Public Health

Prevent. Promote. Protect.

Amarillo

2018 Community Health Improvement Plan

ASCENTHEALTH
CONSULTING

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GREETINGS!

Amarillo Public Health achieved several milestones in 2018. Along the way, we accomplished:

- A Community Health Assessment that provided a great deal of local data with comparisons to state and national data.
- A Community Health Improvement Plan, which is attached here and gives us a path for working with community partners to improve the health of our residents.
- A Strategic Plan for the Department of Public Health that focuses our work over the next five years.

There are many people who deserve credit for helping with these major accomplishments. First, I recognize the Amarillo City Council, Bi-City County Public Health Board and City Management for their support and interest. I am grateful for the advisory group that provided valuable input along the way. The participants in the Community Health Improvement Plan Summit were generous with their time and ideas for making our community healthier. And last, but certainly not least, I am honored to work with an amazingly compassionate Amarillo Public Health staff that truly cares about the people we help.

Going forward, I am excited about the opportunities presented in this Community Health Improvement Plan. The partnerships and collaborations that will come from this Plan have the potential to make life better and healthier for many. I invite everyone in our community to read this Plan and find ways to participate in this important work.

Casie Stoughton, BSN, RN, CPH

Director of Public Health

INTRODUCTION AND COMMUNITY HEALTH IMPROVEMENT PLAN FRAMEWORK

Community Health Assessment and Community Health Improvement Planning

As a neutral convener and facilitator for community health improvement efforts, the City of Amarillo Department of Public Health (COADPH) launched a community health assessment (CHA) process in the Spring/Summer of 2018 focusing on data analysis from primary and secondary sources. This CHA process was comprehensive and trended health metrics over time, comparing with Texas and the United States when possible. The CHA reviewed national county health rankings, primary telephone survey results, previously published community data sources, key informant surveys and focus group interviews. All of these data sources served to provide the most complete CHA performed, to date, in the greater Amarillo area.

To complement and complete the assessment process, a community health improvement plan (CHIP) was initiated in the Fall of 2018. COADPH spearheaded a CHIP process as a natural follow-up and progressive step to take the CHA information and operationalize it into a plan that explores goals and objectives for health improvement. To engage the community, a Summit was planned and facilitated with the stated intent of garnering goals for inclusion in an overall CHIP.

COADPH's Role in CHIP Facilitation

Local health departments are taking the lead in facilitating these assessment and planning conversations all across the country. In fact, local public health entities are expected to evolve and mature into community health leadership roles for these topics. As the local public health agency, COADPH budgeted dollars for the comprehensive CHA, cultivated relationships and participated in multidisciplinary community groups discussing the identified areas of concern, and led the effort for planning the CHIP Summit designed to coalesce the data and existing/planned efforts for health improvement.

The figure on the following page illustrates the expectations of public health agencies and the impetus for COADPH leadership in this effort. Public health services have evolved over time; the efforts have moved from clinical and basic access to care to systems improvements to improving social determinants of health.

CHIP Summit participants listen to presentations.

Figure 1. Public Health 3.0[1]
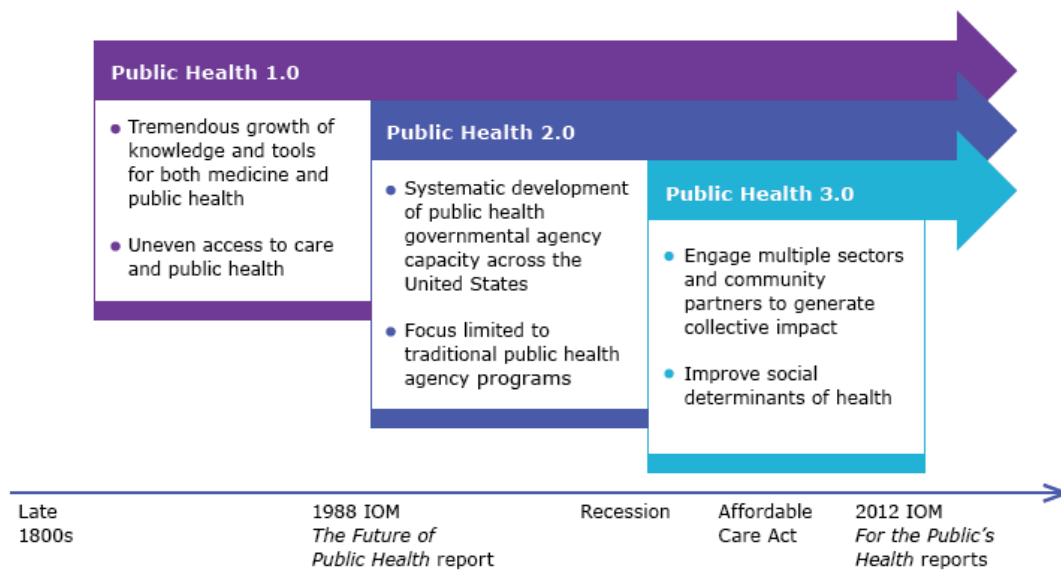
We see the first element of "Public Health 3.0" listed as describing the engagement of multiple sectors for collective impact. COADPH facilitated the CHIP Summit to accomplish precisely that – an engaged community discussion focused on common areas of concern to guide improvement in health outcomes.

The responsibility of this work is becoming part of the national, state and local expectations of local public health departments. The delicate balance of convening the conversation but not being solely responsible for the effort and outcomes is difficult to achieve but important to verbalize. As such, COADPH recognizes this responsibility and balance within its strategic plan and structure.

COADPH Mission and Vision Supporting CHIP Activities

The provision of local public health services – assessment, assurance and policy development – are an expectation of Texas statute. The 10 essential health services are memorialized and authorized in the Texas Health and Safety Code. Community health improvement is a clear consequence of the evolution of public health and can be seen as the product of the assessment, assurance and policy development work being performed.

The mission and vision statements of COADPH dovetail into the planning work needed to construct a CHIP. These statements, as referenced in the COADPH Strategic Plan:

MISSION STATEMENT:

Promoting and protecting health while preventing disease with integrity and compassion for our community.

VISION STATEMENT:

We believe in equitable health for all.

1   DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. Prev Chronic Dis 2017;14:170017. DOI: http://dx.doi.org/10.5888/pcd14.170017

These statements inform the work of COADPH and craft a direction for the facilitation of community health planning. Promoting and protecting health, while viewing work through the lens of equity, is the missional and visionary focus of the local health department. These strategic views complement the investigation and community conversation around the identified areas of concern.

COMMUNITY PLANNING PROCESS

Community Engagement

The Association for Community Health Improvement (ACHI) provides an online toolkit that describes a replicable process for health assessment and subsequent community engagement. Key elements begin with common language and identification of stakeholders. Once identified, the process moves from data to action, then evaluation. COADPH began the CHA process in this same fashion – identifying local stakeholders, collecting data, noting priorities and areas of concern, documenting those results and sharing them, then convening a group for planning strategies to address the concerns. Figure 2 below shows the process from an ACHI graphic:

Figure 2. Community Engagement[2]

It is important to note that this engagement is a *process*; it is never actually finished or completed. The evaluation portion requires an analytical review of the strategies implemented, then revision for future successes. As such, the COADPH CHIP Summit represents the strategy portion of the process. With the application of collective impact theory, the assumption is that the CHIP goals and objectives will provide a

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2   Association for Community Health Improvement. (2017). Community Health Assessment Toolkit. Accessed at www.healthycommunities.org/assesstoolkit

collective framework for considering program and project focus for all involved when pursuing improved health in Amarillo.

CHA/CHIP Committee

A critical step in the CHIP process is convening a smaller, dedicated group of stakeholders to help craft the framework and assist COADPH in the facilitation of the overall effort. This committee reviewed CHA survey language, discussed CHA rollout logistics, honed focus areas and reviewed CHA results. During the CHA implementation, the committee worked with COADPH leadership to formulate the CHIP process and summit concept.

COADPH worked to be inclusive and multidisciplinary in the formation of the CHA/CHIP committee. The committee is ad hoc but can be continued to carry out the plans and support services needed to advise and guide the fulfillment of the CHIP process, outside of the responsible parties for goal completion.

CHIP SUMMIT

The COADPH worked to bring together a diverse, engaged group of community stakeholders who were dedicated to community health improvement either by occupation, volunteerism, advocacy, and/or academic training. The Summit format was chosen to convene this diverse group in a neutral setting to discuss community data and goals without political, financial or organizational influences for programs or projects. Leaders and front-line staffers alike were invited to participate. Experts in social and clinical fields were invited along with grassroots community organizers to consider the highlighted areas of concern.

Collective Impact as a Model

Collective impact is the social theory behind the CHIP Summit process for determining community-wide health improvement goals. Collective impact tracks the process from data and analytics as the foundation for understanding a health concern, sharing the measurement of that data, considering local efforts ongoing and planned, communicating the assessment and efforts being undertaken, and recognizing community support. Figure 3. Illustrates the five conditions referenced.

Common agenda concepts are the infrastructure for the beginning of the CHIP process. The areas of concern, derived from the CHA, highlight the priority areas for the common agenda within the community. Shared measurement is achieved by consensus within the CHIP goals and objectives: the community comes together to form common goals and agrees to the measurement within the objectives to meet those goals. The activities and subsequent communication are built into the organizational structure of the support agencies sponsoring or supporting the goals cited in the CHIP. Finally, the community should recognize which agencies or organizations have the accountability and responsibility for the activities within the referenced goals.

Key Informant Participants and Community Stakeholders List

Key informants and participants were recruited using the "snowball" method of invitation recommendations. The CHA/CHIP planning committee suggested participants and organizations; COADPH invited the participants using multiple email contacts. The participants were varied across occupations, disciplines and organizations. Several organizations were represented by multiple people. Overall, 83 people participated in the CHIP Summit representing 38 different organizations and community groups. Figure 4 lists the organizations and sectors they represented.

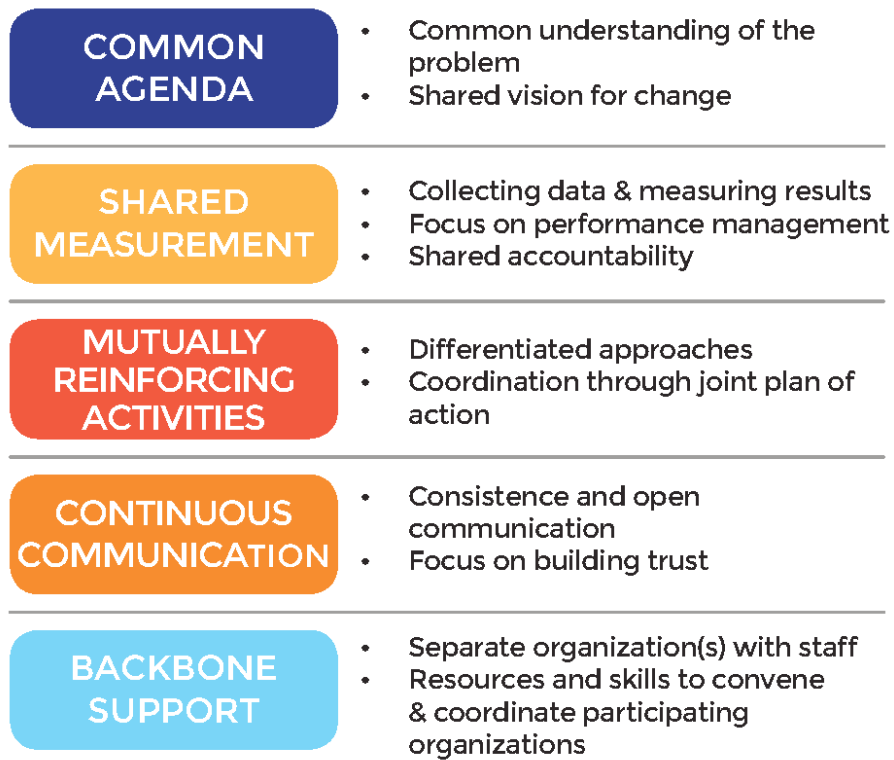**Figure 3. Collective Impact Conditions[3]**

THE 5 CONDITIONS OF COLLECTIVE IMPACT

COMMON AGENDA
- Common understanding of the problem
- Shared vision for change

SHARED MEASUREMENT
- Collecting data & measuring results
- Focus on performance management
- Shared accountability

MUTUALLY REINFORCING ACTIVITIES
- Differentiated approaches
- Coordination through joint plan of action

CONTINUOUS COMMUNICATION
- Consistence and open communication
- Focus on building trust

BACKBONE SUPPORT
- Separate organization(s) with staff
- Resources and skills to convene & coordinate participating organizations

Figure 4: Organization and sector listing

Organization	Type
Amarillo College - Health Sciences/Nursing	Higher Education
Amarillo Barrio Association	Neighborhood
Amarillo ISD	Public School
AMR	Emergency Services
Amarillo Police Department	Law Enforcement
ARAD	Substance Misuse
City of Amarillo (2)	Municipal Management
Baptist Community Services	Philanthropy/Seniors
Board of Health	Local Government
BSA	Hospital
Caldwell Business Group	Consulting
City Council	Elected official
City of Amarillo	Transportation
City of Amarillo - WIC	Local Government / Health
City of Amarillo - Parks and Recreation (2)	Local Government

3   Kania, J; Kramer, M. (2011). Collective Impact. *Stanford Soc Inn Rev,* Vol 9, no.1, 36-41.

Coalition of Health Services	Health
Downtown Women's Center	Homeless
Family Support Services (2)	Community / Mental Health
Harrington Cancer and Health Foundation	Philanthropy / Health
Haven Health	Community / Health
Head Start	Children
Heal The City	Community / Health
Health Authority	Public Health
J.O. Wyatt	Local Government / Health
North Heights Association	Neighborhood
NWTHS	Hospital
Panhandle 2020	Community
Panhandle Behavioral Health Alliance	Mental Health
Park Central	Health / Seniors
Parks Board	Appointed Official
Poison Center, Texas Panhandle	Health
Potter County Sheriff's office	Law Enforcement
River Road ISD	Public School
Snack Pak 4 Kids	Children
Texas A&M University Extension Service	Seniors
Texas Department of State Health Services	State Government
Texas Tech University Health Sciences Center (2)	Medical School
Tobacco Free Amarillo	Health
United Way of Amarillo and Canyon	Philanthropy
Veterans Administration	Federal Government
Vibra Hospital of Amarillo	Hospital
West Texas A&M University - School of Nursing	Higher Education

Participants were provided the Community Health Assessment information links prior to the Summit event and encouraged to review the information. The Summit event staff provided the CHA and summary information both in printed and electronic format at the event for reference.

City Councilmember Elaine Hays addresses the CHIP Summit participants.

Community Presentations

The CHIP Summit began with three community presentations outlining new and continuing efforts in mental/ behavioral health programs, healthcare access for underserved populations, and an overview of the recently completed community health assessment. These presentations were reviewed to allow the Summit participants to have a common frame of reference, with a foundation in data, for CHIP goal discussion and selection.

Each presentation is attached in the Appendices section of this CHIP document. The authors of the presentations agreed to have the information included in the CHIP. This inclusion provides needed context and foundational concepts for the areas of concern and the current status of community health improvement activities already in place prior to CHIP development.

Summit Goal-Setting Exercise Description

After the community presentations, Summit participants engaged in tabletop discussions centered on the areas of concern highlighted within the CHA. For each topic, these discussions were facilitated by subject matter experts who volunteered to assist. Participants were asked to review the data provided (in the form of copies of the CHA or one-page data summaries for each area of concern) and generate consensus around community goals. Scribes were assigned to each table to record the conversations and attempt to refine comments into a cogent, concise goal for further objectives and metrics assignment.

At the end of the Summit, the scribes submitted the worksheets and discussion notes to the facilitators to be tabulated and edited for clarity. Those clarified goals are included in this CHIP with objectives and measures added for further adoption by the Amarillo stakeholders at large.

SUMMIT-DERIVED CHIP GOALS

COMMUNITY HEALTH IMPROVEMENT PLAN GOALS

Goal 1: *Identify causes of infant mortality and prioritize prenatal access to care for Potter County and at-risk populations in Randall County.*

Objective	Activities	Timeline	Outcomes
1.1 Identify high infant mortality zip codes in Potter and Randall counties and publish data.	1.1.1 Publish Community Health Assessment on COA website	1.1.1 January 2019	1.1.1 CHA online
	1.1.2 Press release announcing CHA publication	1.1.2 October 2019	1.1.2 Media coverage of CHA publication
1.2 Analyze data to identify risk factors for infant mortality and potential predictive variables.	1.2.1 Consult with UT Tyler Population Health to determine risk factors or predictors using data previously reported	1.2.1 December 2019	1.2.1 Risk factors or predictors identified and published
	1.2.2 Utilize data from Healthy Texas Babies Grant	1.2.2 December 2020	1.2.2 Risk factors or predictors identified and published
	1.2.3 Disseminate findings in a brief or report	1.2.3 June 2021	1.2.3 Media coverage of CHA publication

Goal 2: Pilot prenatal care program focusing on access to services and health literacy.

Objective	Activities	Timeline	Outcomes
2.1 Form multi-agency prenatal task force.	2.1.1 Convene community stakeholders in planning meeting to describe data, inventory community resources	2.1.1 October 2018	2.1.1 Establishment of task force
	2.1.2 Create program outline to address gaps in services and increased access for inventoried resources	2.1.2 June 2019	2.1.2 Adopted project/ program plan for implementation
2.2 Educate at-risk populations on existing prenatal resources.	2.2.1 Create existing list of prenatal providers and services	2.2.1 June 2019	2.2.1 Published and distributed list
	2.2.2 Advertise/Market/ Distribute/Publish list of resources in prioritized neighborhoods	2.2.2 October 2019	2.2.2 Distributed lists
	2.2.3 Develop relationships with school districts to reach pregnant teens	2.2.3 Ongoing	2.2.3 Identify at-risk campuses for prioritization of education
2.3 Formalize program and pursue backbone support agency or multi-agency funding.	2.3.1 Obtain Task Force approval of program/ project	2.3.1 March 2020	2.3.1 Program/project framework
	2.3.2 Formalize MOU or similar agreement for support agency	2.3.2 May 2020	2.3.2 Executed MOU with support agency
	2.3.3 Budget for program activities	2.3.3 October 2020	2.3.3 Budget posted on websites of public agencies
	2.3.4 Submit grants, philanthropic or governmental financial requests to perform project/ program work plan	2.3.4 Ongoing	2.3.4 Grant submitted and accepted or rejected by funding agency

Goal 3: Increase awareness and availability of mental health services.

Objective	Activities	Timeline	Outcomes
3.1 Identify Panhandle Behavioral Health Alliance community goals.	3.1.1 Coordinate with PBHA to inform the community of established goals	3.1.1 March 2018	3.1.1 PHBA goals noted in public documentation
	3.1.2 Educate and advocate PBHA goals throughout the Amarillo area using social media linkages from member organizations	3.1.2 Ongoing	3.1.2 Social media posts listing resources available by 3 different agencies
3.2 Coordinate with Texas Panhandle Centers for information regarding services.	3.2.1 Distribute resource guide with phone numbers and web information	3.2.1 Ongoing	3.2.1 Resource guides available in public spaces
3.3 Increase access by pursuing statewide grant funding for mental/behavioral health services.	3.3.1 Apply for statewide grant funding through PBHA	3.3.1 June 2018	3.3.1 Completed grant application either funded or rejected
	3.3.2 Identify support agency to sponsor grant funded programming	3.3.2 February 2018	3.3.2 Support agency confirmed MOU for mental/behavioral health program

Participants at CHIP Summit weigh in during exercise to develop community goals.

Goal 4: Enhance mental/behavioral health support systems using academic partnerships and public sector agencies.

Objective		Activities		Timeline		Outcomes	
4.1	Explore innovative solutions for service expansion in Amarillo and pursue new or additional academic program.	4.1.1	Identify "best practice" solutions for service expansion	4.1.1	Ongoing	4.1.1	Best practice intervention cited
		4.1.2	Propose grant, philanthropic or public funding plans to implement identified intervention	4.1.2	Ongoing	4.1.2	Program proposal submitted
4.2	Explore expansion of academic partnerships to provide additional training for MH/BH service providers.	4.2.1	Convene planning meeting with WTAMU and AC to review existing programs	4.2.1	December 2019	4.2.1	Meeting held
		4.2.2	Convene planning meeting with TTUHSC for psychiatric training expansion plan details	4.2.2	June 2019	4.2.2	Meeting held
4.3	Enhance or increase case management or navigation services for MH/BH in Amarillo area.	4.3.1	Identify current case management efforts	4.3.1	December 2020	4.3.1	Resource list of case management providers
		4.3.2	Propose additional service units, resources or staff into current programs to budget requests in current MH/BH agencies	4.3.2	June 2021	4.3.2	Proposal submitted to increase access to current resources

Goal 5: Provide education and offer resources for healthy lifestyles.

Objective	Activities	Timeline	Outcomes
5.1 Identify community-wide best practices for healthy lifestyle interventions.	5.1.1 Create resource list for exercise options	5.1.1 December 2019	5.1.1 Resource list created
	5.1.2 Create resource list for nutrition support programs	5.1.2 December 2019	5.1.2 Resource list created
5.2 Explore community facilities for programs.	5.2.1 Convene meeting to discuss community access to existing exercise facilities at low-or no-cost	5.2.1 December 2020	5.2.1 Meeting held
5.3 Formalize partnerships with community garden organizations.	5.3.1 Convene meeting to discuss community access to existing community garden projects	5.3.1 June 2020	5.3.1 Meeting held
	5.3.2 Advertise community farmer's market access points	5.3.2 Ongoing	5.3.2 Information distributed
5.4 Improve chronic disease management initiatives.	5.4.1 Strengthen existing smoking ordinance	5.4.1 June 2021	5.4.1 Survey public for support for smoking ordinance
	5.4.2 Explore support for chronic disease management solutions and mobile apps	5.4.2 June 2022	5.4.2 List and distribute available apps for chronic disease management

Goal 6: Broaden substance misuse initiatives and explore services expansion in Amarillo area.

Objective		Activities		Timeline		Outcomes	
6.1	Generate data profile on substance misuse statistics for Amarillo area	6.1.1	Investigate and report overdose statistics	6.1.1	December 2021	6.1.1	Community report on substance misuse published
		6.1.2	Investigate and report opioid prescription information for Amarillo area	6.1.2	December 2021	6.1.2	Community report on opioid prescriptions published
		6.1.3	Investigate and report arrest information regarding drug involvement	6.1.3	December 2021	6.1.3	Community report on drug arrests published
6.2	Educate and inform public on available resources for substance misuse.	6.2.1	Publish resource guide for substance misuse with providers, eligibility and cost requirements	6.2.1	June 2021	6.2.1	Published resource guide
6.3	Explore expansion of inpatient and outpatient resources available in Amarillo area.	6.3.1	Convene planning meeting to discuss resource guide results and explore substance misuse expansion in existing facilities and organizations	6.3.1	December 2022	6.3.1	Meeting held
		6.3.2	Explore service expansion with funding opportunities from for-profit regional providers of services and non-profit providers with matching public funds	6.3.2	December 2024	6.3.2	Project or program outline presented for budget adoption in NPO or for-profit organization
6.4	Create Amarillo Substance Misuse Task Force.	6.4.1	Convene planning meeting for ASM Task Force	6.4.1	December 2019	6.4.1	Meeting held
		6.4.2	Identify backbone agency with minimal budget to begin coordination of above objectives (6.1-3)	6.4.2	June 2019	6.4.2	Agency identified with budgeted support for project/ program facilitation

Goal 7: Create "Healthy Amarillo" public/multi-private partnership to leverage resources and expertise for exercise and wellness.

Objective	Activities	Timeline	Outcomes
7.1 Organize "Healthy Amarillo" partnership.	7.1.1 Conduct planning meeting of interested stakeholders to craft vision of an ongoing partnership for exercise, nutrition and wellness programming	7.1.1 December 2020	7.1.1 Meeting held
	7.1.2 Report exercise, nutrition and preventable conditions data for review and priority-setting by the partnership members	7.1.2 December 2021	7.1.2 Report distributed to stakeholders

Goal 8: Empower Potter County neighborhoods to create a shared vision of health and wellness.

Objective	Activities	Timeline	Outcomes
8.1 Conduct neighborhood planning meetings for visioning and feedback on desired programs or projects.	8.1.1 Use neighborhood plans to develop a health and wellness program that meets the needs of each neighborhood	8.1.1 December 2019	8.1.1 List neighborhoods and supporting data
	8.1.2 Conduct focus-group style meetings to generate qualitative data from pre-designed questions to elicit feedback on vision for "Healthy Amarillo" projects or programs in that neighborhood	8.1.2 December 2020	8.1.2 Meeting held

Goal 9: Leverage community health workers to increase healthcare access.

Objective		Activities		Timeline		Outcomes	
9.1	Identify existing CHW resources.	9.1.1	List current formal CHW or informal efforts in lay health navigation or assistance resources	9.1.1	June 2020	9.1.1	List published and distributed to stakeholders
		9.1.2	Meet with current CHW efforts to explore areas of potential growth in CHWs or clients assisted	9.1.2	December 2020	9.1.2	Meeting held
		9.1.3	Identify lead or support agency to facilitate CHW meetings and coalition framework	9.1.3	June 2021	9.1.3	Organization identified and committed
9.2	Design initial (or enhance existing) CHW training program.	9.2.1	Conduct exploratory meetings with interested or existing stakeholders to discuss CHW status and future vision for Amarillo area	9.2.1	December 2021	9.2.1	Meeting held
		9.2.2	Research and list successful CHW programs in Texas most closely aligned with stakeholders' vision	9.2.2	June 2022	9.2.2	Report on CHW programs
		9.2.3	Strategize and plan a program or project proposal for funding opportunities, either academic, governmental or philanthropic	9.2.3	February 2019	9.2.3	Proposal for CHW project completed
		9.2.4	Request funding for two CHW positions within the Department of Public Health 2019-2020 budget cycle	9.2.4	February 2019	9.2.4	Two community health workers positions budgeted
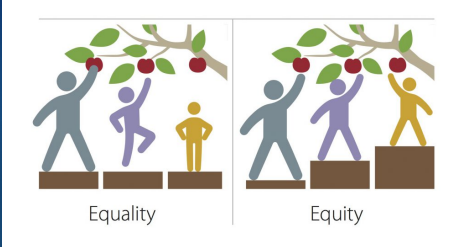
APPENDICES

Appendix A: CHIP Summit Presentations

Welcome!
2018
Community Health Improvement Plan Summit

Public Health
Prevent. Promote. Protect.
Amarillo

Equality   Equity

Amarillo Public Health
Mission: Promoting and protecting health while preventing disease with integrity and compassion for our community.

Vision: We believe in equitable health for all.

Heal the City
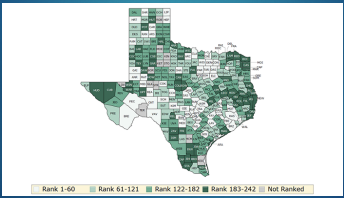Transforming Healthcare. Providing Hope.

OUR MISSION

TO PROVIDE FREE QUALITY MEDICAL CARE AND REFERRAL SERVICES WITH COMPASSION AND DIGNITY TO THE UNINSURED IN OUR COMMUNITY.

Texas Statistics

- 1 in 5 Texans have no health insurance
- Highest uninsured rate in the nation
- 15.6% of the population lives below poverty level of $24,340 for a family of 4

https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201802.pdf

2018 Healthcare Outcomes Rankings

Rank 1-60   Rank 61-121   Rank 122-182   Rank 183-242   Not Ranked

Amarillo Statistics

- 69% of kids in AISD are on free and reduced lunch
- Uninsured rate is 29%- 37% adults, 15% kids
- 22% In Potter County could not see a doctor in the last 12 months due to cost
- Potter County is ranked 200 out of 254 in County health ratings

2018 Community Health Survey Top Health Issues

- Behavioral Health
- Substance Abuse
- Obesity
- Access to Care

How do the Uninsured in Amarillo Receive Health Care?

- J O Wyatt Clinic
- Regence Health Network
- Urgent Care
- Emergency Room

Major Influences

- Poverty
- Culture
- Transportation

Our Vision

- To provide for the medical needs of the uninsured while connecting them to the existing health community
- To share Christ's love and hope with patients and volunteers alike

Resources

- Grants from Harrington Cancer and Health Foundation, Panhandle Women And Children Fund, Amarillo Area Foundation and The Bivins Foundation
- Funding from Baptist Community Services
- Partnership with Maxor, 4 Amarillo, Texas Tech School of Medicine, Texas Tech School of Pharmacy, Amarillo College Nursing Program, and West Texas A&M University Nursing Program
- Financial support from local corporations and businesses
- Private donors
- Community volunteers

Clinic Technology

- eClinicalWorks - Server based EMR to collect and coordinate patient data
- QS1 - Software utilized in on-site Class A Pharmacy

Pharmacy

- Pharmacist joined HTC staff July 2018
- Collaboration with Texas Tech School of Pharmacy
- Class A Pharmacy- No narcotics
- Weekly average of dispensed prescriptions - 375

Shalom Clinic

- Chronic Care Clinic began October 10th, 2017
- Serves the needs of patients with chronic disease- DM, HTN, COPD, Hyperlipidemia, Asthma, Heart Disease, Obesity, Mental Health
- Patients enter covenant agreement for compliance, attendance and active participation in wellness program
- Treated by staffed NP for well and sick visits
- Patients receive care along with prescription medications
- 275 Patients enrolled
- 75 Patients currently in the application process

Results

- Unduplicated Patients Served - 7,302 since 2014
- Total Number of Patient Visits - 24,534 since 2014
- Target is unfunded patients - do not qualify for JO Wyatt, uninsured, underinsured, working poor
- Total Number of Immunizations Administered to Date – 3,257
- Total Number of Dental Patients to Date - 1,411

Shalom Data (n=146)
1st quarterly follow-up

- Of Shalomies with BMI ≥ 30 (n = 92), **54.35%** have lost weight, with an average loss of 5.05 pounds
  - Average of 1.7 lbs. lost per month in Shalom
  - 22.8% of all obese patients lost 5+ pounds between enrollment and their quarterly follow-up
- Of Shalomies with diabetes (n = 57), **75.44%** have decreased HbA1C, with an average decrease of 1.29 percentage points
  - 15.79% of diabetic patients have achieved control of their diabetes (HbA1C < 6.5%) between enrollment in Shalom and their 1st quarterly follow-up
- Of Shalomies with hyperlipidemia (n = 67), **34.78%** have achieved normal lipid levels
- Of Shalomies with elevated blood pressure (n = 87), **42.86%** have achieved normal systolic and diastolic BP (< 125/85 for diabetics, < 140/90 for non-diabetics)
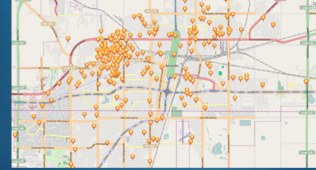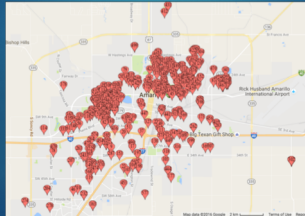
Amazing Stories
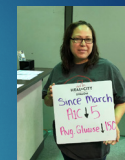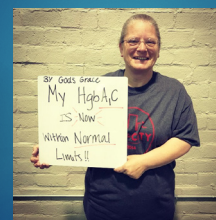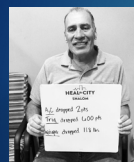
Where do they come from?

- Heal the City's patient base spans 38 counties.
  - 26 counties in the Texas Panhandle
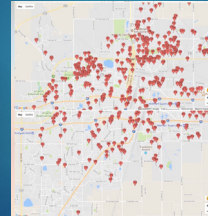 - New Mexico
  - Oklahoma
  - Colorado

Where do they come from?

2016

2017

Collaboratives

- Collaboration with Health Department to give immunizations and STD testing for adults
- Collaboration with Texas Tech Women's Health for breast screening, Pap smears and HPV immunization to decrease the risk of cervical cancer - 333 women to date
- Collaboration with Texas Panhandle Centers (TPC)
  - A grant provides on-site behavioral health workers, including a social worker and a licensed professional counselor.

Our New Home

New Medical Clinic

Contacts

- Heal the City Clinic - 806-231-0364
- www.healthecityamarillo.com
- Email healthecityamarillo@gmail.com

"There is no Health without Mental Health."

--World Health Organization (WHO)

PBHA
Panhandle Behavioral Health Alliance

Public Health
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Amarillo

Community Health Assessment Takeaways!

Behavioral Health Focus of the CHA

Have you or a member of your household sought mental health care services in the last two years?	Are you a family caregiver of someone who is elderly?
• increased to 17%	• increased to 14%

Behavioral Health Focus of the CHA

(CHA Key Informant Survey)

- ▶ Which of the following populations in this community are not being adequately addressed by local health service providers?
  - ▶ **Mental Health Clients** were at the top of the list of responses!
- ▶ What recommendations or suggestions do you have to improve health and quality of life in the community?
  - ▶ **Mental/Behavioral Health Access** was the 3rd most popular response

---

What are the three most important health issues facing our community?

- ▶ Top 2 responses:
- ▶ Mental/Behavioral Health
- ▶ Substance/Opioid Abuse

What are the three most important health issues facing…

- ▶ Children in Amarillo?
  - ▶ #2-Mental/Behavioral Health
- ▶ Adults (19-64) in Amarillo?
  - ▶ #2-Mental/Behavioral Health
- ▶ Seniors (65+)?
  - ▶ #3-Mental/Behavioral Health

Panhandle Behavioral Health Alliance (PBHA)

PBHA
Panhandle Behavioral
Health Alliance

- ▶ Mission: *The PBHA collectively builds systems that improve the behavioral health lifecycle of care for all people of the Texas Panhandle.*
- ▶ Lifecycle of Care —
  - ▶ Prevention, Early Intervention, Treatment, Recovery
- ▶ Behavioral Health
  - ▶ Mental Health, Substance Use Disorder, Other Addictions

---

The PBHA collectively builds systems that improve the behavioral health life-cycle of care for all people of the Texas Panhandle.

- ➢ Resource to Service Providers,
- ➢ Capacity Builder,
- ➢ Convener, Collaborator
- ➢ *Do NOT Provide Direct Services to Clients!*

PBHA & CHA Focus Areas:

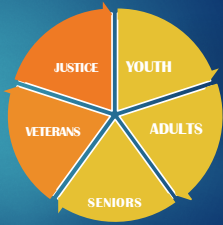IMPROVING ACCESS TO CARE; PREVENTION & EARLY INTERVENTION
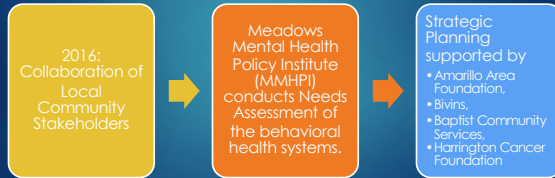
BEHAVIORAL HEALTH WORKFORCE

SUBSTANCE ABUSE

PBHA & CHA Focus Areas:

JUSTICE · YOUTH · ADULTS · SENIORS · VETERANS

PBHA Activity: 2016-2017

2016: Collaboration of Local Community Stakeholders → Meadows Mental Health Policy Institute (MMHPI) conducts Needs Assessment of the behavioral health systems. → Strategic Planning supported by
- Amarillo Area Foundation,
- Bivins,
- Baptist Community Services,
- Harrington Cancer Foundation

Recent Activity: 2018

➢ Fiscal Sponsorship by United Way Amarillo & Canyon

➢ Community Mental Health Grant
  ➢ Representative Four Price -- HB 13
  ➢ Awarded

LIVE UNITED
United Way
of Amarillo & Canyon

Currently: Seeking Collaborations

➢ Workgroup Formations:
  ➢ Community Awareness: Prevention & Early Intervention
  ➢ Integrated Care: Access & Alignment
  ➢ Other

LIVE UNITED
United Way
of Amarillo & Canyon

PBHA
Panhandle Behavioral Health Alliance

What Can You Do?

1. Get Involved in PBHA Workgroups!
2. Mental Health First Aid Classes
   www.mentalhealthfirstaid.com
3. Join the conversation!
   www.okaytosay.org

Our Supporters:

United Way of Amarillo & Canyon · PBHA Panhandle Behavioral Health Alliance · TEXAS STATE of MIND THE MEADOWS MENTAL HEALTH POLICY INSTITUTE · HIGH PLAINS CHRISTIAN · AMARILLO AREA FOUNDATION · HARRINGTON CANCER and HEALTH FOUNDATION · MARY E. BIVINS FOUNDATION

## Slide 1

To Support Panhandle Behavioral Health Alliance

Make Tax Deductible Donations payable to:

United Way of Amarillo Canyon

Message line: *For Panhandle Behavioral Health Alliance (PBHA)*

LIVE UNITED
United Way
of Amarillo & Canyon

PBHA
Panhandle Behavioral Health Alliance

Slide 2

Contact Us:

- www.panhandlebehavioralhealthalliance.org

- *806-376-6359*

- *shree@panhandlebehavioralhealthalliance.org*

United Way
of Amarillo & Canyon

PBHA
Panhandle Behavioral Health Alliance

Slide 4
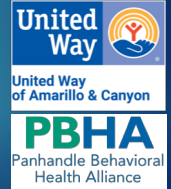
A storm had washed up thousands of starfish. A girl picks one up and tosses it into the ocean. Then another. And another. People watch, amused. A man says, "Little girl, what are you doing? You can't save them all. It's impossible to make a difference." Returning another back to the water, she says, "It made a difference to that one."

Slide 5

**2018
Community Health Assessment**

Public Health
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Amarillo

Slide 6

Steering Committee Participants

- Todd Bell, MD, Texas Tech Physicians
- Brent Collier, Northwest Texas Healthcare System
- Gainor Davis, Harrington Cancer and Health Foundation
- Alan Keister, MD, Heal the City
- Bud Schertler, Texas Panhandle Centers
- Natalie Lowe, Refugee Services of Texas
- Scott Milton, MD, Texas Tech Physicians
- Patricia Miranda, Amarillo Independent School District
- Katie Noffsker, United Way of Amarillo and Canyon
- Kevin Russell, Panhandle Regional Advisory Council
- Rebecca Scott, MD, Amarillo Children's Clinic, Public Health Board
- Delores Thompson, Amarillo College, Public Health Board

Public Health
Amarillo

The Community Health Assessment

- This is a Community Health Assessment – Not a Public Health Assessment.
- Highlights areas of concern regarding the health of the community.
- Designed to provide focus for solutions that will impact community health metrics over time.

Timeline and Deliverables

- June 11-29, 2018 – Conducted random-digit-dial telephone survey with 404 Amarillo residents.
- July 10-21, 2018 – Opened online key informant survey and received 105 completed surveys for a response rate of 64%.
- July 30-August 3, 2018 – Conducted 5 focus groups with discrete groups of healthcare consumers.
- August 8-15, 2018 – Produced community health data scan highlighting areas of concern from publicly available data
- September 8-9, 2018 – Produced 2018 Community Health Assessment

Research Components

- **Community health data scan -** secondary, publicly available data review
- **Random-digit dial telephone survey -** using national Behavioral Risk Factor Surveillance System, as well as locally-directed questions for comparison from prior surveys
- **Key informant survey -** an emailed instrument to community leaders for input
- **Focus groups -** interviews with end users of the health care system within Amarillo

Community Data Scan – County Health Rankings

This chart compares rankings of Potter and Randall counties among the 254 counties in Texas, by indicator. (Lower number indicates more positive ranking.)		
	Potter County	**Randall County**
Health Outcomes	**200**	**27**
Quality of Life	193	42
Health Factors	**202**	**9**
Health Behaviors	238	29
Clinical Care	52	7
Social and Economic Factors	173	9
Physical Environment	63	48

Research Component: Telephone Survey

Respondents rate own health as "fair" or "poor"

Amarillo – 24%
Texas – 22.2%
U.S. – 17.7%

Research Component: Telephone Survey (cont.)

Respondents report being overweight or obese

Amarillo – 70.5%
Texas – 68.6%
U.S. – 64.6%

Obesity self-report increased from 29% in 2013 to 37% in 2018.

Research Component: Telephone Survey (cont.)

Respondents have been diagnosed with diabetes

Amarillo – 21%
Texas – 15.5%
U.S. – 10.5%

Residents reporting diabetes in the Amarillo area increased from 11% in 2013 to 21% in 2018.

Research Component: Telephone Survey (cont.)

Respondents have smoked 100 or more cigarettes

Amarillo – 47%
Texas – 39.2%
U.S. – 40.7%

Amarilloans are decreasing their efforts to quit smoking
2013 – 56% tried to quit
2018 – 37% tried to quit

Research Component: Telephone Survey (cont.)

Respondents reports of seeking mental/behavioral health services increasing

2013 – 12%
2018 – 17%

Research Component: Telephone Survey (cont.)

- 39% limit their drinks to only one or two per month and 25% drink three to five drinks per month. 6% state they have not consumed any in the past 30 days.
- 32% claim that the most they drank in one sitting was only one drink, while 22% state that two drinks was the most that they consumed on any occasion.
- Drinking 5+ drinks in one sitting is considered "binge drinking." 20% of Amarillo residents admitted to binge drinking once in the past 30 days.
- 8% of respondents have driven once after having too much to drink, and 5% of people have driven twice while under the influence.

Research Component: Telephone Survey (cont.)

- A strong majority (81%) of Amarillo residents state that they have not been prescribed opioids in the past 12 months.
- Of the respondents, only 13% had one prescription in the past 12 months, and even fewer (2%) have had two prescriptions.
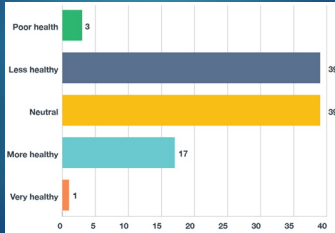- The range of prescriptions was 0-24. (<1% stated they had received the 3, 4, 5, 6, 12, or 24 prescriptions)

Research Component: Key Informant Survey

- Respondents represented healthcare, education, business & industry, nonprofit organizations and governmental entities
- Survey conducted through the online survey platform SurveyMonkey
- 165 key informants invited to participate
- 105 key informants completed the survey
- 64% overall response rate

Slide 1

Key Informants Rate
The Overall Health of the Community

Category	Value
Poor health	3
Less healthy	39
Neutral	39
More healthy	17
Very healthy	1

(x-axis: 0, 5, 10, 15, 20, 25, 30, 35, 40)

Public Health Amarillo

Slide 2

Key Informants:

Top three populations' healthcare needs not being addressed adequately

- ▶ Mental/behavioral health patients
- ▶ Un-/under-insured
- ▶ Low-income

Public Health Amarillo

Slide 3

Key Informants:

Top three health issues facing the community

- ▶ Mental/behavioral health concerns
- ▶ Substance abuse
- ▶ Obesity (tie)
- ▶ Access to care (tie)

Public Health Amarillo

Slide 4

Key Informants:

Risk factors (top three) to be changed or modified

- ▶ Lack of health education
- ▶ Mental/behavioral healthcare access challenges
- ▶ Nutrition and physical activity

Public Health Amarillo

Slide 5

Key Informants:

Resources needed to address risk factors

- ▶ Additional health education
- ▶ Affordable care access
- ▶ Governmental financing for community health
- ▶ Community collaboration

Public Health Amarillo

Slide 6

Key Informants:

Most important health issues facing children
- ▶ Access to primary care
- ▶ Access to mental/behavioral health services
- ▶ Nutrition/physical exercise
- ▶ Food insecurity/hunger
- ▶ Teen pregnancy

Top 4 pediatric healthcare specialists needed in Amarillo

- •Counseling/psychology
- •Psychiatry
- •Neurology
- •Pulmonology

Public Health Amarillo

Key Informants:

Most important health issues facing adults (ages 19-64)
- Access mental/behavioral health
- Access to care
- Access to health insurance
- Obesity

Top 3 adult healthcare specialists needed in Amarillo
- Counseling/psychology
- Psychiatry
- Neurology

Key Informants:

Most important health issues facing senior adults
- Access to primary care
- Chronic disease prevention and treatment
- Mental/behavioral care access
- Food security/nutrition

Top 3 senior adult healthcare specialists needed in Amarillo
- Gerontology
- Counseling/psychology
- Navigation specialist

Research Component: 5 Focus Groups

- Un- and under-insured persons
- Mothers of pre-term or low-birthweight babies
- Former users of opioids
- Professionals who work with users of opioids
- Refugees

Un- and Under-insured Residents:

- **Access to care is a reported concern.**
  - *"I can't get in to the doctor for days, so I go to the ER."*
- **Insurance is difficult to obtain.**
  - *"This is a wealthy country. Everyone should have insurance."*
- **Education on existing resources appears lacking.**
  - *"Make information available about programs, like flu shots, sooner. I watch the news. I don't buy the newspaper. A lot of things we find out by word of mouth, but it's often the wrong information."*
  - *"I live on the north side. A lot of things are not advertised there. They don't target the 79107 area. We miss a lot of information. I would like to have more information about medical care and meetings in the community."*

Mothers of Pre-term or Low-birthweight Babies:

- **Access to care and navigation challenges persist.**
  - *"I didn't get prenatal care until I was six months pregnant. I was young and scared."*
  - *"I didn't find out I was pregnant until I was seven months."*
  - *"A lot of people don't know about these community programs. Many are income-based and people don't think they will qualify. Head Start, for example."*
  - *"I wish I had been given more postpartum information."*
- **Health education, and particularly sex education, is a topic of concern.**
  - *"Everyone makes mistakes. People judge you for your mistakes."*
  - *"More education for fathers and what to do – especially teen dads."*
  - *"More open about birth control. Kids should be able to go to their parents for help."*
  - *"We need more education about STDs and HIV. People don't know you can get these even if you're on birth control."*

Former Opioid Users:

- **Addiction is complex and resources are scarce.**
  - *"I've been a user for 23 years. I've been clean and sober for five now – five months. I've just been in and out of treatment centers and stuff like that to try to cope with the – what I've been struggling with."*
  - *"I had several different programs, but the one that has stuck and the most recently helped is I went through the ARAD program. The one that they had for me for the shelter and not the new one. I also got help at Narcotics Anonymous and Another Chance House. So, those three programs are what worked for me."*
- **Substances, illegal and legal, are readily accessible.**
  - *"Go to the doctor. Go to the Emergency Room. Go to the local corner house. Go to the guy in the car – wherever."*

Appendix B: CHIP Summit Break-out Sessions Notes

Community Health Improvement Plan Summit

Notes from Break-out Sessions

November 29, 2018

Health Disparity/Infant Mortality

GOALS:

1. Leverage current resources for Potter County neighborhoods by connecting them to people in need of all ages.
2. Identify causes of infant mortality in Potter/Randall counties.
3. Focused pilot programs.
4. Develop relationships with school districts.

- Replicate free clinic and prioritize community in need
- Case management
- Explore new funding/grants
- Annual level of data
- Lack of transportation
- Language
- Process of Medicaid/delay
- Health literacy

- Lack of education
- Lack of free services
- Community reaction
- Community initiatives
- Mental health education/role playing activities/classes
- Sensitivity
- Multiple services in one place
- Multigenerational communication
- Identify causes of infant mortality within each zip code
- Remove stigma
- Education/resource building
- Sex education/STD prevention
- Multicultural homes
- Outreach (multiple languages)
  - Reaching through unusual places
- Social media
  - Education
  - Reminders
- Better access to services
- Keep our data updated with infant mortality

Strengths:

- Heal the City
- WIC
- Home visiting models
- FSS – communication
- 211
- City neighborhood plans

Mental/Behavioral Health

GOALS:

1. Increase awareness, linkage and availability of mental/behavioral health services.
2. Develop and improve behavioral and mental health support systems within communities.
- Establish psych residency
  - Military and community mental health
  - Substance abuse fellowship/residency
- Child psych (non-academic counseling)
- Psychiatrist with experience and medical
- Funding – some is secure, need dialogue with legislators
- Tele-psych

- Barriers
  - Not enough resources
  - Time and access
  - Geriatric psych
  - Stigma (decrease)
- Prevention
- Education of nurses and counselors of available resources
- Quality referrals
- Directory (online)
  - Providers and public
- School counselor burden
- Awareness
- Community/funding
- Only resource in the Panhandle
- Transportation
- Inmate behavioral health
- Another facility
- Meals on Wheels
- Child abuse
- Domestic abuse
- Mental health first aid
- Spiritual care
- Resource navigation system
  - The Pavilion?
- Connections to substance abuse
- Appropriate referrals
- Open the conversation about mental health
- Long-term solutions
- Data needs
- Physical access/transportation
- Stigma/awareness
- Justice system – community
- Follow-up
- Support system
- Focus on community wellness
- Understanding cultural diversity
- Medically certified translators
- Faith based
- Community leaders
- Flexibility/adapt
- Connectors

- Directory of resources
- 211 directory updates
- Mobile mental health clinic

Chronic Disease

GOALS:

1. Provide education and offer resources to increase healthy lifestyles, including smoking cessation, healthy eating and activity.
2. Increase health literacy, awareness, education and accountability. Use innovative, non-traditional means to improve education and awareness of chronic disease management.

Smoking

- Engage community partners, medical community
- Identify areas/zips of high-smoking rates
- Offer incentives
- Encourage employers to provide incentives for non-smoking
- Educate, targeting youth, early childhood
- Policies
- Implement creative, flexible solutions that apply to daily life
- Obtain/create curriculum on smoking and healthy eating
- Include tangible, real-life steps in education
- Target kids and mothers
- Research use of vapes, etc.
- Low priority when compared to food, housing needs
- Healthy food and lifestyle are expensive
- Lack of walkability, public spaces, trails
- Lack of knowledge about parks, programs in place, opportunities and resources
- Educate kids
- Encourage employers to cut down on smoking (not hiring smokers, higher premiums for insurance)

Chronic disease

- Use innovative, non-traditional means to improve access to care, education and awareness of chronic disease management
- Build community health apps (tracking health metrics, comm. w/ HCP)
- Survey and utilize current technology
- Expand points of access
- Build community health app
- Survey current technology
- Expand points of access
- Reduce barriers to care

- Increasing education/awareness
- Improving health care system experience
- Reducing barriers to care:
    ◦ Non-traditional hours and locations (churches, pharmacies)
    ◦ Mobile healthcare (and tele)
    ◦ Include home health
    ◦ Survey and utilize existing technology
- Increase education/awareness:
    ◦ Use screens in offices, etc. for education
    ◦ 'Twittorials'
    ◦ Look for new technology, new apps – Amarillo specific
        - Tracking BP, etc.
- Barriers to management:
    ◦ Education/insight
    ◦ Bad previous healthcare experiences
    ◦ Motivation/fear
    ◦ Access
    ◦ Funding – low priority

Substance Misuse

GOALS:

1. Educate the community with multigenerational approaches emphasizing the disease concept and combining behavioral/mental health to destigmatize substance abuse.
2. Decrease the opioid prescription burden responsibly.
3. Education
    a. Stress choice vs. disease model.
    b. Substance/mental health must be treated as one.
    c. Destigmatize the problem.
- Opioids are not a current priority
- Randall County is under-reported
- Why opioids? – In Amarillo
    a. Not as large a problem as other areas
    b. Education – alcohol is a drug
    c. In the dark – trauma
    d. Under reporting – electronic medical records
    e. Long-term process
    f. Need resources for lower income
    g. Chicken or egg
    h. Income – coping methods
    i. Disease – high risk or not a choice

        j.   Education – intervention/prevention

- Increase resources to:
  a. Speedy services
  b. Stigma free assistance
  c. Information clearing house number
  d. Increased education - multigenerational
  e. Availability of treatment
  f. Show need with concrete data
- Opioids – availability
  a. Pain level
  b. Ease
  c. Behavioral health – substance
  d. Generational
  e. Increase behavioral health professionals

Healthy Amarillo – Obesity/Smoking/Exercise

GOALS:

1. Create one public/multi-private partnership to leverage space, resources and expertise. Potential location: Warford Center.
2. Empowering diverse communities to create their own shared visions of health (individual and community) and give them the tools and resources to make that a reality.

Ground rules for goal: First: Community engagement meetings – What do our neighborhoods want? Then: How do they rally around THEIR ideas, not our ideas for them?

Create community champions

Multiple Factors

- Food/poor nutrition
- Activity/exercise
- Poverty
- How to cook/prepare food
- Accessibility to fresh fruits/vegetables
- Chronic disease
- Mental health issues/stress
- Social

Exercise

- Perception of cost
- Access to facilities
  ◦ Information
- Lack of facilities
- Competing mindset for different parts of the city

- It's a luxury – chaos mode/capacity

Education

- Access to what is there
- Healthy eating habits
- Unity of messaging
  - HUB/Communication
- Targeted events/health fairs
- Scalable programs/platform
- Listening – what does this look like?
- ➢ Opportunity
  - ❖ If we offer education, the opportunity should also be accessible
  - ❖ Package right – sustainability
  - ❖ Programs in non-traditional spaces
  - ❖ Opportunity and tools for success

Nutrition

- Education
  - How to be?
  - Where to go?
  - Access
- Access to food – good food
- How to preserve, keep safe to eat
- Time/knowledge/desire to work
- Bad eating habits that have led to chronic disease

Exercise

- Devices – TV, phones, video games
- Time – how to incorporate?
- People are overscheduled
- How to start
- What to do?
- Movement vs. exercise
- Financial barriers for basics like shoes
- Healthy environment
- Few community partnerships – programming
- Families working/economics
  - Kids staying at home when parents are at work
- Lack of motivation
- Social
- Time constraints

Encouraging

- Warford Center
- Childcare options reducing barriers
- Tangible outcomes – it works!
- Enthusiasm is contagious
- Promotion of existing resources – like rails to trails
- Participation in kids' sports
  - Build on for accessibility

Integrated

- Community gardens
  - Expand?
  - Food bank/master gardener (extensive)
- Access to <u>safe</u> exercise
- Specific to different areas of town
- Mindset changes
- Center Without Walls "sits in a community it can serve"

Access to Care – Navigation/Case Management

GOALS – none given from either session

- Mental health/transportation
- Resource guide
- Community health workers
- Stay updated
- Health consultation
- Distribute Info
- Navigation specialist for senior adults – chronic care management (Medicare)
- EMS/AFD = CHW
- Community health workers for navigation services in neighborhood associations, Emergency Medical Services and Amarillo Fire Department
- Know what resources are available
- Communication
- Uber grant – like chemo cars – volunteers
- Gap – J.O. Wyatt clinic and Heal the City
- Expand – when to go to ER class
- Educate – chronic conditions through primary care
- Handout – Pavilion – resource list
- Behavioral care access for children and adults
- Better collaborate with AISD
- Crisis Intervention Team (CIT)

- Meals on Wheels

- Education on rescuer task force

- Church navigation

- One-stop shop for medical resources

- Teach the kids and they take information home

- Transportation, city transportation

- Access all over the city

- Language barriers

- Navigation that can direct them to services

- Obesity – sidewalks for walking

- Database with resources about doctor offices and what insurance they accept

- A center without walls (virtual resource for connecting people to services)

- Listen to people who need the services

- Communicate by text

- Grant for Uber

- Program that can screen you for eligibility

- Tele-medicine

- Embrace technology to help increase access to care

- Kiosk for health services

Acknowledgments

We extend our thanks to all the people who took their time to participate in the Community Health Improvement Plan Summit on November 29, 2018. We are grateful to have had a large turnout of people who represented diverse sectors of our community and who have a passion for improving the healthcare of all our citizens. We look forward to enhanced and new partnerships that will benefit many.

We also extend our gratitude to Xcel Energy for the generous use of their beautiful new conference facilities in Downtown Amarillo. The willing service and hospitality of the Xcel staff helped to make the CHIP Summit a success.

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January 10, 2019