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.

BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

Wednesday, August 7, 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 May 15, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee. (*Action Item*)

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

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

4. Receive and discuss an update on Communications and Community Engagement activities and initiatives.[1] (*Informational Item*)

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

6. Confirm the next regular Strategic Planning Committee meeting date, time, and location. (*Action Item*)

Note 1, Possible closed session item.

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

A quorum of Central Health's Board of Managers may convene to discuss matters on the agenda. 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 as possible, but no less than two days in advance, so that appropriate arrangements can be made. For assistance please contact Briana Yanes 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 2nd day of August 2019.

Dana DeBeauvoir
County Clerk, Travis County, Texas

By A. MACEDO Deputy

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Dana DeBeauvoir, County Clerk
Travis County, Texas

201981054

Aug 02, 2019 02:04 PM
Fee: $0.00 MACEDOS

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 1

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

MINUTES OF MEETING – MAY 15, 2019

CENTRAL HEALTH BOARD OF MANAGERS
STRATEGIC PLANNING COMMITTEE

On Wednesday, May 15, 2019, the Central Health Board of Managers Strategic Planning Committee convened at 5:33 p.m. in the Training Room, 1111 East Cesar Chavez, Austin, Texas 78702. Clerk for the meeting was Ms. Emily Farris.

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

Board Members present: Manager Zamora and Manager Zuniga.

REGULAR AGENDA

1. **Consider and approve the minutes of the April 10, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee.**

Clerk's Notes: Discussion on this item began at 5:33 p.m.

Manager Valadez moved that the April 10, 2019 meeting of the Central Health Board of Managers Strategic Planning Committee be edited to include concerns the member made in regards to the language barriers addressed on our website. Members agreed that the edited minutes would be brought back to the June meeting and approved then.

2. **Receive and discuss an update on the 86th Texas Legislative Session and Central Health's proposed legislative priorities.**

Clerk's Notes: Discussion on this item began at 5:40 p.m. Ms. Perla Cavazos, Vice President of Government Affairs for Central Health, provided the committee with an update on the current status of bills she has tracked in relation to Central Health. Ms. Cavazos presentation included upcoming deadlines on Senate and House actions, bills SB 1142 and SB 1350 that passed, the SB 2 tax cap as a priority concern, bills concerning community health center priorities, and other bills relating to women's health, mental health and cancer.

No action was taken on item 2.

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

Clerk's Notes: Discussion on this item began at 6:02 p.m. Mr. Ted Burton, Vice President of Communications for Central Health, and Mr. Ivan Davila, Director of Communications and Community Engagement for Central Health, provided an update in relation to the communications team projects. The team's mission is to bring more health services to remote areas of Travis County, the goal is to prioritize building trust among communities who have been underserved, marginalized and disenfranchised. The communications team is implementing a community engagement and outreach pilot using state-certified community health workers to perform outreach activities that emphasize community building and empowerment in Creedmoor, Colony Park and Austin's Colony/Hornsby Bend – to help people enroll in coverage and access health services effectively.

No action was taken on item 3.

4. **Receive and discuss an update asset mapping related to the social determinants of health.**

Clerk's Notes: Discussion on this item began at 6:19 p.m. Ms. Megan Cermak, Manager of Community and Population Health Strategy for Central Health, and Mr. Preston Poole, an intern for Central Health,

presented to the members. An outline of the presentation included the goals of the research, understanding public dollars for social services, a local public funds analysis, and social service organization resources, the federal social service dollars, the levels of high services areas being provided, the local funding for social services by category, and the funds for program associated with services for the homeless.

No action was taken on item 4.

5. Discuss the policies and practices of other Texas Hospital Districts in connection with a proposed funding resolution for the development and delivery of future programs and services with non-clinical partners.

Clerk's Notes: Discussion on this item began at 6:43 p.m. Ms. Cermak and Mr. Poole, presented a completion of a board request for research into different equity based policies and practices in connection with a proposed funding resolution for the development and delivery of future programs and services with nonclinical partners. Research reviewed the policies and practices of other Texas health districts and local organizations. Additional research reviewed examples of practices by other government entities that could be considered. A memo was provided to the board with the questions asked of different health/hospital districts and counties in Texas.

No action was taken on item 5.

6. Receive and discuss an update on the health equity road map.

Clerk's Notes: Discussion on this item began at 6:55 p.m. Mr. Mike Geeslin, President and CEO for Central Health, gave a very brief overview of the memo that was provided. This was an informational item only. The members did request a breakdown, from the Central Health HR department, of the current staff diversity based on ages, sex, and race. Mr. Geeslin agreed to provide this at the next board meeting, or in the interim via the Board's public messaging system.

No action was taken on item 6.

7. Receive and discuss the (FY) 2019-2024 Strategic Work Plan.

Clerk's Notes: Discussion on this item began at 7:02 p.m. Mr. Geeslin, provided an overview focusing on the changes Central Health will face on a federal level, an enterprise and operations update in relation to Central Health and CCC merging, the decline of DSRIP, how to better align and manage enterprise resources with CUC and Sendero, and what our strategic focus is moving forward.

Manager Museitif left the meeting at 7:24 p.m.

No action was taken on item 7.

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

Clerk's Notes: Discussion on this item began at 7:35 p.m. Chairperson Greenberg announced that the next Central Health Board of Managers Strategic Planning Committee meeting will be on June 5, 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 Jones seconded the motion.

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

The meeting was adjourned at 7:35 p.m.

_____

Sherri Greenberg, Chairperson
Central Health Strategic Planning Committee

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 2

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

CENTRAL HEALTH

1111 E. Cesar Chavez St.
Austin, Texas 78702
Phone: 512 978-8155
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www.centralheath.net

MEMORANDUM

To: Central Health Board of Managers Strategic Planning Committee
From: Monica Crowley, Chief Strategy and Planning Officer; Megan Cermak, Manager of Community and Population Health
CC: Mike Geeslin, President and CEO
Date: August 7, 2019
Re: Item No. 2 –Receive and discuss an overview of Central Health Enterprise activities related to the social determinants of health. (*Informational Item)*

Overview:
The Central Health Board of Managers Strategic Planning Committee requested 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. This memo includes an inventory of these services and programs along with a description of how social services are integrated into health care delivery within the Enterprise.

Integration of social services into health care delivery:
CommUnityCare (CUC) uses a care coordination and care management model to remove barriers to care and address social determinant of health needs. This model starts with frontline staff including community health workers, medical assistants, medical admitting clerks and pharmacy. These staff members focus on addressing immediate needs identified at the time of visit. Services provided include facilitating transportation assistance, identifying food insecurity, and helping obtain medications. Care coordinators focus on closing gaps in care, while care management team members focus on removing barriers and intervening for medically complex patients. CUC is working toward implementing a community resource platform to identify and refer patients to local social service organizations.

The Community Care Collaborative (CCC) Medical Management Program is a comprehensive model of integrating social services into health care delivery. The Medical Management team is comprised of experienced clinicians including nurses, licensed medical social workers, and a community health worker. Services offered by this team include transitions of care after discharge from the emergency department at the Dell Seton Medical Center at The University of Texas, post-acute care transitions, and support with access to community resources. While supporting the medical needs of the patient, the team connects the patient to transportation, food, housing, and utilities assistance. The team also assists patients with enrollment into Supplemental Security Income and Social Security Disability Insurance and helps connect patients to employment opportunities through community workforce programs.

The local clinical model for integrating social services and health care delivery is the Central Health Southeast Health & Wellness Center—a community hub offering access to an array of social services including:

- Housing assessments for the homeless;
- Free legal services; home buyer workshops;
- Free tax preparation and filing;
- Zumba and yoga classes;
- A partnership with Peloton University, a non-profit university to help adults obtain debt-free post-secondary education and job placement.

While Central Health maintains strong community partnerships and has developed warm hand-off processes to community resources, Enterprise partners pilot various social service interventions and has operationalized some of these successful interventions as part of care. Below is an inventory of these programs and services.

<u>Central Health Initiatives:</u>

- Policy Initiatives - The Central Health Equity Policy Council has worked on the following policy initiatives that create a long-term path to wellness for our communities: Regulating electronic cigarettes including sale and delivery to minors and use of electronic cigarettes in public places; school district polices that created access to daily recess for low-income children that cannot be taken away for punitive or academic reasons; routine HIV screening in safety net clinics and emergency room departments. With screening, we are creating a pathway for referral so that a person who is diagnosed with HIV can be on anti-viral medications within 72 hours of diagnosis and possibly have an undetectable viral load within 30 days of diagnosis. This work has been recognized as a valuable resource for community partners and is a gap filled by Central Health that has a large impact while requiring at little expense.
- Transportation - Central Health worked with CommUnityCare this past year to offer free shuttle services for clients of the Southeast Health & Wellness Center. Central Health is currently operating a pilot in partnership with CUC, United Way and Lyft to offer free rides to and from the Central Health Southeast Health and Wellness Center. This pilot is currently being evaluated. In FY20, Central Health is exploring a new pilot offering free prescription delivery for a targeted subset of CUC patients with high need.
- Food insecurity - Central Health Southeast Health & Wellness Center partners with Farmshare and Austin Public Health for a subsidized, weekly mobile market; offers free healthy cooking with CUC dieticians; gardening classes; and a free summer lunch program.

Community Care Collaborative Initiatives:

- The Community Care Collaborative (CCC) piloted a rideshare service in partnership with Ride Austin in FY19. While the partnership proved valuable, the model was resource-intensive. The CCC will be using a ride dispatcher program, Circulation, to continue offering transportation services in FY20.
- This past year, the CCC partnered with the YMCA to offer the gold-standard in diabetes prevention intervention, the Diabetes Prevention Program (DPP). This is a year- long program focusing on healthy eating and physical activity that can reduce a person's chance of developing Type 2 diabetes.
- The CCC will be launching a pilot of medically-tailored meal delivery service in partnership with Meals on Wheels.

CommUnityCare Initiatives:

- CUC partnered with the Central Texas Food Bank to screen patients for food insecurity and enroll patients in food assistance at the time of visit. The pilot ran from August 2018-April 2019 at the Rundberg Health Center location. Cigna funded emergency food boxes that were provided to the patients during the visit. Based on the success of this pilot, CUC is exploring a more sustainable model including co-locating Central Texas Food Bank screeners and the continuation of the emergency food boxes.
- CUC is in the application process for a grant with the Episcopal Health Foundation for a community resource referral platform to identify and refer patients to local social service organizations. If the platform proves successful, the intent is to link the platform with patients' electronic health records.

Terminology:

- **Social determinants of health**: Conditions in the environments people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-live outcomes and risks. (Healthy People 2020, the U.S. Department of Health & Human Services)
- **Social services**: Programs and services that improve the well-being of individuals, families, and communities. (the U.S. Department of Health & Human Services)
- The Enterprise partners often use the terms *social determinants* of health, *non-clinical factors* of health, and *non-medical drivers* of health in the framing of social services.

Inventory of Enterprise Social Service programs

Enterprise Partner	Program	Resources	# of people served
Central Health	Program development and facilities management at SEHWC	6 Central Health FTE's, 3 CUC FTE's	
Central Health	Zumba classes at SEHWC	$18,200	
Central Health	Yoga classes at SEHWC	$5,000	
Central Health	Healthy cooking classes at SEHWC	$10,000 for food and supplies; CUC provides 3 FTE's in-kind.	
Central Health	Summer Lunch Program at SEHWC	$6000 for adult meals; Central Texas Food Bank provides meals for children as in-kind in FY18	4,330 meals served to adults and children in FY18
Central Health	Mobile market at SEHWC	$5,000 and food is subsidized by Austin Public Health	
Central Health	Gardening class at SEHWC	$2,000	
Central Health	Transportation pilot with Lyft- free rides to and from the SEHWC	$28,811 as of June 30, 2019	1,641 rides as of June 30, 2019
Central Health	Transportation pilot with CUC-shuttle for ETC residents to the SEHWC	$24,000	231 rides over a 6 month period- from July to December 2018
Central Health	Prescription assistance and delivery for targeted CUC patients – to launch in FY20	Anticipated budget of $30,000	Anticipated reach of 900 prescriptions delivered
Community Care Collaborative	Meals on Wheels pilot- delivering medically tailored meals	Anticipated budget of $50,000	Anticipated reach of 30 people
Community Care Collaborative	Diabetes Prevention Program	Offered in partnership with the YMCA	Approx 24 enrollees
Community Care Collaborative	Transportation Pilot with Rideshare Austin	$50,000	2700 rides, 300 unique individuals
CommUnityCare	Rundberg Food Pilot	In partnership with the Central Texas Food Bank	1,924 emergency food boxes were distributed from 8/18 to 4/19
CommUnityCare	Social Services management platform	Grant from Episcopal Health Foundation	N/A

CENTRAL HEALTH

CommUnityCare HEALTH CENTERS

SENDERO HEALTH PLANS

Community Care Collaborative

A Central Health and Seton partnership

Integration of Social Services into Healthcare Delivery

Strategic Planning Committee Meeting

August 7, 2019

Vision

Integration of social services into healthcare delivery

- CommUnityCare- Front line staff (including CHWs), Care Coordinators, and Care Management teams
- Community Care Collaborative- Medical Management teams
- The Central Health SouthEast Health & Wellness Center- a community hub for healthcare and social services

CommUnityCare

Deborah King

Director of Population Health

CommUnityCare


Addressing
Social
Determinants
of Health

CUC Model of Care – Strategic Goals

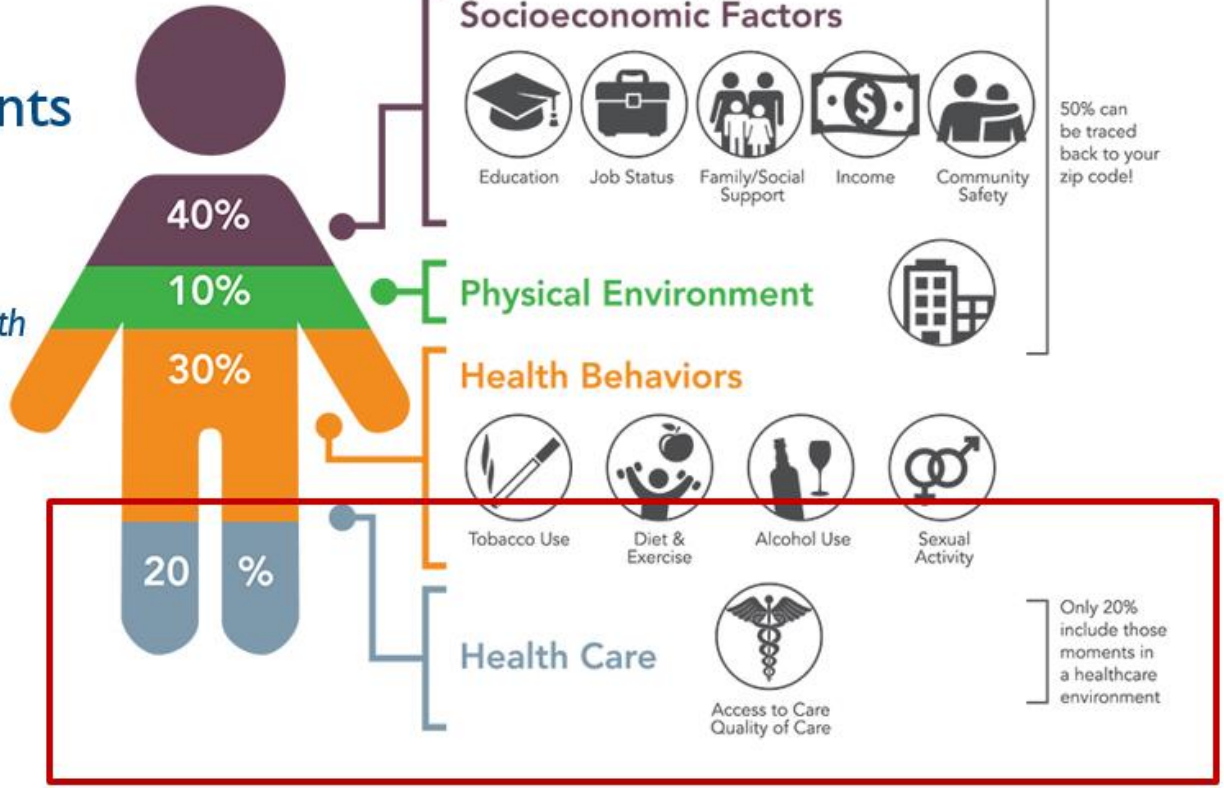
- Team based approach to care delivery and from a population perspective.
- Activate patients in the achievement of long term, health goals that include clinical outcomes and patient reported feedback.
- Target interventions and outreach to local communities identified as having the greatest health disparities.

- **Model of care that integrates the identification and addressing of social determinants of health.**

The Community Health Worker is critical to our model of care.

Social Determinants of Health

The drivers of health are complex and interconnected



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Community Health Workers

Patient Engagement

Remove barriers to care and preventive health screenings, *i.e. transportation, food insecurity, difficulty obtaining medication*

Coordinated population health education approach

Addressing SDOH

Health Promotion & Outreach

QM Calendar

SDOH Self-Management *(Teach a man to fish..)*

Community Resource Assistance & Navigation

Referrals Navigation Assistance

Referrals to Collaborative Care Team

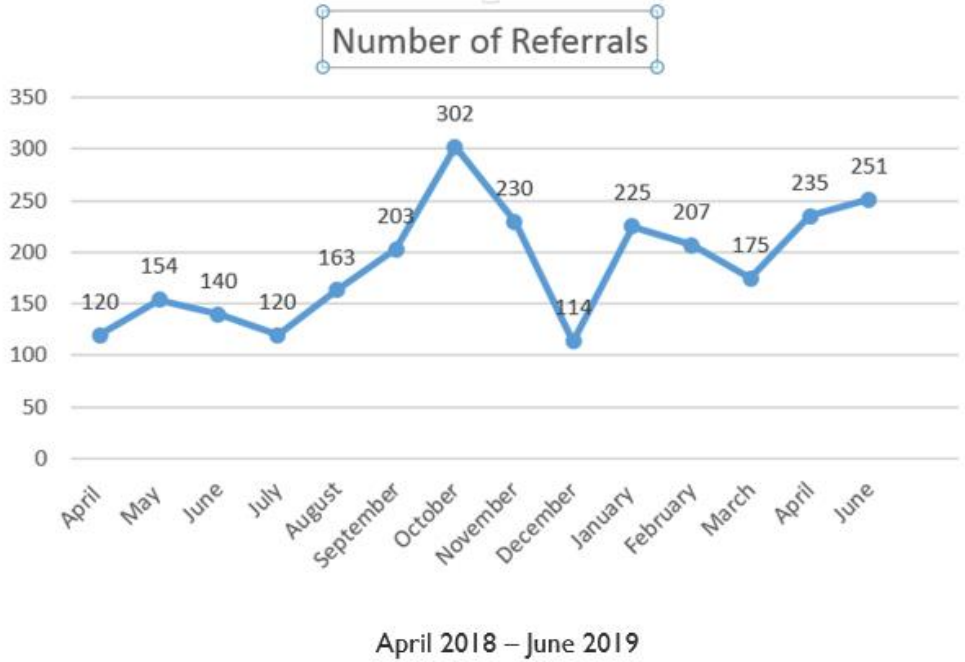
Known outcomes of CHWs' service are:

1) improved access and use of health care services,

2) better understanding of the health and social service system,

3) improved adherence to health recommendations.

CHW REFERRALS TOTAL 2,639



April 2018 – June 2019

COMMON RESOURCE CONNECTIONS

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

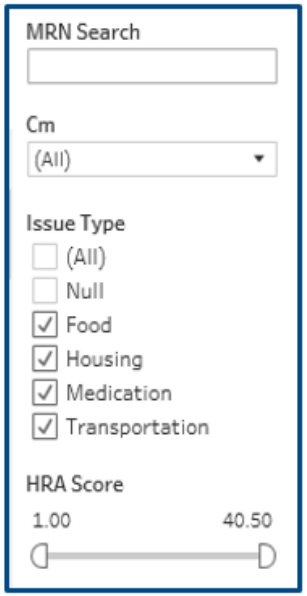
2+ Opportunities

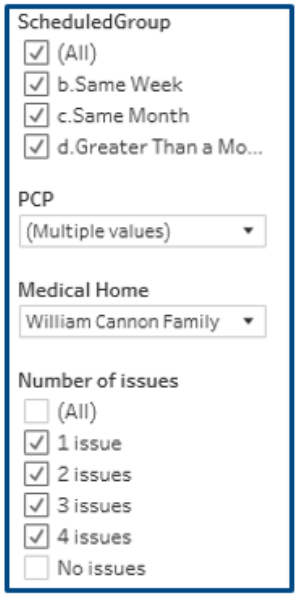
CHW SDOH DASHBOARD

SDOH Dashboard

Live July 15th

- Utilizing HRA data
- Targeting 4 SDOH's
  - Transportation
  - Food Insecurity
  - Difficulty Paying for Medications
  - Housing Instability
- Prioritizing efforts to address needs of most vulnerable in a proactive manner





Addressing Gaps

- Establish community partnerships
  - Central Texas Food Bank- screening for food insecurity and enrolling patients for food assistance, food box distribution for patients at time of visit
  - Rundberg Food Pilot- 1,924 boxes were distributed from 8/18 to 4/19

TACKLING FOOD INSECURITY

TOGETHER

Moving the Community from Hunger to Health

CHW SPECIAL POPULATIONS - CARE CONNECTIONS

Community Health Worker

Connects directly with patients in the hospital (30% of time at hospital)

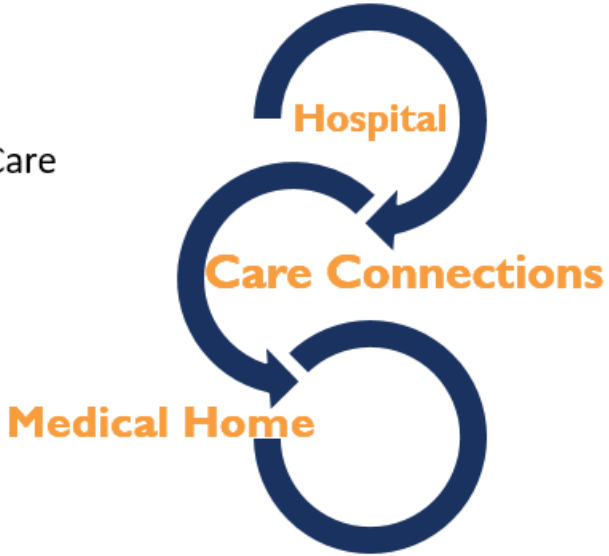
- 239 CHW encounters
- CHW meet and greets
- Telephonic outreach and engagement
- Addressing barriers to care such as transportation and other SDOH's

OUTCOMES

72% Show Rate for patients of which she coordinated post-discharge planning and follow up

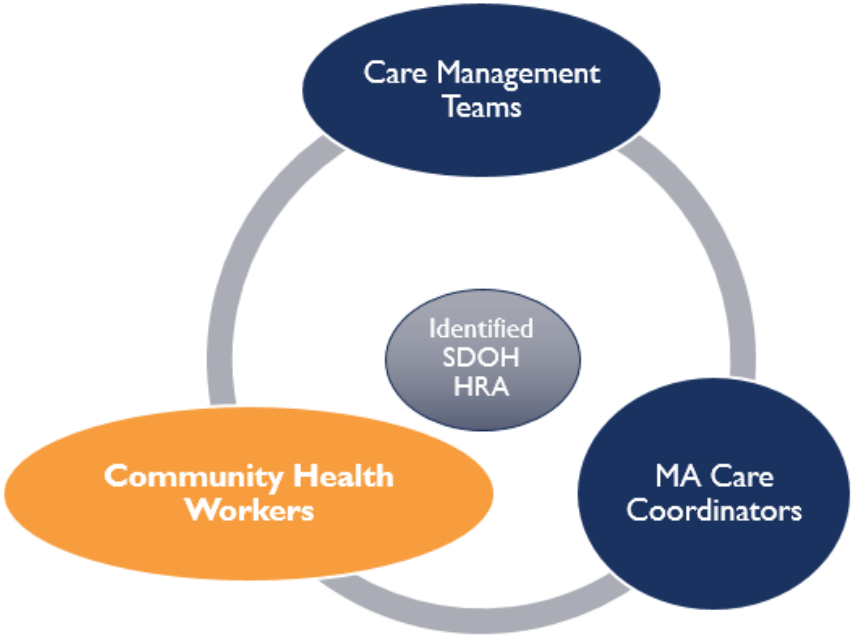
Linkage to Services

- Wound Care & Foot Care
- Hepatitis C tx
- Paracentesis
- Care Management
- MAT
- ECHO onsite
- On site Psychiatry (Integral Care)
- Linkage to SOAR



Utilizing the Community Health Worker to help facilitate the right transitions of care to avoid preventable readmissions.

SYSTEMICALLY ADDRESSING SOCIAL DETERMINANTS



- CHW's – primarily focusing on addressing immediate needs identified at time of visit
- Care Coordinators – addressing transportation needs related to medical appointments as they are focused on closing gaps in care
- Care Management Teams – primarily focusing on remove barriers and intervening for medically complex patients

Care Coordination

MA Care Coordinators

Facilitates the coordination of care for patients

Resource for clinical care team members

Addresses condition specific & Preventive Health Screening

Patient engagement, goal creation & monitoring

Primary Prevention

Dental Referrals

Adult Immunization

Health Promotion & Education

Condition Specific & **Preventive Health Screenings**

Closing Gaps

Tableau Care Management Dashboard & SDO's

Addressing Transportation Barrier

Referrals to Collaborative Care Team

Patient Assignment

Patients with A1c 6.5 – 7.9

MA Care Coordinator Panels

William Cannon - 125
South Austin -203
SEHW - 212
Rundberg – 373
North Central - 617
Arch - 36

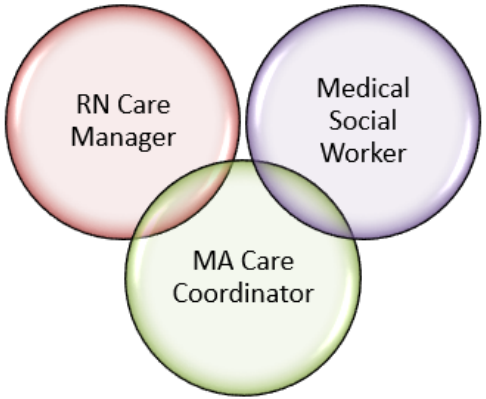
Future…
Sandra Joy Anderson & Hornsby Bend
Oak Hill & Del Valle

Care Management

Care Management process begins with a comprehensive initial assessment

- Prioritization of patient goals
- Patient education: Disease Specific, Survival Skills, Urgent Care Utilization
- Coordination of services with internal and external providers.
- Increased patient self-management through the creation and follow up of Shared care plan

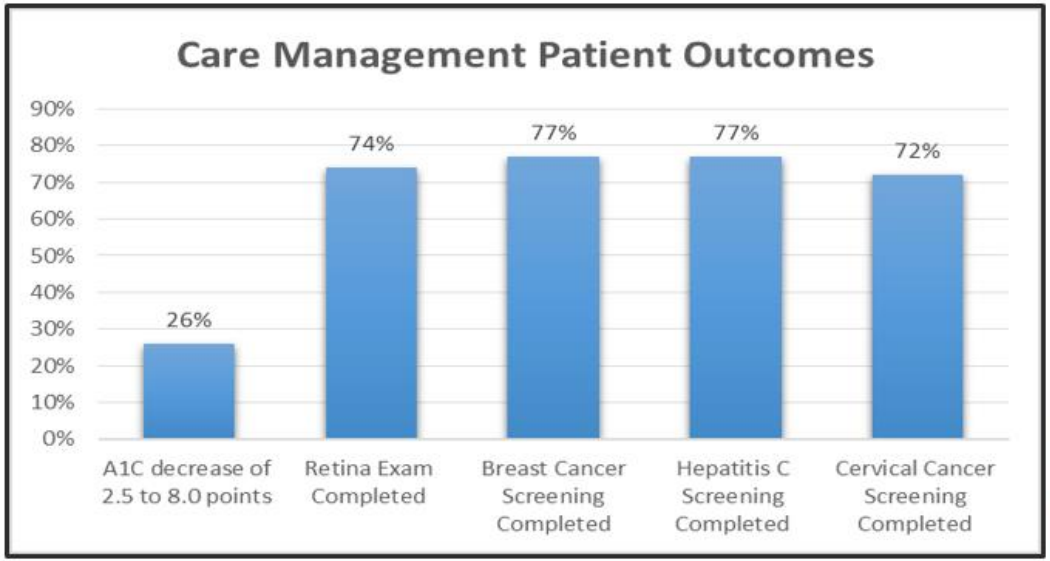
Care management focuses on those patients who are particularly vulnerable through patient education, coordination of services, resources and increasing the patients ability to self-manage.



Care Management focuses on the whole patient

Medical & Social

- Comprehensive Health Risk Assessment
- ***SDOH assessment and intervention through Care Management SW***
- Review of status updates, medications, mood, and goals.
- Continuous and individualized discharge planning.


Care Management Patient Outcomes
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
26%
74%
77%
77%
72%
A1C decrease of 2.5 to 8.0 points
Retina Exam Completed
Breast Cancer Screening Completed
Hepatitis C Screening Completed
Cervical Cancer Screening Completed

TRANSITIONS OF CARE – REDUCING BARRIERS TO CARE

COMPASSIONATE DIALYSIS PILOT

- Undocumented immigrants with ESRD (and residents without enough work quarters) rely on "compassionate" or emergent dialysis.
- CUC Care Management created a patient friendly referral process
- Renal Class

OUTCOMES

- 22 patients have successfully transitioned from emergent dialysis to outpatient dialysis
- 29 additional patients assisted in retaining their outpatient dialysis
- 27 Patient identified for next years program

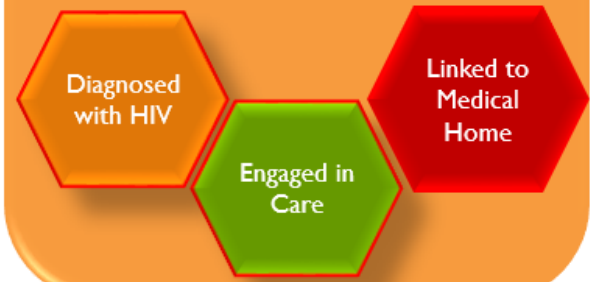
CARECO

- Continue utilizing the Community Health Worker to help facilitate the right transitions of care to avoid preventable readmissions.

Seamless Transitions of Care

EXPANSION OF HIV CARE

- Teams completing National HIV Curriculum
- Preparing to support patients transitioning from David Powell to their medical homes at CUC sites closer to their homes



GET READY IT'S A NEW DAY

Team-Based Care

REACHING FOR
Health Equity

CCC Medical Management

Veronica Buitron-Camacho, MSN, RN
CCC Director of Medical Management

Ccc Med Mgmt Success Story

Who We Are

1 Transition of Care RN at Dell Seton Medical Center – UT for ED patients and identify discharged MAP patients

2 Transition teams with RNs, SWs, and CHW to assist MAP and MAP basic patients who need care

(One complete bilingual team)

1 Post Acute care and homeless patient coordinator

1 Program Coordinator to support medical management teams

1 LVN Care Coordinator to assist patients and community case managers with scheduling appointments

Avenues to Care

- Transition of care nurse
- Hospital case management
- Post acute care transitions
- Community partners

Social services we provide to patients

- Transportation through Ride Austin pilot, cab vouchers, bus passes and Metro Access enrollment
- Food through Meals on Wheels enrollment and connect to local food pantries
- Income through enrollment into SSI/SSDI
- Housing through permanent placement in community programs for qualified applicants
- Utilities support through City of Austin programs and other grant funded programs that offer assistance
- Employment through community workforce programs
- Placement into our residential rooming program

Central Health Southeast Health & Wellness Center

A long-term path to wellness

- Through policy
- Through pilots

Next Steps

Factor Health

- Partnership between the University of Austin's Dell Medical School and Episcopal Health Foundation
- Establishes a platform to test and sustain interventions that address broad health drivers outside the walls of a clinic.

Inventory of programs and services

- Providing medically-related transportation
- Addressing food insecurity
- Healthy eating and physical activity opportunities

CENTRAL HEALTH

CENTRALHEALTH.NET

@CentralHealthTX

CommUnityCare

SENDERO HEALTH PLANS

Community Care Collaborative
A Central Health and Seton partnership

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 3

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

CENTRAL HEALTH

1111 E. Cesar Chavez St.
Austin, Texas 78702
Phone: 512 978-8155
Fax: 512 978-8156
www.centralheath.net

MEMORANDUM

TO: Sherri Greenberg, Chair, Central Health Strategic Planning Committee;
FROM: JP Eichmiller, Senior Director of Strategy and Information Design;
CC: Mike Geeslin, President and CEO; Monica Crowley, Chief Strategy and Planning Officer
DATE: Aug. 2, 2019
RE: Item No. 3- Receive and discuss an update on the medical transportation initiatives of the Central Health Enterprise, including collaborative planning efforts. *(Informational Item)*

Overview
This memo transmits an update regarding the Central Health Enterprise's ongoing transportation initiatives, including the transportation pilot based out of the Central Health Southeast Health & Wellness Center, the Community Care Collaborative's Circulation pilot and the convening of a Health Care Transportation Working Group.

Background
In response to requests to continue providing transportation services for clients of the Central Health Southeast Health & Wellness Center, Central Health launched a pilot transportation program Jan. 16 utilizing the Lyft Concierge service. Central Health initially provided $15,000 to cover the costs of the pilot through April 30. In April, the pilot was extended to run until Sept. 30 with an additional $35,000 in funding. As of June 30, the pilot had provided 1,641 rides at a cost of $28,811.78.

To understand the effect of the initiative on its patient population, Central Health staff developed a comprehensive implementation and evaluation plan. This included building process maps; collecting and analyzing user and ride data; conducting interviews with staff and clients; and analyzing medical records. Initial findings for patients who utilized the transportation services include:

- A 25% decrease in no-show appointments versus the two years prior
- Monthly appointments for chronic condition patients doubled versus the two years prior
- Approximately 3% of the SEHWC patient population utilized the services

Further details of the report and analysis including patient demographics, survey results, overhead costs and ridership will be presented at the Aug. 7 committee meeting. A final version of the report and recommendation regarding future services will be completed later in August.

The Community Care Collaborative is in the process of finalizing a contract with Circulation, a technology company that has developed a web-based platform that allows providers and case managers the ability to book non-emergency medical transportation services through a network of transportation providers. The pilot will target CCC patients being served through the Medical Management program. There are currently approximately 150 patients in the program at any time who will qualify for the program based on their complex medical needs. The pilot is expected to

launch soon after the contract is executed and is being funded through $50,000 set aside from the CCC's Medical Management department budget.

In FY2018 Central Health began convening a group of local health care, social service and transportation providers to share information and discuss possible collaborations. On July 31, the group, informally titled the Health Care Transportation Working Group, met for the third time at the Central Health administrative offices, with 17 people attending. Topics of the meeting included aligning efforts with the Austin/Travis County Community Health Improvement Plan (CHIP); discussions on pursuing common funding opportunities; and updates on current transportation initiatives taking place in the community. Participants of the meeting agreed the group should begin meeting regularly to discuss further opportunities to align health care and transportation efforts.

Action needed
None

Central Health Enterprise Transportation Initiatives Update

Central Health Board of Managers Strategic Planning Committee

Aug. 7, 2019

JP Eichmiller, Senior Director of Strategy and Information Design;

Sarah Cook, Senior Director of Strategy, Communications and Population Health

Agenda

- 2019 Lyft transportation pilot evaluation
- Complex Care Management transportation program
- Health Care Transportation Workgroup

2019 Lyft Pilot

Purpose: Pilot the implementation of a model to address transportation barriers and tie assessment to clinical access measures.

Overview:

- SEHWC staff can book Lyft rides on-site
- United Way staff can book Lyft rides for 2-1-1 callers
- Launched Jan. 18; funded through Sept. 30
- As of May 30: 1,192 rides booked; 421 unique riders

Benefits:

- Rides can be booked on-demand or up to seven days in advance
- No overhead/only pay for what we use
- Lyft Concierge platform allows scheduling and tracking of multiple rides at once

Limitations:

- Does not address patients requiring ADA-compliant transportation

Objectives

- Decrease no-show rates
- Provide rides to those who lack other means
- Increase volume of medical encounters
- Increase follow-up appointments
- Reduce cost per ride

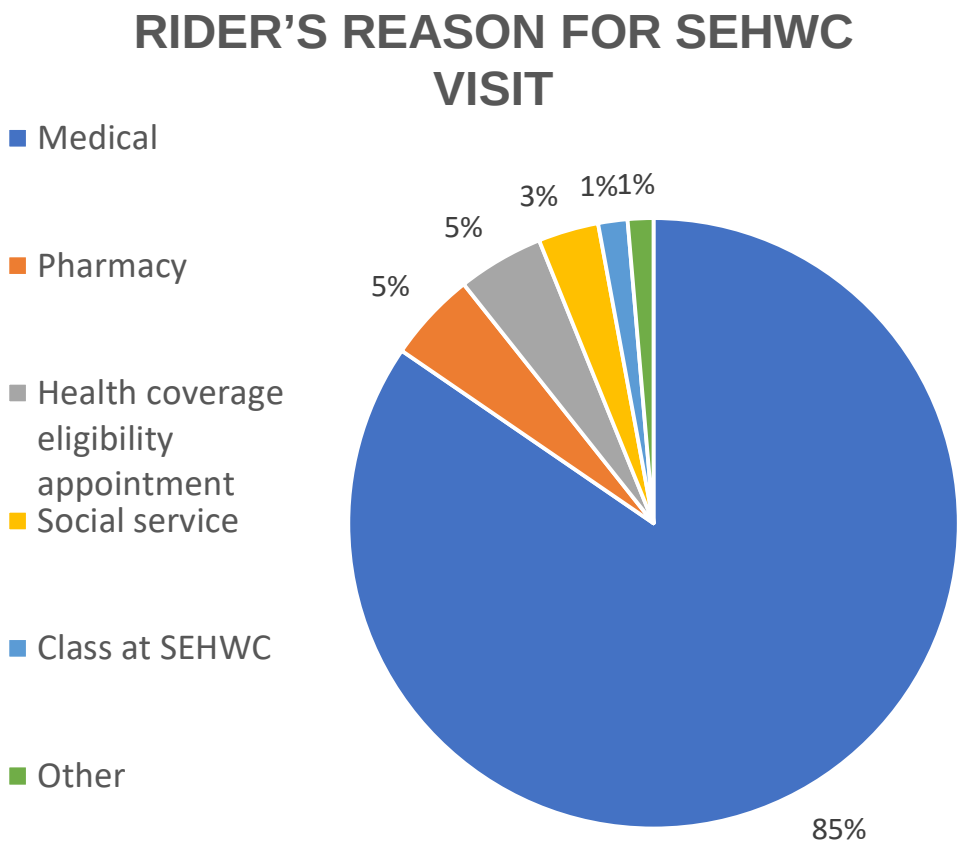
Preliminary Evaluation—No-Show Appointments

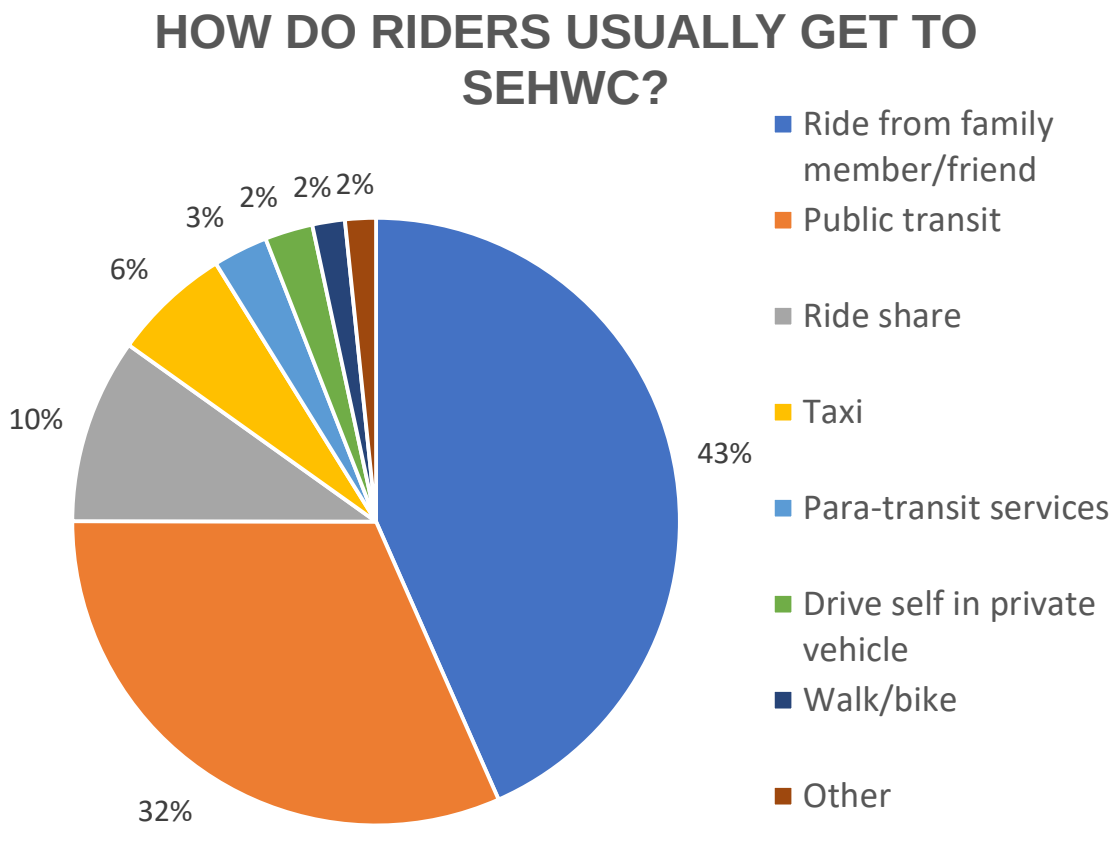
No-show appointment rate pre-pilot (Jan. 2017-Dec. 2018): **24.3%**

No-show appointment rate during pilot (Jan.-April 2019): **18.6%**

Findings: *On average the no show appointment rate was 5.7% points lower among patients after the Pilot was in operation, demonstrating a **23.5%** overall decline in no-show rates.*

Preliminary Evaluation—Transportation Needs

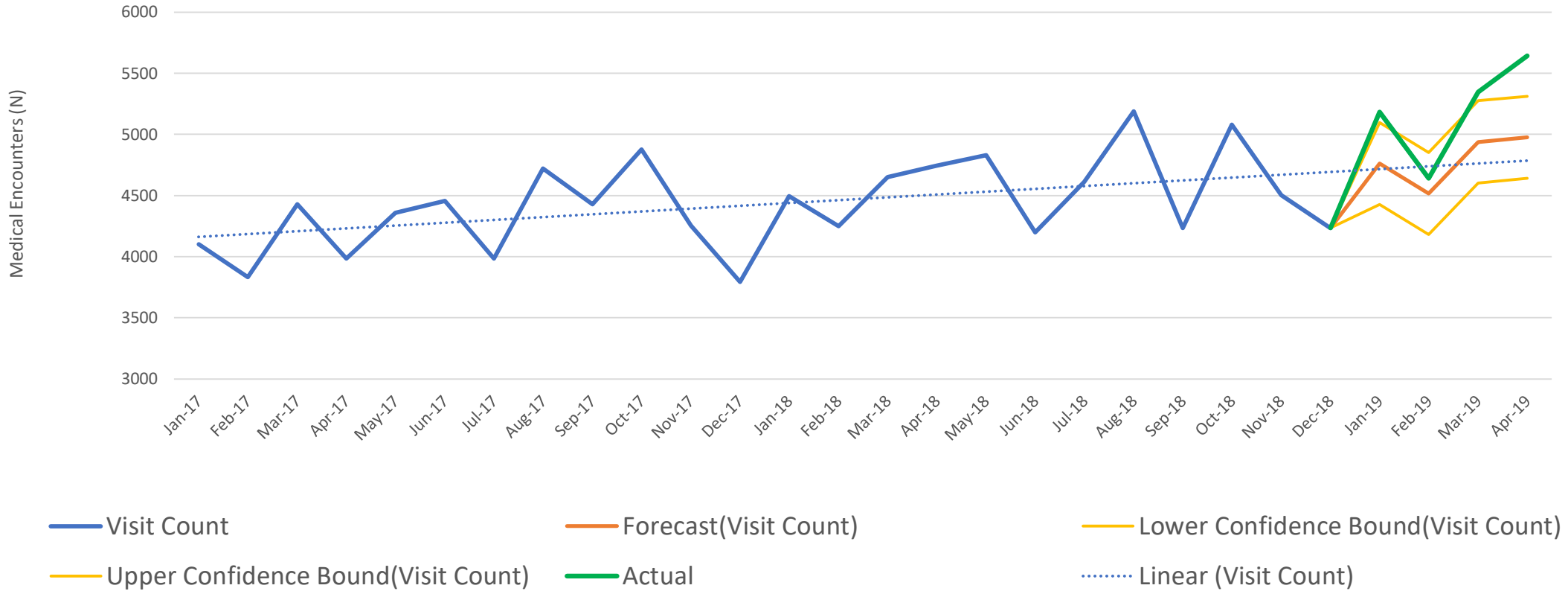




Findings: *35% of users reported missing an appointment in the last 12 months due to transportation problems*

Preliminary Evaluation—Overall Medical Encounters

Findings: *The actual growth in number of medical encounters from January to April 2019 was not statistically significantly different from the expected growth in encounters based on historical trends.*



Preliminary Evaluation—Medical Utilization

Chronic condition patients:

- Average monthly visits pre-pilot (Jan. 2017-Dec. 2018): 0.54
- Average monthly visits during pilot (Jan.-April 2019): 1.05

Findings: *On average, the per-member, per-month medical utilization doubled among patients with chronic disease during the four-month pilot evaluation period.*

Preliminary Evaluation—Costs per ride

2018 CommUnityCare shuttle pilot cost per ride: $104.76

- Does not include per-ride administrative cost

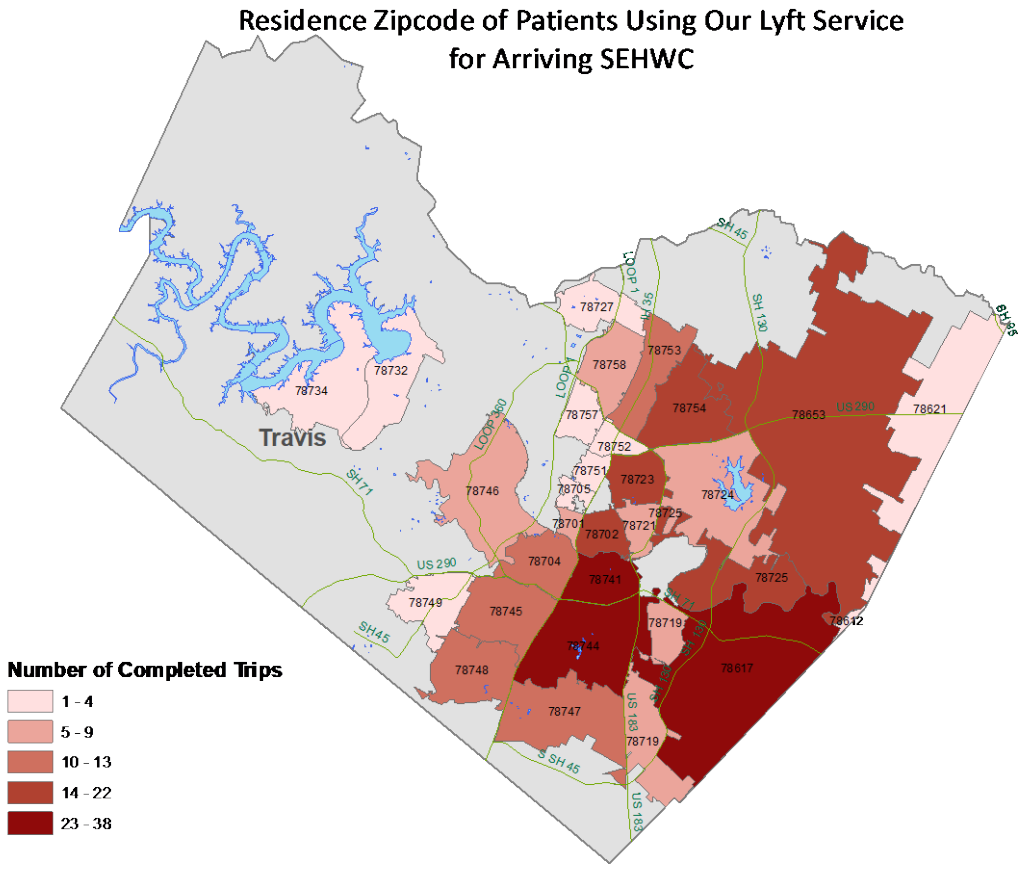
2019 transportation pilot median cost per ride: $23.51

- Includes $9.28 per-ride administrative cost

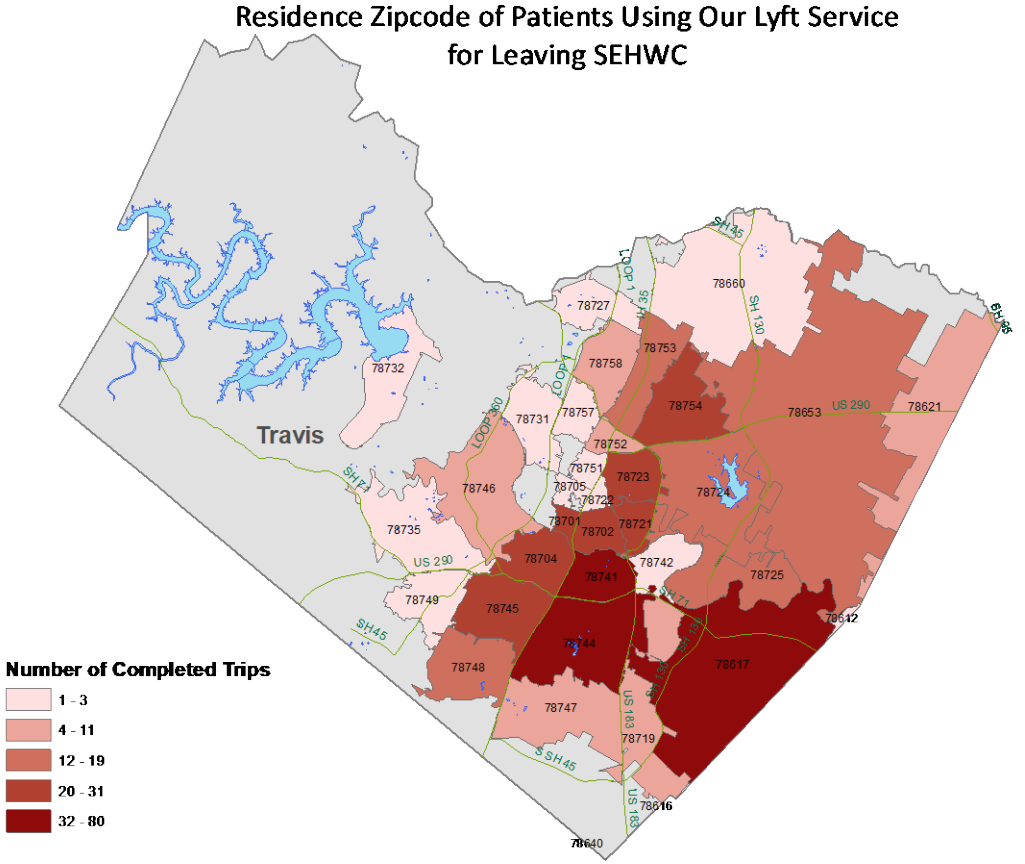
Findings: *The median cost per ride for the 2019 pilot was 78% lower than the cost per ride of the 2018 shuttle pilot, excluding overhead costs.*

Ride Summaries

Total rides arriving: 447 (38%)



Total rides leaving: 725 (61%)



Discussion

- Tied population health interventions to clinical measures
- The pilot demonstrates preliminary improvements in access to care
- Despite improvements in technology vs. previous pilots, operating a transportation initiative remains resource-heavy
- The model used at SEHWC is not scalable to other clinics
- Determining value, impact on health outcomes and system utilization would require a longer measurement/pilot period and additional evaluation

Next Steps:

- Complete evaluation report
- Present report and options to Central Health and CUC leadership, including clinical and case management staff

Complex Care Management Transportation Program

Overview

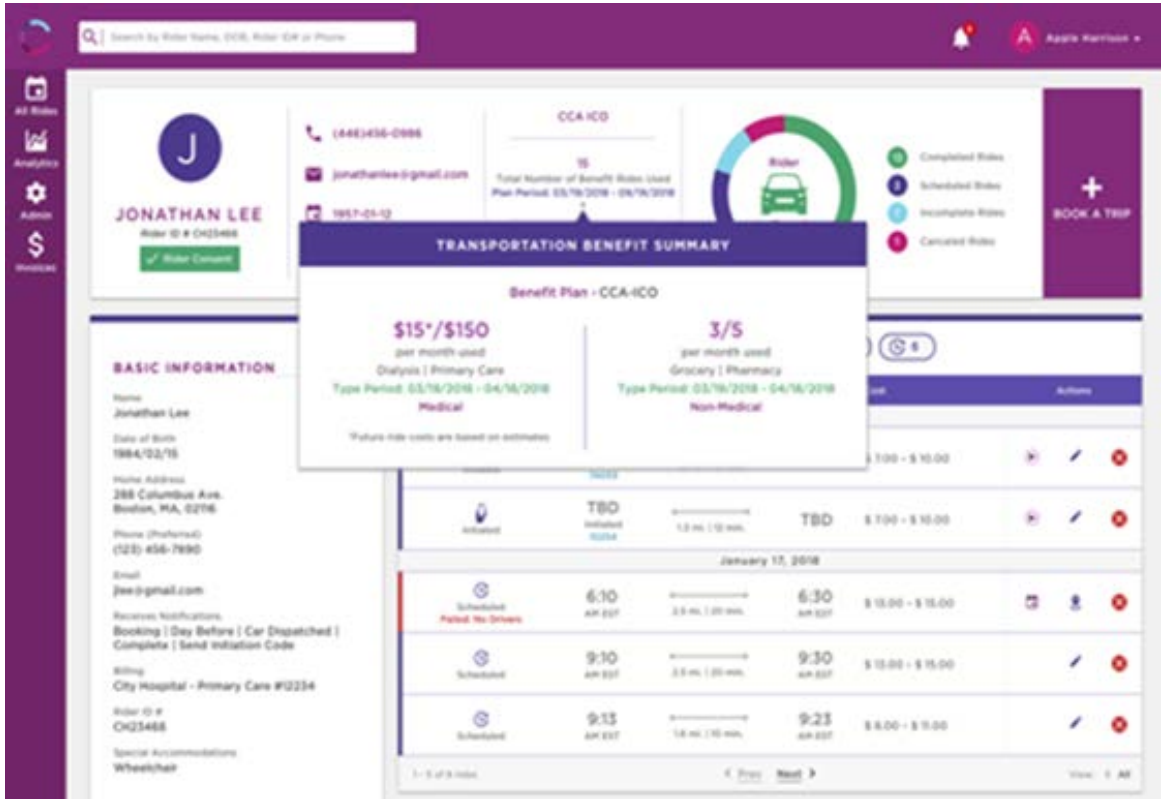
- A contract is being finalized with Circulation—a web based platform for booking non-emergency transportation services.

Scope

- Program will initially serve patients enrolled in the Complex Care Management Programs; approximately 200 at any given time
- Opportunity to expand as needed
- $50,000 budget

Coordination

- Enterprise collaboration to share lessons learned and align measurements/evaluation.



Health Care Transportation Working Group

Purpose

- Informal group of health care and transportation providers convened by Central Health
- Discuss possible collaborations, ongoing initiatives and funding opportunities

Participation

- Three meetings to date (most recent July 31)
- Invited CHIP Access to Care participants to attend
- Attendees include Central Health, CCC, CommUnityCare, Seton, Integral Care, CapMetro, Travis County, City of Austin, CARTS, HACA, United Way, University of Texas and more

Takeaways

- Unique forum that is not being duplicated
- Participant interest in scheduling regular meetings
- Accessing sustainable transportation funding could be a key topic moving forward

CENTRAL HEALTH

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@CentralHealthTX

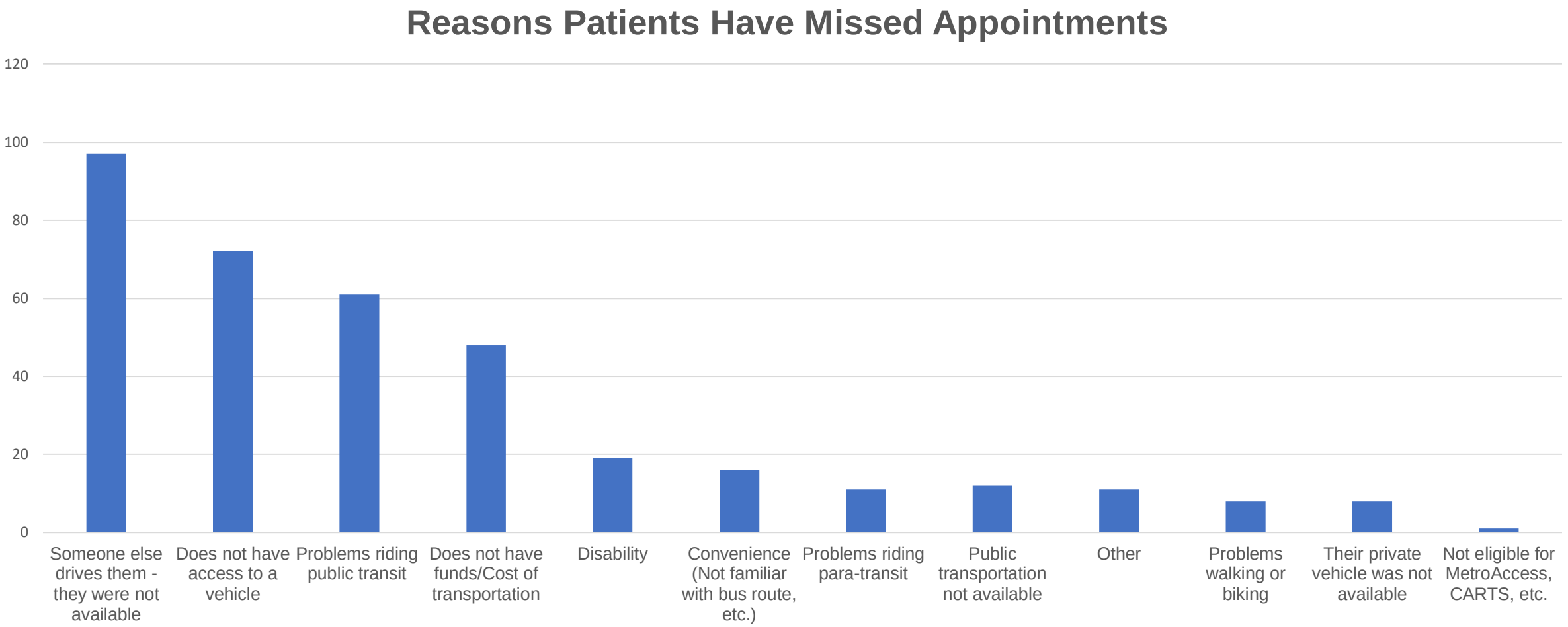
Community Care Collaborative
A Central Health and Seton partnership

CommUnityCare

SENDERO HEALTH PLANS

Appendix

Rider Surveys



Preliminary Evaluation—Demographics

Findings: *The pilot participant group differed from the clinic and all-CUC patient populations in nearly all categories*

	% Pilot Participants	% SEHWC Patients	% All CUC Patients
Female	63.2	64.1	58.1
Male	36.2	35.9	41.9
White	48.2	73.9	68.6
Black	17.6	7.9	9.9
Hispanic	53.1	69.1	62.1
Other	2.3	2.0	3.2
<18	5.9	20.0	21.9
18-29	9.4	12.7	14.5
30-44	16.0	23.8	26.5
45-64	51.8	35.4	29.9
65+	16.9	8.1	7.2

CENTRAL HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 4

Receive and discuss an update on Communications and Community Engagement activities and initiatives.[1]

CENTRAL HEALTH
HEALTH CARE FOR ALL

M E M O R A N D U M

To: Central Health Strategic Planning Committee

From: Ted Burton, Vice President of Communications, Central Health

CC: Mike Geeslin, President and CEO, Central Health

Date: Aug. 7, 2019

RE: Community Outreach and Engagement Update/**INFORMATIONAL ITEM**

Overview:

The Communications Team has been focused on several community outreach and engagement strategies and activities to promote the new mobile unit, the home visit pilot, general awareness about Central Health coverage programs (i.e. MAP), and preparing students from families with low-income for the new school year. We are also preparing to welcome our fourth Central Health Community Health Champions class with a two day health equity training Aug. 2-3. The objective for our outreach and engagement activities is to increase awareness of Central Health services and programs, and build community relationships through face-to-face interactions and collaboration with partner organizations.

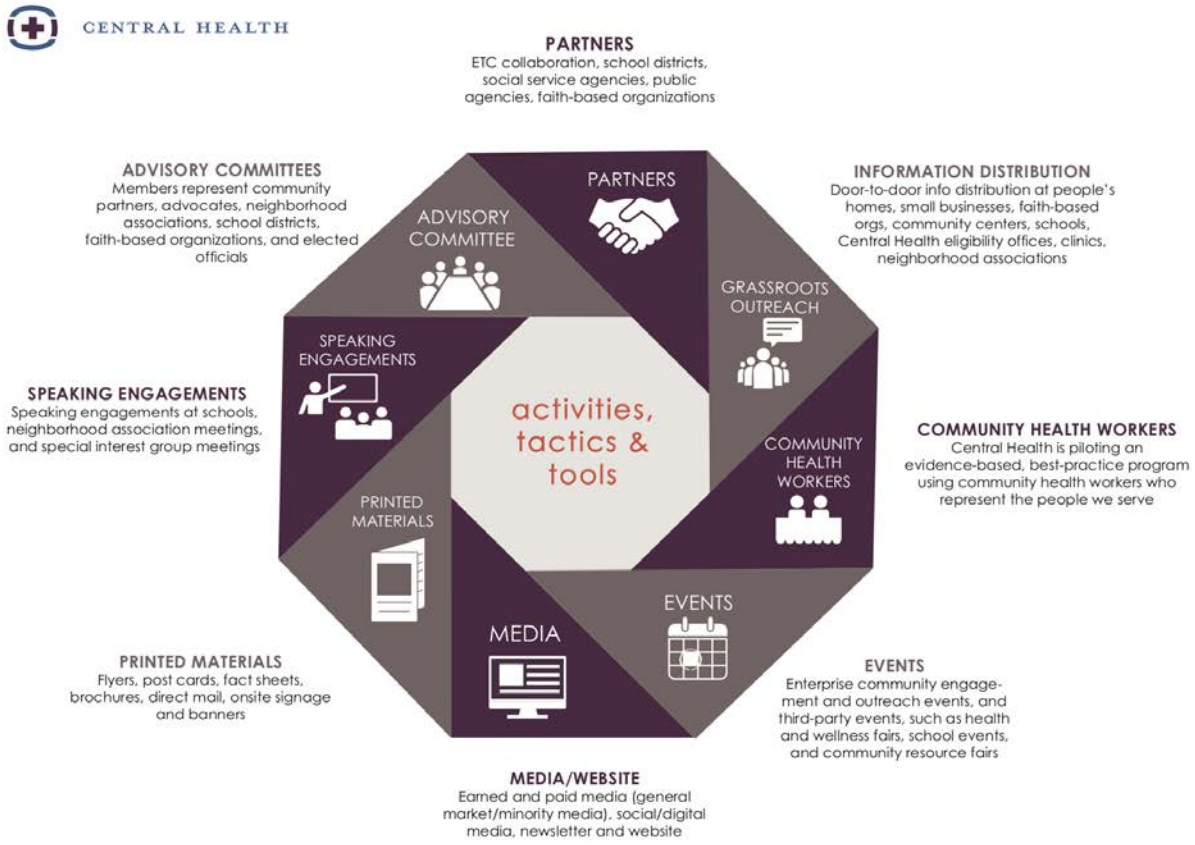
Target audiences for our efforts include residents, community partners, and the media. We measure success in multiple ways including the number of people reached, the number of events attended, and the number of partner organizations connected with.

We use a comprehensive approach to community outreach and engagement, selecting the appropriate tactics and tools to effectively reach our goals.

A Comprehensive Approach to Communications and Outreach

In March 2018, Central Health's community engagement/outreach efforts were integrated into the Communications Department. Central Health is also working with CommUnityCare to implement a comprehensive approach to communications and outreach, using a logic model based on the Theory of Change. The model helps us ensure we are thoughtful and methodical in the selection, implementation, and evaluation of communications, community engagement and outreach tactics.

Central Health and CommUnityCare's Menu of Activities, Tactics and Tools



Synopsis:

MARKETING

Direct Mail
CommUnityCare mails collateral materials to promote health care services to current patients living in a specific ZIP code. When the organization needs to target specific neighborhoods within a ZIP code, CommUnityCare partners with neighborhood associations on direct mail campaigns. CommUnityCare mailed a post card to promote the mobile clinic to more than 2,700 Colony Park residents.

Canvassing (Door-to-door flyer distribution)
Central Health is working with a vendor to help distribute flyers door-to-door in Creedmoor.

Signage
CommUnityCare and Central Health partner to produce and place signage to promote health care services.

ONLINE COMMUNICATIONS

Social Media

Central Health created a video announcing the arrival of the mobile clinic and shared it via YouTube, Facebook, and Twitter in May and June. We boost almost all social posts, using a geo-fencing strategy to specifically target people living in these communities or to those who have expressed an interest in the topic.

E-Newsletters

Central Health distributes a monthly e-newsletter to nearly 7,000 individuals, including health care providers, nonprofit organizations, institutions of higher learning, public agencies, community advocates and interested residents.

Additionally, to keep Eastern Travis County stakeholders informed, in Sept. 2017, Central Health began producing and distributing a quarterly e-newsletter, updating elected officials and actively engaged individuals of any progress. Interested individuals can sign up to receive this monthly e-newsletter via our website, during a public speaking engagement, or at an outreach event. The e-newsletter currently goes to approximately 250 interested and engaged individuals, and it is quickly growing.

Central Health shares content about health care coverage programs and health care services to be shared through partner newsletters.

Website(s)

CommUnityCare and Central Health place content about health care coverage and health care services on their websites. Central Health maintains a section specific to Eastern Travis County at www.centralhealth.net/easterntravco.

MEDIA RELATIONS

The arrival of the mobile clinic was widely reported on by local news stations.

1. On April 2, Patch reported on the mobile clinic. https://patch.com/texas/eastaustin/central-health-rolls-out-mobile-medical-room-wheels-austin
2. On April 3, KVUE reported on the purchase of the mobile clinic https://www.kvue.com/article/news/health/health-care-on-wheels-central-health-buys-new-clinic-for-people-in- underserved-areas/269-128e13b2-b637-4478-a26a-88eba65026a0
3. On May 3, Community Impact reported on the arrival of the clinic at the Southeast Health and Wellness Center https://communityimpact.com/austin/healthcare/2019/05/03/central-health-debuts-mobile-health-clinic-set-to- deliver-health-care-to-underserved-travis-county-communities/
4. On June 20, KXAN reported on the mobile clinic at Creedmoor Grand Opening https://www.kxan.com/top-stories/first-mobile-health-clinic-is-coming-to-travis-county/

5. On June 24, KVUE reported live spots from Barbara Jordan Elementary School about the new mobile clinic. https://www.kvue.com/article/news/health/mobile-clinic-opens-to-help-east-travis-county-community-in-need/269-f10493ff-fa1e-41a1-8d12-6f34de65adea?fbclid=IwAR3
6. On June 24, Spectrum News reported live spots from Barbara Jordan Elementary School about the new mobile clinic. https://spectrumlocalnews.com/tx/austin/news/2019/06/24/clinic-on-wheels-rolls-into-east-travis-county
7. On June 26, The Statesman reported on the mobile clinic in Creedmoor. https://www.statesman.com/news/20190626/mobile-clinic-carries-health-care-options-to-eastern-travis-county

OUTREACH

Central Health and CommUnityCare continue to build a sustainable outreach partner engagement program to amplify our communications efforts. We do speaking engagements at partner organizations, schools, churches, neighborhood associations and other special interest groups. Our Community Health Champions play a major role in these efforts. Collectively, we also share information regarding enrollment for health coverage and new services for outreach partners to place on their newsletters, bulletins, and websites.

Faith-based Outreach

Central Health is growing its faith-based engagement efforts to connect more people to care. Since June, we've connected with:

- **New Hope Missionary Baptist Church:** Attended and spoke at Sunday service to promote Central Health coverage programs and the mobile clinic. Pastor and church administrator agreed to post flyer for the mobile clinic on their platforms.
- **St. James' Episcopal Church:** Attended Neighbor to Neighbor Program, a bi-monthly food pantry and resource distribution, and met with program coordinators and key volunteers. Also discussed how St. James could help distribute MAP eligibility information.
- **Church of Christ at Eastside:** Met with Health Ministry Coordinator prior to Wednesday service to promote the mobile clinic, and the NEHWC Advisory Committee. Discussed the church's health ministry, communication outlets, and perceived health needs of congregants. Health Ministry Coordinator agreed to post flyer in church bulletin.
- **St. James Missionary Baptist Church**: Invited members to join our Northeast Travis County Advisory Committee Meeting and connected with their Health Ministry Leader.

Other leads include:

- Greater Mount Zion Baptist Church (targeting Colony Park residents)
- Greater Union Missionary Baptist Church
- New Ulit Ave. Missionary Baptist Church
- David Chapel Missionary Baptist Church
- Iglesia Evangélica el Remanente de Dios (targeting Colony Park residents)
- Austin Hindu Temple & Community Center (targeting Colony Park residents)

Schools

Staff engage with schools to share information about health coverage and services with parents and their children, and about engagement activities, including advisory committee meetings. We attend school events, "coffee with the principal" meetings, parent support specialist meetings, CATCH Nights, etc. Parent support specialists at area schools have a strong influence on the children and families associated with the school to which they're assigned.

Schools include:

<u>Austin Independent School District</u>

- LBJ High School and feeder pattern
    - Bertha Sadler Means Young Women's Leadership Academy and Gus Garcia Young Men's Leadership Academy
        - Winn Elementary School
        - Volma Overton Elementary School
        - Norman Elementary School
        - Barbara Jordan Elementary School
        - Andrews Elementary School
        - Sims Elementary School
        - Pecan Springs Elementary School
        - Harris Elementary School
        - Blanton Elementary School
- Northeast Early College High School (former Reagan Early College High School)
    - Bertha Sadler Means Young Women's Leadership Academy and Gus Garcia Young Men's Leadership Academy
        - Dobie Middle School
            - Hart Elementary School
        - Webb Middle School
            - Winn Elementary School
            - Pickle Elementary School
            - Andrews Elementary School

<u>Manor Independent School District</u>

- Decker Middle School
- Decker Elementary School

<u>Charter Schools</u>

- KIPP Austin
- East Austin College Prep

Community Health Worker Pilot

In collaboration with CommUnityCare, Central Health is piloting an evidence-based, best practices program using state- certified community health workers who represent the people we serve. Starting this fiscal year, community health workers in Colony Park, Hornsby Bend and Creedmoor will:

- Conduct asset-mapping analyses in these communities to inform residents of available services as well as inform service planning efforts
- Conduct bilingual (primarily Spanish/English) face-to-face grassroots outreach and engagement in each of these communities
- Conduct thorough needs assessments as needed

- Connect resident needs to existing local health and social services, with a particular focus on Central Health's Medical Access Program and existing and new health clinics
- Coordinate culturally appropriate monthly health education workshops in partnership with local health experts, such as CommUnityCare
- Connect residents to the appropriate service expansion advisory committee in the area and facilitate their active

Community Events
Central Health and CommUnityCare staff hosted several outreach and media events to introduce the mobile clinic to community members, and inform them of new health care services coming to their area.

Colony Park
- May 23, 2019 - Barbara Jordan Elementary School Art Night (residents)
- May 24, 2019 - Northeast Health and Wellness Advisory Committee (community partners and residents)
- June 3, 2019 – Barbara Jordan Elementary visit with health screenings (residents)
- June 14, 2019 – Barbara Jordan Elementary visit with health screenings (residents)
- June 17, 2019 - Barbara Jordan Elementary visit with health screenings (residents)
- June 18, 2019 - Northeast Health and Wellness Advisory Committee (community partners and residents)
- June 20, 2019 – LBJ Neighborhood Association Meeting (residents)
- August 2, 2019 – Back-to-School Bash at Turner-Roberts Recreation Center (residents)

Creedmoor
- June 5, 2019 – First Wednesday Community Potluck (residents)
- June 11, 2019 – Creedmoor Community Center visit with health screenings (residents)
- June 20, 2019 – Creedmoor Community Center visit with health screenings (residents)
- June 20, 2019 – Ribbon cutting and lunch at the Creedmoor Community Center, from 11 a.m. to 1 p.m. (stakeholders and media)
- September 27/28, 2019 – Creedmoor Gator Stomp (residents)
- October 19, 2019 – Creedmoor Octoberfest and Parade (residents)
- October 26, 2019 – Del Valle Class Reunion in Creedmoor (residents)

Back-to-School Bashes
- August 2, 2019 – Colony Park Back to School Bash
- August 10, 2019 – Southeast Health & Wellness Center Back to School Bash
- August 17, 2019 – CommUnityCare North Central Back to School Bash

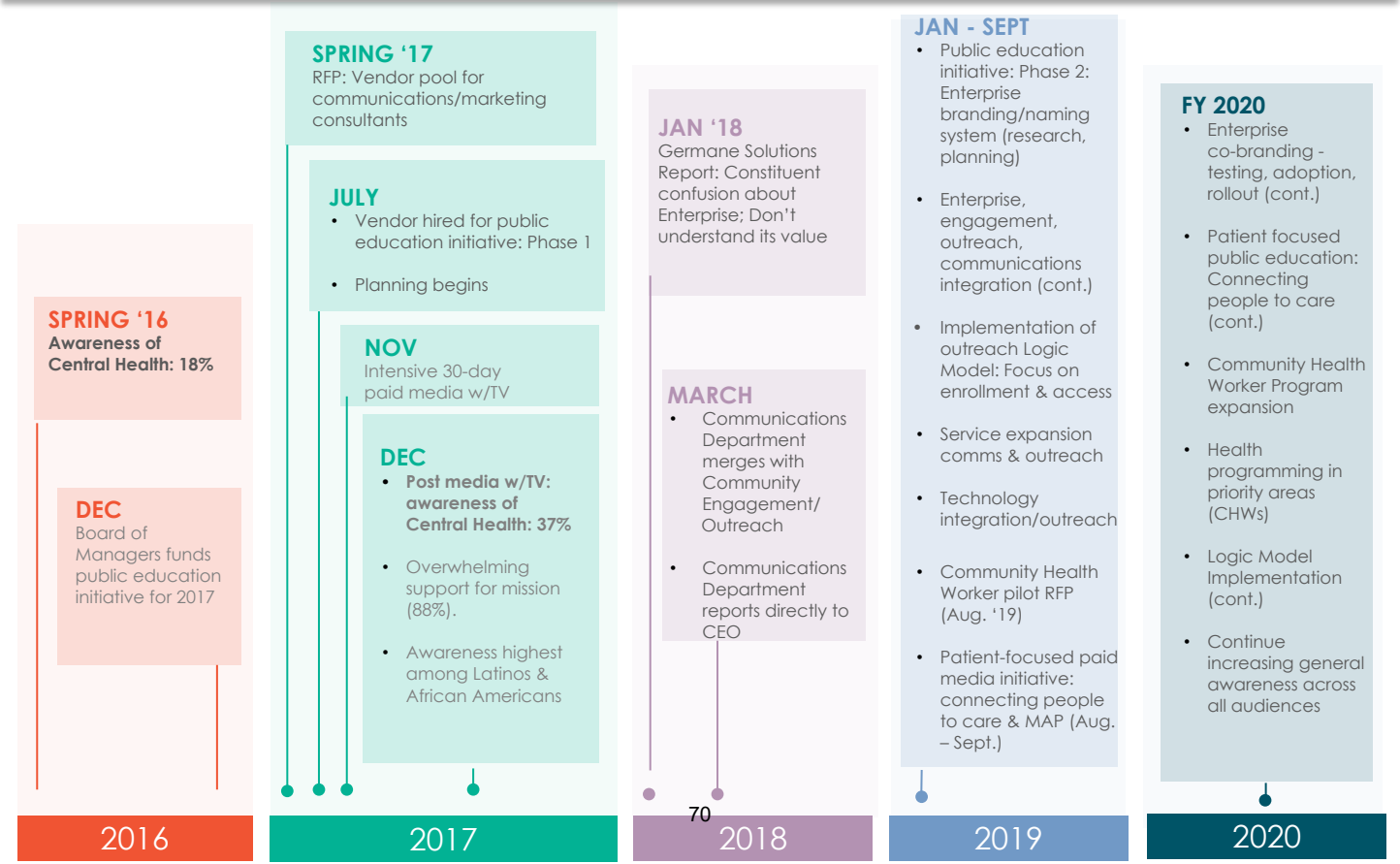
Action Required:
No action is required at this time. This is an informational update for the board.

Communications, Outreach & Engagement

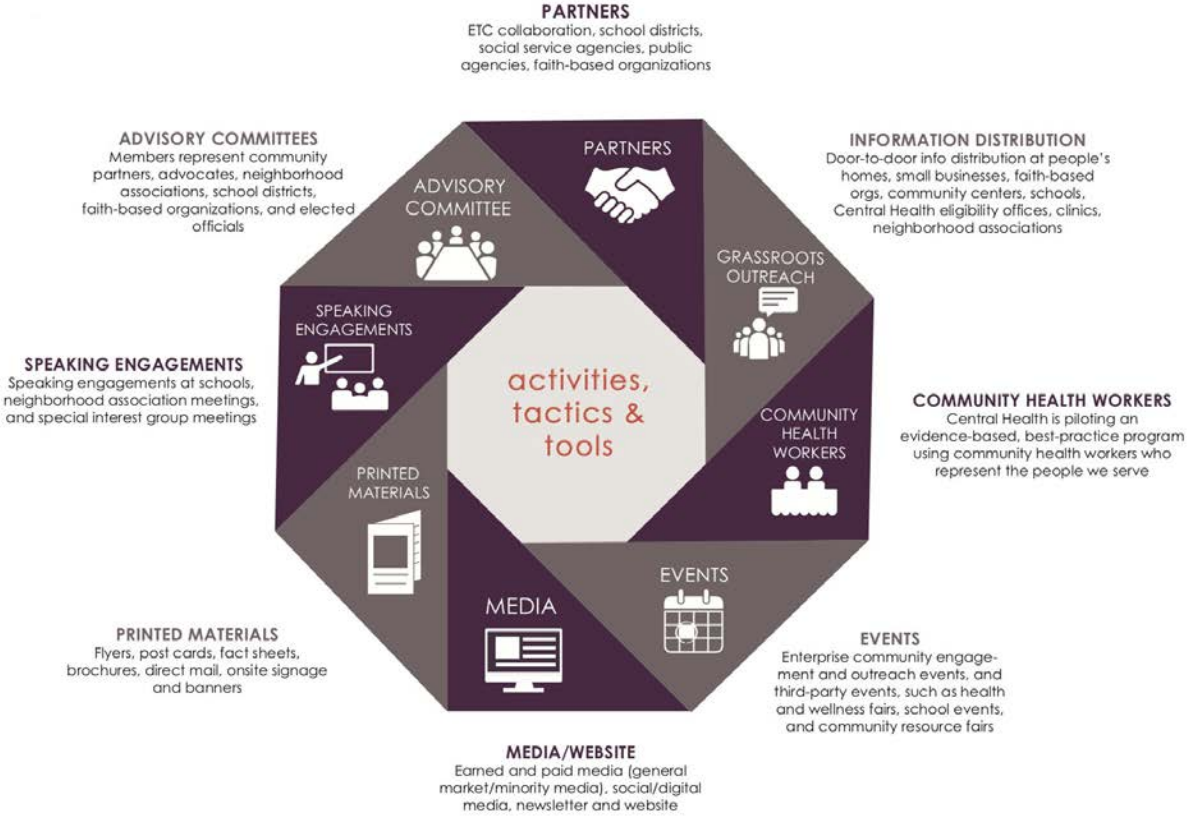
Ted Burton, Vice President of Communications
Iván Dávila, Dir. of Communications & Community Engagement
Isela Guerra, Community Outreach Supervisor
Janna Allen, Program Manager, Community Engagement
Monica Saavedra, Dir. of Marketing and Community Engagement, CommUnityCare

#DreamTeam

Central Health Communications/Community Engagement/Outreach
THE LONG VIEW



A Comprehensive Approach



Central Health Logic Model: Consumer Engagement & Outreach

Long-Term Outcomes:

1. Long-term health care cost savings
2. Improve health outcomes among priority population

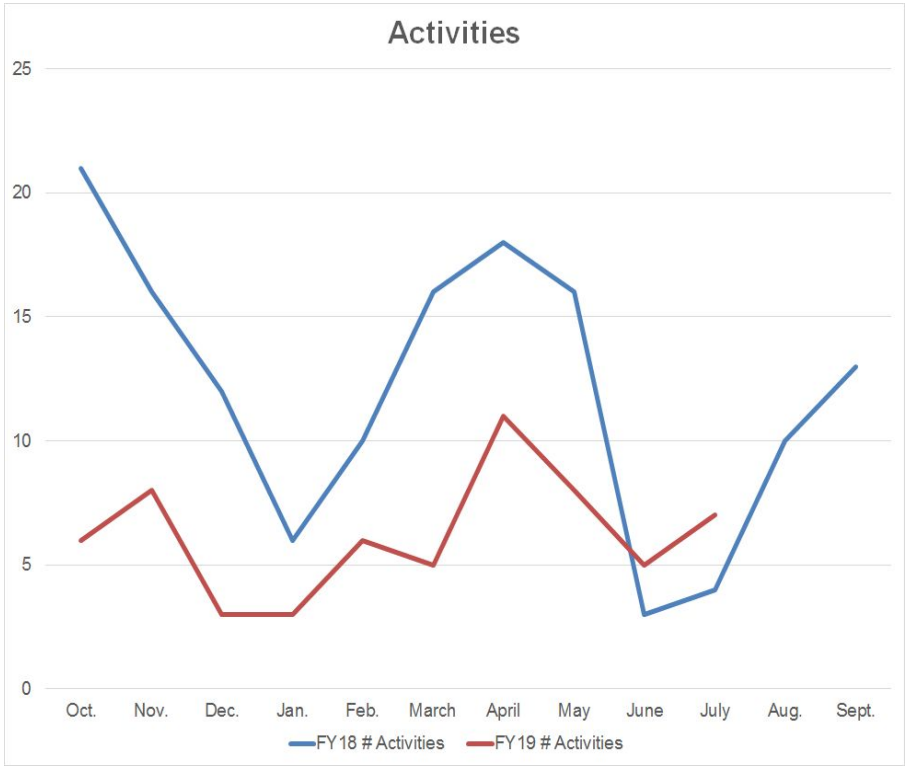
Short-Term Outcomes

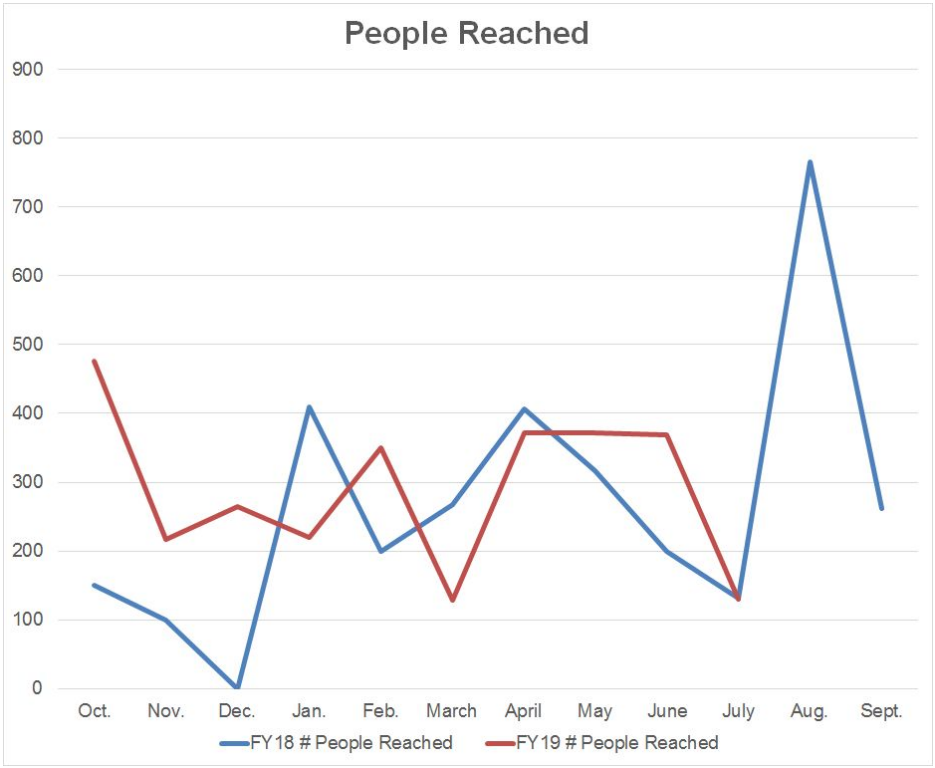
1. Increase current/potential consumer knowledge/awareness of services, including when/where to access primary care vs. urgent care vs. ER services
    - **MEASURE:** Number of people living at or below 200% FPL using Central Health-funded health centers
2. Increase knowledge/awareness of health coverage programs, enrollment process, and coverage benefits
    - **MEASURE:** Number of Central Health Eligibility referrals
3.

Community Outreach

Outreach: At events

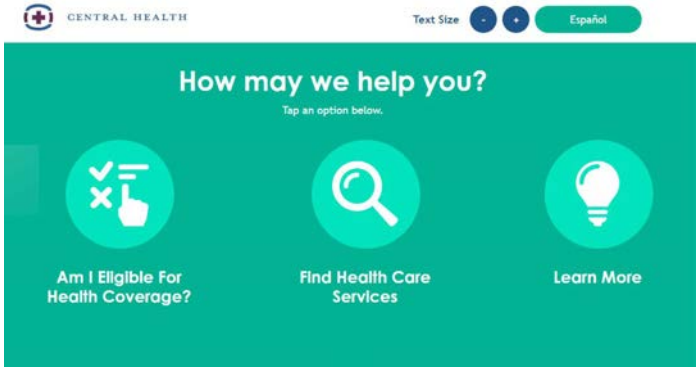
Outreach: Event Outcomes Year-to-Date

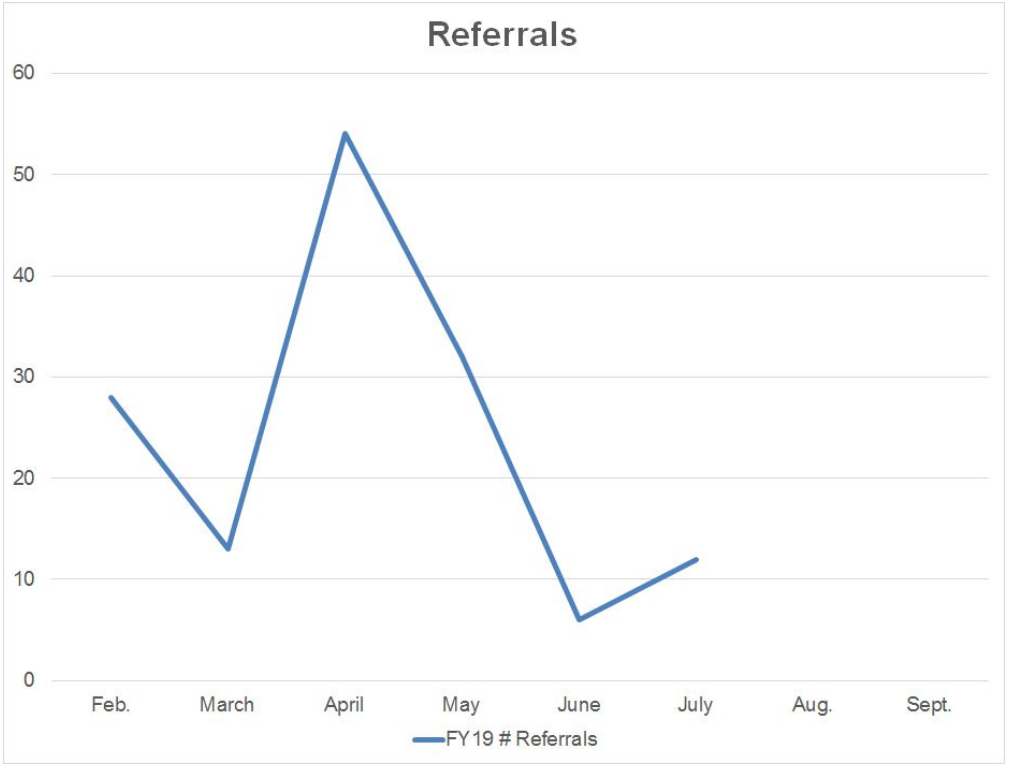




Outreach: Event Outcomes Year-to-Date

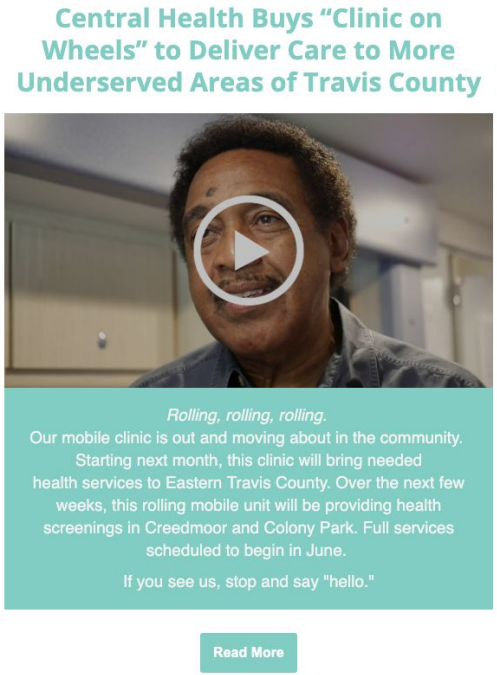
February 2019 we launched our screening tool for the MAP clients.





Mobile Clinic Marketing: Direct Mail, Signage, Flyers

Online Media: Websites, Social Media, Newsletters



Earned Media

Outreach: Partners

SUSTAINABLE COLONY PARK COMMUNITY

Get Care Near You

CommUnityCare Health Center is offering free health screenings, resource information and eligibility services for health coverage:

June 3, 14, and 17
9:00am–1:00pm
Barbara Jordan Elementary School
6711 Johnny Morris Road
Austin, Texas 78724
Information for our Ramp-Up Schedule can be found here.

Outreach: Partnerships

How You Can Help

In Travis County, no one should go without health coverage. With your help, we can make health coverage a reality for everyone.

Partnership Levels*

Bronze
Information Sharing

Central Health will provide your organization with a presentation about the Medical Access Program (MAP) and MAP BASIC, including benefits, eligibility and enrollment. We will also provide your organization with reference materials for MAP, MAP BASIC, and other Central Health initiatives.

Silver
Client Connections

Includes Bronze level elements plus access to Central Health's online eligibility app, which allows partner organizations to prescreen clients for MAP/MAP BASIC. Central Health will also offer training on calling and transferring clients to the Central Health Customer Service Center, and the eligibility screening process – including in-depth information about required documents.

Gold
Health Care Coverage Eligibility

Includes all Bronze and Silver level elements. Additionally, Central Health will train your staff to access, complete and submit the online MAP application on behalf of your clients.

**Gold partnerships are limited to nonprofits, faith-based organizations, associations and social service public agencies. Please contact us for a customized partnership.*

How Central Health Can Support & Promote Your Organization

Bronze Partner	▪ Social media mention. Visuals can include pictures, logo or video[1] ▪ Logo and/or name placement on Central Health's website[2]
Silver Partner	▪ All Bronze partnership benefits ▪ Annual partner mention in the Central Health newsletter[3] ▪ Special invitation for two staff members to attend a Central Health Community Health Champion's alumni event
Gold Partner	▪ All Bronze and Silver partnership benefits ▪ Special invitation and premier exhibitor placement at Central Health's outreach events ▪ Public speaking opportunity at a Central Health event

[1] Over 3,000 individuals like us on Facebook, about 2,000 individuals follow us on Twitter.
[2] On average, 9,400 people visit our website on a monthly basis.
[3] Distribution of e-newsletter to more than 6,000 people

HEALTH COVERAGE PROGRAMS

MAP
Central Health's Medical Access Program offers two different health care coverage programs: MAP and MAP BASIC. MAP covers primary care, prescriptions, specialty care, and hospital care. MAP BASIC covers primary care and most prescriptions.

Sendero Health Plans
Sendero Health Plans provides multiple comprehensive health care coverage plans to Central TX residents on the Affordable Healthcare Act Health Insurance Marketplace .

Medicaid and CHIP
Children in Texas who don't have health insurance may be able to get low-cost or free health coverage from the Children's Health Insurance Program (CHIP) or Children's Medicaid.

Access to Health Care is a Human Right.
Help us connect people to care.

Contact Isela Guerra for a customized partnership or more information:
Isela.Guerra@centralhealth.net | 512-978-8095

CENTRAL HEALTH

1111 E Cesar Chavez St | Austin, TX 78702

centralhealth.net | @CentralHealthTX

Outreach: Faith-Based

COMMUNITY EVENTS

Kick Back For Kids

Kick Back for Kids
Back to School Shoe Distribution Even
Greater Austin FAMU Alumni Chapter
August 10, 2019
The African American Cultural & Heritage Facility
10 AM - 2 PM

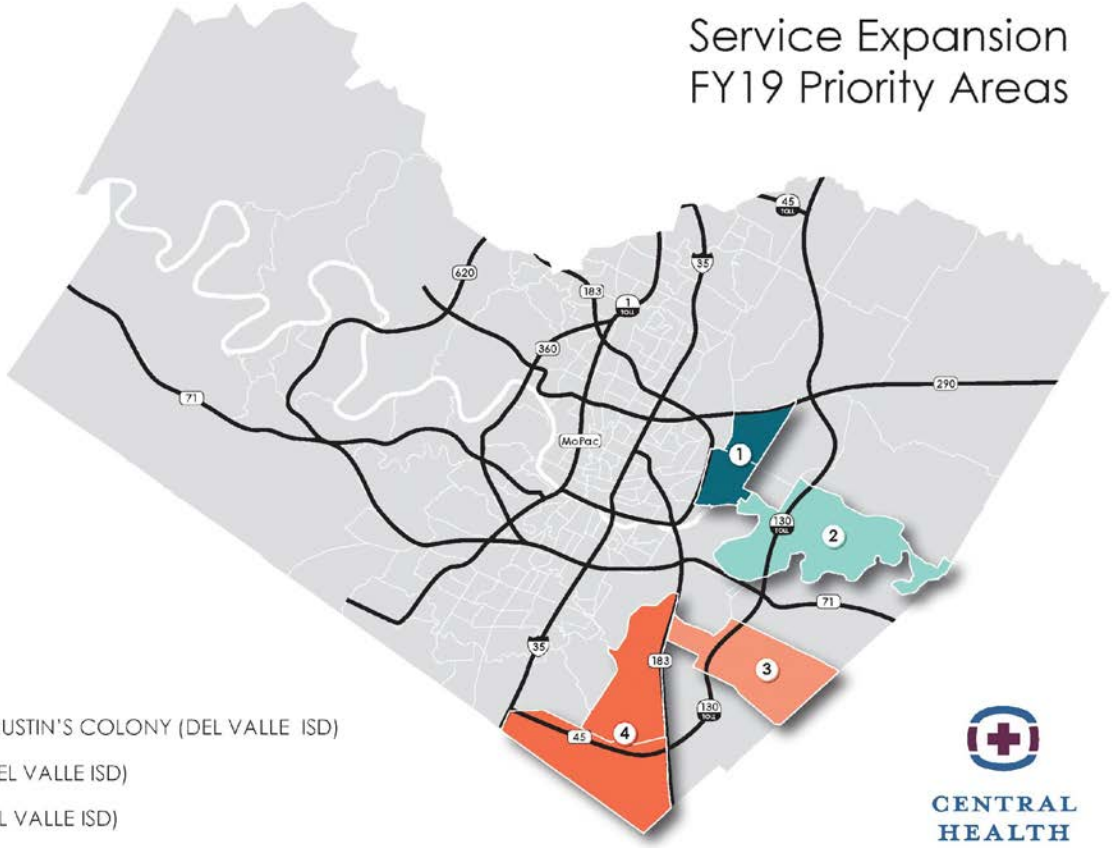
CommUnity Care Mobile Clinic


CENTRAL HEAL
HEALTH CARE FOR AL

Community Health Worker Pilot

Outreach: Community Health Workers

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%

Community Health Worker Activities

- 1:1 education and navigation
- Warm hand-offs or referrals
- Health education sessions – group setting/connecting to existing programming
- Patient interviews, conversations, focus groups
- Cross-training sessions with staff
- Health screenings – or coordination of
- Advisory Committee Recruitment
- Health care promotion

Community Health Worker Success Measures

- # of 1:1 encounters/people reached
- # of people who receive health education
- % of people "very satisfied" with health education session
- # of people interviewed or who attended conversations, focus groups
- # of surveys completed
- # of people who were pre-screened for health coverage programs

Community Health Worker Project: 2019 & Beyond

Aug. - Nov. 2019: Launch pilot, develop and implement training curriculum

FY 2020: Evaluate/expand program

FY 2020/2021: In-house Community Health Workers focused on community outreach

Community Engagement

- Community Conversations (Aug. 26 Budget)
- Community Advisory Committees (Expanding to 4)
- Community Health Champions (Launched Aug. 2)
- Surveys

Advertising Initiative: Connecting people to care

Planning Parameters

Create awareness of Central Health Enterprise: Connect people w/ low income to quality health care; promote MAP; Promote service expansion awareness

Target Audience

Patients (2/3) & nonpatients (1/3)

Timing

Aug.-Sept.

Paid Media

Connecting to Care Initiative: $200,000

Service Expansion (ETC): $45,000

Geography

Travis County

Media Strategy

AWARENESS INITIATIVE

Adopt an "on the go" strategy, complimenting the target's hectic lifestyle. Surround them throughout their daily journey, reaching them while interacting with media on their time and schedule.

Focus on media and partners providing strong coverage and frequent engagement by patients/non-patients.

Launch with quick-to-market media meeting desired start date, layering additional media requiring longer lead time.

EASTERN TRAVIS COUNTY EXPANSION

Focus on media/tactics that provide the strongest coverage and reach potential of Eastern Travis County, particularly the six desired zip codes – 78610, 78719, 78617, 78725, 78653, 78724

Enhance geo-concentrated media with media targeted exclusively towards patient population

Media Strategy

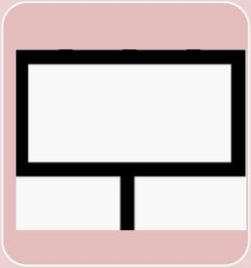
Over half of consumer's time with media is spent with digital. Digital allows for strong targeting, to patient population and general market. Consumed anywhere, anytime

Radio is primarily consumed while away from home; providing strong, cost-efficient reach on the go. Through the varied formats and stations, CH can serve different messaging to patient population and general market

Transit is mobile throughout metro area. Reaches both patients and general market cost effectively. Large creative size generates strong impact, serving as mobile billboard

Gas stations help extend reach of the patient population on their daily journey, at a lower cost. Focuses on locations east of I-35. Multiple pump toppers surround the target as they get gas

Minority Print supplements the broader-reaching mediums by honing in on publicatoins that exclusively target the patient population



Neighborhood boards target the patient population along streets they travel frequently east of I-35 and within desired ZIP codes of clinics/services Provides strongest coverage potential of geo-focused opportunities


Health care works better
when we all work together.
CENTRAL HEALTH
Through our network of partner organizations, Central Health helps thousands of people with low income across Travis County access the care they need.
CommUnityCare
SENDERO
HEALTH PLANS
LEARN MORE ABOUT OUR PARTNERS AND MISSION AT
CentralHealth.net


Los cuidados médicos funcionan mejor cuando todos trabajamos juntos.
CENTRAL HEALTH
A través de nuestras agencias asociadas, Central Health ayuda a miles de personas de bajos ingresos a través de Travis County a tener acceso a los servicios médicos que necesitan.
CommUnityCare
SENDERO HEALTH PLANS
CONOZCA MÁS SOBRE NUESTROS SOCIOS Y NUESTRA MISIÓN EN CentralHealth.net


1 in 7
Travis County residents counts on us for health care.
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Get care at 512.978.8130
or CentralHealth.net
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663


1 de cada 7
habitantes del Condado de Travis
confía su cuidado médico en nosotros.
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Inscríbase en 512.978.8130
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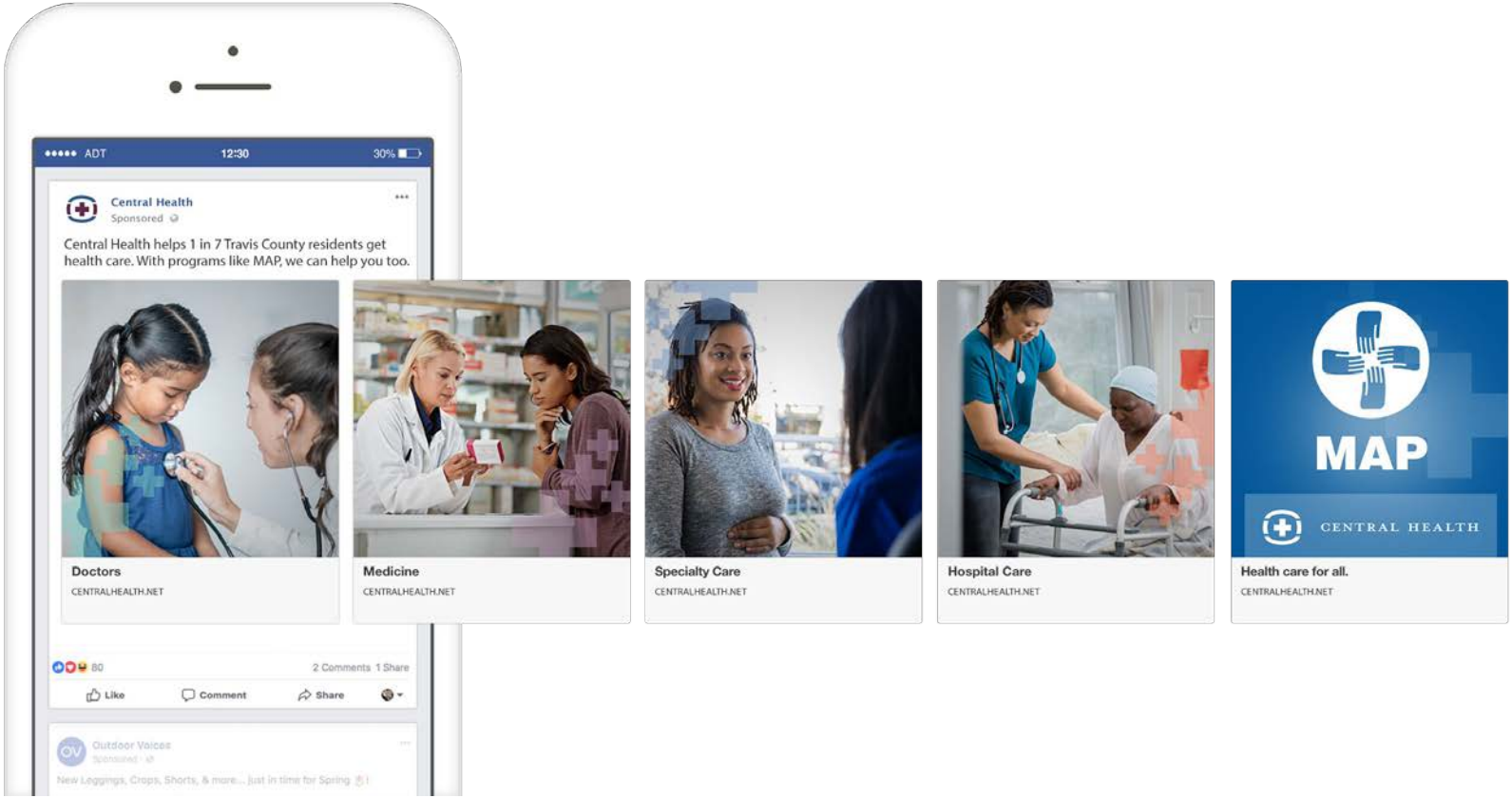
663 LAKE AUSTIN
GUADALUPE
DO NOT ENTER
ONE WAY
MUST TURN RIGHT
Ben Mooney Photography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Central Health helps 1 in 7 Travis County residents get health care. With programs like MAP, we can help you too.
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Medicine
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Specialty Care
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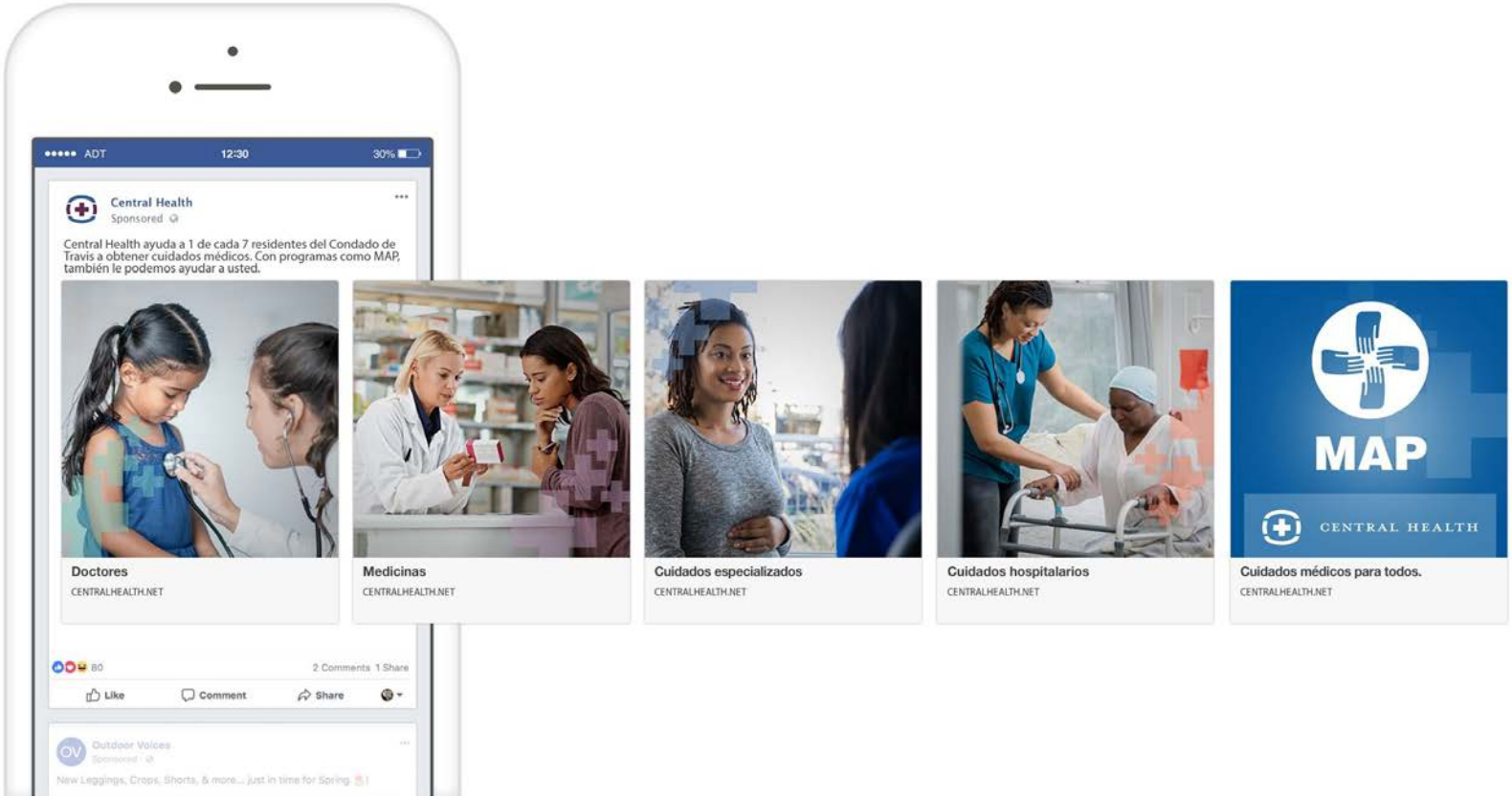
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Central Health
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Central Health ayuda a 1 de cada 7 residentes del Condado de Travis a obtener cuidados médicos. Con programas como MAP, también le podemos ayudar a usted.
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Medicinas
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CENTRALHEALTH.NET
Cuidados hospitalarios
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Cuidados médicos para todos.
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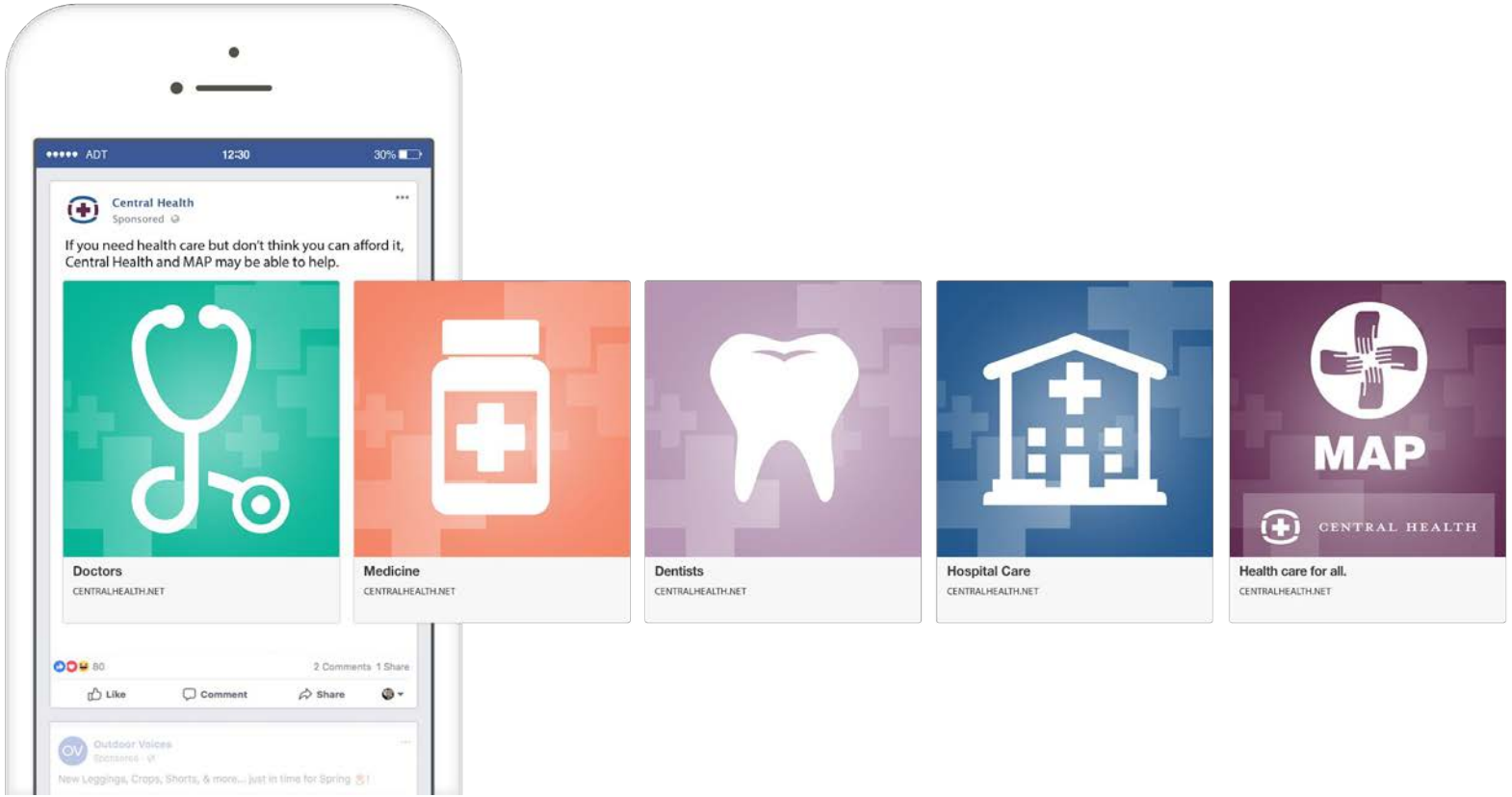
New Leggings, Crops, Shorts, & more... just in time for Spring.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Central Health
Sponsored
If you need health care but don't think you can afford it, Central Health and MAP may be able to help.
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Medicine
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Dentists
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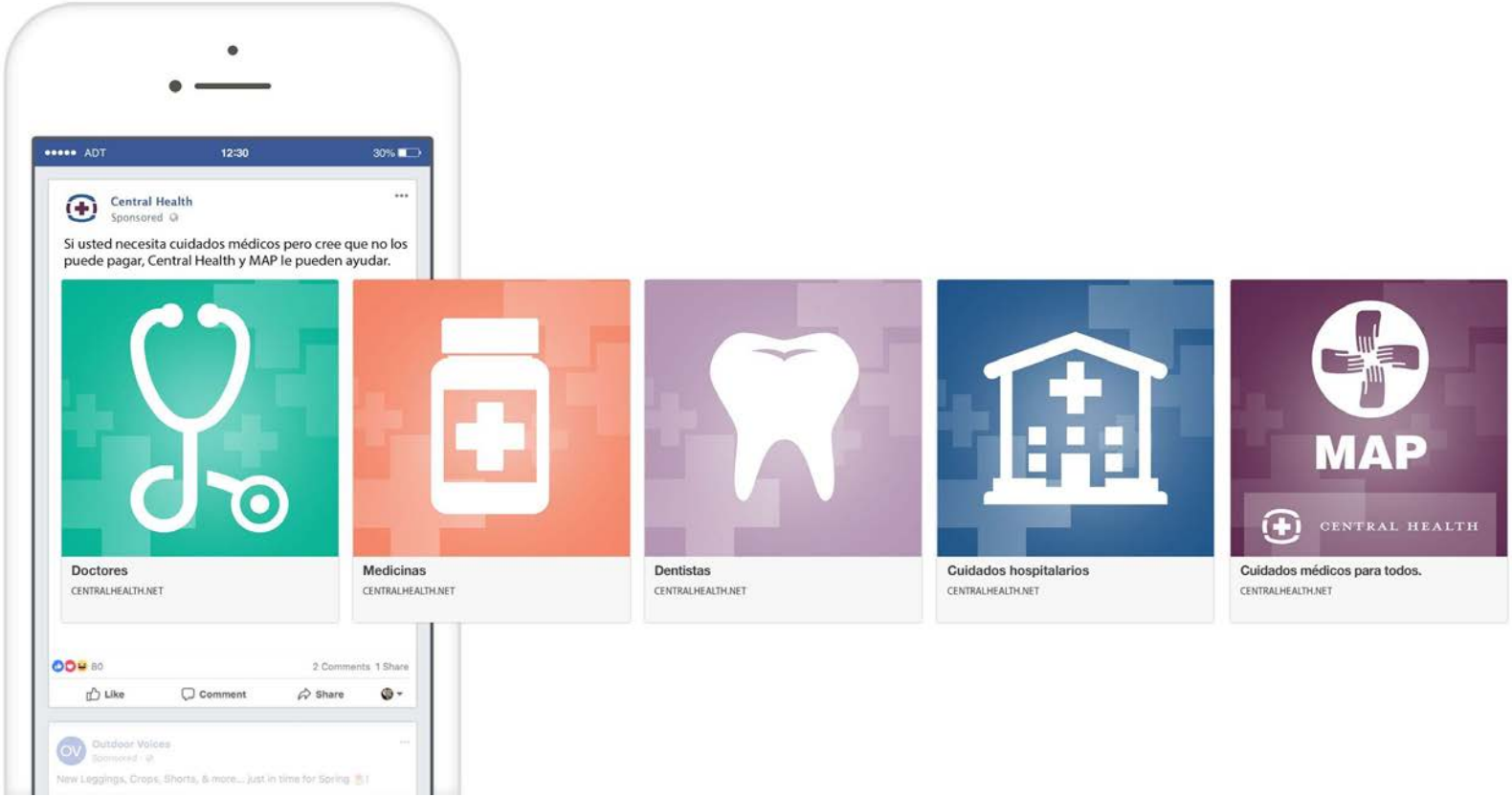
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Si usted necesita cuidados médicos pero cree que no los puede pagar, Central Health y MAP le pueden ayudar.
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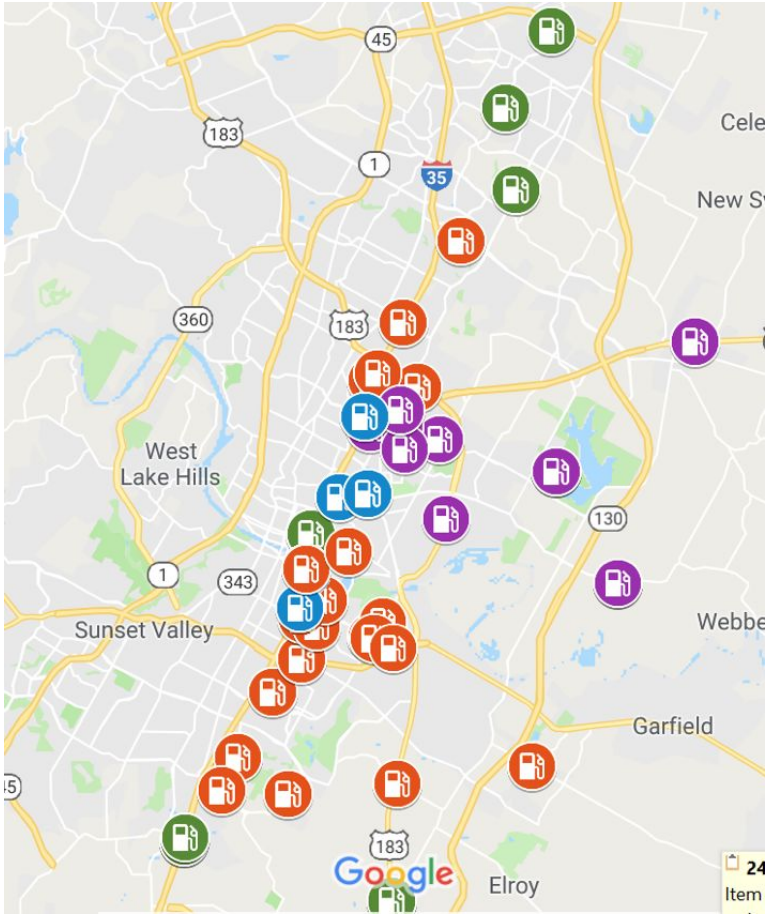
Gas Station Ads: Pump Toppers




1 de cada 7
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confía su cuidado médico en nosotros.
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GALLONS
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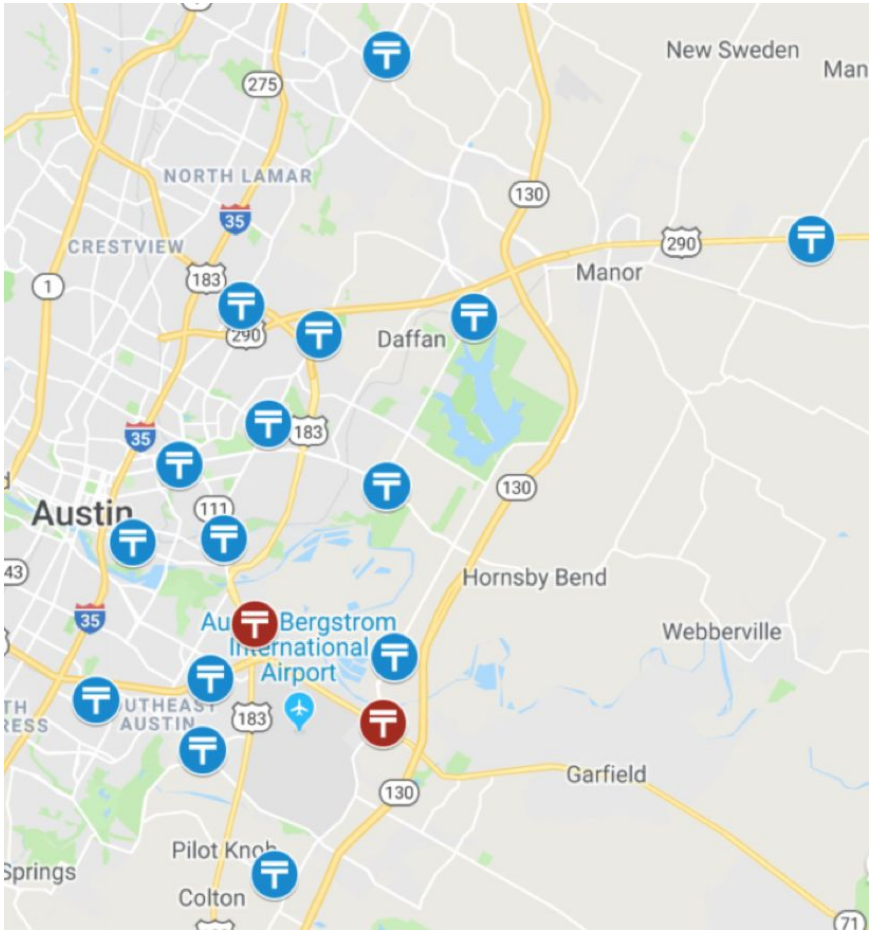
Neighborhood Billboards



Enterprise Co-branding

Co-Branding: Update

Goal:

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

Objective:

•Connect Central Health Enterprise brands and products.

•Educate residents on the collective value and strength the Enterprise brings to the community.

•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 include portion of current names (hybrid approach)

Co-Branding: Update

- Peer Research
- Stakeholder Interviews
- **Pre-Campaign Perception and Awareness Survey (analyzing)**
- Name Exploration
- Patient and Non-patient Focus Groups
- Logo Design and Brand Standards

Implementation Plan for Roll-out

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Community Care Collaborative
A Central Health and Seton partnership

CommUnityCare

SENDERO HEALTH PLANS

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

THE STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 5

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

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1C
Colony Park Phase II: Pursue acquisition of property from City of Austin and business plans will be developed. Program plans were completed in Feb. 2018 for the RFP to inform the Master Developer

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Agreement w/City of Austin

Progress Report:
Central Health and the City of Austin are jointly working on due diligence and feasibility studies for separation of 5 acres for CH development within the City's 208-acre Colony Park Sustainable Community. In August, Austin City Council will discuss and take possible action on an Inter-Local Agreement authorizing City staff to advance and complete initial planning and economic evaluation of this possible transaction. City identified (preliminary) the 5-acre location and site concepts and infrastructure planning were prepared.

Challenges/Issues:
Central Health neither controls the timing nor outcome of decisions on land availability and acquisition means (e.g., donation, ground lease, purchase). City and developer negotiations may be protracted. If CH advances development within the Colony Park site, infrastructure and amenities may be years out. To avoid extended facility delivery delay, CH can advance planning and design in parallel with land transaction agreement, but will need sufficient assurances as to infrastructure, closure and financing.

Next Steps:
Pending positive City Council action on an Inter-Local Agreement, complete site feasibility and initial planning and assessment. Confirm program and gain firm commitments from partner organizations prior to design commencement.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1E
Pflugerville: Pflugerville ISD business plans for CommUnityCare and Integral Care will be developed

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Pro-forma

Progress Report:
CommUnityCare is having ongoing discussions with Pflugerville ISD to discuss scope of services, location, target population, and timelines. Currently they are contemplating a health center that would serve the students. Behavioral Health services will be a key component of the delivery model at the school based health center. The mental health component is necessary in whatever location/programs they have moving forward.

Challenges/Issues:
CommUnityCare is evaluating the request from Pflugerville ISD to also provide care to their staff members (given they are all insured, this might be a difficult sell to HRSA but they are exploring)

Next Steps:
No financial models have been completed. Once the scope and location of the health center are nailed down, CommUnityCare will be able to build to program and financial estimates.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1F
Pflugerville new development (Level 1): Business plans will begin

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Pro-forma and Partner Agreements

Progress Report:
Central Health has identified a diverse group of individuals that are community members and advocate and are collaborating to expand health care services in Pflugerville. We are working on multiple scenarios with providers. An advisory committee is being developed for this community and these meetings will launch by September 2019. The purpose of the Pflugerville Service Expansion Committee is to receive community and stakeholder input regarding health services and programs in Pflugerville. The Advisory Committee will make recommendations to Central Health on matters such as public health, public policy, barriers to care, community needs assessment, planning, health education, and advocacy. Members will also serve in a community liaison capacity to provide a link between the Pflugerville community and Central Health.

Challenges/Issues:
Pflugerville is the fastest growing area in Travis County—with the number of people living in poverty projected to significantly increase. Recognizing barriers to health care people with low income face, Central Health is exploring multiple scenarios for health care service expansion efforts in Pflugerville.

Next Steps:
Business planning scenarios will be discussed with providers and partners. Pro Formas will be developed after scope of services planning has been completed.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1J
Colony Park: Implementation mobile clinic

Milestone Status: Complete

Deliverable: (attachment, if applicable)
Milestone Review Memo

Progress Report:
CommUnityCare began providing clinical services on June 24, 2019 to the Colony Park and Creedmoor communities in a 40-foot bus outfitted with exam rooms, a waiting room and lab area. CommUnityCare provides primary care, preventative care, vaccines, lab services, chronic disease management and limited pharmacy services in the mobile clinic. Even beyond that, there's the behavioral health component. Physicians at the mobile clinic are able to refer patients with behavioral health issues to Integral Care. CommUnityCare provides services at the Creedmoor Community Center in the Del Valle area two days per week - Tuesday's and Thursday's and in Colony Park three days per week - Monday's and Friday's at Barbara Jordan Elementary School and Wednesday's at Turner Roberts Recreation Center 8am-5pm.

Challenges/Issues:
Operations of a mobile clinic does bring unique challenges and considerations when compared to a standard “brick and mortar” clinic. Given the various systems, moving parts, and wear and tear that occurs by operating the vehicle, breakdowns can occur, resulting in vehicle downtime. Regularly scheduled preventative maintenance also results in downtime. However, this investment extends the longevity and expected life of the vehicle. Since delivery, the mobile unit has experienced two full days of downtime (4 sessions) due to the repair or maintenance of various components:
Service Delivery Challenges:
1. Difficult to provide ancillary services consistently (financial screening, care coordination/management)
2. While space is functional, at higher volumes, it may become tight should families with children arrive
3. Turner Roberts location is not visible from main road, minimizing the opportunity for walk in traffic. This will be monitored as school year begins, as Overton is on site.
4.Transportation, particularly in the Creedmoor area, can be challenging for some patients.

Maintenance and Other Considerations:

1. The vehicle requires a CDL, and CUC utilizes a contract driver. While The ramp up period had different drivers, The contractor has found a reliable everyday driver who provides excellent service.
2. Driver coordination can challenging for last minute requests, events, and requests outside of standard operating hours. The contractor has been excellent at meeting requests so far.
3. Preventative Maintenance performed on generator every 200 hours. The mobile unit will hit this benchmark at least once per month. This is typically completed at the vendor's shop, or on site at a significant premium.
4. The vehicle requires a CDL, and CUC utilizes a contract driver. While The ramp up period had different drivers, The contractor has found a reliable everyday driver who provides excellent service.
5. Coordinating refueling is challenging, as only 1 credit card is available. The mobile unit is sometimes refueled 2 times per week, depending on traffic, and generator fuel consumption.

Next Steps:

1. Monitor utilization; data may be used to inform future health care service delivery planning efforts
2. Ongoing communications and outreach efforts including after school begins in the fall

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1M
Provider level update(s) on optimum use of transportation and/or technology solutions

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Milestone Review Memo

Progress Report:
Central Health launched a pilot transportation program January 16, 2019 utilizing the Lyft concierge service for non-emergency medical transportation services to patients and clients of the Central Health Southeast Health and Wellness Center. Central Health is working closely with its provider partner, CommUnityCare, to ensure frontline and administrative staff are informed of the pilot's objectives and how to direct clients to the service. This coordination includes conducting staff interviews for qualitative analysis; regular meetings with staff to discuss progress and issues; and trainings on how to book rides for clients.

Capital Metro worked with Travis County and Central Health in FY18 to develop a Transit Development Plan to expand transportation services to underserved areas of Eastern Travis County. By combining data resources and planning efforts, the organizations identified the Manor and Austin's Colony/Hornsby Bend communities as areas experiencing high transportation barriers. Travis County is providing funding for the expanded services, which are expected to launch in summer 2019.

Challenges/Issues:
CUC has recently experienced a shortage in project managers, leaving the majority of work to manage the pilot on Central Health staff. There has also been a lag in the evaluation process due to a longer than anticipated data analysis process.

Next Steps:
Central Health is working on finalizing its evaluation and analysis of the pilot and will be coordinating with CUC leadership and staff on funding and operational recommendations for FY2020.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1N
Focus Areas: Implementation and service expansions, land procurement, facility construction/installation start
Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Broker Agreement for Land Purchase, Milestone Review Memo

Progress Report:
Central Health is purchasing 10-acres of undeveloped land in Austin's Colony/Hornsby Bend to build a new health and wellness center, which will serve the population we serve in Eastern Travis County. The property is located at the southeast corner of Gilbert and Sandifer streets next to Dailey Middle School located in Del Valle. The purchase price is $770,000, the fair market value as determined by an independent appraiser. Travis County Commissioners approved the land purchase Tuesday, July 23. State law requires Travis County Commissioners approve all Central Health land acquisitions; the district's board of managers already approved the purchase. Funds for the purchase are part of Central Health's FY19 budget and support our multi-year strategy of expanding care in underserved areas east of downtown Austin. Closing expected by end of August, 2019.

Challenges/Issues:
An initial / short-term healthcare center will open in Fall 2019 at ESD-4 station in Hornsby Bend. Services demand and capacity will influence the timing and size of a permanent facility.

Next Steps:
While there is no set timeline for the clinic opening, know that the planning process will involve extensive community involvement alongside the provider, CommUnityCare.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Larry Wallace, Chief Administrative Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.1 Service Location & Care Delivery

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

Milestone: 1.1O
Community First: Fundraising efforts

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Milestone Review Memo

Progress Report:
Central Health is working diligently with partners that include Mobile Loaves and Fishes, CommUnityCare, Integral Care, ACC, Austin Public Health and Travis County Health and Human Services to finalize the case for support. The case for support will be presented to public and private donors for the funding of the clinic and recuperative care facility development. The case for support may also be used for grant purposes for foundations. Mobile Loaves and Fishes plan to activate their fundrasing efforts in October 2019 and they are confidant the funding request will be supported. The health and wellness center design and construction documents are complete and a contractor has been hired.

Challenges/Issues:
Central Health is working closely with Mobile Loaves and Fishes keeping the funding process moving, however it is led by Mobile Loaves and Fishes.
Provider agreement with clinical and mental health providers is unique as services are integrated.

Next Steps:
1. CommUnityCare and Integral Care will finalize their pro-formas and business agreement in the 4th Qtr. CommUnityCare plans to provide primary care as part of the integrated behavioral health model at Community First Village with the help of Integral Care. An array of other non-clinical services will also be made available.
2. Central Health is working with Mobile Loaves and Fishes to finalize the landlord/tenant space use agreement. Central Health is also working with the partners on tenant agreements and will be completed by October 2019.
3. Obtain construction permits

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Monica Crowley, Chief Strategy & Planning Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.2 Population Health/SDOH

Objective:
1 - Develop and execute health care delivery strategy based on people and place
Milestone: 1.2B
Work with governmental, provider partners and other organizations to identify and address specific social determinants or to develop broader social determinant strategy
Milestone Status: Ongoing
Deliverable: (attachment, if applicable)

Progress Report:
The CCC is working with Dell Medical School to participate in Dell Med's "Factor Health" program. Factor Health is an Episcopal Health Foundation funded program that explores the feasibility, scalability, and effectiveness of offering select non-medical services to patients. The Factor Health model: (1) Solicits innovative proposals from organizations working to advance non-medical drivers of health; (2) invests in the proposing organizations over several months by leveraging expertise from across the country to raise the chances of improving health outcomes; (3) Provides funding for two years to the programs most likely to be funded by long-term healthcare payers; (4) Matches the most viable programs with longer-term payers to ensure financial sustainability. The CCC is involved as an advisor with a pool of patients likely to benefit from the intervention, and as a possible longer-term payer. Initial programming is focused on providing meals to patients discharged from the hospital with specific chronic conditions, including CHF and cirrhosis. Another collaborative SDOH initiative that Central Health piloted, in coordination with CUC and United Way of Greater Austin, a non-emergency medical transportation service at the Southeast Health & Wellness Center in January. As of July 1, the pilot had provided more than 1,600 free Lyft rides to SEHWC clients.

Challenges/Issues:
We are working closely with the DellMed team to ensure that the program will be successful.

Next Steps:
Next steps for Factor Health include exploring eligibility criteria for CCC patients suitable to enroll in program and assisting with operational planning. We expect program launch early in FY20.

Next steps for the transportation pilot include finalizing an evaluation report and coordinate with CUC leadership regarding future operational decisions for supporting transportation services.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Monica Crowley, Chief Strategy & Planning Officer
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.2 Population Health/SDOH

Objective:

1 - Develop and execute health care delivery strategy based on people and place

Milestone: 1.2C

Identify ongoing Central Health Population Health-SDOH priorities for FY2020

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)

Meeting agendas and minutes

Progress Report:

1. The Central Health Equity Policy (CHEP) Council will continue to implement the HIV routine screening and rapid linkage to care campaign. Recently, the CMO Council at St. David's agreed to participate in the campaign and will pilot this new policy initiative at the South Austin Medical Center.
2. CHEP Council members have been working to identify the 2020 initiative, which will be one of the Enterprise SDOH strategies. Please see the attached list of Commission reports reviewed and informational interviews conducted.
3. A team of staff from Central Health, the CCC, and CUC have been convening to plan a pilot for prescription home delivery for an identified patient population.
4. The CCC has executed a contract with Circulation, a platform through which CCC Medical Management staff will be able to order on-demand rides for patients enrolled in the complex care management program. Trips can be scheduled in advance; patients receive notifications by text or voice message with all the relevant details they need to complete their rides.
5. In coordination with CUC and United Way of Greater Austin, Central Health piloted a non-emergency medical transportation pilot at the Southeast Health & Wellness Center in January. As of July 1, the pilot had provided more than 1,600 free Lyft rides to SEHWC clients.

Challenges/Issues:

No identified obstacles at this time.

Next Steps:

1. The CHEP Council will be providing technical assistance and connection to resources to St. David's for the HIV campaign.
2. Staff will present the final CHEP policy recommendations for FY2020 to the Board of Managers for approval before deciding on the 2020 campaign.
3. Enterprise staff will finalize the patient population for the prescription delivery service pilot, courier service, and evaluation metrics.
4. The CCC has budgeted $50,000 for the service in FY20.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Ted Burton, VP of Communications
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.3 Communications

Objective:

1 - Develop and execute health care delivery strategy based on people and place

Milestone: 1.3F

Create co-branding strategy for CH Enterprise.

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)

Co-branding strategy planning document

Progress Report:

The goal of the co-branding/naming initiative is to better connect Central Health Enterprise affiliates in the minds of patients and Travis County residents. By creating a solid platform for communication/education about how health care is planned, delivered, and funded in Travis County, the goal will be achieved along with educating residents on the collective value and strength the Enterprise brings to the community. Together with Belmont Icehouse, peer research began in March to analyze organizations inside and outside of the heath care space that have been through similar branding/naming intiatives. Next stakeholder interviews in English and Spanish were conducted with patients, staff, board members, elected officials and community members. These findings were presented to the Strategic Planning Committee in April. The creative branding/naming concepting process began as the online perception and awareness survey was completed in July as a follow up from our December 2017 poll. The results were then analyzed to determine how they can guide the co-branding work. An Employee Communication Workgroup was also created that includes approximately 20 staff members from across the Enterpise and assists with implementation.

Challenges/Issues:

There was a lack of understanding about the purpose and desired outcomes of the co-branding initiative both inside Central Health and across the Central Health Enterprise.The process was then intentionally slowed down to allow for additional research, and involvement from Enterprise affiliates, specifically CommUnityCare (CUC). A meeting was held with CUC's board chair and CEO, then presented to the CUC board on July 23. Although this has delayed the initiative, it was necessary to have buy-in and support across the Enterprise.

Next Steps:

1. Analyze awareness survey results and present to the Strategic Planning Committee on Aug. 7.
2. Gather formal feedback from CUC board.
3. Continue name/brand exploration.
4. Conduct patient, non-patient and employee focus groups.
5. Design logos/brand standards. Finalize and launch implementation plan.

NOTE: This project will carry over into FY 2020.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Ted Burton, VP of Communications
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 1.3 Communications

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

Milestone: 1.3G
Develop co-branding implementation plan and identify opportunities with CH Enterprise Partners.

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Review findings

Progress Report:
Working with our consultant, Belmont Icehouse, Central Health developed an initial implementation plan and checklist for the co-branding/naming initiative. The checklist includes everything from internal communications and office suite needs (i.e. letterhead/business cards), to building signage and trademark requirements should a name/branding change be implemented. Additionally, an Employee Communication Workgroupwas created and convened to assist with implementation, and hosted our first meeting in early July. The workgroup will assist with communications around the naming/branding implementation, and the upcoming Community Care Collaborative organizational shift. The workgroup includes nearly 20 employees representing each of the Central Health Enterprise affiliates. An online survey was also conducted with Travis County residents to establish an accurate and current baseline of brand awareness for Central Health and its affiliates and programs.

Challenges/Issues:
The naming/branding initiative slowed down to allow for additional research and involvement from the Central Health enterprise affiliates, specifically CommUnityCare (CUC). Central Health and Belmont Icehouse presented to the CUC board on July 23. The presentation was originally scheduled for June but the CUC Board Chair asked us to delay the presentation for a month.

Next Steps:
1. Analyze awareness survey results and present to the August 7th Strategic Planning Committee.
2. Gather formal feedback from CUC board.
3. Continue name/brand exploration.
4. Conduct patient, non-patient and employee focus groups.
5. Design logos/brand standards, and finalize and launch implementation plan.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Jon Morgan, Executive Director of CCC
Date: 7/31/2019
Re: Q3 Milestone Review for Strategy 2.2 Patient Reported Outcomes

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

Milestone: 2.2C
Launch Equity Roadmap Work

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Launch Equity Roadmap Work

Progress Report:
The first round of analysis was completed on data from two measure sets: the DSRIP metrics, and our primary care metric dataset. The data show that the Comunity Care Collaborative (CCC) population follows similar patterns of disparities by race and ethnicity when compared to Travis County and the state of Texas. While the CCC population overall is performing at or better than national benchmarks, these overall rates mask differences between racial & ethnic sub-groups. The data was presented to internal CCC and Central Health leaders, and had a meeting with Dr. Jewel Mullen who oversees Dell Medical School and Ascension Seton's equity efforts. Dr. Mullen provided many good ideas for how to think about Health Equity Work.

Challenges/Issues:
The future expectation would be that health equity will be a priority for the Central Health Enterprise as the work moves forward.

Next Steps:
Three immediate next steps have been identified:
1. Take action to reduce disparities where evidence shows that the Central Health Enterprise can close gaps in care.
2. Build on the data collection and analysis infrastructure to facilitate robust disparities monitoring. This includes continuing to monitor disparities based on race and ethnicity, as well as incorporating other sub-populations in the analysis, like persons experiencing homelessness, and those with serious mental illness. Collecting information on gender identity and sexual orientation will also be explored.
3. As data is being developed for external use, continue the conversation on health equity with Central Health Enterprise enrollees, staff, governance structure, and the public.

MEMORANDUM

To: Central Health Board of Managers Strategic Planning Committee
From: Miriam Rosenau, Sarah Cook
Date: May 10, 2019
Re: Community Care Collaborative Health Equity Activity - INFORMATIONAL ITEM

Introduction

In the preface to its "Roadmap to Health Equity", the National Quality Foundation (NQF) notes that "[d]espite the nation's advancements in health and medicine, care is still not equally available and accessible across communities, populations, and socioeconomic, racial, and ethnic groups." As you know, making care "equally available and accessible" to all residents of Travis County is the work of Central Health and the Community Care Collaborative (CCC). Many of the CCC's core functions are broad-based efforts to improve health equity: offering place-based care, expanding access to primary and specialty care, and working to provide patients with all the services they need to optimize their health.

In our FY19 Workplan, the CCC committed to initiate work relating to equity within our covered population. To that end, we adopted the framework laid out by the NQF in its Roadmap, which prescribes a series of steps "for healthcare providers, payers, and others to take action to eliminate healthcare disparities using quality performance measures and related policy levers." This memo will provide you with a progress update on that work.

Initial Phase of Work

Our first activity is to *identify* health disparities within our population. We are using a variety of clinical metrics to analyze the health outcomes of demographic sub-groups: we are reviewing our DSRIP clinical quality measures and our primary care metrics set to identify performance gaps between race and ethnic groups. Our goals in this initial phase are to understand the current state of data and its limitations; understand how our populations compare to other local and national populations; and explore which disparities can be directly impacted by health system design.

Preliminary Analysis

Preliminary analysis indicates that the CCC population follows similar patterns of disparities by race and ethnicity when compared to Travis County and the state of Texas. Additionally, the CCC population overall is performing at or better than national benchmarks; however, these overall rates mask differences between demographic sub-groups. We are limited to reviewing data that is available to us through our existing data sources, such as claims and data submitted by providers as part of the DSRIP program (we cannot see review all metrics of interest on all patients from these data sources)

Future Work

We have identified three immediate next steps. First, we can take action to reduce disparities where evidence shows that we can close gaps in care. For example, evidence shows that outreach with culturally-relevant messaging can increase Breast Cancer Screening rates for black women. We will explore opportunities to connect with community organizations to help implement these initiatives. Second, we will build on our data collection and analysis infrastructure to facilitate robust disparities monitoring. This includes continuing to monitor disparities based on race and ethnicity, as well as incorporating other sub-populations in the analysis, like persons experiencing homelessness, and those with serious mental illness. We will explore collecting information on gender identity and sexual

orientation. We will also explore opportunities to develop disparities-sensitive measures that are shown to illuminate differences between sub-populations through use of sensitive and appropriate questions and indicators. Third, as we develop data for external use, we will continue the conversation on health equity with our enrollees, our staff, our governance structure, and the public.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Stephanie McDonald, Chief of Staff
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 2.3 Women's Health

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

Milestone: 2.3E
Establish a contraceptive Rx and counseling phone line through CUC and expanded Rx

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Implementation plan

Progress Report:
1. Strategic planning sessions with key stakeholders were held in preparation for operational planning of the contraceptive phone counseling pilot. The pilot's business case is under development for review and approval by CommUnityCare (CUC) leadership.
2. CCC pharmacy leader has successfully implemented a $0 co-pay for MAP and MAP Basic enrollees for oral contraception. From June 1 - July 15, 2019 saw 280 unique patients for 300 prescription covered through this program.

Challenges/Issues:
1. Identifying appropriate level of provider to deliver counseling phone services, and staffing the counselor/health educator role for the duration of the pilot.
2. Lone Star Circle of Care uses a different pharmacy benefit mangement provider and discussions are underway to provide this benefit to patients who use LSCC pharmacy services.

Next Steps:
1. The Contraceptive Phone Counseling pilot project team is deciding on what level of provider to utilize for the pilot and adapt (if necessary) the protocols and procedures accordingly. Additionally, more research will be conducted around the questions: Can CUC provide contraception (e.g. Rx, LARC insertion) to teens without parental consent?; Can Central Health reimburse for contraception services to teens without parental consent?
2. Monitor utilization; develop outreach and implement awareness strategy around no co-pay contraception benefit.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: John Clark, Chief Information Officer
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 2.4 Technology & Data

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

Milestone: 2.4D
Develop process to use data warehouse as single data source to support clinical management (Phase II) of selected populations served by Central Health Enterprise partners

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Process workflow documentation & Milestone Review Memo

Progress Report:
There has been significant progress made on gathering data on the MAP and "Sliding Fee Scale" (MAP Basic) populations in the Enterprise Data Warehouse. The warehouse contains current and historical Organized Health Care Arrangement (OHCA) data for CCC primary care and some limited specialty and hospital data. For Sendero, there is eligibility, claims (medical, dental, behavioral health, and vision), pharmacy, and provider data. Community benefit data is available from St. David's Health Care. Additionally, the data warehouse now contains MAP and "Sliding Fee Scale" (MAP Basic) eligibility data, and all patient data from CommUnityCare. There is a real time interface with the ICC (HIE) capturing hospital admission, discharge, and transfer data (Seton only). All of the Organized Health Care Arrangement (OHCA) clinic data in data set one (demographics, encounters, diagnosis, and procedures) has gone through a rigorous quality assurance process, and that process has now been automated using the Board approved data development tools (such as Pentaho) for recurring data feeds from the clinics.

Challenges/Issues:
1. Combined Data Governance between all CH enterprise partners.
2. Centralized and strengthened analysis and data science capability.
3. Hospital partner data feeds need to be re-established.
4. Establishing unique identifiers for all Central Health patients served by any of the enterprise entities.
5. Creating knowledge and buy-in about the power of the data that already exists, the limitations and capabilities of the data warehouse.
6. Continued input from the business (the enterprise data warehouse can do a lot, setting it up effectively requires the business to align, drive the efforts, and actively participate in the development)

Next Steps:

The Enterprise Data Warehouse team is in the process of developing a population health-based dashboard on MAP patients with the goal of monitoring specific chronic conditions and any potential "unnecessary" ED visits by these individuals. Work is continuing on assigning a unique community ID to each unique patient that are considered duplicated patients as well as the construction of new tables within the existing Enterprise Data Warehouse architecture to house the data necessary to develop the new dashboard. The plan is to look for patterns within MAP patients and their clinical history data from 2009 to date. This dashboard is only a launching pad for basic high level analyses, skill sets for true data science reside outside of Joint Tech. Joint Tech's goal in initiating the dashboard is only to inspire thought around the potential uses of the data warehouse. Continued work with various data sources such as direct care data from Seton is essential and will require effort by Joint Tech and other portions of business operations

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Monica Crowley, Chief Strategy & Planning Officer
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 2.6 Cancer Care

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

Milestone: 2.6B
Have received updates from partners and stakeholders around community efforts

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Meeting agenda and minutes

Progress Report:
In fiscal quarter 3, Central Health Manager Museitif, Central Health and CCC executives and staff participated in community efforts related to cancer care including the Dell Medical School convened Cancer Coalition, Breast Health Steering Committee and Breast Health Post-Screening/Diagnosis Workgroup.

Challenges/Issues:
Timing of Budget Presentations - this ended up in Q4

Next Steps:
We will continue participating in these efforts. Dell Medical School representatives will provide an update on these efforts when they present to the Central Health Board of Managers in fiscal quarter 4 of this year.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Steven Lamp, VP of Real Estate & Facilities
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 3.4 Brackenridge

Objective:
3 - Implement sustainable financial model for health care delivery and system strategies through 2024

Milestone: 3.4D
Demolition completed

Milestone Status: Delayed

Deliverable: (attachment, if applicable)
Demolition contract and schedule

Progress Report:
Demolition permit application submitted on April 17, 2019. A "dedicated" permit team is assigned to this project but we have no evident progress from / through the City of Austin.

Challenges/Issues:
City of Austin

Next Steps:
The permit issuance is still being pushed for. Various and increasing information has been submitted repeatedly as requested by the City of Austin. Outside legal counsel has been assigned to aid the effort. Some work has been transferred to The 2033 Higher Education Foundation to avoid possible impact to redevelopment of Block 164.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Steven Lamp, VP of Real Estate & Facilities
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 3.4 Brackenridge

Objective:
3 - Implement sustainable financial model for health care delivery and system strategies through 2024

Milestone: 3.4F
Achieve resolution for zoning and Red River with City of Austin

Milestone Status: Ongoing

Deliverable: (attachment, if applicable)
Status report

Progress Report:
After 5+ years of zero apparent progress, the downtown Property is scheduled to appear before the Codes and Ordinances and the Planning Commission in August, 2019. Central Health's outside legal counsel drafted proposed terms to avoid further delay.

Challenges/Issues:
City of Austin

Next Steps:
1. Present and defend proposed zoning overlay to the Codes and Ordinances and then the Planning Commission.
2. Participate in various community engagement / update sessions to advise on Zoning request.

CENTRAL HEALTH

MEMORANDUM

To: Mike Geeslin, CEO & President
From: Monica Crowley, Chief Strategy & Planning Officer
Date: July 31, 2019
Re: Q3 Milestone Review for Strategy 3.6 Transparency

Objective:
3 - Implement sustainable financial model for health care delivery and system strategies through 2024

Milestone: 3.6B
Present appropriate reporting formats for each strategy

Milestone Status: Complete

Deliverable: (attachment, if applicable)
Report format template

Progress Report:
In order to improve transparency, the Central Health Strategy team developed a reporting template and process that encourages consistent, concise and timely quarterly updates to the Central Health Board of Managers regarding every strategic milestone developed to track progress towards achieving the FY19 strategies that support the long term objectives of the FY19-FY24 Strategic Work Plan. The process includes facilitating the development of the memos at the end of each quarter and presenting the memos at the Central Health Strategic Planning Committee meeting following the end of each quarter.

Challenges/Issues:
There have been no challenges or issues so far.

Next Steps:
The Central Health Strategy team will work with department leaders to develop milestones that will measure progress for each strategy in FY20

CENTRAL
HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

THE STRATEGIC PLANNING COMMITTEE

August 7, 2019

AGENDA ITEM 6

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