CENTRAL HEALTH

Our Vision
Central Texas is a model healthy community.

Our Mission
By caring for those who need it most, Central Health improves the health of our community.

Our Values
Central Health will achieve excellence through:
Stewardship - We maintain public trust through fiscal discipline and open and transparent communication.
Innovation - We create solutions to improve healthcare access.
Respect - We honor our relationship with those we serve and those with whom we work.
Collaboration - We partner with others to improve the health of our community.

CENTRAL HEALTH BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

Tuesday, May 8, 2018 12:30 p.m.

Central Health Administrative Offices
1111 E. Cesar Chavez St.
Austin, Texas 78702
Training Room

AGENDA*

Items for consideration and possible action:

1. Approve the minutes for the following meeting of the Central Health Board of Managers Strategic Planning Committee:
   a. April 10, 2018.

2. Receive and discuss a presentation on an update to the Central Health Demographics Report with an overlay of the Community Indicators Report data.

3. Receive and discuss a summary of work performed by partners related to the Social Determinants of Health, including information on Health Risk Assessments administered by provider partners.

4. Receive and discuss an update on upcoming Community Conversations.

Standing items:

5. Confirm the next regular Strategic Planning Committee meeting date, time, and location.

*The Strategic Planning Committee may take items in an order that differs from the posted order.

Note 1, Possible closed session item.

The Strategic Planning Committee may consider any matter posted on the agenda in a closed session if there are issues that require consideration in a closed session and the Committee announces that the item will be considered during a closed session.

A quorum of Central Health's Board of Managers may convene to discuss matters on the agenda.

Came to hand and posted on a Bulletin Board in the Courthouse, Austin, Travis County, Texas on this the 3rd day of May 2018

Dana DeBeauvoir
County Clerk, Travis County, Texas

By A. MACEDO Deputy

SEAL OF COUNTY COURT ★ TRAVIS COUNTY, TEXAS ★

FILED AND RECORDED

OFFICIAL PUBLIC RECORDS

Dana DeBeauvoir

May 03, 2018 09:40 AM 201880686

FEE: $0.00

Dana DeBeauvoir, County Clerk

Travis County TEXAS

CENTRAL
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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

May 8, 2018

AGENDA ITEM 1

Approve the minutes for the following meeting of the Central Health Board of Managers Strategic Planning Committee:

a. April 10, 2018.

MINUTES OF MEETING – APRIL 10, 2018

CENTRAL HEALTH BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

On Monday, April 10, 2018, the Central Health Board of Managers Strategic Planning Committee convened at 5:34 p.m. in the Board Room, 1111 East Cesar Chavez, Austin, Texas 78702. Clerk for the meeting was Ms. Emily Farris.

Committee Members present: Chairperson Greenberg, Manager Aiken, Manager Jones, and Manager Valadez

Board Members present: Manager Museitif and Manager Zamora

REGULAR AGENDA

1. Approve the minutes of the following meeting of the Strategic Planning Committee:
a. February 13, 2018.

Clerk's Notes: Discussion on this item began at 5:35 p.m.

Manager Museitif moved that the Committee approve the minutes for the following meeting of the Central Health Board of Managers Strategic Planning Committee:
a. February 13, 2018.

Chairperson Greenberg	For
Manager Aiken	For
Manager Jones	For
Manager Valadez	For

2. Receive and discuss information on the Social Determinants of Health as they relate to the FY 2019 Strategic Work Plan.

Clerk's Notes: Discussion on this item began at 5:35 p.m. Ms. Megan Cermak, Senior Healthcare Planner for Central Health, Mr. JP Eichmiller, Director of Strategic Communications for Central Health, and Ms. Sarah Cook, Director of Strategy, Communications and Population Health for the Community Care Collaborative ("CCC"), presented on the item. Ms. Cermak outlined Central Health's goals related to the social determinants of health. Ms. Cook described the CCC's approach to addressing the social determinants of health, which includes working with community health and social service providers, as well as, programs like RideAustin, the Central Texas Food Bank and Austin Energy. Ms. Cook told the Committee that the CCC was assessing, identifying and acting on the data collected through these programs to find ways to support the communities. Mr. Eichmiller gave an update on the implementation of a transportation project made possible through Capital Metro's Community Mobility Grant Program.

No action was taken on item 2.

3. Receive and discuss the Central Health Performance Review conducted by Germane Solutions.

Clerk's Notes: Discussion on this item began at 6:21 p.m. Mr. Ivan Davila, Communications & Community Engagement Manager for Central Health, reported on the feedback received at the Community Conversation events held on March 19, 2018, April 3, 2018 and April 5, 2018 for the purpose of soliciting public comment on the Central Health performance review. Mr. Davila also discussed upcoming Community Conversation events and the goals of those events. Ms. Andrea Guerra, Strategy Project Manager for Central Health, shared comments made by community members at the Community Conversation events.

No action was taken on item 3.

4. Receive and discuss an update on the 2018 Central Health Public Education initiative.

Clerk's Notes: Discussion on this item began at 6:36 p.m. Ms. Elyse Yates and Mr. James Aldrete of Influence Opinions presented their findings on the effectiveness of the 2018 Central Health Public Education initiative. Their findings were based on a survey conducted in December of 2017. The duo provided survey highlights, which included an increase in recognition of, and support for, Central Health within the community following the initiative, and explained that support increases when respondents know more about the organization. Ms. Yates reviewed the findings associated with key population subgroups and explained how Central Health ranks among those subgroups. Ms. Yates also identified the subgroups that expressed a desire to receive more information about Central Health, the subgroups that had informed opinions about Central Health, and the key takeaways from the majority of Central Health's client base.

Manager Museitif left the meeting at 6:39 p.m.

No action was taken on item 4.

5. Confirm the next regular Strategic Planning Committee meeting date, time, and location.

Clerk's Notes: Discussion on this item began at 7:13 p.m. Chairperson Greenberg announced the next regularly scheduled Central Health Board of Managers Strategic Planning Committee meeting is to be determined.

Manager Valadez moved that the Committee adjourn. Manager Aiken seconded the motion.

Chairperson Greenberg	For
Manager Aiken	For
Manager Jones	For
Manager Valadez	For

The meeting was adjourned at 7:13 p.m.

_____
Sherri Greenberg, Chairperson
Central Health Strategic Planning Committee

CENTRAL
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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

May 8, 2018

AGENDA ITEM 2

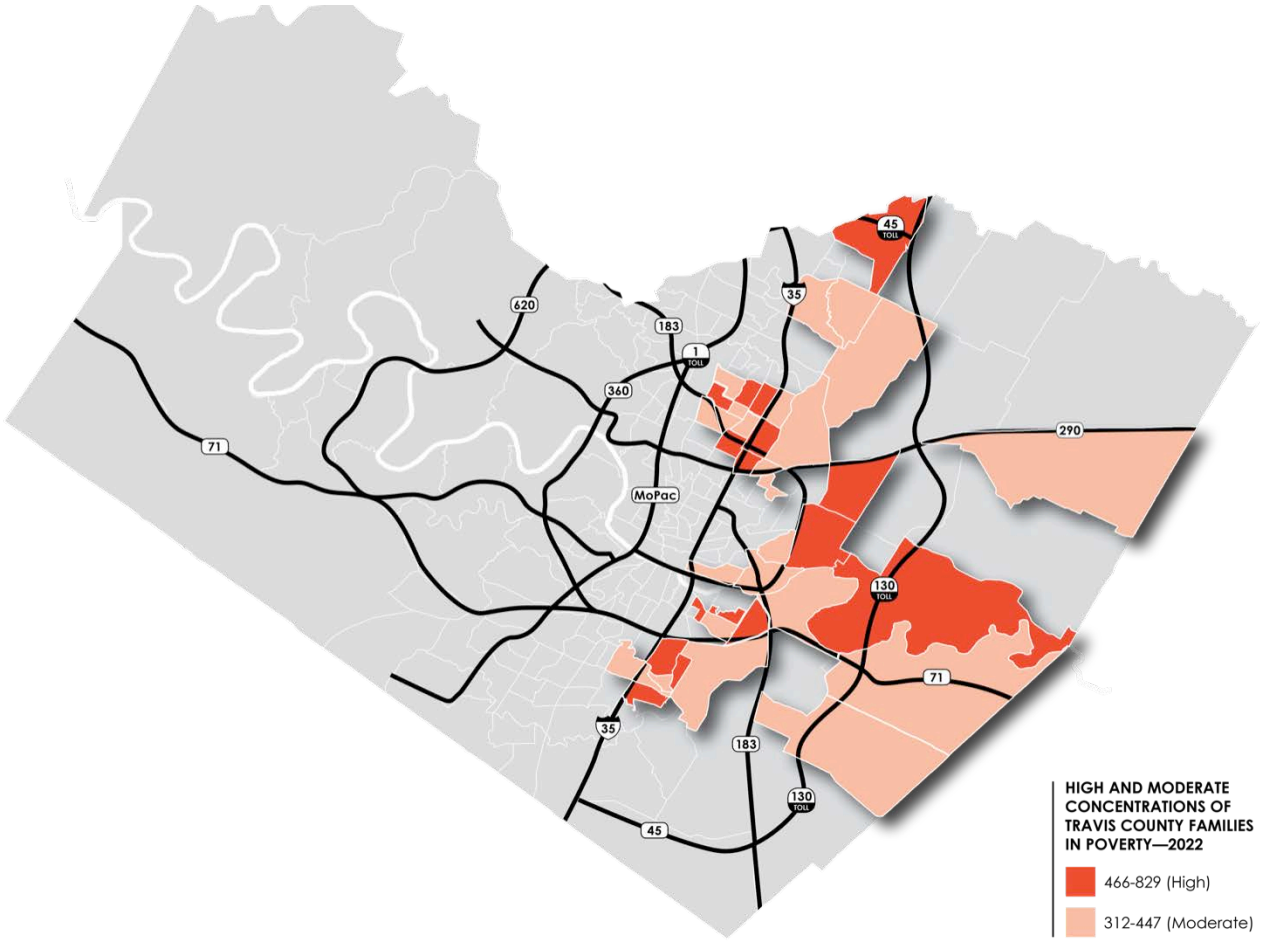
Receive and discuss a presentation on an update to the Central Health Demographics Report with an overlay of the Community Indicators Report data.

CENTRAL HEALTH

Demographic Report Update

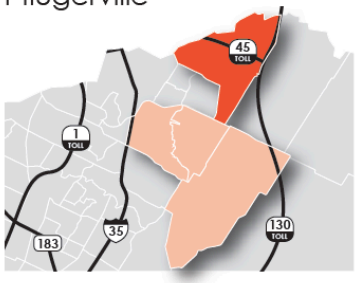
Central Health Board of Managers
Strategic Planning Committee
May 8, 2018
JP Eichmiller, Director of Strategic Communications

Five-Year Projection

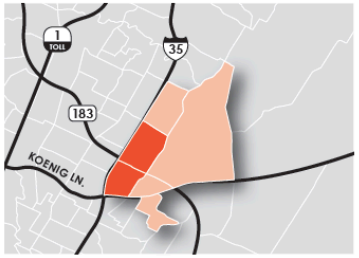


Focus Areas

Pflugerville

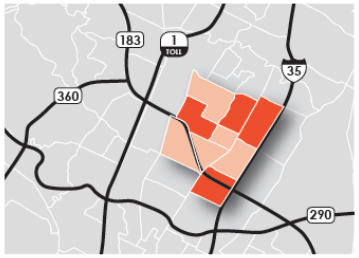


Northeast Austin



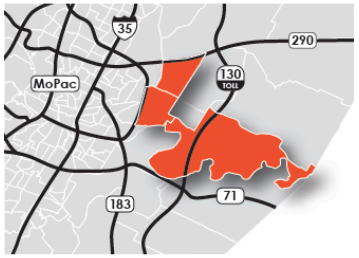
Manor

North Central Austin

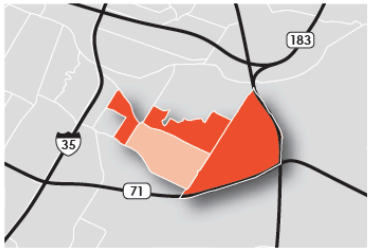


East Austin

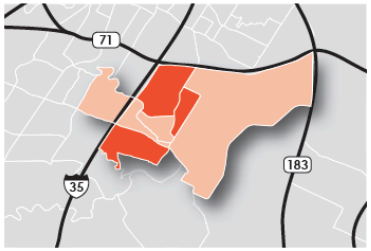
Colony Park/Hornsby Bend



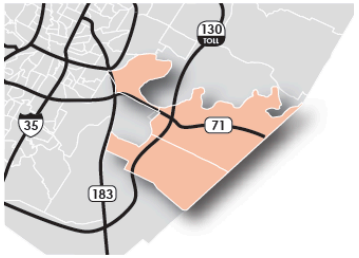
Southeast Austin



South Austin



Del Valle



Current Data Collaborations

Eastern Travis County Health and Wellness Collaboration

Health indicator overlay

- Collaborative Health Planning group (Central Health/Austin Public Health Department/Travis County)

Community Care Collaborative patient utilization analysis

- Central Health Enterprise strategic planning group

Travis County Transit Development Plan

- CapMetro/Travis County Transit and Natural Resources Department/CARTS

Community resilience planning

- City of Austin Office of Sustainability

Future/Developing Collaborations

- Children's Optimal Health
- United Way
- Community Development Block Grant program
- Ending Community Homelessness Coalition (ECHO)

CENTRAL HEALTH

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@centralhealthtx

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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

May 8, 2018

AGENDA ITEM 3

Receive and discuss a summary of work performed by partners related to the Social Determinants of Health, including information on Health Risk Assessments administered by provider partners.

CENTRAL HEALTH

MEMORANDUM

TO: Central Health Board of Managers
CC: Mike Geeslin, President & CEO; Monica Crowley, Chief Strategy and Planning Officer
FROM: Andrea Guerra, Strategy Project Manager
Megan Cermak, Senior Healthcare Planner
DATE: May 8, 2018

SUBJECT: Strategic Planning Committee Agenda Item No. 3—Review and discuss a summary of work performed by partners around Social Determinants of Health including Health Risk Assessments administered by provider partners.

In an effort to better understand the eco-system of work performed in the social determinants of health within the safety net in Travis County, the Central Health Board of Managers requested an inventory of activities performed by provider partners in this area. In addition, the Board requested information on the use of Health Risk Assessment tools among provider partners.

Below is information regarding Lone Star Circle of Care, People's Community Clinic, El Buen Samaritano and Planned Parenthood. CommUnityCare will present on its efforts during the May 8, 2018 Strategic Planning Committee Meeting.

Lone Star Circle of Care

Transportation: LSCC provides approximately 15 bus passes per month, primarily at its South 1st/Ben White Blvd location. LSCC refers patients to Capital Metro's MetroAcccess service, and reviews new patients for transportation access barriers at new patient intake and again annually.

Health Care Access: LSCC offers telephonic appointments (with pharmacy techs or administrative staff) to complete paperwork for prescription assistance programs run by pharmaceutical companies.

Health Risk Assessment tool: LSCC received funding to pilot the PRAPARE tool, a patient survey of patient assets, risks and experiences in Summer 2017. LSCC staff emailed 28,000 patients and approximately 1,000 responded.

- Partnered with Aunt Bertha to send survey respondents links to services in their zip code that addressed needs identified by the PRAPARE tool.
- Based on "click data" from Aunt Bertha, patients frequently indicated a need for medication payment assistance and primarily sought services to help them afford medications, followed by dental services.

People's Community Clinic

PCC has in-house social workers to support patients and connect them to resources.

Legal Services: PCC provides on-site legal services to help with issues negatively impacting health such as: benefits, housing, advanced directives, guardianship, immigration.

Food Insecurity: PCC offers free lunches in the summer to children and their adult companions.

Health & Wellness: PCC offers Zumba classes and weekly healthy cooking classes in English and Spanish.

Health Risk Assessment tool: PCC received funding to pilot the PRAPARE tool, a patient survey of patient assets, risks and experiences in Summer 2017. 200 patients responded. PCC has plans to implement a new tool based on PRAPARE in fall 2018.

El Buen Samaritano

Health & Wellness: El Buen partners with WeViva for exercise classes and provides incentives for participation in long-term exercise. El Buen offers community garden plots and rents supplies for $10 per season. El Buen also offers nutrition classes and cooking classes.

Food Insecurity: An emergency food bank is available to eligible clients who may receive food twice weekly for up to six months.

Youth: El Buen offers after school and summer camps.

Education: El Buen offers English language classes, basic education in Spanish and computer classes.

Patients Served: El Buen has servied 4,427 through Health & Wellness and emergency food programs. El Buen served 818 clients through family literacy programs and 240 clients through health literacy programs.

Health Risk Assessment tool: El Buen does not use a HRA tool.

Planned Parenthood

Health Care Access: Planned Parenthood has partnered with SAFE Alliance for a decade to provide well-women exams, contraception and STI testing for SAFE clients. This work is grant funded.

Education: Planned Parenthood offers English and Spanish language health education sessions monthly at SAFE Alliance for its clients. Planned Parenthood also provides sexual health education and skill-building programing to youth in English and Spanish to prevent unintended pregnancies and sexually transmitted infections (STI). These courses are offered to youth in a range of community locations including schools, after school programs, out-of-home settings, in partnership with youth-serving nonprofits, and in institutions serving high-risk youth.

Clients served: Planned Parenthood provided health education to 4,116 teens and adults in the Austin community in 2017. 1,720 of those participants received multi-session, evidence-based or evidence-informed curriculum to prevent unintended pregnancies and STIs.

Health Risk Assessment tool: Planned Parenthood does not use a specific tool, however, it uses an intake/assessment tool developed through Planned Parenthood's medical standards and guidelines with all its health center patients. Planned Parenthood's intake form assesses sexual practices for a risk assessment for STI testing, PrEP/ PEP, contraception and safer sex education. Patients also receive screenings for BMI, intimate partner violence, depression, tobacco use and accompanying smoking cessation recommendations, and recommendations for diet and exercise when clinically indicated. Planned Parenthood provides patients with resource listings for social services, and medical services when clinically indicated.

THE KRESGE FOUNDATION | KAISER PERMANENTE | blue of california foundation

NATIONAL ASSOCIATION OF Community Health Centers | AAPCHO | OPCA Oregon Primary Care Association | Institute for Alternative Futures

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Version 1.0

September 2, 2016

NOTE: THIS IS A WORKING DOCUMENT RESULTING FROM AN ITERATIVE PROCESS. PLEASE CHECK FOR UPDATES AND CONTACT MICHELLE JESTER AT MJESTER@NACHC.ORG FOR MORE INFORMATION AND TO JOIN THE MAILING LIST TO RECEIVE NOTIFICATIONS OF CHANGES.

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question.

OPTIONAL Feature—Additional More Granular Response Choices that Roll-Up to Options Above:

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/2009/RaceEthnicity Data.aspx) for a list of potential response choices.

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	American Indian/Alaskan Native		White
	Other (please write)_____		I choose not to answer this question.

OPTIONAL Feature—Additional More Granular Response Choices that Roll-Up to Options Above:

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/2009/RaceEthnicity Data.aspx) for a list of potential response choices.

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact Michelle Jester at mjester@nachc.org.

3. At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question.

[Definitions if needed for clarification:]

- ***Migratory agricultural worker:*** *is an individual whose principal employment is in agriculture and who establishes a temporary home for the purposes of such employment. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The family members may or may not move with the worker or establish a temporary home. (according to section 330(g) of the Public Health Service Act)*
- ***Seasonal agricultural workers:*** *individuals whose principal employment is in agriculture on a seasonal basis (e.g. picking fruit during the limited months of a picking season) but who do not establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. (according to section 330(g) of the Public Health Service Act)*

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question.

5. What language are you most comfortable speaking? _____

	English		Language other than English (please write) _____		I choose not to answer this question.

Family & Home

6. How many family members, including yourself, do you currently live with?

_____

	I choose not to answer this question.

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact Michelle Jester at mjester@nachc.org.

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question.

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question.

[Definitions if needed for clarification:]

Homeless Patients*: Patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing.*

"Homeless" for UDS reporting purposes, includes the following:

- ***Shelter:*** *Shelters for homeless persons are seen as temporary and generally provide for meals as well as a place to sleep for a limited number of days and hours of the day that a resident may stay at the shelter.*
- ***Transitional Housing:*** *Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing stays—generally between 6 months and 2 years—in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay some or all of the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, the military, schools or other institutions.*
- ***Doubled Up:*** *Patients who are living with others; the arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.*

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact Michelle Jester at mjester@nachc.org.

- ***Street:*** *This category includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.*
- ***Other:*** *This category may be used to report previously homeless patients who were housed when first seen, but who were still eligible for the Health Care for the Homeless program. Patients who reside in SRO (single room occupancy) hotels or motels, other day-to-day paid housing, as well as residents of permanent supportive housing or other housing programs that are targeted to homeless populations should also be classified as "other".*

9. What address do you live at? (include street and zipcode)

_____

_____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than a high school degree		High school diploma or GED
	More than high school		I choose not to answer this question.

11. What is your current work situation?

	Unemployed and seeking work		Part time or temporary work
	Full time work		Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver) Please write_____
	I choose not to answer this question.		

OPTIONAL Feature—Additional Response Choices

Work less than 20 hours a week		Work 20-34 hours a week	
Work 35-59 hours a week		Work 60 hours or more a week	

OPTIONAL Feature—Additional Question

How many jobs do you work?

	1 job		3 or more jobs
	2 jobs		I choose not to answer this question.

12. What is your main insurance?[1]

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (Not CHIP)		Other Public Insurance (CHIP)
	Private insurance		

OPTIONAL Feature—Additional Question:

Do you have insurance through your job?

	Yes		No		I choose not to answer this question.

[1] If patient is unable to answer this question, health center staff can fill out this question by pulling the information from the EHR or PMS.

13. During the past year, what was the total combined income for you and your family members you live with? This information will help us determine if you are eligible for any benefits.

[NOTE: For organizations that already collect income for other purposes (sliding fee scale, insurance eligibility, other benefits), please map that data such that patients are not asked about their income multiple times. Please report percent of patients by Federal Poverty Level or FPL for PRAPARE reporting purposes.]

_____

	I choose not to answer this question.

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or any health care (medical, dental, mental health, vision)			
Yes	No	Phone	Yes	No	Other (please write) _____
		I choose not to answer this question			

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? [Check all that apply]

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact Michelle Jester at mjester@nachc.org.

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week
	1 or 2 times a week
	3 to 5 times a week
	More than 5 times a week
	I choose not to answer this question.

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		Quite a bit
	A little bit		Very much
	Somewhat		I choose not to answer this question

OPTIONAL Feature: Additional Question

Ask the open-ended follow-up question "Who are the people or groups you usually see or talk to at these times?"

Optional Questions

18. In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question.

OPTIONAL Feature: Additional Question

What was your release date? _____

19. Are you a refugee?

	Yes		No		I choose not to answer this question.

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No
	Unsure		I choose not to answer this question

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No
	Unsure		I have not had a partner in the past year
	I choose not to answer this question		

For more information about this tool, please visit our website at www.nachc.org/PRAPARE or contact Michelle Jester at mjester@nachc.org.

PROVIDING INDIVIDUALIZED CARE FOR PATIENTS: STRATIFICATION OF NEEDS

Central Health Strategic Planning Committee

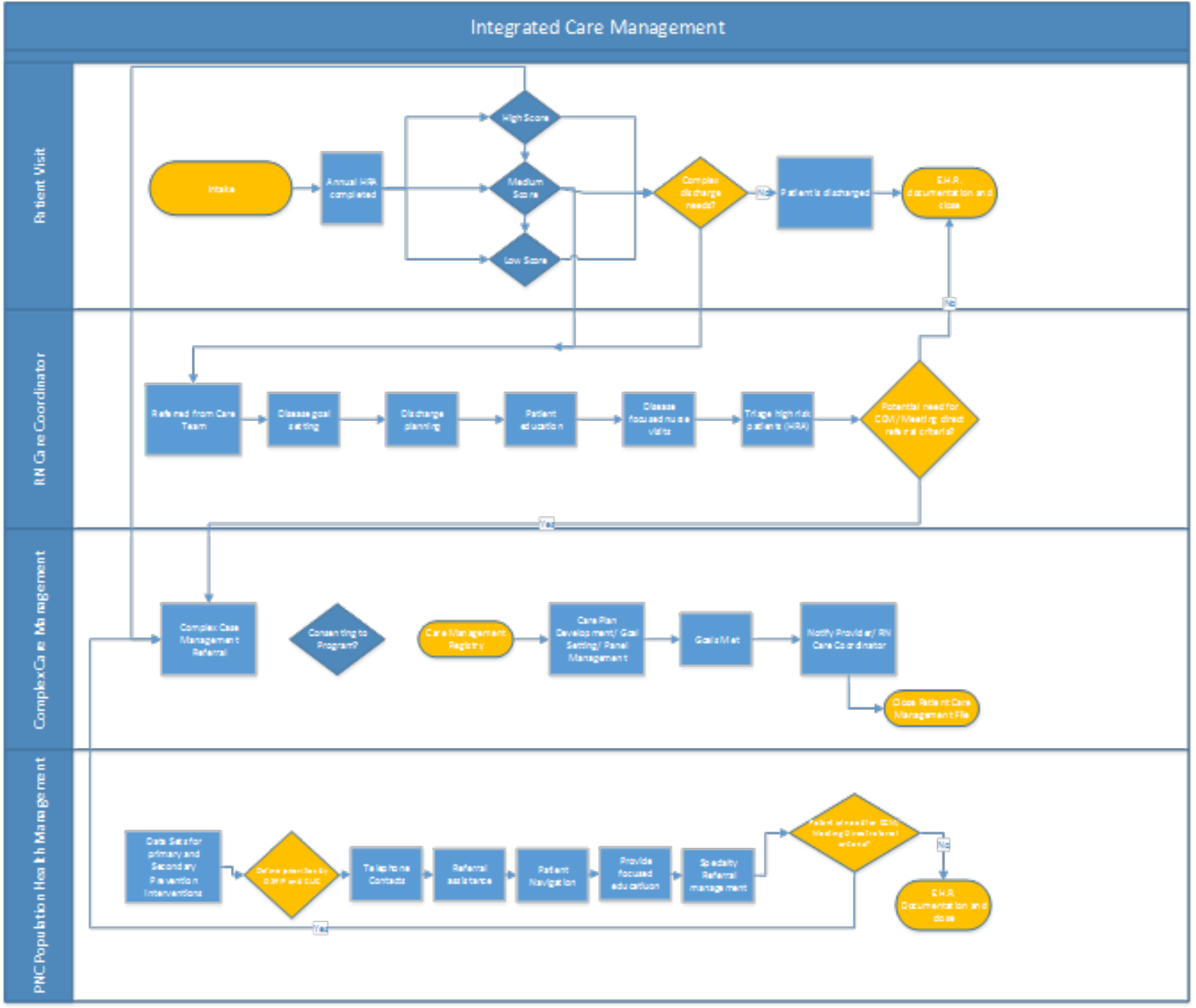
May 8, 2018

AGENDA

- Health Risk Assessment
  - Background
  - Process
  - Content
- HRA Dissemination
- Results
- Resources

COMMUNITYCARE'S HEALTH RISK ASSESSMENT

- Health Risk Assessment = HRA
- Used as a tool to help identify specific patient needs, patient engagement in the development of an individualized care plan, and target resources to the appropriate patients
- Aids in panel stratification
- Primary method of referrals to our Complex Care Management team



CommUnityCare™ HEALTH CENTERS

Care Coordination

Complex Care Management

Population Health Management

COMMUNITYCARE'S HEALTH RISK ASSESSMENT

- Developed the HRA by combining portions of standardized tools
  - Components of PRAPARE,
  - PHQ2 (depression screening tool),
  - Medical history and utilization questions
- Two step HRA (screening and comprehensive)
  - Screening HRA
    - 12 question screening tool
    - Administered annually for every patient
  - Comprehensive health risk assessment
    - 57 questions
    - Administered to those who score "positively" on the screening HRA

	Assessment Type: Annual	Date of Assessment:
1	**In the past 6 months, have you missed any medical appointments because of problems with transportation?**	o Yes o No
2	**In the past 6 months, have you had problems paying for food for you and your family?**	o Yes o No
3	**In the past 6 months, have you had problems paying for medicines prescribed by your doctor?**	o Yes o No

4	**Are you taking your medications as prescribed by your doctor?**	o **Yes** o **No** o **Not sure**
5	**Are you taking 6 or more prescribed medications?**	o Yes o No
6	**Are you following the treatment plan recommended by your doctor? (i.e. taking medications correctly, making diet or exercise changes, etc.)**	o Yes o No
7	**Considering your age, how would you rate your overall health?**	o Poor o Average o Good
8	**Has a doctor or other health care provider ever told you that you have any of the following conditions? If yes, which ones?**	o Cancer o Kidney Disease o Mental Health Condition (Bipolar, Schizophrenia) o Depression o Diabetes o Heart Disease (Coronary Artery Disease, Congestive Heart Failure, Atrial Fibrillation) o Hypertension(High Blood Pressure) o Liver Disease (Hepatitis, Cirrhosis) o Lung Disease (Asthma, COPD, Emphysema) o Stroke o None of These
9	**In the past 12 months, how many times have you been admitted to the hospital?**	o None o 1 time o 2 or more times
10	**In the past 6 months, how many times have you gone to the emergency room for care?**	o None o 1 or 2 times o 3 or more times

11	**Over the past 2 weeks, how often have you had little pleasure or interest in doing things?**	o **Not at all** o **Several days** o **More than half the days** o **Nearly every day**
12	**Over the past 2 weeks, how often have you felt down, depressed or hopeless?**	o Not at all o Several days o More than half the days o Nearly every day
For Staff Use Only		
13	**Blood Pressure at current visit:**	o <120/<80 o 120-139/80-89 o 140-159/90-99 o >160/>100
14	**BMI:**	o 18-24 o 25-29 o ≥30
15	**Age:**	o 18-44 o 45-64 o 65+

DISTRIBUTION

- CommUnityCare began distributing HRAs in the spring of 2017
- Rolled out in a phased approach
- Over 21,000 HRA's have been completed by CommUnityCare patients

RESULTS – SOCIAL DETERMINANTS OF HEALTH

- In the past 6 months, have you missed any medical appointments because of problems with transportation?

  → **16%** of patients answered yes

- In the past 6 months, have you had any problems paying for food for you and your family?

  → **19%** of patients answered yes

- In the past 6 months, have you had problems paying for medicines prescribed to you by your doctor?

  → **22%** of patients answered yes

COMMON RESOURCE CONNECTIONS

- Transportation
  - RideAustin Pilot
  - Taxi Vouchers
  - Bus Passes
  - Metro Access
- Food Resources
  - Central Texas Food Bank
  - Women Infants and Children (WIC)
  - Local churches
  - Farmer's Markets
- Medications
  - Prescription Assistance Program
- Housing
  - ECHO application
  - Rental assistance programs
- Substance Abuse
  - Outreach, Screening, Assessment and Referral Centers (OSAR)
  - National Alliance on Mental Illness (NAMI)
  - Behavioral Health Counselors
  - Medication Assisted Therapy (MAT)
- Other Benefits
  - Application Assistance

CENTRAL HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

May 8, 2018

AGENDA ITEM 4

Receive and discuss an update on upcoming Community Conversations.

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

THE STRATEGIC PLANNING COMMITTEE

May 8, 2018

AGENDA ITEM 5

Confirm the next regular Strategic Planning Committee meeting date, time, and location.