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CENTRAL HEALTH

STAYS IN FILE

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.

BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

Tuesday, October 15, 2019, 5:30 p.m.

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

AGENDA*

*Agenda item numbers are assigned for ease of reference only and do not necessarily reflect the order of their consideration by the Committee.

1. Consider and approve the minutes of the August 7, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee. (*Action Item*)

2. Receive and discuss an update on Communications and Community Engagement activities and initiatives. (Informational Item)

3. Receive and discuss an overview of Central Health Enterprise activities related to individuals experiencing homelessness in Travis County. (*Informational Item*)

4. Discuss and take appropriate action on the Central Health Equity Policy Council's FY2020 campaign. (*Action Item*)

5. Receive and discuss an update on the development of Central Health Board reporting dashboards, and reporting associated with the Fiscal Year 2020 Budget Resolution. *(Informational Item)*

6. Confirm the next Strategic Planning Committee meeting date, time, and location. (*Action 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. However, Board members who are not Committee members will not vote on any Committee agenda items, nor will any full Board action be taken.

Any individual with a disability who plans to attend this meeting and requires auxiliary aids or services should notify Central Health as far in advance of the meeting day as possible, but no less than two days in advance, so that appropriate arrangements can be made. Notice should be given to the Board Governance Manager by telephone at (512) 978-8049.

Came to hand and posted on a Bulletin Board in the Courthouse
Austin, Travis County, Texas on this the 9th day of
October 2019
Dana DeBeauvoir
County Clerk, Travis County, Texas
By A. MACEDO Deputy

SEAL OF COUNTY COURT ★ TRAVIS COUNTY, TEXAS ★

COUNTY OF TRAVIS STATE OF TEXAS

FILED AND RECORDED
OFFICIAL PUBLIC RECORDS

Dana DeBeauvoir

Dana DeBeauvoir, County Clerk
Travis County, Texas

201981457

Oct 09, 2019 01:25 PM
Fee: $0.00 **MACEDOS**

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 1

Consider and approve the minutes of the August 7, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee.

MINUTES OF MEETING – AUGUST 7, 2019

CENTRAL HEALTH BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

On Wednesday, August 7, 2019, the Central Health Board of Managers Strategic Planning Committee convened at 5:30 p.m. in the Training Room, 1111 East Cesar Chavez, Austin, Texas 78702. Clerk for the meeting was Briana Yanes.

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

Board Members present: Chairman Zamora, Manager Oliver

REGULAR AGENDA

1. **Consider and approve the minutes of the May 15, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee.**

Clerk's Notes: Discussion on this item began at 5:30 p.m.

Manager Museitif moved that the Committee approve minutes of the April 10, 2019 and May 15, 2019 meetings of the Central Health Board of Managers Strategic Planning Committee.

Manager Valadez seconded the motion.

Chairperson Greenberg	For
Manager Jones	For
Manager Museitif	For
Manager Valadez	For

2. **Receive and discuss an overview of Central Health Enterprise activities related to the social determinants of health.**

Clerk's Notes: Discussion on this item began at 5:31 p.m. Deborah King, Director of Population Health at CommUnityCare and Veronica Buitrom-Camacho, MSN, RN, Director of Medical Management at the Community Care Collaborative presented information regarding social services offered by or financially supported by Central Health Enterprise partners and how patients are connected to social services offered by other organizations.

No action was taken on item 2.

3. **Receive and discuss an update on the medical transportation initiatives of the Central Health Enterprise, including collaborative planning efforts.**

Clerk's Notes: Discussion on this item began at 6:40 p.m. JP Eichmiller, Senior Director of Strategy and Information Design and Sarah Cook, Senior Director of Strategy, Communications and Population Health shared Central Health Enterprise's ongoing transportation initiatives, including the transportation pilot based out of the Central Health Southeast Health and Wellness Center, The Community Care Collaborative' s circulation pilot and the convening of a Health Care Transportation Working Group. Expenditures have thus far totaled $35,000.

No action was taken on item 3.

4. Receive and discuss an update on Communications and Community Engagement activities and initiatives.

Clerk's Notes: Discussion on this item began at 7:00 p.m. Mr. Ted Burton, Vice President of Communications for Central Health, Mr. Ivan Davila, Director of Communications and Community Engagement, Ms. Isela Guerra, Community Outreach Supervisor, Ms. Janna Allen, Community Engagement Program Manager, and Ms. Monica Saavedra, Director of Marketing and Community Engagement at CommUnity Care shared an update on community outreach and engagement strategies and activities. They discussed their efforts to promote the new mobile unit, the home visit pilot, general awareness about Central Health coverage programs, and how they are preparing students from low-income families for the new school year.

No action was taken on item 4.

5. Receive and discuss the FY 2019-2024 Strategic Work Plan milestones achieved during the third quarter of Fiscal Year 2019.

Clerk's Notes: Discussion on this item began at 7:55 p.m.

Mr. Mike Geeslin, President and CEO of Central Health, gave a brief summary on the milestones achieved during the third quarter of Fiscal Year 2019.

No action was taken on item 5.

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

Clerk's Notes: Discussion on this item began at 8:03 p.m. Chairperson Greenberg announced that the next Central Health Board of Managers Strategic Planning Committee meeting is tentatively scheduled for October 7, 2019 at 5:30 p.m., at Central Health Administrative Offices, 1111 E. Cesar Chavez St., Austin, Texas 78702.

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

Chairperson Greenberg	For
Manager Jones	For
Manager Museitif	For
Manager Valadez	For

The meeting was adjourned at 8:04 p.m.

_____

Sherri Greenberg, Chairperson
Central Health Strategic Planning Committee

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 2

Receive and discuss an update on Communications and Community Engagement activities and initiatives.

CENTRAL HEALTH

Strategic Planning Committee

Communications, Outreach & Engagement

Oct. 15, 2019

Ted Burton, Vice President of Communications
Iván Dávila, Dir. of Communications & Community Engagement
Isela Guerra, Community Outreach Supervisor

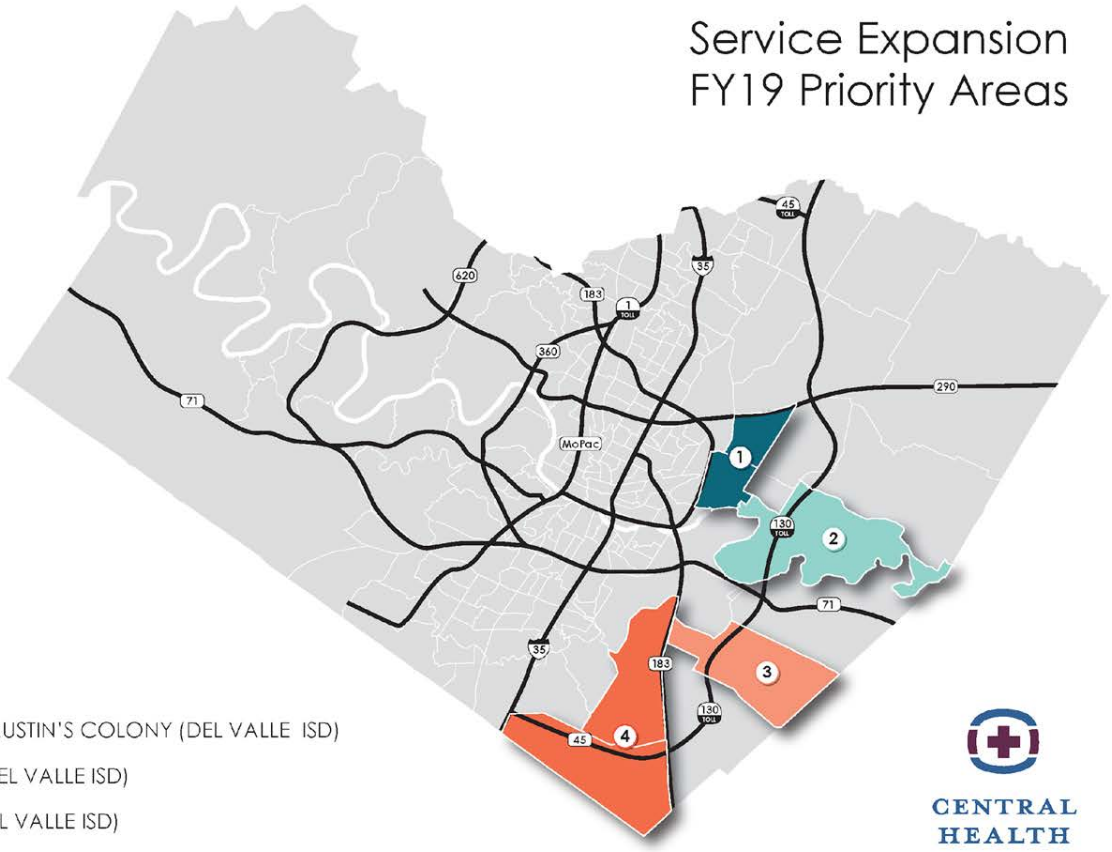
#DreamTeam

Agenda

1. Community Health Worker Pilot
2. Minority Outreach RFP
3. Media Initiative Results
4. Naming/Branding Initiative Update

Community Health Worker (CHW) Pilot Program

Service Expansion
FY19 Priority Areas



1. COLONY PARK
2. HORNSBY BEND/AUSTIN'S COLONY (DEL VALLE ISD)
3. KELLAM ROAD (DEL VALLE ISD)
4. CREEDMOOR (DEL VALLE ISD)

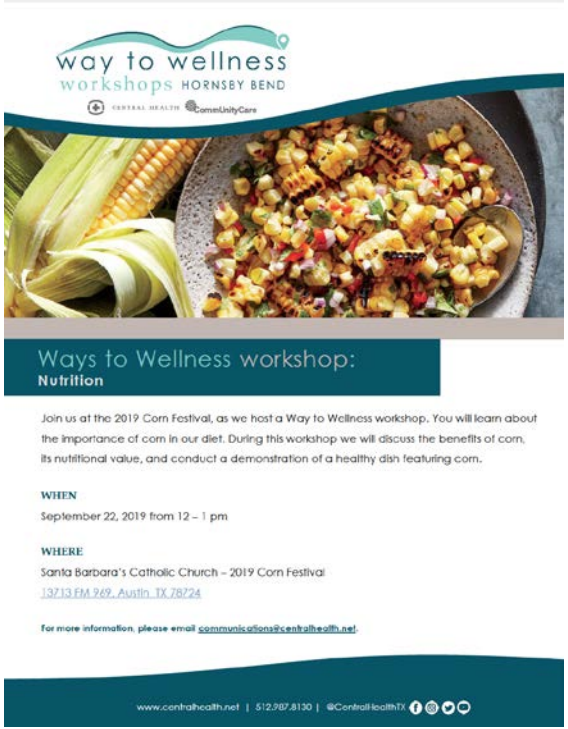
CENTRAL HEALTH

Population Race/Ethnicity

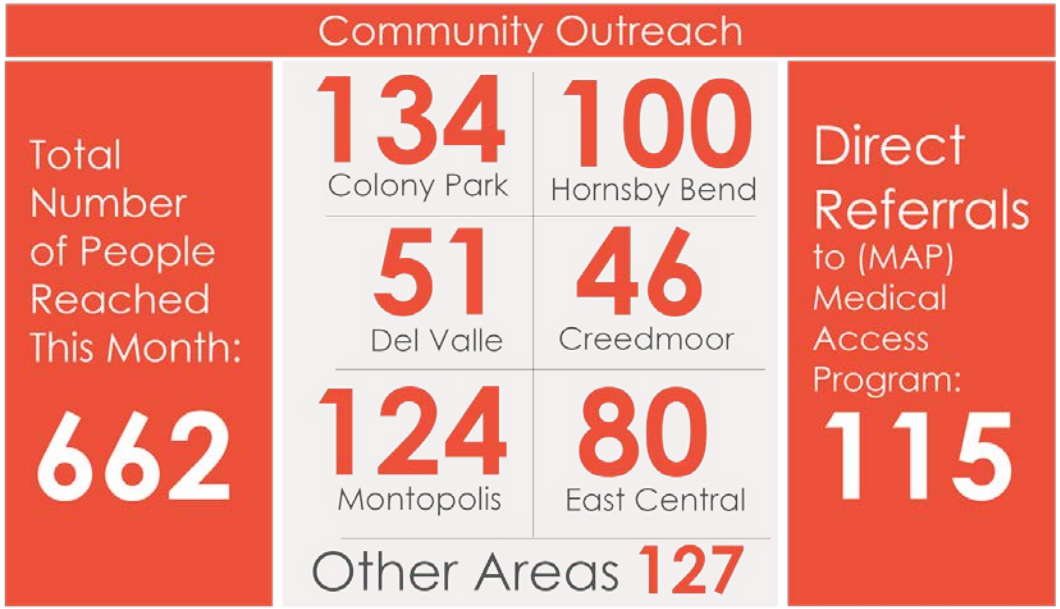
	Latino	African American	White	Asian	Native American	Hawaiian /Pacific Islander
Colony Park & Manor	59.98%	23.97%	14.08%	.67%	2.85%	.11%
Hornsby Bend (Del Valle)	59.70%	24%	12.10%	.50%	1.90%	.10%
Southeast (Creedmoor, Elroy, Del Valle)	69.22%	9.14%	16.11%	1.41%	2.58%	.25%

Outreach: CHWs Hit the Streets

CHW Activities



Outreach: Results



CHW Program: 2019 & Beyond

1. Aug. - Nov. 2019: Pilot launched; training curriculum developed and implemented; Way to Wellness Workshops launched
2. Dec. 2019: Central Health hires CHWs
3. June 2020: Evaluation
4. Aug. 2020: Program expansion

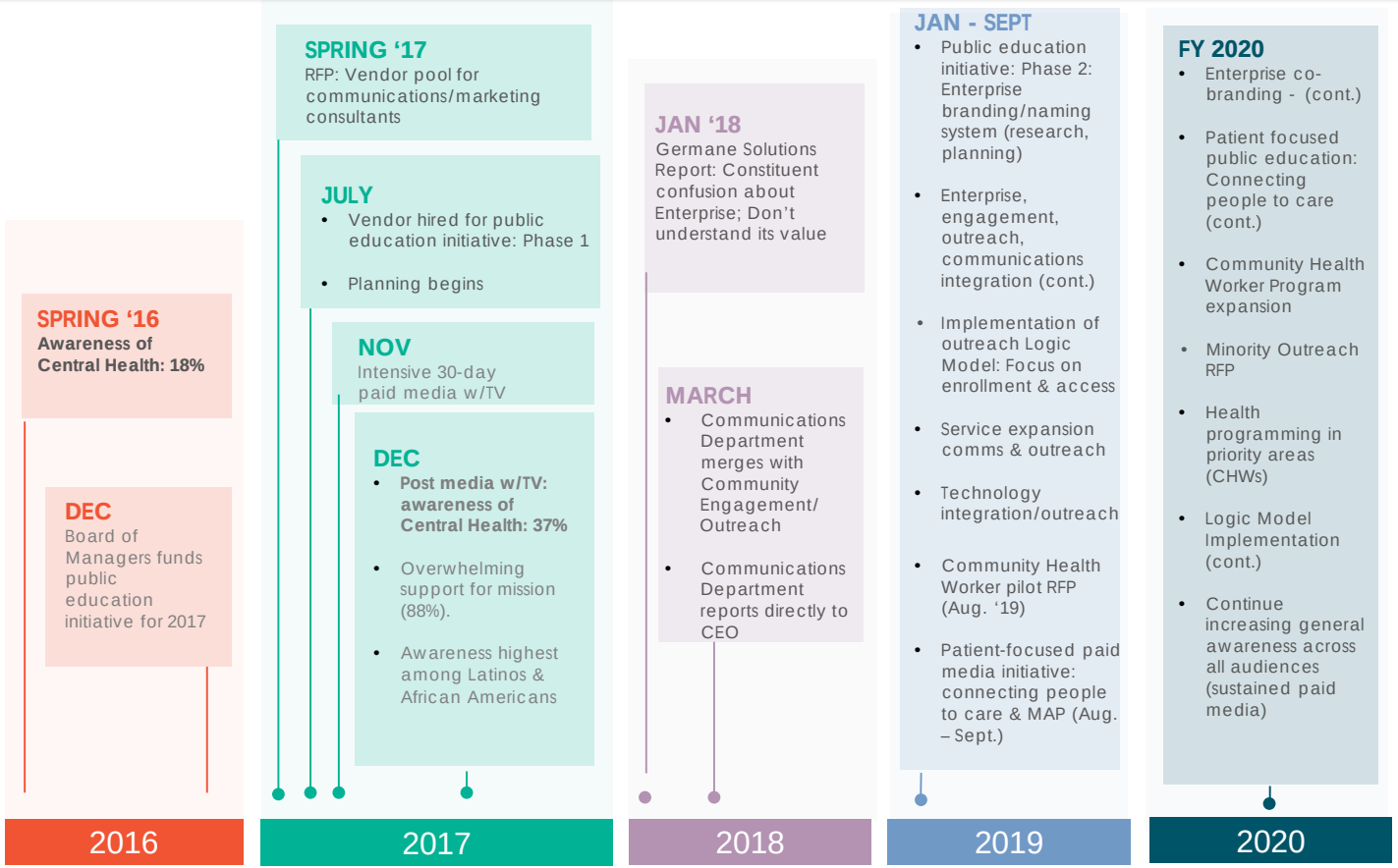
CHW Program: Connecting More People to Care

Area	2017 Families Living in Poverty	2020 Families Living in Poverty	#CHWs: Pilot Aug. 2019-Aug. 2020	#CHWs: Sept. 2020-Aug. 2021	#CHWs: Sept. 2021-Sept. 2022
Colony Park (Including Sendero Hills/Park Place)	1,055	1,167	2	2	3
Hornsby Bend	421	476	0.5	1	1
Creedmoor	212	235	0.5	0.5	0.5
Manor	381	432	0	0	1
Del Valle	318	351	0	1	1
Elroy	401	447		1	1
East Del Valle	285	319		0.5	0.5
Travis County	**33,061**	**36,541**	**3**	**6**	**8**

Expanding Minority Outreach Capacity
Request for Proposal (RFP)

1. Targeting people most affected by health disparities
2. Complement CHW efforts
3. Create community organizing strategy; develop training curriculum to expand/enhance CHW training

Central Health Communications/Community Engagement/Outreach
THE LONG VIEW



Paid Media: Update

Goal:

Connect people with low income to care and coverage (i.e. MAP); promote service expansion.

Audiences:

Patients (⅔) & nonpatients (⅓)

Timing:

Aug. - Sept.

Budget:

$245,000

Paid Media: Tactics

EL MUNDO

The Villager

62 UNIVISION

Paid Media: Results

- 415% increase in MAP page views (compared to 4th quarter 2018)
- 1,000% increase in FB inquiries (compared to 4th quarter 2018)
- 27% increase in calls in Sept. to Eligibility Office (compared to Sept. 2018)
- Nearly 6.5 million impressions (online only)

Co-Branding: Update

Goal:

Better connect Central Health and the Enterprise affiliates (i.e. CommUnityCare, Sendero) in the minds of patients/Travis County residents.

Objectives:

1. Connect Central Health Enterprise brands and products.
2. Educate residents on the collective value and strength the Enterprise brings to the community.
3. Create a platform for communication/education about how health care is planned, delivered, and funded in Travis County

Co-Branding: Update

Name Architecture (Options)

- Explore options that maintain Central Health, CommUnityCare and Sendero Health Plans names in some fashion.
- Explore options that are different from current names
- Explore options that include portion of current names (hybrid approach)

Co-Branding: Process Update

Research

- Peer
- Stakeholder
- Awareness
- Focus Groups
- **Analysis**

Internal Feedback

- Review with Central Health BOM Executive Committee
- Review with CommUnityCare Executive Committee

Development

- Finalize naming system
- Logo design & brand guidelines development
- Present to BOM

Implementation

- Phased rollout campaign

CENTRAL HEALTH

Questions

CENTRALHEALTH.NET

@CentralHealthTX

Community Care Collaborative
A Central Health and Seton partnership

CommUnityCare

SENDERO HEALTH PLANS

Communications and Community Engagement Report

CENTRAL HEALTH
HEALTH CARE FOR ALL

September 2019

CHWs Connecting People to MAP

- 4 CHWs focused on Creedmoor, Hornsby Bend and Colony Park
- Launched a series of health education classes called "Way to Wellness Workshops"

Paid Media Results

- 415% increase in MAP page views (compared to 4th quarter 2018)
- 1,000% increase in FB inquiries (compared to 4th quarter 2018)
- 27% increase in calls to Eligibility Office (compared to Sept. 2018)
- Nearly 6.5 million impressions (online only)

Media Reach:

32,400
Twitter Impressions
28 Tweets

3,434
Facebook Likes
25 posts and 19,708 video views

39,220
Website Page Views
14,915 users

4,417
YouTube Impressions
760 views

14
Media Stories
TV, radio and print

Community Outreach

Total Number of People Reached This Month:

662

134 Colony Park	**100** Hornsby Bend
51 Del Valle	**46** Creedmoor
124 Montopolis	**80** East Central

Other Areas **127**

115 Direct Referrals to (MAP) Medical Access Program

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 3

Receive and discuss an overview of Central Health Enterprise activities related to individuals experiencing homelessness in Travis County.

HOMELESS HEALTHCARE IN AUSTIN AND CARE CONNECTIONS CLINIC

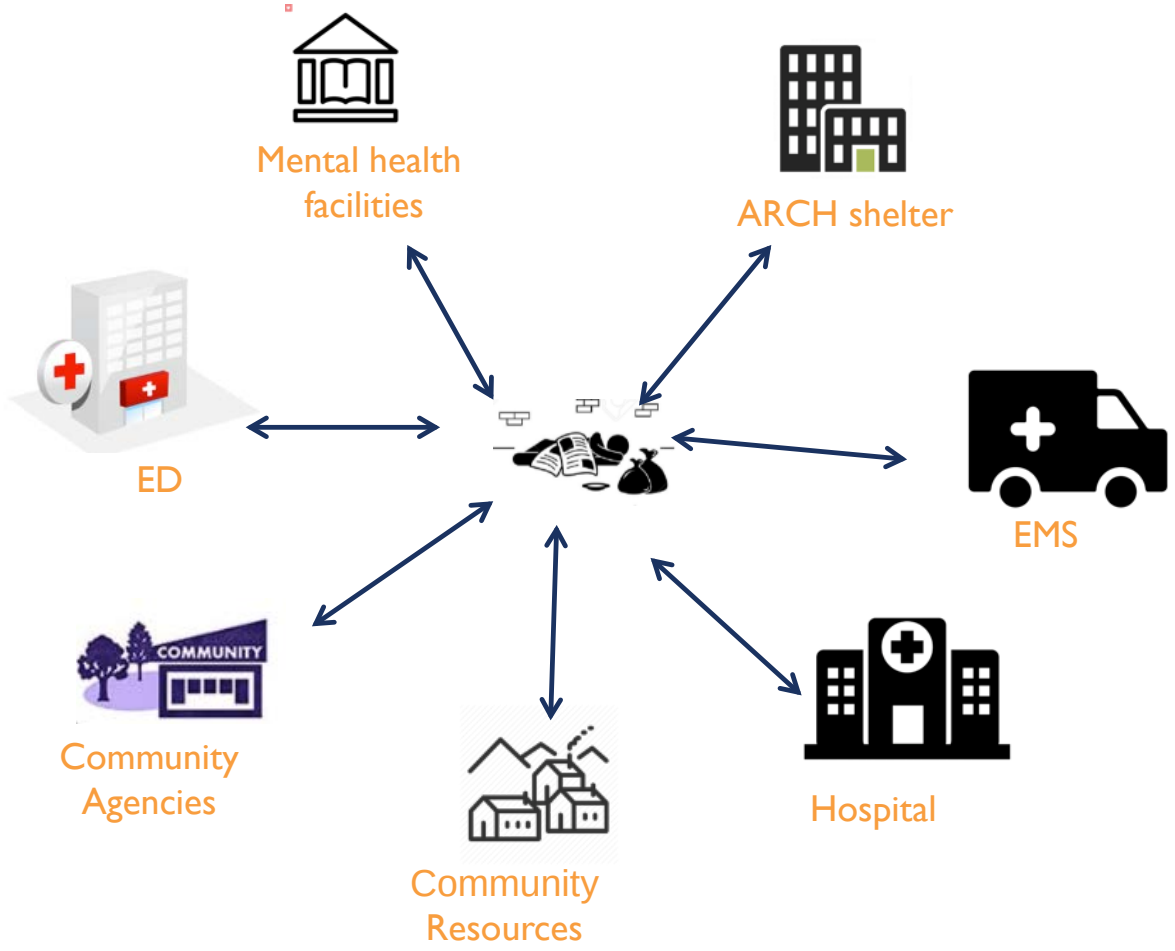
Audrey Kuang

Holli Sadler

Josh Rivera

October 15, 2019

HEALTHCARE IN AUSTIN FOR THOSE EXPERIENCING HOMELESSNESS



HOMELESS HEALTHCARE PROGRAM VISION

ARCH Shelter Clinic
(2004)

Mobile Team-
fixed community sites
(2013)

Street Medicine Team
(2014)

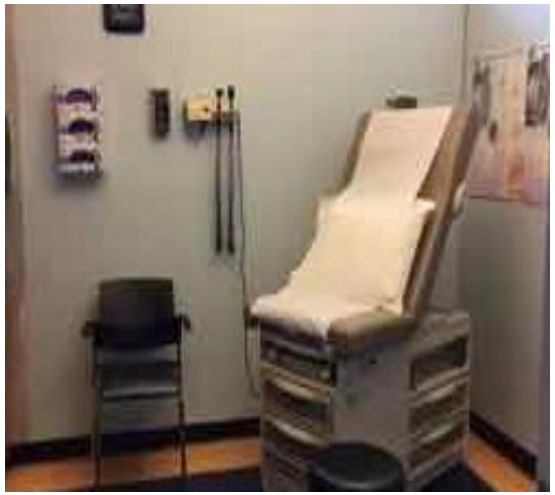
Care Connections Clinic
(2019)

Vision:

1. To deliver comprehensive, integrated, high quality health care to those individuals experiencing homelessness while being part of a broader strategy to provide stable housing and essential support services.

2. To improve the quality of life for vulnerable populations through community collaboration, leadership and advocacy.

SHELTER CLINIC @ ARCH (2004)



- Clinic open Monday-Friday 7:30 am- 4:30 pm
- Offer medical appointments and walk-ins
- Mental Health services, lab, TB testing, Hep C
- Case Management

MOBILE TEAM (2013)

Mobile Fixed-Site Clinics

- Austin Transitional Center
- Austin Recovery
- Sunrise Church
- Community First Village
- Foundation Communities

STREET MEDICINE PROGRAM (2014)

Benefits

- Acute care
- Chronic diseases
- Preventative care
- Blood draws
- Prescriptions
- Diagnostic orders
- Referrals
- Financial screening

Challenges:

- New experience
- Building trust
- Patient transportation
- Test results
- Emergency situations
- Getting medications to patients
- Locating patients for follow-up

JOINING FORCES: CUC + CHP

Benefits of CUC

- Access to primary care
- Access to prescriber
- Connection to MAP network
- ED diversions
- Continuum of care
- Disruption of siloed care
- Access to hospital records

Benefits of CHP

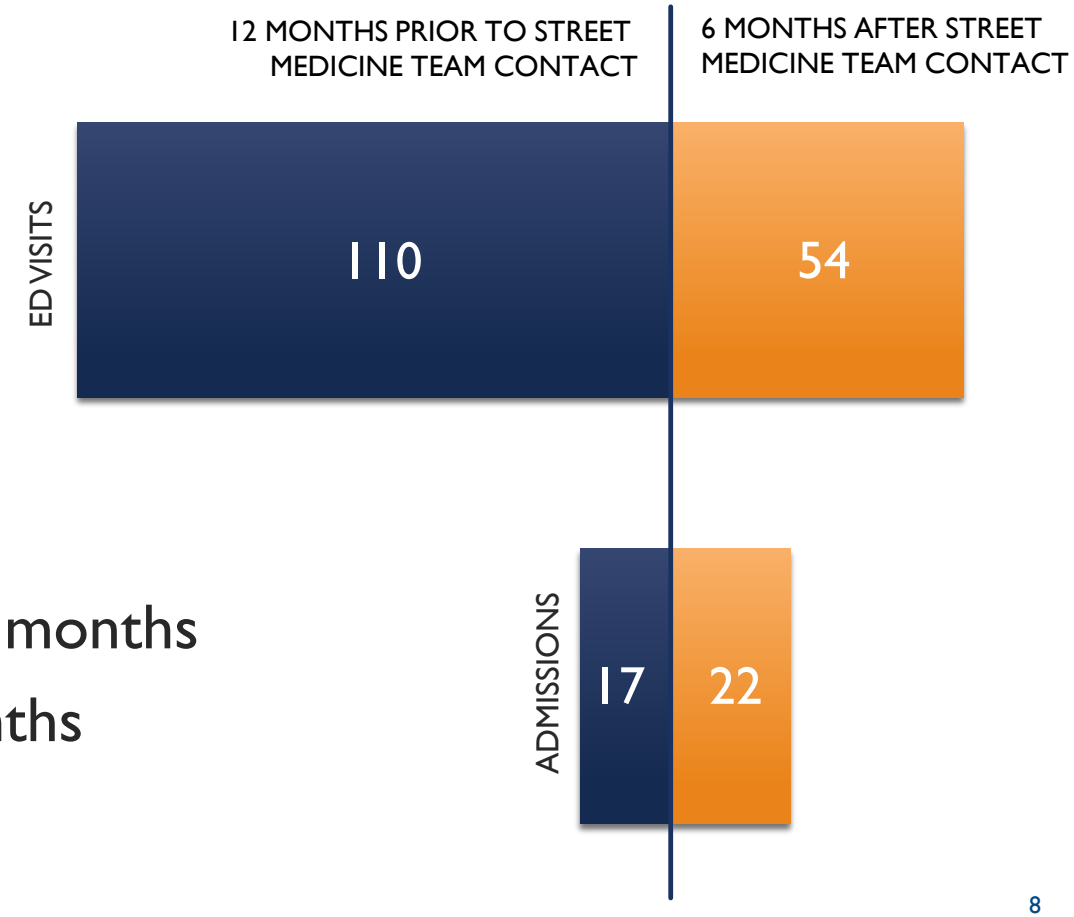
- CUC gained credibility
- Improved logistics
- Patient got medications
- Security/Transportation
- Advocates at ED
- Better follow-up
- “insiders” at fixed sites.

HOSPITAL VISITS

- Began Collecting Data Jan 2019
- 55 Patients Followed for 6 months

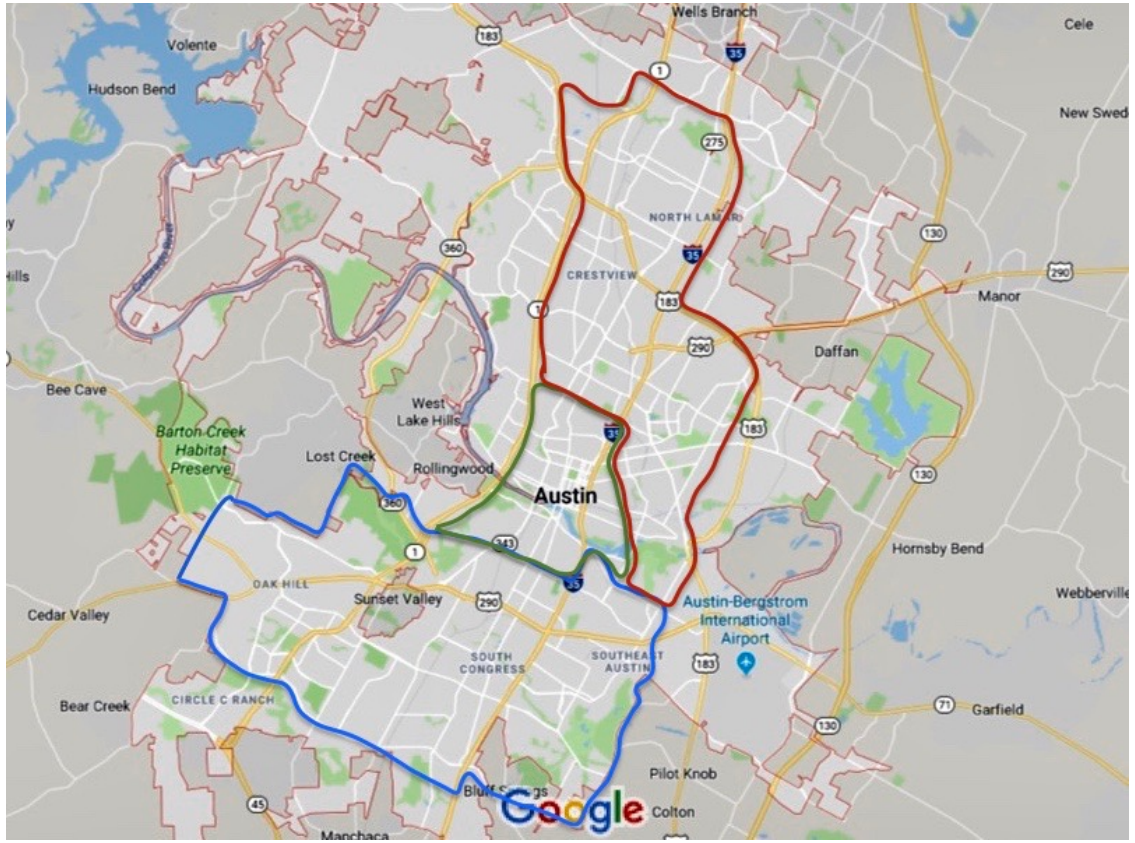
- 2 ER Visits per person prior 12 months
- 1 ER Visit per person at 6 months

- 0.3 Hospital Admissions per person prior 12 months
- 0.4 Hospital Admissions per person at 6 months

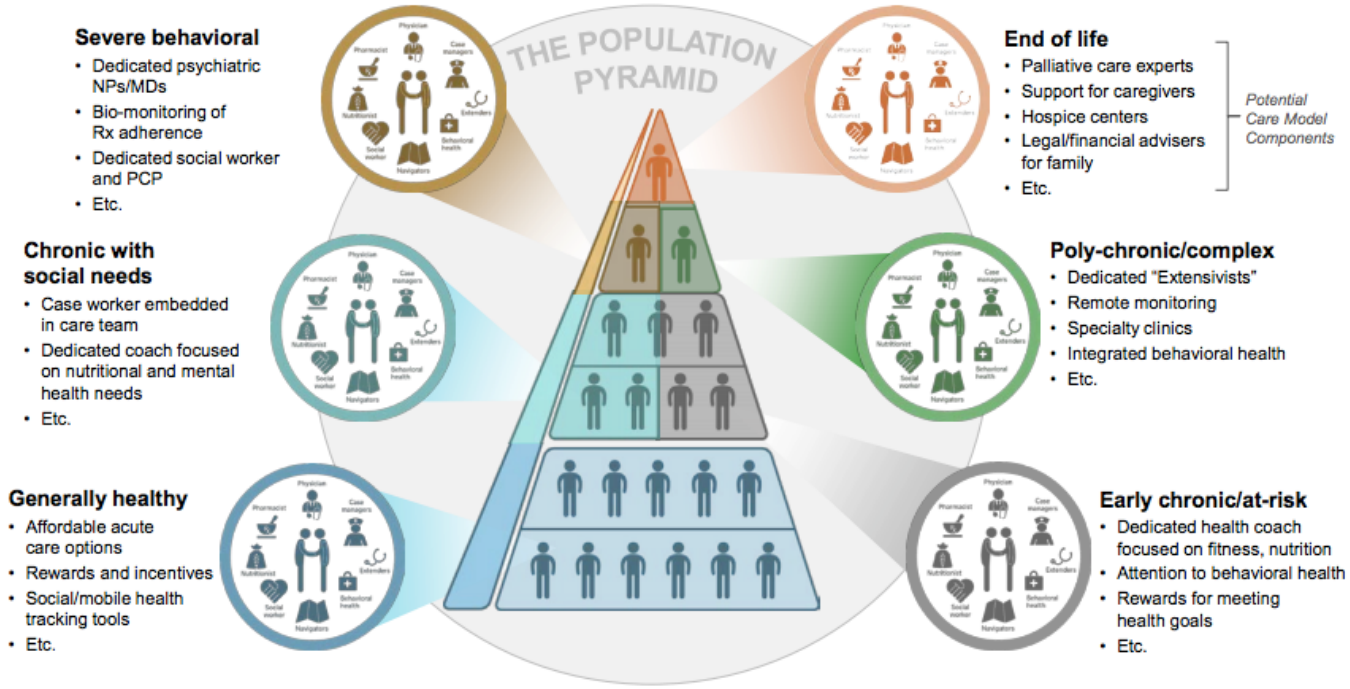


TYPICAL WEEK

- Mondays & Tuesdays
  - CHP outreach
  - Transport to appointments
- Wednesdays & Thursdays
  - 10-12 patients/day
  - Staff – MA, LCSW, CHP, FNP
  - Fully-stocked mobile clinic
- Fridays
  - CHP delivers medications
  - Transport to appointments
  - Urgent follow-up

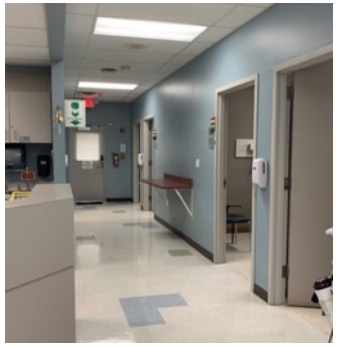


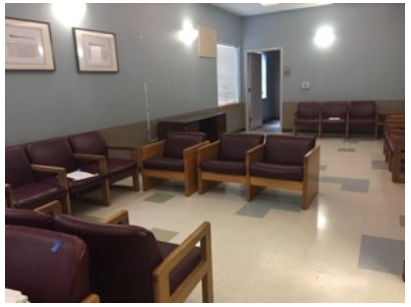
CARE CONNECTIONS (2019)

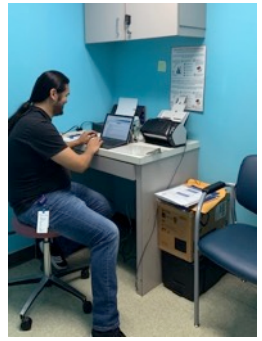


= { Complex Primary Care team + Homeless Health Care team } + Integral Care + ECHO +

CARE CONNECTIONS (2019)





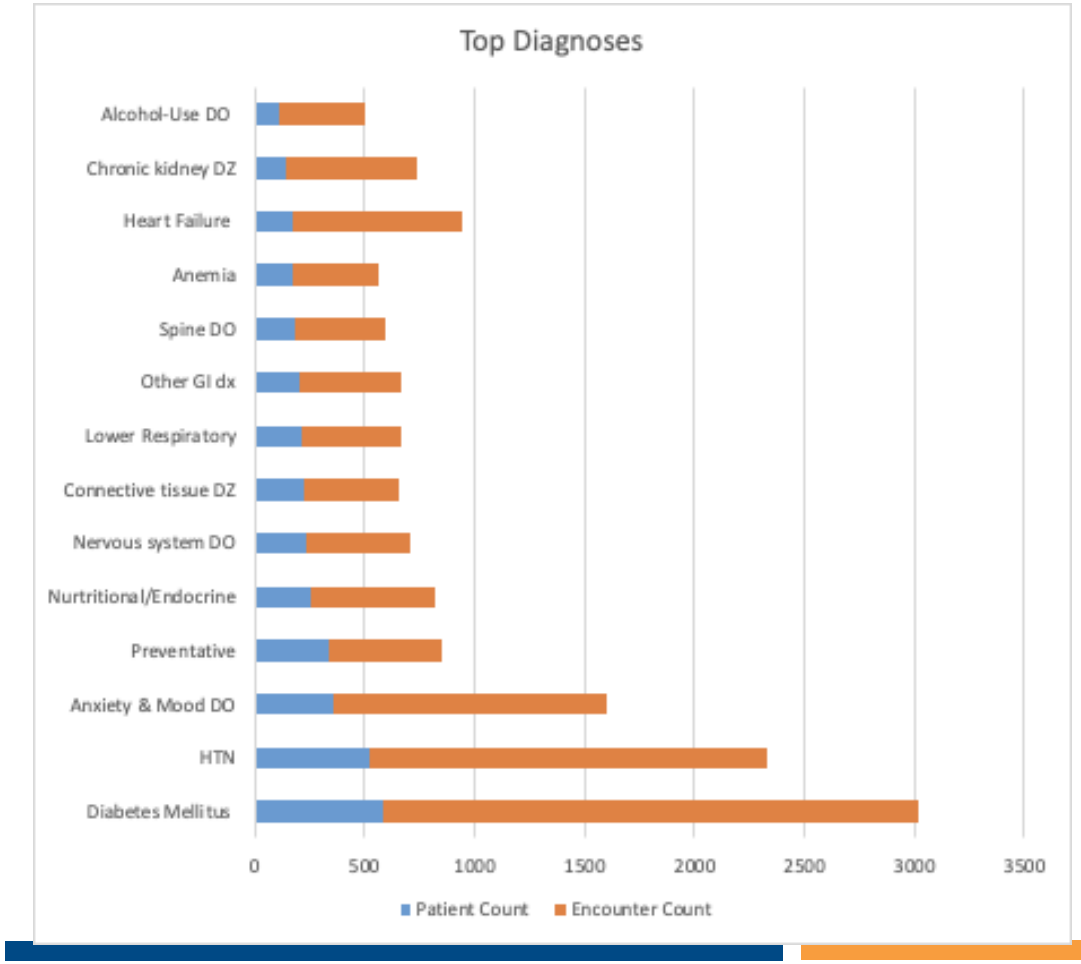


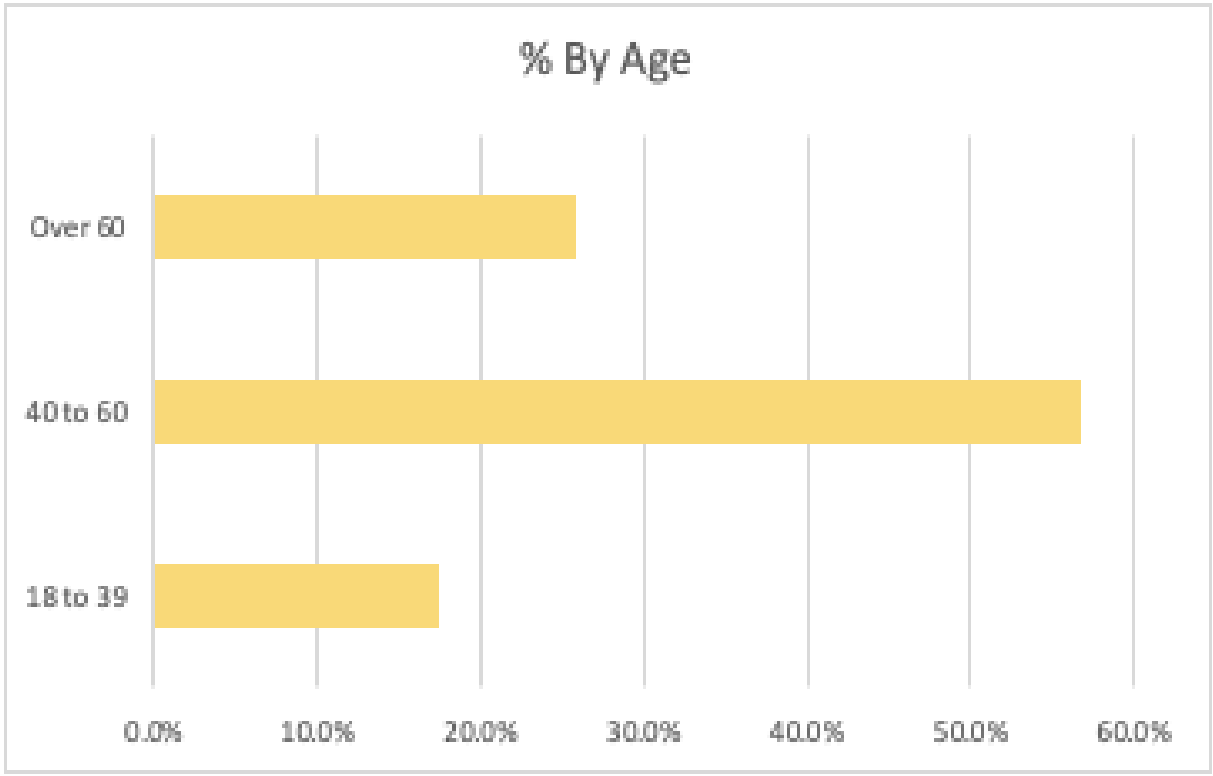
- 10 exam rooms, onsite lab, procedure room
- Care team: providers, MA, RN
- Extended Care team:
  pharmacist, wound care, SW, CM
- Co-location of community partners:
  Integral Care, ECHO, CHP

COMPLEX CARE AT CARE CONNECTIONS

- Iteration of DSRIP program
- Incorporated into CUC 2/2018, Relocated to Care Connections 2/ 2019
  - Combined resources and streamlined processes
- Goals
  - To provide comprehensive transition care for patients with complex medical and social needs, new to MAP with recent hospitalization
  - Increase engagement in primary care and health outcomes for patients that have not historically had their needs met in traditional primary care setting
  - Serve as an innovation space for safety net care in Travis County

COMPLEX CARE AT CARE CONNECTIONS

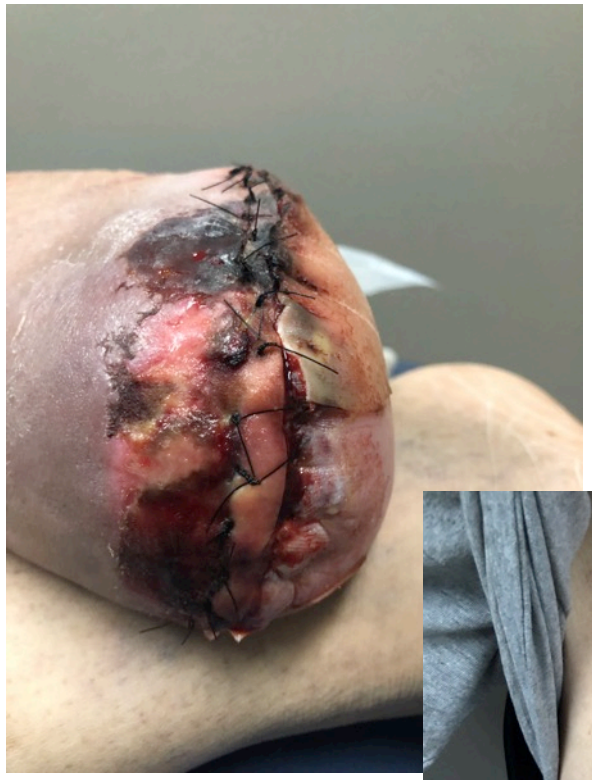


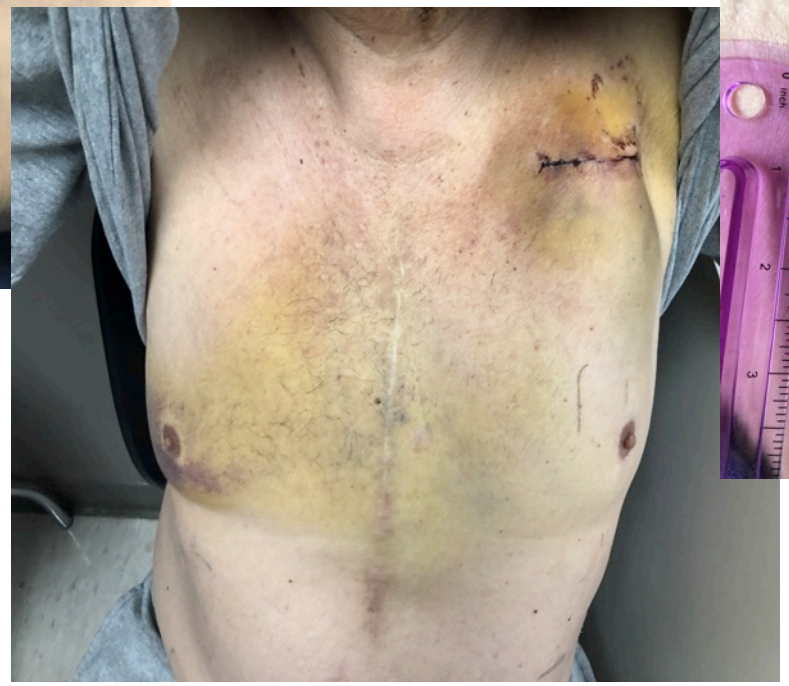


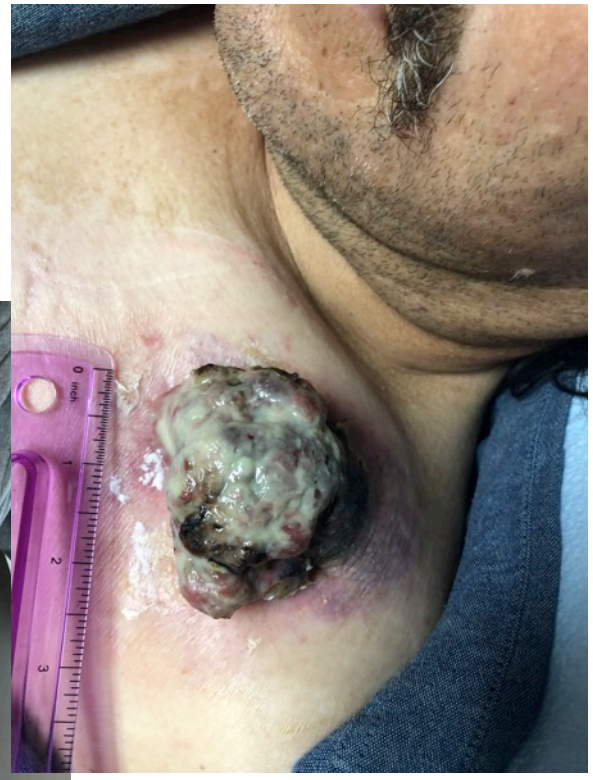
WARNING

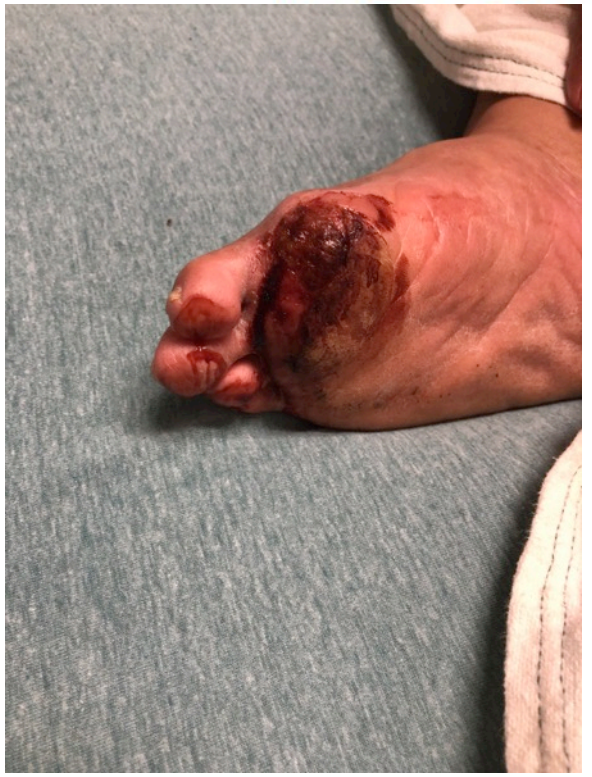
THE NEXT SLIDE CONTAINS GRAPHIC IMAGES

VIEWER DISCRETION IS ADVISED



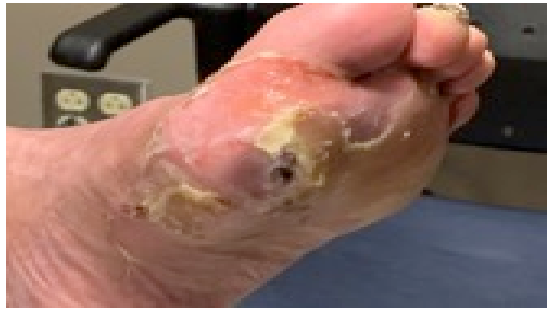


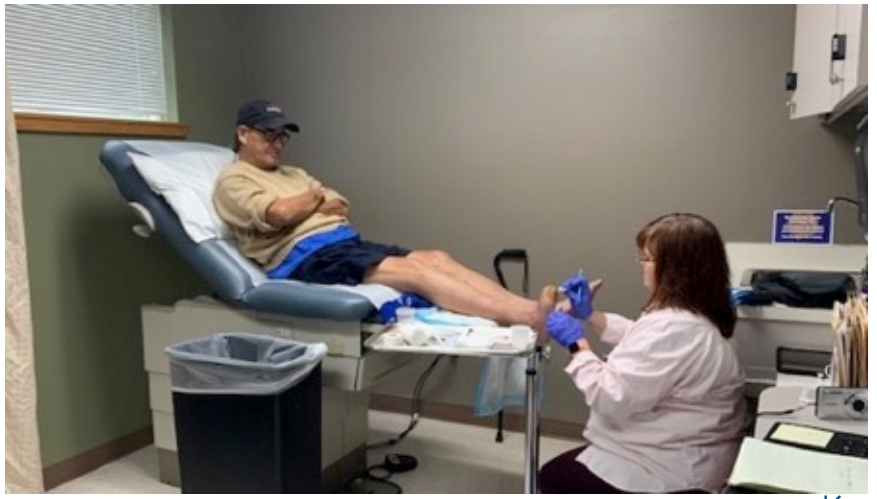




WOUND AND FOOT CARE

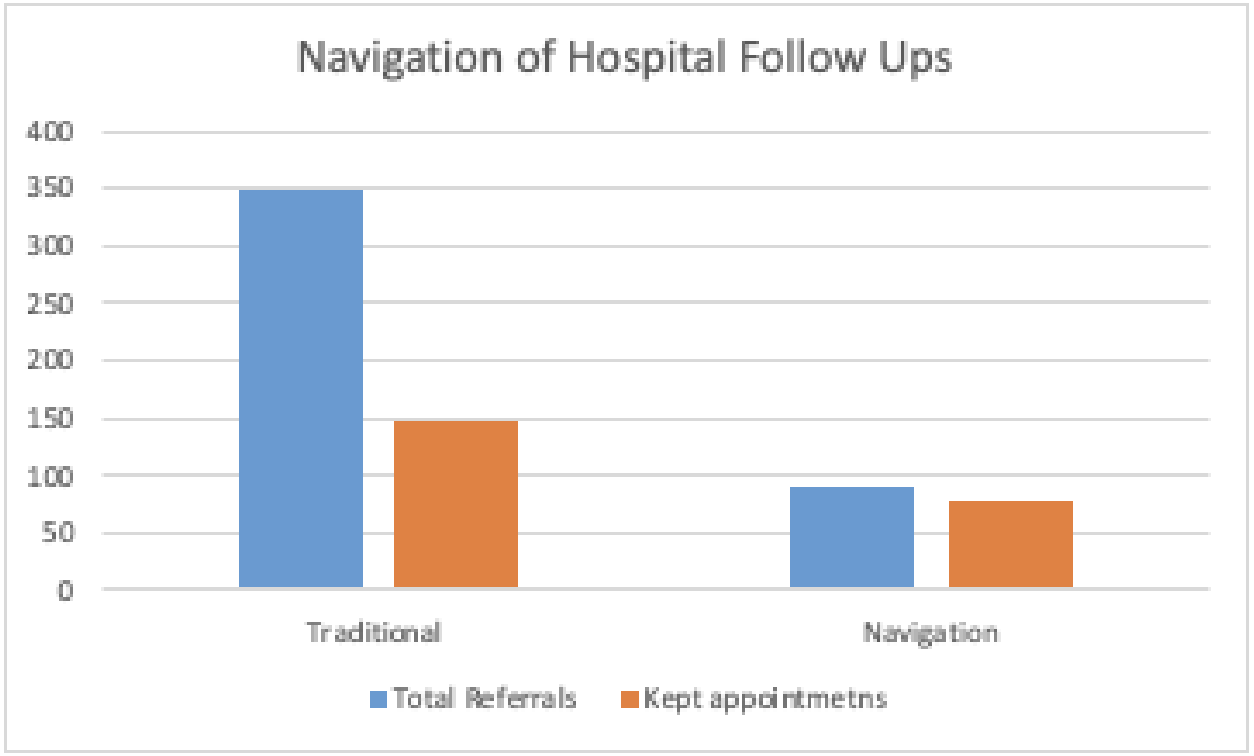
- 200 Wound Care Visits to 75 Unique Patients Delivered since 2/25/19
- Provided Access to Patients Waiting on Access to formal Wound Care Clinic
- Case Review suggests avoidance of 15 amputations and/or avoidable hospitalizations





CARE NAVIGATION

- Improving inpatient to outpatient communication
  - Hospitalist using Extensivist Model
  - Care navigation hospital>clinic>home
  - Joint Quality Improvement related to transitions of care



TRANSITIONS OF CARE

Stuck in Recurrent Loop of Admission for "Compassionate Dialysis" and discharge to street/shelter, receiving substandard care

Per Chart, not eligible for in center hemodialysis

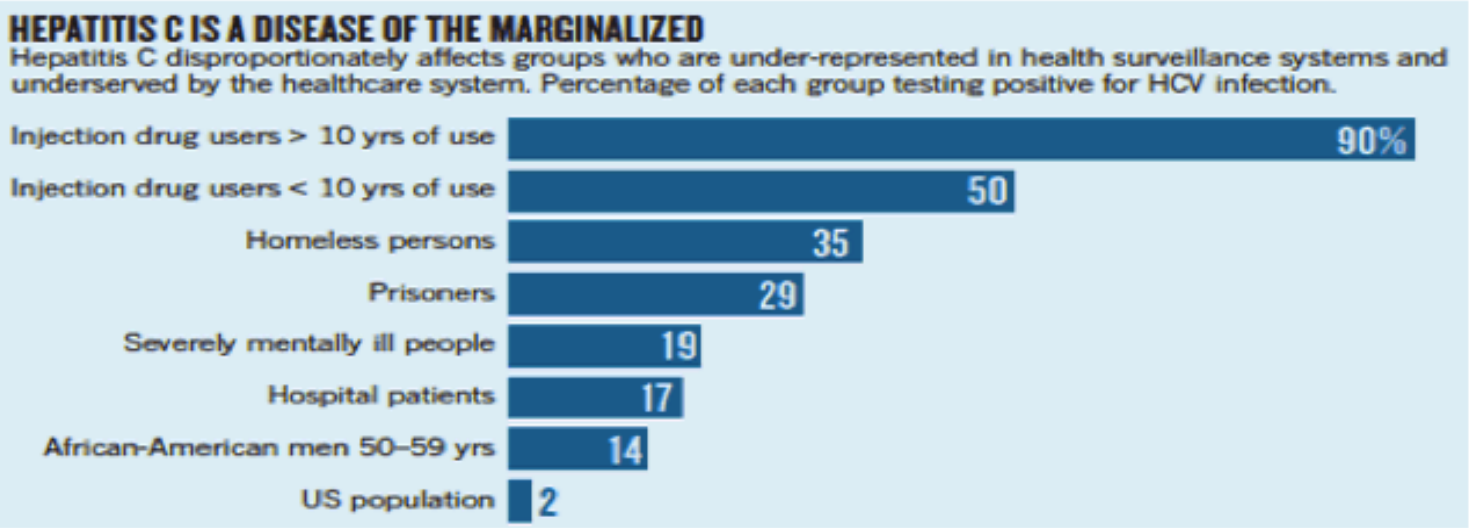
Coordination between Care Connections Medical staff - Nephrology resulting in Referral for Chair

Coordination with SOAR and ECHO resulting in expedited disability application
Now with income, Medicaid/Medicare,
Access to ongoing incenter hemodialysis
On list for housing

PARACENTESIS

- Large volume therapeutic paracentesis
- Typically performed in ER or inpatient setting. Well known to be safe outpatient procedure
- Single outpatient paracentesis provider in safety net
- Continuity and medication titration

HEP C TREATMENT



There is a high prevalence of Hep C in our patient population:

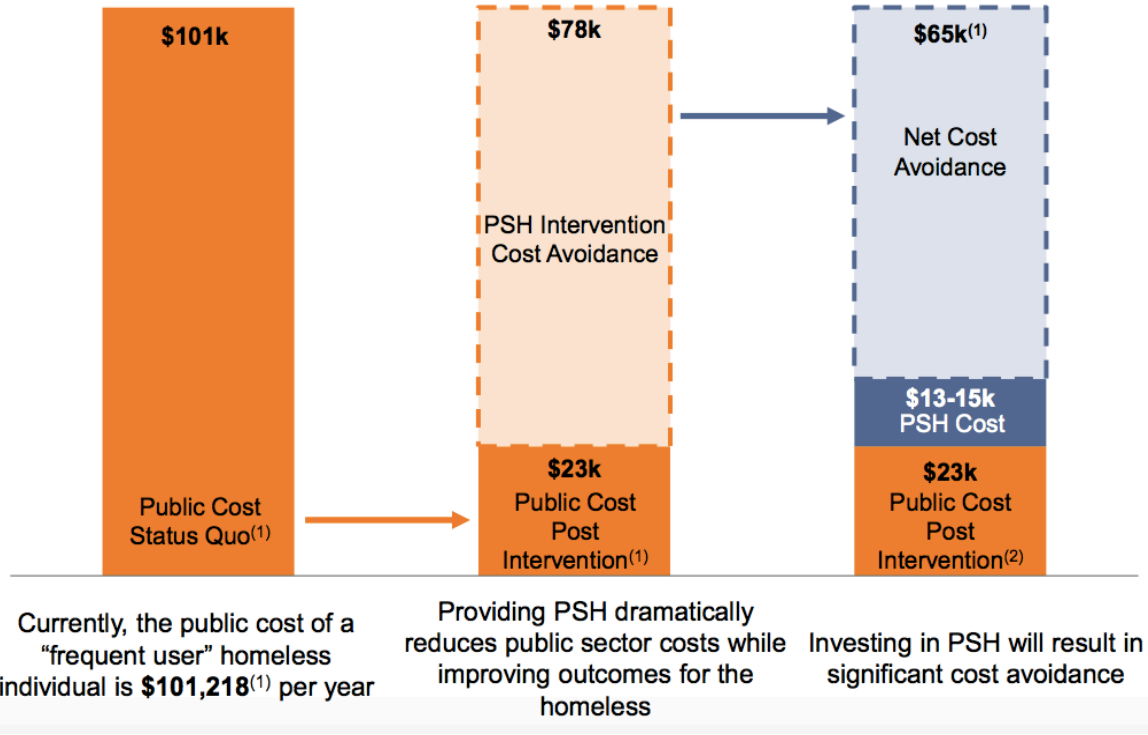
We have treated over 50 patients at our homeless sites, including Care Connections Clinic

Treating /Curing Hep C provides **$15907** in cost savings per year in health care costs asso with the disease (Am J Manag Care 2019 Jun; 25(8 Suppl): S131-S139.)

Breaking down barriers, streamlining care, patient engagement

Carlos and his Hep C meds

HOUSING



Housing leads to cost avoidance of $65000 per year

Richard with keys to his apartment

2016	17 ED visits	
2017	15 ED visits	
2018	11 ED visits	← establishes care
2019	**2 ED visits**	**← HOUSED!**

SOAR (SSI/SDI OUTREACH, ACCESS AND RECOVERY)

- A program to help increase access to SSI/SSDI eligible adults who are experiencing homelessness and have serious mental illness, medical impairment, and/or co-occurring substance use disorder.
- SOAR - trained case managers help gather documents and write a cover letter to help support SSI/SSDI claim.
- Our team has been closely working with SOAR system coordinator and together have had 10 approvals, 1 denial, 2 approvals after appeals
- SSI $771/mo → Medicaid→ Housing, $1500-$27000 backpay

Mary and her case manger Lauren at Community First Village

COMMUNITY HEALTH PARAMEDICS (CHP)

- CHPs bring patients to the clinic 2-4/week, avoiding an unnecessary EMS transport
- These are patients who would have been taken to the ED for evaluation.
- CHPs are able to coordinate care post visit.
  - Pick up meds, deliver them
  - Check on patients later on
  - Find patients, transport to appointments
- Examples
  - cellulitis, sutures/staples removed, wounds, "dizzy"

Walter and Mike Sasser, CHP

DEVELOPING PARTNERSHIPS

- ROIs between agencies
- Timely referrals
- Challenges of EHR/HMIS
- Coordinating schedules/hours
- Aligning approach and philosophy to care

Weekly partner meetings- ECHO, IC, CUC

TABLE 1 Six levels of collaboration/integration between specialties

Coordinated		Co-located		Integrated	
Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on-site	Close collaboration on-site with some system integration	Close collaboration approaching an integrated practice	Full collaboration in a transformed/merged integrated practice

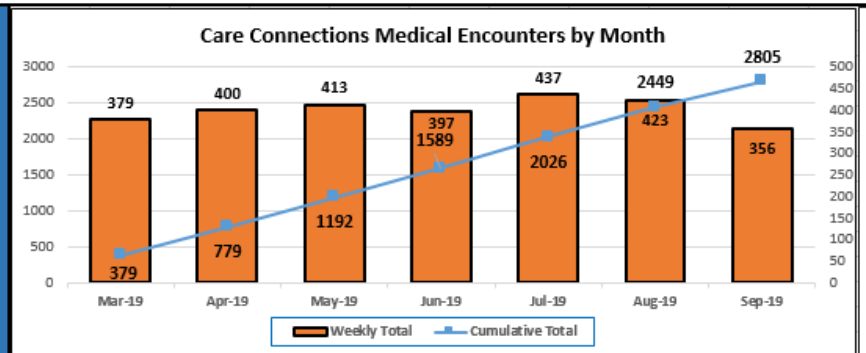
Adapted from Heath B et al. 2013.[10]

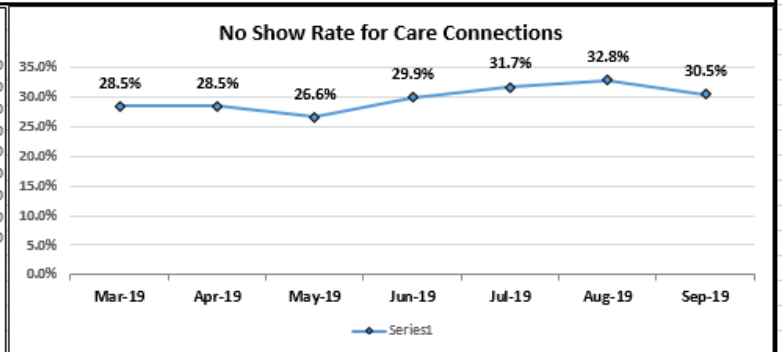
THE COST AND VALUE OF COMPLEX CARE AND HOMELESS HEALTHCARE SERVICES

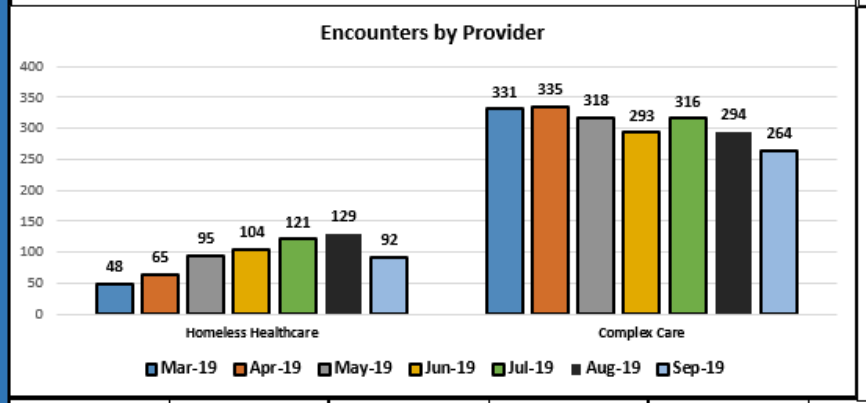
PATIENTS SERVED

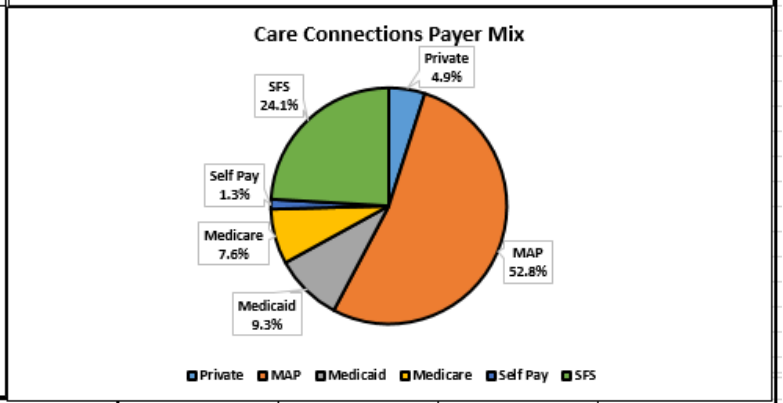
Month: September 2019 | CUC Operations KPI Report - Transitions | Clinic Name: Care Connections

Key Performance Indicators



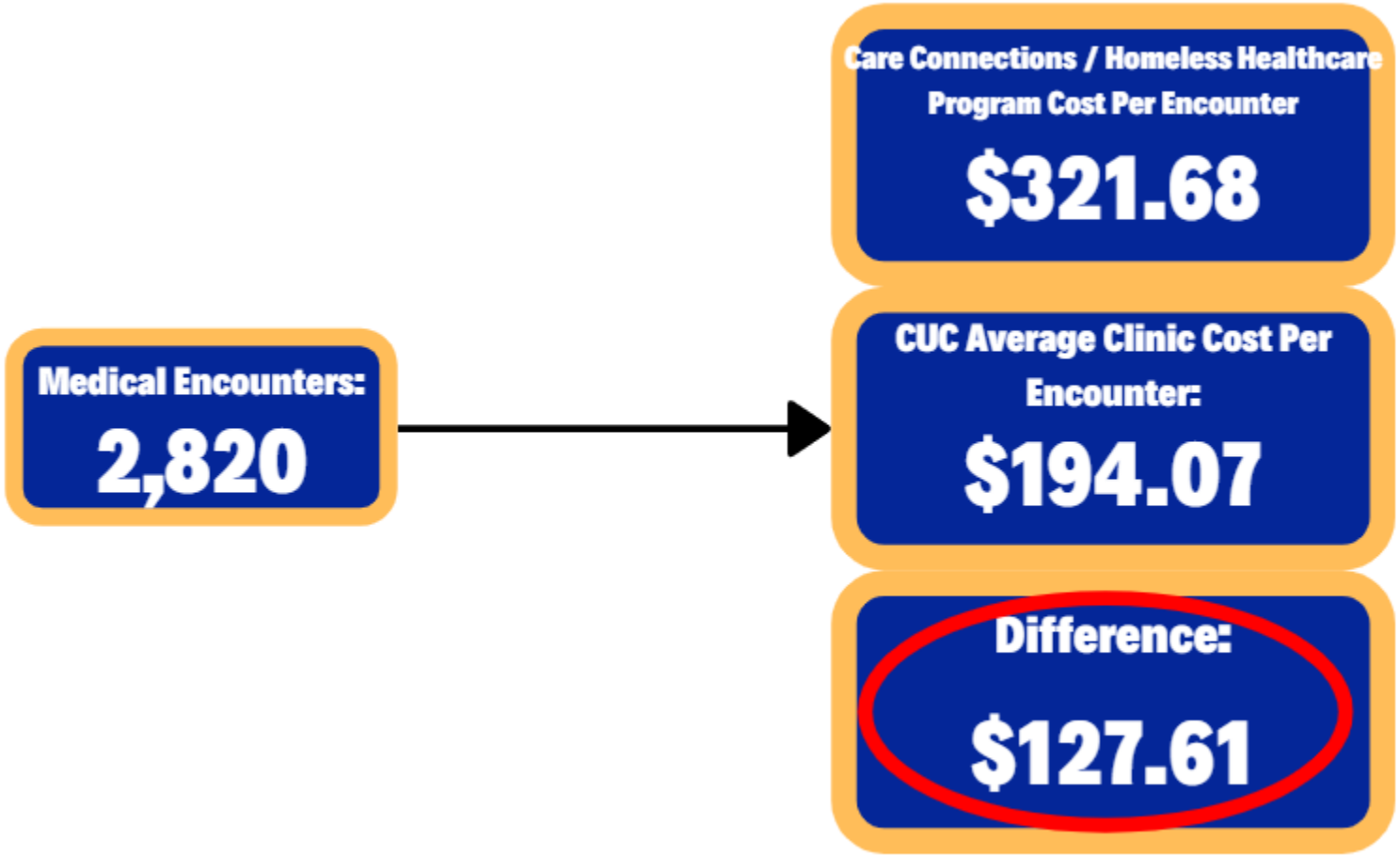




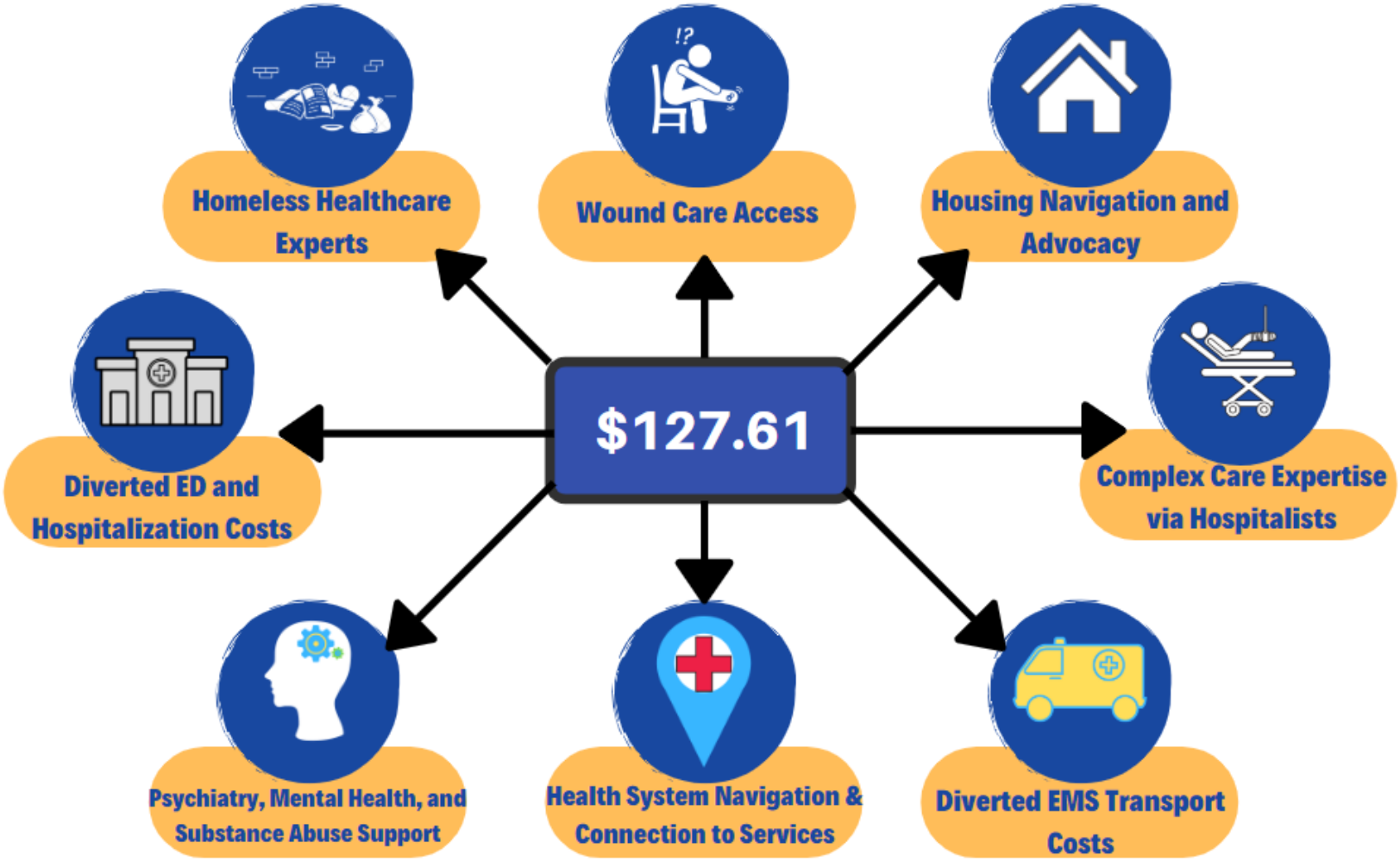


Wound Care Encounters	496	Behavioral Health / Social Work Encounters	344	Case Management Encounters	167	Community Health Worker Encounters	328	Unique Patients Seen	1,127

COST PER ENCOUNTER: CARE CONNECTIONS & HOMELESS HEALTHCARE SERVICES FEB 2019 – SEPT 2019

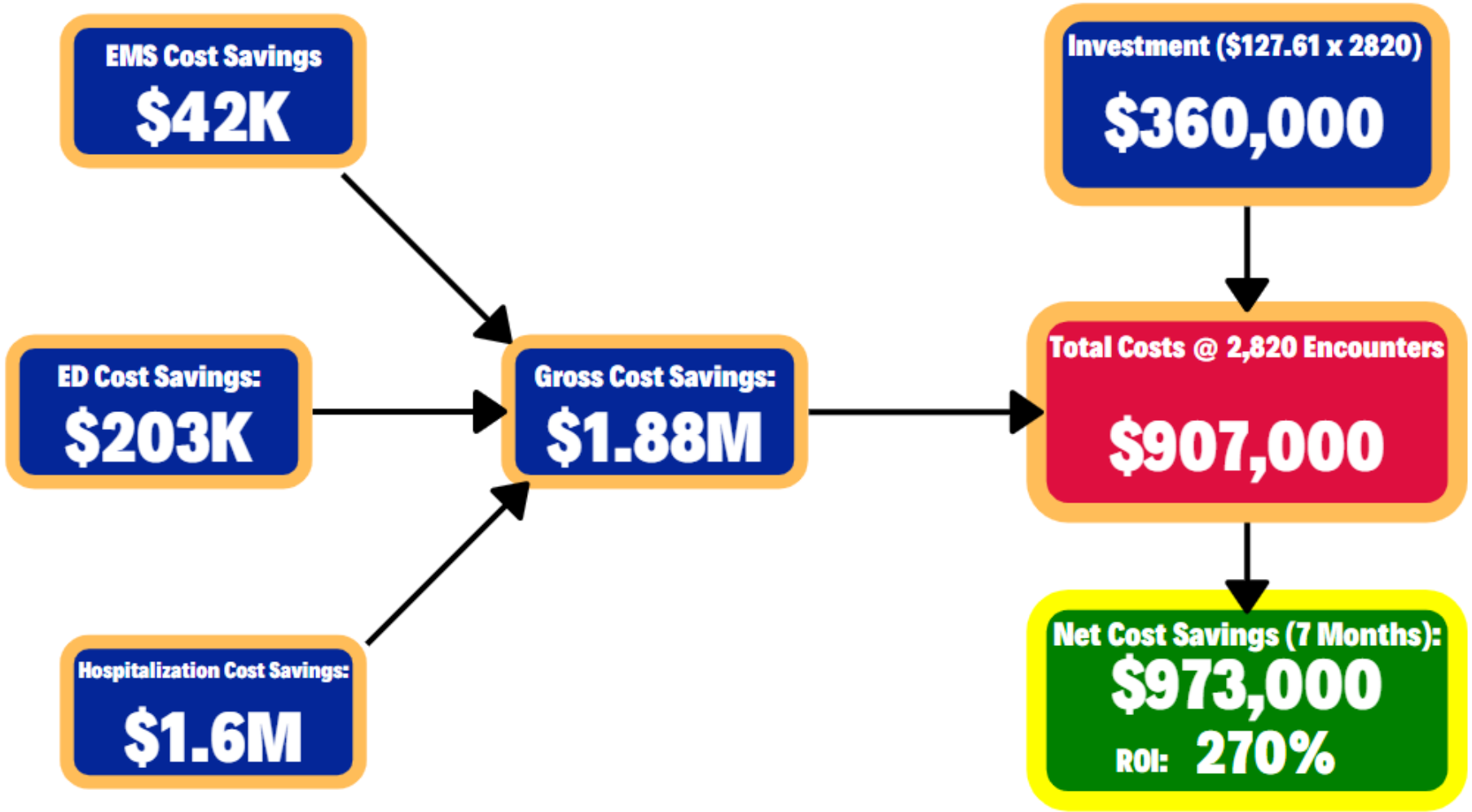


What is Covered by the $127 Investment?



CommUnityCare HEALTH CENTERS

What is the Return on Investment for Complex Care & Homeless Services?



COST SAVINGS – DETAILED ESTIMATIONS

Diverted EMS Costs	
Unnecessary Transports (2/Wk average since April 2019)	48
Cost of Transport	$876
Total Cost Savings	**$42,048**

Diverted ED Costs	
Paracentesis Performed	94
Average ED Visit	$1,400
Cost Savings from Ambulatory Paracentesis	**$131,600**
Total Wound Care Services	494
Unique Wound Care Patients	127
Estimated ED Diversions (40% Rate)	51
Cost Savings from Ambulatory Wound Care	**$71,120**

Diverted Hospitalization Costs	
Amputations Prevented (Est. 15% of Pat)	19
Average LOS for Amputation (Days)	5
Cost per Hospital Day	$4,800
Cost Savings Prevented Amputations	**$457,200**
Unique Patients (Medical)	1225
Readmissions / Complexities Patient Days (Estimated 20% of Population @ 1 Day)	245
Cost Savings Readmissions per Patient Day	**$1,176,000**
Total Cost Savings	**$1,877,968**

Care Connections Clinic: Community Impact

2/25/2019 – 9/30/2019

Over 2,000 Patients Served

500 Wound Care Services
100 Paracentesis Procedures

Over $50K In Disability Back Pay and Future Benefits for Patients

Over $1.8M In Health System Savings

- Integral Care
- ECHO
- ATS-EMS CHP
- SOAR – SSI/SSDI
- Wound Care
- System Navigation & Connection to Services

Estimated Community Impact via Cost Savings, Generated Revenue, and Patient Economic/Social Benefits:

$3.1 MILLION

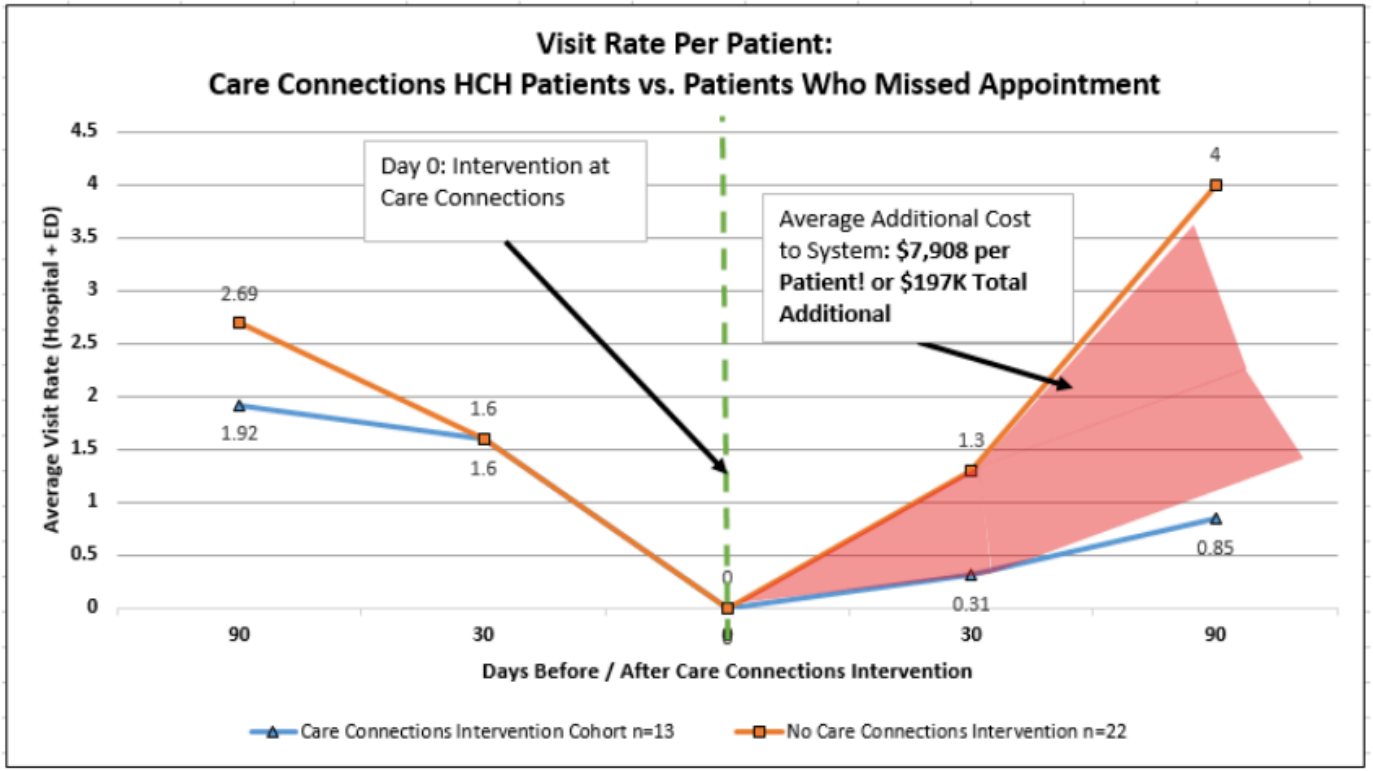
ED VISITS AND HOSPITALIZATIONS - BEFORE AND AFTER (HCH)

Cohort of those who came to appt (13)

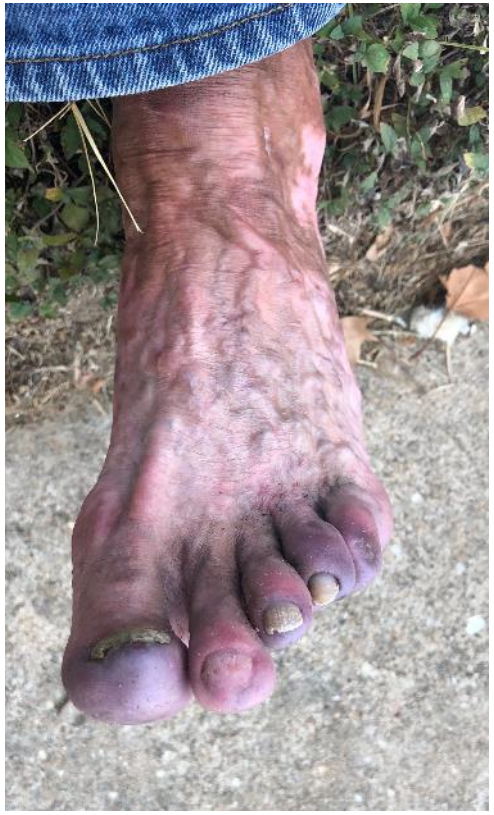
Average visit rate*	30 days	90 days
Before visit	1.6	1.92
After visit	0.31	0.85

Cohort of those who did not come to appt (22)

Average visit rate*	30 days	90 days
Before visit	1.6	2.69
After visit	1.3	4



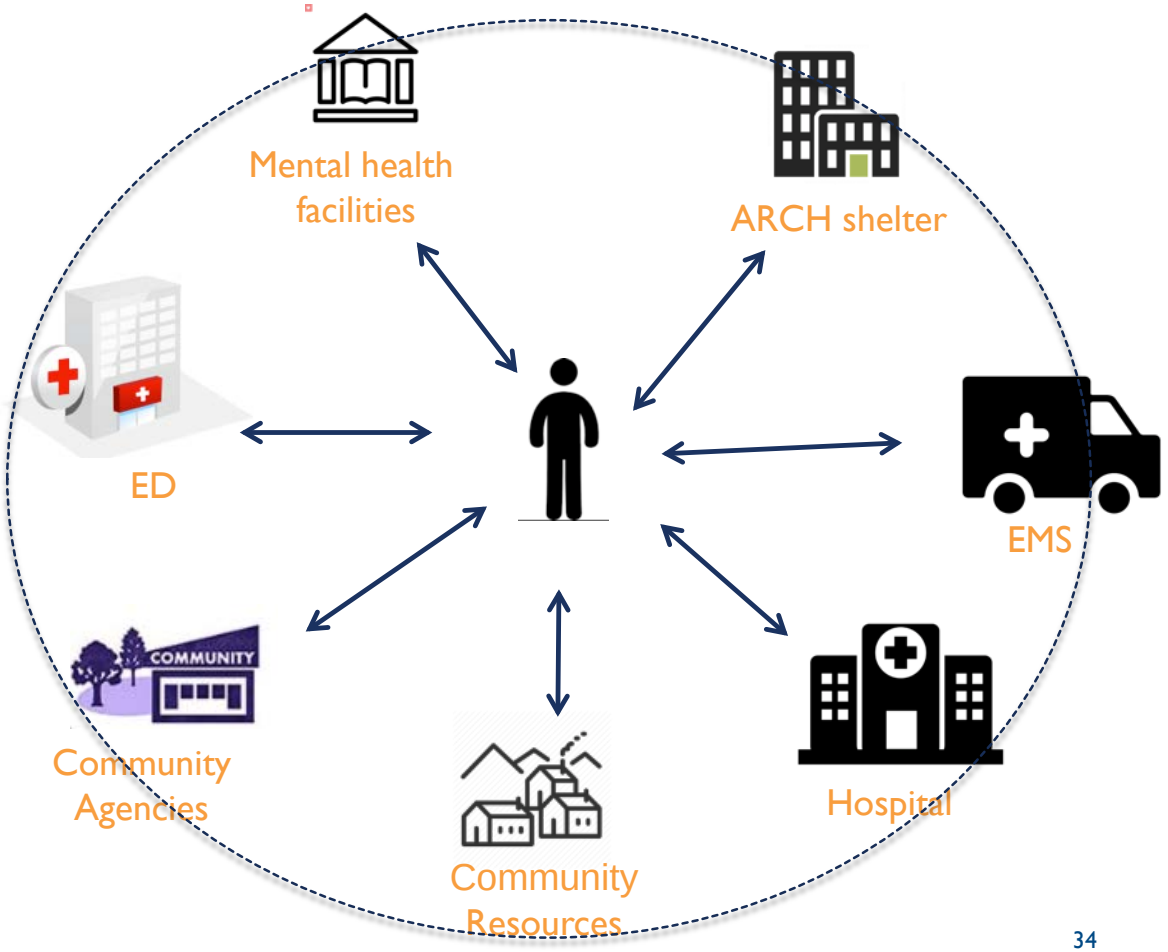
MEET WALTER



CONNECTING THE CARE

Care Connections Clinic

- Addresses health disparities in a way that is proactive, innovative and collaborative
- Integrates primary care, mental health care, and social services that is easy to access by bringing agencies together under one roof
- Proves to be an effective and valuable care delivery model for some of our city's most vulnerable populations



CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 4

Discuss and take appropriate action on the Central Health Equity Policy Council's FY2020 campaign.

CENTRAL HEALTH

CommUnityCare HEALTH CENTERS

SENDERO HEALTH PLANS

Community Care Collaborative
A Central Health and Seton partnership

Central Health Equity Policy Council

Research Committee Findings and Recommendations

About the Council

Vision: Wellness for all through health equity in our community

Mission: Identify and advance effective health equity and wellness policies for Travis County residents

Definitions

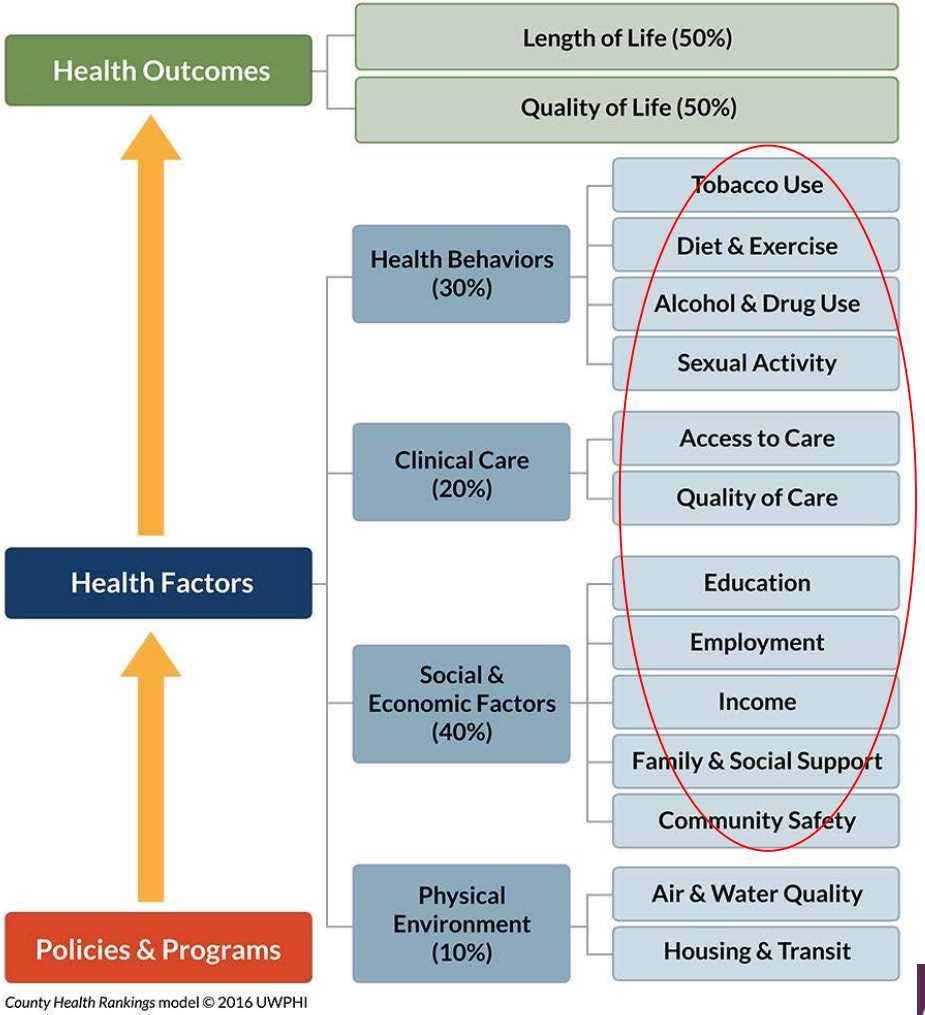
Health Equity: the attainment of the highest level of health for all people. Health Equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health Inequities: Differences in health that are avoidable, unfair, and unjust; often affected by social, economic, and environmental conditions.

Health Disparities: Differences in health outcomes among groups of people.

Research Committee Members

- Ana Almaguel, Travis County HHS
- Marianna Espinoza, DMS
- Kristin duBay Horton, Community Volunteer
- Linnea Lemon, Community Volunteer
- Raul Alvarez, CAN
- Rita DeBellis, Foundation Communities
- Virginia Brown, DMS
- Shelby Massey, AHA
- Ashley LeMaistre, APH
- Iliana Gilman, Volunteer
- Alex Gajewski, Senator Zaffarini's office
- Kelsey Mumford, Student


Health Outcomes
Length of Life (50%)
Quality of Life (50%)
Health Factors
Health Behaviors (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
Policies & Programs
County Health Rankings model © 2016 UWPHI

Public Health Policy

- Static
- Unfunded mandates
- Broad audience

Healthcare Policy

- Dynamic
- Resource driven
- Specific to target populations or conditions

Methodology: Commission Reports

- Arts Commission
- Asian American Quality of Life Advisory Commission
- Austin Travis County Food Policy Board
- Codes and Ordinances Joint Committee
- Commission for Women
- Commission on Seniors
- Community Development Commission
- Community Health Assessment
- Community Health Improvement Plan
- Community Tech and Telecomm Commission
- Comprehensive Plan Joint Committee
- Early Childhood Commission
- Economic Prosperity Commission
- Environmental Commission
- Human Rights Commission
- LGTBQ Quality of Life Advisory Commission
- Mayor's Committee for People with Disabilities
- Urban Transportation Commission
- Zero Waste Advisory Commission
- Housing Authority at the COA
- Independent Citizens Redistricting Commission
- Joint Cultural Commission
- Low Income Consumer Advisory Task Force
- African American Resource Advisory Commission
- Building and Standards Commission
- Board of Adjustment
- City of Austin-LCRA Partnership
- Commission on Veterans Affairs
- Commission on Immigrant Affairs
- Emma S. Barrientos Mexican American Cultural Center Advisory Board
- Joint Inclusion Committee
- Joint Sustainability Committee
- Public Safety Commission
- Austin Water Resource Planning Task Force
- Central Health Board of Managers
- College Student Commission
- Hispanic/Latino Quality of Life Resource Advisory Commission

Methodology: Community Reports

Institute for Urban Policy Research & Analysis - The State of Black Lives in Texas	Center for Public Policy Priorities
Institutional Racism and Systemic Inequities	Integral Care Policy Priorities
American Diabetes Association Policy Prioritie	NAMI Policy Priorities
Livestrong Foundation Policy Priorities	Cancer Action Network Policy Priorities

Methodology: Informational Interviews

- CPPP
- Seton
- Integral Care
- Texas Council of Community Centers
- NAMI
- BlueBonnet Trails
- City of Austin Office of Sustainability
- City of Austin Equity Office
- Central Texas Food Bank
- Judicial Commission on Mental Health
- Austin Independent School District
- Texas Medical Association
- Asian American QoL Commission
- Aging QoL Commission
- LGBTQ+ QoL Commission
- Hispanic QoL Commission
- Asian-American QoL Commission
- Austin Public Health

Areas of Interest

Racism/Systemic Inequities	**Prevention & Wellness**	Access to Child Care
Adverse Childhood Events (ACES)/ Trauma informed care	Access to Behavioral Health/ Workforce Development	Community Health Workers
LGBTQ+ friendly	Mother Friendly	Health in All Policies

Evaluation Criteria

- Political feasibility
- Financial feasibility
- Legal feasibility
- Community Engagement/Readiness
- Equity
- Health Outcomes
- Tracking and Evaluation

Results: Top 3 Policies

- City requirement to capture and analyze comprehensive demographic data and transparently report outcomes.
- Healthier default beverages with restaurant/fast food children's menus
- Prohibit the sale of flavored tobacco products

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

THE STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 5

Receive and discuss an update on the development of Central Health Board reporting dashboards, and reporting associated with the Fiscal Year 2020 Budget Resolution.

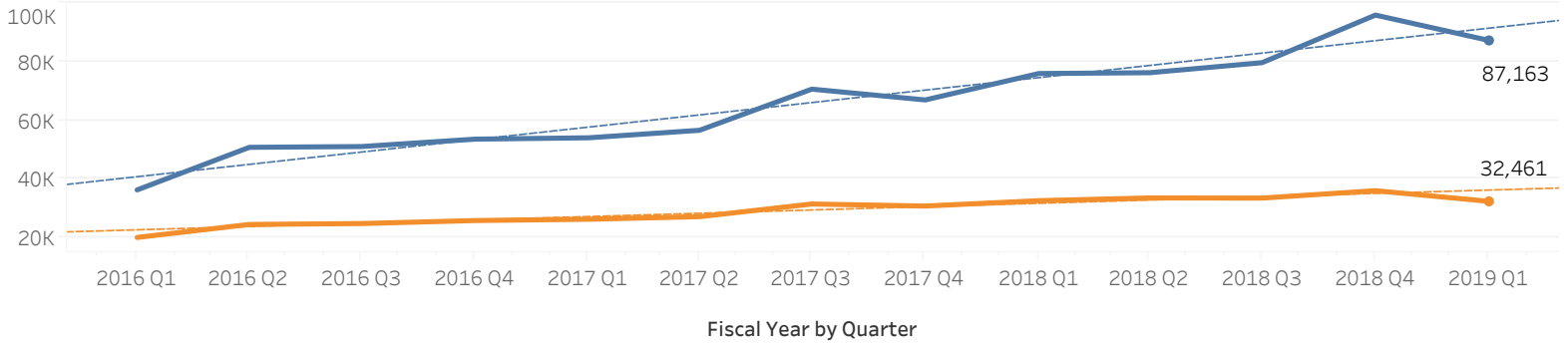
FY2019 CCC Preliminary Reporting

Count Type Encounters Patients

CENTRAL HEALTH

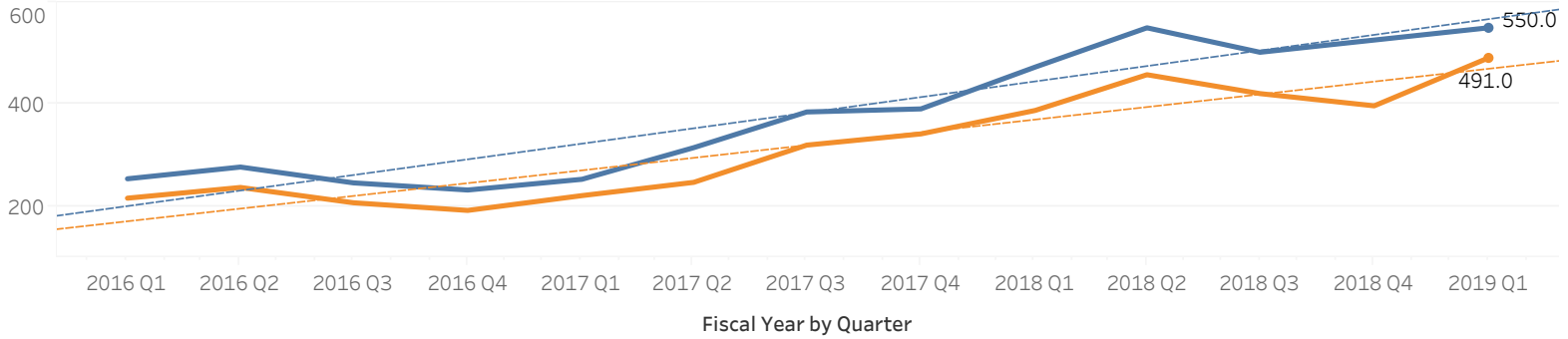
Community Care COLLABORATIVE

CCC Primary Care



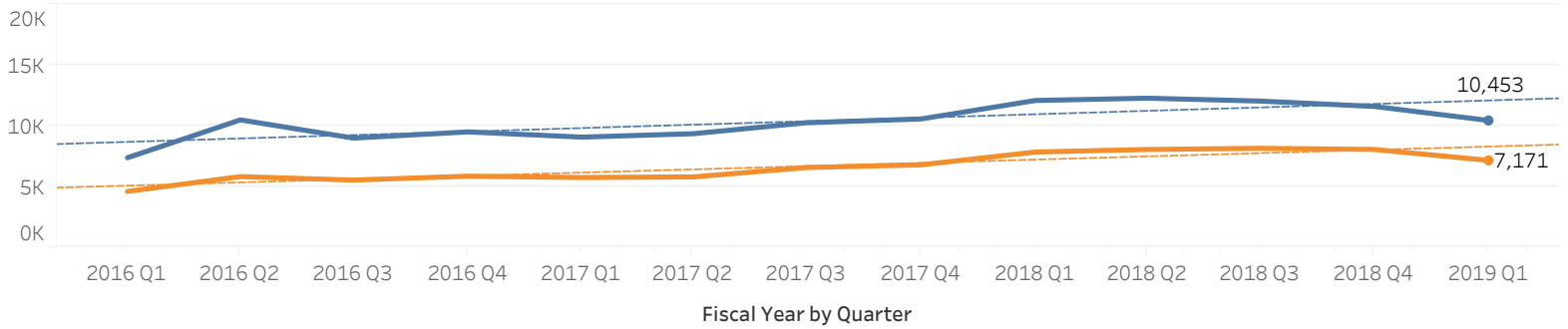
***Primary care summary:** The preliminary encounter count is 87,163 and the preliminary patient count is 32,461 for Q1 of FY2019. The overall trend for encounters and patients is an increase over time. Multiple services provided to a patient on the same day are collapsed into a single visit. FY 2019, particularly the most recent quarter, may represent an undercount due to billing cycle lags.

CCC Urgent Care



****Urgent care summary:** The preliminary encounter count is 550 and the preliminary patient count is 491 for Q1 of FY 2019. The overall trend for encounters and patients is an increase over time. FY 2019, particularly the most recent quarter represents an undercount of urgent care patients and encounters due to a typical 95-day billing cycle lag. Urgent care includes the following providers: FastMed, Nextcare, RediClinic and Benchmark.

CCC Primary Care Dental Encounters



*****Primary care dental summary:** The preliminary encounter count is 10,453 and the preliminary patient count is 7,171 for Q1 of FY 2019. The overall trend is an increase over time. FY 2019, particularly the most recent quarter may represent an undercount due to billing cycle lags. Dental encounters were identified by billing procedure codes that indicated a dental intervention or by place of service that indicated a dental office. Specialty dental is not included.

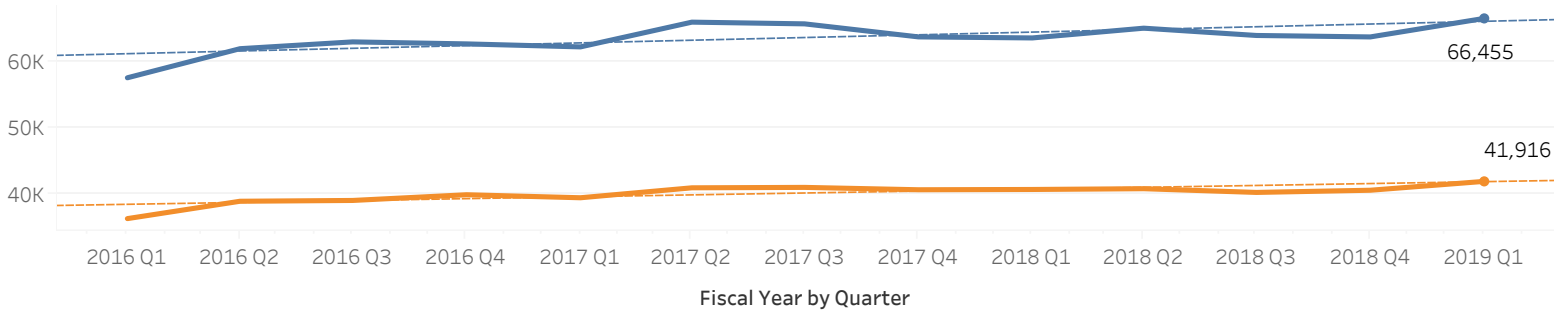
FY2019 CUC Preliminary Reporting - Medical, Behavioral Health, and Dental Services

Count Type Patients Visits

CENTRAL HEALTH

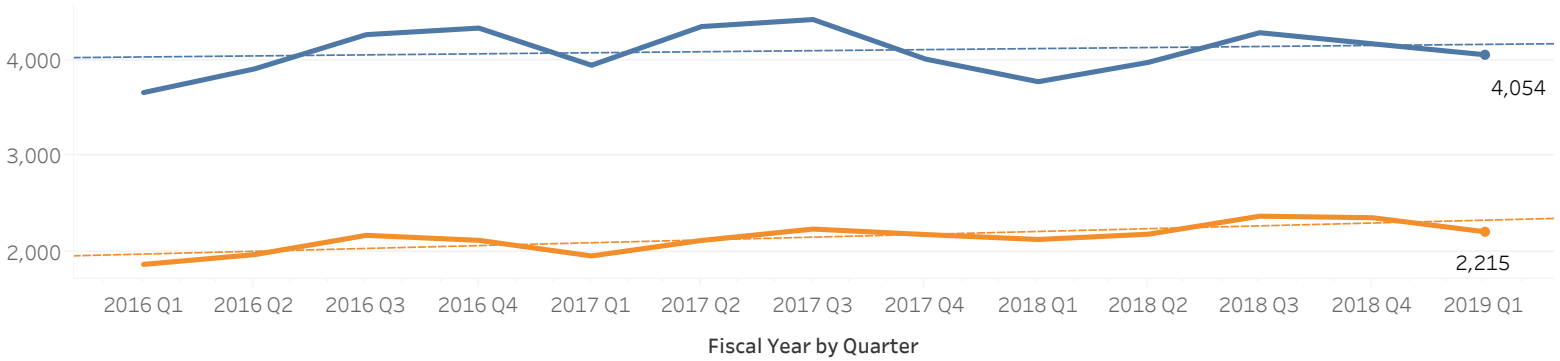
CommUnityCare

CUC Medical



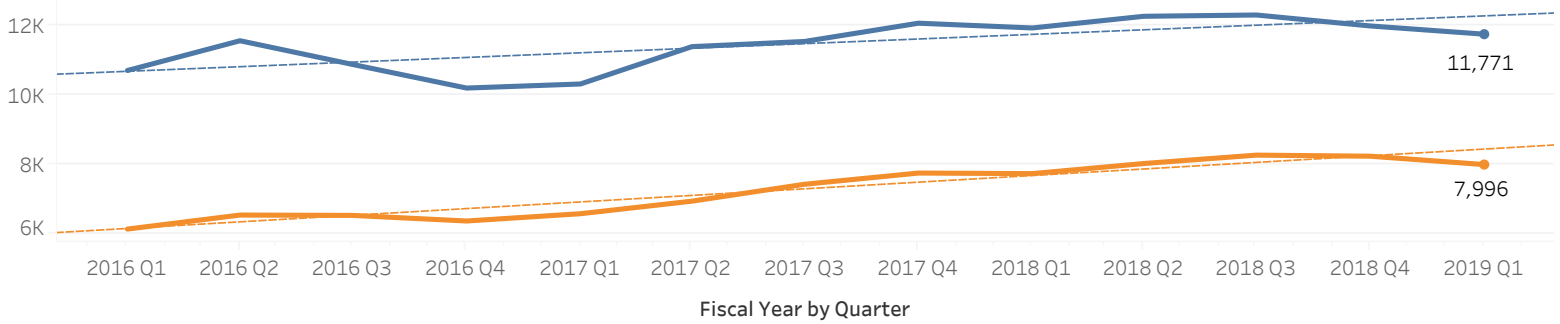
***Medical care summary:** The preliminary encounter count is 66,455 and the preliminary patient count is 41,916 for Q1 of FY2019. The overall trend for encounters and patients is an increase over time. Multiple services provided to a patient on the same day for the same service line are collapsed into a single visit. FY 2019, particularly the most recent quarter, may represent an undercount due to billing cycle lags.

CUC Behavioral Health



****Behavioral health care summary:** The preliminary encounter count is 4,054 and the preliminary patient count is 2,215 for Q1 of FY 2019. The overall trend for patients is an increase over time. FY 2019, particularly the most recent quarter may represent an undercount due to billing cycle lags. These encounters include therapeutic encounters provided by CUC and Integral care staff at CUC locations. They do not include behavioral health intervention services.

CUC Dental Services



*****Dental care summary:** The preliminary encounter count is 11,771 and the preliminary patient count is 7,996 for Q1 of FY 2019. The overall trend for encounters and patients is an increase over time. Multiple dental services provided to a patient during the same visit is collapsed into a single visit. FY 2019, particularly the most recent quarter, may represent an undercount due to billing cycle lags.

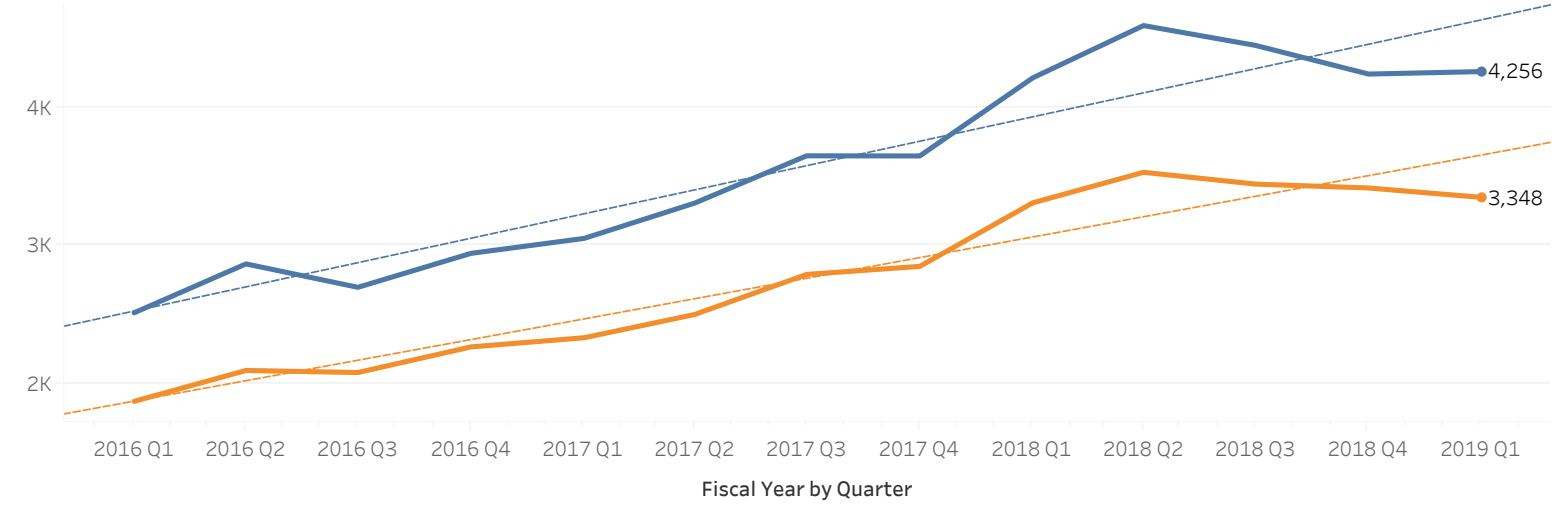
FY2019 CUC Preliminary Reporting - Specialty and Ancillary Services

Count Type Patients Visits

CENTRAL HEALTH

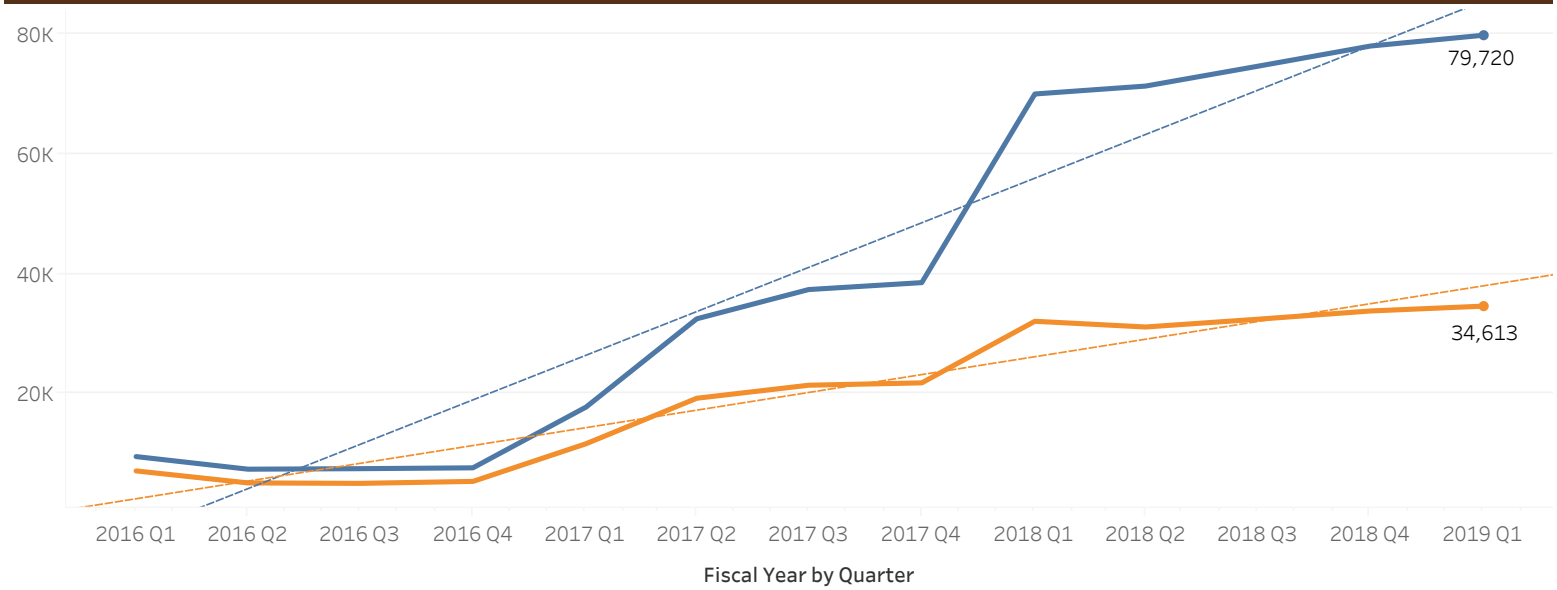
CommUnityCare

CUC Specialty



***Specialty care summary:** The preliminary encounter count is 4,256 and the preliminary patient count is 3,348 for Q1 of FY2019. The overall trend for encounters and patients is an increase over time. Multiple services provided to a patient on the same day for the same service line are collapsed into a single visit. FY 2019, particularly the most recent quarter, may represent an undercount due to billing cycle lags.

CUC Ancillary



****Ancillary care summary:** The preliminary encounter count is 79,720 and the preliminary patient count is 34,613 for Q1 of FY 2019. The overall trend for encounters and patients is an increase over time; the sharp increase is due to the implementation of new contracting to cover the costs of visits with nutritionists, clinical pharmacists, nurses, social workers, and respiratory therapists in FY 2018. FY 2019, particularly the most recent quarter may represent an undercount due to billing cycle lags.

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

THE STRATEGIC PLANNING COMMITTEE

October 15, 2019

AGENDA ITEM 6

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