**Regional Healthcare Partnership 8**

**Monthly Conference Call**

**Tuesday, September 8, 2015 • 10:00 a.m. – 11:00 a.m.**

Phone Number: 877-931-8150 **•** Participant Passcode: 1624814

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**ATTENDANCE**

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| **Organization** | **Name(s)** |
| Bell County Public Health District | N/A |
| Bluebonnet Trails | Meghan Nadolski  Morgan Starr  Penny Christian |
| Center for Life | Ranita Oliver |
| Central Counties Services | Tia Mays  Robert Walker |
| Hill Country MHMR | Kristie Jacoby |
| Little River Healthcare | George DeReese |
| Baylor Scott & White | Tammy Daniels  Candy Gourley |
| Seton Harker Heights | Zach Dietz |
| Seton Highland Lakes | Shannon Robison |
| St. David’s Round Rock Medical Center | N/A |
| Williamson County and Cities Health District | Victoria Lippman  Stephanie Trevino  Mary Beth Gangwer  Matt Richardson |
| RHP 8 Anchor Team | Angie Alaniz  Gina Lawson |
| Other Stakeholders | N/A |

**MINUTES**

1. **Welcome and Introductions**
   * The RHP 8 Anchor team is excited to announce a new addition. Jennifer LoGalbo welcomed Victoria LoGalbo on August 30. Everyone is happy and healthy.
   * Visit our new webpage called [Discover DSRIP](http://www.tamhsc.edu/1115-waiver/rhp8/discover.html.). The webpage provides a central location for the following:
     + - Provider website links to access services and social media outlets.
       - Lead program coordinator contact information.
       - Project narratives
       - RHP 8 newsletter project spotlights
       - Project videos
   * We will send out a regional update email tomorrow with updates from HHSC’s anchor call last Friday, September 4. Be sure to keep an eye out for important news from HHSC and RHP 8.
   * **Reminder: please copy the Angie Alaniz (**[**alalaniz@sph.tamhsc.edu**](mailto:alalaniz@sph.tamhsc.edu)**) and Gina Lawson (**[**GLawson@tamhsc.edu**](mailto:GLawson@tamhsc.edu)**) on communications you would normally copy Jennifer LoGalbo on while she is out on maternity leave through November.**
2. **RHP 8 Learning Collaborative Updates and Upcoming Events**
3. Recap: HHSC Statewide Learning Collaborative Summit

On August 27-28, DSRIP and UC Providers, HHSC staff, Anchor teams, and other stakeholders came together in Austin for the Statewide Learning Collaborative. A few highlights from the Summit included:

* Two of the breakout sessions included presentations from our RHP’s providers such as:
  + Matt Richardson with Williamson County and Cities Health District who presented strategies for collecting and using data more effectively.
  + Christine Jesser & Melanie Diello with Seton Healthcare who presented on conducting meaningful and effective program evaluation.
* RHP 8 had two poster presentations one by Bluebonnet Trails Community Services' "Expanded Access to Care" project & one by Central Counties Services' "Work Adjustment Training" project.
* Day 1’s keynote speakers during lunch included Dr. David Lakey, Associate Vice Chancelleor for Population Health at UT who gave his perspective on the Waiver and its future. And, Dr. Clay Johnston, Dean of the new Dell Medical School at UT Austin who provided an innovative vision of healthcare delivery.
* The future of the Waiver.
* If you would like to access the PowerPoint presentations, they are available in the “Dates and Deadlines” section of HHSC’s waiver website. <http://www.hhsc.state.tx.us/1115-Waiver-Deadlines.shtml>

1. Future Opportunity: RHP 17 Second, DY4, Face-to-Face Learning Collaborative
   1. Date: Wednesday, September 16, 2015
   2. Time: 1:00 – 4:30 p.m.
   3. Location: Baylor Scott & White Hospital – College Station – Bryan Auditorium
   4. Contact to register: Shayna Spurlin - [spurlin@tamhsc.edu](mailto:spurlin@tamhsc.edu)

Presenters/Topics include: Dr. Jay Maddock, dean of the Texas A&M Health Science Center School of Public Health will discuss population health; Rebekah Falkner and Amanda Broden from HHSC will discuss how Category 3 outcome measures relate and what CMS hopes to learn from the reported data; A provider will speak on Category 3 reporting and tracking adventures with real-time data information, and everyone will be able to talk through challenges/questions with others working on similar Cat 3 domains.

1. **“Raise the Floor” – Focus Areas and Open Discussion**
2. Provider Perspectives on Development and Successes of DSRIP Patient Navigation Projects  
   As providers across the state continue to navigate patients to receive the right care, in the right place, at the right time through their innovative, patient navigation projects, the RHP 8 Anchor team welcomes four providers to share project successes, challenges, and best practices.

**Presenter: Penny Christian, Patient Navigator Project Manager – Bluebonnet Trails Community Services,** [**Penny.Christian@bbtrails.org**](mailto:Penny.Christian@bbtrails.org)

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| Project Title and Short Overview | Expanded Access to Care – Two nurse navigators work with patients (at home) to manager chronic disease and change a generational mindset of using the emergency department (ED) for primary care. |
| Goals | Patients together with nurse navigators, access medical, dental, behavioral, vision, and socioeconomic services and overcome barriers by setting attainable goals and creating an action plan. Share data with hospital/partners. To meet Cat 3 hospital readmission metrics, they work with discharge planning staff to connect patients with services before returning home. |
| Target Population | Frequent users of Gonzales Memorial Hospital emergency services (more than 5 ED visits/year). |
| Successes | Various healthcare staff (ex. discharge planning department) and community-based organizations collaborate with the project (i.e. assistance with gas, food, clothing, homeless services (Section 8 housing), etc.) They receive outside referrals, but they cannot count them towards their DSRIP metrics, but they help the clients as another way to connect with community organizations. Three patients received cancer treatment. Presented poster presentation at statewide learning collaborative. They conduct outreach presentations to churches, community groups, federally qualified health centers (FQHCs), and private doctors to explain how the project helps the community. |

**Presenter: Candy Gourley, Vice President, Surgical Services – Baylor Scott & White Health,** [**CGOURLEY@sw.org**](mailto:CGOURLEY@sw.org)

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| Project Title and Short Overview | Patient Navigation Services with Scott & White Memorial Hospital (SWMH). Bell County Indigent Health Services collaborating partner. |
| Goals | Provide navigation services to reduce emergency services use. |
| Target Population | Low-income uninsured/indigent/Medicaid clients. Many are behavior health patients. |
| Impact on Community/QPI | August 2013 – April 2015 served 1986 individuals. |
| Successes | SWMH has seen many successes. SWMH is dedicated to the project and would like to continue after DY5. Nurse practitioner placed at Killeen Free Clinic. |
| Challenges | Originally, SWMH placed navigators at Cedar Crest, Killeen Metro, SWMH, and County Indigent Health Services. Navigator turnover has impacted ability to meet metric goals. Creating a data collection database in-line with their needs and HIPPA requirements. To address all of these challenges SWMH recently hired a project administrator, designated a “lead” navigator, established a set of core navigators housed with County Indigent Health Services, and will work with an analyst to help develop a data collection/reporting/validation system. |

**Presenter: Stephanie Trevino, Health Educator – Williamson County and Cities Health District,** [**strevino@wcchd.org**](mailto:strevino@wcchd.org)

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| Project Title and Short Overview | Patient Navigation/Heath Education Services – Extension of Community Paramedicine project |
| Goals | Lower blood pressure, reduce emergency services use |
| Target Population | Referrals - Patients 18 – 85 with hypertension and who participate in the community paramedicine project (frequent emergency services users) |
| Impact on Community/QPI | Patients receive navigation (navigator) and socioeconomic services (social worker) at the home or work (per patient preference). Use American Heart Association educational materials. |
| Successes | DSRIP team & data/epidemiology department collaboration to maintain updates on metric achievement status. Patients work with registered dietician as needed. Patients meet with social workers at home. Patients get information on exercising. In about two weeks, blood pressure is lowered. |

**Presenter: Shannon Robison, Navigator – Seton Highland Lakes,** [**srRobison@seton.org**](mailto:srRobison@seton.org)

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| Project Title and Short Overview | Patient Navigation Services - Patients receive navigation and socioeconomic services such as access to a medical home, and financial assistance to access medication patient assistance programs. |
| Goals | Reduce emergency services use. Patients become more engaged in their healthcare. |
| Target Population | Low-income uninsured/indigent/Medicaid clients |
| Best Practices | Community collaborations/provider education to gain more referrals. |
| Successes | Medical director sees participants receiving more comprehensive care than they were receiving in the ED. |
| Challenges | DSRIP project serves Burnet County residents, but referring providers are outside of county. |

1. Open Discussion

**Q/A:**

* Candy Gourley with SWMH will share their assessment/in-take form with the Anchor team to include with the minutes. The form assesses DSRIP eligibility and provides an action plan.
* Penny Christian with Bluebonnet Trails suggested obtaining the partnering hospital’s readmission list from the health information manager/medical records manager. The list helps to identify clients they are not already serving.

**Reminders:**

* October Reporting: We are here if you have any October reporting questions. Be sure you are working with your data people and checking your metric achievement status.
* Project Leads: If you have people to add as users to be able to access the Online Reporting System to enter October DY4 reporting, please send Gina Lawson ([glawson@tamhsc.edu](mailto:glawson@tamhsc.edu)) their info by Monday, September 21 via the spreadsheet we sent out on September 2 listing RHP 8 users, if you have not already.

1. **Next Steps/Adjourn**

Next Conference Call: **Tuesday, October 13, 10:00 - 11:00 a.m.**