RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: March 30, 2016

Provider Organization: Bluebonnet Trails Community Services	
Primary Contact: Penny Christian	**Email:** penny.christian@bbtrails.org
Goals	
Goal(s): Continued • Appointments are available for same day/ next day for ER follow up of patients.	
Plan	
Plan for Implementation and Achievement: • During the ER visit if navigator is available, education on scheduling a follow up appointment is completed with the new admission. If patient is admitted after the ER visit then education is completed at the time of admission.	
Do	
Actions Taken: • Educate each patient served either in the ER or at first appointment on scheduling an appointment with their PCP's office. • Assess the patient's level of understanding by using a return demonstration on this subject. • Reevaluate for successes and retrain if needed.	
Study	

Review and Evaluate:
 	
• *Progress Towards Goal(s):*
   o Measure if the patient is able to schedule and attend the PCP visit.
 	
• *Challenges:*
   o Population may not have a phone or minutes on their phone to accomplish this task.
   o Educate on how to use the public library for computer linkage.	

Act	
Next Steps: • Continue all steps with each admission.	

Collaborate
Share Successes and/or Request Assistance   ●

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: Quarter ending 12/31/15

Contact Information

| **Provider Organization:**   Corpus Christi Medical Center |

| **Primary Contact:**   Chris Nicosia | **Email:**   chris.nicosia@hcahealthcare.com |

Goals

Goal(s):

- Increase the number of primary care physicians in our 501a by 1 in 2015
- Increase the number of primary care physicians in our Hospitalist group by 2 in 2015
- Increase the number of Infectious Disease and Neurology Hospitalists by 1 each in 2016

Plan

Plan for Implementation and Achievement:

- Having successfully completed our recruitment for primary care Hospitalists, we are now searching for Infectious Disease and Neurology Hospitalists
- Increase the number of candidates to be interviewed by the groups
- Ensure a prompt interview window so that the groups can make rapid decisions
- Increase the number of places where the hospital can source candidates

Do

Actions Taken:

- All of the above steps for 2015 were implemented and continue to be in place

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    - We successfully recruited 2 physicians to the 501a in 2015
    - We successfully completed recruitment for CC primary care Hospitalists
    - We initiated a search for Infectious Disease and Neurology Hospitalists

- *Challenges:*
    - Recruitment to the Corpus Christi area still remains challenging

Act

Next Steps:
    • Continue recruitment efforts for Infectious Disease and Neurology Hospitalists
    • Continue to work on smooth and prompt interviews
    • Continue to integrate and expand the number of residents in the continuity of care clinic rotations

Collaborate

Share Successes and/or Request Assistance
    • Successful completion of primary care Hospitalist recruitment
    • Expand recruitment efforts to Infectious Disease and Neurology candidates
    • No assistance required at this time

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Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: April 2016

Contact Information
Provider Organization: Corpus Christi – Nueces County Public Health District

Primary Contact: Amy Barresi MSN FNP-C	**Email:** AmyB2@cctexas.com

Goals
Goal(s):   **2.6.3 Implement an innovative and evidence-based (*Diabetes Self-Management Education/Support*) health promotion program to increase health literacy of a targeted population**   • Enroll 360 patients in the innovative diabetes self-management courses   **2.9.1 Establish/Expand a Patient Care Navigation Program**   • Enroll 325 patients in patient navigation program; report all types of navigator services provided; 20% referrals to primary or specialty care in DY5

Plan
Plan for Implementation and Achievement: **2.6.3 (Diabetes)**   • Continue contract with Coastal Bend Health Education Center for DSME; Stanford Chronic Disease Self-Management classes now offered by Pt Navigators in rural / underserved areas Nueces Co. and surrounding Falfurrias w/ CACOST   **2.9.1 (Navigator)**   • 3 Full time patient navigators, with one new hire pending. One staff member recently retired.   • Enrolling chronic disease clients in program for assistance and follow through *(88+ to date DY5)*

Do

Actions Taken:

2.6.3 (Diabetes)

• 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. Staff will be working in conjunction with TMF to attend upcoming local region DEEP training. We hope this will allow increased diabetes self-management program curriculum for outer area plans.

2.9.1 (Navigator)

• Current Pt Navigator team works with underserved clinic and organization groups in Nueces and surrounding area to screen clients for service needs. Our primary goal is to connect chronic disease clients with a primary care home, and get them evaluated for a funding source that provides long term care.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*

2.6.3 (Diabetes)

• *Progress Towards Goal(s):* Both groups working with Healthy South TX 27 County expansion into South TX (TX A&M, CBHEC, AgriLife)
• *Challenges: Patients starting the program but not completing the program. Finding what motivates our client base best. Collaborating with our patient engagement group. [no change in challenges]*

2.9.1 (Navigator)

• *Progress Towards Goal(s): We are gaining clients with high needs both socially and medically. We are expanding services to clients within health department existing programs via screening.*
• *Challenges: Retaining patients through the end of the program. Efficient client tracking for completion of follow up with high risk/and transient patient population. **Both groups are also finding it difficult to get clients to provide Medicaid #'s for tracking purposes.*

• *Challenges: Connecting with collaborating organizations. MOU/Business agreements/HIPPA agreements are time consuming and slow the process to get staff into the field helping clients.*

  o

Act

Next Steps:

• Continue HIE and EMR expansion/connection with partners so that Navigators can access clients through same program without requiring separate HIPAA agreements or MOU's with each entity.

Collaborate

Share Successes and/or Request Assistance

- This is a huge request for assistance! Our area needs a functional HIE that all partner organizations participate in. All of the HIE's within TX are struggling. Our region and RHP5 have proposed to HHSC that we combine chronic disease registry/ HIE projects cross-regionally (HINSTX/HASA locally and RGVHIE in Brownsville). However, the proposal was denied because it did not "fit" the template that HHSC wanted completed in the February combination requests. We commented to HHSC at that time that not allowing HIE/Chronic Disease Registry projects to combine where successful projects are in existence would be a waste of resources and a huge setback for community organization progress. Many hospital-based projects appear to be proposing the combining of their Chronic Disease Registry projects into other Waiver programs within their own organizations for which they are large enough to absorb the costs. Community-based programs such as local health departments, and non-profit organizations that serve underfunded populations need to be included in the Health Information Exchange process on a much larger level in order to promote the referral of clients efficiently through community resources and programs. The data collected from the community-based programs is also imperative to HHSC and payer groups. I would like to ask that RHP4 assist with supporting the continuation of a regional and/or cross-regional HIE project that will encourage larger entities to continue to include the community groups in HIPAA compliant data sharing in order to support better health care and preventive care provision for clients in the Nueces County/Coastal Bend Region expanding all the way into the 27 counties that the A&M Healthy South TX project intends to cover. We all need to share data clearly and efficiently in order to provide our clients with the best care. An HIE helps to remove communication and referral barriers between organizations and client resources.

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Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period:

Contact Information		
Provider Organization: Citizens Medical Center		
Primary Contact: Cherie Brzozowski	**Email:**	cbrzozowski@cmcvtx.org
Goals		
Goal(s): • Increase utilization of appropriate crisis alternatives		
Plan		
Plan for Implementation and Achievement: • Work with the local mental health authority to increase use of the extended observation unit		
Do		
Actions Taken: • Meetings with the local mental health authority to discuss access		
Study		

Review and Evaluate:
 • *Progress Towards Goal(s):*
     o Increase in patients referred to the extended observation unit
     o Goal of 70 patients; exceeded goal by seeing 104 patients
 • *Challenges:*
     o Staffing the extended observation unit
     o Timing of staff to leave the unit in order to go to the ED to evaluation patients		

Act		
Next Steps: • Continue to work on staffing		
Collaborate		
Share Successes and/or Request Assistance • We have seen an increase in patients in the EOU		

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Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: April 2016

Contact Information
Provider Organization: Coastal Plains Community Center

| **Primary Contact:**   America Contreras | **Email:**   acontreras@coastalplainsctr.org |

Goals

Goal(s):

- To ensure that every eligible individual is offered an opportunity to access primary care services.

Plan

Plan for Implementation and Achievement:

- Primary care Navigators will be hired for every service site
- Policy and Procedures will be written addressing service access
- Navigators will be trained on policy and procedures
- Written notification will be made available defining all services in each service area.

Do

Actions Taken:

- At time of Intake, every individual will be assessed for primary care eligibility
- Referrals will be made to the Navigator via a warm hand off procedure
- Navigators 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:

- *Progress Towards Goal(s):*
  - In the first half of DY5 we have served 595 individuals in Primary Care services and 158 individuals in Substance Abuse services.

- *Challenges:*
  - Accepting clients with insurance who have to change providers to CACOST providers
  - Medication costs
  - Meeting our QPI targets
  - Identification of high utilizers and determine method of minimizing services delivered by provider
  - Ensuring that clients do not get cases closed due to noncompliance with MH services. We have created a Waiting List so clients that are closed now go on a waiting list.

Act

Next Steps:
- Monitor medication budget by reviewing the bi weekly reports from ETBHN pharmacy.
- Identify individuals that have a high utilization of service
- Extend primary care education to more individuals, initiate group therapy
- Train Navigators to assist on implementing smoking cessation program for our Center.

Collaborate

Share Successes and/or Request Assistance
- Success: In DY5, 595 individuals have received primary care services.
- Success: Have trained Navigators in DEEP training so that they can provide skills training, and education on Diabetes and High Blood Pressure
- Success: CACOST Providers and CPCC Providers are closely collaborating with each other in the care of shared clients. Warm hand offs occurring.
- Assistance: None at this time

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: 3/30/2016

Contact Information

Provider Organization: DeTar Healthcare System	

Primary Contact: Jace Jones	**Email:**

Goals

Goal(s):

- 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:

- 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
- Develop patient forms and progress notes in EMR
- Participate in ACGME Residency Match
- Accept 6 PGY-1 residents

Do

Actions Taken:

- Opened clinics for extended hours
- Aligned stakeholders and potential collaborators
- EMR notes developed
- Matched with 6 PGY-1 residents in March of 2016 Match

Study

Review and Evaluate:
 	
 • *Progress Towards Goal(s):*
      o Progress Towards Goal(s):
      o Accepting 3rd and 4th year students to rotate in clinic
      o Met Chronic disease program QPI metrics
      o Residency clinic is offering Saturday hours
      o Met with rural county officials and had great success in our programs
      o Pre-Natal project growing in rural areas
 	
 • *Challenges:*
      o Challenges:
      o PCMH guidelines
      o Documentation in EMR
      o Staff buy in

Act
Next Steps: • Continue marketing program   • Continue to engage rural providers

Collaborate
Share Successes and/or Request Assistance   •

RHP 4 | Coastal Bend Region – completed April 15, 2016

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: DY5 Q2

Contact Information	
Provider Organization: Driscoll Children's Hospital	
Primary Contact: Michelle Ramirez	**Email:** michelle.ramirez@dchstx.org
Goals	
Goal(s): • Increase overall operating hours by 6% each demonstration year from baseline hours collectively across the three available urgent care/non-emergent care settings	
Plan	
Plan for Implementation and Achievement: • 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: • Maintaining expanded operating hours on the weekends in the Quick Care-McAllen and Saratoga Urgent Care (Corpus Christi) in April 2014 • Maintaining expanded Summer operating hours on the weekend in Victoria-After Hours Clinic starting in June 2014 • In DY5 we expanded our weekend hours by thirty minutes in the Victoria After Hours clinic in Victoria Tx, starting in January 2016	
Study	

Review and Evaluate:
 	
 • *Progress Towards Goal(s):*
  o We are still tracking the number of patients seen during the expanded time frame
  o We are working to expand Laboratory and Radiology services in the Urgent care setting
   ▪ Construction is currently in Progress
 • Review times and locations of expansion hours starting in October 2015 – Completed
 • Continue to work with physician and staff on coordinating patient access and timeliness	

- *Challenges:*
  - Still competing with expanded hours from outside pediatric facilities which could affect staffing and patient volume
  - Focusing on increasing patient satisfaction to timeliness of access to care

Act

Next Steps:
- Discuss staffing coordination with future expanded operating hours at each clinic location - Completed
- Review patient access times and flow for future expanded operating hours for DY5 - Completed
- 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 - ongoing

Collaborate

Share Successes and/or Request Assistance
- We have already experienced an increase in patient volume from year over year – we continue to see increase though not as drastic as when hours were first expanded
- Increased access to primary care services by offering more operating hours during the weekend outside of pediatrician office hours – continue to coordinate care with pediatric providers

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period:

Contact Information

Provider Organization: Lavaca Medical Center		
Primary Contact: Tracy Green	**Email:**	tgreen@lavacamedcen.com

Goals

Goal(s):

- Increase number of primary care clinic appointments and visits.

Plan

Plan for Implementation and Achievement:

- Increase clinic hours, stay on track with plan to recruit additional physician NLT Sept, 2016.

Do

Actions Taken:

- Continue tracking increasing visits with first additional physician.
- Continued meetings for increased activity of Physician Recruitment. Retained firm chosen for physician recruitment.
- Increased clinic operating hours.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    - Excellent and on track according to time table.

- *Challenges:*
    - Physician recruitment - qualified candidates willing to do primary care in clinic setting and hospital inpatient care

Act

Next Steps:

- Recruitment of primary care physician by September 2016.

Collaborate

Share Successes and/or Request Assistance

-

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: July 2014 – May 2015

Contact Information
Provider Organization: Memorial Hospital (Gonzales Healthcare Systems)

Primary Contact: Leslie Janssen	**Email:** ljanssen@gonzaleshealthcare.com

Goals
Goal(s): • Increase use of rural health clinics rather than emergency room for primary care

Plan
Plan for Implementation and Achievement: • Expand hours of clinic in Waelder. • Locate new clinic space or location on which to build new clinic.

Do
Actions Taken: • 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. • A location for the new clinic was decided and plans were developed. • Groundbreaking for the new clinic occurred March 15, 2016.

Study

Review and Evaluate:
 	
• *Progress Towards Goal(s):*
  o An agreement was reached with the City of Waelder in December 2013 for donation of land for a new clinic.
  o Final approval of the land donation and the go-ahead to build the new clinic was given in August 2014.
  o We saw a 36% increase in visits the first year. Unfortunately, by the end of DY4, we saw a decrease of 5% compared to that. We have, however, continued to see a decrease in ER visits from the community.
  o Plans for the new building were developed and possible additional funding sources identified which would have allowed for even more expanded space. This grant did not come through, however.
  o Ground was broken on the new clinic site in March 2016.

- *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:

- Patient education on the benefits of using the clinic versus the emergency department. Bluebonnet Trails' navigator program is helping with this.
- Construction to begin on new clinic.

Collaborate

Share Successes and/or Request Assistance

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

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period:

Contact Information

Provider Organization:	Otto Kaiser Memorial Hospital	

Primary Contact:	Vincent Sowell	**Email:**	Vincent.sowell@okmh.org

Goals

Goal(s):

- Continued use of tele-medicine. We currently have Neurology and Cardiology available through Tele-Medicine.

Plan

Plan for Implementation and Achievement:

- Quarterly Process Improvement Meetings.
- Continued Education of internal and external staff (contracted physicians, EMS, etc.), promotion of positive results.

Do

Actions Taken:

- In-services for staff, creation of tele-medicine standing protocols, continued promotion of positive patient experiences to staff and community.
- Improved communication with EMS.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    - Staff & physicians have become much more comfortable with the technology and the processes that have been put in place. Our volumes for the service have gone up dramatically since we started the program.

- *Challenges:*
    - Getting new ER physicians and new EMS personnel trained and in-serviced without missing opportunities to use the system.
    - IT challenges (connectivity, bandwidth) can never be totally removed, but as of now, those issues have subsided.

Act
Next Steps: • We have begun incorporating Tele-Medicine training into our orientation for nurses and new ER physicians.
Collaborate
Share Successes and/or Request Assistance   • We have had several successful TPA administrations through the program.

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: 3-30-2016

Contact Information
Provider Organization: Refugio County Memorial Hospital District

Primary Contact: Hoss Whitt	**Email:** hwhitt@rcmhospital.org

Goals
Goal(s): • Improve access to primary care • Increase clinic volume • Decrease ACSC in the E.D.

Plan
Plan for Implementation and Achievement: • Continue to work with our physicians and clinic staff to improve efficiency. • Work to improve our referral process so that patients can get definitive care.

Do
Actions Taken: • Hired two additional physicians in DY4 • Implemented a nurse advice line in DY4 • Hired an additional referral nurse • Completed a system optimization program through Cerner that included efficiency training for our Providers.

Study
Review and Evaluate: • *Progress Towards Goal(s):* • Clinic Volume is increasing; however, we probably will not achieve our Category 3 outcome measures. • *Challenges:* • We continue to struggle with our organizational culture which challenges any change management. • We also have difficulty recruiting skilled labor in our rural market.

Act
Next Steps: • Continue to work with the providers, staff, and our EHR provider to streamline our processes.
Collaborate
Share Successes and/or Request Assistance • None at this time

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | Quarterly Report Form

Reporting Period: March 2016

Contact Information
Provider Organization: Yoakum Community Hospital

Primary Contact: Kim Mraz, RN	**Email:** kmraz@yoakumhospital.org

Goals
Goal(s): • 10% increase over FY15 clinic visits

Plan
Plan for Implementation and Achievement: • Maintain MOB fully staffed with providers

Do
Actions Taken: • Replaced a retired FNP with a PA; Hired a PRN FNP

Study

Review and Evaluate:
 	
• *Progress Towards Goal(s):*
  o On target to meet goal
 	
• *Challenges:*
  o Maintain trained support staff for the providers

Act
Next Steps: • Add a provider and expand the clinic

Collaborate
Share Successes and/or Request Assistance •

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | 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):   Increase number of primary care clinic appointments and visits to all eligible clients

Plan
Plan for Implementation and Achievement: Stay on track with plan to recruit additional physician, need 1 additional provider-Webb County primary care clinic

Do
Actions Taken: Recent meetings for increased activity of Physician recruitment

Study
Review and Evaluate: *Progress Towards Goal(s):*   - Contract with Doctors Hospital of Laredo mobile clinic for additional provider for clients of Jim Hogg county   *Challenges:*   - Recruitment of provider for Webb primary care clinic

Act
Next Steps: Plans for the move – relocation of Border Region Behavioral Health Center in Starr County

Collaborate
Share Successes and/or Request Assistance   All counties, Jim Hogg, Zapata, Webb and Starr have providers for Primary Care clinics. Starr County primary care services will now be located in the same complex where Center is located

RHP 4 | Coastal Bend Region

Improve Access to Care Workgroup | 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): • Connect uninsured MEND participants to medical home.

Plan
Plan for Implementation and Achievement: • Provide referrals and information about local clinics to parents upon MEND registration. • Add question to intake regarding medical home.

Do
Actions Taken: • Write script for MEND intake. • Gather information about clinic registration.

Study
Review and Evaluate: • *Progress Towards Goal(s):* 　○ Implement referral protocol. 　○ Create a list of referred MEND participants 　○ Follow-up to assess whether or not participants were registered as new patients at clinic. • *Challenges:* 　○ Tracking referrals 　○ Getting parents to take kids to clinic 　○ Clinics fees (while sliding scale still a barrier) can prevent participants from making appointments

Act
Next Steps: • Implement above plan.

Collaborate
Share Successes and/or Request Assistance   • Share final report with partner clinic and make connections with additional clinics in other MEND delivery communities.