Welcome and Introduction
Agenda

• Measures progress
• Measures progress for the Learning Collaborative as a whole
• How we did it: Teams describe changes that resulted in improvement
• Story Starters
• Break
• Regional Updates
• Expert Panel: HIE Interoperability
• Lunch
• Keynote Presentation
• Troika activity
• Break
• Sharing your story: Videos
• Wrap-up
Care Transitions and Patient Navigation
Improvement progress,
Care Transitions shared measures

Vincent Do, BSIE, LSSMBB, LBC—Sensei
Sr. Performance Improvement Specialist
The role of shared measures reporting

Learning Collaborative

= 

Best practices
+ 
measureable improvement
+ 
cross-organization learning
What we will cover

• Update on Collaborative teams
• Wins
• Reporting progress of LC overall
• Plan for shared measures
Number of teams reporting

» Care Transitions - Inpatient – 5 teams
  > Texas Health Resources - Fort Worth
  > Baylor Health Care System
  > JPS Health Network
  > UNT Health Science Center
  > Wise Regional Health System

» Care Transitions - Outpatient – 2 teams
  > MHMR Tarrant County
  > UTSW/Moncrief Cancer Institute
Wins

Total interventions achieved for 2014 and 2015

> Care Transition: 45,867

> Care Transition - Outpatient: 1,522
Wins

» Intervention rate for 2014 and 2015

> Care Transition - Inpatient:
  + Increase from 64% to 70%

> Care Transition - Outpatient:
  + Increase from 68% to 88%
Care Transitions - Inpatient

Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary


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Care Transitions - Inpatient

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

Variation and decline in performance for 2015 until August.

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# Care Transitions - Inpatient

Collaborative (4 of 5 Teams): Percentage discharged patients with community provider contact within 7 days

![Graph showing care transitions over time with annotations and data points.](image)

- **Value** (blue line)
- **Median** (red line)
- **Goal** (green line)

### Graph Annotation:

Slight decline in performance for mid 2015.

### Numerical Data

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Collaborative (2 to 3 Teams): Percentage who are provided health education materials related to health condition.

Significant variations throughout the end of 2014 and beginning of 2015.

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Collaborative (2 to 3 Teams): Percentage who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.

Exceptional performance for 2015 YTD!

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Numerator: 1 2 7 11 28 23 54 57 28 14 44 60 55 21 39 44 37 47 66 42

Denominator: 5 4 8 14 37 34 83 94 49 19 63 84 55 27 39 44 37 47 66 42

2014 Performance: 67%
2015 YTD Performance: 93%
2014 Interventions: 329
2015 Interventions YTD: 351
Plan for shared measures

- Continue monthly reporting
- LCC will continue to have 1:1 with collaborative for best practice sharing
- JPS anchor offers data TA as requested
Effective Interventions of RHP 10 Providers
Wellness For Life Mobile Health
Cancer Screenings

September 29, 2015
Provider Contact for NO PCP Patients within 7 days of Screening Visit
The current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) has one 40-foot and two 45-foot mobile units that perform cancer screenings:

- Screening Mammography
- Cervical Cancer Screening
- Colon Cancer Screening (Fecal Occult Blood Test)
- Prostate Cancer Screening
- Skin Cancer Screening
- Cardiovascular and Diabetes Screening

Based out of Texas Health Fort Worth.
Travels to locations in Tarrant and surrounding counties including Dallas, Denton, Grayson, and many others.
» 1 Manager
» 1 Mobile Operations Coordinator
» 1 Clinical Operations Coordinator
» 1 Administrative Assistant
» 3 Drivers/Admissions Clerks
» 2.5 FTE Family Nurse Practitioners
» 2.8 FTE Mammography Technologists
» 1 RN Patient Navigator
» 1 Community Outreach Coordinator
» 1 Data Analyst
» 1 Fleet Specialist (Engineering Department)
» 1 M.D., Medical Advisor

Wellness for Life: Staff
» RHP 10 encompasses a geographic area of 7,221 square miles.

» Breast Cancer age-adjusted rates for females are some of the highest in RHP 10 counties.

» Cervical cancer death rates for women in Texas are higher than those of the United States overall.

» Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall.

**Overview & Background**

Data Source: CMS CHNA
There is a lack of awareness of the availability of low-cost or free screenings. Transportation, scheduling and availability of screening and care are barriers to screening in rural areas and small towns. There is a severe shortage of primary and specialty care available in many rural areas and small towns. Region 10 has very few Texas Breast and Cervical Cancer contractors and Federally Qualified Health Centers.

Table 1: Screen Eligible Population in RHP -10

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<th>County</th>
<th>Medically Underserved Population</th>
<th>2010 Estimated Female Population</th>
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Data Source: Health Resources and Services Administration & Census Bureau
Project expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service)

- To facilitate access to high-quality early cancer detection screening services to medically underserved counties in Region 10 (RHP 10).

Target DSRIP cancer screenings:
- Screening Mammography
- Cervical Cancer Screening
- Colon Cancer Screening (Fecal Occult Blood Test)

The project includes follow up for patients to facilitate care transitions into specialty and primary care through our RN patient navigator.
» A network of primary and specialty care providers will be engaged as collaborators in Region 10.

» Patients identified as NO PCP (primary care physician) will be navigated to primary care by the RN Patient Navigator.

> Approximately 48.65% of our 2,000 patients seen thus far (approx. 973 patients) have identified as NO PCP.

» Patients in need of follow-up as a result of an abnormal cancer screening will be navigated to specialty care by the RN patient navigator.

> Thereby reducing the time to diagnosis.
Uniting with others in Christian love to meet the needs of people.
The JPS Learning Collaborative in DY3 established our Care Transitions measure.

- Percentage of NO PCP patients seen on the mobile unit who received contact with his or her follow-up provider team (primary care team or other, including patient navigator) within 7 calendar days of their appointment.
  - Numerator: Number of patients in denominator with contact by follow-up provider within 7 calendar days of discharge.
  - Denominator: Number of NO PCP patients screened on the mobile unit within the defined time period.

Overview & Background: Care Transitions
» Patients seen on the mobile unit are identified as NO PCP or having a PCP.

» Patients go through the Admissions Process and an XNET report is generated.

  > The Clinical Outcomes Analyst monitors for the number of NO PCP patients identified.
  > Information is exchanged for Admissions and relevant offices to correctly identify DSRIP patients.

» The Nurse Navigator reviews Patient Records and Provider Notes, if available, to see if the patient really has NO PCP or clinic or other place of care.
Once a NO PCP patient is identified the Nurse Navigator:

- Prints snapshot and creates a worksheet to work from.
- Documents her contact/calls and activities in CareConnect (electronic health record).
- Prints patient NO PCP letter from Care Connect and adds patient name and appointment date.
  + Letters are sent within 7 days.
  + Letters come in both English and Spanish & include a clinic list for the patient’s county.
  + Navigator documents that the letter was sent.
**Nurse Navigator Referral Lists for Primary Care**

**RHP 10 & Tarrant Lists sent with NO PCP Letters**

### Ellis County

**Hope Clinic**
- 411 East Jefferson
- Waxahachie 75165
- 972-923-2440 phone

### Erath County

**Cross Timbers Health Center**
- 135 River North Boulevard
- Stephenville 76401
- 254-443-4500

### Dublin Family Medicine

- 305 North Patrick
- Dublin 76446
- 254-443-4500

### Hood County

**North’s Place Clinic**
- 1411 Crawford Avenue
- Granbury 76048
- 817-673-5800

### Lake Granbury Medical Center
- 1310 Paluxy Road
- Granbury 76048
- 817-673-2273

### Johnson County

**Hope Medical and Dental Clinic**
- 111 Meadow View Drive
- Cleburne 76033
- 817-941-5858

### Texas Health Resources Cleburne

**Mammograms Are A Must**
- 203 Wals Drive
- Cleburne 76033
- 817-555-5400

### Texas Health Hugley Hospital
- 11601 South Freeway
- Burleson 76028
- 817-293-9110

### Navarro County

**Navarro County Health Department**
- 518 North Main
- Corsicana 75110
- 903-367-6731

### Ross Breast Center
- 901 East Houston, Suite 650
- Tyler 75702
- 903-531-5883

### Parker County

**Campbell Clinic Health Program**
- 1937 Texas Drive
- Weatherford 76086
- 817-558-3300

**Carydon Foundation**
- 6113 White Settlement Road
- Fort Worth 76116
- 817-862-4100

**Parker County Health Foundation**
- 200 Palo Pinto Highway
- Weatherford 76086
- 817-554-1990

### Center of Hope

- 91901 East Bankhead Highway
- Aledo 76008
- 817-447-2242

### Somervell County

**Glen Rose Medical Center**
- 1011 Hospital
- Glen Rose 76043
- 254-697-2215

### North Texas Area Wide

**Moncrief Cancer Institute**
- 400 West Magnolia Avenue
- Fort Worth 76104
- 1-800-405-7739

### Planned Parenthood

- Fort Worth, Arlington, Dallas
- 1-877-855-7526

### Wise County

**Mary’s Gift Clinic**
- 2000 South FM 51
- Decatur 76234
- 940-626-1384

**Wise County Community Health Center**
- 2000 South FM 51, Suite D
- Decatur 76234
- 940-393-0100

### Tarrant County

**Mission Arlington**
- 210 West South Street
- Arlington 76010
- 817-277-0597

**Cornerstone Medical Clinic**
- 3200 Noble Avenue
- Fort Worth 76111
- 817-632-6000
- [www.carenet.org](http://www.carenet.org)

**JPS Health Center for Women**
- 1201 South Main
- Fort Worth 76104
- 817-702-2500

**JPS Medical Home SE Tarrant**
- 1050 West Arkansas Lane
- Arlington 76013
- 817-702-1100

**Northside Community Clinic**
- 2105 North Main
- Fort Worth 76164
- 817-626-4254
- [www.NorthTACCHO.org](http://www.NorthTACCHO.org)

**SouthEast Community Clinic**
- 2005 Mitchell Boulevard
- Fort Worth 76105
- 817-814-4333

**Grand Prairie Community Health Center**
- 460 Stadium Drive
- Grand Prairie 75050
- 214-540-0300

**Tarrant County Public Health**

1. **101 South Main**
- Fort Worth 76104
- 817-321-4500 (Infection Screening)
- 817-321-5327 (Abnormal Pap)

2. **356 West Randell Hill Road**
- Arlington 76011
- 817-321-7224 (Infection Screening)

**Planned Parenthood of North Texas**
- Arlington or Dallas (Abnormal Pap)
- Main Number: 817-882-1155, #3
- [www.PPNT.org](http://www.PPNT.org)

**Moncrief (Breast Health Program)**
- 1-800-405-7739

**Mission Arlington**
- 210 West South Street
- Arlington 76010
- 817-277-0597

**Cornerstone Medical Clinic**
- 3200 Noble Avenue
- Fort Worth 76111
- 817-632-0000
- [www.carenet.org](http://www.carenet.org)

**JPS Health Center for Women**
- 1201 South Main
- Fort Worth 76104
- 817-702-2500

**Mission Fort Worth**
- 4401 Vernon Avenue
- Fort Worth 76115
- 817-207-0229

**Al-Shifa Clinic – Muslim Community Clinic**
- 7600 Glenview Drive, Suite B
- Richardson 75080
- 817-559-4165

**Open Arms Health Clinic**
- 325 West Green Oaks, Suite D
- Arlington 76016
- 817-496-1919

**GRACE Community Clinic**
- (Serves Grapevine, Colleyville, Southlake)
- 837 E Itzil S
- Grapevine 76051
- 817-484-7009 X 147
- 817-305-4570
- [www.GRACEGrapevine.org](http://www.GRACEGrapevine.org)

**Mercy Medical & Dental Clinic**
- (Must live in 76110 zip code area)
- 776 West Grape
- Fort Worth 76110
- 817-840-3501

**Crowley House of Hope Clinic**
- (Must live in Crowley ISD or 76036 zip code)
- 216 North Magnolia
- Crowley 76036
- 817-297-6400

**The Linda Nix Caring Place Clinic**
- JPS Children’s Clinic
- 901 West Broad
- Mansfield 76063
- 817-473-6611
- Dental Clinic 817-473-6611

**Hope Medical & Dental Clinic**
- 111 Meadow View Drive
- Cleburne 76033
- 817-641-3838

**Bayor Community Care Clinic**
- 1650 West Magnolia, Suite #207
- Fort Worth 76104
- 817-812-8900

**UNT Pediatric Mobile Clinic**
- Call for appointment in Tarrant County
- 817-923-6437

**Catholic Charities**
- 249 West Thornehill
- Fort Worth 76115
- 817-534-2914

- 217 West Sanford
- Arlington 76012
- 817-274-2590
- [www.CatholicCharitiesFortWorth.org](http://www.CatholicCharitiesFortWorth.org)

**Clinica Guadalupe**
- Alberto Flores M.D.
- 1220 North Main
- Fort Worth 76164
- 817-378-0777

**Community Eye Clinic**
- (2nd story of First Christian Church)
- 655 Taylor
- Fort Worth 76102
- 817-296-5800

**Bishop Kevin W. Vann Dental Clinic**
- Provided by Catholic Charities
- 817-289-3862

**Mission Arlington Dental Clinic**
- 210 West South
- Arlington 76010
- 817-699-4474
» An Interpreter is contacted to make follow-up calls within 2-3 weeks.
  > Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    + Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  > If so: Name of clinic/provider and PCP appointment date (if available) are recorded.

» Information from Interpreter calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.

» Clinical Outcomes Analyst records follow-up notes for outcomes.

Interpreter Calls: high resource cost for low return/effect

12 patients connected to PCP out of 419 NO PCP patients. (less than 3%)
» Calls to all NO PCP patients were time and labor intensive for the Navigator.
  > This took time away from the Navigator to work with patients who had abnormal screening results.

» There was a high proportion of Spanish-only speaking patients which required the use of an interpreter to make most of these calls.
  > The interpreter was needed on a regular basis to make approx. 100 calls a month.

» This process did obtain a lot of information but was cost prohibitive and low impact for patients.
  > Relative cost-to-benefit ratio did not even out when the cost of interpreters was high and for the most part patients were not connecting to a PCP.
The Navigator makes the follow-up call via the language line call system utilizing hospital interpreters within 2-3 weeks for patients with abnormal results.

> Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
  + Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.

> If so: Name of clinic/provider and PCP appointment date (if available) are recorded.

Information from these calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.

Clinical Outcomes Analyst records follow-up notes for outcomes.

All NO PCP patients will still be identified and sent letters with a provider/clinic list.

Patients with an identified health issue determined by screening are more likely to seek care and potentially maintain that relationship and be engaged in their health here-afterward as well.
» Before: Approximately 100 NO PCP calls per month, or more.
  > Time and labor intensive for Navigator
  > Took away from navigation for patients with abnormal results
  > Very few patients actually connected with a medical home

» After: Approximately 20 NO PCP patients with abnormal result calls per month, or more.
  > Navigator has more time to navigate patients with abnormal results
  > Utilizing the hospital interpreters via the language line call system means we can still adequately communicate well with our Spanish-speaking patients
  > Patients with abnormal results are more effectively followed-up on regarding contact with primary and specialty care providers

» All NO PCP patients are still contacted within 7 days by letter with clinic list in patient’s county and contact information for navigator.
Questions?
Wellness For Life Mobile Health Cancer Screenings

September 29, 2015

Provider Contact for NO PCP Patients within 7 days of Screening Visit
The current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) has one 40-foot and two 45-foot mobile units that perform cancer screenings:

- Screening Mammography
- Cervical Cancer Screening
- Colon Cancer Screening (Fecal Occult Blood Test)
- Prostate Cancer Screening
- Skin Cancer Screening
- Cardiovascular and Diabetes Screening

- Based out of Texas Health Fort Worth.
- Travels to locations in Tarrant and surrounding counties including Dallas, Denton, Grayson, and many others.
Wellness for Life: Staff

- 1 Manager
- 1 Mobile Operations Coordinator
- 1 Clinical Operations Coordinator
- 1 Administrative Assistant
- 3 Drivers/Admissions Clerks
- 2.5 FTE Family Nurse Practitioners
- 2.8 FTE Mammography Technologists
- 1 RN Patient Navigator
- 1 Community Outreach Coordinator
- 1 Data Analyst
- 1 Fleet Specialist (Engineering Department)
- 1 M.D., Medical Advisor
Overview & Background

- RHP 10 encompasses a geographic area of 7,221 square miles.
- Breast Cancer age-adjusted rates for females are some of the highest in RHP 10 counties.
- Cervical cancer death rates for women in Texas are higher than those of the United States overall.
- Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall.

Data Source: CMS CHNA
Overview & Background

- There is a lack of awareness of the availability of low-cost or free screenings.
- Transportation, scheduling and availability of screening and care are barriers to screening in rural areas and small towns.
- There is a severe shortage of primary and specialty care available in many rural areas and small towns. Region 10 has very few Texas Breast and Cervical Cancer contractors and Federally Qualified Health Centers.

Table 1: Screen Eligible Population in RHP -10

<table>
<thead>
<tr>
<th>County RHP 10</th>
<th>Medically Underserved Population</th>
<th>2010 Estimated Female Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellis</td>
<td>MUA</td>
<td>28,742</td>
</tr>
<tr>
<td>Erath</td>
<td>MUA</td>
<td>6,053</td>
</tr>
<tr>
<td>Hood</td>
<td>No MUA</td>
<td>11,224</td>
</tr>
<tr>
<td>Johnson</td>
<td>MUA</td>
<td>28,377</td>
</tr>
<tr>
<td>Navarro</td>
<td>MUA</td>
<td>8,938</td>
</tr>
<tr>
<td>Parker</td>
<td>No MUA</td>
<td>23,718</td>
</tr>
<tr>
<td>Somerville</td>
<td>No MUA</td>
<td>1,720</td>
</tr>
<tr>
<td>Tarrant</td>
<td>No MUA</td>
<td>921,799</td>
</tr>
<tr>
<td>Wise</td>
<td>No MUA</td>
<td>11,805</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1,042,376</td>
</tr>
</tbody>
</table>

Data Source: Health Resources and Services Administration & Census Bureau
Overview & Background

• Project expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service)
  – To facilitate access to high-quality early cancer detection screening services to medically underserved counties in Region 10 (RHP 10).

• Target DSRIP cancer screenings:
  – Screening Mammography
  – Cervical Cancer Screening
  – Colon Cancer Screening (Fecal Occult Blood Test)

• The project includes follow up for patients to facilitate care transitions into specialty and primary care through our RN patient navigator.
Overview & Background

- A network of primary and specialty care providers will be engaged as collaborators in Region 10.

- Patients identified as NO PCP (primary care physician) will be navigated to primary care by the RN Patient Navigator.
  - Approximately 48.65% of our 2,000 patients seen thus far (approx. 973 patients) have identified as NO PCP.

- Patients in need of follow-up as a result of an abnormal cancer screening will be navigated to specialty care by the RN patient navigator.
  - Thereby reducing the time to diagnosis of cancer.
Uniting with others in Christian love to meet the needs of people.
The JPS Learning Collaborative in DY3 established our Care Transitions measure.

Percentage of NO PCP patients seen on the mobile unit who received contact with his or her follow-up provider team (primary care team or other, including patient navigator) within 7 calendar days of their appointment.

- Numerator: Number of patients in denominator with contact by follow-up provider within 7 calendar days of discharge.
- Denominator: Number of NO PCP patients screened on the mobile unit within the defined time period.
Navigation Process

- Patients seen on the mobile unit are identified as NO PCP or having a PCP.
- Patients go through the Admissions Process and an XNET report is generated.
  - The Clinical Outcomes Analyst monitors for the number of NO PCP patients identified.
  - Information is exchanged for Admissions and relevant offices to correctly identify DSRIP patients.
- The Nurse Navigator reviews Patient Records and Provider Notes, if available, to see if the patient really has NO PCP or clinic or other place of care.
Navigation Process

• Once a NO PCP patient is identified the Nurse Navigator:
  – Prints snapshot and creates a worksheet to work from.
  – Documents her contact/calls and activities in CareConnect (electronic health record).
  – Prints patient NO PCP letter from Care Connect and adds patient name and appointment date.
    • Letters are sent within 7 days.
    • Letters come in both English and Spanish & include a clinic list for the patient’s county.
    • Navigator documents that the letter was sent.
### RHP 10 Counties Primary Care Referral List

<table>
<thead>
<tr>
<th>County</th>
<th>Clinic/Program Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellis County</td>
<td>Hope Clinic&lt;br&gt;411 East Jefferson&lt;br&gt;Waxahachie 75165&lt;br&gt;972-923-2440 phone</td>
</tr>
<tr>
<td>Erath County</td>
<td>Cross Timbers Health Center&lt;br&gt;135 River North Boulevard&lt;br&gt;Stephenville 76051&lt;br&gt;254-956-2810</td>
</tr>
<tr>
<td>Dublin County</td>
<td>Dublin Family Medicine&lt;br&gt;305 North Patrick&lt;br&gt;Durbin 75448&lt;br&gt;254-489-4500</td>
</tr>
<tr>
<td>Hood County</td>
<td>North's Place Clinic&lt;br&gt;1411 Crawfor dAvenue&lt;br&gt;Granbury 76048&lt;br&gt;817-573-5800</td>
</tr>
<tr>
<td>Lake Granbury County</td>
<td>Lake Granbury Medical Center&lt;br&gt;1310 Pecan Avenue&lt;br&gt;Granbury 76048&lt;br&gt;817-573-2273</td>
</tr>
<tr>
<td>Johnson County</td>
<td>Hope Medical and Dental Clinic&lt;br&gt;111 Meadow View Drive&lt;br&gt;Cleburne 76033&lt;br&gt;817-541-5858</td>
</tr>
<tr>
<td>Parker County</td>
<td>Campbell Clinic Health Program&lt;br&gt;1111 Texas Drive&lt;br&gt;Weatherford 76086&lt;br&gt;817-558-3000</td>
</tr>
<tr>
<td>Parker County Health Foundation</td>
<td>200 Palo Pinto Highway&lt;br&gt;Weatherford 76086&lt;br&gt;817-554-2806</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>Northside Community Clinic&lt;br&gt;2104 North Main&lt;br&gt;Fort Worth 76106&lt;br&gt;817-565-4264</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>Silver Rose Medical Center&lt;br&gt;1021 Horizon&lt;br&gt;Granbury 76048&lt;br&gt;817-565-5400</td>
</tr>
<tr>
<td>Somervell County</td>
<td>Glenn Rose Medical Center&lt;br&gt;1021 Horizon&lt;br&gt;Granbury 76048&lt;br&gt;817-565-5400</td>
</tr>
<tr>
<td>North Texas Area Wide</td>
<td>Moncrief Cancer Institute&lt;br&gt;400 West Magnolia Avenue&lt;br&gt;Fort Worth 76104&lt;br&gt;817-505-7739</td>
</tr>
<tr>
<td>Wise County</td>
<td>Mary’s Gift Clinic&lt;br&gt;2000 South FM 51&lt;br&gt;Henderson 76044&lt;br&gt;903-658-1384</td>
</tr>
<tr>
<td>Wise County</td>
<td>Wise County Community Health Center&lt;br&gt;2000 South FM 51, Suite D&lt;br&gt;Dorchester 76334&lt;br&gt;940-393-0100</td>
</tr>
</tbody>
</table>

### Tarrant County Primary Care Referral List

<table>
<thead>
<tr>
<th>Location</th>
<th>Address Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission Arlington</td>
<td>210 West South Street&lt;br&gt;Fort Worth 76101&lt;br&gt;817-277-4557&lt;br&gt;www.MissionArlington.org</td>
</tr>
<tr>
<td>Cornerstone Medical Clinic</td>
<td>3000 Noble Avenue&lt;br&gt;Fort Worth 76111&lt;br&gt;817-632-0000&lt;br&gt;www.carenet.org</td>
</tr>
<tr>
<td>Mission Fort Worth</td>
<td>4401 Verona Avenue&lt;br&gt;Fort Worth 76114&lt;br&gt;817-207-0229</td>
</tr>
<tr>
<td>Al-Shifa Clinic</td>
<td>3201 South Granada&lt;br&gt;Suite D&lt;br&gt;Arlington 76016&lt;br&gt;817-496-1919</td>
</tr>
<tr>
<td>SouthEastCommunity Clinic</td>
<td>2300 Mitchell Boulevard&lt;br&gt;Fort Worth 76105&lt;br&gt;817-895-2300</td>
</tr>
</tbody>
</table>
| Grand Prairie Community Health Center | 405 Stadium Drive<br>Grand Prairie 75050
214-540-0300                                 |
| Tarrant County Public Health | 1) 1101 South Main<br>Fort Worth 76104  
817-321-4800 (Infection Screening)  
817-321-5327 (Abnormal Paps)  
2) 536 West Randol Mill Road
Arlington 76011
817-321-4724 (Infection Screening)
www.tarrantcounty.com/health  |
| Planned Parenthood | 216 North Magnolia<br>Crowley 76033<br>817-275-6400                               |
| Medical & Dental Clinic | (Must live in 76110.zip code area)  
276 West Bowie<br>Fort Worth 76110
817-840-3501                                 |
| Crowley House of Hope Clinic | (Must live in Crowley ISD or 76035.zip code)  
216 North Magnolia<br>Crowley 76033
817-275-6400                               |
| The Linda Nix Caring Place Clinic | 901 West Broad<br>Mansfield 75053<br>817-473-6611  |
| JPS Children’s Clinic | Vision Clinic<br>901 West Broad<br>Mansfield 75053<br>817-473-6611          |

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**Nurse Navigator Referral Lists for Primary Care**

RHP 10 & Tarrant Lists sent with NO PCP Letters
Initial Process

• An Interpreter is contacted to make follow-up calls within 2-3 weeks.
  – Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    • Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  – If so: Name of clinic/provider and PCP appointment date (if available) are recorded.

• Information from Interpreter calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.

• Clinical Outcomes Analyst records follow-up notes for outcomes.

Interpreter Calls: high resource cost for low return/effect

12 patients connected to PCP out of 419 NO PCP patients. (less than 3%)
Lessons Learned

• Calls to all NO PCP patients were time and labor intensive for the Navigator.
  – This took time away from the Navigator to work with patients who had abnormal screening results.

• There was a high proportion of Spanish-only speaking patients which required the use of an interpreter to make most of these calls.
  – The interpreter was needed on a regular basis to make approx. 100 calls a month.

• This process did obtain a lot of information but was cost prohibitive and low impact for patients.
  – Relative cost-to-benefit ratio did not even out when the cost of interpreters was high and for the most part patients were not connecting to a PCP.
Improved Process

- The Navigator makes the follow-up call via the language line call system utilizing hospital interpreters within 2-3 weeks for patients with abnormal results.
  - Did patient get the letter? Did they make an appointment with a Primary Care? If not, why?
    - Issues with: Money, scheduling, transportation, work, and so on are recorded where possible.
  - If so: Name of clinic/provider and PCP appointment date (if available) are recorded.
- Information from these calls is documented by the Navigator in CareConnect. Worksheets with notes are delivered to the analyst.
- Clinical Outcomes Analyst records follow-up notes for outcomes.

All NO PCP patients will still be identified and sent letters with a provider/clinic list.

Patients with an identified health issue determined by screening are more likely to seek care and potentially maintain that relationship and be engaged in their health here-afterward as well.
Improved Changes

• Before: Approximately 100 NO PCP calls per month, or more.
  – Time and labor intensive for Navigator
  – Took away from navigation for patients with abnormal results
  – Very few patients actually connected with a medical home

• After: Approximately 20 NO PCP patients with abnormal result calls per month, or more.
  – Navigator has more time to navigate patients with abnormal results
  – Utilizing the hospital interpreters via the language line call system means we can still adequately communicate well with our Spanish-speaking patients
  – Patients with abnormal results are more effectively followed-up on regarding contact with primary and specialty care providers

• All NO PCP patients are still contacted within 7 days by letter with clinic list in patient’s county and contact information for navigator.
NO PCP Letter Process

Questions?
“Our Success Story”
Care Transitions/CHF360

Shane Jones, MHA
Data Analyst
Wise Regional Health System
Learning Collaborative- September 29, 2015
Wise Regional Health System

3 Hospitals Locations - Wise and Tarrant Counties
Decatur Campus - Level IV Acute Care Hospital
> 145 Beds
  + 21 CCU
  + 27 ED

Multiple Specialty/Primary Care Clinics, Imaging, Dialysis and Rehab Locations

14 Long-term Care Facilities in 5 North Texas Counties

Rapid Growth
> 1,400+ Employees
> 154 Active Physicians
> 5,200+ Admissions
> 8,100+ Surgeries
> 31,000 ED Visits
> 213,908 Outpatient Visits
> $20,230,000 Charity/Indigent Care
> $34,222,000 Uncompensated Care
» Strategy and Methodology to Project Development
  > DSRIP Structure and Direction
  > Project Champions
  > Utilizing Current Staff Members and Other Resources
  > Hired Nurse Practitioner for CHF360

Early Years
Multiple Stumbles Along The Way

- Turnover, Turnover, Turnover
- Educate and Train New Staff
- Re-establishing Roles and Responsibilities
- Policy Changes
- Added Telemedicine Services to Cover Changes
- Change of Hospitalist Group

Project Adolescence
» Solid, Motivated Team
» Expand Project Scope to Other Disease Areas
» Working More with Post-Acute Providers in the Area
» Focus on Bigger Picture and Not Just Meeting Milestones

DY5 and Beyond
1. Decreased the All-Cause Readmission Rate for CHF Specific Patients by 41%
2. Improvement in the Learning Collaborative Metrics

Major Wins
3. Establishment of the Readmission Reduction Committee and Improvement in All-Cause 30 Day Readmission Rate

### 30-day Readmissions to Same Hospital

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Hospital</th>
<th>National: 80th Percentile</th>
<th>Jurisdiction: 80th Percentile</th>
<th>State: 80th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 FY 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 FY 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 FY 2012</td>
<td></td>
<td></td>
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Major Wins
Recommendations Based On Our Experience

- Build a Strategy Bigger than DSRIP - Create Sustainability
- Focus on Future Industry Trends - Value Based Purchasing
- Create More Coordination Between Projects to Build a Continuum of Care
- Invest in Your People
- Work with Post-Acute Care Providers Early and Often

Conclusion
Shane Jones, MHA
Data Analyst
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Office: 940-539-2632
“Our Success Story”

Care Transitions/CHF360

Shane Jones, MHA
Data Analyst
Wise Regional Health System
Learning Collaborative– September 29, 2015
Wise Regional Health System

- 3 Hospitals Locations–Wise and Tarrant Counties
- Decatur Campus– Level IV Acute Care Hospital
  - 145 Beds
    - 21 CCU
    - 27 ED
- Multiple Specialty/Primary Care Clinics, Imaging, Dialysis and Rehab Locations
- 14 Long-term Care Facilities in 5 North Texas Counties
- Rapid Growth
  - 1,400+ Employees
  - 154 Active Physicians
  - 5,200+ Admissions
  - 8,100+ Surgeries
  - 31,000 ED Visits
  - 213,908 Outpatient Visits
  - $20,230,000 Charity/Indigent Care
  - $34,222,000 Uncompensated Care
Early Years

- Strategy and Methodology to Project Development
  - DSRIP Structure and Direction
  - Project Champions
  - Utilizing Current Staff Members and Other Resources
  - Hired Nurse Practitioner for CHF360
Project Adolescence

- Multiple Stumbles Along The Way
  - Turnover, Turnover, Turnover
  - Educate and Train New Staff
  - Re-establishing Roles and Responsibilities
  - Policy Changes
  - Added Telemedicine Services to Cover Changes
  - Change of Hospitalist Group
DY5 and Beyond

- Solid, Motivated Team
- Expand Project Scope to Other Disease Areas
- Working More with Post-Acute Providers in the Area
- Focus on Bigger Picture and Not Just Meeting Milestones
1. Decreased the All-Cause Readmission Rate for CHF Specific Patients by 41%
Major Wins

2. Improvement in the Learning Collaborative Metrics
3. Establishment of the Readmission Reduction Committee and Improvement in All-Cause 30 Day Readmission Rate
Conclusion

- Recommendations Based On Our Experience
  - Build a Strategy Bigger than DSRIP– Create Sustainability
  - Focus on Future Industry Trends– Value Based Purchasing
  - Create More Coordination Between Projects to Build a Continuum of Care
  - Invest in Your People
  - Work with Post–Acute Care Providers Early and Often
Questions?

Shane Jones, MHA
Data Analyst
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Office: 940–539–2632
PRIMARY CARE CONNECTION

How We Did It: Changes that Resulted in Improvement

Providing Information to Follow-up Providers
Primary Care Connection (PCC)

BACKGROUND

Goals:

Reduce patient readmissions to the emergency department, improve overall hospital costs and patient outcomes by connecting patients to a medical home

Population of focus:

ED patients who are uninsured or insured through Medicaid with a chronic diagnosis and/or multiple ED visits

Staffing:

Program Director shares time between 4 hospitals
BASMC- 1 Social Work Supervisor; 3 Community Health Workers (CHW’s)
Primary Care Connection (PCC)

SERVICES

- Schedule medical home and/or medical specialist appointments
- Address barriers that impact patients’ attendance at appointments
- Provide referral to community resources
- Patient education
- Confirm attendance of appointments
- Ensure continuity of follow-up care
- Escalate complex cases to Social Worker
- Care Plan for patients who are identified as high risk based on number of ED visits and chronic illnesses.
ED Utilization decreased by 53% after Primary Care Connection Involvement

*Utilization calculated using number of actual patient encounters for identical time periods 90 days before and 90 days after Primary Care Connection involvement.
Clinical information faxed to follow-up provider when appointment scheduled by Primary Care Connection

- Numerator: Number of scheduled appointments that have documentation of clinical information being faxed to follow-up provider within 7 days.

- Denominator: All scheduled appointments for Medicaid and Unfunded patients
  - Inclusion criteria: Initial encounter between Primary Care Connection and the patient occurred during the reporting month.
Current State/Best Practices

- Information faxed via RightFax (electronic fax)
- Information sent when appointment is scheduled
- Documented by staff in a drop down field in documentation template
- Staff is able to select “Provider has access” for those patients scheduled at a Baylor Clinic that is able to access the hospital medical records.
- Process had been integrated in staff workflow/daily process
Barriers

- Providers decline information
- Training new staff
- Integrating other processes, battle of priorities
Where do We go From Here

- EHRs
- Connections and collaborations
Contact Information

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214-228-9436
Tonya.Selman@baylorhealth.edu
Or
Jennifer Anderson
(469) 579-8293
JennifAn@BaylorHealth.edu
**Session Objectives**

Invite individual reflection and participation
Improve collaboration between projects and organizations
Strengthen relationships & spark partnerships
Share ideas to improve patient engagement
Story Starters

Story starters is a good get-to-know-you icebreaker to help people share interesting stories about themselves, their projects, teams and achievements. This activity works for large and small groups. For very large groups, simply have everyone split into rounds of 8-10 people.
Participants are to complete the following sentences on the cards presented to them:

1. October begins DY4 reporting, I .....  
2. My greatest achievement was ....  
3. One thing I would like to achieve in DY5 is ....  
4. A best patient story is ....  
5. The silliest thing I did with my team was....  
6. If my team were to have a theme song, it would be....  
7. If my team were to have a mascot, it would be....  
8. My greatest challenge during my tenure regarding the 1115 Waiver was...

Take 10 minutes for participants to complete the questions presented and then go around the table and share the results. Answer 1 question at a time going around the table.
Break

10:30-10:45am
Regional Updates

Shelly Corporon, PMP, Director RHP10
Heather Beal, MHA, RHP10 Program Manager
1115 Transformation Waiver
Extension & DSRIP Protocols
• Further incentivize transformation and **strengthen healthcare systems** across the state by building on the RHP structure.

• Maintain **program flexibility** to reflect the diversity of Texas’ 254 counties, 20 RHPs, and almost 300 DSRIP providers.

• Further **integrate with Texas Medicaid managed care** quality strategy and value based payment efforts.

• **Streamline** to lesson administrative burden on providers while focusing on collecting the most important information.

• Improve project-level evaluation to **identify the best practices** to be sustained and replicated.

• Continue to **support the healthcare safety net** for Medicaid and low income uninsured Texans.

**1115 Transformation Waiver Renewal Principles**
• By September 30, 2015, HHSC must submit to the federal Centers for Medicare and Medicaid Services (CMS) a request to extend the waiver.

• In September, HHSC plans to request to continue all three components of the waiver for another five years.

• HHSC anticipates a negotiation period with CMS and will plan for a transition period with interim reporting, if necessary.

• Depending on the timeline for negotiations with CMS on waiver extension, propose to continue DY5 QPI in DY6 as a transition year until negotiations are completed.

• All projects from areas included on the 3-year menu may be eligible to continue pending HHSC review of higher risk projects.

1115 Transformation Waiver Renewal
» HHSC distributed their initial protocol proposal at the Statewide LC for feedback:

- Metrics for continuing Category 1 & 2 projects
- Extension menu and metrics for Category 1 & 2 replacement projects
- Parameters for combining projects
- Uses for funds not allocated to active projects
- Regional shared bonus pools
- Statewide analysis plan

**Waiver Renewal - New Skinny Menu**
• HHSC identified the projects in July that will be reviewed and may not be eligible to continue (or may require changes to the project scope, milestones/metrics, and/or valuation).

• HHSC will notify projects not eligible to continue in early 2016 to give providers time to plan for replacement projects if needed.

• Some projects may be required to take a next step and HHSC may propose further standardization of continuing projects (including related to QPI and project intensity).

Replacement Projects
• There will be fewer metrics to report for achievement, and more standardized metrics.

• QPI milestones will be required each year – 50% of valuation
  > Request partial achievement of QPI metrics, perhaps with a reduced carryforward window?

• For the other 50% of valuation each year, HHSC is considering two metrics reported via templates.
  > Reporting on core components, including continuous quality improvement (CQI)
  > Sustainability planning, including project-level evaluation, health information exchange, and integration with managed care where appropriate

• HHSC is considering changing all QPI metrics to individuals (vs. encounters), though providers will still maintain encounter-level information to support the patient benefit of the project.
• Replacement projects may be submitted for those projects not eligible to continue or withdrawn after June 30, 2014.

• Cross-regional community mental health center projects that are similar may choose to combine into one or more home regions.

• Projects from one or multiple providers within an RHP that provide similar services to different populations may combine into one project.
  > e.g., Two similar prevention projects, one targeting females and the other targeting males.

• The timeline for requesting combining projects is planned to begin in January 2016.
» Assuming most of these providers opt to do replacement projects, HHSC does not anticipate a large amount of leftover DSRIP funds and propose region shared performance bonus pools:

» **Current**
  • Category 3, Quality Improvements – Healthcare outcomes that are tied to Category 1 and 2 projects (combination of pay for performance and pay for reporting)
  • Category 4, Population-Based Improvements – Hospital-level reporting on data in several domains related to potentially preventable events, patient-centered healthcare, and emergency department care (pay for reporting)

» **Proposal**
  • Category 3 – Continue to collect project-related outcome data, but switch to pay for reporting outcomes and building measurement capacity
  • Category 4 – Change to pay for performance based on regional performance in improving on a set of key measures (regional shared performance bonus pools using state-generated data)

**Left Over Funds & Regional Performance Bonus Pools**
• Category 3 is extremely complex and many providers, of all types and sizes, are struggling to accurately complete Category 3 reporting and conform to the technical specifications of the measures.

• There is value in building measurement capacity at the provider level and collecting data on the outcomes related to individual DSRIP projects.

• However, given Texas’ volume and variety of outcome measures, state-level data may better demonstrate the overall impact of DSRIP, along with Medicaid managed care and other initiatives, on improving healthcare outcomes and population health.

Rationale for Switching Cat 3 and Cat 4
• All DSRIP providers will have their Category 3 converted to pay for reporting

• All DSRIP providers will have a portion of their DSRIP valuation converted to their potential earnings from the region’s performance bonus pool
  > 5% of DY5 DSRIP funding for smallest providers
  > 10% of DY5 DSRIP funding for larger providers
  > For Category 4 hospitals: The 10% will be taken from these allocated values

• For non-Category 4 participants, the 5% or 10% will be taken proportionately from their Category 1-3 valuation.

**Regional Performance Bonus Pools**
• State-generated data vs. provider-generated data will be used for the regional shared performance bonus pools.

• There will be some common measures required to be included in the bonus pools for all regions.

• Each region also may select some measures from a list of options for region-specific measures depending on the key community needs and DSRIP areas of focus on in that region.

**Regional Performance Bonus Pools**
Learning Collaborative Participants

Questions??
Expert Panel: HIE Interoperability

Moderator: Kristin Jenkins, DFWHC President
Panel Members:
Bill Stephens, Tarrant County Public Health
Donna DeBoever, JPS Health System
Debbie Jowers, Texas Health Resources
Tarrant County Public Health
Current Status of PH Meaningful Use Stage 3

- Timing – likely not before late 2016; NPRM underway

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Stage 2 Timeline Delayed to 2014

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**HHS** had announced in a November 2011 under the "We Can't Wait" announcement, that the Stage 1 has been extended an additional year for providers who attested in 2011 – meaning that these providers will have to attest to Stage 2 in 2014, instead of in 2013.
### Current Status of PH Meaningful Use Stage 3

- **Reportable Conditions Reporting Requirements**

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<tr>
<th>Public Health and Clinical Data Registry Reporting</th>
<th>Providers must attest YES to three of the following five measures:</th>
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<tr>
<td>1. Immunization Registry Reporting – The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</td>
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<td>2. Syndromic Surveillance Reporting – The EP is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs.</td>
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<td>3. Case Reporting – The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.</td>
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<td>4. Public Health Registry Reporting – The EP is in active engagement with a public health agency to submit data to public health registries.</td>
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<td>5. Clinical Data Registry Reporting – The EP is in active engagement to submit data to a clinical data registry.</td>
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Impact of e-Reporting of Reportable Conditions

- Pertussis reporting example
  - Demographics – 16 fields
  - Clinical – 16 fields
  - Treatment – 5 fields
  - Lab tests – 5 fields
  - Immunization – 4 fields
  - DATA ALREADY PRESENT IN EMRs!
HIE Activities in Texas to Simplify e-Reporting

- ONC/CDC agency participation – focused on streamlining clinical and public health workflows
- DSRIP HIE project in RHP 10
  - Aggregating clinical data through regional HIE
  - Automatic case detection; confirmed or probable
  - Automatic extraction of clinical data from confirmed/probable cases and reporting to public health within statutory time periods, NOT just ELR results
  - Bidirectional communication in MU stage 3, provider receives full disposition case e-report from local/state public health agency through HIE for final review and report to state health department