EQUITY-FOCUSED SERVICE DELIVERY STRATEGIC PLAN (HEALTHCARE EQUITY PLAN)

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Presentation to City of Austin Public Health Committee

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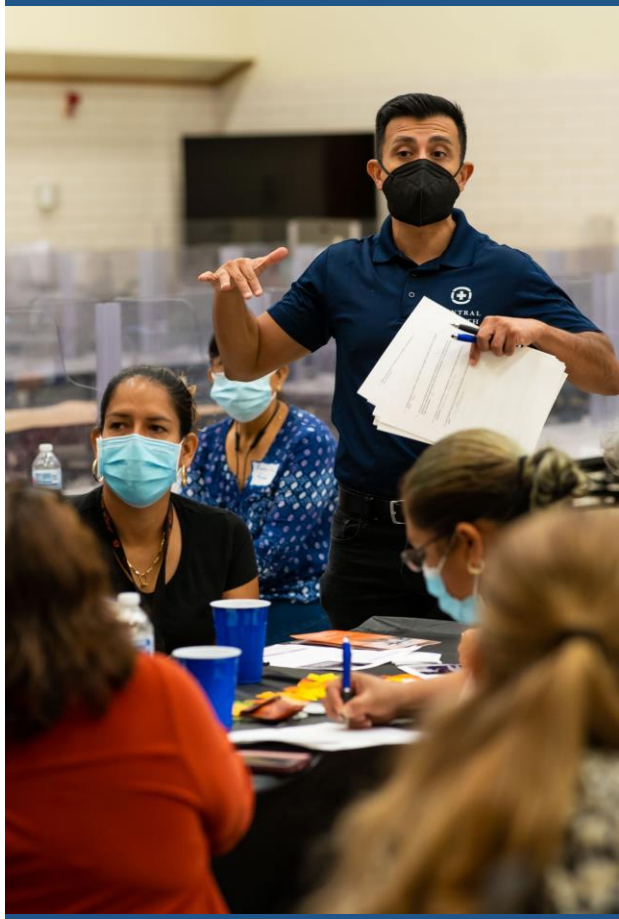
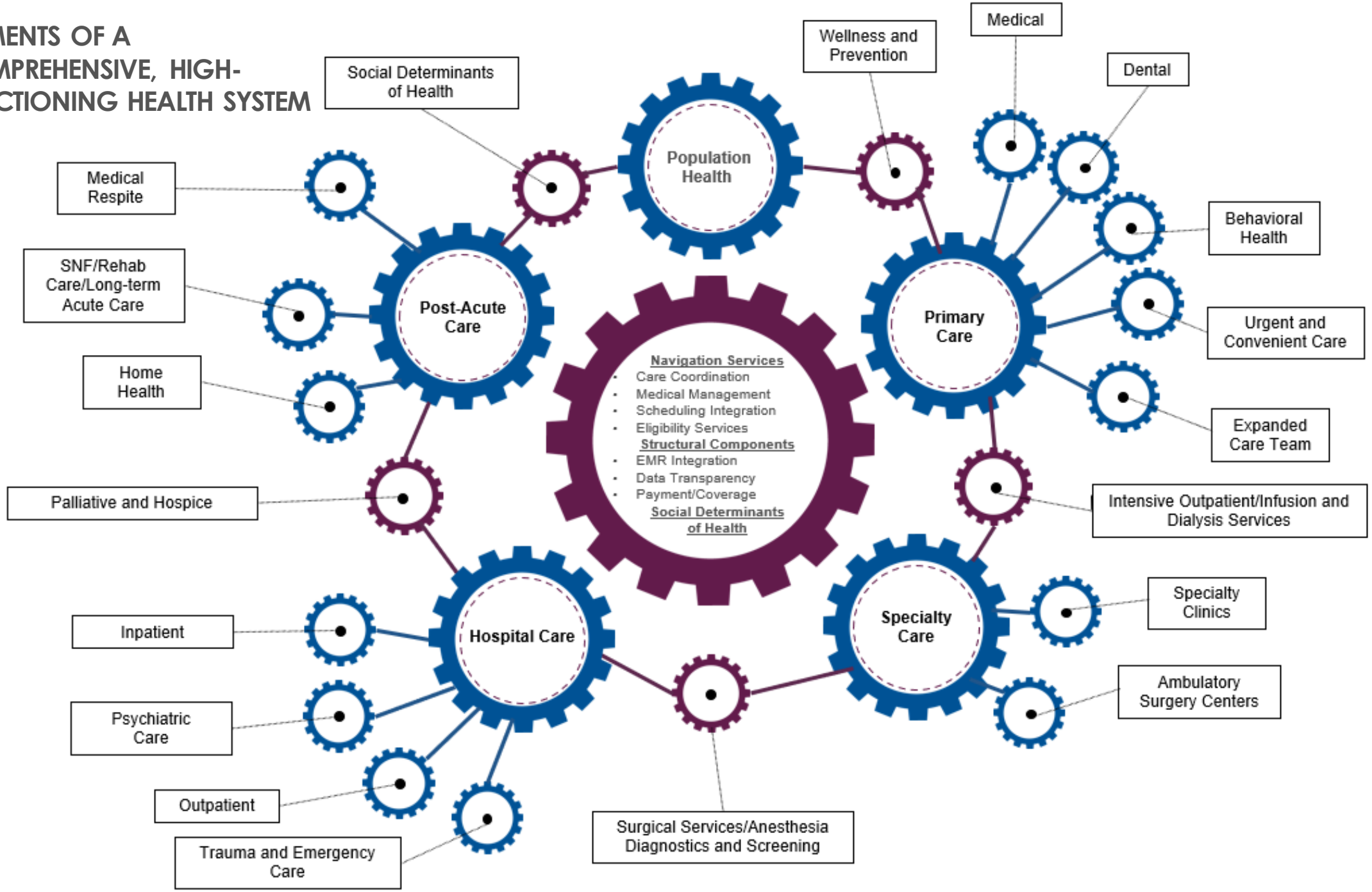
CENTRAL HEALTH

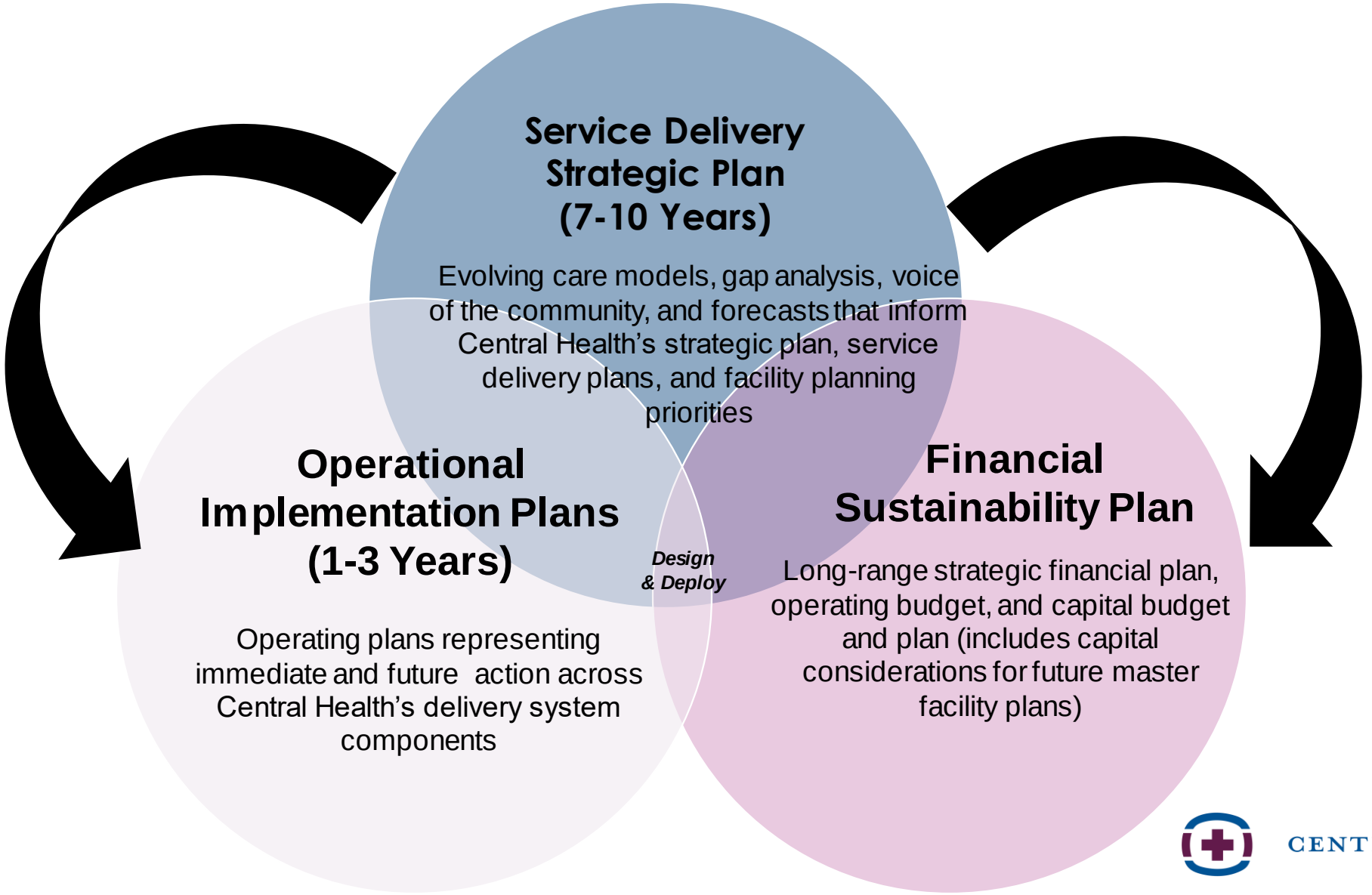


CENTRAL HEALTH

ELEMENTS OF A COMPREHENSIVE, HIGH-FUNCTIONING HEALTH SYSTEM



THE HEALTHCARE EQUITY PLAN WILL INFLUENCE AND DRIVE OPERATIONAL AND FINANCIAL SUSTAINABILITY PLANNING EFFORTS



CENTRAL HEALTH

HEALTHCARE EQUITY PLAN AND STRATEGIC IMPERATIVES

1. Voice of the Community:

Through the **community engagement strategy**, understand the perspectives of patients, providers, and community members and ensure that hard to reach populations are included in our assessment of health care needs in the service area

2. Community Health Needs Assessment:

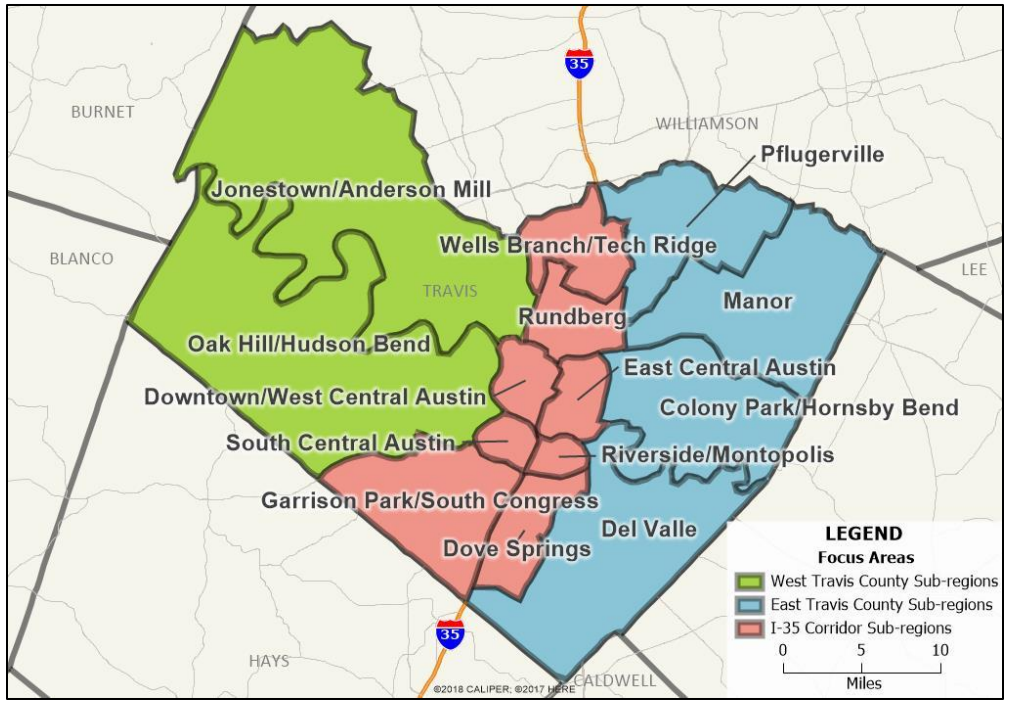
Through development of the **Community Health Needs Assessment Report**, understand the current state of the safety-net health care system in Travis County, gaps, and future needs

3. Health Care Equity Plan

Develop a **Health Care Equity Plan** to build a comprehensive, high functioning health care system to improve the health of Central Health's patients by focusing on these strategic imperatives: **Access and Capacity, Care Coordination, Member Enrollment & Engagement, System of Care Infrastructure**

14 PLANNING & ASSESSMENT REGIONS ALIGN INTO 3 FOCUS AREAS: I-35 CORRIDOR, EAST TRAVIS COUNTY, AND WEST TRAVIS COUNTY

Travis County: Focus Areas



Overview

I-35 Corridor

- **Total Population: 808,534**
- **~ 74% of the total population <200% FPIL** in Travis County
  - **Rundberg makes up 17%** of the total <200% FPIL population
- **Total MAP, MAP Basic and SFS enrollment makes up 67% of total enrollment in Travis County**, and families in poverty make up **71% of the total families in poverty** in Travis County

East Travis County

- **Total Population: 216,404**
- **~ 18% of the total population <200% FPIL** in Travis County
- **Total MAP, MAP Basic and SFS enrollment makes up 28% of total enrollment in Travis County** and families in poverty make up **19% of the total families in poverty** in Travis County

West Travis County

- **Total Population: 282,970**
- **~ 8% of the total population <200% FPIL** in Travis County
- **Total MAP, MAP Basic and SFS enrollment makes up 5% of total enrollment in Travis County,** and families in poverty make up **9% of the total families in poverty** in Travis County

Sources: Planning Regions defined in partnership with Central Health; Poverty Level data from 5-Year estimates obtained from the American Community Survey (2019);
Total MAP, MAP Basic, and SFS Enrollment data is received from Central Health.

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THE SCALE AND SCOPE OF UNMET CLINICAL NEEDS FOR THE SAFETY-NET IS SUBSTANTIAL ACROSS TRAVIS COUNTY AND IS FORECASTED TO INCREASE

Primary Care/ Wellness

① Primary Care

- *Timely service access*
- *Access to social services*
- *Quality care*

Significant Gaps | Moderate Gaps | Minimal Gaps

② Wellness and Prevention

- *Patient communication and education*
- *Prevention and screening*
- *Diet, nutrition & exercise*

Significant Gaps | Moderate Gaps | Minimal Gaps

③ Urgent & Convenient Care

- *Virtual options*
- *Same day and convenient access*

Significant Gaps | Moderate Gaps | Minimal Gaps

Specialty Care/ Behavioral/ Dental

④ Specialty Care

Select services include Cardiology, GI, Hem/Onc, Nephrology, Neurology, Ortho, Gyn Surgery, ENT, Ophthalmology, Psych, Radiology

Significant Gaps | Moderate Gaps | Minimal Gaps

⑤ Behavioral Health

Substance use disorders, serious mental illness, anxiety, depression, also includes psych hospitals

Significant Gaps | Moderate Gaps | Minimal Gaps

⑥ Dental

Primary and specialty dental access

Significant Gaps | Moderate Gaps | Minimal Gaps

Hospital Based/ Post Acute

⑦ Hospital

Surgical Services, ASC Access, Hospital transitions, hospital-based specialty care, diagnostics, infusions, ED Services

Significant Gaps | Moderate Gaps | Minimal Gaps

⑧ Post Acute

Respite care, home health care, custodial care

Significant Gaps | Moderate Gaps | Minimal Gaps

Legend Significant Gaps | Moderate Gaps | Minimal Gaps

CENTRAL HEALTH

RESPITE FOR PEOPLE WITHOUT HOMES

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A VICIOUS CYCLE

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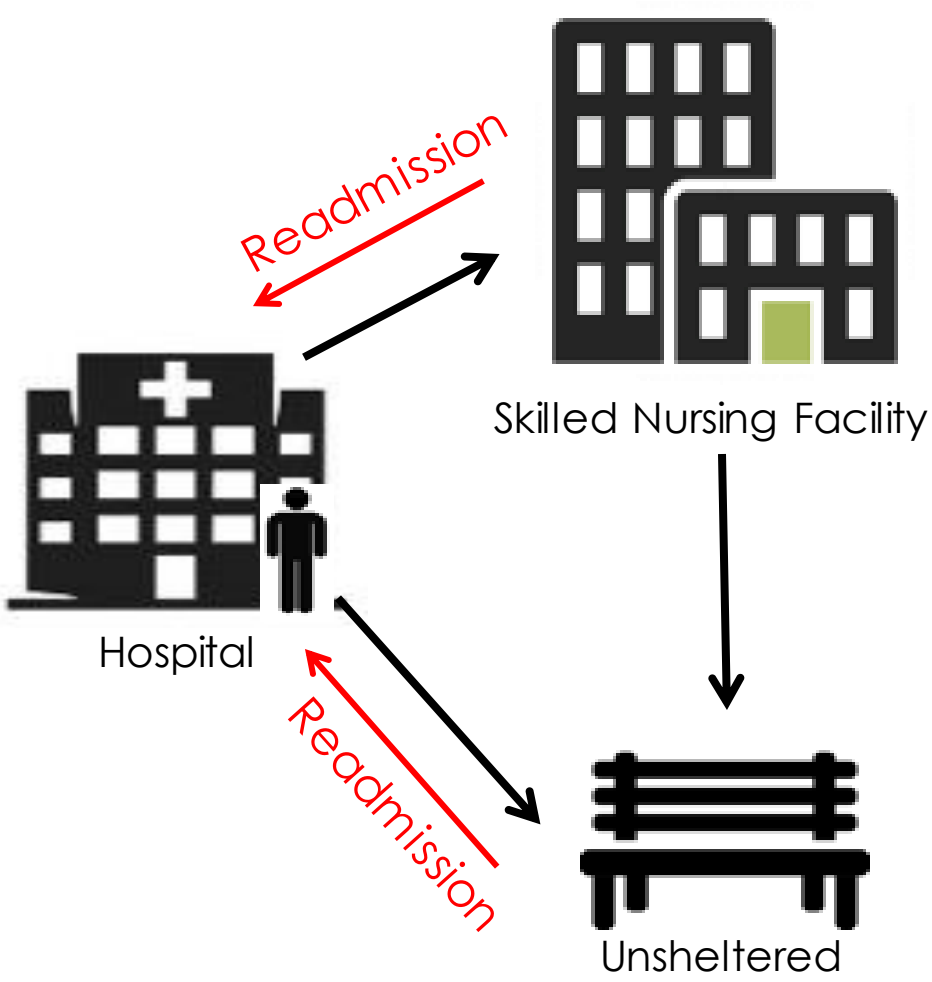
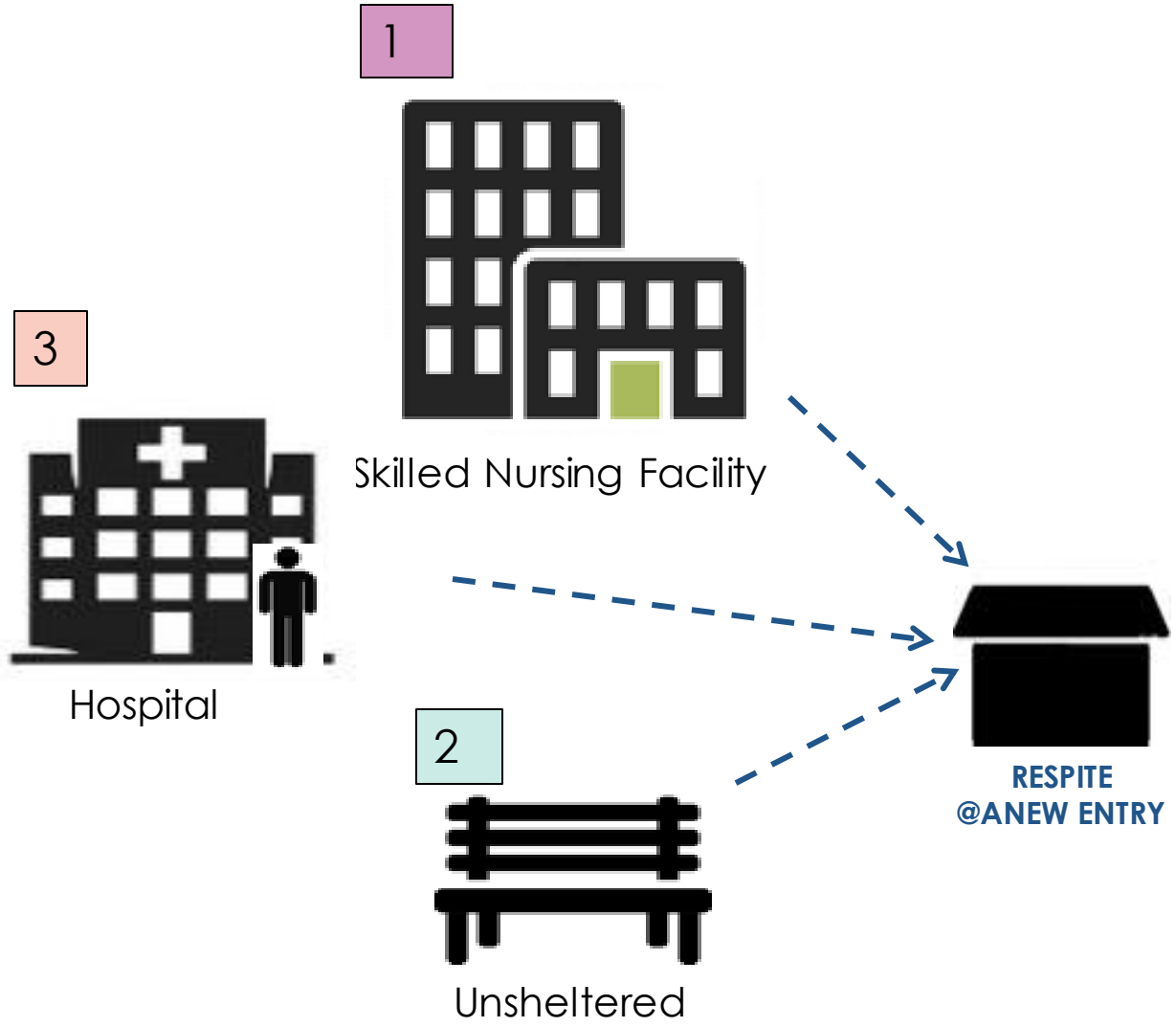


The Problem:

- Homelessness causes health problems AND complicates and limits healing and recuperation
- When patients experiencing homelessness get discharged from the hospital, most only have an option to return to the streets. Some may qualify for a skilled nursing facility, but then get discharged to the streets and ultimately many get readmitted

Medical Respite and Phases of Rollout



Medical Respite gives individuals experiencing homelessness a place to rest and recover from an acute illness.

- prevents discharges back to the street after a hospitalization
- prevent worsening illness or hospitalizations
- give individuals an opportunity to have their surgery and a safe place to recover

	Phases
1	Referrals for patients at Nursing Facilities
2	Referral from Street Medicine/Clinics
3	Referral from Hospitals

PROGRAM OUTCOMES

(MARCH 1, 2022- SEPTEMBER 26, 2022)

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1. Admissions
    - 29 patients admitted:
        - 20 Skilled nursing facility (Phase 1)
        - 9 Healthcare for the Homeless teams- ARCH, street med, MAT clinic, Care Connections (Phase 2)

2. Demographics:
    - Average age: 46.8 (range 29-67)
    - Gender: 23 men, 6 female
    - Race/Ethnicity: 55 % Anglo, 28 % Black, 11% Hispanic, 6% Asian

3. Top Diagnosis
    - #1 fractures (spine, leg, hip)
    - #2 end stage renal disease on dialysis
    - #3 infection (skin, bone)
    - #4 cancer
    - #5 heart failure

PROGRAM OUTCOMES

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4. Disposition
    - 25% move on to transitional or permanent housing
    - 40% leave before they fully recovery (but most able to work on healing, social needs, medical appointments)
    - 20% hospital
    - 15% administrative discharge

5. Average Length of Stay
    - In Respite 1-157 days, **average 22.6 days**

6. Other benefits obtained while at respite
    - MAP renewal
    - Coordinated Assessments
    - Food stamps
    - Transportation: Metro Access
    - ID cards, Birth certificates, SS cards
    - Housing referrals
    - Referrals to Substance use treatment and mental health treatment

MR. P: FROM RESPITE TO PERMANENT HOUSING

64 yo man who had been experiencing homelessness for >15 years

- Hit by a car, broke over 10 bones in his body
- Stayed in the hospital 39 days, then to a nursing home for 48 days
- Instead of being discharged to the street, went to medical respite
- At medical respite, continued recovery with physical therapy, worked on his disability and housing application, treatment for alcohol use disorder
- After 50 days in medical respite, moved to his own tiny home at Community First! Village

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Mr. W: a chance for surgery to restore vision

64 yo man who lost his wife during an apartment fire a year ago.

- He became homeless at that time and eventually found his way to the ARCH
- He has cataracts in both eyes but unable to get surgery while houseless
- He was accepted to medical respite and successfully completed one cataract removal, recovering well and awaiting his second cataract surgery
- "I am so grateful to medical respite to give me a chance to have my surgery and a quiet and calm to recover after my surgery."

Other patients accepted into medical respite:

- 60 yo woman with jaw cancer, underwent chemo and radiation, family stopped paying for her hotel
- 29 yo man with schizophrenia and kidney failure who just started dialysis
- 59 yo man with diabetes and a blocked artery in his neck who just had a stroke, now on blood thinners

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MEDICAL RESPITE IN AUSTIN

1. Unique and Inclusive Access

- Most respite programs focus on hospital discharges.
- Central Health is in a unique position to support patients at all points in care- both after a hospital or nursing home stay and to prevent worsening illness and hospitalization.

2. Unique location

- Most respite programs are located in shelters or hotels.
- The location at A New Entry brings a supportive and healing environment for those with substance use disorder.

3. Unique resources

- Most respite programs start with medical support.
- Central Health leverages their medical management team to assist with appointments, housing, transportation, benefits, food stamps and more.

QUESTIONS/OPPORTUNITIES

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APPENDIX

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FY22-FY23 CLINICAL FOCUS AREAS

Specialty Care

- First podiatric surgery 1/17 – two surgeons operating weekly
- Expanded capacity: Cardiology, Endocrinology, Neurology, Rheumatology, Casting, GI, Dermatology, General Surgery, ENT
- Secured facility and professional agreements for outpatient dialysis
- Negotiating new agreements with UTHA: ophthalmology, reproductive health, long-haul COVID, ASC podiatry, advanced imaging

Healthcare for the Homeless & Behavioral Health

- MAP Basic residential rooming access with Fresh Start complete
- Contracted medical respite now operational with A New Entry
- Planning expanded street/mobile with CUC to include expanded psychiatry access and dedicated mobile units

Substance Use Disorder & Behavioral Health

- Expanded, fully internalized MAT program within CUC with expanded psychiatry access
- IC MAT at Stonegate for co-occurring SUD & unstable mental health condition

Clinical & Patient Education

- Dietician-Health Management Liaison Program:
  - Hired HML & Nutrition Manager/Registered Dietician
  - Kidney disease outreach & screening
  - Heart failure outreach and management

Transitions of Care

- MAP Basic Pharmacy, Hospice, palliative, home health, orthotics, prosthetics, physical therapy expansions complete
- Director of Transitions of Care

Medical Executive Board & Clinical Services positions added:

- Director of High-Risk Populations
- Director of Health Equity and Quality
- Director of Transitions of Care
- Clinical Informatics and Care Integration
- Clinical Podiatrists
- MEB Manager
- Director of Nursing
- Associate Director of Clinical Operations
- Nutrition Manager
- Case Management

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DIRECT SERVICE PLANNING INITIATIVES: SCOPE AND RATIONALE

Transitions of Care	• **FY22 Clinical Focus Area:** *Transitions of Care* • **CHNA Opportunity:** *Care Coordination*
Case Management / Home Visits	• **FY22 Clinical Focus Area:** *Transitions of Care* • **CHNA Opportunity:** *Care Coordination*
Specialty Care Clinic / Diagnostics	• **FY22 Clinical Focus Area:** *Specialty Care Access* • **CHNA Opportunity:** *Access and Capacity, System of Care*
Medical Respite / Skilled Nursing	• **FY22 Clinical Focus Area:** *Health Care for the Homeless* • **CHNA Opportunity:** *System of Care*

CENTRAL HEALTH

HEALTHCARE EQUITY PLAN GOAL AND STRATEGIC IMPERATIVES

Goal: *Develop an equitable system of care that is comprehensive and accountable, while optimizing the collective use of capabilities and resources to serve the safety-net population.*

Strategic Imperatives:

Access and Capacity

Central Health will more equitably meet the health care needs of the safety-net community, by increasing the number of providers and care teams and the availability of comprehensive, high-quality and timely care.

Care Coordination

Central Health will coordinate care for Travis County's safety-net population by optimizing transitions of care by facilitating communication within patients care teams across the care continuum and enabling meaningful information sharing.

Member Enrollment & Engagement

Central Health will focus on enrollment in identified high-need planning and assessment regions and enhance engagement for the enrolled population, with special emphasis on care transitions, people experiencing homelessness, justice involved individuals, and communities where English and Spanish are not the primary language.

System of Care Infrastructure

Central Health will develop a high functioning system of care to improve health for Travis County's safety-net population via alignment of relationships including joint service-delivery planning and facilitation of timely sharing of health care data.

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