GrowHealthy Together
Bexar County

2017 HEALTHY BEXAR PLAN

COMMUNITY HEALTH IMPROVEMENT PLAN

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Health Collaborative
Bexar County's Community Health Leadership

2017
FUNDING PARTNERS

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Health Collaborative
Bexar County's Community Health Leadership

THE STATE OF TEXAS
COUNTY OF BEXAR

THE HEALTH COLLABORATIVE

THE HEALTH COLLABORATIVE BEGAN INFORMALLY IN 1997 WHEN THE CITY'S MAJOR HEALTHCARE ORGANIZATIONS AGREED TO PUT ASIDE THEIR COMPETITIVE BUSINESS PRACTICES TO CONDUCT A COMPREHENSIVE HEALTH NEEDS ASSESSMENT. THE EVOLUTION IN 2000 TO AN INCORPORATED ENTITY WITH A LONG-RANGE STRATEGIC PLAN IS IN RESPONSE TO THE FOUNDING MEMBERS' INTEREST IN IMPROVING THE HEALTH STATUS OF THE COMMUNITY BY WORKING TOGETHER. THE HEALTH COLLABORATIVE HAS DEVELOPED INTO A POWERFUL NETWORK OF CITIZENS, COMMUNITY ORGANIZATIONS AND BUSINESSES. THE RESULT IS A MORE ROBUST, LESS DUPLICATIVE, MORE SYNERGISTIC APPROACH TO SOLVING CRITICAL COMMUNITY HEALTH NEEDS, WHILE EFFICIENTLY UTILIZING RESOURCES.

CITY OF SAN ANTONIO
METROPOLITAN HEALTH DISTRICT

Health Collaborative
Bexar County's Community Health Leadership

On behalf of the San Antonio Metropolitan Health District and the Bexar County Community Health Collaborative, we are pleased to present the 2017 Healthy Bexar Plan. Over the past six months, representatives of various sectors of Bexar County including residents, nonprofit organizations, health care providers, community organizations, educational institutions, businesses and government organizations have worked together to identify community health priorities and develop a strategic action-oriented document to improve the health and well-being of everyone who lives, works, and plays in Bexar County. This plan is a result of many hours of thoughtful analysis, assessment, and creativity by everyone involved. We want to thank everyone who participated in the many meetings, discussions and reviews during the development of this document, and as a result, contributed to its value.

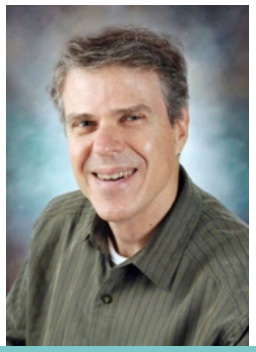
The 2017 Healthy Bexar Plan represents a beginning, not an end. We all need to continue to work collaboratively, engage new partners, and leverage our resources to successfully implement this plan. This is a "living" document that will be modified in response to evolving circumstances, resource availability, and other factors. Through policies, education, and programs/initiatives, we can address the many determinants of health for a better, healthier, and more sustainable San Antonio and Bexar County. We encourage all residents, including elected officials and political and community leaders, to read the report and work with the entire community to implement its recommendations. Our goal is to effectively implement these action steps over the next three years. We will assess and update each year as we engage in implementation, monitoring and evaluation.

We are proud of the work done by our community, and Metro Health and Health Collaborative staff in bringing this forward. We look forward to continuous collaboration with the San Antonio and Bexar community to improve everyone's health and well-being.

COLLEEN M. BRIDGER, MPH, PHD

Health Director

San Antonio Metropolitan Health District



ROBERT L. FERRER, MD, MPH

Board Chair

Bexar County Community Health Collaborative

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EXECUTIVE SUMMARY

The 2016 Community Health Needs Assessment (CHNA) presented the most recent data on the status of the community's health as well as areas needing improvement. By community, we refer throughout this report to the county of Bexar (pronounced "bear"), Texas. Following the CHNA, more than 200 community stakeholders and members started working together to develop the 2017 Healthy Bexar Plan, previously known as the Community Health Improvement Plan.

The plan proposes to improve the community's health in five priority areas: Behavioral and Mental Well-Being, Healthy Child and Family Development, Healthy Eating and Active Living, Safe Communities, and Sexual Health. These priority areas are supported by local data and community feedback in the CHNA as well as an analysis of other local plans. Each priority area was addressed by one workgroup composed of partners and community members.

In contrast to the previous two CHIPs, the 2017 CHIP used selected attributes of the Results Based Accountability (RBA) framework. Starting with the end in mind, the modified RBA process helped each workgroup and its members focus on the results they want to achieve, select key headline indicators to measure success toward this vision, identify and prioritize root causes influencing the indicators, and develop strategies and actions to impact these causes and ultimately make a positive change in the community.

Throughout this process, workgroups were strongly encouraged to keep in the forefront of their work four overarching themes, which were also prominent themes driving the results of the CHNA: life expectancy especially in disparate areas, health outcomes, access to care, and health inequity.

The 2017 Healthy Bexar Plan represents the culmination of this collaborative process where partners worked together cohesively to plan how to address the needs of our community. However, this plan has little value if it is not executed. It is the community's responsibility to implement the actions and strategies set forth in this plan, to monitor and report on the progress made on a regular basis, and to use the next three years as an opportunity to positively impact the health status of Bexar County residents.

A SNAPSHOT OF
THE POPULATION SERVED

Located in South Texas approximately two hours from the Mexican border (See Figure 1), Bexar County has a population of 1.9 million people (U.S. Census Bureau, 2017). The City of San Antonio is the largest city within Bexar County with approximately 1.4 million people. It represents the seventh most populated city in the country. San Antonio's population is expected to grow by 1 million people by 2040 (SA Tomorrow, 2017).

Figure 1. Map of Bexar County within Texas (Source: Metro Health, 2017)

Table 1 below presents some characteristics of the county's population.

DEMOGRAPHIC	PERCENTAGE
RACE/ETHNICITY	
Hispanic	59.9 *
Non-Hispanic white	28.2
Non-Hispanic African American	7.3
AGE	
1 to 17	26.0
18 to 64	62.2
65+	11.8
Language	
Language other than English at home	40.8

Source: U.S. Census Bureau, 2017. *This ratio makes it one of the first majority-minority county in the United States.

Based on the 2016 Bexar County CHNA, significant disparities exist in Bexar County. Approximately 335,000 residents or 18.4 percent of the population live in poverty, with females, minorities, and children being disproportionately impacted (Bexar County Community Health Collaborative, 2016). Approximately 17 percent of all Bexar County residents aged 25 and older have not completed high school (Bexar County Community Health Collaborative, 2016). Almost one in five adults in Bexar County has reported delaying health care because of cost. Limited health insurance among adults is an important barrier to accessing care. In fact, about 32.7 percent of adults without a high school diploma or Texas Certificate of High School Equivalency do not have health insurance. Hispanics and non-Hispanic African Americans are less likely to have coverage compared to non-Hispanic Whites. Overall, residents in the north of Bexar County tend to live 20 years longer than residents living in the south (Bexar County Community Health Collaborative, 2016). See Figure 2. This premature mortality is especially prominent among minorities and low-income individuals.

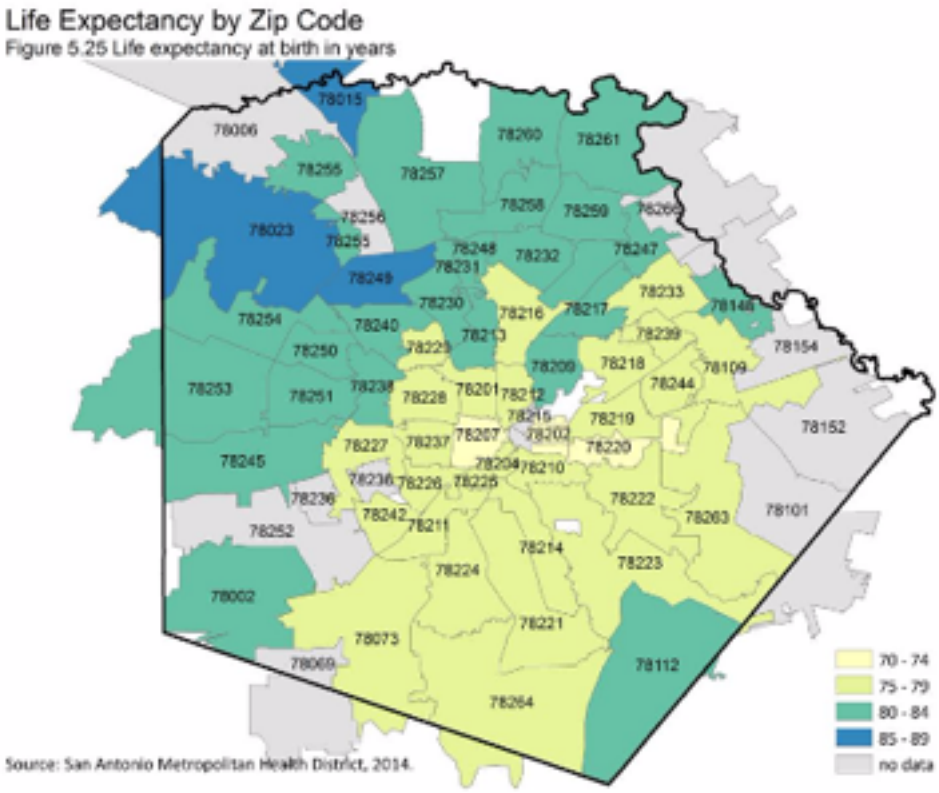

Figure 2. Life Expectancy by Zip Code (Source: Bexar County Community Health Collaborative, 2016, p.85)

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OVERVIEW OF
LEADING & PARTNERING AGENCIES

The Bexar County Community Health Collaborative, also known as The Health Collaborative, and the San Antonio Metropolitan Health District, also known as Metro Health, co-led the 2017 CHIP planning and development process.

For the past 20 years, The Health Collaborative works to improve the health status of the community through collaborative means. It was founded in 1997 when the local hospital systems set aside competitive business practices to create an organization that would develop a countywide CHNA. In 2000, The Health Collaborative became a 501c3 non-profit organization and has continued to provide the CHNAs in 1998, 2002, 2006, 2010, 2013, and 2016. Since its beginnings, The Health Collaborative has expanded beyond the CHNAs into a powerful network of citizens, community organizations, and businesses working together using more robust, less duplicative, and more synergistic approaches to resolve the county's critical community health needs.

In addition, The Health Collaborative provides administrative support to nine learning collaboratives and coalitions including:

- San Antonio Health Literacy Initiative
- Immunize San Antonio
- Active Living Council
- LezRide SA
- San Antonio Grandparents Raising Grandchildren Coalition

The Health Collaborative offers community health programs such as Young Minds Matter and Healthy Me Healthy We, providing free wellness, nutrition education and fitness opportunities for low-income and vulnerable families throughout the county. The Health Collaborative functions under the leadership of an Executive Director and is guided by a Board of Directors comprised of 18 members from all sectors, including the hospital systems, the business sector, the city, the county, non-profits, health insurance providers, and academia, and board members representing the community's interests.

The Health Collaborative co-leads the community health improvement planning process with Metro Health every three years with more than 100 stakeholders across the county. In 2017, Metro Health took the lead in organizing and developing the CHIP and The Health Collaborative will take the lead in the monitoring, implementation and evaluation of the CHIP.

Metro Health is designated by State Law, City Code, and County Resolution with responsibility for the health of the population in San Antonio and all incorporated and unincorporated areas within Bexar County. Although Metro Health is a city and county organization, administrative control is under the City of San Antonio. Metro Health functions under the leadership of a Public Health Director. The director, in consultation with the City Manager, Mayor and City Council sets public health priorities and guides the overall activities of Metro Health.

Metro Health's mission is to prevent illness, promote healthy behaviors, and protect against health hazards throughout the community through education, collaboration, and key services. It has been serving the community and protecting the health of our population as a district since 1966. It routinely publishes health data for the community's use and assists The Health Collaborative with information needed to develop and publish the CHNA.

Metro Health's major services include regulatory functions, environmental monitoring, health code enforcement, preventive health services, including chronic disease prevention, clinical and laboratory services, communicable disease control, oral health, maternal, child and infant health, health education and community outreach, teen pregnancy prevention, violence prevention, neighborhood engagement, health equity, and emergency planning and response for natural and manmade disasters. In addition to these services, Metro Health leads or supports multiple coalitions and collaborations throughout the community, including:

- San Antonio Teen Pregnancy Prevention Collaborative
- Healthy Families Network
- Mayor's Fitness Council
- San Antonio Diabetes Collaborative
- Opioid Task Force

To develop the CHIP, The Health Collaborative and Metro Health partnered with 70 unique organizations. Specifically, 210 unique individuals representing 121 departments and community programs participated in the five CHIP workgroup meetings held between March and July 2017. An average of 97 people attended each meeting. The main types of organizations represented included city and county governments, philanthropic organizations, health systems, health insurance providers, school districts, non-profit organizations, private businesses, faith-based organizations, and community residents. All workgroup participants, including community members, are listed in the acknowledgement section of this report. The Health Collaborative and Metro Health appreciate the time and commitment every community partner and member dedicated to developing this CHIP collaboratively.

THE 2017
CHIP PROCESS

The CHIP process includes five phases: 1) planning; 2) recruitment; 3) development; 4) implementation; 5) monitoring and evaluation. Each phase is described below in Figure 3.

Figure 3. Overview of CHIP Process

PHASE 1: THE PLANNING PHASE

The Health Collaborative and Metro Health started planning the 2017 CHIP in August 2016 after the release of the Community Health Needs Assessment (CHNA). Selected members of The Health Collaborative board serving as a data committee, staff at Metro Health and staff at the Health Collaborative formed the CHIP Steering Committee to plan and guide the 2017 CHIP process. The CHIP Steering Committee's first step was to compile information from several recent local and national and relevant community plans to understand their health priorities, goals, and indicators. As presented in Appendix A, the plans included:

- Healthy People 2020
- Centers for Disease Control and Prevention's Winnable Battles
- SA 2020 Plan
- 2015 SA Tomorrow Comprehensive Plan
- 2017-2019 City of San Antonio Metropolitan Health District Proposed Strategic Plan
- 2014 City of San Antonio Community Survey
- 2016 Bexar County CHNA
- 2014 Bexar County CHIP
- 2013 Austin/Travis County CHIP
- 2013 Houston CHIP
- 2013 El Paso County Community Health Assessment and Improvement Plan

This overview of plans and outcomes provided a realistic comparison of how different entities were proposing to address and measure important health priorities affecting our communities. Over the course of several meetings, the CHIP Steering Committee discussed these plans, brainstormed potential headline indicators to recommend to the workgroups for the 2017 CHIP, and made the determination to maintain the same five CHIP priority areas as selected in 2014. The final five CHIP priority areas are:

- Behavioral and Mental Well-Being
- Healthy Child and Family Development
- Healthy Eating and Active Living
- Safe Communities
- Sexual Health

Through this examination, the CHIP Steering Committee also noticed the emergence of several larger social concerns that were transcending across the potential indicators, such as poverty and education. This is how the four overall themes of the CHIP process were determined. (See Overarching themes within the CHIP process on page 18.)

During the planning phase, it was determined that the 2017 CHIP would be guided by selected features of the Results Based Accountability (RBA) framework. RBA is a "disciplined way of thinking and acting to improve entrenched and complex social problems" (Clear Impact, 2017). It uses a "data-driven, decision-making process to help communities and organizations get beyond talking about problems to taking actions to solve problems" (Clear Impact, 2017). It is effective by keeping the end in mind and working backwards toward the means and strategies needed to achieve this goal. Only a few headline indicators are selected and targeted for improvement in order to maximize the community's efforts and to ensure that the partners involved in the process become accountable for progress made to achieve the expected goal. Metro Health recently used the RBA process to develop its strategic plan for 2017-2019. Several of their staff were well versed in the RBA process already and served as lead facilitators for the five workgroups. A glossary of RBA terms can be found in Appendix B.

The last step of the CHIP planning included identifying people to participate in the development of the CHIP; thus, local collaborations and organizations that were already working in the community on the final five priority areas were identified. In addition, lists of previous CHNA and CHIP attendees were compiled to ensure a broad representation across sectors and types of organizations.

PHASE 2: THE RECRUITMENT PHASE

CHIP workgroup participants were recruited between December and early February via email using a joint letter from Metro Health and The Health Collaborative. Compiled lists of prior CHNA and CHIP participants were utilized to recruit participants as well as word of mouth at various coalitions, taskforces, and community meetings. Participants committed to their preferred CHIP workgroup via email or telephone. The CHIP Steering Committee also took steps to ensure that the same people came to all five workgroup meetings, and if a proxy was sent, that it was for a limited number of meetings. Also knowing that strategies and actions would be requested at the end of the development phase, organizational leaders and decision makers were recruited to participate or send a delegate to participate on their behalf.

PHASE 3: THE DEVELOPMENT PHASE

Metro Health and The Health Collaborative organized a total of five meetings from March to July 2017 to develop the CHIP. The process was guided by selected features of the RBA process illustrated in Figure 3. As Metro Health had recently employed the RBA process for their strategic plan, their staff took the lead in conducting this phase and training the workgroup facilitators. Prior to each CHIP workgroup meeting, the workgroup facilitators (ten Metro Health staff members and five Health Collaborative staff members) and workgroup advisors (five Metro Health staff members) received training on meeting facilitation, the RBA process and methods related to the upcoming meeting. Several tools were used by the facilitators and their workgroup to assist with group decision making. For each step in the CHIP development (e.g., selecting a headline indicator), the workgroups used one or more matrices to rank the potential options being discussed using a list of criteria (e.g., data power, proxy power, communication power, impact on life expectancy likely, significant impact on population health). This helped the workgroups make the best collective decision possible. A guide that includes most of the matrices used in the CHIP process is available in Appendix C.

Specific objectives were set for each CHIP meeting:

- Meeting 1 was dedicated to drafting the results statement and selecting a headline indicator. This was no easy task because each workgroup had to choose from a broad range of important health issues in each priority area.
- Meeting 2 was dedicated to identifying the prioritized root causes of each selected headline indicators and writing the story behind the baseline, i.e., the story that describes the current status of the health indicator in Bexar County. At the start of every meeting, each workgroup also had the opportunity to review what all the other workgroups had been working on and provide feedback. This was very useful for each individual workgroup to refine their own work, as well as for all participants to be able to compare and remain consistent with the overarching themes, while avoiding duplication of efforts.
- Meeting 3 was focused on creating a list of potential partners and their roles and discussing potential strategies to address the root causes. During this meeting, a Health Collaborative graduate intern presented the results of her research comparing all 2014 CHIP strategies to existing population health evidence-based policies and programs from the University of Wisconsin Population Health Institute's What Works for Health tool, as well as the Centers for Disease Control and Prevention's (CDC) HI-5 and 6|18 website. She rated the 2014 CHIP strategies based on whether they had evidence (i.e., scientifically supported, some evidence, expert opinion, insufficient evidence, mixed evidence, evidence of ineffectiveness) and on their likely impact on health disparities (i.e., likely to decrease health disparities, no impact on health disparities likely, and likely to increase disparities).
- Meeting 4 was used to finalize the strategies and to start thinking about specific collective performance measures and actions that different organizations could take to achieve each selected strategy.
- Meeting 5 was dedicated to finalizing specific actions to be taken by each participating agency over the next three years. The action plan can be found in Appendix D. It is included separately because we expect this document to be frequently updated. Meeting 5 was also focused on

planning the targets for each headline indicator that will result in positive health improvements in the community. In other words, if all of these actions and strategies are implemented to address the three or four prioritized root causes that drive the selected headline indicator, how much of an impact can we expect? How much can we turn the curve in favor of population health? Based on a review of the data, each workgroup discussed current efforts and forecasted where the trend line would go over the next three years without additional interventions. The workgroups also discussed how their selected strategies and actions would impact the trend line.

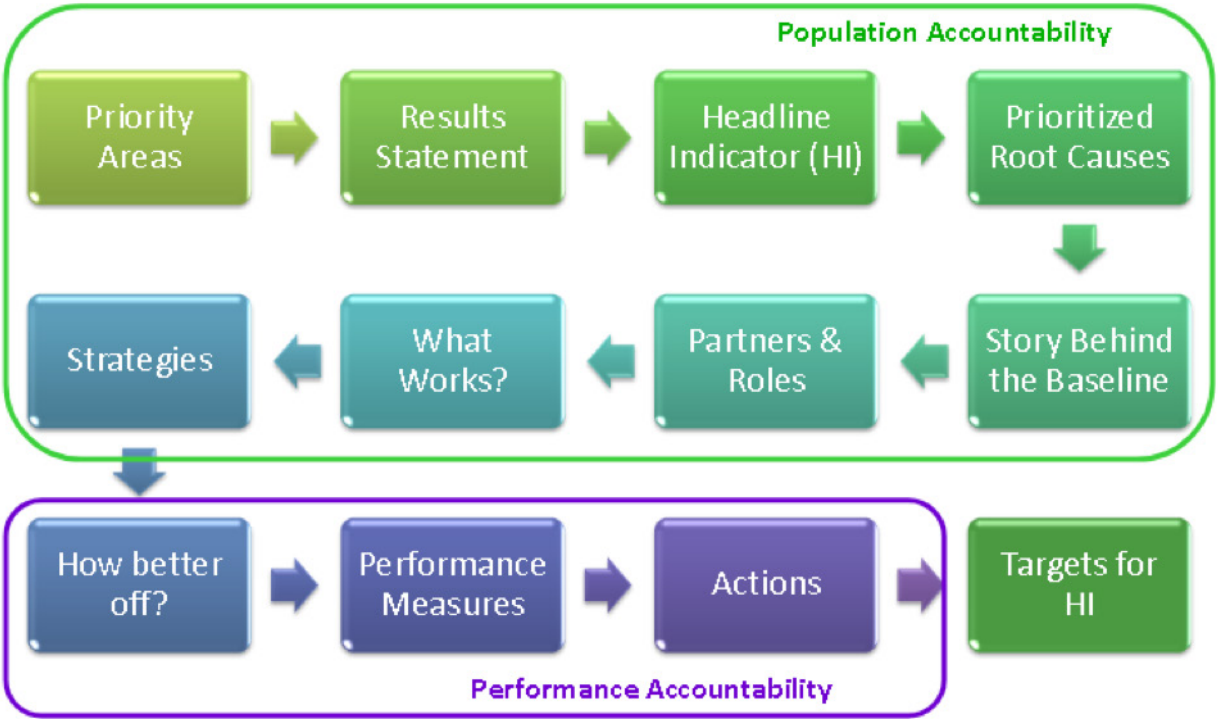

Figure 4. The Modified Results Based Accountability (RBA) Framework that Guided the Development of the CHIP

Workgroup members were in contact between meetings via email or survey monkey to complete their assigned homework and ensure that all the groups followed the planned timeline for these meetings. The CHIP steering committee also met monthly in between the CHIP meetings to receive an update on the progress of each workgroup and to provide data expertise as requested. For example, when selecting headline indicators, workgroup members needed to think about routinely available data sources at the county level that would allow the monitoring of changes in these indicators at the population level over time. Based on recommendations from the CHIP steering committee, a few workgroups changed some of their selected indicators to associated indicators instead to facilitate measurement of their headline indicators.

The community's voice was also present during the entire CHIP development process. Similar to community partners, members of the community were invited to attend the CHIP meetings and

participate in their preferred workgroup. In addition, ten community engagement opportunities were organized across the county to collect feedback from the community and act as a sounding board for the ideas and progress of the workgroups. See Figure 5 for location of community engagement efforts. See Appendix E for examples of qualitative data collected across the county.

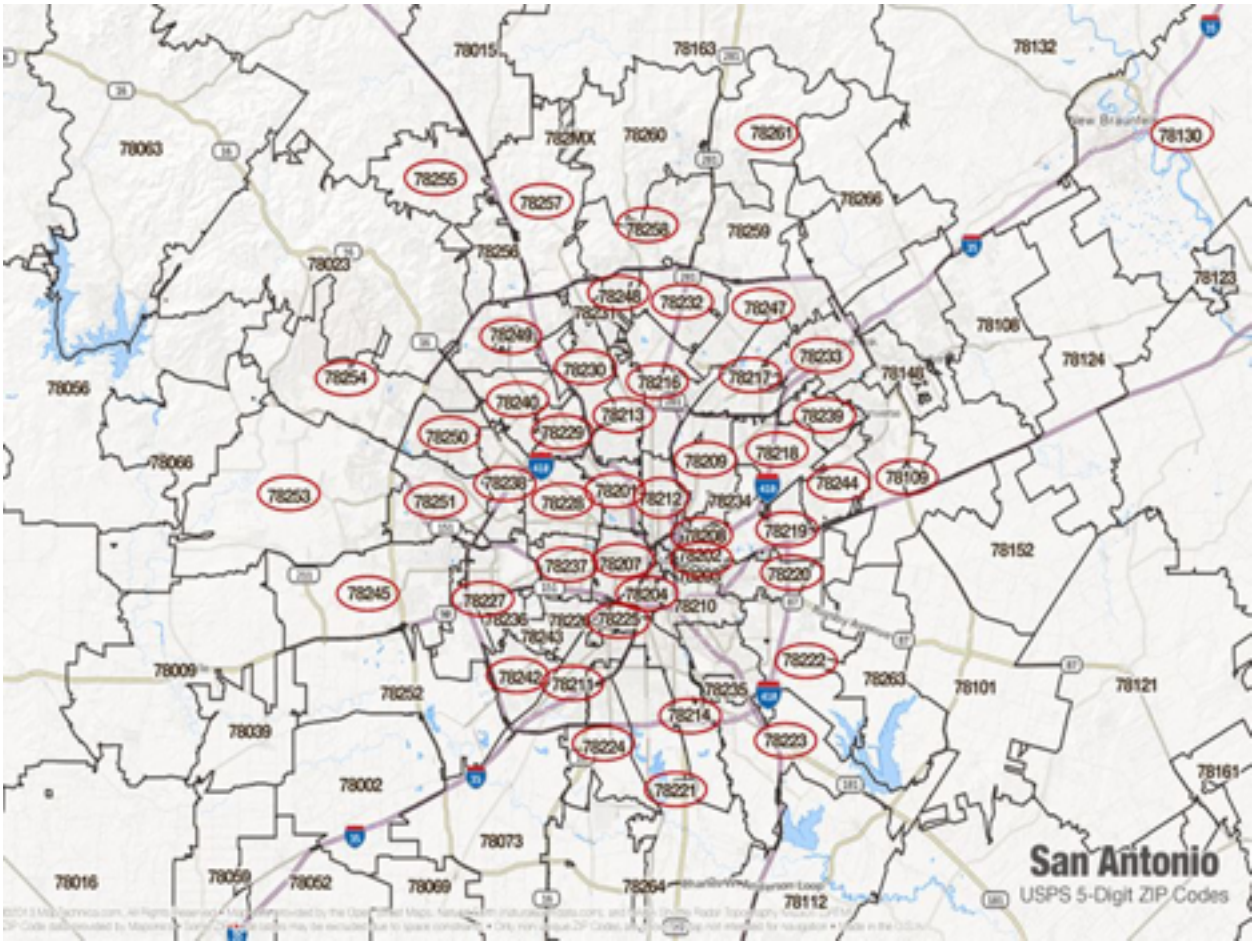

Figure 5. Community Engagement Efforts in Bexar County Zip Codes

Data from community members were collected using dot-voting, paper and online surveys. A total of 310 individuals residing in most of the zip codes in Bexar County provided invaluable input and ideas in both English and Spanish about what is important for good health, which CHIP priority is the most important, and the best ways to address the most pressing health issues in our community. Data collected through the community engagement opportunities helped to inform subsequent decisions made by both the CHIP Steering Committee and the five workgroups. The 10 events and the number of participants per event are described in Table 2.

Table 2. Community Engagement Opportunities during the CHIP Process

NAME OF EVENT	NUMBER OF PARTICIPANTS
SA Tomorrow Open House #1 in zip code 78214	37
SA Tomorrow Open House #1 in zip code 78250	25
SA Tomorrow Open House #1 in zip code 78284	24
SA Tomorrow Open House #1 in zip code 78210	32
Healthy Start Baby ShoweR	23
PreK4SA	97
A Beautiful Mind – Young Mind's Matter event	25
Baptist Healthy Women's & Free Pregnancy Testing Center	7
Mayors Fitness Council Community Committee	16
Planning Department/Office of Sustainability	24
TOTAL	310

PHASE 4: THE IMPLEMENTATION PHASE

The official community release of the CHIP in October 2017 will launch the implementation phase of this plan. A list of current community liaisons, implementing partners and engagement champions for each workgroup can be found in Appendix F. Community liaisons are volunteers from each workgroup who will help lead this process for a one-year term each. They will help keep the workgroups organized, chair the quarterly meetings, and ensure that there is progress toward accomplishing the workgroup's action plans.

Implementation partners in each workgroup are organizations from each workgroup who have a vested interest in the proposed actions because of potential and existing alignment with organizational processes, plans, and programs. They also have the financial and/or human resources to make progress toward these goals and are able to report on the outcomes of their actions. As of the October 2017 launch, implementation partners will start implementing their proposed actions to address the root causes of their respective headline indicators.

Engagement champions will also provide support with community engagement efforts. Engagement champions help tap into the community's voice through outreach and community awareness events. These partners plan conferences, community meetings, and different types of activities where residents gather.

The Health Collaborative will be in communication with the workgroup members and the implementation partners throughout the year to monitor implementation and to receive quarterly progress reports and updates (i.e., in January, April, July, and October). Progress completed in the first year of implementation will be reported on and shared at the annual CHIP meeting in October or November 2018.

Community members and partners interested in becoming community liaisons, implementation partners, or engagement champions can contact the Health Collaborative at 210-481-2573 or by email at info@healthcollaborative.net. Leaders are still needed for the proposed actions. All are therefore welcome to join and help the successful implementation of the CHIP.

PHASE 5: THE MONITORING AND EVALUATION PHASE

The implementation of the CHIP occurs simultaneously with the monitoring and evaluation of the CHIP. Three types of monitoring will be conducted:

1. Implementation monitoring consists of tracking the progress within each workgroup to ensure that the strategies and action plans from the CHIP are being implemented by community partners.
2. Community monitoring will be used to get feedback from community members during the implementation phase. Different events and meetings will be organized throughout the year by the engagement champions. The Health Collaborative will be invited at these meetings to gather community feedback on the CHIP actions and strategies being implemented.
3. Data monitoring will consist of tracking local data to ensure the activities to be implemented are helping to move the trend line of each headline indicator in the direction of the targeted goal.

Rapid adjustments to the strategies and action plans may be made if monitoring shows counter-effective community solutions. The CHIP represents a “living” or evergreen document. All revisions to the CHIP will be marked in Appendix G.

During the monitoring and evaluation phase, Metro Health and The Health Collaborative will collaborate with CI: Now to develop the data dashboard. This online tool will enable the visualization of progress made in each headline indicator over time. The full evaluation of the CHIP headline indicators and associated indicators will be conducted in 2019 for the next CHNA.

OVERARCHING THEMES
WITHIN THE CHIP PROCESS

The four interconnected overarching approaches and themes, which were transparent across the development of the CHIP and will be throughout its implementation, include:

1. improving life expectancy, especially in disparate areas
2. improving the population's health
3. achieving health equity
4. accessing health care

A. IMPROVING LIFE EXPECTANCY

Disparities in life expectancy were one of the main findings from the 2016 CHIP. For this reason, it was a goal throughout the five workgroups to consider whether the root causes to address the main headline indicators, as well as the strategies to address these root causes were going to make a positive change in the community, especially in areas where the resources are scarce and the living situations are of poorer conditions. The lack of resources and infrastructure to be healthy and thrive, including all of the social determinants of health such as education, employment, access to food, and access to transportation, among others, contribute to the higher rates of chronic conditions and violence in those areas, which lead to premature death. Aiming to reverse this trend to improve conditions for those living in underserved areas was therefore one of the main foci of this CHIP. (See Figure 2.)

B. IMPROVING THE POPULATION'S HEALTH

To improve the population's health also means to help Bexar County residents live longer healthier lives, as discussed in the abovementioned theme. Improving the population's health requires upstream interventions and changes to the social and physical environments. It means ensuring that all residents in Bexar County have their most basic needs met (e.g., shelter, food). It involves creating environments that are conducive to the healthy choice being the default or easiest choice.

From a more practical point of view, improving the population's health means to set goals to achieve positive health outcomes and to monitor progress toward that goal until the outcomes are improved.

C. ACHIEVING HEALTH EQUITY

Achieving health equity means to attain the highest level of health for all residents of Bexar County by providing them with full and equal access to opportunities that enable them to lead healthy lives. To achieve health equity, we must address the root causes or the systematic and structural barriers that cause inequities across sectors and people including in education, employment, housing, and health care. Figure 6 provides a simple example of health equity.

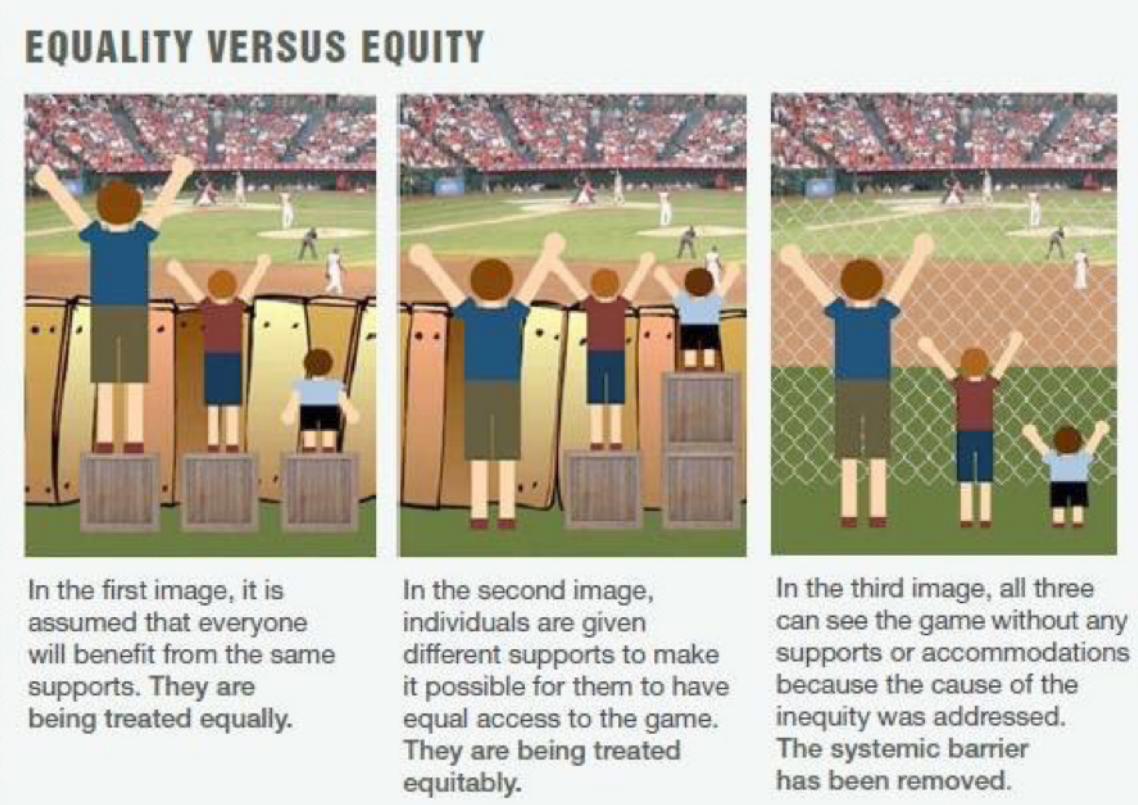

Figure 6. Removing Structural Barriers to Achieve Health Equity (Source: Center for Environmental Change and Human Resilience, 2016)

Achieving health equity also involves investing in innovative solutions such as nationally recognized evidence-based interventions to address the social determinants of health of people at highest risk. The National Quality Forum released a report in September 2017 entitled A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity where they lay out a roadmap with four actions to reduce disparities. The four actions are listed in Figure 7. As an overall theme, these key actions for health equity were kept in mind throughout the planning and development of the CHIP.

Figure 7. The Four I's for Health Equity (Source: National Quality Forum, 2017)

D. ACCESSING HEALTH CARE

Having access to care is essential for prevention (e.g., immunization), screening (e.g., sexual transmitted diseases), diagnosis (e.g., diabetes), and treatment when ill (e.g., mental illness). Accessing health care early, for example through a primary care provider, is associated with better health outcomes, fewer disparities, and lower costs. Health literacy also plays an important role in accessing care to understand health information and make informed health decisions. In addition, having health insurance can help to increase access to care and decrease medical costs. Many providers will simply not treat the uninsured and underinsured, which leaves those without insurance to seek care from publicly funded safety net providers, many of whom are overwhelmed and or underfunded (Chokshi, Chang, & Wilson, 2016). Ensuring access to care can bring about numerous benefits for the health and longevity of county residents, which is why it was considered the last overarching theme of the 2017 CHIP.

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National Quality Forum. (2017). A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. Retrieved from https://essentialhospitals.org/wp-content/uploads/2017/10/disparities1_final_report.pdf

THE PLAN'S
FIVE PRIORITY AREAS

The plan for each priority area is described in the following sections. The RBA process requires the workgroups to select only a handful of indicators (less than five indicators each) in order to better focus community efforts on making an impact on population health. The workgroups found it difficult to select the most important issues to work on over the next three years, because several other health issues are also important. Each workgroup's final decisions are presented next, including their results statements, indicators, root causes, and strategies to move the needle on population health.

Graphs for each headline indicator are also presented. National data are presented in black; Texas data are presented in blue. Values for Bexar County data are in green. The green forecast lines also show what can be expected of this trend by 2019 if no additional intervention is implemented. The pink lines in the graphs display the workgroups' targets or where they expect this value to be by 2019, in part due to their population health strategies and actions. As of October 2017, some workgroups were still setting their targets for their headline indicators.

A. BEHAVIORAL AND MENTAL WELL-BEING

Why is this important?

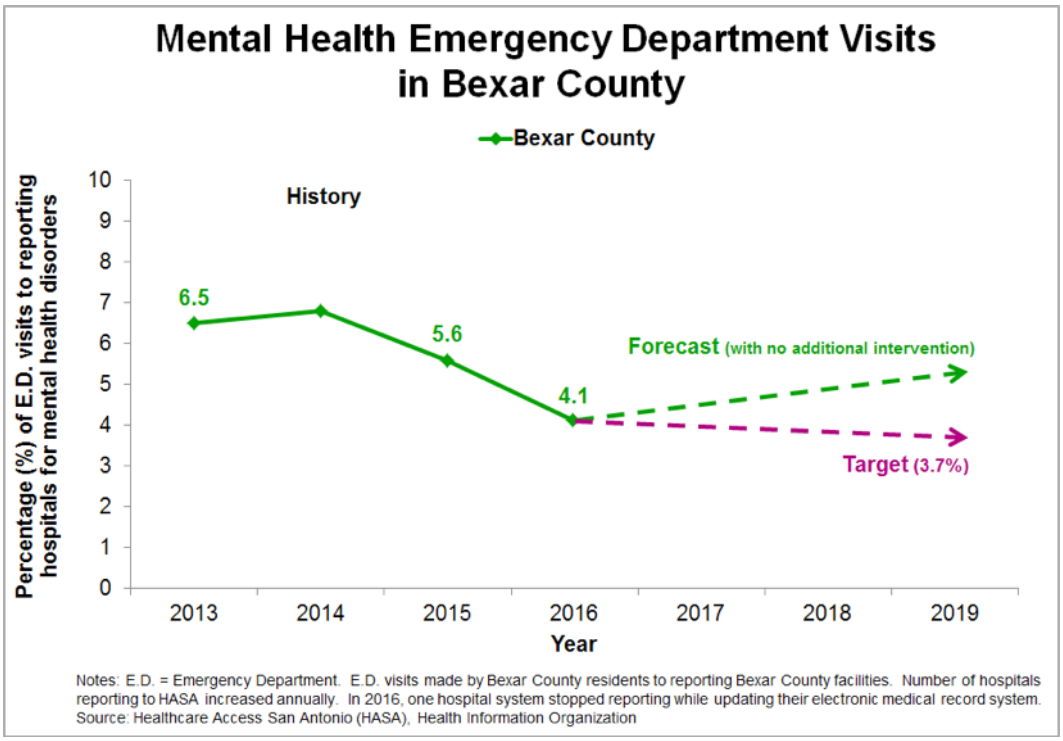
Behavioral health issues, consisting of mental health and substance-related disorders, are associated with family violence, chronic medical conditions, and premature death (Substance Abuse and Mental Health Services Administration, 2017; Surgeon General, 2017). Managing and treating behavioral health issues can lead to behavioral and mental well-being, which is essential for overall health. Behavioral and mental well-being can help individuals realize their full potential, cope with life stresses, work productively, and contribute significantly to their communities.

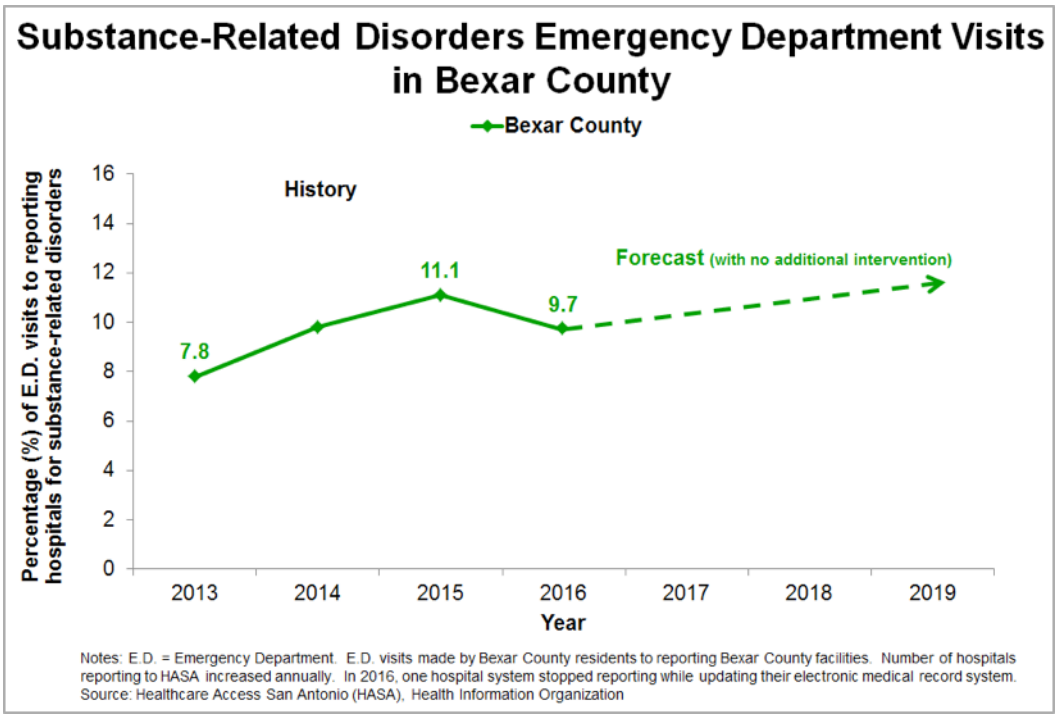
Results Statement

The Bexar County community is committed to hope and recovery through open conversations on emotional wellness, substance-related disorder and mental health, by providing integrated preventive care and clinical treatment that is community based and family and youth guided.

Headline Indicators

- Mental health emergency department visits
- Substance-related disorders emergency department visits


Mental Health Emergency Department Visits in Bexar County
Bexar County
History
Forecast (with no additional intervention)
Target (3.7%)
6.5
5.6
4.1
Percentage (%) of E.D. visits to reporting hospitals for mental health disorders
Year
2013
2014
2015
2016
2017
2018
2019
Notes: E.D. = Emergency Department. E.D. visits made by Bexar County residents to reporting Bexar County facilities. Number of hospitals reporting to HASA increased annually. In 2016, one hospital system stopped reporting while updating their electronic medical record system.
Source: Healthcare Access San Antonio (HASA), Health Information Organization


Substance-Related Disorders Emergency Department Visits in Bexar County
Bexar County
History
Forecast (with no additional intervention)
7.8
11.1
9.7
Percentage (%) of E.D. visits to reporting hospitals for substance-related disorders
Year
2013
2014
2015
2016
2017
2018
2019
Notes: E.D. = Emergency Department. E.D. visits made by Bexar County residents to reporting Bexar County facilities. Number of hospitals reporting to HASA increased annually. In 2016, one hospital system stopped reporting while updating their electronic medical record system.
Source: Healthcare Access San Antonio (HASA), Health Information Organization

Story Behind the Baseline

Carol and Ted were completely taken by surprise when they found the suicide notes left by their 14-year old son. At a loss about what to do, they took him to the emergency department (ED) where he was kept for 16 hours with no psychiatric support while waiting for a bed in a community psychiatric hospital. Finally, their child was transported to a local hospital where he was assessed and received initial care. This story illustrates what is happening in Bexar County: the surprising prevalence of behavioral health issues among youth and adults, the fact that too often the illness is not detected nor treated early enough because of stigma and/or the difficulty in finding mental health or substance-related disorder services, and the fact that these cases end up in ED settings which are often not equipped to treat them.

Prevalence of Behavioral Health Issues

According to the 2016 National Survey on Drug Use and Health, approximately 44.7 million American adults or 18.3 percent of the adult population aged 18 or older had a mental illness in the past year (Substance Abuse and Mental Health Services Administration, 2016). In 2010, rates among children were comparable with one in five children in the United States having a mental health disorder, which impairs how they function at home, school, or in the community (Office of Disease Prevention and Health Promotion, 2014). The 2016 survey also revealed that 20.1 million people or 7.5 percent of people aged 12 or older experienced a substance-related disorder in the past year, including an alcohol disorder and an illicit drug use disorder, such as opioid abuse (Substance Abuse and Mental Health Services Administration, 2016). This percentage represents approximately 4.3 percent of youths aged 12 to 17, 15.1 percent of young adults aged 18 to 25, and 6.6 percent of adults aged 26 or older (Substance Abuse and Mental Health Services Administration, 2016). Substance-related disorders often co-occur with mental illness. People with mental illness often self-medicate with substances such as alcohol and other drugs (Khantzian, 2013; Suh, Ruffins, Robins, Albanese, & Khantzian, 2008). It is also common that children or adults have more than one mental health disorder (Office of Disease Prevention and Health Promotion, 2014).

Texas data follow the national story, with 16.9 percent of all adults experiencing mental health challenges, and 8.0 percent of adults having substance-related disorders (Mental Health America, 2017).

In Bexar County, nearly 60,000 adults or 3.2 percent of adults in 2015 were suffering from a serious mental illness and 37,500 Bexar County children or 2.0 percent of children experienced serious emotional disturbance (The Meadows Mental Health Policy Institute, & Methodist Healthcare Ministries of South Texas, Inc., 2016).

The Use of Emergency Departments

An unintended consequence of the lack of mental health and substance-related disorder care in our community is the increase in emergency department (ED) visits by adults, children, and teens with behavioral health challenges. (Please note that Figures 7 and 8 do not show an annual increase in ED visits because of the addition of new hospitals reporting to the health information exchange. The data would show an increase in ED visits if no new hospital was added.) Individuals access the ED when the behavioral health issue is at a high level of acuity, indicating absent or insufficient previous care, and when all other solutions are unaffordable. Among Bexar County adults alone, 22,087 ED visits took place in 2015 for adults experiencing a mental health crisis or a substance-related disorder (The Meadows Mental Health Policy Institute, & Texas Conference of Urban Counties, 2015). A person presenting at the ED for behavioral health reasons may not receive the care he/she needs including emergency mental health assessments or follow-up outpatient mental health care (Clarity Child Guidance Center, 2013). In addition, accessing the ED to treat mental health and substance-related disorders is the most expensive and ineffective option for community residents. Some community solutions exist to divert frequent ED users, such as the San Antonio Fire Department Mobile Integrated Healthcare (City of San Antonio, 2017). However, greater efforts are needed to address the root causes of behavioral health ED visits.

Based on reported hospital data in 2016, 4.1% of all Bexar County ED visits were for mental health issues, while 9.7% of all ED visits were for substance-related disorders (Healthcare Access San Antonio, 2017). Both of these are expected to increase in Bexar County without additional intervention. By 2019, the partners that are working on mental health disorders are expecting the percentage of ED visits to decrease to 3.7 percent.

Three Prioritized Root Causes that Impact ED Visits

Three root causes that may help explain the surge in ED visits related to behavioral health were identified and prioritized:

1. There is a lack of service capacity to meet targeted mental health and substance-related disorder needs in Bexar County. There are severe psychiatric bed shortages in Texas (Torrey, Entsminger, Geller, Stanley, & Jaffe, 2008) and in Bexar County (Clarity Child Guidance Center, 2013), and the needs for inpatient mental health and substance-related disorder admissions are increasing (Health Care Cost Institute, 2012). Outpatient services are also lacking, where the wait time for an initial appointment with a psychiatrist is between 3 to 6 months (Clarity Child Guidance Center, 2013; Department of State Health Services, 2014).

2. Another root cause of ED use is limited education regarding mental health and substance-related disorders. Family members, school officials, clergy, businesses all need education about recognizing signs that someone needs help, where to go when resources are needed, and learning how to navigate the behavioral health care system. Providing such education can help decrease potential stigma such

as unwarranted assumptions, distrust, avoidance, pity, and gossip that people with mental illness often experience (Moses, 2010). Requiring mandatory screenings for mental health and substance-related disorders in schools may also help raise awareness and promote early detection, thus reducing ED visits.

3. A third root cause is a lack of coordinated care between primary care providers and behavioral health specialists in Bexar County. Providers may use different information technology systems, along with the Health Insurance Portability and Accountability Act, making the dissemination of patient information difficult across systems. In addition, cross-payer and cross-agency collaborations may be limited resulting in limited countywide policies, procedures, and metrics for children and adults with behavioral health issues.

COMMUNITY IDEA
to decrease ED visits for behavioral health:
"Triple the budget for services and outreach."
(zipcode 78238)

Prioritized Root Causes for the Community to Address

- Lack of behavioral (mental health and substance-related disorders) health service capacity
- Lack of overarching education about behavioral (mental health and substance-related disorders) health
- Lack of levels of care or coordinated behavioral (mental health and substance-related disorders) care

Key Strategies

1. Promote building blocks for a community wide system of care.

2. Create a community wide awareness and education plan.

3. Facilitate telemedicine for behavioral health in Bexar County, including mental health and substance-related disorders in primary care settings.

4. Increase interest in behavioral (mental health and substance-related disorders) health training and careers across professions.

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B. HEALTHY CHILD AND FAMILY DEVELOPMENT

Why is this important?

Positive early experiences are essential for a child to enjoy a long and healthy life. These experiences start before and during a mother's pregnancy, and continue through birth, infancy, childhood, and adolescence. Health promotion is crucial to ensure a child grows to be physically, cognitively, socially, and emotionally healthy (Hagan, Shaw, & Duncan, 2008). A child's development is also influenced by his/her family members' wellbeing and access to resources, including being able meet their basic needs and having access to services such as child care, education, and health care. Improving the well-being of mothers, infants, and children determines the health of the next generation (Office of Disease Prevention and Health Promotion, 2014).

Results Statement

Bexar County residents will be healthy and have timely access to and utilization of quality resources needed for lifelong success.

Headline Indicators

- Utilization of preventive primary care measured by:
  - Prenatal care accessed in the first trimester
  - Immunizations in early childhood (<36 months of age)

Associated Indicators

- Prenatal care accessed in the second trimester
- Prenatal care accessed in the third trimester
- Not accessing prenatal care

Figure 10. Prenatal Care Accessed in the First Trimester

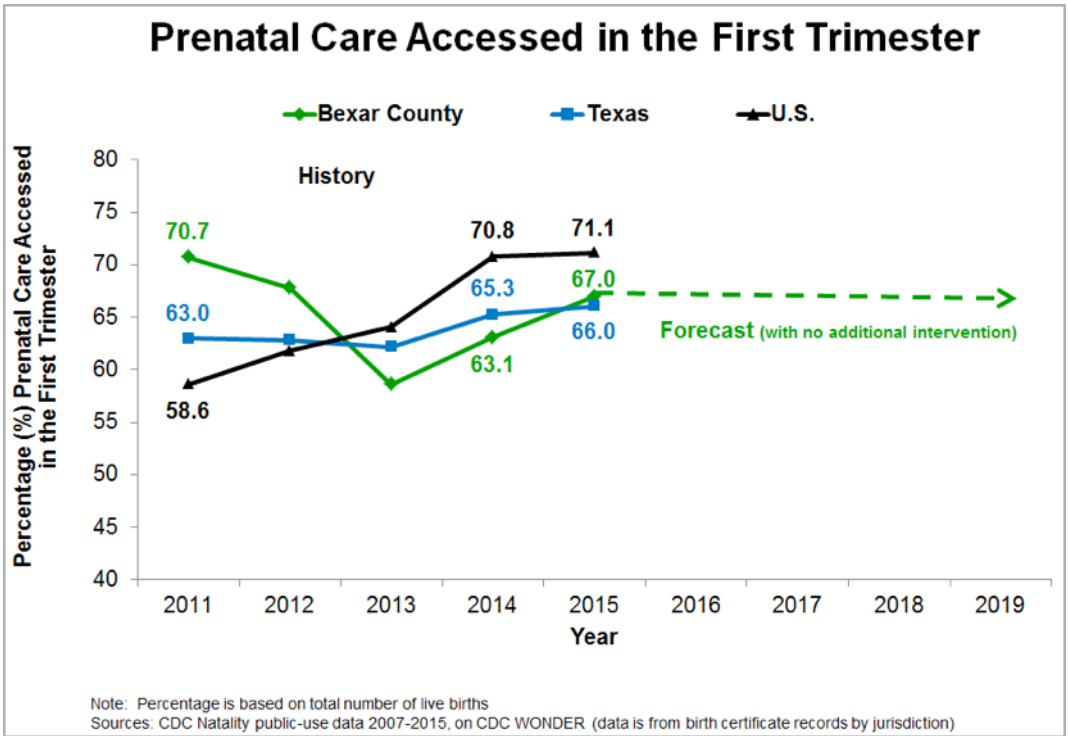
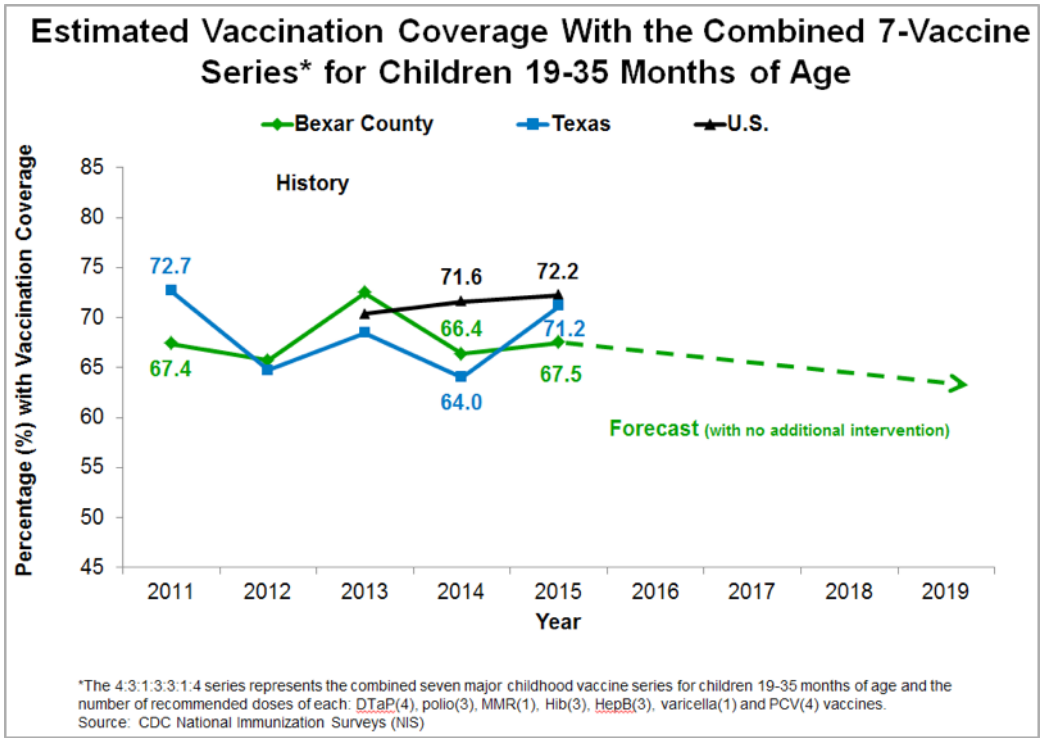


Figure 11. Immunizations in Early Childhood (<36 months of age)



Story Behind the Baseline

Access to preventive primary health care is essential for good health across the life course. It can help detect and prevent serious illnesses and keep individuals healthy, for example, through immunizations and contraception. Establishing a regular primary care provider ensures a continuity of care with a health professional who knows one's health history, habits, and goals. Despite these benefits, Americans use preventive services at about half the recommended rate (Centers for Disease Control and Prevention, 2013). Texas is featured among the bottom five states where preventative primary care is used (United Health Foundation, 2017).

Two ways to measure utilization of preventive primary care is through access to health care and immunizations (United Health Foundation, 2017). These types of preventive primary care were found to vary by income, race/ethnicity, and education. For example, Hispanics report using preventive services less than non-Hispanic whites and non-Hispanic African Americans (United Health Foundation, 2017). Individuals without health insurance access health care and preventive services less often than individuals with health insurance (Almeida, Dubay, & Ko, 20001; United Health Foundation, 2017). Among populations with health coverage, low-income populations face greater barriers to accessing primary care services because they may not be able to afford their premiums, deductibles and copayments associated with accessing care, compared to higher income populations. Other important barriers such as language, immigration status, low education, and limited health literacy affect the individual's ability to effectively navigate the health care system and communicate with providers; these may significantly reduce the likelihood that families will have regular check-ups and immunizations to stay healthy (Centers for Disease Control and Prevention, 2013; Escarce & Kapur, 2006).

When individuals do not have access to a primary care clinic for prevention (e.g., vaccines), acute care (e.g., for colds and flu), or urgent care (e.g., for wheezing or joint pain), they go to the emergency department (ED). However, EDs do not perform preventive measures, but, by definition, are established to address the "ABC's" (Airway, Breathing, Circulation). As the 1986 Emergency Medical Treatment and Labor Act (EMTALA) states that anybody coming to the ED will be stabilized and treated regardless of their insurance status or ability to pay (Centers for Medicare & Medicaid Services, 2012), ED personnel can only provide temporary care and instruct the individual to follow up with their primary care provider. When these individuals have no such relationship or clinic, they avoid going to the ED until their condition gets worse. The rate of ED visits for non-emergency care is therefore an indication of the population who do not utilize preventive primary care. Medicaid managed care organizations gather this type of information, however, this indicator will not be tracked at this time. The Healthy Child and Family Development workgroup will continue to look for the best way to measure and track ED visits for non-emergency care in the near future.

Preventive primary care also includes regular prenatal care visits for pregnant women to promote the health of the mother and the baby as well as treat and prevent potential health problems during pregnancy (U.S. National Library of Medicine, 2017). Women should schedule a prenatal care visit as soon as they know or suspect that they are

pregnant, ideally within the first trimester of pregnancy (U.S. Department of Health and Human Services, 2014). However, close to 40% of Texas women, primarily African American and Hispanic women, receive either late or no prenatal care at all (Texans Care for Children, 2016). No or inadequate prenatal care is more likely to lead to low birth weight babies and pregnancy-related complications (Sunil, Spears, Hook, Castillo, & Torres, 2010). In 2014, more than 1 in 5 pregnant adolescents in Bexar County received no prenatal care (San Antonio Metropolitan Health District, 2017). As of 2015 in Bexar County, 67.0 percent of all live births were from mothers who entered prenatal care in the first trimester, which indicates that one in three mothers did not access prenatal care during these crucial first three months of their pregnancy (U.S. Department of Health and Human Services, 2017). The national Healthy People 2020 goal is that at least 77.9 percent of pregnant women access first trimester prenatal care (Office of Disease Prevention and Health Promotion, 2014). Barriers reported by mothers include lacking information about prenatal care and health insurance such as Medicaid and Children's Health Insurance Program, having difficulty making appointments, not having enough time, transportation, childcare, and not knowing they are pregnant (San Antonio Metropolitan Health District, 2017).

Immunizations are also an important component of preventive primary care. Vaccines are safe and effective; they protect children, adolescents, and adults from infectious diseases and cancer. Universal immunization prevents disease outbreaks in a community and also protects individuals who cannot be vaccinated due to health reasons (Child Trends Databank, 2015). The majority of vaccines are required in the first three years of a child's life because many diseases are more common and deadly among infants and small children (Child Trends Databank, 2015). Seven key childhood vaccines are required between 19 and 35 months of age; the combined seven vaccine series is also known as the 4:3:1:3:3:1:4 series which represents the number of recommended doses for each vaccine: four doses of diphtheria-tetanus-acellular pertussis (DTaP), three doses of polio, one dose of measles-mumps-rubella (MMR), three doses of Haemophilus influenza type b (Hib), three doses of hepatitis B (HepB), one dose of varicella, and four doses of the pneumococcal conjugate vaccine (PCV). 2015 U.S. data revealed that, on average, 72.2 percent of children between 19 and 35 months of age receive the combined 4:3:1:3:3:1:4 series (Centers for Disease Control and Prevention, 2015).

In Texas, approximately 71.2 percent of young children receive the combined seven vaccine series; however, coverage in Bexar County is below state and national averages with only 67.5 percent of children covered in that age group (Centers for Disease Control and Prevention, 2015). Continuity of care is crucial for children to complete all their required doses, however may be challenging when parents have limited understanding of vaccines, or experience problems with insurance, transportation, or getting time off work to get their child vaccinated (Willis et al., 2016). The rate in Bexar County is expected to decline without additional intervention.

COMMUNITY IDEA
to increase utilization of preventive primary care in Bexar County:
"Concientizar que la salud de los niños depende de nosotros."
"Raise awareness that our children's health depends on us."(English translation)
(zip code 78250)

Prioritized Root Causes for the Community to Address

- Lack of access to health care, especially related to preventive primary care
- Lack of health literacy as it relates to education, culture, and language
- Lack of integration and continuity of services including community-based and clinical

Key Strategies

1. Identify, create more, and promote home visiting programs for pregnant and parenting individuals with children up to five years old with less restrictive eligibility criteria and increase linkages of individuals to these services.
2. Provide whole family immunizations at more venues.
3. Develop and promote Patient-Centered Medical Homes (PCMH) where patients are connected to community services and educated about these services by any of the following: community health workers, navigators, case managers, or office practice managers.
4. Develop and connect residents to geographically accessible healthy hubs (e.g., one per area) where families can access medical needs, basic needs, lactation education and support, utilities payments/assistance all at one place.

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C. HEALTHY EATING AND ACTIVE LIVING

Why is this important?

The two most important components to lead a healthy lifestyle include having a healthy diet and being physically active. Together, they can help individuals maintain a healthy weight and reduce their risks of having one or more chronic diseases such as heart disease and diabetes. Healthy eating and active living can therefore result in overall health (U.S. Department of Health & Human Services, 2017).

Results Statement

All Bexar County residents will flourish in a community that encourages healthy eating and active living.

Headline Indicators

- Obesity in adults
- Overweight in adults

Associated indicator

- Diabetes in adults

Figure 12. Obesity in Adults

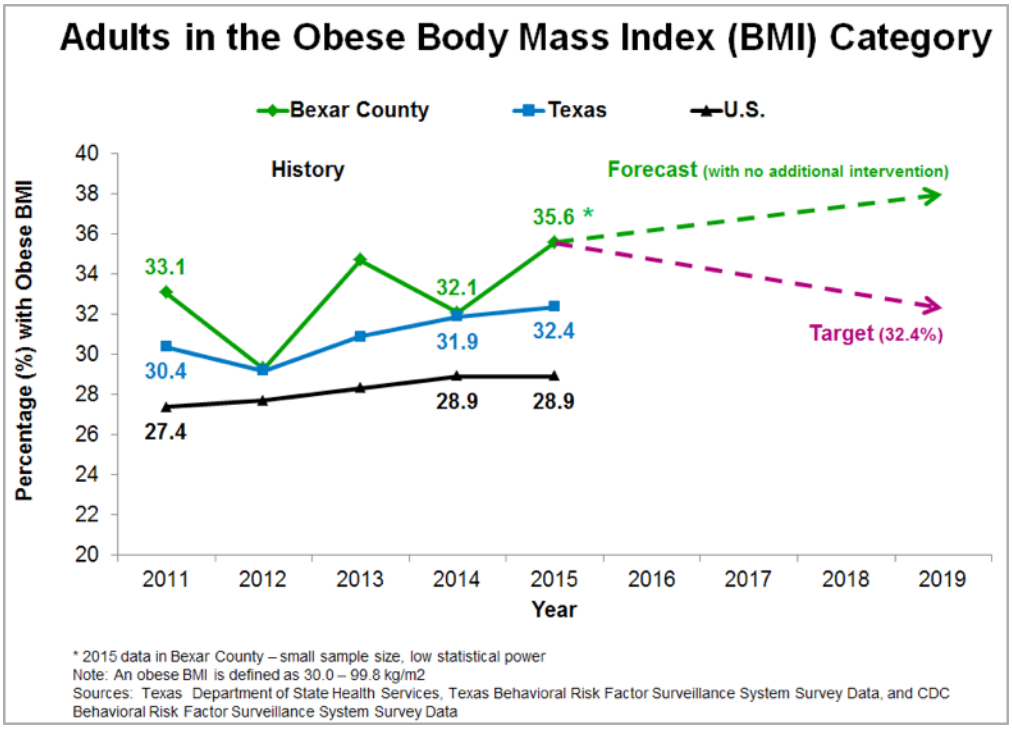
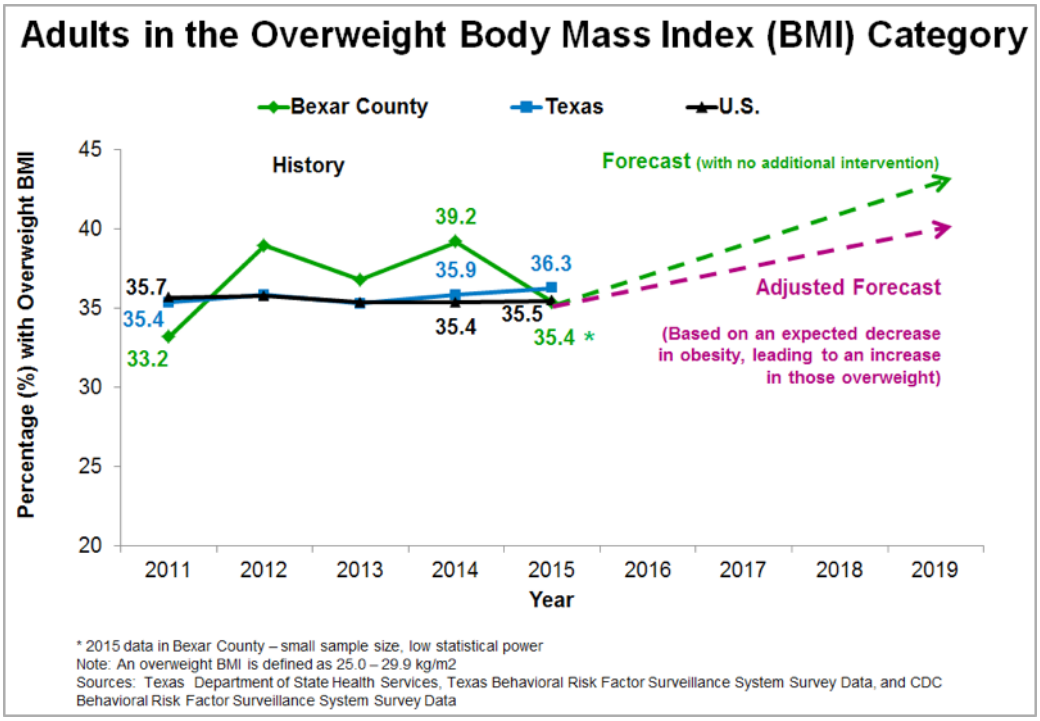


Figure 13. Overweight in Adults



Story Behind the Baseline

Obesity is one of the most serious health threats facing our nation. Adults are overweight when they have a body mass index (BMI) between 25 kg/m2 and 29.9 kg/m2, and are obese when their BMI is of 30 kg/m2 or greater (Office of the Surgeon General, 2001). According to the 2015 U.S. Behavioral Risk Factor Surveillance System Survey, 28.9% of American adults are obese and 35.5% are overweight (Centers for Disease Control and Prevention, 2015). The prevalence is higher among women than men, and racial and ethnic minority populations experience a greater burden of obesity compared to non-minority populations (Obesity Society, 2012). Obesity-related conditions such as heart disease and type 2 diabetes make up several of the leading causes of death in the U.S. (Centers for Disease Control and Prevention, 2017). Even a moderate weight excess such as an extra 10 to 20 pounds for a person of average height increases the risk of death (Calle, Thun, Petrelli, Rodriguez, & Heath, 1999). High rates of obesity are largely responsible for the rapidly rising healthcare costs in the nation (Centers for Disease Control and Prevention, 2017).

For the majority of individuals, obesity is caused by excessive caloric intake, a lack of availability and affordability of healthy foods, and an overwhelming deficiency in physical activity (Office of the Surgeon General, 2001). Regular physical activity can reduce the risk of obesity and chronic disease; even modest increases in activities such as walking and bicycling can help individuals lead longer, healthier lives (Public Health Law Center, 2017).

Texas ranks 8th in the nation for adult obesity (Trust for America's Health, & Robert Wood Johnson Foundation, 2017). Data from 2015 show that 32.4% of adults in Texas were obese, and 36.3% of adults were overweight (Texas Department of State Health Services, 2015; Trust for America's Health, & Robert Wood Johnson Foundation, 2017).

Bexar County is no exception to the alarming prevalence of obesity. In 2015, approximately 35.6 percent of Bexar County adults were obese and 35.4% of adults were overweight (Texas Department of State Health Services, 2015). It is important to note that the Bexar County survey sample size in 2015 was small and had a lower statistical power than in 2014. The rates of both obese and overweight adults in Bexar County are expected to increase without additional intervention. By 2019, the partners that are working to decrease the obesity rate expect to reach a target of 32.4% obese adults in Bexar County. As the rate of obese adults decreases, they expect the rate of overweight adults to increase by 2019.

Several factors impact engagement in healthy eating and active living. At the individual level, Bexar County residents may refrain from eating healthy foods or engaging in physical activity because of their socioeconomic status measured by income and education (McLaren, 2007). In fact, a clinical BMI analysis of 67,000 unique Bexar County patients by zip code showed an association between BMI, income, and zip code (Healthcare Access San Antonio, 2017). Particularly for women, having a low income means they may not have the necessary resources to afford fruits and vegetables and would rather choose inexpensive, unhealthy food instead (Population Reference Bureau, 2010). Greater educational attainment also appears to be a protective factor

for women, where women with college degrees are less likely to be obese compared to less educated women (Centers for Disease Control and Prevention, 2010). No such trend between obesity and education has been identified among men (Centers for Disease Control and Prevention, 2010).

Other factors affecting healthy eating and active living among individuals and their families may include specific mindsets toward food and physical activity norms, limited knowledge about the health benefits of these activities, and a lack of skills to cook and engaging in physical activity.

At a socio-ecological level (McLeroy, Bibeau, Steckler, & Glantz, 1988), individual choices and behaviors regarding healthy eating and active living are affected by the social and physical environments in which people live, including in the organizations where they function such as school and work, and in the broader community. A lack of safe places to be active (e.g., sidewalks, well-lit streets, or parks) can be important barriers for physical activity (Sallis, Floyd, Rodríguez, & Saelens, 2012). As a community, we must continue to create an environment that increases access to healthy foods and safe environments that promote physical activity.

COMMUNITY IDEA
to reduce the rates of obese and overweight adults in Bexar County:
"Host events to bring the community together outside to be active"
(zip code 78224)

Prioritized Root Causes for the Community to Address

- Lack of knowledge and skills of healthy eating and physical activity
- Lack of safe places to be active within communities
- Lack of financial security and affordability
- Mindset of food and physical activity norms

Key Strategies

1. Improve infrastructure to reduce barriers to physical activity and healthy eating.
2. Promote a culture of healthy eating and active living at worksites, faith-based communities, schools, and neighborhoods.
3. Develop a coordinated system of screening for food insecurity.
4. Build relationships with businesses to invest and leverage resources for the health of the community (Health Impact Investing model).

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D. SAFE COMMUNITIES

Why is this important?

Individuals and families have the right to grow and age in a healthy and secure environment, free of violence, abuse, and crime. Feeling secure in one's social and physical environment can lead to ongoing participation in work, leisure and educational opportunities, and ultimately a positive state of well-being and high quality of life (Safe Communities Foundation, 2015).

Results Statement

Bexar County will be recognized as one of the safest places to live, work, play, and thrive for all.

Headline Indicators

- Crime rates as measured by:
- Violent crime
- Family violence crime
- Child abuse and neglect crime
- Traffic fatalities

Associated Indicators

- Homicide age-adjusted death
- Non-natural crude death

Figure 14. Violent Crime

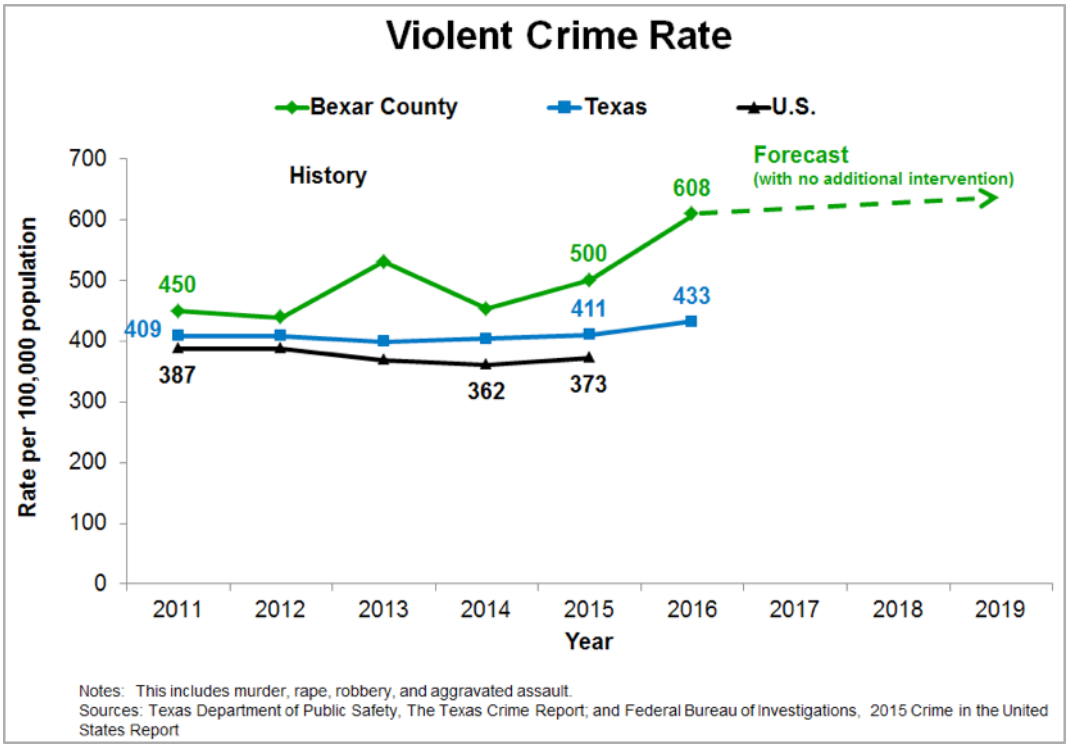


Figure 15. Family Violence Crime

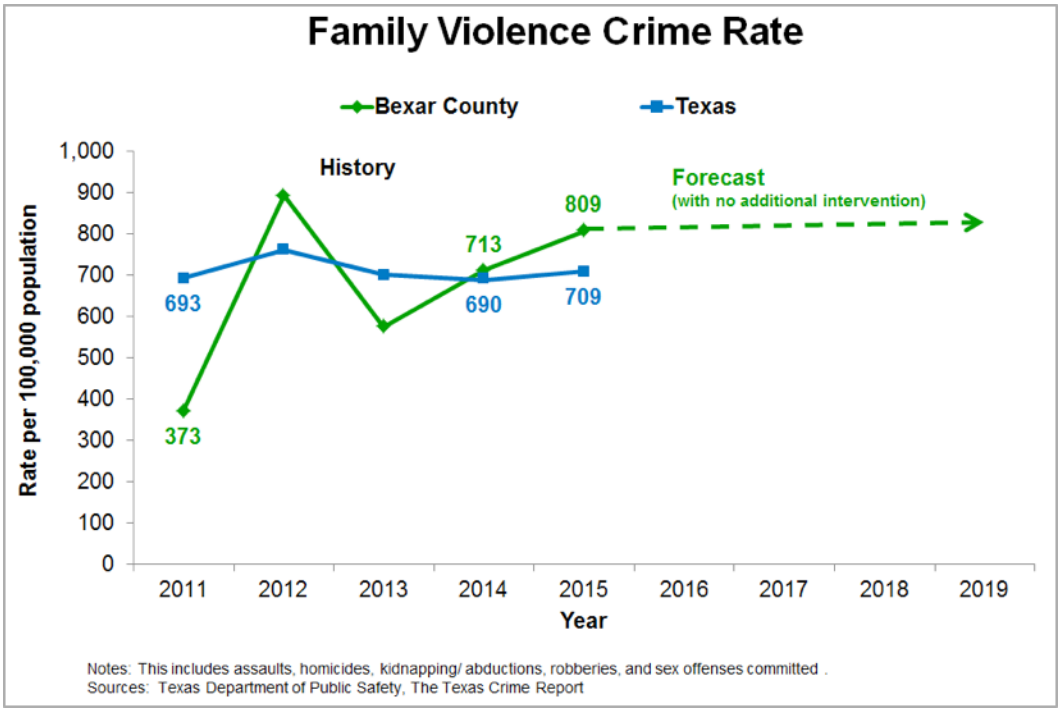


Figure 16. Child Abuse and Neglect

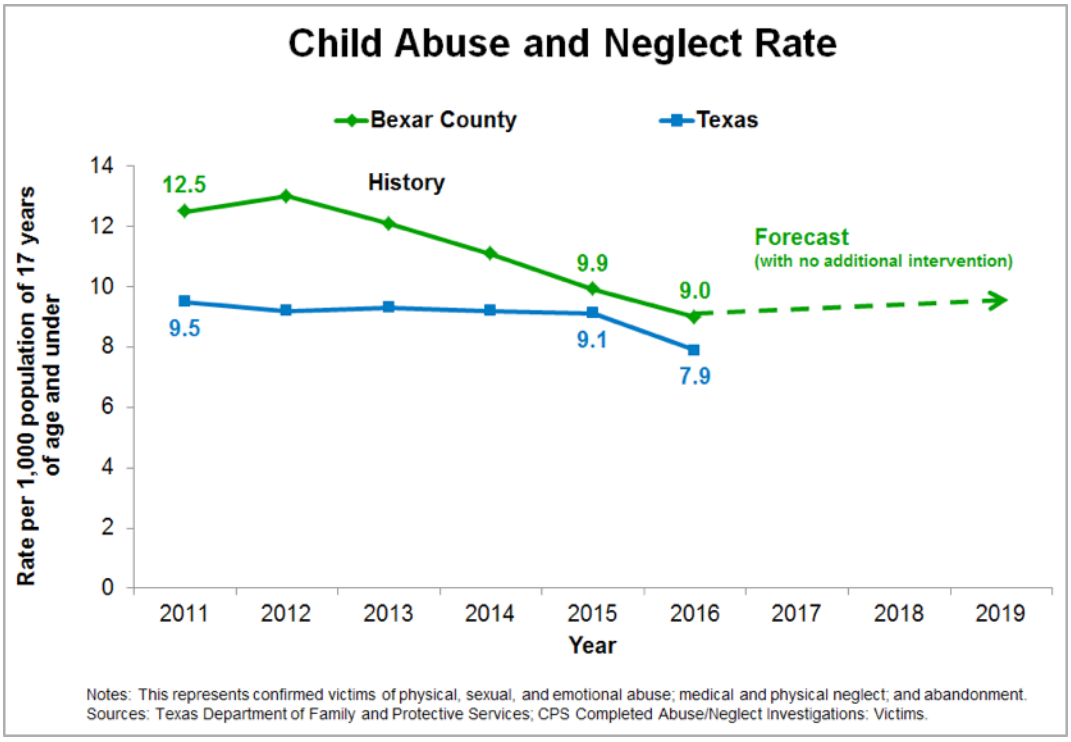
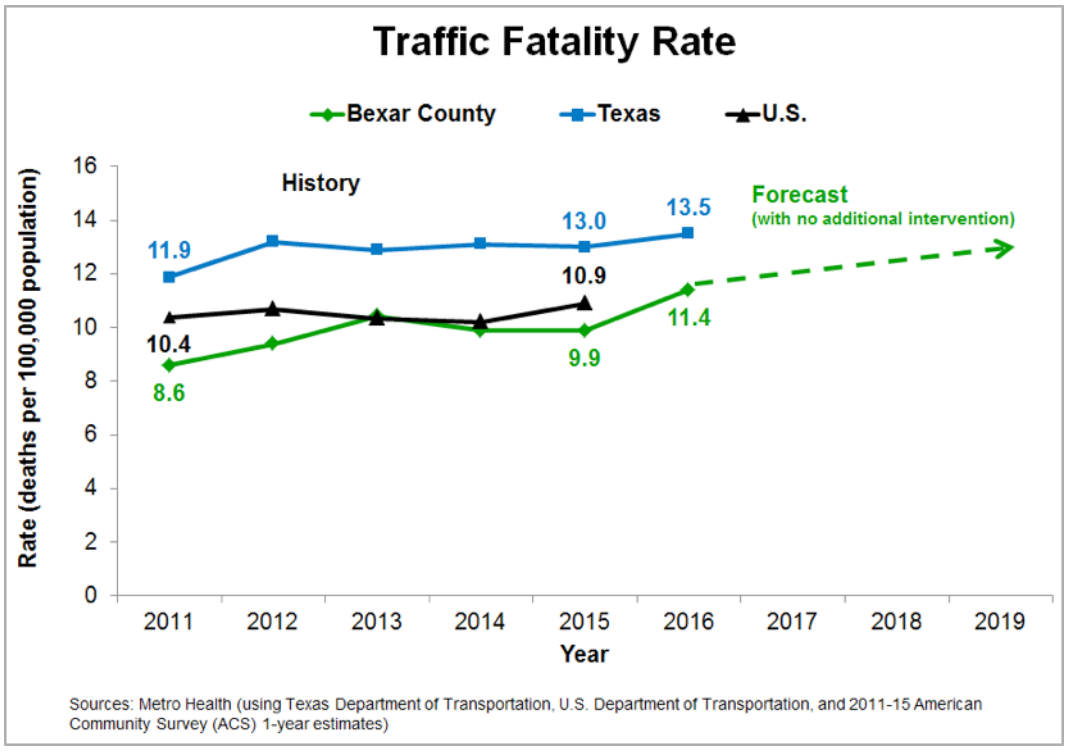


Figure 17. Traffic Fatalities



Story Behind the Baseline

Poverty, defined as a lack of economic resources, can have negative social consequences (Mood & Jonsson, 2016). Poverty may limit access to higher education or employment opportunities (Barr, 2008). Individuals and families living in poverty may experience generational stress and trauma, which can negatively impact their physical and mental health. They may engage in risky behaviors such as substance abuse or risky driving, such as driving over the speed limit. They may feel socially discriminated against or excluded, and may even engage in violence and crime (Duncan & Magnuson, 2011; Macartney, Bishaw, & Footenot, 2013; Oesterle et al., 2004). As families living in poverty have less access to resources to successfully adapt to their circumstances, trauma and violence are often perpetuated over time including through adverse childhood experiences, and intimate partner violence. Evidence suggests that the higher the poverty and unemployment rates, the higher the crime activity in the community (Hooghe, Vanhoutte, Hardyns, & Bircan, 2010). A safe community can therefore be measured by specific crime rates and traffic fatalities.

Crimes

Three specific types of crimes are of interest: violent crimes, family violence crimes, and child abuse and neglect crimes. Violent crimes are crimes where a perpetrator uses force or threat of force upon a victim and commits murder, rape, robbery, or aggravated assault (U.S. Department of Justice, 2012). Family violence crimes are incidents between family or household members (i.e., spouses, parents, children, or any other individuals above the age of 18 related by blood or marriage) that cause physical injury, such as assaults, homicides, kidnapping and abductions, sex offenses, and robbery (Connecticut General Assembly, 2009). Child abuse and neglect crimes are any act or failure to act on the part of a parent or caretaker, which results in death, serious physical, sexual, and emotional abuse, medical and physical neglect, and abandonment of a person 17 years of age or under (U.S. Department of Health & Human Services, 2016).

Across the United States, in 2015, there were 372.6 violent crimes per 100,000 population (Federal Bureau of Investigation, 2015), representing a total of close to 1.2 million violent crimes in one year. In 2016 in Texas, the same crime rate was 432.8 per 100,000 population (Texas Department of Public Safety, 2016). In 2016 Bexar County, the rate was 608 crimes per 100,000 population (Texas Department of Public Safety, 2016); this is 1.4 times higher than the 2016 Texas rate and 1.6 times higher than the 2015 US rate. The Bexar County rate is expected to slightly increase without additional intervention.

National data on family violence crimes and child abuse and neglect crimes are not common, with the last report on family violence crimes from the U.S. Department of Justice published in 2005. At that time, children were included in the rate and there were 2.1 victims per 1,000 U.S. residents age 12 or older (U.S. Department of Justice, 2005). Today, minors are considered under the child abuse and neglect crimes. In 2012 in the U.S., the rate was 9.2 per 1,000 children were victims of child abuse and neglect crimes (Centers for Disease Control and Prevention, 2014). Among those, 1,640 children died from child maltreatment at a rate of 2.2 per 100,000 children (Centers for Disease Control and Prevention, 2014). Despite these numbers, a large percentage of crimes are

not reported to authorities in the hopes of protecting the perpetrator or the victim (U.S. Department of Justice, 2005).

The Texas family violence rate in 2015 was 709 crimes per 100,000 population (Texas Department of Public Safety, 2015). In 2015 in Bexar County, the rate was 809 per 100,000 population (Texas Department of Public Safety, 2015), 14% higher than the Texas rate. The Bexar County rate is expected to slightly increase without additional intervention.

In 2016 in Texas, the child abuse and neglect crimes rate was 7.9 crimes for every 1,000 children (Texas Department of Family and Protective Services, 2016). In Bexar County in 2016, this rate was 9.0 per 1,000 children (Texas Department of Family and Protective Services, 2016); this is 14% higher than Texas. The Bexar County rate is expected to slightly increase without additional intervention.

Traffic Fatalities

Along with crimes, risky driving leading to traffic fatalities also makes our communities unsafe. Risky driving is defined as drunk, drugged, distracted, or drowsy driving, speeding, and not wearing seat belts (National Highway Traffic Safety Administration, 2017). Traffic fatalities can be caused by several factors, including risky driving, road design, and other external factors. Traffic fatalities are defined as deaths from crashes on public roads where at least one vehicle with an engine was involved, and at least one person died within 30 days as a result of the crash (National Highway Traffic Safety Administration, 2015). This could include, a pedestrian being hit by a bus, a motorcyclist losing control of his vehicle and colliding into a tree, or a crash between two vehicles.

In the United States, a total of 35,092 people died in motor vehicle crashes in 2015, representing 10.9 deaths per 100,000 population (National Highway Traffic Safety Administration, 2015; San Antonio Metropolitan Health District, 2017). In 2016 in Texas, the rate of traffic fatalities was 13.5 per 100,000 population, which is slightly higher than the 2015 national average (Texas Department of Transportation, 2016; San Antonio Metropolitan Health District, 2017). Comparatively, in Bexar County in 2016, the rate of traffic fatalities was 11.4 deaths per 100,000 population (San Antonio Metropolitan Health District, 2017; (Texas Department of Transportation, 2016), which is 18% lower than the 2016 Texas rate and 5% higher than the 2015 U.S. rate. The Bexar County rate increased by 33% from 2011 to 2016. The Bexar County rate is expected to increase without additional intervention.

Concerns in Bexar County

Considering that poverty is one of the core components that shapes and determines a community's safety, and that crime and traffic fatalities can both represent community safety and be a symptom of poverty, we will aim to make Bexar County safer by addressing both poverty and its symptoms. It is by resolving issues related to poverty and other systematic root causes that we may begin to alleviate problems of violence.

As a historically and socially stratified county by race/ethnicity and class, focus must be on increasing access to political and social resources in low-income neighborhoods,

as well as investing in public infrastructure and places with community character that enhance safety and livability. For example, investments in road design including sidewalks, lighting, and safe streets for pedestrians and bicyclists could help decrease motor vehicle accidents at intersections (Morency, Gauvin, Plante, Fournier, & Morency, 2012). Simultaneously, building and revitalizing social capital and a sense of belonging among community members while working for the greater good could help increase a perceived order and sense of security, which could decrease crimes and fear of crimes (Scarborough, Like-Haislip, Novak, Lucas, & Alarid, 2010).

COMMUNITY IDEA
to reduce crime and increase social capital in the community:
"Strengthen the family unit, single parent outreaches, and positive mentorship"
(zip code 78232)

Prioritized Root Causes for the Community to Address

- Lack of, or insufficient, educational and economic opportunities
- Lack of quality infrastructure and places with community character that enhance safety and livability and moves beyond providing only minimum safety standards
- History of trauma (e.g., intergenerational, adverse childhood events, from violence)

Key Strategies

1. Increase opportunities and education that address systemic root causes of violence and intergenerational poverty.
2. Increase and improve infrastructure and places in the areas with the most need.
3. Provide intervention programs that break the cycle of trauma and promote trauma-informed care.

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E. SEXUAL HEALTH

Why is this important?

Sexual health can lead to a state of physical, emotional, mental and social well-being in relation to sexuality. Preventing unintended consequences such as unwanted pregnancies and sexually transmitted diseases, as well as seeking sexual health information, education, treatment, and care can promote sexual health and healthy relationships (American Sexual Health Association, 2017).

Results Statement

The Bexar County community will be sexually healthy without abuse, disease, or stigma.

Headline Indicators

- Incidence of sexually transmitted diseases as measured by:
- HIV
- Chlamydia
- Gonorrhea
- Syphilis

Associated Indicators

- Teen births
- HPV vaccinations in teens

FIGURE 18. HIV

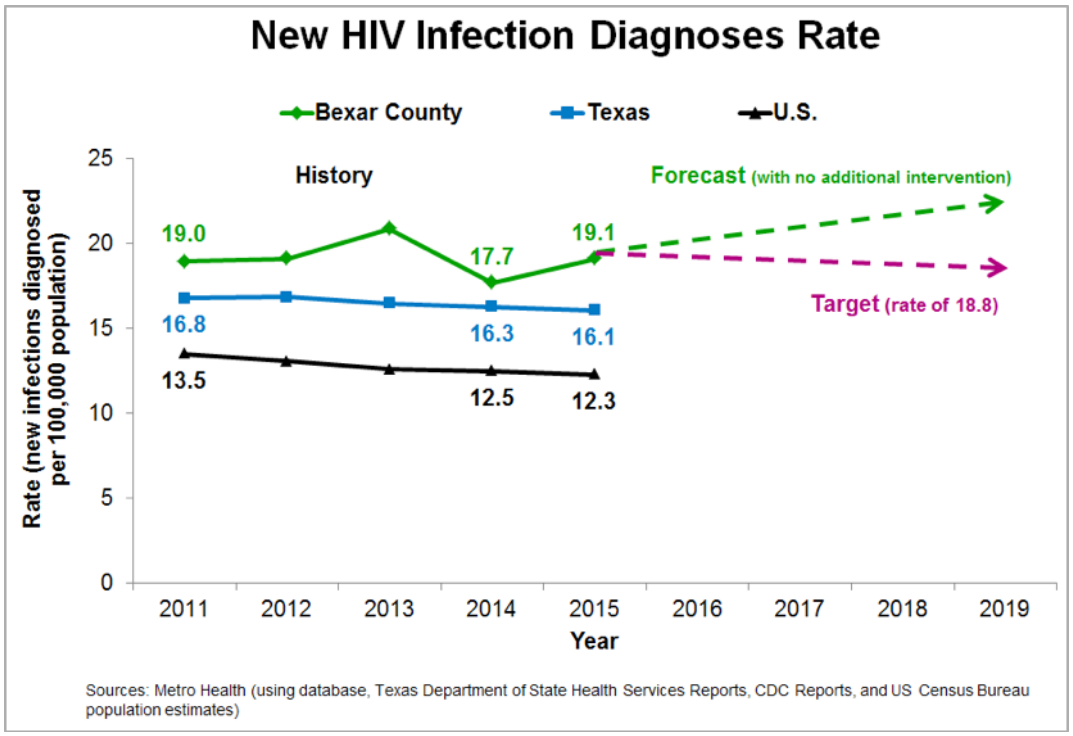


FIGURE 19. CHLAMYDIA

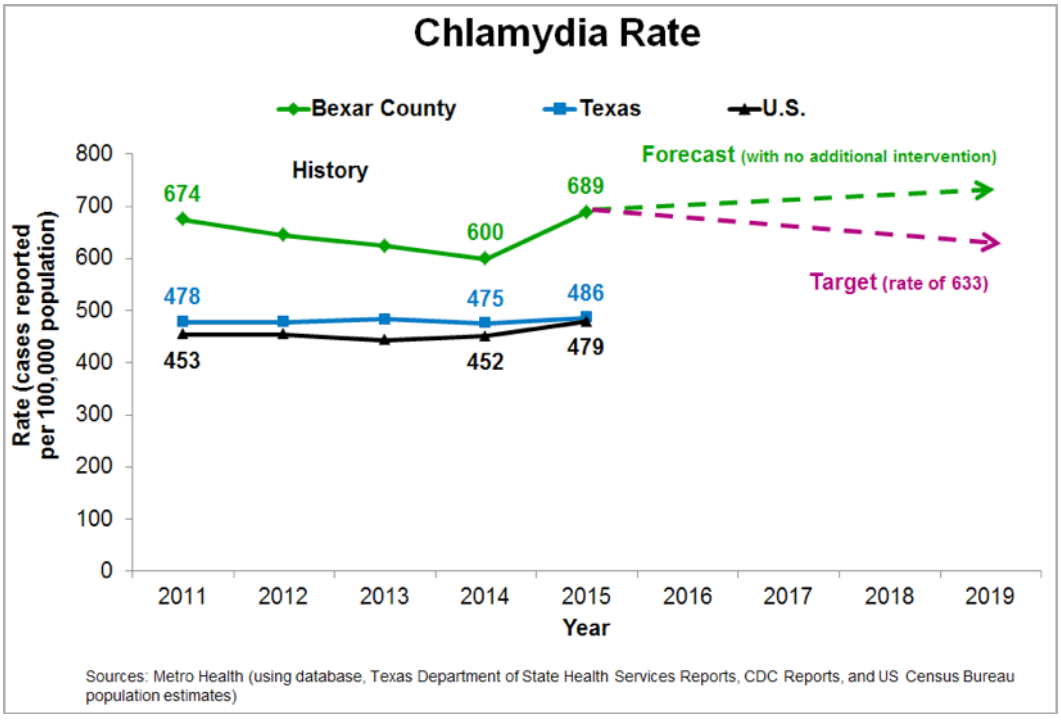


Figure 20. Gonorrhea

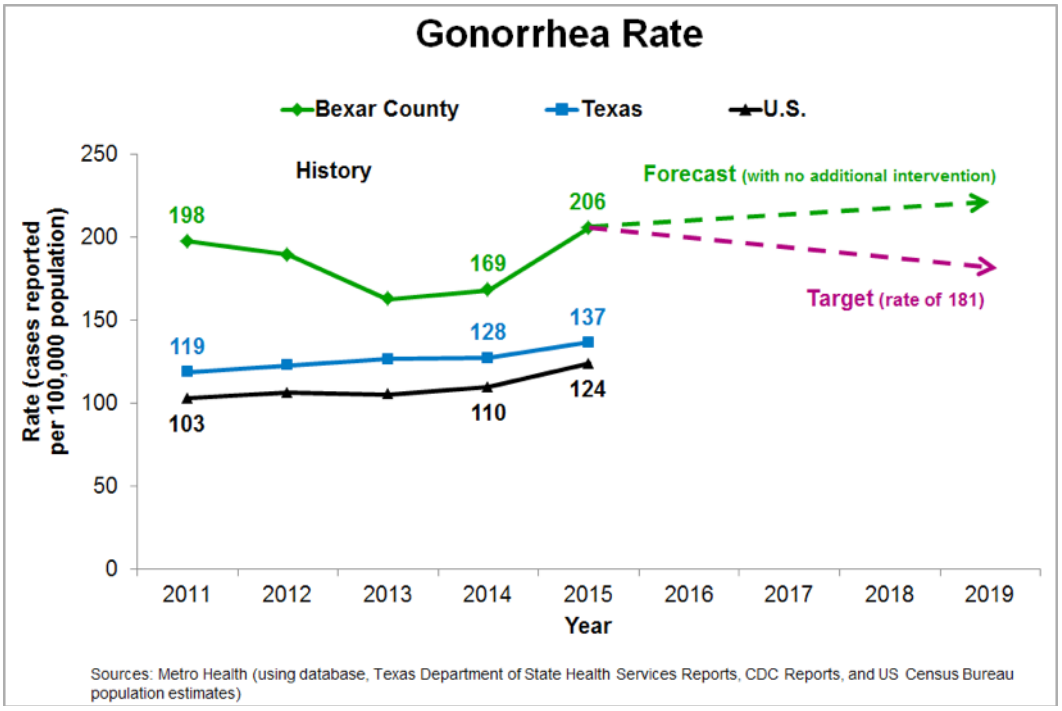
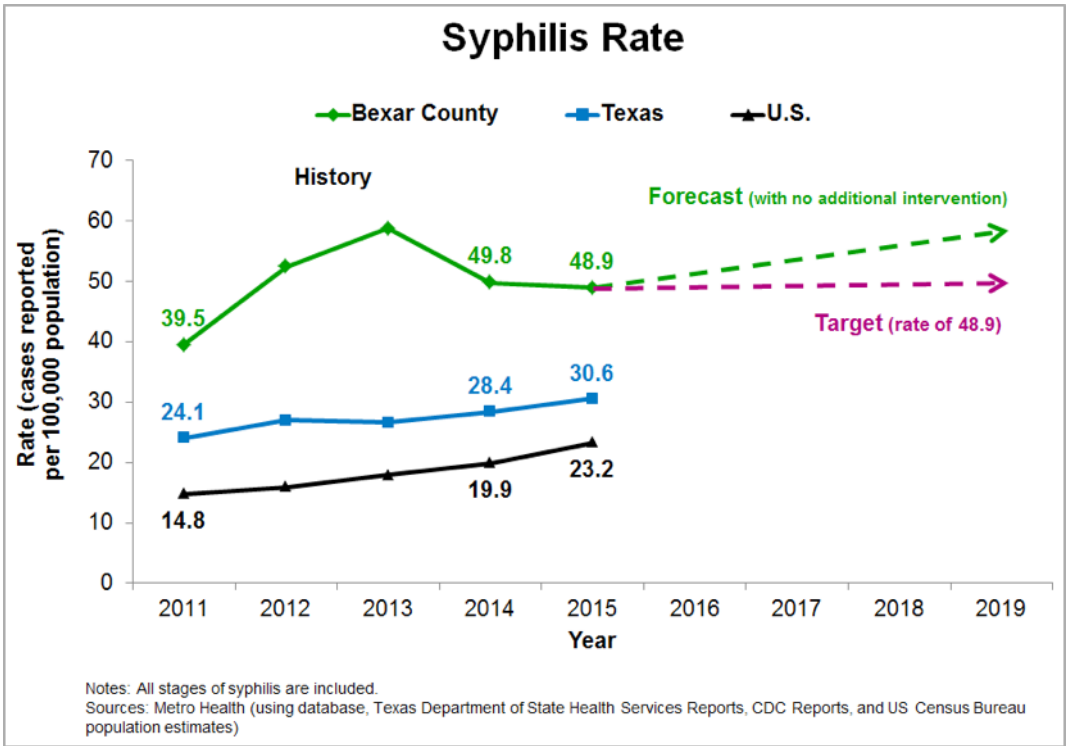


Figure 21. Syphilis



Story Behind the Baseline

Sexually transmitted diseases (STD) are infections spread from person to person through sexual contact such as vaginal, oral, or anal sex (Office on Women's Health, 2017). The most common STDs are chlamydia, gonorrhea, hepatitis B virus, herpes simplex virus type 2, human immunodeficiency virus (HIV), human papillomavirus (HPV), syphilis, and trichomoniasis (Centers for Disease Control and Prevention, 2013). In the United States, close to 20 million new STDs occur every year, with half of new cases being among people age 15 to 24 years old (Centers for Disease Control and Prevention, 2016a). Each infection can have immediate and long-term effects on the health and well-being of the person infected, including causing infertility and chronic pain (Centers for Disease Control and Prevention, 2016a). It is also common for individuals to get more than one concurrent STD (Choudhry, Ramachandran, Das, Bhattacharya, & Mogha, 2010). Having an STD can also make it easier to acquire another STD, such as HIV (Centers for Disease Control and Prevention, 2017a).

Rates of STDs are increasing at an alarming rate. Approximately 1.2 million people in the United States are living with HIV (Centers for Disease Control and Prevention, 2016b). There were 39,393 new HIV infections diagnosed in 2015, representing 12.3 per 100,000 population (Centers for Disease Control and Prevention, 2016c). Gay, bisexual, and other men who have sex with men experience the greatest burden of this disease (Centers for Disease Control and Prevention, 2016b). In Texas, an estimated 4,476 adults and adolescents were diagnosed with HIV in 2015, ranking Texas as the state with the 3rd highest incidence of new HIV diagnoses in the country (Centers for Disease Control and Prevention, 2016c). This incidence represents 16.1 diagnoses per 100,000 population (Texas Department of States and Human Services, 2017). In Bexar County, there were 19.1 new HIV infections diagnosed per 100,000 population in 2015 (San Antonio Metropolitan Health District, 2017); Bexar County's 2015 rate is 1.6 times the U.S. rate and 1.2 times the Texas rate. The rate in Bexar County is expected to increase without additional intervention. By 2019, the partners that are working together to decrease this rate expect it to fall to 18.8 per 100,000 population.

In terms of other STDs, nearly 1.6 million cases of chlamydia were reported across the United States in 2016 alone (Centers for Disease Control and Prevention, 2017b). This represented 497.3 cases per 100,000 individuals, or a 4.7 percent increase since 2015 (Centers for Disease Control and Prevention, 2017b). In 2015 in Texas, there were 486 cases of chlamydia per 100,000 population (Texas Health and Human Services, 2016). Yet in Bexar County there were 689 cases of chlamydia per 100,000 population (San Antonio Metropolitan Health District, 2017), which is 1.4 times both the national and Texas rates. The rate in Bexar County is expected to slightly increase without additional intervention. By 2019, the partners that are working to decrease this rate expect it to fall to 633 per 100,000 population.

Cases of gonorrhea increased by 19.6% from 2015 to 2016 for a rate of 135.6 per 100,000 individuals (Centers for Disease Control and Prevention, 2017c). In 2015 in Texas, there were 137 cases per 100,000 population (Texas Health and Human Services, 2016). In Bexar County there were 206 cases per 100,000 population (San Antonio Metropolitan Health District, 2017), 1.7 times the national rate and 1.5 times the Texas rate. The rate in Bexar County is expected to slightly increase without additional

intervention. By 2019, the partners that are working to decrease this rate expect it to fall to 181 per 100,000 population.

Total syphilis cases reported in the U.S. also increased by 17% from 2014 to 2015 to a rate of 23.2 cases per 100,000 population (Centers for Disease Control and Prevention, 2016a). In 2015 in Texas, there were 30.6 cases per 100,000 people (Texas Health and Human Services, 2016). In Bexar County there were 48.9 cases per 100,000 population (San Antonio Metropolitan Health District, 2017), which represents 2.1 times the national rate and 1.6 times the Texas rate. The rate in Bexar County is expected to increase without additional intervention. By 2019, the partners that are working to decrease this rate expect it to fall to 48.9 per 100,000 population.

A large number of factors have been shown to influence the rates of STDs in our community. At the individual level, lack of education and prevention can lead to risky sexual behaviors, multiple sex partners, and unprotected sex (Centers for Disease Control and Prevention, 2016a; Institute of Medicine Committee on Prevention and Control of Sexually Transmitted Diseases, 1997). Social and cultural factors play an important role in STD prevalence such as the presence of social stigma around STDs as well as difficulty accessing health care and other community resources (Centers for Disease Control and Prevention, 2016b; Institute of Medicine Committee on Prevention and Control of Sexually Transmitted Diseases, 1997). In fact, cases go undiagnosed because individuals are uninsured or cannot afford copayments and deductibles (Institute of Medicine Committee on Prevention and Control of Sexually Transmitted Diseases, 1997) or because some STD have no symptoms or the symptoms resolve on their own, so individuals do not seek treatment (Centers for Disease Control and Prevention, 2016c).

Several community partners have led significant work in the past five years to address STDs in our community. Interventions have included expanded testing for the public, increased condom distribution, case management for pregnant women, and mobile clinics to reach areas in San Antonio that have high incidence of disease. Policies such as the October 2015 mandatory screenings for syphilis among pregnant women during the third trimester have also had an influence. Community partners continue to work together on outreach events to educate and raise awareness. Although a large amount of work has been done in this area, Bexar County rates remain above Texas and U.S. rates for all four headline indicators, suggesting that interventions to address the root causes of these STDs are needed. In other words, more collaboration is needed to help educate about prevention, elevate awareness of community resources, as well as address barriers such as stigma and access to health care.

COMMUNITY IDEA
to reduce sexually transmitted diseases:
"Education is the best medium."
(zip code 78220)

Prioritized Root Causes for the Community to Address

- Culture and presence of stigma in the community
- Lack of preventive care and education
- Lack of access to health care and resources

Key Strategies

1. Increase education (to include stigma and abuse) with improved collaboration and coordination within Bexar County.
2. Increase access to condoms.
3. Increase STD prevention, testing, and treatment, including identification of those who test but do not provide treatment.

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Behavioral and Mental Well-Being

Alanah	Lavinier	Outreach Director	.Cohen Military Family Clinic at Family Endeavors, Inc
Bill	Hubbard	Executive Director	(South Alamo Regional Alliance for the Homeless (SARAH
Brandon	Vaidyanathan	Director of Research	The H.E. Butt Family Foundation
Busola	Babalola	Community Health Intern	Martinez Street Women's Center
Cindy	Urshan	Clinical Liaison	UT Health San Antonio
Dianne	Lavin	Assistant Professor, Psych-NP Concentration Leader	University of the Incarnate Word (UIW) - School of Nursing
Fuji	Walker	Mental Health Community Educator	The Health Collaborative
George	Perez	Strategic National Stockpile Coordinator	City of San Antonio Metropolitan Health District - Emergency Preparedness
Gerard	Migeon	Director of Marketing	Clarity Child Guidance Center
Gilbert	Gonzales	Director	Bexar County - Bexar County Department of Behavioral and Mental Health
Gloria	Miranda	Program Manager	.WellMed Medical Management Inc
Gyna	Juarez	Prevention Resource Center (PRC 8) Director	(SA Council On Alcohol & Drug Abuse (SACADA
Ingrid	Petty	Manager of Initiatives and Partnerships	Kronkosky Charitable Foundation
James	Bossmann	Intern	UT Health - School of Medicine
Jeannie	VonStultz	Deputy Chief	Bexar County - Juvenile Probation
Jeffrey	Dulin	Chief Child and Family Behavioral Health Service	Brooke Army Medical Center

Judy	Johnson	Retired Nurse	San Antonio Grandparents Raising Grandchildren Coalition
Junda	Woo	Medical Director	City of San Antonio Metropolitan Health District
Kat	Cole	Director	.Cohen Military Family Clinic at Family Endeavors, Inc
Lakisha	Flagg	Chief Public Health Nurse	Brooke Army Medical Center
Larry	Parsons	Director	(University Health System (UHS
Lillian	Ringsdorf	Region 8 Medical Director	Texas DSHS Region 8
Linda	Costley	Grants Manager	City of San Antonio Metropolitan Health District - Operations
Liza	Jensen	Consultant	Consultant
Loi	Taylor	Director of Family Initiatives	United Way of San Antonio & Bexar County
Marnie	Staehly	Consultant	Humana
Melinda	Fierros	Medical Director	.Cohen Military Family Clinic at Family Endeavors, Inc
Mercedes	Bristol	Community Advocate	San Antonio Grandparents Raising Grandchildren Coalition
Meredith	Henkel-Green	Clinical Liaison	UT Health San Antonio
Michele	Brown	Director of Development	Clarity Child Guidance Center
Patrick	Kaminski	Assistant Vice President	UT Health Office of Strategic Planning and Business Development
Queta	Rodriguez	Veteran's Service Officer	Bexar County - Veteran's Service Office
Rebecca	Helterbrand	Division Director	Southwest Texas Regional Advisory Council (STRAC), South Texas Crisis Collaborative
Ruth	Morgan	Medical Doctor	Center for Health Care Services - Primary Care
Sabrina	Colon	Business Development Manager	Laurel Ridge Treatment Center
Sally	Taylor	Chief of Behavioral Medicine, Senior Vice President	(University Health System (UHS
Sandra	Preininger	Outreach Coordinator	The Ecumenical Center for Education, Counseling, and Health
Selina	Catala	Program Planning & Development Manager	.Center for Health Care Services - Bexar C.A.R.E.S
Shirley	Schreiber	Director of Health Services	Northside Independent School District
Teresa	Stewart	Evaluator	(SA Council On Alcohol & Drug Abuse (SACADA
Terri	Mabrito	Child Welfare Initiatives Director	VOICES for Children, Alamo Area Teen Suicide Prevention Coalition

Velma	Muniz	LPC-S-Program Coordinator	Bexar County - Mental Health Department
Vickie	Adams	Coalition Director	(SA Council On Alcohol & Drug Abuse (SACADA
Vince	Fonseca	Board of Directors, Public Health	Bexar County Medical Society
Yvonne	Herrera-Rendon	Health Program Specialist	City of San Antonio Metropolitan Health District - Project Worth

Healthy Child and Family Development

Alina	Garza	Intern	The Immunization Partnership
Amanda	Murray	Healthy Start Coalition Coordinator	City of San Antonio Metropolitan Health District - Healthy Start
Ana	Acevedo	Education Policy Administrator	City of San Antonio - Economic Development Dept. - Education Policy
Ana Maria	Garza Cortez	Vice President of Development and Marketing	CentroMed
Angela	Montez	Nurse Supervisor	The Children's Shelter
Barbara	Stoks	Director, Student Health	San Antonio Independent School District
Caroline	Bergeron	Program Manager / Evaluator	The Health Collaborative
Cindy	McComber	WIC Manager	Children's Hospital of San Antonio - WIC
Coda	Rayo-Garza	Director, Community Partner	P16Plus Council of Greater Bexar County
Delia	Martinez	Community Advocates	San Antonio Grandparents Raising Grandchildren Coalition
George	Patrin	Chief Executive Officer, Healthcare Consultant	Serendipity Alliance
Guadalupe	Cornejo	Community Health Worker (Promotoras) Instructor	Northwest Vista College
Heather	Mendizabal	Intern	The Immunization Partnership
Herlinda	Ibarra	Eligibility Manager	CentroMed
Higinia	Paszkowski	Maternal Child Health Director	March of Dimes
(Jacquelyn (Jackie	Darby-Dabney	Program Planner	CentroMed
Jennifer	Bankler (Meyer- (er- Bankler	Dental Clinic Director	City of San Antonio Metropolitan Health District - Oral Health
Jodie	Hostetter	Program Lead	City of San Antonio Metropolitan Health District - Oral Health

John	Ramos	Community Outreach and Public Relations	(Blue Cross Blue Shield of Texas (BCBSTX
Katie	Cunningham	Management Analyst Health, Dental and Nutrition	City of San Antonio - Dept. Human Services - Head Start
Kori	Eberle	Program Manager	City of San Antonio Metropolitan Health District - Healthy Start
Larissa	Wilkinson	Director of Program Innovation	City of San Antonio - Pre-K 4 SA
Laura	Hernandez	Program Coordinator	City of San Antonio Metropolitan Health District - Oral Health
Lauren	Geraghty	Director Strategic Impact Initiatives	Communities in Schools
Lissette	Rubio	Community Health Worker	City of San Antonio Metropolitan Health District - Healthy Neighborhoods
Lucia	Bustamante	Program Manager	(University Health System (UHS
Margaret Peggy	Humm	Asst. Professor	UT Health San Antonio- School of Nursing
Maria	Perez	Director of Health Services	North East Independent School District & Immunizations Collaborative
.Maria H	Martinez	Special Activities Coordinator	City of San Antonio Metropolitan Health District - WIC
Mary Helen	Lopez	Assistant Chief of CSCD	Bexar County - Community Supervision and Corrections Department ((CSCD
Nayely	Briones	Intern	The Health Collaborative
Nicole	Reed	Intern	City of San Antonio Metropolitan Health District - Healthy Start
Norma	Gonzalez	Community Health Program Coordinator	Martinez Street Women's Center
Pamela	Williams	Management Analyst	City of San Antonio Metropolitan Health District - Immunizations
Rachelle	Corcoran	Intern	The Health Collaborative
Shirley	Schreiber	Director of Health Services	Northside Independent School District
Sofia	Castillo	CAC Manager	CentroMed
Teresa	Hines	Program Manager	City of San Antonio Metropolitan Health District - Oral Health
Theresa	Kostelnik	Manager	Texas DSHS Region 8 - Family & Community Health Program
Thomas	Schlenker	Medical Director	Interlex & The Health Collaborative Board & Steering Committee
Tracy	Gamez	Outreach Nurse	City of San Antonio Metropolitan Health District - Immunizations

Healthy Eating and Active Living

Amanda	Merck	Research Area Specialist	Salud America
Amanda	Monsivais	Intern	YMCA of Greater San Antonio
Andrea	Tan	Health Program Specialist	City of San Antonio Metropolitan Health District - Mayor's Fitness Council
Bert	Pickell	Director	SA Walks & Mayor's Fitness Council
Beth	Keel	Sustainability	San Antonio Housing Authority
Brittany	Langevin	Program Supervisor	The Health Collaborative
Bryan	Bayles	Curator of Anthropology & Health	Witte Museum
Caroline	Blanco	Director	American Diabetes Association
Edward	Dick	Sr. Vice President of Integrated Health Services	Methodist Healthcare Ministries of South Texas, Inc. & The Health Collaborative Board & THC Data Committee
Eliani	Uc	Clinical Registered Dietician	Methodist Healthcare System
Ellen	Spitsen	Sr. Management Coordinator	City of San Antonio Metropolitan Health District - Diabetes
Erich	Froese	Intern	City of San Antonio Metropolitan Health District - Chronic Disease
Ericka	Ramirez	Intern	City of San Antonio Metropolitan Health District - Chronic Disease
Haley	Amick	Sr. Management Analyst	City of San Antonio Metropolitan Health District - Chronic Disease
Hannah	Santiago	Strategic Planner	VIA Metropolitan Transit
Herlinda	Ibarra	Eligibility Manager	CentroMed
Jennifer	Quackenbush	Sr. Management Analyst	City of San Antonio Metropolitan Health District - Diabetes
John	Jordan	Consultant	Humana
John	Ramos	Community Outreach & Public Relations	(Blue Cross Blue Shield of Texas (BCBSTX
Jonathan	Malagon	Community Member	Community
Julie	LaBarba	Medical Director	Christus Santa Rosa - CHEF
Katherine	Velasquez	Program Manager	Texas DSHS Region 8
Kathleen	Shields	Manager	City of San Antonio Metropolitan Health District - Chronic Disease
Kimberly	Peacock	Sr. Research Scientist	UT Health San Antonio
Kristen	Hall	Wellness Coordinator	CentroMed

Kristine	Gusman	Y Living Center Director	YMCA of Greater San Antonio & The Health Collaborative Board
Luz Myriam	Neira	Director of Nutrition, Health & Wellness	San Antonio Food Bank
Lynette	De Vaughn-Baker	Management Analyst	City of San Antonio Metropolitan Health District - Healthy Neighborhoods
Mandy	Tyler	Education Specialist	Education Service Center Region 20
Marcus	Primm	Senior Management Analyst	City of San Antonio Metropolitan Health District - Healthy Neighborhoods
Mark	Clark	Associate Professor of Medical Humanities	University of the Incarnate Word (UIW) - School of Osteopathic Medicine
Marnie	Staehly	Consultant	Humana
Meizi	He	Professor	University of Texas at San Antonio - Building a Healthy Temple
Mela	Perez	Sr. Community Health Director	American Heart Association
Nora	Silva	Sr. Director, Health Equity	American Heart Association
Norma Lucia	Sifuentes	Manager	City of San Antonio Metropolitan Health District - WIC
Priti	Mody-Bailey	Chief Medical Officer	Community First Health Plans & The Health Collaborative Board
Rebeca CF	Baquero	Project Manager	City of San Antonio Metropolitan Health District - Mayor's Fitness Council
Robert	Ferrer	Director of Community Engagement, CTSA, Professor and Vice Chair for Research UTHSCSA & THC Board Chair	UTHSCSA - Dept. of Family and Community Medicine & The Health Collaborative (THC) Board & Steering Committee
Rosemarie	Ramos	Assistant Professor, Emergency Medicine	UT Health San Antonio School of Medicine
Rudy	Nino	Assistant Director	City of San Antonio - Dept. of Planning & Community Development
Sarah	Mohmedali	Director of Multicultural Initiatives	American Heart Association
Veronica	Mendez	Management Analyst	City of San Antonio - Dept. of Planning & Community Development
Veronica	Ramirez	Health Program Specialist	American Heart Association

Safe Communities

Allison	Blazosky	Bicycle/Pedestrian Transportation Planner	(Alamo Area Metropolitan Planning Organization (MPO
Andrea	Guajardo	Director, Community Health	CHRISTUS Santa Rosa Health System & The Health Collaborative Board & THC Data Committee
Andrew	Carian	Retired	Retired San Antonio Police Department Special Crimes Unit
Annie	Erickson	Director	(Alamo Area Council of Governments (AACOG
Beth	Davenport	Director & Board Member	Baptist Health System - Community Health Screening & The Health Collaborative Board
Cherise	Rohr-Allegrini	San Antonio Program Director	The Immunization Partnership
Christina	Hernandez	Workforce Development Coordinator	City of San Antonio Metropolitan Health District - Performance Improvement
Claryssa	Cortez	Quality Improvement Coordinator	City of San Antonio Metropolitan Health District - Performance Improvement
Danielle	Housley	Healthy Start Project Facilitator	Northside Independent School District
Dawn	Bridwell	Director	Baptist Health System - Pregnancy Centers
Derek	Taylor	Program Manager	City of San Antonio Metropolitan Health District - StandUpSA
Elizabeth	Lutz	Executive Director	The Health Collaborative & Steering Committee
Eloisa	Portillo-Morales	Sustainability Planning & Community Engagement Manager	City of San Antonio - Office of Sustainability
Enomie	Rosenthal	Wesley Nurse	.Methodist Healthcare Ministries of South Texas, Inc
Greg	Reininger	Transportation Planner	City of San Antonio - TCI
Hannah	Santiago	Strategic Planner	VIA Metropolitan Transit
Heather	Mendizabal	Intern	The Immunization Partnership
Jana	Punelli	Planner	City of San Antonio - Dept. of Planning & Community Development
Janett	Munoz	Community Health Intern	Martinez Street Women's Center
Jennifer	Krueger	Health Services Supervisor	Northside Independent School District
Jennifer	Northway	Director	University Health System (UHS) - Injury Prevention

Judit	Vega	Manager	City of San Antonio Metropolitan Health District - Health Equity
Julie	Stuckey	Director of Health Services	Our Lady of the Lake University & The Health Collaborative Board
Kathy	Fletcher	President & Chief Executive Officer	Voices for Children of San Antonio
Kyle	Cunningham	Air Quality Program Manager	City of San Antonio Metropolitan Health District - Air Quality
Maria	Cesar	Communications & Community Outreach	City of San Antonio - District 8 Council Member - Ron Nirenberg
.Maria H	Martinez	Special Activities Coordinator	City of San Antonio Metropolitan Health District - WIC
Mary Kate	Martin	Research Coordinator	UT Health - School of Public Health
Melissa	Portugal	Program Analyst	Bexar County - Adult Probation
Michelle	Lugalia-Hollon	Director	San Antonio Area Foundation
Pilar	Oates	THC Board Vice-Chair	The Health Collaborative Board & Steering Committee
Rebecca	Pacini	Principal Transportation Planner	City of San Antonio - TCI - Vision Zero
Richard	Milk	Director of Policy & Planning	San Antonio Housing Authority
Sheila	Dismuke-Williams	Equity Specialist	Texas HHSC Region 8
Steve	Blanchard	Professor of Sociology President of the Faculty Assembly & Steering Committee Chair	Our Lady of the Lake University & The Health Collaborative
Theresa	Medina	Manager	City of San Antonio Metropolitan Health District - Performance Improvement
Tracie	Brown	Accreditation Specialist	City of San Antonio Metropolitan Health District - Performance Improvement
Vicente	Escobedo	Community Health Worker	City of San Antonio Metropolitan Health District - Healthy Neighborhoods

Sexual Health

Andrea	Figueroa	Executive Director	Martinez Street Women's Center
Andrea	Johnson	Founder	.Girl U Can Do It Inc

.Anil T	Mangla	Associate Professor, Director of Public Health and Research	University of the Incarnate Word School of Osteopathic Medicine, The Health Collaborative Board & Steering Committee
Ariel	Bazaldua	Sr. Management Analyst	City of San Antonio Metropolitan Health District - Performance Improvement
Bethany	Evans	Program Manager	Healthy Futures of Texas
Brionte	Greene	Intern	The Health Collaborative
Catherine	Johnson	HIV Planning Council Liaison	Ryan White Program
Cherise	Rohr-Allegrini	San Antonio Program Director	The Immunization Partnership
Crystal	Garza	Sr. Management Coordinator	City of San Antonio Metropolitan Health District - STD/HIV Program
Cynthia	Nelson	Chief Executive Officer	San Antonio AIDS Foundation
Diana	Gonzales	Executive Director	University Health System (UHS) - Women's Health Services
Diane Hunt	Bullard	Assistant Director	North East Independent School District
Elisha	Best	Psychometrist	University Health System (UHS) - Detention Health Care Services (DHCS) - Juvenile
Gabriella	Martinez	Draw The Line Specialist	San Antonio Independent School District
(Jacquelyn (Jackie	Darby-Dabney	Program Planner	CentroMed
Janett	Munoz	Community Health Intern	Martinez Street Women's Center
Jennifer	Todd	Project Manager	UT Health San Antonio - UT Teen Health
Jennifer	Tristan	Director of Education & Training	Rape Crisis Center
Laura	Farley	Assistant Director	University Health System (UHS) - Community Initiatives
Lea	Rosenauer	President & Chief Executive Officer	Girls Inc. of San Antonio
Lucia	Bustamante	Program Manager	(University Health System (UHS
Mario	Martinez	Program Manager	City of San Antonio Metropolitan Health District - Project Worth & Steering Committee
Natalie	Lopez	Program Director	The Children's Shelter
Nicole	Dierschke	Senior Project Coordinator	UTHSCSA - UT Teen Health
Rachael	Woodard	Intern	City of San Antonio Metropolitan Health District - Chronic Disease
Rachel	Naylor	Director, Physical Education / Health	North East Independent School District

Rhoda	Leos	Management Analyst	City of San Antonio Metropolitan Health District - Project Worth
Rhonda	Andrew	HIV Planner	Ryan White Program
Rita	Espinoza	Chief of Epidemiology	City of San Antonio Metropolitan Health District - Epidemiology & The Health Collaborative Board & Steering Committee
Roger	Rodriguez	Sr. Coordinator Health / Physical Education	San Antonio Independent School District
Roxanne	Hickman	Epidemiologist	City of San Antonio Metropolitan Health District - STD/HIV Program
Sara	Oswalt	Associate Professor	University of Texas at San Antonio
Shanice	Peacock	Intern	The Health Collaborative
Sian	Hill-Elmore	Program Manager	City of San Antonio Metropolitan Health District - STD/HIV Program
Taylor	Dickerson	Intern	The Health Collaborative
Thankam	Sunil	Director	University of Texas San Antonio - Institute for Health Disparities Research
Vanessa	Cordoba-Vega	Public Education Coordinator	Alamo Area Rape Crisis Center
Vanessa	Lopez	Program Supervisor	The Health Collaborative & Steering Committee
(William (Bill	Sandburg	Clinical Coordinator	UT Health San Antonio- UT Teen Health
Yolanda	Valdez	Clinic Supervisor	University Health System (UHS) - Detention Health Care Services (DHCS) - Juvenile

Overall

Cara	Hausler	Sr. Analyst & School Liaison	City of San Antonio Metropolitan Health District - Community Health & THC Data Committee
Carol	Huber	Director, Regional Healthcare Partnership (RHP) 6	University Health System & THC Data Committee
Carole	Harris	Community Relations	Methodist Healthcare System & The Health Collaborative Board
Chris	Ryerson	Planning Administrator	City of San Antonio - Dept. of Planning & Community Development
Colleen	Bridger	Director	City of San Antonio Metropolitan Health District
Dwayne	Robinson	Director for Constituent Services for Bexar County & Ordained Deacon	Bexar County & Antioch Baptist Church

Edna	Perez-Vega	Director of TX Initiatives	(Blue Cross Blue Shield of Texas (BCBSTX
Jennifer	Herriott	Assistant Director of Health, Community Health	City of San Antonio Metropolitan Health District & The Health Collaborative Board & THC Data Committee
Kimberly	Collins	Senior Planner-Strategic Planning and Urban Design	SA Tomorrow
Phoebe	Smith	Intern	City of San Antonio Metropolitan Health District - Community Health
Trevi	Mancilla	Student	UTHSCSA - Student & THC Data Committee

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- SA Youth
- The University of the Incarnate Word
- Maestro Entrepreneur Center

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Steve Blanchard, Ph.D., Our Lady of the Lake University and Health Collaborative Board Member and Steering Committee Chairman

Robert L. Ferrer, M.D., MPH, Chairman of the Board, Health Collaborative

Pilar Oates, MA, Vice Chair, Health Collaborative

Edward Dick. M.D., MPH, Methodist Healthcare Ministries of South Texas Inc.

Rita Espinoza, MPH, San Antonio Metropolitan Health District

Cara Hausler, MPH, San Antonio Metropolitan Health District
Jennifer Herriott, MPH, San Antonio Metropolitan Health District

Carol Huber, MBA, Regional Health Partnership Region 6, University Health System

Laura McKieran, Dr.PH, CI:Now

Andrea Guajardo, MPH, CHRISTUS Santa Rosa

Anil T. Mangla, B.Sc., MS., PhD., MPH., FRSPH, University of the Incarnate Word School of Osteopathic Medicine

Mario Martinez, MBA, San Antonio Metropolitan Health District
Thomas L. Schlenker, M.D., MPH, Interlex Communications

Julie Stuckey, DNP, APNP-C, Our Lady of the Lake University

Gijs Van Oort, Ph.D., Health Access San Antonio

Melissa Valerio, Ph.D., MPH, UTHealth School of Public Health San Antonio Regional Campus

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APPENDIX A: CHIP OVERVIEW AND ALIGNMENTS

Healthy Bexar 2017 Plan

October 2017 - September 2020 (FY2018-2020)

Priority Area (alphabetical)	Headline Indicators for Bexar County	Strategies
Behavioral & Mental Well-Being	1. Mental health emergency department visits 2. Substance-related disorders emergency department visits	1. Promote building blocks for a community wide system of care. 2. Create a community wide awareness and education plan. 3. Facilitate telemedicine for behavioral health in Bexar County, including mental health and substance-related disorders in primary care settings. 4. Increase interest in behavioral (mental health and substance-related disorders) health training and careers across professions.
Healthy Child & Family Development	Utilization of preventive primary care providers as measured by: 1. Prenatal care accessed in the first trimester 2. Immunizations in early childhood (<36 months of age)	1. Identify, create more of, and promote home visiting programs for pregnant and parenting individuals with children up to five years old with less restrictive eligibility criteria and increase linkages of individuals to these services. 2. Provide whole family immunizations at more venues. 3. Develop and promote Patient-Centered Medical Homes (PCMH) where patients are connected to community services and educated about these services by any of the following: community health workers, navigators, case managers, or office practice managers. 4. Develop and connect residents to geographically accessible healthy hubs (e.g., one per area) where families can access medical needs, basic needs, lactation education and support, utilities payments/assistance all at one place.
Healthy Eating & Active Living	1. Obesity in adults 2. Overweight in adults	1. Improve infrastructure to reduce barriers to physical activity and healthy eating. 2. Promote a culture of healthy eating and active living at worksites, faith-based communities, schools, and neighborhoods. 3. Develop a coordinated system of screening for food insecurity. 4. Build relationships with businesses to invest and leverage resources for the health of the community (Health Impact Investing model).
Safe Communities	1. Traffic fatalities and Crime as measured by: 2. Violent crimes 3. Family violence crimes 4. Child abuse and neglect	1. Increase opportunities and education that address systemic root causes of violence and intergenerational poverty. 2. Increase and improve infrastructure and places in the areas with the most need. 3. Provide intervention programs that break the cycle of trauma and promote trauma-informed care.
Sexual Health	Incidence of sexually transmitted diseases as measured by: 1. HIV 2. Chlamydia 3. Gonorrhea 4. Syphilis	1. Increase education (to include stigma and abuse) with improved collaboration and coordination within Bexar County. 2. Increase access to condoms. 3. Increase STD prevention, testing, and treatment, including identification of those who test but do not provide treatment.

Healthy Bexar 2017 Plan

Alignment of Headline Indicators with Other Local and National Plans

Priority Area (alphabetical)	Headline Indicators for Bexar County		2014 Bexar County Community Health Improvement Plan (CHIP)	2014 COSA Community Survey	2016 Bexar County Community Health Needs Assessment (CHNA)	2017-2019 COSA Metro Health Strategic Plan	RHP 6 DSRIP	SA2020	SA Tomorrow Comprehensive Plan	SA Tomorrow Sustainability Plan	2012 Austin-Travis County CHIP	2013 City of Houston CHIP	2013 El Paso County CHNA with CHIP	CDC Winnable Battle	Healthy People 2020
Behavioral & Mental Well-Being	---	Mental Health Emergency Department Visits	✓		*		✓		✓			*	*		✓
		Substance-Related Disorders Emergency Department Visits	*	✓	*		✓		*			*	*		✓
Healthy Child and Family Development	Utilization of preventive primary care providers as measured by:	Prenatal Care Accessed in the First Trimester	✓		✓	✓	✓					✓	*		✓
		Early childhood immunizations (<36 months)	✓		✓	✓	✓		✓			✓			✓
Healthy Eating & Active Living	---	Obesity in adults	✓	✓	✓	✓	*	✓	✓	✓	✓		✓	✓	✓
		Overweight in adults	*	*	✓	*	*	*	*	*	*		*	*	*
Safe Communities	---	Traffic fatalities	*		*								*	✓	✓
	and Crime as measured by:	Violent crimes	✓	✓	✓			*				✓			✓
		Family violence crimes	✓	✓	✓			✓	*						✓
		Child abuse & neglect	✓		✓			✓	*			✓			✓
Sexual Health	Incidence of sexually transmitted infections as measured by:	HIV	✓		✓		✓				✓	✓	*	✓	✓
		Chlamydia	✓		✓		✓						✓		✓
		Gonorrhea	✓		✓		✓						*		✓
		Syphilis	✓		✓	✓	✓						*		✓

* Issue is not mentioned specifically by this title/topic. Language/wording is broad or in general terms regarding health issue.

COSA = City of San Antonio RHP 6 DSRIP = Regional Healthcare Partnerships (RHP), Region 6, Delivery System Reform Incentive Payment (DSRIP)

APPENDIX B: GLOSSARY

TERM	DEFINITION
Action	An activity or task. A stepping stone that helps to implement strategies.
Associated Indicator	A measure that is related to the headline indicator.
Community Health Improvement Plan	A long-term, systematic effort to address public health problems on the basis of results of the Community Health Needs Assessment and the community health improvement process. The plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.
Community Health Needs Assessment	A local health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.
Evidence-Based Public Health Practice	The development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems and appropriate use of behavioral science theory and program planning models.
Forecast	An estimate of future trends assuming the current level of effort or intervention.
Headline Indicator	The most important measures that rise to the top in the RBA rating process.
Health Disparity	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.
Health Equity	The attainment of the highest level of health for all people.
Indicator	A measure that helps to quantify the achievement of a result.
Performance Accountability	A manager or group of managers within an agency responsible for the performance of a program or service system.
Performance Measure	A measure of how well a program, agency, or service system is working.
Population Accountability	A group of partners responsible for the well-being of a population in a geographic area.
Prioritized Root Cause	A factor causing certain health outcomes that we can influence and that rises to the top in the RBA rating process.
Priority Area	The categories of public health issues that will be addressed in the 2017 CHIP. These include Behavioral and Mental Well-Being, Healthy Child and Family Development, Healthy Eating and Active Living, Safe Communities, and Sexual Health.
Results Based Accountability	A disciplined way of thinking and taking action used by communities to improve the lives of children, families, and the community as a whole.
Result Statement	A condition of well-being for children, adults, families, or communities. Also known as outcome, goal, or vision.
Root Cause Analysis	An analysis to help workgroups determine the factors that are causing certain health outcomes in our community. Also known as the fish bone diagram.
Social Determinants of Health	A range of personal, social, economic, and environmental conditions in which people are born, live, work, and age that affect their health.

Story Behind the Baseline	A narrative that explains the root causes and underlying factors influencing the data.
Strategy	A coherent collection of actions that have a reasonable chance of improving results, usually implemented as programs or initiatives. Also known as programs, initiatives, systems, and services
Target	A specific desired future level of achievement for an indicator.

APPENDIX C: THE MODIFIED RBA PROCESS AND MATRICES USED

This is a guide to the majority of steps utilized to implemented a modified RBA process while developing our 2017 Community Health Improvement Plan for Bexar County.

1. Priority Area

Definition: The categories of public health issues that will be addressed in the 2017 CHIP.
Examples: The five selected 2017 CHIP priority areas:

- Behavioral and Mental Well-Being
- Healthy Child and Family Development
- Healthy Eating and Active Living
- Safe Communities
- Sexual Health

Action: Fill in your Priority Area below. Later, after selecting headline indicators, co-chairs should also write an introductory paragraph for their Priority Area. The introduction should include a high-level summary of each headline indicator.

(First – write priority area)

2. Accountability Type

Definitions: The RBA framework has two components: Population Accountability and Performance Accountability. Population Accountability is used to address the well-being of a population within a specific geographic area—in this case, San Antonio and Bexar County.

- This is a group of partners responsible for the well-being of a population in a geographic area. It starts by identifying a population within a specific geographic area.
- Performance Accountability is used to assess how well a program, agency or, service system is doing. Within an agency, this typically is a group of managers responsible for the performance of a program, agency, or service system. Within a community, this may be a program within an agency.

This guide will focus on the planning process for Population Accountability. Population Accountability starts by identifying a population within a specific geographic area.

Example: The San Antonio Teen Pregnancy Prevention Collaborative is accountable to the community for reducing the rates of teen births in Bexar County.

Action: Write in your type of results accountability below (this template is currently designed for population accountability) and the population you are working to improve, for example Bexar County.

Population Accountability – targeting __(Bexar County)__

3. Results Statement

Definition: A result, also known as an outcome or goal, is a population condition of well-being for children, adults, families and communities, stated in plain language. When thinking about a result statement, begin with the end in mind and be sure to include: 1) a specific geographic area, 2) a condition of well-being, and 3) a population.

Example of a results statement:

- People in Bexar County are preventing and managing chronic diseases such as diabetes, obesity, and heart disease.
- Women of childbearing age, teens, and infants in Bexar County are healthy.

Action: Document your final results statement below.

A Tool to Use to Develop a Results Statement: Your workgroup may choose to use a Victory Circle as a tool to help develop your results statement. A Victory Circle helps create images of success and develops excitement about the project.

Instructions: Draw a large circle on a flip chart paper and title it Victory (or Results). Ask the group to step into the future and visualize the final outcome. Then, ask the following questions: "What did you see? Feel? Hear? Who was involved? What's going on?" Go around the group to get an image from each person. Use several different color markers to write in ideas until the circle is filled in. Your objective is to give the group a sense of the final outcome in a richness of detail that will begin to bring it alive in their imaginations.

(Write result statement)

4. List and Rate Potential Indicators

Definition: An indicator is a measure that helps quantify the achievement of a result, should communicate clearly to relevant constituencies, and is comparable to something larger such as state or national data.

Examples of indicators:

- Violent crime rate helps quantify safe communities
- Adults with obesity helps quantify healthy adults
- Teen birth rate helps quantify the rate of teenage pregnancy in the community

4a. List Potential Indicators

Action: First, in the table below, create a list of 5-7 potential indicators that could measure the desired result. Use the Community Health Needs Assessment (CHNA) and other community data sources as resources.

	(Potential Indicators (Population Accountability
1	
2	
3	
4	
5	
6	

4b. Rate Potential Indicators

Action: Second, move the 5-7 potential indicators from step 4a into the second column of the table below. Then, in the next five columns, rate these potential indicators as High, Medium, or Low within the listed categories:

1. Data Power (essential): Is there quality data for this indicator on a timely basis? To be credible, the data must be consistent and reliable. Timeliness is necessary to track progress. Incomplete data can be added to your Data Development Agenda, reference Step 6.

2. Proxy Power (very important): Does this indicator say something of central importance about the result? Is it a good proxy for other indicators? Data tend to run in a "herd" – in the same direction. Pick an indicator that will tend to run with the herd of all the other indicators that could be used.

3. Communication Power: Does this indicator communicate to a broad range of audiences? Would those who pay attention to your work know what this measure means?

4. *Impact on Life Expectancy: Would efforts to improve this indicator also improve life expectancy in the selected population?

5. *Significant Impact on Population Health: Does this indicator also have a significant impact on community or population health?

   *These two were added to reflect important countywide health concerns as identified in the CHNA.

	Potential Indicator	Data Power	Communication Power	Proxy Power	Impact on Life Expectancy	Significant Impact on Health (Ranking)
1						
2						
3						
4						
5						
6						

5. Headline and Associated Indicators

5a. Select Headline Indicator - one

Definition: Headline indicators are the most important measures that rise to the top in the RBA rating process and ideally rate high across all five rating categories.

Examples of Headline Indicators: Violent crime rate, Adults with obesity, Infant mortality

Action: Select 1 headline indicator, document it in the table below, and include any notes within the indicator column. This will typically be one that is rated "high" in all categories in the table in step 4b, above. We found that sometimes 2-3 indicators need to be combined to tell the story of what the group is trying to impact, such as utilization of preventive primary care providers, as measured by three data points: (1) childhood immunization rates, (2) first trimester access to prenatal care and (3) emergency room visits for non-emergency care. The remaining indicators can be tracked as **associated indicators** that support the headline indicator(s).

	Selected Headline Indicator (Population Accountability)	Data Power	Communication Power	Proxy Power	Impact on Life Expectancy	Significant Impact on Health (Ranking)
1						

5b. Select Associated Indicator

Definition: Associated indicators are measures that are related to and support the headline indicator. Associated indicators will be tracked, but will not be taken through the rest of the RBA process. However, they will play an important role in developing the story behind the baseline and other parts of this process.

Action: List any indicators that did not make the cut for headline indicator and the group feels strongly that these should be monitored.

	Associated Indicator	Data Power	Communication Power	Proxy Power	Impact on Life Expectancy	Significant Impact on Health (Ranking)
1						

6. Data Development Agenda – if applicable

Definition: A data development agenda is a plan that identifies data that is not yet available and how it will be collected. Indicators rating low in data power should be added to your development agenda (RBA Book, page 56).

Example:

- Childhood obesity rates

Action: Make a list of indicators for your data development agenda with ideas for potential data sources and partners. Identify an agency that wants to take the lead on working on developing this indicator.

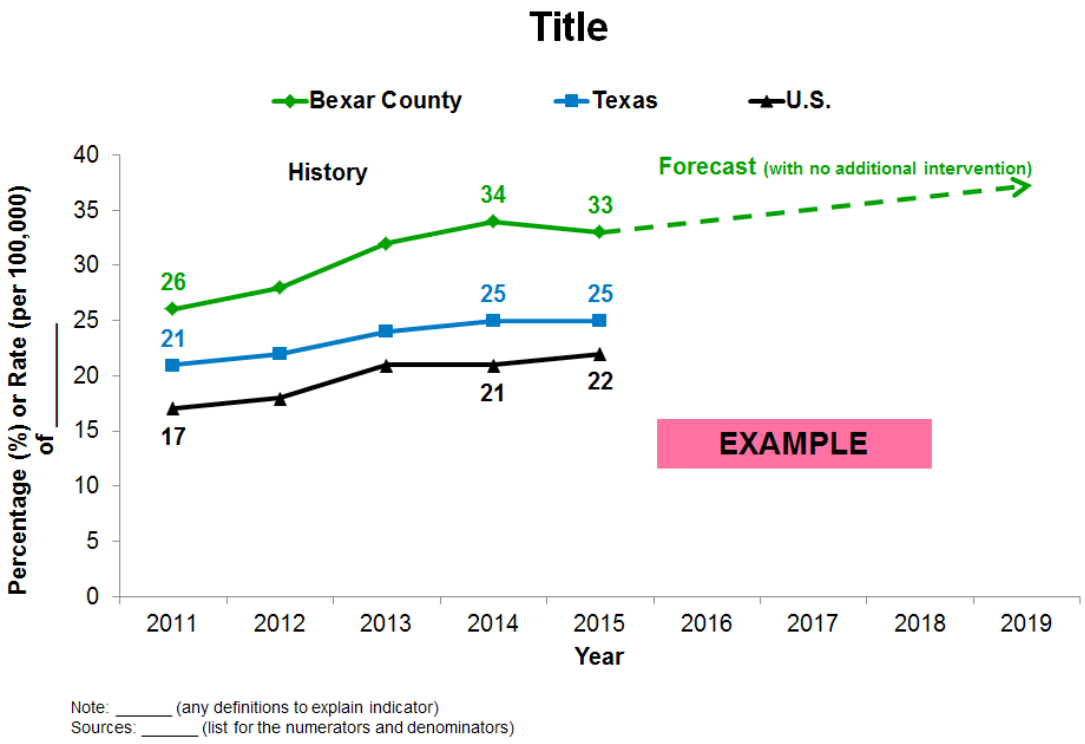
	Data Development – desired future indicator(s)	Potential Sources of data	Potential partners to help obtain this data	Agency - that will take the lead on looking into this
1				
2				

7. Trend Line Graph of Headline Indicator*

*This step will be completed between meetings.

Definition: For this CHIP planning purposes, a trend line has two elements: a historic part (baseline) that tells us where we have been and a forecast that shows where the work-group members predict this indicator will be in the future. The forecast is an estimate of future trends assuming the current level of effort or intervention. A comparison line is added, either a state or national value or state or national goal, such as the EPA attainment level for ozone. Later at the end of the performance accountability process, when all of the actions have been identified, then a target line will be added to display how much improvement the workgroup believes that their identified actions can improve the headline indicator.

Example of a trend line graph:



Action: For each headline indicator, draw a trend line using at least five years of historical data, if possible. The graph should also include a forecast to 2019 (the end of the CHIP we are developing) of what would happen without additional intervention. Clearly label graphs, cite data sources, and develop strong, precise definitions for each headline indicator. Below, make a note of major events over time that might explain sharp increases or decreases in the data.

(Insert trend line graph of headline indicator with comparison line and forecast)

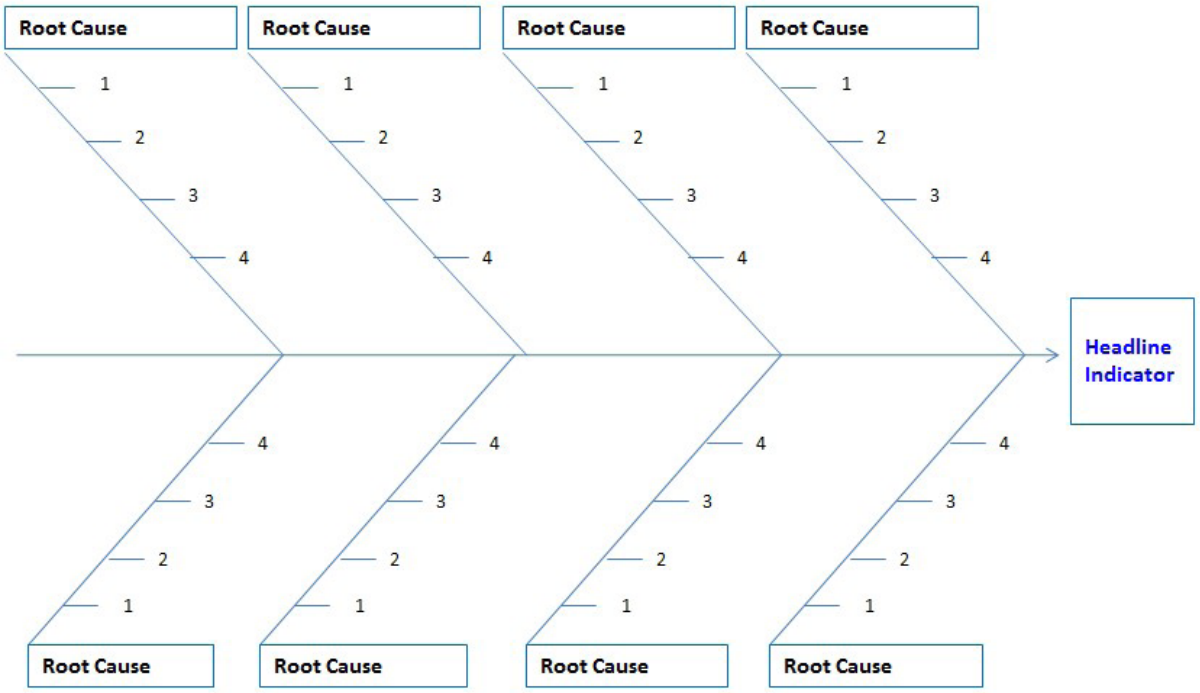
(Write notes about events that greatly impacted changes in direction of the headline indicator trend line)

8. Root Cause Analysis around Baseline – using Fishbone Diagram

Definition: A root cause analysis is an exercise that helps workgroups determine the factors that are causing certain health outcomes in our community. Why does the data look the way it does in our community? This step is a local conversation about health concerns. We will use a fishbone diagram to perform this analysis.

Examples: If the headline indicator focuses on rising juvenile crime, what is causing it to rise in this community? If the headline indicator focuses on decreasing obesity rates, what caused obesity in this community?

Action: Use a Fishbone Diagram to conduct a Root Cause Analysis. Build your diagram below. Start by filling in the selected headline indicator at the "head" of the fishbone. Then ask what caused this health issue to be the way it currently is in the community? Each larger root cause should be written in the boxes of the fish bone diagram; these can then be broken down into smaller causes representing the structural/root causes. Ask "why" five times to drive down to these smaller, structural root causes.



9. Prioritized Root Causes –rate and narrow to three

Definition: A prioritized root cause is a root cause we can influence that rises to the top in the RBA rating process.

Examples: Lack of education about preventative health; Limited access to health care; Limited knowledge of available resources

9a. Prioritized Root Causes –rate

Action: Use the information from the Fishbone Diagram in step 8 above to start this conversation. Move root causes identified into the second column of the table below. Then, in the next four columns, rate these potential indicators as High, Medium, or Low within the listed four categories to determine your top three prioritized root causes to address. Stay focused on the identified population/ community, what we can do in the next 3 years

1. **Leverage (most important):** How much difference will addressing the root cause make on results, indicators, and turning the curve? This is the most important of the criteria. It does not matter how well an idea scores on other criteria if it does not make any difference.
2. **Influence:** How much influence do we have to address this root cause?
3. **Feasibility/Reach:** Is it feasible and affordable? Can it actually be done and when?
4. **Values:** Is it consistent with our personal and community values?

	Root Causes (to rate)	Leverage	Influence	Feasibility	Values
1					
2					
3					
4					
5					
6					
7					
8					

9b. Prioritized Root Causes that we can address - narrow to three

Action: Select 3 prioritized root causes that we can address in our community. These will typically be those rated "high" in all categories in the table in step 9a, above. Document these in the table below.

	Prioritized root causes that we can address	Leverage	Influence	Feasibility	Values
1					
2					
3					

9c. Narrative of the Story Behind the Baseline*

*This step will be completed between meetings. Recommend identifying one person to take the lead.

Definition: The story behind the baseline is a narrative that explains the root causes and underlying factors influencing the data. Example: See the example below from San Francisco's Department of Public Health.

Since the 1990's, smoking rates in SF have declined significantly mainly due to efforts in California to remove advertising, educate the public, and increase cigarette taxes. SF was among the first localities to enact workplace, playground, and restaurant smoking bans and has been a leader in implementing strong and progressive policies to discourage smoking and protect individuals from secondhand smoke. These efforts have reduced smoking in the city from 20% in 1990 to 12-14% in the 2000's. Compared nationally, San Francisco's average annual decrease in adult smoking between 1996 and 2012 has been among the highest in the country for both men and women, at about 3%. However, since 2003, the rate of adult smoking has remained relatively unchanged, around 13% which is higher than most of our neighboring counties in the Bay Area.

Tremendous work to change San Francisco's culture around tobacco use has been facilitated through the SFDPH's Tobacco Free Project. The Project specifically works to reduce exposure to environmental tobacco smoke, reduce youth access to tobacco, and counter pro-tobacco influences. The Project worked to pass specific measures including: banning free distribution of tobacco products, banning tobacco advertising on city property, banning smoking in workplaces including restaurants, mandating that tobacco be sold behind store counters and eliminating vending machines, banning tobacco advertising on taxis, adding a cigarette butt litter mitigation fee to the sale of cigarettes, requiring a permit for tobacco sales, banning tobacco in public parks and plazas, banning smoking at transit stops, banning the sale of tobacco in retailers with a pharmacy, and passage of the Smoke Free Ordinance (Article 19F of the Health Code). In 2013, Article 19M of the Health Code was enacted requiring landlords to disclose whether their lease agreement allows smoking and which of their neighboring units allow for smoking.

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Action: Write a narrative that summarizes steps 7 (trend line), 8 (fishbone), and 9b (prioritized root causes) and describes their influence on the trend line. Explain any major increases/decreases in trend line and why the prioritized factors were selected/why are they important. The narrative should be no longer than one page per headline indicator and should include proposed research and challenges to outdated assumptions. Include citations for references in APA format.

Additional guidance: We recommend at least these 2 sections:

Section 1:

- As an introduction to your headline indicator, use national and state data if available to discuss what the data looks like on a national and state level.
- Please reference national targets and objectives, such as Healthy People 2020 or other standard goals.

Section 2:

Refer back to your Fishbone Diagram.

- Using your prioritized root causes, discuss what Bexar County looks like right now – especially the issues that are unique to Bexar County. (It should not look like another city/county.)
- Compare Bexar County to the national trend/national target. What are the differences and why are they different?
- If applicable, integrate your associated indicators in order to expand your story.

(Write narrative)

10. Partners with Roles to Play in Turning the Curve*

*Information for this step will be collected between meetings; then finalized at next meeting.

Definition: Think about the partners, both internal and external, that you currently work with. Who is missing from the table? Who are the partners that have a role to play in improving results? Who are partners that you would not traditionally consider?

Examples of non-traditional partners:

- The business community
- The media
- Partners outside the health system

Action: Use the table below to make a list of current and future partners that have a role to play in addressing the three prioritized root causes, identified in step 9b, to "turn the curve."

	Current/ Future	Partner Name	Role To Play in Turning the Curve
1			
2			
3			
4			
5			
6			
7			
8			

11. What Works to Address the Prioritized Root Causes?*

***** Information for this step will be researched/ideas collected between meetings, then used at next meeting.

Definition: What are the programs and services that work to turn the curve? What are the best practices and evidenced based interventions? What are you currently doing that works? Consider what research is available to demonstrate that a strategy has a reasonable chance of turning the curve.

Examples:

- Making online training videos helps educate people about safe food handling.
- Improved neighborhood lighting and sidewalks facilitates after-work exercise.

Action: Discuss "what works" to address the prioritized root causes identified in step 9b. Use the outline below to spark discussion and create a list of and categorize potential strategies by options for action, low/no cost ideas, innovative ideas, and research agenda. Be sure to discuss how strategies work to address the root causes/factors your group has identified. Also use the document "What Works for Health in Bexar County" to assist in finding new evidence based strategies

- **Options for Action / What you are currently or should be doing:**
  - o
  - o
- **Low/No Cost Ideas**
  - o
  - o
- **Innovative Ideas / Best Practices:**
  - o
  - o
- **Research Agenda:**
  - o
  - o

12. Strategy Selection

Definition: A strategy is a collection of actions that has a reasonable chance of improving results and may also be known as a service, system, program or initiative. Remember, a strategy may involve the discontinuation of existing activities as well as the implementation of new ones. These could be programs and policies to be developed or enhanced that could have a significant impact on turning the curve on population health. Strategies should be multi-year and integrated. The alignment of a proposed strategy with a root cause provides the rationale for selecting that particular option (it is the link between the "end" and the "means"). Workgroups should utilize their prioritized root causes/factors to determine what works to improve results.

Examples of strategies:

- **Service:** Support staff of small restaurants (by providing a toolkit to help managers monitor restaurants (ex: checklist, training, videos and sample SOP's))
- **System:** Ensuring women receiving a positive pregnancy result from a testing center are linked to pre-natal care.
- **Program:** Cure Violence Program
- **Initiative:** Strengthening the Smoke Free Ordinance (Policy Initiative)

Action: Use the information from the "What Works" discussion in step 11 above to start this conversation. Move potential strategies that address the three prioritized root causes into the second column of the table below. In the third column write the number that represents the prioritized root cause(s) that this proposed strategy supports from step 9b. Then, in the next five columns, rate these potential indicators as **High, Medium, or Low** within the listed categories:

1. **Leverage (most important):** How much difference will the proposed action make on results, indicators, and turning the curve? This is the most important of the criteria. It does not matter how well an idea scores on other criteria if it does not make any difference.
2. **Feasibility/Reach:** Is it feasible and affordable? Can it actually be done and when?
3. **Clearly understood:** Is the idea clear enough to be implemented?
4. Health Disparities: Does it have an impact on health disparities in the community? Does it impact life expectancy and health equity?
5. **Partner Engagement:** Does this foster cross-sector, multiple partner engagement?

	Potential Strategy	Prioritized Root Cause(s)	Leverage	Feasible/ Reach	Clearly Understood	Health Disparities	Partner Engagement
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

12a. Selected Strategies

Definition: Selected strategies are the most important strategies or specific sets of actions that rise to the top in the RBA rating process and ideally rate high across all five rating categories.

Action: Select the top 3-4 strategies that will have largest impact in turning the curve. Document them in the table below, and include any notes to help define them within the strategy column. This will typically be ones that are rated "high" in all categories in the table in step 12, above.

	Selected Strategy	Prioritized Root Cause(s)	Leverage	Feasible/ Reach	Clearly Understood	Health Disparities	Partner Engagement
1							
2							
3							
4							

12b. Strategies to Develop or Research

Action: Additional 1-2 strategies may be documented here as developmental for further research. Please include the agency or agencies that will lead these efforts in the strategy column.

	Strategy to Develop or Research & Agency that will do this	Prioritized Root Cause(s)	Leverage	Feasible/ Reach	Clearly Understood	Health Disparities	Partner Engagement
1							
2							

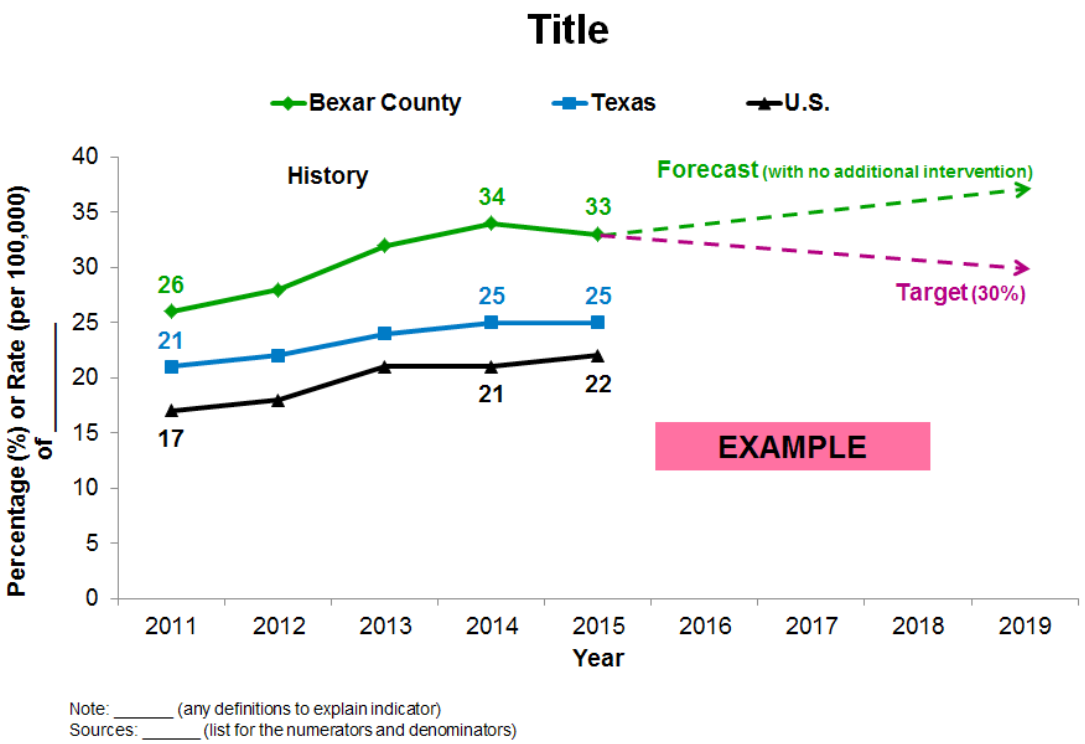
Complete Performance Accountability Steps (Group Performance Measures and Action Plan) in the other document.

13. Last Step. Target for Headline Indicator

Definition: At the end of the performance accountability process, when all of the actions have been identified, the group will set a target of how much improvement the workgroup believes that their identified actions can improve the headline indicator - to "turn the curve" for their population.

Example: A 95percent graduation rate by 2020. (This includes specific number and timeframe.)

Example of a target line added to trend line graph:



Action: For each headline indicator, set a target of how much improvement the workgroup believes that their identified actions can improve the headline indicator. Then add a target line and a targeted percent improvement to the trend line graph.

(Write out target for headline indicator)

(Add target and target line to trend line graph of headline indicator)

Note:
This guide does not detail the steps used in the development process for Performance Accountability. Performance Accountability includes setting performance measures collectively for the agencies participating in a workgroup and committing to actions that are specific, measureable, achievable, realistic and time-bound (SMART).

APPENDIX D: ACTION PLAN

The workgroups are continuously updating their action plans. Please visit the Health Collaborative website at healthcollaborative.net for the most recent action plans.

APPENDIX E: COMMUNITY ENGAGEMENT

2017 CHIP Community Feedback– What would help to improve these health issues in your community?

Behavioral & Mental Well-Being	Healthy Child & Family Development	Healthy Eating & Active Living	Safe Communities	Sexual Health
-Use professional opinions; need more training on how to handle situations. -Provide community events that include churches/pastoral care. -Triple the budget of mental health services and mental health outreach for SA. -Speakers, classroom projects, and education. -Easier access to better stress management. -More mental health facilities. -More counselors in strategic locations. -Expand treatment for behavioral health and substance abuse disorders in the community and outpatient settings.	-Classes, informative sessions, pamphlets. -Make more programs aware of available low-cost or free services to the community. -Not limit services to those that live on the wrong side of the street like me (I live one street over to qualify for Healthy Start). -More education and income based services. -Parenting classes. -Low cost clinics/services and access to health care. -Better insurance options for low income families -Community events with information. -Increase # of people receiving early preventive care. -Community leaders organizing residents to vote and put pressure on elected officials to protect our access to affordable healthcare	-More Exercise/eating healthy. -Host events to bring community and families together outside to be active. -More education and nutrition/cooking classes. -Healthy food should not be so expensive. -More gyms in the area, or free dance classes. -Availability and affordability of fresh foods to all communities throughout the city. -Better school lunch options and healthier options at fast food places. -Reduction in the use of electronic devices among children. -Open and light parks and trails for people to use early in the morning and at night. -Free preventative measures throughout the community, such as free glucose checks and blood pressure checks -Discounted/free access to nutritionists, education, and counseling.	-Better gun control -More traffic signals, signs, and car lanes -More police presence. -Promote teen programs and volunteering. -More security/surveillance (cameras) in our community. -More education on subject. -Positive mentorship. -Having strong churches. -Opportunities for teens with rewards/incentives. -Implement more evidence-based violence prevention programs into K-12 settings. -Encourage more neighborhood focus groups or dialogue with police to increase education and prevention. -Give students more road rage classes. -More free recreation summer activities for kids to go to and stay out of the streets where drugs and crimes lurk.	-More education for kids and the entire family. -Teaching kids in activities that the path of God is better than the path of making out. -Abstinence 101. -Provide teachings/education at schools. -Early education intervention. -More resources. -Awareness of what's out there. -Less unprotected sex from teens and incarcerating sex offenders.

Behavioral & Mental Well-Being	Healthy Child & Family Development	Healthy Eating & Active Living	Safe Communities	Sexual Health
	-More mobile clinics for preventative care, immunizations, and check-ups.	-Additional funding for fitness/nutrition education programming -Helping improve the access to healthy foods in food desserts, and possibly creating a sin tax on junk food/fast food. Healthy food options are more expensive than junk food. -Reduce the intake of sugar-sweetened beverages, smaller portion sizes, and increased access to nutrition counseling. -Open pools more than 2 months out of the year. -Empower people to make lifestyle changes that lead to improved health. -Add playgrounds -More free recreation summer activities for kids to go. -Crosswalk improvements for pedestrians and bike lanes. -Improve walkability and connectivity around the city. Design streets for people, not cars.	-Strengthening the family unit, parent education (including single parent outreaches) -Continue to share the word of Christ with the community and connect people to church. -More family events, not just for families with smaller children, but teen events (free) -More background checks for the people living in the community. -The city of SA does not take burglaries as serious as the other metropolitan cities in TX. -Clean up the city. Hold the homeowners responsible in the upkeep of good living conditions in neighborhoods -Raise awareness. -Infrastructure. -Mentor programs. -More community peace officers. -Judiciary intervention in the form of specialty courts, using the drug court model, to identify and address the core issues that lead to violent behavior. -Community partnership with police.	

APPENDIX F: LIST OF COMMUNITY LIAISONS, IMPLEMENTATION PARTNERS, AND COMMUNITY CHAMPIONS

Behavioral and Mental Well-Being

Community Liaison – Year 1:

Alive Alvarez: aalvarez@kronkosky.org

Implementing Partners:

Name	*Organization*	*Email address*
Junda Woo	Metro Health	junda.woo@sanantonio.gov
Gerard Migoon	Clarity CGC	gerard.migoon@claritycgc.org
Selina Catala	CHCS	scatala@chcsbc.org
Gyna Juarez	SACADA	Gjuarez@sacada.org
Mary Beth Fisk	ECRH	mbfisk@ecrh.org
Kat Cole	Family Endeavors	kcole@familyendeavors.org
Larry Parsons	UHS	larry.parsons@uhs-sa.com
Rebecca Helterbrand	STRAC/STCC	rebeccahelterbrand@strac.org

Engagement Champions:

Name	*Organization*	*Email address*
Jeff Dulin	Brooke Army Medical Center	jeffrey.m.dulin.civ@mail.mil
Junda Woo	Metro Health	junda.woo@sanantonio.gov
Terri Mabrito	Voices/AATSPC	tmabrito@voicessa.org
Gyna Juarez	SACADA	Gjuarez@sacada.org
Selina Catala	CHCS	scatala@chcsbc.org
Alanah Lavinier	Cohen Military Family Clinic	alavinier@familyendeavors.org
Larry Parsons	UHS	larry.parsons@uhs-sa.com
Norma Gonzalez	Martinez Street Women's Center	norma@mswomenscenter.org

Healthy Family and Child Development

Community Liaisons – Year 1:

Guadalupe Cornejo: mcornejo2@alamo.edu

Katie Cunningham: katie.cunningham@sanantonio.gov

Implementing Partners:

Name	*Organization*	*Email address*
Ana Maria Garza Cortez	CentroMed	anamaria.garzacortez@centromedsa.com
Katie Cunningham	Head Start	katie.cunningham@sanantonio.gov
Rachelle Kight	Early Head Start	rachelle.kight@sanantonio.gov
Guadalupe Cornejo	Northwest Vista College	mcornejo2@alamo.edu
Herlinda Ibarra	CentroMed	herlinda.ibarra@centromedsa.com
Amanda Murray	Healthy Start	amanda.murray@sanantonio.gov

Engagement Champions:

Name	*Organization*	*Email address*
Ana Maria Garza Cortez	CentroMed	anamaria.garzacortez@centromedsa.com
Guadalupe Cornejo	Northwest Vista College	mcornejo2@alamo.edu
Herlinda Ibarra	CentroMed	herlinda.ibarra@centromedsa.com
Amanda Murray	Healthy Start	amanda.murray@sanantonio.gov

Healthy Eating and Active Living=

Community Liaisons – Year 1:

Marnie Staehly: mstaehly@humana.com

Nora Silva: nora.silva@heart.org

Implementing Partners:

Name	*Organization*	*Email address*
Caroline R. Blanco	American Diabetes Association	cblanco@diabetes.org
Mandy Tyler	ESC Region 20	mandy.tyler@esc20.net
Haley Amick	SAMHD, Chronic Disease	haley.amick@sanantonio.gov
(Andrea Tan (tentative	Mayor's Fitness Council	andrea.tan@sanantonio.gov
Sarah Mohmedali	American Heart Association	sarah.mohmedali@heart.org
Nora Silva	American Heart Association	nora.silva@heart.org
Beth Keel	SAHA	beth_keel@saha.org

Engagement Champions:

Name	*Organization*	*Email address*
Caroline R. Blanco	American Diabetes Association	cblanco@diabetes.org
Mandy Tyler	ESC Region 20	mandy.tyler@esc20.net
Andrea Tan	Mayor's Fitness Council	andrea.tan@sanantonio.gov
Rose Ramos	UT Health School of Medicine	ramosrg@uthscsa.edu
Sarah Mohmedali	American Heart Association	sarah.mohmedali@heart.org
Nora Silva	American Heart Association	nora.silva@heart.org
Beth Keel	SAHA	beth_keel@saha.org

Safe Communities

Community Liaison – Year 1:

Annie Erickson: aerickson@aacog.com

Implementing Partners:

Name	*Organization*	*Email address*
Greg Reininger	CoSA - TCI	gregory.reininger@sanantonio.gov

Engagement Champions:

None at this time

Sexual Health

Community Liaison – Year 1:

Sian Hill-Elmore: sian.hill@sanantonio.gov

Roxanne Hickman: roxanne.hickman@sanantonio.gov

Implementing Partners:

Name	*Organization*	*Email address*
Roger Rodriguez	SAISD - Health & PE	rorodriguez@saisd.net
Sian Hill-Elmore	Metro Health	sian.hill@sanantonio.gov
Cynthia Nelson	San Antonio AIDS Foundation	cnelson@sanantonioaids.org
Diane H. Bullard	NEISD/HTTX	dbulla@neisd.net
Holly Benavides	UHS Texas Wears Condoms	holly.benavides@uhs-sa.com
Lucia Bustamante	University Health System - Part D	lucia.bustamante@uhs-sa.com
Rhonda Andrew	Ryan White - AA Part A/O	rhonda.andrew@bexar.org
William Sandburg	UT Teen Health	sandburg@uthscsa.edu

Engagement Champions:

Name	*Organization*	*Email address*
Sian Hill-Elmore	Metro Health	sian.hill@sanantonio.gov
Cynthia Nelson	San Antonio AIDS Foundation	cnelson@sanantonioaids.org
Diane H. Bullard	NEISD/HTTX	dbulla@neisd.net
Lucia Bustamante	University Health System - Part D	lucia.bustamante@uhs-sa.com
Catherine Johnson	Ryan White Planning Council	catherine.johnson@bexar.org
Rhonda Andrew	Ryan White - AA Part A/O	rhonda.andrew@bexar.org
Jenn Tristan	The Rape Crisis Center	jtristan@rapecrisis.com

APPENDIX G: REVISION HISTORY

Version	Date	Edited By	Changes
1.0	October 20, 2017	Created	Version 1 printed for CHIP release

GrowHealthy Together
Bexar County

2017 HEALTHY BEXAR PLAN

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The Health Collaborative

3010 N St Mary's St,
Suit 1101
San Antonio, TX 78212

(210) 481-2573