

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period:

Contact Information	
Provider Organization: Behavioral Health Center of Nueces County	
Primary Contact: Victoria Rodriguez	Email: vhuerta@bhnc.org
Goals	
Goal(s): <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• Have televisions installed.• Identify materials needed for purchase to begin classes.	
Do	
Actions Taken: <ul style="list-style-type: none">• Purchased televisions.• Ordered class materials for DEEP classes.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Outreach has begun in the integrated health clinic.○ Promotion of client engagement materials to unit directors here at BHCNC○ Handing out of flyers to clients, encouraging attendance for patient engagement activities.○ TVs with DVDs were purchased so videos can be recorded onto them and played.○ Patient target population identified.	

- *Challenges:*
 - Purchasing televisions from only one location as we have to use purchase orders.
 - Not having the televisions we needed.
 - Having only one maintenance person to mount the television.

Act

Next Steps:

Gather client feedback and data on participation on class offerings, and videos that show in clinic and wait rooms, make changes as appropriate.

Collaborate

Share Successes and/or Request Assistance

- How are other centers implementing patient engagement materials?

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Reporting Period: September, October, November - 2014

Contact Information	
Provider Organization: Bluebonnet Trails Community Services	
Primary Contact: Penny Christian	Email: penny.christian@bbtrails.org
Goals	
Goal(s): <ul style="list-style-type: none">• Increase available appointments at PCP office and at local Mental Health Agency• Educate patients on making appointments on line or via the telephone• Educate patients on using the Web-Portal provided by their PCP to schedule appointments• Educate Patients on the management of their Chronic Disease Processes	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Develop an assessment to identify the needs of each individual client.• Evaluate each client for needs and develop a plan for training each individual based on their specific needs.• Assist/teach each client to scheduling appointments with their PCP-and/or Specialty Providers.• The process and steps of scheduling appointments and follow up needs such as labs, x-rays outpatient scheduling	
Do	
Actions Taken: <ul style="list-style-type: none">• Each Client is given a Patient Navigation Notebook on admission to keep up with medications, appointments, names and phone numbers of PCPs and other needs outlined in their care plan.• Evaluate progress of each individual at admission and monthly and during case management visit (during demonstration of skill)• Adjust plans as required by achievements and needs.• Encourage compliance of each individual to achieve their highest level of self-care.	

Study

Review and Evaluate:

- *Progress towards Goal(s):* Clients are willing and able to engage in care and follow plans to move towards self-management of health care needs. They readily engage with case manager to develop their plan of care and establish needs and goals to work towards.
- Evaluation of methods of training and compliance.
- Evaluate needs of each individual and their level of understanding.

- *Challenges:*
 - Telephone access
 - Computer access
 - Patient Education process/levels
 - Transportation

Act

Next Steps:

Continue to evaluate each patient/client's needs and educate them to reach their goals using with return demonstration for evaluation of all needs.

Monitor compliance of each individual and reevaluate as needed, measure levels of achievement at client appointments/visits.

Collaborate

Share Successes and/or Request Assistance

- Clients are engaging in developing their care plans and are making progress towards their goals.
- Two clients are able to schedule with their PCP and their specialty MDs as well as scheduling their transportation through the Medicaid Transportation line.

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Reporting Period:

Contact Information	
Provider Organization: Camino Real Community Services	
Primary Contact: Dennis Scholl, PhD	Email: denniss@caminorealcs.org
Goals	
Goal(s): Increase patient engagement in services	
Plan	
Plan for Implementation and Achievement: Offer standardized assessment to 100% of our consumers	
Do	
Actions Taken: PHQ9 being given to 100% of our consumers	
Study	
Review and Evaluate: <ul style="list-style-type: none"><i>Progress Toward Goal(s):</i> We continue to administer the PHQ9 in established locations. It is used to screen for depression and assess again for improvement after an appropriate period of treatment.<i>Challenges:</i> Getting enough antidepressant treatment by appropriate physicians is difficult in any underserved area.	
Act	
Next Steps: Begin second administrations of the instrument and assess progress for indicated patients.	
Collaborate	
Share Successes and/or Request Assistance: Revising our Electronic Health Record to allow entry of PHQ9 scores makes tracking and reporting easier.	

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Reporting Period:

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 (<i>Diabetes</i>); Implement/enhance and use chronic disease management registry functionalities. <ul style="list-style-type: none">Have 1,000 patient records in the Health District registry 2.7.5 Implement <i>innovative evidence-based strategies (MEND) to reduce and prevent obesity in children and adolescents. This project will address the obesity epidemic by applying an internationally recognized and scientifically sound method for supporting and coaching underserved and minority families to achieve better nutrition and physical activity habits.</i> <ul style="list-style-type: none">Enroll 500 children in the 10 week MEND program; participate in face to face learning collaborative; develop focus groups to project data and test for new ideas	
Plan	
Plan for Implementation and Achievement: 1.3.1 <ul style="list-style-type: none">Contracted with Chart Relay to interface with partners EMR software to further develop our Chronic Disease Registry while waiting HINSTXs participation cost to be distributed;Hired EMR application specialist for setup, maintenance and training of partners;Attended Chronic Disease Registry collaborative Conference at UT Health Science Center Brownsville, RHP 6 2.7.5 <ul style="list-style-type: none">Successfully established 17 program sites delivering MEND programsIdentified and trained additional leaders to run MEND programs	

Do

Actions Taken:

1.3.1

- Met with Chart Relay to interface data between Health District and community partner EMR's until HINSTIX is available

2.7.5

- Work on establishing additional program sites; recruit and hire a manager for the program; advertise and recruit additional children in the target population

Study

Review and Evaluate:

1.3.1

- *Progress Towards Goal(s): Signed contract with Chart Relay for local HIE capabilities for Chronic Disease Registry*
- *Challenges: Lack of HINSTIX pricing information continues to cause delays in connectivity*

2.7.5

- *Progress Towards Goal(s): The program team has visit with additional community partners for the delivery of the program, including, but not limited to Boys and Girls Club, daycare centers, elementary schools, middle schools, faith based organizations, YMCA, small gyms, latch-key and other community based organization; in addition we have re-strategized on how to improve program implementation at the ISD level*
- *Challenges: Negative media surrounding this program has caused some resistance on retaining new delivery partners*

Act

Next Steps: Continue to enhance the programs, contact families that need assistance with nutritional needs and developing good physical activity behaviors; have delivery partners sign on with Chart Relay

Collaborate

Share Successes and/or Request Assistance

- 293 children attended and completed the MEND program; retained all but one delivery partner in our community; signed a contract with Chart Relay to share EMR information between delivery partners

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Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: October 2014 – December 2014

Contact Information	
Provider Organization: Jackson County Hospital District	
Primary Contact: Donna Coleman	Email: dcoleman@jchd.org
Goals	
Goal(s): <ul style="list-style-type: none">• Improve patient engagement and responsibility by reducing the number of unnecessary ER visits.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Support team established for Outpatient Pulmonary Rehabilitation Program in the hospital and the clinic.• Community education for COPD and the OPR Program.• Patient educational material development.• Established outreach services to local church groups, nonprofit groups and civic organizations.• Program is supported by Senior Staff Team and implemented throughout the hospital campus with ongoing monitoring.	
Do	
Actions Taken: <ul style="list-style-type: none">• Continue to monitor program implementation and education services for the reduction of unnecessary ER visits.	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Staff/Physicians understanding goals and structure of OPR Program – ongoing.○ Onsite OPR Support Team established to improve patient engagement through education /understanding of the program.○ Community education enhancement follow-up by OPR Support Team.○ Review education materials and accessibility to the public.• <i>Challenges:</i><ul style="list-style-type: none">○ Ongoing updates of education materials needed for staff and patients to assure patient engagement and responsibility for the program.	

Act

Next Steps:

Continue to monitor and evaluate processes for deliverance of program to increase effectiveness of availability and acceptance to the public with the intent to enhance quality of life and reduce unnecessary ER visits by utilization of the program.

Collaborate

Share Successes and/or Request Assistance

- Throughout the quarter the utilization of the OPR Program has increased. The Support Team has evaluated the OPR Program and assures tools, staff and physicians are available for monitoring patients with respiratory/pulmonary diseases. Educating patient with these conditions will give them accessibility to the program and they will be able to enhance their quality of life by utilization of resources available for their disease process. Utilization of the OPR Program will continue to reduce unnecessary ER visits.

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Reporting Period: September 2014- December 2014

Contact Information	
Provider Organization: CHRISTUS Spohn – Alice	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">Develop long term plan for program design and implementation to improve patient engagement	
Plan	
Plan for Implementation and Achievement: <ol style="list-style-type: none">To increase health literacy and access to careIncrease communication and forge collaborative relationships with community partners	
Do	
Actions Taken: <ol style="list-style-type: none">To increase health literacy and access to care<ul style="list-style-type: none">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 availableHealth resources disseminated region wide October 1, 2014Sharing community resources and events via CHRISTUS Spohn’s FacebookIncrease communication and forge collaborative relationships with community partners<ul style="list-style-type: none">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. 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
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.

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Improve Patient Engagement | Quarterly Report Form

Reporting Period: September 2014- December 2014

Contact Information	
Provider Organization: CHRISTUS Spohn – Beeville	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">Develop long term plan for program design and implementation to improve patient engagement	
Plan	
Plan for Implementation and Achievement: <ol style="list-style-type: none">To increase health literacy and access to careIncrease communication and forge collaborative relationships with community partners	
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Collaborate

Share Successes and/or Request Assistance

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Reporting Period: September 2014- December 2014

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Provider Organization: CHRISTUS Spohn – Corpus Christi	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
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Reporting Period: September 2014- December 2014

Contact Information	
Provider Organization: CHRISTUS Spohn – Kleberg	
Primary Contact: Sherry Wachtel	Email: Sheryln.wachtel@christushealth.org
Goals	
Goal(s): <ul style="list-style-type: none">Develop long term plan for program design and implementation to improve patient engagement	
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Collaborate

Share Successes and/or Request Assistance

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RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: 10/1/14-present

Contact Information	
Provider Organization: Border Region Behavioral Health Center	
Primary Contact: Alda Rendon	Email: aldar@borderregion.org
Goals	
Goal(s): <ul style="list-style-type: none">To improve patient engagement and communication by enabling the patient to participate in consistent and customized outreach for both Regions 5 & 20.	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">Identify how we could accomplish this for our patients (appointment reminders using automated patient messaging, confirmations, reactivation, referrals, birthday wishes, surveys, newsletters, patient portal, E-surveys, waiting room check in)	
Do	
Actions Taken: <ul style="list-style-type: none">Contract signed 9/30/14, working on implementation of program.Currently working with engineer from Solutionreach to access data (read only) for implementation of service.Support request submitted to CernerScheduled staff for Solutionreach webinar trainings	
Study	
Review and Evaluate: <ul style="list-style-type: none"><i>Progress Towards Goal(s):</i><ul style="list-style-type: none">We are in implementation stageWebinar training available for staff to prepare for implementation of serviceAll scheduled appointments now scheduled for each providerConsistent documentation of no showsIdentified which clients had cell phones, landlines and/or emailUpdated client informationIPad available for patient access (waiting room check in)	

- *Challenges:*
 - Communication with IT Dept and Solutionreach to implement service
 - Submitted support request to Cerner for guidance to IT director as Solution Reach is trying to access our Database. They just need read access (Cerner)
 - Implementation taking longer than expected
 - Getting started

Act

Next Steps:

- Implementation expected by last week in Feb, only for Webb, (Starr) in stages
- Ensure that all support staff (outpatient & primary care) are trained
- Inform clients of this service and instruct them

Collaborate

Share Successes and/or Request Assistance

- Identified a vendor who can provide all the services that we have identified and more than we expected for patients (appointment reminders using automated patient messaging, confirmations, reactivation, referrals, birthday wishes, surveys, newsletters, patient portal, E-surveys, waiting room check in)
- Contract signed 9/30/14

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period:

Contact Information	
Provider Organization: Harlingen Medical Center	
Primary Contact: Deborah Meeks	Email: dmeeks@primehealthcare.com
Goals	
Goal(s): <ul style="list-style-type: none">• Improve Care Transitions	
Plan	
Plan for Implementation and Achievement: <ul style="list-style-type: none">• Perform discharge follow up phone calls within 72 hours of discharge• Provide follow up appointments to patients on discharge• Provide education during admission on community resources• Provide information regarding admission and care to PCP	
Do	
Actions Taken: <ul style="list-style-type: none">• Discharge phone call check list created and implemented• Discharge appointments made prior to discharge• Education materials provided during admission• EMR available to all PCP's	
Study	
Review and Evaluate: <ul style="list-style-type: none">• <i>Progress Towards Goal(s):</i><ul style="list-style-type: none">○ Greater than 90% of all discharged patients are contacted within 72 hours of discharge○ Follow up appointments are made for patients prior to discharge○ EMR available to PCP's• <i>Challenges:</i><ul style="list-style-type: none">○ Patient information for contact is not correct○ Physician offices closed on weekend and holidays○ Physician engagement in EMR	

Act

Next Steps:

- Attempt to verify patient information prior to discharge to get accurate phone contact information
- Anticipated weekend and holiday discharges and make follow up appointments early
- Continue educating physicians and promoting EMR

Collaborate

Share Successes and/or Request Assistance

- Follow up phone calls have provided additional information for improvement of care transitions during admission
- Appointments are rescheduled during follow up phone calls if the patient did not make appointment as scheduled
- Assistance with medication and transportation provided during follow up phone calls

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: February 9, 2015

Contact Information	
Provider Organization: Rio Grande Regional Hospital	
Primary Contact: Rosalinda Rangel	Email: Rosalinda.rangel@hcahealthcare.com
Goals	
Goal(s):	
<ul style="list-style-type: none"> Increase diabetes education and screenings for school-aged children. 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> Partner with local school districts to increase awareness of diabetes and school-aged population. <ol style="list-style-type: none"> McAllen ISD PSJA ISD Screen school-aged population, and contact those at high risk for diabetes education and management using a family and team approach. 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> Currently we have screened over 360 students. In progress of contacting those at high risks for education and management. <ol style="list-style-type: none"> Clinic began contacting students and their families this month; we should have an update by the end of the month. 	
Study	
Review and Evaluate:	
<ul style="list-style-type: none"> <i>Progress Towards Goal(s):</i> <ul style="list-style-type: none"> Conducted screenings, and provided diabetes education during screenings. <i>Challenges:</i> <ul style="list-style-type: none"> Parents' view of screening as something negative. This presents a challenge to us since without their consent we cannot screen or educate children. <ol style="list-style-type: none"> We have seen an increase in consent forms, as three program has increased outreach efforts. 	
Act	
Next Steps:	
<ul style="list-style-type: none"> Contact the families and students who are at risk for education. 	
Collaborate	
Share Successes and/or Request Assistance	
<ul style="list-style-type: none"> No TA needed at this time. 	

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: DY4 – Quarter 2

Contact Information	
Provider Organization: Tropical Texas Behavioral Health (TTBH)	
Primary Contacts: Diana Maldonado, Primary Care Services Director	Email: dmaldonado@ttbh.org
Jim Banks, Business Development Director	Email: jbanks@ttbh.org
Goals	
Goal(s):	
<ul style="list-style-type: none"> • Provide health education and training for patients with, or at high risk for, diabetes. 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> • Identify clients seen in the primary care clinic with diabetes or at high risk for diabetes. • Schedule appointments for these clients with the TTBH Chronic Care Nurse and Registered Dietitian. • Enroll patients in 16 week Diabetes Education Empowerment Program (DEEP). • Develop educational material related to diabetes including nutritional information. • Collaborative development of individualized care plans that include disease self-management and nutrition goals. 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> • Since the 2014 opening of our “reverse” co-located primary care clinics: <ul style="list-style-type: none"> ○ primary care has been delivered to 822 unduplicated clients at our Edinburg clinic; ○ primary care has been delivered to 647 unduplicated clients at our Harlingen clinic; and ○ although construction of our Brownville clinic is pending completion, chronic care management and dietitian services have been delivered to 79 unduplicated clients at our Brownsville behavioral health clinic. • Integrated services provided have included: <ul style="list-style-type: none"> ○ Scheduling clients for monthly appointments with registered dietitian; ○ Scheduling clients for bi-weekly appointments with chronic care nurse; ○ Monitoring blood glucose and HbA1c at intake and on a quarterly basis thereafter; ○ Supporting clients efforts to achieve collaboratively developed self-management goals; and ○ Providing clients and family members with educational materials and following up on their understanding of the disease and progress with self-management goals. • Educational posters and pamphlets have also been distributed to resources in the community. 	

Study

Review and Evaluate:

- *Progress Towards Goal(s):*
 - Improvement of overall health was documented for clients enrolled in Chronic Care Management Program.
 - 92% of clients enrolled in Chronic Care Management Program have set self-management goals.
- *Challenges:* Some clients served report they are unable to follow nutritional guidelines due to lack of financial resources.

Act

Next Steps:

- Continue to provide services/education as needed to at risk patients.
- Encourage all chronic care patients to set self-management goals.
- Continue to promote TTBH's integrated BH/PC services to our clients and throughout our communities.

Collaborate

Share Successes and/or Request Assistance

- Success: Improved health outcomes observed and documented.
- Success: 92% of Chronic Care clients have set self-management goals.
- Collaborate: Determine if other providers are aware of community resources available to assist clients with basic needs.
- Collaborate: Request and review examples of promotional/educational materials that have been successful for other healthcare providers in our region.

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

Reporting Period: October 2014 – December 2014

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):	<ul style="list-style-type: none">To retain families in the MEND (Mind, Exercise, Nutrition, Do it) program and improve families' engagement.
Plan	
Plan for Implementation and Achievement:	<ul style="list-style-type: none">Implement several strategies to retain families in the program and measure the impact on families' engagement (attendance to sessions, active participation)Offer post-program activities to extend families' engagement.
Do	
Actions Taken:	<ul style="list-style-type: none"><u>Sending text messages to families:</u> During the 10 week program: text messages are sent to the families to remind them of the sessions. Reminder messages are sent to parents who opt for text messaging. Messages are sent the day prior as reminder and the day of if there is a schedule or location change due to weather or host facility. After the 10 weeks program: text messages are sent to families upon completion of the ten weeks in order to remind them of the free monthly exercise sessions.<u>Providing incentives:</u> Incentives are provided to kids at the first session and at multiple points in the program. Some incentives include t-shirts, athletic equipment like basketballs and a chance each session to win a bicycle in drawings for those present.<u>Offer post program activities:</u> Monthly exercise sessions are 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. First session was held on February 7, 2015.

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 parents. Those who do not opt for text messaging receive a phone call.
 - Providing incentives: Our attendance across sessions has increased since we started providing larger incentives to participants.
 - Offer post program activities: First session was hold on February 7, 2015. About 25 children participated.
- *Challenges:*
 - Cost of incentives
 - Staff time purchasing, obtaining donations and logistics of delivery and tracking across programs.
 - Multiple groups with diverse schedules and messages to keep track of for texting programming can be challenging.

Act

Next Steps:

- Text messages will be expanded with motivational text messages to be sent to families upon completion of the ten weeks in order to sustain program impact and motivate continued behavior change maintenance.
- Monthly exercise sessions offered at the local Farmers Market will also feature role model speakers (past program participants) and measurement activities (BMI, step test, etc.).
- Family “group texting” will be formed in which families in sessions remain connected and plan outings (park, walking, potluck healthy meal, etc.) post program
- Incentives for maintenance stage like reduced sports league registrations, or gym memberships for the family will be initiated.

Collaborate

Share Successes and/or Request Assistance

-

RHP 4 | Coastal Bend Region

Improve Patient Engagement and Responsibility | Quarterly Report Form

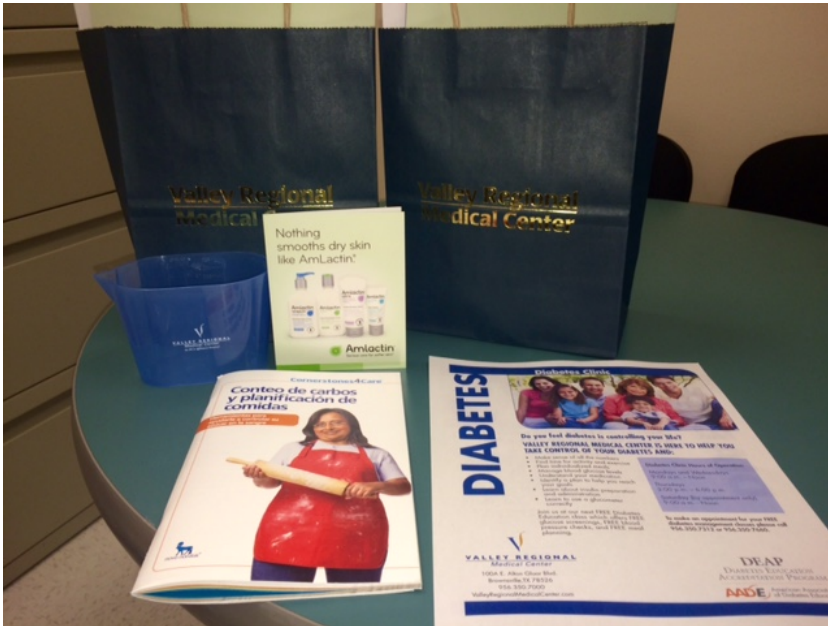
Reporting Period: September 30, 2014

Contact Information	
Provider Organization: Valley Regional Medical Center	
Primary Contact: Rosalinda Rangel	Email: Rosalinda.rangel@hcahealthcare.com
Goals	
Goal(s):	
<ol style="list-style-type: none"> Increase patient access and retention to our Outpatient Clinic. Specifically provide health education and training for patients with diabetes (or other conditions). 	
Plan	
Plan for Implementation and Achievement:	
<ul style="list-style-type: none"> Create a Marketing Strategy to increase reach of outpatient clinic. Refer discharge patients with uncontrolled diabetes to outpatient clinic. Increase our local health care providers' partnerships. 	
Do	
Actions Taken:	
<ul style="list-style-type: none"> Create a Marketing Strategy to increase reach of outpatient clinic. <ol style="list-style-type: none"> Increased our Social Media presence with clinic articles and hours of operation. Working with our Media Specialist in house to promote clinic services as a "mobile" clinic. Refer discharge patients with uncontrolled diabetes to outpatient clinic. <ol style="list-style-type: none"> Currently providing on-the-spot appointments to patients during outside/partner health fairs. Trained Nursing staff to connect patients after discharge to the outpatient clinic. Increase our local health care providers' partnerships. <ol style="list-style-type: none"> We are currently waiting for CVS to join our effort and let us screen their clients. We have been extending our services to physicians and we have been participating in health fairs for them to provide our services. 	
Study	
Review and Evaluate:	
<ul style="list-style-type: none"> <i>Progress Towards Goal(s):</i> <ul style="list-style-type: none"> Marketing items are complete; we provide "packets" to all participants both in English and Spanish with information about our program and the clinic. (See attached Picture) <i>Challenges:</i> <ul style="list-style-type: none"> Partnerships with local FQHCs as they also have DSRIP projects. 	
Act	
Next Steps:	
<ul style="list-style-type: none"> Try to close the gap between FQHCs and other local health care providers with marketing and referrals systems. 	

Collaborate

Share Successes and/or Request Assistance

- No TA needed at this time.



Adult Packet (Marketing)



Children (School-Based) Packet