Provider Presentations

RHP4 Learning Collaborative

November 19, 2015

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Successes and Accomplishments

Dual Diagnosis Clinic –

- "Graduated" first five consumers from program;
- Expanded contracted services to three community HCS/TxHmL providers;
- Demonstrated improvement in measure that monitors incarcerations, psychiatric hospitalizations, and change in home environment due to behaviors (reduced to 30% from 45% baseline);
- Took first referral from a local school district;
- Two individuals previously unable to work because of behaviors have been referred for employment upon completion of program;
- Have achieved a CCISD administrative contact who is supportive of our participation in the implementation of Behavioral Intervention Plans within CCISD;
- Reduction in Aberrant Behavior Checklist scores to 19 from 81.63 baseline.

Safety Net Services - Provided Summer Respite camp for many consumers who desired socialization and whose caregivers were in need of respite.

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Successes and Accomplishments

Integrated Health Clinic-

- Project selected to present as a high impact and transformative project at the Statewide Learning Collaborative during the Peer to Peer Breakout session.
- Successfully met each milestone/metric for DY4, including a no show rate of 13.1%, 60.42% of individuals with survey results that show an increase on standardized health metrics and 80.77% of consumers served have controlled hypertension.
- Increase in collaboration with all center staff.
- Continued collaboration with TAMU-CC College of Nursing and Health Sciences, Charlie's Place Recovery Center, and Methodist Healthcare Ministries-Wesley Nurse Program.

Patient Navigation Services-

- Two patient navigator staff currently provide assistance with transportation, medication pick up/drop off, data tracking, offering health education classes, and providing linkage and referrals to outside agencies.
- Navigators started to complete physical health treatment plans with all clients who receive primary care services in Integrated Clinic.
- First Certified Application Counselors within the center and assist clients in enrolling for the Marketplace Insurance.

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Successes and Accomplishments

Peer-Run Day Center-

- Certified Peer Specialists have increased group offerings from 1 group session of 2 hours per week to 4 group sessions of 7 hours per week
- Met all milestones and metrics, including QPI, which had previously been carried forward.
- Referrals have increased from all staff including clerical/support staff.
- Positive changes in group members have been reported through client feedback and observation
- Medication adherence rates have improved in identified targeted population 76.31% adherent
- Through medication adherence interventions some clients have been able to transfer to more appropriate levels of care to better meet their needs
- Certified Peer Specialist staff completed training as Community Health Workers

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Successes and Accomplishments

Social Media New Outreach and Education-

- Met all of project milestones and metrics
- Established relationships with other agencies and resources in the community
- Developed and began posting to social media accounts, Twitter and Instagram
- Followers on social media accounts have steadily increased
- Created and presented multiple presentations for outreach and education
- Attended multiple events, conferences, and hosted an event
- Drastic improvements in 7 and 30 day hospital discharge follow up rates
- Increased contracted hours with psychiatrist to meet the need for hospital discharge follow ups
- Transitioning to 1 full time Program Supervisor
- Coordinating to enact system wide changes within Youth Services, coordinating with program staff for the successful scheduling 7 and 30 day f/up appointments
- Website development completed and in maintenance mode
- Designed and ordered program deliverables (JOIN wristbands)
- Gained access to school groups through Communities in Schools relationship

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Implementation Challenges

Dual Diagnosis Clinic –

- Contracting with additional HCS/TxHmL providers in the community who do not want to pay for the additional supports from our DSPs;
- Challenge obtaining continuous participation and implementation by family caregivers of individuals participating in the program.

Safety Net Services –

- Receiving program referrals quickly and efficiently;
- Receiving records and paperwork for consumers desiring services in an efficient and timely manner;
- Finding and maintaining quality staff to provide services to consumers in this program; having enough vehicles to provide transportation for services.

Integrated Health-

- There has been difficulty transitioning clinic progress notes, paperwork, and data entry from ICD-9 to ICD-10 codes.
- Fist primary care provider no longer working within the clinic, had to identify a new provider, train, and credential two new primary care providers.
- Integrated clinic hours of operation remain limited

RHP 4 Learning Collaborative – November 2015

Behavioral Health Center of Nueces County

Recent Project Implementation Challenges

Patient Navigation Services-

- Navigators have limited time to spend in face to face interaction and education with clients due to data tracking and other duties related with the Integrated Clinic.

Social and New Media Outreach and Education-
Initial difficulty gaining access to school groups for presentations

- Time management for project's components that require daily maintenance
- Hospital discharge coordinator turn over at the hospital who discharges their patients to us
- Conducting regular maintenance on program's website
- Increasing followers from target population on social media

RHP 4 Learning Collaborative – November 2015

Bluebonnet Trails Community MHMR

Recent Project Successes and Accomplishments

- The two Registered Nurses (RN) continue to establish a rapport with the Gonzales Healthcare Systems staff provide training to the community and hospital staff to ensure appropriate referrals to the project are received. At this time, the project has served a total of 82 patients that meet QPI criteria and has been successful in establishing patients without Primary Care Providers (PCP) with a local clinic as well as specialty physicians as indicated by the clients' assessment and needs with regard to their disease process.
- RN staff were trained on the Electronic Health Record (EHR) utilized by Bluebonnet Trails Community Services (BTCS) and are utilizing Health Information Management (HIM) staff at the hospital for the sharing of Protected Health Information (PHI) on referrals received from the Emergency Department (ED). The Navigator staff are notified when a client presents to the ED and is in need of navigation services. The Patient Navigators work with the Providers in the community as well as the individuals being served to develop a plan of care that will assist them in meeting their needs.

RHP 4 Learning Collaborative – November 2015

Bluebonnet Trails Community MHMR

Recent Project Successes and Accomplishments
• The Navigators are able to assist patients with applying for Medicaid, Charity Programs offered by the County Hospital, the Federally Qualified Health Center (FQHC) as well as BTCS for needed services. The Navigators have learned to apply for Patient Assistance Programs (PAP) which is assistance for medications that are often not affordable to the patients being served.
• The Patient Navigation submitted a DSRIP Impact Summary and were selected to present a poster at the state learning collaborative in DY 4. The Navigation Project recently presented on the RHP 8 Learning Collaborative Webinar along with three other Navigation projects.

RHP 4 Learning Collaborative – November 2015

Bluebonnet Trails Community MHMR

Recent Project Implementation Challenges

- As the Patient Navigation Program has been successful, ED staff continue to refer all individuals they assess who need intervention instead of just frequent utilizers of the ED. The Navigators serve all those referred which can take away from time allocated from those who meet QPI criteria. On occasion, the nurses of private MD offices call and request assistance with clients with complex needs. The navigators are local and have an expanded knowledge of the local resources and have been able to assist these clients with their needs.
- Receiving data and reports are difficult to obtain but this is improving with the continued stakeholder meetings. Time has been spent to explain metric data needed to further support data requests. Continued learning and training are an important part of this project to ensure growth and development.

RHP 4 Learning Collaborative – November 2015

Bluebonnet Trails Community MHMR

Recent Project Implementation Challenges

- DY 4 began with renewed training for the hospital staff in the ED department after assessing that many of the referrals did not have the six visits as required by the QPI criteria and did not have a signed consent for patient navigator services. The Navigators work with the Hospital staff clerks to obtain the information needed to contact patient referrals and to verify the number of visits that have been completed in the ED by the patient. This information is pulled by the ED clerical staff and given to the Navigator staff. Overall challenges have been small and have been easily resolved by stakeholder training and interaction
- The project did not achieve the required 5% improvement for the Category 3 metric. BTCS staff believe the change in community population was a large factor in this shortfall. Program staff have been proactive in planning process improvements to reach metric achievement in DY5.

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Hospital - *Corpus Christi*

Recent Project Successes and Accomplishments

- Primary Care
  - Increased hours 40+ hours (DYs 2-4) and 2 additional providers (DY4). Establish a walk-in clinic serving all FHCs
  - Enrolled 1100 patients in Cellular Blood Glucose Monitoring self-management program
- Acute Care
  - Increased access to Specialty Care through Intensivist program
  - Achieved quality improvement initiative's targets for Sepsis, Medication Management and Safety
- Community Outreach
  - Enrolled over 1200 patients in Care Transition/Care Partner program with substantial reduction in readmissions for CHF for patients completing these programs
- Behavioral Health
  - Enrolled 9 in PMHNP program with 1 graduate to date
  - Improved care coordination PC/BH through referrals and chronic disease depression screening

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Alice Hospital

Recent Project Successes and Accomplishments

- Primary Care
  - Increased visits at the Freer Family Health Center – 1490 (218) visits
  - Enrolled over 170 patients in the Chronic Disease Registry as part of regional disease management
- Acute Care
  - Achieved quality improvement initiative's targets for Sepsis and Medication Management
- Community Outreach
  - Enrolled 90 patients in Care Transition/Care Partner program with substantial reduction in readmissions for CHF for patients completing these programs
- Behavioral Health
  - Improve care coordination PC/BH through referrals and chronic disease depression screening

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Beeville Hospital

Recent Project Successes and Accomplishments

- Primary Care
  - Increased visits at the Beeville Family Health Center – 1888 (1000) visits
  - Enrolled over 100 patients in the Chronic Disease Registry as part of regional disease management
- Acute Care
  - Achieved quality improvement initiative's targets for Sepsis and Medication Management
- Community Outreach
  - Enrolled 105 patients in Care Transition/Care Partner program with substantial reduction in readmissions for CHF for patients completing these programs
- Behavioral Health
  - Improve care coordination PC/BH through chronic disease depression screening in the FHC and ED

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Kleberg Hospital

Recent Project Successes and Accomplishments
• Primary Care
• Enrolled over 130 patients in the Chronic Disease Registry as part of regional disease management
• Acute Care
• Achieved quality improvement initiative's targets for Sepsis and Medication Management
• Community Outreach
• Enrolled 219 patients in Care Transition/Care Partner program with substantial reduction in readmissions for CHF for patients completing these programs
• Behavioral Health
• Improved care coordination PC/BH through chronic disease depression screening in the FHC and ED

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Hospital – *Corpus Christi*

Recent Project Implementation Challenges
• Dissemination of Information
• Limited marketing of PMHNP opportunity to external partners • Regularity of meetings for PCMH accreditation – standard changes Fall of 2014
• Process Coordination
• Workflow coordination between primary care, acute care and behavioral health partners
• Patient Engagement
• It's still their choice to participate! • Difference between needing service and wanting service • No-show rates in primary care
• Technology
• Data - sharing, definitions and validation
• Category 3 audits by Myers & Stauffer

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Alice Hospital

Recent Project Implementation Challenges

- Process Coordination
  - Workflow between primary care, acute care and behavioral health partners
  - Workflow for telehealth referral system from primary care to specialist
- Patient Engagement
  - It's still their choice to participate!
  - Difference between needing service and wanting service
  - No-show rates in primary care
- Technology
  - Data - sharing, definitions and validation
- Category 3 audits by Myers & Stauffer

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Beeville Hospital

Recent Project Implementation Challenges

- Process Coordination
  - Workflow between primary care, acute care and behavioral health partners
  - Workflow for telehealth referral system from primary care to specialist
- Patient Engagement
  - It’s still their choice to participate!
  - Difference between needing service and wanting service
  - No-show rates in primary care
- Technology
  - Data - sharing, definitions and validation
- Category 3 audits by Myers & Stauffer

RHP 4 Learning Collaborative – November 2015

CHRISTUS Spohn Kleberg Hospital

Recent Project Implementation Challenges

- Process Coordination
  - Workflow between primary care, acute care and behavioral health partners
  - Workflow for telehealth referral system from primary care to specialist
- Patient Engagement
  - It's still their choice to participate!
  - Difference between needing service and wanting service
  - No-show rates in primary care
- Technology
  - Data - sharing, definitions and validation
- Category 3 audits by Myers & Stauffer

RHP 4 Learning Collaborative – November 2015

Citizens Medical Center

Recent Project Successes and Accomplishments
• Additional Staff member at FQHC to increase visits/week
• EOU successfully met the goal for patients seen
• Medicaid/Uninsured prenatal patients achieved over goal
• Two Lean Teams successfully completed – Breast Cancer Referral and Bill Hold

RHP 4 Learning Collaborative – November 2015

Citizens Medical Center

Recent Project Implementation Challenges
• Providers completing documentation and authentication timely
• Obtaining data from multiple programs
• Disconnect between providers intent and HHSC interpretation
• Philosophical differences surrounding the goal of the FQHC

RHP 4 Learning Collaborative – November 2015

Coastal Plains Community Center

Recent Project Successes and Accomplishments
• We developed a total of 5 integrated primary care clinics this year with sufficient staffing for each clinic. Staffing consisted of a 0.2 PA, LVN, and receptionist. A full time Navigator is also assigned to for each clinic. Substance Abuse services are also provided in 4 of our clinics
• Our Provider, Community Action Corporation of South Texas (CACOST) also provides preventative services to our integrated individuals. This year 987 individuals received integrated services.
• We were able to submit the Blood Pressure Category 3 metrics as complete.
• Our doctor No Shows improved significantly from 22.19% to 16.44%
• We have improved our Level 4 Close Collaboration with our providers by having monthly meetings with our Medical Director and CACOST Medical Director and other administrators to closely monitor and collaborate on PC integration services.
• 90% Satisfaction with Integrated Services was reported by individuals who responded to our Satisfaction Survey

RHP 4 Learning Collaborative – November 2015

Coastal Plains Community Center

Recent Project Implementation Challenges

- Meeting QPI has been a challenge for us. Our original QPI targets were very high. In DY3 our target was 1,000 individuals would receive MH and PC integrated services and 700 individuals would receive MH and SA integrated services.
- In DY4 we were able to report in the October Report that we met both DY3 targets and had to carry forward our QPI DY4 targets.

- Establishing our Baseline for Category 3 regarding Diabetes has been another challenge. Baseline is pending approval from Myers and Stauffer. We have had to carry forward this milestone.

- Gathering data for both our Category 3 milestones has been difficult. Even though we have an electronic record system , we are having to manually get the lab readings for the A1C and also have to manually get BP readings from the records.

RHP 4 Learning Collaborative – November 2015

Corpus Christi Medical Center

Recent Project Successes and Accomplishments
• We continue to grow our GME program with a total of 45 IM/ FP residents enrolled as of July 1, 2015.
• American Osteopathic Association (AOA) approval for 4 cardiology and 4 pulmonary / critical care fellowship residents.
• June 2015, two Community Health Workers (CHWs) were added to the team.
• Substantial growth with our behavioral health project.
• Sepsis Coordinator hired.

RHP 4 Learning Collaborative – November 2015

Corpus Christi Medical Center

Recent Project Implementation Challenges
• Sepsis ED order-set was initially a paper product with little adoption by nurses and physicians.
• Tracking of resident and fellow encounters.
• Continued deficit in behavioral health providers in the community.
• Care transitions (post discharge) documentation is not tied to the EMR.
• Identified need for further IT enhancements to our databases to reduce redundancy in documentation and improve interdisciplinary communication post discharge.

RHP 4 Learning Collaborative – November 2015

Corpus Christi-Nueces County Public Health District

Recent Project Successes and Accomplishments

- CCNCPHD is working closely with the Board of Directors of HINSTX as HINSTX works to partner with HASA (Healthcare Access San Antonio) to provide the resources that HINSTX has been unable to provide.
- The Corpus Christi-Nueces County Public Health District (CCNCPHD) is researching the use of the Health District to provide clinics with a method of meeting Stage 2 criteria.
- The Corpus Christi-Nueces County Public Health District (CCNCPHD) has hired an experienced EMR Application Specialist/IT Tech to complete change over from paper records to digital records.
- CCNCPHD has contracted with a third party database manager (Chart Relay) as an interim for HINSTX.

RHP 4 Learning Collaborative – November 2015

Corpus Christi-Nueces County Public Health District

Recent Project Implementation Challenges

- HINSTX is our area designee for the Health Information Network (HIE) software system. It has not completed the part of the setup that allows the upload and access to records.
- The cost of getting a portal between our partners EMR software and Medicity which is the database for the HINSTX data is projected to be in excess of $20,000.00 per customer.
- Contracts and other legal documents are continuing to be a time consuming task.

RHP 4 Learning Collaborative – November 2015

Corpus Christi-Nueces County Public Health District

Recent Project Successes and Accomplishments
-617 Children reached through program in DY4
- Metrics met at 100% for DY4
-Re-opened discussions with CCISD to offer program again in January
- Adding new partners for DY5
- Media outreach through Facebook and partner websites

RHP 4 Learning Collaborative – November 2015

Corpus Christi-Nueces County Public Health District

Recent Project Implementation Challenges
-Recruitment and retention
-Staff changes
-Cultural / family dynamics
-Category 3 calculations

RHP 4 Learning Collaborative – November 2015

DeTar Healthcare System

Recent Project Successes and Accomplishments
• Participating in the residency match process
• Successfully reported our DY 3 carry forward goals in the chronic disease program
• New medical director of our IOP/Behavioral Health project – Dr James Haliburton
• Met our Category 2 metrics for our Pre-Natal project

RHP 4 Learning Collaborative – November 2015

DeTar Healthcare System

Recent Project Implementation Challenges
• Meyers and Stauffer baseline audit delayed reporting of some Category 3 metrics
• Some difficulty reporting Category 3 improvements for our pre-natal project because delivering provider would not always send post delivery data
• Confusion regarding one of our Category 1 metrics for our IOP project
• Initial IOP director resigning due to family reasons
• Low volume in the pre-natal clinic

RHP 4 Learning Collaborative – November 2015

Driscoll Children's Hospital

Recent Project Successes and Accomplishments
• Maternal Fetal Medicine program: We have experienced an increase in referral volume which has increased patient volume. We also moved to another clinic location within Bay Area hospital to increase patient access.
• Urgent Care/Non-Emergent Clinics: We will be increasing the operating hours at our Victoria After Hours clinic after the first of the calendar year to increase patient access. Our volume continues to increase at all three locations.
• Telemed: We continue to experience an increase in patient volume through increased access hours.
• Cadena de Madre Program: We have reallocated resources to address patient needs and we have increased staffing efforts, locations, and marketing with our service communities. We continue to increase communication to members through mobile text messaging.
• Specialty Services for Endocrinology project: We have continued to increase our clinic days to meet patient needs, increase providers and begun collecting Cat. 3 data on HbA1c testing and 3rd next available.
• High Risk Follow-up Program: We have continued to increase staffing, provider relations and the number of clinical days available to patients to meeting volume needs.
• The Oral Health project: We continue to incentivized providers to increase services and have increased provider training efforts in outlying areas of Nueces County.

RHP 4 Learning Collaborative – November 2015

Driscoll Children's Hospital

Recent Project Implementation Challenges
• We have had recent changes to our Category 3 Outcome measurements on two projects which affected the DY 4 and Baseline information.
• We continue to work towards achievement of higher goals each demonstration year

RHP 4 Learning Collaborative – November 2015

Gulf Bend Center MHMR Center

Recent Project Successes and Accomplishments
RHP4 2.1 - Integrative Care Clinic. GBC has seen a significant increase in integrative care treatment plans this past DY4. Since June of 2015 we have a full-time physician assistant (PA) working in our clinic under the supervision of our clinical physician and our clients are taking advantage of seeing a primary care provider, some for the first time in many years. This has increased the number of clients that can be seen considerably as well as improved collaboration and referral processes.
RHP4 1.2 - Tele – health/medicine. We are pleased to report the implementation of our tele-health/medicine program. We have developed curriculum that address 5 specialty nursing modules, or areas of concern for clients and consumers enabling them to meet and talk about areas of concern regarding their health via tele-health mobile devices. This allows case management to take the tele-health mobile device to the consumers home, linking them to the RN or PA available to discuss their health issues. This service is particularly useful to those clients who do not have transportation and/or live in out laying counties also without transportation.

RHP 4 Learning Collaborative – November 2015

Gulf Bend Center MRMH Center

Recent Project Implementation Challenges
RHP4 – Integrative Care. * Our most challenging issue this past year was hiring a physician assistant or nurse practitioner to work our clinic. While we have had a medical physician to oversee the clinic and see patients, his time is limited to 4 hours per week which is hardly enough to increase and develop the integrative care clinic process. So the hiring of a full-time PA was paramount to really getting the clinic developed. Not that we are completely satisfied with our intake process and the flow of the clinic but we are well on our way to further developing these services and meeting the long overdue needs of our priority population. * Sustainability continues to be a challenge as we work to balance our mix of Medicaid within our MLUI population.
RHP4 – Tele-health/medicine. With the implementation of our specialty nursing modules we have found challenges in getting the services to those clients most in need, in rural areas, because of internet access and/or lack thereof. The quality of the connections is of concern because the flow of conversation can be poor which is frustrating to both the client and the presenter. We are currently working on establishing other paths of connectivity.

RHP 4 Learning Collaborative – November 2015

Jackson County Hospital District

Recent Project Successes and Accomplishments

- Utilization of the Outpatient Pulmonary Program to reduce the number of unnecessary ER visits for patients with COPD and Pulmonary Diseases.
- Continued improvement in patient quality of life who have COPD and Pulmonary Disease.
- Increased "community buy in" supporting results of clinic / patient outcomes and benefits through testimonials and referrals to the program.
- On site meetings with hospitals in the region to supply educational materials and training regarding the Outpatient Pulmonary Rehabilitation Program.
- Community program and education for staff and physicians continues.
- On site evaluations available by OPR Staff at the request of the physician.

RHP 4 Learning Collaborative – November 2015

Jackson County Hospital District

Recent Project Implementation Challenges
Updating educational materials needed for staff, physician and providers. Utilization of program by patients. Motivating patients due to fatigue from pulmonary diseases. Training all staff in regards to the Outpatient Rehabilitation Program. Availability of Outpatient Pulmonary Rehabilitation Staff to Clinical Staff for patient referrals.

RHP 4 Learning Collaborative – November 2015

Lavaca Medical Center

Recent Project Successes and Accomplishments
Increase Access To Primary Care
October DY4
• Increased the hours of the Primary Care Clinic
• Exceeded the QPI goal of 2800 additional face to face patient encounters over the DY2 baseline. Actually increased the patient encounters by 5000+ additional visits.
• Actively interviewing additional Family Practice physicians (DY5 milestone)
The clinic has grown so quickly that outside the DSRIP project's metrics we've had to hire an additional midlevel provider and are strongly considering adding another.

RHP 4 Learning Collaborative – November 2015

Lavaca Medical Center

Recent Project Implementation Challenges
Increase Access To Primary Care
October DY4
A change in the facility’s CEO and a new Medical Director in the clinic has been a challenge in getting the details of the DSRIP plan totally understood.
The clinic still not transitioned to an EMR has made the Cat 3 data collection a real burden, particularly because the providers use 3 different styles of documentation: dictation, T sheets, and SOAP notes.

RHP 4 Learning Collaborative – November 2015

Memorial Hospital (Gonzales)

Recent Project Successes and Accomplishments
• 121785303.1.1 – Although we didn’t meet our goals on the number of clinic visits in DY4, we did reduce ER visits from the Waelder zip code.
• 121785303.1.100 – We didn’t meet our goals on the number of patients who underwent home glucose monitoring, but did on the number of patients whose A1c levels were below 9.0.
• 121785303.1.3 – We met our goals on the number of patients on the home health service undergoing home monitoring, but the number of patients whose blood pressure was not controlled also increased.

RHP 4 Learning Collaborative – November 2015

Memorial Hospital (Gonzales)

Recent Project Implementation Challenges
121785303.1.1 – Clinic replacement has not begun which has limited the number of patients that can be seen.
121785303.1.100 – Providers are not seeing the value in home glucose monitoring and are reluctant to prescribe it for their patients.
121785303.1.3 – We need to identify the patients whose blood pressure is not controlled and try implementing home monitoring.

RHP 4 Learning Collaborative – November 2015

Otto Kaiser memorial Hospital

Recent Project Successes and Accomplishments
• Tele-Neurology Consult Volumes have now hit consistent levels that meet our metric achievement goals.
• We have now achieved successful TPA administration on 3 patients. Those 3 patients are a great example of how access to tele-medicine in our community is improving patient outcomes.
• EMS plays a huge role in our stroke protocols, and good communication with them is key. Our relationship with county EMS has improved dramatically during this project, and recently our county commissioners approved for local EMS to handle our ER transfers. With no private ambulance services in our county, this has greatly reduced the amount of time it takes us to get patients to their final destination . With the time crunch that exist for stroke patients, this is a huge development.

RHP 4 Learning Collaborative – November 2015

Otto Kaiser Memorial Hospital

Recent Project Implementation Challenges
• IT/Connectivity problems arise from time to time
• Our ER physicians are provided by a contract, and it is a challenge to get new docs trained and comfortable with the system and protocols prior to their ER shifts.
• EMS Issues have greatly improved, and continued communication with them moving forward will be key for our project.

RHP 4 Learning Collaborative – November 2015

Refugio County Memorial Hospital District

Recent Project Successes and Accomplishments
• Nurse Advice Line is in place
• Automated Tracking System and Policies are in place for calculating time to next appointment.
• We are finally able to extract accurate data/reports from our EHR
• Although we did not meet our numeric goals for increased visits to our Rural Health Clinic, the primary care practice is growing.

RHP 4 Learning Collaborative – November 2015

Refugio County Memorial Hospital District

Recent Project Implementation Challenges
• Our project focused on the expansion of primary care by increasing our number of full-time physicians from two to three. Since the start of this project, we have not yet had a full year in which we have kept three full-time physicians on staff. Provided we do not lose any physicians this year, DY5 will be the first year that we will have had three full-time physicians for the entire reporting period.

RHP 4 Learning Collaborative – November 2015

Yoakum Community Hospital

Recent Project Successes and Accomplishments
* October reporting was baseline numbers only
➢ IT 1.10: Diabetes care: HbA1c Poor Control (>9.0%)
➢ IT 1.11: Diabetes care: BP Control (<140/90mm Hg)

RHP 4 Learning Collaborative – November 2015

Yoakum Community Hospital

Recent Project Implementation Challenges
➢ Provider out for 5 weeks
➢ Provider out for 2 weeks

RHP5 Providers

RHP 4 Learning Collaborative – November 2015

Border Region Behavioral Health Center

Recent Project Successes and Accomplishments
• Region 5 –Starr County, total measures reported and submitted pending approval = 14, total measures submitted as carryforward pending approval =19
• Region 20 – Webb, Zapata and Jim Hogg Counties, total measures reported and submitted pending approval = 20, total measures submitted as carryforward pending approval = 10
• Region 5 & 20- cat 3- 7day/30day intensive outpatient encounter after hospitalization goal exceeded and met
• Region 20-cat 3 - risk adjusted measure- submitted correction
• Region 5 & 20 –Cat 3 – reduce ED visits, submitted corrections for Myers & Stauffers 11/13/15
• Region 5 & 20- submitted Cat 3 baseline data
• Region 5 & 20- increased number of individuals receiving primary care services for all counties.

RHP 4 Learning Collaborative – November 2015

Border Region Behavioral Health Center

Recent Project Implementation Challenges
• Region 5- 1.1 Meeting our goal for telemedicine encounters in Starr County, carryforward measure,
• Region 5- (3.4-Cat 3) risk adjusted measure, obtaining data from Starr County Memorial Hospital for measure
• QPI reports
• Region 20- billing for primary care services, not able to get started

RHP 4 Learning Collaborative – November 2015

Harlingen Medical Center

Recent Project Successes and Accomplishments

- Over 968 likes on our social media Facebook page today
- Provide 40 to 50 Health Fairs annually community wide including 3 at our Hospital
- Provide community outreach at winter Texan parks and recreation centers
- Since launching patient portal last quarter of 2014, we have signed up 55- 60% of our inpatients and 15% have utilized it thus far.
- For the period of Oct. 2014 to Sept. 2015 we have increased our percentage of patients receiving bedside pharmacist consultations
- Percentage of patients receiving E-scribing increased
- Percentage of patients receiving electronic medication reconciliation also increased

RHP 4 Learning Collaborative – November 2015

Harlingen Medical Center

Recent Project Implementation Challenges
Patient portal currently only for inpatient use. Working to include outpatients
Struggling in patient experience related to discharge preparation
Percent of patients receiving CPOE order entry for medications needs improvement

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Summary Listing of RHP Projects
1. 112716902.2.103- 2.6.1 - Implement Evidence Based Health Promotion Programs – Lactation Program
2. 112716902.2.101- 2.6.1 - Implement Evidence Based Health Promotion Programs- Asthma School-Aged Intervention
3. 112716902.2.100- 2.6.1 - Implement Evidence Based Health Promotion Programs- Diabetes School-Aged Intervention
4. 112716902.2.102- 2.12.2- Implement Pilot Intervention – Emergency Department Care Transitions
5. 112716902.1.100- 1.1.2 - Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity
6. 112716902.1.101- 1.1.2 - Expand Primary Care Capacity – Primary Care Physician Recruitment
7. 112716902.1.102- 1.9.1 -Expand Specialty Care Capacity – Expand Urological Service Capacity

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Update of the RHP Projects- Implement Evidence Based Health Promotion Programs – Lactation Program DY4

Metric	Goal	Status End of DY4	Reporting
I-6 Provide Breastfeeding Education new mothers	1,563	**2,000***	**Completed**
P-8 Participate in Learning Collaboratives	2	**2**	**Achieved-Reported in Round 1**

Overview of Project: Utilize lactation specialists and RNs to increase encounters with women who have delivered in the hospital to increase the new mother's exposure to the education material surrounding the benefits of breastfeeding.

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Update of the RHP Implement Evidence Based Health Promotion Programs- Asthma School-Aged Intervention DY4

Metric	Goal	Status End of DY4	Reporting
P-8 Participate in Learning Collaboratives	2	**2**	**Achieved- Reported in Round 1**
I-6 Screen school-aged children for Asthma.	1,080		

Rio Grande Regional Hospital

RHP 4 Learning Collaborative – November 2015

Update of the RHP Projects- Implement Evidence Based Health Promotion Programs- Diabetes School-Aged Intervention DY4

Metric	Goal	Status End of DY4	Reporting
P-8 Participate in Learning Collaboratives	2	**2**	Achieved- Reported in Round 1
I-6 Provide Diabetes Screenings to 1,080 school-aged children.			

Rio Grande Regional Hospital

Update of the RHP Projects-Emergency Department Care Transitions DY4

Metric	Goal	Status End of DY4	Reporting
I-11 Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.			
P-12: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP			

Rio Grande Regional Hospital

Update of the RHP Projects-Expand OB/GYN Care
DY4

Metric	Goal	Status End of DY4	Reporting
I-12 Provide OB/GYN services to 960 patient encounters. (38% MLIU)			

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Update of the RHP Projects-Expand Specialty Care- Urology Recruitment DY4

Metric	Goal	Status End of DY4	Reporting
P-21 Participate in the RHP Learning Collaboratives	2	**2**	Reporting Completion in **April 2015**
I-23 Provide specialty care services to 90 patient encounters	180	**0**	Metric Carry Fwd for **October 2015**
I-34 Increase specialty care clinic volume of visits and evidence of improved access for Medicaid and Uninsured patients seeking services	72	**0**	Metric Carry Fwd for **October 2015**

- Currently, Rio Grande Regional Hospital is actively searching for a Urologist.
  - We will be conducting an interview in April.

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Update of the RHP Projects-Expand Primary Care- PCP Recruitment DY3

Metric	Goal	Status End of DY4	Reporting
P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours.	40	**0**	Metric Carry Fwd for **October 2015**
P-5 Train/hire additional primary care providers and staff.	1	**0**	Metric Carry Fwd for **October 2015**
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services	1,000	**0**	Metric Carry Fwd for **October 2015**

Rio Grande Regional Hospital
RHP 4 Learning Collaborative – November 2015

Update of the RHP Projects-Expand Primary Care- PCP Recruitment DY4

Metric	Goal	Status End of DY4	Reporting
P-4 Expand the hours of a primary care clinic, including evening and/or weekend hours.	60	**0**	Metric Carry Fwd for **October 2015**
I-12 Increase primary care clinic volume of visits and evidence of improved access for patients seeking services	1,500	**0**	Metric Carry Fwd for **October 2015**

- Rio Grande Regional Hospital submitted an inquiry to HHSC regarding the use of a Nurse Practitioner as a Primary Care Provider.
    - HHSC has accepted our request, and we will proceed to search and hire a Nurse Practitioner, who will report to a Medical Director.
        - This is the model we currently utilize in our Women's Clinics.

RHP 4 Learning Collaborative – November 2015

University of Texas Health Science Center at Houston

Recent Project Successes and Accomplishments

2.7.5 Implement innovative Evidence-based Strategies to Reduce and Prevent Obesity in Children and Adolescents (MEND)

- ✓ Enrollment in DY4: A total of 43 MEND programs were delivered with 645 children enrolled and served in total.
- ✓ Patient Impact for Medicaid/Low-Income Uninsured Population: Of those 23.41% are not insured (151 children) and 53.33% have Medicaid/CHIP (344 children). Therefore, 83.41% (538 children) of our DY4 population was Medicaid/ Low Income Uninsured.
- ✓ Improvement in children's metrics: Comparison of pre and post-intervention data revealed on a subset of participants (n=161), who are overweight and 6-13 years old, that 85.71% have decreased their BMI, 71.01 % have increased the time spent in physical activity (n = 169) and 78.26% have increased their nutrition score (indicate improvement in eating habits and nutritional intake (n=138).
- ✓ Increase in the number of team members: 8 theory Leaders, 6 exercise coaches, and 6 program aids. To meet our QPI metric, we had to increase the number of delivered programs. Therefore, eighty-nine local individuals were trained as MEND leaders. Of these trained individuals 20 individuals were hired to meet the needs of the program.

RHP 4 Learning Collaborative – November 2015

University of Texas Health Science Center at Houston

Recent Project Implementation Challenges

1- Balancing Recruitment and Retention of Trained Personnel: Up to 30 qualified, bilingual, MEND trained leaders are needed at any given time to cover concurrent programs. This has been a challenge all along during DY4 reporting period due to the added burden of expanding geography and additional program sites (looking for full-time work or have full-time jobs or not able to travel to the expanded program site locations).

- New locations are in more rural towns with less qualified professionals to pull from.

2- Retention of participants into the program: Retention of participants continues to be a challenge.
Our attendance across sessions has increased since we started providing larger incentives, yet we are striving for a 100% attendance at the Healthy Growth Check 2 (upon program completion) and Healthy Growth Check 3 (at 6 months post enrollment)

- Children who attended at least 5 sessions: 75.1%
- Children who attended at least 10 sessions: 56.3%
- Children who attended at least 15 sessions: 36.4%

Category 3 Outcome:
Baseline: overweight/obese children ages 6-13 who were served in the baseline period.
We have achieved our DY4 (5% increase over baseline goal); yet we are in the process of investigating the feasibility of reaching the DY5 (10% increase over baseline goal).
- Our baseline score for the PEDSQL is already very high (average score 77.47).We are working with Intervention Developers (MEND) to clarify the PEDSQL score ceiling in our population. As per HHSC recommendation, we are working on locating a body of literature to support our claim and thus modify our goals.

RHP 4 Learning Collaborative – November 2015

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Recent Project Successes and Accomplishments

1. Establish/Expand a Patient Care Navigation Program Based on a Mobile Clinic Model

Project Partners: UT School of Public Health Brownsville Regional Campus UTHealth Mobile Health Clinic

- Successful completed 75% of milestones (1 milestone was carried forward)
- Enrolled 951 individuals in the MC- Navigation Program
- The program provided a total of 80 education classes in DY 4, serving a total of 1,029 unique individuals.
- The program established new baselines in DY 4 for 3 Category 3 Outcomes
- The program recently began using a new data system to track all participants enrolled in the Navigation Program.

RHP 4 Learning Collaborative – November 2015

WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER®
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Recent Project Implementation Challenges

1. Establish/Expand a Patient Care Navigation Program Based on a Mobile Clinic Model

Project Partners: UT School of Public Health Brownsville Regional Campus UTHealth Mobile Health Clinic

- The program has struggled with obtaining referrals from local hospitals on patients that are frequent ED users and that do not have a PCP. This milestones was carried forward to DY 5.
- Participants enrolled in the program do not always know their insurance type and often confuse managed Medicaid with private insurance.
- The program recently began using a new data system to track all participants.
- Staff are learning to use a new data system

RHP 4 Learning Collaborative – November 2015

Valley Regional Medical Center

Summary Listing of RHP Projects
1. 020947001.1.100- 1.9.2 - Expand Specialty Care Capacity – Improve Access to Specialty Care – Diabetes Clinic.
2. 020947001.2.100- 2.12.2 – Implement Care Transitions Programs – Focused on Chronic Disease Management of Diabetes.
3. 020947001.2.101- 2.6.1 - Implement Evidence Based Health Promotion Programs – Diabetes Education.

RHP 4 Learning Collaborative – November 2015

Valley Regional Medical Center

Update of the RHP Projects- Expand Specialty Care Capacity (DY4)

Metric	Goal	Status End of DY4	Reporting
(I-23) Patient Encounters-Carry Forward- DY3	1,500	**1,882***	Completed
(I-34)MLIU Patient Encounters	600	**978***	Completed
(I-22) Provide hours Weeknights/weekends (Additional)-DY4 (Baseline 138)	100	**300***	Completed

Overview of Project: Valley Regional will expand the services provided at the diabetes outpatient clinic. This program will focus on evaluation, education, nutrition, and ongoing assessment to reduce the complications of diabetes and help our diabetic population better manage their disease.

RHP 4 Learning Collaborative – November 2015

Valley Regional Medical Center

Update of the RHP Projects- Implement Care Transitions Programs (DY4)

Metric	Goal	Status End of DY4	Reporting
(P-11) New Ideas, Practices, tools by Provider/weekly.	1	**4**	Completed
(I-11) Individual Patients Educated/Transitioned	1,500	**600**	Carry Fwd

Overview of Project: Valley Regional will focus on preventing readmissions for diabetes patients. Under the program, a nurse practitioner and certified diabetes educator will facilitate an interdisciplinary collaboration to transition patients from hospital to home self-care.

RHP 4 Learning Collaborative – November 2015

Valley Regional Medical Center

Update of the RHP Projects- School Intervention (DY4)

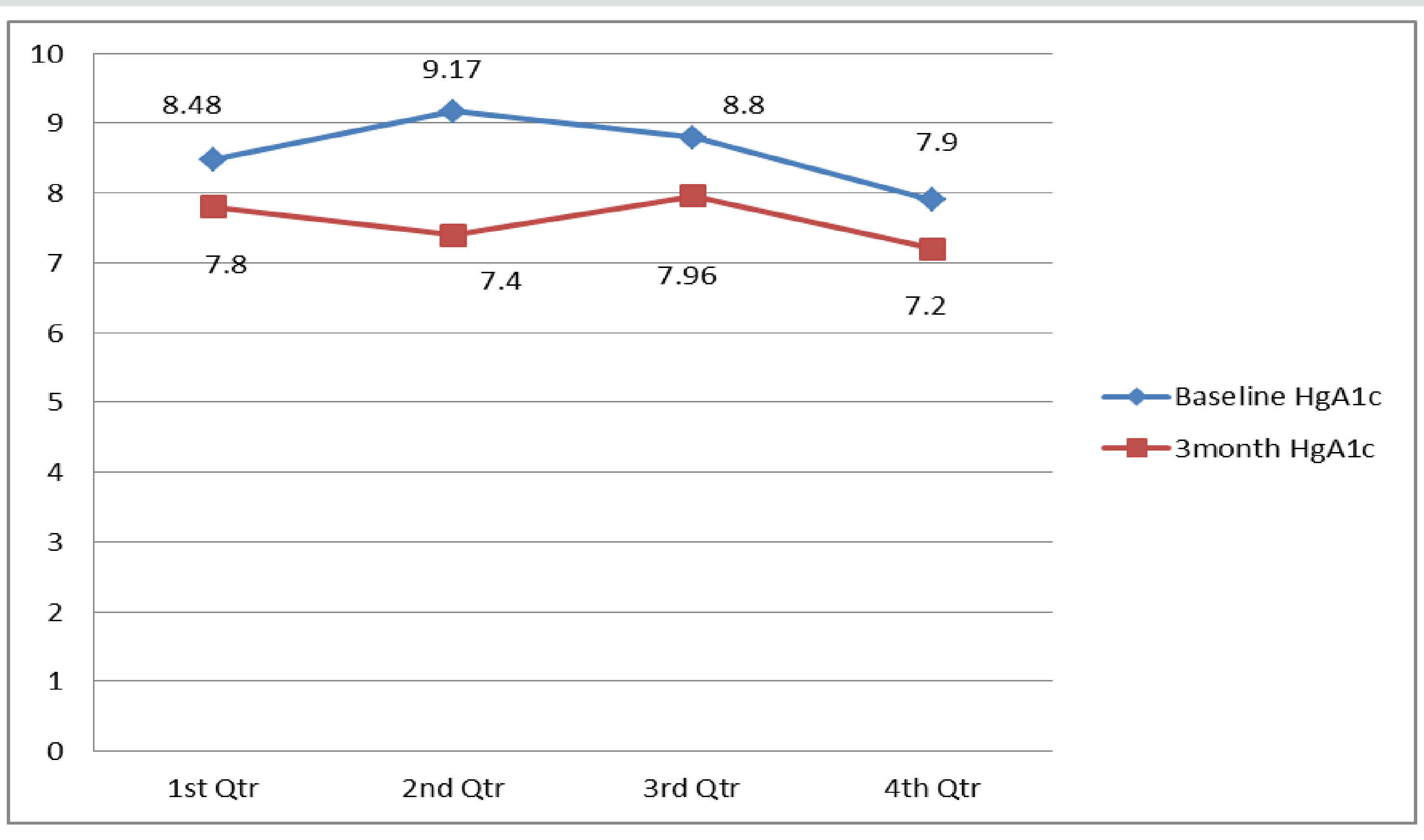
Metric	Target	YTD Outcomes	Reporting
(P-7) Tools, Ideas, Solutions or Practices.	1	**4**	Completed
(I-6) Number of Students Participating in Intervention	1,250	**1,300**	Completed

Overview of Project: Valley Regional will hire a health promotion specialist to establish community outreach and school-based interventions for diabetic children, and the patient population susceptible to diabetes (specifically the overweight / obese population in the surrounding school districts.

Valley Regional Medical Center

Project Impact

1. Reduction of HgA1C.



Valley Regional Medical Center

Project Impact

2. Increased Community Partnership and Exposure.

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Project Impact

3. Certification and Accreditation of Services.