Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) 10
Annual Anchor Report: Appendices

December 15, 2014

Region 10 RHP

Appendices: Table of Contents

Appendix A: Patient Impact and Success Stories

Appendix B: Provider Survey Results

Appendix A: Patient Impact and Success Stories

Celebrating Breastfeeding August 8, 2014-

Five new lactation consultants are now on board at JPS, adding breastfeeding support to the line-up of outpatient services for new moms. They started visiting community health centers this week — World Breastfeeding Week — getting acquainted with the nine clinics where they will see patients.
The lactation consultants will be backed up by six new community care partners, who will make home visits, helping new moms navigate around potential breastfeeding deterrents. The new Community Lactation Team is a DSRIP project, federally funded by the state's Medicaid 1115 Waiver to improve healthcare delivery and population health.
Breast milk contains hormones and antibodies that help keep babies healthy. Research has found that breastfed babies have lower risk of asthma, eczema, childhood leukemia, ear and respiratory infections, obesity and Type 2 diabetes, and Sudden Infant Death Syndrome (SIDS.)
A sizable study published in Pediatrics concluded that promoting breastfeeding has the potential to prevent more than 700 post-neonatal deaths every year in the United States — a top priority for JPS, which is committed to reducing Tarrant County's historically high infant mortality rate.

Children's Health DSRIP Success Story RHP 10

A twelve year old boy was referred for patient navigation and disease management services after multiple Children's Health Emergency Department visits and two inpatient admissions for poorly controlled asthma. After mom did not respond to repeated calls by a case management nurse, a case management social worker was able to contact the mom. Mom had questions about her son's medical care and the nurse was able to engage with her. Mom stated that she had difficulty communicating with her son's outpatient providers and "prefers to go to the ED" where she knows she will be able to communicate with Spanish speaking providers or through interpreters. The family had been offered asthma disease management services in the past but had refused additional services after an initial home visit.

During the initial phone conversation with the mom, the patient navigation nurse assessed the boy's current asthma status in the "yellow zone" and encouraged the mom to take the boy to his primary care provider as is outlined in the boy's asthma management plan. The mom brought her son to the primary care provider who referred the family to the Emergency Department when the boy did not respond to treatment in the office.

The patient navigation nurse met the family in the ED and discussed the care plan and barriers. Mom stated the current primary care provider was too far from their new home and that the boy's Medicaid coverage had lapsed. Mom was provided assistance with reapplying for Medicaid and was given information about primary care providers close to her home. Mom selected a Grapevine Children's Health Pediatric Group provider for her son. She was given training on using the patient portal My Chart feature of the electronic medical record to have access to her son's medical information and to schedule appointments.

Since the initial engagement with the patient navigation program, the family has been able to keep all their son's appointments. The boy was referred to a pulmonologist for additional management of his asthma. The pulmonologist discussed the boy's obesity as contributing to his asthma. The primary care provider is now discussing nutrition and weight management with the family. The family is now re-engaged with the asthma management program.

Mom states she likes her son's new primary care doctor. Mom is now an active member of her son's care team and remains in contact with the disease management team, the care management team and patient-centered medical home team. She reports her son's asthma is now under control and he is doing well in school.

Without the Children's Health disease management, patient navigation and patient-centered medical home DSRIP projects, this boy's health needs could have remained in crisis management mode with only episodic care through the Emergency Department and hospitalizations.

Code Sepsis June 5, 2014-

A frontal assault on sepsis at JPS has cut the mortality rate in half, saved 38 people who otherwise would likely have died and reduced the length of stay for sepsis patients, saving nearly $1.2 million in three years.

A sepsis patient brought to JPS today is twice as likely to survive as in 2011, before the sepsis DSRIP project got under way with targeted federal healthcare-improvement funds. The sepsis mortality rate at JPS fell to 12.1 percent in 2013. Estimates for the national average range from 20-50 percent. Only one other hospital in the country has reported a sepsis mortality rate below 13 percent.

"It's like night and day," said Mark Oltermann, MD, the project's lead physician. "Now we are making truly data-driven decisions. It makes all the difference in the world."

"We're doing it right," said Lori Muhr, ACNS-BC, clinical coordinator of the sepsis DSRIP. "We have seen how early diagnosis and early treatment have improved the care of the cardiac and stroke patients. We are now being as proactive as possible when the sepsis patient arrives at our door."

Sepsis is the leading cause of death for hospitalized patients and is the tenth leading cause of death in the U.S.A single episode of sepsis during a person's lifetime cuts overall life expectancy by five years. Sepsis rivals heart attack and kills more people than breast cancer and AIDS combined, but gets little public attention. "There's no 'American sepsis society,' no telethon," said Muhr.

Sepsis is a complication of infection. The infection could be pneumonia, a kidney infection, an infected wound on the skin or anywhere else. As the immune system responds to the infection, chemicals are released that trigger inflammation in blood vessels, which then cannot deliver adequate blood supply to vital organs. Treating the original infection does not immediately eliminate the danger; as bacteria die, they release endotoxins that cause blood pressure to drop, leading to septic shock. Among pneumonia patients who do not survive, sepsis is often what killed them.

The sepsis project implemented national Surviving Sepsis Guidelines at JPS, established Code Sepsis in the Emergency Department and a medical team dedicated to rapid diagnosis and treatment. Code Sepsis is called when a patient exhibits signs of infection along with at least one sign of sepsis (low blood pressure, high serum lactate or evidence of organ dysfunction.) Within three hours of the patient's arrival, blood is drawn for culture and the patient receives a broad-spectrum antibiotic and IV fluid to support blood pressure. A second bundle of tests and treatment is required within six hours.

"We have seen a 7 percent increase in the number of Code Sepsis calls since the program started, and a 4 percent decrease in admissions to the ICU," said Muhr. "Turning around a sepsis patient in the ED has helped decrease ICU admissions and decrease length of stay, which in turn reduces medical costs and improves the outcome for sepsis patients."

In addition to Muhr and Oltermann, the sepsis team includes Donna Bryant, Meg Bryant, Chris Cook, Melissa Cook, Seham Cramer, Greg Fuhrmann, Rebecca Gomez, James Graves, Christy Johnson, Stephanie Maine, Trudy Sanders, Tonia Torregrossa, Jana Villanueva, Katie Watson, Hua Xin, Renee Yarbrough and physicians Stefan Buca, Chet Schrader, Brad Silver, Ryan Stroder and Daniel Ziegler. The project's executive champion is Aubrey Augustus, senior vice president. "Without a major commitment from administration, you couldn't make this happen," said Oltermann. "We have commitment to quality, all the way to the top."

JPS Health Network Community Health Focus

MedStar Patient Navigation 126675104.2.8
The JPS sponsored MedStar Patient Navigation program was featured at "EMS on the Hill Day" in Washington D.C. The purpose of the conference is to educate EMS providers on transformational programs and funding models to leverage the EMS infrastructure in innovative ways.

Care Connections for the Homeless patient impact story 126675104.2.10
Recognizing that homelessness presents a unique set of challenges to our patient population JPS has decided to use Community Health Workers(CHW) to help patients access care in the right setting. The first CHW hired for the Care Connections for the Homeless program knows homelessness firsthand. We were introduced while doing an pilot outreach to those who are unsheltered and living in camps. This member of the homeless community has now been employed with JPS for 5 months, has gotten an apartment and is giving back to the community they came from.

Patient Centered Medical Home impacts 126675104.2.2
JPS has seen multiple patients impacted by the addition of the Patient Navigator role in the PCMH model.

Possible admission avoidance: Asthmatic patient mentioned they were having symptoms and had been trying to get a refill. Christina and Mary (Patient Navigators) communicated with Dr. Hyder and his Nurse who then decided to prescribe a small dose of that medication to hold them over until their April 8th appointment. We recognized we may have avoided an admission by resolving this issue. Kudos to Dr. Hyder and his nurse for owning that situation and a special thanks to Christina and Mary for managing that issue up.

Informed Decisions: A call to a Diabetic patient who was overdue for both an A1C (ordered recently) and a Mammogram (ordered back in February) resulted in the patient agreeing to have those tests completed before their appointment with Dr. Fain on 4/8/2014. Christina (Patient Navigator) provided them with information on where and when they could have those services completed. Once these labs are completed, the physician might be able to make more informed decisions at the patient's upcoming appointment.

Transitions of care: Christina called a patient with multiple co-comorbidities, and overdue for at least 4 specialty referrals and multiple labs (all had been ordered previously). During the call, Christina discovered the patient's appointment with the PCP had been rescheduled without the patient's knowledge. This was resolved. Before disconnecting the call, Christina discovered that the patient "needed extra help" with getting connected to a nursing home. The patient referenced the name of a case manager. Christina closed the loop by sending an in-basket message to the

provider, the nurse and the case manager on the care team – requesting them follow-up with the patient. We all acknowledged that while this patient may be transitioning to another care setting, it is still important for her to receive care from her PCP in the interim to keep her out of the hospital, if possible.

Health Coach Graduation: 49 JPS team members - including case managers, social workers, dieticians and a clinical pharmacist - have completed a six-week training program provided by the Iowa Chronic Care Consortium (ICCC). Several took an optional certification test to become the first Health Coaches at JPS and currently, 14 are working in the health coach role at JPS. In April, 30 more team members are set to begin the next round of on-site training. "It's a big part of patient-centered care, involving the patient in their own care," said Sheila Poe, Community Health staff educator. "It will lead to increased patient satisfaction and our goal is also to decrease their emergency department and inpatient admissions." The approach comes from a philosophy that patients are the "greatest untapped resources" in taking responsibility for their own chronic health conditions. Health coaches work together with patients, asking open-ended questions and guiding the conversation to identify goals and strategies for success. It reflects a shift for healthcare providers from "teaching and telling" to "listening and engagement".

JPS Health Network Discharge Management Project 126675104.2.7

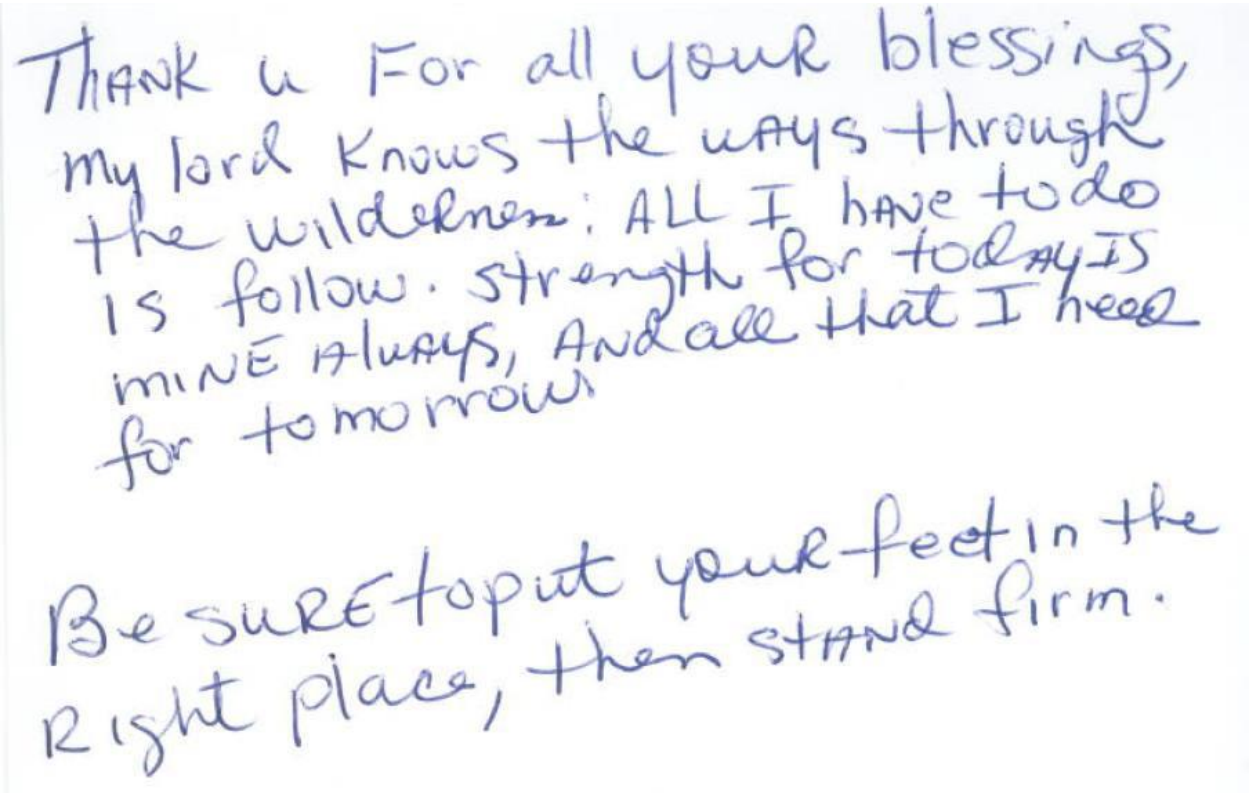
[Said patient] is a smart, easy going, funny, wonderful, and overall great [person]. Talk to [said patient] and you will find a normal 2X year old young that is ambitious, responsible, and comes from a happy and supportive family. It is hard to believe that between the months of September 2013 and January 2014 [said patient] had 3 Psychiatric Emergency Center admissions, 2 Trinity Springs Pavilion Admissions/Readmissions, a Long Term Commitment Alternative admission at Trinity Springs, and incarceration at Tarrant County Jail.

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

[Said patient] had to move in with [their] grandmother. She and [said patient] 's mother were at a standstill of what to do with [said patient] . The situation seemed hopeless. Because of the new Discharge Management program, [said patient] started receiving case management services from a transition coordinator. The transition coordinator was able to work with [said patient] and [their] 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. [Said patient] and [their] family learned about [their] 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 [said patient] is successful in [their] recovery. [Said patient] is now medically compliant with psychiatric services, adherent to medications, and practicing coping skills. [Said 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. [Said patient] has not been readmitted to Trinity Springs Pavilion since January 9, 2014. This was and will continue to be hard work for [said patient] , [their] family, community, and [their] support team, but [said patient] has the tools, education, and resources for [their] recovery. If that isn't enough, [said 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.

JPS Palliative Care Project 126675104.2.13



Dear Chaplain Hamilton,
I wanted to let you know that my brother, Timothy Young, left us on Thanksgiving morning. Your words during his final weeks brought much comfort to our family and I wanted to personally thank you for your humble servanthood. It will be a long holiday season but knowing he was able to make peace with his life and after death is irreplaceable. God has many plans for our lives and while I'm not sure what this one is meant to teach me, you helped restore my faith that Tim never forgot the teachings from our childhood.

Please keep in touch, UR blessing helped pulled him thru

Many God Send u many Blessings

God loves u, 4

so do I,

From: Doris mcLANE JACKSON CURVEY

To Blessed Saints
Who helped me
Eugene, JR

LOVE U ALL

THE PHP PROGRAM

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 the trash bin.

You guys don't realize how significant and important you are in our 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 through those 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'm 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!

MHMR of Tarrant County Regional Highlight

RN Care Management

MHMR of Tarrant County's (MHMR) RN Care Management initiative provides targeted nursing care coordination to individuals with intellectual and developmental disabilities (IDD) and co-occurring chronic disease(s). Registered Nurses (RN) provide the needed link to assist patients and caregivers with understanding and follow-through related to chronic disease management. Individuals with IDD have unique needs related to their behaviors and potential lack of understanding of the care needed for their chronic health conditions. The program utilizes the Wagner's Chronic Care Model to apply best practices for disease management, optimize the patient's ability to take care of their disease, while identifying and coordinating needed resources and support to individuals and their families. Through the model, health system improvements are focused on 6 primary aspects including: Effective team care, planned interactions, self-management support, community resources, integrated decision support and clinical information systems.

During the early phase of the initiative, the program conducted a data matching study identifying individuals with gaps in care and service utilization patterns of patients within the targeted population. Nine chronic diseases where identified most prevalent for the population including: Hypertension, Epilepsy, Cerebrovascular Accident, Cardiovascular Diseases, Diabetes, Asthma and Osteoarthritis. Care coordination protocols and disease management guidelines were developed by the clinical team to promote quality, safety and greater efficiency in providing care to individuals.

The inter-disciplinary team currently comprises of: 12 RN Care Managers, 2 Board Certified Behavior Analysts, a recreational therapist and nursing management staff working closely with the patient and other care providers to meet the patient's needs and goals.

As a core component of the program, MHMR developed a functional Chronic Disease Registry (CDR) for tracking patient information and clinical outcomes for the initiative. RN Care Managers utilize the CDR to access critical and current patient records to provide disease management support, and to identify and correct gaps in patient care.
Individuals without proper primary care management for their chronic disease(s) are provided clinical services and education using current evidence-based practices gained from the Lippincott Nursing Solutions. The program also effectively utilizes MHMR linkages and is progressively building community partnerships to provide interventions that fill gaps in needed services. In addition to providing intensive care coordination and patient education, the RN Care Managers are raising awareness with care providers in the community and improving the overall system of care.

By applying this intensive model of care management and using evidence based tools and practices, the program is demonstrating an improvement in communication and access while decreasing episodes resulting in individual hospitalization, disability and premature death.

Success Stories

The school based clinics implemented Wagner's Chronic Care model in the second quarter of 2014. As part of this program, community health workers were engaged to provide home visits to vulnerable patients with asthma. During these visits, the community health worker identified a family who was striving to provide the proper environment for their asthmatic child. It was noted that the family was cleaning the carpet by mopping instead of vacuuming. Upon further review, it was discovered that the family could not afford a vacuum cleaner. A vacuum was later purchased and presented to the family so they could properly care for their carpet. In addition, other asthma inducing triggers in the home were noted, such as mold and lack of ventilation. The provider furnished a letter to the landlord for repairs citing the home environment was negatively impacting the child's health.

In another case, the program nurse practitioner, clinical pharmacist and school nurse collaborated together to develop a medication management system for a child with severe, uncontrolled asthma. The patient had frequent emergency room visits due to lack of self- management skills and parental asthma education. Due to the child's living situation, medications were not available to each caregiver. In order to properly manage the patient's condition, it was necessary to disburse medication among the three households and the school. The school nurse became the primary source of medication administration during the school week and the remaining households were responsible for medication administration during their visitation weekends. To date, the child has not experienced any further asthma exacerbations requiring emergency care.

Another success story involves a child with uncontrolled asthma whose mother was unable to pay for prescription. The parent had recently lost her job and did not have resources to pay for the medication. A social worker arranged for the patient to receive asthma medication at no cost until the parent could resume financial responsibility for the medication. In addition to providing assistance with medication, a home visit was completed by a community health worker. During the home assessment, the community health worker noted a severe insect infestation. This was reported to the program nurse practitioner who subsequently wrote a letter to the landlord addressing the issue.

BAYLOR
All Saints Medical Center
at Fort Worth

Baylor All Saints Behavioral Health Project 135036506.2.1

I am the Licensed Clinical Social Worker at Baylor Community Care at Fort Worth. Since the Behavioral Health program launched, I have screened over 140 patients for depression or anxiety. 24 patients of those patients have enrolled in the Behavioral Health program, but more important for this clinic is the number of high acuity patients that disclose their suicidal ideation to me during the assessment process, and the crisis intervention that is able to take place.

I would like to share one such success story with you, and how this program can give you a glimpse of how the social worker is able to assess, educate and provide key intervention and resources that can help improve and even save these patients' lives at such a critical time. This patient is a XX year old X X who lives in the Region 10 area, and has two young grade-school children; [their] medical issues include headache and gastro esophageal reflux. When I initially assessed [them] in mid-November, 20XX, [their] PHQ score was 21 and [they] were having suicidal thoughts in the previous two weeks. Not only did I provide educational resources to [the patient] about depression, but most importantly, I did crisis intervention with [them] and provided all the vital crisis emergency resources needed in the event [they] had any more suicidal thoughts, and I established a safety plan.

[The patient] started counseling in the Behavioral Health program, and received counseling services every two weeks in the program, where [they] discussed [their] goals and activities; and in between counseling sessions [they] worked on and accomplished those goals and activities. This patient also discussed the option of starting a low dose anti-depressant medication, with [their] physician, and the patient decided to pursue this option for a period of four months. On 12/XX/1X, six weeks after starting the Behavioral Health program, patient's PHQ score had decreased from a 21 to a 6. [They] continued counseling, because [they] felt it really helped [them] to work on [their] goals and activities, and it has helped improve [their] self-esteem, emotional well-being, and physical well-being. [The patient] feels better overall, and has now weaned off the anti-depressant medication (after discussing this with [their] physician). At [their] last counseling appointment, the patient's PHQ score was a 3 on 2/XX/1X, and is now in the maintenance phase of counseling, where [they] does not need to come in for counseling as often and can contact me when [they] feel the "warning signs" of anxiety or depression coming on.

Thank you for giving us the opportunity to help improve these patients' lives!

Texas Health Resources – Hurst- Euless- Bedford 136326908.2.2

Your actions have been recognized as a…

Safety Catch!

Congratulations **Donna Ingram, RN** for this exceptional example of living and promoting our Promise behaviors making you truly deserving of Applause! Thanks for going above and beyond.

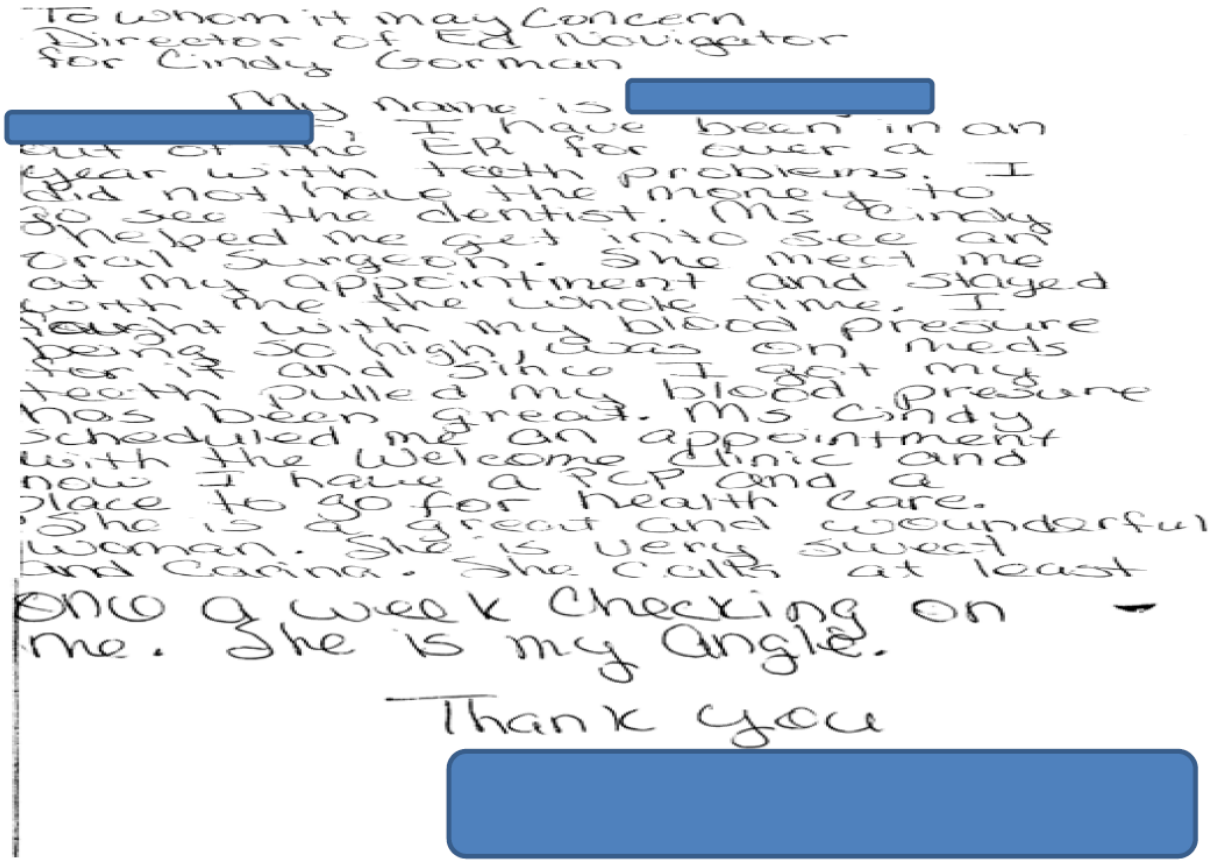
"During a telephone follow-up call Donna found out the patient had only been taking her diuretic once a day instead of twice a day as ordered by the physician. The patient had gained 6 pounds since discharge from the hospital and was becoming short of breath. Donna educated the patient and informed the physician, the home health nurse, and the Nurse Practitioner who was also seeing the patient, avoiding a readmission."

Texas Health Harris Methodist Hospital HURST-EULESS-BEDFORD

Your name will also be entered into a quarterly drawing for a prize worth $50.00!

Texas Health Resources – Hurst- Euless- Bedford ED Navigation Project

136326908.2.4



To whom it may Concern
Director of ED Navigator
for Cindy Gorman

My name is [redacted] I have been in an out of the ER for over a year with teeth problems. I did not have the money to go see the dentist. Ms Cindy helped me get into see an Oral Surgeon. She met me at my appointment and stayed with me the whole time. I [redacted] with my blood pressure being so high I was on meds for it and since I got my teeth pulled my blood pressure has been great. Ms Cindy scheduled me an appointment with the Welcome Clinic and now I have a PCP and a place to go for health care. She is a great and wounderful woman. She is very sweet and caring. She calls at least one a week checking on me. She is my Angle.

Thank you

[redacted]

JPS Day Psyc Rehab

Wow! I could not thank the staff of this fantastic program enough. I had just graduated from the JPS PHP a great experience also but was sad it was over. They told me about this new program and I started right away. Having been homeless for years and suffering anxiety and depresion I was soon at ease for the first time in quite a while. [redacted] talked to me the first day and told me to Like/Love myself, taught me to in a short period of time- it has worked. From the first day I knew this was where I needed to be actually wanted to be, and would still like to spend my days if this team of professional caring knowledgeable people had not done their jobs so well and things started to get

better. By learning to set daily goals and completi
them I began to make progress, all my concerns abo
medication, physical and mental health were discussed a
questions were answered. I was able to talk freely
and openley for the first time in my life an
was comfortable doing so. Plans for relapse preventio
were put in place. I was asked what my goal for
the program was and I said employment not
really thinking it possible. I am starting a new job
tomorrow. They went well beyond my expectations
everyday. When I went to jail on an old
warrent the called to check on me. Any problem

I had ath the shelter I stay at they comunicated with them and got results I caldnot get. I wald hot have been abtke to write this letter a month ago let alone finish it in any amaint of time. All aspects of my job search from resume to sending it out, interview skills and practice interviews weredone. Interview clothes were provided for me. When I missed the train they made sure I was there on time Workboots? no problem they fand me just what I needed. One month ago I wald not have thaght what I have acomplished was possible. My symptams are well under contrd. I understand my condition much betler than when I started. I am starting a job I never thaght I would get. Withat a doubt the best manth I have ever spent.

Thank you so much [redacted]

I will miss you all for sure and never forget what you have done for me.

[redacted]