Strategic Pillar: Health Care

1.1	Initiative	Create the Community Care Collaborative (CCC)					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Create a Health Information Exchange (Disease Management Registry or DMR)**	Enhance the existing electronic health record (EHR) capabilities of participating providers to implement DMR functionalities	The Community Care Collaborative (CCC) enhanced the existing information technology (IT) capabilities of CommUnityCare (CUC), participating provider in FY14, to implement DMR functionalities. These new functionalities allow clinicians to identify patients with targeted chronic conditions, diabetes and hypertension, when they access care. The DMR supports the chronic disease management program and the protocols the CCC has adopted.	[REVISED] 50% of health centers will use DMR	There are four clinic systems with the potential to use DMRs: CommUnityCare, Lone Star Circle of Care (LSCC), People's Community Clinic (PCC) and El Buen Samaritano. Half (50%) of those four, CUC and LSCC, are using DMRs.	Improve annual screening rate for diabetic nephropathy	89.8% of Medical Access Program (MAP) diabetic patients received an annual screening for nephropathy (kidney disease) per disease management protocols. That is 3.25% above target for Delivery System Reform Incentive Payment (DSRIP) DY4.
2	**Implement a Patient Centered Medical Home (PCMH) Model**	25% of CCC Providers will use the CCC medical home model	50% of providers, PCC and CUC, adopted CCC medical home model principles.	75% of Community Care Collaborative Providers will use the PCMH model as defined by the certifying agency	As of September 2015, three of the four clinical systems CUC, PCC, and LSCC, have adopted and implemented the CCC's PCMH Principles.	Improve patient satisfaction scores over baseline	Outcome to be reported in FY16
3	**Implement a Chronic Disease Management (CDM) Model**	A. Publish and implement an evidenced-based comprehensive disease management program for CCC patients with multiple chronic conditions	CDM program published and implemented at CUC Rosewood-Zaragosa and Pflugerville health centers for patients with diabetes and at least one other specified chronic condition. CDM program published and implemented at People's Community Clinic for patients with diabetes and hypertension.			Increase blood pressure control in Chronic Care Model (CCM) participants	73.18% of MAP diabetic patients (served by LSCC, CUC and PCC) had controlled blood pressure (3.27% above target).
		B. Enroll 1,000 patients in the CDM program	2,660 patients were enrolled in the CDM program at Rosewood-Zaragosa and Pflugerville from May 16, 2014 to September 30, 2014. Two hundred and sixteen (216) patients were enrolled in the CDM program at PCC from June 27, 2014 to September 30, 2014.	Enroll an additional 5,000 patients in the CDM (a total of 6,000 patients for years 1 & 2)	25,033 patients were enrolled and treated under chronic care model protocols.		
4	**Implement a Coordinated Patient Navigation Program**	Train five (5) patient navigators on CCC patient navigation protocols	Thirteen (13) patient navigators have been trained.	Train an additional 10 patient navigators on CCC patient navigation protocols (15 total navigators for years 1 & 2)	The CCC trained 21 patient navigators from all contracted providers.	[REVISED] Reduce preventable utilization of the emergency department (ED)	The CCC reduced the rate of emergency department visits for MAP patients with ambulatory care sensitive conditions by 1.9% (37.96% to 37.11%).

1.2A	Initiative	Increase Access to Primary Care and Dental Care					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	Increase Primary Care Capacity at Community Health Centers	A. Expand primary care hours by 45 per week (15 per week at each of three targeted clinics)	Hours were expanded in three CommUnityCare (CUC) health centers: Rosewood-Zaragosa, Pflugerville, and North Central. For Rosewood-Zaragosa, 20 hours were added each week. For Pflugerville, 20 hours, 15 minutes were added each week. For North Central, 20 hours, 30 minutes were added each week.	A. Begin operation of the Southeast Health and Wellness Center by end of Year 2	The Expanded Access DSRIP initiative added to the Southeast Health & Wellness Center (SEHWC) in FY15. An additional 1,431 visits were completed in FY15 as a result of the expansion. The North Central health center also participated in the initiative, expanding from 55 to 75.5 hours a week, an increase of 20.5 hours a week. The increase of these clinic hours provided an additional 6,576 visits in FY15. Altogether, North Central and SEHWC were able to increase capacity by a combined total of 8,007 visits. In FY14, there were three CUC health centers participating in this project: Pflugerville, Rosewood-Zaragosa, and North Central. These three centers provided 209,139 visits in FY14. In FY15, Pflugerville and Rosewood-Zaragosa did not participate and SEHWC opened. SEHWC and North Central provided 223,356 visits in FY15. As a result of the Expanded Access DSRIP initiative, the total number of visits for participating health centers increased 6.8% from FY14 to FY15.	[REVISED] Reduce preventable utilization of the emergency department (ED)	The Community Care Collaborative (CCC) reduced the rate of emergency department visits for MAP patients with ambulatory care sensitive conditions by 1.9% (37.96% to 37.11%).
		B. Provide 5,000 primary care visits over baseline	Provided 6,069 primary care visits over baseline.	B. Provide 16,000 primary care visits over baseline (21,000 total visits over baseline for years 1 & 2)	The CCC provided 21,790 encounters over baseline (6,069), exceeding our target.		
2	Implement Mobile Health Clinics	A. Establish two (2) mobile health teams	[UPDATED] Two (2) mobile health teams established	A. Establish a third mobile health clinic	The CCC and CUC added a third mobile health team for a total of nine (9) FTEs. The staff members required by the DSRIP project include one medical provider, one nurse, and one medical assistant per team. These core staff were augmented by other personnel. The project team also created a Street Medicine clinical team that reached out to the homeless population, completing 302 encounters. Many of the homeless patients did not have health insurance so the team also began to enroll all patients into MAP.	Decrease hypertension in target population	73.18% of Medical Access Program (MAP) diabetic patients (served by Lone Star Circle of Care, CUC and People's Community Clinic) had controlled blood pressure (3.27% above target)
		B. Provide 1,300 visits through the mobile health teams	Provided 2,236 visits through the mobile health teams	B. Provide 2,000 mobile health clinic visits over prior year (3,300 total visits for years 1 & 2)	In DY4, the CCC and CUC provided 4,406 mobile encounters.		
3	Increase Access to Regular Dental Care	A. Increase the number of available dental hours per week by six (at one targeted clinic)	Hours were expanded for dental care at North Central by 20.5 hours per week.			[NEW] Increase dental services for pregnant women	There were 715 pregnant patients that had a dental encounter in FY15. In FY14, the number of pregnant patients at CUC decreased and there was a high no-show rate for pregnant dental patients. To encourage CUC obstetrics (OB) patients to show up for appointments, the CUC dental services team purchased patient handouts detailing the benefits of dental care during pregnancy. PCC was selected as a pilot to test a referral process from OB patients at non-CUC providers to CUC's Dental Clinic. In FY15, the team took additional steps to improve the coordination between PCC and CUC, making/getting a referral, ensure there is a warm handoff, and scheduling a patient to a dental appointment. This opportunity was a win-win for the two safety net providers to expand dental services for OB patients, share DSRIP resources, and meet the DSRIP performance metric in FY15.
		B. Increase the number of patients with chronic medical conditions with a dental visit within past 12 months by 750 over baseline	883 patients above the baseline with two or more chronic diseases were seen for a dental visit and 158 pregnant patients above the baseline were seen for a dental visit at North Central.	Increase the number of patients with chronic medical conditions with a dental visit in the past 12 months by 2,200 over prior year (2,950 total visits over baseline for years 1 & 2)	The CCC and CUC provided dental services to 7,266 adult patients with chronic conditions, 4,207 over the DSRIP baseline.		

1.2B	Initiative	Increase Access to Specialty Care					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Increase Gastroenterology (GI) Care**	A. Add one FTE GI provider over baseline	Added one FTE gastroenterology (GI) provider at CommUnityCare.	A. Add 0.5 FTE GI Provider over prior year (1.5 total)	In FY15, the Community Care Collaborative (CCC) contracted with an additional 0.5 FTE, bringing the total GI provider capacity to 1.5 FTEs at CommUnityCare.	[NEW] Increase the cure rate for Hepatitis C patients	The Hepatitis C Clinic use the latest treatment protocols, which is more tolerable and effective. Prior Hepatitis C treatment protocols were intolerable due to a strict regime and side effects. Two hundred and thirty three (233) patients have been cured of Hepatitis C since the launch of the Hepatitis C clinic on March 1, 2014.
		B. Provide 1,285 GI visits over baseline (1,343)	[UPDATED] There were 2,665 GI visits provided; 1,322 over baseline.	B. [REVISED] Provide 128 visits over prior year (1,450 total visits over baseline)	The CCC and CommUnityCare (CUC) provided 3,889 GI encounters in FY15; 1,224 visits over the prior year (2,546 visits over the baseline).		
2	**Increase Pulmonology Care**	A. Add one FTE pulmonology provider over baseline	Added one FTE pulmonary physician capacity at CommUnityCare through pulmonary group Emergency Service Partners.	A. Add 0.5 FTE pulmonology provider over prior year (1.5 total)	In FY15, the CCC contracted with an additional 0.5 FTE to bring the total Pulmonology capacity to 1.5 FTEs at CommUnityCare.	[NEW] Improve the percentage of asthmatics receiving required tests in ambulatory settings	In FY15 the percentage of asthmatics receiving required tests was 37.29% (21.1% over the baseline of 16.19%). The CCC and contracted providers structured the clinic workflow to manage patient care and follow the protocols to assess and manage patient severity.
		B. Provide 1,836 pulmonology visits over baseline	[UPDATED] The Delivery System Reform Incentive Payment (DSRIP) FY14 target was not achieved. Only 1,338 pulmonary visits were provided over baseline. Implementation was delayed and there were only six months to complete the project and meet milestone in the FY14 DSRIP demonstration year. With additional provider capacity at two health center sites, this project is on track to meet and exceed FY15 targets.	B. [REVISED] Provide 1,294 pulmonology visits over prior year (2,768 total visits over baseline)	In FY15, the CCC and its contracted providers provided 3,003 pulmonology visits; 1,529 visits over the prior year (2,867 visits over the baseline).		
1.2C	**Initiative**	**Increase Access to Women's Health Services**					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Increase Pregnancy Planning Services**	Provide consultations for an additional 1,564 patients over baseline	In FY14, consultations were provided to 1,730 patients over FY13's baseline.	[NEW] Provide free Long-Acting Reversible Contraception (LARCs) for 500 patients per year	The DSRIP pregnancy planning program provided LARCs to 901 women in FY15, a 220% increase from pre-program expansion.	No outcome measure	

1.2D	Initiative	Increase Access to Behavioral Health Services					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Community-Based Services - Telepsychiatry**	A. Implement telepsychiatry functionality in four (4) community health centers	CommUnityCare (CUC) implemented telepsychiatry at eight (8) health center sites.			[REVISED] Reduce reported level of depression in target population, indicated by improvement of PHQ-9 (mental health assessment) score	The average PHQ-9 score for patients pre-treatment was 13.56 and the average post-treatment score was 10.42, demonstrating an improvement in patient depression by 3 points. The Community Care Collaborative's (CCC's) contracted partner, CUC expanded access to mental health providers through Telepsychiatry services and changes to clinic workflow to ensure that pre- and post- intervention screenings occurred more consistently. In FY15, the CCC added telepsychiatry services at David Powell Community Health Center.
		B. [REVISED] Provide 500 telephsyciatry visits	CUC provided 1,112 telepsychiatry visits in FY14.	Provide telepsychiatry visits to an additional 700 patients over prior year (1,200 total patients for years 1 & 2)	CUC provided 2,045 telepsychiatry visits in FY15 and served 1,214 patients, which is nearly double the visits and patients served in FY14. A total of 3,157 telepsychiatry visits were provided in years 1 & 2.		
2	**Community-Based Services - Integrated Behavioral Health**	Ensure 300 individuals with both diabetes and depression receive instructions according to health intervention care protocols	Patients entered in the registry and enrolled have received appropriate instructions during their visit. In FY14, LSCC, the provider for the Integrated Behavioral Health (IBH) Delivery System Reform Incentive Payment (DSRIP) project, enrolled 455 patients in the registry.	Ensure an additional 500 individuals with both diabetes and depression receive instructions according to health intervention care protocols (800 individuals total for years 1 & 2)	447 individuals with both diabetes and depression received instructions according to health intervention care protocols (902 individuals total for years 1 & 2). This is slightly less than the target for Year 2 (500) but more than the target for years 1 & 2 combined (800).	[REVISED] Reduce reported level of depression in target population, indicated by improvement of PHQ-9 (mental health assessment) score	The average PHQ-9 score for patients pre-treatment was 13.56 and the average post-treatment score was 10.42, demonstrating an improvement in patient depression by 3 points. The CCC's contracted partner, CUC expanded access to mental health providers through Telepsychiatry services and changes to clinic workflow to ensure that pre- and post- intervention screenings occurred more consistently. In FY15, the CCC added telepsychiatry services at David Powell Community Health Center.
						[NEW] Decrease hypertension in target population.	
3	**Crisis Services - Psychiatric Emergency Department for Crisis Stabilization Services**	Provide 2,500 patient visits for psychiatric emergency services through University Medical Center Brackenridge (UMCB)	The Psychiatric Emergency Department of UMCB served 2,001 patients in FY14.	Provide 5,500 additional patient visits over prior year for psychiatric emergency services through UMCB (8,000 total visits for years 1 & 2)	The Psychiatric Emergency Department (ED) of UMCB provides access to acute psychiatric care and inpatient beds to individuals in psychiatric crisis particularly for Medicaid recipients (28%) and low-income persons without insurance (27%). The department served 2,001 individuals in FY14 and 5,103 individuals in FY15.	[NEW] Reduce the median time from arrival to departure for discharged patients at Psychiatric ED at UMCB	The DSRIP goal from FY14 to FY15 was to reduce the median time from arrival to departure for discharged patients at Psychiatric ED from 274 minutes (4.57 hours) to 246.6 minutes (4.11 hours). In FY15, this goal was exceeded by reducing the median time from arrival to departure to 197 minutes (3.28 hours).
4	**Crisis Services - Increase Psychiatric Inpatient Beds**	Fourteen (14) new beds are included in architectural plans for hospital	Plans for the new teaching hospital include 12 medical psychiatric inpatient beds to service patients with medical and psychiatric needs.	[REVISED] Construction of new teaching hospital underway	The construction of the new teaching hospital is underway and is expected to open May 2017. In addition, the network of private hospitals was expanded as new private hospitals have opened in the community. This expansion of system capacity ensures that patients have more treatment and care options at the most appropriate level of care.	Expanded inpatient psychiatric capacity with co-located medical services	Progress on this outcome will be reported in FY16. The crisis center and teaching hospital are still under construction and there is no data for this outcome.
5	**[NEW] Crisis Services - Mental Health Crisis Center**	Collaborate with community partners to develop a plan for new crisis stabilization services to be offered at mental health crisis center	Central Health has leased the land adjacent to the SEHWC to Austin Travis County Integral Care (ATCIC) for $1 per year for a new facility to offer care for crisis stabilization in the community. St. David's Foundation awarded ATCIC the funds to build and begin operations of a 16 bed mental health crisis center.	[NEW] Finalize the plan for the new mental health crisis center	Planning continued for a new mental health crisis center that will be built by ATCIC on Central Health property to offer an alternative to higher level psychiatric services. The mental health crisis center opening is planned for late 2016 with 16 beds.	No outcome measure	

Year 2 (FY15) Report of the Strategic Plan Targets - Appendix

1.3	Initiative	Collaborate on Planning for Comprehensive Cancer Care					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Comprehensive Cancer Care**	With community partners, review recommendations and develop plan for FY14-16, including clarifying the role for Central Health	The Livestrong Foundation granted $50 million to the Dell Medical School at the University of Texas at Austin to create the Livestrong Cancer Institute. Central Health will continue to be a collaborative planning partner with Livestrong and the Dell Medical School.	Implement plan identified in Year 1	Central Health participated in interviews for the Dell Medical School Cancer Institute director. The Cancer Plan was re-directed to the Dell Medical School.	No longer under the purview of Central Health, now a collaboarating partner	No longer under the purview of CH.

1.4	Initiative	Leverage Health Care Investments					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Leverage Health Care Investments**	Monitor agreed-upon metrics and reporting for community partners to determine local inter-governmental transfer amount and subsequent funding to be received by community	In FY14, Central Health provided $37.9 million to draw down $91.4 million in federal dollars as part of the 1115 Waiver. Of that total, $13.1 million supported Seton Healthcare Family projects at UMCB. Also, $2.6 million supported Seton Healthcare Family projects at Dell Children's Medical Center. The remaining $20.4 million supported Community Care Collaborative (CCC) Delivery System Reform Incentive Payment (DSRIP) projects. Intergovermental transfer (IGT) payments to support the DSRIP project at St. David's HealthCare lagged behind project implementation in FY14 and will be seen in later Strategic Plan reporting.	Monitor agreed-upon metrics and reporting for community partners to determine local inter-governmental transfer amount and subsequent funding to be received by community	For FY15, Central Health provided a total of $132.3M in local funds under three programs, DSRIP, Uncompensated Care (UC) and Disproportionate Share (DSH), which returned a total of $319.8 million which consists of local funds and federal and state matching funds. For every $1 in local funds sent as IGT, $2.42 was returned in order to provide hospital care and transformational services. For the DSRIP program, Central Health provided $51.5 million of local funds which returned a total of $122.6 million, including local and federal share. Providers for DSRIP include University Medical Center Brackenridge (UMCB), Dell Children's, St. David's and the CCC. For the UC program, Central Health provided $52.2 million of local funds which returned a total of $126.9 million. Providers include UMCB, St. David's HealthCare, and the Seton Healthcare Family. For the DSH program, Central Health provided $28.6 million of local funds which matched state and federal funding for a total of $70.3 million. Providers for this program include UMCB, St. David's Medical Center and Dell Children's.	No outcome measure	

Strategic Pillar: Health Promotion

2.1	Initiative	Develop and Implement Health Promotion Programs that Support CCC Clinical Services					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	**Implement Health Promotion in Support of Health Care**	A. Establish a Community Care Collaborative (CCC) Health Promotion work group to plan strategies	Established CCC Health Promotion work group.	A. Implement process for integrating evidence-based health promotion practices	The CCC Population Health Workgroup created and implemented an evidence-based tobacco assessment and cessation protocol that was implemented by all CommUnityCare (CUC) health centers. The Workgroup also assisted with the creation of a pre-diabetes protocol and piloted a training on motivational interviewing for 34 nurses, medical assistants, and providers at the Southeast Health & Wellness Center (SEHWC).	Targeted evidence-based health promotion effort implemented	Outcome to be reported in FY16
		B. Identify at least one health promotion goal and associated milestones to support CCC clinical efforts	The work group is implementing an improved and updated clinical tobacco protocol for assessment and cessation. The protocol supports a Delivery System Reform Incentive Payment (DSRIP) Category 3 metric showing health outcomes.	B. Achieve milestones based on identified health promotion goal	The CCC Population Health Workgroup focused on reviewing and improving tobacco use screening and referrals to cessation programming to support a DSRIP Category 3 outcome measure. The DSRIP outcome measure requires that 80% of Medical Access Program (MAP) patients be screened for tobacco use at least once during the two-year measurement period and received cessation counseling intervention if identified as a tobacco user. The protocol created by the Population Health Workgroup gave providers messages and tools to provide cessation counseling interventions and recommendations for pharmacotherapy. By the end of the measurement period, all of the CCC's contracted providers reported that over 94% of MAP patients were being screened and receiving cessation counseling.		

2.2	Initiative	Establish and Communicate Community Health Indicators					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	Community Health Indicators	A. Convene stakeholders to develop agreed upon list of community health indicators	Central Health, City of Austin Health & Human Services Department, and Travis County Health & Human Services have developed a collaborative health planning process and agreement.	A. Report health status via multiple channels	Central Health, City of Austin Health & Human Services, and Travis County Health & Human Services entered in a new partnership to share public data, plan together, and align the three agencies' goals and activities related to critical health issues and the social determinants of health. Through this partnership, four priority health indicators (Diabetes, Obesity, Tobacco, and HIV) were chosen based on the health disparities in Travis County. These indicators were announced at a major press event tied to launch of the Healthy ATC website and data portal. The indicators were reported to and aligned with the Community Advancement Network (CAN); the City of Austin's Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP); the Central Health Equity Policy Council; and are being promoted through these partners' websites and community engagement efforts.	No outcome measure	
		B. Establish process or tool for collecting and reporting information	A web/data portal was jointly purchased by the City of Austin Health & Human Services Department, Travis County Health & Human Services, and Central Health. The data portal will be used to collect and report data on community health indicators and the web presence will be used to create synergy among current health efforts targeting indicators.	B. Through partnership, identify one goal to improve over baseline based on indicators	In FY15, the Healthy ATC partnership identified the following overarching goal: decrease tobacco use, obesity, preventable diabetes hospitalization and HIV rates in Travis County by 5% from the baseline by 2020. Based on 2014 Behavioral Risk Factor Surveillance System (BRFSS) and 2013 hospital discharge data, tobacco use would decline from 10.7% to 10.2%; obesity would decline from 19.1% to 18.1%; preventable diabetes hospitalizations would decline from 430 to 409 per year; and HIV would decline from 21.2 new cases to 20.1 new cases per year of HIV per 100,000 people.	No outcome measure	
				C. [NEW] Launch Community Health Indicators Project	Healthy ATC was launched at a major press event on Aug. 19, 2016 as a collaborative effort among Central Health, City of Austin Health & Human Services, and Travis County Health & Human Services to tackle our community's most critical health disparities. The Mayor, County Judge, and Central Health Board Chair announced the new partnership, four priority health indicators, and unveiled the new data portal, www.healthyatc.org. Healthy ATC empowers Travis County residents with data, tools, and resources about the health of the community. The Healthy ATC website helps community members and policy makers learn about health indicators that affect the quality of life for residents of Austin and Travis County. Healthy ATC displays the health status of the community, provides information about health disparities that need to be addressed and where improvements can be made, showcases best practices and current evidence-based research, and provides opportunities to join in the work that will make the community healthier.	No outcome measure	

2.3	Initiative	Develop a Health Policy Council					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	Health Policy Council	A. Develop Health Policy Council proposal to present to potential partners	The concept of the Health Policy Council and proposal began to rollout to initial key stakeholders and community partners in FY14.	A. In collaboration with community partners, launch Council and establish foundational documents to govern Council operations	The Central Health Equity Policy Council was launched in September with more than 60 community partners. The four priority health disparity indicators (tobacco, diabetes, obesity and HIV) served as the foundation for the Council policy agenda. Foundational documents were created to govern Council operations.	The community will achieve a measureable positive impact on goals identified by the Council	Outcome to be reported in FY16
		B. Convene stakeholders to consider Health Policy Council concept	While obtaining stakeholder buy-in, Central Health was called upon by a City of Austin Council member for assistance with a specific health policy. Central Health responded by convening partners and leading the successful adoption of an ordinance that regulates electronic cigarettes.	B. Identify first year goals	The first year goal has been identified: selection of an evidence-based policy that will move the needle on one of the four priority health indicators.		

Strategic Pillar: Health Coverage

3.1	Initiative	Expand Eligibility and Enrollment to Support New Health Coverage Options					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	Expand Eligibility and Enrollment services	A. Establish baseline call volume to Central Health's Health Care Navigation Center around health coverage through the Affordable Care Act (ACA)	In FY14, the Navigation Center received 2,992 inbound calls related to ACA, serving an estimated 1,608 unique clients. The Navigation Center made 701 outbound calls to an estimated 563 unique clients who were identified as possibly eligible for health coverage though the ACA.	A. [REVISED] Maintain call volume to Central Health Call Center for calls related to the ACA/Marketplace as the pool of eligible enrollees decreases	In FY15, the Central Health Navigation Center received 1,420 inbound calls related to ACA, serving an estimated 1,175 unique clients. The Navigation Center made 464 successful outbound calls to an estimated 282 unique clients who were identified as possibly eligible for health coverage though the ACA. In the first year of open enrollment the identified pool of eligible clients was larger than the second year as the Navigation Center reached out to all clients with active MAP enrollment who were potentially eligible for advanced permium tax credits (APTCs). For FY15, only those clients who applied for MAP when open enrollment was closed (nine months) were identified for the Navigation Center's outbound calls. In addition, during the Open Enrollment Period of the Health Insurance Marketplace the local United Way 2-1-1 Call Center received 4,005 inbound calls related to ACA, resulting in a combined 5,425 callers seeking assistance with health coverage from the Navigation Center and United Way's 2-1-1 Call Center.	Help increase health coverage for Travis County residents in public programs by 10%	Outcome to be reported in FY16
		B. Establish a baseline number of expanded Health Coverage outreach efforts	The baseline for outreach activities related to enrollment and eligibility performed by Central Health staff in FY14 was 67. Central Health continued to expand available methods to renew or apply for MAP in FY14. This led to a 6% decrease in office-based interviews for Medical Access Program (MAP) enrollment from FY13 to FY14. Central Health contracted with outside organizations for Marketplace/ACA outreach services in FY14. These contracted organizations participated in 925 outreach activities.	B. Increase the number of outreach efforts by 5%	In FY15 Central Health's Community Outreach staff participated in 188 outreach activities. These efforts led to an increase of 181% over the FY14 baseline for outreach performed by Central Health's staff.		
3.2	Initiative	Offer Health Coverage Options Through the Affordable Care Act Marketplace					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	ACA Qualified Health Plan	Process all health plan enrollees with all systems (claims, premium processing, medical management, etc.) operational	Sendero Health Plan's third party adminstrator (TPA) is processing all claims for IdealCare enrollees in a timely fashion with the majority of claims processing within 12 calendar days in FY14 with almost no errors found in audit. For FY14, Sendero IdealCare offered the third-lowest premiums in subsidized Silver plans* in the Health Insurance Marketplace, and over 3,000 previously uninsured individuals enrolled. In the Health Insurance Marketplace, Silver plans split the costs between the insurer and the plan member 70/30 respectively.	Enroll 2,500 members	6,000 members were enrolled in IdealCare in FY15, more than double the target for FY15. In FY15 Sendero created a call response program and the call-in numbers were used on all marketing materials. During the four months of open enrollment Sendero handled more than 18,000 inbound and outbound calls. Outreach and enrollment specialists were available 8a.m. - 8p.m., Monday through Saturday. As a result of these efforts, the coordination of Sendero and Central Health resources, and the attractive product design (low premiums and affordable copays) Sendero surpassed its goal and ended with 6,000 effectuated enrollees for 2015.	Break even on a pro-forma financial basis	Outcome to be reported in FY16

Strategic Pillar: Health Infrastructure

4.1	Initiative	Support Planning for New Medical School					
	Measure	FY14 (Year 1) Target	FY14 Reported	FY15 (Year 2) Target	FY15 Actual	Outcome FY15	Outcome Progress FY15
1	Medical School	Serve on identified committees related to the Medical School Development Steering Committee, Dean Selection Committee, Women's Engagement Committee, and Community Involvement Team	Central Health negotiated and implemented an affiliation agreement and ground lease for the Teaching Hospital with the University of Texas (UT). Central health made the first annual UT payment of $35 million. Served on all identified committees, and interviewed DMS candidates for numerous positions.	Participate in readiness assessment for school	The ground lease for the land to locate the new teaching hospital was executed between Central Health and UT. The sublease of that land was executed between Central Health and Seton. Central Health, Seton and UT instituted and held Joint Affiliation Committee meetings pursuant to the affiliation agreement. Central Health, Seton and UT published the first Community Benefit Report, highlighting the value to the community derived from our public investment in the Dell Medical School's and the ongoing development of an integrated delivery system. Concurrently, the Community Care Collaborative (CCC) made the second annual payment of $35 million to The University of Texas. Central Health executives participated in interviews for prospective Dell Medical School professional staff.	Initial class of 50 medical students begins in 2016	Outcome to be reported in FY16.
4.2	Initiative	Help Plan and Implement New Teaching Hospital					
	Measure	FY14 (Year 1) Target	FY14 Reported	FY15 (Year 2) Target	FY15 Actual	Outcome FY15	Outcome Progress FY15
1	New Teaching Hospital	Develop and implement plan for services to be provided at the new teaching hospital	Negotiated and implemented the ground sublease to Seton for the new hospital site. Participated in planning meetings regarding the design and function of the new teaching hospital.	Monitor development and implement transitional care plans as needed to ensure timely completion of Teaching Hospital	Central Health and CCC management participated in regular and ad hoc meetings involving the transition of operations to the new teaching hospital. These meetings included developing plans to ensure specialty care services are enhanced and/or maintained in new settings without interruption upon deconstruction of current University Medical Center Brackenridge (UMCB) settings in late 2017.	New Teaching Hospital begins operation	New Teaching Hospital is scheduled to be opened in 2017; Status on the outcome to be reported in FY16
		Execute all necessary agreements for hospital, including ground lease	Negotiated and implemented the ground sublease to Seton for the new hospital site. Participated in planning meetings regarding the design and function of the new teaching hospital.				
4.3	Initiative	Repurpose the Existing UMC Brackenridge Campus					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	Redevelopment of the Current UMCB Campus	A. Engage consultant to develop a master plan for the existing UMCB campus; including financial projections of capital and operating expenses and income opportunities	Through a competitive process Gensler was selected as the lead consultant for the development of a master plan. An ad hoc Central Health Board Committee was created to guide this work. The guiding principles for the plan were developed and approved by the Central Health Board of managers. The community was engaged in responding to the project elements through numerous public presentations and interactive forums. A Central Health Downtown Master Plan, Phase 1 Report was delivered in August 2014. Work began on Phase 2 of the plan in September.	Develop necessary contractual arrangements to implement approved repurpose plan	Phase 2 planning progressed and the Master Plan neared completion with an extensive community engagement program that included input from more than 8,400 community members, partners and subject matter experts. The Brackenridge Advisory Team (BAT) was established to advance partnership coordination for the Brackenridge Campus and areas surrounding the Campus including the teaching hospital and medical school, and the City of Austin.	Services initiated in coordination with opening of new teaching hospital	Outcome to be reported in FY16

4.4	Initiative	Open the Southeast Health and Wellness Center					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	**Southeast Hub Community Health Center**	A. Complete service delivery plan	The Service Delivery Plan and renovations plan were completed for the Central Health South East Health & Wellness Center (SEHWC) in FY14. In total, 67,400 square feet will be renovated. In Phase 1, completed in FY14, 33,589 square feet of interior space was renovated. In Phase 2, 32,900 square feet will be renovated including a new Community Plaza and a new Demonstration Garden Area.	A. Execute service provision agreements	The Central Health SEHWC began providing services with CommUnityCare (CUC) on Oct. 13, 2014. CUC provides medical and specialty care, behavioral health, dental services, and pharmacy on site. In addition, through service agreements with Mi Madre, the City of Austin, WIC, Capital Area Food Bank, Foundation Communities, YMCA, and the Latino Healthcare Forum, the following complimentary wellness services were provided at the SEHWC: cooking classes, breastfeeding support groups, tax services and 1,800 meals to children and families though the summer nutrition program, and program enrollment in MAP and Sliding Fee Scale (SFS) and SNAP/Food Stamps.	All 1115 Waiver projects to be performed at SEHWC are initiated according to target timelines	Outcome to be reported in FY16
		B. Complete plan for renovations	The Service Delivery Plan and renovations plan were completed for the SEHWC in FY14. In total, 67,400 SF will be renovated. In Phase 1, completed in FY14, 33,589 SF of interior space was renovated. In Phase 2, 32,900 SF will be renovated including a new Community Plaza and a new Demonstration Garden Area.	B. Complete renovations	Phase 1 of the building has been completed. The Phase 2 rennovations neared completion, progress included: the Communty Resources Center opened in July 2015; the Graduate Medical Education and administrative area of the building opened in June 2015.		
4.5	**Initiative**	**Enhance Health Information Technology Infrastructure**					
	Measure	FY14 (Year 1) Target	Progress on FY14 Target	FY15 (Year 2) Target	Progress on FY15 Target	Outcome FY15	Outcome Progress FY15
1	**Expand Health Information Technology Infrastructure**	A. Develop, test, and launch health information exchange (HIE) to include HIE core and point-of-care capabilities to support clinical decision-making capabilities	Central Health Joint Technology (Joint-Tech) and the CCC-Information Technology (CCC-IT) teams created the IT infrastructure needed to meet Delivery System Reform Incentive Payment (DSRIP) milestones for all projects, including Disease Management Registry (DMR) and Paramedic Navigation, and provided data analysis reports to support the creation of baseline metrics. The IT teams led an emergency recovery of iCare community HIE and the Integrated Care Collaboration (ICC) organization and launched the "one-button" pilot project that queries data in real-time across iCare HIE to Seton dbMotion HIE.	A.1 [REVISED] Develop components of the HIE to identify target population for chronic disease management and supported coordinated care efforts	The ICC developed several reports for the CommUnityCare (CUC) Patient Navigation Center (PNC) on a daily basis via a secured file transfer protocol (FTP) site. These daily reports include data on CUC patients who had been discharged from the Emergency Department (ED) or hospital within the previous three days so that the PNC could follow up with these patients and get them back to their primary care provider. The same report was also sent to CUC IT staff who loaded it in the NextGen Electronic Health Record (EHR) so that the providers could also see that one of their patients had recently had an ED or hospital visit.	Maximize provider use of the HIE. Specific determination of "maximized use" to be developed as system is implemented and in coordination with providers to identify most important data points/components to support care decisions and coordination	The Community Care Collaborative (CCC) staff worked in conjunction with the ICC staff on their HIE system (iCare) to maximize provider use of the system. Additional users of iCare were added from El Buen Samaritano, the Travis County Sheriff's Office (TCSO) jail clinic staff and CommUnityCare pharmacy staff. In addition, Central Health worked with the TCSO, CommUnityCare pharmacy vendor Script Care, and the local community homeless coalition, Ending Community Homelessness Coalition (ECHO) to add new data in the HIE that is accessible to providers.
				A.2 [NEW] Develop, test and launch patient navigation and care management software	The Community Care Collaborative (CCC) partnered with the Aunt Bertha website to develop an online community resources directory (CRD) that allows users to search for federal, state, and local (city and county) social services. The CRD provides patient navigators and care managers with easy access to information on social services to better address patients' needs.		
		B. Initiate and complete planning for data warehouse	Joint Tech and the CCC-IT completed "as-is" assessment of current analytics infrastructure state, then designed and began planning of a long-term analytics and research data platform plan.	B. Test and refine reporting capabilities of data warehouse	Joint Tech and the CCC-IT continued on-going data collection, mapping and data management. A new analytical tool, Tableau, was selected and implemented in the preliminary phase of the development of a data warehouse.		

4.6	Initiative	Coordinate the 1115 Waiver RHP 7 Activities					
	Measure	**FY14 (Year 1) Target**	**Progress on FY14 Target**	**FY15 (Year 2) Target**	**Progress on FY15 Target**	**Outcome FY15**	**Outcome Progress FY15**
1	**Coordinate the 1115 Waiver RHP 7 Activities**	A. Receive approval for DSRIP projects and Regional Healthcare Partnership (RHP) 7 plan	The RHP 7 anchor entity role is administrative at its core with responsibilities to coordinate RHP plan development and facilitate meeting reporting requirements for the region's providers. In that role, Central Health coordinated and provided technical assistance to providers as they reported performance activity to the State Health and Human Services Commission (HHSC), developed and submitted new three-year projects, proposed plan modifications and technical change requests.	A. Convene at least two (2) learning collaboratives for RHP 7 partners	Central Health hosted two Learning Collaborative meetings for RHP 7 members on Feb. 17 and Sept. 3, 2015. For the first meeting, 110 DSRIP providers and project managers in attendance developed cross-organizational partnerships to improve patient engagement. The second meeting focused on creating a culture of patient engagement, including sharing DSRIP progress at a public event and an interactive session for the 174 DSRIP providers, and project managers and public attendees, which was designed to further cross-organizational collaboration and problem solving. RHP 7 anchor staff hosted conference calls on the theme of patient engagement to keep RHP participants engaged between meetings.	No outcome measure	
		B. Submit all required reports within designated timeframes	Central Health launched RHP 7's Learning Collaborative which will focus on aiding performing providers to enhance patient engagement in support of RHP 7 DSRIP projects.	B. Submit all required reports within designated timeframes	RHP 7 coordinated and provided technical assistance to providers as they reported performance activity to HHSC, completed the required Annual Anchor Report, and responded in a timely manner to all HHSC request for information, both formal and informal.		