



Leading Communities
Toward a Culture of Health



STRATEGIC PLAN
2017 - 2019

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About Gateway to Care

Gateway to Care (GTC) is a 501(c)(3) non-profit organization dedicated to ensuring that each resident of the Houston/Harris County area has a gateway to affordable and accessible health care. GTC operates as a health care access community based organization and the facilitator of the Gateway to Care Full Collaborative comprised of nearly 190 member and affiliate organizations.



History

GTC began in 2000 as a program of Harris County Public Health & Environmental Services (HCPHES) and was conceived as a collaboration of health care partners in search of strategies to address the serious imbalances to the health care system created by the region's exceedingly high rate of uninsured individuals. In 2002, given its focus on reducing emergency room 'frequent flyer' use, it became a department of the Harris County Hospital District (HCHD). After four supportive years at HCHD, it was decided that GTC could have more operational flexibility and better serve its target population as a not-for-profit organization. In 2006 GTC was incorporated as an independent non-profit organization. Today, GTC continues a legacy of innovation and facilitation of adequate access to health care for residents in the Houston/Harris County area through education, outreach, and training; health care access and navigation services; and specialty care navigation and coordination with a goal of 100% access to health care for the uninsured and underinsured in our community.

Our Vision

To empower communities, families, and individuals to achieve health literacy and sustain better health.

Our Mission

To promote a culture of health through education, health care access, innovation, and community collaboration.

Leadership

Executive Director

2014 – Present Idonia L. Gardner JD, MPS
2000 - 2014 Ronald R. Cookston Ed.D.

Chair of the Board

2014 – Present Jean Dols Ph.D., RN, NEA-BC, FACHE,
University of the Incarnate Word
2011 - 2014 Charles Begley Ph.D., UT School of Public Health
2010 - 2011 David Wood BA, Marsh USA
2008 - 2010 Carol Paret MPH, Memorial Hermann
2006 - 2008 Dee Murray LMSW, LCDC

Executive Summary

An April 2015 report by the Episcopal Health Foundation and Rice University's Baker Institute for Public Policy found that although the percentage of uninsured Texans ages 18-64 dropped from 25% to 17% between September 2013 and March 2015, Texas remains the state with the highest percentage of those without health insurance. Additionally, for the first time, Texas now has the highest number of uninsured residents in the U.S., with the biggest concentrations in Harris and Dallas counties, and Texas continues to have the highest rate of uninsured children in the U.S.

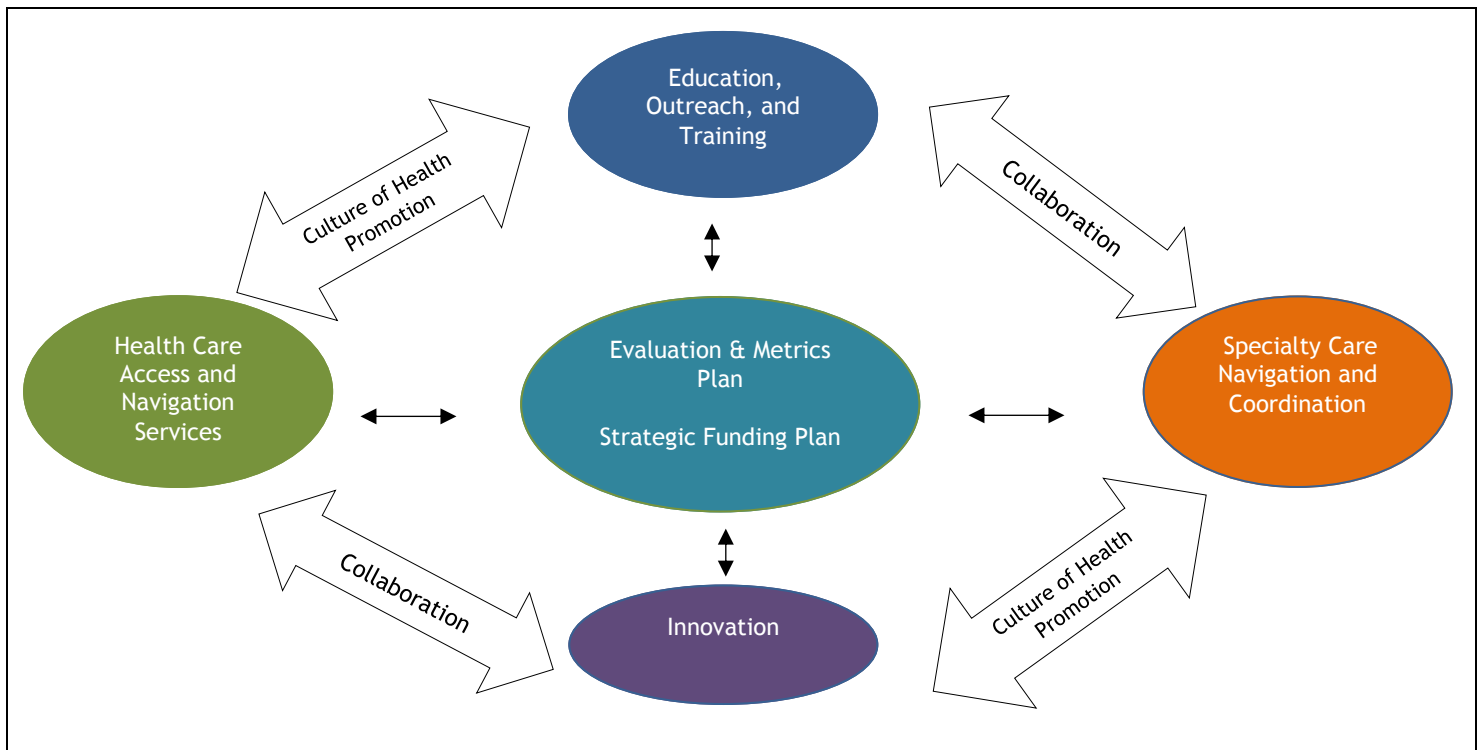
The 2015 *Code Red: The Critical Condition of Health in Texas* report (UT System) identified that "more uninsured and underinsured people seek access to care in a fragmented health care system or delay seeking care due to costs. Uninsured Texans unable to access early diagnosis and treatment for advanced diseases increase costs for all who pay for or provide care in the state." In addition, those who lack insurance coverage typically experience far worse health status than their insured counterparts. With the advent of the Affordable Care Act (ACA), the health care system is rapidly changing. Due to the Texas legislature's decision not to expand Medicaid in the foreseeable future, many Texans remain uninsured and fall into the insurance coverage gap. The situation in Harris County was exacerbated in March 2016, when an estimated 15,000+ individuals were no longer eligible for the county's indigent program.

As a result, Gateway to Care, as a non-profit and a local, robust collective-impact Collaborative, has mapped out a strategic plan with initiatives aimed at remaining a leading force in the Region for navigating uninsured and underinsured constituents through the complex health care access maze. Gateway to Care will accomplish this through its Key Strategic Initiatives of Education, Outreach and Training; Health Care Access and Navigation Services; Specialty Care Navigation and Coordination; and Innovation. In addition, the Gateway to Care Collaborative will compliment these efforts with a key focus on Health Care Access via the promotion of Public Policy, Chronic Disease Prevention, Education, and Health Equity (*see pages 12-14*).

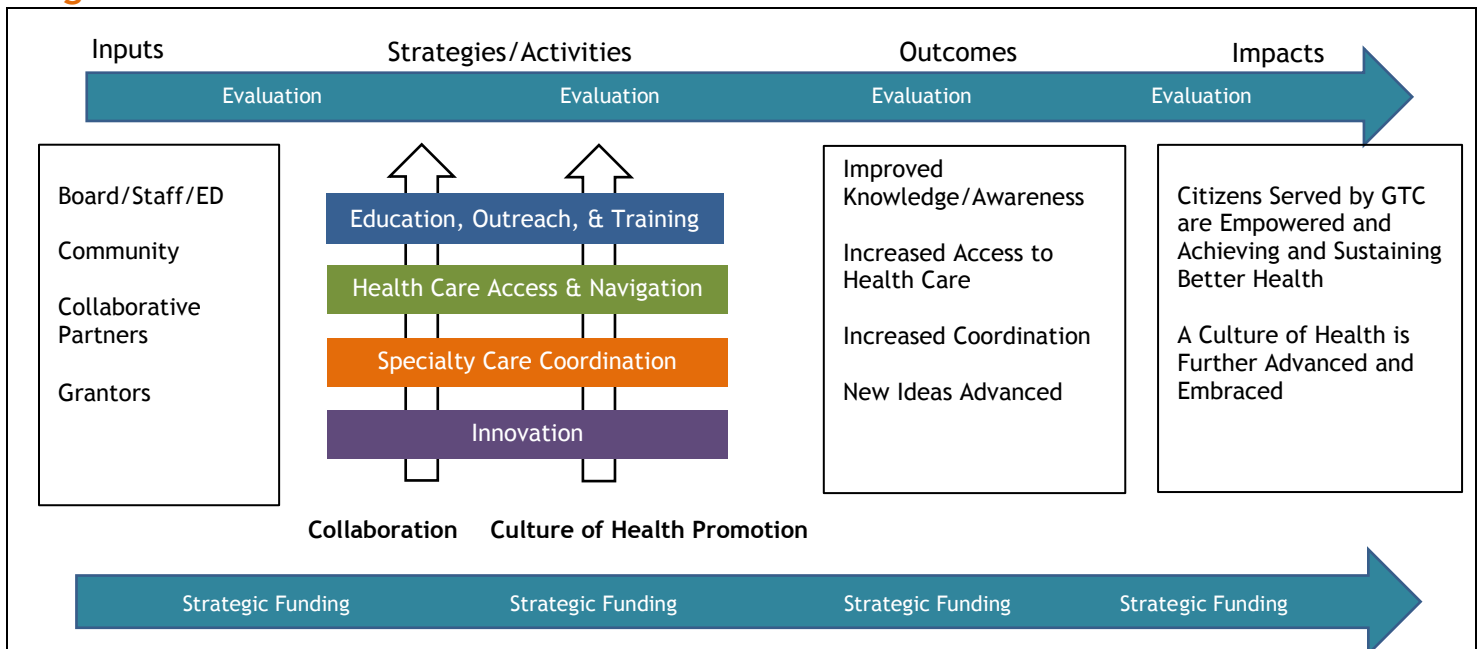
This plan is the culmination of a tireless commitment by the Board of Directors, Executive Director, GTC Strategic Planning Committee, Evaluation Subcommittee, Development Subcommittee, and the Key Staff Management Team of GTC. In addition, visionary guidance was provided by the membership of the GTC Collaborative Advisory Committee, Full Collaborative membership, and Collaborative Executive Leadership for the key strategy and initiatives of the Full Collaborative.

The resulting document is designed to provide a roadmap in carrying out the mandates and intent of the non-profit and Full Collaborative mission, vision, bylaws, and strategic planning. Most importantly, this three-year plan is set forth to improve the overall health of vulnerable populations served with the audacious goal of achieving 100% access to health care for the uninsured and underinsured residents in the Greater Houston and Harris County area by *Leading Communities Toward a Culture of Health*.

Key Strategic Initiatives of Gateway to Care (Non-Profit) - Gateway to Care's key strategic initiatives are Education, Outreach, and Training; Health Care Access and Navigation Services; Specialty Care Navigation and Coordination; and Innovation. All are facilitated by a strong commitment to *community collaborations* and the systemic *promotion of a culture of health*. At the center of these initiatives are robust evaluation and sound strategic funding plans.



Logic Model



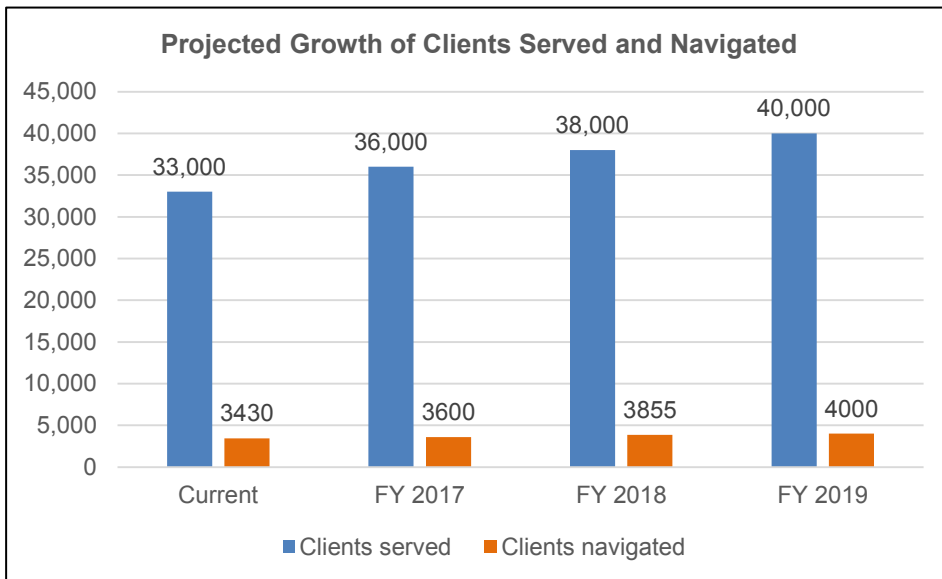
Strategic Goal 1: Provide health screening, navigation, health education, and referral services to 40,000 clients per year at three Latin American Consulates in the Houston/Harris County area by June 2019.

Working with the Mexican Consulate’s Consumer Affairs Department for the past six years, Gateway to Care has provided one-on-one navigation services to visitors of the Mexican Consulate-Houston from 8:00 a.m. to 1:00 p.m. each day in the lobby. Additionally, we provide educational programs and private consultations after 2:00 p.m.



The goal of **Ventanilla de Salud (Window on Health)** is to provide Mexican citizens or 1st generation U.S. citizens living in the United States

health care resources, services, and information. At the current location, the Consulate averages about 300 visits per day, and, on a monthly basis, GTC assists almost 400 individuals and provides educational programs to over 6000 visitors. In addition to those services, GTC’s Community Health Worker/Navigator works with the Consulate’s legal department, recommends programs, assists Community Affairs in meeting their program needs, and consults with other consulate staff as health related issues arise.



Education

Access/Navigation

Coordination

- ✓ Increase clients served from 33,000 to 40,000
- ✓ Increase clients navigated from 3430 to 4000
- ✓ Increase consulates served from 1 to 3
 - ✓ More clients aware of resources
 - ✓ More clients establish a health home
 - ✓ Higher percentage of follow-ups
- ✓ Increase monthly health screening events from 2 to 6
 - ✓ More screenings
 - ✓ More abnormal screens detected
- ✓ Increase mobile mammogram events from 2 to 4
 - ✓ More referrals
 - ✓ Higher percentage of follow-ups

Strategic Goal 2: Provide education and training to 1150 seniors and their caregivers per year by June 2019.

GTC's Senior and Caregiver Education Services empower and speak up for seniors and those who are caring for loved ones with a chronic illness or disability. We empower our aging population, their families, and informal caregivers with support, education, and tangible resources toward a healthy lifestyle through the following Evidence Based Initiatives (EBI):



Chronic Disease

Self-Management Training Program (CSDMP) –

An evidence-based workshop conducted over six weekly two-hour sessions. The workshop builds the self-confidence of participants to assume a major role maintaining their health and managing their chronic health conditions such as hypertension, arthritis, heart disease, stroke, and lung disease.

A Matter of Balance –

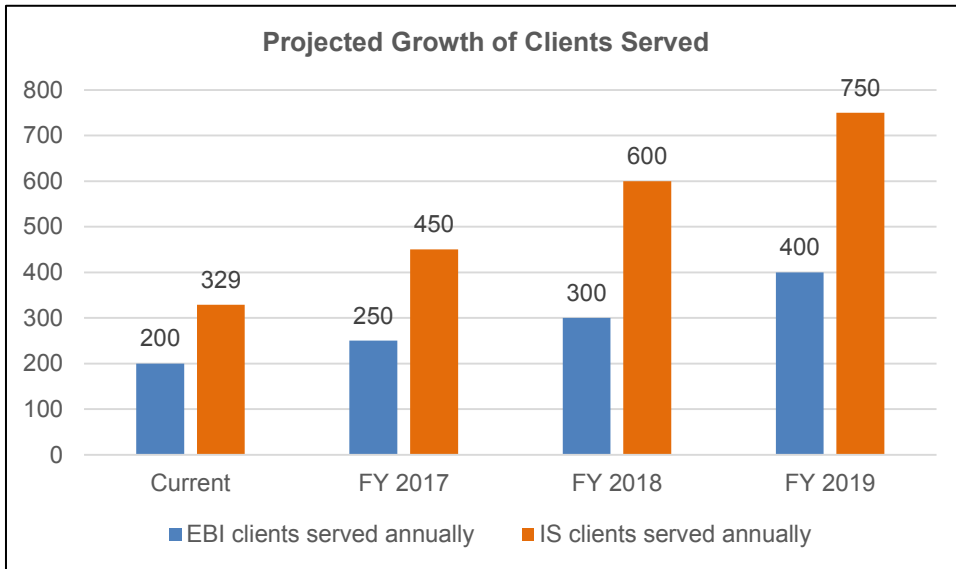
An award-winning program that helps people over 60 learn to control fear of falling through exercise, practical tips, and problem solving in a supportive group environment.

Diabetes Self-Management Training Program – This program follows the same format as CDSMP but is focused on diabetes.

Education

Access/Navigation

Coordination



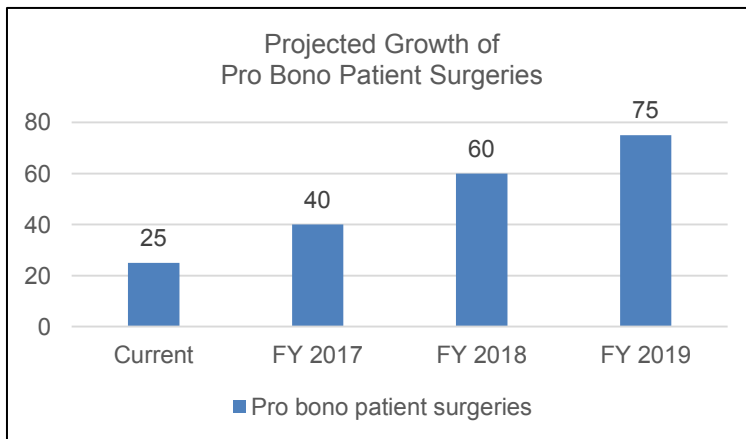
- ✓ Increase EBI clients served from 200 in 1 county to 400 in 2 counties
- ✓ Increase Information Services (IS) clients served from 329 to 750
 - ✓ More seniors and caregivers with knowledge of chronic diseases
 - ✓ More seniors and caregivers aware of learning techniques and skills to prevent/manage chronic disease, diabetes, and falls
 - ✓ More seniors reporting improved self-management of their chronic disease, diabetes, and falls
 - ✓ More class completions
- ✓ Increase EBI classes from 1 to 4 per month
- ✓ Increase IS classes from 2 to 5 per month

Strategic Goal 3: Navigate to available resources and coordinate the delivery of specialty care navigation and services to underserved populations of the Texas Gulf Coast Region, and increase the number of pro bono patient surgeries to 75 per year by June 2019.

Provider Health Network – The Provider Health Network (PHN) is comprised of volunteer health care providers and health systems who donate, at no charge, specialty care to low-income uninsured persons. PHN navigates and facilitates access to services for uninsured residents Monday through Friday. Our clinical navigators have extensive knowledge of community programs, resources, and health education. PHN’s RN patient care coordinator works closely with clinical navigators and volunteer physicians to identify health and social needs and give the patients the specialty care they need. We also relieve the specialty care provider of the burden of coordinating the many other health care services needed for the procedure. This coordination includes navigating clients to prescription medications, labs, radiology, and other services at no or very low cost.



Surgical Saturdays – Surgical Saturdays is a pilot project initially sponsored by collaborative partner Memorial Hermann Community Benefits Division that offers pro bono navigation services and surgeries to eligible individuals on designated Saturdays. The pilot ‘share the care’ model is being expanded to other hospital systems and surgical centers in the Greater Houston area.



Education

Access/Navigation

Coordination

Innovation

- ✓ Increase pro bono patient surgeries from 25 to 75 per year
- ✓ Increase the number of health systems engaged from 2 to 5
- ✓ Increase the number of referrals from 174 to 300
- ✓ Increase the number of referring clinics from 11 to 22

Strategic Goal 4: Train and educate 1500 volunteer members of the community with needed information and services before, during, and after times of natural disasters by June 2019.

The **Medical Reserve Corp (MRC)** is a national network for local groups of volunteers committed to improving the public health, emergency response, and resiliency of their communities.

Trainings are offered throughout the year usually at no charge and include disaster preparedness and access to resources for developing personal preparedness plans for households and businesses.



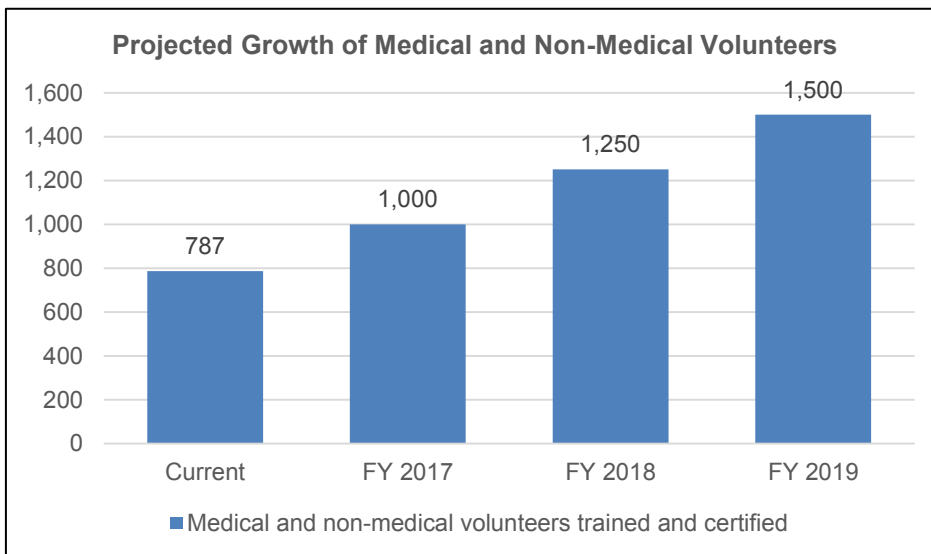
Past MRC volunteer events include:

- providing volunteer assistance during major flooding events
- staffing medical special-needs shelters after a hurricane
- augmenting hospital and clinic staff during mass surges
- providing assistance to City of Houston, HCPHES and American Red Cross shelters
- providing over 100 non-clinical volunteers for the City of Houston's H1N1 flu vaccination clinics
- assisting with local blood drives for Gulf Coast Regional Blood Center and MD Anderson Hospital

Education

Access/Navigation

Coordination



- ✓ Increase medical and non-medical volunteers that are trained and certified from 787 to 1500
 - ✓ More volunteers available to assist first responders during disasters
 - ✓ More volunteer service hours
- ✓ Increase the number of medical professional volunteers from 50 to 150
 - ✓ More medical professionals from a balanced set of professions
- ✓ Increase the number of languages in which materials are available from 8 to 14.
 - ✓ More culturally and linguistically fluent volunteers that are representative of the community
 - ✓ Materials that reflect the cultural and linguistic diversity of the community.

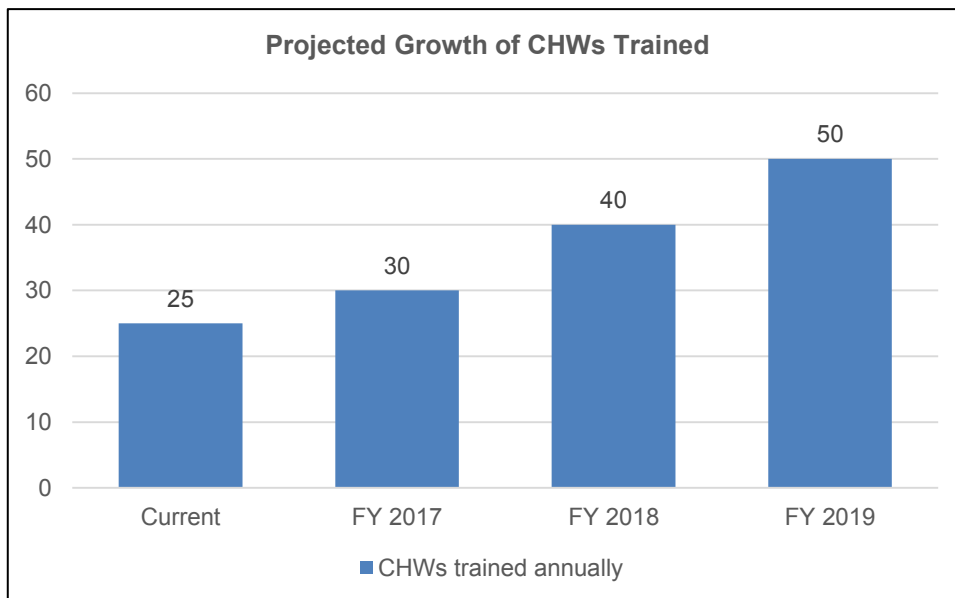
Strategic Goal 5: Provide state and peer recognized training in the greater Houston/Harris County area to achieve and maintain certification of 50 community health workers per year under the Texas Department of State Health Services by June 2019.

The Texas Department of State Health Services (DSHS) mandates a 160-hour curriculum for certification as a Community Health Worker (CHW). The curriculum must include eight competencies: communications skills, interpersonal skills, service coordination skills, capacity building skills, advocacy skills, teaching skills, organization skills, and knowledge base.

Gateway to Care's 11 year running **Community Health Worker Training Institute** (CHWTI) provides participants with information about resources, service coordination, and health education specific to the diverse communities in the Texas Gulf Coast region. Many are employed, volunteer, and/or are placed in hospitals, clinics, and social service organizations in the region.



Through CHWTI, we offer a 20-week certification program that results in eligibility for DSHS state certification. We also offer continuing education programs that provide CHWs with CEU hours needed to meet the 20 CEU hours required bi-annually by DSHS.



- ✓ Increase the number of CHWs trained annually from 25 to 50
 - ✓ More students trained and eligible for state certification
 - ✓ More students participating in CEUs
 - ✓ More students obtaining employment as CHWs
 - ✓ Improved community recognition of CHWs' role as a bridge between providers and patients



- ✓ Develop & implement training in 3 CHW specialty areas
 - ✓ Training meets current needs of community
- ✓ Increase the # of CHWs sponsored by collaborative partners from 3 to 15
 - ✓ Broaden scope of organizations that train through CHWTI

Strategic Goal 6: Provide expert navigation services to 1620 underserved individuals per year to obtain health services and social determinants of health resources by June 2019.

Gateway to Care’s expert navigation services assist underserved populations in obtaining health services. Navigators also train clients on how to enroll and use their health insurance. Additionally, navigators help clients understand the importance of a primary health home.

GTC works toward leading health care away from intermittent emergency room care (also referred to as 'sick care') toward a health care system focused around a 'health home' where managed and coordinated care will lead to better health outcomes and a reduction in the overall cost and burden to the health care system in our region.

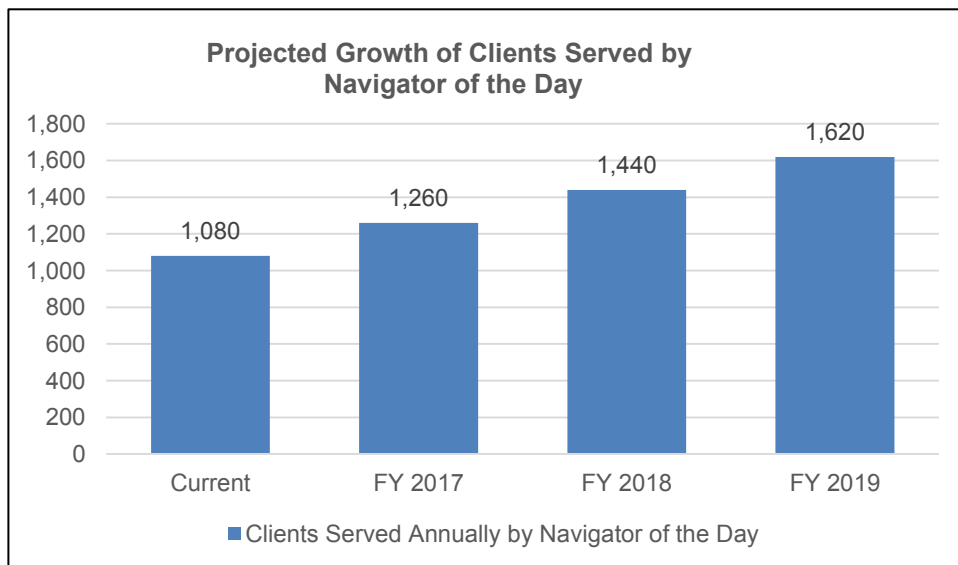
Education

Access/Navigation

Coordination



Navigators increase access to health care by providing cultural linkages between communities and health care providers. Navigators reduce the cost of health care by helping people obtain services at the lowest level of care, improving quality of care through services that promote health and prevent disease, and enable better communication between patient and provider.



- ✓ Increase navigator of the day clients served from 1080 to 1620
 - ✓ More clients aware of services
 - ✓ More clients establish health home
 - ✓ Higher percentage of follow ups
- ✓ Increase the number of navigators completing certification training from 2 to 12
 - ✓ Enhanced ability to connect individuals to services and resources
 - ✓ Navigators seen by peers as experts
- ✓ Increase providers completing health home training
 - ✓ More knowledge of health home concept

Strategic Goal 7: Increase health literacy and insurance enrollment in available insurance programs (CHIP/Medicaid, Marketplace, etc.) to 655 uninsured and underinsured individuals by June 2019.

Connecting Kids & Families to Coverage - For more than a decade, Gateway to Care has engaged in programs, projects, and partnerships that facilitate health care access and resource navigation services for children and their families.

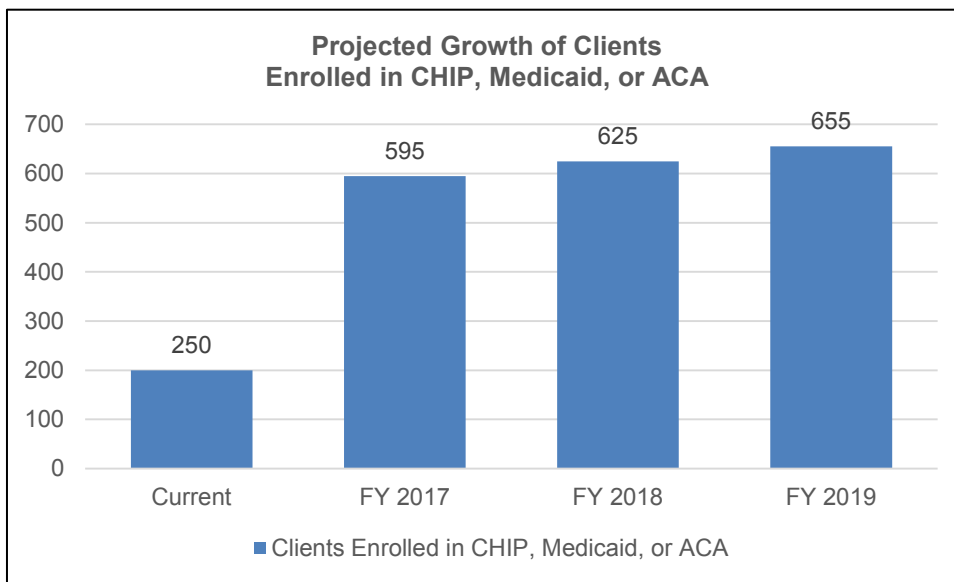
From engaging residents in programs that navigate persons to local health care resources and training community leaders on CHIP, Medicaid, ACA and Medicare as 'Champions for Coverage' to adhering to culturally and linguistically competent services, GTC educates diverse communities on health insurance coverage options available (based on their specific circumstances) and assesses each case towards meeting clients' overall health care needs. This long-standing, two-way community engagement has engendered Gateway to Care's trusted and broad tentacles into the grassroots communities we serve.



Education

Access/Navigation

Collaboration



Note: For the past three years, Gateway to Care has served as a 'training' entity within the community preparing individuals to become Certified Application Counselors and equipping enrollment navigators with training on cultural competency, health literacy, protecting personal identification and more. In February 2016, GTC expanded its services to include direct enrollments. Therefore, enrollment numbers are anticipated to rise dramatically over the next three years.

- ✓ Increase clients enrolled in CHIP, Medicaid, and ACA from 250 to 655
- ✓ Increase clients attending education workshops and presentations from 3722 to 4400
 - ✓ More clients are health literate
 - ✓ More clients have knowledge of health insurance products, terminology, and benefits
- ✓ Maintain number of collaborative partners engaged at 30
 - ✓ More clients aware of resources
 - ✓ More clients establish and use health home

GTC Full Collaborative Strategic Plan

Since 2000, the members of the Gateway to Care (GTC) Full Collaborative have had a long-standing tradition of working together to achieve better public and personal health for residents of the Greater Houston/Harris County area. From December 2015 through April 2016, an advisory committee, executive leadership group, four sub-committees, and the Full Collaborative membership met monthly to define a vision and mission for the Collaborative for FY2017-2019. They identified a key strategic initiative – **Health Care Access** – that will be addressed through 1) public policy, 2) disease prevention, 3) health equity, and 4) education. Each area will have measurable metrics to enable the GTC Collaborative to determine the success of its initiatives and adjust as needed.

Collaborative Vision and Mission

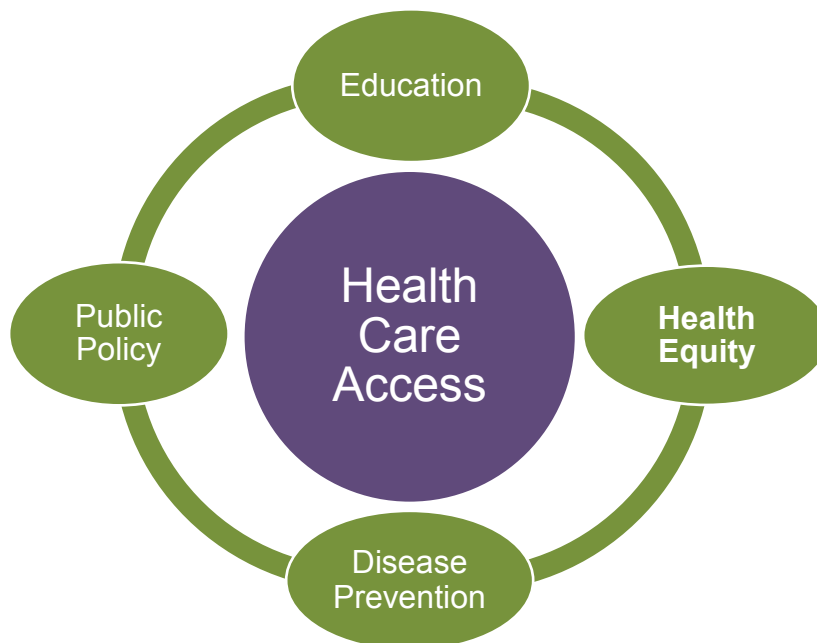
Collaborative Vision

Leading communities toward a seamless health system and a culture of health.

Collaborative Mission

To achieve better health through health care access, utilizing public policy, disease prevention, health equity, and education.

Collaborative Key Strategic Initiative and Tactics



Collaborative 2017-2019 Focus Areas and Activities

Public Policy	Disease Prevention
<ul style="list-style-type: none">✓ Develop policy priorities of interest to grassroots and grass-tops member organizations<ul style="list-style-type: none">✓ Convene decision makers to speak to grassroots✓ Provide relevant and timely policy presentations at collaborative meetings✓ Educate grassroots and grass-tops on policies, laws, and regulations impacting target communities✓ Work with other policy advocacy groups to reduce duplication and set unified priorities✓ Incorporate Social Determinants of Health (SDOH)✓ Resource clearinghouse (grants/speakers/research)✓ Advocate on behalf of the un- and under-insured<ul style="list-style-type: none">✓ Conduct annual visits with policymakers at the local, state, and federal levels✓ Communicate policy priorities and recommended actions to decision-makers✓ Dedicate one meeting of the Collaborative annually to public policy	<ul style="list-style-type: none">✓ Promote and support collaboration for disease prevention community funding. For example:<ul style="list-style-type: none">✓ Cities Changing Diabetes✓ Healthy Living Matters✓ Go Healthy Houston/Can Do Houston✓ Hospitals/organizations focusing on disease prevention programming✓ Create database and resource directory of disease prevention initiatives and resources of member organizations✓ Develop training modules for partners regarding chronic disease prevention✓ Focus on obesity and nutrition broadly, as they are the foundations that impact most diseases, including diabetes and heart disease✓ Incorporate SDOH in disease prevention efforts✓ Dedicate one meeting of the Collaborative annually to Disease Prevention

Health Equity

- ✓ Provide health equity education and training to members of the Collaborative
- ✓ Encourage member organizations to take the Texas Health and Human Services Commission's Center for Elimination of Disproportionality and Disparities' "Advancing Health Equity In Texas Through Culturally Responsive Care" self-study course
- ✓ Encourage education and training among staff of Collaborative members on Culturally and Linguistically Appropriate Services in Healthcare
- ✓ Assess Collaborative membership to find gaps in representation from agencies that work on SDOH
- ✓ Disseminate information to Collaborative members on local summits, conferences, and meetings focused on Health Equity for continued education
- ✓ Present 'to' and 'at' Summits, Conferences, etc.
- ✓ Establish ability/connections to Offer CEU's
- ✓ Dedicate one meeting of the Collaborative annually to Health Equity

Education

- ✓ Develop knowledge of Health/Social Services among partners
 - ✓ Map/geo-map Collaborative partners and their specific niches
- ✓ Drive people to the GTC Collaborative website
- ✓ Educate on issues impacting un- and under-insured
 - ✓ Disseminate information via Collaborative meetings, list-servs, social media, and calendars
 - ✓ Convene to learn about best practices
- ✓ Provide projections of matters impacting members such as changes to 1115 Waivers and reimbursement of physicians and hospitals
- ✓ Work with partners to strengthen navigation service systems
 - ✓ Create CHW Training Institute Learning Collaborative
 - ✓ Ensure community needs are being addressed
 - ✓ Continue to create opportunities to interact, share observations, and identify deficiencies for navigator service delivery improvement
 - ✓ Standardize navigation follow-up processes system-wide
 - ✓ Improve continuum of navigated services
 - ✓ Improve management and fulfillment of client expectations
 - ✓ Develop referral system of well-qualified CHWs to fill provider/community need for excellence in navigator staffing

Gateway to Care Non-Profit Strategic Planning Team

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