**Category 2 Project Narrative – Pass 2**

**Williamson County and Cities Health District – 126936702.2.2**

**Project Area, Option and Title:** 2.6.1- Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

**Unique Project ID:** 126936702.2.2

**Performing Provider Name:** Williamson County & 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 a1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** This project will use an interdisciplinary team to promote preventive health awareness by offering health education classes, case management, social media messaging and health literacy education in the community, specifically women of child bearing age, high incidence rate of frequent hospitalizations for chronic conditions and women entering prenatal care after the first trimester.
* **Project Status:** This is a new project.
* **Project Need:** CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease. According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health and the county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; low health literacy and access to healthy food options, which indicates that residents are in need of accessible health promotion options and connection to available resources. Currently, health educators offer health education programs consistent with evidence-based models to the community at no cost; however, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.
* **Target Population:** The project seeks to increase the availability of access to health promotion programs and activities strategically located in identified areas with a high rate of incidence in chronic illness and/or women of child bearing age. According to the latest Behavioral Risk Factor Surveillance Survey (BRFSS) from 2007-2010, 117,725 of the total population of Williamson County reported being diagnosed with either heart disease, diabetes, obesity or asthma. That is 31.7% of the total population. And, according to the 2100 Census Data, there are 96,246 women of children bearing age in the county. The target population is our patients that need access to health education programs in venues accessible to them, specifically those with limited or no transportation. Approximately 60% of our current patients are either indigent, Medicaid -eligible or low-income uninsured, so we expect they will benefit from more than half of the proposed project.
* **Category 1 or 2 Expected Project Benefit for Patients:** The target population is patients that need access to health education programs/activities in venues accessible to them, specifically those with limited or no transportation. Because there are no public transportation services in Williamson County, geographically placing these services in venues that are within walking distance and utilizing trained community health workers will augment the patient’s knowledge related to their chronic illness or their pregnancy, thereby increasing the probability they will maintain their health through self-management and/or appropriate primary care. It is estimated that approximately 261 patients attended over 26 health promotion-related classes/programs which were hosted by WCCHD Health Educators at one of the four Public Health Center locations. By the end of DY4, the goal is to increase the number of targeted population reached by 20% or 42,000 through health promotion activities and/or awareness campaigns (social media included). In DY5, approximately 25% of targeted population reached or 54,000 through health promotion activities and/or awareness campaigns (social media included). The increase in classes/activities, awareness campaigns and strategically placing community health workers in areas with high incidence rate of chronic illness and/or women of child bearing age, will bring a robust awareness in healthy lifestyle thereby potentially reducing hospitalization costs related to services that could have been prevented.
* **Category 3 Outcomes:** The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.
  + 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 patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.
* **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project. The project would promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. Plans include the development of a team consisting of community health workers, health educators, registered dietitians, and marketing professionals. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Marketing strategies, methods and interventions will be tailored to the specific needs of the targeted population within each community. In alignment with WilCo Wellness Alliance (WWA) community initiatives, WCCHD will develop health promotion activities through this interdisciplinary approach. WWA is a coalition built with representation of community business leaders, health care providers, school personnel and community based organizations.

**Project Description:**

The team will strategically position themselves in identified areas to promote, educate, empower and link targeted populations towards appropriate utilization and knowledge of their health care and medical homes, if applicable. WCCHD will utilize current methods of marketing and promotion as well as education such as; social media (i.e. Facebook and You Tube) and texting. Without reinventing the system for social media campaigns, WCCHD will reference the Centers for Disease Control (CDC) and Prevention toolkit for connecting the community through social media. In addition to utilizing social media, the team will engage targeted populations through local venues where they live, work and pray. WCCHD understands these methods and others will need to be culturally competent, English proficient and literacy level appropriate.

According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of residents who do not have health insurance coverage (County Health Rankings (2012) [www.countyhealthrankings.org](http://www.countyhealthrankings.org)). This statistic, in addition to the fact that this county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; and access to healthy food options, indicates that Williamson County residents are in need of accessible health promotion options and connection to available resources. Currently, WCCHD health educators offer health education programs and self-management education consistent with evidence-based models to the community, at no cost to attendees. However, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.

WCCHD proposes to target zip codes in Williamson County with the poorest perinatal outcomes, low rates of entry to prenatal care within the first trimester, highest hospital utilization rate for targeted chronic conditions (Diabetes, Asthma, Hypertension and Obesity), and available resources. This data is currently available from the State, Community Health Profiles and County Rankings.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use an interdisciplinary team to promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. This is in alignment with regional goals of developing projects and interventions designed to reduce the need for inappropriate utilization of services.

**Project Goals:**

* Health promotion in targeted population of women of child bearing age;
* Health promotion in targeted population of individuals with chronic disease;
* Improved health literacy among targeted populations;
* Self-management education and information for individuals with chronic disease;
* Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
* Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction

**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; and
* Reducing inappropriate utilization of services.

**Challenges:**

The challenge in working with a population who has limited understanding and knowledge base of their health with obstacles in transportation could have an effect in engaging targeted population. For this project to be effective, we must build rapportwith the targeted populations. Training community health workers in cultural competency, health literacy, and health education along with positioning them in identified areas within the county will help to establish rapport and encourage/support participation in programs.

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

WCCHD expects to increase the number of health promotion programs accessible to clients, in the targeted populations—women of child bearing age and residents with chronic disease, eventually leading to a reduction in health disparities related to prenatal care and chronic disease. 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, population-based campaigns or a program to promote healthy lifestyles using evidence-based methodologies through social media and the incorporation of Community Health Workers does not exist at this time. Therefore, the baseline for number of participants, as well as the number reached by these efforts, begins at 0 in DY2.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.1 – Limited Access to Primary Care
* Specific Community Need: CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease

According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report*, 2005-2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congenital Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) ([http://www.wcchd.org/statistics and\_reports/](http://www.wcchd.org/statistics%20and_reports/)) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (e.g.; diabetes). The current safety-net providers have waiting lists for new patients, making it difficult for chronically-ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver, learn, and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

Vulnerable RHP 8 citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five-year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to direct these patients to other community services in a more seamless and effective system.

As the United States health care system strives to promote healthy lifestyles, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Community health workers can increase access to care and facilitate appropriate use of health promotion resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, and improve quality by contributing to patient‐provider communication, continuity of care, and consumer protection. In addition, community health workers will incorporate case management services for high risk patients. According to the latest issue of *Guide to Community Preventive Services 2005,* case management is effective when delivered in conjunction with education and support interventions. Interventions combined with case management include self-management education, home visits, telephone call outreach, and client reminders. Utilizing Community Health Workers to strengthen case management services will prove improvements within the targeted population. Several studies related to the utilization of community health workers reported significant improvements in participants' self-management behaviors, including appointment keeping and adherence to antihypertensive medications. Similar studies reported positive changes in healthcare utilization and in systems outcomes (Addressing Chronic Disease through Community Health Workers: A Policy and Systems-level Approach <http://www.cdc.gov/dhdsp/docs/chw_brieft.pdf>). Reducing illness, disability, and premature death and improving the quality of life for people is a major public health objective found in Healthy People 2020.

One simple conclusion can be drawn and that is a project promoting healthy lifestyles and access to care is needed in Williamson County. It already has been proven to be effective when combining case management, community support, interventions and promotion.

**Project Core Components:**

We propose to meet the following required project component through the health promotion program:

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 health promotion program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications, community relations and research staff.

**Continuous Quality Improvement:**

Continuous quality improvement is a core component of the health promotion 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.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Currently, an initiative utilizing community health workers in the community does not exist for Williamson County. However, providing case management is a service offered but only to patients enrolled in the County Indigent Health Care Program. This initiative is in alignment with the U.S. Department of Health and Human Services (DHHS) initiative on patients with multiple chronic conditions. Managing these clients in the community (such as with self-management educations and case management) can have a significant impact on their need for accessing the emergency departments (EDs) or hospitals. This project seeks to augment the work of the community health centers in providing coordinated care to clients and connect them to a medical home. Furthermore, by utilizing a multi-disciplinary team approach, client’s medical, social, and diet needs will be addressed, in a culturally-competent manner. WCCHD does not receive funding from DHHS that will be used for this program.

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

The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.

* 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 patient navigation services provided by WCCHD staff (facility subset).
* IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.

Reasons/rationale for selecting the outcome measure: This particular domain was chosen to help evaluate this project’s interventions. We propose to address the community’s limited access to preventive interventions.

* IT-6.2a: By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention and a positive impact on the community. In DY3, we worked to increase access to health promotion programs and activities, performed project planning activities, and established a baseline for patient satisfaction. Simultaneously, we will develop health promotion programs and increase access points to health promotion activities. Meeting the needs of the clients in the community will augment their knowledge related to their chronic disease or their pregnancy, increasing the chance that they will maintain their health through self-management and appropriate primary care.
* IT-1.7: If the patients are receiving the benefit of the combined efforts of the WCCHD Health Promotions Team and the Williamson County EMS Community Paramedicine Team, we should expect that patients with hypertension would have their blood pressure under control as a result of these interventions. Thus, the IT-1.7 outcome is an appropriate measure of our effectiveness.

**Relationship to Other Projects:**

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; and
* 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

No other providers in RHP 8 are establishing this type of initiative, though several are working with chronic disease. This project is focused on increasing access to preventive interventions in Williamson County, ultimately reducing health disparities. We have collaborated with other performing providers in the RHP to include the continuum of care necessary for targeted population served. Through the St. David’s Round Rock Medical Center project (#020957901.1.1), Williamson County residents under 200% FPL will be referred and connected to acute care type of services. In addition, we are working with Bluebonnet Trails Community Services – Emergency Services Diversion Project (#126844305.2.2) which will identify high utilizers of emergency services; provide early intervention or intensive wraparound services and supports for a targeted behavioral health population, including people with co-occurring disorders. By coordinating with these projects and providers, we can contain costs by avoiding the duplication of services, and provide meaningful delivery system reform to the underserved and low-income populations. Several learning collaboratives of professionals from the areas of primary care and mental health services exist in Williamson County. These active groups, who meet monthly, strive to provide continuous quality improvements, seek new ideas and solutions to improve patient outcomes, and share with others across the State of Texas and the nation. In addition, WCCHD will participate in RHP 8 learning collaboratives on at least a semi-annual basis.

**Project Valuation:**

The value cost of this project for DYs 2-5 is estimated at $1,342,175. Cost covers recruitment, hiring, and training staff; tools and equipment necessary for the implementation of the project; and promotional campaigns, material 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 residents in the community, specifically those that encounter barriers to accessing health promotion services. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Use of methodologies such as social media and text messaging will make the programs even more accessible to the increasingly tech-savvy population. Providing these types of health promotion services/programs, such as self-management programs, will serve to divert these types of needs from the urgent and emergent care facilities.

See also:

* American Journal of Preventive Medicine – 2007 May; 32(5): 435-47
* [www.ncbi.nlm.nih.gov/pubmed/17478270](http://www.ncbi.nlm.nih.gov/pubmed/17478270);
* Texas Department of State Health Services – Health Facts Profiles (2009) <http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/>;
* FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report: <http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf>; and
* Community Health Profile of Williamson County Precincts (2011) <http://www.wcchd.org/statistics_and_reports/>