**Category 2 DSRIP Project Summary**

**Williamson County and Cities Health District – 126936702.2.100**

**Project Area, Option and Title:** 2.7.5 Implement innovative evidence‐based strategies to reduce and prevent obesity in children and adolescents.

**RHP Project Identification Number:** 126936702.2.100

**Performing Provider Name:** Williamson County and Cities Health District

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** Project plans include the development of an interdisciplinary team consisting of health educators, registered dietitians, community health workers, social workers, marketing staff, and healthcare professionals. Utilizing this team is a fundamental approach to providing health education consistent with evidence-based models, nutrition counseling, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community.
* **Project Need:** CN 3 .3 – Lack of coordinated care for those with multiple needs - Inconsistency in data collection which identifies health disparities and populations at risk.Williamson County ISD’s collection of Fitnessgram and Texas Risk Assessment for Type 2 Diabetes in Children data is inconsistent, including different data collection time frames and grade levels. There is a lack of consistent coordinated care for children identified as at risk through Fitnessgram and Texas Risk Assessment for Type 2 Diabetes in Children.
* **Target Population:** We will be targeting the 18 and under population in Williamson County, which makes up 28.7% of our county’s population (2010 Census data). Additionally, we will focus on low-income children enrolled in Medicaid, uninsured, and underinsured. According to Medicaid enrollment reports from May 2013, there were 14,874 children age 1-18 enrolled in Medicaid. By the end of DY5, we will provide interventions to 810 unique individuals. We estimate that approximately 30% of the individuals will be Medicaid eligible and 5% uninsured.
* **Expected Category 2 Project Benefit for Patients and a Description of the QPI Metric(s):** The improvement goal of this project is to provide approximately 810 individuals with access to childhood obesity prevention and management programs (DY3: 180 individuals, DY4: 270 individuals, and DY5: 360 individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-5, allowing us to increase the number of individuals participating in the innovative intervention. Each year, we aim to increase the number of individuals participating in this intervention, as measured by Milestone I-5, Metric I-5.2: Number of individuals of target population reached by the innovative project.
* **Category 3 Measure(s):** The following category 3 measures were proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents).
	+ IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by individuals receiving one of the health education services provided by WCCHD staff (facility subset).
	+ IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents): We will demonstrate improvement in the percentage of children 3-17 years of age who had a WCCHD visit and had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity. This includes health education services and excludes children *only* receiving an immunization services

**Project Description:**

Implement innovative strategies consistent with evidence-based models to reduce and prevent obesity in children and adolescents.The purpose of this project is to prevent and reduce childhood and adolescent obesity, specifically in the underinsured, uninsured, low-income and indigent populations. According to the CDC, children and adolescents who are obese are likely to be obese as adults and are more at risk for adult health problems such as heart disease, type-2 diabetes, and stroke. By tracking and monitoring the early childhood, middle childhood, and adolescent populations, this project has the potential to prevent youth from developing chronic diseases or conditions as adults.

Project plans include the development of an interdisciplinary team consisting of health educators, registered dietitians, community health workers, social workers, marketing staff, and healthcare professionals. Utilizing this team is a fundamental approach to providing health education, nutrition counseling, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community. WCCHD currently provides obesity prevention awareness and weight management education in the community which is open to all.

Program components will vary based on children and adolescent age groups – 2-5 years, 6-13 years, and 14-17 years – and their families. Since the project will work with both adolescents and adults, this project will focus on capturing QPI for individuals. Primary components include outreach, marketing, and health education classes. Extensive nutritional counseling, case management, and social support will be provided to those with obesity-related comorbidities. In Year 3, the project will serve 180 individuals, 270 individuals in Year 4, and 360 individuals in Year 5. All activities will be documented and analyzed by WCCHD Data Reporting & Information Management team.

The WilCo Wellness Alliance, an established coalition focused on preventing and reducing chronic diseases as part of the community efforts. Therefore, the likelihood of project success is high utilizing these existing partnerships and structure. Sustainability will be achieved through education as well as policy, systems, and environmental changes through schools, communities, workplaces, and families making this truly a combination of individual and population based health transformation. Further analysis at the neighborhood level will help drive targeted interventions and education. The WilCo Wellness Alliance is a countywide health and wellness coalition comprised of government, schools, healthcare, business, faith-based, and non-profits. WCCHD will implement new programs and activities specifically for targeted populations that are in alignment with existing programs and WilCo Wellness Alliance initiatives. Current initiatives focus on healthy eating, active living, use of the built environment, and behavioral health.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use an interdisciplinary team to provide a culturally competent and holistic approach in the prevention and reduction of obesity in children and adolescents. Key partners in this endeavor include the school districts and the health department through the WilCo Wellness Alliance’s School Health Forum. The approach, consisting of health education, nutrition counseling, case management, outreach, care coordination, and social support, will ensure program participants receive support and services necessary to positively managing their health.

**Project Goals:**

1. Implement innovative strategies consistent with evidence-based models to reduce and prevent obesity in children and adolescents

Milestones are provided below for DY 3-5:

In DY 3:

1. P-2: Implement evidence-based innovational project for targeted population.
2. I-5: Identify 180 unique patients in defined population receiving innovative intervention consistent with evidence-based models.
3. P-X.1: Hire and train 5 FTE equivalents. Train an additional 9 FTE’s existing staff for the interdisciplinary team. A total of 14 staff will be trained for the interdisciplinary team.
4. P-6.1: Documentation of tested ideas, practices, tools, and/or solutions In DY 4-5:
5. I-5: Identify 270 (DY4) and 360 (DY5) unique patients in defined population receiving innovative intervention consistent with evidence-based models.
6. P-6.1: Documentation of tested ideas, practices, tools, and/or solutions

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents, including those with multiple needs;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs

This project is related to the above Regional Goals. Children and adolescents who are overweight and obese, or at risk will have increased access to programs and activities; those with multiple needs (i.e., obesity-related comorbidities) will receive additional services including care coordination, social support, nutrition counseling, and case management.

**Challenges:**

Challenges in this project include lack of transportation to services, perceived low health literacy, cultural traditions pertaining to food, and family time constraints. For this project to be effective, we must build rapport with the targeted populations. Strategies to build rapport and participation include using an interdisciplinary team trained in cultural competency, health literacy, and health education and positioning programs and activities in identified areas of need within the county.

**3-Year Expected Outcome for Provider and Patients:**

WCCHD expects to increase the number of childhood obesity prevention programs accessible to clients, in the targeted populations – children and adolescents with high incidence of overweight and obesity and associated risk factors – eventually leading to a reduction in health disparities related to childhood obesity. WCCHD proposes to expand programs each year to the broader community, taking into consideration the population that is currently served by this agency (the safety-net population who is uninsured and underinsured).

**Starting Point/Baseline:**

Currently, childhood and adolescent obesity prevention and management programs are provided in the community sporadically. The WCCHD existing weight management program reached 120 individuals (2010-2011).

**Quantifiable Patient Impact (QPI):**

WCCHD will use HHSC’s recommended QPI (individuals impacted) for this project. Each year we will seek to increase the number of patients that are participating in the innovation intervention. Over the course of the project, we expect the total patient impact to be approximately 810 individuals with access to childhood obesity prevention and management programs (DY3: 180 individuals, DY4: 270 individuals, and DY5: 360 individuals). In DY3, the quantifiable patient impact (QPI) will be measured by Milestone I-5, allowing us to increase the number of individuals participating in the innovative intervention. Each year, we aim to increase the number of individuals participating in this intervention, as measured by Milestone I-5, Metric I-5.2: Number of individuals of target population reached by the innovative project.

**Rationale:**

Community Need Addressed: CN.3 – Lack of coordinated care for those with multiple needs - Specific Community Need: CN.3.3 - Inconsistency in data collection which identifies health disparities and populations at risk. Comprehensive overweight and obesity rates for adolescents in Williamson County are not known at this time. However, we do have snapshot indicators that give a glimpse into the prevalence of obesity and overweight adolescents.

What we do know:

*In Texas-*

* Approximately 27.8% of Texas population is under the age of 18, making up to 1.5 million young people at risk of developing serious medical conditions.
* In 2011, Texas was ranked as the 12th most obese state in America (Obesity in Texas).
* In 2011-12, 37% of the children age 10-17 in Texas were either overweight or obese(Kids Count)

*In Williamson County-*

* Approximately 67% of adults in Williamson County are overweight or obese
* 77% reported consuming four or fewer servings of fruits and vegetables per day (HCI).
* According to available Fitnessgram data from 2011-2012 for Williamson County ISD’s, out of 56,373 students who had their BMI measured, 23% of students had a BMI that put them “at risk” for weight-related health conditions.
* Approximately 13% of children aged 2-4 living in households with an income less than 200% of the federal poverty level are obese (HCI).

Projected outcomes of current rates of overweight and obesity-

* By 2030, rising obesity rates in Texas are projected to triple the cost of health care to a total of $325 billion dollars (Texas Comptroller of Public Accounts, 2011).
* According to the CDC, obese children may experience immediate health consequences which can lead to weight-related health problems in adulthood
* Further, In addition to suffering from poor physical health, overweight and obese children can often be targets of early social discrimination which can hinder academic and social functioning that may persist into adulthood (CDC)*.*

Healthy lifestyle habits, such as healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases (CDC). Using the information available, we can see that overweight and obesity are serious conditions that are projected to continue to increase without intentional comprehensive lifestyle interventions. Through our health management programs and outreach, we will be able to target both families and children and with the goal of impacting the lifestyle habits of the entire family.

Fitnessgram1 is a comprehensive educational and reporting tool used in Williamson County ISDs to assess physical fitness and physical activity levels for children. Components of the tool include measures related to aerobic capacity, muscular strength, muscular endurance, flexibility, and body composition. Fitnessgram measurements are now required in Texas schools. A key component of this project will be to gather Fitnessgram data from all school districts in Williamson County to provide a more substantive baseline of childhood overweight and obesity rates. Additionally, we will work with our WIC program to identify the magnitude of overweight and obesity in children ages 0-5.

**Project Core Components:**

1. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications and research staff.

**Continuous Quality Improvement:**

Continuous quality improvement is a core component of this project. WCCHD is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

As part of P-6.1, provider will document tested ideas, practices, tools, and/or solutions through:

* Healthy Communities Section meeting minutes
* Integrated Care Team meeting minutes
* Plan-Do-Check-Act cycle
* Review of evidence-based curriculums

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

This project will significantly enhance the existing childhood obesity weight management program provided by WCCHD. This project will provide the opportunity to utilize curricula consistent with evidence-based models for the 2-5, 6-13, and 14-17 year old populations. While WCCHD is the primary provider of the childhood and adolescent obesity prevention and management program, community support will be through stakeholders involved in the WilCo Wellness Alliance. This includes schools, healthcare agencies, nonprofits and community-based organizations, faith-based community, governmental agencies, and businesses.

Initiatives that will enhance the existing delivery system reform include menu labeling at local restaurants or local food establishments, health education messaging on local parks and trails, healthcare providers participating in the Health Information Exchange (HIE), and physician or healthcare provider prescribed exercise. School personnel and members of the School Health Advisory Committees (SHACs) will participate in a School Health Forum at least quarterly to discuss health and wellness for school age children. Stakeholders will also be involved in the implementation of health education classes through referral system, facility space, personnel, and/or supplemental materials. WCCHD does not have additional funding through DSHS that will duplicate these services. The existing Medicaid 1115 waiver projects will enhance the project by maximizing the utilization of Community Health Workers for health promotion and wellness activities as well as connecting clients to medical and social services through patient navigation, community paramedicine, clinical preventive services, and expanded access to care.

Customizable Process or Improvement Milestone:

The interdisciplinary team will consist of 14 staff including health educators, registered dietitians, community health workers, social worker, marketing professionals, and marketing staff. There will be 9 existing staff trained for the team and 5 new FTE equivalents hired and trained for the team.

Initial training will include review and application of the program consistent with evidence-based models to be implemented, electronic documentation required to track participation and outcomes, and ongoing review and training on findings in the obesity literature. Ongoing CQI will be integrated into all training activities.

**Related Category 3 Outcome Measure(s):**

The following category 3 measures were proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]) and IT-1.29 (Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents).

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**Relationship to Other Projects/Regional Goals:**

This project is one in a system of DSRIP projects that will increase access to health care, improve quality of care, and improve health outcomes for rural populations including:

* 126936702.1.1 - Expanded Capacity for Access to Care
* 126936702.1.2 - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care
* 126936702.1.3 - Implement project to enhance collection, interpretation, and/or use of REAL data
* 126936702.2.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
* 126936702.2.2 - Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an unified population
* 133340307.2.4 - Recruit, train and support consumers of mental health services to provide peer support services
* 081771001.2.1 - Apply evidenced-based care management model to patients identified as having high-risk care needs

**Plan for Learning Collaborative:**

WCCHD will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. Participation in these learning collaborative meeting events, as well individual training opportunities, regional spotlights and routine collaborative communications in the region, will allow WCCHD to work with other Providers within this specific project area or with similar targeted outcomes in an effort to share what we are doing, what we are learning, and how we might all leverage this shared information to continually improve and benefit the projects. The results of each learning collaborative meeting will be compiled and disseminated electronically to the entire RHP within 30 days after the meeting and will be archived on the RHP website hosted by the anchor ([www.tamhsc.edu/1115-waiver](http://www.tamhsc.edu/1115-waiver)). In addition, opportunities may exist and will be explored for WCCHD to interact with providers in other RHPs who may have an implementation of an innovative evidence‐based strategy to reduce and prevent obesity in children and adolescents focus to expand learning and quality improvement initiatives. Additionally, WCCHD looks forward to participating in HHSC’s statewide learning collaborative activities as available.

**Project Valuation***:*

The value cost of this project for DY 3-5 is estimated at $307,998. Cost covers recruitment, hiring, and training staff; tools and equipment necessary for the implementation of the project; and promotional campaign materials and literature. The valuation of this project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high need because it will serve a significant number of obese children and adolescents residing in the community, specifically those that encounter barriers to accessing health promotion services. Utilizing the interdisciplinary team is a fundamental approach to providing health education, health promotion, and health screening based on cultural background, English proficiency, and health literacy level of the individual or community.

See also:

* Fitnessgram. *Program Overview*. 2013. <http://www.fitnessgram.net/programoverview/>;
* CDC. *Childhood Obesity Facts*. 2013. <http://www.cdc.gov/healthyyouth/obesity/facts.htm>;
* HHSC. *Medicaid Enrollment by County*. May 2013. <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/ME/201305.html>;
* Healthy Communities Institute (HCI). *Williamson County Community Dashboard*. <http://www.healthywilliamsoncounty.org/modules.php?op=modload&name=NS-Indicator&file=index>; and
* Kids Count. *Children and teens overweight or obese by gender*. <http://datacenter.kidscount.org/data/tables/27-children-and-teens-overweight-or-obese-by-gender?loc=1&loct=2#detailed/2/10-19,2,20-29,3,30-39,4,40-49,5,50-52/false/1021,18,14/14,15,16/296>