TAHOE FOREST HOSPITAL DISTRICT

Board Community Benefit Committee

May 04, 2015 at 05:30 PM - 07:30 PM

Eskridge Conference Room

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Meeting Book - 2015 May 04 Board Community Benefit Committee

Agenda Packet Contents

TAHOE FOREST HEALTH SYSTEM

COMMUNITY BENEFIT COMMITTEE

Amended AGENDA

Monday, May 4, 2015 at 5:30 p.m.
Eskridge Conference Room - Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA.

1. CALL TO ORDER

2. ROLL CALL
Charles Zipkin, M.D., Chair; Karen Sessler, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

5.1. **Proposed Strategies and Corresponding Draft Budget for Board Approved Priority Community Wellness Initiatives** ..... ATTACHMENT
The Committee will review priority initiatives and budget scope for the Wellness Neighborhood/Community Health FY2016 budget for possible recommendation to the full board for approval consideration.

6. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

7. AGENDA INPUT FOR NEXT COMMITTEE MEETING

8. NEXT MEETING DATE

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

Board Executive Summary

By: Caroline Ford
Executive Director
Wellness Neighborhood
Community Health

DATE: May 1, 2015

ISSUE:

Continued discussion of the Fy 16 Wellness Neighborhood/Community Health priority initiatives and strategic interventions for the TFHS Community Health Improvement Plan.

BACKGROUND:

The TFHD Board of Directors approved the Wellness Neighborhood/Community Health priority health issues based on the 2014 Community Health Needs Assessment for Fy 16. This action was performed at the Board of Director's meetingin February 2015, and these priorities will provide the strategic directions for community interventions and for TFHS services delivery. These priorities are aligned with the TFHD Strategic Plan, and the TFHD Triple Aim, most specifically in the area of population health, and are gauged to synchronize with the health system's transition from fee-for-service to value based care.

The priority initiatives are executed in concert with community partners and rely on advanced methods/evaluation efforts of Collective Impact to produce expanded results through the engagement of community organizations. The priority issues are: Optimizing Community Health, Substance Use and Abuse, Mental/Behavioral Health, and Access to Care and Preventive/Primary Health Services.

The strategic interventions rely on alignment of the priority health issues within community organizations to maximize the education and health improvement of populations within the region.

ACTION REQUESTED:

Feedback from the Committee is requested.

Alternatives:

WN/CH Programs/Priorities
Red indicates high priority
Green indicates next highest
Purple indicates phased priority

Optimizing Community Health

Program Area	In-Process	Impact	Population Served
FRC/TFHD Promotores-Chronic Disease Mang.	Ongoing 2012	Targeted health status Ethnic Disparities indicators	All ages, all races, low-income, + undocumented
TFHS Care Coordination Chronic Disease	New 2015	Reduced hospital re-admits. Improved health outcomes, registered medical homes, Potential for billing	Selected depending on funding-Youth (12-19); all ages low income
Rethink Healthy!	Ongoing 1990s	Targeted Chronic Disease + Prevention	All ages, all races, targeted low income
Collective Impact	New 2015	Region-wide community collab., Measured impacts, + high potential to attract philanthropy	All ages, all races, all regions
Healthy Communities Inst. Website	Ongoing 2014	Community benefit transparency of assessment results, health status benchmarking, reporting, best practices, TFHD communication with public;	All ages, all races, all regions + beyond
Community Grants Initiative	New 2015	Targeted, leveraged expansion of Comm. initiatives addressing WN Priorities	All ages, all races, all regions of
Athlete Committed	Jan. 2015	AOD targeted prevention	TTUSD Youth 10-18yrs
Programming/Reporting	Ongoing 2011	Community reporting, analysis	All ages, all races, all regions

Substance Use and Abuse

Program Area	In-Process	Impact	Population Served
Alcohol Edu	Ongoing 2012	Alcohol education + substance use	TTUSD High School Youth + Sierra Continuation High
At-Risk Youth Mt Gateway Cnt	Ongoing 2014	Avert 5150s; behavioral health high risk youth	Youth + young adults, all regions
TTFWDD	Ongoing 2012	AOD education, safe prescribing	All regions, all ages, targeted youth,
SBIRT	Ongoing 2012	TFHD ER-AOD intervention	All regions, all ages, targeted AOD abusers
DUI Court	New 2015	Public safety of DUI offenders	Targeted DUI offenders with high BAC

Mental/Behavioral Health

Program Area	In-Process	Impact	Population Served
Integrated Behavioral Health Clinical Services (Tele-psy + Direct services)	Ongoing 2014	Access to Mental Health Services, decrease ER crisis patients, increase primary care access, potential for billing	Primary care patients with behavioral health conditions, targeted populations
FRC MH Services	Ongoing 2013	Access to MH community services	Low income, all races, all regions
Youth Suicide Prevention Expansion	Ongoing 2013	Reduce youth suicide, community education, behavioral health access	Targeted youth, all communities, all regions
TFHS BH Care Coord.	New 2015	Reduce MH ED visits, care coord., MH medical home, potential for billing	Targeted patients with behavioral health conditions
TFHS Mental Health Directory	Ongoing 2013	Community education of resources	All regions, all populations

Access to Care and Preventive/Primary Health Services

Program Area	In-Process	Impact	Population Served
School Health Initiative	Ongoing 2014, New 2015	Increased access of youth to Primary care, BH, Oral; medical Home identification; potential for Services/billings	Targeted youth 12-18 yrs TTUSD
School Health Programs	Ongoing 2005	Reduced obesity, increased physical Health, education/outreach	Targeted youth K-12 grade TTUSD
Oral Health Services	Ongoing 2012	Expansion of clinical services to Under and uninsured community and Insured; potential for billings	Youth K-1st grade; 7th grade; Targeted adults
Community Health Education	Ongoing 1990s	Expanded screenings, community edu	All ages, all populations, all regions
Affordable Preventive Health Screening	Ongoing	Expanded ancillary services, registered medical home, care coordination	Targeted to patients utilizing services

Budget Forecasting
Addressing Priorities
Fy 16

	Optimize CH	Substance Use	Mental Health	Access to Care	Totals
Red	$ 428,939	$ 118,392	$ 173,951	$ 210,000	$ 931,282.00
Green	$ 40,843	$ 17,963	$ 32,713	$ 50,013	$ 141,532.00 +
Purple	$ 13,000		$ 22,000		$ 35,000.00 +
Totals	$ 482,782	$ 136,355	$ 228,664	$ 260,013	$1,107,814.00

Resource Sharing

TFHS Foundation (Dream Home Revenue) investment of $ 50,0000 to Community Grants Program
Non-profit organizations contribution of shared match and direct dollars to execute programs within the community
Revenue generation initiated with direct services billing (e.g. Tele-psychiatry, mental health services, oral health treatment)
Revenue generation initiated with enhanced reimbursements through Meaningful Use, HPSA 10% trigger payments for mental health services and oral health services, other Medicare enhanced payments
Potential external grant generation (current Chronic Disease application-$ 600,000 Fy 16-18)
Other philanthropy (community physicians, foundations, etc.)

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Optimizing Community Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
Promotores Care Coordinator Combined resources between TFHD & Family Resource Centers; base of operation at the community level at the FRCs	Care Coordinator is certified in Stanford's Chronic Disease Self-Management Program (CDSMP). Promotores are trained in CDSMP by Master Trainers. Promotores receive on-going continuing education & skills development by TFHD staff; Promotores are trained and utilize remote monitoring of chronic disease clients and sync care coordination with TFHD Chronic Disease Care Coordinator.	Promotores and Care Coordinator work together to guide identified patients through the CDSMP process. Patients collaborate with Promotores and Care Coordinator and treatment plan and self management plans are developed. Promotores ensure each client identifies a Medical Home and is assisted in enrollment into the practice. Treatment adherence (Medication reconciliation) Service adherence (number of missed appointments)	Patients guided in the CDSM program are better able to self manage chronic diseases with modified behaviors (i.e. demonstrate healthy blood sugar levels), practice healthy behaviors (i.e. not smoking, not drinking and exercising) and can identify a Medical Home immediately after completing the program. Short-term clinical outcomes (e.g., glycated hemoglobin levels for diabetic patients) Improved functional status (e.g., for congestive heart failure patients) Improved quality of life Other patient outcomes (e.g., missed school days for children due to illness)	Reduction in unnecessary ED visits Decrease disease-specific hospital admissions Decrease disease-specific mortality Reduction in health disparities based on ethnicity. Healthier and more stable community members. Enrollment in a medical home for continuous care in an appropriate setting. ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.
Healthy Communities Institute Website through TFHD	Launch HCI Website Maintain the website with current information on health education activities, community health events, e.g. Affordable screenings, health fairs, dental screenings etc.; ability to link to WN priority issue areas and linked activities; ability to link interactive devices/tracking and monitoring and comparisons of	Number of visitors to the site; Aggregated monitoring and tracking of participants participating in events and establishing improvements (e.g. Walking Challenge);	Improved awareness of Tahoe Forest Health System health statistics, demographics, health programs & educational events. Improved access to evidence-based practices, best practices and comparison data; ability of the public to access the Community Health Needs Assessment data and understand benchmarks of	A transparent health system with current and continuously updated data/information. Improved education of health status and social determinants within the region Ability of professionals and the community to generate health and demographic reports in applications for external resources;

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Optimizing Community Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
	benchmarks for health conditions; linkages to community partners e.g. CCTT Results Scorecare		health status, other important health information;	ACA Goal: Improving the Experience of Care; Understanding Population Health;
Expansion of current Health Education programming through TFHD; partnership and contributions by various community org. and sites partnered on specific topics	Rethink Healthy! Harvest of the Month BFit Yoga	Rethink Healthy! Monthly articles in the Sierra Sun, Pacesetter, Email blasts. Accessible employee/community walking trail TFHS becomes certified as a Fit & Friendly Work Place by the American Heart Association; Presence at 3 health fairs/community events; Harvest of the Month and BFit themes expanded into Pine St Café, 5 local restaurants, 5 businesses and TFHD Board Meetings. Continuous health messaging on digital monitors in Pine St. Café and ED; Yoga classes implemented into Truckee High and North Tahoe High Physical Education classes and during Stress Week to all students.	Increased community knowledge about nutrition, physical activity, and monthly health themes. Students have improved self-management of stress. Employees and the community have increased access to safe walking routes. Attendees at specific health promotion events participate in baseline screening and are monitored over the course of education interventions to track improvements. Results rolled up into collective impact data.	Reduction in health care utilization for treatment of preventable conditions. Reduction in health disparities in health status based on ethnicity. Healthier and more stable community members. ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Optimizing Community Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
BFit through TFHD in partnership with TTUSD	Monthly themes in TTUSD classrooms.	1000 youth educated in BFit monthly themes.	Improved BMI in tested students, improved performance in chin hang exercises, improved performance in the One mile run, improved daily healthy behaviors measured through Day in a Life self-report survey;	Reduction in obesity and Type 2 Diabetes in youth; Improvement in youth health indicators over time monitored in the Calif. Healthy Kids Survey; ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care.
Harvest of the Month through TFHD and school-based PTOs	Monthly fruit/vegetable themes in TTUSD classrooms	1000 youth educated in HOM monthly themes	Improved awareness and access to seasonal, fresh fruits and vegetables; Improved student education of nutrition and how to incorporate healthy foods in daily diets; Educated students bring health education into the home to further influence healthy eating in the home environment;	Reduction in obesity and Type 2 Diabetes in youth; healthy eating by families demonstrated through 2017 Community Health Needs Assessment; ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care associated with chronic disease related to nutrition.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Optimizing Community Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
Collective Impact approach in partnership with community organizations Community Grants Initiative	Collaboration between TFHS and community organizations through design and alignment of priority issues, evaluation and tracking of improvements; Collective impact metrics embedded into Community Grants program through targeted shared outcomes;	Common agenda; Shared measurement systems; Mutually reinforcing activities; Continuous communication between organizations and the public; Backbone support organizations aligned with community non-profits; Number of community organizations receiving grants	Increase the number of organizations engaged in specific activities targeted at shared goals.	Systematic change in how organizations target community needs. Healthier and more stable families and community members. Community health improvements evidenced by collective activities by multiple organizations. Achieving targeted goals of the priority health issues with decreased disease burden-reduced cost burden of disease ACA Goal: Improving the Health of Populations. Reducing per Capita Cost of Care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Mental and Behavioral Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
Tele-psychiatrist + Direct Services Mental Health Care Coordinator	Integrate Behavioral Health Clinical Services into Primary Care; Tele-psychiatry for ED use and for outpatient care; Care Coordination for Mental Health Services	Number of patients referred to Tele-psychiatry; Improved patient care for psychiatric needs in the ED; Improved patient care of behavioral health needs in the primary care setting; Number of patients referred to the Care Coordinator. Caseload for the Mental Health Care Coordinator. Coordination of care for MH needs with community practitioners and systems of care.	Improved access to Mental Health Services by TFHD patients and others; Decreased ED crisis patients, 5150s; Reduced 5150 and other patient waiting time in the ED through Tele-psy services; Increased Primary Care access through reduced utilization by behavioral health patients; Improved potential for billing for increased services; Reduced suicides and other serious MH disorders through increased access to care;	Healthier and more stable community members; Improved coordination of care; Improved access to appropriate MH services; Increased access to psychiatric care; ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.
Mental Health Fund for Services within the FRC and Behavioral Health curriculum for Promotores Outreach	Family Resource Centers refer clients in need and unable to afford Mental Health to services through the Mental Health Fund. Promotores train and possess improved skills in working with clients having mental health disorders; Improved identification of need, referral and tracking of client outcomes;	Number of FRC clients referred to services; Training in behavioral health curriculum instituted with Promotores; Coordination of care between clients, Promotores, Care Coordinators and Practitioners	Improved access to Mental Health Services; Decreased ED crisis patients, and 5150s; Improved patient outcomes associated with mental health disorders; Reduced suicides through improved patient referral;	Healthier and more stable community members. Reduction in health disparities based on health insurance coverage, ethnicity or income; improved mental health indicators tracked in the 2017 Community Health Needs Assessment ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Mental and Behavioral Health

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
Youth Suicide Prevention Task Force Coalition in partnership with community organizations; Placer Co. MH	Expansion to a Community focus for suicide prevention activities; Establishing Mental Health in the Mountains educational outreach region-wide	Number of community members educated with the Know the Signs suicide prevention campaign. Number of local businesses educated in the Know the Signs suicide prevention campaign. Enhanced training in Mental Health First Aid	Increased numbers of people able to recognize the signs of potential suicide, is comfortable asking if someone is considering suicide, and know what resources to call for help. Reduced suicides-lives saved; Number of 5150 evaluations conducted in the ED (may increase or decrease because of increased community awareness).	Healthier and more stable community members; increased educated community in mental illness and healthy emotional balance on a daily basis; measured with 2017 Community Health Needs Assessment; ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care.
TFHS Mental Health Directory	Update the MH Directory in Fall of 2015 and Spring 2016	Number of directories printed and distributed in the community; accurate reflection of behavioral health resources in the community; linkages to MH practitioners by TFHD	Improved awareness of Mental and Behavioral Health Services by the community; Reduced suicides through access to practitioners and services; Decreased ED crisis patients, &5150s through access to services on an outpatient basis;	Healthier and more stable community members; practitioner and community member understanding and linkage to mental health services; ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Substance use and Abuse

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
AlcoholEdu through TFHD in partnership with TTFWDD and TTUSD for combined resource sharing	Implement AlcoholEdu online curriculum in TTUSD with instruction by TTUSD health faculty and TTFWDD personnel	Number of TTUSD students educated in AlcoholEdu; measured and tracked results each year and over time compared within district, state of California and the nation.	Increased number of students who have never had a drink of alcohol. Reduced AOD (Alcohol and/or other Drugs) use and binge drinking in youth. Reduced youth driving under the influence or driving in a car with a driver under the influence. Reduced youth seen in the ED due to substance use.	Reduction in youth who become problematic or high-risk drinkers as adults. Healthier and more stable families. Reduction of chronic disease costs associated with consumption of AOD. ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care.
TTFWDD and TFHD, Town of Truckee Police Department organizational partnerships	Alcohol and Other Drugs Education /Parent and Community Committed Pledges Safe Prescribing education and CURES (drug monitoring program) registration; Safe Disposal of Rx Program	Number of parents and community members who have signed the commitment to not provide underage youth with alcohol. Number of health care providers and dentists trained in Safe Prescribing best practices and registered for the CURES program.	Reduced youth access to AODs. (Also see Short Term Outcomes above) Reduction in Emergency Department use and drug seeking behaviors. Increase knowledge base for medical providers Reduction in ED 5150s in youth having AOD involvement. Reduced DUIs Reduced binge drinking	Healthier and more stable families; Improvement in community impact of Rx prescribing; Family education of AOD issues and reduction of use behaviors as evidenced in 2017 Community Health Needs Assessment; ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Substance use and Abuse

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
At-Risk Youth-Mountain Gateway Center Programming; Placer and NV. Counties; TTUSD	One-on-one alternative therapies conducted through programming provided by Mountain Gateway Center	Number of youth participants; coordinated referrals and tracking of youth outcomes;	Improved access to behavioral health services. Number of 5150s averted for participants; Youth participate in healthy behaviors (not using AODs, physical activity, healthy eating); Improved coordination of care for at-risk youth by community organizations;	Healthier youth; Resources in place for at-risk youth; program graduates become safe& healthy adults and mentor the next generation of youth; ACA Goal: Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Access to Care and Preventive/Primary Health Services

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
School Health Initiative/Hub Service Manager support	Expansion of the TTUSD Wellness Centers into Wellness Hubs as an access point for wellness services and leadership opportunities. Hub Service Manager who would serve as the first point of contact for all student referrals and be responsible to coordinate student care.	Percent of TTUSD students with medical homes; Percent of TTUSD students who take the Staying Health Assessment; Percent of youth with depressive symptoms/suicidal ideation referrals into treatment; Pregnancy rates and STD screening;	Improved access to primary care, reproductive services, mental/behavioral services and dental services; Increased youth referred into medical homes in the community; Fewer youth seen in crisis in the ED; Reduced student suicides; Reduced youth pregnancies; Increased youth referrals to oral health screenings and services;	Reduction in youth health disparities based on insurance coverage, ethnicity or income. Healthier and more stable students with better education outcomes; Healthier youth as evidenced in Calif. Healthy Kids Survey; Healthy youth transitioning into adulthood and guiding the next generation of youth; ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.
School Health Programs	Nutrition groups Increased physical education Health outreach and education	Number of students involved in groups. See BFit outputs in Optimizing Community Health	Improved BMI in youth; Improved healthy eating, positive body image and self esteem; Increased youth participating in health programs;	Reduction in youth health disparities based on insurance coverage, ethnicity or income. Healthier and more stable students. ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.

Logic Model

Organization Name: Wellness Neighborhood

Priority Issue: Access to Care and Preventive/Primary Health Services

Inputs / Resources	Key Activities	Measurable Outputs	Measurable Short Term Outcomes	Community Impact Long Term
Oral Health Services	Targeted expansion of clinical services to under and uninsured community members; access to age specific youth for dental screenings/sealants	Percent of TTUSD students completing dental screenings; Percent of 1st graders with sealants; Percent of 6th graders with caries &sealants; Percent of TTUSD students identified with oral treatment needs receiving treatment; Number of adults receiving dental screening and treatment.	Improved access to dental services in the community; Reduced ED utilization associated with dental emergencies; Improved management of Type 2 Diabetes (Diabetics are at risk of periodontal (gum) disease which may make it difficult to control blood sugar);	Reduction in health disparities based on insurance coverage, ethnicity or income. Healthier and more stable students. Increased access to oral health services in targeted populations; ACA Goal: Improving the Experience of Care. Improving the Health of Populations. Reducing per capita costs of health care.

Alignment of WN/CH Initiatives with TFHD/Triple Aim Goals

Triple Aim	TFHD Strategic Plan	WN/CH Initiatives/Strategies
Patient Experience	2. Develop an accountable and fully engaged team. Regularly communicate system-wide services, priorities, projects and activities to **health** system community advisory groups and agencies that re-presentdemographic interests of the community.	Chronic Disease Self-Management Chronic Disease Case Management Patient Advisory Groups Primary Care Medical Homes Affordable Preventive Health Screens
	4.Make the most effective investment in and use of Informationsystems. 5: Partner w/regional and local medical providers. Explore partnership opportunities with regional & local health systems to improve efficiency and effectiveness of care delivery.	Health Information Technology Interactive Website Health promotions education Community outreach
	6. Grow market share in select clinical service lines.	
	7. Positioned as a high-value service provider Develop programming to enhance patient care navigation and coordination.	
	8. Achieve equitable, sustainable programs and partnerships that respond to local health priorities. Attain effective, equitable and accessible health & wellness services with evidenced-based practice to align& strengthen existing community hlth services.	

Population Health

Chronic Disease Self-Management-Promotores (TFHD + FRCs)
Behavioral Health Access + Services
Chronic Disease Care Coordination
Disparities outreach-Promotores
Behavioral Health Care Coordination
Oral Health Screening + Access
Youth/Community Suicide Prevention
At-risk community youth services
Adolescent Health Care Coordination
Primary Health Care Infrastructure assessment
AOD (Alcohol + Other Drugs) education
Population health education*Rethink Healthy!*e.g. chronic disease, nutrition, BeFit, physical exercise, Kick Nicotine, Pre/Post Natal, substance use, mental health, etc.
Practitioner education e.g. Safe Pre-scribing
TTFWDD partnership
DUI Court-Public Safety
Community Grants-Population Health priorities

Reducing Per Capita Cost

Primary Care restructuring
Investigate maximizing Provider-Based reimbursements
Chronic Disease Care Coordination
Promotores Outreach/patient referral
Chronic Disease Case Management