**Minutes**

1. **Welcome and Introductions/Roll Call**

Ms. Spurlin began call at 10:00 a.m. and welcomed participants

**Meeting Attendees**

***Members: Representing:***

Ms. Bridget Marburger and Ms. Tammy Stanfield Huntsville Memorial Hospital

Mr. Andrew Karrer and Mr. Brett Allen Montgomery County Public Health District Mr. Michael Smith Conroe Regional Medical Center/ Kingwood Ms. Krystle Riley St. Luke’s The Woodlands Hospital

Mr. Tim Ottinger St. Joseph’s Regional Health Center

Ms. Karla Blaine, Ms. Melanie Janak, and Ms. Doris Howell Texas A&M Physicians

Ms. Cynthia Peterson Tri-County Services Ms. Lynn Yeager The Prenatal Clinic

1. **Raise Performance – Focus Area and Open Discussion** 
   1. **April Spotlight:** Presentation: “Making the Case for Evidenced-Based”

Ms. Spurlin explained that HHSC and CMS have both used the term “evidence-based programs” throughout all phases of waiver implementation. This topic is particularly important when considering waiver renewal or extension. A tool was disseminated in early March where providers could voluntarily document components of their program should be considered evidence-based. The purpose of the call is to illustrate the definitions and differences between evidence-based practices, evidence-based programs, evidence-based medicine and promising practices.

* 1. **Innovator Agent(s):** Learn more about what an evidenced-based program is, as well as the differences between evidence-based practice and evidence-based programs. Hear more about some references/sources to seek out relevant research and information about your programs that may document them as evidenced-based or help support your project-specific model and data to build your case.
     + - * **Presenter(s): Shayna Spurlin, RHP 17 Program Director**

Ms. Spurlin began by informing the group of the following definitions:

*Evidence-based*: it (program, practice, or medicine) has been proven to have a specific positive outcome when implemented within defined parameters through research

*Evidence-based practice:* are skills, techniques, and strategies, supported by research that can be used when a practitioner is interacting directly with a customer. This is where you start to close the research/practice gap through practical application and continuous process improvement.

*Evidence-based programs:* Programs comprised of a set of coordinated services/activities that demonstrate effectiveness based on research. Criteria for rating as such depend upon organization or agency doing the rankings.

*Evidence-based medicine*: is a form of medicine that aims to optimize decision-making by emphasizing the use of evidence from well designed and conducted research

*Promising practice:* when providers or implementers, change components of an evidence-based practices or implement outside of the researched parameters, the practices based on an evidence-based model, but due to the changes, are not generalizable

The 1115 Medicaid Waiver program is designed to transform the health care delivery system through innovation. The evidence-based program model increases the likelihood that the program can be replicated and sustainable because it has been researched and proven to work within specific parameters and models. If projects are truly innovative, then they may have components that are outside of the parameters by which evidence-based programs are researched and tested, thus making them promising practices.

Ms. Spurlin informed the group that as part of Waiver renewal or extension, HHSC is working on a peer assessment tool that would be voluntarily reported by providers and then assessed to identify areas that are showing transformation and early success under DSRIP to highlight for CMS. The tool will ask providers to describe how the program is evidence-based. CMS is looking for project that can be a return on their investment, that are sustainable, and can be replicated; evidenced-based would satisfy all of these intentions as it is proven to have the desired health impact.

Ms. Spurlin reminded participants that evidence-based programs and practices can be incorporated into projects outside of DSRIP. Ms. Spurlin provided a list of online resources that could be used to find research relating to a provider’s type of program or process.

Ms. Spurlin articulated some questions for providers to consider regarding the evidence-based status of their own projects: What portions of the program structure are essential to replicating the positive impacts? If instituting or implementing the core components of the model that is being used, could someone expect to see the same positive outcomes you’ve seen? Are the results you’ve seen in DSRIP project generalizable to populations outside of the project’s target population or area?

* 1. **Open Discussion:**

Ms. Doris Howell provided an example of how she used evidence-based programs in DSRIP. She indicated that, as part of the Texas A&M Evidence-based Resource Center, she implements standardized, community health & wellness programs that have been proven through research to have positive health outcomes when implemented with fidelity to the core components of the prescribed model. To innovate these programs for DSRIP, Ms. Howell explained that she implements the evidence-based programs through new community partnerships. Ms. Howell provided a specific example of utilizing nursing students, through a new partnership with the Texas A&M nursing program, to have them implement the senior fail prevention program ‘A Matter of Balance.’ Ms. Howell’s project is to utilize a train the trainer methodology to train the nursing students to lead A Matter of Balance courses in the community.

Ms. Spurlin asked Ms. Howell if there were specific parameters that could be changed while keeping the evidence-based status or if any change resulted in the project being a promising practice, rather than evidence-based? Ms. Howell indicated that her Center worked closely with the model creators to determine the line between evidence-based and promising practices.

Mr. Andrew Karrer provided an example of utilizing evidence in the implementation of community paramedicine projects. While the project, as a whole is not evidence-based, the model is based on evidence from a 10 year study performed by CMS that found that in-home follow-up visits had a significant reduction in emergency department utilization, while telephone-based follow-up had no effect. The CMS study also found that in-home follow up programs were significantly more cost-effective than the telephone-based follow-up programs. Mr. Karrer incorporated this evidence into the community paramedicine model and eventually hopes that the model itself will become evidence-based.

Ms. Spurlin posed the following question to the group: Is anyone else seeing early improvements from DSRIP projects that they feel could be replicated by other providers?

Ms. Peterson indicated that Tri-County Services had implemented an integrated behavioral and primary care model that utilized an integrated care tool designed by the Center for Evidence-based Practices through Case Western Reserve. While this tool is not strictly evidence-based, Ms. Peterson indicated that she had created a fidelity monitoring tool that utilized the Case Western Reserve tool to evaluate Tri-County Services’ DSRIP program, which could eventually show the effectiveness of the program.

Ms. Peterson also indicated another one of Tri-County Service’s DSRIP projects was based on the Assertive Community Treatment (ACT) model constructed by the National Alliance for Mental Illness (NAMI). NAMI’s ACT model is generally focused on long-term mental health care, while Ms. Peterson’s project utilizes similar components to focus on prevention and crisis care. Ms. Peterson utilized the ACT model to create a fidelity tool for her DSRIP project.

Ms. Howell highlighted that a crucial part of evidence-based programs is fidelity to the core components and the importance of simultaneous fidelity monitoring and data collection. A lay leader may stray from the prescribed program in a way they find helpful, but the objective evidence from the data monitoring would suggest that the effectiveness of the program decreased due to the change in the core components.

Ms. Riley informed the group that CHI St. Luke’s The Woodlands Hospital recently implemented a new evidence-based practice in their chronic disease registry program called Project RED (Re-Engineering Discharge). Ms. Riley explained that Project RED is evidence-based and is designed to decreased readmission rates through a prescribed educational methodology and follow-up. Project RED was designed at Boston University’s Medical Center and lays out the 11 steps of the evidence-based program; however, built into the program is leeway for tweaking of hospital implementation, within a defined set of parameters, to fit the facility implementing the program, all while standardizing the data collection process. Ms. Riley indicated that other CHI hospitals were implementing Project RED. Ms. Riley indicated that while CHI paid to use the Project RED methodology at a system-level, the actual implementation cost at the hospital-level was minimal. Ms. Riley indicated that Conroe Regional Medical Center was also utilizing Project RED.

Ms. Spurlin asked providers to consider, that under Waiver renewal or extension, what would be the next step of their current DSRIP projects?

Ms. Riley inquired if existing projects would be continued or if new projects would be added under Waiver renewal or extension. Ms. Spurlin indicated that her belief was that HHSC was proposing to allow both the continuation of existing DSRIP projects and the addition of new projects.

1. **Learning Collaborative Recap & Upcoming Events**

Participants are reminded that Regional Meeting will take place on April 15th at 1:30 p.m. at the College Station Medical Center and to RSVP, whether they are attending in person or dialing in to the conference line, ASAP to the Anchor Team ([rhp17@tamhsc.edu](mailto:rhp17@tamhsc.edu)). This will be a joint meeting with RHP 17 and RHP 8.

1. **Next Steps & Adjourn** 
   1. Next call scheduled for Thursday, May 14, 2015 at 10 a.m.

*Have an idea/suggestion to share or topic to recommend for future Learning Collaborative calls, articles, or upcoming events? We want to know! Email the Anchor Team at* [*rhp17@tamhsc.edu*](mailto:rhp17@tamhsc.edu)*.*