**Agenda**

1. **Welcome and Introductions** 
   1. **Roll Call – By Provider and then Open to anyone else joining**

**Meeting Attendees: Representing:**

Ms. Angie Alaniz, Ms. Shayna Spurlin, Ms. Cooper McLendon RHP 17

Ms. Jennifer LoGalbo RHP 8

Ms. Sara Mendez Brazos County Health Department

Ms. Frances Hansen Conroe Regional Medical Center

---------------- College Station Medical Center / Washington County EMS – not able to attend

Ms. Bridget Bilski Huntsville Memorial

Ms. Adeolu Moronkeji, Mr. Andrew Karrer Montgomery County Public Health / Hospital District

---------------- MHMR ABV – not able to attend

---------------- S&W Brenham – not able to attend

Ms. Lynne Yeager St. Joseph Regional / Prenatal Clinic

---------------- St. Luke’s The Woodlands – not able to attend

Ms. Lisa Mcnair Texas A&M Physicians/Hospice Brazos Valley

Ms. Doris Howell, Ms. Suzie Van, Ms. Carly McCord Texas A&M Physicians

1. **RHP 17 Learning Collaborative Recap** 
   1. **Cohort workgroup development**: Ms. Spurlin thanks those who volunteered to facilitate cohort work groups and explains that cohort packets will go out tomorrow. Group meetings will take place the last week of July which will be accompanied by a call and a scheduled face to face meeting coordinated by the group facilitators for August- after plan modifications are complete.
   2. **July Lunch & Learn webinar –** Ms. Spurlin provides a recap from the July Lunch and Learn webinar on Six Sigma. The presentation with transcript is going through some edits to make it ADA compliant for web posting. Materials should be available next week.

Ms. Spurlin explains that feedback received from the June call is what drove the format of this month’s call. The purpose of this call is to allow providers to spotlight their projects so that other providers and stakeholders can have an idea of all projects are taking place in RHP 17.

1. **Raise Performance – Focus Area and Open Discussion** 
   1. **July Spotlight:** This call will allow call participants to Get-to-Know Your Fellow Collaborators by hearing summaries of each project taking place in RHP 7
   2. **Innovator Agent:** All RHP 17 Providers/Projects will be featured (presenting in alphabetical order)

* + - **BCHD –** Sara Mendez, Director of Health Education & Promotion

**Project Summary**: Ms. Mendez describes the first project that BCHD is implementing. This project aims to implement an electronic health record (EHR) system in the Brazos County Health District. Ms. Mendez describes that services that are offered though BCHD are very individualized as paperwork and reports are concerned. Currently, BCHD has different health record systems for the various clinics provided (paper charts and on-line systems) . An EHR would consolidate information into one system. Implementation of an EHR system would also allow staff immediate access to all client information. This would also improve quality of patient care, avoid duplication of services (i.e. vaccines), and give staff the ability to share patient information more efficiently with other providers

The second project being implemented by BCHD is rapid HIV testing. The purpose of this project is to provide free HIV testing to targeted clients at high risk for contracting HIV, as well as implement an educational campaign to promote HIV testing awareness and availability, in an effort to not only improve awareness and prevention, but to provide early detection and referral to treatment to help reduce health care costs related to this immunosuppressive virus. Ms. Mendez indicates that project is going well and over 500 people have been tested this year; the Cat 3 outcome measure for this project is to look at other STIs.

* + - **Conroe Regional** – Frances Hansen, attorney, Gjerset & Lorenz

**Project summary:** CRMC has one project which is a specialty care project aimed at trying to move CRMC from a level 3 trauma center to a level 2 trauma center. This project will expand access to specialized trauma services through the development and implementation of new trauma care processes, expansion and renovation of current trauma care clinical facilities, and improved access to specialty care physicians. Level II Trauma Center: During the project period, CRMC will pursue designation as an American College of Surgeons Level II Trauma Center. The development and implementation of a Level II Trauma Center at CRMC will enhance specialty care services in Montgomery County while reducing the number of patients transferred to Level I Trauma Centers in Houston. Ms. Hansen explains that the DY2 milestone for this project is to complete a gap assessment, which is currently being completed. The project is going very well! A lot of recruitment efforts have been made. CRMC is working with the local hospital district to develop a door in a door out process where high acuity patients are brought to the Conroe ED where they are evaluated. Conroe Regional then has 30 minutes to determine whether or not the patient should be transferred to the nearest level 2 facility.

* + - **College Station Medical –** Ms. Spurlin provides project summary on behalf of CSMC.

**Project Summary:** The Advanced Community Paramedicine (ACP) project is a navigation project that is partnered with Washington County to identity the users that are calling 911 for non-emergency services. Frequent users are reached out to by EMTs to help navigate and get them enrolled into a program that encourages right care right setting, which will further reduce inappropriate use of the ED. Using current 12-month data from the Washington County EMS database, it was identified that nearly 20% of annual 911 callers are considered frequent users of the system (calling more than 3 times in a 12-month time frame) and thereby frequent users of the ED. In 7 months, 30 patients have been enrolled and about 15-20 home visits have taken place/ month. These visits equate to approximately $12,000 per month in cost savings. This project is seeing very tangible results as well as improved health outcomes. Challenges reported have been identified as staffing and logistical issues.

* + - **Huntsville Memorial –** Bridget Bilski, Financial Analyst, coordinator of 1115 projects

Project 1: This project aims to implement a Cardiac Catheterization Laboratory at Huntsville Memorial Hospital in order to improve access to specialty care. This project will require HMH to renovate the current facility to support a Cardiac Catheterization Laboratory (Cath Lab) as well as invest resources into creating a referral management system, which will be a critical part of Walker County’s specialty care infrastructure. Cardiac Catheterization lab was opened last October. Volumes are rising and HMH is seeing a great impact on their community.

Project 2: The second project at HMH aims to implement an inpatient Dialysis Lab at Huntsville Memorial Hospital in order to improve access to specialty care. HMH will begin contracting with an organization to provide dialysis treatment for patients during their stay in HMH. This contract company will work with HMH to provide staff and equipment on-site, so inpatient treatment can be provided when needed. HMH will communicate to the clinical staff changes in how to referral patients for dialysis treatment within the hospital as well as to other dialysis providers within the community. Ms. Bilski indicates that one goal of the project is to implement an electronic system in DY3.

Project 3: The nursing fellowship program- HMH has teamed up with a local college with the goal to increase the number of students accepting positions at HMH. Meetings will occur between HMH and the local university, Sam Houston State University (SHSU), regarding HMH’s recruitment of BSN students. HMH will attract these students through a paid, two-stage Nursing Fellowship program lasting a minimum of six months. The first stage of the program is a 12-week part time position where the student works as a Tech in the targeted specialty field (TSF) they have been selected for. The second stage of the program is when the graduated student has obtained GN/RN status and began working on the TSF as a Fellow or GN. Both stages of the program are done under close supervision with a preceptor.

Project 4: HMH is implementing a mobile office/clinic to improve and expand access to care by providing screenings, vaccinations, physicals and health education. By partnering together HMH’s healthcare services can be delivered to the partnering facility’s location in the community at scheduled times. The mobile clinic will be staffed by healthcare professionals who travel into the community to provide screenings, vaccinations, physicals and healthcare education.

Project 5: The Chronic Care management program goal is to help patients better manage their health by contacting them regularly to follow up on their health. More specifically, this project will require HMH to expand its role in patient’s healthcare and establish protocols and models that help patients maintain healthy behaviors after discharge from the hospital. Establishing this project will require HMH to take on roles that previously the hospital did not consider, such as communicating with patient after discharge about their follow-up treatment, risk factors and post discharge activities.

Project 6: The sixth project, primary care and non-emergent services in a rural area project, aims to set up 2 clinics. This project will implement non-traditional clinics in small rural communities throughout the hospital's primary and secondary service areas in an effort to improve services available in these rural areas and increase the frequency of primary care visits. HMH prioritized expanding clinics services as a high second objective on the Community Benefit Plan. The first non-traditional clinic is said to open very soon and the second one is set to open next year.

* + - **Montgomery County Public Health District-** Ms. Adeolu Moronkeji & Mr. Andrew Karrer

**Project Summary:** Ms. Moronkeji explains the healthcare navigation program as a community-based effort that utilizes health workers to reach out to residents who are using the ER for their primary care needs. The goal is to seek out the indigent and low-income patients who for one reason or another that shy away from seeking medical help. The project is working to develop a trusting relationship with patients, which will help to divert patients from the ED to a primary care provider or a medical home. One of the goals is to help people to sift through the complexity of the healthcare system. The DY3 metric was to increase the number patients enrolled in the program; the goal was to enroll 180 patients and 260 have been enrolled. Out of the 260, 170 of those patients now have medical homes.

Mr. Karrer, the Community Paramedicine Program Manager, explains MCHD’s three-year project: Montgomery County Community Paramedicine. The target population of this project is those who are using frequenting the ER with a baseline of 3 times per year. The project has identified extreme high users and is unique because as the program manager, Mr. Karrer is a licensed paramedic who works with an RN case manager. The program is seeing about an 80% decrease in 911 use. This is a huge costs saving to healthcare system, which in turn is freeing up those advanced life-support paramedic units. In DY4, the program plans to enroll 120 patients.

* + - **MHMR ABV –** Ms. Spurlin provides summaries on the MHMRs projects.

The first project is integrated primary care and behavioral health service project. This project will improve access to primary health treatment as it will allow staff to establish baseline and track vital health indicators gathered at regularly scheduled visits, conduct primary care screening assessments, document presence of co-occurring mental health and substance dependence, and treat those individuals with chronic conditions of high blood pressure, cholesterol, obesity and diabetes. The idea behind this project is to co-locate primary care services within the MHMR service site so that patients who need treatment for primary care can receive those services along with behavioral health services. This availability of services makes patients more likely to seek follow up for primary care services. The related category 3 outcome is to help control patients who have high incidence of hypertension and those that also suffer with mental health issues.

The second project being implemented by MHMR ABV is the development and implementation of a crisis triage unit in an effort to provide care in the appropriate setting for persons experiencing a mental health crisis. This would be in lieu of the person being inappropriately transported to an emergency room or to another high cost and/or less safe venue. The team would also maintain mobile capacity to perform crisis assessments in other community settings as needed. The triage center would be staffed 24 hours 7 days a week with Qualified Health Professionals (QMHPs) and/or License Professional Counselors (LPCs) and ideally located at or near a crisis residential or crisis respite center. The crisis team would assess and coordinate crisis services/treatment, ensuring the most appropriate and least restrictive treatment options including, crisis respite centers and crisis residential units located throughout the region, as well as crisis follow-along services.

The last project is the rural assertive community treatment/ jail diversion project. The purpose of this project would be to implement high intensity, evidence based community treatment services to patients who have a history of multiple hospital visits. This approach merges clinical and rehabilitative staff related to psychiatric issues, substance abuse, vocational employments, and trying to help find supportive housing within one system. The staffing goal is to maintain a ratio of 1:8. The patients targeted are at high risk that have behavioral health needs and have been identified as frequent users of the health system.

* + - **S&W Brenham** Ms. Spurlin provides summaries of the two projects at S&W Brenham.

The first project is focused on increasing primary care at the local free clinic in Brenham. Through the addition of increased staffing, the project is hoping see increase in service to community patients and indigent care patients. The expected benefit to the hospital is to see a decrease in appropriate use in the ER.

The second project being implemented at S&W Brenham will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, to identify causes of avoidable ED/hospital utilization, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles on chosen improvements. This project will apply process improvement methodology to identify causes of avoidable ED and hospital utilization, prioritize potential solutions, and launch PDSA cycles to implement iterations of chosen improvements. This project will employ the Model for Improvement to pursue continuous process improvement with the aim of addressing the problem of avoidable ED and hospital utilization.

* + - **St. Joseph Regional / Prenatal Clinic –** Lynn Yeager, Executive Director of the Prenatal Clinic

**Project Summary:** This project aims to establish and implement a prenatal care navigation program to address the needs and provide services to prenatal patients with co-occurring chronic disease conditions that can cause high-risk pregnancies, in an effort to decrease the percentage of high-risk deliveries, provide referral to a primary obstetrician to reduce inappropriate ED use during pregnancy, provide health education, and connect both mother and baby to primary care providers postpartum. Ms. Yeager declares that project aims to provide positive birth outcomes by identifying high risk patients. The project aims to identify that people get the adequate resources and education that they need so that they know where to go to avoid ER visits during pregnancy. SJRHC’s goals for the PCNP are to connect women who have no obstetrical provider to an obstetrician, and then to identify women who have, or may develop diabetes or hypertension, (known low birth weight risk factors) to the PCNP.

* + - **St. Luke’s The Woodlands** –Ms. Spurlin provides project summaries on the two SLWH projects

The first project at SLWH is related to expanding primary care access in Montgomery County. This project aims to improve/expand access to primary care in Montgomery County though an increase in clinic hours, staffing and/or clinic space. Primary care access will be increased through additional primary care staffing. The project seeks to expand the capacity of primary care to better accommodate the needs of the regional, growing patient population and community, as identified by the Montgomery County needs assessment, so that patients have enhanced access to primary and preventative care services, allowing them to receive the right care at the right time in the right setting. This project is unique because of the way that primary care is defined; in a lot of cases obstetrics represents primary care for women and similarly pediatrics represents primary care for children. Specifically this project aims to bridge services. The three focuses are standard primary care, OBGYN services, and pediatric services. Through that, additional staff has been hired. A pediatric bridge clinic has also been developed. This clinic is located next door to the obstetric clinic so that they when new mothers come in to their appointments, it is more likely that the babies will attend their follow up appointments as well.

The second project is a 3 year project that is implementing a chronic disease registry system. This project seeks to implement a disease management registry for one or more patient populations diagnosed with selected chronic diseases. A multidisciplinary team will use the registry to continuously identify, track, and evaluate high-risk patients that are non-complaint or in need of testing, education, and follow up. Registry data will be leveraged to develop and implement cost-effective, evidence-based chronic disease management programs. SLWH’s ultimate project goal is to identify the highest risk patients and develop specific follow up practices that ensure patients who may have otherwise pursued more costly interventions seek the right care at the right time in the right setting. The two chronic conditions that are being focused on are congestive heart failure and COPD. Data collected will be used to develop evidence based chronic disease management programs. The use of community health workers is allowing SLTW to help follow with those patients.

* + - **Texas A&M Physicians**
      1. HFA –Ms. Spurlin describes the Health For All project. The goal of this project is to expand primary care capacity at the local clinic as well as improve the transition of care and the quality of care that was available to the indigent and low income population. The primary goal of the clinic was to increase primary care capacity by more than 100% and improve the chronic disease management for that population, which in turn helps to save dollars in the community healthcare resources. This project is on track for expansion.
      2. Rural Fellowship – Ms. Spurlin describes that recruiting and retaining staff in rural areas can be difficult. This project aims to develop a post-graduate training fellowship to prepare Family Medicine and primary care physicians (targeting non-TAMFMR graduates) in the skills, expertise, and procedures necessary to deliver the full scope of primary care in rural and underserved settings. The intended outcome of the project is to identify, recruit, and train physicians who intend to provide a broad scope of high-quality services to rural and underserved populations in the region and in Texas. To support the training and increase the impact of the project, TAMP aims to establish one or more new clinical training sites in rural, underserved communities in the region. Approval has been received from the state board and the project managers are now looking for a site to host the first fellow.
      3. Telehealth – Carly McCord, Clinical Director of the Telehealth Counseling Clinic. Ms. McCord explains that this project aims to expand mental health services throughout the Brazos Valley through tele-counseling. Through Texas A&M Physicians, the project will set up and maintain three access points in different counties in the Brazos Valley to expand mental health services to low-income and indigent persons. Services include psychological therapy and assessment to individuals in these counties. The goal of the project is to increase access to and participation in mental health services to indigent and low-income residents throughout the Brazos Valley. The project will expand current telemental health services provided in Leon County (in Centerville) and establish new sites to provide services to Burleson (in Caldwell), Washington (Brenham) and Grimes County (Navasota). Metrics for the project include set up of sites, tracking depression scores, tracking patient satisfaction, and tracking the number of provided sessions.
      4. PCMH – Ms. Spurlin explains the patient centered medical home model project is aimed at assisting high-risk, high- utilization patients. The goal of this project is to transform primary care clinics and providers to the Patient-Centered Medical Home (PCMH)/Guided Care Model through development and implementation of a redesign process in an effort to assist and support high-risk/high-utilization patients in the area and thereby improve quality and satisfaction of care, while decreasing inappropriate utilization of services. The A&M group sees about 22,000 patients per year. This project would aim to implement teams to enhance the care of patients with chronic diseases.
      5. Evidence Based Program – Doris Howell, Research Associate – Ms. Howell describes the EBP by explaining that it aims to expand evidence based programs across the 9 county region. This project, "EBP Resource Exchange", will address self-management and wellness needs among chronically ill older adults who have been shown to benefit from such evidence based programs.Thus, the EBP Resource Exchange will establish an infrastructure through TAMP to assist health care systems in Region 17 identify and select evidence-based programs; provide a centralized venue for training health care professionals and lay leaders in the delivery of evidence-based self-management and wellness programs especially targeted toward chronically ill and older adults; offer technical assistance and oversight for ensuring intervention fidelity and quality assurance; assist providers in tracking referral patterns, program reach and adoption, and eventually patient outcomes; and serve as a community repository of such programs by maintaining an inventory of available courses and community offerings.
      6. BVCCP – Suzie Van, Nurse Program Manager and coordinator of the Brazos Valley Care Coordination Program project –The goal of this project is to develop and implement a post-discharge care coordination program that provides patient navigation services to targeted frequent ED users at high risk of disconnect from institutionalized health care. The Brazos Valley Post Discharge Care Coordination Program (Hereinafter referred to as Care Coordination Program) aims to decrease the number of frequent emergency department (ED) users by ensuring appropriate follow-up care upon discharge from the hospital, and connecting these patients to a regular source of primary care and supportive health services. Ms. Van describes that the project is currently working with one local hospital to try and identify users that are utilizing the ER for primary care or for conditions that could be treated through primary care in the community. 257 patients will be enrolled by the end of the June.
      7. Palliative Care – Lisa McNair, Chief Planning Officer of Hospice Brazos Valley and collaborative partner. Ms. McNair describes the project aims to take palliative care into the home. The goal of this project is to develop and implement a home-based palliative care program for patients with chronic conditions who are not “sick” enough to qualify for hospice because they have longer than six months to live. These patients have end-stage chronic conditions and no access to comfort care. This program is an effort to improve quality of life through pain and symptom management, improving activities of daily living and bridging care to hospice. Working with the patient’s attending physician, the palliative care team will assess patient needs and coordinate care through the development of a plan of care to treat the patient at home, improve quality of life, and address acute symptom crises without re-admitting the patient to the hospital whenever medically appropriate. It’s not about stopping treatment, but rather coordination of treatment. Hospice services are also provided if necessary. One obstacle being faced by the project is staffing; a nurse practitioner was hired but was not appropriate for the position. Later an RN and physician were hired.
    - **Tri-County Services** – Cynthia Peterson, Medicaid Transformation Waiver Administrator-

Ms. Peterson describes the integrated primary care and behavioral health project. This project is a reverse co-location model where primary care is being integrated into behavioral health. The project currently has a waiting list of 200 patients. This project aims to develop/implement a program for integrated primary care & behavioral health care services, with included mobile clinic component, to improve care/access to needed primary health care for individuals receiving behavioral treatment services from Tri-County Services in Montgomery and Walker Counties. Tri-County will co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased and equipped to provide physical and behavioral health services for our individuals in locations other than existing Tri-County clinics. The mobile clinic component is yet to get started, but Tri-County staff is working on getting that going.

The intensive evaluation diversion program- This project aims to implement an intensive evaluation and diversion program to provide a community-based alternative for crisis evaluation and diversion screenings, assessments and activities, in an effort divert individuals in a mental health crisis from emergency rooms and local jails, as well as minimize placement in inpatient psychiatric facilities. Tri-County proposes an Intensive Evaluation and Diversion Program as an alternative evaluation and intervention to hospital emergency rooms, jails, and hospitals. In this program, a team of psychiatric professionals would be located at an alternative service site where crisis stabilization and rapid treatment is conducted. There have already been 100 patients been seen, even without the expansion.

The third program is expanded psychiatry. Tri-County is implementing a tele-psychiatry program that they are hoping to expand. With this Region 17 Expanded Psychiatric Delivery Program, Tri-County proposes to provide specialty psychiatric services to persons who are otherwise unable to receive necessary psychiatric care in Montgomery and Walker Counties. The primary intervention will be the provision of medication and case coordination to persons with diagnoses which do not meet DSHS contract requirements. This proposed program will provide basic services requested and needed by these individuals and reduce inappropriate care. This program will admit and serve these individuals in medication services and care coordination to meet their primary treatment needs. PDSA data is being maintained and they are hoping to have more data by the October reporting period.

The fourth program is meant to serve IDD patients who may have MH diagnosis or behavior crisis. The goal of this project is to implement an intellectual and developmental disability (IDD) assertive community treatment program to assist patients with co-occurring serious/persistent mental illness and/or severe acting out behavior and to provide crisis evaluation and diversion screenings, assessments and activities, in an effort to divert individuals into appropriate care settings and reduce the strain/costs associated with crisis intervention in hospitals and criminal justice facilities. The program/project proposal consists of an alternative crisis stabilization service, by utilizing professionals with focused expertise in addressing these crisis circumstances, and the set of conditions that lead to the crisis. A Mobile Team, led by a specialty trained Behavior Intervention Specialist, will provide services in natural environments, predominantly in homes, to address the disruptive and threatening behaviors manifested by these individuals. The project has hired a board certified behavior analyst and an IDD case manager who do functional assessments and triage. The emphasis of this program is to divert those patients from the ER and jails to get them to the appropriate services. Marketing is soon to take place. The project currently has a tele-doctor who is available Mondays and Thursdays. Data is being collected so it can be electronically extracted at a later date.

**Open Discussion:** Ms. Spurlin asks call participants if they had questions/comments for providers and project leads about their projects and any quality improvement activities

1. **Learning Collaborative Updates**
   1. RHP 17 Discussion Group – Ms. Spurlin explains that the discussion group is live and populated with approximately 18 members so far. No one has posted yet but the anchor team is going to post a welcome message tomorrow and start a discussion thread to kick things off! Anyone wanting to join can inform the anchor.
   2. Upcoming regional events
      * July newsletter will go out today or tomorrow – The newsletter will have a provider spotlight each month rather than just spotlighting one project.
      * Face-to-face LC event is planned for August 12, 2014 from 9 a.m. to 12 noon. Details will be forthcoming in the next week or so with agenda and the formal save the date will go out tomorrow.
      * Next Lunch & Learn presentation will be another joint event with RHP 8, and have it is tentatively planned it for September 24, 2014.
   3. Statewide Learning Collaborative
      * September 9-10, 2014 in Austin, Texas
      * Providers with less than 10 projects can send one in-person attendee
      * registration information has been sent to all providers
      * There will be live online web streaming and chat functions so that anyone interested can participate remotely.
      * HHSC plans to reach out to providers and make selections for poster presentations and panel speakers in the next 2-3 weeks.
      * We will share the agenda and remote log-in information with everyone once HHSC releases that information
2. **Next Steps & Adjourn** 
   1. DSRIP Providers – Ms. Spurlin encourages providers to review the project summary workbook that was sent out yesterday and update the project summary as needed. An updated version will be sent to everyone to use as a tool. Please take a few minutes to look at that and send it back to the anchor next week before plan modifications really get underway.
   2. Send the anchor any successes, events or trainings your are hosting, etc., for the newsletter.
   3. Next call scheduled for Thursday, August 14, 2014 at 10 a.m. Please inform the anchor if there is a topic you would like to cover or a specific feature of DSRIP you’d like to review. An agenda will be developed and sent out at the end of the month.

**Have an idea/suggestion to share or topic to recommend for future Learning Collaborative calls, articles, or upcoming events? Hosting an event or celebrating an achievement you’d like featured in the newsletter? We want to know!** E*mail the Anchor Team at* [*rhp17@tamhsc.edu*](mailto:rhp17@tamhsc.edu)*.*