RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: May 2015

Contact Information

Provider Organization: Behavioral Health Center of Nueces County

Primary Contact: Victoria Rodriguez	**Email:** vhuerta@bhcnc.org

Goals

Goal(s):

- Improve patient engagement and responsibility through health education and care coordination activities.
- To use electronic and print media in our medication clinic and waiting area.
- Have televisions installed in patient rooms.
- Have 55 inch television installed in medication clinic waiting area for e-signage.
- Hold classes to educate and supplement the integrated care (PH and BH) treatment.

Plan

Plan for Implementation and Achievement:

- Have televisions installed.
- Identify materials needed for purchase to begin classes.
- Set up a survey on Survey Monkey or Access Database to interview clients about their knowledge of new programs.
- Implement client prizes for attendance.

Do

Actions Taken:

- Television installed in exam room playing a DVD about eating healthy and diabetes education geared for the South Texas Population.
- Installed a 55" television in our medication clinic which runs promotions for all center activities highlighting our clinic, groups and presence on social media.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
  - Videos began playing in exam room and in clinic waiting area.
  - Storyboard development for videos highlighting patient engagement activities.
- *Challenges:*
  - Client attendance for our groups has been low.

Act

Next Steps:

Gather client feedback and data on knowledge of center offerings.

Collaborate

Share Successes and/or Request Assistance

- How are other centers implementing patient engagement materials?

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: May 2015

Contact Information

Provider Organization: Bluebonnet Trails Community Services

Primary Contact: Penny Christian | **penny.christian@bbtrails.org**

Goals

Goal(s):

- Increase available appointments at PCP office and at local Mental Health Agency
- Educate patients on making appointments and attending appointments
- Educate patients on using the Web-Portals provided by their PCP offices to review medical records results and to schedule appointments
- Work with Community Agencies to develop good working relationships

Plan

Plan for Implementation and Achievement:

- Develop a Care Plan for each patient to address their needs
- Evaluate each individual for training and educational needs
- Train and evaluate training to assess continued support
- Survey each patient for XXXXX of services received
- Train and give knowledge to all agencies the Navigator staff is working with in the Community

Do

Actions Taken:

- Evaluation of progress made towards goals
- Survey ED staff for review of processes
- Nurses staff meeting to reeducate on the 115 Waiver Project

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    - Currently we have clients that are able to schedule and attend appointments without coaching they are able to complete goals without assistance
- *Challenges:*
    - Access to computers and telephone systems
    - Transportation to appointments

Act

Next Steps: Continue to assess each person/individual for their needs and address each one for support and success.

Continue to work with Community Agencies to develop relationships for assistance with client/patient's needs.

Collaborate

Share Successes and/or Request Assistance

- We have patients able to follow through on their care at this time.
- We are receiving referrals from the Community including Physicians that have patients with needs.

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: May 2015

Contact Information

Provider Organization: Corpus Christi – Nueces County Public Health District

Primary Contact: Annette Rodriguez, MPH	**Email:** annetter@cctexas.com

Goals

Goal(s):

1.3.1 Implement a Chronic Disease Management Registry (*Diabetes*); Implement/enhance and use chronic disease management registry functionalities.

• Have 1,000 patient records in the Health District registry (continue this DY4 goal while also converting partner clinics/programs to EMR system)

2.7.5 Implement *innovative evidence-based strategies (MEND) to reduce and prevent obesity in children and adolescents.*

• Enroll 500 children in the 10 week MEND program; Increase number of partners offering program

Plan

Plan for Implementation and Achievement:

1.3.1

• Continue to monitor HINSTXs participation cost issues and partner concerns
• EMR application specialist continues setup, and training of partners;
• Pilot projects with willing partners to provide local examples as advertising to other partners

2.7.5

• Successfully established 17 program sites delivering MEND programs
• Identified and trained additional leaders to run MEND programs

Do

Actions Taken:

1.3.1

• Additional equipment purchases
• Pilot 3 month project set with Mission of Mercy to compare EMR conversion to current system on clinic use and data collection process

2.7.5

• New program manager hired; Continue work on establishing additional program sites; advertise and recruit additional children in the target population; increased social media campaign

Study

Review and Evaluate:

- *Progress Towards Goal(s):*

1.3.1

• Progress Towards Goal(s): Pilot project with Mission of Mercy, data to be presented in September; goal to convince with small scale results that large scale conversion is worthwhile and possible

• Challenges: Pricing of HINSTX is prohibitive to many partner clinics (over $20,000 each per conversion). Many volunteer providers are reluctant to go through EMR conversion.

2.7.5

• Progress Towards Goal(s): Catholic Charities, Boys and Girls Club of Corpus and Robstown, and local small gyms, are currently offering the MEND program. There are ongoing efforts to re-strategize and discuss 2015-2016 school year collaboration with CISD.
• Challenges: Previous negative media. Community/cultural resistance to children being labeled as overweight and the lifestyle/food changes that the program promotes.

Act

Next Steps:

Next Steps: Continue social media campaign and new partner recruitment. Focus on CISD inclusion of MEND program in 2015-2016 school year. Focus EMR conversion from paper charting systems for smaller non-profit groups, utilizing the data from their projects to demonstrate the process to other non-profit organizations with concerns about going through the hassles of an EMR conversion.

Collaborate

Share Successes and/or Request Assistance

Our 1115 waivers, including Diabetes and MEND work together frequently to assist family members in varied age groups. Recently the Diabetes waiver was presenting to a community advisory committee who requested data on childhood diabetes statistics. We provided them data on both pediatric diabetes and obesity, and emphasized that obesity in childhood is the issue to focus on from a public health perspective. The committee has become a strong supporter of the MEND waiver after seeing the statistical data, and are now active in pushing for CISD to again offer MEND in the 2015-2016 school year.

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: January 2015-March 2015

Contact Information	
Provider Organization: CHRISTUS Spohn – Alice	
Primary Contact: Sherry Wachtel	**Email:** Sheryln.wachtel@christushealth.org

Goals

Goal(s):

- Develop long term plan for program design and implementation to improve patient engagement

Plan

Plan for Implementation and Achievement:

1. To increase health literacy and access to care

2. Increase communication and forge collaborative relationships with community partners

Do

Actions Taken:

1. To increase health literacy and access to care
   - Implemented Care Transitions/Care Partners at CHRISTUS Spohn Memorial. As of October 1, 2014 expanded to CHRISTUS Spohn Hospital-Shoreline, Kleberg, Alice, and Beeville.
   - Walk in clinic opened (4th Floor Memorial)
   - Extended hours and Saturday appointments available
   - Health resources disseminated region wide October 1, 2014
   - Sharing community resources and events via CHRISTUS Spohn's Facebook

2. Increase communication and forge collaborative relationships with community partners
   - Interagency collaborative meetings continue with shift in focus toward Marketplace enrollment.
   - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services
   - To improve communication and build upon Regional Collaborative efforts, "Meet & Greet" scheduled at each CHRSITUS Spohn Hospital campus-Alice, Beeville, and Kleberg.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
  1. To increase health literacy and access to care
     - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
     - Increased interest in program from other disciplines; pharmacy, case management, physicians.
     - Transition from hospital to home work-flow has been challenging , but goal is to hardwire into discharge process
  2. Increase communication and forge collaborative relationships with community partners
     - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Multiple agencies came together to provide health screening, health education, and vaccines. Served 750 people at this event.
     - Collaborative group identified other venue opportunities, to address faith based community needs.
- *Challenges:*
  1. To increase health literacy and access to care
     - High participant drop-out rate
     - Trust building between community and organization
  2. Increase communication and forge collaborative relationships with community partners
     - Buy-in from community partners in terms of time and different goals

Act

Next Steps:

1. To increase health literacy and access to care
   - Evaluate marketing strategy
   - Involve healthcare providers (i.e., physicians)
   - Educate hospital staff
   - Engage and collaborate with community partners to improve health literacy
2. Increase communication and forge collaborative relationships with community partners
   - Monthly communication collaboration meetings

Collaborate

Share Successes and/or Request Assistance

- Decreased 30-day readmission rates (all cause) from 13.8 % to 3 % amount program participates at the Corpus Christi campus DY3.

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: January 2015-March 2015

Contact Information	
Provider Organization: CHRISTUS Spohn – Beeville	
Primary Contact: Sherry Wachtel	**Email:** Sheryln.wachtel@christushealth.org

Goals

Goal(s):

- Develop long term plan for program design and implementation to improve patient engagement

Plan

Plan for Implementation and Achievement:

1. To increase health literacy and access to care

2. Increase communication and forge collaborative relationships with community partners

Do

Actions Taken:

1. To increase health literacy and access to care
    - Implemented Care Transitions/Care Partners at CHRISTUS Spohn Memorial. As of October 1, 2014 expanded to CHRISTUS Spohn Hospital-Shoreline, Kleberg, Alice, and Beeville.
    - Walk in clinic opened (4th Floor Memorial)-Corpus Christi Project
    - Extended hours and Saturday appointments available
    - Health resources disseminated region wide October 1, 2014
    - Sharing community resources and events via CHRISTUS Spohn's Facebook

2. Increase communication and forge collaborative relationships with community partners
    - Interagency collaborative meetings continue with shift in focus toward Marketplace enrollment.
    - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services
    - To improve communication and build upon Regional Collaborative efforts, "Meet & Greet" scheduled at each CHRSITUS Spohn Hospital campus-Alice, Beeville, and Kleberg.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    1. To increase health literacy and access to care
        - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
        - Increased interest in program from other disciplines; pharmacy, case management, physicians.
        - Transition from hospital to home work-flow has been challenging , but goal is to hardwire into discharge process
        - Program marketing is key
    2. Increase communication and forge collaborative relationships with community partners
        - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Multiple agencies came together to provide health screening, health education, and vaccines. Served 750 people at this event.
        - Collaborative group identified other venue opportunities, to address faith based community needs.
- *Challenges:*
    1. To increase health literacy and access to care
        - High participant drop-out rate
        - Trust building between community and organization
    2. Increase communication and forge collaborative relationships with community partners
        - Buy-in from community partners in terms of time and different goals

Act

Next Steps:

1. To increase health literacy and access to care
    - Evaluate marketing strategy
    - Involve healthcare providers (i.e., physicians)
    - Educate hospital staff
    - Engage and collaborate with community partners to improve health literacy
2. Increase communication and forge collaborative relationships with community partners
    - Monthly communication collaboration meetings

Collaborate

Share Successes and/or Request Assistance

- Decreased 30-day readmission rates (all cause) from 13.8 % to 3 % amount program participates at the Corpus Christi campus DY3.

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: January 2015-March 2015

Contact Information	
Provider Organization: CHRISTUS Spohn – Corpus Christi	
Primary Contact: Sherry Wachtel	**Email:** Sheryln.wachtel@christushealth.org

Goals

Goal(s):

- Develop long term plan for program design and implementation to improve patient engagement

Plan

Plan for Implementation and Achievement:

1. To increase health literacy and access to care
2. Increase communication and forge collaborative relationships with community partners

Do

Actions Taken:

1. To increase health literacy and access to care
   - Implemented Care transitions/Care partners at CHRISTUS Spohn Memorial. As of October 1, 2014 expanded to CHRISTUS Spohn Hospital-Shoreline, Kleberg, Alice, and Beeville.
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   - Sharing community resources and events via CHRISTUS Spohn's Facebook
2. Increase communication and forge collaborative relationships with community partners
   - Interagency collaborative meetings continue with shift in focus toward Marketplace enrollment.
   - Enhanced community website (coastalbendhealthfinder.com) to encourage information sharing of community resources and services

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
    1. To increase health literacy and access to care
        - Program is fully implemented with distinct roles for Registered nurses and Community Health Workers.
        - Increased interest in program from other disciplines; pharmacy, case management, physicians.
        - Transition from hospital to home work-flow has been challenging , but goal is to hardwire into discharge process
    2. Increase communication and forge collaborative relationships with community partners
        - Yearlong community relationships have been forged. We now have common goals. Multiple collaborations have occurred. Working with multiple agencies to provide health screening, health education, and vaccines to the communities we serve.
        - Collaborative group identified other venue opportunities, to address faith based community needs.
- *Challenges:*
    1. To increase health literacy and access to care
        - High participant drop-out rate
        - Trust building between community and organization
    2. Increase communication and forge collaborative relationships with community partners
        - Buy-in from community partners in terms of time and different goals

Act

Next Steps:

1. To increase health literacy and access to care
    - Evaluate marketing strategy
    - Involve healthcare providers (i.e., physicians)
    - Educate hospital staff
2. Increase communication and forge collaborative relationships with community partners
    - Monthly communication collaboration meetings
    - To improve communication at Regional Collaborative meetings; added “Meet and Greet” at each community hospital campus.

Collaborate

Share Successes and/or Request Assistance

- Decreased 30-day readmission rates (all cause) from 13.8 % to 3 % amount program participates.

RHP 4 | Coastal Bend Region

Improve Patient Engagement | Quarterly Report Form

Reporting Period: January 2015-March 2015

Contact Information	
Provider Organization: CHRISTUS Spohn – Kleberg	
Primary Contact: Sherry Wachtel	**Email:** Sheryln.wachtel@christushealth.org

Goals

Goal(s):

- Develop long term plan for program design and implementation to improve patient engagement

Plan

Plan for Implementation and Achievement:

1. To increase health literacy and access to care
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Do

Actions Taken:

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   - Implemented care transitions/care partners at CHRISTUS Spohn Memorial. As of October 1, 2014 expanded to CHRISTUS Spohn Hospital-Shoreline, Kleberg, Alice, and Beeville.
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   - Extended hours and Saturday appointments available- Corpus Christi Project
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   - To improve communication and build upon Regional Collaborative efforts, "Meet & Greet" scheduled at each CHRSITUS Spohn Hospital campus-Alice, Beeville, and Kleberg.

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Review and Evaluate:

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   - Evaluate marketing strategy
   - Involve healthcare providers (i.e., physicians)
   - Educate hospital staff
   - Engage and collaborate with community partners to improve health literacy
2. Increase communication and forge collaborative relationships with community partners
   - Monthly communication collaboration meetings

Collaborate

Share Successes and/or Request Assistance

- Decreased 30-day readmission rates (all cause) from 13.8 % to 3 % amount program participates at DY3 Corpus Christit

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: May 2015

Contact Information	
Provider Organization: Jackson County Hospital District	
Primary Contact: Donna Coleman	**Email:** dcoleman@jchd.org

Goals

Goal(s):

- Improve patient engagement and responsibility by reducing the number of unnecessary ER visits.

Plan

Plan for Implementation and Achievement:

- Support Team estabilished
- Community educational materials developed.
- Established outreach services to local groups.
- Continued support and monitoring by the Senior Staff Team.

Do

Actions Taken:

- Continue to monitor the program and implement updated educational materials and services.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
  - Continue to improve accessibility of the program for the public.
  - Onsite OPR Team evaluation of the program – ongoing.
  - Community education / enhancement of the program.
- *Challenges:*
  - Ongoing updates for educational materials.
  - Ongoing education for the community, staff and physicians.

Act

Next Steps:

Monitor and evaluate the program to continue to strengthen goals and care received by the patient.

Collaborate

Share Successes and/or Request Assistance

- The Outpatient Pulmonary Rehabilitation Program has implemented the OPR Maintenance Program which assures that once the individuals complete the treatment program that they continue to have support for their disease processes. To date, within this reporting period, eight have graduated from the program and continued to remain on the maintenance program independently. Each graduate received a free one year membership to the gym to give them an incentive to remain independent and manage their pulmonary diagnosis with the education and training they received in the treatment plan.

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: May 2015

Contact Information	
Provider Organization: University of Texas Health Science Center at Houston	
Primary Contact: Anaelle Moal	**Email:** Anaelle.moal@uth.tmc.edu

Goals

Goal(s):

- To maintain families engagement and responsability after their participation in the MEND program.

Plan

Plan for Implementation and Achievement:

- Implement several strategies to maintain families' engagement after the program.

Do

Actions Taken:

- Sending text messages to families:

  After the 10 week program, motivational text messages are sent to families that attended at least 10 sessions (out of 20) included the last session (sessions #20). The objective of the motivational text messages are to sustain program impact and motivate continued behavior change. Families receive one text/week.

- Offer post program activities:
  A monthly exercise session is offered at the local Farmers Market along with market produce coupons to serve as an after program support session and to maintain contact with the MEND families. The monthly exercise session is held every first Saturday of the month. The very first session was held on February 7, 2015.

- Implement 6 month follow-up session:
  As part of the MEND protocol, we are required to collect 6 month post program data in order to evaluate the impact of the program on participants. Families that attended at least 10 sessions (out of 20) included the last session (sessions #20) are contacted to attend a 6 month follow-up session. In addition of collecting data, the 6 month follow up session allows to maintain contact with families and re-engage them on behavior changes for healthier lives.

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
  - Sending text messages to families:
    Text messaging seems to be an effective way of reminding, motivating and reaching families.
  - Offer post program activities:
    First session was hold on February 7, 2015. At least one session has been offered from March to May 2015. About 15 to 20 children participated at each exercise session.
  - Implement 6 month follow-up session:
    The 6 month follow up session seems to be an effective way of motivating and re-engaging families into their behavioral change objectives.
- *Challenges:*
  - Multiple groups with diverse schedules and messages to keep track of for texting programming can be challenging.
  - Some families did not show up to the 6 month follow up session. It is difficult to reach families by phone since many have changed phone numbers or simply do not answer.

Act

Next Steps:

- Monthly exercise sessions offered at the local Farmers Market will also feature role model speakers (past program participants).
- During the month of July 2015, 2 exercises sessions will be offered in a public park each week.
- Family "group texting" will be formed in which families in sessions remain connected and plan outings (park, walking, potluck healthy meal, etc.) post program.

Collaborate

Share Successes and/or Request Assistance

-