

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: Quarter Ending 12/31/14

Contact Information	
Provider Organization: Corpus Christi Medical Center	
Primary Contact: Chris Nicosia	Email: chris.nicosia@hcahealthcare.com
Goals	
Goal(s): <ul style="list-style-type: none">• Increase the number of primary care physicians in our 501a by 1 for 2014 and an additional 1 for 2015• Increase the number of primary care physicians in our Hospitalist group by 2 for 2014 and an additional 2 for 2015	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Expand the approved search parameters currently in place with the recruitment agencies• Increase the number of candidates to be interviewed by the groups• Shorten the interview window to ensure the groups can make decisions quickly• Increase the number of places where the hospital can source candidates	
Do	
Actions Taken: <ul style="list-style-type: none">• All of the above steps were implemented in late Q2	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ We have one active contract for a new physician in our 501a. The start date of this contract is 9/1/15.○ Recruitment efforts continue for a second new physician to join our 501a○ Hospitalist group has increased to 15 from the baseline of 12• <i>Challenges:</i><ul style="list-style-type: none">○ Difficult to recruit to Corpus Christi	

Act

Next Steps:

- Continue recruitment efforts for a second physician to join the 501a
- Continue Hospitalist recruitment
- Develop 2-3 year plan for primary care recruitment – plan to include all groups on our campus
- Develop expansion plan for FP residency continuity of care clinic

Collaborate

Share Successes and/or Request Assistance

- No assistance required at this time

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Reporting Period:

Contact Information	
Provider Organization: Corpus Christi-Nueces County Public Health District (MEND)	
Primary Contact: Annette Rodriguez, MPH	Email: annetter@cctexas.com
Goals	
Goal(s): 2.6.3 Implement an innovative and evidence-based (<i>Diabetes Self-Management Education/Support</i>) health promotion program to increase health literacy of a targeted population <ul style="list-style-type: none">Enroll 300 patients in the innovative diabetes self-management courses ; participate in face to face learning collaborative 2.9.1 Establish/Expand a Patient Care Navigation Program <ul style="list-style-type: none">Enroll 275 patients in patient navigation program; report all types of navigator services provided; develop focus groups to project data and test for new ideas	
Plan	
Plan for Implementation and Achievement: 2.6.3 (Diabetes) <ul style="list-style-type: none">Continue contract with Coastal Bend Health Education Center to run the diabetic programs; running additional diabetic programs in the rural community 2.9.1 (Navigator) <ul style="list-style-type: none">Hired 1 navigator and oriented her on the program to continue registering patients with diabetes and other chronic diseases to assist them with referral & resource needs	
Do	
Actions Taken: 2.6.3 (Diabetes) <ul style="list-style-type: none">Working closely with Coastal Bend Education Center and the navigator project to keep patients engaged in diabetes self-management referral needs and assist with resources for increased access to care. 2.9.1 (Navigator) <ul style="list-style-type: none">Interviewed and offered 3 individuals positions as navigators that can assist the HD and our community FQHC and other community clinics in referrals for diabetic patients as well as navigate patients through their continuum of care	

Study

2.6.3 (Diabetes)

- *Progress Towards Goal(s): Continue to work on recruiting efforts and incentivizing patients to remain with the program to completion*
- *Challenges: Patients starting the program but not completing the program*

2.9.1 (Navigator)

- *Progress Towards Goal(s): Have exceeded the number of patients we initially thought we would be able to reach with the program*
- *Challenges: Retaining patients through the end of the program*

- *Challenges: Lack of HINSTX pricing information continues to cause delays in connectivity*

Act

Next Steps:

- Continue working with diabetics on teaching diabetes self-management courses as well as work with navigating patients through health care systems that are needed for their type of care

Collaborate

Share Successes and/or Request Assistance

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Reporting Period:

Contact Information	
Provider Organization: Citizens Medical Center	
Primary Contact: Cherie Brzozowski, CQO	Email: cbrzozowski@cmcvtx.org
Goals	
Goal(s): <ul style="list-style-type: none">• Increase hours of clinic operations• Relocation of FQHC to hospital campus	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Hire staff to accommodate increased clinic hours• Relocate FQHC to hospital campus in order to ease access for patients	
Do	
Actions Taken: <ul style="list-style-type: none">• Hired a provider to cover additional clinic hours• Relocated FQHC to hospital campus	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Additional provider hired and trained○ Relocation complete• <i>Challenges:</i><ul style="list-style-type: none">○ Delay in relocating FQHC○ Staff resistance to refer out of the ER for non-emergent care to FQHC or other provider	
Act	
Next Steps: <ul style="list-style-type: none">• Monitor number of clinic visits to validate staffing• Host collaborative meetings to correct issues related to operations and referrals	

Collaborate

Share Successes and/or Request Assistance

- Longer hours have been established in order to assist patients for non-emergent care needs

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Reporting Period: February 2015

Contact Information	
Provider Organization: Coastal Plains Community Center	
Primary Contact: America Contreras	Email: acontreras@coastalplainsctr.org
Goals	
Goal(s): <ul style="list-style-type: none">To ensure that every eligible individual is offered an opportunity to access primary care services.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">Primary care Navigators will be hired for every service sitePolicy and Procedures will be written addressing service accessNavigators will be trained on policy and proceduresWritten notification will be made available defining all services in each service area.	
Do	
Actions Taken: <ul style="list-style-type: none">At time of Intake, every individual will be assessed for primary care eligibilityReferrals will be made to the Navigator via a warm hand off procedureNavigators will register individuals for primary care services and individual will receive a doctor's appointment , a reminder call, and will be met by Navigator on the day of the appointment	
Study	
Review and Evaluate: <ul style="list-style-type: none"><i>Progress Towards Goal(s):</i><ul style="list-style-type: none">Monitor the number of individuals referred and accepted to primary care servicesRandomly pull records of individuals not deemed eligible to ensure that eligibility screening was accurate<i>Challenges:</i><ul style="list-style-type: none">Accepting clients with insurance who have to change providers to CACOST providersProviding individual and group skills training on living a healthy life stylesMedication educationA mutual agreed upon formularyIdentification of high utilizers and determine method of minimizing services delivered by provider	

Act

Next Steps:

- Monitor medication budget
- Identify individuals that have a high utilization of service
- Initiate case management meetings to develop interventions to reduce high utilization
- Extend primary care education to more individuals, initiate group therapy

Collaborate

Share Successes and/or Request Assistance

- Success: In DY3, 857 individuals received primary care
- Success: Have trained Navigators in DEEP training so that they can provide skills training, and education on Diabetes and High Blood Pressure
- Assistance: Will look at in depth training regarding hyperlipidemia
- Assistance: Investigate process to certify Navigators as Community Health Workers

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Reporting Period: 02/18/2015

Contact Information	
Provider Organization: DeTar Healthcare System	
Primary Contact: Jace Jones	Email: jace.jones@detar.com
Goals	
Goal(s): <ul style="list-style-type: none">• Expand access to chronic disease management and pre-natal clinics• Expand access to behavioral health programs• Expand clinic hours• Increase Primary Care Providers	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Align stakeholders in local and rural areas• Get approval for needed staff• Staff buy in for extended hours• Develop budget and impact analysis• Align rural and local providers to benefit of the programs• Obtain needed FF&E• Obtain clinic spaces in chosen markets• Develop marketing pan• Develop patient forms and progress notes in EMR• Submit Residency Application	
Do	
Actions Taken: <ul style="list-style-type: none">• Hire needed faculty• Aligned stakeholders and potential collaborators• Prepared for ACGME site visit• EMR notes developed	

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
 - All faculty members have been hired for FM Residency clinic
 - ACGME decision coming this week
 - Met Chronic disease program QPI metrics
 - Residency clinic on track to meet QPI target in DY 4
 - Pre-Natal project growing in rural areas
- *Challenges:*
 - ACGME
 - Documentation in EMR
 - Staff buy in

Act

Next Steps:

- Design Family Residency clinic and start build out
- Continue marketing program
- Continue to engage rural providers

Collaborate

Share Successes and/or Request Assistance

- Enrollment in Pre-Natal clinics has increased in the rural areas
- Increased communication between local primary care providers and IOP
- Younger physicians

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Reporting Period:

Contact Information	
Provider Organization: Driscoll Children's Hospital	
Primary Contact: Michelle Ramirez	Email: michelle.ramirez@dchstx.org
Goals	
Goal(s): <ul style="list-style-type: none">• Increase overall operating hours by 4% each demonstration year from baseline hours collectively across the three available urgent care/non-emergent care settings	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Meet with medical staff to discuss future hours at each urgent care location• Discuss a date of expansion• Discuss coordination of medical staff for additional operating hours• Discuss marketing efforts for changes to operating hours	
Do	
Actions Taken: <ul style="list-style-type: none">• Maintaining expanded operating hours on the weekends in the Quick Care-McAllen and Saratoga Urgent Care (Corpus Christi) in April• Maintaining expanded Summer operating hours on the weekend in Victoria-After Hours Clinic starting in June	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ We have been tracking the number of patients seen during the expanded time frame• <i>Challenges:</i><ul style="list-style-type: none">○ Still competing with expanded hours from outside pediatric facilities which could affect staffing and patient volume	

Act

Next Steps:

- Discuss staffing coordination with future expanded operating hours at each clinic location
- Review patient access times and flow for future expanded operating hours for DY5
- We will be working with the Driscoll Healthplan to provide location information on our non-emergent clinic via text messaging to Healthplan Members recently seen for a low-acuity visit in the emergency room

Collaborate

Share Successes and/or Request Assistance

- We have already experienced an increase in patient volume from year over year
- Increased access to primary care services by offering more operating hours during the weekend outside of pediatrician office hours

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Reporting Period:

Contact Information	
Provider Organization: gulf bend center	
Primary Contact: David Way	Email: dway@gulfbend.org
Goals	
Goal(s):	
<ul style="list-style-type: none"> Fully implement integrated care leadership team Finalize staffing compliment and onboard personnel 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> Orient new integrated care coordinator director Establish time sensitive objectives for director Operationalize partnership vision with county hospital 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> Hired care coordinator director Established leadership team for partnership 	
Study	
Review and Evaluate:	
<ul style="list-style-type: none"> <i>Progress Towards Goal(s):</i> <ul style="list-style-type: none"> Developed protocols for patient registration <i>Challenges:</i> <ul style="list-style-type: none"> Culture and technology 	
Act	
Next Steps:	
<ul style="list-style-type: none"> Codify patient flow procedure between county hospital and gulf bend 	
Collaborate	
Share Successes and/or Request Assistance	
<ul style="list-style-type: none"> partnerships 	

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Reporting Period: Report date February 2015

Contact Information	
Provider Organization: Lavaca Medical Center	
Primary Contact: Bill Emery	Email: wemery@lavacamedcen.com
Goals	
Goal(s): <ul style="list-style-type: none">• Increase number of primary care clinic appointments and visits.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Add new primary care physicians, increase clinic hours.	
Do	
Actions Taken: <ul style="list-style-type: none">• Successfully hired new physician, added a minimum of 20 new appointment slots 4 days a week, through advertising and targeted marketing, welcomed walk-in visits.• Working with providers in order to plan the increase of the clinic's hours.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Excellent and on track according to time table.• <i>Challenges:</i><ul style="list-style-type: none">○ None to report.	
Act	
Next Steps: <ul style="list-style-type: none">• Increase operational hours of the primary care clinic NLT September 1, 2015.	
Collaborate	
Share Successes and/or Request Assistance <ul style="list-style-type: none">•	

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Reporting Period: July 2014 – January 2015

Contact Information	
Provider Organization: Memorial Hospital (Gonzales Healthcare Systems)	
Primary Contact: Leslie Janssen	Email: ljanssen@gonzaleshealthcare.com
Goals	
Goal(s): <ul style="list-style-type: none">• Increase use of rural health clinics rather than emergency room for primary care	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Expand hours of clinic in Waelder.• Locate new clinic space or location on which to build new clinic.	
Do	
Actions Taken: <ul style="list-style-type: none">• A new mid-level practitioner was hired and the clinic hours in Waelder were doubled from half days to full days Monday through Friday in November 2013.• Negotiations with the City of Waelder were begun to try and find a new location for the clinic.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ An agreement was reached with the City of Waelder in December 2013 for donation of land for a new clinic.○ Final approval of the land donation and the go-ahead to build the new clinic was given in August 2014.○ We're seeing a significant increase in the number of patients using the clinic in Waelder. We saw a 36% increase in 2013-14 over 2012-13 and we're seeing a 16% increase in visits so far this year. We have also seen a decrease of about 11% in emergency department visits from the Waelder zip code.○ Plans for the new building are being developed and additional funding sources identified.	

- *Challenges:*
 - The current clinic is in an old low income housing complex and is in poor repair. Some patients won't come to the location and it's difficult to staff.
 - We still face some ingrained habits in that patients, particularly unfunded patients, still think if they go to the emergency department for services they don't have to pay for them. It's difficult for them to understand it's actually less expensive to go to the clinic.

Act

Next Steps:

- Plans for the new clinic need to be developed and construction initiated.
- Patient education on the benefits of using the clinic versus the emergency department.

Collaborate

Share Successes and/or Request Assistance

- The expanded clinic hours do appear to be having an impact on reducing emergency department visits.

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Reporting Period:

Contact Information	
Provider Organization: <u>Otto Kaiser Memorial Hospital</u>	
Primary Contact: <u>Vincent Sowell</u>	Email: <u>Vincent.sowell@okmh.org</u>
Goals	
Goal(s): <ul style="list-style-type: none">• Improve use of tele-medicine.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Education of internal and external staff (contracted physicians, EMS, etc.), promotion of positive results.	
Do	
Actions Taken: <ul style="list-style-type: none">• In-services for staff, creation of tele-medicine standing protocols, continued promotion of positive patient experiences to staff and community.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Staff & physicians have become much more comfortable with the technology and the processes that have been put in place.• <i>Challenges:</i><ul style="list-style-type: none">○ Getting new ER physicians and new EMS personnel trained and in-serviced without missing opportunities to use the system.○ IT challenges (connectivity, bandwidth), although these issues are certainly decreasing.	
Act	
Next Steps: <ul style="list-style-type: none">• Incorporate Tele-Medicine training into our orientation for ER nurses and new ER physicians.	
Collaborate	
Share Successes and/or Request Assistance <ul style="list-style-type: none">• We have had several successful TPA administrations through the program.	

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Reporting Period:

Contact Information	
Provider Organization: Refugio County Memorial Hospital District	
Primary Contact: Hoss Whitt	Email: hwhitt@rcmhospital.org
Goals	
Goal(s): <ul style="list-style-type: none">• Improve access to primary care• Hire additional physicians• Increase clinic volume• Decrease ACSC in the E.D.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Hire two additional physicians to replace the physicians that resigned in 2014.	
Do	
Actions Taken: <ul style="list-style-type: none">• Temporarily filled the vacant physician positions with locum tenens.• Contracted with a Physician Recruiting Service	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">• Hired one physician to begin work in April of 2015.• Currently in negotiations with an additional physician to start work late summer of 2015.• <i>Challenges:</i><ul style="list-style-type: none">• Our clinic volume has declined instead of increasing due to our physician shortage.• E.D. volume has risen as a result of the limited access to primary care.	
Act	
Next Steps: <ul style="list-style-type: none">• Continue our recruiting efforts.	

Collaborate

Share Successes and/or Request Assistance

- None at this time

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Reporting Period:

Contact Information	
Provider Organization: Yoakum Community Hospital	
Primary Contact: Karen Barber	Email: kbarber@yoakumhospital.org
Goals	
Goal(s): <ul style="list-style-type: none">Hire Allied Health Professional for Medical Office Building	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">N/A	
Do	
Actions Taken: <ul style="list-style-type: none">Additional FNP hired and is seeing patients	
Study	
Review and Evaluate: <ul style="list-style-type: none"><i>Progress Towards Goal(s):</i> Access to care improved with a fully staffed Medical Office Building<ul style="list-style-type: none"><i>Challenges:</i><ul style="list-style-type: none">Provider is out on leave for 12 weeks	
Act	
Next Steps: <ul style="list-style-type: none">Business plan for FY16 projects a 10% increase over total FY15 visits	
Collaborate	
Share Successes and/or Request Assistance <ul style="list-style-type: none">Provider has seen 935 patients since July 2014	

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Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period:

Contact Information	
Provider Organization: Harlingen Medical Center	
Primary Contact: Deborah Meeks	Email: dmeeks@primehealthcare.com
Goals	
Goal(s): <ul style="list-style-type: none">• Improve Care Transitions	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Provide online access to medical records for patients and providers• Provide patient education on social media• Schedule follow up appointments prior to discharge• Call patients within 72 hours of discharge to review discharge plan and goals	
Do	
Actions Taken: <ul style="list-style-type: none">• All nursing staff engaged in scheduling follow up phone calls prior to discharge• Greater than 90% of patients are called within 72 hours of discharge	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Follow up appointments are scheduled and documented on patient discharge record○ Follow up phone calls are completed• <i>Challenges:</i><ul style="list-style-type: none">○ Patients will not make appointments that are scheduled○ Phone numbers provided by patients are incorrect	
Act	
Next Steps: <ul style="list-style-type: none">• Coordinate appointments with patients on discharge• Continue to reschedule missed appointments during discharge phone calls• Verify contact phone number prior to discharge	

Collaborate

Share Successes and/or Request Assistance

- Able to reschedule missed appointments and assist with challenges such as transportation, information, and coordination with physician offices
- Patients will not provide accurate information if they think it is related to billing inquiries