**Regional Healthcare Partnership 8**

 **Monthly Conference Call**

 **Tuesday, October 14, 2014 • 10:00-11:00 a.m.**

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

****

|  |  |
| --- | --- |
| **Organization** | **Name(s)** |
| Bell County Public Health District | Renee Stewart |
| Bluebonnet Trails | Amy PierceVicky HallJennifer BourquinJamie Schmitt |
| Center for Life | Alexis FletcherJoey Smith |
| Central Counties Services | Michael PinonSharon McCannTia Mays |
| Hill Country MHMR | Kristie Jacoby |
| Little River Healthcare | George DeReese |
| Scott & White – Llano | Kim Schroeder |
| Scott & White – Memorial | Bill Galinsky |
| Seton Hospital System | N/A |
| Seton Harker Heights | Zach Dietze |
| Seton Highland Lakes | Crissy Calvert |
| St. David’s Round Rock Medical Center | N/A |
| Williamson County and Cities Health District | Mary Beth GangwerMatt RichardsonErin Rigney |
| RHP 8 Anchor Team | Jennifer LoGalboGina Lawson |
| Other Stakeholders | Erine Gray – Aunt Bertha Shayna Spurlin – RHP 17 AnchorAnnie Burwell – Williamson County Mobile Outreach & Healthcare Link |

**ATTENDANCE**

**AGENDA**

1. Welcome and Introductions
2. [RHP 8 Learning Collaborative Updates and Upcoming Events](http://www.tamhsc.edu/1115-waiver/rhp8/lc/index.html)
	1. RHP 8 Monthly Learning Collaborative Conference Call
3. As a reminder, starting this month the Anchor team will move from a bi-weekly call schedule to a monthly call.
4. The Anchor team is hosting calls during DY4 on the second Tuesday of the month from 10-11 a.m.
5. [Minutes](http://www.tamhsc.edu/1115-waiver/rhp8/lc/calls.html) and attendance lists are posted online.
	1. [RHP 8 Monthly Newsletter](http://www.tamhsc.edu/1115-waiver/rhp8/lc/archive.html)
6. The RHP 8 regional newsletter went out Tuesday, October 7th.
7. October’s newsletter highlights two transformational projects in our region:
	1. Seton Highland Lake’s patient navigation project in Burnet County, and
	2. Little River Healthcare’s expanded specialty care project in Milam County.
		1. Little River’s project allows for expanded screenings and early detection of breast, cervical, and colorectal cancers.
	3. [RHP 8 Behavioral Health and Primary Care Cohort](http://www.tamhsc.edu/1115-waiver/rhp8/lc/cohort.html)
8. The next RHP 8 Behavioral Health and Primary Care Cohort meeting date is planned for Wednesday, November 5th, at Seton Highland Lakes in Burnet.
9. The purpose of the meeting is to review and determine goals and aims for the team to focus on during DY4.
10. If interested in learning more about this upcoming meeting, please visit the [RHP 8 Cohort website](http://www.tamhsc.edu/1115-waiver/rhp8/lc/cohort.html) or contact the Anchor team.
	1. [RHP 2 Behavioral Health Learning Collaborative Status Call](http://www.utmb.edu/1115/)
11. The Anchor for RHP 2, University of Texas Medical Branch at Galveston, has extended an invitation for RHP 8 DSRIP Providers to dial-in for their monthly Behavioral Health Learning Collaborative calls.
12. These calls are hosted on the 3rd Tuesday of the month, from 2-3 p.m.

Phone: 1-877-226-9790

Participant Code: 3535427

1. “Raise the Floor” – Focus Areas and Open Discussion
2. Project Spotlight: Increasing Awareness and Decreasing Diabetes in Williamson and Bell Counties

*Presented by: Erin Rigney, Healthy Eating Liaison Supervisor - Community Health Services
Williamson County & Cities Health District (WCCHD)*

1. One of the health district’s DSRIP projects is a 3-year project focused on providing evidence-based health education, nutrition counseling, and health screening to prevent and reduce childhood and adolescent obesity, specifically to the underinsured, uninsured, low-income and indigent populations.
2. Program: [Get Fit, Get Healthy, Get Movin’ (3G)](http://www.wcchd.org/services/health_education/children_s_health/get_fit.php)
	1. Consists of an interdisciplinary team who focus on comprehensive health – physical, dietary, social, and mental
	2. Age Groups: 3 – 5, 6 – 13, and 14 – 17
	3. 10-week program meeting once a week; 1 hour nutrition education and 1 hour physical activity
	4. Participants: parents and children
	5. Program served 26 parents and children in Round Rock pilot
3. After evaluating the pilot project with ages 6 – 13 in Round Rock, WCCHD revamped the curriculum using evidence-based tools including Energy Balance 101 which also has a self-esteem component.
4. A new 10-week program started in Taylor with 4 families having perfect attendance.
5. The 14-17 age group has been the most challenging to get started; they are still working on reaching these kids with the right resources/curriculum. The goal is to get started in DY4.
6. Questions:
	1. Joey Smith, Center for Life Resources – Would like more information about evidence-based resources for adults. Erin to follow-up with Joey about resources.
	2. Jennifer LoGalbo, Anchor - Are Spanish materials available? Yes, Energy Balance 101 offers materials in Spanish.

*Presented by: Zach Dietze, Assistant Administrator
Seton Harker Heights (SHH)*

1. SHH joined RHP 8 in fall 2013 with a new, 3-year project – hospital opened in June 2012, and project was implemented in May 2014.
2. The SHH project aims to expand primary care in Bell County (Harker Heights is near Belton) with a goal on diabetes management and prevention.
3. Project collaborates with the Killeen Free Clinic in Bell County.
	1. Cat 3 measure focuses on diabetes management and prevention by reducing blood pressure.
4. Challenges:
	1. Getting started - hiring process, employee turn-over, staff with family/medical extended leave
	2. Difficulty meeting patient number goals due to not enough staff and starting late in the year
5. Success stories:
	1. Patients finally getting connected to healthcare Providers
	2. Free clinic coordinating with local community resources for socio-econ/emotional service referrals
	3. Patient accountability/engagement - patients meet in a large group orientation setting for program eligibility screening and sign-up. Patient signs contract and can be removed from program if not meeting the responsibilities. Patients make a commitment to receive these free health care services. The spots are limited so they need to take these free services seriously because there are many people on the waiting list. Patients are engaged and taking ownership in self health care.
		1. *See attached Patient Contract for both English and Spanish version*
6. Comments: Matt Richardson, Williamson County and Cities Health District (WCCHD) – identified with SHH’s hiring process as a difficulty they experienced in Williamson County. Zach suggested involving staff in the hiring process.
7. Innovator Agent: Aunt Bertha.com – Bridging the Gap between Client Needs and Available Services

*Presented by: Erine Gray, Founder
Aunt Bertha, Inc.*

[Aunt Bertha.com](https://www.auntbertha.com/) focuses on connecting the underprivileged with need-based services while significantly improving the backend operations, and customer outreach for government and charity social service programs that provide these services. The solution delivered via Software-as-a-Service (SaaS) allows these organizations to significantly drive down operational costs (reference: <http://bit.ly/1vX4t4w>).

Prior to founding Aunt Bertha in 2010, Erine has filled various leadership roles: Organizational Leader, Developer, Project Manager, and Director. He has been recognized as a 2014 TED Fellow, 2014 Aspen Ideas Festival Scholar, and 2012 Unreasonable Institute Fellow.

1. Aunt Bertha, a certified B corporation, is a website that makes it easy for people to find food, health, housing, and education programs, and then assist them with application processes.
2. Their mission is to make human service program information more accessible, to both people and agencies/programs.
3. Aunt Bertha revamped the common search engines from using “area” (zip code/city) to using “coverage” (services available to my area).
4. Aunt Bertha offers a feature to pre-screen state benefits you could qualify for by anonymously entering the number of people in your family and household income.
5. An enrollment platform is available on Aunt Bertha that speeds up the process for clients.
	1. The system safely stores info for cross-application entry to other agencies enrollment applications who partner with Aunt Bertha. The client would not have to re-enter the same info again and again.
6. Aunt Bertha performs data collection and assessment, tracking search topics and number of results to assess needs.
7. Features for users:
	1. Users can update their program data online at [www.auntbertha.com/claim](http://www.auntbertha.com/claim)
	2. Community hub available for agencies wanting to review data collected by Aunt Bertha
	3. “Social Mondays” – get feedback from social workers
	4. Trainings offered
	5. Referrals functionality – helps identify if client connected with referral
8. Questions/Comments
	1. Matt Richardson, WCCHD – Would like to discuss data exchange and adding WCCHD programs to Aunt Betha.com.
	2. Joey Smith, Center for Life Resources – Brownwood is in a rural area and he inquired about how to get rural resources listed on Aunt Betha.com. Erine mentioned conducting a pilot in a rural county and offered Aunt Bertha.com staff could work with Joey to identify local resources that serve his area as well as adding the providers who offer free or sliding scales.
	3. Annie Burwell, Williamson County Mobile Outreach – Management had questions about working with Aunt Betha.com regarding data exchange/ownership. Erine has been working with City of Austin and can share his feedback. Annie also inquired about a hospital discharge planning feature. It’s not available yet but Superior is developing/using a tool for post-care processes.
9. Open Discussion
10. Next Steps/Adjourn