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.

STRATEGIC PLANNING COMMITTEE MEETING

Wednesday, June 9, 2021 1:00 p.m.

Via toll-free videoconference[1]
Members of the public may observe and participate in the meeting by using the Ring Central meeting link below (copy and paste into your web browser):
https://meetings.ringcentral.com/j/1461630112?pwd=K0hQZnlUakFHR1VpaisveWtsTG0vdz09
Password: 625484

Or to participate by telephone only:
Dial: (888) 501-0031
Meeting ID: 146 163 0112

And/or
In person at:
Central Health Administrative Offices
1111 East Cesar Chavez Street
Austin, Texas 78702
Board Room

A member of the public who wishes to make comments during the **Public Communication** portion of the meeting must properly register with Central Health ***no later than 11:30 a.m. on June 9, 2021***. Registration can be completed in one of two ways:

- Complete the virtual sign-in form at https://www.centralhealth.net/meeting-sign-up/, or
- Call 512-978-9190. Please leave a voice message with your full name and your request to comment via telephone at the meeting.

PUBLIC COMMUNICATION

Public Communication will be conducted in the same manner as it has been conducted at in-person meetings, including setting a fixed amount of time for a person to speak and limiting

Board responses to public inquiries, if any, to statements of specific factual information or existing policy.

COMMITTEE AGENDA[2]

1. Review and approve the minutes of the May 12, 2021 meeting of the Strategic Planning Committee. (*Action Item*)

2. Receive and discuss an update on the proposed Fiscal Year (FY) 2022 Strategic Priorities, including Systems Planning for immediate service delivery focus areas (Part I):
    a. Healthcare for the Homeless and Respite Care; and
    b. Specialty care initiatives. (*Informational Item*)

3. Receive an update on the data analysis of demographics and health disparities among the Central Health patient population. (*Informational Item*)

4. Receive an update on the FY 2021 and FY 2022 Strategic Priority to develop an equity focused system-of-care plan, including information about the consultant selected and grant funding to support the work. (*Informational Item*)

5. Confirm the next Strategic Planning Committee meeting date, time, and location. (*Informational Item*)

[1] By Emergency Executive Order of the Governor issued March 16, 2020, Central Health may hold a videoconference meeting with no Board members present at a physical meeting location. If the Governor's Executive Order is not extended, members of the Central Health Board of Managers may participate by videoconference with a quorum of the Board present at the physical location posted in this notice. In either case, members of the public are encouraged to view the meeting and provide public comment through one of the meeting links provided.

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

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 or participate via videoconference 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 or view 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.

Cualquier persona con una discapacidad que planee asistir o ver esta reunión y requiera ayudas o servicios auxiliares debe notificar a Central Health con la mayor anticipación posible de la reunión, pero no menos de dos días de anticipación, para que se puedan hacer los arreglos apropiados. Se debe notificar al Gerente de Gobierno de la Junta por teléfono al (512) 978-8049.

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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

June 9, 2021

AGENDA ITEM 1

Review and approve the minutes of the May 12, 2021 meeting of the Strategic Planning Committee.

MINUTES OF MEETING – MAY 12, 2021
CENTRAL HEALTH
STRATEGIC PLANNING COMMITTEE

On Wednesday, May 12, 2021, a meeting of the Central Health Strategic Planning Committee convened in open session at 1:01 p.m. remotely by toll-free videoconference. Clerk for the meeting was Briana Yanes.

Committee members present via video and audio: Chair Bell, Manager Brinson (left at 3:05 p.m.), Manager Motwani (arrived at 1:28 p.m.), Manager Jones (arrived at 1:23 p.m.) and Manager Valadez.

Board members present via audio and or video: Manager Zamora (arrived at 1:57 p.m.), Manager Greenberg

PUBLIC COMMUNICATION

Clerk's Notes: Public Communication began at 1:02 p.m. Anais Cruz introduced one speaker for Public Communication.

Members of the Board heard from: Ivan Davila

COMMITTEE AGENDA

1. **Review and approve the minutes of the April 14, 2021 meeting of the Strategic Planning Committee.**

Clerk's Notes: Discussion on this item began at 1:05 p.m.

Manager Valadez moved that the Committee approve the minutes of the April 14, 2021 meeting of the Strategic Planning Committee.

Manager Greenberg seconded the motion.

Chairperson Bell	For
Manager Brinson	For
Manager Jones	Absent
Manager Motwani	Absent
Manager Valadez	For

2. **Receive and discuss an update on Fiscal Year 2021 strategic priorities and Fiscal Year 2022 proposed strategic and operational priorities.**

Clerk's Notes: Discussion on this item began at 1:05 p.m. An update on Fiscal Year (FY) 2021 priorities and FY 2022 proposed priorities was presented. Mr. Mike Geeslin, President & CEO, began the presentation by recognizing the different types of board knowledge, which include culture updates, dashboards, annual reports, strategic objective updates, email updates, and biannual demographic reports. He noted that this update would be focused on strategic objectives. He reviewed the strategic timeline, which includes years 2018-2024. Ms. Monica Crowley, Chief Strategy and Planning Officer VP & Senior Counsel, then shared the Board defined objectives and how the adopted strategic priorities for FY 2021 move Central Health towards achieving the Board defined objectives.

Ms. Stephanie McDonald, VP of Enterprise Alignment and Coordination, and Ms. Rachel Hardegree, Senior Project Manager for the Healthcare Delivery Division, presented an update on Eastern Travis

County but noted that a full presentation would be coming to the Board at the May 26, 2021 Board of Managers meeting. They discussed the Hornsby Bend Health and Wellness Center and the Del Valle Health and Wellness Center.

Ms. Megan Cermak, Director of Public Health Strategy, Policy, and Disaster Response, presented on the pandemic response, specifically the funding and programmatic support. Mr. Ted Burton, VP of Communications, presented on engagement, outreach, and media surrounding the pandemic response.

Mr. John Clark, Chief Information Officer, presented on the FY 2021 strategic objective of Epic implementation. He announced that the go-live date for Epic was March 27, 2021. He noted that there were eleven months' worth of constructive build that went into the development and implementation of the system. Lastly, he stated that over 1,000 staff members have been trained during the process of this implementation.

Ms. Kit Abney-Spelce, Senior Director of Eligibility Services, presented on the FY 2021 strategic objective of eligibility services. She discussed the Central Health customer service center and how the Eligibility Call Center was transitioned to Central Health. She stated that eligibility and enrollment specialists now answer all calls at the call center. She also noted that in-person appointments resumed April 5, 2021, at the Northeast Health Resource Center and the Southeast Health and Wellness Center for individuals experiencing homelessness.

Ms. Cynthia Gallegos, Director of Service Delivery Operations, presented on the FY 21 strategic objective of specialty care access. She shared updates on IRIS Camera Expansion, which offers diabetic retinopathy screenings in the primary care medical home. She also shared updates on surgical podiatry, endocrinology, cardiology expansion, and dialysis.

Ms. Veronica Buitron-Camacho, Director of Medical Management, presented on the FY 2021 strategic objective of medical management expansion. She noted that eleven new staff members have been on-boarded and trained, which included five Health Management Liaisons, two Social Workers, two Registered Nurses, one Resource Eligibility Social Worker, and the Manager of Medical Management. She noted that with the additional team members, there is now additional outreach capacity with on-site staff at two additional Ascension Seton Facilities and virtually at St. David's hospitals. There is also a Special Populations Team to address congestive heart failure and end stage renal disease. Lastly, she noted that they have a post-acute skilled nursing facility transitions team.

Ms. Monica Crowley presented on the equity-based systems planning prioritization timeline. Ms. Sarita Clark-Leach, Director of Analytics and Reporting, presented on the disparity identification of hypertension and diabetes. Mr. Jonathan Morgan, Chief Operating Officer, presented on the proposed strategic priorities for FY 2022. Mr. Geeslin presented the proposed organization excellence priorities for FY 2022. Lastly, Ms. Crowley discussed next steps, which include deep dives on priorities at the June and August Strategic Planning Committee meetings, a Community Conversation on June 17 on proposed priorities, and the budget resolution adoption in September.

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

Manager Greenberg moved that the Committee adjourn.

Manager Valadez seconded the motion.

Chairperson Bell	For
Manager Jones	For
Manager Brinson	Absent
Manager Valadez	For
Manager Motwani	For

The meeting was adjourned at 3:49 p.m.

_____
Charles Bell, Chairperson
Central Health Strategic Planning Committee

ATTESTED TO BY:

_____
Cynthia Valadez, Secretary
Central Health Board of Managers

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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

June 9, 2021

AGENDA ITEM 2

Receive and discuss an update on the proposed Fiscal Year (FY) 2022 Strategic Priorities, including Systems Planning for immediate service delivery focus areas (Part I):

a. Healthcare for the Homeless and Respite Care; and
b. Specialty care initiatives.

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	June 9, 2021
Who will present the agenda item? (Name, Title)	Dr. Audrey Kuang; Dakasha Leonard; Cynthia Gallegos; Jonathan Morgan; Monica Crowley; Alan Schalscha
General Item Description	Proposed Strategic Priorities Deeper Dives - Systems-Based Planning Immediate Service Delivery Focus Areas (Part I) • Healthcare for the Homeless & Respite Care • Specialty Care
Is this an informational or action item?	Informational
Fiscal Impact	
Recommended Motion (if needed – action item)	N/A

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Each year, nearly one in four MAP enrollees (approximately 11,000 annually) experience homelessness.
2) The traditional healthcare system and methods of care delivery do not meet the needs of this complex and vulnerable subset of our population. Our data indicates that enrollees experiencing homelessness have worse health outcomes, are not as likely to receive behavioral health services when needed, and are more likely to utilize the emergency room for care.
3) Central Health is prioritizing improvements to services for persons experiencing homelessness in in its FY22 budget including expanded street medicine/mobile services and the addition of medical respite care.
4) Improving access to specialty care remains a priority focus area for Central Health in FY22.
5) Central Health plans to continue building on multi-year initiatives including podiatry services/diabetic limb salvage and outpatient routine dialysis while launching efforts to expand clinic access across multiple specialties and beginning development of service enhancements related to medical weight loss, cardiology diagnostics and transitions of care for patients with congestive heart failure, among others.

CENTRAL HEALTH

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Presentation
Estimated time needed for presentation & questions?	1.5 total (split into 2 parts)
Is closed session recommended? (Consult with attorneys.)	N/A
Form Prepared By/Date Submitted:	C. Gallegos/J. Morgan 6.3.2021

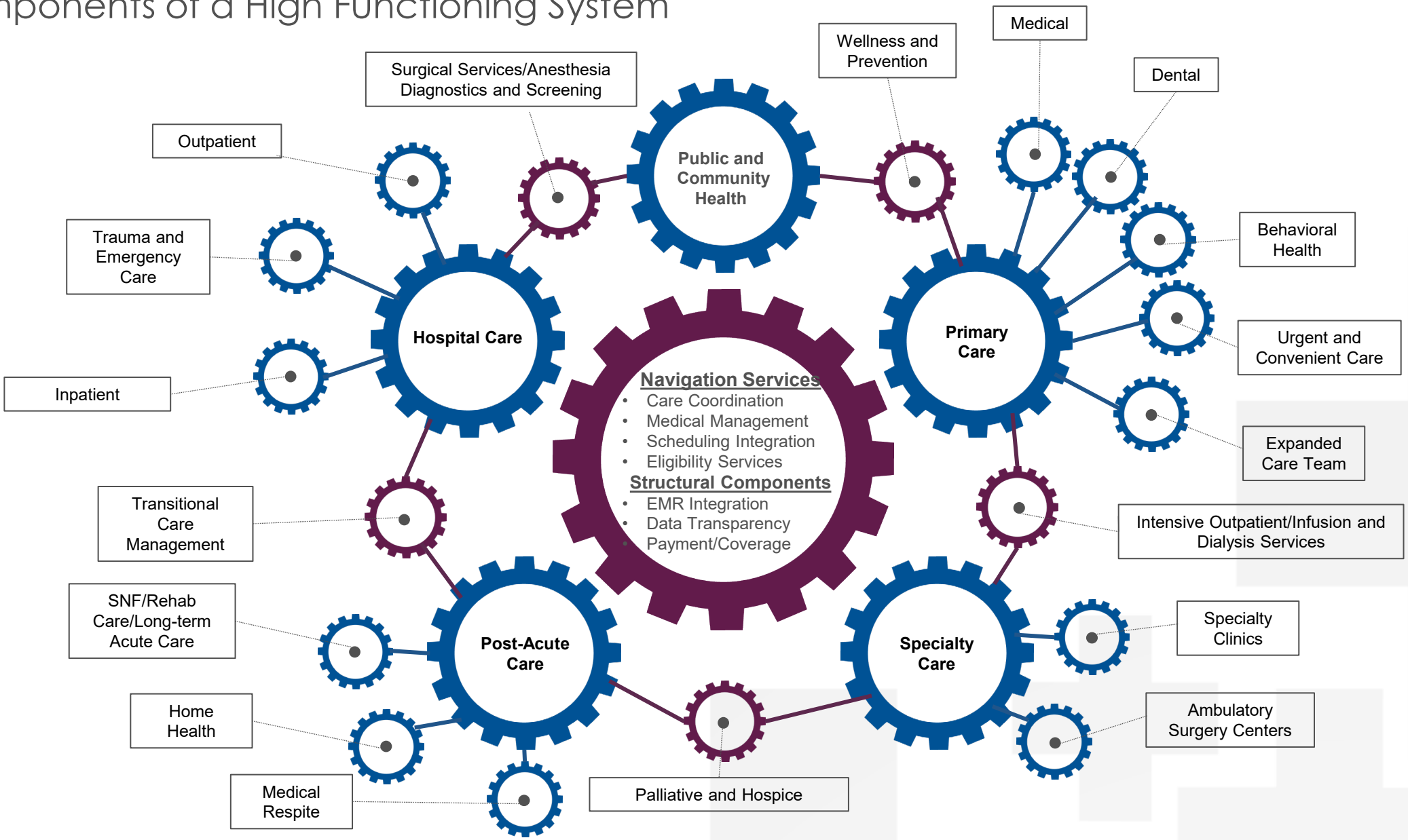
Update on Proposed Fiscal Year (FY) 2022 Strategic Priorities, Including Systems-Based Planning Immediate Service Delivery Focus Areas (Part 1):

a. Healthcare for the Homeless
b. Specialty Care Initiatives

Central Health Strategic Planning Committee
June 9, 2021

Dakasha Leonard, Service Delivery Operations Manager
Dr. Audrey Kuang, Clinical Lead, CommUnityCare Healthcare for the Homeless
Cynthia Gallegos, Service Delivery Operations Director
Jon Morgan, Chief Operating Officer
Alan Schalscha, Chief Medical Officer
Monica Crowley, Chief Strategy Officer

Components of a High Functioning System



Proposed Strategic Priorities: FY22

Objective 1: Develop and execute health care delivery based on people and place

- Eastern Travis County Site expansions
  - Hornsby Bend
  - Del Valle
  - Colony Park

Objective 2: Implement patient-focused and coordinated health care system

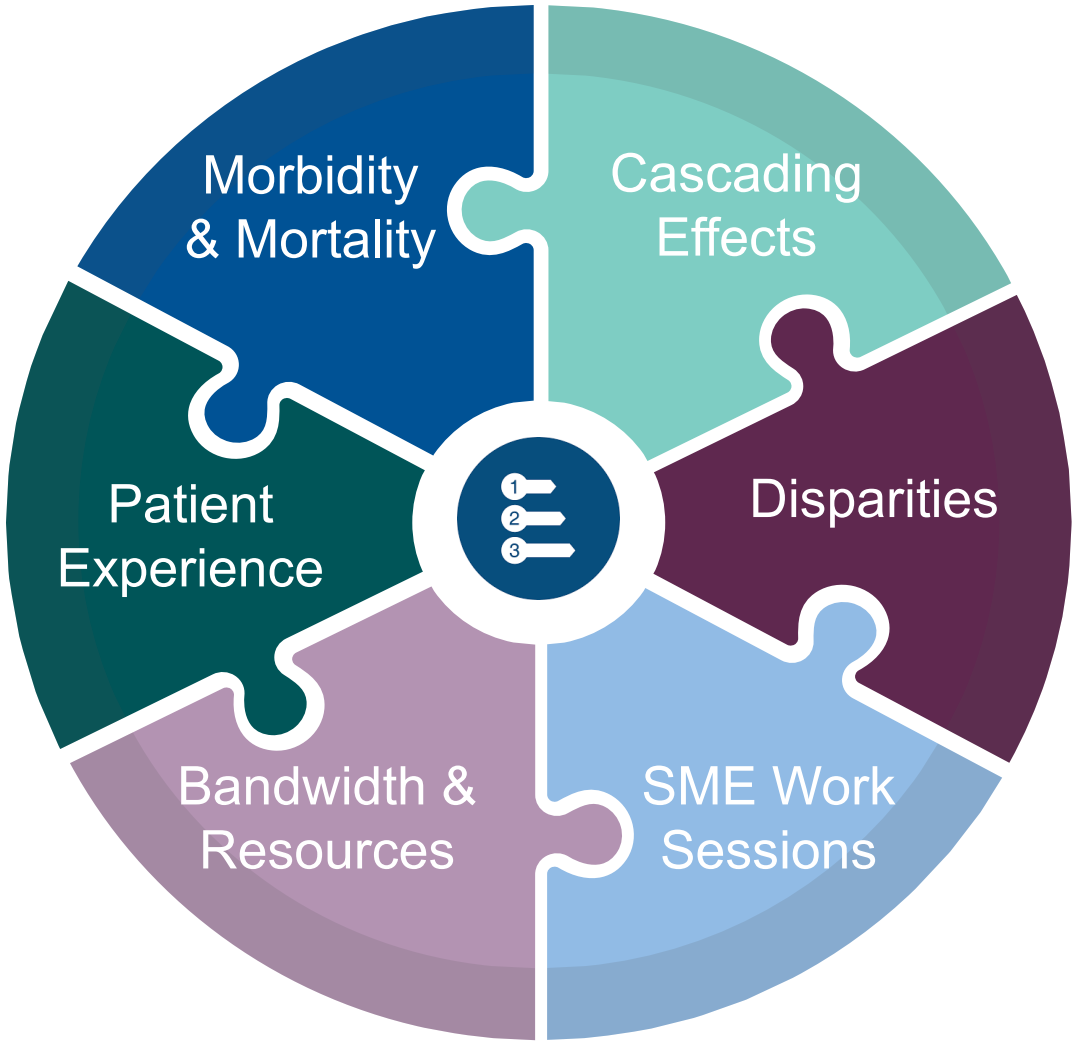
- Systems-Based Planning & Health Equity - Phase III and IV
  - Strategic services plan
  - Operational implementation plan
  - Operational financial plan
- Systems-Based Planning & Health Equity - Immediate Service Delivery Focus Areas
  - Specialty care access
  - Health care for the homeless
  - Behavioral health
  - Substance use disorder
  - Clinical and patient education
  - Transitions of care

Objective 3: Sustainable financial model for health care delivery

- Ensure sustainable hospital service funding model that provides measurable timely access and high-quality care
- Ensure long term efficiency in land use
  - Brackenridge/Downtown Campus
  - Administration consolidation

Prioritization Factors

- Impact on morbidity and mortality
- Drive multiple downstream improvements
- Reduce disparities and promote health equity
- Close gaps identified by clinical subject matter experts
- Availability of resources and clinical partner bandwidth
- Responsive to patient surveys and care team feedback



Agenda - Healthcare for the Homeless

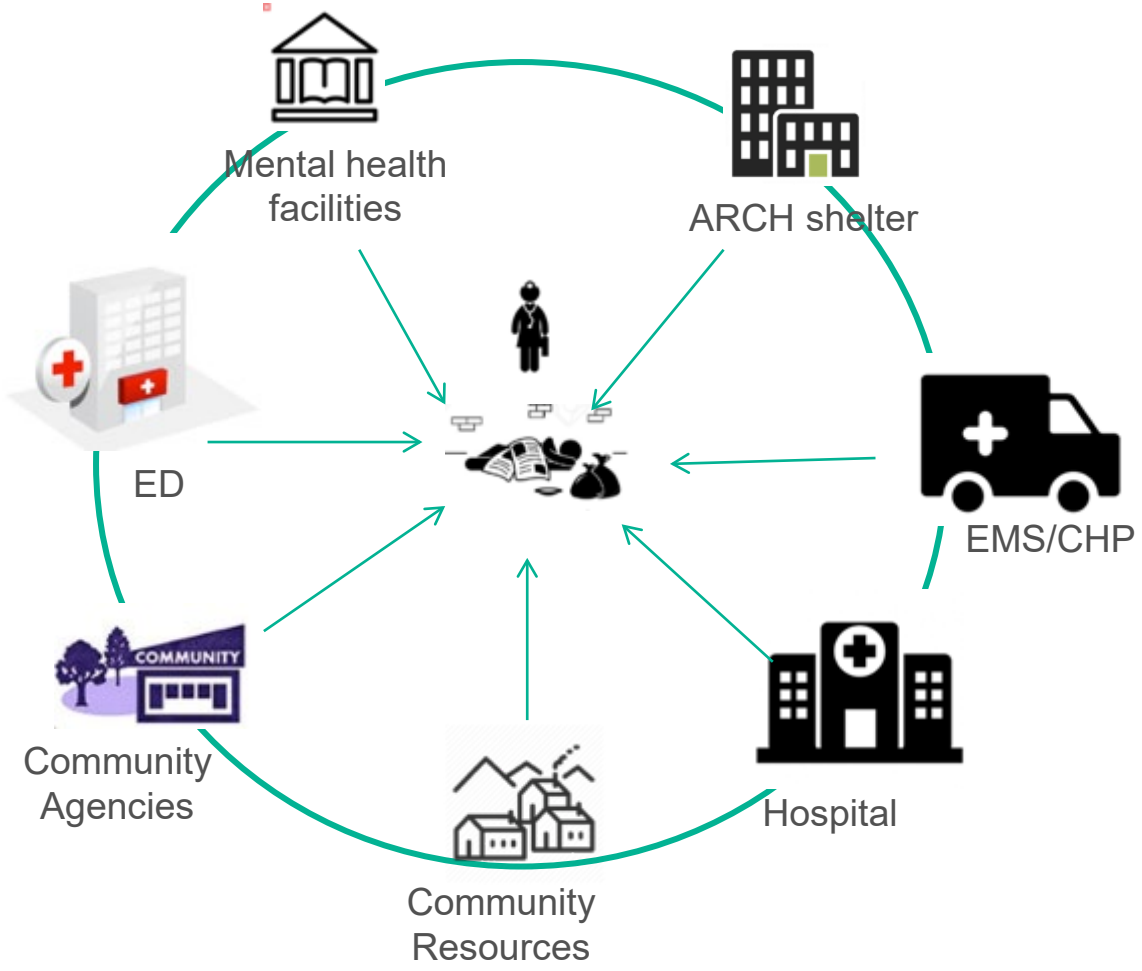
Background

- Current Healthcare for the Homeless

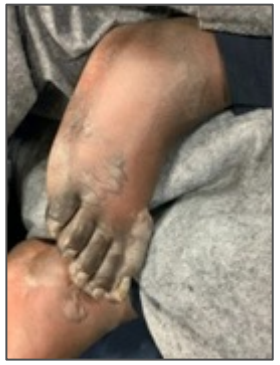
Gaps in Care/ Areas for Expansion

- Respite
- Street Medicine Expansion
- Case Management

Healthcare for Persons Experiencing Homelessness in Austin Today



Care Across the Continuum



Cold Weather Shelter-PEC (Dr Kuang) 2-19-21

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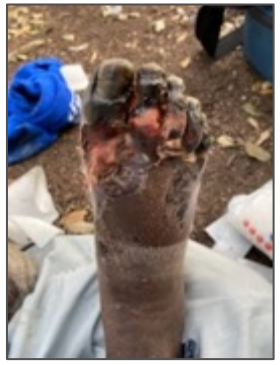
Dell Seton (Dr. Mercer) 2-20-21

→



Street Med (Matt Hunt) 3-11-21

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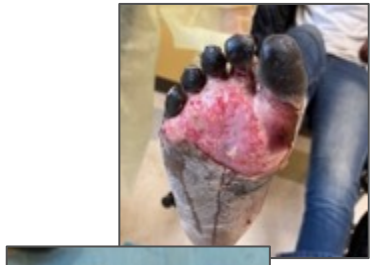

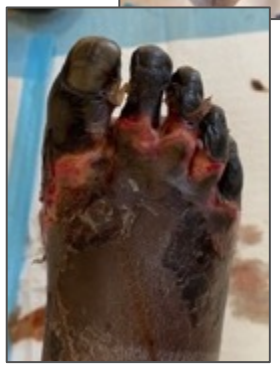

CareCo (Dr. Peele) 3-12-21

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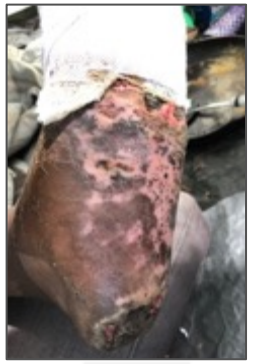


Street Med (CHP) 3-17-21

→

Dell Seton

Central Health Heritage Park 3-24-21

Current Healthcare for the Homeless Teams

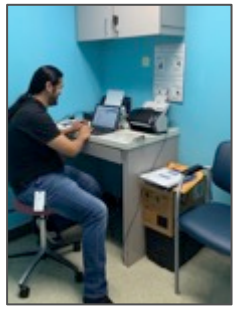
ARCH Clinic
(2004)

Mobile Team
(2013)

Street Med Team
(2014)

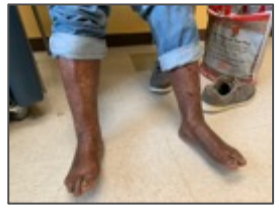
Care Connections
Clinic
(2019)

Inside Care Connections Clinic



Eligibility- MAP

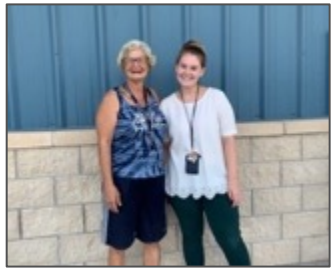
Podiatry



Wound Clinic

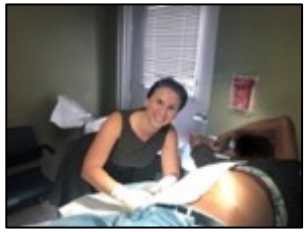
Primary Care

Hep C- GI clinic



Intensive Case Management/ SOAR

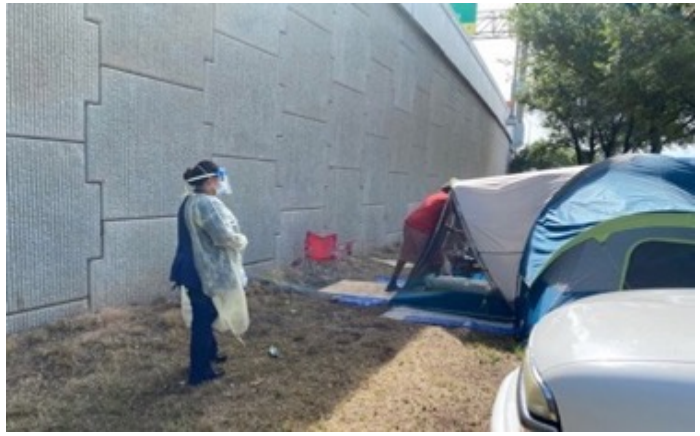
Paracentesis - Hospital

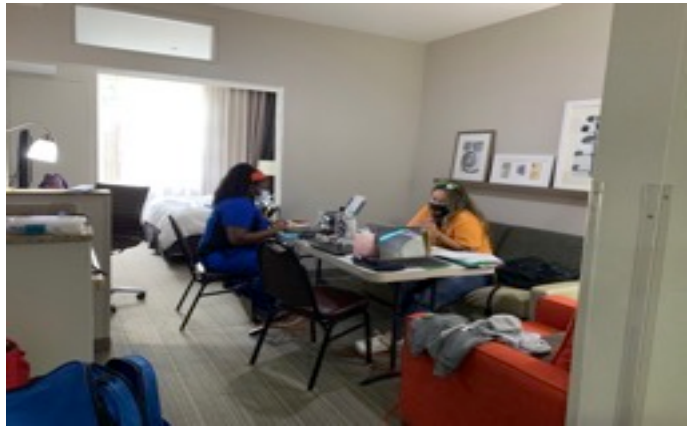


Special Sauce

- **Sophisticated, integrated, complex services are the foundation of care, but equally important are:**
  - Desire for true, heartfelt connection
  - Respect for all as fellow human beings
  - Interest in working with people on their priorities, at their pace
  - Understanding that housing is essential to health.

COVID response:
Testing, Prolodge Care, Vaccinations





Community Partnerships are Critical

FRONT STEPS

Caritas of Austin

lifeworks

THE SALVATION ARMY

Integral Care

ECHO

CENTRAL HEALTH

St David's

Seton Healthcare Family

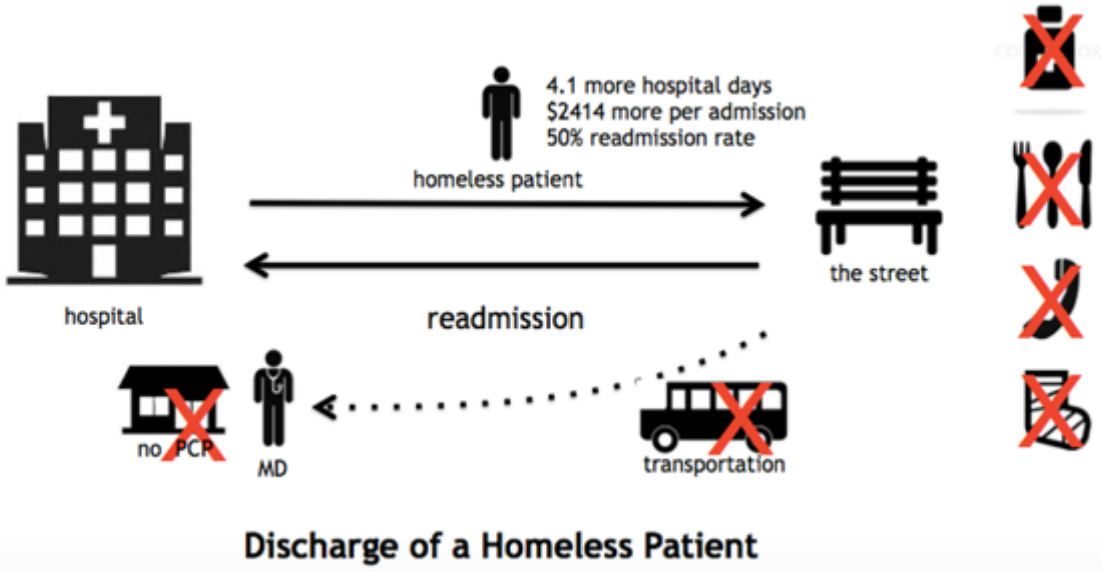
The University of Texas at Austin
Dell Medical School

Gaps in Care

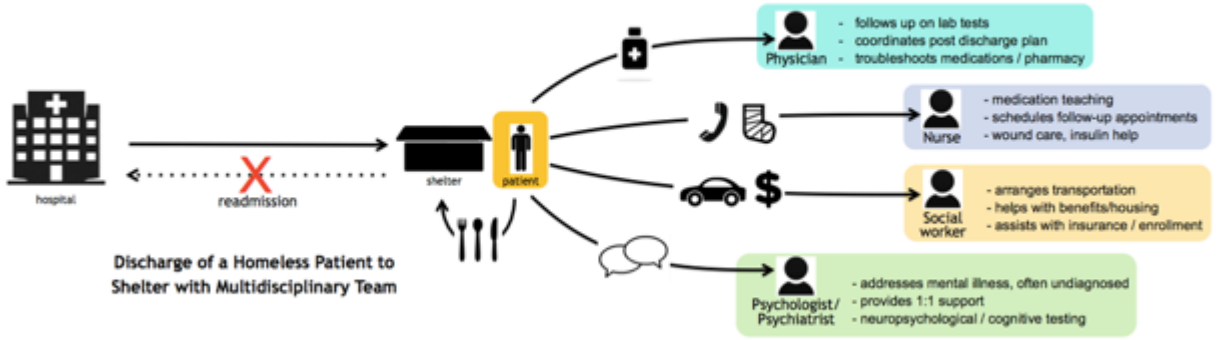
- Medical respite
- Street/mobile medicine
- Case management
- CareCo expansion (North)
- Access mental health

Why Medical Respite is Needed

Respite care is short term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services so they can heal.



Discharge of a Homeless Patient



Discharge of a Homeless Patient to Shelter with Multidisciplinary Team

Respite Decreases Hospital Readmissions and ED Usage

On ONE day at Dell Seton
(10/21/19)

109 patients
(medicine service)

PEH
24 patients
(22%)

Readmission in 30 days:
54%*

*only to Seton Hospitals

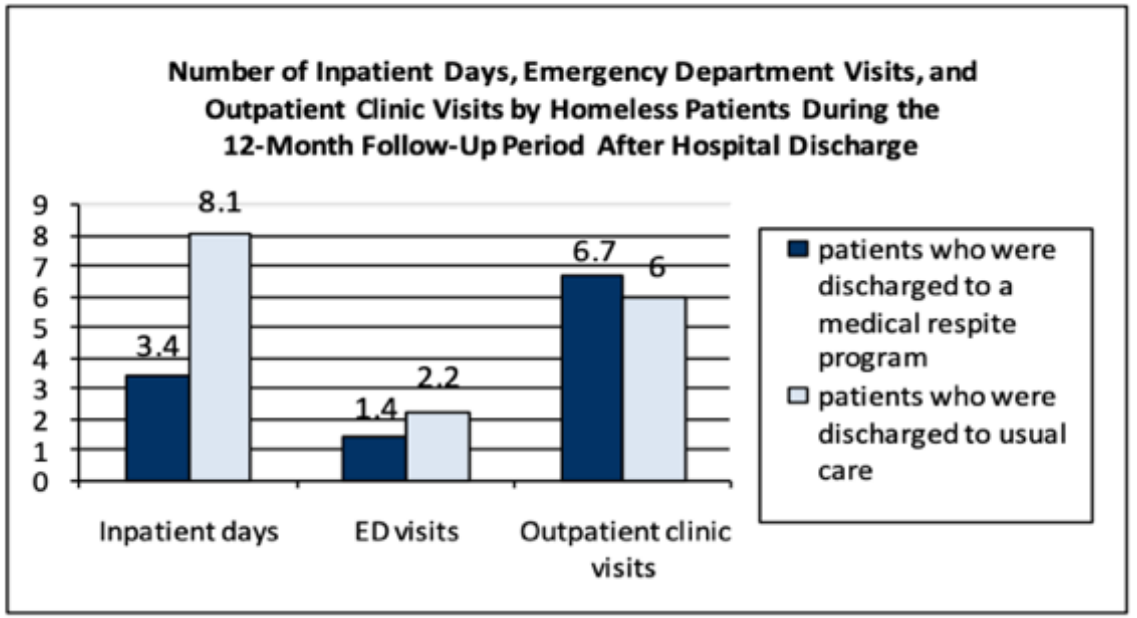


Figure 1: Hospital and clinic utilization before and after medical respite program participation

Source: Buchanan, D., Doblin, B., Sai, T., & Garcia, P. (2006). The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health, 96*(7), 1278–1281.

Respite in Austin

Central Health proposed pilot

- “A New Entry’s” non-licensed recovery center
- 1808 Webberville Rd., Austin
- 20 beds

Services will include:

- Initial nursing assessment by RN
- Bed
- 3 meals and fruit or snacks between meals.
- Laundry access
- Some supervision provided by 24/7 staff available at the facility

Respite in Austin

Requested Funding includes:

- Use of “A New Entry’s” staff to support the program
- A designated medical respite team:
  - Registered nurse with wound care/ER experience
  - Community health worker
  - LCSW

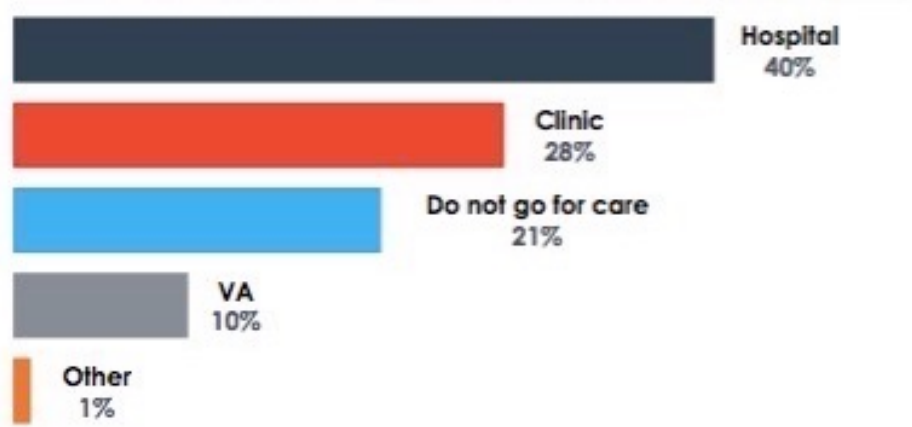
Why Mobile/Street Med is Needed

1. PEH either don't go for care, can't get to care or use hospitals for regular care. This was exacerbated even more by the pandemic.

2. We need care teams that are nimble and flexible.
   - Natural Disasters- Hurricane Harvey (2017)
   - Winter Storm (2021)
   - Pandemic- drive thru testing, Prolodge care

Mobile Team at LBJ HS after Hurricane Harvey

Where do PEH go in Austin when they don't feel well?



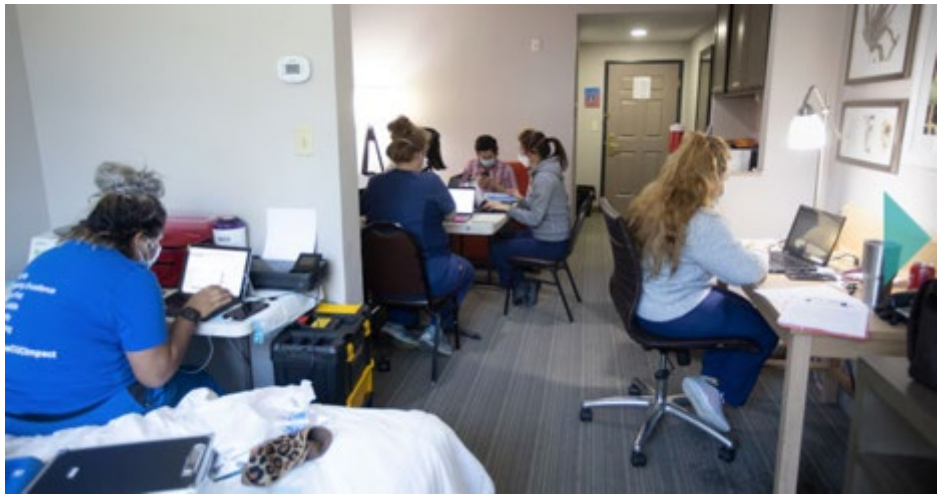
ECHO PIT count data, 2017

Mobile/Street Teams - Current

Current Street/Mobile Medicine

- Encampments- North, South, Central
- Street MAT (1 day)
- Community First Village
- Sunrise Church
- Camp Esperanza*
- Terrazas Library*
- Prolodges*
- COVID- testing/vaccines*

Street Med team providing wound care



Mobile team at the Prolodge

Mobile/Street Future

Another Mobile/Street Team could:

- Support Medical Respite program
- Support PSH program
- Targeting hospital discharges
- Targeted populations - PEH with HIV
- COVID support

Mobile/Street Med team:

- provider
- nurse
- 1-2 medical assistant/MAC
- case manager
- (mental health, CHW)

Mobile team at state camp

Mobile team providing care under bridge

Why Case Management/CHWs are Needed

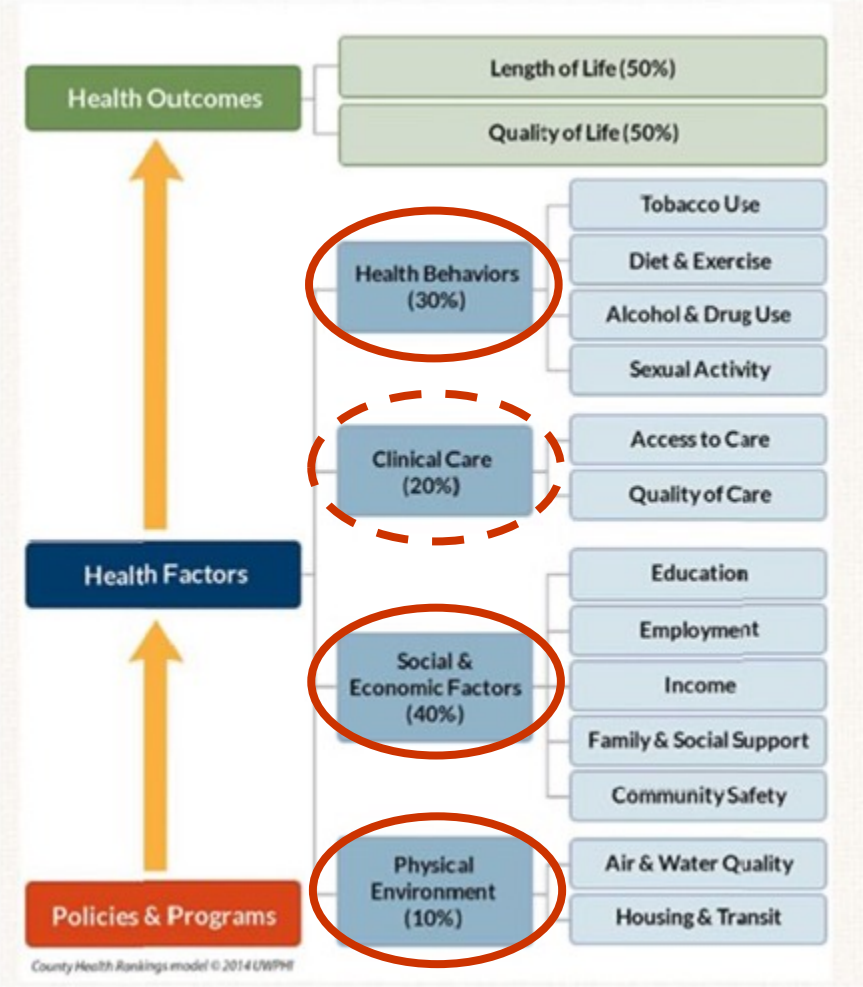
Traditional Role Clinic Case Manger:

- Assess needs and link to resources.
- In health clinic- scheduling appts, helping with transportation.
- Recent expansion to SDOH

Healthcare for the Homeless Environment

Additional assistance is needed because of limited transportation, limited communication, lack of social support and higher prevalence of severe mental illness
and addiction

- Persistent and assertive outreach
- Active assistance
- SDOH focused

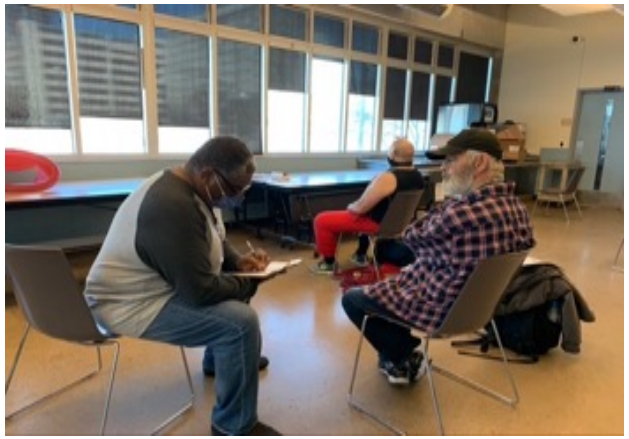


Expansion of Case Management and Community Health Workers

Addresses Social Determinants of Health

- Assist with housing needs or coordinate with community agencies
- Assist with Coordinated Assessment for Housing
- Assist with disability (SOAR), insurance, food stamps
- Able to meet patients at their appointments or where they live

Lauren Christiansen (right), Case Manager



Richard Johnson (left), CHW

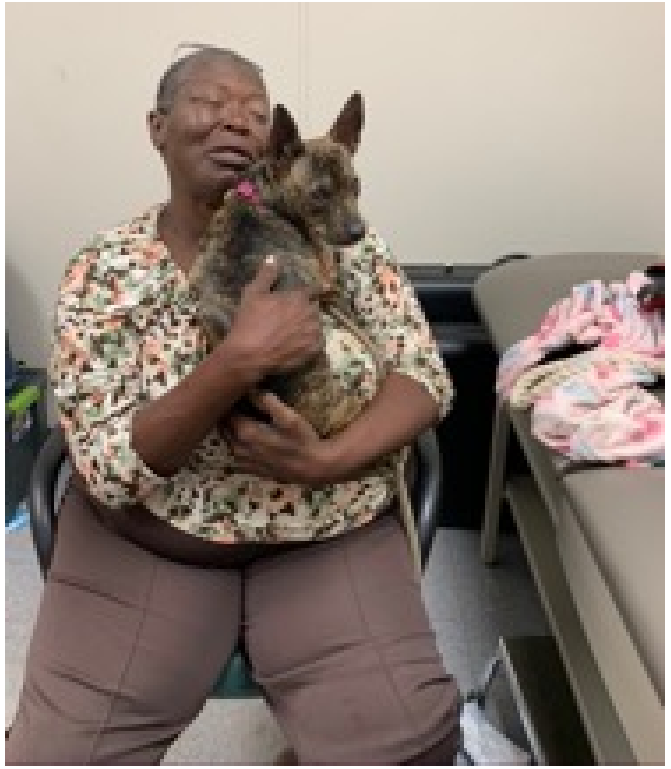
The Impact of One Case Manager

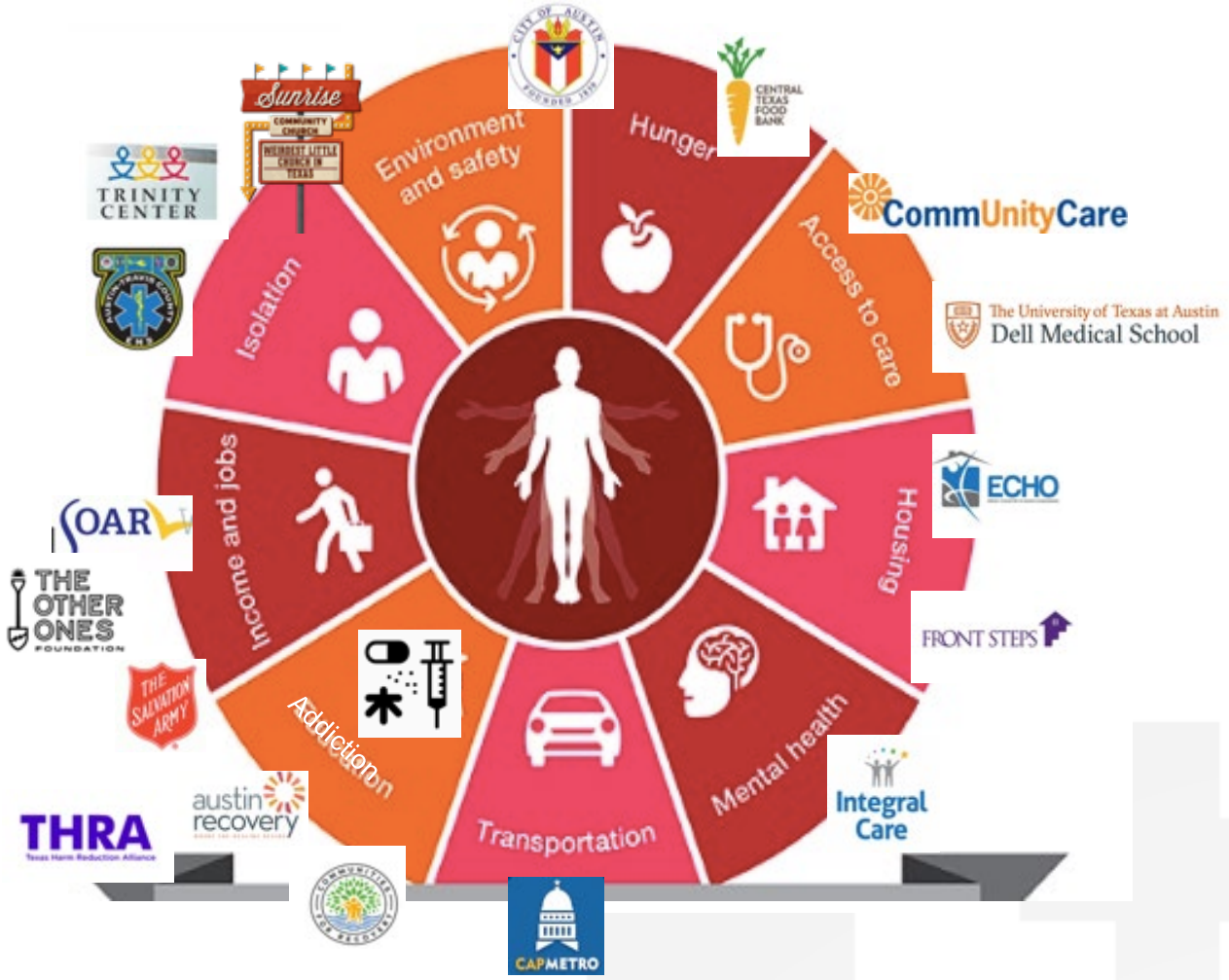
Patient

- 60 year-old woman at State Camp
- Severe heart failure
- Three hospitalizations in the last two months
- Needing/requiring readmission-refusing

Outcomes

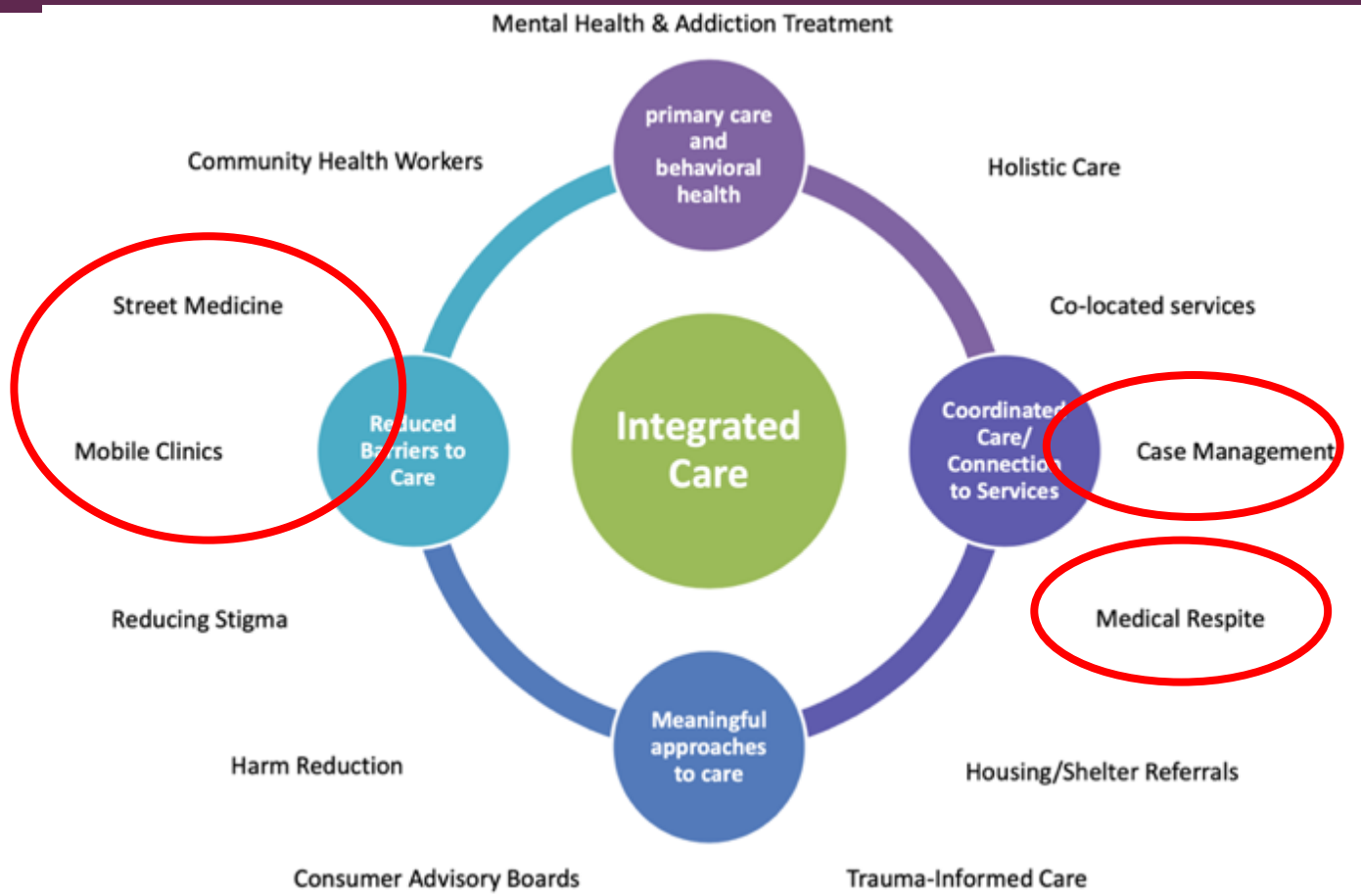
- Arranged housing for her dog at Austin Animal Shelter
- Called community agency at encampment to lock up her belongings when she went to hospital.
- Called HEB to have meds delivered
- Coordinated with CH to help with food stamp paperwork, MAP reenrollment, MetroAccess paperwork
- Coordinated with Integral Care for treatment of severe depression
- Assist with application for SSI (SOAR)




Environment and safety
Hunger
Access to care
Housing
Mental health
Transportation
Addiction
Income and jobs
Isolation
Sunrise
TRINITY CENTER
CENTRAL TEXAS FOOD BANK
CommUnityCare
The University of Texas at Austin
Dell Medical School
ECHO
FRONT STEPS
Integral Care
CAPMETRO
austin recovery
THRA
Texas Harm Reduction Alliance
THE SALVATION ARMY
THE OTHER ONES FOUNDATION
SOAR

Conclusions

- People experiencing homelessness (PEH) are medically and socially complex, and highly vulnerable, with disproportionately higher morbidity and mortality.
- The health system is fragmented, provider-centric, and ill-equipped to address social determinants of health.
- Current system needs include Medical Respite, Intensive case management support, Mobile/street medicine teams.
- An integrated, multidisciplinary approach is needed to improve outcomes with patients with multiple co-morbidities and many complex needs.



FY22 Proposed Initiatives

- Acquire mobile unit to support street medicine teams
- Fund additional CUC mobile/street team configuration to support homeless/PSH
- Expanded Infectious Disease at Care Co
- Medical Respite
- Women-only safe respite space and wheelchair accessible spaces for respite care

DISCUSSION

Specialty Care Access- Priority Initiatives

Clinical Capacity Expansion

- Cardiology
- Endocrinology
- Nephrology
- Neurology
- Podiatry
- Rheumatology
- Wound Care
- eConsults

Specialty Service Expansion

- Podiatry Surgical Services
- Outpatient Dialysis
- Cardiology Diagnostics and Transitions
- Medical Weight Loss

Clinical Capacity Expansion

- **20,000+ MAP & MAP Basic enrollees are diagnosed with 2 or more chronic diseases**
- **Reducing wait lists and improving access to specialty services within medical homes is an important component of timely diagnosis and management of chronic diseases**
- **Each year, Central Health works with partners across the health system to expand capacity, introduce new models of care, and reduce wait times**
- **<u>Proposed Initiative</u>: Partner with CommUnityCare and other community specialists to add clinic capacity, provide enhanced care team support and expand use of technology for referrals and eConsults for selected specialties**

Specialty Care Integration within FQHC's

<u>Expand</u>

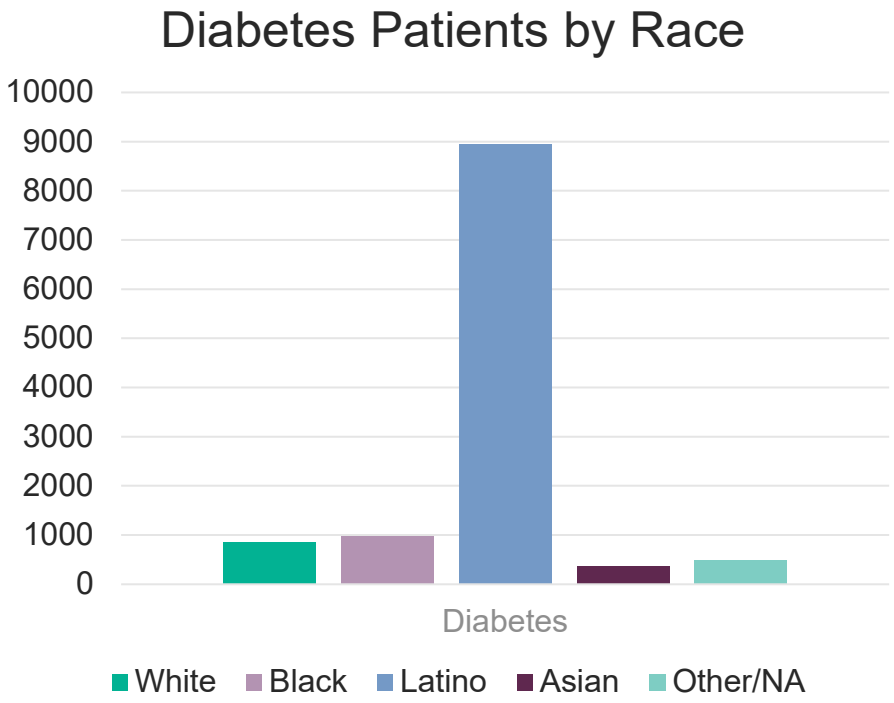
- Cardiology
- Endocrinology
- Nephrology
- Podiatry
- Rheumatology
- Wound Care
- eConsults

<u>Introduce</u>

- Neurology

Podiatry Services

- **Timely access to podiatry services is important for the comprehensive treatment of Central Health's 13000 enrollees diagnosed with diabetes**
- **Over the past two years, Central Health has worked closely with CommuUnityCare to introduce podiatry and wound care services in the primary care environment**
- **In FY22, Central Health will continue building podiatry infrastructure, including expanded clinical capacity and diabetic limb salvage surgeries**



Implemented Initiatives

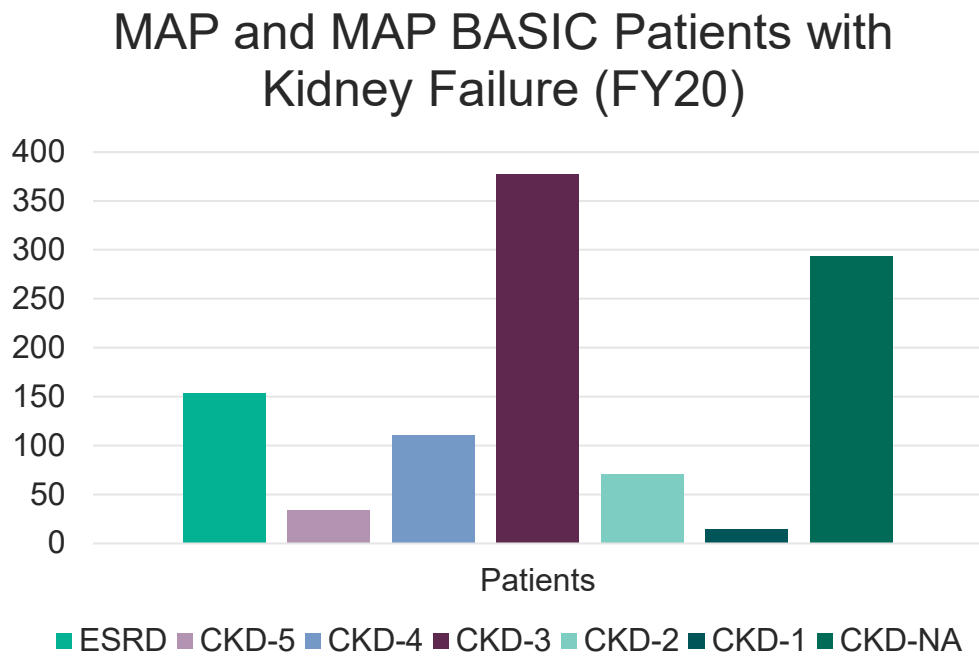
- Introduce Podiatry in Primary Care
- Expanded Clinical Capacity
- Wound Care & DME Expansion

Proposed Initiatives

- Expand Clinical Capacity
- Podiatry Surgical Services

Outpatient Dialysis

- **Approximately 35 MAP enrollees diagnosed with End-Stage Renal Disease (ESRD) at any point in time**
- **In recent years, Central Health worked with partners to establish primary care-based nephrology services, develop case management supports and enroll eligible patients into long-term coverage programs for access to dialysis**
- **Outpatient and home-based routine dialysis will reduce mortality and hospitalization rates and improve quality of life for enrollees with ESRD**
- **Proposed Initiatives**:
  - Expand clinical capacity
  - Scale and optimize current year efforts to contract with dialysis facilities and nephrology groups to provide outpatient dialysis
  - Introduce disease-specific nutrition support services for enrollees with chronic kidney disease



Implemented Initiatives

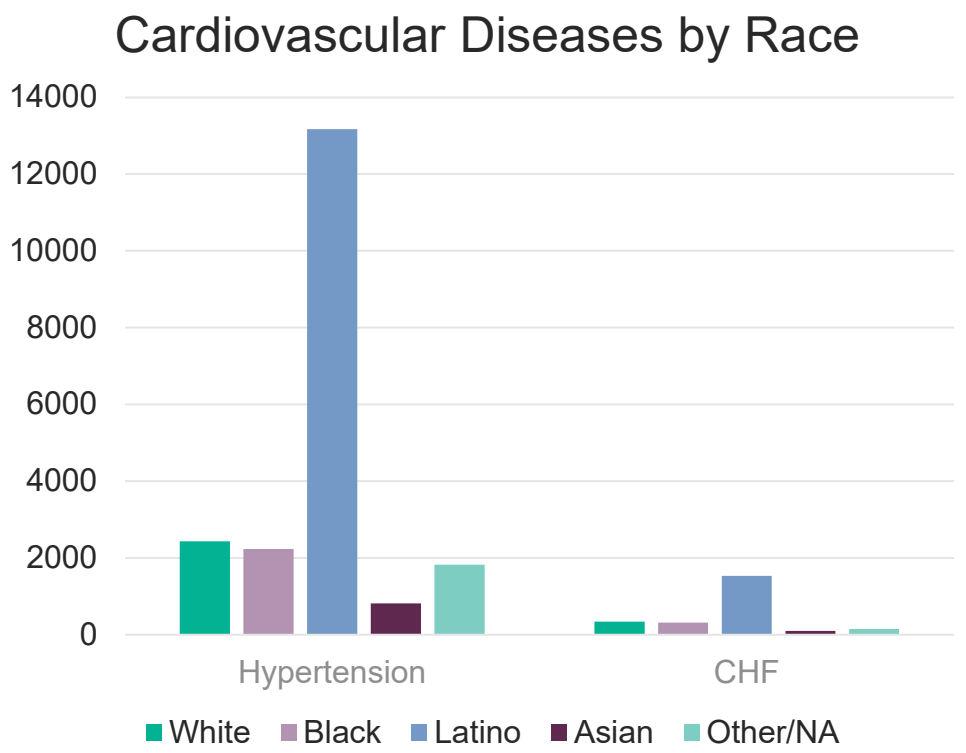
- Coverage Program Transitions
- ESRD Case Management
- Nephrology Integration in FQHC

Proposed Initiatives

- Transitional Dialysis Program
- Expanded Clinical Capacity
- Kidney Disease Nutrition Services

Cardiology Diagnostics and CHF Transitions

- **Hypertension affects 24% (more than 20,000) MAP and MAP BASIC enrollees annually**
- **Black enrollees are 1.75 times as likely to have a hypertension diagnosis than our overall enrollee population**
- **Enrollees experiencing homelessness are more likely to be diagnosed with hypertension that housed enrollees**
- **Proposed Initiatives for FY22:**
  - Expand cardiology clinic capacity
  - Enhanced access to cardiology diagnostics
  - Design and implement transitions of care for complex, high risk enrollees with congestive heart failure



Implemented Initiatives

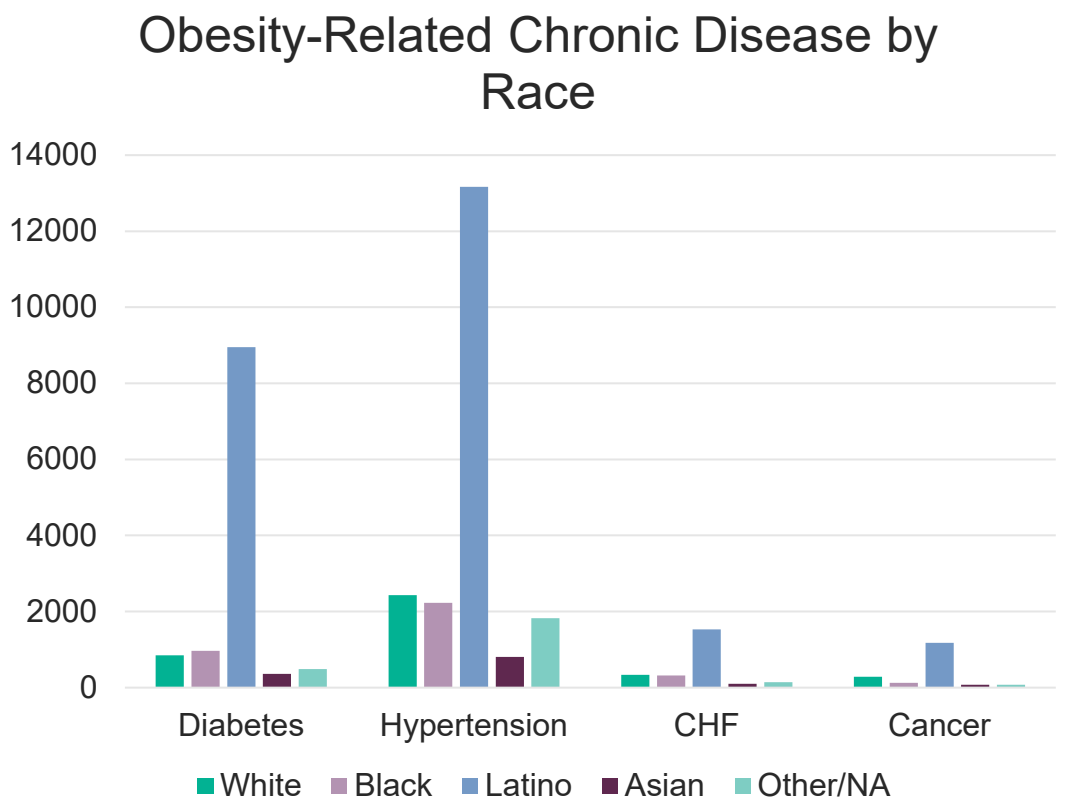
- Clinical Capacity
- eConsults

Proposed Initiatives

- Additional Capacity
- Cardio Diagnostics
- CHF Pilot

Medical Weight Loss

- **40%+ of MAP enrollees are diagnosed with or meet the clinical criteria for obesity with a higher relative risk for Black and Hispanic enrollees**
- **Obesity is a contributing factor to chronic disease prevalence and treatment complexity**
- **Medical weight loss is currently not offered for Central Health patients**
- **Effective medical weight loss programs often rely on patient access to dietician and behavioral health services**
- **Proposed Initiatives**:
  - Introduce access to medical weight loss services through new program development with primary care partners or other community providers in FY22
  - Develop and implement a Dietician/Community Health model for condition-specific dietary support outside of the clinic setting



Implemented Initiatives

- Nutrition Counseling
- Dietician Incorporation into Care Team

Proposed Initiatives

- Introduce Medical Weight Loss
- Dietician/ CHW Model

DISCUSSION

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

June 9, 2021

AGENDA ITEM 3

Receive an update on the data analysis of demographics and health disparities among the Central Health patient population.

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	June 9, 2021
Who will present the agenda item? (Name, Title)	Sarita Clark-Leach; JP Eichmiller
General Item Description	Demographics and Disparities Data Update
Is this an informational or action item?	Informational
Fiscal Impact	N/A
Recommended Motion (if needed – action item)	N/A

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Improved internal capabilities providing new change-over-time data of enrollees and patients.
2) Additional analysis is being conducted to determine causes of enrollment shifts in neighborhoods.
3) Rates of chronic disease are generally higher among Black and Asian race groups, Non-Latino, Male and Homeless populations. Clinical measure performance is below-average for Non-White, Non-Latino, Male and Homeless populations.
4) Hypertension and Diabetes are the chronic conditions with the highest prevalence rates in our MAP and MAP BASIC populations.
5) East Central Austin and Leander/Lago Vista are among the focus areas that have high prevalence rates across eight chronic disease conditions examined. These focus areas have a particularly high burden of disease despite having lower number of diagnosed patients than other focus areas.

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Presentation slides
Estimated time needed for presentation & questions?	30 minutes

CENTRAL HEALTH

Is closed session recommended? (Consult with attorneys.)	N/A
Form Prepared By/Date Submitted: Sarita Clark-Leach and JP Eichmiller/ June 1, 2021	

CENTRAL HEALTH

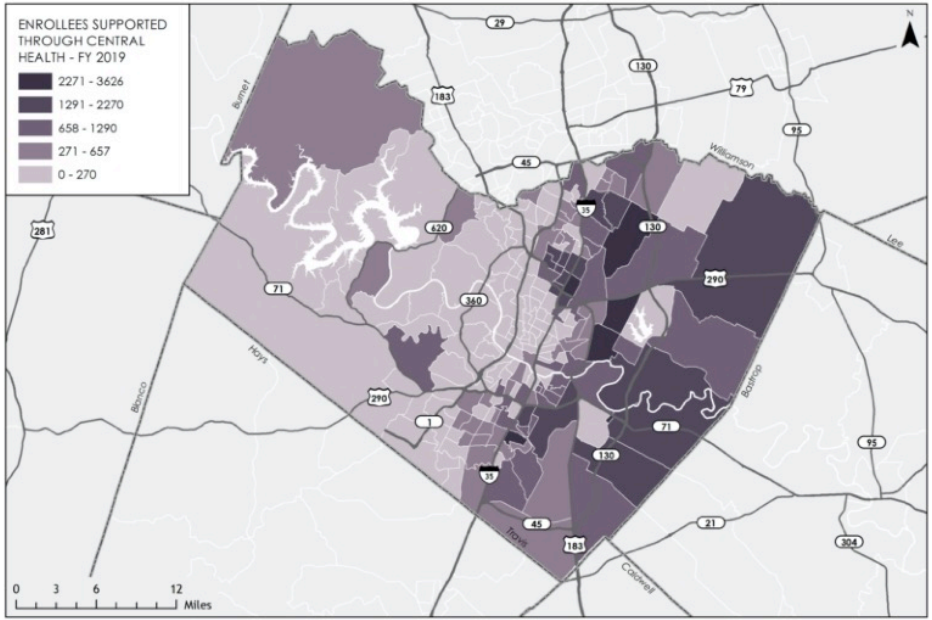
Demographic and Disparity Update

Central Health Board of Managers
Sarita Clark-Leach, Director of Analytics and Reporting
JP Eichmiller, Senior Director of Strategy and Information Design

Demographic Highlights

- Decreased enrollment in 2020 was primarily driven by losses in MAP-BASIC/SFS enrollees.
- Latinos represent the overwhelming majority of Central Health's enrolled members.
- Non-citizen MAP members were the only demographic subset to increase enrollment in 2020.
- Spanish speakers enrolled in greater numbers, and retained their membership at greater rates than English-speaking enrollees.
- The rate of homeless members who dropped out of enrollment in 2020 (43.5%) was the highest of any demographic subset (5,208/11,962)
- The rate of homelessness was much higher among Black (28.3% or 1,983/7,003) and White (23.5% or 2,844/12,106) enrollees than Latino (3.1% or 2,164/69,381)
- Non-citizen enrollees tend to reside in concentrated geographic clusters.

Central Health's Enrolled Population by Census Tract - FY2019

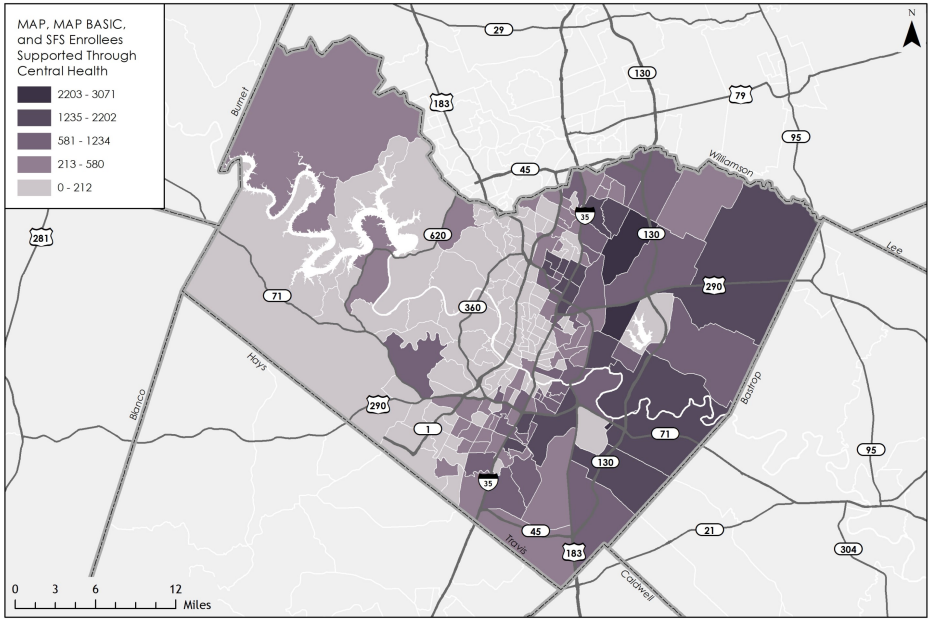


CENTRAL HEALTH

Created September 8, 2020

Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health in fiscal year 2019 (Oct. 1, 2018 - Sep. 30, 2019).

Central Health's Enrolled Population by Census Tract - FY 2020



CENTRAL HEALTH

Created November 3, 2020

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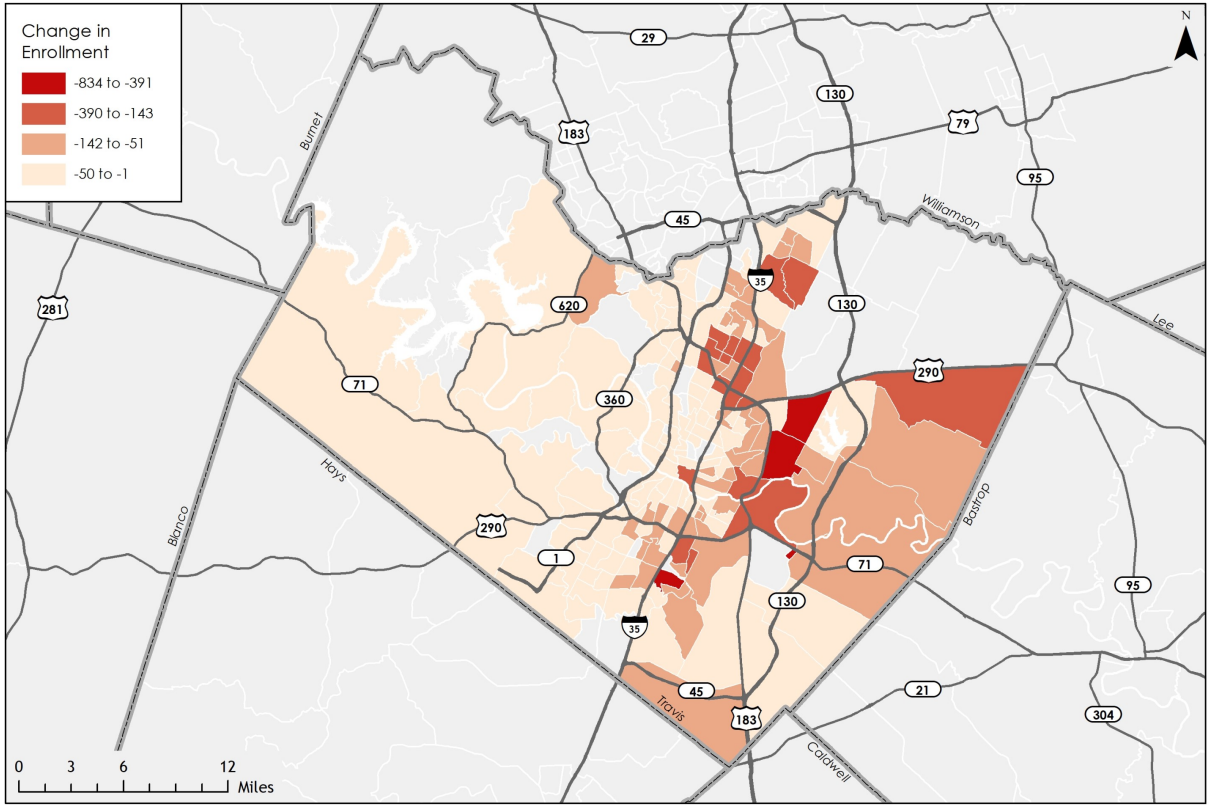
Census Tracts With a Decrease in Enrollment from FY 2019 to FY 2020



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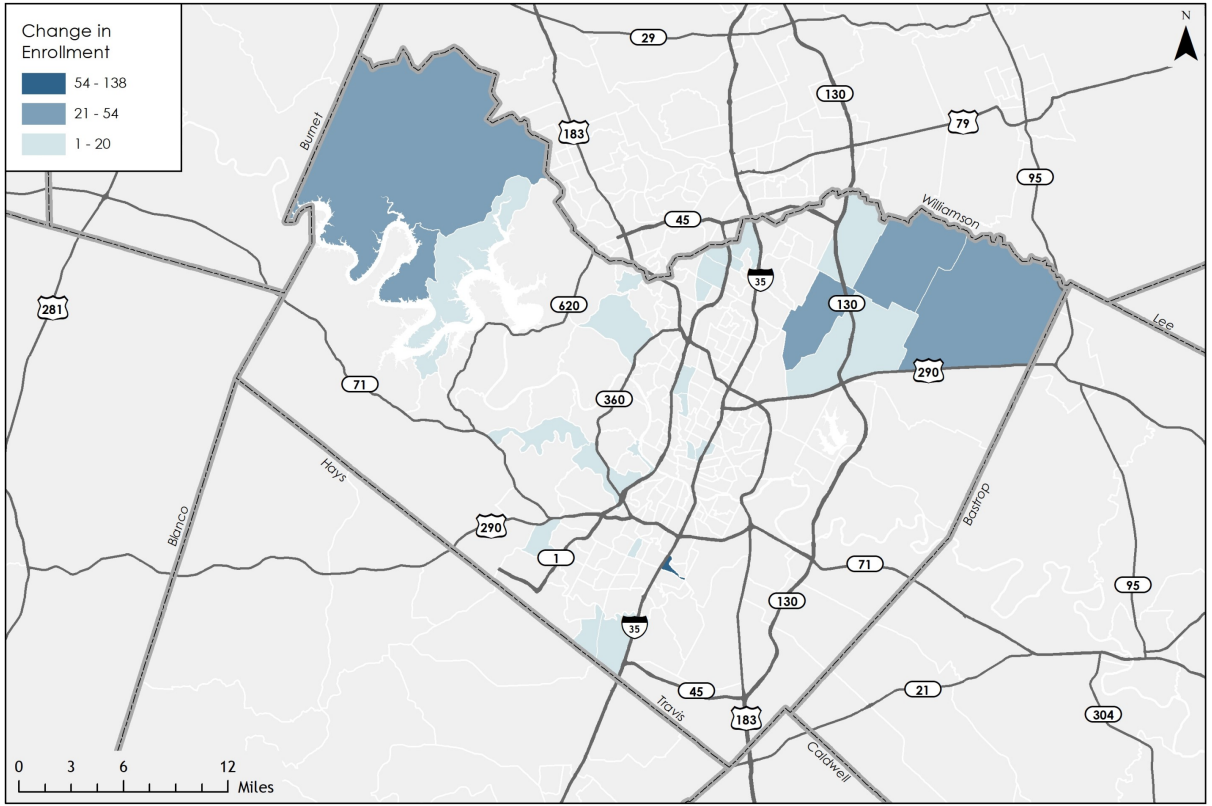
Census Tracts With an Increase in Enrollment from FY 2019 to FY 2020



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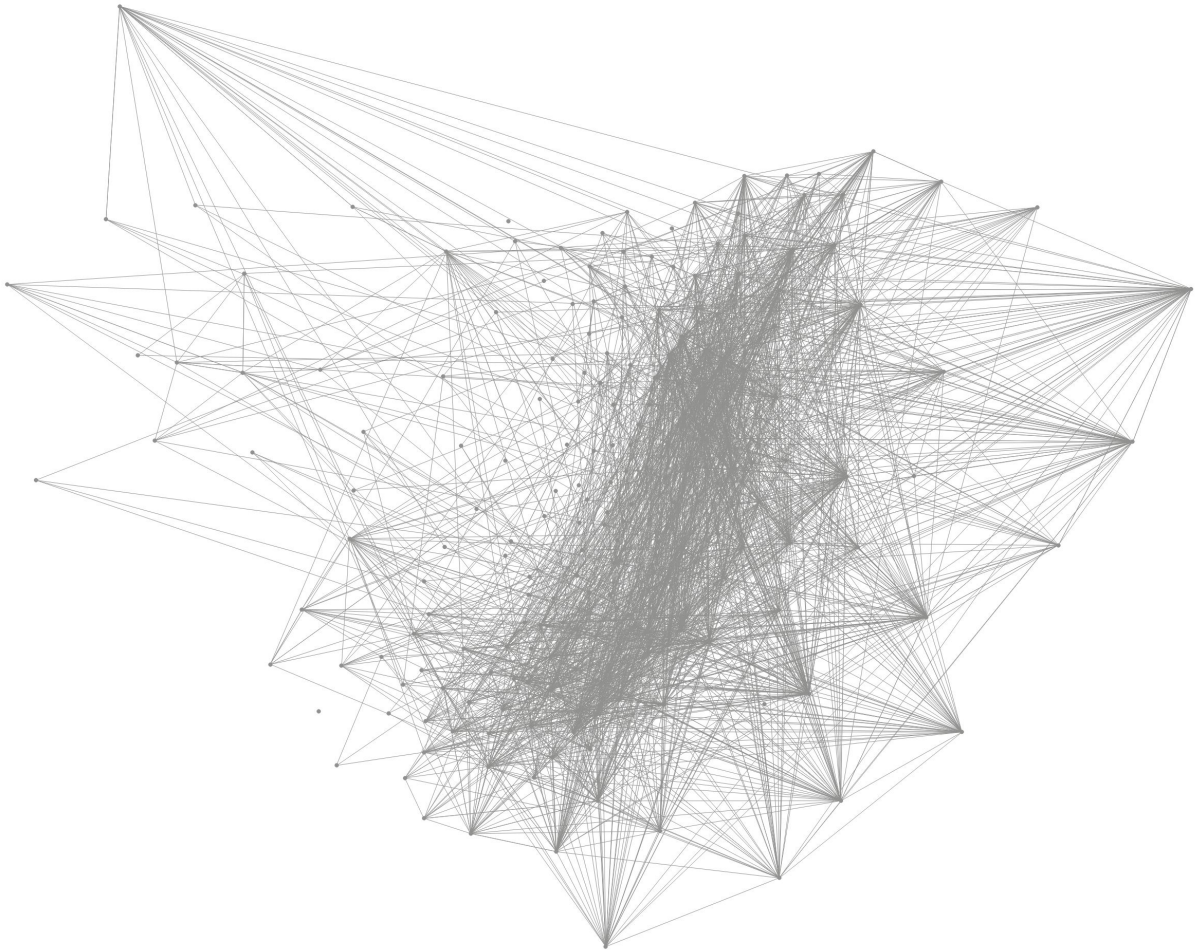
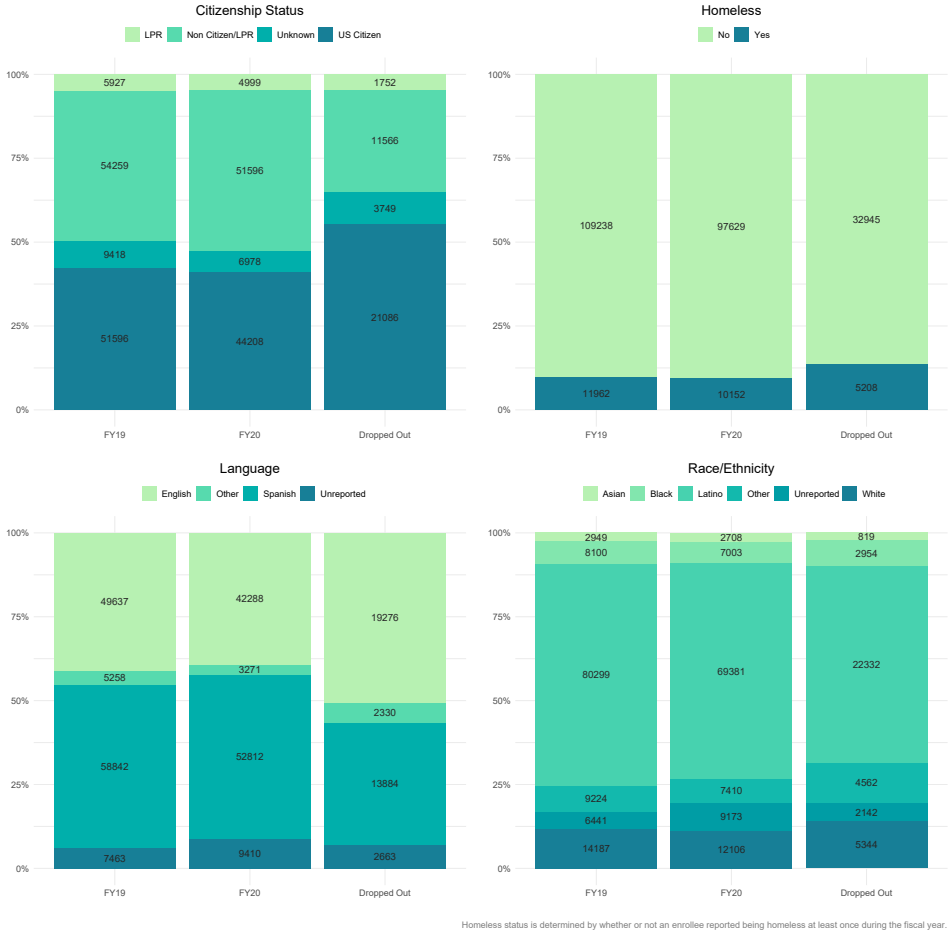
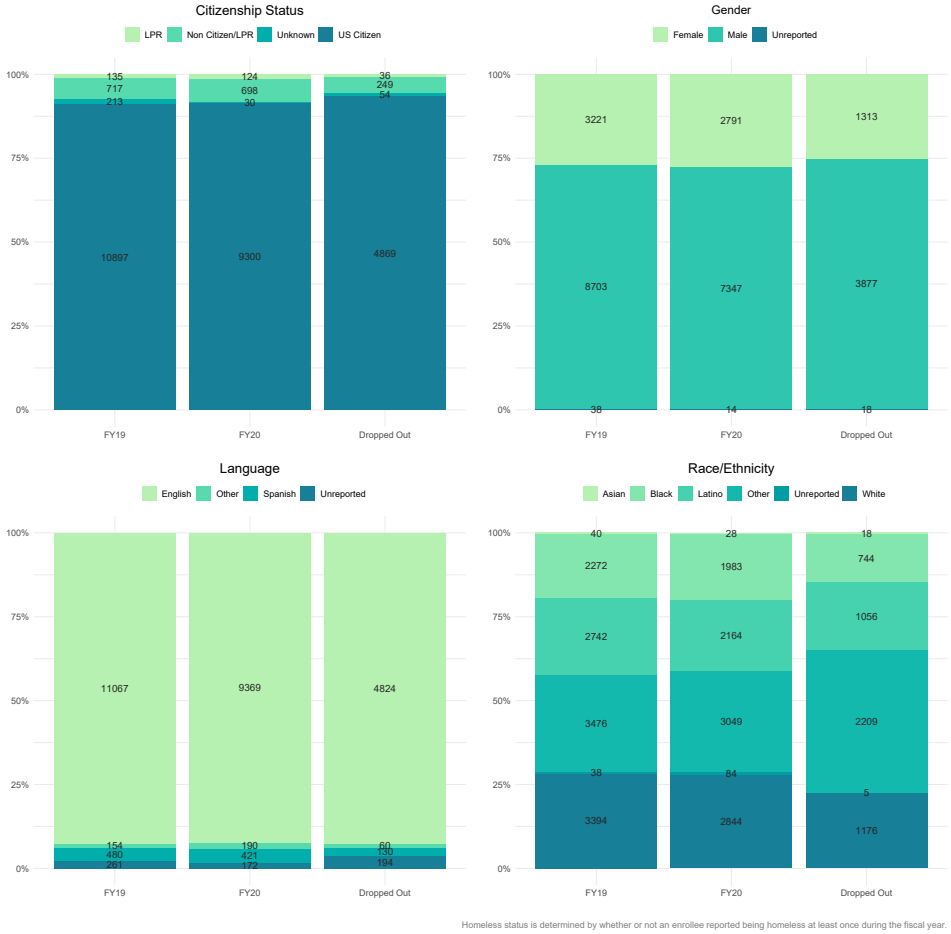


Demographics of Central Health's Enrolled Population



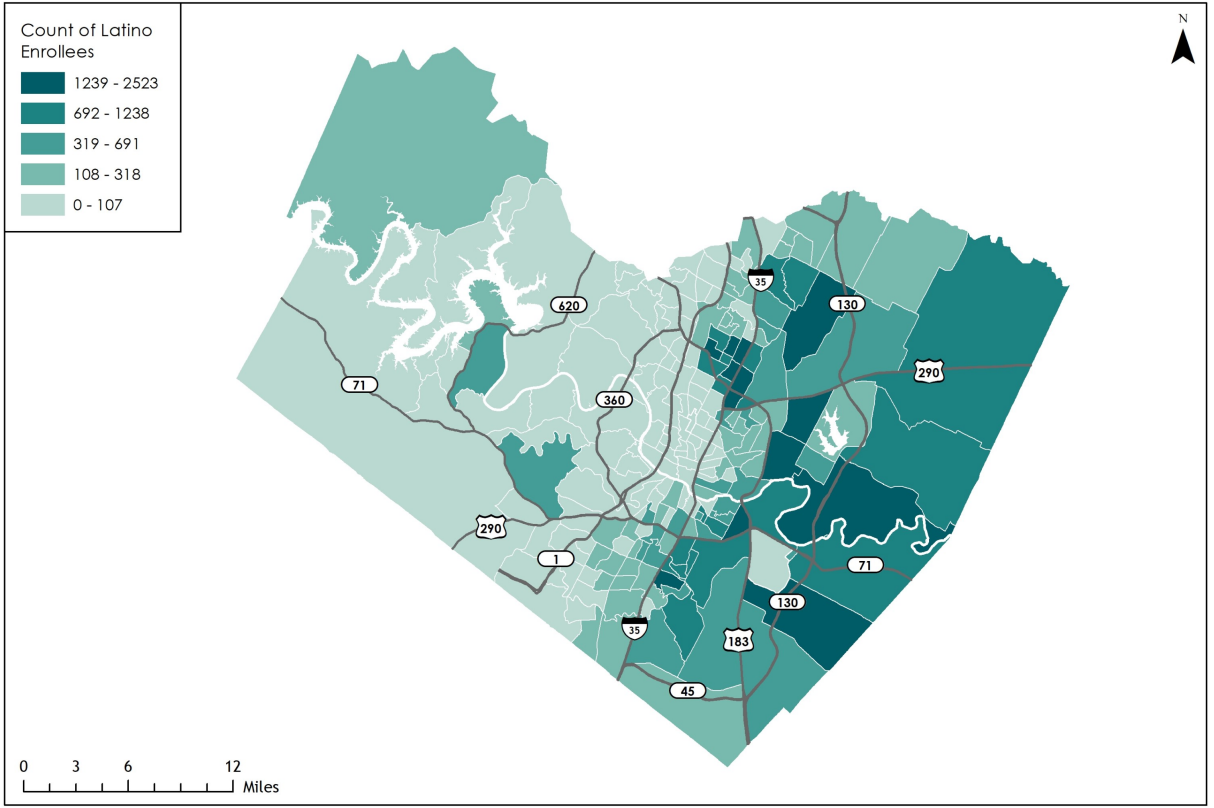
Homeless status is determined by whether or not an enrollee reported being homeless at least once during the fiscal year.

Demographics of Central Health's Homeless Enrolled Population



Homeless status is determined by whether or not an enrollee reported being homeless at least once during the fiscal year.

Distribution of Latino Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

Created January 20, 2021
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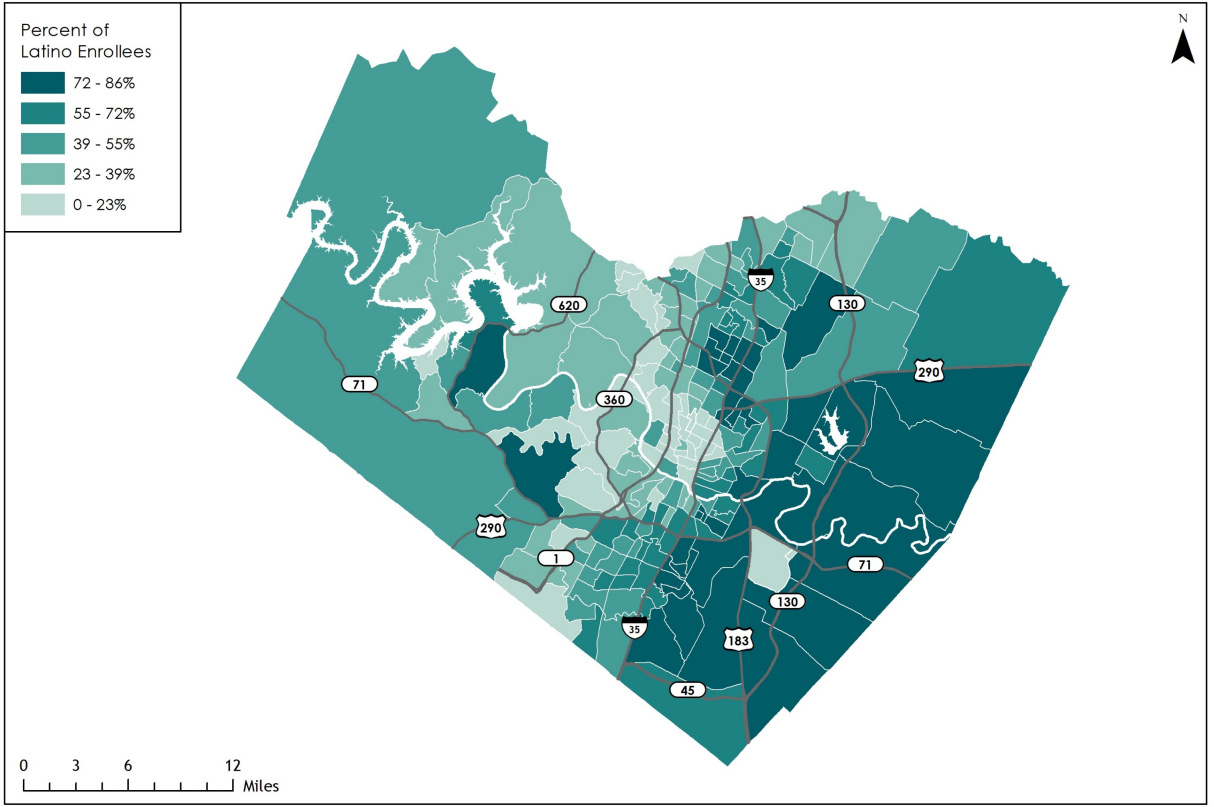
Distribution of Latino Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

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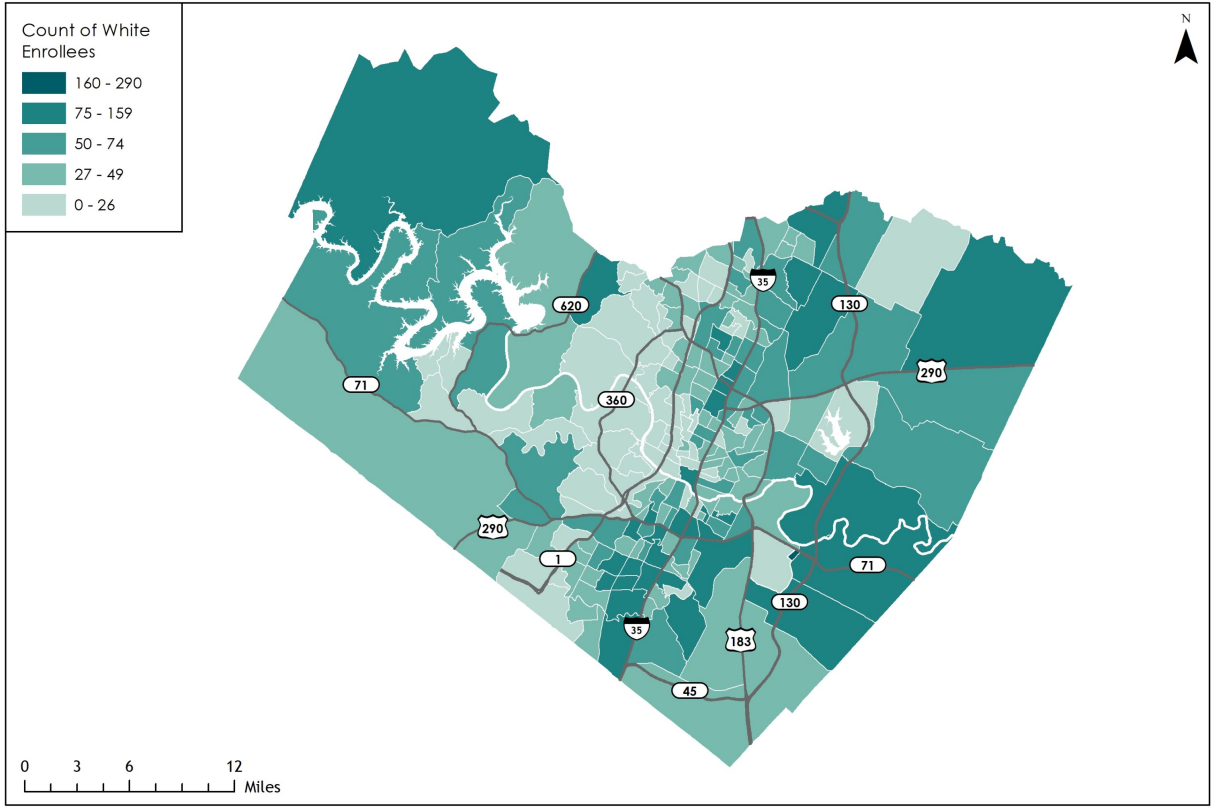
Distribution of White Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

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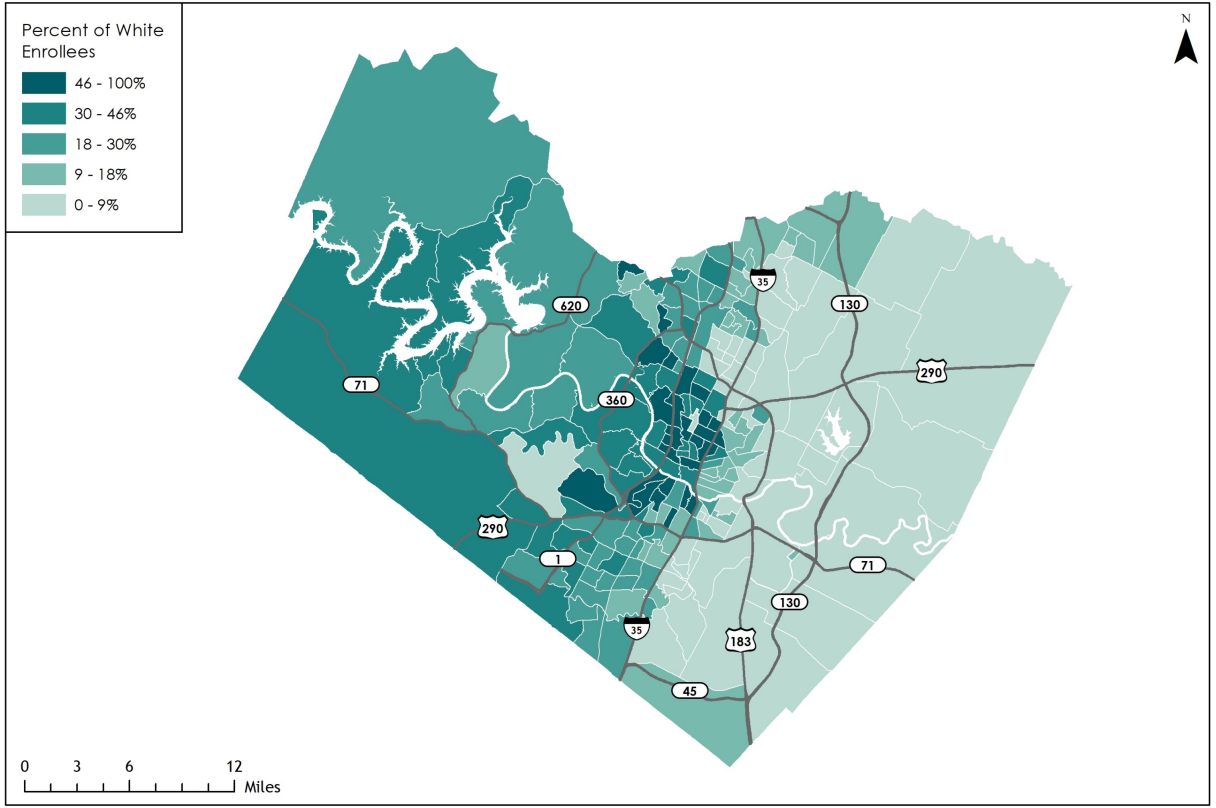
Distribution of White Enrollees in Fiscal Year 2020 by Census Tract



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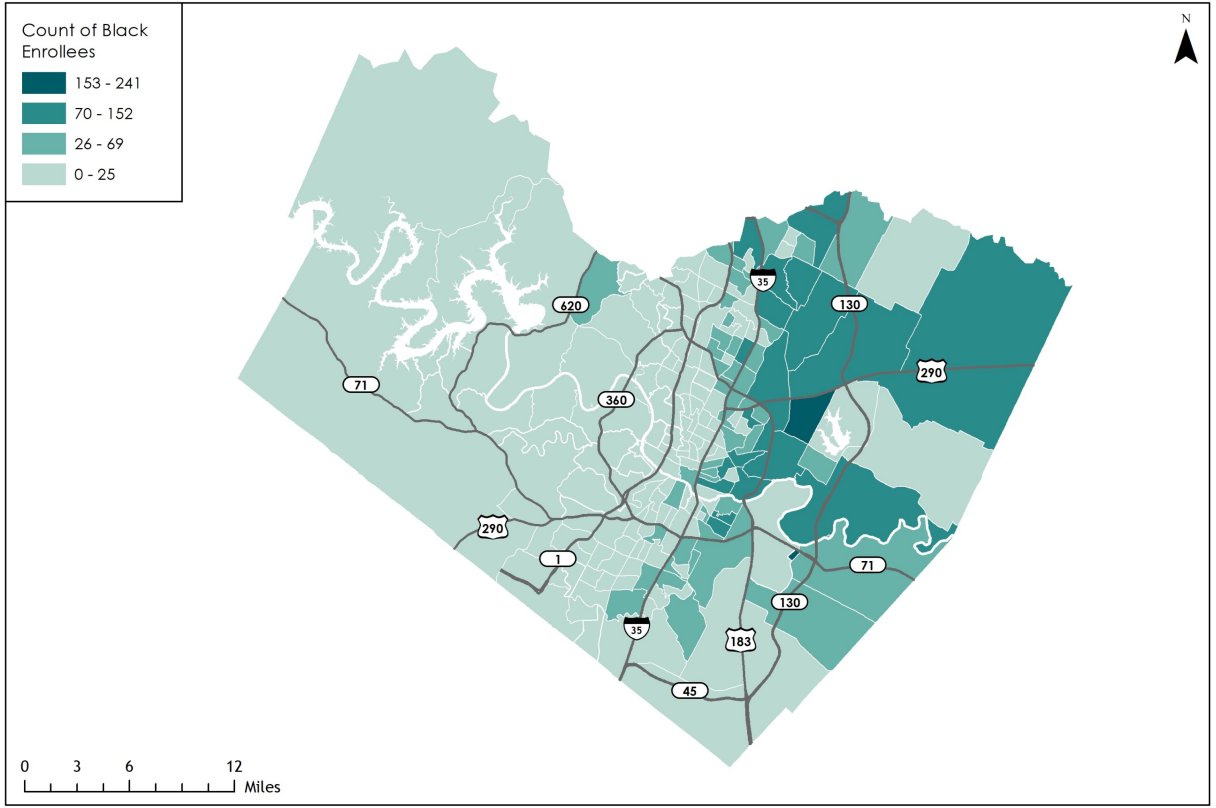
Distribution of Black Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

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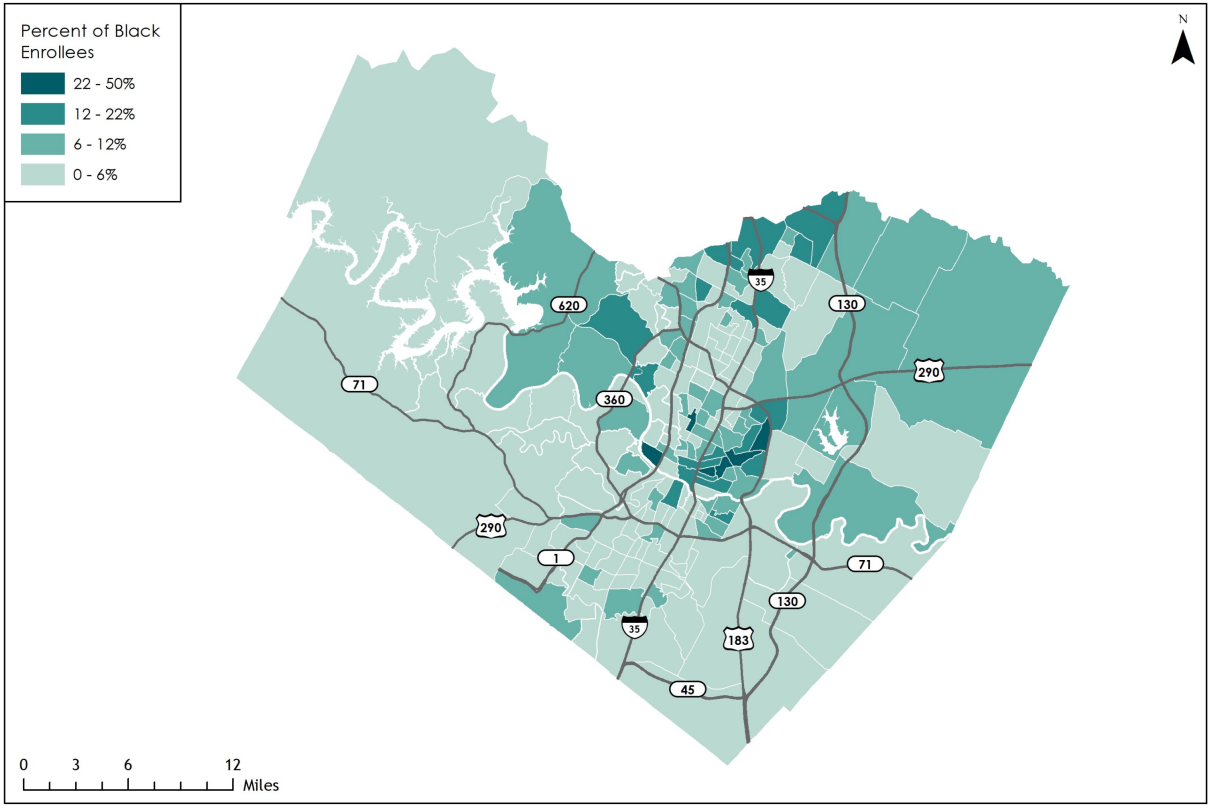
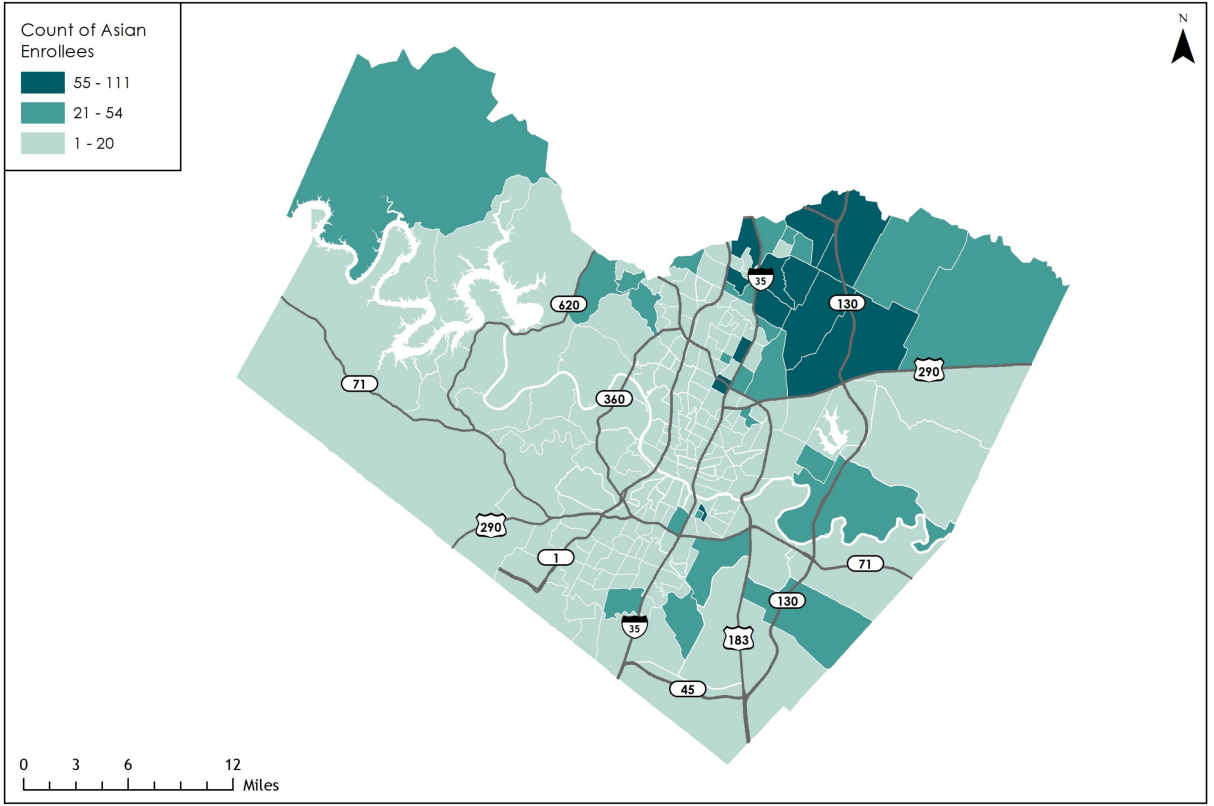
Distribution of Black Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

Created January 20, 2021
Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health in fiscal year 2020.

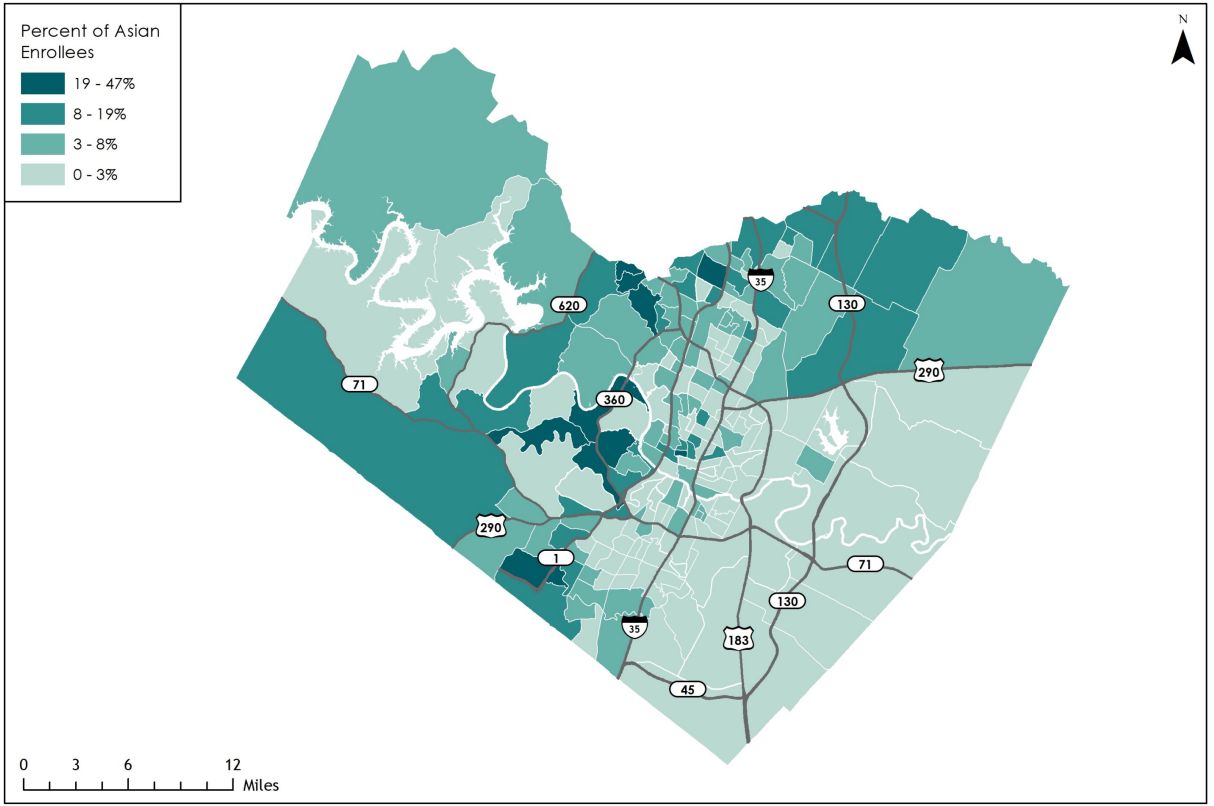
Distribution of Asian Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

Created January 20, 2021
Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health in fiscal year 2020.

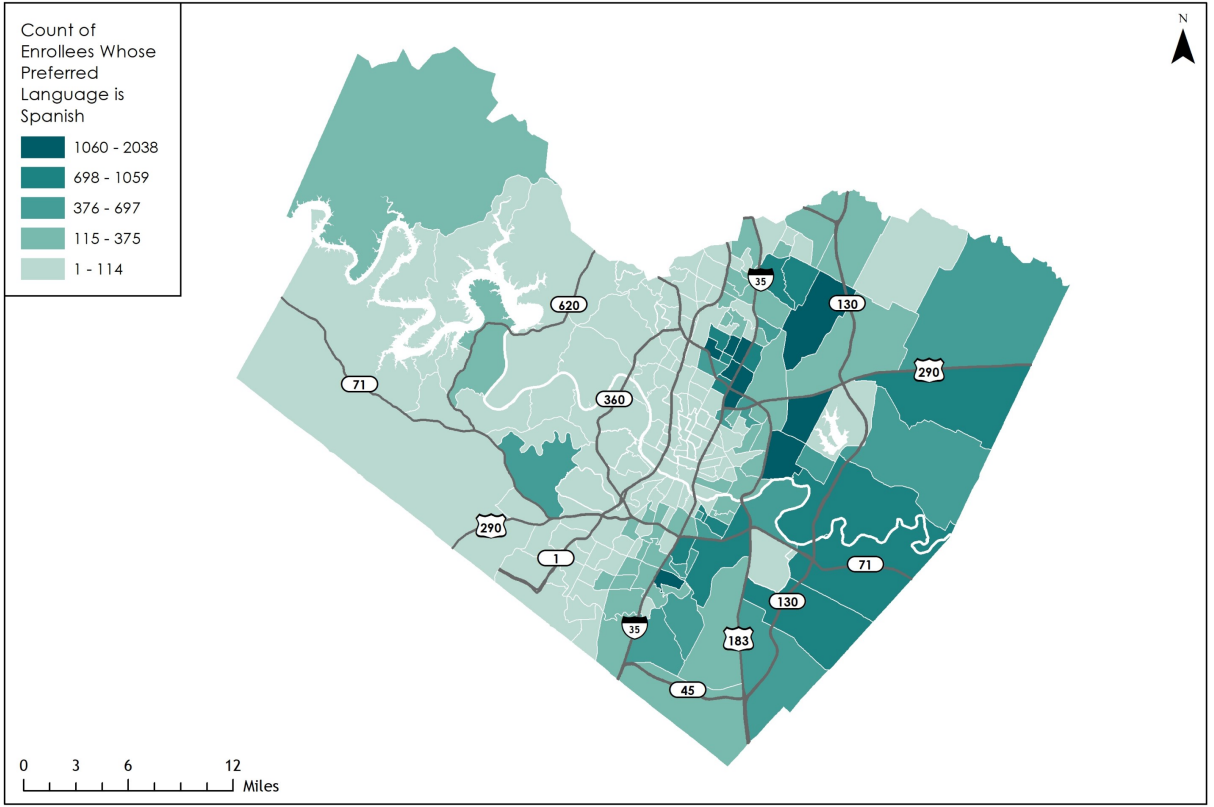
Distribution of Asian Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

Created January 20, 2021
Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health in fiscal year 2020.

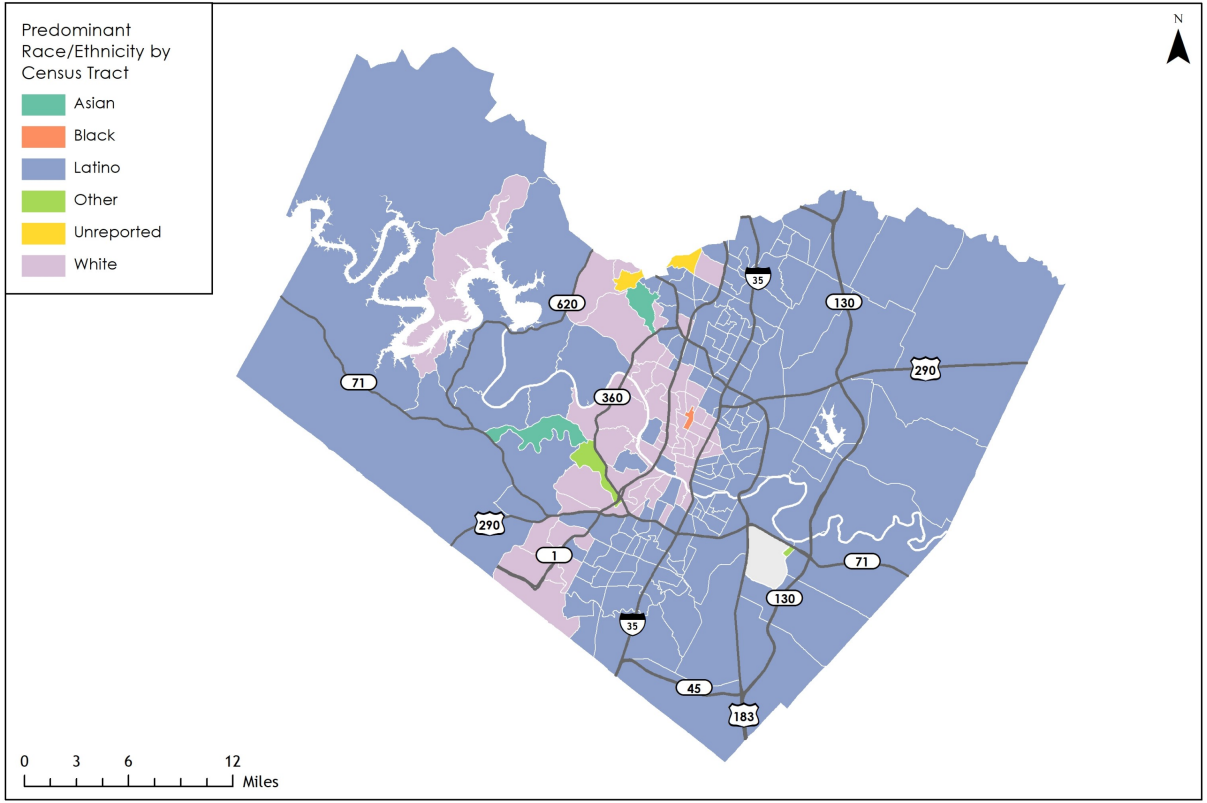
Distribution of Spanish-Speaking Enrollees in Fiscal Year 2020 by Census Tract



CENTRAL HEALTH

Created January 20, 2021
Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health in fiscal year 2020.

Predominant Race/Ethnicity of Enrolled Members in Fiscal Year 2020



CENTRAL HEALTH

Created December 21, 2020
Enrollees are defined as individuals who were enrolled in Central Health's Medical Access Program (MAP), MAP BASIC, or local sliding fee scale (SFS) subsidy programs reimbursed by Central Health.

Demographic Highlights

- Decreased enrollment in 2020 was primarily driven by losses in MAP-BASIC/SFS enrollees.
- Latinos represent the overwhelming majority of Central Health's enrolled members.
- Non-citizen MAP members were the only demographic subset to increase enrollment in 2020.
- Spanish speakers enrolled in greater numbers, and retained their membership at greater rates than English-speaking enrollees.
- The rate of homeless members who dropped out of enrollment in 2020 (43.5%) was the highest of any demographic subset
- The rate of homelessness was much higher among Black (28.3%) and White (23.5%) enrollees than Latino (3.1%)
- Non-citizen enrollees tend to reside in concentrated geographic clusters.

Next Steps

- Continue neighborhood-level analysis of year-over-year enrollment changes (Central Health + ICC data)

- Utilize databases to inform strategic systems planning

Chronic Conditions Through an Equity Lens

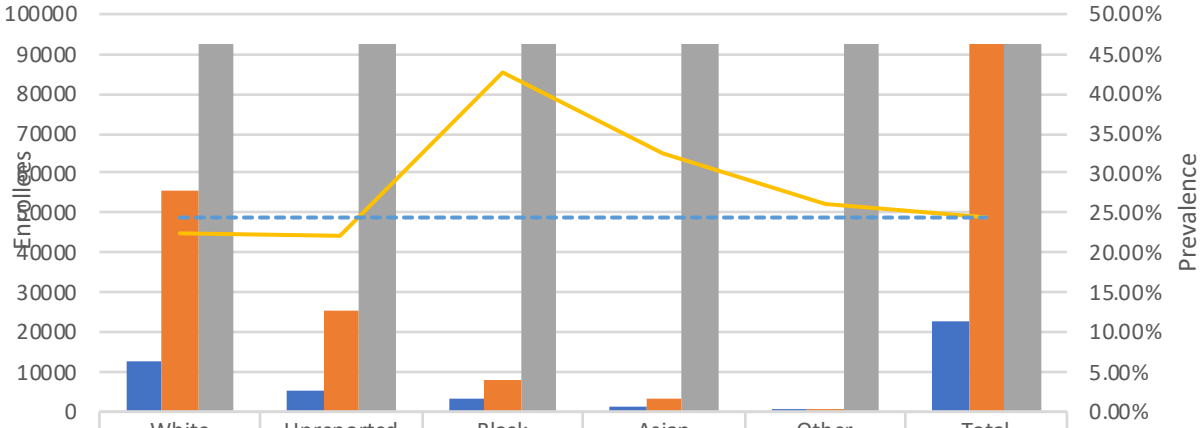
with a focus on Hypertension and Diabetes

Hypertension

Hypertension in the **MAP and MAP BASIC** population: **Race**

While greater numbers of White enrollees are diagnosed with hypertension because they compose a larger number of the population, Black and Asian enrollees have higher prevalence of the disease in their respective populations.

Relative Risk calculations tell us that Black enrollees have 1.75 times the risk of having HTN than the general population, Asians have 1.34 times the risk, while White enrollees are 8% **less at risk** for the diagnosis.

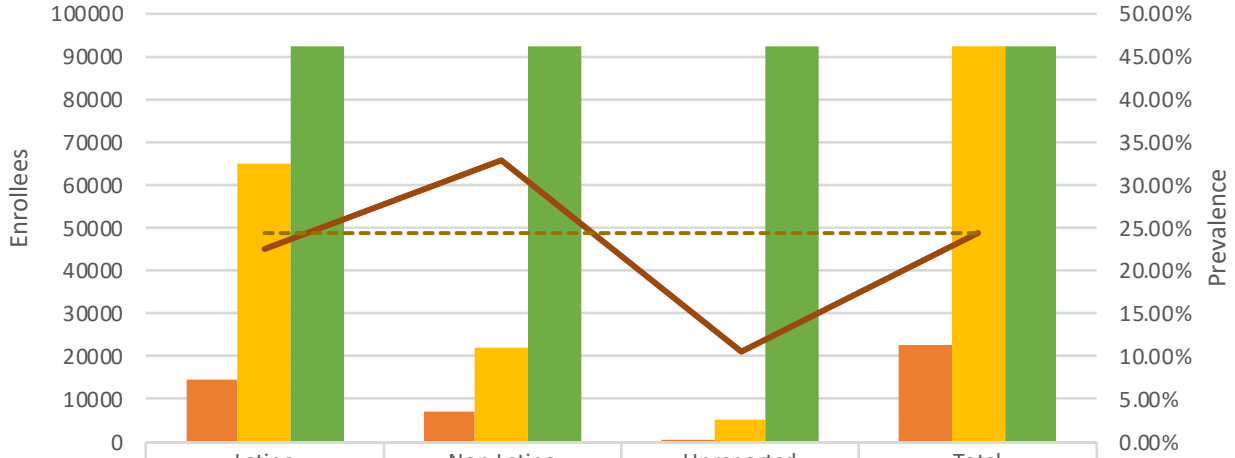


	White	Unreported	Black	Asian	Other	Total
Number of Enrollees with Hypertension Diagnosis	12539	5579	3296	1074	140	22628
Number of Enrollees in Race Category	55877	25219	7725	3292	538	92651
Total Number of Enrollees	92651	92651	92651	92651	92651	92651
Prevalence	22.44%	22.12%	42.67%	32.62%	26.02%	24.42%
Prevalence for Overall (Referent) Population	24.42%	24.42%	24.42%	24.42%	24.42%	24.42%
Relative Risk	0.92	0.91	1.75	1.34	1.07	1

Hypertension in the **MAP and MAP BASIC** population: **Ethnicity**

While there are greater numbers of Latino enrollees are diagnosed with hypertension, enrollees who identify as Non-Latino have higher prevalence of the disease.

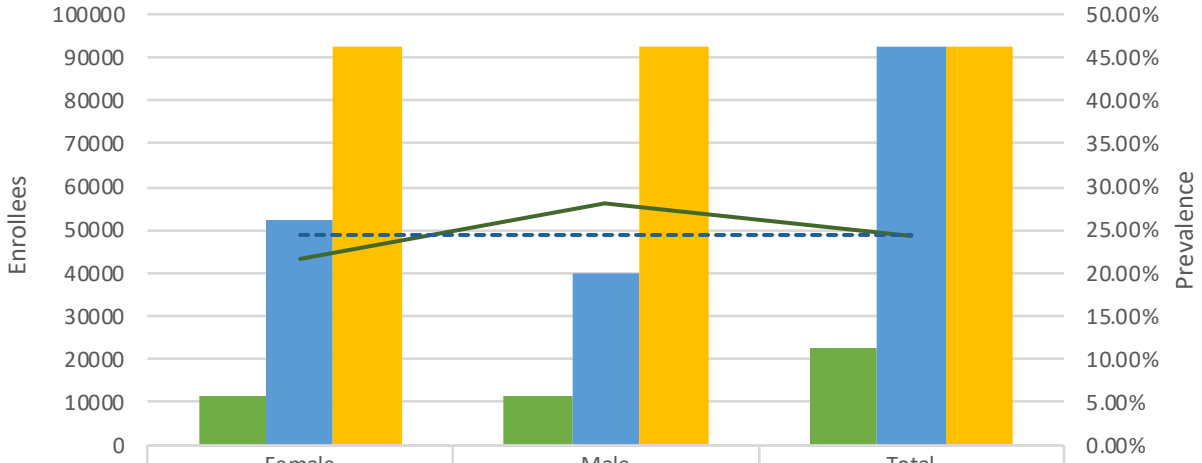
Relative Risk calculations tell us that Non-Latinos have 1.35 times the risk of having HTN than the general population, Latino enrollees are 7% **less at risk** for the diagnoses



	Latino	Non-Latino	Unreported	Total
Number of Enrollees with Hypertension Diagnosis	14751	7337	540	22628
Number of Enrollees in Ethnicity Category	65260	22292	5099	92651
Total Number of Enrollees	92651	92651	92651	92651
Prevalence	22.60%	32.91%	10.59%	24.42%
Prevalence for Overall (Referent)Population	24.42%	24.42%	24.42%	24.42%
Relative Risk	0.93	1.35	0.43	1.00

Hypertension in the **MAP and MAP BASIC** population: **Sex at Birth**

Relative Risk calculations tell us that Males have 1.15 times the risk of having HTN than the general population, Female enrollees are 11% **less at risk** for the diagnosis.

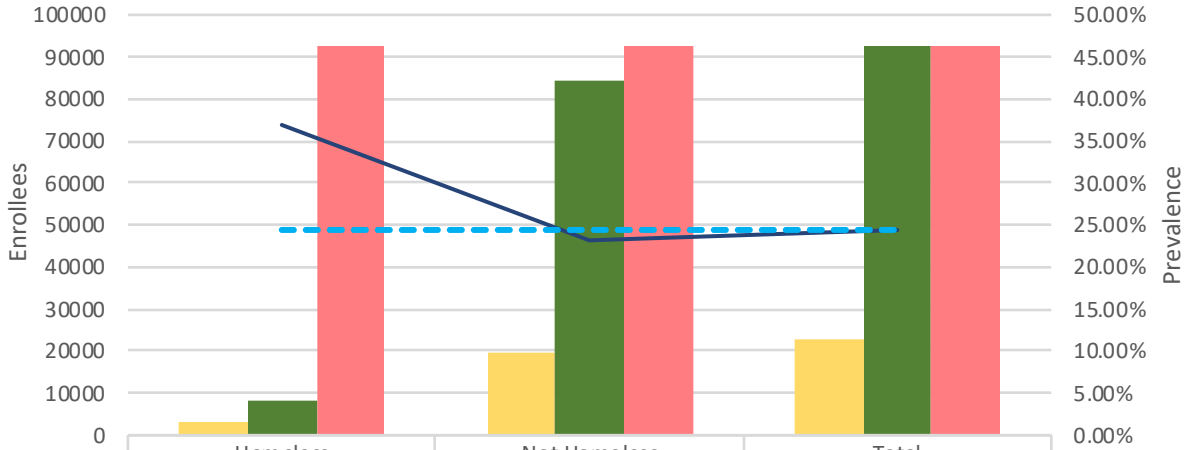


	Female	Male	Total
Number of Enrollees with Hypertension Diagnosis	11380	11225	22605
Number of Enrollees in Sex at Birth Category	52592	39975	92567
Total Number of Enrollees	92567	92567	92567
Prevalence	21.64%	28.08%	24.42%
Prevalence for Overall (Referent)Population	24.42%	24.42%	24.42%
Relative Risk	0.89	1.15	1.00

Hypertension in the **MAP and MAP BASIC** Population: **Residence Status**

While greater numbers of enrollees who are not homeless are diagnosed with hypertension because they compose a larger number of the population, homeless enrollees have higher prevalence of the disease in their respective populations.

Relative Risk calculations tell us that homeless enrollees have 1.51 times the risk of having HTN than the general population, compared to non-homeless enrollees who have a 5% **less risk** of being diagnosed with hypertension than the overall population.



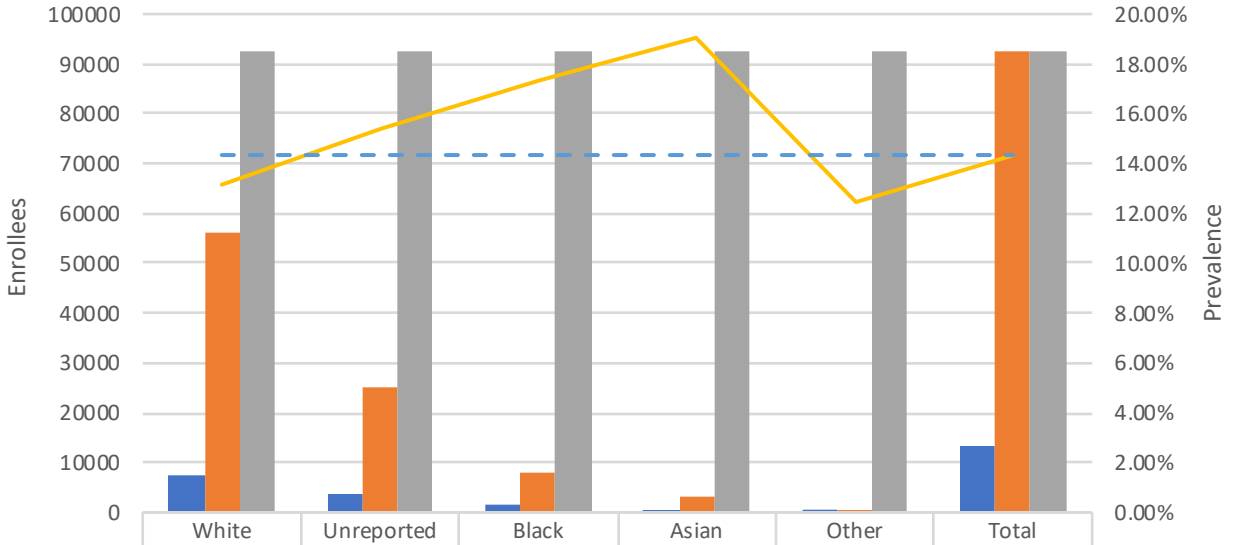
	Homeless	Not Homeless	Total
Number of Enrollees with Hypertension Diagnosis	3086	19535	22621
Number of Enrollees in Residence Status Category	8362	84272	92634
Total Number of Enrollees	92634	92634	92634
Prevalence	36.91%	23.18%	24.42%
Prevalence for Overall (Referent)Population	24.42%	24.42%	24.42%
Relative Risk	1.51	0.95	1.00

Diabetes

Diabetes in the **MAP and MAP BASIC** population: **Race**

While greater numbers of White enrollees are diagnosed with diabetes because they compose a larger number of the population, Black and Asian enrollees have higher prevalence of the disease in their respective populations.

Relative Risk calculations tell us that Black enrollees have 1.21 times the risk of having HTN than the general population, Asians have 1.21 times the risk, while White enrollees are 8% **less at risk** for the diagnosis.

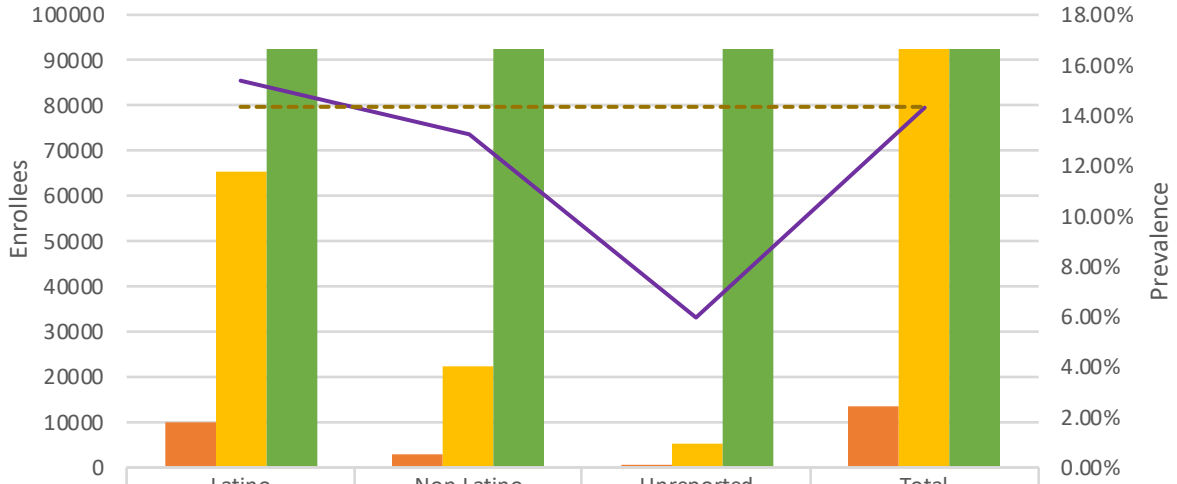


	White	Unreported	Black	Asian	Other	Total
Number of Enrollees with Diabetes Diagnosis	7374	3879	1340	627	67	13287
Number of Enrollees in Race Category	55877	25219	7725	3292	538	92651
Total Number of Enrollees	92651	92651	92651	92651	92651	92651
Relative Risk	0.92	1.07	1.21	1.33	0.87	1.00
Prevalence	13.20%	15.38%	17.35%	19.05%	12.45%	14.34%
Prevalence for Overall (Referent) Population	14.34%	14.34%	14.34%	14.34%	14.34%	14.34%

Diabetes in the **MAP and MAP BASIC** population: **Ethnicity**

Most of our MAP and MAP BASIC enrollees identify as Latino. A greater number of Latinos are diagnosed with diabetes when compared to our Non-Latino population. They also have a higher prevalence for the disease than our Non-Latino enrollees.

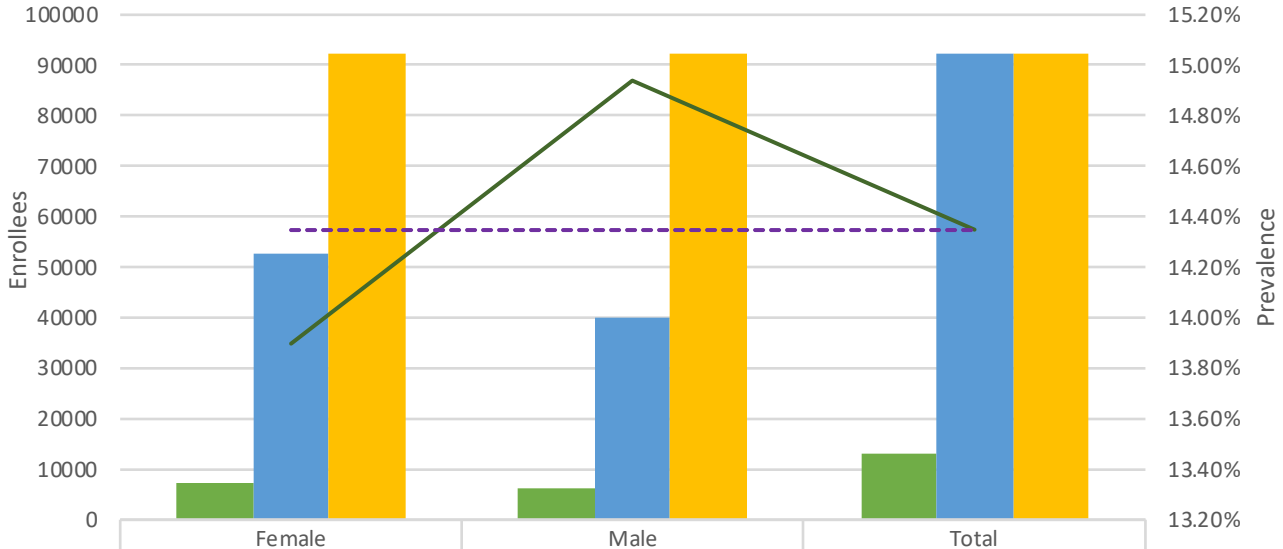
Relative Risk calculations tell us that Latinos have 1.07 times the risk of having HTN than the general population, Non-Latino enrollees are 8% **less at risk** for the diagnoses



	Latino	Non-Latino	Unreported	Total
Number of Enrollees with Diabetes Diagnosis	10038	2945	304	13287
Number of Enrollees in Ethnicity Category	65260	22292	5099	92651
Total Number of Enrollees	92651	92651	92651	92651
Relative Risk	1.07	0.92	0.42	1.00
Prevalence	15.38%	13.21%	5.96%	14.34%
Prevalence for Overall (Referent)Population	14.34%	14.34%	14.34%	14.34%

Diabetes in the **MAP and MAP BASIC** population: **Sex at Birth**

Relative Risk calculations tell us that Males have 1.04 times the risk of having Diabetes than the general population, Female enrollees are 3% **less at risk** for the diagnosis.

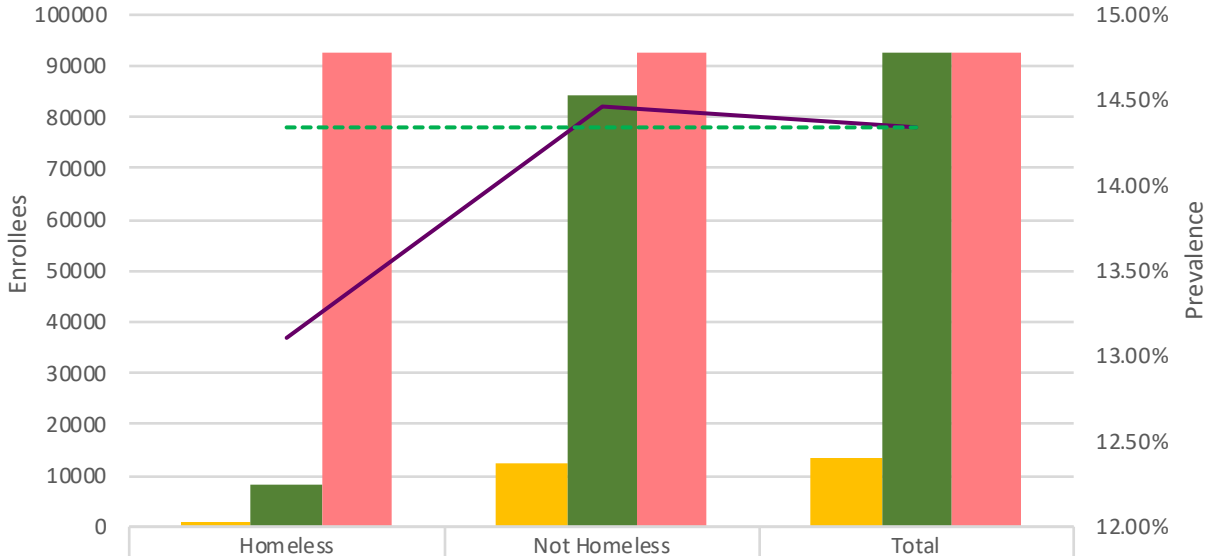


	Female	Male	Total
Number of Enrollees with Diabetes Diagnosis	7309	5972	13281
Number of Enrollees in Sex at Birth Category	52592	39975	92567
Total Number of Enrollees	92567	92567	92567
Relative Risk	0.97	1.04	1.00
Prevalence	13.90%	14.94%	14.35%
Prevalence for Overall (Referent)Population	14.35%	14.35%	14.35%

Diabetes in the **MAP and MAP BASIC** Population: **Residence Status**

Non-homeless enrollees compose most of the MAP and MAP BASIC population and also have a higher prevalence of diabetes when compared to our homeless population.

Relative Risk calculations tell us that non-homeless enrollees have a 1.01 times the risk of having diabetes than the general population, compared to non-homeless enrollees who have a 9% **less risk** of being diagnosed with hypertension than the overall population.



	Homeless	Not Homeless	Total
Number of Enrollees with Diabetes Diagnosis	1096	12188	13284
Number of Enrollees in Residence Status Category	8362	84272	92634
Total Number of Enrollees	92634	92634	92634
Relative Risk	0.91	1.01	1.00
Prevalence	13.11%	14.46%	14.34%
Prevalence for Overall (Referent)Population	14.34%	14.34%	14.34%

Chronic Conditions – A bigger picture

Relative Risk for Chronic Conditions – A Bigger Picture

		Relative Risk									
		Race					Ethnicity		Sex		Homeless
Chronic Condition	Overall Percent (referent)	White RR	Black RR	Asian RR	Other RR	Unreported RR	Latino RR	Non-Latino RR	Female RR	Male RR	Homeless RR
Hypertension	24.4%	0.92	1.75	1.34	1.07	0.91	0.93	1.35	0.89	1.15	1.51
Diabetes	14.3%	0.92	1.21	1.33	0.87	1.08	1.08	0.92	0.97	1.04	0.92
Obesity	40.8%	1.01	1.02	0.67	0.97	1.04	1.11	0.81	1.11	0.87	
Asthma	6.2%	0.95	2.13	0.77	0.81	0.81	0.84	1.60	1.10	0.89	1.94
COPD	5.9%	0.97	1.58	1.15	1.00	0.90	0.85	1.64	1.05	1.00	2.09
Renal Failure	3.2%	0.94	2.31	0.88	1.22	0.72	0.78	1.78	0.53	1.59	2.77
Heart Failure	2.9%	0.90	1.97	1.59	0.97	0.93	0.90	1.55	0.90	1.17	1.39
Cancer	2.2%	0.99	1.05	1.42	0.77	0.97	0.95	1.32	1.09	0.88	0.84
Cervical Cancer	0.1%	0.88	0.95	0.55	-	1.41	1.18	0.82	1.00	-	0.55
Breast Cancer	0.4%	0.87	1.06	2.14	-	1.13	1.07	0.93	1.73	0.03	0.23
Colorectal Cancer	0.3%	1.00	1.30	1.40	0.72	0.90	0.92	1.42	0.78	1.32	1.12

Relative Risk (RR) values <1 indicate less risk for the disease, values >1 indicate greater risk.

Overall Referent population

Disease Condition	Central Health Population (%)	Numerator	Denominator
Hypertension	24.4%	22,628	92,651
Behavioral Health	21.7%	20,083	92,651
Diabetes	14.3%	13,287	92,651
Asthma	6.2%	5,788	92,651
COPD	5.9%	5,489	92,651
Obesity (BMI >= 30)*	40.8%	3,931	9,636
Renal Failure	3.2%	2,952	92,651
Heart Failure	2.9%	2,716	92,651
Heart Disease	2.5%	2,297	92,651
Cancer (all sites)	2.2%	2,020	92,651
Stroke	1.0%	952	92,651
ESRD	0.2%	208	92,651

*All values based on MAP and MAP BASIC enrollees except Obesity figures that are sourced from DSRIP data and represent MAP patients only

For Context…

Disease Condition	FY2020 Central Health Population (%)	2018 Travis County BRFSS Estimate (%)
Hypertension	24.4%	30.8%
Diabetes	14.3%	9.2%
Asthma	6.2%	13.5%
COPD	5.9%	2.9%
Obesity (BMI >= 30)*	40.8%	29.4%
Renal Failure	3.2%	No Data
Heart Failure	2.9%	No Data
Cancer (all sites)	2.0%	9.7%

Differences in CH population prevalence and BRFSS Estimate are can be attributed to the difference in data source and the population examined.

BRFSS diagnosis information are derived from a survey where people are asked, "Have you had ever been diagnosed with *XX*?"
Respondents are a general population (18+ ages, all income levels etc)

Central Health data are sourced from ICD 9/10 diagnoses codes in our data warehouse and are limited to our population: low-income, fewer individuals 65+. The presence of a diagnosis on an enrollee's chart is dependent upon utilization.

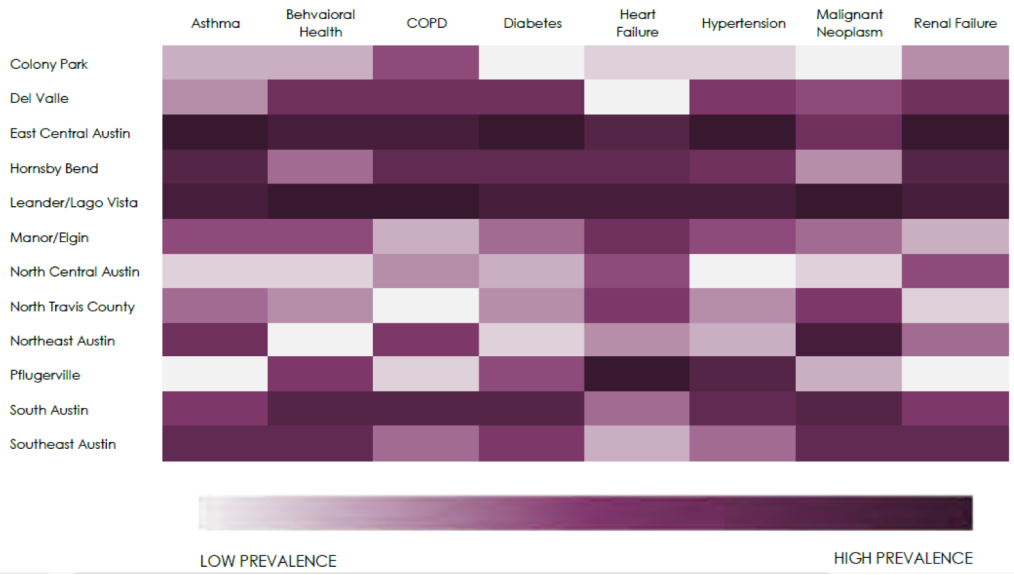
Hypertension and DM most prevalence chronic conditions

*Obesity data is from DSRIP performance measure, representing MAP patients only (N=9,636)

Chronic Condition Prevalence by Geography

HEAT MAP OF CHRONIC CONDITION PREVALENCE ACROSS FOCUS AREAS IN FY 2019

In the heat map below, each chronic condition has been ranked based on prevalence rates among Central Health's enrolled population in the twelve identified focus areas. Focus areas with darker shades of purple have higher prevalence rates than those with light shades of purple.



Key Takeaways:

- Of the eight disease conditions analyzed in this report, hypertension, behavioral health, and diabetes have the greatest number of diagnosed patients .
- East Central Austin and Leander/Lago Vista are among the focus areas that have high prevalence rates across all disease conditions.
    - These focus areas have a particularly high burden of disease despite having lower number of diagnosed patients than other focus areas.

Chronic Conditions: Key Takeaways

- Chronic disease prevalence are generally higher among Black and Asian race groups, people who don't identify as Latino, Male and Homeless populations. Clinical measure performance is below-average for people who don't identify their race as White, people who don't identify as Latino, Male and Homeless populations.

- Hypertension and Diabetes are the chronic conditions with the highest prevalence rates in our MAP and MAP BASIC populations.

- East Central Austin and Leander/Lago Vista are among the focus areas that have high prevalence rates across eight chronic disease conditions examined.

    - East Central Austin is an area that has a large MAP and MAP BASIC population and is also an area with high chronic disease prevalence. Leander/ Lago Vista is an area with a relatively small concentration of MAP and MAP BASIC patients but with a chronic disease prevalence.

Next steps for Analysis

- Continue to refine analysis including a look at prevalence for multivariate subpopulations – e.g., Latino Women, Black Women, White Homeless Men, etc.

- Update geographic prevalence mapping

- Continue to work to acquire mortality data with identifiers from APH or DSHS to calculate age-adjusted mortality rates or years of lives lost for our MAP and MAP BASIC population or acquire de-identified data to calculate those rates for all of Travis County.

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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

June 9, 2021

AGENDA ITEM 4

Receive an update on the FY 2021 and FY 2022 Strategic Priority to develop an equity focused system-of-care plan, including information about the consultant selected and grant funding to support the work.

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	June 9, 2021
Who will present the agenda item? (Name, Title)	Monica Crowley
General Item Description	Receive an update on the FY 2021 and FY 2022 Strategic Priority to develop an equity focused system-of-care plan, including information about the consultant selected and grant funding to support the work.
Is this an informational or action item?	Informational
Fiscal Impact	N/A
Recommended Motion (if needed – action item)	N/A

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Central Health has preliminary chosen a consultant to support the development of an equity focused, strategic system of care plan
2) This work includes a community needs assessment for the low income population in Travis County; extensive community engagement; and the development of a proposed strategic service delivery plan for recommendation to the board in December of 2021
3) Selecting a consultant was one of two requirements to begin to draw down funding related to the Episcopal Health Foundation $600,000 grant to support this work
4) We will be presenting a resolution at the June board meeting for the board to accept the grant funds
5) Contract negotiations with the selected consultant are underway and we will be returning to the board with more information.

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Verbal
Estimated time needed for presentation & questions?	30 minutes

CENTRAL HEALTH

Is closed session recommended? (Consult with attorneys.)	N/A
Form Prepared By/Date Submitted:	Monica Crowley/ June 2, 2021

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CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

June 9, 2021

AGENDA ITEM 5

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