St. David's North Austin Medical Center

Community Health Needs Assessment Implementation Plan

April 18, 2017

Description of Significant Health Needs

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

1. Need for improved healthcare access, quality and insurance coverage
2. Need for improved socioeconomic factors that contribute to health
3. Need for improved health and well-being of children
4. Need for improved health and well-being of women
5. Need for improved health and well-being of seniors
6. Need for improved health and well-being in rural communities

To assist in communicating these areas to the public in a straightforward manner, we have developed the following categories:

A. **Healthiest Care**, which addresses:
   - Need for improved healthcare access, quality and insurance coverage

B. **Healthiest People**, which addresses:
   - Need for improved health and well-being of children
   - Need for improved health and well-being of women
   - Need for improved health and well-being of seniors

C. **Healthiest Places**, which addresses:
   - Need for improved socioeconomic factors that contribute to health
   - Need for improved health and well-being in rural communities

In addition to these six priority needs, four additional health needs emerged throughout the Community Health Needs Assessment process across the 5 Central Texas counties:

- Transportation
- Affordable Housing
- Child Care
- Poverty Alleviation

St. David's does not intend to specifically address these four needs in our implementation plan. The reasons we do not intend to address these needs are twofold:

a) Our financial and staff resources will be dedicated to the substantial work outlined in the six priority need areas, and we will not have the resources available to adequately address these needs.

b) Other organizations in the community are already dedicated to addressing these needs.

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

The tables in Appendix A outline the steps St. David's intends to take to address the health need, including the intended impact, the method (grant vs. internally-operated program), the lead staff person, timeline for implementation, indicator(s) of progress, and the measurement at baseline (2015). The tables are organized according to the Healthiest Care, Healthiest People, and Healthiest Places framework described above.

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 60+ grantees, public health departments in Travis and Williamson counties, and various planning entities related to the community health areas of focus.

Appendix A: Strategic Initiatives and Evaluation Plan

Healthiest Care

Strategic Objective 1: Improve Healthcare Access, Quality and Insurance Coverage							
Goal	**Method**	**Assigned**	**Timeline**			**Indicators**	**Baseline**
			2016	**2017**	**2018**		**2015**
Strategic Initiative: Increase access to & quality of patient-centered medical homes (including primary, dental and mental health care)							
1. Increase access to primary care services for the unfunded in Central Texas.	Grants	Abena A	X	X	X	Primary care visits at grant partner clinics	30,721
2. Increase integration of care by supporting behavioral health programs in primary care settings.	Grants	Abena A	X	X	X	Patients receiving mental health services through an integrated model at grant partner clinics	2,213
3. Reduce burden of navigating a complex health system by supporting case management/patient navigation services.	Grants	Abena A	X	X	X	Patients receiving navigation services at grant partner sites	1,321
Strategic Initiative: Increase access to specialty care (medical and mental health specialists)							
4. Increase access to specialty medical care services (e.g. retinopathy, endocrinology).	Grants	Abena A	X	X	X	Specialty care visits at grant partner clinics	733
5. Increase access to mental health services for highly prevalent conditions (e.g. anxiety and depression).	Grants	Kim M	X	X		Patients receiving behavioral health services at grant partner sites	3,322
Strategic Initiative: Increase access to dental care and improve oral health							
6. Increase access to dental services for low-income adults.	Grants	Elizabeth K	X	X	X	Adult dental visits at grant partner clinics	8,478
7. Increase access to free preventive and restorative dental care through school-based dental program.	Internally Operated Program	Madge V	X	X	X	Dental care visits on the mobile clinics of the St. David's Dental Program	20,198
Strategic Initiative: Increase enrollment and utilization of insurance coverage							
8. Increase ability of eligible low-income families to enroll in medical insurance (e.g. through tax preparation services).	Grants	Elizabeth K		X	X	Patients newly enrolled at grant partner sites	*New*
Strategic Initiative: Ensure workforce is adequate and reflective of community diversity							
9. Increase recruitment and retention of medical providers (e.g. physicians, dentists, psychiatrists, nurse practitioners) in safety-net clinic settings.	Loan Repay Program	William B	X	X	X	Loan repayment participants	85
10. Increase ability of colleges and other institutions to train more medical professionals to address workforce shortages (e.g. nurse practitioners).	Grants	William B	X	X		Funding amount to institutions	$1,154,076
11. Increase the interest level and likelihood of high school students to enter the medical field through Neal Kocurek Scholarships and mentorship.	Internally Operated Program	April R	X	X	X	Scholarships awarded (4 - 8 years of dedicated support for each)	55

Appendix A: Strategic Initiatives and Evaluation Plan

Healthiest People

Strategic Objective 2: Improve the Health and Well-being of Children

Goal	Method	Assigned	Timeline 2016	Timeline 2017	Timeline 2018	Indicators	Baseline 2015
Strategic Initiative: Increase prevention and treatment of trauma in children							
1. Increase access to counseling services for at-risk students	Grants	Kim M	X	X		Students receiving mental health services through school and after-school programs	2,331
Strategic Initiative: Reduce teen pregnancy							
2. Increase access to comprehensive sexuality education and pregnancy prevention programming for young adults.	Grants	Andrew L		X	X	Students participating in programming provided by grant partners	*New*

Strategic Objective 3: Improve the Health and Well-being of Women

Goal	Method	Assigned	Timeline 2016	Timeline 2017	Timeline 2018	Indicators	Baseline 2015
Strategic Initiative: Increase access to comprehensive women's health services							
1. Increase access to pre and postnatal care to improve birth outcomes for both mother and child	Grants	Elizabeth K			X	Patients receiving services at grant partner clinics before and after birth of child	*New*

Strategic Objective 4: Improve the Health and Well-being of Seniors

Goal	Method	Assigned	Timeline 2016	Timeline 2017	Timeline 2018	Indicators	Baseline 2015
Strategic Initiative: Improve quality and ability for seniors to age in place							
1. Reduce caregiver burden by providing training (e.g. fall prevention, dementia, chronic disease self-management) to family members and caretakers.	Grants	Andrew L	X	X		Participants in trainings provided by grant partners	421
2. Increase access to geriatric health services (e.g. end-of-life care, speech therapy, medication management).	Grants	Andrew L	X	X		Elderly patients receiving health services at grant partner clinics	402
3. Increase access to services (e.g. meals, home health visits, transportation, house maintenance) for home-bound older adults to assist them in aging in place.	Grants	Andrew L	X	X	X	Elderly clients served by grant partners	3,262
4. Increase awareness and interest of younger generations by providing volunteer opportunities to assist older adults.	Internally Operated Program	Taylor G	X	X	X	Members of the Health's Angels volunteer program	150

Healthiest Places

Strategic Objective 5: Improve Socioeconomic Factors that Contribute to Health							
Goal	**Method**	**Assigned**	**Timeline**			**Indicators**	**Baseline**
			2016	**2017**	**2018**		**2015**
Strategic Initiative: Increase availability and utilization of healthy food and physical activity options							
1. Increase access to programs that address nutrition and physical activity for children and their families.	Grants	Elizabeth K	X	X		Participants in health promotion and behavior change programs at grant partner sites	10,985
2. Improve access to environments (e.g. parks, recreational facilities) that promote physical activity in high-need areas of Central Texas.	Grants	Elizabeth K			X	Funding amount to "built environment" projects	$700,000
Strategic Initiative: Improve delivery and coordination of wrap-around services for low-income housing developments							
3. Increase access to support services for families living in supportive, affordable housing (e.g health and education facilities onsite).	Grants	Kim M	X	X	X	Funding amount to affordable housing improvement projects	$2,795,000

Strategic Objective 6: Improve the Health and Well-being in Rural Communities							
Goal	**Method**	**Assigned**	**Timeline**			**Indicators**	**Baseline**
			2016	**2017**	**2018**		**2015**
Strategic Initiative: Increase access to primary care in rural areas							
1. Increase access to diagnostic and primary care services through new, nontraditional access points (mobile clinics, telehealth, etc.)	Grants	Abena A		X	X	Primary care visits provided to residents of targeted rural communities	*New*
Strategic Initiative: Reduce substance use in rural areas							
2. Increase understanding concerning underlying causes and best approaches	Grants	Kim M			X	Convenings of rural community members conducted	*New*

Methodology

Grant partners are required to report progress towards goals either quarterly or semi-annually which are then reviewed by SDF staff. In order to estimate our impact as a funder, the total of the output (e.g. patients seen) is multiplied by the proportion of the project budget funded by the Foundation. For example, if our funding makes up 25% of the total project budget, we estimate that 25% of patients (or visits) were made possible by the Foundation. This is summed across grant partners and compared by year. For internal programs fully funded and operated by the Foundation, 100% of patients are reflected.

Generally, the Foundation has two “grant cycles” and after approval, grant terms either start January 1st or July 1st. For the purposes of reporting, the year in the column refers to the project start date. 2015 refers to grants where the term covers the calendar year and when the term covers July 1, 2015 to June 30, 2016. Twelve months of funding is always used to keep comparisons equal.