

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: March 30, 2016 Quarterly Report

Contact Information	
Provider Organization: CHRISTUS Spohn – Beeville	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">• Develop long term plan for program design and implementation to improve patient engagement	
Plan	
Plan for Implementation and Achievement: <ol style="list-style-type: none">1. To increase health literacy and access to care2. Increase communication and forge collaborative relationships with community partners	

Do

Actions Taken:

1. To increase health literacy and access to care
 - Implemented Care Transitions/Care Partners at CHRISTUS Spohn Beeville.
 - Health Resource Guide disseminated region wide, updated quarterly.
 - Sharing community resources and events via CHRISTUS Spohn's Facebook
 - Implemented Tele-health capacity:
 - i. preventive disease peripheral vascular screening technologies
 - Improved access to behavioral health services via dual diagnosis project.
 - Providing educational scholarships to aid registered nurses to pursue the specialty of Mental Health Nurse Practitioner.
 - Assisted our local community partner's impact Marketplace enrollment-20,000 lives for the CHRISTUS Spohn Region.
2. Increase communication and forge collaborative relationships with community partners
 - Interagency collaborative meetings continue with shift in focus towards health literacy and access to care.
 - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
 1. To increase health literacy and access to care:
 - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
 - Increased interest in program (Care Transitions) from other disciplines; pharmacy, case management, physicians.
 - Transition from hospital to home work-flow has been challenging, but goal is to hardwire into discharge process
 - Tele-health services have impacted eligible recipients with new advanced technologies.
 - Behavioral health services have increased access to this specialty service.
 - Mental Health Nurse Practitioner- 8 students currently enrolled, 3 additional students will begin fall 2016.
 2. Increase communication and forge collaborative relationships with community partners
 - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Multiple agencies came together to provide health screening, health education, and vaccines.
 - Collaborative partnership established to assist with Market Place enrollment. Role directly impacted access to healthcare, 20,000 HIX enrollment directly tied to this endeavor.
 - Collaborative group identified other venue opportunities, to address faith based Community needs.

- *Challenges:*
 1. To increase health literacy and access to care
 - High participant drop-out rate
 - Patient health literacy
 - Trust building between community and organization
 - Community and organizations willing to assist but may have different goal set.
 2. Increase communication and forge collaborative relationships with community partners
 - Buy-in from community partners in terms of time and different goals

Act

Next Steps:

1. To increase health literacy and access to care
 - Evaluate marketing strategy
 - Involve healthcare providers (i.e., physicians)
 - Educate hospital staff
 - Engage and collaborate with community partners to improve health literacy
2. Increase communication and forge collaborative relationships with community partners
 - Monthly communication collaboration meetings

Collaborate

Share Successes and/or Request Assistance

- Decreased INSERT CAT 3 CTN

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: March 30, 2016 Quarterly Report

Contact Information	
Provider Organization: CHRISTUS Spohn – Alice	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">• Develop long term plan for program design and implementation to improve patient engagement	
Plan	
Plan for Implementation and Achievement: <ol style="list-style-type: none">1. To increase health literacy and access to care2. Increase communication and forge collaborative relationships with community partners	

Do

Actions Taken:

1. To increase health literacy and access to care
 - Implemented Care Transitions/Care Partners at CHRISTUS Spohn Alice.
 - Health Resources Guide disseminated region wide, updated quarterly.
 - Sharing community resources and events via CHRISTUS Spohn's Facebook
 - Improved access to behavioral health services via dual diagnosis project.
 - Improved access to behavioral health services via integration of Primary Care (Spohn Freer Family Health Clinic) & Coastal Plains.
 - Providing educational scholarships to aid registered nurses to pursue specialty of Mental Health Nurse Practitioner.
 - Assisted our local community partner's impact Marketplace enrollment-20,000 for CHRISTUS Spohn Region.
2. Increase communication and forge collaborative relationships with community partners
 - Interagency collaborative meetings continue with shift in focus toward Community Needs Assessment-access to care, health literacy.
 - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
 1. To increase health literacy and access to care
 - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
 - Increased interest in program from other disciplines; pharmacy, case management, physicians.
 - Transition from hospital to home work-flow has been challenging , but goal is to hardwire into discharge process
 - Program marketing is key
 - Behavioral health services have increased access to this specialty service.
 - Mental Health Nurse Practitioner- 9 students currently enrolled, 3 additional students will begin fall 2016
 2. Increase communication and forge collaborative relationships with community partners
 - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Multiple agencies came together to provide health screening, health education, and vaccines.
 - Collaborative partnership established to assist with Market Place enrollment. Role directly impacted access to healthcare, 20,000 HIX enrollment directly tied to this endeavor.

- *Challenges:*
 1. To increase health literacy and access to care
 - High participant drop-out rate
 - Patient health literacy
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 2. Increase communication and forge collaborative relationships with community partners
 - Buy-in from community partners in terms of time and different goals

Act

Next Steps:

1. To increase health literacy and access to care
 - Evaluate marketing strategy
 - Involve healthcare providers (i.e., physicians)
 - Educate hospital staff
 - Engage and collaborate with community partners to improve health literacy
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 - Monthly communication collaboration meetings

Collaborate

Share Successes and/or Request Assistance

- Decreased INSERT CAT 3 CTN

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: March 30, 2016 Quarterly Report

Contact Information	
Provider Organization: CHRISTUS Spohn – Corpus Christi	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">• Develop long term plan for program design and implementation to improve patient engagement	
Plan	
Plan for Implementation and Achievement: <ol style="list-style-type: none">1. To increase health literacy and access to care2. Increase communication and forge collaborative relationships with community partners	

Do

Actions Taken:

1. To increase health literacy and access to care
 - Implemented Care Transitions/Care Partners at CHRISTUS Spohn Memorial. Expanded to CHRISTUS Spohn Hospital-Shoreline, Kleberg, Alice, and Beeville.
 - Extension of Northside Walk in clinic opened (4th Floor Memorial)-Corpus Christi Project.
 - Northside Extension Walk in clinic extended hours, Saturday appointments available.
 - Health resources disseminated region wide, updated quarterly.
 - Sharing community resources and events via CHRISTUS Spohn's Facebook
 - Implemented Tele-health capacity:
 - i. cellular based glucometer and
 - ii. preventive disease peripheral vascular screening technologies
 - Improved access to behavioral health services via integration of Primary Care (Spohn Robstown Family Health Center) & Behavioral Health Center-Nueces County. In the Corpus Christi EDs screening the diabetics and CHF patient population for depression; if positive further screening by LMSW and referred to appropriate behavioral health services within the community.
 - Providing educational scholarships to aid registered nurses to pursue specialty of Mental Health Nurse Practitioner
 - Assisted our local community partner's impact Marketplace enrollment-20,000 for CHRISTUS Spohn Region.
2. Increase communication and forge collaborative relationships with community partners
 - Interagency collaborative meetings continue with shift in focus towards improved health literacy and access to care.
 - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
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 - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
 - Increased interest in program from other disciplines; pharmacy, case management, physicians.
 - Transition from hospital to home work-flow has been challenging , but goal is to hardwire into discharge process
 - Program marketing is key
 - Tele-health services have impacted over 2000 eligible recipients with new advanced technologies.
 - Behavioral health services have increased access to this specialty service.
 - Mental Health Nurse Practitioner- 9 students currently enrolled, 3 additional students will begin fall 2016
 2. Increase communication and forge collaborative relationships with community partners
 - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Multiple agencies came together to provide health screening, health education, and vaccines.
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 - Involve healthcare providers (i.e., physicians)
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Collaborate

Share Successes and/or Request Assistance

- Decreased INSERT CAT 3 CTN

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Contact Information	
Provider Organization: CHRISTUS Spohn – Kleberg	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
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Goal(s): <ul style="list-style-type: none">• Develop long term plan for program design and implementation to improve patient engagement	
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Collaborate

Share Successes and/or Request Assistance

- Decreased INSERT CAT 3 CTN

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: April 2016

Contact Information			
Provider Organization:	Corpus Christi – Nueces County Public Health District		
Primary Contact:	Amy Barresi MSN, APRN, FNP	Email:	AmyB2@cctexas.com
Goals			
Goal(s):			
1.3.1 Implement a Chronic Disease Management Registry (<i>Diabetes</i>); Implement/enhance and use chronic disease management registry functionalities.			
<ul style="list-style-type: none">• Include additional 1,000 patient records in the Health District Chronic Disease registry (continue this DY5 goal while also converting partner clinics/programs to EMR system, and connecting them to HIPAA compliant Health Information Exchange within region)			
2.7.5 Implement <i>innovative evidence-based strategies (MEND) to reduce and prevent obesity in children and adolescents.</i>			
<ul style="list-style-type: none">• Enroll 1500 children in the 10 week MEND program; Increase number of partners offering program			
Plan			
Plan for Implementation and Achievement:			
1.3.1			
<ul style="list-style-type: none">• HINSTXs has joined with HASA out of SA to decrease costs for HIE participation. Project is closer to full implementation.• EMR application specialist continues setup, and training of partners;• Collaborate with RGVHIE and UT Brownsville on MU and Wellcentive projects			
2.7.5			
<ul style="list-style-type: none">• Currently 1100 children enrolled in DY5 programs as of 3/29/16• Identified and trained additional leaders, partners, and new concepts for MEND programs			

Do

Actions Taken:

1.3.1

- Additional equipment purchases for partner organizations/clinics
- Chart Relay currently collecting EMR data for HIE upload for CCNCPHD partners

2.7.5

- New administrative manager hired; Continue work on establishing additional program sites to meet 1500 children served in DY5; advertise and recruit additional children in the target population; increased social media campaign

Study

Review and Evaluate:

- *Progress Towards Goal(s):*

1.3.1

- *Progress Towards Goal(s): Automated data upload with Chart Relay for Mission of Mercy, Metro Ministries, and CBHEC data to date. Goal is HIE connectivity by June 2016*

- *Challenges: Many volunteer providers continue to be reluctant to go through EMR conversion (often due to provider age and computer proficiency issues.)*

2.7.5

- *Progress Towards Goal(s): Continued ongoing efforts to re-strategize and discuss 2015-2016 school year collaboration with CISD.*
- *Challenges: Previous negative media. Community/cultural resistance to children being labeled as overweight and the lifestyle/food changes that the program promotes.*

Act

Next Steps:

Next Steps: Focus EMR conversion from paper charting systems for smaller non-profit groups, garner support for regional HIE/HIPAA compliant data sharing

Collaborate

Share Successes and/or Request Assistance

Suggest HIE focus for the RHP4 DY6 shared goal that HHSC is requiring all DY6 transition projects show in their goal set. This would increase collaboration among all groups by assisting with shared information, HIPAA compliance, and referrals. In addition, it would help to support a shared project in our region that truly improves patient engagement and responsibility by teaching them ownership of their own health record and information. This empowers individual clients to be a stronger partner in their own health management by including them in planning, responsibility for complete record accuracy and availability, and the better understanding of their own labs/procedures/medications/appointments.

RHP 4 | Coastal Bend Region

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Reporting Period:

Contact Information	
Provider Organization: Citizens Medical Center	
Primary Contact: Cherie Brzozowski	Email: cbrzozowski@cmcvtx.org
Goals	
Goal(s): <ul style="list-style-type: none">• Increase inpatient influenza vaccine status	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Screen all inpatients to identify the population appropriate for the flu vaccine	
Do	
Actions Taken: <ul style="list-style-type: none">• Patients screened and give vaccine as appropriate	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Goal achieved. The goal was set at 90%, we achieved 92.67% by giving the vaccine to 468 patients during reporting time period• <i>Challenges:</i><ul style="list-style-type: none">○ none	
Act	
Next Steps: <ul style="list-style-type: none">• Continue to monitor and screen during flu seasons	
Collaborate	
Share Successes and/or Request Assistance <ul style="list-style-type: none">• Goal achieved at 92.67%	

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Reporting Period: March 2016

Contact Information	
Provider Organization: Jackson County Hospital District	
Primary Contact: Donna Coleman	Email: dcoleman@jchd.org
Goals	
Goal(s): <ul style="list-style-type: none">Expand use of social media to improve patient engagement and responsibility by reducing the number of unnecessary ER visits by offering educational opportunities pertaining to the Outpatient Pulmonary Rehabilitation Program.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">Post Information about the OPR Program and educational opportunities available to the community in relation to COPD patients.	
Do	
Actions Taken: <ul style="list-style-type: none">Implemented the Better Breathers Club to serve as an anchor for education to the community.First Better Breathers Club initiated and posted to our FB page for a community education opportunity.	
Study	
Review and Evaluate: <ul style="list-style-type: none"><i>Progress Towards Goal(s):</i><ul style="list-style-type: none">To have educational opportunities and successes posted on Facebook to educate and encourage the community to participate.<i>Challenges:</i><ul style="list-style-type: none">Provide alternate information tool for patients and community members who do not have social media so that have the same information as social media users.	
Act	
Next Steps: Post educational opportunities for the OPR Program, Better Breathers Club and additional education in relation to COPD patients.	

Collaborate

Share Successes and/or Request Assistance

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RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: March 2016

Contact Information	
Provider Organization: Behavioral Health Center of Nueces County	
Primary Contact: Victoria Rodriguez	Email: vhuerta@bhccnc.org
Goals	
Goal(s): <ul style="list-style-type: none">• Improve patient engagement and responsibility through health education and care coordination activities.• To use electronic and print media in our medication clinic and waiting area.• Have televisions installed in patient rooms.• Have 55 inch television installed in medication clinic waiting area for e-signage.• Hold classes to educate and supplement the integrated care (PH and BH) treatment.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Have televisions installed.• Identify materials needed for purchase to begin classes.• Set up a survey on Survey Monkey or Access Database to interview clients about their knowledge of new programs.• Implement client prizes for attendance.	
Do	
Actions Taken: <ul style="list-style-type: none">• Television installed in exam room playing a DVD about eating healthy and diabetes education geared for the South Texas Population.• Installed a 55" television in our medication clinic which runs promotions for all center activities highlighting our clinic, groups and presence on social media.• Materials purchases for health education classes 2015• Installed and began monthly bulletin board themes in the hallway directly across from medication clinic. 2015• MOU signed with Methodist Healthcare Ministries• Bus passes purchased for clients to attend groups and doctor's appointments	

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
 - An MOU was signed in October 2015 with Methodist Healthcare Ministries of South Texas, Inc. – Wesley Nurse Program
 - Wesley Nurse program has provided educational groups for a minimum of one hour on a monthly basis to adult MH consumers.
 - They have provided curriculum and educational information for programs/topics such as: Diabetes and Hypertension Education, Exercise Classes, Blood Pressure Screenings, Glucose Screenings, and Nutrition and Weight Management Education
 - Provide links to community resources for health and wellness education materials, referral assistance, prescription assistance, resources and programs to be utilized with consumers of Integrated Care
 - Purchases for materials made for hosting our own health education classes using our patient navigators as educators include: Powermind Nutrition Curriculum, Cholesterol Flip Chart, Hypertension Model Set, What You Should Know HBP.
 - Bus passes purchased have been successful in helping clients attend groups and their doctor's appointment. The no-show rate in DY 4 was 13.41%.
- *Challenges:*
 - Staff limitations. We have two patient navigators who track and chart our outcomes and data for reporting as well as working in the clinic and having them run the classes was an additional duty that took time away from clinic operations.

Act

Next Steps:

Continue to promote class offerings and health screenings.

Collaborate

Share Successes and/or Request Assistance

- How do other centers provide patient education?

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: 2nd Qtr

Contact Information	
Provider Organization: Border Region Behavioral Health Center	
Primary Contact: Alda Rendon	Email: aldar@borderregion.org
Goals	
Goal(s):	
<ul style="list-style-type: none"> To get clients to get actively involved in their health care; to have clients experience better health outcome and to possibly lower health care cost. 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> Providing DEEP training-diabetes empowerment education program Get clients to enroll in the patient portals for primary care via PrognoCIS (primary care software) Get client o actively participate in the patient portal to obtain information on their health care 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> Recently purchased and are in the final implementation stages of transferring/scanning all patient information to PrognoCIS. 	
Study	
Review and Evaluate:	
<ul style="list-style-type: none"> <i>Progress Towards Goal(s):</i> <ul style="list-style-type: none"> Purchased primary care software-PrognoCIS Scanning client information to PrognoCIS IT working with PrognoCIS to ensure all applications are ready for use DEEP training is being provided to diabetic clients receiving primary care services at Border Region – 8 clients have graduated from the DEEP training program(6 weeks course) <i>Challenges:</i> <ul style="list-style-type: none"> Time, it has taken more time than expected to scan/transfer all client information Not all clients attend the DEEP education classes, 6 week course took 9 weeks but all completed the course. 	

Act

Next Steps:

1. Ability to scan, fax information via PrognosisCIS
2. Ability to use SureScripts
3. Ability to participate in meaningful use

Collaborate

Share Successes and/or Request Assistance

- Purchasing primary care software

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: Jan to March 2016

Contact Information	
Provider Organization: Rio Grande Regional Hospital	
Primary Contact: Rosalinda Coronado	Email: Rosalinda.rangel@hcahealthcare.com
Goals	
Goal(s): <ul style="list-style-type: none">• Increase diabetes education and screenings for school-aged children.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Partner with local school districts to increase awareness of diabetes and school-aged population.<ol style="list-style-type: none">1. McAllen ISD2. PSJA ISD3. Weslaco ISD4. Boys and Girls Club of McAllen• Screen school-aged population, and contact those at high risk for diabetes education and management using a family and team approach.	
Do	
Actions Taken: <ul style="list-style-type: none">• Currently we have screened over 1300 students.• In progress of contacting those at high risks for education and management.<ol style="list-style-type: none">1. Clinic began contacting students and their families this month; we should have an update by the end of the month.2. Began offering additional services such as vaccinations.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Conducted screenings, and provided diabetes education during screenings.• <i>Challenges:</i><ul style="list-style-type: none">○ Parents' view of screening as something negative. This presents a challenge to us since without their consent we cannot screen or educate children.<ol style="list-style-type: none">1. We have seen an increase in consent forms, as three program has increased outreach efforts.	
Act	
Next Steps: <ul style="list-style-type: none">- Continue to contact the families and students who are at risk for education.	

Collaborate

Share Successes and/or Request Assistance

- No TA needed at this time.

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period:

Contact Information	
Provider Organization:	University of Texas Health Science Center at Houston
Primary Contact: Ghadir Helal	Email: ghadir.helal@uth.tmc.edu
Goals	
Goal(s):	<ul style="list-style-type: none">To maintain participant and family engagement post MEND program.
Plan	
Plan for Implementation and Achievement:	<ul style="list-style-type: none">Provide incentives for post program engagement and participation to include registration fees for gymnastics, Capoeira and soccer classes.
Do	
Actions Taken:	<ul style="list-style-type: none">Established agreements with local soccer, Capoeira and gymnastics instructors to provide two months of instructions in a group setting to MEND participants who have completed the 10-week program and attended at least 50% of the MEND Classes.
Study	
Review and Evaluate:	<ul style="list-style-type: none"><i>Progress Towards Goal(s):</i><ul style="list-style-type: none">Provided 82 graduating MEND participants incentives to attend soccer classes, capoeira classes or gymnastics classes.18 participants have been served through the incentivesParticipants have given positive feedback and we have benefited from continued engagement and improved participation in 6 month data collection.<i>Challenges:</i><ul style="list-style-type: none">Schedule, ability and willingness of parents to transport kids to lessons.Cost of sustaining the program.

Act

Next Steps:

- Extend post-program participation to all completing families.
- Evaluate costs of program and look for other funding sources to cover this cost.
- Identify other incentives for patient engagement like Schlitterbahn passes, zoo passes, etc.

Collaborate

Share Successes and/or Request Assistance

-

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: Jan to March 2016

Contact Information	
Provider Organization: Valley Regional Medical Center	
Primary Contact: Rosalinda Coronado	Email: Rosalinda.rangel@hcahealthcare.com
Goals	
Goal(s):	
<ol style="list-style-type: none"> Increase patient access and retention to our Outpatient Clinic. Specifically provide health education and training for patients with diabetes (or other conditions). 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> Create a Marketing Strategy to increase reach of outpatient clinic. Refer discharge patients with uncontrolled diabetes to outpatient clinic. Increase our local health care providers' partnerships. 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> Create a Marketing Strategy to increase reach of outpatient clinic. <ol style="list-style-type: none"> Increased our Social Media presence with clinic articles and hours of operation. Working with our Media Specialist in house to promote clinic services as a "mobile" clinic. <ul style="list-style-type: none"> Refer discharge patients with uncontrolled diabetes to outpatient clinic. Refer physician patients to clinic. Refer bariatric patients to the Clinic. <ol style="list-style-type: none"> Currently providing on-the-spot appointments to patients during outside/partner health fairs. Trained Nursing staff to connect patients after discharge to the outpatient clinic. <ul style="list-style-type: none"> Increase our local health care providers' partnerships. <ol style="list-style-type: none"> We have been extending our services to physicians and we have been participating in health fairs for them to provide our services. We are also participating in local Committees and Coalitions to raise awareness of our project. 	
Study	
Review and Evaluate:	
<ul style="list-style-type: none"> <i>Progress Towards Goal(s):</i> <ul style="list-style-type: none"> Marketing items are complete; we provide "packets" to all participants both in English and Spanish with information about our program and the clinic. (See attached Picture) We also posting on social media, and recently participated in an article for the local newspaper. <i>Challenges:</i> <ul style="list-style-type: none"> Partnerships with local FQHCs as they also have DSRIP projects. 	

Act

Next Steps:

- Try to close the gap between FQHCs and other local health care providers with marketing and referrals systems.

Collaborate

Share Successes and/or Request Assistance

- No TA needed at this time.