**Care Transitions & Navigation Cohort Group**

**Initial Kick-Off Meeting**

**Minutes**

1. **Welcome and Introductions**

Participating Organizations included: HCA (Conroe Regional & Kingwood Medical); Huntsville Memorial Hospital (HMH); Montgomery County Public Health District/Hospital District (MCHD); St. Joseph Regional Health Center; Texas A&M Physicians (Evidence-Based Programming and BV Care Coordination Programs); Texas A&M Health Science Center.

1. **Goals and Purpose of Cohort**

* Broad, collaborative learning efforts were identified by HHSC and CMS as a focus of the 1115 Waiver.
* The cohort group is a way to bring together all types of stakeholders, community partners and DSRIP providers, to identify themes and community resources that maximize the impact of projects, as well as address community needs beyond the waiver.
* Cohort groups can help to address these by bringing the community partners and stakeholders together with the DSRIP providers to identify challenges faced and consider possible solutions, share resources existing in the community and region at large, share best practices and strengthen services, etc.
* Cohort Groups are a chance to expand out of the waiver “silo” that has been so provider-centric (reporting, QPI establishment, Cat 3 measures, etc.) and really give all stakeholders in the region the opportunity to actively participate and build community relations and collaborative networks.

1. **Participant Summary Presentations**

* Cohort group members are reminded to complete and return the Tabletop Discussion document, if they haven’t already – this can help identify partners to invite to the group, as well as themes across stakeholders for aims the group may want to focus on.

***Participant Summary Presentations, continued***

* A regional list of Category 3 measures used by each project was shared as a starting point to allow providers to identify other themes through projects using similar measures, or measures that may be of interest to a stakeholder type, align with community resources, etc., and facilitate collaboration through the sharing of best practices.
* A regional Quick Facts sheet was shared to allow participants to see the overview of the region, the breakdown of projects across the region by provider and type, how projects fit in the regional profile, estimated impact and funding, etc.
* Region 17 has 5 navigation projects, 1 palliative care (true care transition) project, and 4 providers tracking true ED diversion Cat 3 measures. However, other projects can also fall into care transitions and/or benefit from collaborating with those providing navigation and care transition services.
* As an example of interested collaboration to address challenges and improve services, MCHD provided an overview of how they are trying to promote ED diversion through their standard patient navigation project. MCHD’s program is to identify frequent and inappropriate ED users and connect them to a permanent medical home. MCHD faced a challenge gaining access to ER data for this project. MCHD faced the challenge of a lack of knowledge of community resources by providers.
* The Anchor team shared challenges identified in the Tabletop Discussion documents received, to highlight several themes for the group to consider, including but not limited to:
  1. Lack of community and internal buy-in for DSRIP projects
  2. Communicating benefits of programs to end users
  3. Staffing issues

1. **Group Activity/Discussion**

* MCHD faced the challenge of finding Category 3 milestones and metrics that fit program aims; no true diversion measures for non-hospital providers who don’t have open access to ED data.
  1. The provided list of regional Category 3 measures by projects could facilitate providers using the same measures to share experiences, challenges and best practices in fitting measures to programs.
* Some sample group charters from other regions were provided to facilitate consideration of possible group outputs; examples that were both simple and qualitative and some that were more clinical/quantitative.
  1. One sample showed a similar concern of improving stakeholder communication with an aim of developing a region-wide resource guide to address the challenge of lack of program awareness. The group could compile a resource guide to assist program navigation and care transition services. Also consider identifying established resource guides and set aims to add DSRIP programs to those guides to help communicate program benefits to end users and other community partners. Think about adding programs to the Texas 211 system.
* MCHD shared an example of collaborating with community partners as they are working with a local non-profit community center, who provide transportation services to the elderly population to also provide transportation to the program participants to get them to their medical homes.
* Several non-hospital providers expressed challenges related to data access or sharing with hospital providers that would be needed to demonstrate the efficacy of their programs on ED diversion and inappropriate hospital use.
  + St. Joseph Regional shared some information on the challenge of data exchange across multiple collaborating facilities that utilize different EHR systems, as well as issues related to PHI and HIPAA compliance as factors.
* HMH provided an example of community partnerships in their mobile clinic project, as they have partnered with several local businesses and churches to provide mobile health services at locations 3 or 4 times a month.
* TAMP EBP posed the challenge of collaborating with a hospital as a community provider. Buy-in for evidence-based, chronic disease management programs is difficult to establish as it is hard to identify key collaborators within that organization to reach out to.

1. **Next Steps**

* Commit to active participation
  1. Participate in cohort meetings and also draw in key program workers to meet as an internal quality improvement team to implement the goals and themes of the cohort group. Designate other coworkers/team members to participate if you cannot.
* Participants are to send a couple dates and times (for end of January/beginning of February) to the Anchor team to help set the date/time for the next development meeting.
* Identify community partners and resources that should be included in the cohort group and send contact info to Anchor team to help get a truly collaborative and transformative partnership going.
* Activities to complete prior to the next development meeting. This homework will facilitate the development meeting to allow the group to identify themes and group goals.
  1. Using the SMART Aims sheet provided, participants are to identify possible goals and aims for the group to focus on
  2. Complete the provided Activity Checklist to help with the administrative buy-in that was listed as a challenge, as well as consider aims and themes
  3. Identify success stories, best practices and favorite tools to share with group and bring those to the development meeting