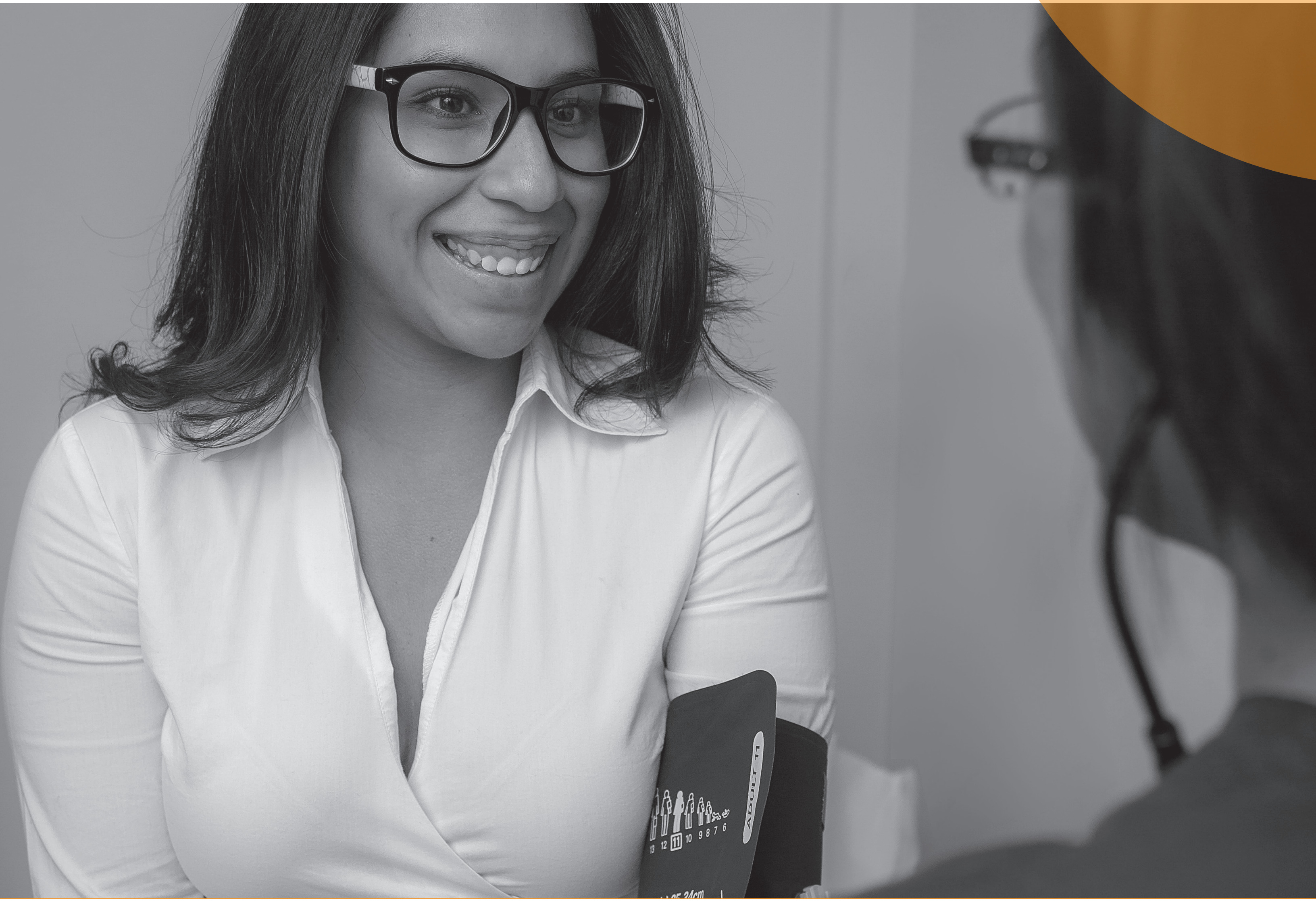
Methodist Healthcare Ministries
OF SOUTH TEXAS, INC.
"Serving Humanity to Honor God"

Health Resources in Action
Advancing Public Health and Medical Research



Advancing Health in South Texas Engagement Series:

Comprehensive Report
June 2017

FINAL PROJECT REPORT | AWARD #: EAIN-2381

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Executive Summary

Introduction and Background

Methodist Healthcare Ministries of South Texas, Inc.—a private, faith-based, not-for-profit organization—was awarded the Eugene Washington Patient-Centered Outcomes Research Institute (PCORI) Engagement Award to implement a project titled ***Advancing Health in South Texas Engagement Series*** in the fall of 2015. Through this award Methodist Healthcare Ministries convened patients and key stakeholders across a 20-county area in Southern Texas to develop a plan for a coordinated regional approach for patient-centered research, evaluation and dissemination among university systems, academic institutions, managed care organizations (MCOs), and public health systems.

The ***Advancing Health in South Texas Engagement Series*** aimed to create a safe space to facilitate meaningful dialogue between patients and institutional systems to ensure trusted relationships were formed, information was shared, and all voices were heard in the planning and co-creating of solutions. The series also attempted to identify and adopt multi-sector strategies based on differentiated but aligned activities through a common research framework by identifying cross-cutting themes in each group.

These objectives were achieved through an iterative, five-session series that convened over the course of one year. Each session involved a unique, but equally important stakeholder focus, and was designed to build upon the previous session to ensure that various perspectives were reflected. The initial session of the engagement series, ***What Matters to You?,*** consisted of six community focus groups meant to serve as the project foundation in order to frame and contextualize each discussion. Through this process, cross sector participants were involved in meaningful dialogues that were guided by authentic patient feedback.

In total, over 300 residents, stakeholders, and community partners participated in the Engagement Series. The following summary provides a high-level overview of the findings and cross-cutting themes across sessions, and the subsequent sections of the report detail the approach and findings specific to each of these convened sessions, emphasizing commonalities by stakeholder group and geographic region throughout. The final section of this report presents conclusions, next steps, and lessons learned for consideration in future planning endeavors.

Overview of Approach

The focus on thoughtful partnerships has been a cornerstone of Methodist Healthcare Ministries' strategy to encourage authentic engagement throughout the series. Since the onset of the PCORI initiative, Methodist Healthcare Ministries relied on trusted partners to assist with recruitment of stakeholders and to ensure consistent engagement throughout the process.

The format of each convening began with a presentation of data findings, where the key themes of the community focus groups and preceding sessions were shared and discussed. Once a contextual understanding of the project was established, groups participated in a series of facilitated discussions regarding patient-centered research, evaluation, and dissemination that was tailored to each stakeholder group. Grouping, or cooperative learning—which refers to participants working together to accomplish a common goal or purpose—was the main engagement strategy used for the series.

> *"We are a united community—when someone needs help we all come together."*
>
> *— FOCUS GROUP PARTICIPANT*

Limitations

A limitation that arose early in the convened series was the varying levels of readiness to discuss patient-centered research among stakeholder groups; community members and health payers alike reported being largely unaware of research initiatives in the area. Because of these varying levels of readiness, findings from several of the convened sessions focused more on problem identification and brainstorming, and less on specific research-dissemination strategies than originally intended. Nonetheless, findings from these sessions provide valuable insight to the opportunities for each of these groups to address patient-centered research moving forward to create a common level of understanding.

What Matters to You? Community Focus Groups

In February 2016, Methodist Healthcare Ministries and HRiA facilitated the first of the ***Advancing Health in South Texas Engagement Series: What Matters to You?*** The session consisted of six, two-hour focus groups across the upper and lower Rio Grande Valley and the Coastal Bend areas to explore community residents' perceptions regarding research dissemination and communication strategies related to health; community strengths and challenges; and the quality and accessibility of patient-centered health care. Main findings from these groups are highlighted below, and further detailed in the body of the report.

- Dissemination and Communication: ***Residents Prefer a Mixed-Method Strategy for Receiving Health and Research Information.*** When asked how patients would like to receive health-related information and research findings, many residents agreed that **face-to-face** communication and **word of mouth** were the preferred method of engaging residents in health-related topics and research.

- Community Strengths: ***Resilient Communities Strengthened by Strong Cultural Ties.*** Focus group participants described their community as **tight-knit** with **shared values;** hard work and a devotion to one's family were described as core principles across the six groups.

- Social Determinants of Health: ***Socioeconomic and Environmental Factors Negatively Impact Health.*** While participants did not explicitly use the phrase *social determinants of health*, much of what was discussed in the focus groups consisted of socioenvironmental barriers to wellness—specifically **poverty, employment, access to care,** and **housing.**

- Chronic Disease: ***High Burden of Chronic Diseases and Risk Factors.*** Apart from socioeconomic factors, focus group participants described a high burden of chronic diseases and their risk factors – mainly **diabetes, cancer, obesity, and substance abuse** – as significant concerns that impact many residents. In addition, **mental health** issues including stress and anxiety were frequently cited as challenges among participants.

Knowledge Sharing Champions

The ***Knowledge Sharing Champions*** session aimed to build off the ***What Matters to You?*** groups by bringing together university systems and academic institutions with a regional footprint to discuss and inventory current areas of research and identify opportunities for intersection and alignment. In addition, the session created a space to discuss how and/or if patient stakeholder groups are currently engaged in the research process, and how research findings and evaluation results are, or are not, being disseminated and communicated to patient stakeholder groups.

Common themes that arose in the ***Knowledge Sharing Champions*** session were challenges related to: **communicating effectively** between partners, understanding the **differences in language** and **expectations** between academia and community, and the **ongoing need to keep community informed** of research and vice versa. Participants acknowledged the importance of deriving research initiatives based on **community-driven interests.** The challenge, some shared, is that institutional research agendas are not always aligned with community interests. Key conclusions from this session included the following:

- There is an opportunity to **define a common vision** for patient-centered research in the greater South Texas area, by answering the following questions:
    - *What do we believe and value about patient-centered research? What does it mean to be patient-centered?*
    - *What would patient-centered research look like in the ideal? What would be its key success elements?*
- There are a **variety of definitions** and terms used when discussing community engagement, and **shared language** would be helpful moving forward.
- While each region is unique, there is a need to **build the knowledge base** with a deeper dive using a **mixed-methods approach** of both quantitative and qualitative data.

> *"Sometimes authentic engagement means accepting when the community is not interested in your research topic."*
>
> *— EXPERT PANELIST*

Engaging Health Payers

The third convened session of the Series, ***Engaging Health Payers,*** aimed to build off the preceding sessions by bringing together leadership representing managed care organizations (MCOs) from across the state of Texas. The main objective of this convening was to engage MCOs leadership to discuss strategies that can be made under the purview of the public health systems, policy makers and health care payers to align and encourage future development and integration of patient-centered research, evaluation and dissemination. Similar to the community focus group findings, health payers reported being largely unaware of research initiatives in the area, instead emphasizing the many structural challenges faced by health payers to address care throughout the state.

Nonetheless, there were many commonalities between the preceding stakeholder groups and the health payer session. Specifically, participants emphasized the need to: focus on **prevention,** the importance of considering the **social determinants of health,** and the need for **culturally-responsive approaches.** The problem, as participants shared, is that the state's reimbursement structure was such that preventative care was not rewarded. Health payers also described the challenges of balancing **long-term goals with short-term objectives** that are more relevant for the industry of health payer organizations. The most frequently cited research topics suggested by the health payer group included **obesity, smoking,** and **maternal and child health.**

Engaging the Community Voice

The fourth convened session of the Series, ***Engaging the Community Voice (ECV)*** aimed to re-engage end-users of Methodist Healthcare Ministries-sponsored initiatives and programs—including consumers, stakeholders, academic institutions, health advocacy groups, health care providers, and payers--through facilitated "town-hall" discussions to ask for additional suggestions or clarifications and to discuss next steps in the process. Main discussion topics discussed in the session included the following:

- **Promote Authentic Engagement and Reframe Research Agenda.** Validating findings from the previous sessions, participants acknowledged the complexities and challenges of authentic community engagement; one challenge was being perceived as *"elitist"* by community members.
- **Consider a Mixed-methods Communication Strategy for Future Endeavors.** Participants across geographies preferred a **mixed-method communication strategy** for health-related information. Focus group and town-hall participants alike cited that **in-person** and **face-to-face interactions** were the preferred methods of disseminating research-related information—with the caveat that this information should come from **trusted sources.**
- **A Focus on Prevention and Wellness.** Similar to key findings in the previous sessions, town-hall participants overwhelming agreed that there are not enough resources allocated for **primary prevention efforts** on a **systems-wide** basis for initiatives such as **smoking cessation** and physical education.
- **More Emphasis on Policy and Advocacy.** Another theme that was prominent among groups was that more efforts are needed for collaboration on systems-level and policy changes at the **state** and **local levels.** More importantly, there is a need to contextualize the work being done at the state and federal level that impacts health payers, researchers, and providers' ability to **think longitudinally** in relation to population health.

> *"Insurers are not the most trusted organizations in the world. We have to look for strategies to connect with residents in a way that is meaningful to the community."*
>
> *— PARTICIPANT*

Building the Patient-Centered Partnership

In the final afternoon planning session following the community town-hall meeting, participants began the process of identifying the key elements of the *Collaborative Research Framework*, which includes both the focus of the research, as well as the specific strategies for developing and sustaining the collaborative partnership and effectively disseminating the research to key groups in the community.

During this session, participants worked in small groups to answer questions about the content and shared metrics for future research; the components that would support collaboration; key criteria for selecting partners; potential "quick wins" that could be developed and achieved in the near term to sustain enthusiasm and momentum; and critical groups/individuals who should be at the table for the next stage of planning. Key themes included:

- **Content and Metrics.** Chronic diseases and their risk factors—especially **diabetes, obesity, heart disease,** and **cancer**—were reported as priority content areas to consider for a future collaborative research agenda. The built environment—especially **transportation, safe, walkable communities,** and **food access**—were reported as areas to explore moving forward.

- **Partnership Inclusion Criteria.** Groups also discussed components or strategies that would be essential to consider when crafting the collaborative framework. Among the most frequently cited, ensuring that partners had shared visions and goals, clear expectations regarding roles and responsibilities, and a plan for sustainability were most prominent. In line with findings from the previous sessions and town-hall meetings, participants also stressed the importance of a neutral convener to bring institutions together.
- **Quick Wins.** The session concluded with a discussion around possible "quick wins" to focus on when creating a shared research framework. **Strengthening** and **leveraging established partnerships** through frequent convened sessions and summits would be a quick win to increase collaboration and communication.

Engagement Series Conclusions, Next Steps, and Lessons Learned

A key learning from the PCORI initiative was understanding the differing levels of readiness to discuss research and dissemination strategies among stakeholder groups. Although these issues created challenges to operationalizing the final *Collaborative Patient-Centered Research Framework*, also evident was the enthusiasm and desire to continue these conversations which can be leveraged moving forward. Below are reflections of key lessons-learned to consider in future planning endeavors:

➔ **There is a need for long-term and focused relationship building within and across sectors prior to convening.** A cornerstone of the ***Advancing Health in South Texas Engagement Series*** has been Methodist Healthcare Ministries' intentionality of deliberate partnerships to support authentic engagement. Throughout the convened sessions, there was robust participation among sectors in which Methodist Healthcare Ministries has a long-standing history, namely healthcare providers and consumers. However, more challenging was the engagement and recruitment of sectors that have not historically been at the table during these collaborations, including health payers and academicians. This resulted in a smaller sub-set of participants representing these important groups, which may limit the generalizability of the discussions. The participation imbalance between sectors emphasizes the ***importance of long-term and focused relational building prior*** to engaging in planning efforts moving forward.

➔ **There is a need to identify a convener to maintain momentum and establish a shared vision for collaboration.** As discussed throughout this report, a reoccurring theme among sessions was the importance of a neutral convener to facilitate collaborations within and across sectors. Participants shared that this neutral entity has not been identified, and those groups interested may be constrained by time, resources, or staff capacity to take the lead, making the continuity of collaboration challenging. A strong convener, as shared by participants, must be **neutral, strategic, and have a proven history of collaboration** throughout the region.

➔ **Sustainability planning should happen earlier throughout the process.** Many conversations throughout the *Engagement Series* led back to the ultimate question of sustainability—both financial and structural—moving forward. Participants shared concerns about the ever-changing nature of the political climate across the country, which may impact funding opportunities to maintain collaborative partnerships in the future. Thus, a key learning from this *Engagement Series* is the need for sustainability planning to occur earlier, to reassure participants of the continuity of and commitment to the process.

➔ **Engaging a wider audience will ensure appropriate stakeholders are at the table.** Lastly, while many of the key stakeholders from population-health initiatives were involved in this convened series, it is evident that the process could have been strengthened with the participation of additional groups, namely legislators and grassroots mobilizers. Participants acknowledged that convening these groups would be challenging, but suggested leveraging technology to engage and solicit feedback on an on-going basis.

> *"There is no policy change without advocacy; we should also be talking about how to mobilize the community moving forward."*
>
> *— PARTICIPANT*

Introduction and Background

Methodist Healthcare Ministries of South Texas, Inc. is a private, faith-based, not-for-profit organization dedicated to providing medical, dental and health-related human resources to low-income families, the uninsured and underinsured in 74 counties across South Texas, approximately one-third of the state. The mission of Methodist Healthcare Ministries is "Serving Humanity to Honor God" by improving the physical, mental and spiritual health of those least served. This mission is achieved through programs owned and operated by Methodist Healthcare Ministries as well as strategic investments made to non-profit partners with similar missions. Since its founding in 1995, Methodist Healthcare Ministries has provided more than $600 million in healthcare services through its own clinics and programs as well as through funding to its community partners. Methodist Healthcare Ministries is one of the largest private health care funding sources for the underserved and uninsured in South Texas.

In the fall of 2015, Methodist Healthcare Ministries was awarded the Eugene Washington PCORI (Patient-Centered Outcomes Research Institute) Engagement Award to implement a project titled ***Advancing Health in South Texas Engagement Series***. Through this award Methodist Healthcare Ministries convened patients and key stakeholders across a 20-county area **(Figure 1)** to develop a plan for a coordinated regional approach for patient-centered research, evaluation and dissemination among university systems, academic institutions, managed care organizations (MCOs), and public health systems. The engagement series service area included: Aransas, Bee, Brooks, Cameron, Dimmit, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Maverick, Nueces, San Patricio, Starr, Refugio, Webb, Willacy, Zapata, and Zavala counties.

The ***Advancing Health in South Texas Engagement Series*** aimed to create a safe space to facilitate meaningful dialogue between patients and institutional systems to ensure trusted relationships were formed, information was shared, and all voices were heard in the planning and co-creating of solutions. The series also attempted to identify and adopt multi-sector strategies based on differentiated but aligned activities and a common research framework by identifying cross-cutting themes in each group. As a result, Methodist Healthcare Ministries has been very intentional in identifying institutional partners and equally deliberate in defining their roles to assure the long-term sustainability of this effort.

These objectives were achieved through an iterative, five-session series that convened over the course of a year. Each session involved a unique, but equally important stakeholder focus, and was designed to build upon the previous session to ensure that various perspectives were reflected. The initial session of the engagement series, ***What Matters to You?,*** consisted of six community focus groups meant to serve as the project foundation in order to frame and contextualize each discussion. Through this process, cross sector participants were involved in meaningful dialogues that were guided by authentic patient feedback.

Methodist Healthcare Ministries partnered with Health Resources in Action (HRiA), a non-profit public health organization, to serve as the series facilitators to identify appropriate patient engagement models for the region. The engagement series began in February 2016 with the ***What Matters to You?*** session, which consisted of six, two-hour focus groups across the Methodist Healthcare Ministries service area to explore patients' and community residents' perceptions regarding: strengths and challenges in their communities related to health, and the quality and accessibility of healthcare; how they receive information on health, wellness, and medical treatments; who are considered trusted health information sources; and recommendations for information dissemination strategies in the future.

The ***Knowledge Sharing Champions*** session was conducted in May 2016 in McAllen, TX, and aimed to build off the community sessions by bringing together university systems and academic institutions with a regional footprint to discuss and inventory current areas of research and to identify opportunities for intersection and alignment around population health outcomes. In addition, the session created a space to discuss how and/or if patient stakeholder groups are currently engaged in the research process, and how research findings and evaluation results are, or are not, being shared and communicated to patient stakeholder groups.

The third convened session, ***Engaging Health Payers,*** was conducted on August 2016 in Austin, TX, and brought together leadership representing managed care organizations (MCOs) from across the state of Texas. The main objective of this session was to engage MCOs leadership to develop short-term and long-term strategies that can be made under the purview of the public health systems, policy makers and health care payers to align and encourage future development and integration of patient-centered research and evaluation programs.

The fourth session, ***Engaging the Community Voice*** aimed to re-engage end-users of Methodist Healthcare Ministries-sponsored initiatives and programs – including consumers, stakeholders, academic institutions, health advocacy groups, and health care providers – through facilitated "town-hall" discussions to ask for additional suggestions or clarifications, and discuss next steps in the process. During the 90-minute sessions held in Corpus Christi, Laredo, and McAllen in February 2017, findings from the three preceding engagement sessions, **What Matters to You?**, ***Knowledge Sharing Champions, and Engaging Health Payers*** were presented to the group, followed by facilitated discussions to elicit feedback and suggestions for future planning.

Following the community town-hall meeting in McAllen, participants began the foundational planning process described as ***Building the Patient-Centered Partnership.*** This structured, facilitated planning session engaged participants in a discussion to identify potential areas of collaborative research moving forward, as well as the specific strategies for developing and sustaining the collaborative partnership and effectively disseminating the research to key groups in the community.

In total, over 300 residents, stakeholders, and community partners participated in the *Engagement Series*. The proceeding sections of this report detail the approach and session findings and key themes from each of these convened sessions, emphasizing commonalities by stakeholder group and geographic region throughout. The final section of this report presents conclusions, next steps, and lessons learned for consideration in future planning endeavors.

Engagement Series Service Area

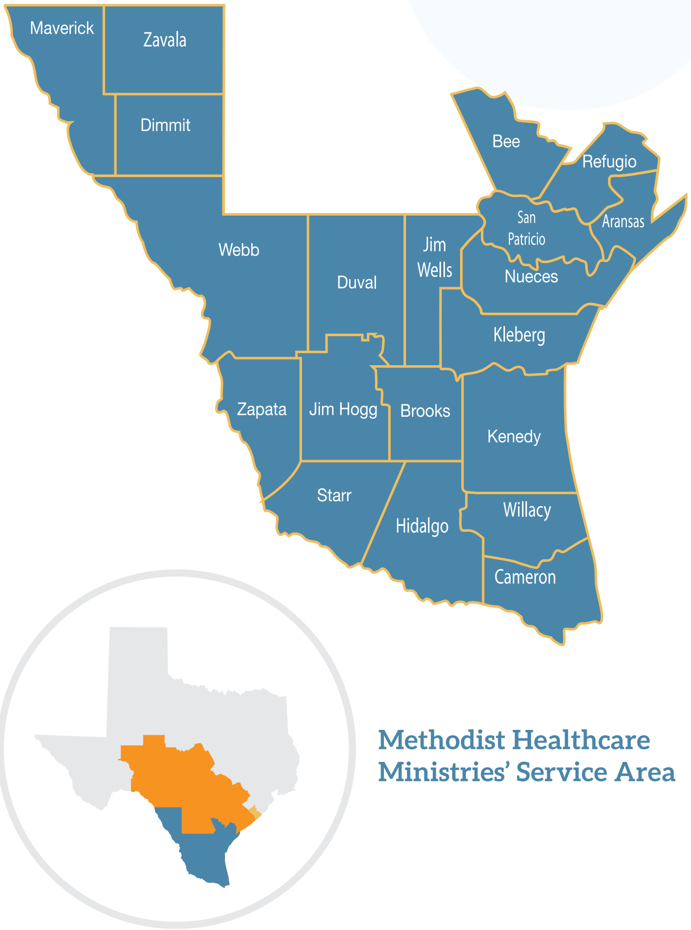


FIGURE 1. Engagement Series Service Area

Overview of Approach

Recruitment Strategy

The focus on thoughtful partnerships has been a cornerstone of Methodist Healthcare Ministries' strategy to encourage authentic engagement throughout the *Engagement Series*. Since the onset of the PCORI initiative, Methodist Healthcare Ministries relied on trusted partners to assist with recruitment of stakeholders and to ensure consistent engagement throughout the process.

Methodist Healthcare Ministries identified internal and external participants to invite to the *Engagement Series* sessions. They were selected because they represented active researchers, patients/clients, community stakeholders, and healthcare provider systems in the region with a specialty on community engagement and a patient-centered focus that influence outcomes of care. Individuals were personally contacted by high-touch phone calls facilitated by Methodist Healthcare Ministries.

Factors Influencing Health

Social Determinants

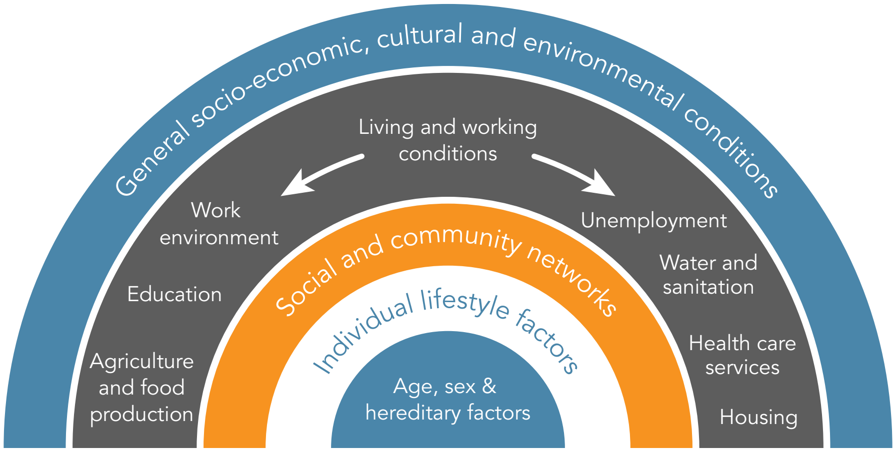
When discussing population health, it is important to recognize that multiple factors affect health and there is a dynamic relationship between people and their environments. The social determinants of health—defined as the conditions in which people are born, grow, live, work and age—are critical to consider when talking about health. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by more upstream factors such as employment status and quality of housing stock. The social determinants of health framework, depicted in **Figure 2,** addresses the distribution of wellness and illness among a population—its patterns, origins, and implications.

While the qualitative data presented are often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. Building on this framework, the ***Advancing Health in South Texas Engagement Series*** utilizes qualitative findings to examine community-level influences, including social and economic factors that have an impact on health and health outcomes.

Health Equity

In addition to considering the social determinants of health, it is critical to understand how these characteristics disproportionately affect vulnerable populations. Health equity is defined as all people having the opportunity to

FIGURE 2. Social Determinants of Health Framework



Source: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005. Graphic reformatted by Health Resources in Action "attain their full health potential" and entails focused societal efforts to address avoidable inequalities by equalizing conditions for health for all groups, especially for those who have experienced socioeconomic disadvantages or historical injustices. When examining the larger social and economic context of the population (e.g., upstream factors such as housing, employment status, racial or ethnic discrimination, the built environment, and neighborhood-level resources), a robust assessment should capture the disparities and inequities that exist for traditionally underserved groups. Thus, a health equity lens guided the ***Advancing Health in South Texas Engagement Series*** to ensure qualitative data comprised a range of social and economic indicators and were presented for specific population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Integration of Perspectives and Approaches

The strategy behind the *Engagement Series* was to identify the areas of synergy among unique but equally-important stakeholders in regard to patient-centered research in the PCORI service area. The center of the Venn diagram concept, depicted in **Figure 3**, would be used to identify priority areas to leverage in future efforts among varying sectors, stakeholders, and/or areas of alignment.

FIGURE 3. Engagement Series Venn Diagram: Areas of Alignment Between Varying Stakeholder Groups

Limitations

As with all data collection efforts, there are several limitations related to these data that should be acknowledged. A limitation that arose early in the convened series was the varying levels of readiness to discuss patient-centered research among stakeholder groups; community members and health payers alike reported being largely unaware of research initiatives in the area. Because of these varying levels of readiness, findings from several of the convened sessions focused more on problem identification and brainstorming, and less on specific research-dissemination strategies than originally intended. Nonetheless, findings from these sessions provide valuable insight to the opportunities for each of these groups to address patient-centered research moving forward to create a common level of understanding.

Next, while efforts were made to talk to a diverse cross-section of individuals, demographic characteristics were not collected on town-hall participants, so it is not possible to confirm whether they reflect the composition of the region. The community findings represent a sub-set of community residents and stakeholders, with more women participants than men, and may be limited in their generalizability.

Further, a conscious effort was made to make the dissemination of findings accessible to all engagement participants. Methodist Healthcare Ministries attempted to recruit community members that participated in the original focus groups to the final planning session; however, due to logistical constraints, town-hall discussions were hosted in only three of the six counties where the original focus groups were conducted, possibly limiting access to some participants.

While the findings from this process provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Lastly, it is important to note that data was collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

What Matters To You? Summary

February 2016

Overview

In February 2016, Methodist Healthcare Ministries and HRiA facilitated the first of the ***Advancing Health in South Texas Engagement Series: What Matters to You?*** The session consisted of six, two-hour focus groups across the upper and lower Rio Grande Valley and the Coastal Bend areas, where rates of chronic disease and related mortality among the population exceed those in most other regions of the state and the nation (Fisher-Hoch et al., 2012; Davila, Rodriguez, Urbina, & Nino, 2014).

Seventy-three South Texas residents were engaged in discussions to gather meaningful feedback regarding: what patients identify as important health issues for their communities; how these issues are communicated to them; and solutions to feel actively engaged in co-constructing solutions. The following report summarizes the findings and common themes of ***The Advancing Health in South Texas Engagement Series: What Matters to You?*** Findings from this report guided further discussions throughout the project with academic researchers, healthcare leadership, public health leadership, and other community stakeholders.

Methods

Focus groups were used as the strategy to obtain in-depth accounts of community members' experiences with healthcare and dissemination strategies in this 20-county area. Six, two-hour groups with 73 individuals (17 men, 56 women) were convened in: Nueces, Zavala, Jim Wells, Hidalgo, Cameron, and Webb counties. The groups were facilitated in English (n=2 groups) and Spanish (n=3 groups), as well as bilingually (n=1 groups), depending on the preference of the participants. The focus groups spanned across age groups, geography, and participants' role in the community. **Table 1** details the community partner and target populations for each of these groups.

Below is a detailed overview of the focus group findings, highlighting the main topic areas of: dissemination and communication strategies, community strengths, social determinants of health, chronic diseases and their risk factors, and access to care. The section concludes with community recommendations and vision setting shared within the focus groups.

Session Findings and Key Themes

Dissemination and Communication: Residents Prefer a Mixed-Method Strategy for Receiving Health and Research Information

When asked how patients would like to receive health-related information and research findings, participants overwhelmingly agreed that a **mixed-method** communication strategy was important. Many residents agreed that **face-to-face communication and word of mouth** were the preferred method of engaging patients in new treatment plans and research studies, saying *"I want to be able to look someone in the eye when they're telling me about this stuff because that's how I know I can trust them."* Many also described wanting to talk to people in the community who had participated in new studies or treatment options before making a decision.

The **internet** was the second most cited source to receive up-to-date medical information and research findings, with residents citing Facebook and email as the most popular ways to reach them. However, many participants indicated that television was the least effective way to get information out, saying *"you always see them trying to sell medications to you on TV, then at the end they describe a million side effects that will happen to you if you participate."*

Community Health Workers or promotores were seen as assets in communities, namely in the border regions of Laredo and the Rio Grande Valley. Residents in the upper

Table 1. What Matters to You? Focus Group Recruitment Partners and Target Populations

Community Partner:	Target Population
Corpus Christi Metro Ministries- Nueces County (Corpus Christi, TX)	Self-described homeless adults
Vida y Salud- Health Systems- Zavala County (Crystal City, TX)	Community residents receiving care at a federally qualified health clinic (FQHC);
Mercy Ministries of Laredo- Webb County (Laredo, TX)	Community residents receiving care at a federally qualified health clinic (FQHC)
Rural Economic Assistance League (REAL) - Jim Wells County (Alice, TX)	Rural healthcare providers and patients in the Coastal Bend area
La Unión del Pueblo Entero (LUPE) – Hidalgo County (San Juan, TX)	Upper Rio Grande community members living in colonias
Proyecto Juan Diego- Cameron County (Brownsville, TX)	Lower Rio Grande community members living in colonias

Valley agreed that community health workers were effective, but stressed the importance of also **partnering with a local neighborhood champion** to conduct outreach with community health workers, saying, *"If promotoras worked with the leaders in the colonias they would have more success reaching residents who aren't engaged. They need to accompany the promotoras on their home visits, because many of us won't even open the door if we don't recognize the person knocking."*

The importance of **considering health literacy levels**– the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions–was also mentioned, with one resident saying, *"My parents only have a 4th grade education, and they often need me to reinterpret what the doctors are saying to them. When me or my brothers can't be there, I'd like them to have a written document that they can understand, something self-explanatory instead of using big words or medical terms."* Many residents agreed, and added that **family engagement was important** as well. As one resident described, *"Families need to be told this information too because many times we are the sole caregivers."*

It is important to note that focus group participants were mostly unaware of research strategies and opportunities in their surrounding area, and instead, focused the conversations around addressing socioeconomic barriers and accessing healthcare – the basic physiological and safety issues of immediate and pressing concern.

As such:

- **Very few focus group participants were aware of new research** studies or treatment options in their communities. Residents who were aware of research studies were engaged with the local universities in some capacity, whether through employment or attending university-sponsored events.
- Of the few participants who reported participating in clinical trials, none of them was told about the **results of the study**, which frustrated many.
- In-person interactions, flyers, local radio, and community events were the most frequently suggested ways to disseminate information to the masses. However, focus group participants stressed the importance of **understanding the unique communities** being engaged before disseminating health information.
- When asked what questions participants would have if a doctor asked them to be part of a new research study, the majority of focus group participants said **knowing the side effects** and success rates were most important.
- Participants expressed **frustration over complicated medical jargon and acronyms** and stressed the importance of considering health literacy levels and terminology when disseminating health-related information. Providing a lay summary of study findings in both English and Spanish were strategies mentioned by focus group participants.
- Participants reported making **healthcare decisions based on how much trust** they had in their providers. Residents described trust as a bridge to active engagement by creating and maintaining mutual respect.
- **Continuous partnering** with the community through group discussions and focus groups was described as a way to keep community members engaged throughout the research process. Further, participants described the importance of engaging family members in discussions around health and new treatment options.
- **Trusted organizations,** whether faith-based or community-based, were described as gatekeepers between healthcare providers and community residents, and should be engaged in future dissemination strategies.

Community Strengths: Resilient Communities Strengthened by Strong Cultural Ties

"The Hispanic culture is one where the **family is at the center** *of everything."*

–Focus group participant

Though residents in Southern Texas encounter numerous social and economic challenges to health including poverty and barriers to access, focus group participants shared stories of **resilience** and **community cohesion strengthened by strong cultural ties** that can be leveraged upon in future dissemination strategies. Additional strengths noted include:

- Residents described their communities as friendly, "tight-knit" and united. Values such as hard work and a devotion to one's family were described as core principles across the six groups.
- Participants commonly **attributed culinary norms to poor health behaviors** and outcomes, noting that: *"There are certain cultural things that we can't get rid of… the tamales and the tortillas that we love so much."*
- Lastly, focus group participants described being actively engaged in their political and civic environment. Residents across all six groups described volunteering and fundraising for issues and organizations they cared deeply about.

Social Determinants of Health: Socioeconomic and Environmental Factors Negatively Impact Health

"The increase of **drugs has affected** *everyone; there's more crime and vandalism than ever before."*

–Focus group participant

Focus group participants described social and environmental concerns including **poverty, crime and safety, employment, and transportation** barriers among the most concerning stressors in their lives. While the term social determinants of health was not explicitly used by focus group participants, for purposes of this report, findings that focused on socioenvironmental concerns are hereby referred to as the social determinants of health, or the conditions in which people are born, live, work, and grow.

Across groups, residents reported that the **cost of healthcare** was the biggest financial burden to families and communities in the region. In border regions, more so than other groups, participants described seeking care across the border in Mexico, many times having to discontinue treatment due to financial barriers. Further, Nueces, Zavala, and Jim Wells counties were described as areas strongly impacted by the **declining oil industry**, with some residents describing their communities as "ghost towns." Additional findings include:

- Focus groups members generally s**poke positively about their surroundings, noting** that many of the communities in the region had access to parks and recreational activities. Yet across geographies, residents described a **desire for more structured after-school activities** and community events to keep youth busy.
- In border regions, more so than other groups, participants described **seeking care across the border in Mexico.** Participants described better care coordination, timeliness, bedside manner, and higher quality care across the border.
- **Specialty care** such as cancer treatment and dental check-ups were the most commonly reported to be sought in Mexico. The cities of Matamoros, Reynosa, and Nuevo Laredo were the most frequently cited cities for routine care.
- While many who sought care across the border reported being content with the quality of care they received, **concerns were raised about the increasing risks of routinely crossing the border** for healthcare. As one resident noted, *"I'd rather take the risk and drive across the border for care. You'll die waiting for an appointment before doctors will see you here* [resident's community in the Valley]."

Chronic Disease: High Burden of Chronic Diseases and Risk Factors

"We **lack a sense of consistency** *around wellness in the community."*

–Focus group participant

Apart from socioeconomic factors, focus group participants described a high burden of chronic diseases and their risk factors– **mainly diabetes, cancer, and substance abuse** – as significant concerns that impact many residents. In addition, mental health issues including **stress** and **anxiety** were frequently cited as challenges among participants. In regard to **preventive health**, focus group participants described **healthy eating** and **physical activity** as ways to stay healthy, but cited a lack of **health literacy** and **affordable recreational programming** in their communities. Among all focus groups, Hispanic culinary norms were attributed to poor health outcomes including diabetes, cardiovascular disease, and high cholesterol. As one resident noted, *"My whole family has diabetes…it's expected that we'll either be fat or diabetic because of the way we eat."* Additional findings include:

- **Substance abuse** was mentioned in every focus group, with participants concerned about a range of substances ranging from marijuana to opioids.
    - Synthetic marijuana known as "K-2" was mentioned in three of the groups, in Nueces, Jim Wells, and Webb counties.
    - Across geographies, participants strongly agreed that there was a **lack of substance abuse and recovery services** in their communities, noting: *"You don't see any detoxes around."*
- Lastly, focus groups participants expressed concern over the lack of community resources around **sexual health, particularly for youth.** Teen pregnancy and sexually transmitted infections were perceived as especially concerning, with residents describing *"thirteen and fourteen year olds running around having kids,"* and the importance of *"communicating in the home."*

Access to Care: Difficulty Navigating a Complex Health System

"I'm educated and **I feel really dumb** *when it comes to navigating the healthcare system."*

–Focus group participant

Across several groups, many participants also described feeling **"dumb" when navigating the healthcare system,** saying: *"Everything is in acronyms. Terminology is a big problem…they might as well be speaking in Greek. I need to know what they are actually saying in layman's terms so I don't feel stupid."*

Programs such as *Salud y Vida* and nutrition classes at Mercy Ministries of Laredo were cited as valuable community resources addressing preventive health. However, a majority of focus group participants reported that they **did not typically seek out preventive services,** citing that it was more a cultural norm to wait until things got very bad before seeking help. Across geographies, many focus group participants agreed that they **would not seek care for a general issue** such as the common cold or an ear infection. For more severe health problems, most participants sought care at **hospital emergency rooms** or **private urgent care clinics.**

Timeliness of care was a common concern across the six groups, with residents reporting long wait times and follow-ups. Further, some groups voiced frustration **over perceptions that undocumented citizens received care faster** than American citizens. As one resident noted, *"I pay my taxes and have all the required documents, and yet, I have to wait six months to see a doctor because people who are undocumented can walk right in."* Many participants reported **navigating long wait times by traveling to Mexico** for care, or attempting to treat ailments with **over the counter or home remedies.** As one participant described, *"I know if I try to go to the doctor I'll have to wait three or four months for an appointment, so it's better if I go to Wal-Mart, the Dollar Store, or Mexico and guess what medicine will make me feel better."* Additional findings include:

- Most focus group participants cited **receiving care at federally qualified health centers,** mobile health clinics, emergency rooms, and urgent care centers.
- Across geographies, participants reported a **healthcare system that was confusing and inaccessible,** sharing that terminology and acronyms are barriers that often make deter patients from seeking care.
- Among all six groups, participants described having to leave their communities in order to receive **quality health care.** Residents in the Coastal Bend area cited having to drive between 1-4 hours to receive care in larger cities such as Corpus Christi, San Antonio, and Houston, where they perceived to have more engaged providers.
- **Insurance barriers** were also attributed to the over-utilization of emergency rooms. As one participant noted, *"People go to the ER because they don't have insurance. When you go to the doctor you have to pay a co-pay, and for people who can't afford it, they'll go to the ER because they're not charged immediately."*
- There were **mixed opinions regarding care coordination** throughout the region. Residents in Webb County praised their care coordination and noted, *"There is always a willingness to share resources to provide better services for those in need."* On the contrary, residents in the Coastal Bend and Rio Grande Valley described their care as **fragmented and uncoordinated.** In Nueces County, residents voiced mistrust of the hospital system, with several participants sharing stories of being denied care because they were homeless. For purposes of this report, this concept of coordination described in the focus groups will be referred to as "care coordination"– the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.
- Focus group participants across all groups commented that they **believed doctors were over-medicating and over-testing residents.** Participants perceived that doctors ordered unnecessary testing, as one example from a participant illustrates: *"I got sent to a specialist and they ordered the exact same tests I took two days before."*
- Many residents thought **money was the driving factor** behind their concerns. As one participant noted, *"Doctors took an oath to care for the person, not to get rich off of their illnesses."*

Community Recommendations

Community residents provided valuable feedback for areas of improvement related to the health systems and health information dissemination strategies. The following sections highlight the community recommendations that were common across the six focus groups:

More Culturally Competent, Patient Empowering Education. Focus group members were interested in greater access to health literacy resources including nutrition classes and preventive health available in both English and Spanish. Residents also stressed the importance of engaging, culturally-appropriate health literacy options. Many women mentioned enjoying Zumba and nutritional classes that focused on Hispanic foods, saying *"They need to understand the cultural environment we come from and approach the audience from our perspective."*

Mixed-methods Communication Strategy. As previously discussed, participants across geographies preferred a mixed-method communication strategy, with most preferring face-to-face interactions. A key suggestion was that: *"People in different cities get their information from different sources. You have to find out where they hang out and who they talk to, then you will know how to best communicate with them."*

More Information and Navigation Around the Health Care System. A prominent theme across focus groups was the need to break down barriers to navigating the complex health system. Focus group members spoke about the struggle to understand their healthcare benefits, and often found that they were being charged for treatments that were not covered by Medicaid and private insurance. In the words of one resident, *"I have rights as a patient. I want to know how the medications I'm being prescribed will interact with my other medications. I want to be told about options that I qualify for and why they are better or worse."* Focus group participants also shared the desire for more in-person discussions with their peers, noting: *"If we had groups like this more frequently we could learn a lot from each other."*

Patient Empowerment. Focus group participants voiced many concerns about patients being afraid to speak openly and honestly with healthcare providers. A strategy to reduce this fear, said one participant, *"is to change the patient perspective."* A clinic provider described how nurses could encourage patients, saying *"My elderly patients are very timid to ask questions because they think the doctor is very busy and doesn't want to take up his time. I try to turn the table and say 'you're his boss, the doctor is working for you so you need to make sure you get what you need from him.' "*

Support for Youth. Participants frequently mentioned the need for more youth services and recreational activities in their communities. Across regions, there were many concerns about how young people were occupying their free time, with residents in rural areas saying: *"They have nothing to do after school, so they get tempted and try things like drugs."* Sexual health in schools and the community was also mentioned as a key issue to focus on. Residents were interested in their children knowing more about healthy relationships, contraception, and sexually transmitted infections.

Support for Seniors. The aging population was recognized as vulnerable and disenfranchised, with one resident saying, *"All elderly patients should have a patient advocate with them at the doctor's office. I see so many patients who are mistreated and neglected just because they're old."* Many participants envisioned a community where the elderly had access to transportation, homebound services, and patient navigators.

Community Champions. Many participants, namely in the Coastal Bend area, described the need for *"an initiator"* in the community, someone who was trusted and could mobilize members to participate in healthy-living activities. In the Rio Grande Valley, residents described partnerships between community health workers and neighborhood champions that could improve patient turn-out at mobile health clinics in *colonias*.

Health Literacy, Language, and Medical Explanations. Many residents described the need for written and oral medical explanations to be simplified in a language that they understood. Accessible language means eliminating acronyms and medical jargon, as well as having information available in both English and Spanish. Considering reading levels would be important to consider, shared participants. Apart from academic literacy levels, patients expressed the desire for increased health literacy—the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions. There was strong agreement about including family members in health-related discussions, particularly when it involved elderly patients.

Mutual Aid. Focus group participants described a system of care in which those receiving services and those providing them could be more integrated. As one participant noted, *"We can give back to the state by cleaning up the area in return for care. Something where both sides can come to an agreement and benefit."*

Session Conclusions

The focus groups conducted in the ***What Matters to You?*** session provide valuable insights to the unique strengths and challenges experienced by South Texas residents. Findings from this report served as the foundation that guided discussions throughout the *Engagement Series* with academic researchers, health payers, public health leadership, and other community stakeholders that focused on improved system alignment through authentic patient engagement and dissemination strategies. More importantly, this foundation highlights commonalities across municipalities that can be leveraged to actively involve South Texas residents in co-constructing solutions to the health challenges experienced in the region. The following Venn diagram presents key concepts that arose in the focus group discussions. The next session in the Engagement Series, ***Knowledge Sharing Champions***, aimed to build off these key concepts and identify areas of synergy and cross-cutting themes for patient-centered research and dissemination.

FIGURE 1. Community Focus Groups Venn Diagram of Key Concepts

Knowledge Sharing Champions Summary

May 2016

Overview

The ***Knowledge Sharing Champions*** session (KSC) was conducted on May 18, 2016 and aimed to build off the ***What Matters to You?*** community sessions by bringing together university systems and academic institutions with a regional footprint to discuss and inventory current areas of research and identify opportunities for intersection and alignment around population health outcomes. In addition, the session created a space to discuss how and/or if patient stakeholder groups are currently engaged in the research process, and how research findings and evaluation results are, or are not, being disseminated and communicated to patient stakeholder groups.

Methods

A group of 95 participants from across the United States was recruited to participate in the KSC session. They were selected because they represented active researchers in the region on key topics such as cultural sensitivity; influence in community; community engagement; prevention of chronic disease; and patient-centered focus that influences outcomes of care. A total of 24 participants attended the session. The six-hour session aimed to fulfill three main objectives:

- Share the key themes from community focus groups and discuss the **implications for patient-centered research and dissemination**
- Discover the **research topics, indicators, and dissemination methods already in place** with peer institutions
- **Generate working statements** for developing and discussing a collaborative, patient-centered research and dissemination framework that would address the needs and concerns of community members and advance the research interests of participating institutions

Presentation of Data Findings

The primary discussion topic for this session consisted of presenting the main findings from the six community focus groups to reinforce the commitment of honoring the community voice in patient-centered outcomes research throughout each of the sessions. Findings were presented by HRiA staff who collected and analyzed data from the **What Matters to You?** session to ensure consistency throughout the process. Grouping, or cooperative learning, which refers to participants working together to accomplish a common goal or purpose, was the main engagement strategy used for the **Knowledge Sharing Champions Session.**

After the presentation of findings, participants could share feedback in a facilitated large-group discussion. Similar to discussion topics in the community focus groups, the researcher and academicians expressed concerns over the **rising costs of healthcare**, especially for those who were indigent and homeless. Another commonality among stakeholder groups was the perception of ineffective **continuity of care** in the region—that is, the process by which the patient and his/her physician-led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost-effective medical care.

Similar to findings from the focus groups, it was acknowledged how important it was to **engage the community**—and particularly more underserved populations—in research strategies in a language that is easily accessible and free from medical jargon. Several ***KSC*** participants discussed the need to establish a common language moving forward, defining specific terms including “community”, “engagement”, and “health literacy.” As noted by participants, these terms differ by organization and sector, and collaboratively defining these terms in future endeavors would mitigate confusion. Lastly, participants shared challenges related to measuring subjective perceptions and behavior changes through qualitative data collection, and noted that more clearly defined metrics were needed to quantify progress.

Expert Panel and Jigsaw

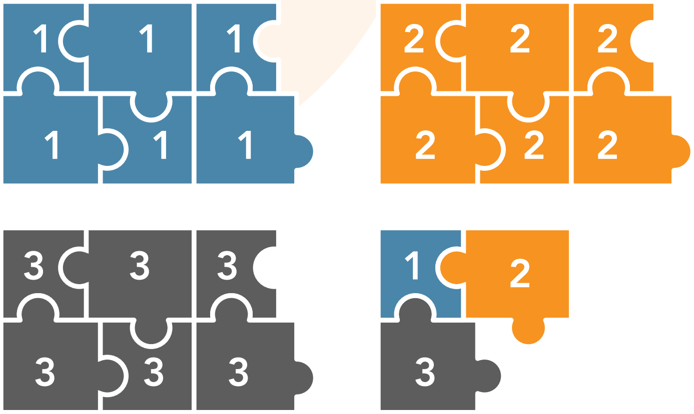
Next, an expert panel and small group breakouts were employed using the *Jigsaw Approach*—a research-based cooperative learning technique meant to encourage listening and engagement while emphasizing cooperation and shared responsibility within groups. The goal was for this “cooperation by design” to facilitate interaction among all group participants, leading them to value each other as contributors to their common task. Cross-cutting themes that emerged in this session included the importance of **authentic community engagement/ empowerment,** and the need for increased **evidence-based health literacy initiatives** that were **culturally-sensitive and accessible.**

Team members were in charge of thoroughly discussing, synthesizing, and presenting responses for the question assigned to them. Participants were then asked to switch to question-specific groups, with a representative from each table being responsible for “reporting out” what was discussed in the original groups.

Lastly, participants were asked to reconfigure and begin brainstorming consensus statements in the newly formed groups. With those key details and ideas, Methodist Healthcare Ministries and HRiA drafted “working statements” that were used as a tool for discussion in proceeding sessions.

A visual representation of the Jigsaw schema, as well as key themes from these discussions can be found below.

FIGURE 2. Jigsaw Exercise Schema



[1] Aronson, Elliot (2000) "Jigsaw Classroom"
http://www.jigsaw.org/index.html

The following key questions were discussed in the Jigsaw Exercise:

- **Question 1:** What are content areas of research we have in common? Where could we focus/prioritize our collaborative research efforts?
- **Question 2:** What things do we need to consider when engaging patients in our research and dissemination strategies? What strategies can we agree on using collaboratively?
- **Question 3:** What should be the guiding principles for our collaboration in these areas?

The following section provides an overview of each session component and key themes that emerged from these discussions.

Session Findings and Key Themes

Expert Panel Themes

An expert panel, comprised of four renowned researchers in the region representing diverse areas of interest, aimed to inform and engage participants by discussing the current research interests and community engagement strategies happening throughout the region. The presentation proceeded with a moderated discussion with key questions provided by HRiA facilitators, and concluded with open questions and answers from the floor. Key themes from the expert panel were as follows:

- **Theme 1: Capacity and sustainability for research are often challenges, but by engaging authentically in the community, there is an opportunity to build trust and better understand these problems.**

A prominent theme across the discussion was the need to build "heart" in the community before engaging in research efforts. This includes **establishing rapport early in the process** by engaging residents in community advisory boards, group discussions, and one-on-one interviews. Sustaining long-term engagement, shared panelists, is among the most difficult, but critical, challenge in community-based efforts.

Also stressed was the importance of thoroughly explaining and **reinforcing the purpose** of research endeavors to the community throughout the research process. This includes creating a deliberate strategy to disseminate information that is **mutually beneficial** for both researchers and participants. For example, if participants involved in research are asked to provide A1C levels, those data should be reported back to and explained to participants to build **health literacy and awareness** in the community.

Lastly, panelists described the complexities of **authentic engagement**, with one researcher sharing an important lesson learned early in their career, explaining *"sometimes authentic engagement means accepting when the community is not interested in your research topic."* She described learning this lesson when approaching a community after receiving funding for a diabetes program only to learn that residents were not interested in the topic. This lesson, she shared, taught her that **engaging the community *before*** pursuing research funding is critically important.

- **Theme 2: Robust research methods are critical to our work; there is a need for evidence-based metrics to quantify community engagement and behavior changes.**

All panelists agreed that strong research methods were among the most important aspect of their work, noting the need to establish legitimacy and publish high-quality data. The problem, shared panelists, is that standard metrics to measure community engagement initiatives have not been robustly established in the literature.

Two panelists discussed the lack of empirical evidence around behavior change initiatives noting that, *"Sometimes well-intentioned strategies do not show much change on a deeper level,"* alluding to health initiatives that have not sustained long-term changes in health outcomes and behaviors. This creates many challenges when assessing the efficacy of programs.

Further, panelists explained that while randomized control trials are considered the gold standard among researchers, it may not be the most appropriate design in some communities. Panelists shared feelings of mistrust and resentment stemming from randomized controlled trials; those assigned to the control groups can often feel that they are being denied services, creating tension between researchers and the community. A way to counter this approach, shared participants, is to identify stakeholders that are involved in various stages of implementation to allow researchers to look at comparisons

- **Theme 3: More needs to be done to reward prevention initiatives at the policy level.**

  All panelists agreed that there are not enough resources allocated for primary prevention efforts. Participants explained that there has been an increased focus on prevention initiatives at the policy level, yet funding and rewards for prevention measures have not followed suit.

- **Theme 4. There is a need for increased awareness of research efforts in the community across health outcomes. Clinical coordination and patient navigation, especially as facilitate by community health workers, are critical services that would benefit from expansion and enhancement.**

  Lastly, panelists discussed the importance of increasing awareness of the ample research efforts happening in the region. This communication, shared participants, is important **between and across sectors.** Areas for collaboration included shared data sets, leveraging HIE's, and distributing shared learnings from previous community engagement efforts.

  During the Q&A that followed the panelist discussion, audience members shared similar experiences to those mentioned in the panel, namely: the need for **financial support around primary prevention,** the importance of **robust research methods** to improve population health, and challenges related to sustaining **community engagement.** These similarities, shared participants, created a unique opportunity to delve deeper into potential areas for collaboration in future research endeavors and partnership.

Jigsaw Exercise Themes

The following section provides an overview of key themes discussed in the Jigsaw exercise by priority question.

Question 1: What are content areas of research we have in common? Where could we focus/prioritize our collaborative research efforts?

The most frequently cited content areas of interest included obesity, diabetes, disease management, behavioral health, and health literacy. Also noted was the interest in community-level data specific to the large Mexican-American population in the region. Participants noted the need to *"bring together multiple methods of research,"* describing the shared benefit to studying process and implementation indicators in future. Opportunities to align implementation efforts across programs may encourage shared research in the future. These efforts, shared participants, could be especially useful for programmatic and quality improvement initiatives.

Question 2: What things do we need to consider when engaging community members in our research and dissemination strategies? What strategies can we agree on using collaboratively?

Participants overwhelmingly agreed that considering cultural context is of the upmost importance when disseminating health and research findings across the region. Considering factors such as cultural norms, fear and stigma, and collective approaches that include family members can increase engagement among the community. Having a strong cultural awareness, said participants, also includes considering factors such as socioeconomic status, literacy level, and lived experience.

Forming community linkages between community, patients, and researchers was a common theme discussed. Group members shared the importance of relationship building early in the research process, and suggested *"meeting the community where they are"* in areas such as schools, clinics, churches, and community organizations. Participants described this strategy as *"taking healthcare beyond clinic walls."* Community Health Workers and providers—including nurses, physician's assistants, and medical doctors–were reported as strong assets to leverage for these efforts.

Further, participants stressed the importance of follow-up in the research process, which was described as traditionally lacking in past endeavors. This follow-up can include creating a cycle of information-sharing after the publication of data through community forums, focus groups, and community advisory boards. Participants described this as *"redefining the research team"* to include community members.

Question 3: What should be the guiding principles for our collaboration in these areas?

General principles that emerged from small-group discussions included strong ethical conduct, based on trust and respect; strong research methods that promote legitimacy and high-quality data; communication; and patient empowerment. The key, shared participants, is finding the mutual benefits among collaborators and the community by *"painting a broad brush of principles between population, health payers, and academics."* As previously mentioned, identifying mutual benefits among these stakeholders can stem from sharing and explaining data findings; building capacity of local institutions; promoting health literacy initiatives; and continuously engaging the community through dialogues and group discussions.

Participants also explained the need to focus more efforts on policy changes. Like the panelist discussion, Jigsaw participants described the importance of demonstrating the value of **primary prevention** in research efforts. *"There has to be long term commitment through various policy level initiatives like income tax credits and incentives for prevention,"* shared one participant. Other participants agreed and said that cost analyses and effectiveness should be standard practice in future research initiatives.

Working Statements

After discussing, participants reconfigured into question-specific groups and synthesized the ideas from their specific small groups to develop and come to consensus on key themes around each of the questions. The most frequently discussed concept was the need to **increase health literacy** in authentic, and **culturally-appropriate** ways. To do so, shared participants, **robust methods** were critical to identify evidenced-based practices. Lastly, **collaboration between and within** sectors would enable the sharing of data and information, ultimately leading to better outcomes and consumer experiences. The following statements were developed by Methodist Healthcare Ministries and HRiA from a synthesis of the key themes that emerged from these discussions.

- **Statement 1: Through patient education, we engage patients to own their healthcare.**

  A common discussion theme was the importance of empowering patients to "own" their healthcare. This includes focusing on barriers that the community described during the focus groups such as health literacy and navigation challenges. Knowledgeable patients are empowered patients, shared participants, and more can be done to focus on culturally-sensitive approaches to health.

- **Statement 2: Robust methods are critical to our work and critical to improved health outcomes in population health.**

  As previously mentioned, participants stressed the importance of producing high-quality research through rigorous research designs, implementation, and data tracking. Participants discussed areas for collaboration including shared metrics to focus on regionally, including HbA1C and BMI. Also noted was the need for a systematic way to share data, such as a health information exchange (HIE).

- **Statement 3: We agree that working collaboratively among regional institutions could lead to better care outcomes and a better patient experience.**

  Several regional academic institutions and public health systems are actively involved in large health-related and research initiatives throughout the Rio Grande Valley and/or Coastal Bend regions. However, research and dissemination strategies are not coordinated across systems, or at times even within systems, to ensure purposeful and respectful patient engagement.

  The need to work and communicate collaboratively was a common theme among the groups. Participants noted the importance of not only building relationships among other institutions, but also stressed the need to improve collaboration within individual institutions, which is currently a challenge among the group. Recognizing these internal challenges, participants shared, is a positive step towards future efforts to create a system where shared metrics and transparent communication were standard and easily available.

Session Conclusions

Commitment to ongoing collaboration among academic leaders in our community was a vital first step toward expanding and further elevating the goal of the ***Advancing Health in South Texas Engagement Series.*** Like the first session, findings from this report served as a guiding document for proceeding discussions throughout the PCORI project with academic researchers, healthcare leadership, public health leadership, and other stakeholders in the community. Common themes that arose in the ***Knowledge Sharing Champions*** session were **challenges related to: communicating effectively between partners; understanding the differences in language and expectations between academia and community; and the ongoing need to keep community informed of research and vice versa.** As such, key learnings for consideration from the ***Knowledge Sharing Champions Session*** were as follows:

There is an opportunity to define a common vision for patient-centered research in the greater South Texas area, by answering the following questions:

- What do we believe and value about patient-centered research? What does it mean to be patient-centered?
- What would patient-centered research look like in the ideal? What would be its key success elements?

Participants in the ***Knowledge Sharing Champions*** Session expressed excitement over the idea of collaborations and partnerships in the future. Success of these collaborations will be largely dependent on clearly articulating a common vision for patient-centered research in the region.

Participants acknowledged the importance of deriving research initiatives based on **community-driven interests.** The challenge, some shared, is that institutional research agendas are not always aligned with community interests. Ongoing conversations about whether/how research can/should be “generated” by community (i.e., community-initiated) vs. engaged with community (researcher-initiated) should be included in this vision. Also discussed was the importance of **strengthening relationships between academic research and clinical partnerships.** While engagement across sectors was identified as important moving forward, participants also noted the challenges of engagement and coordination even within sectors. For example, participants indicated that communicating between different university systems and research institutions is often a challenge in the area – one that makes collaboration difficult.

There are a variety of definitions and terms used when discussing community engagement, and shared language would be helpful moving forward.

As previously discussed, ***KSC*** participants explained that terminology differs across the region and **establishing a common language** would be important in the future. Even during the session, participants continually used different terms from each other and noted that it was not clear how everyone is conceptualizing and speaking about these issues. Key terms to clarify included community vs. patient, engagement vs. participation, empowerment, and health literacy. An important next step to consider in future planning endeavors would be to collaboratively define these terms and elicit feedback from members across sectors on how they would operationalize these terms.

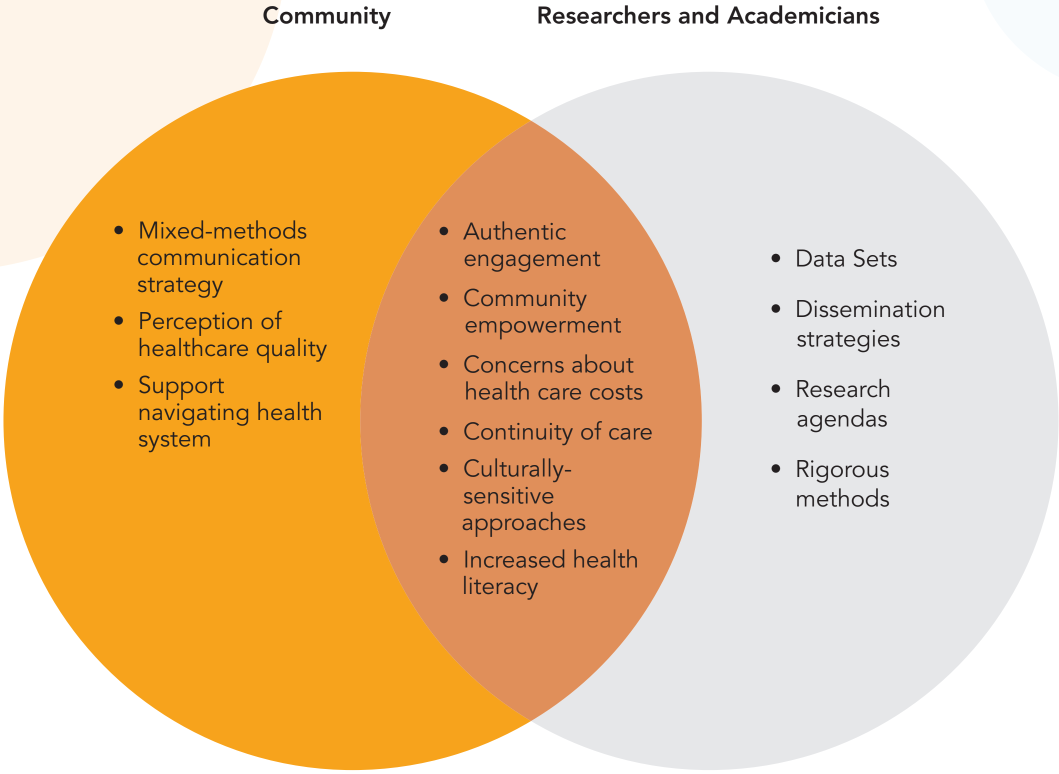
While each region is unique, there is a need to build the knowledge base with a deeper dive using a mixed-methods approach of both quantitative and qualitative data.

A common theme described was the importance of preserving **strong research methods** when engaging the community. This includes utilizing a **mixed-methods approach** in future research endeavors to ensure that the community voice is taken into consideration. As mentioned in the Expert Panel discussion, there are many complexities to authentic community engagement, and approaching a community **before** seeking research funding is a best practice to consider.

Also noted was the importance of disseminating research findings back to the community in a timely fashion. Suggestions to do this included developing a **communication strategy** to share research findings and raise awareness of the research initiatives happening in Southern Texas. Lastly, participants discussed the importance of sharing de-identified data and metrics that can facilitate a deeper understanding of the health status of residents of South Texas.

The following Venn diagram presents an overview of the ***What Matters to You?*** and ***Knowledge Sharing Champions*** sessions’ key findings, what was unique from each session, and the cross-cutting themes that emerged from the first two sessions (Figure 3). Future sessions in the E*ngagement Series* focused on the synergy between stakeholders in order to continuously identify opportunities for a common framework and encourage commitment to ongoing collaboration.

FIGURE 3. Key Themes, Differences, and Commonalities from What Matters to You? and Knowledge Sharing Champions



Engaging Health Payers Summary

August 2016

Overview

The third convened session of the Series, ***Engaging Health Payers (EHP),*** aimed to build off the ***What Matters to You?*** and ***Knowledge Sharing Champions*** sessions by bringing together leadership representing managed care organizations (MCOs) from across the state of Texas. The main objective of this convening was to engage MCOs leadership to develop short-term and long-term strategies that can be made under the purview of the public health systems, policy makers and health care payers to align and encourage future development and integration of patient-centered research, evaluation and dissemination.

Methods

Like the recruitment strategy used in the first two sessions, Methodist Healthcare Ministries reached out to trusted institutional partners to assist with the recruitment process. From these conversations and a desire to reach as many payers as possible came the decision to merge the ***EHP*** session with a monthly meeting of the Texas Association of Community Based Health Plans (TACHP), an association of 11 non-profit safety net health plans affiliated with health care systems. TACHP members all contract with the State of Texas to administer Medicaid Managed Care, serving 1.3 million low-income Texans. Participants included leadership representing a geographic spread of approximately 3/4 of the state of Texas.

The ***Engaging Health Payer*** session occurred on August 22, 2016 with a total of 12 participants from managed care organizations and affiliates. The main objectives for the ***Engaging Health Payer*** session were as follows:

- Provide a **high-level summary** of the Patient-Centered Outcomes Research Institute award - short-term, mid-term and long-term objectives.
- **Share the key themes** from the community focus groups, knowledge champions' session, and their implications for the resulting research, care, and education programs as well as the effective dissemination of the information.
- **Develop ideas for actionable and measurable engagement strategies** between both public and private health payer organizations and academic systems related to identification of tangible research that can be done to improve health outcomes; and further increase effective sharing and dissemination of research findings and evaluation with the community of providers in a manner that improves patient and population health.
- **Identify short-term and long-term policy changes** that can be made under the purview of the public health systems, policy makers, and Managed Care Organizations to align and encourage future development and integration of patient-centered research and evaluation programs.

Presentation of Data Findings

Like the previous convened session, the basis of the ***EHP*** discussion centered on presenting the main findings from the ***What Matters to You?*** session and ***Knowledge Sharing Champions*** session to reinforce the commitment of honoring the community voice in patient-centered outcomes research throughout each of the sessions. Findings were presented by HRiA staff who collected and analyzed data from both sessions to ensure consistency throughout the process. An overview of this discussion is outlined below.

Small Group Discussion

Following the presentation of data findings, HRiA facilitated a small group discussion as part of the ***EHP*** session to inventory participants' perspectives on the importance of, the gaps in, and possible strategies to redefine engagement regarding patient-centered research and evaluation. The following section summarizes the themes that emerged from this conversation—many of which strongly resonate with key themes from the ***What Matters to You?*** and ***Knowledge Sharing Champions*** sessions.

Session Findings and Key Themes

It should be noted that like community focus group findings, health payers reported being largely unaware of research initiatives in the area, instead emphasizing the many structural challenges faced by health payers to address preventive care. Like the community focus groups, these varying levels of readiness to discuss research limited the specific research-dissemination strategies and instead focused on problem identification and brainstorming. Nonetheless, the proceeding findings highlight the various strengths and challenges faced by health payers to consider in future planning endeavors.

Question 1: What would we see as a benefit for having common metrics to collect and report on population health data?

Among the most prominent themes, participants discussed the **importance of shared language**—especially when collaborating across sectors. Having a common understanding of language, acronyms, and metrics is especially critical when looking across state-wide initiatives that can be replicated in other parts of the state.

Electronic Medical Records and Health Information Exchanges were described as tools to leverage to collect and track population health data across the region, although many participants perceived that the time demands of using EMR's and HIE's could also cause an undue burden for healthcare providers. Despite the limitations, participants in the ***EHP*** session overwhelmingly agreed that ***more needs to be done to explore how EMR's and HIE's can drive population health initiatives*** by using large-scale analytics to inform shared strategic efforts amongst regions across the state.

Lastly, participants stressed the importance of not **only being able to access health data,** but making sure that it is **easily digestible and understandable.** Also noted were challenges of sharing data because of unclear HIPAA regulations. Others felt that to some extent, HIPAA was used as an excuse not to collaborate and share metrics. As one participant shared, *"There is not a common understanding of HIPAA in the area and that hugely impedes data sharing; some understand HIPAA but will use it as an excuse. When you think of non-disclosures etc., hospitals are willing to share with each other but are concerned about sharing anything with insurers in fear that rates will adjust."*

Question 2: What should be our population health topic areas for data sharing and why?

The most frequently cited health topics included **chronic diseases and their risk factors**, including obesity and smoking, as well as **maternal and child health**. Participants acknowledged the importance of considering the upstream and environmental factors that affect health such as poverty and housing—also known as the **social determinants of health**—when thinking about population health across the region, yet there was overwhelming agreement that this was **not currently the state's approach.** The challenge of this perspective, some shared, is that the current **reimbursement and funding structures** set by the state are mainly void of these considerations.

These counterintuitive structures are also common for initiatives that focus on prevention. Like key findings in the ***Knowledge Sharing Champions*** session, participants in the ***Engaging Health Payers*** session overwhelming agreed that there are **not enough resources** allocated for **primary prevention** efforts on a systems-wide basis for initiatives like smoking cessation and **health literacy.** This sentiment echoes the academician's concerns regarding the increased focus on prevention initiatives at the **policy level** with a misaligned incentive and reimbursement process for research endeavors.

Validating findings from the previous two sessions, participants acknowledged the complexities and challenges of authentic community engagement. Continuing community engagement —not only from patients, but also from academic, health, and state institutions—is of the upmost importance when working towards improved population health. Participants also echoed the importance of trust and rapport when relaying health-related information to the community. As one participant shared, *"Insurers are not the most trusted organizations in the world. We have to look for strategies to connect with residents in a way that is meaningful to them."*

Lastly, health payers described challenges of balancing **long-term goals with short-term objectives** that are more relevant for the industry of health payer organizations. A common discussion point was the fleeting nature of the health insurance-consumer relationship, with many consumers switching in a span of less than three years. One participant described the difficulties of trying to get members to pick a "health home," which he also attributed to generational differences saying, *"We used to have consumers who were members for twenty years or more, but this younger generation seems to be less interested in company loyalty and more interested in how quickly they can attain [insurance] services."* This, they shared, makes it difficult to invest in more long-term approaches to population health.

Question 3: What are strategies to enhance and reduce barriers to sharing this population health data with researchers, philanthropy, health systems, and community?

Though many challenges were discussed throughout the day, participants in the ***EHP*** session offered valuable suggestions for consideration to reduce barriers moving forward. First and foremost, participants overwhelmingly agreed that more efforts are needed for **collaboration on systems-level** and **policy changes.** There is a need to contextualize the work being done at the state and federal level that impacts health payers' ability to think longitudinally in regard to population health. Also noted was the need to engage major stakeholders in these state-wide considerations–community, academics, healthcare, and philanthropy–and **find mutual benefits among all collaborators** that are clearly articulated and routinely revisited.

A short and long-term strategy to bridge these gaps that emerged from the discussion included **collaborating with philanthropic organizations** in the region, which contribute upwards of $300 million to the health infrastructure throughout the state. This would not only improve the fragmented system of communication, resource allocation, and navigation challenges alluded to in all three convening sessions, but would also alleviate some of the state's burden to sustain the collaborative process.

As previously mentioned, participants described exploring HIE's as a tool to leverage information sharing for these goals—with the caveat that these approaches must be sensitive to the burden placed on health care providers. HIPAA regulations would need to be clarified and understood by all stakeholders before utilizing this approach, they noted. As for time burden caused by tracking process and implementation measures, participants suggested that staff from all levels—including nurses, social services, and community health workers—be more involved in the process.

In terms of **research agendas**, the health payers resonated more with aspects of the Community Venn circle than with the Academic circle. Specifically, there was more agreement around the need for flexible approaches to research and evaluation, including mixed-methods communication strategies, a balance between rigor and relevance (i.e., robust research methods vs. feasibility within community), and **timeliness** of results. Participants acknowledge that there would have to be a compromise in these arenas to satisfy researchers' needs to identify the best **evidence-based approaches** to care, while also producing interim information that could help guide short-term strategies and decision-making for health payers.

Session Conclusions

Many cross-cutting themes emerged from the ***What Matters to You?***, ***Knowledge Sharing Champions***, and ***Engaging Health Payers*** sessions. However as discussed in the limitations section, there were varying levels of readiness to discuss patient-centered research strategies among stakeholders. Namely, community focus group participants and health payers **were largely unaware of research initiatives in the area**, which limited specific strategies pertaining to patient-centered research. As such, many of the commonalities focused on healthcare access and delivery.

Among the most prominent commonalities included: the **emphasis on the social determinants of health, chronic diseases and their risk factors, culturally responsive approaches, authentic engagement, collaboration, and the development of a shared agenda with a common language.**

Figure 4. shows an abbreviated visual representation of the findings mentioned above, and the table in Appendix 7 provides a more detailed description of the terms used in the Venn diagram.

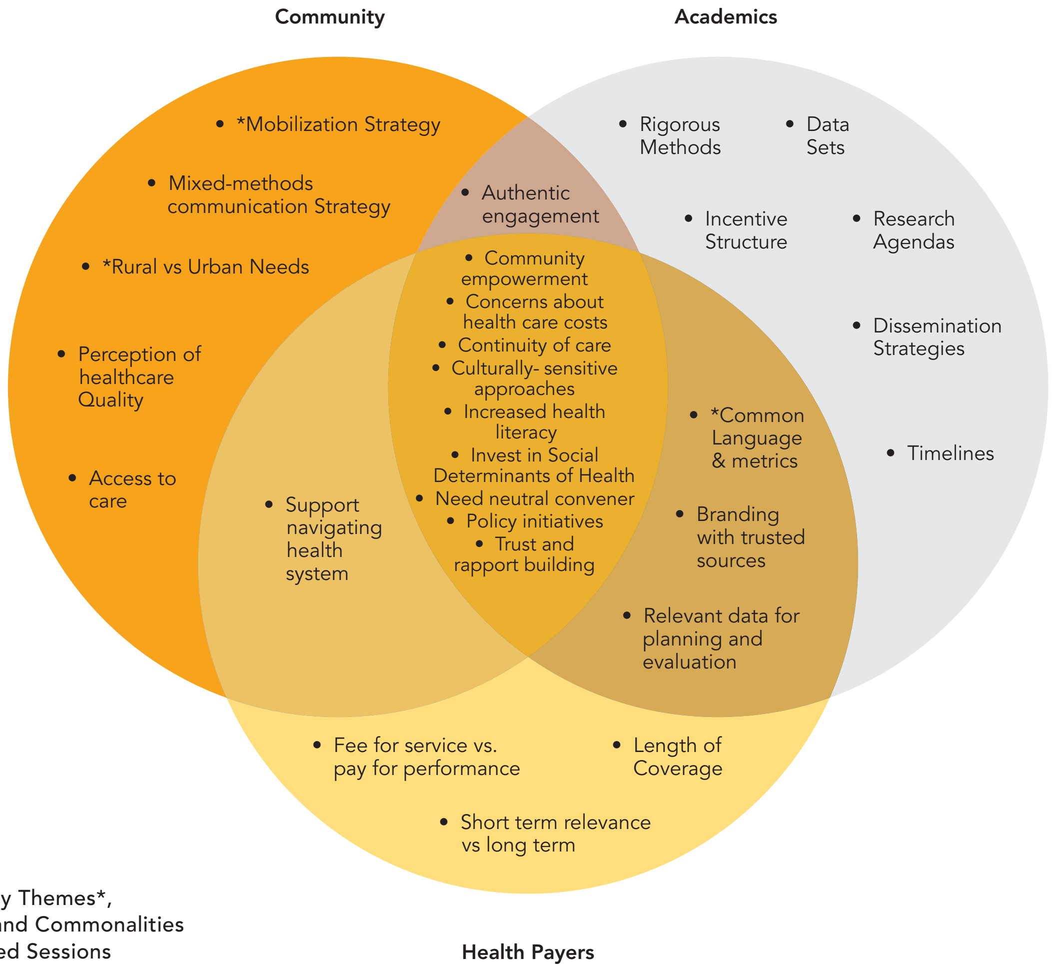


FIGURE 4. Key Themes*, Differences, and Commonalities from Convened Sessions

Engaging the Community Voice/ Building the Patient-Centered Partnership

February 2017

Overview

The fourth convened session of the Series, ***Engaging the Community Voice (ECV)*** aimed to re-engage end-users of Methodist Healthcare Ministries-sponsored initiatives and programs—including consumers, stakeholders, academic institutions, health advocacy groups, health care providers, and payers--through facilitated "town-hall" discussions to ask for additional suggestions or clarifications, and discuss next steps in the process. During the 90-minute sessions held in Corpus Christi, Laredo, and McAllen in February 2017, findings from the three preceding engagement sessions were presented to the group, followed by facilitated discussions to elicit feedback and suggestions for future planning guiding by the following questions:

1. **What is missing** that you would want added and why?
2. **What do you like** about the information presented thus far?
3. **What would you change or clarify** about what has been presented?

Methods

As part of this process, every participant was also given an index card to solicit additional written feedback that may have not been discussed. In total, 122 participants were involved in the town-hall style discussions. The objectives for the day included the following:

- Provide a **high-level summary** of the Patient Centered Outcomes Research Institute award - short-term, mid-term and long-term objectives. The overall goal of POCRI is to improve population health for the communities served.
- **Share the key themes** from the community focus groups, academic and payer sessions, and their implications for the resulting research, care, and education programs as well as the effective dissemination of the information
- **Engage end users**, such as consumers, caregivers, policy makers, and health advocacy groups, to discuss best-in-class strategies for research dissemination.

The following section summarizes the themes that emerged from this conversation—many of which strongly resonate with key themes from the ***What Matters to You?***, ***Knowledge Sharing Champions,*** and ***Engaging Health Payers sessions***. The table that proceeds the narrative represents a visual of cross-cutting themes among town-hall discussions.

As previously discussed, the varying levels of readiness to discuss patient-centered research among stakeholder groups limited the discussion regarding specific research dissemination strategies than originally intended. Nonetheless, findings from these sessions provide valuable insight to the opportunities for each of these groups to address patient-centered research moving forward.

Session Findings and Key Themes

Promote Authentic Engagement and Reframe Research Agenda

Validating findings from the previous sessions, participants acknowledged the **complexities and challenges of authentic community engagement;** one challenge was being perceived as *"elitist"* by community members. Also noted was the importance of clarifying the different needs of **rural and urban areas.** As one participant shared, *"What we need in [rural areas] is nothing like what they need in Laredo [urban]. Our [rural] needs are very different and sadly, overlooked."* This sentiment also came up in McAllen, TX, where one index card submission read, *"I wonder what the outcomes would've been if smaller colonias outside of the [Rio Grande] Valley were interviewed; I bet they never are."*

A participant in Corpus Christi, TX also explained the importance of **considering cultural nuances** when framing discussions by avoiding language that overgeneralizes antiquated cultural norms -- for example, not assuming that all men operate from a *"machismo"* perspective, the concept associated with "a strong sense of masculine pride". Further, participants stressed the need for using language and terminology that was accessible, clear, and free of negative connotations (e.g., "patient" could connote one who is a passive recipient of information rather than an active participant in his/her own health).

In terms of engaging with research, participants emphasized the **importance of follow-up and rapport building** among providers and researchers; the need for face-to-face communication was crucial for this process. Apart from face-to-face contact, town-hall participants suggested highlighting qualitative stories in marketing efforts to *"understand the person vs aggregate data."*

Consider a Mixed-methods Communication Strategy for Future Endeavors

Participants across geographies preferred a **mixed-method communication strategy** for health-related information. Focus group and town-hall participants alike cited that **in-person** and **face-to-face interactions** were the preferred methods of disseminating research-related information—with the caveat that this information should come from trusted sources.

Modes of preferred written or oral communication also differed by municipalities, but **word-of-mouth** and the **internet** were reported as the most trusted sources to receive health-related information. The next most frequently cited included **local radio, community events,** and **flyers.** Lastly, participants stressed the importance of **understanding the unique communities** being engaged before disseminating health-information and research opportunities.

A Focus on Prevention and Wellness

Similar to key findings in the previous sessions, ***Engaging the Community*** Voice town-hall participants overwhelming agreed that there are not enough resources allocated for **primary prevention** efforts on a systems-wide basis for initiatives such as smoking cessation, physical education in schools, and health literacy. As one interviewee observed, *"All of us should agree that P.E. needs to be a requirement in schools to make sure our kids are exercising."* Participants suggested more parks, walkable communities, and expanded grocery stores in low-income or rural areas; they suggested building on existing healthy living initiatives in the community, but emphasized the need for **continuity** and **consistency** among wellness programs, which, due to funding cycles, many reported as lacking in the past. Enhanced information about prevention was also seen as a need: as one community participant shared, *"getting information about resources should be easier than it is now."*

Further, finding new ways to deliver health care in underserved communities was also a common theme in conversations, especially in rural communities that reported challenges recruiting and retaining specialists. In Laredo, TX, for example, telemedicine was suggested as a possible strategy to bridge the gap in specialty care in provider-shortage areas that are more rural.

Addressing the Social Determinants of Health

An overarching theme among the town-hall meetings was **the importance of addressing key barriers**—poverty, access to care, transportation, and employment—also known as the social determinants of health—that prevent South Texas residents from achieving optimal health. This theme is consistent with findings from the three preceding convened sessions. Of the environmental factors mentioned, **poverty** and **increasing access to care** were most frequently cited as top barriers to improved health for low-income residents. Participants acknowledged the importance of considering environmental factors when thinking about population health across the region, yet there was overwhelming agreement that this was not currently the state's approach. This gap created future research opportunities to study the impacts of these social determinants on population health, shared academicians, which could build the case for a more upstream approach to health on a state-wide basis.

Improved Health Care Access

Access to care was identified as a concern in all town-hall meetings. Similar to the first three sessions, the following barriers were identified: **lack of specialty providers—especially behavioral health—, challenges with health insurance coverage, navigating a complex health system, lack of coordinated care, and transportation.** Helping individuals obtain and understand health insurance, accessing behavioral health services, and increasing services for low-income individuals were identified as high priorities by participants. Further, many agreed that improved alignment and coordination was needed among the community, hospitals, local institutions, and health centers, citing that it was difficult to know what resources were available.

More Emphasis on Policy and Advocacy

Another theme that was prominent among groups was that more efforts are needed for **collaboration on systems-level and policy changes** at the state and local levels. More importantly, there is a need to contextualize the work being done at the state and federal level that impacts health payers', researchers, and providers' ability to think longitudinally in regard to population health.

Participants noted that policy changes come in varying shapes and sizes. Some use the idea of "Big P and Little p policy"; a Big P policy might be one that is at the state level through legislation, regulations, and taxes, while Little p policy are smaller initiatives—possibly at the local government, worksite policies/investments, and norms and standards that drive other action. A common discussion among participants was the need to leverage "Little p" initiatives and mobilize local organizations through grassroots efforts. As one participant shared, *"There is no policy change without advocacy; we should also be talking about how to mobilize the community moving forward."* These efforts should also engage local officials and health payers, shared participants.

The table below synthesizes the cross cutting town-hall themes by geographic location (Table 3).

Session Conclusions

Table 3. Town-Hall Responses to Data

Cross-Cutting Key Themes	Corpus Christi	Laredo	McAllen
Health Literacy: Culturally-relevant and accessible • Simplify terms • Demystify process • Treat community respectfully, not elitist • Use of language (e.g., the term patient connotes passive)	x	x	x
Communication: Utilize a mixed-methods communication strategy and reframe research agenda to include residents in planning and dissemination: • Face-to-face communication • Internet • Word-of-mouth • Advisory committees	x		x
Research: Reframe research to change community context and enhance continuity of care among providers and stakeholders	x		
Social Determinants of Health: Focus on "upstream" factors (e.g., poverty, employment, access to healthy food)	x	x	x
Urbanicity: Clarify urban vs rural needs—very different; small towns are "overlooked"	x	x	x
Sustainability: Programs lose traction when funding falls off—no consistency- still require follow up, navigation	x		x
Health Investments: Payer and MCO investment needed- in prevention, wellness, and in public health infrastructure	x	x	x
Best Practices: Learn from successful campaigns and models and replicate (e.g. Seattle smoking campaign)	x	x	
Recruitment: Need to attract and retain medical doctors and specialists		x	x
Policy and Advocacy: Mobilize for systems-level change locally and across the state. Policies mentioned: • Health Education K-12 • Maternal and child health • Reciprocity and reimbursement laws for provider recruitment	x	x	x

Building the Patient-Centered Partnership

Overview

In the final afternoon planning session in McAllen following the community town-hall meeting, participants began the process of identifying the key elements of the *Collaborative Research Framework*, described as **Building the Patient-Centered Partnership,** which includes both the focus of the research, as well as the specific strategies for developing and sustaining the collaborative partnership and effectively disseminating the research to key groups in the community.

Methods

During this session, participants broke into different configurations of small work groups to answer questions about the content and shared metrics for the research; the components that would support collaboration, with a strong focus on authentic engagement; key criteria for selecting partners in the collaborative effort; potential "quick wins" that could be developed and achieved in the near term to sustain enthusiasm and momentum; and critical groups/individuals who should be at the table for the next stage of planning. The following section summarizes these key themes by topic area.

Session Findings and Key Themes

Key Themes: Content and Metrics

- **Chronic diseases and their risk factors—especially diabetes, obesity, heart disease, and cancer**—were reported as priority content areas to consider for a future collaborative research agenda. Participants were especially concerned about the perceived increase in childhood obesity. As one resident shared, *"more and more of our kids are overweight too; we should be focusing on what kids are eating at schools and at home."* Competing time commitments, the availability of accessible and affordable healthy food, and cultural norms were attributed as challenges to maintaining a healthy weight. Again, participants stressed a need for research-informed systems-level strategies to promote healthy eating and physical activity to reduce chronic illness in the community; examples of strategies included requirements for physical education in schools, healthy school lunch programs, and worksite wellness initiatives.
- In addition to looking at chronic diseases and their risk factors, participants also shared the **importance of access to healthy food** as a top concern. Many participants described multiple pockets of food deserts in the region that made access to healthy foods difficult. This problem, shared participants, was exacerbated by limited transportation options. Participants suggested that future research topic areas could explore successful models of rural mobile food outreach, and the impact of local farms supplying local markets with healthy food.
- **Mental health – which often co-occurs with substance abuse,** was identified as a top health issue in the community; especially noted was the lack of services to address these growing behavioral health issues. Participants described issues of anxiety, stress and substance abuse for adults—largely attributed to poverty—as the most common concerns. Session participants in both Laredo and McAllen explained the challenges of behavioral health services because of limited providers, reimbursement models for behavioral health, and stigma. Future research topics discussed included the intersection of poverty and mental health diagnoses, anti-poverty initiatives, and access to substance abuse treatment services that were culturally relevant.
- **The built environment—especially transportation, safe, walkable communities, and food access—were reported as areas to explore moving forward.** These key determinants of health were seen as impeding improved health, especially for low-income residents who live in areas with limited infrastructure. While individual challenges such as time constraints were mentioned as barriers to a healthy lifestyle, structural challenges such as living in a food desert and having limited access to sidewalks, arose as a prominent theme among discussions for future research topic areas to explore.

Participants were asked to suggest possible indicators to include in future research endeavors. The table below shows topic area and indicators that were discussed during this session.

Topics	Indicators
Chronic Diseases and Risk Factors	• HbA1c, BMI • Rates of medication adherence • Utilization of Emergency Medical Services • Disease incidence and mortality
Access to Healthy Foods	• Supermarkets per capita
Mental Health	• None discussed
Built Environment	• Public transportation routes

Key Themes: Components/Strategies that Support Collaboration, Communication, and Engagement

Groups also discussed what components or strategies would be essential to consider when crafting the collaborative framework. Among the most frequently cited, ensuring that partners had **shared visions and goals, clear expectations regarding roles and responsibilities, and a plan for sustainability** were most prominent. In line with findings from the previous sessions and town-halls, participants also stressed the **importance of a neutral convener** to bring institutions together.

In terms of communication, session participants suggested monthly meetings or quarterly meetings where stakeholders could identify areas of collaboration and discuss needs and opportunities on an on-going basis. Community engagement would also be essential throughout this process, and **deliberate opportunities for engagement** should be created to support inclusion. Participants stressed the importance of not making community members feel "acted upon" or "experimented with" but rather meaningfully and substantively engaged in processes that are important to them. Specific suggestions included: **bilingual meetings, minimal use of acronyms and jargon, transportation support to and from meetings, childcare support, and community panels.**

Similar to the town-hall findings, participants stressed the need for a **mixed-methods communication strategy** to engage residents who were not involved in ongoing discussions of patient-centered research. Specifically, **in-person interactions, local radio, and community events** were the most frequently suggested ways to disseminate information and invite feedback. Participants expressed frustration over complicated jargon and acronyms and stressed the importance of considering literacy levels and terminology when disseminating health-related and research information. Providing a lay summary of study findings in both English and Spanish were strategies mentioned by focus group participants. Lastly, the importance of **follow-up and follow-through** was discussed as a critical factor for building trust and maintaining effective relationships; those who are asked to provide information or input, or to participate in some way in a research study, should be informed of the results of their involvement.

Finally, it should be reiterated that throughout these conversations, **the importance of keeping systems-level strategies top-of-mind was critical.** Specific suggestions included looking at current policy proposals and adding voice/weight at the local level through advocacy days; building advocacy capacity in the region through awareness and training; and using return on investment-based arguments for stakeholders such as health payers and academicians. Participants explained that the foundation for this work has already begun through various organizations throughout the region, and suggested collaborating and supporting those efforts to not "reinvent the wheel."

Specific strategies were discussed among participants throughout this session. The following table summarizes the components and strategies referenced.

Components	Strategy
Communication and Dissemination	• Create a communication and dissemination strategy through trusted community organizations • Decrease acronyms and research-specific jargon; accommodate language preference • Regular meetings with stakeholders
Policy and Advocacy	• Build advocacy capacity at the local level • Continuously reiterate the history of the research process (i.e., where have they been and where are they now?) • Increase knowledge of healthcare policies • Plan to re-align incentives to focus on prevention and wellness
Collaboration	• Plan to reduce competition among providers and institutions • Shared templates for partnership agreements • Regular convening both within sectors and across sectors • Sustainability planning

Key Themes: Partnership Inclusion Criteria (and who should be at the table)

Also discussed was partnership criteria to consider when moving forward with planning processes. Participants shared that **having similar target populations, aligned visions and goals, and strong credibility in the community** were among the most important when selecting potential partners for the collaborative research process. The need for a neutral convener to ensure that partners were held accountable was described as a critical, but currently unidentified, component to success. Lastly, there was discussion around the need to have diverse sectors represented in future partnerships. For example, participants discussed the benefits of having a mix of local institutions with established rapport, and corporate institutions with a wider reach, at the same table. As a note, there was a strong effort to recruit diverse sectors in these conversations, however, more can be done to engage entities that have not historically been involved in health and philanthropic initiatives. Specific stakeholders identified in this session included:

- Policy makers-local, regional, state
- Universities and Community Colleges
- County Health Departments
- Community Providers
- Legal counsel for organizations
- Promotoras and community health workers
- Medical schools and medical residents

Key Themes: Quick Wins

The ***Building the Patient-Centered Partnership*** session concluded with a discussion around possible "quick wins" to focus on when creating a shared research framework. **Strengthening and leveraging established partnerships** through frequent convened sessions and summits would be a quick-win to increase collaboration and communication. In terms of access to care, participants suggested leveraging mobile clinics to increase the reach of vulnerable populations or patients without established "medical-homes". Lastly, there are a variety of definitions and terms used when discussing community engagement, and **shared language—including definitions and defined processes and expectations—would be helpful moving forward.**

Session Conclusions

In order to strengthen the foundational work that has been established through the PCORI project, a potential next step is to re-engage academicians and researchers who participated in the ***Knowledge Sharing Champions*** session in order to further reflect on the outcomes of this report and to continue the process of outlining a *Collaborative Research Framework* and plan that would include all of the elements above, as well as more specific strategies around decision making structure and accountability, financial structure and incentives, sustainability and scalability, data sharing, and dissemination.

Engagement Series Conclusions, Next Steps, And Lessons Learned

Throughout the course of the *Engagement Series*, over 300 South Texas residents from various sectors have been engaged in the foundational processes that will ultimately inform the ongoing *Collaborative Patient-Centered Research Framework*. As detailed throughout this report, there were various levels of readiness to discuss patient-centered research among stakeholders, with many participants reporting being unaware of research initiatives throughout the region and two specific groups (payers and academicians) having seemingly different goals and timelines for research. Although these issues created challenges to operationalizing the final *Collaborative Patient-Centered Research Framework*, also evident was the enthusiasm and desire to continue these conversations that can be leveraged moving forward.

The immediate next steps are to share this report with all participants in an effort to promote transparency and follow-through in the process. In addition, there is clearly a need for continued collaboration to flesh out the details of the *Collaborative Patient-Centered Research Framework*, reconnecting the discussion to the dissemination strategies and patient-centered research language with the aid of a neutral facilitator. Funding options should be explored to support this effort moving forward.

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Several challenges and lessons-learned emerged throughout the planning and facilitation of the ***Advancing Health is South Texas Engagement Series*** that should be considered in future planning endeavors. Among them, the importance of **foundational relationship building and sharing, a need for a convener, sustainability planning, and engaging a wider range of stakeholders** were among the most prominent. The following section reflects on some of these lessons-learned, and provides suggestions and recommendations for vfuture endeavors.

- **There is a need for long-term and focused relationship building within and across sectors prior to convening.** A cornerstone of the ***Advancing Health in South Texas Engagement Series*** has been Methodist Healthcare Ministries' intentionality of deliberate partnerships to support authentic engagement. Throughout the convened sessions, there was robust participation among sectors in which Methodist Healthcare Ministries has a long-standing history, namely healthcare providers and consumers. However, more challenging was the engagement and recruitment of sectors that have not historically been at the table during these collaborations, including health payers and academicians. This resulted in a smaller sub-set of participants representing these important groups, which may limit the generalizability of the discussions. The participation imbalance between sectors emphasizes the ***importance of long-term and focused relational building prior*** to engaging in planning efforts moving forward.
    - Further, participants suggested that preliminary conversations focus on identifying mutual benefits of participation among sectors to maintain buy-in. Also noted was the need for incorporating **incentives to compensate for participants' time**—a component that was lacking from this Engagement Series—to improve recruitment efforts moving forward.
- **There is a need to identify a convener to maintain momentum and establish a shared vision for collaboration.** As discussed throughout this report, a reoccurring theme among sessions was the importance of a neutral convener to facilitate collaborations within and across sectors. Participants shared that this neutral entity has not been identified, and those groups interested may be constrained by time, resources, or staff capacity to take the lead, making the continuity of collaboration challenging. A strong convener, shared participants, must be **neutral, strategic, and have a proven history of collaboration** throughout the region. The cornerstone of the convener's purpose will be to define and clearly communicate goals of the collaborative—recognizing the unique power dynamics and timelines of each of these institutions. Participants suggested that lead partner organizations can begin to build a shared platform for knowledge-sharing and dissemination by identifying a lead for establishing and maintaining a clearinghouse for future, patient-centered research in the region.
- **Sustainability planning should happen earlier throughout the process.** Many conversations throughout the *Engagement Series* led back to the ultimate question of sustainability—both financial and structural—moving forward. Participants shared concerns about the ever-changing nature of the political climate across the country, which may impact funding opportunities to maintain collaborative partnerships in the future. Thus, a key learning from this *Engagement Series* is the need for sustainability planning to occur earlier, to reassure participants of the continuity of and commitment to the process.
- **Engaging a wider audience will ensure appropriate stakeholders are at the table.** Lastly, while many of the key stakeholders involved with population-health initiatives were involved in this convened series, it is evident that the process could have been strengthened with the participation of additional groups, namely legislators and grassroots mobilizers. Participants acknowledged that convening these groups would be challenging, but suggested leveraging technology to engage and solicit feedback on an on-going basis. **Figure 6** depicts a suggested stakeholder structure for future planning efforts.

FIGURE 6. Possible Stakeholder Structure

List of Appendices

Appendix 1: What Matters to You? Supporting Documents

Health Resources in Action
Methodist Healthcare Ministries PCORI Engagement Series
Community Focus Group Guide

Goals of the focus groups:

- To gain an understanding of people's experiences with and barriers to accessing health care services in the community
- To identify people's communication with their health care providers and ways of receiving health information
- To identify strategies for engaging community members in research findings and dissemination

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5-10 MINUTES)

- Welcome everyone. My name is ____________, and I work for Health Resources in Action, a non-profit public health organization in Boston.
- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.
- Methodist Healthcare Ministries is conducting a series of discussions to better understand the health issues facing South Texas residents, how these needs are currently being addressed, and opportunities to improve health-related communication and research findings in the community. We are funded by the Patient-Centered Outcomes Research Institute (PCORI). PCORI's goal is to help people make better health care decisions by having a say in the research that affects their health. PCORI's goal is different than most organizations that give money for research. PCORI wants [you/people] to have a say in what research studies should focus on so that future research can answer the questions that are most important to [you/them].
- As you can see, I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so she is helping me out by taking notes during the group and she doesn't want to distract from our discussion.
- [NOTE AUDIOTAPING IF APPLICABLE] Just in case we miss something in our note-taking, we are also audio-taping the groups tonight. We are conducting several of these discussion groups around Texas, and we want to make sure we capture everyone's opinions. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.
- You might also notice that I have a stack of papers here. I have a lot of questions that I'd like to ask you tonight. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don't be offended. I just want to make sure we cover a number of different topics during our discussion tonight.

- Lastly, please turn off your cell phones or at least put them on vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.
- Any questions before we begin our introductions and discussion?

II. INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what community you live in; and 3) something about yourself – such as how many children you have or what activities you like to do in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY AND HEALTH PERCEPTIONS (10 MINUTES)

2. Today, we're going to be talking a lot about the community that you live in. How would you describe your community?
3. If someone was thinking about moving into your community, what would you say are some of its biggest strengths or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]
    a. What are some of the biggest problems or concerns in your community? [PROBE ON ISSUES IF NEEDED – HEALTH, ECONOMIC, SOCIAL, SAFETY, ETC.]
4. What do you think are the most pressing health concerns in your community?
    a. How have these health issues affected your community? In what way?
    b. What specific population groups are most at-risk for these issues?
5. What are some factors that make it easier to be healthy in your community?
6. What are some factors that make it harder to be healthy in your community?

IV. DECISION MAKING AND ACCESS TO HEALTH CARE SERVICES (40 MINUTES)

7. I'd like to ask specifically about health care in your community. What do you think about the health care services in your community? [PROBE – perceptions of quality, accessibility, etc.]
8. Have you or someone close to you ever experienced any challenges in trying to get health care? What specifically? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTION, ETC.]
9. For your own personal health care - if you or your family had a general health issue that needed a doctor's care or prescription medicine – such as the flu or a child's ear infection– where would you go for this type of health care? [PROBE IF THEY GO TO PRIVATE PRACTICE, ED, ETC]

10. What about if you had a more urgent health problem that needed a doctor's care – such as a serious illness or injury – where would you go for this type of health care? Why? [PROBE FOR SPECIFIC INSTITUTIONS]
    a. How do you decide where to go for care? What things do you consider when making the decision of who to go to for routine care? How about for more urgent or serious care?
    b. Do you have someone that you consider your own personal health care provider (doctor, nurse practitioner)?

. **[IF YES to 10b.]**

- i. Do you see this same person each time?
- ii. What type of setting does this person work in – a clinic, hospital, private practice, etc?
- iii. How did you pick this person?
- iv. What do you think this person's interaction is with any other providers you see?
    1. How much do you think your care is coordinated among the providers you see?

. **[IF NO to 10b.]**

- v. Why not? What has made it hard to be able to see the same person each time you need health care?

c. How would you describe your relationship with your healthcare providers?

d. How comfortable do you feel asking your provider questions?
  - i. What makes it hard to ask questions to your provider about your health or health care?
  - ii. What makes it easier to ask him/her questions?

e. How much do you feel that your health care providers give you the most up-to-date information about your health?
  - i. What makes you say that? Are there specific examples you can provide?
  - ii. When you provider gives you health information, does he/she talk about where it's from? (e.g., a new study, their colleagues, etc.)
  - iii. Is there anything you would like to change about your relationship with your health care provider(s) or how you talk to each other? What specifically?

ENGAGING PATIENTS/DISSEMINATING HEALTH INFORMATION (30 MINUTES)

- f. How do you currently find out about new health findings or treatment options? (Doctors, nurses, community leaders, community health workers, peers, family, etc.)?
    - i. From what source do you prefer to receive this type of health information?
        1. Why? What about that source do you find appealing?
    - ii. Who do you trust most to give you information about health and treatment options?
        1. Why? What about that source is trustworthy?

11. If an organization in the community wanted to provide more information about new health findings, what is the best way to communicate it to you and your friends or family? [PROBE SPECIFICALLY ON COMMUNICATION CHANNELS: TV (what language?), newspaper (which ones?), magazines, through community leaders (examples), through churches or other organizations, online]
12. There are hospitals, healthcare providers, and universities in the region that conduct studies to test new treatments and options of care. Have you heard about any studies in your community? Which ones?
    - a. If your doctor asked you or your family to be part of a new study for a health issue you have, what would you want to know? What questions would you have?
        - i. In what way would you want to receive this information (Written, oral)?
    - b. What is the best way for people to understand what the study is about so that they can decide whether or not to participate?
        - i. What would you want to know about the results of the study?
        - ii. How can a provider or someone else talk about these studies so they can help you make decisions about your health?
        - iii. What are some of the things you would want to know?
        - iv. How would you decide whether or not to make changes about your health because of these results?

V. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Before we end the discussion, is there anything that you wanted to add that you didn’t get a chance to bring up earlier?

I want to thank you again for your time. And we’d like to express our thanks to you. [DISTRIBUTE STIPENDS AND HAVE RECEIPT FORMS SIGNED]

Appendix 2: Knowledge Sharing Champions Supporting Documents

AGENDA: ***KNOWLEDGE SHARING CHAMPIONS*** SESSION AGENDA

Methodist Healthcare Ministries: PCORI Engagement Series

Objectives:

- Share the key themes from community focus groups and implications for research and dissemination
- Discover the research topics, indicators, and dissemination methods already in place with peer institutions
- Develop ideas for framing a shared research and dissemination agenda that would address the needs and concerns of community members

May 18. 2016	9:00 am-3:00 pm
Welcome and Introductions Patricia Mejia, MA, Director of Community Engagement, Methodist Healthcare Ministries Lisa Wolff, ScD, Vice President, Health Resources in Action *Review agenda and objectives* *Overview of project and roles of stakeholders*	9:00-9:30 a.m.
Presentation of Data and Findings Erika Gaitan, MSW, Research Associate, Health Resources in Action *Review key themes from community based focus groups* *Identify implications for research and dissemination* *Q&A*	9:30 – 10:15 a.m.
Break	10:15 – 10:30 a.m.
Expert Panel *Defining Research Agendas and Dissemination Strategies* Lisa Wolff, ScD, Vice President Health Resources in Action *Academic researchers will have the opportunity to offer a short presentation on their research topics and agendas, followed by a moderated discussion with key questions provided by facilitators, and concluding with Q&A from the floor.*	10:30 a.m. – 12:00 p.m.
Lunch & Break	12:00 – 1:00 p.m.
Small Group Table Discussion (Jigsaw Exercise) *Brainstorm Solutions* *Participants will answer key questions at their small table discussions (groups of 4), with each participant responsible for taking notes on one of the questions. Questions could include: What should be our top priorities for a shared research agenda and why? What would success look like? What are current barriers? What are strategies to enhance collaboration and reduce barriers?*	1:00 – 1:45 p.m.

Consensus Statements *Bridging the Gap* Lisa Wolff, ScD, Vice President, Health Resources in Action *Report Out Working Consensus Statement*	1:45-2:30 p.m.
Closing Patricia Mejia, MA, Director of Community Engagement, Methodist Healthcare Ministries *Wrap-Up and Next Steps*	2:45-3:00 pm

Knowledge Sharing Champions Participant List

Dr. Charles Begley
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I Coach U

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Violeta Davila
Reigon Evaluator
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Student Education Coordinator
University of Texas Rio Grande Valley, Brownsville Campus

Dr. Lisa Wolff
Vice President
Health Resources in Action

Knowledge Sharing Champions Expert Panelist Biographies

Knowledge Sharing Champions Session
Panelist Biographies

Janani Krishnaswami, M.D., M.P.H

Dr. Krishnaswami is currently the Program Director of the Preventive Medicine Residency Program at University of Texas – Rio Grande Valley. Her work centers on health "outside the hospital": engaging in community-based, participatory efforts to promote wellness, prevent chronic disease, and sustain health. Her goal is to adopt a collaborative, systematic approach to building health, while involving residents in the formation of community networks and environments which promote and sustain healthy behavior.

Prior to her role as Program Director, Janani served as the Associate Program Director for Preventive Medicine at the University of California – Los Angeles, where she led discussion and curriculum development on community engagement and quality improvement for UCLA Primary Care residents. As a Kennamer Community Medicine Fellow, Janani provided clinical care, led health improvement and innovation projects, conducted research and mentored residents in various Los Angeles safety net clinics. Here, she received an Innovation Grant and award for her project involving gaming technology in adolescent obesity prevention. In addition, she developed and taught a novel health policy curriculum for the Kaiser Permanente Los Angeles Internal Medicine residency program, and mentored Family Medicine and Internal Medicine residents through the program's first community-engaged research elective. Based on her work in curriculum design and medical education, she was invited to serve on a national steering committee directing the creation of a novel interresidency health policy fellowship, led by George Washington University and Kaiser Permanente.

Dr. Krishnaswami received her M.D. from the University of Michigan Medical School in Ann Arbor, Michigan, where she was named a Dean's Scholar. She completed training in Internal Medicine (IM) and Preventive Medicine (PM) at University of California, San Francisco and Kaiser Permanente. She was awarded a University Fellowship to pursue her Masters in Public Health (epidemiology) at University of California – Berkeley. Her research and publications center on the cultural context of wellness, humanism in medicine, and measuring "best practices" of community engaged programs focusing on adolescent obesity. Dr. Krishnaswami is also an avid writer, singer, and traveler. She enjoys spending most of her spare time in the company of her 4-month old son, Kavi, and husband, Kurt.

Scott Lillibridge, M.D.

Dr. Scott Lillibridge is the Deputy Principal Investigator and Chief Scientific Officer for the Texas A&M Center for Innovation in Advanced Development and Manufacturing. This Center is a public-private partnership with the U.S. Department of Health and Human Services and GlaxoSmithKline that is designed to enhance the nation's defense against emerging infectious diseases and other chemical, biological, radiological and nuclear threats.

Dr. Lillibridge's career has focused on the delivery of emergency health care services and public health programs dealing with infectious diseases. During his federal career with the Department of Health and Human Services (HHS), he served as Special Assistant to the HHS Secretary and was the founding Director of the Bioterrorism Preparedness and Response Program at the Centers for Disease Control and Prevention (CDC). He was appointed by President George W. Bush as an Advisor to the Office of Homeland Security in 2002 to assist with developing US initiatives related to health and security.

Dr. Lillibridge served with the US Army Special Forces in 1973-1974. He received his B.S. degree in Environmental Health at East Tennessee State University in 1977 and received his Medical Doctorate from the Uniformed Services University of the Health Sciences in Bethesda, Maryland in 1981. In 1984 he completed specialty training at Baylor College of Medicine in Family Medicine and completed an epidemiology fellowship with the CDC Epidemic Intelligence Service (EIS) in 1992.

Joseph B. McCormick, MD, MS

Dr. McCormick was raised on a farm in Indiana. After graduating from Florida Southern College with majors in chemistry and mathematics, he attended L'Alliance Française and the Free University in Brussels in preparation for teaching sciences and mathematics in French in a secondary school in the Congo where in the local hospital he was introduced to medicine. He entered Duke Medical School in 1967 graduating in 1971 with an intercalated MS from Harvard School of Public Health (1970) under Dr. Thomas Weller (Nobel Laureate 1954). His internship and residency were at Children's Hospital of Philadelphia under Dr. C. Everett Koop (later became US Surgeon General). In 1974 he became an Epidemic Intelligence Service Officer (EIS), at the CDC, and a fellow in Preventive Medicine. He was a PAHO/CDC consultant for the Brazilian government for the extensive meningococcal outbreaks of 1974/6. In 1977 he founded the CDC Lassa fever Research Project in Sierra Leone, where he received an emergency call to join the team investigating the first Ebola epidemic in 1976 and again in 1979. In Sierra Leone he conducted definitive studies of the epidemiology and successful antiviral treatment of Lassa hemorrhagic fever. He became Chief, Special Pathogens Branch, Division of Viral Diseases at the CDC in 1982, directing the Biosafety level 4 laboratories for 9 years. He organized and led the original team in the first AIDS investigation in Africa in 1983 and established the Project SIDA in Kinshasa, Zaire, and later, with Dr. DeCock an EIS officer the Project Retro-Ci in Abidjan, Ivory Coast. In 1983 he identified the virus that causes Hemorrhagic Fever with Renal Syndrome (Hantavirus) in his laboratory at CDC.

Returning to the international world in 1993, he became Chairman, Community Health Sciences Department, at the Aga Khan University Medical School (AKU) where he established an epidemiology program, resembling the CDC Field Epidemiology Training Programs, and a Masters' degree in Epidemiology, and a family Medicine Residency. He returned to the US in 2001 to start a new regional campus of the UT Houston School of Public Health in Brownsville. A measure of the impact of the program in Brownsville is illustrated by a (4 minute) video: **http://www.youtube.com/watch?v=-bOLx282R2c&feature=youtu.be**

During his 15 years in Brownsville, Dr. McCormick has been PI on 3 NIH grants and 3 CDC grants, a Co-Investigator on several including the two CTSA grants for UTHealth. The campus has published over 190 peer reviewed articles characterizing the extraordinary level of health disparities in the region. Dr. McCormick has been instrumental in bringing in over $65 million in external funding to Brownsville campus.

His awards include the USPHS Meritorious Service Medal, and humanitarian awards from Florida Southern College and Duke University Medical School, and Friend of Public Health award from the Texas DSHS. Dr. McCormick has over 250 scientific publications with co-authors from over 20 countries. He has contributed to television, newspapers and periodicals and is featured in several books for the lay reader (e.g., The Coming Plague, The Hot Zone). With his wife, Sue Fisher-Hoch he co-authored a popular account (Level 4, Virus Hunters of the CDC) of their professional adventures that was translated into seven languages. He was an expert commentator for CNN, Fox, and MSNBC during the Ebola epidemic. He is an accomplished amateur pianist, and enjoys outdoor activities such as biking, back packing, skiing and fly-fishing.

Melissa A Valerio, PhD, MPH

Research interests: Health literacy and disease management intervention design and evaluation using a community based participatory research approach.

Melissa A. Valerio, PhD, MPH, is the Regional Dean and an Associate Professor of Health Promotion and Behavioral Science at the UTHealth School of Public Health, San Antonio Regional Campus. Prior to returning to her native Texas, she served as an Assistant Professor of Health Behavior and Health Education at the University of Michigan School of Public Health. She currently serves as a Chancellor's Fellow for the UT Health System and is leading the design of a strategic plan for addressing Hispanic and border health in partnership with UT Health Systems across Texas.

Dr. Valerio is originally from Duval County, Texas (San Diego) and received her bachelor's degree from the University of Texas at Austin. She obtained her Master's degree in Health Behavior and Health Education at the University of Michigan School of Public Health and her PhD in health behavior and health education from the University of Michigan.

Dr. Valerio's interests include chronic disease management and prevention, the design and evaluation of effective health education messages and materials, and survey methods. She is particularly interested in health literacy and cultural competence issues related to health education and communication in minority underserved communities. Dr. Valerio has been involved in the planning, implementation, and evaluation of community-based coalitions and partnerships. She has served as PI on studies focused on the design and evaluation of innovative functional health literacy related interventions and strategies to promote disease management (type 2 diabetes, asthma, and oral health) and prevention (type 2 diabetes). Dr. Valerio also serve as an investigator on NIH, AHRQ, CDC, PCORI and foundation studies examining the use and influence of genetic explanations in prevention of type 2 diabetes, comparative effectiveness research practices in diabetes management and a center initiative addressing health disparities in cardiovascular risk.

Appendix 3: Engaging Health Payers Supporting Documents

Methodist Healthcare Ministries: PCORI Engagement Series
Knowledge Sharing Champions Session
August 22, 2016
Courtyard Marriott at 5660 N. IH 35/Austin

Objectives:

1. Provide a high level summary of the Patient Centered Outcomes Research Institute award - short-term, mid-term and long-term objectives. The overall goal of POCRI is to improve population health for the communities served.
2. Share the key themes from the community focus groups, academic sessions, and their implications for the resulting research, care, and education programs as well as the effective dissemination of the information
3. Develop ideas for an actionable and measurable engagement strategies between both public and private Managed Care Organizations and academic systems related to identification of tangible research that can be done to improve health outcomes; and further increase effective sharing and dissemination of research findings and evaluation with the community of providers in a manner that improves patient and population health.
4. Identify short-term and long-term policy changes that can be made under the purview of the public health systems, policy makers and Managed Care Organizations to align and encourage future development and integration of patient-centered research and evaluation programs.

Thursday, August 18, 2016	10:00 am-11:30 am
Welcome and Introductions Becca Brune, Sr. VP Strategy and Growth, Methodist Healthcare Ministries Rose Swensen, Director of Strategic Planning, Health Resources in Action *Review agenda and objectives* *Overview of project and roles of stakeholders*	10:00-10:15 a.m.
Presentation of Data and Findings Erika Gaitan, Research Associate, Health Resources in Action Rose Swensen, Director of Strategic Planning, Health Resources in Action *Review key themes from community based focus groups* *Key themes and ideas from **Knowledge Sharing Champions** Session* *Identify implications and synergy for research and dissemination* *Q&A*	10:15 – 10:35 a.m.
Break	10:15 – 10:30 a.m.

Small Table Discussion *Rose Swensen, Director of Strategic Planning, Health Resources in Action* *Participants will have the opportunity to participate in a small group discussion to identify the differences and areas of synergy from previous sessions to guide the creation of the "third circle" of the PCORI Venn diagram.* *Participants will answer key questions at their small table discussions, with each group responsible for taking notes. Questions include: 1) What would we see as a benefit for having common metrics to collect and report on population health data? 2) What should be our population health topic areas for data sharing and why? 3) What are strategies to enhance and reduce barriers to sharing this population health data with researchers, philanthropy, healthy systems, and community?*	10:35 – 11:25 a.m.
Closing and Next Steps	11:25-11:30 a.m.

Engaging Health Payers Participants List

Tim Bahe
Executive Director
Parkland Community Health

Rebecca Brune
Senior Vice President of Strategic Planning & Growth
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Rose Swensen
Managing Director
Health Resources in Action

Appendix 4: Engaging the Community Voice Supporting Documents

Methodist Healthcare Ministries: PCORI Engagement Series
Engaging the Community Voice
February 2017
Corpus Christi, Laredo, & McAllen, TX

Objectives:

1. Provide a high level summary of the Patient Centered Outcomes Research Institute award - short-term, mid-term and long-term objectives. The overall goal of POCRI is to improve population health for the communities served.
2. Share the key themes from the community focus groups, academic sessions, and their implications for the resulting research, care, and education programs as well as the effective dissemination of the information
3. Engage end users, such as consumers, caregivers, policy makers, and health advocacy groups, to discuss best-in-class strategies for research dissemination.

Time	Title	Discussion
7:30-8:00 am	**Check in**	–
8:00-8:15 am	**Welcome/Introduction**	Welcome
	Review Agenda, objectives & Overview	Review agenda & objectives Overview of Project and Roles of Stakeholders
8:15-8:45 am	**Presentation of Data and Findings/Q&A**	Review key themes from community based focus groups & Integrate with key themes and ideas from Knowledge Sharing Champions and Health Payer Session Q&A
8:45-9:15 am	**Facilitated Large-Group Discussion**	**Facilitated Questions:** 1. What do you like about the information presented thus far? 2. What would you change or clarify about what has been presented? 3. What is missing that you would want added and why?
9:15-9:30 am	**Closing**	Report Out Discuss Next Steps for Planning

Engaging the Community Voice Participants List

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Ernest Buck
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Driscoll Health Plan

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Elvira Cruz
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Jesse Elizondo
Presient
H.I.P.

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Lolo Hernadez
Taft First United Methodist church

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Jennifer Knoulton
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Cliff Krcha
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Appendix 5: Building the Patient-Centered Partnership Supporting Documents

Methodist Healthcare Ministries: PCORI Engagement Series
Building the Patient-Centered Partnership
February 2017
McAllen, TX

Time	Title	Discussion
9:00-9:15 am	**Welcome/Introduction**	Welcome
	Review Agenda, objectives & Overview	Review agenda & objectives Overview of Project and Roles of Stakeholders
9:15-9:45 am	**Presentation of Data and Findings/Q&A**	Review key themes from community based focus groups & Integrate with key themes and ideas from Knowledge Sharing Champions and Health Payer Session Q&A
9:45-10:30 am	**Facilitated Large-Group Discussion**	**Ask large-group three questions and bring together to report out.** 1. What do you like about the information presented thus far? 2. What would you change or clarify about what has been presented? 3. What is missing that you would want added and why?
11:15-11:45 am	**Networking lunch**	
11:45-12:30 pm	**Synthesis on all the town-halls information**	Recap information gathered throughout the 3 town-halls
12:30-1:30 pm	**Content Area and Metrics Discussion** 1. What do you like about the information presented thus far? 2. What would you change or clarify about what has been presented? 3. What is missing that you would want added and why?	
1:30-1:45	**Break**	

1:45-2:15	**Building Consensus** 1. What is the current state of patient centered research, including challenges, enablers and opportunities? 2. What are possible strategies to address these?
2:15-3:00 pm	**Large-Group Planning** 1. What are quick wins to work towards? 2. What is our long-term strategy to move agenda forward? 3. Who needs to be at the table?
3:00-3:15pm	**Report out**

Building the Patient-Centered Partnership Participants List

McAllen, TX

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Methodist Healthcare Ministries

Conrado Alvarado
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Texas Health Plan United Healthcare Community & State

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Community Outreach Specialist
La Union del Pueblo Entero

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Valley Baptist Legacy Foundation

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K Vanessa LeVine
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Appendix 6: Definitions of Terms

Term	Detailed Description of Findings
Access to Care	Access to health care means having "the timely use of personal health services to achieve the best health outcomes". Attaining good access to care requires three discrete steps: Gaining entry into the health care system; getting access to sites of care where patients can receive needed services; paying for it.
Authentic Engagement	Both focus group participants and academics reported that authentic engagement is critical to bridging the gaps between researchers and community members. This includes genuinely taking into account the context, culture, and expectations of the region. Authentic engagement also includes continuously asking for feedback and incorporating community suggestions in future research endeavors.
Branding with Trusted Sources	The issue of branding, or the process involved in creating a unique image or message, was raised in the EHP session. Health payers agreed that consumers were less likely to read engagement materials that were branded with insurance logos. However, participants shared that by teaming up with trusted local institutions like community health centers, residents were more likely to trust the content if it was branded with trusted logos.
Increased Health Literacy	Although not explicitly defined as "health literacy" by community focus group participants, members did stress the importance of increasing the knowledge around health risks and behaviors in the region. Also stressed was the importance of focusing on prevention. Academics described this as building the capacity and awareness of community members to "own" their health.
Concerns about Health Care Costs	Focus group participants described the cost of health care being among the most challenging aspects to maintaining a healthy life. Decreasing the cost of care, said participants, is critical to improving both access—and therefore health—in the future. Likewise, academics involved in the KSC session described addressing health care costs as an important result and justification for secure more funding for research initiatives. As they could show greater returns on investment of different initiatives, they could improve population health. Participants agreed that it is critical to include the discussion of health care costs within larger initiatives to improve population health as it is a driving force among many stakeholders.
Continuity of Care	Continuity of care is concerned with quality of care over time. It is the process by which the patient and his/her physician9led care team are cooperatively involved in ongoing health care management toward the shared goal of high quality, cost9effective medical care.
Community Empowerment	Similar to authentic engagement, participants in both community sessions and KSC agreed that community members can be empowered to improve population health. Ways to do this include creating more community advisory boards, health coalitions, and collaborative communication strategies. Also noted was the opportunity to leverage technology in these efforts.
Culturally sensitive approaches	One strength noted in the focus group discussions was the strong cultural identity shared by residents in the area. Participants noted that taking these cultural nuances into account, specifically those in the predominantly Mexican-American community, would be critical moving forward.
Data Sets	Academicians noted the different data methods, indicators, and sources that were important to their work. Collectively, these were referred to as data sets.

Term	Detailed Description of Findings
Dissemination strategies	Dissemination is the targeted distribution of information and intervention materials to a specific public health or clinical practice audience.
Fee for service vs. pay for performance	Participants in the EHP session discussed the importance of finding the right balance between fee for service and pay for performance models. While there was agreement that focusing on prevention was critical to improving population health, EHP participants noted that the reimbursement process for these initiatives negatively impacted the bottom line for health payers. Fee for service incentivizes providers to increase the volume of transactions (visits, tests, procedures) pay for performance incentivizes providers to keep patients healthy (reduced readmissions, declining ED rates, increase in chronic disease self-management, etc.).
Mixed methods	Mixed methods research is a methodology for conducting research that involves collecting, analyzing and integrating quantitative (e.g., experiments, surveys) and qualitative (e.g., focus groups, interviews) research. In terms of communication strategies, mixed-methods is defined as the integration of oral, written, and face-to-face interactions.
Mobilization strategy	Community mobilization is essentially a process for reaching out to and engaging different sectors of a community to create collaborative partnerships and strategies that focus on, and ultimately address, a pressing issue such as diabetes or preventive health.
Perceptions of healthcare quality	As discussed in the What Matters to You? and Knowledge Sharing Champions reports, there were varying levels of satisfaction regarding healthcare quality throughout this region. For purposes of synthesizing this theme in the Venn diagram, this was described as perceptions of healthcare quality.
Population Health	Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. The term is often seen in policy discussion, research, and in the name of new academic departments and institutes.
Relevant data for planning and evaluation	Both KSC and EHP sessions stressed the need for relevant data for all stakeholders. Participants recognized the need to compromise agendas to gather usable, accurate data to inform planning and evaluation of population health strategies.
Research agendas	A research agenda is a roadmap or framework that guides inquiry. A research agenda may be both global and specific. Ideally it is used to specify gaps in knowledge in a specific area and serves to guide the direction and development of new projects and research questions.
Rigorous methods	Conducting research by abiding to best practices in method selection (from appropriate fields) and high-quality research design and reporting of results to the academic community.
Short term relevance vs. long term	Health payers explained that the nature of health insurance is fleeting, with many members switching insurers in less than five years. For this reason, participants identified long-term planning for population health a significant challenge as it is often counterintuitive with the short horizon of health payer structure.

Term	Detailed Description of Findings
Social determinants of health	The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.
Timelines	The term is used to describe the competing schedules of priorities for various stakeholders throughout the region. For example, health payers cited working on short-term timelines as it related to their bottom line, whereas academicians focused on long-term population health research (e.g. 1-3 years vs 10 or more years).

About Methodist Healthcare Ministries of South Texas, Inc.

Methodist Healthcare Ministries of South Texas, Inc. is a private, faith-based not-for-profit organization dedicated to creating access to health care for the uninsured through direct services, community partnerships and strategic grant-making in 74 counties across South Texas. The mission of the organization is "Serving Humanity to Honor God" by improving the physical, mental and spiritual health of those least served in the Rio Texas Conference area of The United Methodist Church. The mission also includes Methodist Healthcare Ministries' one-half ownership of the Methodist Healthcare System, the largest health care system in South Texas, which creates a unique avenue to ensure that it continues to be a benefit to the community by providing quality care to all and charitable care when needed. For more information, visit www.mhm.org.

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