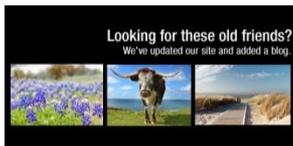
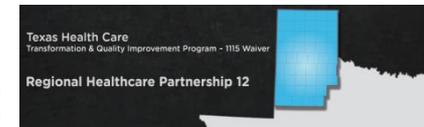


## 20 Regional Healthcare Partnerships

# Collaboration and Innovation



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# **Regional Health Partnership 1**

## **Anchor: UT Health Science Center at Tyler**

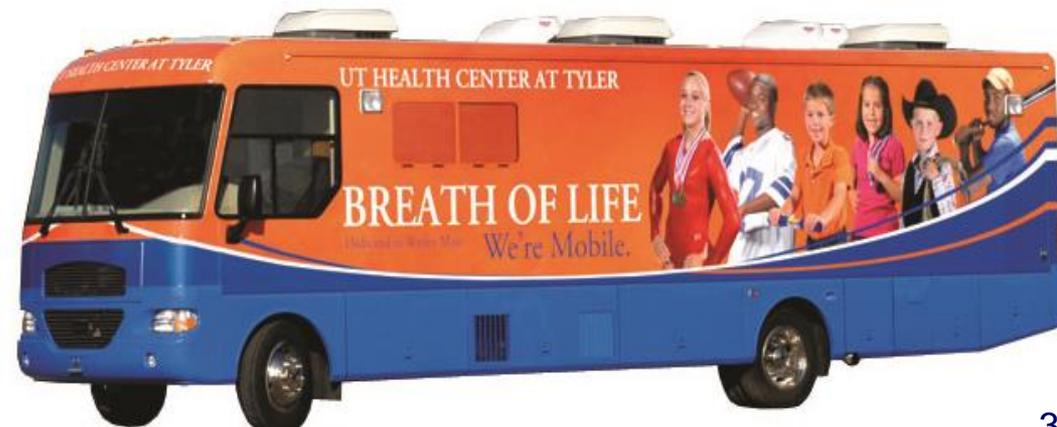
- **Northeast Texas is older, poorer, less well educated, and at greater risk of early death than the state average.**
- **Over half of counties in RHP 1 are in the bottom 20% of health outcomes in Texas.**
- **At 21,000 square miles, RHP 1 is larger than 8 states and the District of Columbia but has no city larger than 100,000 in population.**

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***UT Health Northeast Breath of Life Mobile Clinic travels to schools and clinics throughout Northeast Texas to help diagnose and treat children resulting in:***

- Reduced Emergency Department Use
- Decreased Hospital Admissions
- Fewer Missed School Days

**Patient Impact:  
3,800 children**



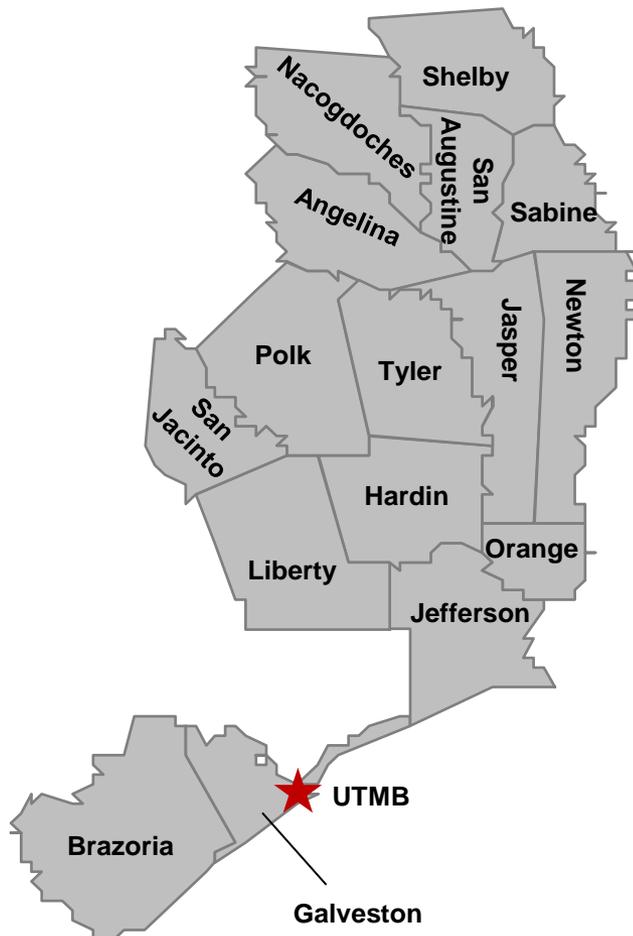
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## Patient Impact

### Tens of Thousands of New Mental Health Patient Encounters

- “Our region has a suicide rate that is 65% higher than the State. *DSRIP is one of the most important investments in mental health in decades.*” (Rick Roberts, Community Healthcore)
- “I’ve been treating this patient for years and never knew he was depressed. Because of our integration project, I learned he was suicidal and was able to get him treatment. *DSRIP has changed how I practice medicine.*” (A local primary care physician)

## Regional Health Partnership 2



### 16 counties

- Population of nearly 1.5 million people
- Covers nearly 14,500 square miles
- Urban and rural with varying infrastructure challenges
- 25% of population is uninsured
- 27% of population is on Medicaid or Medicaid/Medicare (dual eligible)
- More than 50% of the region is designated as Health Professional Shortage Area in Primary Care and/or Mental Health
- Common health challenges: obesity, disability, hypertension, stroke, asthma and cancer

### CHRISTUS St. Elizabeth

CHRISTUS Hospital News  
**Heart Failure Clinic bridges care gap**

CHRISTUS Hospital - St. Elizabeth's new Heart Failure Clinic bridges care gap for patients

*Patients with heart failure closely monitored to assure proper medications, exercise, diet*

October 2, 2013. When it comes to matters of the heart, CHRISTUS Hospital - St. Elizabeth Heart Failure clinic director Susan Kasserler, RN, GNP-BC, P/HNP-BC, takes it seriously. "These patients need the utmost attention and care to assure their health," said Kasserler. "For so many reasons, they were falling through the care gap—and we just had to do something to catch them."

Since the opening in November 2012, the clinic has received over 100 heart failure patients for which Kasserler and nurse navigator Sheryl Whipkey, RN, guide them through the care process, helping patients learn and understand their disease. From administering and reviewing lab work and results, providing consultations with a registered dietician, making medication adjustments and offering varied educational seminars on heart healthy nutrition, spiritual care and stress management, the clinic serves as a community resource for those with heart failure.



### Baptist Hospitals of Southeast Texas Beaumont



### University of Texas Medical Branch at Galveston



Category 3 Summit Team



Spindletop Center's Primary Care Clinic  
Exterior

### Gulf Coast Center



### Sabine County Hospital New Rural Health Clinic Ribbon Cutting



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## **Patient Impact**

**The Gulf Coast Center’s Bayou House Crisis Respite Care Center (BHCRC) reopened in August 2013, thanks to the Section 1115 Medicaid Waiver. BHCRC stabilizes individuals suffering from a mental health crisis through a short-term stay in its facility where clients receive guidance counseling and psychological and social rehabilitative services.**

- **Story of “Jim”:** a homeless, 62-year-old male called BHCRC while crying hysterically and showing signs of severe depression and was not aware that he was eligible to receive social security retirement
  - **BHCRC staff took Jim to the social security office, got his social security retirement payments started, and connected him with a psychiatrist, who started him on anti-depressant medications. BHCRC was able to help Jim turn his life around.**

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## Patient Impact

**Gulf Coast's waiver-funded Crisis Respite and Stabilization Service for Individuals with Intellectual and Developmental Disabilities (IDD) works to prevent persons with IDD from being hospitalized, incarcerated or removed from their home because they are a danger to themselves or others. The program started in October of 2013.**

- **Story of a single parent: Cynthia contacted the service in January for help with her 17-year-old son Brandon, who was exhibiting behavioral problems at home and had been jailed for an incident at school.**
  - **Crisis Respite and Stabilization team helped get Brandon placed back in his home, implemented a behavior plan, and has been providing weekly follow-up sessions based on the principles of applied behavior analysis. Brandon's behavior has turned around. The team has given the family members the support that they had been seeking for three years.**

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## Regional Health Partnership 3

### Anchor: Harris Health System

- Largest region in the State
- 1.2M uninsured residents
- Estimated 750 people per day move into the metro area
- Significant behavioral health needs



**Southeast Texas Regional Healthcare Partnership**

Texas Healthcare Transformation and Quality Improvement Program ☆ Medicaid 1115 Waiver

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## Successes and Discoveries

- **A shared understanding has led to increased collaboration – formally and informally.**
- **New partnerships**
  - **Methodist, Memorial Hermann & MHMRA**
  - **Harris Health System and MD Anderson**
  - **Fort Bend Health Department and law enforcement**
  - **Expanded referral network**
  - **Additional opportunities built on RHP structure**
  - **FQHC partnerships**
  - **Exposure to new methodologies**

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# Patient Impact – MHMRA Clubhouse Expansion

**“I am a member of the Clubhouse movement in Houston Texas. My membership started at the St. Joseph House. Since the Legacy Clubhouse opening, I have been attending here more because the location is really convenient for me.**

**“The Clubhouse has helped me establish stability in my life. I was in such a different place back in 2010 when I first found out about it. The positive changes that happened to me were a result of the fact that I was surrounded by people who are there to help me, and empower me. The Clubhouse model is set up to allow a person to come to recovery at his own pace. For example, I was given an opportunity in the transitional employment program. It turned out that I was not ready to be employed so this caused a minor setback in my recovery. I believe the reason was that I was not ready to take on that much responsibility. Thankfully, during that period, I had staff and member friends around to help me get through that difficult time. This is a big part of the Clubhouse model. A community to help you through the hard times, and also celebrate the good times, like now!**

**“In closing, I have obtained employment, (I manage the resource center), and my housing has also been stabilized. This has all happened to me because of the great influences that I was getting from the Clubhouse. This kind of thing is very important, and it is helping many people. I understand that without my continued involvement in the Clubhouse movement, I would not be where I am today.”**

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## Regional Health Partnership 4

### Anchor: Nueces County Hospital District

- 18 semi-urban/rural counties; diverse race and ethnicity; median income \$26,027-\$46,566; limited education, high poverty rate and high uninsured
- Healthcare infrastructure located in two counties (Nueces and Victoria)
- Roughly one acute care bed for every 290 persons and one PCP for every 1,495 persons
- Challenges: all counties are partially or fully medically underserved with shortage of primary care, specialists, behavioral health and dental professionals; high chronic disease; limited public transportation and EMS

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## **Successes and Discoveries**

### **Strategy:**

- **Weekly anchor sponsored conference calls; website**
- **Anchor and performing providers outreach to community stakeholders and elected officials**
- **Quarterly learning collaboratives plus collaboration among local mental health clinics, hospitals, FQHCs, and academic institutions**
- **Successes: integration of BH and physical health; use of telemedicine to expand specialty care; increase access to care via recruitment and residency programs**

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## Patient Impact

- **Rural hospital: telemedicine for neurology consults and TPA administration**
  - Patient presented at local ER with complaint of not being able to move left side; neurology consult via telemedicine - diagnosis acute ischemic stroke; recommended administration of Activase; outcome: visual field loss – none; palsy – none; patient stable. ER arrival 16:00 hours; treatment administered 17:35 hours
  - Had telemedicine/TPA administration not been available patient would have been transferred by ambulance over 100 miles and outcome could have been significantly different

- 
- **Local community mental health center – patient navigator services and integration of BH and physical health**
    - 26 year old male client/referral was a frequent visitor to the ED for complaints of abdominal pain. Not able to keep employment due to his illness and frequent absences. ER referred to the local FQHC and Behavioral Health services for an evaluation of this needs and complaints. He was transported to the visits to ensure compliance. Now in counseling and treatment for his medical complaints and is able to be employed and enjoy his family. Frequently texts Navigator staff with his feelings and accomplishments and is doing well. No longer visits the ED for his medical needs and schedules with his PCP and counselors.

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## **Regional Health Partnership 5**

- **Anchor – Hidalgo County**
- **Comprised of Cameron, Hidalgo, Starr, and Willacy counties in South Texas**
- **Population projected to increase from 1.26 million in 2010 to 1.65 million in 2020**
- **Significant number of individuals residing in RHP 5 suffer from diabetes, obesity, and mental health issues**

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## Successes and Discoveries

- **The Oral Health and Health Promotion strategies are intended to replicate successes associated with the reduction of dental caries and preterm deliveries in RHP 5 and, currently, providers associated with these initiatives are both engaged and actively participating in achieving success. In recent communications and meetings, providers have embraced these projects and are attending/collaborating to achieve success.**
- **The Maternal Fetal Medicine Program has been able to increase accessibility to care through increasing the number of clinical operating days and staff available to patients in Region 5. The program will continue to collaborate with providers in the Region to reduce the overall NICU LOS for babies born through high risk pregnancies.**

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## Patient Impact

### Julian-

A 4-D sonogram revealed her baby's heart was having a hard time beating. Her toddler had recently had fifth disease, also known as parvovirus infection. What Mayra didn't know is that she also had the illness and that her fetus was infected as well. Mayra's obstetrician in Brownsville reviewed her sonogram images and advised Mayra to have an immediate maternal-fetal medicine evaluation. Mayra traveled from the Rio Grande Valley to Corpus Christi in mid-February for an evaluation of her baby's condition. A diagnosis of severe fetal anemia resulting in heart failure was established by maternal-fetal medicine specialists at Driscoll Children's Hospital. During her month-long stay in Corpus Christi, Mayra had several intrauterine fetal blood transfusions that helped with her baby's anemia and corrected his heart failure. Her son, Julian, was born healthy at 38 weeks in her hometown and has a promising future.

**"We are so grateful for Driscoll Children's Hospital and all the doctors, nurses and staff who were there in the toughest days of our lives. Our little Julian wouldn't be here today if it wasn't for their dedication and hard work. They became part of our family and will always be close to our hearts. Thank you for bringing joy back into our lives."**

**- Mayra Manos**

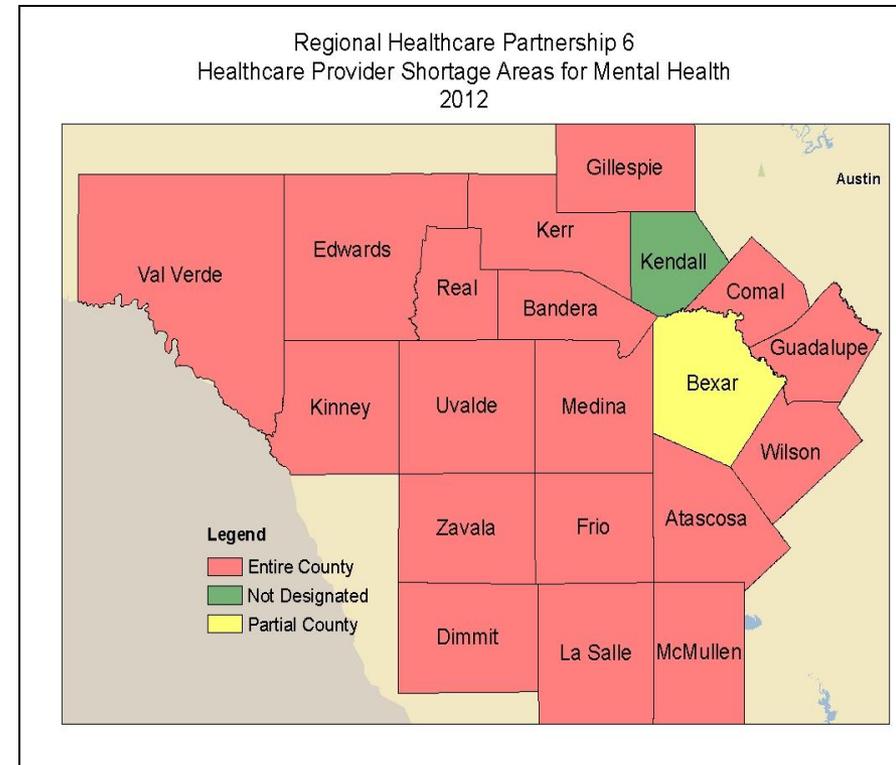
# Regional Healthcare Partnership 6

Anchor:



**University  
Health System**

- **24,734 square miles**  
*larger than 10 states*
- **2.3 million residents**  
*more than 15 states*
- **RHP 6 is comparable to the state on many socioeconomic and health measures, but there is significant variability among counties in the region.**



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## Successes and Discoveries

- **Collaboration is key! Examples:**
  - Community mental health centers working with hospitals
  - Private hospitals working with public hospitals
  - Providers working with small businesses, community organizations, public health departments, and the Health Information Exchange
  - Learning Collaborative events
- **Disciplined project management and good data are critical.**



## Patient Impact

- Retired engineer William visited Medina Regional Hospital, a critical access facility in Hondo, Texas, to attend a demonstration of the new tele-stroke program. While there, he experienced stroke symptoms and became one of the first patients to benefit from the teleconference system, which connected William to a neurologist in Denver. He was then transported via helicopter to a hospital in San Antonio. He had a successful recovery!



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## Regional Health Partnership 7

### Anchor: Central Health

- Diverse six-county (Bastrop, Caldwell, Fayette, Hays, Lee, and Travis) region including urban (Austin/Travis County) and rural areas
- Region's population growing significantly in every county and is increasingly diverse
  - Hays and Bastrop counties are expected to grow by more than 30% during the waiver period.
  - 32% of people in the largest county, Travis, speak a language other than English at home.
- Lack of health providers often drives residents to Travis County to seek care, creating a provider deficit in every county.
- Rising rates of chronic conditions are a key concern in the region.
- Crisis services comprise the majority of the limited behavioral health resources in the region, leaving a significant gap in community-based care. Estimates suggest that over 50% of Region 7 residents below 200% FPL are not receiving needed mental health care.

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## Successes and Discoveries

- **Strong behavioral health focus responding to the critical regional need – more than half of all Region 7 projects have a behavioral health focus, including (among many others):**
  - Veteran’s Mental Health Services by Hill Country MHDD Centers
  - Telepsychiatry in the ED by St. David’s Healthcare
- **Unique partnerships**
  - Sheriffs of Bastrop, Lee, and Fayette counties have unprecedented agreement to allow Crisis Intervention police officers to cross county lines to provide service in Fayette and Lee counties for Bluebonnet Trails’ project, Services for Justice Involved Persons.
  - School district funding in Travis County is providing mental health care on school campuses through Dell Children’s Medical Center.
- **The Community Care Collaborative is coordinating safety net providers across Travis County to create an integrated delivery system, using DSRIP to build the foundation of care transformation and expansion.**
- **Strong collaborative interest across all regional providers has spawned multiple issue-based workgroups.**
- **Primary and specialty care expansions in suburban and rural areas**
  - Central Texas Medical Center – primary care expansion in Hays County
  - St. Marks Medical Center – specialty care expansion serving Fayette and Lee Counties
- **Population Health Improvements**
  - Tobacco prevention, diabetes education, teen pregnancy prevention, and other projects by the City of Austin Health and Human Services Department

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## Patient Impact

- Bluebonnet’s crisis support team created an individualized behavior support plan for Mike, a 17-year-old diagnosed with high functioning autism, that significantly reduced self-injury, aggression, and arguing. The family is extremely pleased with his progress, and they are working with the team to prepare for a successful school year.
- Gloria, who struggles with diabetes and liver disease, visited the ER 11 times in 2013. After participating in UMCB’s DSRIP Project, Seton Total Health Partners, Gloria has visited the ER only once.
- A 62-year-old Travis county woman was told for years that her Hepatitis C was untreatable due to her mood disorder. After being referred to the Community Care Collaborative’s Hepatitis C clinic, she was able to receive no-cost, innovative pharmaceutical treatment that has minimal side effects and has rendered her Hepatitis C virus undetectable. As a result, her quality of life has improved, and she has become one of the clinic’s best advocates in the community.



**Neighborhood Block Walk in suburban Travis County to outreach for Mobile Primary Care Services through the Community Care Collaborative**

**A different kind of first responder: the Austin Travis County Integral Care (ATCIC) behavioral health crisis counselor who, for the first time, can be dispatched from the 911 call center**



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## Regional Health Partnership 8

- **Nine counties - one urban area surrounded by a number of rural and suburban communities.**
- **Covers 8,547 sq. mi. with a total population of 860,803 (2010 U.S. Census).**
- **Bell and Williamson Counties consist of roughly 85% of RHP 8's residents**
- **Williamson County fastest growing county in the U.S. (2010-2012) with a projected growth rate of 7.94%**
- **Majority of RHP 8 counties have a greater proportion of older residents; at least 17% of residents are older than 65 years; Llano County has the 31.1%, compared to Texas average of 10.3%**
- **All counties except Bell and Williamson designated as a single county Health Professional Shortage Area (HPSA) in at least one category**
- **37 unique community needs identified in the RHP plan**

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## Successes and Discoveries

2 local mental health authorities are participating in 4 RHPs

16 projects focused on Behavioral Health; 5 focused on Primary Care Expansion; 5 focused on Health Promotion & Disease Prevention

3 telehealth projects are underway with an estimated impact of over 6,000 encounters

61% of RHP 8 Cat 1/2 projects are being implemented by a local mental health authority

6,340 individuals are anticipated to be served by 3 Patient Navigation projects

RHP 8 Cohort is comprised of collaboration amongst: DSRIP and UC hospitals, health districts, and local mental health authorities, EMS; and an FQHC

## Patient Impact

### Bluebonnet Trails Community Services

This program is a peer-supported project which offers a place of recovery for individuals stepping down from respite services, hospital discharge for psychiatric illness, individuals at risk for becoming homeless, or individuals who are homeless.

#### Success Story:

One individual enrolled in the program had faced many hardships in the past and still had a long road ahead, but for the first time this individual felt they could overcome their challenges, even saying, "I'm a winner!" while working with their counselor to develop an action plan. This person went on to get a job, establish living arrangements, and is now a thriving member in our community!

### Seton Highland Lakes Hospital

Implementing a patient navigation project to connect uninsured patients with primary care or medical homes in order to reduce emergency department utilization and provide cost-effective, timely, and site-appropriate health care services.

#### Increasing Collaboration:

The Seton Highland Lakes patient navigation team meets weekly to share notes, concerns, and to discuss the navigation related to patients enrolled in the program, which may also include patients who exhibit behavioral health problems. This includes team navigators including the case manager and sometimes the local mental health authority staff.

### Hill Country MHDD Centers

The project aims to help veterans and their families with behavioral and mental health concerns. Hill Country staff collaborates with social services, law enforcement, and the healthcare community to find veterans in need of their services. Services are provided by peers.

#### Creative Ways to Bring Veterans to Behavioral Health Groups:

Hill Country counselors offer group activities that are geared toward the outdoors setting which has increased the number of veterans participating in these services. Examples of group therapy settings include hikes and kayaking adventures.

## **Regional Health Partnership 9**

- **3 counties: Dallas, Denton, & Kaufman**
- **2,530 square miles**
- **Population of 3.1 million, 40% are low-income**
- **26 providers**
- **Needs assessment is similar to other urban areas in Texas: Gaps in access, behavioral health, and care coordination**

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## Successes and Discoveries

- **Oral Health:** TAMU Baylor College of Dentistry collaborating with provider THR-Dallas to provide follow-up care for patients who present in their ED with dental pain
- **Behavioral Health:** Metrocare collaborating with Baylor Scott & White to provide psychiatric consults for their primary care clinics
- **Criminal Justice System:** Dallas County HHS collaborating with regional partners to integrate and coordinate behavioral health crisis services that can be accessed by consumers instead of the ED



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## Patient Impact: Peer Navigation

- **Parkland Health & Hospital System Peer Navigation project provides care coordination and focused individual support assistance for patients with a mental disorder**
- **Patient BB is a high risk BH/SA patient:**



- **BB enrolled in the peer navigation program and currently has had 6 contacts with peer navigator resulting in access to community resources such as transportation and a variety of support groups**
- **BB has had 2 months of sobriety, ongoing compliance with court-ordered meetings, and has re-established custody of son**
- **Peer navigation project currently has 261 patients enrolled**

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# Patient Impact: ED Navigation

## Texas Health Resources Denton ED Navigation

- Patient “Susie”
  - Frequent user of ED due to uncontrolled Type 1 DM, asthma, multiple persistent psychiatric disorders
  - Social history: Physical and SA, homeless, completed 8<sup>th</sup> grade, no stable job history, volatile relationship with boyfriend
- Outcomes since enrolling in the program
  - Reduction of ED visit from 9 in 2013 to 1 in 2014
  - Reduction in inpatient admissions from 4 in 2013 to 0 in 2014
  - Improved DM management
  - Better control of MH allowing better decisions and improved relationships
  - Keeps primary and behavioral health appointments
  - Established place to live



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## Regional Health Partnership 10

- **Nine counties covering 7,221 square miles**
- **One urban center surrounded by a number of rural and suburban communities**
- **2.4 million people lived in Region 10 in 2011**
- **Regional growth over the Waiver period is projected at nearly 10% - up to 2.7 million residents regionally**
- **Across the Region, there are 46 acute care hospitals and 3,721 physicians (1,512 primary care providers and 2,209 specialty providers)**
- **Region has 6,491 acute care licensed beds and 170 psychiatric care licensed beds, four community mental health centers (CMHCs), and one federally qualified health center (FQHC)**
- **Four of Region 10's nine counties are also designated as partial primary care Health Professional Shortage Areas (HPSAs)**
- **22 unique community needs were identified in the RHP plan**

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## Successes and Discoveries

**Implementing 126 approved projects aligned with 22 regional community needs**

**26 projects focused on behavioral health; 9 focused on specialty care; 15 focused on primary care expansion**

**8 projects targeted at greater than 50,000 pediatric & young adult patients**

**8,000 unique patients from seven projects will be positively impacted through improved sepsis diagnosis and treatment**

**More than 4,800 homeless individuals will be impacted by multiple projects**

**25 projects focused on care transitions across settings**

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## Patient Impact (Multiple stories available on [www.rhp10txwaiver.com](http://www.rhp10txwaiver.com))

*Enjoy this poem from a patient who was impacted by the Partial Hospitalization DSRIP Program at JPS Health Network*

When I first came to PHP I didn't know what to expect.  
I was broken, lost hopeless, sad, and upset.  
You guys welcomed me with open arms.  
You made me feel safe, secure, and right at home.  
So my anxieties and fears of the unknown were gone.

Two weeks ago I was confused and didn't know which way was up.  
Two weeks later my mind is clear with the desire to never give up.

The groups, resources, coping skills, and grounding skills have made me a better person.  
I am strong, beautiful, and capable with a passion and a purpose.  
Thank you guys for being my friend.  
For allowing me to put those negative thoughts and feelings into a trash bin.

You guys don't realize how significant and important you are in my eyes.  
You absolutely have given me the willpower to strive.  
You guys helped me turn my situation around.  
You helped me place my feet on solid ground.  
It's going to take some time for me to heal but at least I can say "I'm still here!"

Sometimes I wonder how I've made it this far.  
I realize now it was through the grace of God.  
Only God knows his plan for my life.  
I just have to hold on, be strong and do what's right.  
This is my story, my journey, my testimony, my life.

My grounding skills will sooth me though these dark and gloomy nights.  
I will turn into a twinkle star, blink twice, and sleep tight.  
Dream about the PHP my safe place where I am alright.

I will wake up in the morning with a smile upon my face.  
The courage to move forward and say it's going to be a great day!



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## Patient Impact

[Patient] is a smart, easy going, funny, wonderful, and overall great [person]. Talk to them and you will find a normal 2X-year-old that is ambitious, responsible, and comes from a happy and supportive family. It is hard to believe that between the months of September 2013 and January 2014 they had 3 Psychiatric Emergency Center admissions, 2 Inpatient Psychiatric admissions, a Long Term Commitment Alternative admission at JPS, and incarceration at Tarrant County Jail.

In those four months [patient] struggled with [their] mental illness, behaviors, coping, medication adherence, medical compliance, and legal issues. To make matters worse, [patient's] mother that had been in remission was diagnosed again with cancer.

They had to move in with their grandmother. She and [patient's] mother were at a standstill of what to do with [patient]. The situation seemed hopeless. Because of the new Discharge Management program, they started receiving case management services from a transition coordinator. The transition coordinator was able to work with [patient] and [patient's] family to notice patterns of behavior/s, symptoms, and mood while encouraging and educating the family on the importance of medication adherence and medical compliance. The patient and their family learned about [patient's] illness and the treatment options for it, practiced patience, and put a recovery plan together.

I [JPS Employee] am extremely honored and proud to report that the patient is successful in their recovery. The patient is now medically compliant with psychiatric services, adherent to medications, and practicing coping skills. The patient is active in attending outpatient behavioral health recovery groups provided by the Discharge Management program, and receives case management services through a partnering agency. The patient has not been readmitted to Trinity Springs Pavilion since January 2014. This was and will continue to be hard work for the patient, their family, community, and their support team, but the patient has the tools, education, and resources for their recovery. If that isn't enough, the patient is also now employed for the first time in almost 2 years and thinking about a future that seemed so unobtainable just only months ago.

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# Regional Health Partnership 11

## Palo Pinto General Hospital – Anchor

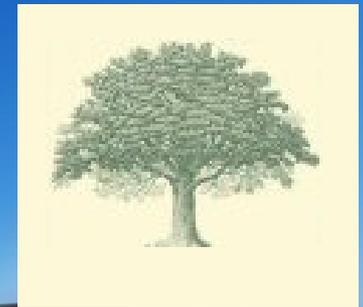


- **15 Counties**
  - **5 Frontier Counties**
  - **ALL Counties are Medically Underserved Area (MUA) and have a Health Professional Shortage Area (HPSA) designation, including Primary Care and Mental Health Care Professionals**
- **5 LMHAs**
- **5 Private Hospitals**
- **12 Public Hospitals**
- **20 IGT Entities**
- **Almost 20% of all people in the RHP fall below the poverty line. The percentage of children living in poverty is close to 30%. Texas is 17%.**
- **Economic and Shale oil boom in the Big Country**
- **Limited Water Supply**

# Increase Access to Primary Care- 1/3 Projects



**Palo Pinto General Hospital**



**Stephens Memorial Hospital**



**Stamford Healthcare System**

**Comanche County Medical Center**



### Eastland Memorial Hospital

#### Specialty Care



#### Hendrick Medical Center Palliative Care

#### Telemedicine



#### CFLR

#### Haskell Substance Abuse Expansion



#### Helen Farabee Center

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# Regional Health Partnership 12

## Anchor: University Medical Center

- **RHP 12 region is comprised of the 47 counties in the Texas Panhandle**
  - Geographically the largest region in the state
  - Urban region square miles= 2,745 with a population density of 189.66 residents per square mile
  - Rural region square miles= 42,793 with a population density of 8.65 residents per square mile
  - RHP 12 region is larger than the state of Ohio and 17 other states in the union.
- **38 performing providers; 22 are rural**
- **Most counties designated HPSA for both primary and mental health**
- **13.4% of residents in the region were uninsured (2010 data)**
- **Key health challenges are diabetes, access, and high ED utilization**

## Successes and Discoveries



**CN.1 Severe Primary Care Shortage (Golden Plains Primary Care Clinic)**



**CN.2 Lack of Mental Health Services (West Texas Center Crisis Intervention)**



**CN.4 High Incidence of Obesity, Diabetes (BSA Patient Navigation Program)**



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## Patient Impact

### Peer Specialist-Central Plains Center

- Patient would not leave her home.
- Diagnosed with depression, schizophrenia, hypertension and DM. Also has a pacemaker.
- Peer Specialist accompanied patient to dollar store, grocery store and Dairy Queen (First time in 2 years that patient had left home)



### Tele-Monitoring-Medical Arts

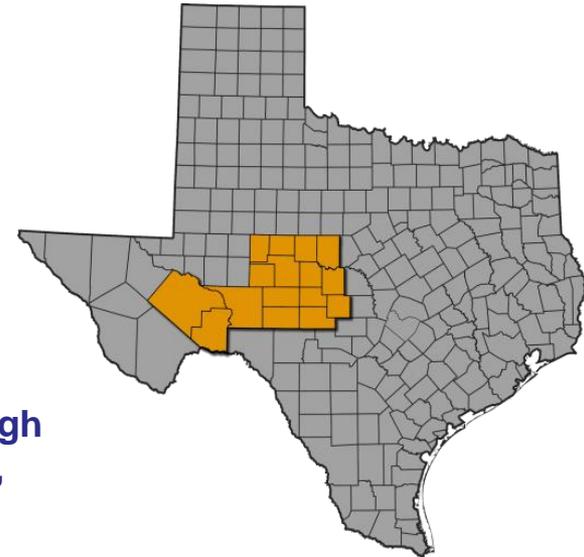
- Patient was placed on tele-monitoring for diabetes. The machine is programmed to rotate a series of questions decided by the medical team. 2 questions included for this patient 1) Do you generally feel positive about life? 2) Do you feel life is worth living?
- Patient answered “No” to both-this response flagged the nurse to intervene
- Nurse was able to intervene by assembling a interdisciplinary team and together they came up with a plan of care to provide the patient the services he needed for his depression.



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## Regional Health Partnership 13

- **17 Counties:** Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green
- **Population:** 190,079 or less than 1 percent of the state's population
- **Top soil and sand:** almost 10% of the state's total square miles (larger than West Virginia!)
- **Geographically isolated, plus low rates of educational attainment , high rates of poverty, and high rates of chronic diseases, such as obesity, diabetes, and heart disease.**
- **Uninsured rates are higher than national and state rates, ranging from 25.7% (Tom Green County) to 42.5% (Concho County).**
- **Collaboration between providers, universities, and school districts critical to meeting the needs of the region**





## Patient Impact: Coordinated Approach to Child Health

Joint project among Heart of Texas Medical Center, Pecos County Memorial Hospital, Shannon Medical Center, Brady ISD and Fort Stockton ISD

“To date, we have over 130 children registered for Saturday CATCH Kids Clubs. One Saturday a month we keep the kiddos for 2 hours. Our focus is kinder through 6th grade but we never turn anyone down. Our youngest participants are 2 years old, anyone in 6th grade and up we invite to volunteer as Junior CATCH Coaches.

Something that makes our time special is that we encourage our parents to be involved, it gives the kids another healthy role model to look up to!

We also always take time for a Healthy Lifestyle lesson that includes topics such as screen time, how to choose foods that work with your body, reading labels, teaching children the positive effects of being healthy, and the negative effects that come from an unhealthy lifestyle.”

**In Texas, one in three children over the age of 5 is considered obese, according to the CDC.**



**CATCH**  
COORDINATED APPROACH TO CHILD HEALTH



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# Regional Health Partnership 14

## Anchor: Medical Center Health System

- **Rapid Population Growth**
  - Population expected to increase by 10% from 2012 to 2030 (385,144 to 424,968)
  - **Region topped 450,000 last year (only 16 years ahead of schedule 😊)**
- **Relatively low education rate and high poverty rate**
- **Teen pregnancy rate higher than state average**
- **10/16 counties are frontier counties (<7 people/sq. mi.); 13/16 counties MUAs**
- **40% commercial, 29% uninsured, 31% Medicaid, Medicare or CHIP**
- **Higher death rates than state for heart disease, chronic lower respiratory disease, accidents, Alzheimer's disease, motor vehicle accidents, influenza/pneumonia, and cancers of colon, rectum, anus, and suicide**



## Successes and Discoveries

- Numerous examples of collaboration between providers.
- **Project Focus:**
  - Primary Care Expansion
  - Behavioral Health Integration
  - Care Navigation
  - Chronic Disease Management



## Patient Impact

### Patient Navigation MCHS (135235306.2.2)

"Angels really I say angels have landed at Medical Center Hospital," Patient said.

Prior to receiving community navigation services patient had not been treated for his cancer diagnosis for several years for various reasons. He visited the ER in late 2013 regarding pain and other oncology-related symptoms but did not receive a formal oncology consult at that time due to lack of funding and primary care provider. By word of mouth, the Community Health Department received a referral for patient and immediately began the navigation process. The same day, a community nurse navigator visited his home and helped him complete the necessary paperwork to begin the financial assistance. Within the week, he was seen by a new oncologist and further diagnostics were completed. He began chemotherapy and radiation within 2 weeks and is now stable while receiving necessary treatment. He has only had 1 hospitalization in 2014 since navigation services began in late 2013 due to an infection secondary to chemotherapy. He now receives assistance with medications, has been approved for disability, and receives assistance with all Oncology related treatment. Additionally, his wife was also provided assistance with medications prior to a surgical procedure. He has since been interviewed for several news stories on behalf of navigation services explaining how it benefited him.

This is a write up of one of patient's testimonials

<http://www.newswest9.com/story/24594725/new-program-at-mch-helps-patients-with-health-care-struggles>

## Patient Impact

### MMH

### (136143806.2.4)

"Hope Chest has given me a sense of security and comfort. I'm truly grateful knowing that I have been given some extra guidance with what to expect throughout pregnancy, labor, and even life itself (becoming a mother)."

-- Ali, Hope Chest participant

"I give a lot of credit to the enthusiastic support I got from several ladies down at the DHLC. From Adrianna at the scheduling desk to Megan in our class sessions and to Jessica who sparked this whole health journey with her chance appearance that day at our safety meeting. Each of these ladies showed a sincere interest in my health and my success. They made me WANT to succeed just so I would not let them down. They have faith in me and that faith is infectious. When I told Adrianna that my health plan gave me a blood glucose meter that transmits to a web site and that I could give them access to my numbers and also send them emails whenever my numbers fall outside a certain range, she eagerly said they would love to participate and have that access. Sadly my doctor's office has not yet even showed an interest in this. They have given me the tools deal with food situations. All my life I was raised to not leave anything on my plate. Trust me, you don't get to be over 300# by not being good at cleaning your plate. But have you seen what restaurants give you to eat at a meal? So, the other day we tried out a new restaurant in town and I did something I have never done before. Based on a suggestion I learned while going to my classes at DHLC, when my meal arrived I asked the server to bring me a 'to go' box and I immediately cut my meal in half and put it in the box. So the plate I cleaned that night was just half of what I normally would have eaten. Plus, I had tomorrow's lunch or dinner already to reheat and enjoy."

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## Regional Health Partnership 15

- Serves El Paso County (pop. 800,000)
- Covers over 1,000 square miles in far west tip of Texas
- Shares international boundary with Mexico
- Has one of largest Army installations in U.S.
- Culturally diverse population; over 80% of Hispanic ethnicity
- Base undergoing unprecedented growth – more military families
- 30% of residents are linguistically isolated due to limited English proficiency
- 25% of residents live below poverty
- Higher percentage of Medicaid and underfunded population in RHP 15
- Highest percentage of diabetes in Texas; subject of learning collaborative

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## **Successes and Discoveries**

- **Many providers are engaged in projects that expand access to primary care or improve upon the transition of care following acute discharge.**
- **The City's department of health successfully transformed some fire station space into mini clinics that provide flu shots and other preventive medicine. In another project, they were able to fund a mobile dental clinic and extend service capacity for pediatric oral health services in low-income children living in unincorporated areas of the region, including migrant service worker areas.**
- **Nursing care is also now available on-site at two area homeless shelters, Salvation Army and Rescue Mission. Providers are discovering that earlier interventions with shelter residents in need have prevented or diverted unnecessary ED utilization and subsequent hospital admission. UMC also collaborated with Hospice El Paso to provide compassionate end-of-life care to underfunded patients. As a result of this collaboration, two shelter patients are currently receiving hospice care.**

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## Patient Impact

- One of the many successes to date includes the following event reported by a mental health provider implementing a crisis stabilization project for individuals with mental illness. A family reached out for help due to verbal abuse by an individual with mental health impairment. A START service coordinator (SC) responded to their home and successfully diverted an inpatient psychiatric admission. The SC was able to calm the individual and help the family access other services. The SC greeted the enraged individual and spoke about topics of interests such as basketball activities and a pet ferret. The individual seemed open to suggestions and asked for help with attending creative activities at a multi-purpose center. Following this service, the individual remained in his home, in stable condition, without need for an inpatient admission.

## Patient Impact

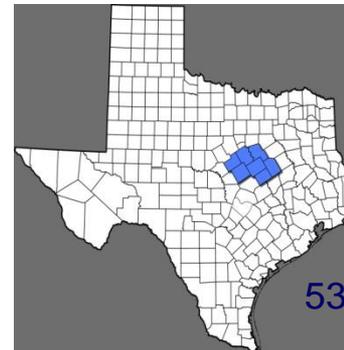
- Another success story is one from a home-based therapeutic project providing mental health services. This project helped a mother change her parenting style and improved her involvement with her son's school. Her teenage son's behavior went from juvenile arrest and detention to successful elimination of deviant behaviors. The mother went from giving her son rewards for misbehaving to implementing consequences and rewards for positive behavior. The mother and the son's probation officer were very satisfied with the tremendous progress that was made with MST services. Mom stated that she highly recommended MST to anyone having problems with their teenagers, as she had tried various counseling services for youth and all were unsuccessful. She said that MST services were a huge blessing to her family.
- Salvation Army shelter resident, Maria, had this to say: "We learned a lot from the clinic nurse. I did not know my daughter was on track to become a diabetic. We learned what it takes to keep *mija* healthy."

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## Regional Health Partnership 16



- RHP 16 represents 7 counties in Central Texas.
- Two large urban hospitals are centrally located in Waco, TX, and have traditionally shared the role as tertiary care centers for the rural communities in RHP 16.
- Five of the seven counties in RHP 16 suffer from a major shortage of Primary Care Physicians.
- Fort Hood is partially located in Coryell County and has created a significant need for mental health services to serve this population of adults and children.
- Projections by the Texas State Comptroller's Office show an increase in population of 21.2% for the Region by 2030.
- **Community Needs Assessment:**
  - The number of uninsured children and adults is 27.5%
  - Children below the poverty rate is in excess of 31%
  - RHP 16 is considered a Mental Health Professional Shortage Area



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## Successes and Discoveries

- Learning collaboratives centered around regionally-focused projects have improved communication and patient care. Partners include not only local hospitals, physicians and mental health agencies but also local law enforcement groups, community-based social services and Texas A&M Agri-Life Extension. Our goal is to bring together providers and community leaders to merge our strengths to provide a cohesive range of services resulting in improved care coordination and communication. Some of our *regional* projects include:
  - Chronic Disease Management/ Childhood Obesity
  - Health Literacy Program
  - Diabetes Education
  - Telepsychiatry in the Emergency Room
  - Introduction of Palliative Care
  - Innovative Behavioral Health Projects



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## Patient Impact

### Crisis Respite Transition Services – Coryell County

This project provides 24/7 residential-based crisis respite, transitional living and supportive day services at a properly-equipped facility within the service area to persons with severe and persistent mental illness who have experienced a recent mental health crisis in lieu of these persons being sent to the state psychiatric hospital system or incarcerated in local jails.

*"I would recommend CRTS to anyone dealing with issues that have spiraled out of control. The week I spent here was a spiritual awakening for me in my goal of obtaining an enjoyable and fulfilling sober life. Thank you all for helping my cause and your complete professionalism."*

*"The day time staff was absolutely amazing. They were positive and showed concern for my well being. I can't tell you how grateful I am for having had the opportunity to come here."*

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## Regional Health Partnership 17



### Anchor: Texas A&M Health Science Center

- Covers 6,986 sq.mi. with population of 843,054 (2010 census)
  - **54% of the region's population resides in a single county (Montgomery)**
- All counties have partial or full HPSA designations in primary care
- Eight of nine counties have full HPSA designations in mental health
- Key health challenges
  - **Poor access to primary and specialty care**
  - **Poor access to behavioral/mental health services**
  - **Lack of coordinated care, especially for those with multiple needs**

# Successes and Discoveries

## Regional Themes & Impact

### Themes

- Diversion: ED & Jail (10 projects)
- Improved Rural Access (12 projects)
- Coordinated Care (12 projects)

*Note: Projects may address more than one need and feed into multiple themes*

### Estimated Patient Impact

24,570 individuals (17 projects)

- DY3: 5,636 patients
- DY4: 8,083 patients
- DY5: 10,851 patients

76,112 encounters (15 projects)

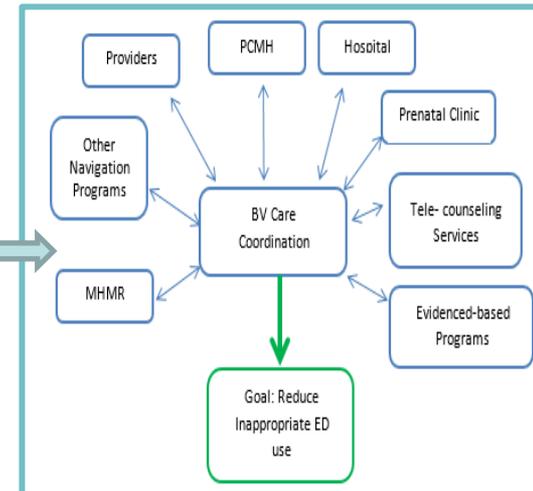
- DY3: 12,374 services
- DY4: 28,800 services
- DY5: 34,938 services

## Inter-DSRIP Collaboration Example

Referrals/collaboration between providers to maximize programs are occurring more frequently as projects gain traction. The illustration shows all the DSRIP referrals from one care coordination project.

### Common Project-to-Project Referrals

- Telehealth Counseling Clinic (6)
- Evidence-based Programs (5)
- Local Mental Health Authorities (5)
- ACP & Prenatal Navigation (4)



## Community Collaboration Example

### BVCCP "It Takes a Village" Concept

Collaboration with the community is key to make resources available and more affordable to patients.

- Free Clinics & FQHCs (care & treatment)
- Dentists (care & treatment)
- Pharmacies (meds/supplies)
- Food Banks (nutrition)
- Church/Civic Organizations (transportation)



## Successes and Discoveries

### MHMR ABV Rural ACT Program

Expanded assertive community treatment to rural Brazos Valley to support mental health patients with history of multiple hospitalizations

Since Jan. 2014, ACT program clients increased from 28 to 45

80% decrease in hospital admission rates for ACT clients during same time

### SLWH Pediatric Bridge Clinic

Partnered w/Texas Children's to address frequent ED use of SLWH neonates during 1<sup>st</sup> week of life

Approx. 88 babies (50%) delivered each month have no medical home

Limited providers take Medicaid & backlog in other offices cause non-emergent use of ER

Clinic growth has quadrupled since May 2014 opening

### TAMP Telehealth Counseling Clinic

Partnered with counties & community agencies to provide free behavioral health services in rural areas

In DY2 & DY3, expanded program to 2 new rural sites and 1 new site in local free clinic

Serving est. 80% Medicaid/Uninsured  
4,400 new sessions to be provided under waiver

### SLWH Chronic Disease Registry

Registry development led to understanding that CD patients are most frequent SLWH users.

Shifted focus from inpatient to chronic disease efforts spanning continuum of care

Adding Population Health Coach & RN Transition Coordinator to coordinate care/provide education up to 6 mo. after discharge

Project serving as pilot model for 6 hospital system

### Advanced Community Paramedicine

Four-year project (Washington County) and three-year project (Montgomery County) in which paramedics act as navigators for patients identified as frequent users of 911

Washington County: Approx. 30 patients enrolled in DY3 w/15-20 home visits provided. Reduced EMS transports/ED visits = \$12,000/month savings

Montgomery County: Project started in early 2014; now 21 patients enrolled. Pre-enrollment EMS responses = 95; down 53% to 45 EMS responses post-enrollment

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## Patient Impact

A 50-year-old male patient was referred to the rural telehealth project by a local community health clinic. He suffered from panic attacks, for which he called EMS each time. He started therapy, where they were able to identify the cause of his anxiety and help him develop coping skills. As a result of the project and the availability of this new service in his rural area, he has been able to transition out of routine counseling and all inappropriate use of EMS and the emergency room has stopped.

The waiver has not only allowed care/services for patients needing it on an ongoing basis but has also made resources available to identify and help those in transition or facing the unexpected. A patient with multiple chronic conditions lost her job and her insurance. Given that she'd previously had insurance, she was unaware of resources in the community and became a frequent user of the ED to manage her conditions. She was referred to the BVCCP program, where they worked with her and gave her a referral to a community free clinic. She was able to receive care at the clinic until she started her new job and her insurance became effective. She never made another visit back to the ED after enrolling in the BVCCP program and now has established medical care in the community.

A 28-year-old female patient with uncontrolled diabetes, hypertension and hyperlipidemia called EMS 14 times in the first half of 2014 for nausea and abdominal pain. Patient enrolled in the ACP program, connected with a primary care physician, properly evaluated and medicated, and has had ACP follow-up visits. Since enrollment in the program, patient has had zero additional calls to EMS and her chronic conditions are well controlled, quality of life is improved.

A homeless patient was being helped by a local faith-based organization, who was working to get him a place to stay and food as well as care and treatment services. The co-location of telecounseling services allowed referral of the patient to the program. Following evaluation and treatment, his minor depression is now managed and he has developed coping skills. Treatment and the availability of continued care have allowed him to be able to complete workforce training, and he is now employed in a \$40,000 a year job, has a home, and is thriving!

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## Regional Healthcare Partnership 18

- As a Tier IV RHP, opted IN to the Learning Collaborative Plan
- Contiguous with both Dallas County and the State of Oklahoma
- Fluid movement of healthcare consumers in metroplex
- Total population of 0.9 million
- *7 highly innovative and cooperative* Participating Providers
  - 23 Infrastructure and Innovation Projects
  - 25 Outcomes Projects
  - 3 Category 4 hospitals
  - Five year value ~\$120M
- Accomplished 100% of DY2 Metrics
- Challenges: hiring and retaining providers, communicating with non-participating hospitals, monitoring PPAs in outpatient populations, time



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## Successes and Discoveries



- Partnering activities developed in Learning Collaborative (LC) events facilitated new, innovative services expansion.
- Early and frequent LC activities fostered Anchor-Provider team cohesion and adaptability.
- Providers have coalesced around on-going services gap analysis process.
- Great appreciation for HHSC team's commitment to excellence.

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## Patient Impact

In Grayson County, two hospitals, the county health department, and two foundations established a new primary care clinic to identify adults who have habitually used or are identified as at-risk for using the ER for outpatient treatable conditions.

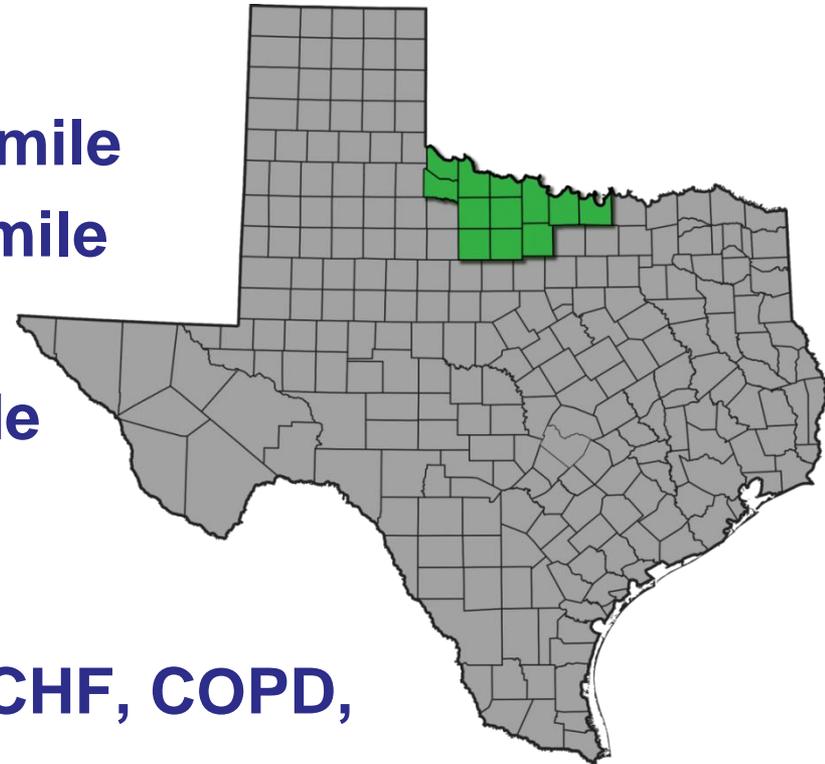
- Recently an uninsured woman, unable to work due to three months of abdominal pain, had gallbladder surgery and back at work.
- An uninsured male suffering from an undiagnosed malignant lesion, was connected to needed treatment as well as registering as a regular outpatient for hypertension, now under control.

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## Regional Health Partnership 19

### Rural Region in North Texas

- Population density 24.75/sq. mile
- Statewide average 95.92/sq. mile
- 502.9 residents/M.D.
- 460.5 residents/M.D. statewide
- Region-wide HPSA
- Health challenges:  
Adult Obesity, Pneumonia, CHF, COPD,  
Diabetes



### Successes and Discoveries



New Primary Care  
Providers –  
← Clay County Memorial

North Texas  
Medical Center ↓



← Back to School  
Backpack distribution  
& immunization clinic  
– Faith Community Hospital



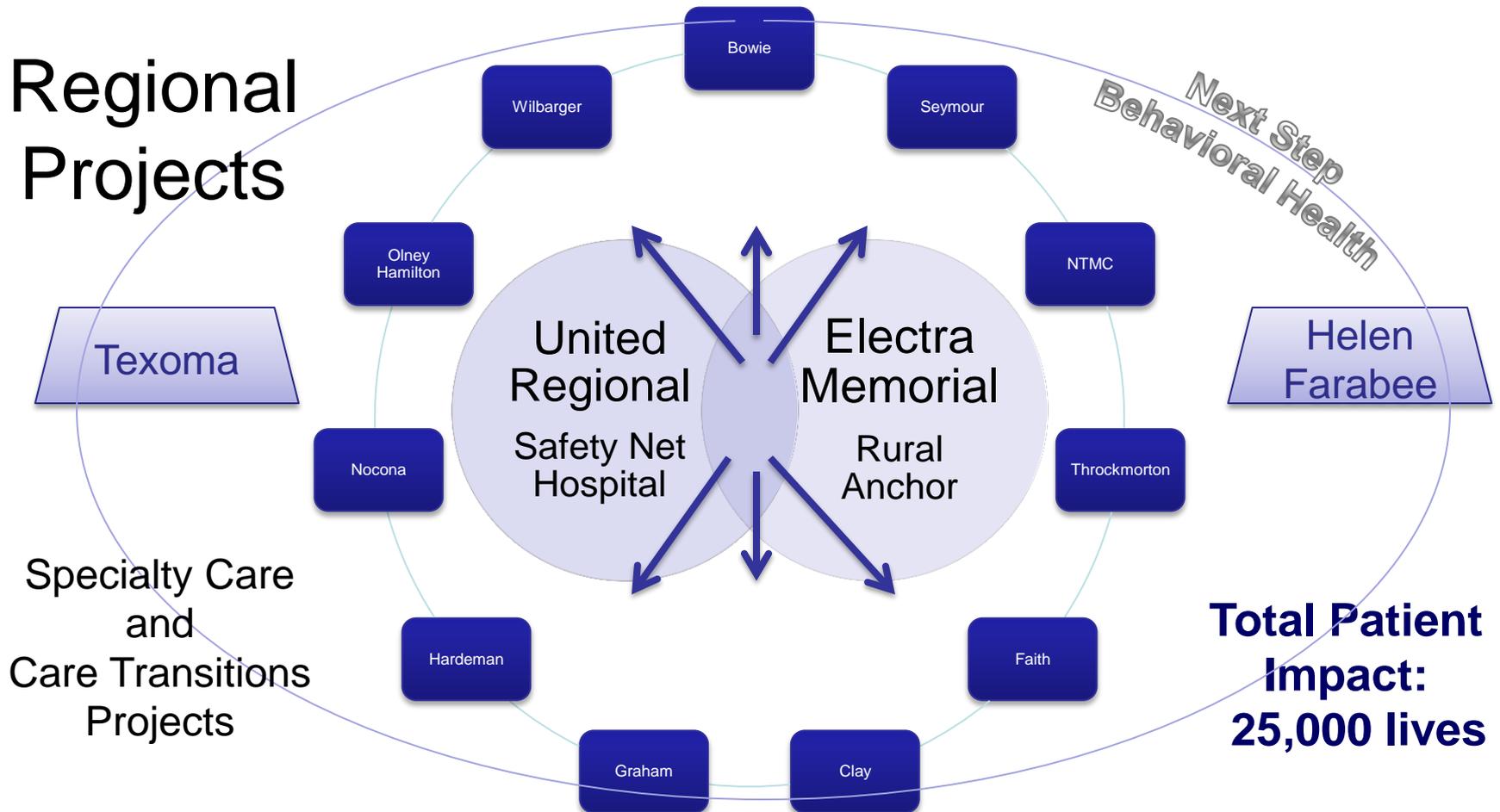
Behavioral Health  
Crisis respite unit –  
→ Helen Farabee Center



↑ Drive-thru Blood Sugar  
Testing – Bowie Memorial



# Integrated Model: Cross-Provider Collaboration



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## Regional Health Partnership 20

### Anchor: Webb County

- Small four-county region (Jim Hogg, Maverick, Webb & Zapata)
- Total population approx. 330,000
- Substantial poverty and needs in RHP 20
- Limited access to health care, poverty, and low levels of education combine to impact provision of health care and the health care system



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## Successes and Discoveries

The majority of projects proposed in RHP 20 address mental/behavioral health and access to primary care. There has been some unexpected collaborations, such as Border Region Behavioral Health's collaboration with Bayview Behavioral Health Services in Corpus Christi to provide telepsych services beginning October 1, 2014. Additionally, during our Regional Provider Meeting, providers were able to work on additional collaborations and exchange information that would be helpful to all present. The City of Laredo Health Department reported high success in their Disease Self-Management project using a self-created DSM program based on other curriculum but tailored to the local community and population.

## Patient Impact

### Maverick County

Peer-to-Peer outreach workers in the Camino Real Community Services Veteran's Project in Maverick County, both veterans themselves, were able to identify a homeless veteran in the community in need of their counseling and support services. They assisted the homeless veteran in finding a place to stay and encouraged him to begin receiving mental/behavioral health services through Camino Real Community Services.

### Webb County

Doctors Hospital of Laredo's Family Clinic has been able to identify and refer about 80% of the children seen at their clinic to local dentists for dental evaluations. During the checkups that these children received, they were found to have severe dental issues that would ultimately result in needing surgical interventions due to the extent of the damage to their teeth.

## 20 Regional Healthcare Partnerships

# Collaboration and Innovation

