

# Strategic Refinement

2020-2022

Across all the Foundation's goals and principles, we are guided by a **commitment to advance health equity.**

## Mission

St. David's Foundation will help improve the health and well-being of our most underserved Central Texas neighbors using our resources to reduce health inequity, increase access to healthcare focused on the whole person through integrated care, and support Central Texans in taking an active role in their health and healthcare needs.



## Guiding Principles

- We believe in having **bold, meaningful, measurable goals** that serve as a compass to our work, allowing us to strategically adapt our efforts to achieve these goals.
  - We believe that **health equity is essential** for improving the community's well-being and therefore we seek to improve the health of the most vulnerable communities.
  - We believe in **inviting new perspectives** and co-creating with community members to ensure our work continues to evolve and encompass different perspectives and experiences.
  - We believe **collaboration with others** is essential - either by leading, leveraging, and/or partnering - to achieve the impact we desire and therefore we seek to build authentic, trusting, strategic relationships.
  - We believe **taking risks is required for change** that drives innovation and scaled impact.
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# Overview

We believe all Central Texans should have the **opportunity** to achieve optimal health.

## Background

As the **largest health philanthropy in the state**, St. David's Foundation plays a critical role in advancing health equity within Central Texas.

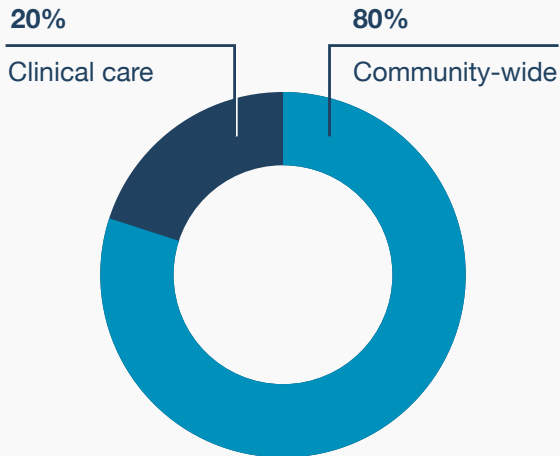
Our starting point is defining "health." Borrowing from the World Health Organization, we define health as a state of physical, mental, and social well-being and not merely the absence of disease.<sup>1</sup>

**Access to high quality medical care is essential to overall health**, and research suggests that clinical care contributes to approximately 20% of our health status.

Although some aspects of a person's health depend on individual behaviors and choice, approximately 80% of health is shaped by community-wide factors.

Figure 1

### Factors Contributing to a Person's Overall Health



Problems such as poverty, unemployment, inadequate housing, lack of public transportation, low educational attainment, and neighborhood deterioration shape health.<sup>2</sup> Also referred to as "**social determinants of health**" (SDoH), some of the most influential drivers of health include economic, environmental, and behavioral factors that exist outside of the healthcare system.<sup>3</sup>

## Our Current Thinking

This document outlines our current thinking and our place-based approach to serving the Central Texas community. We lay out five goals, various approaches to achieve those goals, and how we will measure progress.

As St. David's Foundation refines its strategic approach, we remain committed to promoting health and well-being in our five-county area in Central Texas (Bastrop, Caldwell, Hays, Travis, and Williamson counties) – especially among underserved communities.

St. David's Foundation will continue to strengthen **institutions that support health**, such as strong safety net and specialty care clinics, while also prioritizing other factors that contribute to health and well-being across the lifespan.

While we devote most of our financial resources to grantmaking, we are dedicated to **activating other levers** - such as strategic communications, capacity building, evaluation and learning, and convening - to advance our goals. These levers will assist us in achieving long-lasting results that cannot be met through grantmaking alone.

## OVERVIEW

While this plan reflects our current thinking, we recognize that addressing complex and systematic issues requires continuous reflection and adaptation.

We are **committed to learning** with community members, non-profit partners, and the philanthropic community to improve existing supports and test new solutions.

Our learning must be grounded in high quality data and shared openly so that we invite others to further our thinking. This plan seeks to address the needs we heard from community members and build on the opportunities they identified.

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# Our Goals

Across all of our goals we are guided by a commitment to achieving **health equity**.

## Health Equity

We believe that all Central Texans should have the opportunity to achieve optimal health and there are no avoidable, unnecessary, unfair, or systemically-caused differences in health status due to ethnicity, gender, age, or geography.

Interventions targeting systemically-caused differences in health status hold the greatest promise for promoting and achieving health equity.<sup>4</sup>

Eliminating health disparities cannot be accomplished without seriously addressing the underlying social determinants of health, many of which are shaped and perpetuated by bias, injustice, and inequality.<sup>5</sup>

Shifting our mindset to equity requires **centering the people and communities** whose lives we seek to impact in our goals.

Figure 2

### Our Commitment to Health Equity

We will focus on periods of **vulnerability** and **opportunity**

Across the lifespan of **children, women and girls, and older adults**



## Our Goal Areas

### 1. Resilient Children

*Priority population: Families experiencing poverty with children ages 0-5.*

### 2. Healthy Women and Girls

*Priority population: Women experiencing poverty and women of color across the socioeconomic spectrum.*

### 3. Older Adults Age in Place

*Priority population: Older adults navigating Medicaid, just over the Medicaid threshold, those living in rural areas, and older adults of color, along with their caregivers.*

### 4. Thriving Rural Communities

*Priority population: Non-metro communities, specifically Bastrop, Caldwell, Hays, and eastern Williamson County.*

### 5. Clinics as Community Hubs for Health

*Priority population: Safety-net clinics poised to serve individuals experiencing poverty.*

Each goal is led by a Senior Program Officer, in close partnership with Learning & Evaluation, Capacity Building, and Communications colleagues.

## Strategic Focus Areas

In selecting these five goals, we have focused on **periods of high vulnerability and opportunity**.

We see periods of vulnerability and opportunity across the lifespan for individuals – for our youngest children, women, and older adults. We also see both vulnerability and opportunity in communities such as our rural neighbors and clinic partners during this time of transition in how services are funded.

We recognize the overlap within and between the five goals, and that much of this work is intersectional in nature.

In addition, we believe people are generally strong, capable, and inventive. We believe people are the solution, not the problem. Therefore, we are committed to taking a **strengths-based approach** to social services in which we listen to and trust the communities we serve. This also means focusing on changing systems and conditions rather than trying to dictate how individuals should live or behave.

Finally, our goals focus on achieving community change which inherently recognizes that we are social creatures by nature and change happens through community connection and social support. We believe **social connection is a key driver of health** and sustainable change. When facing a health-related crisis, the presence of informal networks of support can be as beneficial as having access to social services.

Therefore, the Foundation aims to improve the built environment as well as support policies and groups that facilitate relationship-building within and between individuals and communities.



## Our Approaches

Within each goal, we drew on research and best practices to develop a theory of change that identified the key **outcomes** that define success and the known and emerging pathways to achieve them.

Staff then determined the approaches we are best positioned to test over the next three years. Our effort to lead with goals results in a broad range of approaches being tested simultaneously across areas.

**However, across the five goals we see three key strategies underpinning the work:**

1. **Leading** philanthropic efforts to fund key services and improve the built environment in our community

*Core lever: Grants*

2. **Leveraging** evidence to catalyze change at the systems level

*Core lever: Evaluation/Communications*

3. **Partnering** with communities to ensure sustainable solutions

*Core lever: Community Engagement/Capacity Building*

Figure 3

## Principles of Health Equity



**Systems are designed to benefit some more than others, and this drives health inequities between groups of people**



**People are not the problem to be fixed, rather the solution**



**Social connection**  
(or community) is a powerful driver of health

*Below are definitions of the terms we use to describe what we hope to achieve through our work.*

**Goal:** Our big hope. What we hope to see in this domain in the future.

**Outcomes (long-term):** The goals unpacked. What needs to change in order for the goal to be achieved? We expect these to remain relatively consistent over time (10 plus years), while our approaches to reach these outcomes may change. Outcomes can include a mix of system, community, and individual/family-level changes.

**Approaches:** What the Foundation is testing to achieve outcomes. Should only include what we reasonably expect to work on in the next three years. Will be revised as we learn from our work. Utilizes different levers (described below) as part of the approach.

**Levers:** Tools at our disposal. The Foundation's primary role in this domain. Examples include strategic communications, capacity building, community engagement, convening, and grant making.

## Tracking Progress

Our approach to evaluation focuses on using data as a tool for learning. This fundamentally changes the way we use data by reorienting the questions we ask from compliance – “Did we do what we said we would?” – to strategic learning – “Are we headed where we wanted to go? Is that still the right direction? And what is causing this change?”

This shift recognizes the complexity of the issues we are trying to impact and allows for emergence which leads to innovation.

Our measurement framework leads with **Progress Indicators** that are intended to be used as reflection points for our approaches that aim to achieve transformative community change by improving systems. They reflect our current thinking on how to create change and should evolve as we learn from our work.

Therefore, we hope that they serve as a conversation tool around what led to this change and how can we adapt our workplan based on what we've learned.

For approaches that focus on addressing immediate individual needs, we have included **Metrics for Key Services**. The measures reflect the intended outcomes of the strategy – individual access to key services – and do not attempt to answer questions related to system change that are outside the scope of the activities they are measuring.

The Foundation will conduct semi-annual Strategy Reviews to check on progress, gather insights, and make adjustments to our approaches based on what we've learned.

# Resilient Children

## GOAL 1

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.

## The Issue

The majority of human brain development occurs by age five. Our early experiences shape not just our behavior, but also our biology.

Children who are exposed to high levels of adversity (e.g. abuse, neglect, domestic violence, etc.) are more likely to become adults who face a large burden of disease and social problems, such as depression, alcoholism, lung disease, and heart disease. To promote child resilience, St. David's Foundation aims to create the conditions for a thriving childhood and optimal brain development.

Research in this area points to one major factor that creates child resilience, even in the face of high adversity: **the presence of a stable, caring adult.**

Therefore, we strive to create the conditions for healthy relationships to flourish.



## By the Numbers

- E3 Alliance reports that 51% of all and 40% of Central Texas students experiencing poverty are ready for kindergarten.<sup>6</sup>
- Over 62,000 children in Central Texas (about 12%) live in poverty. Living in poverty is linked to higher levels of Adverse Childhood Experiences (ACEs) and lower presence of resilience factors.<sup>7</sup>
- In Central Texas, 6.7% or 6,500 teens ages 16-19 are disconnected, meaning they are neither working nor in school. This proportion is even higher in our rural counties, at 13% and 9% in Caldwell and Bastrop, respectively.
- Disconnected youth are at an increased risk of violent behavior, smoking, alcohol consumption and marijuana use, and may have emotional deficits and less cognitive and academic skills than their peers.<sup>8</sup>
- There are over 42,000 uninsured children in our five-county region.<sup>9</sup>

Figure 4

**About 12% of Central Texas Children Live in Poverty**



## The Population

Adverse childhood experiences (ACEs) are linked to adverse community environments and systemic issues, such as poverty, discrimination, community disruption, lack of economic mobility, and poor housing quality and affordability. The primary focus of St. David's Foundation's child resilience efforts is on **families experiencing poverty with children ages 0-5**. We believe that when we target support to the families that most need it, the benefits will extend to the broader community.

Some work within this portfolio overlaps with the Women's Health portfolio, improving both child health and women's health through a two-generational approach.

To sustain the gains we make among children 0-5, a smaller portion of our resources and efforts will include work with primary care providers, schools, child-serving organizations, and community leaders to build resiliency and protective factors in systems beyond early childhood.

## Change for Children and Families

To build resilience, all children need at least one stable, caring adult present in their lives. Parents and caregivers need the bandwidth to play, support, and talk to their children and the skills to know that this behavior is critical.

To prevent ACEs, families need access to high-quality, affordable childcare; affordable and accessible healthcare; safe, affordable, and convenient transportation; quality food and water; and safe, stable, and affordable housing.

Under optimal conditions, neighborhoods would have communal open spaces that promote social connectedness, and neighbors would know and help each other, making mutual support the norm rather than the exception.

Additionally, children would be screened for ACEs in their pediatric offices and be referred to easily accessible and appropriate treatment as necessary, and they would have ample opportunities at school to engage in social-emotional development.

## Change for the Field

Under optimal conditions, systems that interact with young children and families would have an understanding and shared commitment to preventing ACEs and building resilience.

These systems include childcare centers and schools, pediatric practices, and prenatal and parenting programs. To help children thrive and foster resilient communities, it is vital that these systems use **trauma-informed approaches** and that the people within them know the science behind brain development.

Schools should offer opportunities for social-emotional development; pediatric providers should have the knowledge and tools to address social determinants of health; and prenatal and parenting programs should promote caregiver networking, parent-child attachment, and universal screening and education about trauma.

The systems that interact with children must be connected. For example, when pediatricians screen for ACEs, they need the knowledge and resources to refer children to treatment services as necessary.

## Long-Term Outcomes

- **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.

## The Actual Work

St. David's Foundation's work in child resilience rests upon three guiding principles:

### 1. Brains are built, not born

*Experience, especially early experience, shapes who we are and who we become.*

### 2. We are social creatures

*Thousands of years of evolution have wired our brains to depend on and respond to social connections.*

### 3. The science demands broad participation

*No one sector owns or is responsible for implementing this science.*

## Approaches

1. **Inform the public** by promoting the science of brain development to guide clinical practice, public policy, and resource decisions.

#### Key indicators of progress:

- Increase percentage of Brain Story Certifications completed by Texas organizations/individuals by 30% over baseline

2. **Screen at key intercept points** such as pediatric clinics for childhood adversity, relational health, and other related factors.

#### Key indicators of progress:

- Increase the percentage of safety net clinics in Central Texas screening target populations for adverse childhood experiences/relational health/social determinants of health using a Foundation approved screening tool over baseline

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.

#### Metrics for key services funded:

- Number of youth receiving specialized treatment to address trauma and adversity
- Number of people who have received Trauma Informed Care trainings

Key indicators of progress:

- Increase (or maintain) the number of safety net clinics that offer Integrated Behavioral Health
  - Establish a baseline for therapeutic services received for key demographics in order to adjust accessibility of services as needed
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.

Metrics for key services funded:

- Number of families receiving home visiting

Key indicators of progress:

- Establish universal home visiting models in at least two counties, including rural, that achieve certification
- Increase percentage home visiting slots in Central Texas by 10 points and monitor public payers support
- Increase the percentage of local school districts that have incorporated social emotional learning district wide

## Spotlight Initiative

### Home Visiting RFP

In April 2019, St. David's Foundation released a request for proposals (RFP) to identify organizations able to expand the capacity of home visiting programs in Central Texas.

The RFP defines home visiting programs as those that seek to improve the well-being of young children (prenatal to age five) and their families by using the home as the primary mechanism to provide direct support and coordination of services.

Providing services at home can reduce barriers to participation and offer opportunities to educate, model, and coach caregivers.

In Central Texas, home visiting programs are unavailable to many families that could benefit from this model, reaching fewer than 10 percent of Central Texas' families experiencing poverty with young children.

**Expanding access to home visiting is one component of a larger strategy** to prevent childhood adversity and build resilience by creating the conditions necessary for healthy relationships to flourish.

# Healthy Women and Girls

## GOAL 2

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



## The Issue

Healthy women are a cornerstone of healthy families, communities, and economies. Women are often gatekeepers to the health of their children, partners, and aging relatives. Therefore, investing in women's health, rights, and well-being produces benefits that can empower entire communities. Currently, women and girls in Central Texas do not have adequate access to the resources they need to care for their health and well-being.

This issue is largely due to a fragmented health system, which leads to barriers in obtaining continuous, comprehensive women's health services. Women struggle to access contraception, comprehensive sex education, prevention and care for sexually transmitted infections, alternative birth options, and adequate pregnancy care.

When women and girls do access health services, they often are not trusted to make decisions about their own needs. **Women of color especially experience this distrust and other forms of discrimination**, both in health settings and in their everyday lives. Black women experience high rates of toxic stress, which a growing body of evidence suggests is a potent contributor to the alarming rates of morbidity and maternal mortality among this population.

## By the Numbers

- 55% of Texas women reported at least one barrier to accessing reproductive healthcare services.
- 38% of these women reported cost of services as the primary barrier.<sup>10</sup>
- Black women's pregnancy-related mortality rate in Texas was 2.3 times higher than the rate for Non-Hispanic White women (2011-2012). The increased risk of pregnancy-related death persists independent of age, parity, or education. Black women with at least a bachelor's degree experience higher rates of infant mortality than White women who did not graduate high school.<sup>11,12</sup>
- 39% of births in Caldwell and 29% in Bastrop did not receive first trimester prenatal care.<sup>13</sup>
- 83% of Texas schools taught abstinence-only or no sexual education.<sup>14</sup>

**Healthy women are a cornerstone of healthy families, communities, and economies.**



## The Population

St. David's Foundation's Women's Health work focuses on women experiencing poverty as well as women of color across the socioeconomic spectrum. Many of these women live in the eastern crescent of Travis County and in Central Texas' rural areas. This portfolio supports women and girls, **regardless of whether they choose to have children.**

We view the perinatal period as a critical period of vulnerability and opportunity, during which women have specific health needs, such as family planning services, pregnancy-related health care, and maternity care.

Some work within the Women's Health portfolio overlaps with the Resilient Children portfolio, improving both child health and women's health through a two-generational approach.

## Change for Women and Girls

Under optimal conditions, women's lives would not be more difficult because they are women, nor because they are members of other historically disenfranchised groups. Women should have access to childcare, family-friendly workplaces, and health services.

Furthermore, all women deserve the human right to personal bodily autonomy, to have or not have children, and to raise the children they have in safe communities with social connections that support their parenting efforts and overall well-being.

Ideally, women would not experience gender-based violence, discrimination, or wage inequality.

Meanwhile, they need access to services that alleviate the effects of these stressors and enable them to care for their health and well-being, as well as that of their families.

## Change for the Field

Underserved women must be at the center of driving change for their communities and defining what they need. Only with this foundational element in place will change for the women's health field meet their diverse needs. Cross-sector collaborations among medical providers, governments, community organizing groups, direct service providers, and philanthropy, are needed to bridge the gaps in services for women and connect the dots of the health system.

Additionally, public and private sector partners must come together to create family-friendly workplaces, provide affordable and high-quality childcare, and combat gender-based violence.

Finally, women and girls live intersectional lives—race, income, sexual orientation, citizenship status, and other factors all contribute to inequities in women's health.

To create community momentum, we must forge connections with related groups and causes, and strengthen the field to support all women.

Ultimately, we envision players from across the field coming together to dismantle the structural inequities that lead to poor health outcomes.

## Long-Term Outcomes

- Women and girls of color experience **birth equity** (including, but not limited to equitable outcomes in perinatal care, maternal morbidity and mortality, 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.

## The Actual Work

We acknowledge that women's health exists in a system, and the context of that system contains several uncertainties. There are things we have not yet learned from the communities we serve, uncertainties in the policy environment and whether it will be supportive of women, and whether cross-sector collaboration will occur.

As a relatively new women's health funder, St. David's Foundation's approach will evolve as we learn more about the women's health ecosystem.

Regardless of the shifts that occur, four guiding principles inform our work:

### 1. Women and girls live intersectional lives

*This means that we must address societal inequities, such as wages, domestic violence, racism, and access to safe, affordable housing, that contribute to health inequities.*

### 2. Women and girls should be trusted to make decisions about what they need

### 3. The community must drive the change

### 4. Women and girls have innate inner strength

*Our society does not always allow them to use it. We aim to bring these natural assets out.*

## 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.

Key indicators of progress:

- Increasing number of leaders attending St. David's Foundation's Women's Health convenings
- Completion of a Perinatal Safe Zone engagement plan

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).

Key indicators of progress:

- Increasing the number of women of color included in key stakeholder convenings
- Increase the diversity of Women's Health partners including, but not limited to, the percentage of grant partner organizations led by women of color

3. **Fill gaps in the fragmented safety net** women's health system and fund select innovations.

Metrics for key services funded as a result of gaps in the system:

- Number of people receiving family planning services
- Number of students receiving comprehensive sexuality education
- Number of people receiving culturally congruent perinatal support

Key indicators of progress:

- Completion of gaps and opportunities systems map
- Increase the number of school districts implementing comprehensive sexuality education

## Spotlight Initiative

# Collaborative Strategy Setting

As part of the process of developing the strategies described in this plan, St. David's Foundation hosted strategy sessions to hone our thinking.

The Women's Health strategy session involved several community organizations in the women's health arena. A facilitator engaged participants in a conversation about gaps within the women's health system and the resources or strategies needed to address these gaps.

Through this strategy session, St. David's Foundation began to shift the traditional approach of grantees operating in silos and competing for funds **to one where grantees and funders worked collectively to develop strategies.**

# Older Adults Age in Place

## GOAL 3

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

## The Issue

Central Texas has one of the fastest growing aging populations in the country and it is predicted to double over the next 20 years.

As we age, we become more vulnerable to chronic conditions and functional disabilities that make it challenging for us to remain safe and independent in our homes and connected to our communities.

Older adults often desire to remain living in their communities, and **support services are critical** in helping them to achieve this goal.

To meet the growing demand, St. David's Foundation is working to increase services that support aging in place at a large scale appropriate for our five-county region.

## By the numbers

- The number of people 65+ in Central Texas will more than double by 2040 (currently 220,000 in 5 county area).<sup>15</sup>
- 24% of older adults in Central Texas live alone.<sup>16</sup>

Figure 5

### About 1/4 of Older Adults in Central Texas Live Alone



## The Population

In Central Texas, an estimated 48,334 older adults 65+ are living under 200% Federal Poverty Level.

While the poorest older adults, living at \$22,000 per year or below, can qualify for Medicaid, the process of navigating covered services can be complicated and services are often unavailable. Additionally, older adults just over the Medicaid threshold do not qualify for assistance and are particularly vulnerable to being left unserved.

Older adults living **in rural areas are disproportionately affected** by having less access to services, limited transportation options, and increased social isolation.

Finally, older adults of color often live in areas with a historical lack of economic and social investment.

These demographics of older adults, along with their caregivers, form the population St. David's Foundation serves through our Older Adults portfolio.

## Change for Older Adults

Aging adults need access to services that enable them to remain safe and independent in their homes and connected to their communities.

**These services must be easy to navigate, geographically accessible, and covered by Medicaid or affordable** for those just over the Medicaid income threshold. The care older adults receive should be of high-quality and, for those at the end of their life, it should enable them to have a better death.

## Change for the Field

Central Texas has an inadequate supply of services for older adults.

To address this issue, governments, managed care organizations (MCOs), and other philanthropists must coordinate their efforts and implement public policy changes, changes in legislative appropriations, new benefit coverage by MCOs, and new investments (philanthropy, government, private sector) that create sustainable change for older adults in Central Texas.

These changes could include MCOs and legislators adopting cost-effective, evidence-based aging services; governments increasing appropriations for Medicaid services for older adults; and foundations collectively establishing a fund to increase public support and awareness around aging issues.

## Long-Term Outcomes

- 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.

## Approaches

The Foundation will move toward these outcomes by activating two main 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:

- Core services for vulnerable homebound older adults;
- Resources and education for family caregivers;
- Adult day health centers;
- Programs that reduce social isolation;
- Palliative care and end of life planning; and
- Workforce development of highly-skilled geriatric social workers.

#### Metrics for key services funded as a result of gaps in the system:

- Number of older adults receiving core services
- Number of older adults participating in adult day programs
- Number of individuals with advanced directives
- Number of caregivers receiving training and resources

#### Key indicators of progress:

- Increase the number of Central Texas counties, including rural counties, with adult day and/or respite care services
- Increase number of Central Texas counties, including rural counties, piloting CAPABLE model

### 2. **Bring services to scale in ways beyond grantmaking.** Specifically, the Foundation will use the following approaches:

- Build evidence for new models by piloting and evaluating innovative services in Central Texas and demonstrating the “double impact” of intergenerational approaches
- 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

#### Key indicator of progress:

- Central Texas CAPABLE model participates in an external evaluation designed to prove the cost effectiveness of the model to third party payers



3. **Engage and activate community** around aging issues.

Key indicators of progress:

- Establishment of a Dignity Fund with local support and national engagement
- Increase number of media stories on issues facing older adult in Central Texas in order to increase the percentage of older adults with an established Advance Directive

**Spotlight Initiative**

**CAPABLE RFP**

St. David's Foundation has issued a request for proposals (RFP) to provide a home-based "aging in place" intervention to older adults experiencing poverty in Central Texas through the replication of the Community Aging in Place—Advancing Better Living for Elders (CAPABLE) model, developed by the Johns Hopkins School of Nursing.

CAPABLE is an innovative model that, thus far, has been implemented in 12 U.S. states and in Australia. The intervention is targeted toward older adults experiencing poverty who have the desire and cognitive ability to remain in their home, but who have difficulty with activities of daily living that threaten their ability to remain safely at home.

**Participants receive home modifications, so that their physical environments better fit their needs, and support with other goals** related to physical ability and routines (e.g., strength/balance and medication regimen).

# Thriving Rural Communities

## GOAL 4

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

## The Issue

Rural communities in Central Texas experience **significant health disparities**. On average rural residents are older, more impoverished, and in worse health than their urban counterparts. They are less likely to have health insurance (employer-based or Medicare/Medic-aid), and often experience barriers in obtaining specialty care services.

Furthermore, encroaching population growth from urban and suburban communities has led to longer commutes to work, increased pollution, rising home prices, increased taxes, increased crime rates, fewer agriculture-based industries, and less farmland. The loss of key community institutions, such as farms, rural hospitals, banks, and schools, has led to cultural fragmentation in these communities.

Finally, demographic shifts have increased the number and diversity of residents experiencing poverty in rural communities, creating a higher level of need in these areas.

### **Despite these challenges, rural communities in Central Texas possess several key assets.**

They have a strong sense of community, a culture of caring, and a commitment to strengthening local capacity. This often translates into a shared responsibility to address issues, community resilience, and an innovative spirit to do more with less.

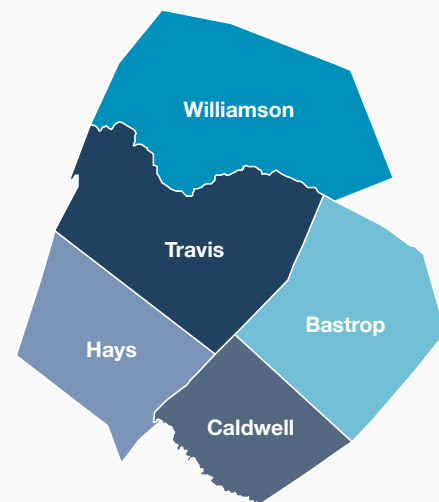
We believe that in working with the community to amplify voices least engaged and by elevating community driven solutions we could collectively, over time, improve rural health and well-being through targeted investments with other public and private co-investors to support thriving rural communities.

## By the Numbers

- County Health Rankings (2019): While urban counties have remained consistent or improved in ranking (Travis), rural counties continue to drop in 2019.<sup>17</sup>
- According to the Cantril Scale used by Wellbeing in the Nation 55% of those in Bastrop, 61% in Caldwell and 66% in Hays counties are thriving. The national and state averages are 57% and 60%, respectively.<sup>18</sup>

Figure 6

### **Five County Area of Central Texas**



There is great potential for an investment in the community to create multiple outcomes across the Foundation's other goals (e.g. aging in place, women's health, and child resilience). St. David's Foundation will focus on each of these communities incrementally, beginning with Bastrop County.

## The Population

Defining rural communities as those that are non-metro, we have **chosen to prioritize Bastrop County, Caldwell County, the eastern part of Williamson County, and Hays County.**

These communities were selected based on a set of readiness criteria, including: local investments and engagement of diverse partners; completion of a community assessment process; existing momentum in the community; previous investment in the region by St. David's Foundation; existing networks or the potential to build effective, robust networks; engaged leaders and institutions; and the potential of an investment in the community to create multiple outcomes across the Foundation's other goals (e.g. aging in place, women's health, and child resilience).

St. David's Foundation will focus on each of these communities incrementally, beginning with Bastrop County.

## Change for Residents of Rural Communities

People living in rural counties need the resources and conditions to care for their health. Under optimal conditions, they would have economic stability, including steady employment; neighborhoods and physical environments supportive of their health, including access to safe and affordable housing, transportation, parks, and walkable spaces; access to the education needed to support their goals; access to healthy food; social support systems and connection; and easy access to high-quality healthcare.

## Change for the Field

For community-level change to take root, rural communities must be the drivers of change and robust networks must exist among stakeholders from across sectors.

Networks are sets of relationships and the patterns they create that influence the quality of communication and the likelihood of collaboration and innovation. The relationships within networks can shift group dynamics from hierarchy to peers, from conformity to appreciation of differences, and from control to a web of support. **In rural communities, networks can create change across several areas.**

Three of the five counties in Central Texas – Bastrop, Caldwell and Hays – have been designated Health Professional Shortage Areas because the population-to-provider ratio is significantly above the national average, measuring at 1,320 people for every one doctor.

Rural communities have more older adults, a higher prevalence of mental and behavioral health issues among children, a lack of OB/GYNs leading to long travel times for deliveries, high-risk pregnancies, and high rates of teen pregnancy.

In short, **the needs in rural communities are great, the resources are limited, and solutions are complex** and dependent upon collaboration of multisector stakeholders.

## Long Term Outcomes

- Rural communities have a **culture of health** that transcends beyond healthcare access.
- Rural residents experience **strong social connection**.
- Rural residents 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.

## The Actual Work

St. David's Foundation's rural strategy has shifted from working "in a place" to a deliberate place-based strategy. In the past, we made programmatic grants to produce better outcomes in rural communities.

**Our new, place-based approach will involve changing systems** so that they continually produce better outcomes even after investments are removed. This approach acknowledges the complexity of issues and systems impacting community, and the fact that each community is unique, faces particular challenges, and must be central in shaping its own solutions.

To address the exacerbated health disparities in our rural communities, St. David's Foundation must address the social determinants of health (SDoH).

Potential areas of investment include economic stability, neighborhood infrastructure, education, food, community and cultural context, and the healthcare system.

## 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.

### Key indicators of progress:

- Establishment of Bastrop County resident advisory groups for two key issues and develop workplans to advance towards their goals
- Increase philanthropic resources to Central Texas rural communities through dissemination of network weaving assessment to local and national rural funders

2. **Build the capacity of people and places** including formal and informal leaders within communities and organizations.

### Key indicators of progress:

- Development of leadership training program co-designed with nationally recognized leadership development group and a local capacity building organization
- Increase capacity of a local nonprofit to serve as a backbone organization for community led efforts

3. **Strategically invest** in solutions that harness community assets to support innovation, ecosystem building, and other promising rural-relevant approaches that can be scaled.

Key indicators of progress:

- Increase number of proposals from rural communities across all portfolios
  - Release of RFP focused on increasing health literacy in rural communities
- 

### Spotlight Initiative

## Network Weaving

From September 2019 to April 2020, St. David's Foundation will collaborate with Texas A&M AgriLife Extension and Bastrop County Cares to host a Network Weaver Leadership Learning Series.

This series provides Bastrop County residents with an opportunity to learn alongside diverse residents from surrounding areas, and to develop skills to promote effective collaborations for the health and well-being of all residents.

Session topics include:

- Understanding Networks - Values, Behaviors, and Network Practices
- Expanding and Deepening Relationships; Network Mapping
- Leading Collaborative Community Action for Change
- Catalyzing Community Action - Moving from Talking to Action

# Clinics as Community Hubs for Health

## GOAL 5

Facilitate the growth of clinic infrastructure and capacity as they transition to serve as community hubs for health.

This goal differs from the other four goals in two important ways:

1. **Clinics are a platform for health** – the communities described in Goals 1 – 4 utilize clinics as an important tool to get and stay healthy.
2. **Clinics include not only the Foundation’s community grant partners, but also our own St. David’s Dental Program.** As the Dental Program considers expanding its role to include broader support for health and well-being, we intentionally include these plans in the context of Goal 5 to show the intersection between how our work shows up externally (grantmaking) and internally (direct programs).

## The Issue

St. David’s Foundation believes that when Central Texans get sick or need medical attention, all people should be able to easily access the care they need.

Community Health Clinics (CHCs) provide medical care to those experiencing poverty and uninsured Central Texans and have been a key partner in ensuring community members have access to healthcare. While providing access to care continues to be important, we also recognize the major transition across the healthcare system to payment models that are tied to value, quality, and/or health outcomes rather than fee-for-service reimbursement.

Our funding approach supports CHC as they incorporate necessary changes to their care models to be able to succeed in new payment approaches that reward value over volume.

In addition to serving the preventive and urgent healthcare needs of community members experiencing poverty, clinics in our community are well positioned to address and influence the non-clinical factors that impact the health outcomes of the larger community.

Because we know that an estimated 80% of health is shaped by factors outside of the medical setting, the Foundation has increasingly prioritized funding for social determinants of health (SDoH) across our grantmaking portfolio. Because community clinics have not traditionally been designed or incentivized to accommodate this expanded scope, there are many challenges to be addressed. CHCs have many of the right pieces in place, but they will need additional support to prepare for the next steps.

## By the Numbers

- According to the Austin Area Sustainability Indicators, an average of 10% of uninsured residents in the five counties, over 292,000 people, did not seek needed medical care in 2018 because of costs.
- Access to care remains a relevant issue in our community and our clinic partners act as a key safety net for individuals who otherwise would not have access to needed care.<sup>19</sup>

Figure 7

**Costs Can Prohibit Care for Uninsured**

**10%** of uninsured residents did not seek needed medical care **because of costs**



## The Population

Texas has the highest uninsured rate in the country, and an estimated 300,000 (14.5%) Central Texans do not have health insurance. Texas has not expanded Medicaid, **virtually ensuring that the uninsured rate will remain high.**

In addition, while some that are currently uninsured may qualify for private or government sponsored insurance, many will not pursue these options due to concerns about citizenship status, or complicated application or eligibility requirements.

The Foundation will continue the long-standing function of providing resources specifically for clinics to provide care to “unfunded” patients. Even for those who have the benefit of health insurance, navigating the health system can be complicated and an overall negative experience if care is not well coordinated by the primary care provider, which is often at the CHC.

The goal of the Foundation is to **support safety net clinics** (clinics poised to serve individuals experiencing poverty) to institute clinical enhancement and community outreach efforts to impact the overall health of patients and the community at large as well as to improve the overall patient experience.

Figure 8

### Uninsured Rate in Central Texas



An estimated **300,000** people do not have health insurance in Central Texas

## Change for the Individual

Individuals under a community hub model engage with their local clinic very differently.

Clinics serve as an “anchor” institution that individuals can look to as an opportunity to connect with their neighbors and the broader community.

While participating in health-promoting activities at the clinic, individuals may also strengthen their informal networks of support.

In very practical terms, clinics are uniquely positioned to identify the needs of patients, both medical and non-medical, and assist patients with acquiring that assistance. In order to do this, clinics must strengthen their ability to screen for social needs and develop workflows to connect patients with social services and follow-up with those patients.

A few examples of **SDoH needs that clinics can assist with include transportation, housing, and food security issues.**

## Change for the Field

The healthcare funding landscape is evolving in complex and uncertain ways, particularly concerning how public resources will be allocated and what clinics will have to accomplish to preserve funding streams.

Clinical organizations, specifically Federally Qualified Healthcare Clinics (FQHCs), find themselves continuing to serve their patients as they adapt to ongoing changes in how they are paid for these services and what payers are incentivizing them to do.

What is certain is that clinics are being asked to be responsible for not only for the health and well-being of their own patients, but for the broader population's as well. If accomplished, this move to focusing on population health could benefit the entire community.

The Foundation seeks to learn with our clinical partners how best to transition from a fee-for-service model to a community hub for health. In other words, a **model that incentivizes keeping communities healthy** rather than one that promotes increased procedures for sick patients.

## Long Term Outcomes

- 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 with those operating outside of the clinic to **strengthen community linkages** and ultimately improve the health and well-being of patients and of the population overall.

## Approaches

### 1. **Provide access to primary care and behavioral health services for the uninsured.**

Work under this approach focuses on funding access to key medical services for uninsured at grant partner locations. We will track services provided through St. David's Foundation funding under this approach and recognize that the expected outcomes are focused on those receiving the services, not the community as a whole.

#### Metrics for key services funded:

- Uninsured and "unfunded" Central Texas patients receiving medical care
- Improvements in selected measures of effectiveness, access/availability, and experience of care

### 2. **Expand capacity of clinics** to provide activities, processes, and strategies to improve the care delivery model.

#### Key indicators of progress:

- Development and implementation of a care coordination approach at partner clinics to expand their capacity to provide activities, processes, and strategies to improve the care delivery model
- Increased percentage of patients receiving care coordination, patient engagement activities, and medication management at partner sites
- Engagement in an external evaluation to deepen our understanding of the role of philanthropy in supporting clinics as they adapt to changes in their care delivery approach required by payment reform

3. **Encourage clinics to look outside of their four walls** to develop and strengthen community linkages to improve community health and well-being.

Key indicators of progress:

- Increased number of partner clinics implementing social determinants of health screening
- Increased number of partner clinics with established relationships to key social services providers
- Increased number of partner clinics with closed loop referral programs in place
- Engagement in an external evaluation to deepen our understanding of the role of philanthropy in supporting clinics as they adapt to changes required by community hub models

## Spotlight Initiative

### E-Consults

The uninsured and underinsured in Central Texas face significant barriers to accessing specialty care resulting in a lack of care coordination and poorer health outcomes.

In order to maximize the capacity of primary care providers to manage complex cases, St. David's Foundation launched the E-Consult Initiative in 2018.

Within the first year, primary care providers at Lone Star Circle of Care, CommuniCare, and Community Health Centers of South Central Texas consulted with specialists on 394 patient cases.

For 83% of cases, E-Consults made it possible for the PCPs to successfully manage the complex case without sending the patient for a face-to-face visit with a specialist, proving the **cost-effectiveness of the model.**

## Internal Goal

# St. David's Dental Program

Over the next 3 years, the Dental Program plans to:

- Bring our Complex Care Program in house in order to assist families requiring more complex procedures than we can provide on our vans. We plan to provide care to these patients through our own staff.
- Deepen the Dental Program's work and impact in our existing communities by providing more education to pre-K students and their families, providing care at Charter schools where the dental need is high, and providing more outreach to our Complex Care families.
- Design a rural strategy to engage rural communities in our work. The Dental Program will develop relationships and provide dental care to those communities with the highest need.



# Tracking Progress

Using resources such as the County Health Rankings, we plan to monitor key community metrics to understand how Central Texas is changing in the long term in relation to our focus on health equity and the five goals described in this plan.

## 2020-2022 Measurement Framework

We believe that all Central Texans should have the opportunity to achieve optimal health and there are no avoidable, unnecessary, unfair, or systematically caused differences in health status due to ethnicity, gender, age or geography.

But, how will we know when we get there?

**Eliminating health inequities requires the Foundation to go beyond funding critical services** for the most vulnerable and employ additional tools to create transformational community change.

Over the next three years, our approaches incorporate interventions that target systemically-caused differences in health because they hold the greatest promise for promoting and achieving health equity.

## Key Indicators of Health Equity

### Central Texas Rural Counties Rank as Highly as Urban Counties

The County Health Rankings measure the health of counties across the nation, using a variety of national and state data sources, and ranks each county within their respective state. Comprised of over thirty-five county level metrics, it is the most encompassing gauge of community improvements available to the foundation.

Urban counties in our region (Travis, Williamson, and Hays) have consistently ranked as some of the healthiest counties in Texas. However, **rural counties within Central Texas have continued to decline in ranking**. Much of this is due to rapid demographic shifts as more families experiencing poverty have moved outside the Austin city limits to more rural and suburban neighborhoods, including rural counties.



### No Significant Disparities by Race/Ethnicity on Key Health Metrics

While helpful to look at county-level data, disparities exist within and between communities that county averages do not convey.

More granular data by geography and race/ethnicity is needed to deepen our understanding of the disparities within our community.

The Foundation is dedicated to using data to uncover inequities and catalyze community conversations around potential solutions.

The goal for the following measures is the same: **health outcomes should not be influenced by demographics such as geography, race/ethnicity, or gender.**



Figure 9  
Examples of Health Disparities by Race/Ethnicity

	Black	Hispanic	White
Overall Life Expectancy (years)	<b>77</b>	83	82
Social Connection Score	<b>-4.9</b>	-0.29	+1.3
Low-Birthweight Rate	<b>14%</b>	7%	7%
Kindergarten Readiness (for not low-income)	<b>47%</b>	<b>50%</b>	63%
Adults Reporting Bad Health	12%	<b>24%</b>	8%
Preventable Hospital Stays/100,000 Medicare Enrollees	<b>5,926</b>	<b>5,067</b>	4,309

**Bolded:** significant disparity

### Community Targets

In addition to reviewing all indicators available through County Health Rankings, we have identified key metrics related to the work of the Foundation and identified long term targets using community developed goals or national benchmarks.



Figure 10

#### Long-Term Community Goals

Outcome	Current Date	2030 Target
Proxy measurement of improvement		
<b>Children enter school ready and able to learn</b> Increase kindergarten readiness rate	<b>51%</b> 2019	<b>75%</b>
<b>Women are trusted with their reproductive health</b> Reduce low-birthweight rate	<b>7.6%</b> 2017	<b>6%</b>
<b>Older adults remain independent longer</b> Reduce hospital visits for preventable conditions (per 100K Medicare enrollees)	<b>4,230</b> 2016	<b>2,765</b>
<b>Clinics support population health</b> Reduce proportion of adults reporting bad health	<b>14%</b> 2017	<b>12%</b>
<b>Rural communities thrive</b> Improve overall health ranking	<b>Bastrop: 79<sup>th</sup></b> <b>Caldwell: 146<sup>th</sup></b>	<b>Bastrop: 61<sup>st</sup></b> <b>Caldwell: 122<sup>nd</sup></b>



## Additional Community Indicators from County Health Rankings

Figure 11  
2019 Rankings

		Bastrop	Caldwell	Hays	Travis	Williamson
Health Outcomes	Length of Life	84	93	9	8	7
	Quality of Life	104	199	74	27	7
Health Factors	Health Behaviors	211	157	49	3	17
	Clinical Care	104	133	28	6	3
	Social & Economic Development	92	120	16	23	3
	Physical Environment	215	134	240	210	186



# TRACKING PROGRESS

Figure 12  
Measures

			Better than average	Top 10% in the nation	Worse than average		
		National	Bastrop	Caldwell	Hays	Travis	Williamson
Length of Life	Premature Death (per 100,000)	6,900	7,723	7,908	5,094	4,649	4,567
Quality of Life	Poor or Fair Health (% of population)	16%	18%	23%	17%	14%	13%
	Poor Physical Health Days (per month)	3.7	3.7	4.1	3.5	3.1	3.0
	Poor Mental Health Days (per month)	3.8	3.8	3.7	3.7	3.3	3.1
	Low Birthweight (% of all births)	8%	8%	9%	7%	8%	7%
Health Behaviors	Adult Smoking (% of population)	17%	17%	16%	15%	13%	13%
	Adult Obesity (% of population)	29%	35%	29%	28%	22%	31%
	Food Environment Index (0-10, 10 being best)	7.7	7.4	7.7	7.7	7.3	7.7
	Physical Inactivity (% of population)	22%	19%	27%	17%	16%	17%
	Access to Exercise Opportunities (% of population)	84%	46%	59%	73%	92%	89%
	Excessive Drinking (% of population)	18%	20%	18%	22%	23%	22%
	Alcohol-Impaired Driving Deaths (% of all driving deaths)	29%	29%	22%	31%	28%	33%
	Sexually Transmitted Infections (per 100,000)	497	801	1,071	660	733	259
	Teen Births (per 1,000 female teens)	25	36	40	19	28	17
	Clinical Care	Uninsured (% of population)	10%	21%	21%	16%	15%
Primary Care Physicians		1,330:1	3447:1	3430:1	2378:1	1171:1	1506:1
Dentists		1,460:1	2734:1	3257:1	2786:1	1450:1	1789:1
Mental Health Providers		440:1	1843:1	1460:1	1111:1	397:1	1016:1
Preventable Hospital Stays (per 100,000 Medicare enrollees)		4,520	4,632	5,915	3,824	4,268	4,113
Flu Vaccinations		45%	41%	44%	44%	48%	49%
Mammography Screening (% of Medicare enrollees)		41%	33%	33%	36%	40%	44%
Social & Economic Environment		High School Graduation (% of population)	85%	92%	90%	89%	90%
	Some College (% of population)	65%	48%	42%	69%	73%	75%
	Unemployment (% of population)	4.4%	3.5%	3.9%	3.1%	3.0%	3.2%
	Children in Poverty (% of population)	18%	19%	21%	12%	15%	7%
	Children in Single-Parent Households (% of population)	33%	29%	34%	27%	30%	22%
	Income Inequality (higher number indicates more inequality)	4.9	4.1	4.3	4.7	4.6	3.6
	Social Associations (per 10,000)	9	8	10	7	10	6
	Violent Crime (per 100,000)	386	407	219	244	370	165
	Injury Deaths (per 100,000)	67	86	73	49	57	40
Physical Environment	Air Pollution - Particulate Matter (per cubic meter)	8.6	10.1	10.1	10.3	10.5	10.4
	Drinking Water Violations	N/A	Yes	No	Yes	Yes	Yes
	Severe Housing Problems (% of households)	18%	15%	16%	22%	21%	13%
	Driving Alone to Work (% of workforce)	76%	81%	79%	79%	74%	80%
	Long Commute - Driving Alone (% of commuters)	35%	55%	51%	49%	35%	43%

The County Health Rankings model was originally developed by the University of Wisconsin Population Health Institute and has since been adopted as an important tool by many groups including the Robert Wood Johnson Foundation and the CDC. Learn more at [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

# Conclusion

We believe that these five goals, fueled by a commitment to health equity, and the power of social connection and strengths-based approaches, will lead St. David's Foundation into the next stage of our evolution as a **funder and change-maker** in Central Texas.

With new leadership and a renewed commitment to achieving our vision of building the healthiest community in the world, staff looks forward to meeting the challenges and opportunities that lie ahead.

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