



# TARRANT COUNTY HOSPITAL DISTRICT/JPS HEALTH NETWORK **2017 IMPLEMENTATION PLAN**

May 4, 2017



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*Advancing Public Health and Medical Research*

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# Introduction

## Overview of JPS Health Network

JPS Health Network is the County's public hospital system that provides medical services to Tarrant County residents, including underserved residents. The network includes John Peter Smith Hospital, a 573-bed acute care hospital in Fort Worth; home to the county's only Level I Trauma Center and only Psychiatric Emergency Center. JPS also operates more than 40 outpatient clinics and 20 school-based health centers across Tarrant County, providing 1.7 million patient encounters annually, including more than 120,000 emergency room visits.

## Implementation Plan

JPS Health Network partnered with Health Resources in Action (HRiA), a non-profit public health organization, to conduct its 2017 Implementation Plan. This plan builds on the 2017 CHNA to further advance JPS Health Network's community efforts and priority topic areas. This report describes the process and findings from this effort to achieve the following goals:

- Develop a 3-year plan for JPS to address the priority health issues identified by the CHNA process
- Describe a rationale for any priority health issues JPS does not plan to address
- Describe current JPS Health Network and Community assets and programming opportunities in the areas identified
- Identify a strategic direction and metrics for each priority area, taking into account existing assets and resources

## Methodology

The CHNA and Implementation Plan development took approximately five months to complete and included the input of a 30-member Advisory Committee that included local health department representation. The Advisory Committee participated in a kick-off meeting and strategic discussions to inform the priorities of the Implementation Plan. A steering committee of JPS staff was engaged in bi-weekly conference calls and e-mails throughout assessment planning and implementation phases.

HRiA facilitated several discussions with the Advisory Committee. HRiA presented the assessment findings and facilitated a discussion on areas of need that could be priorities, and how the findings aligned with current and potential initiatives. Following that HRiA facilitated a discussion to review highlights from the CHNA data, map current programs and initiatives to identified priority areas and brainstorm gaps, needs and possible programs that could be incorporated into the Implementation Plan. Feedback and ideas from this session were gathered and incorporated into the plan templates.

The outcomes of these meetings along with input from JPS senior management resulted in the development of the plan outlined in this document. The 2017-2020 Implementation Plan is meant to be a working document that can be updated, reviewed and modified as needed. A comprehensive plan examines these multiple factors of health that can identify community-wide health issues and facilitate data-informed strategies in programming and partnerships. All priority community needs identified in the CHNA are addressed in the Implementation Plan. There are sub issues not mentioned specifically in the Implementation Plan, that are being addressed through current Delivery System Reform Incentive Payment (DSRIP) programs, which are presently actively engaged in multiple focus areas throughout Tarrant county. Please see the appendices for a summary of DSRIP programs in which JPS is the leader or a partner in administering.

While the CHNA provided an overview of leading health conditions in Tarrant County, the Implementation Plan seeks to analyze that data, consider selection criteria for planning and execute a plan for implementation. As a

foundation to the selection of priority areas for planning, we considered the leading indicators of health, as well as the leading causes of mortality in Tarrant County.

### Social Determinants of Health

It is important to recognize that multiple factors affect health and that there is a dynamic relationship between people and their environments. Where and how we live, work, play, and learn are interconnected factors that are critical to consider. That is, not only do people’s genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing. The social determinants of health framework addresses the distribution of wellness and illness among a population—its patterns, origins, and implications. While the data to which we have access are often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. Building on this framework, this assessment utilizes data to discuss who is healthiest and least healthy in the community as well as to examine the larger social and economic factors associated with good and ill health.

### Leading Causes of Mortality

From 2013 through 2015, the two leading causes of death in Tarrant County were heart disease and cancer (all-sites) (Table 1). At a rate of 46.2 deaths per 100,000 population, cerebrovascular disease became the third leading cause of death in 2015, surpassing chronic lower respiratory disease. In 2014, Alzheimer’s became the fifth leading cause of death in Tarrant County (31.3 deaths per 100,000 population) with a continued upward trend in 2015 (41.2 deaths per 100,000 population), though notably responsible for substantially fewer numbers of deaths than heart disease or cancer in those same years. These patterns were consistent with statewide data each year (data not shown).

**Table 1. Top Five Leading Causes of Mortality, Age-adjusted Rates per 100,000 Population, Tarrant County, 2013-2015**

Rank	2013	2014	2015
1	Heart disease 162.3	Heart disease 158.6	Heart disease 157.6
2	Cancer 155.5	Cancer 156.1	Cancer 148.9
3	Chronic lower respiratory diseases 45.3	Chronic lower respiratory diseases 45.7	Cerebrovascular diseases 46.2
4	Cerebrovascular diseases 40.6	Cerebrovascular diseases 45.6	Chronic lower respiratory diseases 44.6
5	Accidents 29.1	Alzheimer's disease 31.3	Alzheimer's disease 41.2

DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2013-2015

## Selection Criteria

While all of the current and emerging health issues reflected in the CHNA data are important and relevant to the Tarrant County community, the purpose of planning is to narrow our focus in areas where we can show demonstrable impact to improve community health outcomes. One tool that we use to narrow this focus is the selection criteria in table 2 below. This tool was used to help us identify the areas where we have support and can leverage our resources.

**Table 2. Selection Criteria for Planning**

<b>RELEVANCE</b> <i>How Important Is It?</i>	<b>APPROPRIATENESS</b> <i>Should We Do It?</i>	<b>IMPACT</b> <i>What will We Get Out of It?</i>	<b>FEASIBILITY</b> <i>Can We do It?</i>
<ul style="list-style-type: none"> <li>- Burden (magnitude and severity; economic cost; urgency) of the problem</li> <li>- Community concern</li> <li>- Focus on equity and accessibility</li> </ul>	<ul style="list-style-type: none"> <li>- Ethical and moral issues</li> <li>- Human rights issues</li> <li>- Legal aspects</li> <li>- Political and social acceptability</li> <li>- Public attitudes and values</li> </ul>	<ul style="list-style-type: none"> <li>- Effectiveness</li> <li>- Coverage</li> <li>- Builds on or enhances current work</li> <li>- Can move the needle and demonstrate measurable outcomes</li> <li>- Proven strategies to address multiple wins</li> </ul>	<ul style="list-style-type: none"> <li>- Community capacity</li> <li>- Technical capacity</li> <li>- Economic capacity</li> <li>- Political capacity/will</li> <li>- Socio-cultural aspects</li> <li>- Ethical aspects</li> <li>- Can identify easy short-term wins</li> </ul>

In addition to the selection criteria above, the proposed 1115 Medicaid Waiver DSRIP payment bundles were also considered as a potential source of funding and program development. Figure 1 below displays the proposed DSRIP payment bundles as of March 2017. The categories highlighted are aligned with the needs identified.

**Figure 1. DSRIP Program Alignment**



## Key Findings and Key Recommendations

The following table reflects the priority areas of need and the needs identified by the Advisory Committee, JPS leadership and external stakeholders. When developing the opportunities to address the identified needs, resource management and the ability to develop partnerships and collaborations were discussed and considered.

Area of Need	Identified Needs
<b>Health Conditions/Service Lines</b>	<ul style="list-style-type: none"> <li>• Diabetes &amp; Obesity: Prevention and Management</li> <li>• Heart Disease &amp; Stroke: Prevention and Management</li> <li>• Cancer: Education &amp; Screening</li> <li>• Behavioral Health</li> <li>• Maternal &amp; Child Health</li> <li>• Aging Adults</li> </ul>
<b>Information and Coordination</b>	<ul style="list-style-type: none"> <li>• Access to Health Care</li> <li>• Navigation of Health Care System</li> <li>• Lack of Awareness of Services</li> <li>• Care Coordination</li> </ul>
<b>Social Determinants of Health</b>	<ul style="list-style-type: none"> <li>• Poverty</li> <li>• Access to Healthy Food</li> <li>• Housing</li> <li>• Transportation</li> </ul>

The tables on the following pages represent the Areas of Need and the specific needs identified in each area. Each table includes:

- statement of need/data
- assets; both internal to JPS and community,
- programming; current initiatives as well as opportunities, and
- objectives; including strategic direction and metrics.

The full Community Health Needs Assessment (CHNA) can be found at: [insert link]

\* Asterisks indicate current community partners.

## Diabetes & Obesity: Prevention and Management

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>Diabetes and Obesity were priority needs in the 2013 CHNA and were again identified as top needs in the 2016 CHNA. Resources and investments were made to address Diabetes. The self-reported rate of Diabetes in Tarrant County has been trending down over the past three years (2013-2015), from 12.4% to 9.6%. Obesity was not addressed in the 2013 implementation strategy. The self-reported rate of Obesity in Tarrant County has been steady over the past three years (2013-2015), averaging around 64% of the population.</p> <p><b>Challenges</b> to address this identified need include: 1) lack of healthy foods and other social determinants, 2) lack of community dietitians, 3) obese population, and 4) delayed preventative care.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Community Health/Ambulatory Clinics</li> <li>• Acclaim Physician Group</li> <li>• Community Outreach</li> <li>• Inpatient Staff</li> <li>• Nutritional Services</li> <li>• Care Management Services</li> <li>• IT/EPIC Team</li> <li>• Office of Clinical Research</li> <li>• Center for Outcomes Research</li> </ul> <p>DSRIP Funds</p>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• Tarrant County Public Health*</li> <li>• Meals on Wheels of Tarrant County</li> <li>• YMCA Fort Worth</li> <li>• Weight Watchers</li> <li>• Tarrant Area Food Bank</li> <li>• Diabetes Collaboration of Tarrant County*</li> <li>• TCU Nutritional Sciences*</li> <li>• Texas Women’s University Nutrition and Food Sciences*</li> <li>• Abilene Christian University Department of Kinesiology &amp; Nutrition</li> </ul>
Programming	
Current JPS Programming	Opportunities
<ul style="list-style-type: none"> <li>• Joslin Diabetes Center engagement to assess inpatient and outpatient clinical care</li> <li>• Education classes for Diabetes, Hypertension, Asthma/COPD, and CHF</li> <li>• Support of <a href="#">Healthy Tarrant County Collaboration</a> to increase fresh produce availability through Healthy Corner Store Initiative</li> <li>• Collaboration with Trolley Pride to provide FARMacy prescription (vouchers) to purchase fresh produce</li> <li>• Developing clinical research program to allow patients to enroll in intervention studies for diabetes care</li> <li>• Developing agenda for research on modifiable factors associated with poor outcomes among diabetics</li> </ul>	<ul style="list-style-type: none"> <li>• Grow successful current diabetes initiatives</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for Diabetes</li> <li>• Implement long term Joslin Diabetes Center engagement to improve inpatient and outpatient clinical care</li> <li>• Achieve Accreditation of Diabetes Education Program</li> </ul> <p>New Obesity partnerships:</p> <ul style="list-style-type: none"> <li>• Explore opportunity to develop partnership with YMCA Diabetes Prevention Program</li> <li>• Explore opportunity to develop partnership with Weight Watchers Meeting program</li> <li>• Leverage Tarrant Area Food Bank Cooking Matters Classes</li> <li>• Leverage Tarrant Area Food Bank mobile pantry</li> <li>• Leverage community dietitians</li> <li>• Expand Dietitian Clinical Rotation programs</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Grow diabetes initiatives and strategies</li> <li>• Develop and formalize partnership to address Obesity</li> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> </ul>	<ul style="list-style-type: none"> <li>• Continue downward trend in prevalence of Diabetes in Tarrant County</li> <li>• Decrease diabetes related health indicators in Tarrant County</li> <li>• Decrease the prevalence of Obesity in Tarrant County</li> </ul>



## Heart Disease & Stroke: Prevention and Management

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>Heart Disease and Hypertension were top needs in the 2013 CHNA and were again identified as top needs in the 2016 CHNA. Resources and investments were made to address Congestive Heart Failure (CHF). Heart Disease mortality has been steadily decreasing over the past three years (2013-2015), from 162.3 to 157.6 per 100,000 population. Cerebrovascular Disease mortality has been increasing over the past three years (2013-2015), from 40.6 to 46.2 per 100,000 population.</p> <p><b>Challenges</b> to address this identified need include: 1) lack of healthy foods and other social determinants, 2) prevalence of diabetes, obesity and hypertension, and 3) delayed preventative care.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Cardiovascular and Stroke Teams</li> <li>• Community Health/Ambulatory Clinics</li> <li>• Community Outreach</li> </ul> <p>DSRIP Funds</p> <p>Accreditation and Designations</p> <ul style="list-style-type: none"> <li>• Joint Commission AMI Certification</li> <li>• Joint Commission Comprehensive Stroke Center</li> <li>• Intersocietal Accreditation Commission</li> </ul> <p>Accreditations: Ultrasound and Nuclear Imaging</p> <p>Participation in National Benchmark Registries</p>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• Tarrant County Public Health</li> <li>• American Heart Association</li> <li>• American Stroke Association</li> <li>• Meals on Wheels of Tarrant County</li> <li>• North Central Texas Trauma Regional Advisory Council – Cardiac and Stroke Committee*</li> <li>• Emergency Physicians Advisory Board – Acute Outcomes Collaborative*</li> </ul>
Programming	
Current Programming	Opportunities
<ul style="list-style-type: none"> <li>• Cardiology and CHF Clinics</li> <li>• Clinical Care Services (i.e. Device Clinic; Cardiac Non-Invasive Testing; Invasive Procedures; Electrophysiology Procedures; Open Heart Surgery; Neurointerventional Program)</li> <li>• Coordinated CHF Program</li> <li>• Community Outreach <ul style="list-style-type: none"> <li>• North Central Texas Trauma Regional Advisory Council – Cardiac and Stroke Committee</li> <li>• Emergency Physicians Advisory Board – Acute Outcomes Collaborative</li> <li>• Community Events – Empowering Seniors; Senior Synergy; Feast of Sharing and speakers bureau requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Maintain current Cardiovascular initiatives</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for Heart Disease</li> <li>• Support Diabetes &amp; Obesity prevention initiatives</li> <li>• Home monitoring for CHF and device patients</li> <li>• Cardiac Rehab program</li> <li>• Explore addition of niche invasive procedures</li> <li>• Explore collaborative Research opportunities</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Implementation of Cardiac Rehab program</li> <li>• Implementation of Transcranial Doppler Testing</li> <li>• Implementation of bioresorbable stents</li> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> </ul>	<ul style="list-style-type: none"> <li>• Continue downward trend in prevalence of Heart Disease mortality in Tarrant County</li> <li>• Decrease the prevalence of Cerebrovascular Disease mortality in Tarrant County</li> </ul>

## Aging Adults

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>The growth of the aging adult population was a top need in the 2013 CHNA and was again identified as a top need in the 2016 CHNA. Resources and investments were made addressing this growing population. The geriatric population (those 65 and older) has increased by 13.8% in Tarrant County since 2006. This population faces many health challenges and is cross cutting to the other 2016 identified needs. Social Determinants of Health needs impacting the aging population are poverty, housing and transportation. Behavioral Health needs are social isolation, Alzheimer's, and Geriatric Psychiatric issues. As well as health care access needs.</p> <p><b>Challenges</b> to address this identified need include: 1) lack of healthy foods and other social determinants, 2) lack of geriatric specialized and/or certified providers, 3) prevalence of co-morbidities, 4) increased need for care coordination, and 5) lack of geriatric friendly facilities.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Geriatric Service Line</li> <li>• Magnolia Health Center</li> <li>• Acclaim Physician Group</li> <li>• Academic Affairs</li> <li>• Inpatient Services</li> <li>• Community Outreach</li> </ul> <p>Accreditation and Designations</p> <ul style="list-style-type: none"> <li>• NICHE designation</li> </ul>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• United Way Tarrant County*</li> <li>• Area Agency on Aging</li> <li>• Aging and Disability Resource Center</li> <li>• Meals on Wheels of Tarrant County</li> <li>• Tarrant County Public Health*</li> <li>• Sixty and Better*</li> <li>• Alzheimer's Association</li> </ul>
Programming	
Current Programming	Opportunities
<p>Inpatient:</p> <ul style="list-style-type: none"> <li>• Mobile Acute Care for the Elderly (MACE)</li> <li>• Hospital Elder Life Program (HELP)</li> <li>• Delirium Inpatient protocol</li> <li>• Geriatric Trauma (GT 55)</li> </ul> <p>Outpatient:</p> <ul style="list-style-type: none"> <li>• Magnolia Health Center</li> </ul> <p>Community Based:</p> <ul style="list-style-type: none"> <li>• GME Program</li> <li>• Provider Home Visits</li> <li>• Care Transitions - Skilled Nursing Facility Partnership (10 SNFs)</li> <li>• A Matter of Balance</li> <li>• WeHail HRSA Grant</li> <li>• Community Outreach</li> </ul>	<ul style="list-style-type: none"> <li>• Expand successful Aging Adult initiatives</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for innovative approaches to serve the Aging Adult population</li> <li>• Develop full wrap around services for aging adults</li> <li>• Expand Geriatric provider network</li> <li>• Expand provider home visit program</li> <li>• Explore Programs of All-inclusive Care for the Elderly (PACE) - letter of intent submitted to State</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> <li>• Enhance the development of the Geriatric Service Line to increase access to health services for growing geriatric population</li> <li>• Geriatric Friendly Emergency Department</li> </ul>	<ul style="list-style-type: none"> <li>• Achieve Joint Commission Delirium Certification</li> <li>• Increase geriatric providers in Tarrant County</li> <li>• Increase percentage of aging adults accessing primary care regularly</li> <li>• Increase annual medical wellness appointments</li> <li>• Decrease Emergency Department visits for Ambulatory Care Sensitive Conditions</li> </ul>

## Cancer: Education and Screening

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>Cancer was a top need in the 2013 CHNA and was again identified as a top need in the 2016 CHNA. Resources and investments were made addressing breast, cervical and colorectal screening. Cancer mortality rate in Tarrant County has been trending downward over the past four years (2010-2013), 171.4 to 156.4 per 100,000 population. The rates of screening for cervical, prostate, and colorectal cancer in Tarrant County are greater than the state. Screening for breast cancer is on par with the state.</p> <p><b>Challenges</b> to address this identified need include: 1) cultural barriers to cancer screening, 2) delayed preventative care, and 3) wait times for treatment.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>Center for Cancer Care</li> <li>Community Health/Ambulatory Clinics</li> <li>Community Outreach</li> <li>Office of Clinical Research</li> <li>Center for Outcomes Research</li> </ul> <p>DSRIP Funds</p> <p>Accreditation and Designations</p> <ul style="list-style-type: none"> <li>American College of Surgeons Commission on Cancer</li> <li>American Society of Clinical Oncologist partnership</li> </ul>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>Moncrief Cancer Institute*</li> <li>American Cancer Society*</li> <li>Center for Cancer and Blood Disorders*</li> <li>Cancer Care Services*</li> <li>Healthy Lives Matters, Tarrant County Precinct 1*</li> <li>Tarrant County Public Health*</li> </ul>
Programming	
Current Programming	Opportunities
<ul style="list-style-type: none"> <li>CPRIT grant partnership with Moncrief Cancer Institute (CSPAN, XSPAN)</li> <li>Partnership with Moncrief Cancer Institute to offer mobile mammography at JPS clinics</li> <li>Annual Community Prostate Cancer screening event</li> <li>JPS Community Health – Physician Approved Order for FOBT and FOBT packs distributed</li> <li>Partnership with American Cancer Society</li> <li>Participate at broad community events, Senior Synergy and Feast of Sharing</li> <li>Participate at Speaking Engagements</li> <li>Developing clinical research program to allow patients to enroll in cancer therapy trials</li> <li>Multi-institutional working group assessing modifiable factors associated with poor outcomes among cancer patients</li> </ul>	<ul style="list-style-type: none"> <li>Maintain successful current Cancer initiatives</li> <li>Identify and understand impact of DSRIP Bundle Metrics for Cancer Screening</li> <li>Explore and implement Prostate cancer risk assessment</li> <li>Explore options for new infrastructure for the Center for Cancer Care</li> <li>Explore opportunities to partner with American Cancer Society, Tarrant County Public Health and JPS School Based Health Centers to provide cancer prevention education</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>New and expanded facilities</li> <li>Explore potential and additional partnerships to expand services in the community</li> <li>Adoption of relevant DSRIP metrics to fund potential new programs</li> </ul>	<ul style="list-style-type: none"> <li>Increase the prevalence of timely screening</li> <li>Reduce time from screening to diagnosis and treatment</li> <li>Decrease the amount of patients seeking treatments at later stages</li> </ul>

## Behavioral Health

Need/Data	
<b>Statement of Need</b>	
<p>Behavioral Health was a top need in the 2013 CHNA and was again identified as a top need in the 2016 CHNA. Resources and investments were made addressing behavioral health. The rate of Adults reporting Depressive Disorder Diagnosis is steadily increasing over the past three years (2013-2015), 17.3% to 18.4%. Substance Abuse disorders are also becoming more prevalent. From 2013 to 2015, monthly alcohol consumption increased from 44.9% to 59.3% across Tarrant County; in contrast, self-reported alcohol consumption statewide remained relatively stable between 48.0% and 49.7%.</p> <p><b>Challenges</b> to address this identified need include: 1) stigma associated with mental health issues, and 2) local and regional capacity.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Behavioral Health Emergency</li> <li>• Behavioral Health Inpatient</li> <li>• Behavioral Health Ambulatory</li> <li>• Behavioral Health Social Services</li> <li>• Peer Support Services</li> <li>• Acclaim Physician Group</li> <li>• JPS Pharmacy</li> <li>• IT/ EPIC</li> <li>• Nutritional Services</li> <li>• Employee Assistance Program (EAP)</li> <li>• Human Resources</li> <li>• Center for Outcomes Research</li> </ul> <p>DSRIP Funds Grant Funds/Foundation support</p>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• MHMR*</li> <li>• Challenge of Tarrant County*</li> <li>• DFWHC Foundation Community Health Collaborative</li> <li>• Millwood Hospital</li> <li>• Sundance Hospital</li> <li>• Mesa Springs Hospital</li> <li>• Wellbridge Hospital</li> <li>• Mental Health America of Greater Tarrant County*</li> <li>• International Behavioral Health Institute (IBHI)*</li> <li>• Mental Health Connection</li> <li>• Tarrant County Police Departments</li> <li>• School Districts</li> <li>• Tarrant County Mental Health/Probate Court</li> <li>• NAMI</li> <li>• HHS Center for Elimination of Disproportionality and Disparities</li> <li>• Jordan Elizabeth Harris Foundation</li> </ul>
Programming	
Current Programming	Opportunities
<ul style="list-style-type: none"> <li>• Psychiatric Emergency Evaluation and Services</li> <li>• Inpatient Psychiatric Services</li> <li>• Psychiatric Consult Liaison</li> <li>• Integrated Behavioral Health Into Primary Care</li> <li>• Psychiatric Care Transitions</li> <li>• Virtual Psychiatric and Clinical Guidance</li> <li>• Partial Hospitalization / Intensive Outpatient Programs</li> <li>• Psychiatric Day Rehab</li> <li>• Behavioral Health School Based Clinics</li> <li>• Behavioral Health Ambulatory Clinics (Medication Management, Intake, Therapy, Psychological Testing)</li> <li>• Research Initiative</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain successful current Behavioral Health initiatives</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for Integrate Behavioral Health into Primary Care and Behavioral Health Appropriate Utilization</li> <li>• Increase capacity in inpatient and outpatient behavioral health settings</li> <li>• Develop Outpatient Behavioral Health Care Management and integrate into virtual behavioral health strategy</li> <li>• Expand Peer Support Services</li> <li>• Explore community based strategies and partnerships to address substance abuse</li> <li>• Explore opportunity to divert behavioral health patients from jail</li> <li>• Explore opportunity to address supportive employment</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Adoption of relevant DSRIP metrics required to meet objectives</li> <li>• CMS required reporting metrics</li> </ul>	<ul style="list-style-type: none"> <li>• Continue downward trend in readmission rates</li> <li>• Maintain community suicide rates below national and state levels</li> <li>• Reduce waiting list for Substance Abuse services</li> </ul>

## Maternal and Child Health

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>Infant Mortality due to low birthweight and lack of early prenatal care was a top need in the 2013 CHNA and was again identified as a top need in the 2016 CHNA. Resources and investments were made addressing infant mortality. The rate of infant mortality in Tarrant County has been steady over the past five years (2010-2014), 7.5 to 7.2 per 1,000 live births. However, Black women continue to have a higher rate of infant mortality, at 13.6 per 1,000 live births. 14% of Black infants are born at a low birth weight and 15.4% of Black infants are born premature.</p> <p><b>Challenges</b> to address this identified need include: 1) reaching at risk women before pregnancy, 2) social determinants of health, 3) environmental factors, 4) prevalence of diabetes, obesity and hypertension, 5) prevalence of STIs and 6) lack of funded coordinated effort.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Women’s Services</li> <li>• School Based Health Centers</li> <li>• Community Health/Ambulatory Clinics</li> <li>• Community Outreach</li> <li>• Center for Outcomes Research</li> </ul> <p>DSRIP Funds</p> <p>Accreditation and Designations:</p> <ul style="list-style-type: none"> <li>• Mother Friendly Worksite</li> <li>• Distinguished Infant Hearing program</li> <li>• ILCA Care Awards for Inpatient &amp; Outpatient Lactation Services</li> <li>• Certified Centering Institute Program</li> <li>• Texas HHS Texas Ten Step Member</li> </ul>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• Tarrant County Public Health*</li> <li>• Infant Health Network*</li> <li>• March of Dimes*</li> <li>• HealthyStart*</li> <li>• Independent School Districts</li> <li>• Girls, Inc.</li> <li>• Boys and Girls Club</li> <li>• Faith Based Communities</li> <li>• YMCA</li> <li>• Healthy Moms – Healthy Babies – Healthy Community (H3)*</li> <li>• MHMR</li> </ul>
Programming	
Current Programming	Opportunities
<ul style="list-style-type: none"> <li>• CenteringPregnancy</li> <li>• Breastfeeding Inpatient and Outpatient Services</li> <li>• Preconception/Interconception Health</li> <li>• Prenatal Education at Tarrant County Jail</li> <li>• Breast Milk Pumping Program at Tarrant County Jail</li> <li>• One Key Question</li> <li>• Healthy Texas Women Grant</li> <li>• Family Planning Grant</li> <li>• Mom &amp; Baby Specialized Services</li> <li>• Community Collaborations/Partnerships</li> <li>• Multi-institutional working group assessing modifiable factors associated with poor pregnancy outcomes (e.g. mortality, preterm, birth, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain successful current Maternal and Child Health</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for Maternal Perinatal</li> <li>• Explore opportunity to serve homeless women at True Worth Clinic</li> <li>• Increase access to care through grants</li> <li>• Leverage School Based Health Centers and adolescent health, upstream preconception</li> <li>• Identify and establish a funded collaborative structure for Tarrant County</li> <li>• Explore opportunities to develop Faith based outreach strategy</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Increase target population in programs</li> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease the overall Infant Mortality Rate for Tarrant County</li> <li>• Decrease the Infant Mortality Rate for Black women of Tarrant County</li> </ul>

## Information & Coordination

Need/Data	
<p align="center"><b>Statement of Need</b></p> <p>Care Coordination was a top need in the 2013 CHNA and again identified as a top need in the 2016 CHNA. Community members face several challenges in coordinating care, from accessing the health care system, navigating the health care system, and lack of awareness of the services available in healthcare and social services. In Tarrant County, 19.3% have no health insurance coverage, 28.1% of adults have no personal doctor or health care provider and 34.5% of adults have not had a routine check-up in the past year.</p> <p><b>Challenges</b> to address this identified need include: 1) cultural barriers to care, 2) low health literacy, 3) linguistic and social isolation, 4) transportation, 5) funding for awareness campaigns and staffing, 6) access to primary care and clinic capacity and 7) lack of providers.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Care Management Services/Social Workers</li> <li>• Community Health/Ambulatory Clinics</li> <li>• Acclaim Physician Group</li> <li>• Women’s Services</li> <li>• Behavioral Health</li> <li>• Emergency Department</li> <li>• Community Outreach</li> <li>• Human Resources</li> </ul> <p>DSRIP Funds</p>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• Tarrant County Public Health*</li> <li>• UNT Health Science Center</li> <li>• DFW Community Health Worker Coalition</li> <li>• Tarrant Literacy Coalition</li> <li>• HOPE Literacy, Inc.</li> <li>• Mental Health Connection                             <ul style="list-style-type: none"> <li>• Tarrant Cares website</li> </ul> </li> <li>• United Way 2-1-1</li> </ul>
Programming	
Current Programming	Opportunities
<ul style="list-style-type: none"> <li>• Patient Education</li> <li>• 24/7 Call Center</li> <li>• Patient Centered Medical Homes</li> <li>• Care Transitions</li> <li>• MedStar Patient Navigation</li> <li>• Community Connect (partnership with 3 charitable clinics)</li> <li>• Behavioral Health Navigators</li> <li>• LACE index – Risk for readmission patient stratification</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate current Care Coordination initiatives, improve promising initiatives and maintain successful initiatives</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for Care Transitions and Primary Care</li> <li>• Build strong JPS care management infrastructure and process, including warm handoff from inpatient to outpatient care</li> <li>• Explore opportunities to increase community based Certified Community Health Workers through partnership opportunities with Tarrant County Public Health and UNT Health Science Center.</li> <li>• Explore AMR Patient Navigation Program</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> <li>• Leverage Acclaim Physician Group to strengthen and improve access to patients</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the number of certified Community Health Workers in Tarrant County</li> <li>• Improved coordinated services for vulnerable population</li> <li>• Increase the usage of Tarrant Cares website</li> </ul>

## Social Determinants of Health

Need/Data	
<b>Statement of Need</b>	
<p>Social Determinants of Health was a top need in the 2013 CHNA and was again identified as a top need in the 2016 CHNA. Resources and investments were made addressing select social determinants of health. Nearly 1 in 5 Fort Worth residents live below 100% poverty. About 1 in 5 homeowners in Tarrant County spend 35% or more of their income on their mortgage; in contrast, nearly twice as many renters spend 35% or more of their income on their rent. Participants reported a lack of accessible and reliable transportation in communities. Participants also reported a lack of grocery stores and prevalence of convenience stores and fast food in these communities.</p> <p><b>Challenges</b> to address this large complex set of issues is that it will require full community participation and action, requiring significant resources and engagement beyond the scope of a single entity.</p>	
Assets	
JPS Health Network	Community
<p>JPS Teams:</p> <ul style="list-style-type: none"> <li>• Community Health/Ambulatory Clinics</li> <li>• Care Management Services</li> <li>• Community Outreach</li> </ul> <p>DSRIP Funds</p>	<p>Community Partners:</p> <ul style="list-style-type: none"> <li>• Tarrant County Public Health*</li> <li>• Meals on Wheels of Tarrant County</li> <li>• Catholic Charities*</li> <li>• Healthy Tarrant County Collaboration*</li> <li>• Trolley Pride*</li> <li>• Amerigroup*</li> <li>• Tarrant County*</li> </ul>
Programming	
Current Programming	Opportunities
<p>Poverty</p> <ul style="list-style-type: none"> <li>• Support of <a href="#">Catholic Charities Padua Pilot Project</a></li> <li>• Collaboration with <a href="#">True Worth Place</a></li> </ul> <p>Food Access</p> <ul style="list-style-type: none"> <li>• Support of <a href="#">Healthy Tarrant County Collaboration</a> to increase fresh produce availability through Healthy Corner Store Initiative</li> <li>• Collaboration with Trolley Pride to provide FARMacy prescription (vouchers) to purchase fresh produce</li> </ul> <p>Housing</p> <ul style="list-style-type: none"> <li>• Pathway to Housing, partnership with Amerigroup</li> </ul> <p>Transportation</p> <ul style="list-style-type: none"> <li>• Collaborating with Tarrant County’s Director of Mobility</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain successful current collaborations addressing Social Determinants of Health</li> <li>• Identify and understand impact of DSRIP Bundle Metrics for innovate approaches to address Social Determinants of Health</li> <li>• Implement Social Determinants of Health screening tool for JPS Community Health patients (aligns with updated 2017 NCQA PCMH guidelines).</li> <li>• Increase JPS engagement with community organizations addressing social determinants of health</li> </ul>
Objectives	
Strategic Direction	Metrics
<ul style="list-style-type: none"> <li>• Adoption of relevant DSRIP metrics to fund potential new programs</li> <li>• Strengthen existing and develop collaborations that improve Social Determinants of Health in Tarrant County</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in availability of access to healthy food</li> <li>• Improve JPS’ poverty penetration Tarrant County</li> <li>• Increase screening of Social Determinants of Health</li> </ul>



## Additional Considerations

JPS recognizes that the opportunities outlined in the previous tables, if deployed, will address multiple identified needs. Many of these opportunities use a systems-change approach. It will be necessary to collaborate with internal and external stakeholders. JPS also recognizes the need to enhance the capacity and availability of primary care in the county. Access to primary care will directly influence and improve community health outcomes in the areas highlighted in the plan. The following areas of focus are cross-cutting in nature; they will be considered and employed where appropriate throughout the plan as a whole.

### Care Management

Our assessment and planning discussions have highlighted the state of care management throughout the county. While multiple access points tend to lead to fragmented care, we recognize the need for continuity and a holistic approach for each patient. This will lead to an enhanced continuum of care and positive health outcomes. This plan reflects a focused effort to increase awareness to engage and coordinate the broad depth of resources we have into a coordinated care management approach. Leveraging existing community programming around resource databases, specifically, Tarrant Cares and United Way 2-1-1, will be one approach to increase the awareness of our broader care management system.

### Community Collaboration

As identified as a strength in the CHNA, organizations in Tarrant County come together and work well collaboratively. Continued attention to community collaboration will allow JPS to maximize our resources. We aim to broaden our outreach to include a broader spectrum of stakeholders at the table when strategizing about how to best address identified needs. Improved system coordination and communication will facilitate improved health outcomes. JPS recognizes the need to address the social determinants of health. These upstream indicators will require the community to collaborate to formulate a plan to address these needs.

### Health Equity

Health disparities and health equity are identified throughout the report. JPS intends to elevate the health status of Tarrant County through quality care, health access and providing a continuum of care. Diversity and Inclusion and enhanced capacity for expanded language services are consistently addressed. We will focus on Culturally and Linguistically Appropriate Services (CLAS) standards, and address the gaps in why people delay seeking care.



## Current Programming and Other Identified Needs

The needs listed in the table below were identified through the assessment and are reflected in the CHNA. They are not reflective in separate implementation grids due to current programming that is already addressing the needs. The following table provides a rationale and brief description of current programming for each identified need not being addressed.

Identified Need	Current Programming
Primary Care and Behavioral Health Providers	Maintain current programming, including a robust Academic Affairs department overseeing 18 residency and fellowship programs, from Orthopedic Surgery and Psychiatry to Clinical Pharmacy and Nursing. The JPS family Medicine Residency is the nation’s largest. Through closer alignment with the hospital district, Acclaim Physician Group is facilitating physician recruiting and engagement.
Oral Health	Maintain current programming, including integrated dental health at 6 Community Health Clinics and Community Outreach through Healthy Smiles program.
Respiratory Diseases	Maintain current programming, including chronic disease education classes for COPD and a DSRIP Childhood Asthma program.
Sexually Transmitted Infections	Currently addressed by Tarrant County Public Health and also through current referral, treatment and reporting partnership between the County and JPS.
Trauma, Violence and Injury	Maintain current programming, including Level 1 Trauma Center designation, Geriatric Trauma program, community based efforts include Shattered Dreams, Stop the Bleed and Fall Prevention efforts, as well as various speaking engagements on intimate partner violence and personal safety.

For a brief summary of the current DSRIP projects, please see Appendix B.

## APPENDICES

### A. Advisory Committee

<b>Name</b>	<b>Title</b>
<b>Community Partners</b>	
<b>Vinny Taneja</b>	Director, Tarrant County Public Health
<b>Yvette M. Wingate</b>	Health Equity Coordinator, Tarrant County Public Health
<b>Ann Salyer-Caldwell</b>	Deputy Director, Tarrant County Public Health
<b>Melodia Gutierrez</b>	Associate State Director, AARP Texas
<b>Sherry Simon</b>	Vice President, Nutrition and Programs, Meals on Wheels
<b>Don Smith</b>	Vice President, Community Development-Health Director, United Way of Tarrant County, AAA
<b>Ramey Heddins</b>	Service Director, MHMR Tarrant
<b>Frances Villafane</b>	Health Systems Manager, American Cancer Society
<b>Frank Lonergan, M.D.</b>	Acclaim Physician Group, Primary Care Physician
<b>Richard Young, M.D.</b>	Acclaim Physician Group, Primary Care Physician
<b>JPS Core Team</b>	
<b>Amanda English</b>	Manager, Community Outreach
<b>Merianne Roth</b>	Vice President, Chief Strategy Officer
<b>Shelly Corporon</b>	Director, 1115 Medicaid Waiver
<b>Heather Beal</b>	1115 Medicaid Waiver Program Manager
<b>Bonnie McCamey</b>	Manager, Waiver Analytics
<b>Scott Rule</b>	Vice President, Chief of Staff
<b>Wayne Young</b>	Senior Vice President, Behavioral Health
<b>JPS Internal Stakeholders</b>	
<b>J.R. Labbe</b>	Vice President, Communications & Community Affairs
<b>Frank Rosinia, M.D.</b>	Vice President, Chief Quality Officer
<b>Rohit Ojha, DrPH</b>	Director, Research Institute
<b>Dianna Prachyl</b>	Senior Vice President, Community Health and COO, Acclaim Physician Group
<b>Dawn Zieger</b>	Executive Director, Primary Care and Access Integration
<b>Emil Kalloor</b>	Administrative Fellow
<b>Kyle Sechrist</b>	Director, IT
<b>Sajid Shaikh</b>	Manager, IT Applications
<b>Mona Gaw</b>	Executive Director, Quality
<b>Hope Willis</b>	Manager, Knowledge Management
<b>Kia Jackson</b>	Director, School Based Health Center

## B. DSRIP One Sheet Summaries

Project Name	Project Owner	Project Manager	
Behavioral Health Expanding Hours	Wayne Young	Brenda Gomez	x3725
Call Center	Dianna Prachyl	Constance Jackson	x4834
Expand Specialty Care	Dianna Prachyl	Eve Asuelime	x3567
Partial Hospitalization Program	Wayne Young	Chris Wall	x2058
Innovation and Transformation Center	Dr. Rosinia	Greg Fuhrmann	x2227
Diabetes Chronic Care Management	Dianna Prachyl	Susan Reed	x7381
Patient Centered Medical Home	Dianna Prachyl	Seme Dewees-Cooper	x7126
Care Connections for the Homeless	Dianna Prachyl	Tammy McGhee	x6504
Coordinated CHF Program	Kathleen Whelan	Carol Johnson	x2170
Implement/Expand Care Transitions	Dianna Prachyl	Nikki Choyce	x2927
Integrated Behavioral Health	Wayne Young	Chris Wall	x2058
Behavioral Health Discharge Management	Wayne Young	Brenda Gomez	x3725
MedStar Patient Navigation	Dianna Prachyl	Tammy McGhee	x6504
Virtual Behavioral Health	Wayne Young	Chris Wall	x2058
Community Connect	Dianna Prachyl	Gail Warren	x7140
Redesign to Improve Patient Experience	Lara Burnside	Annica Fischer	x7110
Sepsis	Wanda Peebles	Lori Muhr	x1717
Palliative Care Program	Wayne Young	DiAnn Young	x6825
Integrated Care Model with Outcome Based Payments	Dianna Prachyl	Karen Goodwin	x7141
Journey to Life	Wanda Peebles	Anjali Desai	x7597
School Based Collaborative	Dianna Prachyl	Lynette Hallett	x1220
Central Assessment	Wayne Young	Chris Wall	x2058
Breastfeeding	Wanda Peebles	Anjali Desai	x7597
Pregnancy / Inter-Conception	Wanda Peebles	Anjali Desai	x7597
Care Transitions for Long Term Care	Dianna Prachyl	Monique Barber	x7130
Psychiatric Day Rehab	Wayne Young	Chris Wall	x2058
Expand Pain Management	Dianna Prachyl	Eve Asuelime	x3567



## Behavioral Health Expanding Hours

Establish extended operating hours at a select number of local mental health clinics or other community-based settings

### The Challenge

- The Region’s community health needs assessment identified inadequate follow-up care as a major behavioral health need.
- Most ongoing behavioral health issues were addressed in the inpatient setting, which is more costly and designed for more acute health needs.
- Behavioral health clinics had limited hours of operation and availability for follow-up.

### The Project

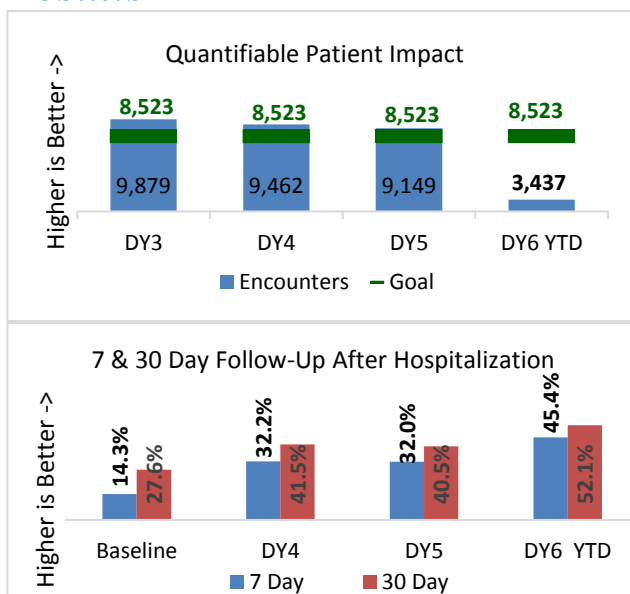
- This project serves a large group of mentally ill patients in Tarrant County through expanded outpatient services. Specifically, this project offers a larger score of behavioral health services with expanded hours, increased appointment availability, individual therapy, group therapy, local support groups, and improved staffing.
- This project enhances behavioral health service availability by utilizing multiple evidence-based strategies that will result in expanded depth and breadth of outpatient behavioral health services.

### Target Population

The target population for this project is the additional patients accessing outpatient behavioral health services in expanded hours/services.

*JPS Health Network will design and develop the full continuum of behavioral health capacity to improve access to appropriate levels of behavioral health services for population health needs.*

### Results



### Community Needs Addressed

- ✔ Increase access to mental health services

### Triple Aim of Transformation

- ✔ Improve Quality of Care
- ✔ Improve Population Health
- ✔ Reduce Cost of Care



## Call Center

Establish a centralized 24/7 call center with nurse advice to increase patient access to timely medical advice

### The Challenge

- There were several decentralized telephone entry points.
- The standardization that this project will provide is aimed at reducing unnecessary ED utilization.
- Providing urgent nurse advice has been shown to reduce unnecessary emergency department services in other systems.

### The Project

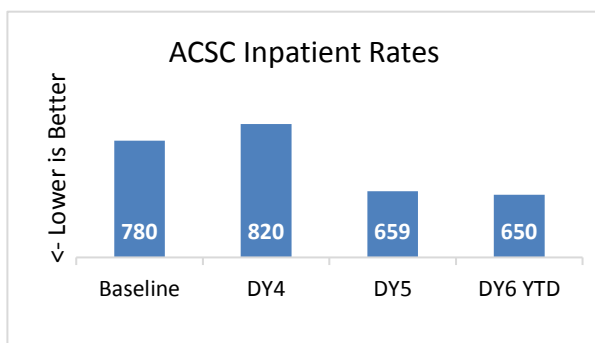
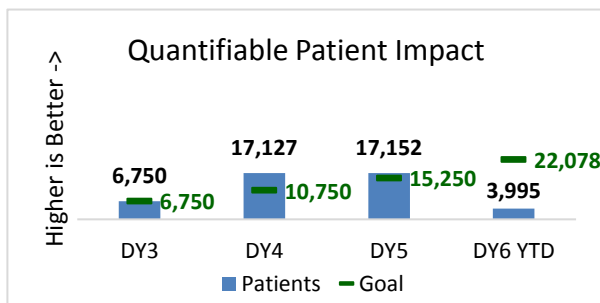
- Implement a centralized call center with a focus on one call resolution including a nurse advice team to direct callers to the right place for the right level of service.
- A nurse advice team is available 24/7 to provide timely medical advice, triage need for urgent or emergent medical care, assist with needed same day or next day appointment scheduling in the patient's medical home.
- Assist with prescription refills.

### Target Population

Patients and family members that access network services within the Tarrant County Hospital District will benefit from the 24/7 nurse advice line and call center.

*By directing patients and family care givers first to the call center, we can provide information and triage patients to the appropriate level of care.*

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Decrease financial barriers to access
- ✓ Decrease overuse of emergency services
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



# Expand Specialty Care for Ophthalmology and Wound Care

Increase capacity in targeted specialties within the JPS Health Network

## The Challenge

- Wait times for ophthalmology at JPS Health Network were increasing with wait times for new patients averaging over 100 days and 75 days for follow-up appointments.
- Long wait times for appointments contributed to low patients satisfactions scores and a general perception of outcomes impacted by delays in time to care.
- Data for JPS Health Network patients in 2011 revealed that 141 patients left the hospital with a wound vacuum, averaging \$3,654 per patient in supplies and equipment rental.

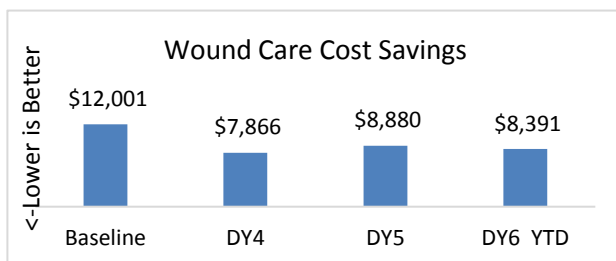
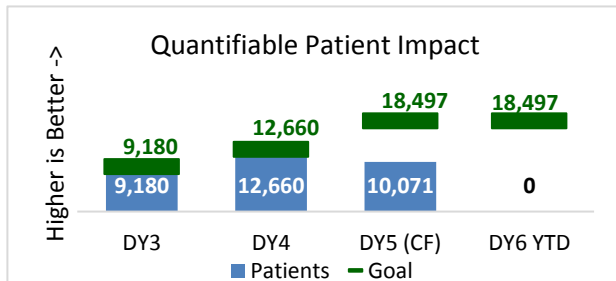
## The Project

- Enhance access to specialty care for both routine eye exams and wound care; reducing unnecessary hospital stays and improving compliance with routine eye exams.
- The optometrists will be first responders and will work closely with our ophthalmology medical director for appropriate referrals.
- JPS Health Network will launch a Wound Care Center.
- The medical director will work with administration to develop a comprehensive wound program for both inpatient and outpatient care.

## Target Population

The target population is current and future JPS patients.

## Results



## Community Needs Addressed

- ✓ Increase care coordination
- ✓ Increase access to specialty care
- ✓ Decrease overuse of emergency services
- ✓ Increase provider capacity
- ✓ Increase education, resources and promotion of healthy lifestyles

## Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



# Partial Hospitalization Program

Expanding and Improving Behavioral Health Services

## The Challenge

- Community Health Needs Assessment identified lack of access to mental health services.
- Significant gaps were present within the continuum of care for individuals at JPS Health Network.
- Overuse of emergency department (ED) services occurred.
- Lack of alternative intensive outpatient care opportunities for behavioral health to prevent inpatient admissions.

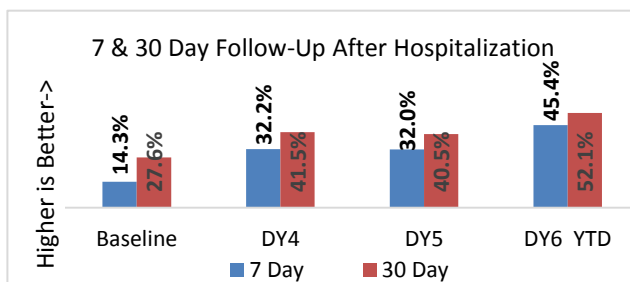
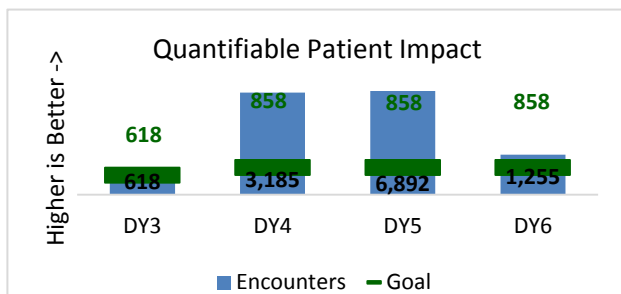
## The Project

- Four new partial hospitalization and intensive outpatient programs across Tarrant County.
- Delivers behavioral health services targeted to individuals with serious mental illness and concomitant circumstances such as homelessness or chronic physical health conditions.
- Specialized behavioral therapies including Cognitive Behavioral Therapy.
- Care coordination for follow-up after leaving the program.
- PHP is a 5 day a week program.

## Target Population

Psychiatric patients in need of expanded behavioral health services meeting level of care criteria for intensive outpatient or partial hospitalization care.

## Results



## Community Needs Addressed

- ✓ Increase access to mental health services

## Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Innovation and Transformation Center

Build and staff a continuous quality improvement infrastructure for JPS Health Network

### The Challenge

- A strong Continuous Quality Improvement infrastructure would be essential to support the degree of change necessary to successfully drive improvement and support the 27 1115 Waiver Projects.
- The reduction of Potentially Preventable Conditions (PPC) is a regional goal lead by the Innovation and Transformation Center across the network.
- 

### The Project

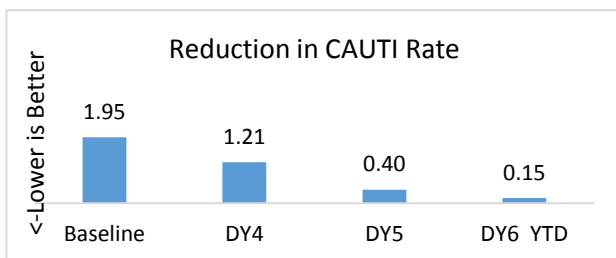
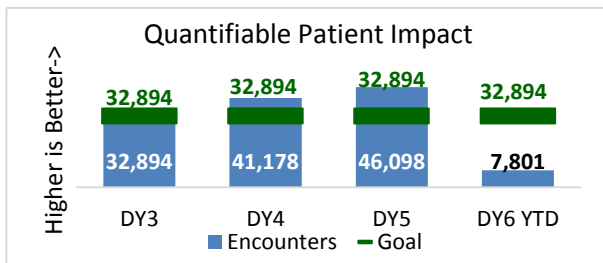
- JPS Health Network established The Innovation and Transformation Center (ITC) to be the authority for organizing, evaluating and documenting change efforts and promoting continuous quality improvement throughout the organization.
- The ITC is an internal training, education and process improvement resource for JPS Health Network and leads initiatives to improve efficiency.
- The ITC will play an integral role in reducing the aggregate harm rate resulting from Central Line Infections, Foley Catheter Infections and Falls within the JPS Health Network.

### Target Population

All patients served by and within JPS Health Network.

*Create a JPS Health Network Innovation and Transformation Center that will coordinate the implementation of major organizational performance improvement and transformational activities and spread learning and capacity at all levels of the organization.*

### Results



### Community Needs Addressed

- ✓ Increase care coordination
- ✓ Decrease overuse of emergency services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care





# Diabetes Chronic Care Management

Improve diabetes clinical outcomes and self-management skills in a patient-centered medical home (PCMH).

## The Challenge

- Diabetes is one of 10 major causes of morbidity in our Region. Diabetes prevalence in Tarrant County is at 8.3%, according to the Behavioral Risk Factor Surveillance System (BRFSS) report in 2007.
- JPS Health Network medical homes serve 17,000 patients annually with a diagnosis of diabetes. Of these patients, 60% are obese and 80% have a diagnosis of hypertension.

## The Project

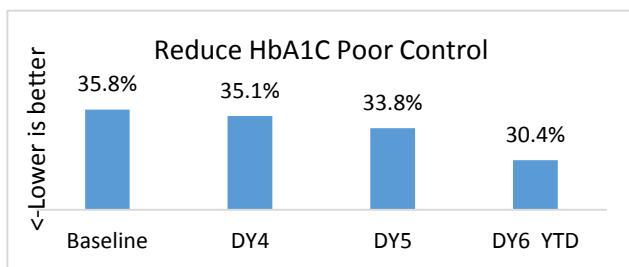
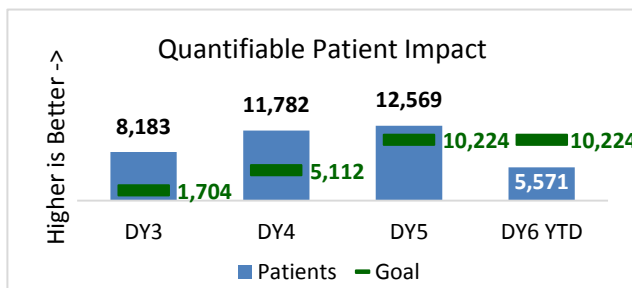
- JPS Health Network will improve diabetes management for our medical home patients by implementing a chronic care model in each of our PCMH clinics that will:
  - Decrease complications and improve quality of life through evidence-based interventions and age appropriate prevention.
  - Improve care coordination through planning, coaching and navigation with the medical home team.
  - Increase health literacy of patients and enhance educational materials provided by JPS Health Network.

## Target Population

The target population is adult patients with diabetes who are seen in a medical home.

*Empowering our patients to take an active part in their own care; while decreasing complications and improving quality of life.*

## Results



## Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase care coordination
- ✓ Increase culturally competent care
- ✓ Create patient education programs
- ✓ Increase education, resources and promotion of healthy lifestyle

## Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Patient Centered Medical Home

Providing coordinated care organized around the patient, not the provider.

### The Challenge

- Rising incidence of chronic disease (diabetes, hypertension, COPD and CHF).
- Avoidable use of emergency services due to ineffective chronic disease management.
- Avoidable hospital admissions for preventable exacerbation of chronic disease.
- Lack of coordination between providers.
- Providers in separate locations, presenting barriers to care.
- Patient under-use/misuse of prescription medication.
- Suboptimal use of preventative screenings.

### The Project

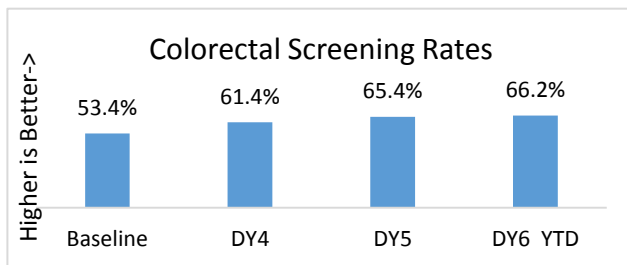
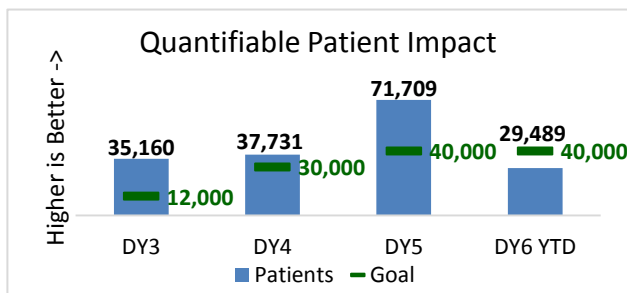
- Transform JPS community clinics to Patient Centered Medical Home facilities meeting NCQA standards.
- Transform the patient visit into one involving multiple providers.
- Incorporate NCQA quality measures into the electronic medical record system.
- Create patient navigators to remain in frequent contact with patients.
- Create health coaches to teach chronic disease management and help patients establish attainable goals.

### Target Population

100,293 current and future patients enrolled in the JPS Connection financial assistance program, residual uninsured and Medicaid patients under 75 years of age.

The Patient Centered medical Home coordinates care across the healthcare system, including specialty care, hospitals, home health care and community services and supports.

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase primary care services
- ✓ Increase access to mental health services
- ✓ Decrease avoidable use of emergency

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Care Connections for the Homeless

The right care at the right time and place for those most vulnerable

### The Challenge

- Homeless patients discharged from the hospital lack adequate support structure.
- Transportation barriers to primary care.
- Poor diabetes control.
- Absence of follow-up care after psychiatric hospitalization.
- Lack of coordination between medical and social services providers.

### The Project

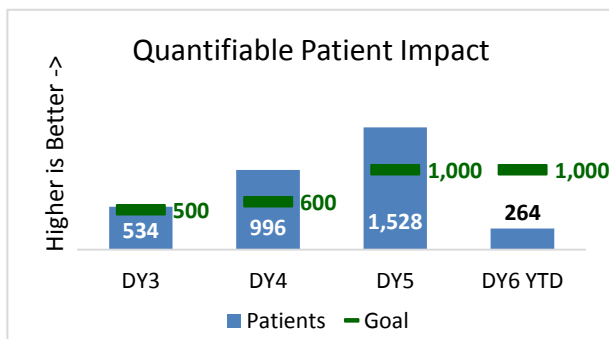
- Deploy a multidisciplinary team of medical, mental health, advanced practitioners, paramedics and care transition support staff to provide services for the homeless.
- Establish partnerships with homeless clinics, MedStar, City of Fort Worth, MHMR of Tarrant County and Tarrant County Medical Society's Project Access.
- Identify common characteristics of high utilizers.
- Institute care transition policies to ensure post-hospital discharge follow-up.

### Target Population

2,100 patients living in Tarrant County in emergency shelters, supportive housing, cars, abandoned buildings or otherwise unsheltered

*A seamless network of care will improve emergency department use, improve health outcomes and reduce costs through reduced emergency room visits and hospital admissions.*

### Results



- 21.74% decrease in emergency department (ED) visits and a 58.15% decrease in Behavioral Health ED visits by homeless high utilizers who obtained housing through Care Connections Team services.
- The JPS Cypress Clinic leads the network with a cervical cancer screening rate of 82%, compared to the JPS overall rate of 73%.

### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to mental health services
- ✓ Decrease inappropriate use of emergency services
- ✓ Increase care coordination
- ✓ Improve integration of mental health in primary care

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Coordinated CHF Program

Reduce readmissions, reduce length of stay and improve quality outcomes

### The Challenge

- JPS Health Network has an identified CHF patient population that relies unnecessarily on the emergency department for management of the CHF symptoms.
- Patients with primary or secondary diagnosis of CHF accounted for approximately 4,000 annual emergency department visits at JPS.
- JPS Health Network has over 2,200 annual inpatient admissions for CHF as the primary diagnosis.

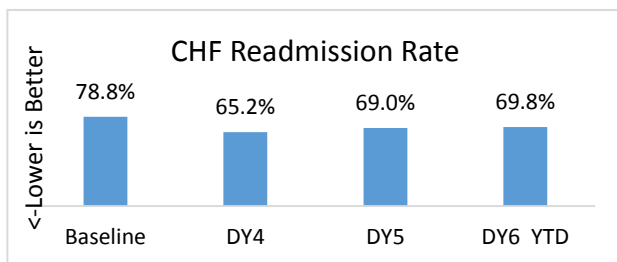
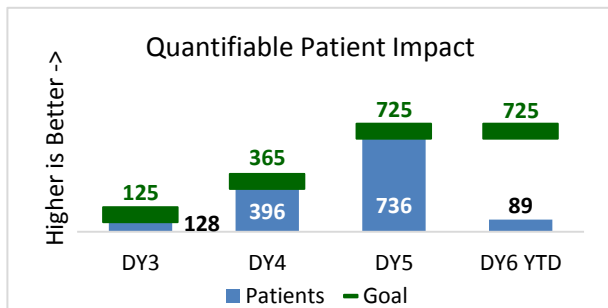
### The Project

- The Program encompasses a team that partners with the CHF population to improve their quality of life by facilitating self-management thus reducing CHF related hospital encounters.
- The dedicated CHF clinic will focus on reducing the incidence of unnecessary ED visits and inpatient admissions of identified CHF patients through disease-specific counseling that includes medication management and dietary management as well as ongoing telephonic counseling and appointment scheduling assistance.

### Target Population

The target population is approximately 4,000 patients that annually visit the ED with a primary or secondary diagnosis of congestive heart failure.

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to specialty care services
- ✓ Decrease overuse of emergency services
- ✓ Increase care coordination
- ✓ Increase patient education programs

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Implement/Expand Care Transitions

Implement a best practice model to design and implement a comprehensive discharge planning and discharge support program

### The Challenge

- Avoidable readmissions often occur as a result of patients being discharged from the hospital without fully understanding how to take their medications, the discharge plans or follow-up instructions.
- In a 2012 patient survey 33% of patients perceived they could “never access care” or only “sometimes access care” in the primary care clinics.

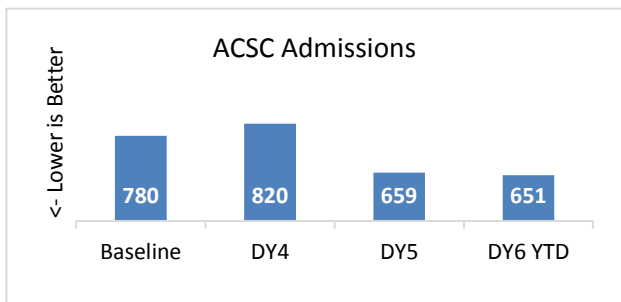
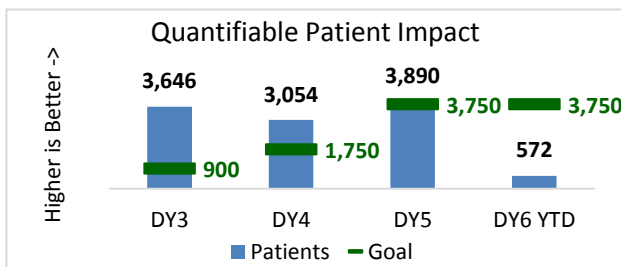
### The Project

- Create a network-wide care transitions program to reduce avoidable inpatient admissions and readmissions, and reduce inappropriate emergency department (ED) utilization.
- Provide intensive case management to avoid all-cause readmissions, and ensure effective care coordination/navigation.
- Promote effective transfer to post-acute care agencies, and improve access to preventive health care and discharge planning with post discharge support, based on the evidenced-based model, The Care Transitions Intervention.

### Target Population

Medicaid and uninsured patients discharged from JPS Health Network inpatient or ED settings that are transitioning to a medical home.

### Results



### Community Needs Addressed

- ✓ Increase care coordination
- ✓ Decrease overuse of emergency department services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Integrated Behavioral Health

Removing the barriers between primary care and behavioral health

### The Challenge

- Less than one-third of patients with a diagnosable mental health disorder were able to receive treatment.
- Primary care physicians failed to recognize 30% to 50% of depressed patients.
- There was a shortage of mental health professions.
- Of 38,000 suicides per year, 75% of them saw their primary care provider within 30 days prior.

### The Project

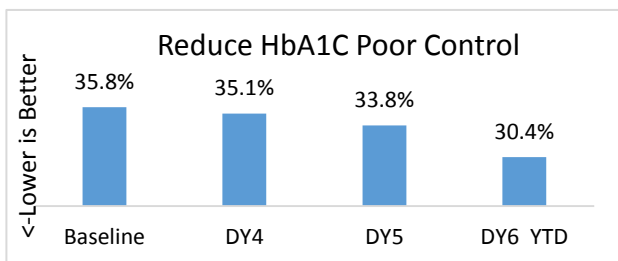
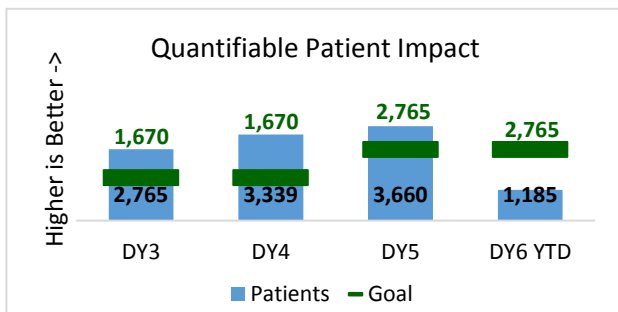
- Implemented standardized depression screening (PHQ-9) in primary care.
- Developed practice and referral agreements between primary care and behavioral health.
- Increased the capacity for primary care providers to manage low acuity behavioral health needs in their practices.
- Embedded Behavioral Health Specialists provide brief, solution focused counseling, care coordination, follow up, and co-facilitated medical and skills group therapy within primary care.

### Target Population

Individuals receiving behavioral health and physical health interventions in the same location.

*Mental health care can be made more accessible in the community by supporting primary care providers with less acute behavioral health conditions in order to increase specialty capacity for acute issues.*

### Results



### Community Needs Addressed

- ✓ Increase access to mental health services
- ✓ Improve integration of mental health in primary care
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Behavioral Health Discharge Management

Reducing psychiatric hospital readmission

### The Challenge

- Patients with psychiatric illnesses often struggle to maintain stability after being discharged, resulting in high rates of 30 day readmissions.
- No evidence-based tool to predict 30-day readmission risk.
- No targeted interventions based on risk.
- Lack of post-discharge support.
- Lack of assistance with transition to outpatient treatment.
- High no-show rates for follow-up outpatient appointments.

### The Project

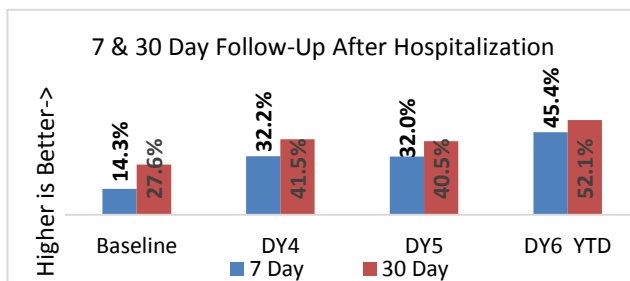
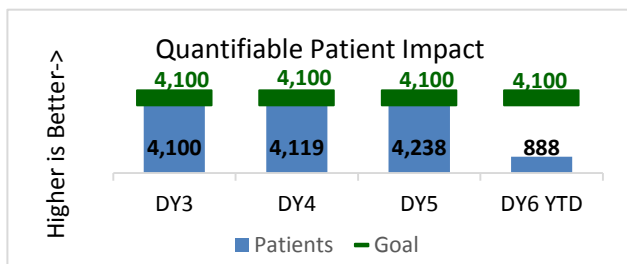
- Engage physicians, staff, management, IT and Discharge Management.
- Involve Patient and Family Advisory Council.
- Recruit four transition coordinators.
- Recruit eight peer support specialists.
- Identify predictors for readmission.
- Screen all patients for readmission risk.
- Provide discharge medication education.
- Schedule follow-up appointments before discharge and provide reminders.

### Target Population

4,142 psychiatric patients discharged annually

*The value of hospital care to the community is maximized when patients leave with a good outcome they are able to sustain.*

### Results



### Community Needs Addressed

- ✓ Increase access to mental health services
- ✓ Improve integration of mental health care in primary care
- ✓ Reduce inappropriate use of emergency department services
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care





## MedStar Patient Navigation

Navigate patients accessing emergency services for low acuity needs

### The Challenge

- There is a high volume of patients who use the Emergency Department (ED) for primary care issues.
- While patients' immediate health care needs may be dealt with in the ED, the ED is not set up to provide the longitudinal care and care coordination necessary for overall patient health.
- Often 911 calls are for low-acuity medical complaints but can result in an ambulance response and transport to an ED when alternate resources could meet the need at a lower cost.
- Patients discharged from the hospital with chronic disease are often readmitted due to lack of follow up care.

### The Project

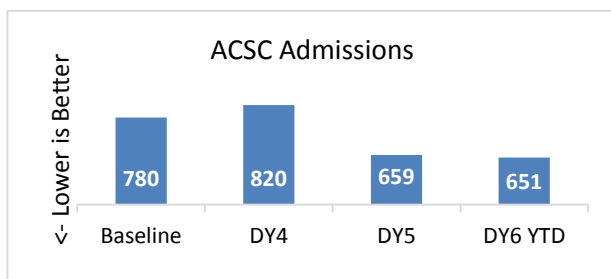
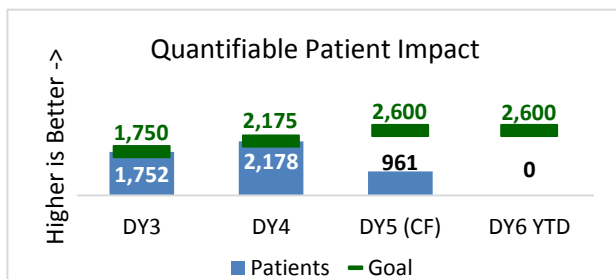
- Redirect low acuity 911 calls to a Nurse Triage line to determine appropriate care setting.
- 90 day program to train high ED utilizer patients how to access care in the appropriate settings.
- 30 day readmission avoidance program to assist patients post discharge with accessing appropriate care.
- Using mobile Community Health Paramedics (CHPs), the program aims to respond proactively to patients who may normally access the emergency care system to provide in-home education, assessments and interventions and build patients' ability to better manage their own care.

### Target Population

Patients accessing emergency services for low acuity needs, and patients at-risk for preventable readmissions.

*Program will provide education to enrolled patients on how to best utilize the healthcare system, provide home evaluations to enable safe environments, and assist in chronic disease management.*

### Results



### Community Needs Addressed

- ✓ Need for more care coordination
- ✓ Decrease avoidable use of emergency services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care





## Virtual Behavioral Health

Expanding the reach of existing psychiatric resources

### The Challenge

- Fewer than one-third of patients with a diagnosable mental health disorder receive treatment.
- Primary care physicians fail to recognize 30% to 50% of depressed patients.
- Shortage of mental health providers in eight of nine counties in the region.
- Only 21 percent of patients with mood disorders receive even minimally adequate treatment in primary care.

### The Project

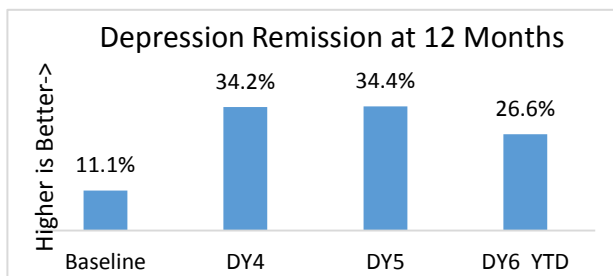
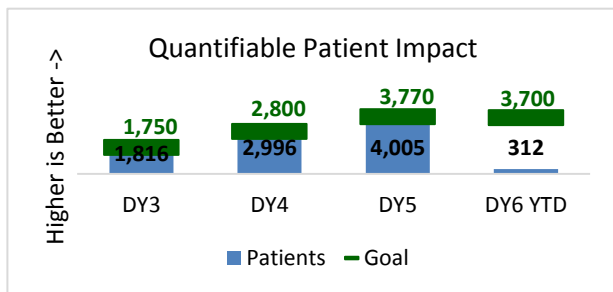
- Build an experienced team – psychiatrist, psychiatric social worker, and psychiatric nurse – to provide psychiatric clinical guidance to primary care providers.
- Respond to primary care provider requests within 30 minutes, 24 hours a day, by phone, fax or e-mail.
- Develop and maintain an accessible resource center of psychiatric literature and best practices.
- Build an educational library with easy-to-read information on behavioral health.
- Increase the capacity for primary care providers to manage low acuity behavioral health needs in their practices.

### Target Population

8,325 patients treated for mental health disorders by primary care physicians in a nine-county region.

*A primary care provider may suspect that a patient's physical symptoms are tied to a mental health disorder, but be hindered by limited or out-of-date training in psychiatry.*

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to mental health services
- ✓ Improve integration of mental health care in primary care
- ✓ Compensate for geographic barriers that impede access to care
- ✓ Decrease avoidable use of emergency services
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Community Connect

Connecting uninsured and low-income individuals with primary and specialty care

### The Challenge

- Uninsured individuals struggle to access outpatient services in our community and will continue to do so even with public program expansions.
- Fragmented care is problematic for low-income residents who do not qualify for health insurance.
- Our region has experienced steady and rapid population growth combined with a shortage of primary and specialty care for uninsured individuals.
- Many patients utilizing the ED or urgent care for their primary care needs as they do not currently have access to primary care providers.

### The Project

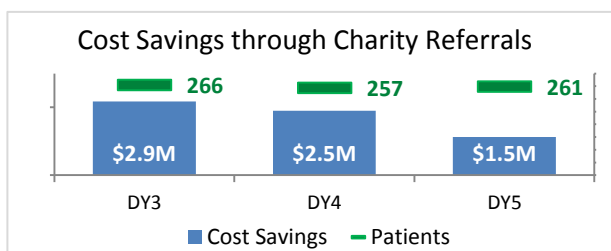
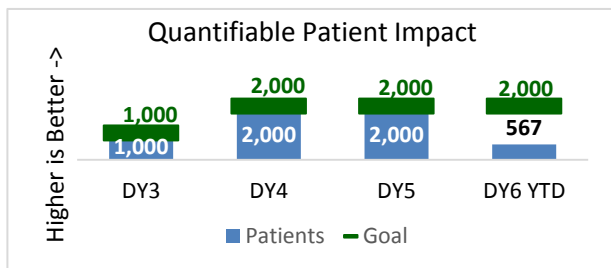
- Collaborate with charity care clinics throughout Tarrant County to increase access to primary and specialty care services, and improve quality outcomes for the residually uninsured Tarrant County residents through care coordinators, expanded primary care and specialty services.
- Improves information sharing with JPS Health Network collaborative partners.
- Develops and maintains IT systems information processes across the identified entities to facilitate better patient tracking and outcomes monitoring.

### Target Population

The target population includes uninsured patients currently utilizing the ED or urgent care for their primary care needs or do not currently have access to primary care providers.

*Connecting uninsured and low-income individuals with primary and specialty care.*

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to Specialty Care
- ✓ Decrease financial barriers to healthcare access
- ✓ Increase care coordination
- ✓ Decrease overuse of emergency department services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



# Redesign to Improve the Patient Experience

Develop a patient experience focus within the organization with a multipronged strategy

## The Challenge

- Needed an organization-wide patient experience focus at every touch point with dedicated leadership.
- Need to improve patient perception of care scores and establish a culture of service through awareness.
- Serving a population with low health literacy and a broad spectrum of languages and cultures.

## The Project

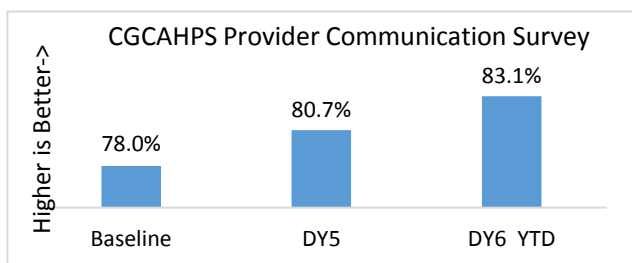
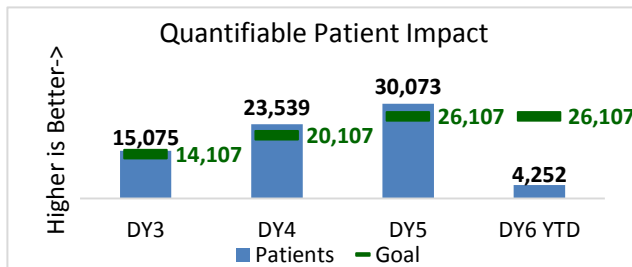
- Shared organizational vision led by the executive team, and the development and adoption of a strategic plan for patient experience.
- Increase staff education by creating focused training opportunities that build competency in patient and family centered principles.
- Utilize CMS CAHPS survey tools to assess patient perception of care and establish improvement plans.
- Create a repository to hold shared lessons learned and best practices.
- Increase patient and family engagement through the expansion of new patient activations to the online patient portal for their health record.
- Communicate perception of care scores to internal team members and the patients and family members in the community we serve.

## Target Population

Patients and their families accessing care in the JPS Health Network.

*A successful project will improve coordination of care across the district thereby improving health and patient/family satisfaction.*

## Results



## Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase culturally competent care
- ✓ Decrease overuse of emergency department services
- ✓ Increase care coordination

## Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Sepsis

Implement an evidence-based early detection and treatment plan for patients presenting with sepsis

### The Challenge

- Sepsis is difficult to detect, both from a clinical judgement perspective and through diagnostic coding, because the symptoms of sepsis and the International Classification of Diseases (ICD) codes could indicate a number of other conditions.
- JPS Health Network did not have standardized processes for early detection and treatment of patients with sepsis who present to the Emergency Department.
- During 2011 the Sepsis mortality rate was 20%.
- Severe Sepsis mortality is greater than breast cancer and AIDS mortality.

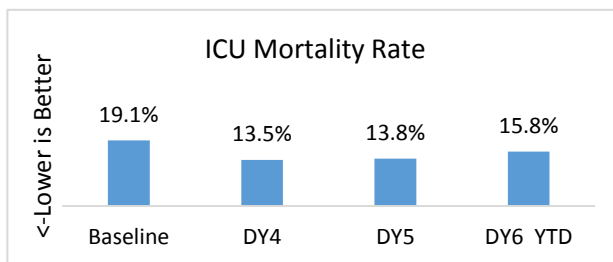
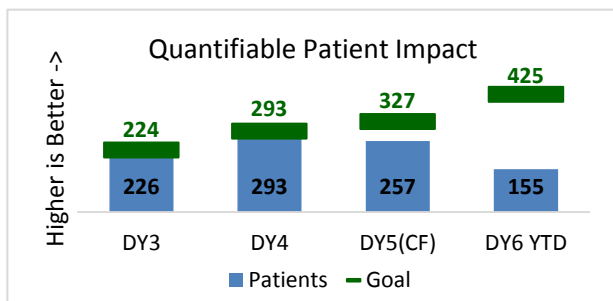
### The Project

- Develop a multi-disciplinary Code Sepsis Team to standardize the process and define outcome definitions.
- Implement the Sepsis Coordinator role to provide analysis, reporting, and continuous improvement through collaboration with the Critical Care, Emergency Department, and Medical Emergency Teams
- Increase the correct diagnosis of Sepsis using the Surviving Sepsis criteria.
- Increase compliance with use of the 3-hour and 6-hour Surviving Sepsis Bundles.
- Improve the Sepsis mortality rate.

### Target Population

The target population for this project includes patients with a diagnosis of severe sepsis, septic shock, and /or lactate >4mmol/L (36mg/dl).

### Results



### Community Needs Addressed

- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Palliative Care

Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

### The Challenge

- JPS did not have an organized inpatient palliative care program.
- Lack of trained/experienced palliative care staff/providers.
- 70% of people who experience chronic pain report they do not receive adequate pain relief.
- Caregivers of people with chronic or life-threatening illnesses felt alone in their struggle to provide good care.

### The Project

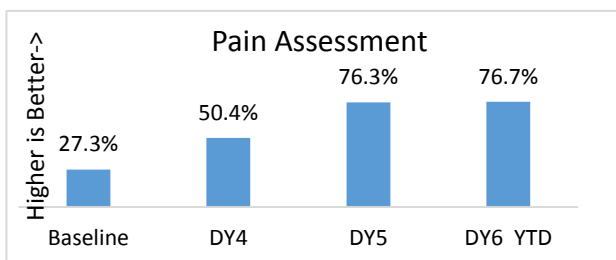
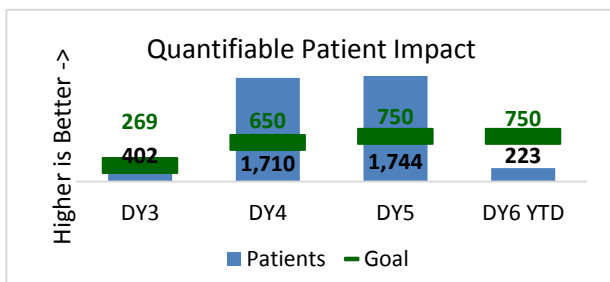
- Project optimizes patients' quality of life and centers treatment around the goals of the patient and family to include:
  1. Pain and symptom management
  2. Spiritual and psychosocial support
  3. Treatment goal planning
  4. Alternatives to aggressive treatment
  5. Advanced care planning
  6. End of life decisions and care needs

### Target Population

Patients with an irreversible, serious, chronic or life threatening illness.

*JPS will develop palliative care competencies and capacity across the continuum to meet population health needs.*

### Results



### Community Needs Addressed

- ✓ Increase geriatric, long-term and home care resources
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce cost of Care



## Integrated Care Model with Outcome-Based Payments

Develop a payment model that is based on outcomes

### The Challenge

- The need existed to realign the payment structure from a fee-for-service model to an access, outcome and performance-based system.
- Change the culture of healthcare at the provider level from a system in place for over a century.

### The Project

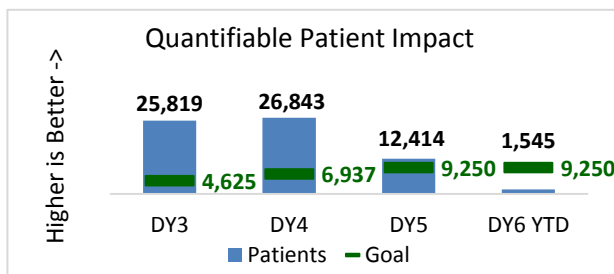
- This new payment model will integrate the providers into the development of the model to increase access for patients while reducing costs, duplication of tests, and scheduling issues.
- Connections members will have a medical home (primary care physician) that can coordinate their care reducing unnecessary emergency services utilization and duplication of tests.
- The goal of this project is to provide better care with a focus on access, quality and outcomes with the lowest cost.

### Target Population

The target population is JPS Connections members.

*Provide better care with a focus on access, quality and outcomes with the lowest cost.*

### Results



The implementation of the Provider Feedback System<sup>SM</sup> to those actively practicing under Acclaim has positioned the organization to move from a fee-for-service model to an access, outcome and performance-based system through:

- transparency of data across disciplines
- tracking of provider performance evaluation conversations
- inter-department collaboration in applying evidence-based best practices

### Community Needs Addressed

- ✓ Increase health IT infrastructure
- ✓ Decrease overuse of emergency department services
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Journey to Life

### Prenatal Care and Healthy Babies Initiative

#### The Challenge

- Tarrant County has the second highest infant mortality rate among Texas counties with 10,000 or more live births per year.
- 48% of women giving birth in Tarrant County received late or no prenatal care.
- Lack of prenatal care is associated with preterm birth, low birth-weight and infant mortality.
- Only 48% of women received a postpartum check-up on or before 21 days and 56 days after delivery.

#### The Project

##### Centering Pregnancy™

- Provide comprehensive prenatal care in a group setting
- Allow extended time with provider
- Provide support group for soon-to-be mothers
- Available in clinics with high pregnant population

##### Maternity Medical Home

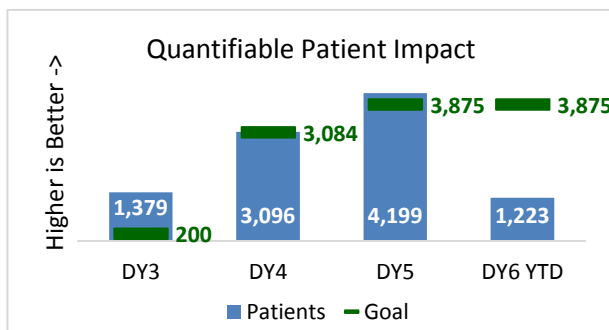
- Provide comprehensive prenatal care
- Coordination of care with primary providers and specialists
- Available in clinics with smaller pregnant population

#### Target Population

Medically underserved, Medicaid, indigent and underinsured women in Tarrant County.

*Babies born to mothers who receive prenatal care are more likely to be healthy children able to fulfill their potential, growing to be healthy adults.*

#### Results



- Car seat education classes have been provided to approximately 500 people.
- Mothers enrolled in the Centering Program had a lower preterm birth rate of 5.25%, compared to 8.68% for mothers not enrolled in the Centering Program.
- Patients with 8 or fewer prenatal visits had a higher preterm birth rate than those with 8 or more visits.

#### Community Needs Addressed

- ✓ Increase percentage of women receiving prenatal care
- ✓ Increase care coordination
- 

#### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care





## School Based Collaborative

Improving the health of children in our community

### The Challenge

- 18.6% of children in Tarrant County have asthma.
- 32% of children are overweight/obese, at risk for diabetes.
- Asthma is twice as likely in children from low-income families.
- Education, prevention and chronic disease management is lacking for underserved children.

### The Project

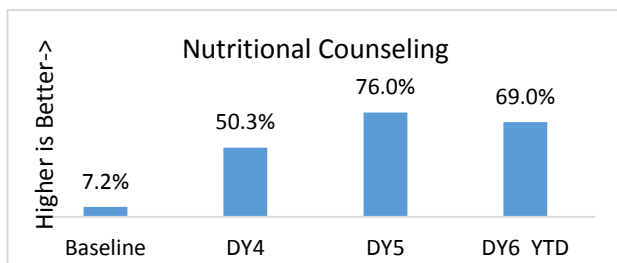
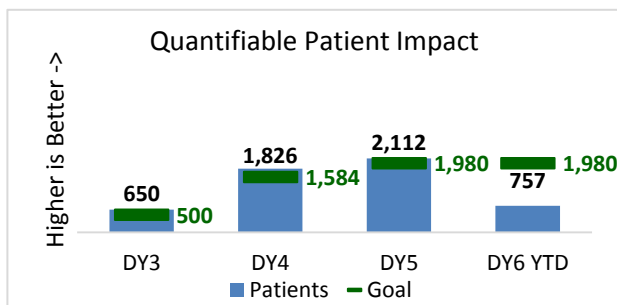
- Expand partnerships with school districts and area non-profit organizations focused on chronic disease prevention for children.
- Increase clinic emphasis on improving health outcomes.
- Reduce avoidable urgent care and emergency room visits.
- Create multidisciplinary teams focused on children and teens with asthma, obesity or diabetes.

### Target Population

More than 4,000 children and adolescent patients of JPS School-Based Health Centers and JPS Health Centers diagnosed with asthma, obesity or diabetes.

*Chronic disease management and education for children has far-reaching implications for the health and well-being of the future adult population of Tarrant County.*

### Results



### Community Needs Addressed

- ✓ Decrease financial barriers to healthcare access
- ✓ Increase education, resources and promotion of healthy lifestyles
- ✓ Decrease avoidable use of emergency services
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



**DSRIP Project Snapshot**

*Medicaid 1115 Healthcare Transformation Waiver*

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Centered in Care  
Powered by Pride



## Central Assessment

Expanding and Improving Behavioral Health Services with a new Central Assessment program

### The Challenge

- Less than one-third of patients with a diagnosable mental health disorder received treatment.
- Community Health Needs Assessment identified lack of access to mental health services.
- 8 of the 9 counties within RHP 10 are recognized as healthcare shortage areas for behavioral health.
- Overuse of emergency department (ED) services.
- Limited opportunity to receive behavioral health services without a pre-existing appointment or admission through the Psychiatric ER.

### The Project

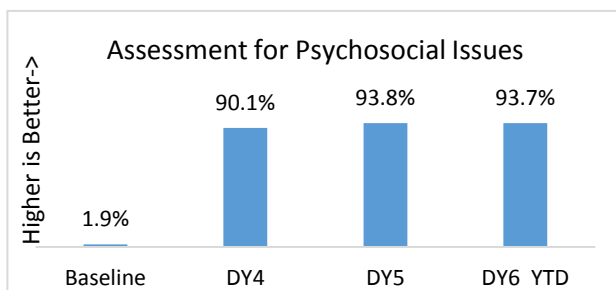
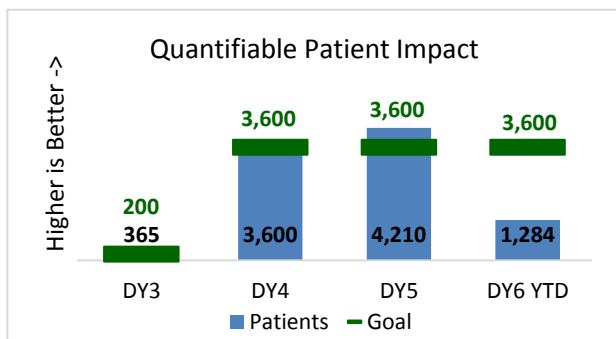
- Expand behavioral health services (Psychiatrist, Psychologist, Therapist, and Intake) within a new facility at JPS Health Network.
- Develop a standardized intake and assessment process to improve access and capacity for behavioral health needs.
- Conduct a Mental Health First Aid Training and Mental Health Stigma Campaign.
- Improve screening for behavioral health issues.

### Target Population

All patients seeking care and treatment for behavioral health issues in the JPS Health Network.

*Mental health care can be made more accessible in the community by increasing capacity and improving efficiencies. Not all individuals seeking behavioral health care are in need of a psychiatrist.*

### Results



### Community Needs Addressed

- ✓ Increase access to mental health services
- ✓ Decrease overuse of emergency department services
- ✓ Increase culturally competent care

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care

**DSRIP Project Snapshot**

*Medicaid 1115 Healthcare Transformation Waiver*

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## Breastfeeding

Engage in population-based campaigns or programs to promote healthy lifestyle

### The Challenge

- According to ACOG, health disparities are associated with lower breastfeeding rates for non-Hispanic blacks and economically disadvantaged groups compared to the general population.
- Breastfeeding duration and exclusivity falls below the target objectives for the Healthy People 2010 and below the national average.
- Texas ranked 33<sup>rd</sup> in the 2009 CDC Maternity Practices in Infant Nutrition and Care Survey indicating that practices in Texas hospitals diverge greatly from the standards of care in the Ten Steps.

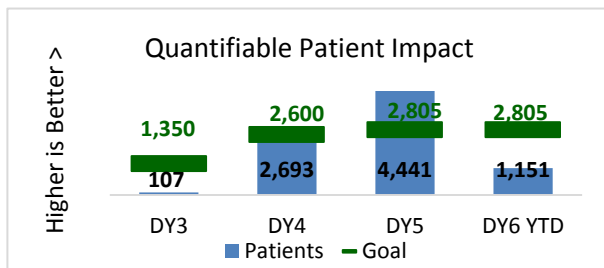
### The Project

- JPS Health Network will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding.
- Work towards bringing pregnant women into care earlier so that can receive additional opportunities for education on breastfeeding.
- Patients will be able to access ongoing and timely information on breastfeeding at home, in the clinics and in the hospital.

### Target Population

Expecting and/or recently delivered women who are breastfeeding and in need of breastfeeding services/support.

### Results



- 219 healthcare workers were educated through our Breastfeeding Boot Camp.
- 70 babies were kept exclusively breastfed through the utilization of donor breast milk.
- 66 women have attended prenatal breastfeeding education.

### Community Needs Addressed

- ✓ Increase education, resources and promotion of healthy lifestyles
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Pregnancy - Interconception

Engage in population-based campaigns or programs to promote healthy lifestyles.

### The Challenge

- There is a high incidence of unintended pregnancies in our teenage population – data for 2008 ranks Texas to have the 3<sup>rd</sup> highest pregnancy rate and 3<sup>rd</sup> highest birth rate for women aged 15-19 years.
- According to the Guttmacher Institute (Kost, 2013) in 2006 in Texas 53% of pregnancies were unintended as compared to the national average of 49%.
- Interconception stabilization of health issues such as diabetes and blood pressure will ultimately impact maternal and fetal morbidity and mortality.
- Tarrant County with a rate of 7.6 has the highest infant mortality in the State of Texas among Texas counties with 10,000 or more live births (national rate is 6.1).

### The Project

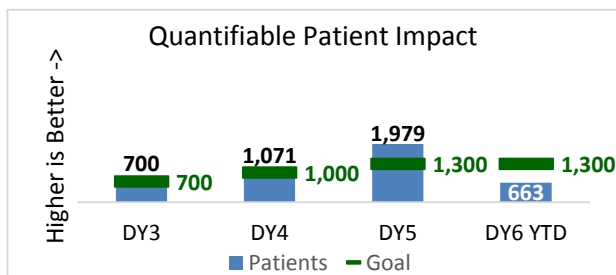
- Create a model focused on serving women who have in the past had limited or no access to preconception and/or interception care.
- Improve care coordination for women that are identified as having high risk factors for poor birth outcomes and provide outreach, home visitation and linkages to education, medical, and social services.
- Provide medical services at JPS Health Center for Women Clinics and other JPS Clinics providing prenatal services.
- Focus on identifying low income/at risk women in targeted zip codes with the highest incidence of infant mortality throughout Tarrant County and provide linkages to care.

### Target Population

Women residing in Tarrant County who are at high risk for poor birth outcomes who currently receive no preconception/interconception care as evidenced by unintended pregnancy, low birth-weight, and prematurity and ultimately increased infant mortality.

*Through better management and education, we will improve health outcomes and quality of life, while lowering healthcare costs and impacting the reduction in infant mortality.*

### Results



- In collaboration with the Tarrant County Correctional Health program, our PI social worker has provided preconception/interconception education and support to 49 pregnant inmates.
- The program has helped several women and their children escape domestic violence situations and provided them with information on protective orders.

### Community Needs Addressed

- ✓ Increase care coordination
- ✓ Increase culturally competent care
- ✓ Decrease financial barriers to health care access
- ✓ Increase patient education programs
- ✓ Increase education, resources and promotion of healthy lifestyles

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Care Transitions for Long Term Care

Develop, implement, and evaluate standardized clinical protocols and evidence based care delivery model to improve care transitions

### The Challenge

- Care coordination between the hospital and skilled nursing facilities posed a challenge at JPS. Standardized information sent to the receiving facility proved difficult to reliably complete with a need to develop community-wide partnerships as a key intervention area.
- Reducing high rates of readmissions from Skilled Nursing facilities
- Care coordination efforts across the continuum to anticipate and potentially treat appropriate illnesses were needed.

### The Project

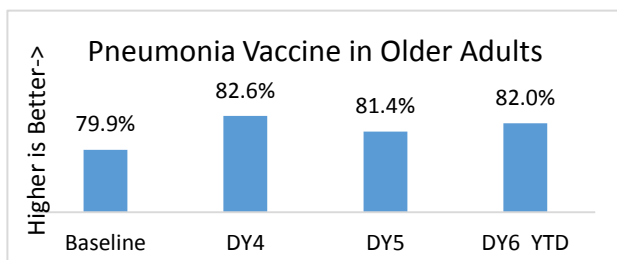
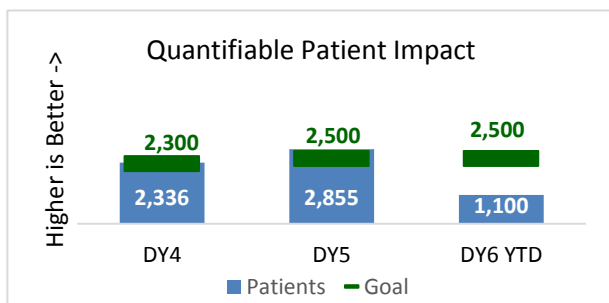
- Addresses the need for access to, and coordination of, care for all individuals, especially those with Medicaid and the uninsured who need long-term care in a skilled nursing facility. It will create partnerships between JPS Health Network and Medicaid long-term care providers within Tarrant County so that care may be provided in an appropriate setting.
- Enables the successful placement of Medicaid, dual eligible and uninsured individuals into an appropriate long-term care setting in a timely manner through increased resource awareness and contract utilization.

### Target Population

This project will impact patients requiring care in a long term care setting.

*By partnering skilled nursing facility providers and acute care facilities, the health outcomes of the patients across the care continuum should be improved.*

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to mental health services
- ✓ Decrease overuse of emergency services
- ✓ Increase access to geriatric, long term, and home care resources
- ✓ Increase care coordination

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



## Psychiatric Day Rehab

Unraveling the complex combination of homelessness, mental illness and substance abuse

### The Challenge

- Individuals in the community marginalized by severe mental illness, chronic health conditions, cognitive decline and homelessness.
- Inappropriate use of emergency services.
- Lack of services aimed at improving psychosocial functioning.
- Lack of care coordination among providers.

### The Project

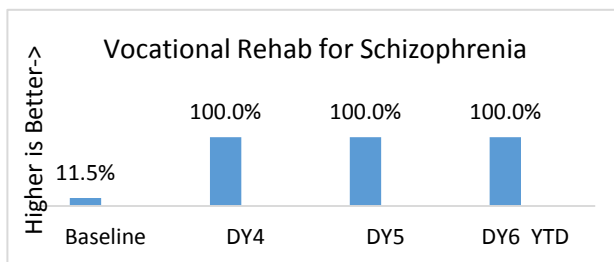
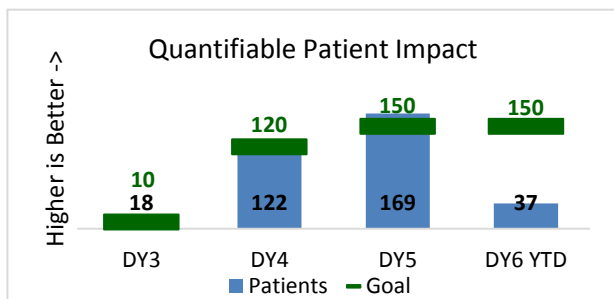
- Locate services near homeless shelters.
- Provide comprehensive day rehabilitation program for patients with a serious mental illness and experiencing homelessness to include:
  - Cognitive Adaptation Training
  - Psychosocial/psychiatric rehabilitation
  - Specialized behavioral therapies
  - Psychiatric medication management
  - Peer support
  - Substance abuse counseling

### Target Population

280 homeless patients with severe mental illness in Tarrant County

*“With your resources, your time and your help I was able to get housing, a job, health management and coping skills that I desperately needed... but most importantly the feeling that I matter.” - Patient*

### Results



### Community Needs Addressed

- ✓ Increase access to mental health services
- ✓ Decrease inappropriate use of emergency department services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care

## Expanded Pain Management

Effective pain relief and alternatives to addicting narcotics

### The Challenge

- Limited access to pain management services for low-income and Medicaid patients.
- Wait times
  - 120 days for new patient appointment
  - 30-60 days for established patient appointment
  - 240 patients wait-listed
- Limited number of providers and clinic space.
- Lack of advanced pain therapies.
- Extended use of narcotic medication.
- Avoidable use of emergency and inpatient services.

### The Project

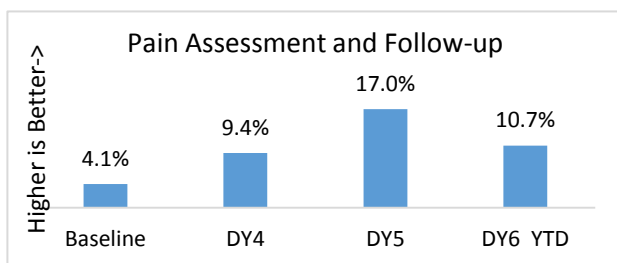
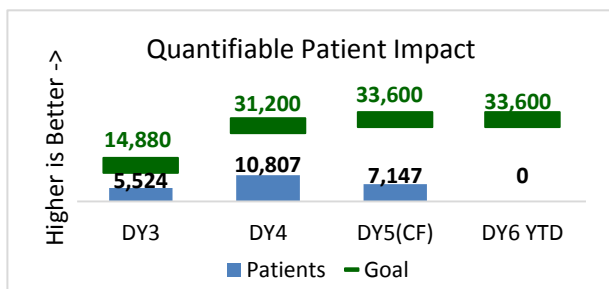
- Increase access to specialized pain management.
- Develop a free-standing pain management clinic with advanced procedure room.
- Integrate pain management into Patient Centered Medical Home clinics.
- Expand services to include advanced therapies (nerve blocks, epidural injection, non-opioid medication).

### Target Population

Low-income and Medicaid patients with chronic pain.

*With limited access, patients without resources go longer without effective treatment, developing chronic, complex pain that can be more difficult to control and require intensive management.*

### Results



### Community Needs Addressed

- ✓ Increase provider capacity
- ✓ Increase access to specialty care
- ✓ Improve access for patients with financial barriers
- ✓ Decrease avoidable use of emergency services

### Triple Aim of Transformation

- ✓ Improve Quality of Care
- ✓ Improve Population Health
- ✓ Reduce Cost of Care



Please address written comments on the Implementation Plan and requests for a copy of the plan to:

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