St. David's Medical Center

and

South Austin Medical Center

Community Health Needs Assessment Strategic Implementation Plan 2019 – 2021

Community Health Needs Assessment Implementation Plan

April 27, 2020

Description of Significant Health Needs

As noted in the Community Health Needs Assessment (CHNA) summary, St. David's has identified the following five areas as the priority health needs to be addressed in our hospitals' Implementation Plans:

1. Improved health and well-being of children
2. Improved health and well-being of women
3. Improved health and well-being of older adults
4. Improved health and well-being in rural communities
5. Health clinics to become community hubs for health

Additionally, St. David's has identified the need to invest in two areas internally identified as Critical Infrastructure and Innovation. **Critical Infrastructure** refers to the continued support of long-standing non-profit partners that play a pivotal role in our community. While all supported partners serve the populations identified in the CHNA, they may provide a service that falls outside our organization's specific strategic plan. However, because of the role they serve, they remain mission-critical and a substantial reduction in funding would be detrimental to the health of the community. Investments in **Innovation** recognizes that to be successful, we must allow for new and emergent strategies that grow from partnering with the community. Again, these investments will still address the needs of the populations above, but are often cross-cutting, do not fit neatly into one category, and have multiple benefits.

Description of How St. David's Plans to Address Significant Health Needs

The following pages illustrate in more depth the specific strategies St. David's intends to take to address the needs identified in the CHNA. In addition to providing funding for **direct services**, St. David's will invest in **capacity building** to help strengthen the non-profit ecosystem, **research and evaluation** to build evidence concerning promising programs and scale as appropriate, **community engagement** to identify new solutions created by those with lived-experience and expertise, and **strategic communications** to grow awareness of the important issues and share resources with our community.

In addition to grantmaking, St. David's Foundation (SDF) manages three internally operated programs designed to address community needs. These include the St. David's Dental Program, which utilizes nine mobile clinics to provide free dental care to primarily low-income children in Central Texas. Over $8 M in resources and staff were dedicated to this important program. SDF also manages a scholarship program designed to encourage high school students to enter a medical field and a volunteer program designed to connect younger generations with programs that support older adults.

To track progress, each strategy includes our monitoring and evaluation framework developed for that area including the intended impact, the lead staff person, goals and indicators, and baseline (2019) data when available. Metrics are divided into **Key Services** and **Progress Indicators**. Progress indicators include both internal and external changes we hope to accomplish over the next three years.

Additional Needs Identified in the CHNA

While additional community needs are listed under the various county health assessments, we have embedded these as either strategies or approaches under the five priority areas developed in the implementation plan. For example, needs related to mental health arose as a high priority for the community. Mental health shows up in several of our priority areas, most prominently under Children's well-being with a focus on preventing and treating trauma and the effect of adverse childhood experiences (ACEs), and under the Clinics area with a focus on integrating behavioral health services within primary care

settings. Addressing social determinants of health (SDOH) is another need that is embedded across priority areas and particularly in the Clinics strategy of supporting the development of SDOH screening protocols and referral systems to assist with non-medical needs. Finally, ongoing engagement and the importance of addressing power dynamics is central in our work and is highlighted in the Rural priority with a focus on leadership development of diverse leaders and the co-creation of future strategies with community members leading the work.

Resources Available to Address these Needs
St. David's will utilize a variety of resources to address these needs, including distributions from St. David's HealthCare Partnership, income from investments, and capacity of staff, including expertise in public health, grantmaking, strategic communications, and organizational capacity building.

Planned Collaboration in Addressing these Needs
St. David's has a long history of collaboration in addressing community health needs and will continue those relationships as part of this new Implementation Plan. Existing and planned collaborations include those with our 100+ grantees, public health departments in Travis and Williamson counties, and various planning entities related to the community health areas of focus.

Evaluation Methodology
For key services provided, grant partners are required to report progress towards goals either quarterly or semi-annually ,which are then reviewed by Foundation staff. Total number of clients served by the grant partner is presented here, regardless of the proportion of the project supported by St. David's. In 2019, the median grant size was $240,000 and represents 56% of the average grant project.

Generally, the foundation has two "grant cycles" and after approval, grant terms start January 1st or July 1st of a given year. For the purposes of reporting, the year in the column refers to the project end date. Data is presented once a grant closes and thus 2019 generally refers to grants with a term that covers the entire calendar year or covers July 1, 2018 through June 30, 2019. Twelve months of funding is always used to allow for comparison of data.

A Note about the COVID-19 Pandemic
The entirety of the Community Health Needs Assessment and the majority of this Implementation Plan was finalized prior to the pandemic experienced by Central Texas and the nation in the Spring of 2020. Although our philanthropic response is still being finalized, we estimate that a portion of our grantmaking budget will be reallocated from strategic investments to the development of a recovery fund designed to help non-profits in our community with basic operational support during this challenging period. We also project that the challenges of social distancing and stay-home orders will impact our non-profit partners ability to provide services and the numbers reported by grantees will likely decline over the next year or two. The long-term impact of the pandemic on non-profit organizations is unknown and may require shifts in the strategies presented here. We will continue to monitor the needs of both communities and organizations and will revise our plans as necessary.

1. Improve the health and well-being of **Children**

Theory of Change Statement

Foster the conditions that create positive early experiences for young children, knowing these early experiences are the foundation for later health, social, and economic outcomes.

Lead Staff: Kim M. **Target Population:** Families experiencing poverty with children ages 0-5.

Approaches

1) Inform the public by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.
2) Screen at key intercept points such as pediatric clinics for childhood adversity, relational health, and other related factors.
3) Treat children through a strong therapeutic web that includes specialized treatments that incorporate research on the effects of trauma and adversity, as well as tools to build resiliency, such as parenting supports.
4) Prevent adversity and build resiliency, using avenues such as parent engagement and education campaigns, and engaging children and their communities in their own healing.

Vision of Success

- Families are supported and have the key services they need to remove sources of stress, strengthen core life skills, and foster positive relationships between children and caregivers.
- Communities are connected, with built environments and norms that promote social interaction among community members.
- Stakeholders are informed about the science behind brain development. These stakeholders include practitioners, policy makers, and the general public.

Tracking Progress

Key Services Goals *Indicators*	Planning Year 2019
Increase access to treatment to address trauma and adversity *Children under 18 receiving services*	5,503
Increase practitioners utilizing trauma-informed care best practices *Clinicians trained with trauma-informed care resources*	189
Reduce stress by increasing support available to parents such as home-visiting *Families receiving parent support services*	3,073

Progress Indicators *(will report date achieved or progress made)*
Increase Brain Story Certifications statewide by 30%
Increase proportion of clinics that include relational health as part of their patient screening
Increase number of clinics that offer integrated behavioral health
Establish therapeutic services for rural and hard to reach populations
Establish universal home visiting models in two counties that achieve national certification
Increase home visiting slots in Central Texas by 10%
Increase proportion of local school districts that have incorporated social emotional learning (SEL)

2. Improve the health and well-being of **Women**

Theory of Change Statement

Ensure women and girls are supported with the resources, respect, and conditions vital for equitable health and well-being.

Lead Staff: Lourdes R.
Target Population: Women experiencing poverty and women of color across the socioeconomic spectrum.

Approaches

1) Establish Central Texas as a women's health and perinatal safe zone. Lead and join in a shared community commitment to protecting women's resources, respect, and conditions regardless of what happens in the broader environment.
2) Center women of color (e.g. listen to them, step back while they drive the agenda, include them at key tables, enable them to tell their own stories, invest in their leadership).
3) Fill gaps in the fragmented safety net women's health system and fund select innovations.

Vision of Success

- Women and girls of color experience birth equity (including but not limited to equitable outcomes in perinatal care, maternal morbidity and mortality, and newborn outcomes).
- Women's health safety net policies and programs are less fragmented, resulting in continuity of access between primary care, sexual and reproductive health care, and perinatal care.
- Women and girls can obtain low barrier family planning and contraceptive care, including the most effective methods, in clinical and community settings.
- Communities are empowered to share their own narratives and stories.
- St. David's Foundation's women's health work aligns with other issues and movements relevant to the health of women and girls (e.g. improving conditions for caregivers, gender-based violence), expanding our intersectional partners and community impact.

Tracking Progress

Key Services Goals *Indicators*	Planning Year 2019
Increase access to family planning and contraceptive care *People receiving family planning services*	2,465
Increase access to comprehensive sexuality education and pregnancy prevention programming for young adults. *Students receiving comprehensive sexuality education*	1,029
Increase access to culturally congruent perinatal care *People receiving culturally congruent perinatal support*	114

Progress Indicators *(will report date achieved or progress made)*
Increase number of leaders attending SDF Women's Health convenings
Increase number of women of color included in key stakeholder convenings
Increase proportion of grant partner organizations led by women of color
Completion of a Perinatal Safe Zone engagement plan
Increase number of school districts implementing comprehensive sexuality education

3. Improve the health and well-being of **Older Adults**

Theory of Change Statement

Increase support for older adults to live safely and independently in their own community.

Lead Staff: Andrew L.
Target Population: Older adults navigating Medicaid, just over the Medicaid threshold, those living in rural areas, and older adults of color, along with their caregivers.

Approaches

1) Directly fund services and support the health of organizations providing services. This approach includes programmatic and capacity building grants in six key funding areas including (a) Core services for vulnerable homebound older adults; (b) Resources and education for family caregivers; (c) Adult day health centers; (d) Programs that reduce social isolation; (e) Palliative care and end of life planning; and (f) Workforce development of highly skilled geriatric social workers.
2) Bring services to scale in ways beyond grantmaking using the following approaches:
    a. Build evidence for new models by piloting and evaluating innovative services in Central Texas and demonstrating the "double impact" of intergenerational approaches
    b. Lead new payment models and public system improvement by advocating to MCOs and legislators on the cost effectiveness of adopting evidence-based services, advocating for increased appropriations for Medicaid services for older adults, and engaging local organizations to advocate for supportive aging policies.
3) Engage and activate community around aging issues.

Vision of Success

- Older adults remain safe and independent in their homes as they age.
- Older adults have a better end of life experience.
- Central Texas supports older adults and engages them as a vital part of the community.
- Central Texas has an adequate supply of accessible, high quality services for older adults.

Tracking Progress

Key Services Goals *Indicators*	Planning Year 2019
Increase access to services for older adults to assist them in aging in place *Older adults receiving core services (meals, transportation, home repair)*	12,650
Increase access to adult day programs to reduce isolation for older adults and caregiver stress *Older adults in adult day programs*	1,817
Increase confidence and reduce stress by providing resources to family caregivers. *Caregivers receiving training and resources*	2,153
Increase awareness of importance of end-of-life discussions and documenting plans *Older adults with advanced directives*	*New Metric*

Progress Indicators *(will report date achieved or progress made)*
Increase number of Central Texas urban and rural counties with adult day and/or respite care
Increase number of Central Texas urban and rural counties piloting CAPABLE model
Participation of CAPABLE model in an external evaluation designed to prove cost effectiveness
Establishment of a Dignity Fund with local support and national engagement
Increase number of media stories on issues facing older adults in Central Texas in order to increase the percentage of older adults with an established Advance Directive

4. Improve the health and well-being of **Rural Communities**

Theory of Change Statement

Build community capacity while co-creating and investing in long term place-based solutions.

Lead Staff: Abena A.
Target Population: Non-metro communities, specifically Bastrop, Caldwell, Hays, and eastern Williamson County.

Approaches

1) Engage and empower rural communities to strengthen networks and transform policies, practices, and alignment of resources to address prioritized social determinants of health.
2) Build the capacity of people and places including formal and informal leaders within communities and organizations.
3) Strategically invest in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.

Vision of Success

- Rural communities have a culture of health that transcends beyond healthcare access.
- Rural residents experience strong social connection and are engaged in thriving cross-sector, community-based networks that promote health and well-being.
- Rural systems undergo change that includes policy, practices, behaviors, and resources to promote health and well-being.
- Rural organizations have a strong infrastructure in place with adequate capacity.
- Rural residents are engaged and empowered by diverse civic leadership to activate and improve community well-being.

Tracking Progress

Key Services Goals *Indicators*	Planning Year 2019

No Key Service Goals for this area. As a relatively new area of investments for the Foundation, the focus will be community engagement and solutions will be co-created with community members.

Progress Indicators *(will report date achieved or progress made)*
Establishment of Bastrop County resident advisory groups for two key issues and develop work plans
Increase philanthropic resources to Central Texas rural communities through dissemination of network weaving assessment to local and national rural funders
Development of leadership training program co-designed with national & local capacity building organizations
Increase capacity of a local nonprofit to serve as a backbone organization for community-led efforts
Increase number of proposals from rural communities across all portfolios
Release of RFP focused on increasing health literacy in rural communities

5. Health clinics to become **Community Hubs** for health

Theory of Change Statement

Facilitate growth of infrastructure and capacity as clinics transition to serve as community hubs for health.

Lead Staff: Amy E. **Target Population:** Safety-net clinics poised to serve individuals experiencing poverty.

Approaches

1) Provide access to primary care and behavioral health services for the uninsured.
2) Expand capacity of clinics to provide activities, processes, and strategies to improve the care delivery model.
3) Encourage clinics to look outside of their four walls to develop and strengthen community linkages to improve community health and well-being.

Vision of Success

- The uninsured and underinsured have access to high quality care.
- Clinics are prepared to incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume.
- Patients are satisfied with their experience as they interact with the primary care health system.
- Clinics deliver comprehensive primary care and interact effectively outside the clinic to strengthen community linkages and ultimately improve the health and well-being of patients and the population overall.

Tracking Progress

Key Services Goals *Indicators*	Planning Year 2019
Increase access to primary care services for the unfunded in Central Texas *Uninsured patients receiving medical care*	25,447
Increase integration of care through behavioral health programs in primary care settings *Patients receiving integrated behavioral health services*	7,172
Increase access to dental services for adults experiencing poverty *Adults receiving dental care*	8,581
Reduce burden of navigating complex health system through case management services *Patients receiving care coordination*	380
Internal Program Goals (Operated by St. David's Foundation)	2019
Increase access to free preventive and restorative dental care through school-based program *Patients receiving dental care on mobile clinics of St. David's Dental Program*	9,343
Increase mentorship and pathways for high school students to enter medical field *Neal Kocurek Scholarships awarded (4-8 years of support per scholarship)*	61

Progress Indicators *(will report date achieved or progress made)*
Engagement in external evaluation of care delivery approach required by payment reform to inform evolving philanthropic role
Development and implementation of a care coordination approach at partner clinics
Increase proportion of patients receiving care coordination, engagement activities, and medication management at partner sites
Increase number of partner clinics implementing social determinants of health screening of patients
Increase number of partner clinics with established relationships to key social services providers
Increase number of partner clinics with closed loop referral programs in place