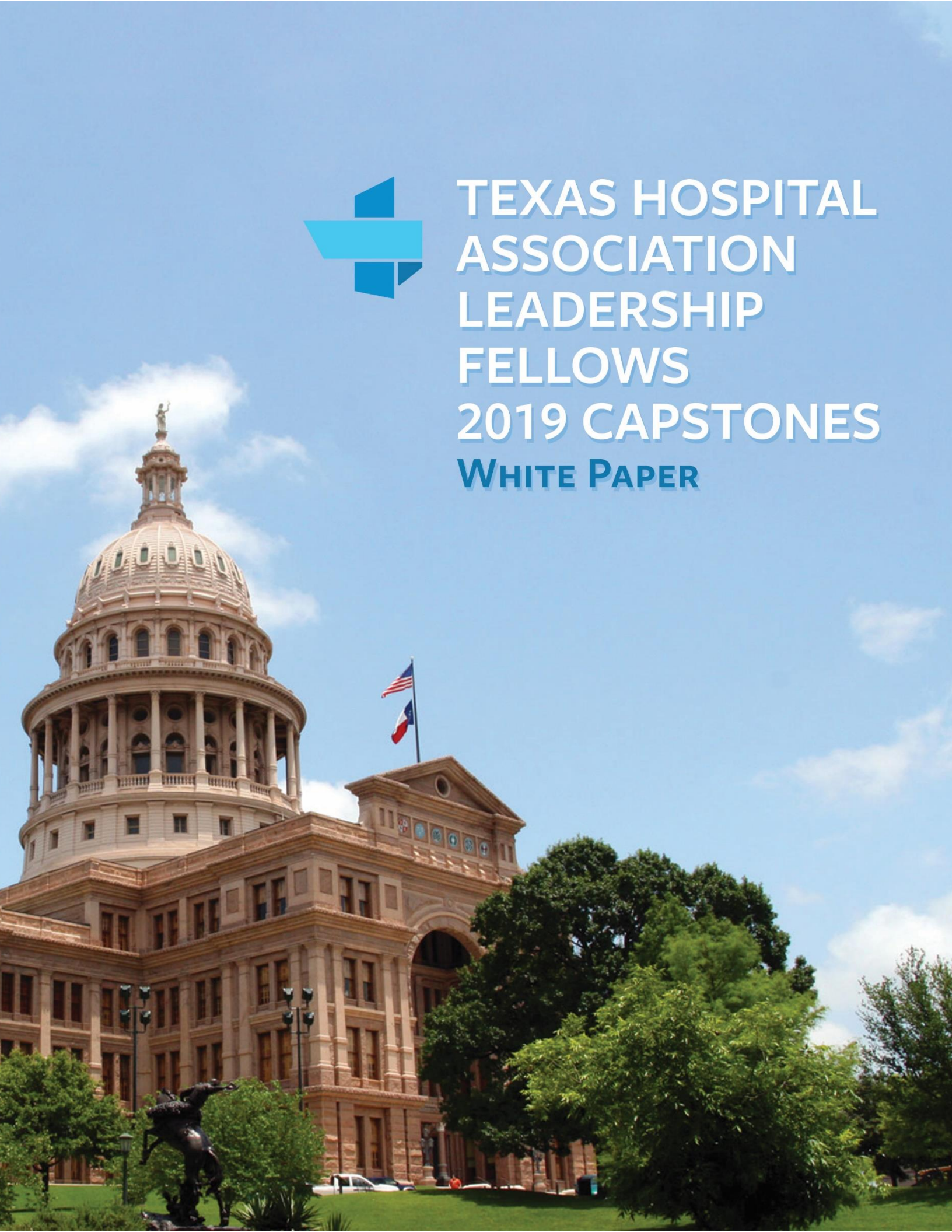
TEXAS HOSPITAL ASSOCIATION LEADERSHIP FELLOWS 2019 CAPSTONES

White Paper



THA LEADERSHP FELLOWS CLASS OF 2019

The Texas Hospital Association Leadership Fellows Program is intended to bring together health care leaders across the state for a focused study in becoming effective health care advocates and developing comprehensive knowledge on health care integration. The program provides a collaborative and dynamic curriculum which discusses the challenges of complex adaptive systems. THA Fellows grow as leaders who are fully equipped to lead policy discussion, drive integration and create an environment that enables the best possible patient care outcomes.

Over the course of their year of study, Fellows identify and conduct a capstone project to pursue during the program. The THA Leadership Fellows capstone project allows participants to demonstrate their ability to apply principles and competencies of the Leadership Fellows program to a current real-world organizational issue, challenge or opportunity.

Three capstone projects have been chosen by THA leadership to be presented at the 2020 THA Annual Conference and Expo. These presenters, and their research, represent the best of the best among upcoming health care leaders in Texas and their white papers are included here.

2019 Fellows (L-R): *Row 1* – Christopher Sandles, Natasha D. Montez, Terry Scoggin, Jennifer Ware, Paul Aslin, Jyric Sims, Megan Powe, Debra A. Sayles, Carolynn Jones. *Row 2* – Jessica Loy, Lindsey Tyra, Toya White, Susan Wade. *Row 3* – Ben Benitez, Vishal Bhalla, Ajith Pai, Wes Barnt, Loren Fouch, Bryan McLeod. *Row 4* – Ted Shaw.

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About THA

Founded in 1930, the Texas Hospital Association is the leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. One of the largest hospital associations in the country, THA represents more than 450 of the state's non-federal general and specialty hospitals and health care systems, which employ some 400,000 health care professionals statewide. Learn more about THA at www.tha.org.

THA LEADERSHP FELLOWS CLASS OF 2019

Presenting Fellows

High Reliability Organization Journey

Christopher R. Sandles, FACHE, CEO/Medical Center Director, South Texas Veterans Health Care System, San Antonio

Christopher R. Sandles, was appointed Director for the South Texas Veterans Health Care System recently, and previously was the Director for the Central Texas location since February 2017. As Chief Executive, he is responsible for the day-to-day operations of this multimillion-dollar VA health care system with an annual budget of approximately $740 million and more than 4,100 employees. Christopher has 15 years of progressively responsible health care leadership roles and began his health care career in 2002 at Covenant Health System in Lubbock. In 2003, he was accepted into the Government Health Administration Training Program and served his post graduate fellowship with VA North Texas Healthcare System in Dallas. His years of VA service include positions as Associate Director of the Houston VA Medical Center, Assistant Director of the VA Greater Los Angeles Healthcare System, Chief of Health Administration Service at VA Loma Linda Health Care System, Assistant Chief of Medical Administration at VA North Texas Health Care System, Special Assistant to the Director-VA North Texas Health Care System, and Administrative Director for Pathology and Laboratory Medicine at VA North Texas Health Care System.

Christopher received both his bachelor's degree in Business and his Master of Healthcare Administration from Texas Tech University and holds a green belt certification in Lean Six-Sigma from Villanova University. He is a Fellow in the American College of Healthcare Executives and is on the faculty for the Veteran Health Administrations New Executive Training Program. In January 2017, Christopher was commissioned as a Lieutenant with the United States Navy Reserve Medical Services Corps.

Delivery System Reform Incentive Payment (DSRIP) Program

Paul Aslin, FACHE, Chief Transformation Officer and Senior Vice President of Strategic Alignment, Wise Health System, Decatur

Paul Aslin currently leads the system's participation in the 1115 Waiver program and has administrative responsibility for quality, patient experience, population health, telehealth, value-based care, community health improvement, and organizational performance excellence. Prior to his current role as Chief Transformation Officer, Paul served as Chief Population Health Officer for Wise Health System and Chief Operating Officer for Wise Health Clinics.

Before joining the hospital in 2011, Paul held management positions beginning in 1999 in telecommunications and in 2007 in financial services. He received his Bachelor of Business Administration and Master of Science in Healthcare Administration from the University of Texas at Arlington where he won first place in the graduate division of the national ACHE Richard J. Stull Student Essay Competition in Healthcare Management. Paul resides in Haslet with his wife, Amanda, and three daughters.

Jyric Sims, FACHE, CEO, Medical City Fort Worth, Arlington

Jyric Sims serves as Chief Executive Officer of Medical City Fort Worth, a health system that includes a 320-bed medical center, an ambulatory surgery center, a free-standing emergency room and more than 1,200 employees. Sims previously served as Senior Vice President and Chief Operating Officer of Tulane Health System in New Orleans, Louisiana, and in executive roles in hospitals in Port St. Lucie, Florida, Houston, Texas, and Little Rock, Arkansas.

Jyric has received numerous accolades, including 2017 National Healthcare Executive of the Year by the National Association of Healthcare Executives, 2017 Alumni of the Year by University of Arkansas for Medical Sciences and 2016 Modern Healthcare Up and Comer. He was also appointed to serve on a national delegation to Israel. He is an active member of Alpha Phi Alpha Fraternity Inc. Academically, Jyric Sims serves on the Louisiana State University National Diversity Advisory Board and is an adjunct faculty member at Tulane University School of Public Health. He received a Bachelor of Science degree from Louisiana State University, a Master of Science in Healthcare Administration from University of Arkansas for Medical Sciences and a certificate in healthcare leadership from Harvard University. Sims is married to his college sweetheart, Maisha, and they are the proud parents of Sabriya (daughter) and Noah (son).

Toya White, J.D., Service Line Director, Oncology/GI/Bariatrics/Robotics, Texas Health Presbyterian Dallas

Toya White has held progressive leadership roles within the organization. She started her health care career with Texas Health Dallas in 2001, and has since practiced as a Registered Nurse, Advanced Practice Provider, and in leadership. In her current role, Toya is responsible for the operational performance and advancement of multiple service lines in alignment with the organization's mission and vision.

Toya is actively engaged in the community and with professional organizations. She serves on the Texas Board of Nursing Practice Advisory Committee and is a board member of North Texas Nurse Practitioners. Toya holds a Master of Science in Nursing and a Master of Business Administration from Texas Woman's University, as well as a Juris Doctorate from the University of North Texas Law.

Improving Pediatric Behavioral Health Care by Using Advocacy Efforts to Increase Medicaid Funding During the 2021 Legislative Session

Ben Benitez, Vice President of Clinical Operations, The Children's Hospital of San Antonio

Ben Benitez joined The Children's Hospital of San Antonio, a CHRISTUS Health entity, as the VP of Clinical Operations in December 2018. Prior to his current role, he was with Memorial Hermann Healthcare System for 12 years. His most recent role was a Director of Hospital Operations at the Texas Medical Center location in Houston. Ben's experience within the health care industry includes surgical services, operations, ambulatory services, and human resources. He has played a vital part in accomplishments relating to expansions, operational excellence and strategic growth.

Ben earned his Master of Healthcare Administration at the University of Houston in Clear Lake and Bachelor of Healthcare Administration at Texas State University in San Marcos. He also went through the Executive Education Program through Memorial Hermann and Rice University at the Jones Graduate School of Business.

Loren Fouch, Chief Executive Officer, Mayhill Hospital

Loren Fouch joined Universal Health Services in 2014 and currently serves as the Chief Executive Officer of Mayhill Hospital in Denton, TX. Mayhill Hospital provides inpatient and outpatient behavioral health services to include ECT to adult and geriatric populations. Loren has held multiple clinical and administrative roles in behavioral health settings throughout Texas.

She began her career as a therapist working with children, adolescents, and adults in acute and residential settings, further expanding her expertise in mental health and substance abuse treatment within inpatient and outpatient facilities. Loren's clinical experience provided her a unique understanding on how to guide teams in providing high quality, patient centered care. She is driven by a passion dedicated to helping individuals and families find peace and understanding on their journey towards recovery.

Loren is an active member of her local community; serving with the Junior League of Richardson, Don't Wait To Vaccinate no cost immunization clinic, National Alliance for Mental Illness and is a member of EWF International. Loren graduated from The University of Texas with her Master of Science in Social Work and from Louisiana State University

with her Bachelor of Arts in Sociology and Communication Studies. She is a Licensed Clinical Social Worker and a Licensed Chemical Dependency Counselor.

Debbie Sayles, Vice President/Chief Nursing Officer, Texas Scottish Rite Hospital for Children

Debbie Sayles works closely with the nursing staff and physicians at this tertiary referral center for children with complex orthopedic needs, to ensure a safe environment that provides the highest quality of patient care for all the children of Scottish Rite Hospital. In her role, she is also responsible for Quality Assurance and Performance Improvement throughout the organization and develops and sustains an environment that supports excellence and innovation in clinical practice and patient care that supports positive patient outcomes.

Debbie is a native of Rhode Island and received her Diploma in Nursing from Rhode Island Hospital School of Nursing. Before joining Scottish Rite Hospital, she served in various staff nursing and leadership positions in Iowa, Michigan and Texas. She completed her bachelor's degree in Health Services Administration at The University of Texas-Southwestern and her master's degree in Business Administration at the University of Dallas.

Debbie is a member of the American Organization of Nurse Executives and holds her certification as a Nurse Executive through the American Nurses Credentialing Center. Other professional organizations to which she belongs include the American Nurses Association and the American College of Health Care Executives. For more than ten years she has been an active volunteer with the Highland Park United Methodist Church "Night OWLS" program, which provides respite care for families of children with special needs and their siblings. Debbie also serves as a member of the church's Special Needs Ministry Advisory Board.

Lindsey Tyra, Vice President of Strategy & Business Development, Children's Health

Lindsey Tyra joined the Children's Health team in August 2014 and oversees the planning, development, and implementation of innovative business initiatives and tactics that address market dynamics, optimize the organization's competitive position, and advance Children's Health strategic plan. Most recently, Lindsey led the organization through the development and deployment of its five-year enterprise strategic plan and developed an analytical framework to stratify and prioritize investments in clinical programs that has become a standard operating model across the organization.

Prior to joining Children's Health, Lindsey was the Vice President of Corporate Services for one of the 15th largest Federally Qualified Health Centers in the nation. In this role, Lindsey served as the relationship executive for national and community partnerships, secured over $50 million in foundation and federal funding, and oversaw the establishment and operation of primary care and behavioral health services in five school districts. She holds a bachelor's degree and a Master of Health Administration from the University of Kentucky.

To view the full roster for the 2019 Leadership Fellows class, visit: www.tha.org/fellows/class2019

Creating a High Reliability Organization in the Veterans Health Administration

Christopher R. Sandles, FACHE, CEO/Medical Center Director, South Texas Veterans Health Care System

Executive Summary

"To Care for him that shall have borne the battle, for his widow, and for his orphan." - President Abraham Lincoln, 1865

From these words, spoken by the 16th President of the United States; a nation mortally wounded by a Civil War, recognized that its national consciousness could not endure without ensuring that those who fought, died, or were forever wounded would not be left behind or forgotten. From this solemn oath, the Department of Veterans Affairs was born. As with most anything in its infancy, the department did not move swiftly, have all the answers, or anticipate the challenges that lay ahead. I think one might be sufficed to say, that in its infancy the organization fell flat on its face, again, and again and again.

However, I think it would be completely reasonable to expect this of anything created in passion, unexpected, inexperienced and surrounded by different people, cultures, and beliefs. Sound familiar? It should.

Organizational growth and evolution is very similar to that of living organisms. They are conceived, and they mature. Like living organisms, an organization can also choose to either die or evolve into another organism. Living organisms do this over time and across generations, slowly altering genes, and through natural selection. Organizations do this as well, choosing to survive by changing its behavior, partners, priorities, or environment. Alternatively, choosing not to do these things, is an often-unconscious choice for extinction. This bifurcation, or fork in the road, is where the Veterans Health Administration is today. The world of health care is changing rapidly. Patients demand choice and convenience, payers demand price reductions, staff demand work-life balance and engaged leaders, accreditation requires excellence not existence, and successful strategy requires clarity not just communication.

For the Veterans Health Administration, this industry-wide chaos has created a necessity for organizational evolution, a rebirth. The environmental factors dictate that if the Veterans Health Administration wishes to survive, it must change, becoming not the same organism it was, or is, but a new version of itself designed with the lessons and experience of prior generations. This means, that the Veterans Health Administration of today, while better than the Veterans Health Administration of the 1980's, 1990's and early 2000's, must become more agile if it is to survive the faster, service oriented, lower cost, higher quality, tech savvy, integrated, forces of the future. This will be no easy task for the government's second largest bureaucracy, but the DNA is beginning to change in favor of its survival.

The Veterans Health Administration's culture, the structure upon which organizational DNA rests, is changing. From the ashes of an agency that, just a decade ago believed that it could fire its way to clinical excellence, is emerging a foundational culture which recognizes "failure" as a means to success. This new culture of High Reliability is creating the lattice, upon which rapid change and adaptation to the environment is more likely.

Introduction

In 2018, The Veterans Health Administration announced that the organization, the largest integrated health care system in the United States, was committing to becoming a High Reliability Organization. While the concept of High Reliability is mature in many high-risk and high-complexity industries, it remains less pervasive in health care, though the need for its principles is perhaps greater in health care than in any other industry. It is currently estimated that between 250,000 to 400,000 Americans die each year as a result of medical errors, making it the third leading cause of death. For the Veterans Health Administration, achieving its goal of High Reliability was defined as "reaching zero harm, with an unmatched experience." With 162 health care systems, 1600 sites of care, and 320,000 employees, embarking on its journey to High Reliability required thoughtful scoping, planning, and implementation. As a result, the organization decided to phase implementation, identifying 18 (5%) of its health care systems to lead the cultural transformation and alter the trajectory of the larger organization. This paper will review the initiation of High Reliability principles at The South Texas Veterans Health Care System in San Antonio, Texas; one of the 18 flagship Veterans Affairs Health Care Systems selected.

About the STVHCS

South Texas Veterans Health Care System (STVHCS) is comprised of two inpatient campuses: the Audie L. Murphy Memorial Veterans Hospital in San Antonio and the Kerrville VA Hospital in Kerrville, Texas. STVHCS serves one of the largest primary service areas in the Veterans Health Administration providing health care services for 100,000 unique Veterans.

The Audie L. Murphy Memorial Veterans Hospital, named after the nation's most decorated World War II soldier, is a quaternary care facility, which is affiliated with the University of Texas Health Science Center at San Antonio (UTHSCSA). Comprehensive health care is provided through acute medical, surgical, mental health, physical medicine and rehabilitation, geriatric, and primary care services. Comprised of a Spinal Cord Injury Center, a Community Living Center, a Domiciliary, and a Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), the health care system's services also include specialty areas in bone marrow transplantation, open-heart surgery, an oncology center, dialysis unit, robotic surgery, and positron emission tomography. As a Level II Research facility, the health care system has projects that include aging, cardiac surgery, cancer, diabetes and HIV. The facility has one of three National Institutes of Health sponsored clinical research centers in the VA. In addition, the Geriatric Research, Education & Clinical Center (GRECC) is a "Center of Excellence." The Kerrville campus of the STVHCS, located 65 miles northwest of San Antonio, provides primary care, some specialty care, geriatric evaluation and management, palliative care, and long-term care services with a Community Living Center. The health care system's fiscal year 2019 operating budget was $802 million dollars, with 4,300 salaried personnel.

High Reliability Foundational Pillars

There are three essential pillars required to establish a High Reliability Organization, the first is leadership commitment, second a culture of safety, and finally continuous process improvement.

These pillars are illustrated in graphic below. Each of these comes with its own depth of requirement to ensure the intent of the underlying High Reliability principle is met, and therefore explaining their implementation would fill a volume of texts. For the purposes of this paper, specific emphasis will be paid to the culture of safety pillar, and continuous process improvement and their emphasis during the initial implementation of

High Reliability concepts at the STVHCS. Less detail will be provided for leadership commitment, but some detail is required to provide context to the overall outcomes achieved to-date.

Evaluating the Culture of Safety

In October 2018, the STVHCS was notified of its selection as one of 18 Veterans Health Administration facilities to lead the national transition to High Reliability. In a matter of months following this notification, the Chief Executive, Chief of Staff, and Nurse Executive were engulfed by an agency defined process to educate themselves on High Reliability principles. This required they attend learning sessions with the other 17 facility senior leaders, and to engage in the national governance of the implementation. In addition, they were assigned a High Reliability coach consulting firm with High Reliability implementation experience in both healthcare, and from other industries such as aeronautics where the high reliability principles are considered more mature.

In addition to these external educational opportunities, the organization was required to complete the Oro 2.0 Assessment. Created by the Joint Commission Center for Transforming Healthcare, Oro 2.0 is available to Joint Commission accredited health care institutions at no additional fee. Oro 2.0 is designed to help institutions on their journey to High Reliability, with significant emphasis on the culture of safety within the institution. The assessment helps health care leaders know where their organization is on its path to high reliability and is meant to encourage an honest, in-depth conversation among senior leaders and create alignment.

To utilize this tool, senior leaders, members of the Executive Governing Board, and key leaders in the local labor union took the assessment individually and then came together as a group to take the assessment again, with the goal of reaching a consensus on their institutions' strengths and weaknesses. The Oro 2.0 assessment was then compared to the prior two years results of the Safety Perception Survey, an annual internal

employee survey developed by the Department of Veterans Affairs. The scoring results from the Safety Perception Survey are in Figure 1. Each domain scored by employees utilized a 1-5 scale.

Figure 1

	2016	2018
Overall Perception of Patient Safety Culture	4.21	4.39
Non-Punitive Response to Error	3.84	3.97
Education Training and Resources	3.91	4.13
Shame From Error	3.07	3.17
Communication/Openness		
Teamwork within Hospital Unit	3.84	3.92
Teamwork Across Hospital Units	3.4	3.55
Organizational Learning-Cont. Improvement	3.83	3.93
Feedback and Comm Re: Error	3.46	3.58
Pat Safety in Comparison to Other Facilities	3.33	3.44
Frequency of Event Reporting	3.55	3.7
Senior Management Awareness/Safety Promo	3.64	3.76

The results indicated that staff perceived the organization to have an improved overall perception of safety with nearly every category seeing improvement in 2018 from the base year of 2016. However, with the requirement that the organizations culture of safety set the foundation for the evolution to a highly reliable organization, scores below 4.0 were considered by the governing board to reflect room for improvement.

Defining True North

As stated previously, the concept of high reliability in health care is to achieve zero harm for the patients served. For the Veterans Health Administration, this was defined as "Achieving zero harm, with an unmatched experience." For the South Texas Veterans Healthcare System, the difficult task left to do was making both harm reduction and experience measurable, with clear baselines and the ability to track progress over time. The result of this process was the establishment of three value streams, where if excellence was achieved in each, the organization was assured that it was moving towards its "true north" of zero harm and an unmatched experience.

The value streams created were safety, quality, and experience with specific data points identified under each after significant deliberations with the organization's key clinical leaders and executive governing board. The performance metrics chosen came primarily from a much larger set of clinical outcome and process measures used by the Veterans Health Administration to score and rank its facilities on a 5-star scale, akin to what the Centers for Medicare & Medicaid Services (CMS) does for its participating hospitals. The evaluation model, known as Strategic Analytics for Improvement and Learning (SAIL) uses many of the industry accepted indicators of harm and quality to give an overall rating to each of its health care systems. Measures such as hospital acquired infections, catheter associated urinary tract infections (CAUTI), central line associated blood stream infections (CLABSI), ventilator associated events (VAE), and risk standardized mortality rates (SMR) are prevalent in this internally developed model. The SAIL model also evaluates preventative care processes associated with evidence-based practice guidelines that have been shown to improve health care outcomes generally referred to as HEDIS and ORYX measures for inpatient and outpatient settings. In total the SAIL model has 10 domains: Performance Measures, Mental Health, Mortality, Access, Care Transitions, Length of

Stay/Throughput, Employee Satisfaction, Patient Experience, Efficiency, and Avoidable Adverse Events. Prior to the start of its High Reliability journey, the STVHCS was ranked as a 3-star facility, having improved from a 2-star rating the prior year.

Figure 2 below reflects the ranking of the facility as of the 4th quarter of fiscal year 2018, the final performance period before the high reliability flagship designation and principle implementation. To illustrate this scoring system and facility ranking, see Figure 2.

Figure 2

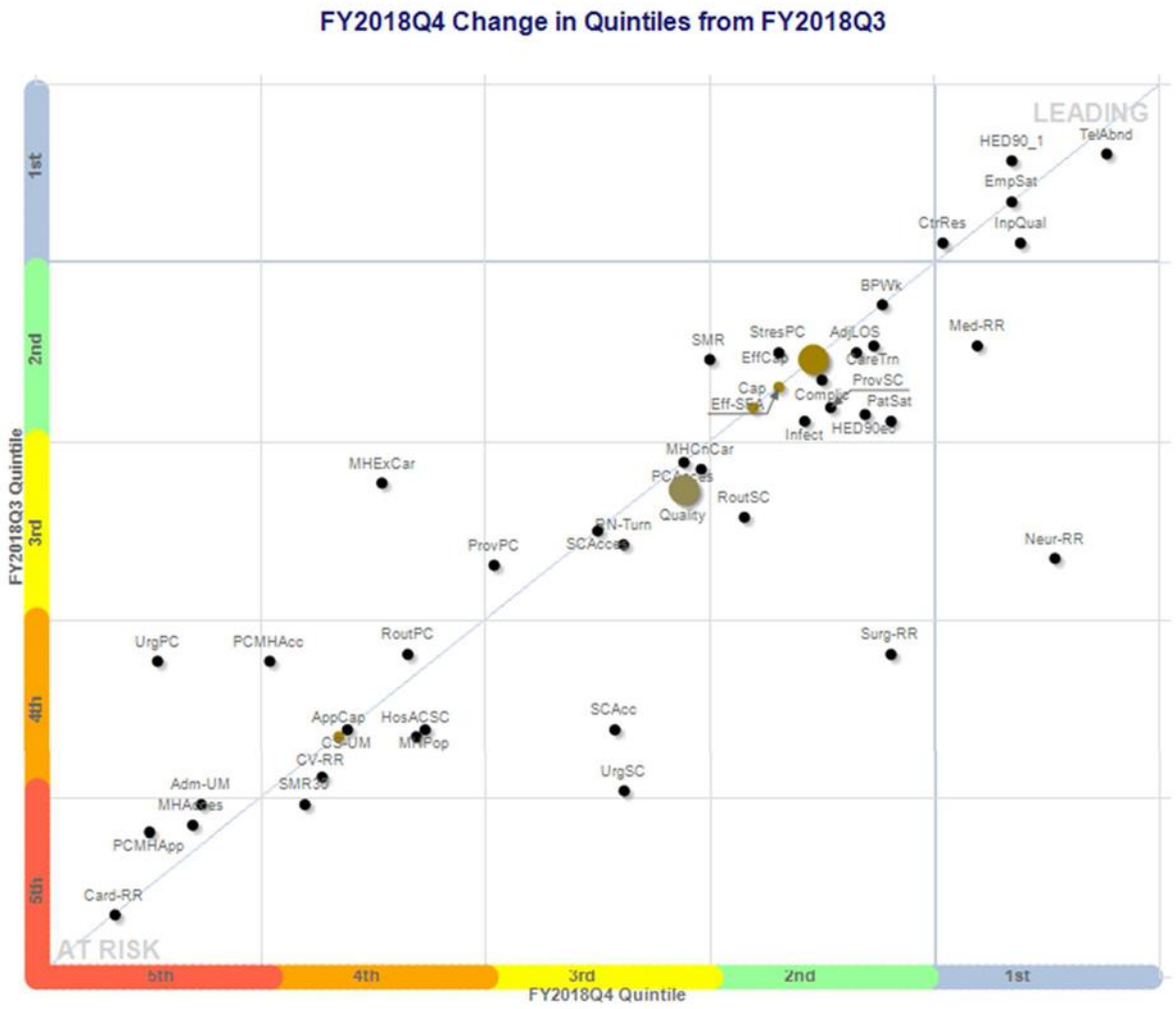


Figure 3 below lists the specific metrics the South Texas Veterans Healthcare System selected as key performance indicators (KPIs) for its High Reliability journey. These measures are predominately from the SAIL model previously discussed and whose current performance is reflected in Figure 2. The data in Figure 3 is updated to reflect 2019 performance for the purposes of this paper. The HRO Dashboard compares the healthcare system's performance to its VHA regional peers (VISN) as well as its national VHA or private sector competitors.

Figure 3

Topic #1 HRO Metric Establishment

JLC Approved HRO Metrics

Strategic Goal: Create "True North" with HRO to validate activities to move STVHCS towards zero harm.

- **Quality**
  - ED metrics of ED1, ED2 and ED3
  - ~~SAIL SMR~~
  - SAIL SMR30
  - Sepsis Identification
- **Safety**
  - SAIL Hospital Associated Infections (CAUTI, CLABSI, MRSA, C. diff, VAP/HAP)
  - SAIL MH Population Coverage Metric
  - % Incident Report submissions classified as near misses
  - Hospital Falls with fractures
  - Care Transitions HCAPS
  - Communication re: Medications SHEP

Figure 4

HRO Dashboard (*Measure Set 1.0*)

	National	VISN	STVHCS
Hospital Acquired Conditions (quarterly)			
PSI 04 Death among Surgical Inpatients (treatable conditions)	0.86	0.56	**0.62**
PSI 12 Perioperative PE or DVT	0.91	1.29	**1.06**
PSI 13 Postoperative Sepsis	0.59	0.55	**0.54**
Clostridium difficile Infection Rate*	0.42	0.47	**0.35**
Falls with ***any*** Injury*	1.36	1.13	**0.64**

* Rate (*case per 1,000 BDOC*)

Figure 5

HRO Dashboard (*Measure Set 1.0*)

	National	VISN	STVHCS
Reporting (monthly)			
Adverse Event Reporting	*TBA*	*TBA*	***169*** *(↑23%)*
Close Call Reporting	*TBA*	*TBA*	**48** (↑65%)
RCA Reporting Ave. Score	*TBA*	*TBA*	***2.17 , 2.5***
Employee Safety (yearly)			
Annual Workplace Evaluation Score	*FY19 Score Pending*		

Figure 6

HRO Dashboard (*Measure Set 1.0*)

	National	VISN	STVHCS
Additional Measures (quarterly)			
CLABSI Rate	1.07	0.61	1.06
ED LOS (Discharged)	-	-	165 min
ED LOS (Admitted)	-	-	347 min
ED LWBS	-	-	0.4 %
Influenza Vaccination	-	-	2,941 (64.2%)

Figure 7

HRO Dashboard (*Measure Set 1.0*)

	National	VISN	STVHCS
Leadership (yearly)			
AES: Managers communicate the goals of the organization	3.74	3.78	**3.79**
Culture (yearly)			
AES: Best Place to Work	66%	67%	**68%**
Vsignals: Trust Score	88%	85%	**87%**

Figure 8

HRO Dashboard (*Measure Set 1.0*)

Voice of The Veteran (quarterly)	National	VISN	STVHCS
Hosp Compare: Patients who gave their hospital an overall rating of 9 or 10	73%	-	**73%**
Hosp Compare: Patients who reported Yes they would definitely recommend their hospital	70%	-	**72%**
Inpt Survey Q#23 - Staff took preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left.	45.1	44.6	**54.5**

South Texas Veterans Health Care System

Figure 9

HRO Dashboard (*Measure Set 1.0*)

Voice of The Veteran (quarterly)	National	VISN	STVHCS
Outpt Q#20 - How often did this provider listen carefully?	77.2	71.3	**74.6**
Outpt Q#24 - How often did this provider show respect for what you had say?	81.9	76.4	**79.0**
Outpt Q#54 – Overall How Satisfied are you with the health care you have received at your VA facility during the last 6 months?	81.2	75.2	**76.7**

South Texas Veterans Health Care System

Figure 10

HRO Experience Metrics

MEASURES:

Leadership	AES: Managers communicate the goals of the organization.
Culture	AES: Best Place To Work Score SAIL
Employee Engagement	AES: How satisfied are you with your involvement in decisions that affect your work.
Employee Engagement	AES: Workgroups collaborate to accomplish shared objectives.
~~Voice of the Veteran*~~	~~HOSP COMP: Patients who gave their hosp an overall rating of 9 or 10 SAIL (Q21)~~
Voice of the Veteran*	HOSP COMP: Patients who reported YES they would definitely recommend their hospital
Voice of the Veteran	SHEP: IP SHEP Question #23: Staff took preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left. IBN, SAIL
Voice of the Veteran	SHEP: PCMH SHEP Question #20: How often did this provider listen carefully? IBN
Voice of the Veteran	SHEP: PCMH SHEP Question #24 : How often did this provider show respect for what you had to say? IBN, SAIL
Culture	VSIG: Trust Score
*Voice of the Veteran**	*SHEP: PCMH SHEP Question #54: Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*

South Texas Veterans Health Care System

Beginning the Journey

In March 2019, the STVHCS made two significant leadership announcements. The first was the selection of a new Chief Experience Officer, a new senior leadership role, reporting directly to the Chief Executive Officer, with a singular focus on improving both the veteran and employee experience. This made STVHCS only the second Veterans Healthcare System in the country to establish such a role. The second was a newly consolidated quality, safety, value clinical product line with a physician executive reporting directly to the Chief Executive with primary responsibility for coordinating performance improvement, patient safety, and process improvement activities across the enterprise. These were the final pieces of the senior leadership infrastructure determined necessary before making the formal announcement of the organization's High Reliability intentions.

In June 2019, with the results of its internal assessment in hand, and an additional external assessment conducted in April, the South Texas Veterans Healthcare System officially announced to its staff and stakeholders the intent to become a High Reliability Organization. This announcement was intended to be dramatic and attention-grabbing to ensure that staff understood that this was not another initiative of the month, or a public relations stunt, but was in fact a change in direction for the health care system at large. Intended to reflect the pillar of leadership commitment, the announcement was recorded by the Chief Executive Officer, and sent to all staff, posted on the organization's internet homepage, and sent to all external stakeholders. In his address to staff and stakeholders, the Chief Executive laid out the activities that were to occur going forward, including staff training, and the need for their engagement in the High Reliability journey if it was to be successful. (The Chief Executives HRO declaration video is viewable at the following link: https://youtu.be/_BSrsQhEj4w). Following this initial public announcement, the organization aggressively pushed supplemental media and messages to staff to educate them on the concepts of High Reliability, including a video from the Physician Executive for Quality, Safety, and Value (viewable here: https://youtu.be/N421dnmiE3w) in which the principles are reviewed in detail. This was followed by a message from the Chief Experience Officer to explain the connection between Experience and the High Reliability journey through staff engagement (viewable here: https://youtu.be/61lrpeHDmHY).

For the next three months, STVHCS invested considerable resources into deploying four key high reliability behaviors in the organization. These were, conducting safety forums, implementing lean daily management huddles, utilization of a visual management systems, and leadership rounding for purpose. These four activities were determined to have the greatest potential impact on the culture of safety and ensuring that the greatest number of staff were exposed to the three high reliability pillars. The health care system set out providing training to its senior, mid-level and frontline leadership and front-line staff on topics such as Just Culture, and patient safety incident reporting. This helped to ensure universal understanding that the STVHCS was willing to acknowledge to its staff that in the complex health care environment, errors would occur. It also emphasized that learning about the errors and using continuous process improvement techniques to eliminate the process failures that cause most errors is the goal, not settling with a culture of blame or solving errors with discipline.

In three months, the organization trained 1,548 (36%) of its 4,300 employees, and the training effort continues. In July 2019, the organization initiated its first safety forum. These are public sessions where staff are debriefed on root cause analysis and near misses in the organization and given the opportunity to provide input as to whether they felt the actions proposed were strong enough to prevent the errors from reoccurring. These forums are now held one to two times a month with rotating presenters. In late July, and into early August, the health care system initiated lean daily management huddles, training senior leaders and work units on the Safety, Methods, Equipment, Supply, and Staffing (SMESS) method of huddling at the start of the day/shift to ensure the organization is focused on safety at this core, and then that staff have everything they need to be support that effort. To reinforce the use of the lean daily management system, the organization released another message to staff linking patient safety, Process improvement and staff engagement in a joint message from the Chief Experience Officer and Chief of Systems Engineering (viewable here: https://youtu.be/N421dnmiE3w)

Results to Date

In August 2019, the Veterans Health Administration released the fiscal year 2019 All Employee Survey results, which was consolidated for the first time with the Safety Perception Survey. The All Employee Survey was taken by staff in June 2019, just as the facility made its formal announcement of its high reliability journey but closed prior to the initiation of the training and information sessions previously referenced. The results of the

2019 survey were plotted with the 2016 and 2018 results and included the Veterans Health Administration average per measured domain. The results are represented in Figure 5:

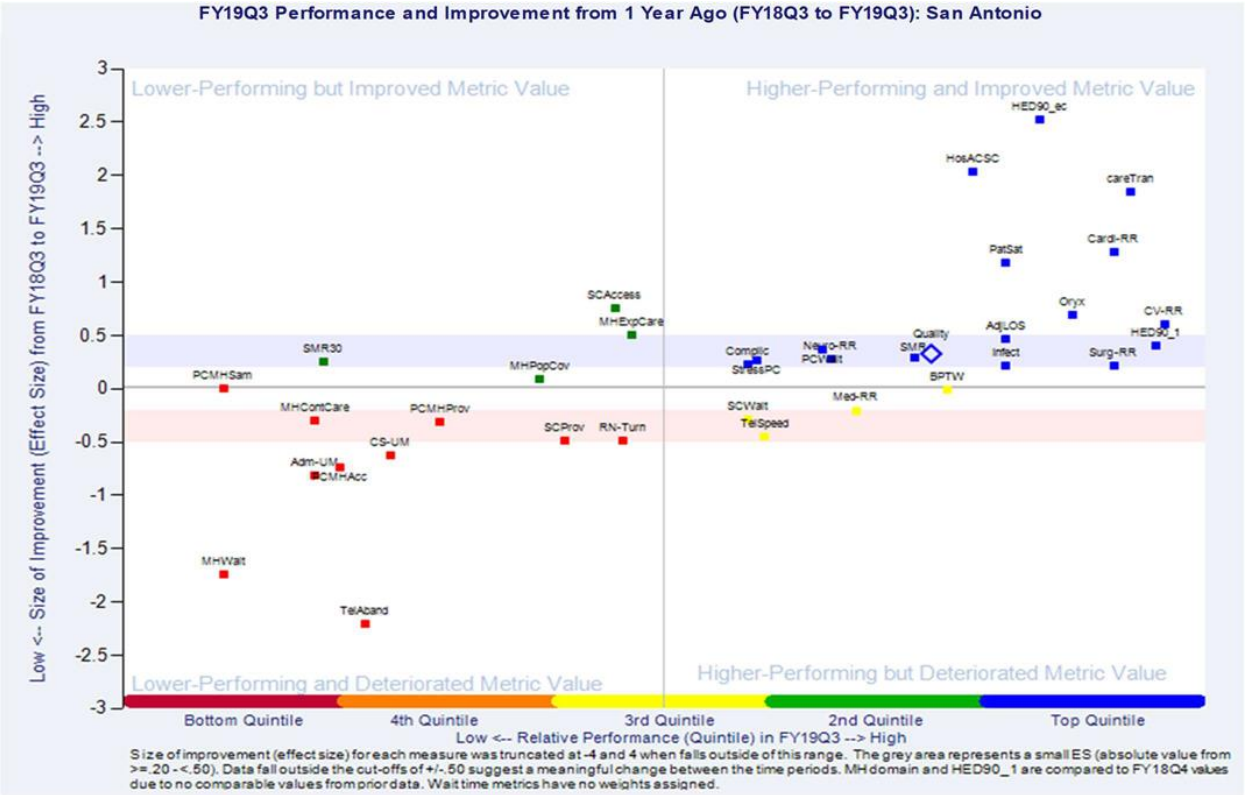
Figure 11

Domain	2016	2018	2019	VHA 2019
Overall Perception of Patient Safety Culture	4.21	4.39	4.27	4.23
Non-Punitive Response to Error	3.84	3.97	4.02	3.97
Education Training and Resources	3.91	4.13	4.21	4.16
Shame From Error	3.07	3.17	3.43	3.44
Communication/Openness			3.98	3.93
Teamwork within Hospital Unit	3.84	3.92	3.86	3.82
Teamwork Across Hospital Units	3.4	3.55	3.64	3.51
Organizational Learning-Cont. Improvement	3.83	3.93	3.74	3.65
Feedback and Comm re: Error	3.46	3.58	3.82	3.73
Pat Safety in Comparison to Other Facilities	3.33	3.44	3.78	3.64
Frequency of Event Reporting	3.55	3.7	3.69	3.6
Senior Management Awareness/Safety Promo	3.64	3.76	3.86	3.73

The results of the survey were promising in that 11 of 12 categories evaluated outperformed the Veterans Health Administration national average, indicating that characteristics of its safety culture were considered above average. Additionally, 7 of 12 categories outperformed the prior fiscal year, also indicating that taken collectively, the STVHCS continued to progress in its safety culture relative to itself. Specific to note is a significant increase in the Senior Management Safety Promotion metric, perceptions of safety relative to other facilities, and feedback/communication regarding errors. It is also worth noting that two measures did experience more significant declines in score, the overall perception and the perception of continuous process improvement.

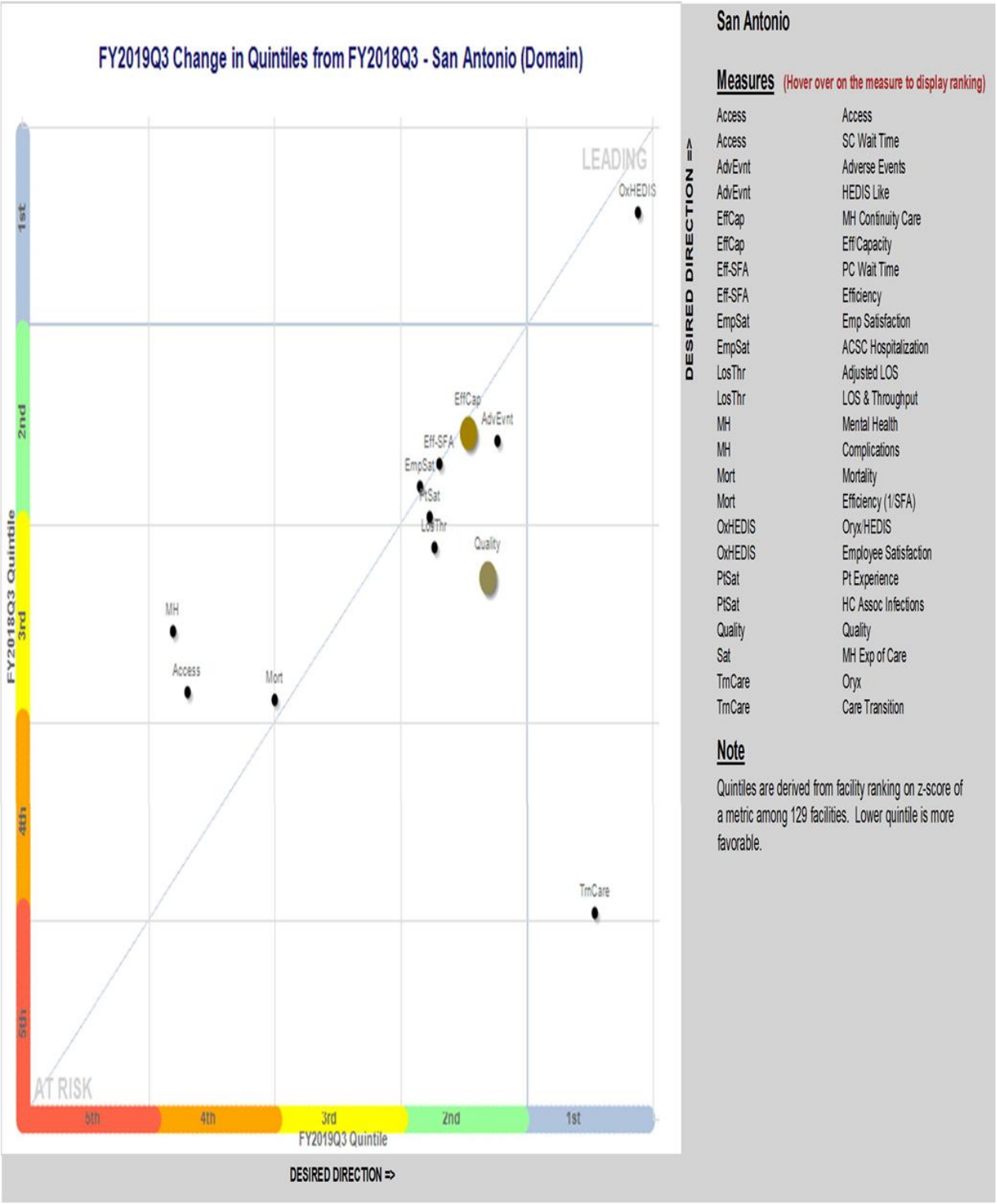
In October of 2019, the Veterans Health Administration released its 3rd quarter SAIL results, and the STVHCS had moved from its FY18 3rd quarter 3-star designation to its first ever 4-star designation. Most important to the facility executive leadership is that the principle areas of improvement were in areas linked to harm, or in those process metrics linked to improved health outcomes. Figure 6 and Figure 7 Illustrate the change in ranking for each domain over the twelve-month period evaluated in this paper.

Figure 12



easures		**easures**			
AdjLOS	Adjusted LOS	MHExpCare	MH Experience of Care	Surg-RR	RSRR-Surg
Adm-UM	%Adm Reviews Met	MHPopCov	MH Population Coverage	TelAband	Tel Abandonment
BPTW	Best Places to Work	MHWait	MH Wait Time	TelSpeed	Tel Answer Speed
Cardi-RR	RSRR-Cardio	Neuro-RR	RSRR-Neuro		
careTran	HCAHPS Care Transition	Oryx	Oryx		
Complic	Complications	PatSat	Rating Hospital		
CS-UM	%CS Reviews Met	PCMHAcc	PCMH Survey Access		
CV-RR	RSRR-CV	PCMHProv	Rate PC Provider		
HED90_1	HEDIS-EPRPM Based	PCMHSam	PCMH Same Day Appt		
HED90_ec	HEDIS-eQM Based DM IHD	PCWait	PC Wait Time		
HosACSC	ACSC Hospitalization	Quality	Quality		
Infect	HC Assoc Infections	RN-Turn	RN Turnover		
Med-RR	RSRR-Med	SCAccess	SC Survey Access		
MHContCare	MH Continuity of Care	SCProv	Rate SC Provider		
SMR30	SMR30	SCWait	SC Wait Time		
StressPC	Stress Discussed (PCMH Q40)	SMR	SMR		

Figure 13


FY2019Q3 Change in Quintiles from FY2018Q3 - San Antonio (Domain)
LEADING
AT RISK
OxHEDIS
EffCap
AdvEvnt
Eff-SFA
EmpSat
PtSat
LosThr
Quality
MH
Access
Mort
TrnCare
1st
2nd
3rd
4th
5th
FY2018Q3 Quintile
FY2019Q3 Quintile
DESIRED DIRECTION =>
DESIRED DIRECTION =>
San Antonio
Measures (Hover over on the measure to display ranking)
Access Access
Access SC Wait Time
AdvEvnt Adverse Events
AdvEvnt HEDIS Like
EffCap MH Continuity Care
EffCap Eff Capacity
Eff-SFA PC Wait Time
Eff-SFA Efficiency
EmpSat Emp Satisfaction
EmpSat ACSC Hospitalization
LosThr Adjusted LOS
LosThr LOS & Throughput
MH Mental Health
MH Complications
Mort Mortality
Mort Efficiency (1/SFA)
OxHEDIS Oryx/HEDIS
OxHEDIS Employee Satisfaction
PtSat Pt Experience
PtSat HC Assoc Infections
Quality Quality
Sat MH Exp of Care
TrnCare Oryx
TrnCare Care Transition
Note
Quintiles are derived from facility ranking on z-score of a metric among 129 facilities. Lower quintile is more favorable.

Conclusion

The Veterans' Health Administration's emphasis on harm reduction, solidified with its commitment to reaching zero harm has the early signs of improving health care outcomes, and increasing staff engagement and empowerment to drive change. This is evident in the early results seen at the STVHCS, where in a 12-month period, the organization has improved its overall quality ranking and absolute improvement relative to its own performance a year ago in key performance indicators relevant to its High Reliability aspirations. Only time will tell if these improvements will be the difference between survival and extinction of the larger health care system, but it can't be denied that the DNA is changing in its favor.

Resources

Veterans' Health Administration: www.va.gov

SAIL Public Reporting:
https://www.va.gov/QUALITYOFCARE/measureup/Strategic_Analytics_for_Improvement_and_Learning_SAIL.asp

South Texas Veterans Healthcare System Website: www.Southtexas.va.gov

Texas Delivery System Reform Incentive Payment Program: What the Future Holds?

Paul Aslin, Chief Transformation Officer, Wise Health System
Jyric Sims, Chief Executive Officer, Medical City Fort Worth
Toya White, Service Line Director, Texas Health Dallas

Executive Summary

Texas' Delivery System Reform Incentive Payment (DSRIP) Program has been a significant incentive-based funding source to hospitals, physician practices, and other health care service providers since the initiation of the program. DSRIP is part of the broader Texas Medicaid 1115 Transformation Waiver that was approved by the Centers for Medicare and Medicaid Services (CMS) in December 2011 to help fund vital health programs without expanding Medicaid. The funding under DSRIP allowed health care providers to pursue key elements of delivery system reform and to target the main goal of the DSRIP initiative: addressing the "Triple Aim" of improving the health of the population, enhancing the experience and outcomes of patients, and reducing the per capita cost of care.[1]

Historically, the waiver was successfully extended multiple times due to the steadfast support from the Texas congressional delegation. However, CMS never intended DSRIP to be a permanent funding source and the current waiver extension ends September 2022. The Special Terms and Conditions of the 1115 waiver included a requirement for the Texas Health and Human Service Commission (HHSC) to submit a draft transition plan that details how Texas will further develop its delivery system reform without DSRIP to CMS by October 1, 2019.[2] HHSC has queried stakeholders on alternative transition models and further engaged these stakeholders prior to the submission of their proposed alternative delivery model on September 30, 2019. From a legislative perspective, there were limited proposals docketed for Texas 86th legislative session related to DSRIP; none of these proposals were approved.

The positive impact of DSRIP from both an outcome and cost perspective has been widely published in Texas. From 2012 through January 2019 alone, DSRIP program participants received payments of over $15.1 billion and 72-90% of the projects fully achieved their improvement goals between DY4-DY 6.[3] However, this funding source is time-limited and at immediate risk of reduction in the next two demonstration years and total abolition on September 30, 2022. The lack of funding provided by DSRIP or an alternative model to sustain these initiatives will adversely impact Texas hospitals and the services they provide. Critical resources and programs are at stake and the lack of these resources pose a major impact, including discontinuation of programs and the closure of health care facilities in some rural communities. The imminent changes to the 1115 Waiver and subsequent impact to Texas hospitals and other health care providers necessitates the need for a robust, transitional care delivery model.

[1] Schlenker, T., & Huber, C. (2015). A Unique Funding Opportunity for Public Health in Texas. Journal of Public Health Management and Practice, 21, S81-S86. doi: 10.1097/phh.0000000000000131

[2] Texas Health and Human Services. "Waiver Renewal." Retrieved from https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal

[3] Texas Health and Human Service Commission. DSRIP Impact Summary. Retried from https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/vbpqi/may-2018-vbpqi-agenda-item-5c.pdf

We seek to establish a framework for an alternative, sustainable care delivery model to succeed DSRIP in order to sustain Texas hospitals and projects created under this program.

Background of DSRIP Funding

A community physician recently said the two most important things that impact a person's quality of life were health and money. Unfortunately, when you remove one, you usually remove access to the other.

In 2011, Texas HHSC began a move toward Medicaid managed care. In the years prior, the Upper Payment Limit (UPL) Program had been used to draw federal funds for hospitals across Texas as a supplemental payment for providing Medicaid services. Texas HHSC then wanted to move to Medicaid managed care, which was allowable under section 1115 of the Social Security Act. This new program, referred to as an 1115 Waiver, created two pools of funds which totaled $6.2 billion annually for participating health care providers. The first pool created was called Uncompensated Care (UC), and the second pool was named Delivery System Reform Incentive Payments (DSRIP). The initial waiver was approved by CMS for five years.

The UC pool acted similarly to the old UPL Program. Hospitals who serve Medicaid patients submitted figures showing the amount of Medicaid, charity, and uncompensated care they provided, and they were eligible to draw down a percentage of that amount by submitting non-federal dollars and receiving a federal match back on those funds, also known as an intergovernmental transfer (IGT).

DSRIP funds were earned through projects which expanded access to care and found new and innovative ways to provide care. This pool of funds was meant to incentivize providers to transform to improve quality, patient experience, coordination, and cost-effectiveness. Many long hours were spent with participating providers and HHSC to refine a menu of projects that would meet these requirements. The first couple of years required putting resources in place, such as hiring personnel or creating policies, to support the projects. The latter years paid for meeting specific outcome measurements, such as reduced emergency department visits or increases in percentage of diabetic patients with blood sugar control. Participating providers included hospitals (private, non-profit, and governmental), physician groups, academic medical centers, and local mental health authorities.

The participating providers were divided into 20 different regions called Regional Healthcare Partnerships (RHPs). Each RHP was assigned an anchor entity who became the liaison between the state and the participating providers in the region. The first few years required participants to put the resources in place to impact the outcomes in future years. All Texans were eligible for these services, but most projects targeted the Medicaid, low income, and uninsured populations (MLIU). Since Texas did not choose to expand Medicaid under the Affordable Care Act, these projects were a way to provide some level of care to a vulnerable population.

The initial waiver was renewed for a year and then extended, although with somewhat different measurements, for an additional five years. Waiver 2.0 would base payments mainly on achieving quality outcomes and sustaining the number of MLIU beneficiaries as served by the entire system, not just individual projects, as prior years.

Although the projects themselves created many new successes, there were some challenges to the program. First, using the IGT model required all participating providers to have access to governmental funding, which is required to draw down the federal match from which came the payments for meeting the goals. Partnerships between private hospitals and governmental within each RHP were formed in order to give access to IGT

funds to the private hospitals. Some of the arrangements in the partnerships were scrutinized by CMS as being an "impermissible provider related donation" and thus were disallowed under federal regulations. The clarity and consistency of these arrangements would later shape the guidance from CMS on future funding allowances.

Community and Patient Impact

Texas' DSRIP project is the nation's largest and opportunities created through these projects cannot be overstated, and neither can the innovation for patients and impact to providers. Across the state, there were approximately 1,400 DSRIP projects implemented that served about 12 million individuals.[4] Part of the Special Terms and Conditions required an evaluation to be conducted of the first five years. This evaluation included a case study which reported a decrease in hospital encounters of 19%.[5] In the study, 9 out of 11 evaluation goals in Medicaid Managed Care showed improvements in access to care, 10 out of 13 showed improvements in quality of care or care coordination, and two out of two showed marked improvements in cost of care.

Looking at a wider span of projects across Texas, we see in DY5 that 74 out of 84 projects reported improvement over the prior year with a median improvement of HbA1c control of 17%. Double digit improvements were also reported in areas of reduction of hospital readmission rates, reduction of ED visits, cancer screening, and seven-day follow up for behavioral health. Although these are impressive results, the study also showed the concern providers had in being able to sustain this work without continued funding. The evaluation concluded "Providers seemed unsure even in the fifth year of the Demonstration about how to sustain DSRIP projects without continued DSRIP funding."

It is easy to reference numbers as successes for these projects, but each number represents a Texan whose life has been changed, or even saved, because of these funds.

Early in the structure of performance measures, providers were required to report Quantifiable Patient Impact (QPI) through either measuring the unique number of patients or the total number of visits. Although the 1115 Waiver was setup to target Medicaid, these numbers were measuring all patients served who received an intervention. Later, this population was measured in a subset called Medicaid, Low-income/uninsured (MLIU).

Other stakeholders who have benefitted were businesses and local economies. The projects were made available to any payer in most cases, so employers may have realized a slower growth in health care costs in the duration of a project. Healthier employees mean fewer sick days. The 19% decrease in hospitalization mentioned earlier certainly had an impact on the costs of health care provided by employers. Local economies may have received a boost as well as hospitals and academic medical centers had to hire individuals to be able to provide and track the interventions mentioned in each project. Many of the projects even required hiring of people as a required reporting measurement. The incentive funds certainly added to the economic and job growth in Texas as unemployment in Texas during this time went from above 8% back in 2011 down to below 4% in 2019.[6]

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[4] Green, D., Grubbs, S., & Jauer, J. (2019). Texas and the 1115 Medicaid Waiver: Actions Needed to Ensure Federal Aid. Retrieved from https://comptroller.texas.gov/economy/fiscal-notes/2019/aug/healthcare.php

[5] Texas Health and Human Services Commission (2017). Evaluation of the 1115(a) Texas Demonstration Waiver-Healthcare Transformation and Quality Improvement. Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf

[6] Texas Economic Indicators. Retrieved from https://www.dallasfed.org/research/indicators/tei/2019/tei1909.aspx

Health Care Infrastructure Impact

Although the infusion of funding has made a tremendous impact in the ability to provide less costly and innovative ways to provide care, it has not reduced the number of Texas who do not have health insurance. Texas has both the highest number, 4.5 million, and the highest percentage, 17%, of residents who do not have health insurance. According to a report by the U.S. Census Bureau, Texas was one of nine states who saw an increase in the number of uninsured in 2018. Although it has not closed this gap, DSRIP projects as a whole did target those without insurance.

Since the passage of the Affordable Care Act, hospitals have begun to play an active role in community health. Section 501(r) of the IRS code requires non-profit health care organizations to conduct a Community Health Needs Assessment (CHNA) every three years. Further clarification in recent years has also asked hospitals for a plan to respond to the community needs identified. Additionally, each RHP had to conduct a regional CHNA. For many hospitals, DSRIP was the answer to the plan. Steps to bring in providers who would serve the underserved were taken. Non-traditional roles, such as community health workers and patient navigators were hired. These people provided valuable education and resources to community members, sometimes before they became patients, in order to reduce hospital use. Hospitals began to provide services that would ultimately save costs within the health system, and they did this without a fee schedule in place for those services. Behavioral health and the need for the integration of primary care with behavioral health was a common discovered need. So great was the need identified, that DSRIP now makes up one-third of the budget of the 39 local mental health authorities across the state. The value of these funds was touted recently by pointing to the response of those local agencies to recent gun violence in El Paso and Midland. The mental health infrastructure throughout Texas has been buoyed by these funds.

State Action

The state, through HHSC, has been active in trying to identify solutions which would continue work to support transformation HHSC has proposed. There was a bill introduced during the 2019 legislative session, SB 2480, by State Senator Lois Kolkhorst, that would have created an oversight committee on Waiver renewal, but it was not passed. There have been some multi-stakeholder lobbyist groups working to find some solutions, such as the Texas Alliance. Also, the Texas Hospital Association with Texas Organization of Rural and Community Hospitals have written articles in support of continued funding. HHSC has worked through the transition process to get stakeholder feedback and has created workgroups and committees to garner feedback into the transitions process. Thus far, there have not been any specific solutions which might support funding for all the participating providers under DSRIP.

Texas Hospitals' Perception

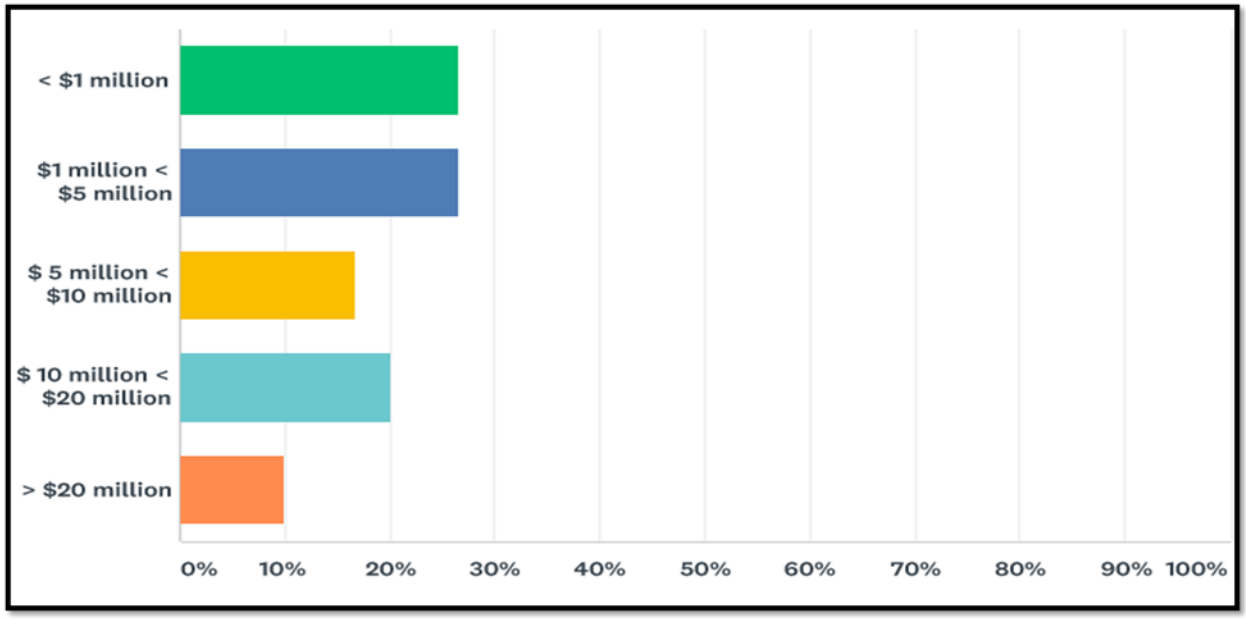
While state legislators and concerned trade organizations continue to debate solutions to DSRIP funding erosion, there appears to be a void in actual qualitative and/or quantitative data on Texas hospital executive's perception of hospital and community impact. In many communities across Texas, the local hospital is the largest employer. Reliance on DSRIP funding is pivotal to maintaining hospital operations and continuing to serve the community. We sought to better understand this topic to better inform the statewide discourse.

In an effort to capture qualitative and quantitative data directly from Texas hospital executives, a seven-question survey was composed and, in coordination with THA, disseminated to all hospital CEO's/ Administrators in the state of Texas. (Table 1). The goal of the survey was to ascertain a geographically diverse catchment of rural, suburban, and urban Texas markets. The survey had 31 respondents, of which 51% (16

respondents) were CEO/president and 49% (15 respondents) administrator/other. Respondents represented a very diverse geographical reach with 48% (15 respondents) rural, 22% (7 respondents) suburban, and 19% (6 respondents) urban. Greater health disparities and access to care disproportionately affects rural communities.

To further understand the current impact of DSRIP funding to surveyed hospitals, we needed to understand current funding levels. 26% (8 respondents) reported DSRIP funding is less than $1 million, while 26% (8 respondents) between $1 million and $5 million, 16% (5 respondents) between $5 and $10 million, 20% (6 respondents) between $10 and $20 million, and 10% (3 respondents) greater than $20 million. Given nearly half of respondents, reported current DSRIP funding being $5 million or greater and 66% of responding hospitals were in areas classified as rural or suburban, we really needed to understand the current hospitals plans to offset losses if DSRIP funding subsides.

Figure 1: Annual Impact of Loss of DSRIP Funds



When asked if alternative revenue streams were planned to offset DSRIP funding, only 3% (1 respondent) had alternate funding stream to completely offset the loss of DSRIP. Sixteen percent (5 respondents) had alternative revenue stream to partially offset loss, and the majority, 80% (25 respondents), either had a plan to marginally offset loss or no plan at all. While hospitals continue to grapple with real consequences of funding going away, 32% (10 respondents) reported it will case major impact or modifications to hospital including major layoffs greater than 20 employees, three or more key service line closures, and/or potential entire hospital closure. Of those surveyed, 32% (10 respondents) reported will have moderate impact as defined by 5-20 employee layoffs and one to two key service line closures. Only 6% (2 respondents) reported no changes in their forecast. Finally, we wanted to understand what key services the hospital will discontinue. The key theme in responses was closing outreach clinics, programs for the uninsured, and general across the board cuts to community programs and sponsorships.

Recommendations

The Texas 1115 Medicaid Waiver was comprehensive, impactful, and innovative in incenting collaboration and making Texans healthier while supporting the institutions best positioned to do this work. In order to meet the needs of Texans and sustain the investment health care providers have made, as well as encourage population health management, there needs to be something in place when DSRIP funds end in 2021. New funding models for Texas hospitals seem to support one initiative or one hospital class but still are limited to budget neutrality rules, managed care rules, access to non-federal share of IGT, and Medicaid managed care organizations' (MCO) willingness and ability to partner with providers of all sizes. Our recommendation is to provide broad support for continued care by a multifaceted solution that is flexible enough to reach all or most current participants in DSRIP, regardless of provider type, geographic area, access to IGT, or Medicaid-only volume.

The proposed solutions below are in addition to existing directed payments such as the Uniform Hospital Rate Increase Program (UHRIP) and Quality Incentive Payment Program (QIPP) and are in addition to enhanced or current supplemental payments outside of UC and DSRIP.

1) **Structure Medicaid benefits to include payment for chronic disease management.** This could include services such as diabetes education, transition of care, annual wellness visits, and chronic care management. Medicare has already begun to provide reimbursement for these types of interventions that can be provided by a nurse or physician. Many of the DSRIP projects showed improvement in the diabetic and multiple comorbidity populations. Payment for the services that resulted in the improvement could be structured within the current Medicaid system by expanding billable services. This would provide funding for some of the interventions. This funding could flow through an 1115 extension, similar to the North Carolina model, or it could be supported through the state's general revenue if approved through the 2021 legislature.

2) **Authorize payment related to social determinants of health.** CMS recently approved the use of new ICD-10 Z codes, so there now exists a method to collect the data required to track social determinants of health. Adopting a model that pays for this information and possible interventions, similar to the North Carolina Healthy Opportunities, would further the adoption of value-based care in Texas. This could take the form of collecting data into a statewide database that could be used to determine future resource allocation, or it could be used to support local providers in identifying interventions needed in the communities, furthering the work started under DSRIP. Future models could be based on pay-for-performance or shared savings similar to the Healthy Opportunities model.

3) **Support rural providers through an enhanced payment.** The fixed costs of rural providers cannot always be supported by volume, thus Rider 38 Hospitals and those affiliated with rural health clinics or physician groups should have an enhanced payment because of their role in providing services to uninsured and Medicaid. This could include an opportunity to provide funding for rural health clinics and physician practices who have access to IGT.

4) **Use Directed Payments to target disease-specific or geographic-specific peripheral populations.** A directed payment program through the MCOs is tied to Medicaid utilization, but should also be targeted to populations who are at-risk of becoming Medicaid eligible, who are "peripheral" to Medicaid eligibility. These payments would still be based on Medicaid utilization, but would be flexible enough to be directed at specific

populations served by DSRIP providers who may not currently be Medicaid eligible, but who may become eligible at some point.

Figure 2: DSRIP Funding Models

Impacts:	Medicaid Chronic Disease Management	Social Determinants	Enhanced Rural	Peripheral Directed Payments
Provider Type				
Hospital	x	x	x	x
Behavioral		x		x
Physician Groups	x	x	x	x
Funding				
General Revenue	x	x	x	x
IGT - Govt		x	x	x
IGT - LPPF		x		x
Stakeholder				
Urban	x	x		x
Rural	x	x	x	x
Payer Source				
Medicaid	x	x	x	x
Low income/Uninsured			x	x

In addition to the four recommended funding models, we recommend the following actions to support adoption of these changes:

1) **Use and build on the existing Regional Healthcare Partnership model.** The RHPs have close working relationships by the participating providers. This geographic network could be leveraged to garner support for new funding models, serve as a learning and innovation resource, or be utilized as a grouped population for population-based payments. This may require aligning the MCOs and Service Delivery Areas with the RHPs.

2) **Obtain stakeholder input on the proposed funding models to include not only participating providers but also state and federal regulatory agencies.** The direction of the need in this situation puts the onus on Texas to come up with solutions, but we would like to see federal engagement to help us.

3) **Hold learning and working sessions with the MCOs to learn how to work together and lessen the administrative burden of participation on both stakeholder groups.** Too much expectation has been placed on the MCOs without the knowledge or incentive to meet those expectations. Bringing payers and providers together to discuss solutions would be beneficial.

4) **Create a stakeholder group that includes patients who are impacted by the DSRIP program and would be willing to leverage support for continued funding for**

participating providers. Other than celebrating impact stories of the collaborative, the patient voice has been absent from this important work. Regulatory agencies should have the opportunity to hear from those impacted by the decisions.

5) **Create legislative action to authorize a study on the long-term viability of rural health care providers and see what would need to be done to support the sustainability of those organizations.** When a community hospital closes down, the community viability descends as well. We owe it to these communities to see what long-term solutions exist in the quickly changing health care landscape.

Conclusion

The ending of the current 1115 Waiver is a problem for every Texan. The funds do not just support, but are the lifeblood for many rural hospitals and mental health infrastructure throughout the state. It also serves as the source for care for the uninsured and many Medicaid patients. The funding through the 1115 Waiver is as important to the people served by the hospitals as the services are to the people served through the projects created by DSRIP. In other words, the funding sustains not only projects created through DSRIP but also the ability of many hospitals to continue to operate. As ideas are developed and details are added, this needs to remain the focus of state and CMS officials. Nothing short of an extension would sustain the current funding distribution, but fortunately, there are some proposals that would continue to infuse funding to allow these health care safety net providers to remain in existence. It is going to take efforts through state and federal levels, but also cooperation and collaboration between providers that were created through the initial waiver.

Acknowledgments

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Improving Pediatric Behavioral Health Care by Using Advocacy Efforts to Increase Medicaid Funding During the 2021 Legislative Session

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Executive Summary

More than a half a million children in Texas have a significant behavioral health disorder. In Texas, the number of inpatient discharges for pediatric psychiatry increased 8.1% between 2014 and 2017 with 46,848 pediatric psychiatry discharges in 2017 (Source: THCIC). It is estimated that the inpatient demand for pediatric psychiatry is expected to grow by 19.6 % from 2017-2027 in Texas. (Source: Sg2 Analytics-Market Demand Forecast).

Continued inappropriate utilization of the emergency department as a site of care for behavioral health treatment is driving up health care costs as a result of insufficient access to more appropriate treatment sites. Providers encounter several obstacles, which include the following: a lack of inpatient behavioral beds, a shortage of board-certified psychiatrists, overuse of inpatient bed utilization from foster care and juvenile criminal justice agencies, the inability to care for children and adults with medical issues, and the lack of trained pediatric trained psychiatric professionals.

The Texas Legislature has actively pursued this issue and it continues to be a priority for the 2021 legislative agenda. During the 2019 legislative session, the House and Senate passed at least 13 different bills related to behavioral health. The following legislation will provide access and programs for children with behavioral health and substance use disorders: Senate Bill (SB) 11, Texas Mental Health Care Consortium/School Safety; SB 633, Local Mental Health Authorities Increased Capacity to Provide Access to Mental Health Services; SB 1177, MCO's Offering Evidence-Based Services in Lieu of Mental Health or Substance Abuse Disorders; SB 2111, THHSC to Contract with A Local Public Institution of Higher Education to Transfer Operations of Austin State Hospital; and House Bill (HB) 4455, Mental Health Services Provided Through Telemedicine Medical Service or Telehealth Service.

Despite the significant strides made in passing important legislation to address behavioral health issues, the recent legislation does not address the need for acute care pediatric behavioral health needs, the need for recruiting new psychiatry residents, physicians and nurses to address the shortage of these professionals, or the need for an enhanced rate of reimbursement for hospitals and providers.

A budget rider for a two-year Medicaid rate enhancement for pediatric and adolescent behavioral health care services is necessary to ensure there is adequate funding for inpatient beds, and provider reimbursement to ensure the future and well-being of Texas children.

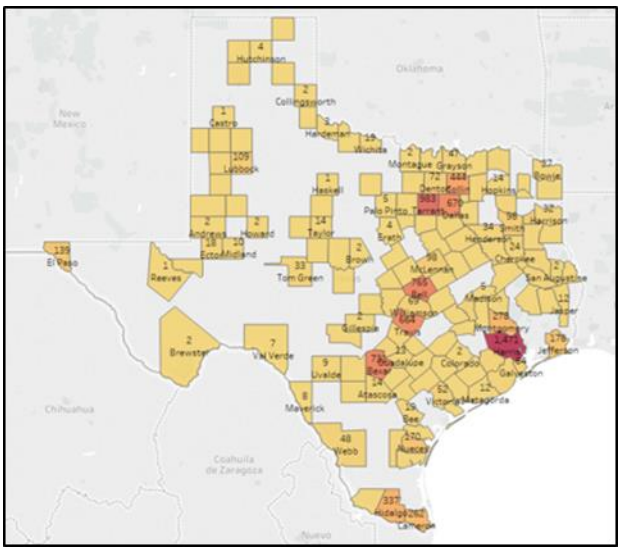
Reason for Addressing

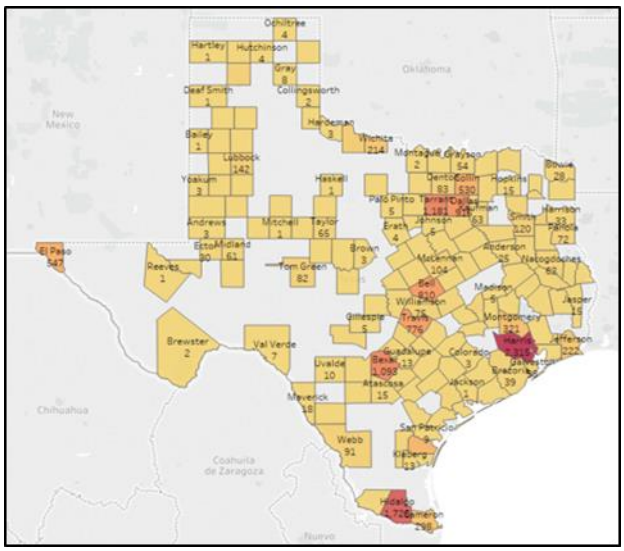
Today, it is estimated that there are more than 28 million Texans, of which approximately 7 million are children age 17 years old and younger (Source: HHSC). More than half a million children in Texas have a significant behavioral health disorder and over 20% of children ages 9-17 have a diagnosed mental illness (Source: Mental Health Texas). In Texas, the number of inpatient discharges for pediatric psychiatry have increased 8.1% between 2014 and 2017 with 46,848 pediatric psychiatry discharges in 2017 (Source: THCIC). From 2017-2027, the inpatient demand for pediatric psychiatry in Texas is expected to grow by 19.6% (Source: Sg2 Analytics - Market Demand Forecast). For this same time period, pediatric psychiatry emergency department visits are projected to increase by 10.6% (Source: Sg2 Analytics. Market Demand Forecast). In the past three years, Texas teen suicides increased 28% from 8.7 to 11.1 deaths per 100,000 adolescents ages 15-19 (United Health Group).

Texas Pediatric Discharges (THCIC October 2015 – December 2018)

IP Discharge Status	Not ED	ED	Grand Total
Discharged to Home or Self Care	3,220	293	3,513
Left Against Medical Advice or Discontinued Care	23	4	27
Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List	14		14
Discharged/transferred to a Psychiatric Hospital	3	10	13
(blank)	9	3	12
Discharged/Transferred to a Designated Cancer Center or Children's Hospital	2	7	9
Discharged/Transferred to a Facility that Provides Custodial or Supportive Care	7		7
Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital	2	2	4
Discharged/Transferred to a Short-term General Hospital for Inpatient Care	2	2	4
Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care	4		4
Discharged/Transferred to Court/Law Enforcement	2		2
Discharged/Transferred to a Medicare Certified LTC	1		1
Discharged/Transferred to Home Under Care of Organized Home Health Service Organization	1		1
Hospice - Medical Facility	1		1
Grand Total	**3,291**	**321**	**3,612**

Texas Pediatric Psychiatry Inpatient and Outpatient Discharges from the Emergency Department based on Hospital Counties (THCIC October 2015-December 2018)

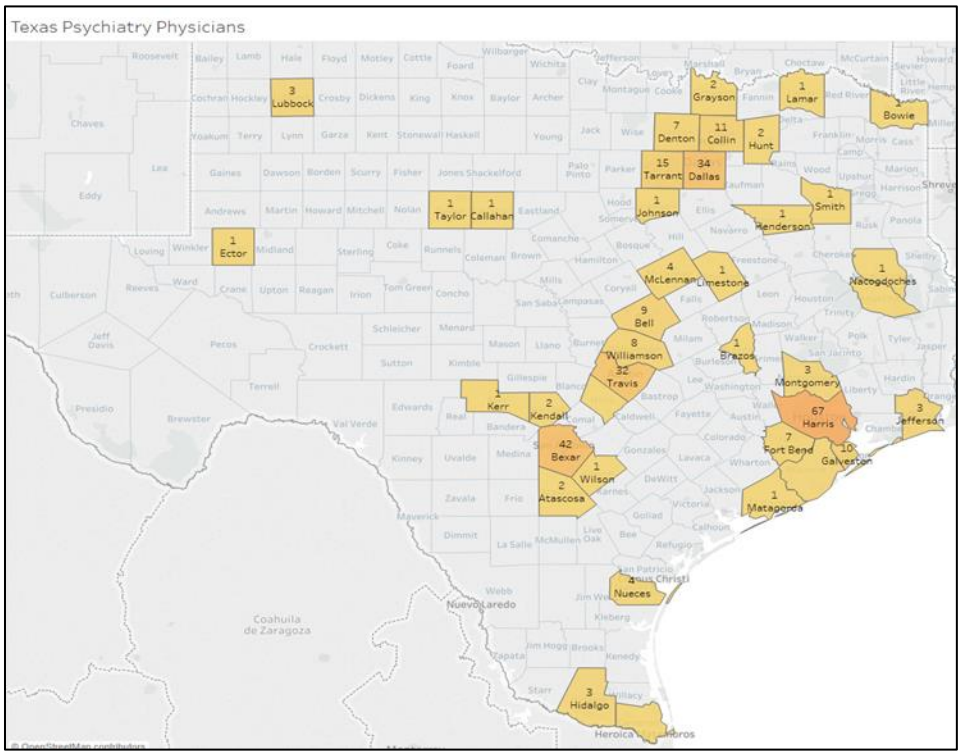




Despite the increasing need for inpatient behavioral health services for children in Texas, there has been a decline in the number of acute inpatient behavioral health beds available across the state. StateMaster reports that there are 2,479 inpatient psychiatric beds throughout the state. In the Dallas region alone, there has been a loss of 282 beds since December 2017 (D Magazine, September 2019). Continued inappropriate utilization of the emergency department as a site of care for behavioral health treatment is driving up health care costs as a result of insufficient access to more appropriate treatment sites. Emergency department visits for behavioral health related concerns for children 5-17 has increased by 22% from 2015 to 2018 (DFWHC). Rural emergency departments are finding an increase of behavioral health visits due to lack of available alternative resources. Of the state's 254 counties, 182 counties in the state have no behavioral health resources and 177 counties are considered rural (HHSC). Inpatient facilities that do treat children tend to be in metropolitan areas, resulting in families driving multiple hours in order to be a part of their children's treatment. The lack of behavioral health resources throughout communities in Texas negatively impacts the outcome of treatment and decreases the likelihood of follow up treatment post discharge, ultimately increasing the risk of readmission in the future.

Providers encounter several obstacles including a lack of inpatient pediatric behavioral beds, a shortage of Board-Certified psychiatrists and a lack of pediatric psychiatric nurses. As of May 2019, there are 3,054 board certified psychiatrists in Texas with a total of 30 pediatric psychiatrists (Texas Board of Medicine). Texas is seeing an increase of nurses in the workforce, but is only at 91% of the national average for RN's per 100,000 population and only 3.1% of RNs in the state identify as psychiatric nurses (Health Professions Resource Center and 2015 Nursing Workforce in Texas: Demographics and Trends). Existing inpatient behavioral health facilities are hesitant, if not resistant, to opening additional pediatric beds due to a low return on investment.

Number of Texas Psychiatrists by Location



These issues are largely attributed to limited state funding for pediatric behavioral health care provider encounters when seeking insurance reimbursement. This makes it difficult for health care organizations to

increase services and sufficiently staff pediatric inpatient psychiatry beds to care for these children appropriately. More than 60% of Texas's children are covered by Medicaid, which continues to rank the lowest in reimbursement for behavioral health care (American Academy of Pediatrics and Children's Hospital Association, Texas Medicaid Highlights). In addition, a 2013 Kaiser Family Foundation Study found that Texas ranked 48th amongst states in per capita mental health funding from the State Mental Health Agency. Steve Love, President and CEO of the DFW Hospital Council, recently stated, "Even though the insurance industry strives for parity with acute care payments, sometimes the impact of less reimbursement and increased expenses compress margins in behavioral health." Reporting data from 15 inpatient facilities that currently treat children report an average cost per day of $555 per patient day, while the average Medicaid published rate for these facilities has remained at $530.16 since 2011. Medicaid Published Rates have remained flat for eight consecutive years while costs have continued to exponentially rise.

Advocacy Analysis Process

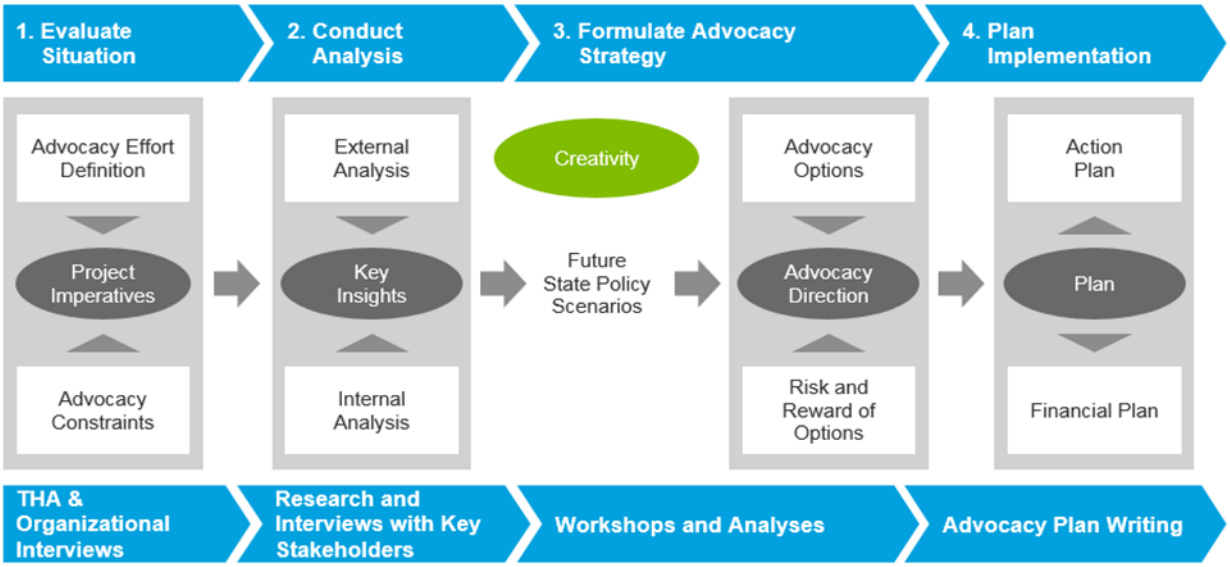
To determine the optimal approach for advocating for increased pediatric and adolescent inpatient behavioral health funding, we went through a multi-phased process. The initial stage focused on evaluating the various contributing factors to the pediatric and adolescent behavioral health crisis in Texas. Given the breadth and depth of behavioral health issues in Texas, we determined it was critical to focus on one specific contributing factor to the current behavioral health landscape such as the workforce shortage, existing payment models, or the foster care system. Given the complexity of the topic, this approach would help ensure we had a clear and concise advocacy message. In reviewing each of these topics, we discussed the challenges and barriers of advocating for change as well as the defined goal for that specific approach.

Once we narrowed down our topic, we conducted extensive internal and external analysis to gain key insights into the issue and to determine the most favorable advocacy approach. Within each of our respective institutions we spoke with policy, operational, and payor subject matter experts as well as reached out to subject matter experts outside of our organizations such as the Texas Hospital Association (THA) and the Dallas Fort Worth Hospital Council. These conversations focused on gaining a deeper understanding of the problem, securing key data points, and identifying key stakeholders (i.e. The Meadows Foundation, the Psychiatry Lobby, etc.) who would be critical in supporting our efforts to advocate for legislative change.

Based on our analysis, we identified a number of potential approaches to impact future state policy such as advocating for an increase in specific Medicaid CPT and ICD 10 codes, introducing a bill to request a new dedicated funding stream, advocating that the current Texas Medicaid Published Rates be retired, and advocating for the inclusion of a budget rider to provide a Medicaid rate enhancement. For each of these options, we identified challenges and barriers to the approach, if this method had successfully been utilized in the past, and how the approach would be perceived in the current political environment.

Upon review of these options, we determined that the optimal strategy would be to advocate for a two-year Medicaid rate enhancement for pediatric and adolescent behavioral health care services during the 2021 legislative session. We determined this was the ideal path forward as there was demonstrable need for a funding increase, there is precedence for the legislature approving this payment model, it is only an increase in funding, the political climate is ripe to address this issue, and the ability for us to show long-term savings on health care spending. Upon the decision to move forward with this advocacy approach, we developed an action and communication plan which is discussed in detail in the next section.

Advocacy Evaluation Process Summary



Action and Communication Plan

As discussed earlier, the demand for pediatric and adolescent inpatient behavioral health beds continues to increase and Texas is currently in the bottom five states in the US on behavioral health spending. The number of pediatric behavioral health beds in Texas is 2,479. The Treatment Advocacy Center in 2008 estimated that states need 60 beds per 100,000. No official effort has been made to validate or revise this estimate. There are 5,278,887 children 5-17 years of age, which requires a 27% increase in the number of inpatient beds. The aim of this project is to increase Medicaid funding for inpatient pediatric and adolescent behavioral health care services during the 2021 legislative session by advocating for the inclusion of a budget rider in the 2022-2023 Health and Human Services Commission budget that will provide a two-year $4.5 million rate enhancement for these services. The existing Texas Medicaid Publish Rates were set in 2009 and have not been increased since 2011. In reviewing cost data from 15 inpatient facilities, the average cost of services per day per patient is $555 and reimbursement is only $530. A $4.5 million rate enhancement will help alleviate existing, substantial losses for these services and encourage existing behavioral health facilities and hospitals to add additional pediatric and adolescent behavioral health bed capacity throughout the state.

Initial advocacy efforts will focus on building a key constituency group in late 2019 with key stakeholder/policy advocacy groups such as The Meadows Foundation, The Hogg Foundation, THA, the Children's Hospital Association of Texas, the Texas Medical Association, the Federation of Texas Psychiatry and other related specialty associations. A briefing document (Appendix A) will be reviewed with key stakeholders that outlines and clearly articulates the need for increased funding and how the proposed budget rider will result in increased inpatient pediatric and adolescent behavioral health bed capacity. The goal of these meetings will be to reach alignment and support of the proposed budget rider as well as obtain approval to add this advocacy initiative to each individual entity's 2021 legislative priorities list.

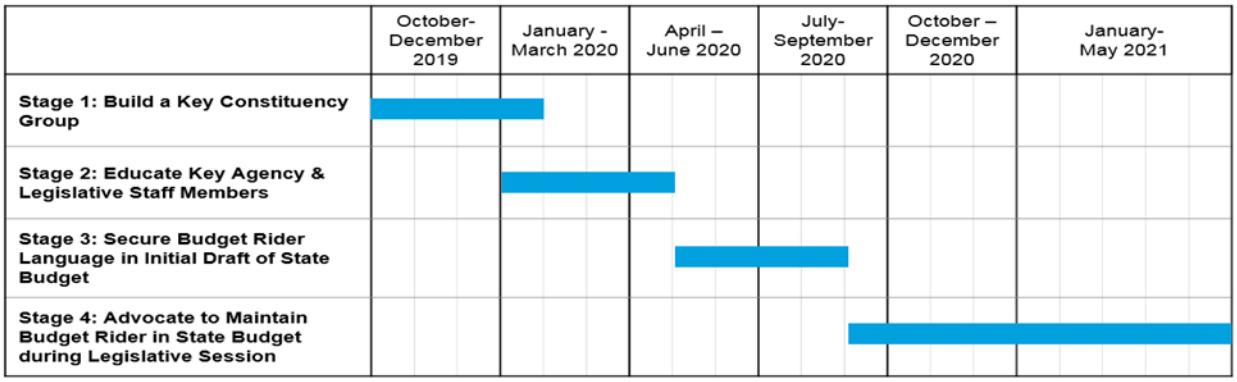
Once a key constituency group has been formed, in support of the budget rider, meetings will be held with key staff members from the HHSC, the Governor's and Lieutenant Governor's Office, Speaker and the chairs of the Senate Finance and House Appropriations Committees. The message in these meetings will focus on how

additional dollars will increase access to pediatric and adolescent inpatient behavioral health services. The briefing document previously mentioned as well as additional supporting documents will be used to educate key staff members on the importance of this budget rider inclusive of demonstrating the need for increased services, how the proposed investment will impact existing bed capacity, and cost savings that will be achieved as a result of being able to provide these patients, the right care, in the right place, and at the right time.

Critical to our advocacy efforts will be ensuring that the budget rider is included in the initial draft of the State budget, specifically Article 2. In early Spring 2020, we will begin circulating the budget rider language with the appropriate staff members in the HHSC as well as with key legislative staff members. The focus on this phase of advocacy will be the hard sell and justification of the requested dollar amount in budget rider and how this budget rider will support existing strategies within the HHSC such as an increase in the number of kids served. In addition, we will work with key staff members to identify which Chapter in Article 2 the budget rider will be most appropriately placed.

Once the proposed budget rider has successfully been included in the initial draft of the State budget, advocacy efforts will shift to focus on maintaining budget rider language in the State budget during the negotiation process between the Senate and the House. Advocacy efforts will target the Senate and House Finance Committees as well as key legislative members and their staff. Messaging will continue to focus on the same concepts in the previous advocacy phase: justification of the requested dollar amount and how increased funding will result in more kids receiving inpatient behavioral health care.

Action and Communication Plan Summary and Timeline



Post legislative session, we will track key data points to determine the impact of the rate enhancement in expanding inpatient pediatric behavioral health access. Most importantly, we will deploy a communication plan that targets organizations who will positively be impacted by the increase in available funds. This will ensure the benefits of the budget rider can be maximized by allowing the targeted organizations to tailor their business plans to include the introduction or expansion of care for this patient population.

Project Challenges and Barriers

There will be challenges and barriers encountered along the way of messaging the proposed budget rider and obtaining key stakeholder buy-in. There will be many competing priorities being pushed by advocacy groups for these same dollars in the 2021 legislative session. The timeline outlined is aggressive and engagement with the key advocacy groups will be initiated immediately. This effort will require dedicated resources as consistent follow-up with the identified key constituency group is critical to ensure full alignment of our efforts.

Development of the briefing document will be imperative to ensuring we create a meaningful and effective advocate pitch that demonstrates the vital need for additional funding in the 2022-2023 HHSC budget. As part of this briefing document, we will need to ensure we can communicate the most recent published data in a compelling way as well as ensure the document can easily be updated as we receive new data or refine our message based on feedback from our meetings with key constituency groups.

While the development of messaging for key constituency groups will be a focus, we must also ensure our advocacy efforts are aligned and communicated in a way that non-health care entities and/or stakeholders understand the current challenges facing this patient population. These individuals and groups can easily be overlooked but should be included in the initial phase of our communication plan development. It is imperative that we utilize as much as possible real-life experiences and patient/health care provider stories in our advocacy plan as this is often the most effective way to communicate the issue on a personal level and demonstrate the barriers of care that exist for this patient population.

Lastly, quantifying the funding needs will require us to provide specific, not generalized data points to justify the requested funding increase. The budget rider is a specific ask for $4.5 million and this request must be justified and shown through appropriate supporting documentation. THA will be an important partner in validating our increased funding request. Key examples of probable outcomes from this additional funding will be used to show a possible return on investment. These examples must have the ability to be reported out and will be part of the plan to track progress of an approved Medicaid rate increase.

Conclusion

The National Council for Behavioral Health published a report in March of 2017 "The Psychiatric Shortage: Causes and Solutions" outlining many of the challenges faced with the ongoing psychiatric shortages throughout the country. The lack of access to psychiatric services has been a challenge for decades and this challenge is only growing greater as children diagnosed with a behavioral health condition grows.

Reimbursement for behavioral health should have parity with reimbursement for medical-surgical services in hospitals and other primary care settings to provide incentives for psychiatric providers and health systems to participate in these programs, increase access points, improve outcomes, and reduce over utilization of emergency departments.

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Appendix A

Texas Behavioral Health Statistics

Statistics from 2018

- **175 counties** do not have a single licensed psychiatrist, leaving more than 3 million Texans living in counties with no psychiatrist.
- **20 counties** have only one psychiatrist, serving nearly 50,000 individuals.
- **186 of 254** or **73% of counties** are designated as having a Mental Health Professional Shortage.
- **60%** of Behavioral Health professionals practice in the five most populous counties.
- **2,479** reported inpatient pediatric behavioral health beds in Texas.
- **8.1% increase** in inpatient discharges from 2014-2017.
- **19.6% expected growth** for inpatient demand from 2017-2027.

Texas ranks **41st** out of **50** for Physician-to-Population Ratio

DID YOU KNOW?

Average cost of services is **$555** per patient day versus **$530** of average Medicaid reimbursement per patient day. A **5%** variance which does not account for denials.

*Only **3.1% (7,247)** registered nurses practice in psychiatric, mental health and substance abuse specialties.*

Estimate of need is **40-60** inpatient behavioral health beds per 100,000 people, which would require a **27% increase** in number of beds.

Notes

Other Capstone Projects from the 2019 THA Leadership Fellows

Addressing Workplace Violence in Healthcare

Ajith Pai, PharmD, FACHE, President, Texas Health Harris Methodist Hospital Cleburne

Consumerism in Health Care

Wesley Barnt, Vice President, Ancillary Services, Midland Memorial Hospital
Susan Wade, Vice President, Human Resources and Compliance, Hendrick Medical Center

Creating Broader Avenues to Quality Health Care Access Through the Expansion of Telehealth Services

Jessica Loy, Physician Recruiter, The Hospitals of Providence, El Paso
Megan Powe, Chief Strategy Officer, The Hospitals of Providence Sierra Campus, El Paso

Lobbying CMS to Accept E-Surveying as a Mode for HCAHPs and Provide Access to "Current Data"

Vishal Bhalla, vice president, chief experience officer, Parkland Health & Hospital System

Physician Recruitment Redesign: Designing a Recruitment Strategy around Physician Practice Critical Success Factors

Natasha Montez, Chief Executive Officer, Guadalupe Regional Medical Group

Addressing Workplace Violence in Health Care

Ajith Pai, PharmD, FACHE, President, Texas Health Harris Methodist Hospital Cleburne

Executive Summary

Workplace violence in health care, predominantly patient on employee, has historically occurred at high rates, is underreported, and existing processes and legislation to address are inconsistent and/or lacking. Data show that the rate of incidence is increasing and occurs at levels far above those seen in other industries. Further complicating the issue, the care and compassion required to provide the calling of the mission and ministry of health care can often blur the lines between what behavior is tolerable and what is unacceptable.

Currently, there are initiatives taking place across the country to begin to address this important issue, however there remains an urgent opportunity for many to begin to define the problems that exist within their organizations and communities. Lacking a single known best-practice, it is our desire to share the journey of one North Texas Health System's, Texas Health Resources, approach to address this important issue. We hope this creates dialogue and awareness of workplace violence in health care and helps to provide a foundation for those in need to initiate programs.

As we continue to be challenged by skill shortages, a tightening labor market, an increasingly empowered workforce, and non-traditional provider entrants competing for our existing labor supply it is incumbent on employers to ensure the work environment is safe and engaging to provide stable, sustainable employment to care for an ever-aging population.

Introduction

Workplace violence in health care can no longer be accepted or tolerated as part of the job. According to the Occupational Safety and Health Administration (OSHA), from 2002-2013 the health care industry averaged four times higher serious workplace violence incidents than private industry. OSHA considers serious workplace violence as those that require an injured employee to take days off from work to recover. As noted with other recent movements in health care related to a safe culture and high reliability, it is believed that the events experienced by employees subject to workplace violence is significantly underreported. For example, a survey of over 4,700 nurses in Minnesota revealed that 69% of physical assaults and 71% of non-physical assaults were reported to the manager, while another medical center found that only half of verbal and physical assaults were reported at all. Reasons given for not reporting incidents included fear of retaliation, an absence of policy, or a lack in faith in the reporting system. In 2015, a study bill supported by the Texas Nurses Association (TNA) and in partnership with State Representative Donna Howard showed that one in two nurses were subject to workplace violence in their careers.

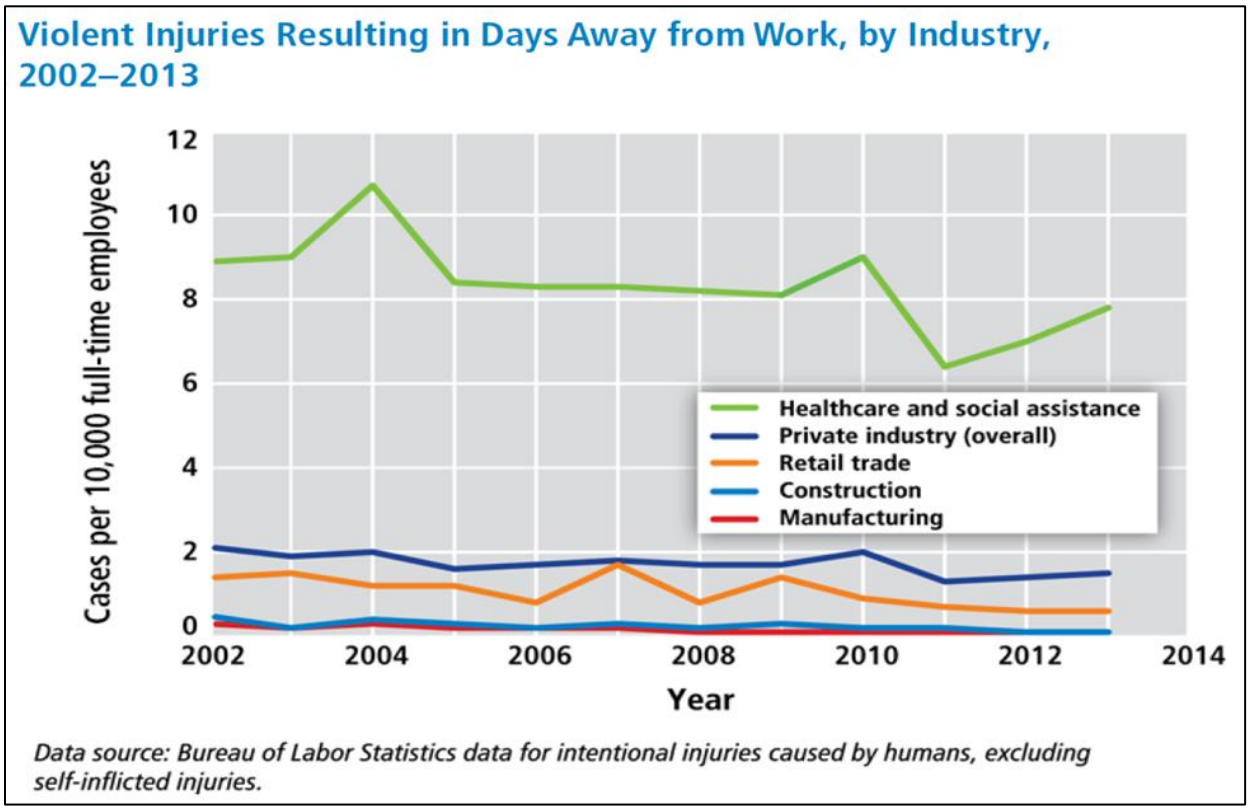
As we seek to find ways to create improved outcomes in quality, experience, and value for our patients and consumers, our employees must feel engaged in the ability of the organization to provide a safe and supportive workplace to allow them to provide the best care to our community. In his 2019 annual State of the Clinic speech, president and CEO of the Cleveland Clinic, Dr. Tom Mihaljevic, stated that violence against health care workers was a national epidemic. "It is an epidemic, because it is an epidemic that nobody speaks about," he said in an interview after his speech. "Yet it strains those who are trying to help others. It is very

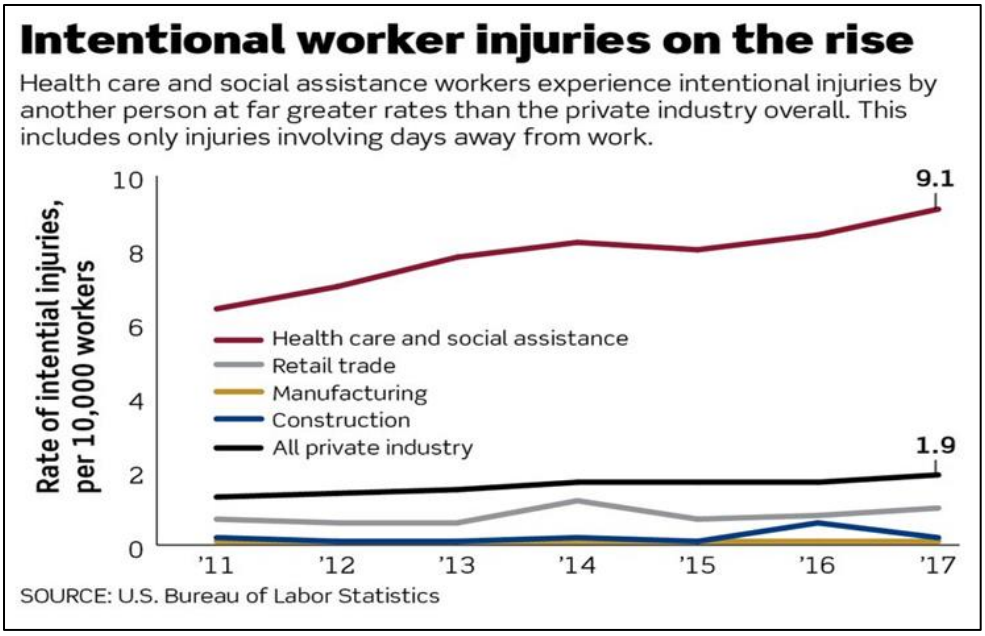
disconcerting to have well-meaning people who dedicated their lives and their careers being put in harm's way by trying to help others."

Our hope through this discussion and information sharing, is that it creates a larger dialogue and platform for leaders and organizations to work together to share best practices and to advocate for legislative support to ensure solutions that provide an engaged workforce and a safe workplace. A sustainable workforce in a tight labor market with an aging population having increased demand for care, helps to further the proposal to manage all aspects of safety, reliability, and engagement to manage costs and improve efficiency and quality in care.

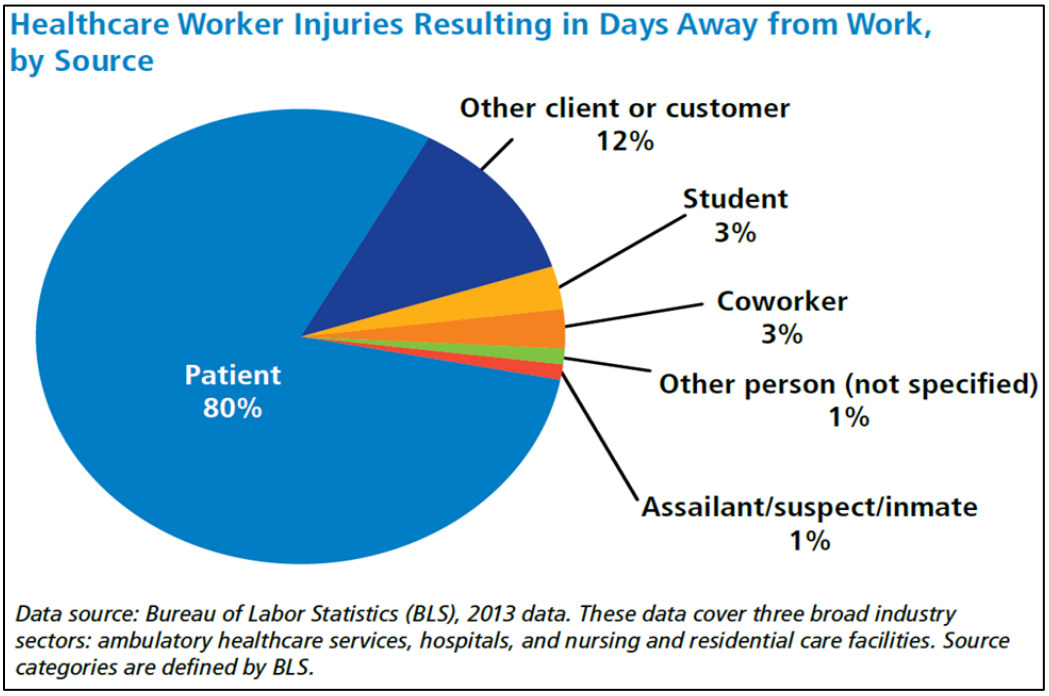
Current State

As noted, the incidence of serious workplace violence is significantly higher in health care than in the private industry. The two subsequent graphics below illustrate the rate of injury in health care as compared to other industries, and the increasing trend as of late whereas the private sector appears to trend relatively flat.





Additionally, although violence can occur through different interactions a health care worker may have throughout their shift, the overwhelming risk is put forth by the individual receiving care.



For the 86th Texas Legislature regular session, the TNA once again partnered with State Representative Donna Howard to pursue HB 1146 which would require providers to adopt and enforce a workplace violence and prevention policy and plan. HB 1146 would apply to: hospitals, nursing homes, home and community support services, ambulatory surgery centers (ASCs), freestanding emergency medical care facilities, and behavioral health hospitals.

One Health System's Approach – Best Practice Sharing

As with other cultural and organizational shifts regarding safety and high reliability, the leadership must set the tone. Texas Health Resources CEO Barclay Berdan stated the organization's view of having zero tolerance for workplace violence and supported through the following position statement:

> Texas Health is committed to providing a safe and secure healing environment for patients, family members, visitors and employees.
>
> Threatening or aggressive language or behavior is unacceptable at Texas Health. This includes:
>
> - Physical assaults/Outbursts
> - Verbal harassment
> - Abusive language
> - Sexual language directed at others
> - Threats
>
> Anyone exhibiting threatening or aggressive language or behavior will receive instruction on expected behavior from their caregivers, including nurses and physicians on the medical staff. If they persist, Security may be called; a Threat Management Team may be assembled; and the patient, family member, visitor or employee may be asked to leave by the entity. Texas Health supports staff in pressing charges for malicious physical attacks they encounter while caring for patients.
>
> For more information, please contact Human Resources.

Additionally, Texas Health Resources adopted the following goals in alignment with our organizational values:

- Recognizing potential risks and communicating them to others
- Reporting potential workplace violence, a responsibility of all employees
- Responding to potential workplace violence, with the goal to de-escalate a situation before it becomes physical
- Reducing risk of workplace violence through use of controls such as security cameras and following personal security measures

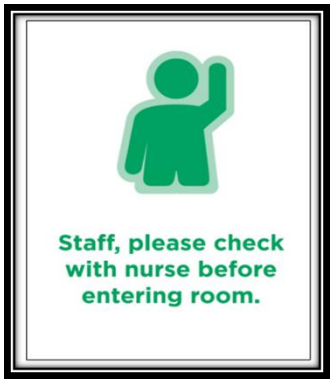
Our program started with assessing employee feedback utilizing a survey in June 2018. Subsequently, the position statement stated above, and a policy including processes and tools were released to employees. Some of the expectations and tools developed and shared with leaders and staff included:

- Employees are empowered to speak up for safety for themselves, their co-workers, those they care for, and all they come in contact with.
- De-escalation strategies for critical interactions.
- Intervention tips.
- Leadership responses and escalation processes.
- Post-incident resources and documentation.
- Threat Management Team (TMT)—entity-based team of cross-functional staff that assesses threat and determines an action plan, which includes security and HR personnel.

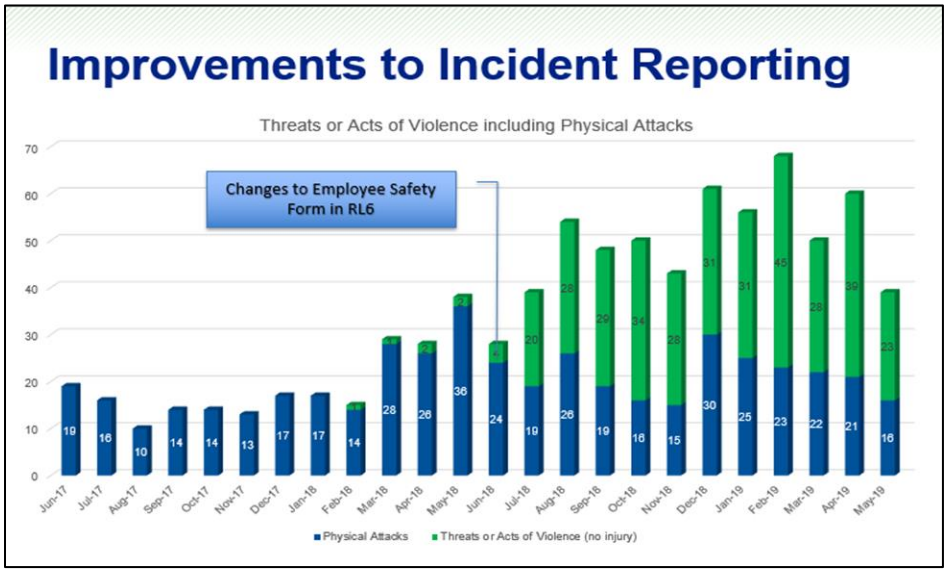
- Crisis Prevention Institute (CPI) training—gives employees the skills to safely respond to various levels of risk behavior while balancing the responsibilities of care.
- Critical Incident Stress Management (CISM)—a structured group discussion (debriefing) concerning a critical incident.
- Employee Assistance Program (EAP)—one-on-one counseling via phone, web or chat.
- Chaplains—provide spiritual guidance and consolation.
- Ongoing organizational communication strategy to keep employees current on tools and resources.

Additionally, we have worked to improve care team coordination and communication regarding behaviors or incidents that may put others at risk during the patient's stay:

- Leverage technology to enhance communication between nursing staff and other clinical staff by using the EHR for awareness and documentation.
- Signage is posted on the patient's room door with scripting available if care team is questioned. This symbol is our adopted universal icon for patients that may be at risk to act out:



- Utilize our existing incident reporting system (RL6), we incorporated the above symbol to create consistency and reliability in the employee's ability to use the tool for ongoing events.
- Our success is capturing more events to better define the issue is shown below:



Conclusion

For too long, health care workers have had to accept workplace violence as just a part of their daily duties in caring for our communities. As the evidence shows, health care has led in incidence and seen a rise in trend of events, however has transversely lagged in addressing this important employee engagement and workforce sustainment issue.

With a tightening labor market, increased competition for skilled labor from non-traditional health care entrants, and a changing labor demographic it is incumbent on employers to ensure the work environment is safe and employees have the opportunity to be empowered to speak up for safety.

The first step is for leadership to set the tone and be open to discussing the workplace violence daily risks impacting our staff. We should then work together to define the problem as it exists in our workplaces, and subsequently utilize resources and tools that allow us to follow the goals mentioned in this article: recognize, report, respond, and reduce to ultimately best serve the caregivers that care for our communities. Partnering with the Texas Hospital Association and our governing bodies will help to ensure that support and resources are available to better serve our workforce and thus most importantly our patients.

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Consumerism in Health Care

Wesley Barnt, Vice President, Ancillary Services, Midland Memorial Hospital
Susan Wade, Vice President, Human Resources and Compliance, Hendrick Medical Center

Executive Summary

The health care industry must become more consumer-focused to remain competitive as traditional patients are becoming more educated and demanding consumers. Consumers are becoming more cost-conscious as high deductible health plans and other health plan modifications designed to control cost are resulting in patients shouldering more of the cost of health care. New providers are entering the health care market to meet unmet needs of consumers. Health care consumers are demanding: easily accessible care that meets their schedule - not the schedule of their provider, patient experience that is personal yet prompt, pricing transparency, reduced personal expense, and technology that provides access to both services and personal health information. Health care providers must meet these emerging needs to sustain and grow their markets. If they do not meet these emerging needs, they are in danger of reduced market share and margins, potential closure or acquisition. While these changes are significant and shift the focus of health care from more traditional models of care, they are necessary to remain competitive.

Background

Competition in health care is not a new concept, but the type of competition is evolving. The days of hospitals and health systems facing the greatest competition for inpatient business with the health system across town are likely over. The competitors today are entrants from other non-health care industries, large tech companies and innovators that are seeking to pull outpatients away from traditional health care providers. This threat of disintermediation is acknowledged by the majority of those who responded to the 2019 Kaufman Hall Healthcare Consumerism survey with 88% agreeing or strongly agreeing that health care systems are vulnerable to non-hospital competitors. The new players to the industry that respondents felt generated the greatest threat were United Health Group/Optum, CVS Health/Aetna and Amazon (Kaufman Hall, 2019).

This competition is being driven by the health care consumer no longer being content to be satisfied but now placing more value on care that is delivered conveniently. NRC's Healthcare Consumer Trends Report for 2019 indicates that national averages for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) "Would Recommend" scores are the highest they have been in nine years while hospital volumes are flat and some health systems reporting decreases. Forty-seven percent of respondents report that they will be embarking on a technology initiative to garner health care consumer feedback (NRC, 2019). Consumers prefer to provide their feedback via email (55%), only 10% desired to respond via postal mail and 11% via phone calls. (Kaufman Hall, 2019)

These consumers also desire to provide their feedback soon (83%) after their encounter and after each encounter (44%). While HCAHPS has its role, it does not give health care organizations real time feedback they can use to build relationships and loyalty with their patients. Health care consumer feedback is mostly positive related to their caregivers with 87% highlighting courtesy and respect. Feedback on wait times tells another story with 77% of comments being negative. Consumers are demanding that all services be delivered when they want it and how they want it. Preston Gee, vice president of strategic marketing at Texas-

headquartered CHRISTUS Health sums up this new era, "It's only going to get more consumer-centric from here". (Kaufman Hall, 2019)

While the consumer is craving more from their provider in terms of convenience, health systems persist in building facilities over providing convenient care for their patients. One half provide urgent or ambulatory care centers only one third currently offer online scheduling. The consumer of today is calling for quick, efficient access to all services including health care. Millennials are leaving traditional primary care practices and opting to seek care through telemedicine, retail clinics and urgent care providers. The Kaiser Family Foundation poll noted that 45% of adults age 18 to 29 do not have a primary care physician (PCP) and 28% of adults age 30 to 49 do not either. Retail clinics have increased by 500% since 2006 and overall 30% of patients now rely on these clinics to provide their primary care. (Zuehlke-Heuser, 2017)

Another driver of consumerism is the rise of high deductible plans creating deferment of care with 22.7% indicating they are delaying needed care because of cost. Health systems operate on slim profit margins and lack an ability to provide discounted care. Seventy percent of those responding Definitive Healthcare's Annual Healthcare Trends Survey indicated their health care bill was difficult to understand and 61% were surprised at the amount of the bill. They also indicated that they received unexpected bills from multiple providers. As more health care cost is pushed to consumers, they are demanding simplification and a reduction in personal expense. If health systems do not meet these emerging needs consumers will continue to delay care and seek other modes of health care delivery. (Daughtery, 2019)

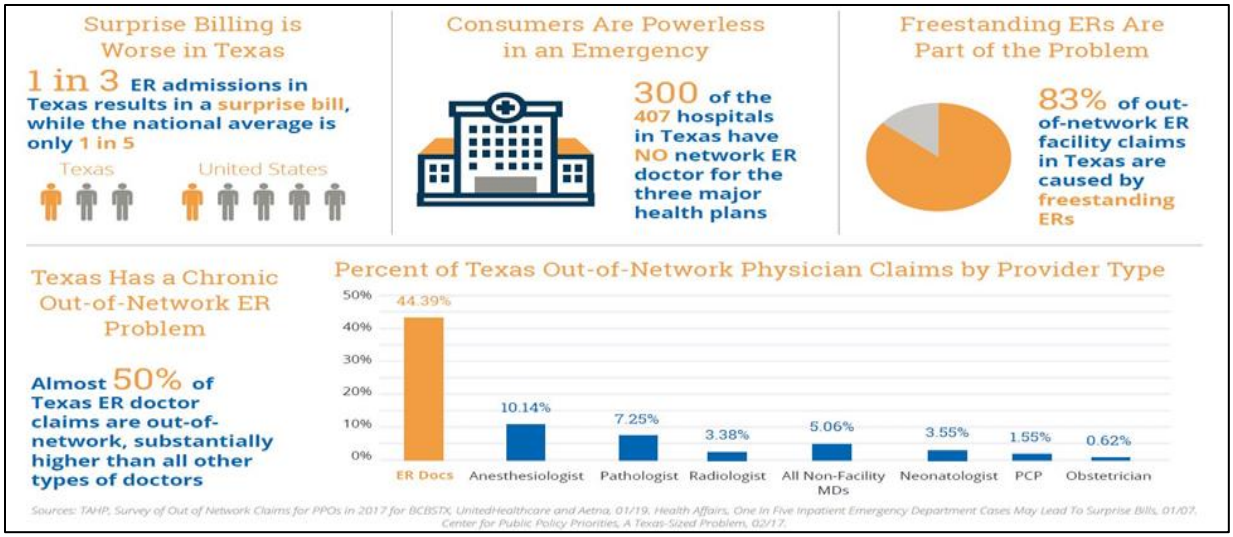
Texas Legislation Addressing Consumerism

On June 14, 2019, the state of Texas joined several other states providing consumers with protection against surprise billing or balance billing with the signing of Senate Bill 1264. This law became effective in September of 2019. This bill addresses: limitations on surprise billing information reported by consumer reporting agencies, elimination of surprise billing for specific health plans, and mandatory mediation requests. (Murphy, 2019)

Senate Bill 1264 no longer requires the patient to be involved. The mediation now occurs between the administrator of the health plan and the provider. The mediation is overseen by an impartial mediator. Arbitration only applies to bills in excess of $500 and services rendered in emergency departments or medical care provided within a facility that is a preferred provider.

Prior to this new law, mediation protected some Texans from expensive surprise medical bills but not many Texans understand the process or even knew mediation was an option. According to Texas Department of Insurance, out of the 250,000 Texans that receive surprise medical bills every two years, fewer than 10,000 use the mediation process. ("Surprise Billing Drives Up Costs for All Texans," 2019)

The table below summarizes the problem with surprise billing:



The most significant issue Senate Bill 1264 addressed is the fact that 44.39% of ER physicians are considered out of out-of-network with 83% of out-of-network facility claims were caused by freestanding emergency rooms.

Under this new law, an emergency care provider, a hospital-based provider (i.e. anesthesiologist, radiologist, etc.), the health plan issuer, or an administrator can now request mediation from the state of Texas. The expense of the mediator will be divided evenly amongst all the parties involved. The state is required to provide notification to all the parties involved in the mediation request.

Regarding the amounts of surprise bills, Senate Bill 1264 requires health plans to now pay for emergency care furnished by out-of-network providers at a contracted rate. Under no circumstances is the provider to bill a patient for an amount higher than the patient's financial responsibility under a specific plan.

Two bills were introduced during the 2019 legislative session that were intended to protect consumers. House Bill 3862 would require disclosure of the cash price for any health care services provided by a hospital. House Bill 2785 also requires a hospital owned or operated by the state or operated by a political subdivision of the state to disclose the cash price to patients for any health care service provided. Neither bill was enacted but there is likelihood the issue of cash price disclosures will be considered again during the 2021 legislative session.

Health Care Meeting the Consumer Demand Access

CVS MinuteClinics and Health Hubs coupled with the recent launch of Amazon's own in-house health care service are just two examples which emphasize the rapid rise of competition to traditional primary care models. CVS is the largest and fastest growing retail clinic in the United States boasting 1,100 clinics now representing more than half of all retail clinics. Their goal is 1,500 clinics with 50% of Americans having access to their clinics within 10 miles of their home. Health Hubs provide care for minor illness and injuries, vaccinations, screening and monitoring, wellness visits and even some elements of women's care. For those who choose to not leave their home to seek care, video care is offered through their site.

In November of 2018 CVS acquired $70 billion health insurance giant Aetna. In the words of Dr. Alan Lotvin, executive vice president for transformation of the company, "We're trying to transform the industry." The

health care industry is organized currently around the needs of the doctors, hospitals and other providers of care. "I think there is an opportunity to organize around the consumer." With the acquisition of Aetna, CVS now provides health insurance for 22 million people. Coupling that with its 10,000 stores they are positioned to be a game changer in providing convenient, affordable care (Bannow, 2019).

Urgent care centers have seen tremendous growth with over 8,200 nationwide generating in excess of $18 billion. They have 89 million patient encounters each year providing primary care for 29% of primary care visits in the U.S. Health care systems are increasingly opening their own urgent care centers at almost 25% in 2019. The rise of utilization of urgent care centers emphasizes the consumers demand for easy access and prompt service. These centers offer extended hours to include evenings, weekends and holidays as well as online scheduling. It also emphasizes the consumer's declining loyalty to one provider. (Egan, Umansky & Woods, 2016)

Telehealth is another emerging mode to provide easily accessible, quick health care as it can literally be accessed from the comfort of ones living room or during a hectic day at work. It also includes remote patient monitoring and its use is on the rise with 61% of hospitals reporting they have some form of remote patient monitoring in 2017, up from 43% in 2015. (Lagasse, 2019) A national study of insurance claims indicated that care sought through telehealth from 2016 to 2017 increased by 53%. This increase far outweighed the growth for other nontraditional mode of delivery with urgent care access increasing 14% and retail clinics 7%. (AMA, 2019)

According to a research letter published in The New England Journal of Medicine while patients have historically been slow to begin utilizing telehealth, those who do are extremely satisfied with their experience. 70% of these visits were with their own primary care physicians. The visits lasted only an average of 8.2 minutes and 93% reported that the telehealth visit met their health care needs. The research letter indicates that telehealth is best received when coupled with a relationship with a primary care provider. (Spitzer, 2018)

The trend of telehealth utilization is expected to grow as due to physician shortage for primary and specialty care, the technology has advanced to provide this type of care effectively and insurance companies are reimbursing for this care. (Lagasse, 2019). While the investment to provide this type care is significant, it is one that should be explored as another way to meet the needs of the health care consumer.

Patient Experience

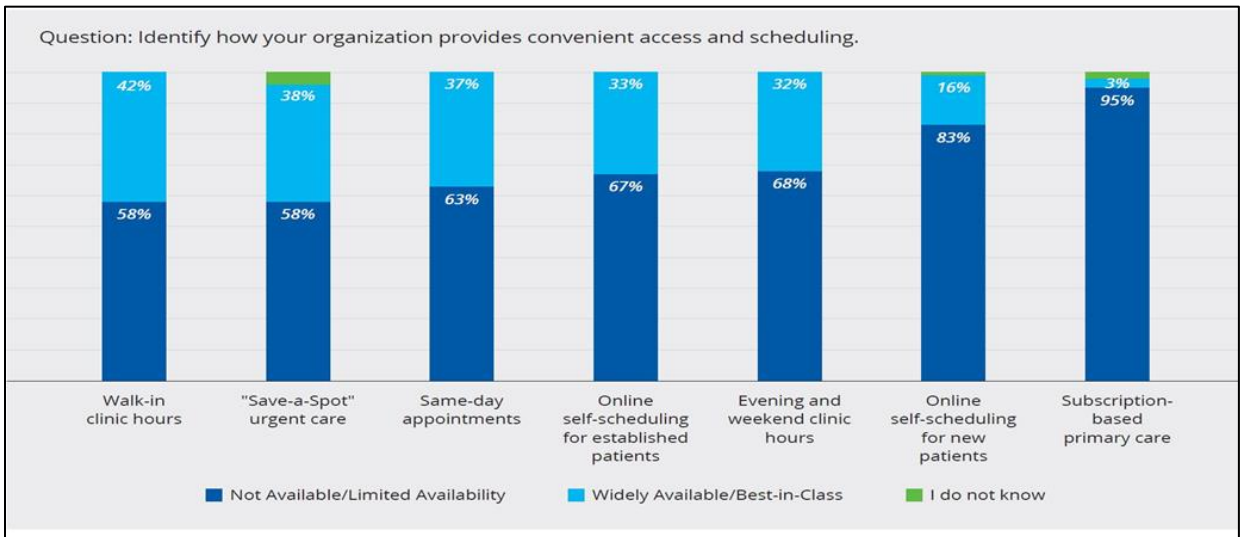
Patients today are more financially responsible for their health care than ever. With increased financial responsibility, patients expect more from their health care providers. Patients are transforming into health care payers who are keenly searching for the lowest cost, the best value, and the highest level of convenience with regards to their care. This shift suggests a more patient- and consumer-centric approach. (Heath, 2019) Health care consumerism will continue to be an industry trend for the foreseeable future. Health care providers will need to focus their efforts to improve not only the patient experience but also the consumer experience.

Health care providers must make the shift to providing an experience that results in consumer loyalty. Organizations must move away from solely focusing on patient satisfaction, looking for ways to improve the consumer experience. Health care consumers are demanding more from their providers, to fully address all aspects of creating an optimal consumer experience, including developing a culture of service, patient-centered workflows, and enabling tools and technology. Providers must address the most important pain points across the entire care journey, not just during a specific touchpoint or episode of care. ("The Bar is Rising," 2019) The entire consumer experience should become the focus of all health care organizations. The

experience should be seamless with little variation as the patient accesses services in different departments throughout the organization.

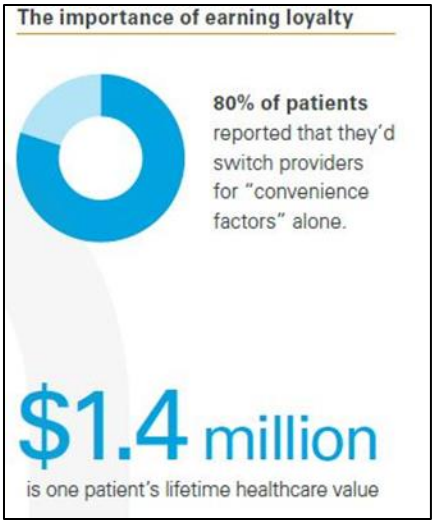
Consumers no longer want to access health care in the traditional way that it has been provided. The patient experience of the future includes new ways to access health care. Telemedicine will likely be one method that consumers will utilize to achieve both faster and easier access. Consumers are accustomed to ordering goods and services through an app on their phone. Organizations must provide consumers with multiple methods to access care. These include virtual, physical, and convenient points of access. The health care providers who can provide consumers with these new methods to access care will build customer engagement while developing consumer loyalty.

The table below from a Kaufman Hall survey lists access initiatives that provide convenience for consumers.



Source: Kaufman Hall 2019 Healthcare Consumerism Survey.

The access strategies identified are walk-in hours, save-a-spot urgent care, same-day appointments, online scheduling, evening and weekend clinic hours, and subscription-based primary care. Nearly 80% of organizations report having no subscription-based primary care services. One-third offer widespread online self-scheduling for existing patients, but few offer this service for new patients. Same-day appointments and extended and walk-in hours are common access strategies. Thirty-eight percent of respondents offer widespread save-a-spot urgent care, while nearly 60% offer it on a limited basis or not at all. ("The Bar is Rising," 2019)

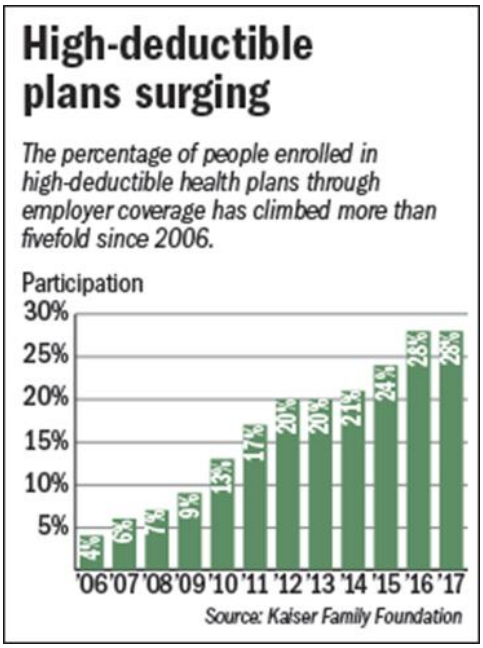


Just because a patient is satisfied doesn't mean that they are loyal to a provider. According to new research by NRC Health and The Metrohealth System in Cleveland, 80% of patients reported they would switch for "convivence factors" alone. Health providers need to understand that the average patient will have $1.4 million in health care spending in their lifetime. (Laskey & Jackson, 2018) With all providers experiencing declining reimbursement, the loss of patients due to poor consumer experience can have long-term negative consequences for the provider.

Price Transparency

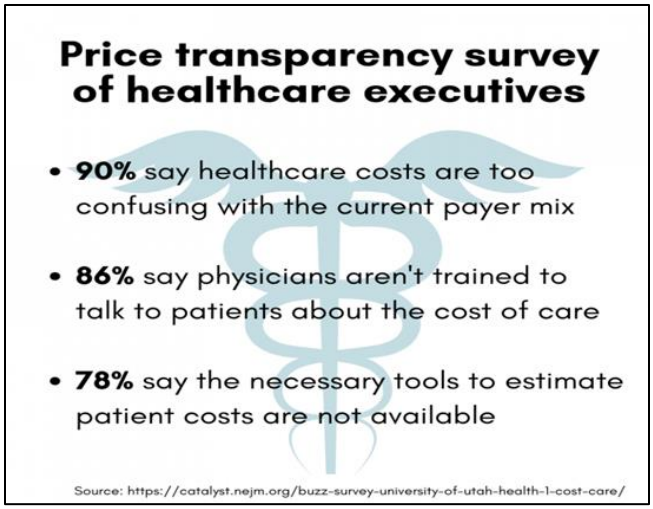
The most recent attempt to provide consumers with price transparency occurred on June 24, 2019, when President Donald Trump issued an executive order on health care price and quality transparency. The executive order is designed to provide consumers with information on not only the price of health services but also the quality of the service. The executive order intends to provide patients with enough information in order to make informed decisions about their health care. The executive order is like recent rules requiring pharmaceutical companies to provide list prices in any advertisements or require hospitals to provide patients with list prices on their websites. This is only an executive order and is not itself a change in law or regulations. Rather, it is a directive to draft new rules or guidance. From here, various agencies will have to develop and publish proposed rules and then receive and respond to public comments before finalizing the rules. This process could take months, if not years. Only then would the changes go into effect. (Keith, 2019)

The executive order is also attempting to prevent consumers from receiving surprise medical bills. Increased transparency, in the administration's view, would help protect patients from surprise medical bills - by knowing cost information in advance, patients could avoid unexpected excessive charges from out-of-network providers. (Keith, 2019) Texas has provided patients with the ability to address any surprise medical bills through Senate Bill 1264. Trump's executive order provides consumers with the information to make an informed decision on the cost of treatment prior to receiving care.



The rise of consumerism in health care coincides with the rise in high deductible health plans provided by employers. In 2017, the percentage of people who have a high deductible plan is at 28% according to the Kaiser Family Foundation.

High-deductible health plans continue to become more popular providing health insurance coverage for nearly one-third of Americans. The high annual deductibles with an average of $4,647 for families, encourage consumers to think twice about running to a doctor every time they get a cold, and to shop around for the lowest prices on drugs, X-rays and surgeries. (Russell, 2017) The high deductibles are designed to encourage consumers to shop around for the best price on health services. The intent of the high deductible plan has not resulted in as much consumerism as intended. The lack of consumerism is likely due to the complexity of the health care system and inability of consumers to compare prices. Below are the results of a survey of health care executives. Both health care executives and physicians are struggling to provide consumers with price transparency.



Providing price transparency to consumers can providers with a competitive advantage. Although price transparency tools are not currently affecting the rise in health care costs, these tools could offer consumers reduced out-of-pocket spending and improve the patient experience. If properly utilized, cost compare technology should help patients cut their own health care spending because they know the lower-cost providers to visit. Patients with access to a price transparency tool could compare cost and quality and make their preferred treatment selection based on that data. Ideally, this will lead patients to a lower-cost option. (Heath, 2018)

Technology

U.S. consumers have been accustomed to utilizing apps and other forms of technology to manage their daily lives whether it be for paying bills, providing feedback or scheduling appointments. The rise of Amazon to own 49% of the U.S. e-commerce market and selling over 12 million products demonstrates the power of easy to use, intuitive technology that requires the fewest clicks to drive sales. In order to maintain consumer loyalty in the health care industry they too will have to focus on ease of use an accessibility.

The 2019 Accenture digital health survey indicated than 50% of health care consumers expect the ability to connect electronically with their provider for scheduling of appointments, follow-up care and prescription refill requests. These consumers indicate that they will choose a provider with these capabilities over one without.

Allscripts provides such capabilities with its FollowMyHealth patient engagement platform provides such capabilities while also serving as patient portal to ones EHR, telehealth and remote monitoring. Hendrick Health System has embarked on the journey towards Connected Care with the implementation of FollowMyHealth. Integration of the vast majority of patient care systems will all be moved to the Allscripts platform with the most significant being the EHR for the hospital and physician offices. The tagline developed by their CEO, Brad Holland "One Patient – One Record – One Hendrick" encompasses the goal of the organization to make Hendrick the one-stop shop for their patients. FollowMyHealth has been the patient portal for Hendrick's patients for several years and with its enhancements Hendrick began offering these additional features to their patients: welcome messages, appointment confirmations, patient engagement surveys, on demand messaging and 24-hour follow up and post-care summaries.

Additional features that will be added to this app in the coming months include mobile check-in, visit summary with patient education and online scheduling. FollowMyHealth will also integrate with Apple Health. Apple Health allows you to monitor your health trends over time such as glucose levels, blood pressure, exercise and sleep patterns. Hendrick has realized that simply providing the required patient portal for patients to access their results and records is not enough. Their patients will experience unified access to care at their fingertips. (Allscripts Healthcare Solutions, 2018)

Seventy-seven percent of consumers said the capability to schedule, change or cancel an appointment online is important and 80% say they would rather interact with their provider through their mobile device.

Traditionally health care leaders have believed that aging consumers would not be willing to engage online but recent studies indicate they are willing to do so with two-thirds desiring to access health care services from the convenience of their own home. Sixty-four percent indicate that convenience and access are just as valuable as benefits.

As technological advances continue to develop in other industries the health care consumer will demand they be available as they seek care. (Allscripts Healthcare Solutions, 2018)

Recommendations

1) Evaluate new legislation involving price transparency and balanced billing and ensure all areas of the health system are meeting these requirements.

2) Educate key stakeholders: patients, organizational leadership and employees, board members, physicians and volunteers about the driving forces of consumerisms in health care, and the organization's need to meet these needs to remain viable and relevant to the new market needs.

3) Develop a task force to develop strategies to meet the emerging needs that includes:
    a. Ease of access to all health care services
    b. Enhanced patient experience that focuses on speed of care coupled personalization
    c. Pricing transparency
    d. Use of technology to access services and receive ongoing feedback from the patient

4) Evaluate success by developing and monitoring key metrics (market share, volumes, patient survey scores, utilization rates of technology and direct patient feedback) to ensure changes in delivery are meeting the needs of the patient.

5) Develop a nimble mindset and push the organization to modify its strategies quickly as the needs of the health care consumer change rapidly with the evolution of other markets and competing service providers.

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Creating Broader Avenues to Quality Health Care Access Through the Expansion of Telehealth Services

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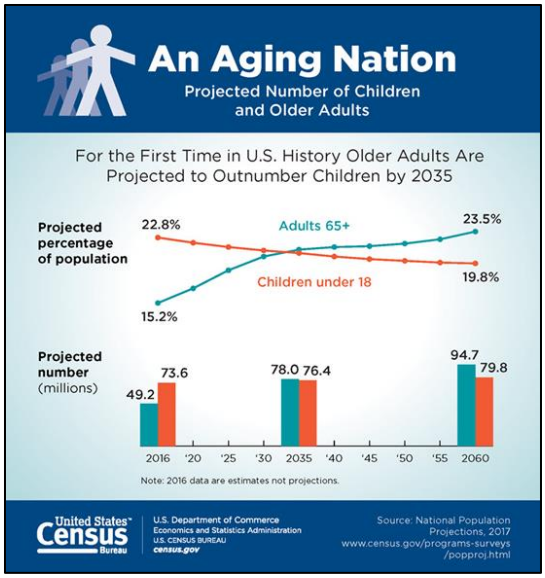
Megan Powe, Chief Strategy Officer, The Hospitals of Providence Sierra Campus, El Paso

Executive Summary

As the U.S. population continues to grow, people are living longer, and predictions estimate that by 2060 the number of Americans 65 and older will be approximately 98 million which is almost double the current number.[1]

At the same time, research shows that we continue to suffer from a shortage of physicians. Recent forecasts estimate that the U.S. may have a shortage of more than 100,000 physicians by 2030.[2] Given these staggering numbers, it is paramount that efforts be undertaken to find delivery systems that will help the population access quality health care. This paper will explore the documented benefits of providing health care services via telehealth mediums as well as the current issues that must be addressed in order for telehealth services to be more widely adopted.



Introduction

How many times have you felt a sore throat or body aches coming on and you know should see your family physician as soon as possible to stop it? However, instead of making an appointment immediately to stop the issue from becoming worse, you put it off because you have a meeting at work you must attend, or your child has an event you know they will be upset to miss? How helpful would it be for you to press an app on your phone and connect with a physician who can video chat with you within minutes and prescribe medication that you can pick up on your way home?

For many of us, our hectic work lives and family demands mean that we put off seeing a physician. For many others, it is much more difficult to access quality health care. Age, lack of transportation, proximity, chronic illness and expense are just some of the reasons why many people cannot access quality care. Their illnesses are then exacerbated by time and substandard care. Telehealth services can help in many of these situations. However, due to current regulations, laws and variations in coverage, telehealth services adoption has been sluggish and our citizens are needlessly suffering in this void.

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[1] Older People Projected To Outnumber Children
US Census Bureau - https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

[2] Research Shows Shortage Of More Than 100,000 Doctors By 2030
Sarah Mann - https://www.aamc.org/news-insights/research-shows-shortage-more-100000-doctors-2030

One of the goals of the Texas Hospital Association (THA) is to be an effective advocate for state and national legislative, regulatory and judicial actions in support of accessible, cost-effective, high-quality health care delivered through a system that emphasizes integration, community health and equitable funding.[3] In a time where approximately 1,000 people move to Texas per day[4], the average American life span is increasing and the number of physicians providing health care services is shrinking, achieving the goal of providing "accessible, cost-effective and high-quality health care" is growing more challenging. An effective means of stretching the reach of providers in more accessible and efficient ways is going to be paramount in providing health care to our citizens. While the federal and state governments are taking steps to increase the number of medical students and related funding to support more medical students, the staggering fact is that "[t]he United States would need an additional 95,900 doctors immediately if health care use patterns were equalized across race, insurance coverage, and geographic location."[5]

A report issued by The Commonwealth Fund ranks Texas last in the U.S. in health care access and affordability.[6] While this result is partially attributed to the state failing to expand eligibility for Medicaid coverage, it also stems from the fact that people are living longer, geographic disparities (which are especially evident in a large state such as Texas,) the increasing population as well as the current physician shortage across the nation. The increasing difficulty to access health care can be easily understood when examining the physician shortage issue. According to data included in a recent article in Texas Hospital Magazine, "35 Texas counties have no physician, 80 counties have five or fewer physicians, 58 counties are without a general surgeon, 147 counties have no obstetrician/gynecologist and 185 Texas counties have no psychiatrist."[7]

While the first thought that may come to one's mind when hearing about these counties with physician shortages is a rugged stretch of rural Texas with one long highway extending out as far as the eye can see, however the physician shortage is also felt in the urban areas of Texas as well. In the city of El Paso, a current Community Needs Assessment, which is a third-party report that measures the need for physician specialties based on the number of current providers available to the associated population, provides that the service area for just of the city's hospitals has a deficit of 245 primary care physicians. This is not inclusive of the needs for medical and surgical specialists which in aggregate, demands that an additional 233 physicians would need to be added to the area. Therefore, a total of 478 physicians would need to be added just to this one service area of El Paso in order to meet the need of the current population. It is important to emphasize that this is just one service area, in one city in the state of Texas. The effects of the physician shortage are similarly being felt across the nation. The Association of American Medical Colleges released new findings earlier this year that the United States will see a physician shortage of approximately 122,000 physicians by 2032.[8] As our population and life expectancy increases and an estimated 10% of the current physician population will reach age 65 or older in the next decade[9], it is difficult to fully understand the impact the impact that is coming to our health care system.

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[3] Mission, Vision and Values
https://www.tha.org/About/Mission-Vision-and-Values

[4] Méndez, M. (2019, May 8). Where is Texas' growing population coming from? Retrieved from https://www.texastribune.org/2019/05/08/texas-keeps-growing-where-are-newest-transplants-coming/.

[5] https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

[6] Radley, David C., et al. 2019 Scorecard on State Health System Performance. The Commonwealth Fund, 2019, pp. 7–7, 2019 Scorecard on State Health System Performance, https://www.commonwealthfund.org/sites/default/files/2019-06/Radley_State_Scorecard_2019.pdf.

[7] Access To Care: Addressing Texas' Physician-to-population Ratio
https://www.tha.org/TexasHospitalsMagazine/SeptOct2019/Access-to-Care-Addressing-Texas-Physician-to-Population-Ratio

[8] New Findings Confirm Predictions on Physician Shortage
https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

[9] New Findings Confirm Predictions on Physician Shortage
https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

Considering the growing population, the increasing average life-span and the fact that the physician shortage will not be remedied in the near future, we must consider and support additional methods to provide accessible, high-quality healthcare in an efficient and cost-effective manner. One way the state can achieve this goal is through the use of telehealth and telemedicine. Studies looking into the use of telehealth have demonstrated that correct implementation of these services have improved patient outcomes, increased patient access to services and decreased costs for health care systems.

While the benefits of telehealth are apparent and its uses are desired across many specialties, its adoption has been slow moving. The issues continually cited as contributing to this slow adoption include:

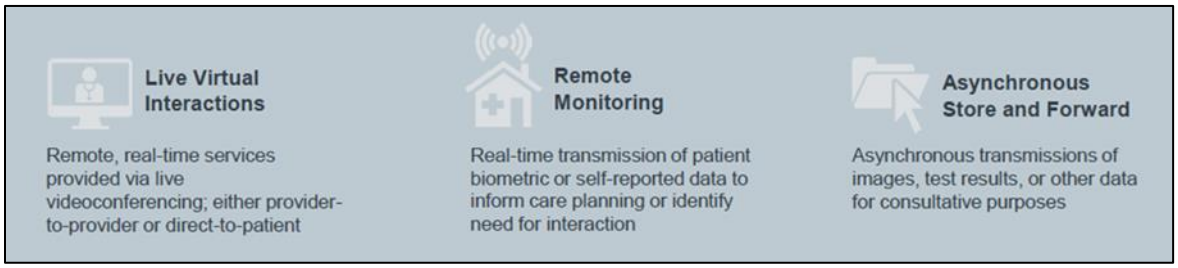
- The modality and coverage of telehealth services being provided, specifically:
  - Live Virtual Interactions,
  - Remote Patient Monitoring (RPM) and
  - Store and Forward
- Variations in coverage and reimbursements across payors
- Variations in geographic location requirements across payors
- Legal and regulatory challenges

Telehealth, Telemedicine and eHealth

While the terms telehealth, telemedicine and eHealth are used interchangeably, the definitions differ across somewhat depending upon which organization, state or payor is using the term. However, the general understanding is that the term "telehealth" is an overarching term, encompassing the definitions of telemedicine and eHealth. In Texas, both of the terms telehealth and telemedicine refer to providing some type of health care service through "the use of advanced telecommunications technology, other than telephone or facsimile," the differentiation between the two seems to be that the former refers to a "licensed or certified health professional" providing a service within the scope of said professional's license or certification as compared to a physician or a health professional acting under physician delegation and supervision initiating or providing a health care service in the latter.

Modalities

The exchange of information via telehealth services is most commonly divided into three categories, Live Virtual Interactions, Remote Patient Monitoring (RPM) and Store and Forward.



Location and Institutions: Medicare

Medicare has the most restrictive policies regarding what types of telehealth services are eligible for reimbursement and coverages. These restrictions extend beyond the modality, (currently, only live virtual

interactions are covered), but also are the most restrictive regarding the type of provider that can provide healthcare services as well as specifically identifying where the patient and the provider must be located geographically. These sites are referred to as the "Originating Site" and the "Distant Site" respectively.

Medicare requires that the Originating Site be in a Health Professional Shortage Area (HPSA) and must be one of the following types of health facilities:

- Provider offices;
- Hospitals;
- Critical access hospitals;
- Rural health clinics;
- Federally qualified health centers;
- Skilled nursing facilities;
- Community mental health centers;
- Hospital-based or critical access hospital-based renal dialysis centers.[10]

HPSAs are designations that indicate health care provider shortages in primary care, dental health and mental health relative to the population in a geographic area.[11] Given that the Originating Site must both lie in a HPSA and be located in one of the above listed health care facilities, these restrictions allow only a very narrow sliver of the Medicare population to access telehealth services.

These restrictions exclude Medicare patients who do not reside in rural areas but who could very much benefit from the use of telehealth services. Many telehealth services can be provided via smart phones and monitoring technology within patients' homes The Medicare restrictions also do not take into account that it may be quite a burden for those who live in rural to access the required health care facilities. Similarly, due to issues like lack of transportation and chronic illness, it may be difficult for a rural or urban patient to see a provider in person.

Location and Institutions: Medicaid

The Texas state Medicaid program is less restrictive and provides more telehealth coverages than Medicare. The Medicaid program has provisions for reimbursement for Live Video, Store and Forward as well as Remote Patient Monitoring.

Texas Medicaid Telehealth/Telemedicine Reimbursement

Texas Medicaid reimburses for live video for the following services provided through telemedicine:

- Consultations
- Office or other outpatient visits
- Psychiatric diagnostic interviews
- Pharmacologic management
- Psychotherapy
- Data transmission and
- Supportive encounters for persons with intellectual disabilities or related conditions.[12]

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[10] National Policy
https://www.cchpca.org/telehealth-policy/telehealth-and-medicare

[11] Health Professional Shortage Areas (hpsas)
https://bhw.hrsa.gov/shortage-designation/hpsas

[12] Center for Connected Health Policy's (CCHP). (2019). State Telehealth Laws & Reimbursement Policies. Retrieved from https://www.cchpca.org/sites/default/files/2019-05/cchp_report_MASTER_spring_2019_FINAL.pdf.

Texas Medicaid provides separate definitions for telehealth and telemedicine however; the distinction lies in the type of provider (see below).

Texas Medicare Live Video Distant Site Providers – Telehealth vs Telemedicine[13]	
Telemedicine eligible distant site providers:	*Telehealth eligible distant site providers:*
• Physician • Certified Nutrition Specialist (CNS) • Nurse Practitioner (NP) • Advanced Practice Registered Nurse (APRNs) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • A distant site provider is the physician, or PA, NP or CNS who is supervised by and has delegated authority from a licensed Texas physician who uses telemedicine to provide health care services in Texas. Hospitals may also serve as the distant site provider.	• Licensed professional counselors • Licensed marriage and family therapist (LMFT) • Licensed clinical social worker (LCSW) • Licensed psychologist • Licensed psychological associate • Provisionally licensed psychologist • Licensed dietician • Durable medical equipment suppliers

Texas Medicaid has provisions to allow reimbursements for Remote Patient Monitoring and Store and Forward telehealth services. Moreover, while the term Originating Site is listed within the plan, patients do not face the same geographic and facility restrictions placed on Medicare patients. These patients are not require to be in a HPSA and can access telehealth services not only at healthcare facilities but in their home as well.

Additionally, we see that Texas keeps making strides to expand telehealth services and access to more people. Texas currently has the greatest number of bills in process than any other state which if passed, would help expand reimbursements and access to telehealth. Some of the issues addressed in these bills include access to broadband connections/ alleviating the digital divide, cross-state licensing, and increasing/ expanding Medicaid reimbursements for home telemonitoring service as well as Prenatal and Postpartum care.

Private Insurance

Private insurers in general have the least restrictive plans and provide the greatest telehealth coverage to their members. Policies that provide coverage generally allow their members to access telehealth services from any location. Moreover, there are provisions for telehealth services for Worker's Compensation claims.[14]

Case Study – VA Telehealth Services

The Department of Veteran Affairs (VA) claims it is the "largest integrated health care system" in the United States, boasting "1,255 health care facilities, including 170 medical centers and 1,074 outpatient sites of care of varying complexity serving 9 million enrolled Veterans each year[15]." However, almost half of veterans eligible to

[13] Center for Connected Health Policy's (CCHP). (2019). State Telehealth Laws & Reimbursement Policies. Retrieved from https://www.cchpca.org/sites/default/files/2019-05/cchp_report_MASTER_spring_2019_FINAL.pdf

[14] Center for Connected Health Policy's (CCHP). (2019). State Telehealth Laws & Reimbursement Policies. Retrieved from https://www.cchpca.org/sites/default/files/2019-05/cchp_report_MASTER_spring_2019_FINAL.pdf

[15] Veterans Health Administration – Providing Health Care for veterans. https://www.va.gov/health/

receive VA health care services live in rural and remote locations, not in close proximity to a VA facility. In order to provide access to their patients, the VA utilizes telehealth services to provide care. According to the VA, "telehealth increases access to high quality health care services by using information and telecommunication technologies to provide health care services when the patient and practitioner are separated by geographical distance."

The VA uses three Connected Care technologies.

- VA Telehealth Services: interactive, real-time video conferencing and store-and-forward technology used to asses, treat, and provide care to a patient remotely. These services can be used in the patient's home, or while they are in a clinic and the provider is in another location.
- My HealtheVet: allows for Veterans to track and refills prescriptions, send secure messages, request appointments, view/download medical records, and access various tools and resources
- VA mobile apps: Weight management program with MOVE! Coach app

The Fact Sheet provided by the VA lists 38 clinical programs currently offered through telehealth services. These services include, but are not limited to, programs such as TelePrimaryCare, TeleCardiology, TeleNutrition, and women's telehealth. According to the fact sheet, the VA states about 12% of the nation's veterans experienced treatment in their telehealth services, resulting in more than 2.17 million telemedicine visits in one year. In the same year, the VA cites telehealth as the main driver of reduced inpatient admissions. Veterans utilizing the VA's telemedicine services experienced a 31% decrease in hospital admissions, and a 59% decrease in patient days. Additionally, patients receiving mental health services reduced patient days by 39% and inpatient admissions by 32%.[16]

Conclusion

While the Texas Medicaid program is lessening restrictions and proposed legislation is making requests that would help expand health care access, these charges alone will not solve the issues regarding the ever growing and aging populations need for quality healthcare services.

Unfortunately, this need is exacerbated by the number of uninsured in Texas. The number of uninsured in Texas is estimated to be around 5 million people which accounts for approximately 17.7% of the total Texas population.[17] This ranks Texas as the state with the highest number of uninsured people in the U.S.

Especially considering the current and expected physician shortage, more efficient ways of using providers time and effort must be realized. The use of technology to provide telehealth services is a crucial step toward meeting that need. However, the barriers to access and adoption must be addressed.

Considering the strict guidelines that must be obeyed in order for a Medicare telehealth service to be covered, it is not hard to understand why many hospitals and providers are reluctant to adopt and invest in the infrastructure to provide telehealth services. Removing these restrictions will create a larger pool of patients who have coverage for telehealth services and will thereby lessen the anxiety and prohibitive cost hospitals and providers currently resist in order to adopt providing telehealth services.

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[16] Department of Veterans Affairs. Fact Sheet. VA Telehealth Services. https://www.va.gov/COMMUNITYCARE/docs/news/VA_Telehealth_Services.pdf

[17] Texas Ranks Highest in Uninsured People Across Nation, Again
Staff - http://dallasexaminer.com/health/texas-ranks-highest-in-uninsured-people-across-nation-again/

Furthermore, the Texas Medicaid program should move more swiftly and lead the country in demonstrating that telehealth services can provide high quality care to greater numbers of people while at the same time, increase quality care and decreasing poor outcomes and readmissions.

Perhaps through strategic use of telehealth services, Texas can be the model for other states as well as the federal government to implement quality health coverage for all.

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Lobbying CMS to Accept E-Surveying as a Mode for HCAHPs and Provide Access to "Current Data"

Vishal Bhalla, vice president, chief experience officer, Parkland Health & Hospital System

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) currently permit Patient Satisfaction surveys for hospitals (HCAHPS) via the following modes: Mail only, telephone only, mail with telephone follow-up (also known as "Mixed" mode), and active interactive voice response (IVR)[1]. Surveys by mail take excessive cycle time, thereby reducing the efficiency of the process. Phone surveys are very expensive. As people across demographic profiles and socioeconomic means increasingly have access to and comfort with digital communications[3] (email and text messaging in particular), it is time to add electronic surveys (e-surveys) as a viable mode for CMS-required HCAHPS.

Health care organizations spend an inordinate amount of resources collecting more "current data" to impact patient care and ensure better outcomes with efficient operations. Consumers expectations of health care are no different than any other industry – with increasing knowledge and awareness of choices, expectation for value, cost transparency and desire for being engaged in their own care[5].

The prospect of real time surveys over a central platform that serves the purposes of the primary stakeholders is logical; in this case the stakeholders being the patient, the organization providing care and the government (CMS). Such a solution would reduce duplication of surveys thereby reducing costs while providing actionable data to the organization thereby increasing responsiveness and possibly further reducing costs, and provide better care to the consumer, for better value.

Current State

The department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), clearly outlines a Value Based Purchasing (VBP) program, under which value-based incentive payments are made in a fiscal year to hospitals based on their performance on measures established for a performance period for such fiscal year. In order to measure such performance, (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), another agency in the federal Department of Health and Human Services, to develop HCAHPS. CMS mandates the use of HCAHPs surveys for organizations that wish to participate in Medicare and Medicaid programs, and provide medical care in inpatient settings and abide by HACAHPS rules of participation[1]. A random sample of eligible discharges are surveyed monthly. Data are aggregated quarterly to create a rolling four quarter data file for each hospital, and a minimum of 300 surveys is the target in a 12-month reporting period. Patients are surveyed between 48 hours and six weeks following discharge. Data is submitted to HCAHPS data warehouse, after which CMS cleans, analyzes, calculates hospitals' HCAHPs scores (including making some adjustments) and publicly reports them on Hospital Compare website.

The survey is composed of 27 items in eight dimensions to measure a HCAHPS base score with two "overall" questions; one being overall rating of the hospital and the other asking the willingness to recommend Hospital.

The three goals of publicly reported HCAHPS survey results are to[1]:

1. Produce comparable data on patients' perspectives of care that allow objective, meaningful comparisons among hospitals on topics that are important to consumers.
2. Create incentives for hospitals to improve quality of care.
3. Enhance public accountability in healthcare by increasing transparency.

Consumers today expect prompt action to any inefficiencies or complaints brought forward. Waiting to survey 48 hours to six weeks after discharge, after which the data are collected, scrubbed and distributed hamper the effectiveness of any service recovery an organization may attempt. In order to overcome this challenge, hospitals resort to a parallel but more timely option of surveying the patients. Effectively this is duplication of work and produces two sets of data. One being more immediate, and another being lagged. Operationally, and from a customer perspective, the teams focus on the immediate data. From a VBP and financial payment perspective, the finance teams and often senior leaders focus on the reimbursements from VBP – i.e. lagged data. While the front-line teams are confused as to which data they need to focus on, the impact they see from the work they did on the lagged data is also lagged. In an over simplified calculation, if the survey is sent to the patient six weeks after discharge (6), received by the patient and sent right back in one week (7), reviewed and assimilated by the hospital in one week (8), actioned by the team into a new process in one week (9), the new process experienced by another patient in one week (10), this patient who is discharged at the end of the 10th week, is sent a survey 6 weeks after discharge (16), and the survey from this patient is received back in one week (17), data is reviewed and assimilated in one week (18), and shared with the team that worked on the solution the same week it was reviewed, the improvement cycle took 18 weeks! No organization in today's marketplace deserves to survive if it was to change their operation in response to a customer complaint so as to prevent further complaints, while continuing to operate with the deficiencies for 18 weeks. When compared to mail or phone surveys, the cycle time of an e-survey would be much shorter.

The Context

A more efficient, effective survey methodology would align the survey efforts for the needs of CMS and of the hospitals. Since the population has increased access to smartphones, a web push generates higher response rates[4]. Over 96% of Americans now own a cellphone of some kind. The percentage of smart phone owners is 81%, up from 35% in 2011, per Pew Research Center[3].

E-surveys are customer-centric: the patient receives it closer to receiving the service and is able to respond with ease. The costs of conducting e-surveys are much lower than that of paper or telephone; as is the manipulation of data, as it is already in an electronic format. In a comparison of web-based and paper-based surveys[7], the cost of paper surveys was $4.78 compared to that of a web survey at $0.64. While it may vary based on the vendor used and local market factors, the differential is substantial. Another study, this one by BMC Medical, found that paper surveys cost at least 40% higher than e-surveys[4].

A study conducted by the American Evaluation Association (AEA) found that while paper surveys had a response rate of 39.1%, web-based surveys had a response of 61.7% [7]. In another recent study[6], a random sample of 26,991 ED discharged-to-community patients (Jan 2018 –March 2019) from 16 hospitals were sent a mixed mode protocol survey (email, text and mail). Protocol comparisons demonstrated that both text outreach and phone had significantly higher responses. Age was a factor mode of preference, with younger age groups preferring electronic versions, especially text. As our population ages, this younger age group that favors e-surveying will continue to increase!

Table 5. Summary of respondent characteristics, by completion mode.

Characteristic	Sampled	Web	Mail	Phone	Chi-squared P-value
	N (%)	N (%)	N (%)	N (%)	
Age					
18-24	4114 (15.4%)	98 (6.6%)	81 (4.4%)	169 (12.1%)	**<0.001**
25-34	6175 (23.1%)	171 (12.1%)	139 (6.6%)	264 (18.7%)	
35-44	4517 (17.6%)	243 (17.6%)	160 (7.7%)	204 (14.3%)	
45-54	3865 (14.3%)	227 (16.5%)	226 (11.0%)	216 (15.4%)	
55-64	3332 (13.2%)	260 (18.7%)	415 (19.8%)	231 (16.5%)	
65-74	2162 (7.7%)	237 (16.5%)	476 (23.1%)	167 (12.1%)	
75-84	1416 (5.5%)	127 (8.8%)	388 (18.7%)	96 (6.6%)	
85 +	706 (2.2%)	41 (3.3%)	218 (9.9%)	39 (3.3%)	

Source: https://www.surveypractice.org/article/9772-effects-of-push-to-web-mixed-mode-approaches-on-survey-response-rates-evidence-from-a-randomized-experiment-in-emergency-departments

While gender, severity index (of care needed), primary diagnosis, health and race/ethnicity had variation, age is the most relevant metric that impacts survey participation over the longer term.

Another factor is ability of the survey to change in tandem with the needs of the market and the consumer. A major case in point is the opioid crisis. The CMS, in the Federal Register, talks about removing the pain management questions due to unintended consequences. CMS hear from their stakeholders that the misuse or misunderstanding of the HCAHPS survey may contribute to the perception of a link between the "pain management questions" and opioid prescribing practices[8]! Therefore, after consideration of public comments, the three pain management questions were slated to be removed effective October 1, 2019. This process could have been much faster in an electronic mode, while we admit that the paper surveys would have taken the same amount of time to have the newer version. If majority of the patient population was taking the e-survey, the possibility of making a decision to change the e-survey questions, would have reduced the negative impact in the same proportions, which again amounts to large costs in health care including opportunity costs and the suffering.

Envisioning Success

Per the Federal Register, CMS was asking for input and comments to include e-surveying as a mode of HCAHPs and other surveys. While this came to our attention after the topic was selected, however there is no discussion yet, that we are aware of, regarding:

a. aligning the objectives of CMS and that of hospitals thereby reducing the duplicity of efforts, nor
b. considerations we are aware of that would provide more timely feedback from the consumer to the service provider, via the same survey.

The ideal platform would be one where the survey was sent to the patient at the time of discharge (automatically via the EMR, in the mode of preference of the patient), and a reminder sent after 72 hours if the survey was not taken. A multimodal approach would be essential to ensure the population responding to the survey was reflective of the population served by the institution. A higher percentage of respondents would use one of the e-survey formats thereby drastically *reducing the costs* of the survey. E-surveys would also *increase participation rates*, thereby *reducing error reporting* and *making data more meaningful.*

The survey itself would be in a logic tree format, whereby further questions could be asked automatically, if the response of the patient warranted it, *making the data more actionable and relevant to the care giver.* The data

from the survey would be in "raw state" but qualitative data would be accessible to the organization providing the service immediately, and the quantitative data would follow, after a thorough scrubbing using artificial intelligence. This would enable the providers to initiate responding to information received from the customer in a timelier manner. The *cost savings from implementing efficiencies* desired by the patient, along with the impact on team member engagement of being able to address concerns meaningfully *would improve the experience of patients and care providers* substantially.

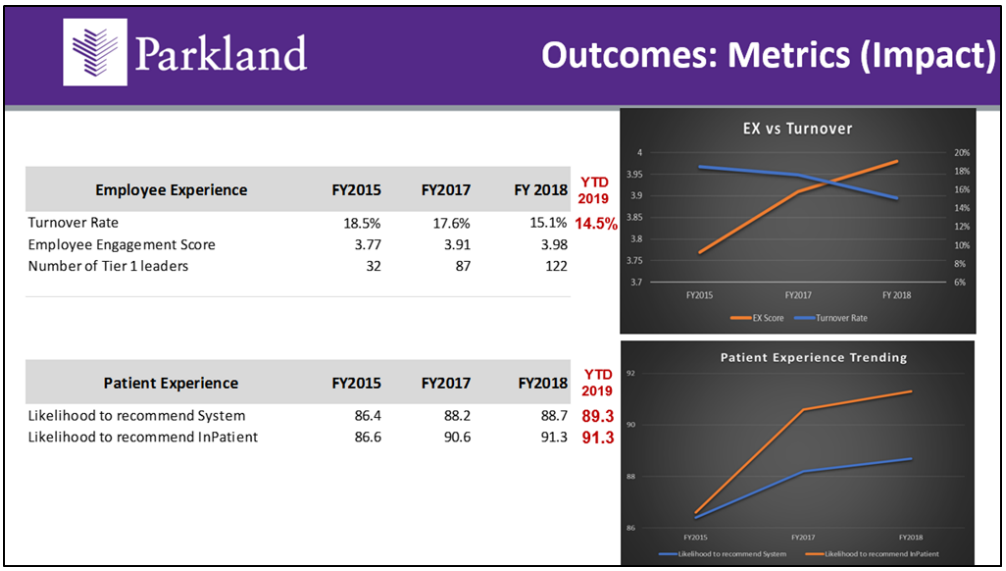
Metrics and Impact

As the data would be available in near time, and in electronic format, it could be managed easily by the organization (cost savings) and the interventions implemented sooner (shorter cycle time). Metrics that would measure these outcomes would include:

- Cost per completed survey
- Survey participation rate
- Employee experience metrics
- Patient experience metrics
- Overall score
- Cost per encounter
- Throughput metrics

The win-win scenario would be when the industry benchmarks would improve as a whole, bringing down cost of health care while improving the experiences and the outcomes of patients, and engagement of the team members.

Accepting e-surveys as an HCHAPS mode will generate benefits for patients, health care organizations and providers as they are customer-centric, decrease costs and reduce cycle time to actionable data. Data analytics tools can be either built into the platform or utilized by the organization to ensure *only relevant data and recommendations to operationalize it are provided to our care givers* to improve the experience of our patients and our providers. We tried this approach to simplifying data and providing only relevant data – while also engaging change management techniques to see statistically significant improvement in the patient experience and employee engagement at Parkland Health & Hospital System in Dallas[9].



Employee Experience	FY2015	FY2017	FY 2018	YTD 2019
Turnover Rate	18.5%	17.6%	15.1%	14.5%
Employee Engagement Score	3.77	3.91	3.98	
Number of Tier 1 leaders	32	87	122	

Patient Experience	FY2015	FY2017	FY2018	YTD 2019
Likelihood to recommend System	86.4	88.2	88.7	89.3
Likelihood to recommend InPatient	86.6	90.6	91.3	91.3

To facilitate such a change, multiple stakeholders must be involved, and a cost-benefit analysis performed (similar to one done in 2005[2]). It is the opinion of the author that such a study is necessary, as it has been almost 14 years since the last study was performed, and costs, benefits and consumer bias to various modes of surveying have since changed with the proliferation of mobile technology[3].

Key Stakeholders would include:

- Associations (THA, DFWHC, AHA)
- Governing bodies that helped create the current HCAHPS model (CMS, AHRQ, NQF)
- Vendors (Press Ganey, NRC, Gallup, Advisory Board, Qualtrics)
- U.S. Congressional Champions (in both the House of Representatives and Senate)

DFWHC, THA, Press Ganey and Qualtrics have indicated their support for such an initiative. The author is continuing to engage other stakeholders to bring more attention to the need.

Barriers and Possible Solutions

The complexity of health care and the constantly shifting backdrop of factors outside the control of the stakeholders creates an ecosystem where there is fluctuating convergence and divergence of objectives of various stakeholders, which makes this an interesting project. Mandating clear policies that evolve based on those currently established, while minimizing political impact on the direction, while focusing on the greater good, is the only logical way ahead. This is from the policy and technocrat perspectives.

From an organizational level, grappling with change and moving to a responsive culture will generate market forces that deepen the divide between high performing and low performing operations. The organizations slow to respond to customers will fail, and there would be a time where there could be a lack of options for patients in markets with low competition.

Switching costs for patients would decrease substantially, health care would be more commoditized than it currently is, making the market more attractive to disruptors. While barrier to entry is typically high for new entrants, the attractiveness of succeeding would possibly enable higher risk for innovators with the right mindset.

Resistance from some stakeholders such as vendors that cannot easily move to the new modality would be felt, especially if they have political clout.

From an individual consumer level, not all patients have email addresses or cellphone, or if they have them, they may not want to share them with the provider. Rural communities may not have access to internet[10]. For this segment, the multiple modality retains its importance, knowing that this segment of the population will decrease over time due to various factors including adoption of technology and aging.

Conclusion

Developing an integrated data and management strategy is foundational to empowering leaders and engaging the workforce in efficiently taking care of our patients. Operational data and experience data need to be as real time as possible to ensure effective response to the consumers' needs and now demands, which are being met in other industries! It is the only way to enable teams to drive change using data transparency, focusing on accountability of timely execution.

The cost of health care needs to be curtailed and duplicating efforts in order to provide lagged data is an expense that can be better managed. While the solution may not be completely formed and defined accurately in this paper, the possibility of enabling real time and lower cost surveys and data to patients and providers is exciting and will be impactful. This would not only improve the experience of our caregivers and patients, but hold organizations accountable, help them be more efficient and help tame the health care cost dragon, which is the underlying intention of the VBP system, as described in the objectives of the HCAHPs survey.

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Physician Recruitment Redesign: Designing a Recruitment Strategy Around Physician Practice Critical Success Factors

Natasha Montez, Chief Executive Officer, Guadalupe Regional Medical Group

Executive Summary

Every organization has its established mission, vision, core values and organizational culture. As physicians transition to the employed model of practice, executives have to develop a well-defined recruitment strategy that aligns with the goals of the organization and the growth of the market in which they serve. Executives develop intricate strategic roadmaps; however, the question must be asked, "Of what is the recruitment roadmap comprised?" Recruiting the right specialist is often presumed to be the primary goal executives have when hiring physicians. But this paper proposes that the primary and true measure of success lies in hiring the correct individual who also happens to hold a medical license in that specialty.

As with any process or program that impacts an organization, leaders should assess the efficacy to determine what works and where opportunities for improvement exist. Therefore, in 2016, executives of the recruitment team with Guadalupe Regional Medical Center (GRMC) and Guadalupe Regional Medical Group (GRMG) recognized the recruitment process in place needed to be reassessed due to higher than desired physician attrition.

A blog post by Dike Drummond, MD, (2019) states that physician decisions to quit or change jobs in order to recover from burnout hinge on:

- A toxic culture
- The way the group makes decisions
- Their immediate supervisor

Therefore, the recruitment team posed the question - how can we mitigate recruitment failures, reduce physician attrition all the while creating a structure that addresses expectations and critical factors prior to hiring? In 2009, the Camden Group (T. Atchison, personal communication, June 11, 2019) created a matrix that outlined Critical Success Factors that impact physician practices. Although this tool was introduced after the recruitment team had already established their processes and methodology, analysis and comparisons indicated that the redesigned recruitment strategy addressed 19 of the 23 critical factors.

Executives must ask, "Are the organizational expectations discussed and are the candidate's expectations also addressed thoroughly during the interview process?" If operational and organizational expectations are not part of the recruitment process, executives should look to determine how addressing and discussing expectations can be integrated into the process. Research has shown that addressing expectations initially can mitigate future issues in a number of professional situations (Hamidi, Maryam S., et al., 2019, Maylett, Tracy, 2019). Executives must also appreciate the fact that for long-term provider retention a number of important foundational items must be managed such as provider satisfaction, creating good lines of communication, and establishing trusting relationships to improve the overall provider experience. Other considerations include

behavioral attributes of the candidate, career aspirations, and other personal and professional characteristics that impact whether the provider will thrive in the organizational culture.

This white paper will demonstrate how GRMC and GRMG collaboratively developed their recruitment team, refined the recruiting strategy and introduced professional behavioral traits into the discipline of recruitment. Also, the Physician Practice Critical Success Factors matrix will be presented which could be used as a guide for redesigning and integrating critical factors into other's recruitment strategy while setting expectations initially for the candidate to consider.

GRMC/G's recruitment strategy is not the only or "correct" design or method of delivery. This is an example of how a team intentionally refined its process to fit the organization.

Purpose

The harsh financial reality is that the overall costs to recruit, relocate, onboard, front the operational startup costs, and the lost revenue while recruiting providers can be estimated to cost up to two to three times the physician's annual salary (Shanafelt, Tait D., and John H. Noseworthy 2017, p. 129). For example, the potential cost to recruit a family medicine physician could cost $350,000 (Merritt Hawkins 2019). However, what also should be considered is that the vacancy of that medical provider has a much farther-reaching impact within the community in which the vacancy exists. For one family physician, that vacancy can cost that community over $1 million per year in areas such as tax revenues, wages and benefits, economic output and other revenues a physician would generate in the community in which he or she lives and works (Merritt-Hawkins 2019).

Therefore, with increasing monetary commitments placed upon organizations and the impact on communities, making the best hiring decisions the first time are key for long-term alignment, cultural fit and of course physician retention. What may be overlooked is the aspect of addressing expectations while also ensuring the characteristics of the organization's culture align with the behavioral traits of the physician. This is a vital element to long-term physician satisfaction and future retention.

Organizational History

Guadalupe Regional Medical Center (GRMC) has been built upon a rich history of more than 50 years of service to the community. The Medical Center is licensed for 153 beds and currently has over 800 employees. It is located in the City of Seguin and is a joint city and county-owned facility that operates without the support of a tax district. The Medical Center is designated a Level 4 trauma facility and has a comprehensive line of medical specialties and sub-specialties, which include interventional specialties and robotic service lines.

Guadalupe Regional Medical Group (GRMG) was created in 2010 in response to growing demands for employment of specialty physicians coming into the local market. The organization has become a central driver for physician recruitment and retention which is key to the Medical Center and overall community development. As the market has grown and the need for expansion has been established, GRMG no longer employs only specialty or sub-specialty providers, but its services have grown to include primary care and internal medicine. GRMG employs 16 primary care, specialty and subspecialty providers in addition to more than 50 clinical and support staff.

The Initial Model of Recruitment

For many years, the model of physician practices in Seguin and surrounding areas had been solo practices that were independent or part of a larger independent established group. In 2014, GRMG, recruited the largest number of physicians in a single year. The number of total physicians in the Group more than doubled in a year from five to 11. Of the six physicians that were recruited, only half of the providers currently remain as part of the Group. As physicians were terminated or left voluntarily, the current recruitment team sat back and asked the questions - when these providers were recruited, did we hire them because they were a good fit for our culture and they were who we were looking for? Or did we hire them only because they offered a particular skillset that was sought and needed at that time? The group concluded that the problem was not in the operations of the organization, but in the adequacy of delivering stated expectations of the practice to determine whether the candidates selected were the appropriate individuals that met those requirements. The previous process did not fully account for candidates' behavioral characteristics or the delivery of expectations necessary for success within the organizations.

As with many small independent organizations, change is facilitated due to necessity and with necessity executives in the organization assume multiple roles in areas of need. With that, a core skillset is needed; however, there is a learning curve in the acquisition of the skills and the need to develop a process that is most fitting for the single organization. Therefore, during GRMG's infancy, the recruitment team was comprised of the Medical Center's Chief Operating Officer and the Vice President of Physician Services. In addition to these two executives, physicians from the local medical society were invited to join into the conversation when candidates were brought in for interviews. Because many of the physicians in the community were solo practitioners, the collective fear was that the Medical Center was going to bring providers into the community that competed with existing practices, thus significantly impacting them.

Therefore, to involve the established providers, the local Medical Society put together a Recruitment Committee that worked collaboratively with the Medical Center's administrative team to provide input or their overall thoughts about the candidate and the services he or she would offer to their patients. In addition, they also had a voice as to who was offered the position or not.

To illustrate a misalignment of expectations, a neurologist that was hired during the 2014 recruitment campaign stated that when he interviewed, he was told that no more than 10 patients per day would be required to be seen in his clinic. This misaligned expectation was not the only one encountered and would contribute to a financially unsustainable practice. Ultimately the expectations were not clearly defined from a financial or operational perspective during the interview process which resulted in the physician having an unrealistic expectation of patient volumes necessary to support a financially viable practice. In addition, the physician did not possess the personality or behavioral characteristics that aligned with the organizational culture resulting in him not being willing to work collaboratively to make the practice work. He became hostile, untrusting and generally dissatisfied with the organization because he believed that he was lied to and was promised something initially and it was later changed.

Recruitment Redesign and Strategy

The Medical Center's and Group's recruitment team began evolving in 2016. As the group began to mature and grow, the team concluded that many fundamental changes needed to be made. In order to positively impact the recruitment process and to retain the providers that were recruited, the core recruitment team began making transitions.

The evolution of the recruitment team began by lessons learned from previous failures. What the team observed was that many of the providers recruited prior to this change did not possess the same goals or values of the organization and therefore would never embrace or conform to the organizational culture, operational developments, or financial requirements necessary for long-term sustainability. In short, previously providers were hired for their medical licenses and not for being the right individual for the organization.

Given the capital investment, resource development and the drive to maintain and sustain the organizational culture, the team felt it was imperative to have representation from the both the Medical Center and from the Medical Group. Therefore, the core recruitment team now includes the Medical Center's CEO, VP of physician services, and Medical Group's CEO. Of the three executives, the two CEOs began their careers in clinical roles and were at the bedside for many years before attaining their executive positions. Providers appreciate the fact that the leaders running the organizations have been in direct-patient care.

As the core team matured, they recognized the need to comprehensively yet simply convey GRMC/G's culture to the potential candidate. The attributes used when describing the culture are:

- Physician-driven
- Administration-facilitated
- Collaborative
- Transparent

The core team also recognized ideal behavioral and personal characteristics they were seeking from potential candidates:

- Personable
- Genuine
- Humble
- Collaborative
- Confident
- Compassionate
- Passionate about patient care
- Desires to make a positive difference
- Understands that learning is a life-long process
- Wants to honestly be part of something bigger than self
- Understands that the practice of medicine can be challenging because of
    - Patients
    - Financial constraints
    - Administrative burden
    - Regulatory requirements
- Understands the demographics of the population they will be serving
- Has the drive and desire to serve the community they live in and work
- Is flexible and understands the need to modify operational practices and help in the development of service lines to move the organization forward
- Understands that physician leadership is an essential element in becoming a positive change agent in the organization and community
- Personal financial gain is important; however, it is not the driving force of their motivation

The initial phase of the recruitment process is for the core team to review potential candidates' CVs and for those who meet the skill and experience criteria, a telephone conversation is completed. During this conversation, the three members of the team speak with the candidate and each introduces themselves, their role in the organization, role in the process, and their experience. The topics of the conversation are as follows:

- GRMC/G organizational history
- GRMC's organizational culture
    - Physician driven
    - Administration facilitated
    - Collaborative
    - Transparent
- Why the search is being conducted for that specialty
- Medical specialties that are offered at the Medical Center and employed by the group
- GRMC's non-corporate structure
    - Candidates are educated that decisions are made locally and without corporate oversite.
    - Importance of being good financial stewards in an independent organization

Once the team has addressed the above topics, candidates typically ask questions that had not already been discussed. Because information is presented in a structured and comprehensive format, candidates often do not have many follow-up questions, but all questions are fully welcomed and answered as thoroughly as possible.

During this conversation, the team garners an understanding of what the candidate is looking for from a professional and personal standpoint. At the conclusion of the conversation, the team suggests that the candidate think about the discussion and visit the Medical Center and Group's websites and explore Seguin and the surrounding communities. The candidate is then informed the Group's CEO will follow-up with him or her on next steps. Based on the phone interview, the team discusses and determines if the candidate warrants an onsite interview or not. Follow-up with the candidate occurs within 24-48 hours.

Key topics that are purposely avoided by the recruitment team are salary, specific patient volumes, clinical, and financial obligations. These topics are not brought up because the team feels that if the primary driver for a physician is financial, then this organization will not be a fit for the candidate. Although the team understands the importance of compensation, it has found that candidates which are primarily financially driven do not lead to long-term retention in the organization. With that said, if the candidate asks questions and wants information on this topic, then it is addressed.

For the onsite visit a more extensive and broader group of staff and providers are involved. If the Medical Group already employs or offers the specialty that is being recruited, that same specialty provider will have a large role in the recruitment process as well as which candidate is ultimately chosen.

On the day of the onsite visit, arrangements are made for the candidate to meet with the core recruitment team and review the agenda for the day. Next, a primary care provider that leads the Medical Society's Recruitment Committee meets with the candidate and discusses the essential elements of the medical community, referrals, types of patients that providers manage, general expectations of provider collaboration are set and the general skills that are needed for this specialty based on the demographics. The primary care provider also discusses the strong relationship that the medical community, Medical Center and administration has developed. The culture of both the Medical Center and Group are discussed and how communications

and issues are addressed as they arise. The dialog is open, transparent, and straight forward regarding the physician and organizational relationship. This meeting typically lasts for approximately 30-45 minutes or until all parties are satisfied.

The candidate is then given a tour of the facility and introduced to floor staff, managers/directors, and other providers rounding in the hospital. Specific times are not established with all parties because the intention is to allow a more honest and transparent encounter to occur organically. This allows for the candidate to get a realistic "feel" of the true culture within the facility.

Once the tour of the hospital is complete, the candidate is taken to the local medical office buildings and shown where the practice would be located. Technology, equipment, and the facilities are showcased during this time. The candidate observes that the environmental aspects of the organization are important and well maintained. While touring, he or she is introduced to clinic staff and other employed providers within the ambulatory setting.

The Medical Group is governed by a board which includes the hospital CEO, hospital CFO, group CEO and three community-based physicians. The recruitment team makes time for each of the board members to sit down and meet the candidate. This is a casual meeting and lasts no longer than 15 minutes per board member. This aspect of the interview is important because the candidate understands that he or she is not only governed from an administrative standpoint but governed from a quality standpoint as overseen by other physicians.

The candidate then meets with the entire administrative team which includes the following individuals:

- Hospital CEO
- COO
- CNO
- CFO
- VP physician services
- VP of finance
- VP quality
- VP revenue cycle
- Medical Group CEO
- Group operations manager
- Clinical process improvement coordinator

To ensure alignment, operational expectations from each entity are discussed during this meeting so the candidate has a complete understanding of what would be required if he or she were to join the group. Financial and revenue cycle scorecards are presented to demonstrate what metrics are measured and how the financial metrics will be presented monthly and quarterly. Because providers are often times less involved in the billing and collections processes, the VP of revenue cycle provides the candidate with actual metrics of the Medical Group's upfront collections, billing lag time, coding and communications, denial rates, account receivable over 180 days, and other revenue cycle metrics that impact the financial health of the practice. The provider can see the level of financial and operational transparency the organization offers, thus facilitating trust.

The operations manager and clinical process improvement coordinator for the Medical Group discuss the daily operations of the practices, the continuous clinical and operational improvement projects, management

of regulatory and compliance programs and other items that impact the practice. The candidate obtains a level of understanding of what the operations team manages and how the practices run.

A social luncheon is then conducted with the Medical Society's Recruitment Committee along with the administrative team. There has been intentional work over the past 15 years to align the medical community and the administration of the Medical Center. This allows the candidate to gain an understanding of the alignment between community physicians and administrators.

The final component of the on-site visit is a community tour with a local realtor. Although not employed by our organization, the realtor is an integral part of the recruitment team. The realtor spends time with the candidate and insight is gained into his or her wants, needs, goals, what their overall perspective of the visit was and their general level of true interest.

The team has standardized the content and processes so the visit is comprehensive and thorough, although it can vary slightly to meet the candidate's availability limitations. Follow-up with the candidate is performed quickly and diligently to ensure expedient and thorough follow thru. Being quick in response to questions and follow up is imperative because this characteristic is organic to the organization and remains the central aspect post hire.

Retention

Once the physician is hired, the core recruitment team ensures they remain accessible and connected because expectations were established during the recruitment process. What will be judged going forward is the delivery of those expectations. Establishing interpersonal trust and honesty must be maintained and fostered to build upon the relationship that was begun during the recruitment process. An error that often occurs is that once the recruitment team has the signed contract from the provider, they move out of the picture and on to the next project. However, the candidate frequently makes the decision to join the group based on the interactions and trust established with the recruitment team. If they are out of the picture and abruptly begin working with other members of the operations team without a fluid handover, her or she may not have the confidence and trust as before which leads to physician dissatisfaction. The GRMG CEO remains involved in the physician on-boarding process all the way through to daily operations. The new provider is introduced to the operations manager who ensures all items that are needed are obtained and the timeline for starting is established. The soft handover is performed gradually until the provider is completely transitioned over to the operations manager.

Once the new physician starts, a structured training and orientation timeline is followed. One-month post start, the GRMG CEO meets with the provider and begins to review the financial and operational metrics that are presented during the recruitment process. Quarterly meetings are then scheduled with the revenue cycle team to review the billing metrics of the practice. Although the financials and volumes may be less than optimal, it allows the physician to see the capital investment that is being made by the organization. The transparent review of the financials fosters trust and physician engagement. They better understand the business elements of the practice and can see the true costs it takes to run a practice.

As part of the continued on-boarding process, the GRMC VP of physician services meets with the physician within the first 60 days of starting in order to continue that strong relationship that began during the recruitment process. The purpose of this meeting is to garner feedback on the startup process and to address any issues or answer questions related to hospital operations. This executive obtains information and relays the information to the appropriate department of the Medical Center for explanation or resolution.

Issues encountered are resolved expeditiously and efficiently. Meetings with the VP of physician services continues throughout the physician's employment for engagement and continued connectivity.

Conclusion

As with any lesson in life and in business, experience and lessons learned are the greatest teachers that can lead us to success. During the redesign of GRMC/G's recruitment process, the team recognized and learned valuable lessons in the recruitment and hiring of physicians. The lesson that has been the most influential on the process is only proceeding forward when all members of the team and the physician are in alignment. Critical elements of both the clinical skillset and the emotional intelligence of the physician must exist and be engaged if long-term sustainability and trust are the desired outcomes. The recruitment team has learned to say no to candidates even when they possess the desired skillsets and are highly interested in the organization. Recently the team collectively decided to wait more than a year for a much-needed specialty because the candidate that was best suited for the organization's culture and he also had the desired skillsets but was not available immediately. From lessons learned, the team knows that it is better to wait than to hire just to fill a vacancy. The redesign has yielded a ratio of successful recruitments of 100%, or 8 for 8.

Having a tool such as the Physician Practice Critical Success Factor Matrix can assist in guiding recruitment teams of organizations both large and small. The tool represents critical success factors in six sections with subsets categories. These items consider key factors that contribute to the success of physician practices. This tool can assist in developing or enhancing a recruitment strategy by addressing and setting expectations upfront. Executives can look at their recruitment process and determine if the categories and subcategories present are being addressed at the time of the interview. Although there is no tool or strategy that will yield a perfect score in choosing the right candidate, this tool can be used as a guide for identifying critical factors during the recruitment process. Successful physician recruitment is vital to any organization's long-term success and when a considerable capital investment is appropriated to a critical strategy, developing a strategy to get it right is crucial. At GRMC/G we understand that medicine begins at the bedside with the patient and the physician. Therefore, the team understood and continues to know the importance of developing and refining a process that is structured and addresses critical factors to improve the success rate of recruiting the right individual for our organization.

Appendix A


Physician Practice Critical Success Factors
Effective Governance and Management Structure
Governance
Organizational Structure
Strong Physician-Administrative Leaderships
Leadership
Communication
Strategy/New Business Development
Financial Processes and Systems to Maximize Revenue
Revenue and Expenses
Physician Performance
Contracting
A/R Management
Coding and Documentation
Central Business Office
Patient Oriented Efficent Operating Systems
Policies and Procedures
Non-provider Staffing
Use of Technology
Patient Retention, Satisfaction, and Service
Human Resources
Practice Operations
Facilities
Aligned Incentives Physician Compensation
Physician Managment and Compensation
Quality Management and Controls
Risk Management
Quality Improvement
Clinical Operations
Medical Records
THE CAMDEN GROUP
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Notes