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CENTRAL HEALTH

CENTRAL HEALTH BOARD OF MANAGERS

SPECIAL CALLED MEETING

Agenda

Friday, June 28, 2013
2:00 p.m.

Central Health Administrative Offices
1111 E. Cesar Chavez St.
Austin, Texas 78702
Training Room

REGULAR AGENDA*

1. Receive and discuss a draft strategic plan for Central Health for Fiscal Years 2014 through 2016.¹
2. Confirm the next regular Board meeting date, time, and location.

* The Board of Managers may take items in an order that differs from the posted order.

Note 1, Possible closed session item.

The Board of Managers may consider any matter posted on the agenda in a closed session if there are issues that require consideration in a closed session and the Board announces that the item will be considered during a closed session.

Came to hand and posted on a Bulletin Board in the Courthouse,
Austin, Travis County, Texas on this the 25th day of

June 20 13

Dana DeBeauvoir

County Clerk, Travis County, Texas

By A. Morales Deputy

A. MORALES

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Dana DeBeauvoir, County Clerk
Travis County TEXAS



Central Health Board of Managers Meeting
June 28, 2013
2:00 to 4:00 p.m.

DRAFT AGENDA

Objective:

1. Allow opportunity for full board to understand and discuss the goals and initiatives of the draft FY14-16 Central Health Strategic Plan
2. Receive confirmation on direction of the plan

Welcome Rosie Mendoza	2:00 - 2:05
Introduction to Discussion Christie Garbe	2:05 - 2:15
Strategic Plan Presentation and Discussion Christie Garbe Ellen Richards	2:15 - 4:00
• Health Infrastructure	2:20 - 2:40
• Health Care	2:40 - 3:10
• Health Promotion	3:10 - 3:30
• Health Coverage	3:30 - 3:50
Next Steps	3:50 - 4:00
Adjourn	4:00

CENTRAL HEALTH STRATEGIC PLAN FY14-16
DRAFT OUTLINE

- I. Title Page
- II. List of Board of Managers (with photos)
- III. Central Health Leadership Message (from Trish and Board Chair)
- IV. Table of Contents
- V. **Executive Summary**/Strategic Plan at a Glance
 - a. Concise **visual image** that conveys overall structure of plan
 - i. Highlights elements of the mission components
 - ii. Highlights four priority areas
 - iii. Highlights community needs
- VI. **Who is Central Health? – a description of the core basics of the organization**
 - a. Local governmental entity with jurisdiction in Travis county
 - b. Created in 2004 to provide healthcare services for Travis County indigent populations
 - c. Have a 9 member governing board with appointments from both City of Austin and Travis County
 - d. Current service
 - i. MAP enrollees
 - ii. Number of people served through safety net payments
 - iii. Quantify growth in service since inception.
 - e. Bylaws
 - i. Furnish healthcare for indigent populations
 - ii. Provide educational opportunities and encourage healthy living habits.
 - f. **Why do we need to take this direction? – current health status context and trends**
 - i. Not enough access now
 - ii. Rising rates of chronic disease
 - iii. People need to be taught the skills to be healthy and need environments that support their health.
 - iv. Our current system is fragmented, expensive, and inefficient
 - v. If we can achieve our goals, we expect health status of the community will improve.
 - g. **Context for this work – state national local**
 - i. Our efforts fall in line with national, state and local trends toward improving the health system
 - ii. The Affordable Care Act is a major attempt to refocus the healthcare system toward better care, lower costs, and better outcomes.
 - iii. Additionally, the ACA brings new health coverage opportunities through the health insurance exchange and potential Medicaid expansions.
 - iv. Central Health is able to work toward its' goals because of the state level opportunity of the 1115 Medicaid waiver.
 1. Waiver program also supports the triple aim
 2. Provides a funding source for uncompensated care and health system transformation that CH is able to take advantage of and is playing a leadership role in implementing reform projects.

- v. Locally there is significant momentum for changes in health and health care as evidenced by Senator Watson's 10 goals in 10 years, laying out a forward thinking vision for the health system Central Texas needs as we grow. Central Health is a major player in making this vision come to life.

VII. Central Health Vision and Mission

- a. We envision Central Texas as a model healthy community.
 - i. A broad vision of an end state for our work to achieve health for all people in our community.
- b. We work toward our vision through our mission: Creating Access to Healthcare for those Who Need it Most.
- c. In this community and in our work, Central Health sees the work to creating access as falling in four priority areas. These areas serve as the basis for our strategic plan.
 - i. Health Care
 - 1. Central Health provides **healthcare** for vulnerable populations.
 - 2. Our goal is to:
 - 3. This plan will demonstrate CH's innovative approaches for restructuring and transforming the health care delivery system to make health care services more effective, more efficient, and more responsive to patient needs.
 - ii. Health Coverage
 - 1. Whether you can access care often depends on whether or not you have health insurance.
 - 2. Our goal is to: Increase access to healthcare coverage for TC residents
 - 3. While maintaining our existing role in offering a coverage option for low-income population with no other access to public coverage, CH will be expanding over the next three years to include more outreach and education to help our community access new coverage options through the affordable care act.
 - iii. Health Promotion
 - 1. Central Health recognizes that simply expanding and increasing the amount of clinical services we provide will not address the "demand side" of healthcare.
 - 2. We must invest in keeping people healthy so care access can be reserved for those who need it most.
 - 3. We also want to expand access to information about healthy living and work in partnership with others in the community to develop and implement policies that support community health.
 - 4. Our goal is to – Promote healthy living among travis county residents.
 - iv. Health Infrastructure
 - 1. Underlying and supporting our access efforts in care, coverage, and promotion is Central Health's work to lay a strong health infrastructure

foundation to support our community and its health needs as we grow into the future.

2. Our goal is to....
3. Long term, foundational efforts, ensuring the community has what it needs to support and maintain health into the future.

VIII. How do our four priority areas collectively reach our vision?

- a. Visual description of priority areas
- b. Narrative describing how they work together/ interrelate
- c. Each area has specific initiatives designed to achieve each goal

IX. Initiative Descriptions

a. Health Care: *State Health Care Goal –*

- i. Community Care Collaborative
- ii. Central Health Priority Health Care Services
- iii. Behavioral Healthcare Planning and Investment

b. Healthcare Coverage: *State coverage goal*

- i. Health Coverage Navigation
- ii. Eligibility and Enrollment
- iii. Sendero-Healthcare Marketplace

c. Health Promotion – State goal

- i. Health indicators project
- ii. Health Policy Council
- iii. Alignment with CCC clinical goals

d. Health Infrastructure – state goal

- i. Medical School
- ii. Teaching Hospital
- iii. Southeast Hub Development
- iv. RHP Anchor Role
- v. Health Information Technology Infrastructure

X. Conclusions (?)

Priority Area 1: Health Care

Goal: Transform healthcare delivery to create high quality, cost-effective, person-centered care for vulnerable people in Travis County.

Context: The growing population, changing demographics and evolving healthcare environment, both at a local and federal level, are creating a need and opportunity to expand access to care while significantly transforming how services are delivered. Over the next three years, Central Health will work closely with its community partners to address identified priority community needs by effectively implementing the healthcare strategies identified below, thereby maximizing the impact of new funds available through the 1115 Medicaid Transformation Waiver.

Desired Outcome: Central Health, in partnership with others, will create a person-centered integrated care delivery system that expands access to priority services, improves the quality of care and manages costs. In addition, Central Health will play a key role in the expansion and transformation of healthcare services by other community partners by providing the source of local public funds that will be used to receive federal matching funds based on successful implementation of agreed-upon healthcare projects.

Central Health's aim is to achieve federal approval for 100% of agreed-upon 1115 Waiver projects that support innovative strategies to --

- Enhance access and continuity of care;
- Use technology to identify and effectively manage the patient population;
- Establish a shared set of standards of care based on best practices;
- Assist patients in navigating care and linking patients to needed support services;
- Provide clinicians with the tools and information needed to provide the best care; and
- Pay for outcomes achieved rather than services provided.

Initiatives:**Initiative 1.1: Community Care Collaborative (CCC)**

Strategy. In order to increase access and improve patient care and navigation, Central Health and the Seton Healthcare Family have formed the Community Care Collaborative, a non-profit, 501(c)3 organization to integrate and manage outpatient, inpatient and post-acute care for vulnerable people in Travis County. Additional community partners will participate in order to provide the care needed to best serve the target population.

The CCC will align with national accountable care organization (ACO) and patient-centered medical home principles which promote a strong, comprehensive primary care base, collective responsibility for patient care across the delivery continuum, linkage of payments to quality improvements, and reliable and progressively stronger performance measurement and reporting. To achieve this, the CCC will create operational changes to support clinical care, identified under this initiative, as well as support the expansion of services, identified under initiative 1.2. The operational changes will be implemented to create effective coordination between providers across the continuum of care; increase and integrate the capabilities of

providers' Electronic Health Records (EHR) and the system's Health Information Exchange; and align payments with outcomes.

The CCC will work to improve care by transforming the health care delivery system to one that is health-focused, patient-centered, data-driven, and accountable for health outcomes.

- *Health-Focused* – The CCC will incorporate new capacities and services that shift the healthcare system from a focus on treating illness to emphasizing the prevention of illness, management of chronic diseases and the promotion of health in partnership with the patient.
- *Patient-Centered* -- Services that were once separate and disconnected will be integrated through a single system of care that is dedicated to supporting the patient. The patient will experience better integration into one network of services where care is facilitated by that system. Patients will not be required to navigate the system alone; instead, they will be aided and encouraged through the system by dedicated system staff.
- *Data-Driven* – Continuous collection and analysis of patient utilization data will support the CCC and partner providers to improve patient care and health outcomes. Access to real time data by providers will decrease redundancy and support and improve decision making related to patient care.
- *Accountable* -- The fee-for-service methodology of payment will be replaced over time by a value-based system that emphasizes patient health outcomes. The new system will have in place appropriate technology that knits together providers, navigators and care managers. This will include a comprehensive patient database and analysis tools that support improved clinical care, patient management and navigation.

Initially the CCC will serve an estimated 50,000 individuals who are at or below 200% of the federal poverty level (FPL). These will be individuals who currently have health care coverage through Central Health's Medical Access Program (MAP) or are uninsured. It is estimated that approximately 18,000 of the initial 50,000 served will be MAP recipients with two or more chronic diseases.

Project(s) and Funding. Under this initiative, the CCC will implement three projects – the creation of a health information exchange (HIE)/disease management registry, the implementation of a patient-centered medical home model (PCMH), and the implementation of a chronic disease management model.

Central Health is leveraging the opportunity provided by the 1115 Medicaid Waiver to bring federal dollars to the community to implement these projects. Once the projects are approved by the Center for Medicare and Medicaid Services (CMS) and successfully implemented through the achievement of agreed-upon targets and outcomes identified below, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Create a Health Information Exchange (Disease Management Registry)

Year 1	Target:	Enhance the existing electronic health record (EHR) capabilities of participating providers to implement disease management registry (DMR) functionalities
Year 2	Target:	50% of facilities will use DMR
Year 3	Target:	90% of facilities will use DMR
	Outcome:	Improve annual screening rate for diabetic nephropathy – percent improvement to be determined with CMS in fall of 2013.

2: Implement a Patient-Centered Medical Home Model (PCMH)

Year 1	Target:	25% of Community Care Collaborative Providers will use the PCMH model as defined by the certifying agency
Year 2	Target:	75% of Community Care Collaborative Providers will use the PCMH model as defined by the certifying agency
Year 3	Target:	100% of Community Care Collaborative Providers will use the PCMH model as defined by the certifying agency
	Outcome:	Improve Patient Satisfaction Scores over Baseline – percent increase to be determined with CMS in fall of 2013

3: Implement a Chronic Disease Management Model

Year 1	Target:	Publish and implement an evidenced-based comprehensive care management program for patients with multiple chronic conditions within the CCC
Year 2	Target:	Enroll 5,000 patients in the Chronic Care Model (CCM)
Year 3	Target:	Enroll 7,000 patients in the CCM (12,000 total patients for Years 2-3)
	Outcome:	Increase blood pressure control in CCM participants – percent increase to be determined with CMS in fall 2013

Initiative 1.1a: Patient Navigation**TO BE DEVELOPED – new DSRIP project****Initiative 1.2: Expand Health Care Capacity for Current and New Services**

Central Health has prioritized four major healthcare service areas – primary care, specialty care, women’s health, and behavioral health care. Service expansion in these areas will improve access to care at the right time and in the most appropriate settings.

- System changes will focus on ensuring individuals have timely access to preventive and *primary care* through a medical home that would help prevent or treat early on-set medical, dental, and/or behavioral health care issues.
- Expansion of *women’s health* services benefits fills gaps in services and maintains Central Health’s commitment to women’s access to a full range of reproductive health services.

- Individuals with chronic health issues and or needs for more intensive interventions must have timely access to *specialty care* services to manage or treat them.
- Central Health will leverage partnerships and funding to expand community based and crisis *behavioral health* services in order to fill gaps in services and expand access to care.

The planned initiatives for each of these priority areas are detailed below.

Initiative 1.2a: Increase Access to Primary Care

Strategy. Primary Care is the basic building block of the health care continuum. Timely, affordable access to primary care allows for the early treatment of non-emergent conditions, effective management of chronic conditions, as well as screening and prevention services that may identify a health issue before symptoms arise. An on-going relationship with a primary care provider team allows for an understanding of what is “normal” health status for the patient and allows for the most cost-effective means of maintaining or improving individual health.

Access to primary care means that there are a sufficient number of providers that are accepting new patients, a sufficient number of appointment times available at hours convenient for the patient, and service sites that the patient can easily access. To this end Central Health will focus on increasing the number of providers, service hours, and locations where services can be accessed.

Project(s) and Funding. Specifically over the term of this plan, the CCC has prioritized expanding primary care capacity through existing and new community health centers and by implementing mobile health services as well as expanding dental services.

Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund and implement these projects. Once approved by CMS and successfully implemented, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized. .

1: Increase Primary Care Capacity at Community Health Centers

Year 1	Target a:	Expand primary care hours by 45 per week (15 per week at each of three targeted clinics)
	Target b:	Provide 5,000 primary care visits over baseline
Year 2	Target a:	Begin operations of the Southeast Health and Wellness Center by end of Year 2
	Target b:	Provide 16,000 primary care visits over baseline (21,000 total visits over baseline for Years 1-2)
Year 3	Target b:	Provide 28,000 primary care visits over prior year (49,000 total visits)

	over baseline for Years 1-3)
Outcome:	Reduce unnecessary emergency department (ED) utilization – percent reduction to be determined with CMS in fall of 2013

2: Implement Mobile Health Clinics

Year 1	Target a: Establish 2 mobile health clinics Target b: Provide 1,300 visits through the mobile health clinics
Year 2	Target a: Establish a 3 rd mobile health clinic Target b: Provide 2,000 mobile health clinic visits over prior year (3,300 total visits for Years 1-2)
Year 3	Target b: Provide 1,500 visits over prior year (4,800 total visits for Years 1-3) Outcome: Decrease hypertension in target population – percent decrease to be determined with CMS in fall of 2013

3: Increase Access to Regular Dental Care

Year 1	Target a: Increase number of available dental hours per week by 6 (at one targeted clinic) Target b: Increase the number of patients with chronic medical conditions with a dental visit within past 12 months by 750 over baseline
Year 2	Target b: Increase the number of patients with chronic medical conditions with a dental visit within past 12 months by 2,200 over prior year (2,950 total visits over baseline for Years 1-2)
Year 3	Target b: Increase the number of patients with chronic medical conditions with a dental visit within past 12 months over prior year by 3,050 (6,000 total visits over baseline for Years 1-3)
	Outcome: Increase referrals for dental services – percent increase to be determined with CMS in fall of 2013

Initiative 1.2b: Increase Access to Specialty Care

Strategy. Specialty Care is a critical component of the health care continuum. Access to affordable specialty care allows for the timely treatment of health conditions that may have been identified in the primary care setting and/or through diagnostic testing but which require specialized care that cannot be provided in the primary care setting. Close coordination between an individual's primary and specialty care teams can help ensure that the patient receives the most appropriate care in the most appropriate setting and is able to access necessary support services to facilitate self-care and management of a health condition.

Timely access to specialty care means that there are a sufficient number of providers that are accepting new patients and a sufficient number of available appointment slots. To this end, Central Health will focus on increasing the number of targeted specialty care providers and visits over the next three years to improve patient outcomes and increase quality of life.

Project(s) and Funding. Specifically over the term of this plan, Central Health has prioritized expanding capacity in two specialty areas -- gastroenterology and pulmonology.

Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund and implement these projects. Once approved by CMS and successfully implemented, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Increase Gastroenterology (GI) Care

Year 1	Target a: Add 1 FTE GI provider over baseline Target b: Provide 1,285 GI visits over baseline
Year 2	Target a: Add .5 FTE GI provider over prior year Target b: Provide 643 GI visits over prior year (1,928 total visits over baseline for Years 1-2)
Year 3	Target b: Provide 642 GI visits over prior year (2,570 total visits over baseline for Years 1-3) Outcome: Increase the rate of colorectal screening – percent increase to be determined with CMS in fall of 2013

2: Increase Pulmonology Care

Year 1	Target a: Add 1 FTE pulmonology provider over baseline Target b: Provide 1,836 pulmonology visits over baseline
Year 2	Target a: Add .5 FTE pulmonology provider over prior year Target b: Provide 922 pulmonology visits over prior year (2,758 total visits over baseline for Years 1-2)
Year 3	Target b: Provide 923 pulmonology visits over prior year (3,681 total visits over baseline for Years 1-3) Outcome: Decrease hospital admissions for COPD – percent decrease to be determined with CMS in fall of 2013

Initiative 1.2c: Increase Access to Women’s Health Services

Strategy. Central Health supports a full continuum of health care for women including preventive care and all allowable reproductive services to support each woman’s decisions around birth and spacing of children. These services have been a priority service for Central Health for a number of years.

Timely access to women’s health services means that there are a sufficient number of providers that are accepting new patients and a sufficient number of available appointment

slots. Additionally, access means that there are sufficient available facilities at which all medically necessary and personal choice services are provided.

In addition, to the targeted expansion project identified here, the expanded primary care services identified in Initiative 1.2a will also expand access to basic reproductive health services such as birth control.

Project(s) and Funding. In addition to the expanded access to preventive services under Initiative 1.2a that will allow for more access to care for women, Central Health will focus its efforts to expand women’s health services on facilitating access to pregnancy prevention services for women under the age of 25 in order to minimize the occurrence of unintended pregnancies which research shows improves the health of women and children.

Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund and implement these projects. Once approved by CMS and successfully implemented, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Increase Pregnancy Prevention Services

Year 1	Target:	Provide an additional 500 pregnancy prevention visits over baseline
Year 2	Target:	Provide an additional 50 visits over prior year (550 total visits for Years 1-2)
Year 3	Target:	Provide an additional 100 visits over year 2 (650 total visits for Years 1-3)
	Outcome:	Reduce unintended pregnancy rate – percent decrease to be determined with CMS in fall of 2013

Initiative 1.2d: Increase Access to Behavioral Health Services

Strategy. The need to improve and expand access to behavioral health care services in the community has been an area of focus for Central Health since 2005. Central Health has worked closely with Austin Travis County Integral Care (ATCIC), the Local Mental Health Authority for Travis County, along with a broad consortium of other community partners to improve access to care in this area. The community partners have focused on expanding access to crisis behavioral services to fill critical gaps. While those efforts continue and are still essential, recent analyses of community needs highlight the importance of further developing a continuum of behavioral health services to prevent unnecessary reliance on inpatient crisis services and support individuals to remain stable and healthy in the community.

A model healthy community can only be achieved when individuals within the community are knowledgeable about and have affordable access to services that support both physical and mental health. To that end, Central Health has worked with its community partners to identify a desired continuum of care for a mentally health community. This continuum identifies four levels of care –

- Level 1 includes the most cost efficient, community-based services to promote behavioral wellness and support recovery and includes both Prevention Services and Supported Recovery Services;
- Level 2 provides early interventions and treatment supports and includes -- Screening for Mental Health and/or Substance Use Disorders, Outpatient Treatment, and Integrated Physical and Behavioral Health Care;
- Level 3 provides intensive interventions for individuals with complex needs -- Intensive Outpatient Services, Supported Housing Services, and Residential Treatment; and
- Level 4 effectively responds to individuals in crisis -- Crisis Stabilization Services, Detoxification, Medical/Psychiatric Unit, and Inpatient Psychiatric Services

To help create a more robust continuum of services, Central Health will leverage the opportunity presented by the 1115 Medicaid Waiver to expand outpatient and crisis services. Central Health will work with its partner, ATCIC, and others to ensure these services align with those being expanded by community partners. As a neutral convener focused on the interests of the community, Central Health will continue to convene and chair the Psychiatric Services Stakeholders and Crisis Intervention Care committees. These collaborative partnerships will work to identify and implement best practices around the coordination of crisis care and ensure that the multitude of new services coming online throughout the county are coordinated for the best outcomes of the patient and the community.

Project(s) and Funding. During the period of this strategic plan, the CCC and Central Health will implement new or expanded outpatient and crisis services

Outpatient Services –

Telepsychiatry. The addition of telepsychiatry to existing integrated behavioral health service locations will increase access to psychiatric assessment and consultation services. These services will help primary care providers and behavioral health counselors provide better, more appropriate, more timely care to individuals seeking care in primary care settings. The CCC will implement this project.

Outpatient integrated services. The CCC will implement a targeted project focusing on individuals with co-occurring depression and diabetes to help improve patient outcomes through treatment and management of both conditions.

Crisis Services --

Psychiatric Emergency Department. A new psychiatric emergency department will fill a significant gap in the service continuum by adding much needed emergency services. These services will alleviate the strain on hospital emergency rooms,

support law enforcement and provide more appropriate care for people experiencing mental health crises. Earlier, more appropriate intervention can prevent the need for more expensive inpatient services as most crises resolve in less than 48 hours. Seton Healthcare Family will implement this project.

Inpatient Psychiatric Beds. Central Health will leverage its commitment to support the development of a new teaching hospital (detailed under Initiative 4.2) by securing 14 medical psychiatric beds in the new facility. These beds will fill a significant gap of medical/psychiatric beds that exists within inpatient services continuum. Seton Healthcare Family will construct these new beds.

Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund and implement these projects. Once approved by CMS and successfully implemented, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects. All projects are implemented by agencies best suited to provide services.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

Outpatient Services

1: Implement Telepsychiatry Services

Year 1	Target a:	Implement telepsychiatry functionality in 4 community health centers
	Target b:	Provide telepsychiatry visits to 500 patients
Year 2	Target b:	Provide telepsychiatry visits to an additional 700 patients over prior year (1,200 total patients for Years 1-2)
Year 3	Target b:	Provide telepsychiatry visits to an additional 600 patients over prior year (1,800 total patients for Years 1-3)
	Outcome:	Reduce reported level of depression in target population – percent reduction to be determined with CMS in fall of 2013

2: Implement Integrated Behavioral Health Services for Targeted Patients

Year 1	Target:	Ensure 300 individuals with both diabetes and depression receive instructions according to health intervention care protocols
Year 2	Target:	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)
Year 3	Target:	Ensure an additional 700 individuals with both diabetes and depression receive instructions according to health intervention care protocols (1,500 individuals total for years 1-3)
	Outcome a:	Reduce reported level of depression in target population – percent reduction to be determined with CMS in fall of 2013

	Outcome b: Increase management of blood sugar levels in program participants – percent increase to be determined with CMS in fall of 2013
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Crisis Services

1: Create a Psychiatric Emergency Department for Crisis Stabilization Services

Year 1	Target: Provide 2,500 patient visits for psychiatric emergency services through UMCB
Year 2	Target: Provide 5,500 additional patient visits over prior year for psychiatric emergency services through UMCB (8,000 total visits for Years 1-2)
Year 3	Target: Provide 10,500 additional patient visits over prior year for psychiatric emergency services through UMCB (18,500 total visits for Years 1-3)
	Outcome: Reduce behavioral health readmission rate -- percent reduction to be determined with CMS in fall of 2013

2: Increase Psychiatric Inpatient Beds (under development)

Year 1	Target:
Year 2	Target:
Year 3	Target: Support the development of 14 psychiatric beds in the new Teaching Hospital.
	Outcome: Expanded inpatient psychiatric capacity with co-located medical services

Initiative 1.2e: Comprehensive Cancer Care TO BE DEVELOPED

Initiative 1.3: Leveraging Healthcare Investments

Strategy. In the next three years, Central Health will focus on maximizing the public funds available to provide care for vulnerable populations in our community, expanding access to care and transforming the care delivery system. As a financing and policy entity, Central Health will partner with entities across Travis County to achieve its goals.

Since its inception, Central Health has used local tax dollars to draw down federal funds through participation in the Upper Payment Limit (UPL) program, which provided reimbursement to hospitals for uncompensated care provided to the un- and underinsured. Over the next three years, Central Health will work with its community partners to maximize the receipt of additional federal funding available through the 1115 Medicaid Transformation Waiver to both increase access to care and transform the local healthcare delivery system. Many of these efforts will be directly managed by Central Health through the Community Care Collaborative and have been identified under Initiatives 1.1 and 1.2a-d; however, other community partners will implement a number of new efforts. Central Health will provide the local matching funds that will be matched by federal funds, which in

turn will help its partners implement important healthcare initiatives. In this way, more funds are made available to those best qualified to provide care.

Project(s) and Funding. In addition to the Initiatives identified in 1.1 and 1.2a-d, other initiatives will be implemented implemented by community partners - Dell Children’s Medical Center and the University Medical Center Brackenridge (UMCB).

Dell Children’s Medical Center Projects

- School-based behavioral health clinics
- Family and child obesity program
- Pediatric chronic care management

University Medical Center Brackenridge (UMCB) Projects

- *Psychiatric Emergency Department
- Expand post-graduate training for psychiatric specialties
- Psychiatric telemedicine in emergency department
- Language services resource center
- Culturally competent care training
- OB navigation
- Women’s oncology care screening
- Substance abuse navigation
- Behavioral health assessment and navigation
- Care transitions intervention
- Chronic care management – adults
- Palliative care
- Women’s oncology care navigation
- Diabetes chronic care management

Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund these projects. Once approved by CMS and successfully implemented by our partners, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative as agreed upon with CMS. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Leverage Healthcare Investments

Year 1	Target a:	Monitor agreed-upon metrics and reporting for community partners to determine local inter-governmental transfer amount and subsequent funding to be received by community.
Year 2	Target a:	Monitor agreed-upon metrics and reporting for community partners to determine local inter-governmental transfer amount and subsequent funding to be received by community.
Year 3	Target b:	Monitor agreed-upon metrics and reporting for community partners to determine local inter-governmental transfer amount and subsequent funding to be received by community.

	<p>Outcome: By the end of 2016, X% of total estimated federal funds will have been received based on project performance.</p>
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Priority Area 2: Health Promotion

Goal: Support the improved health of individuals and the community through implementing new health promotion activities, collecting and reporting community health indicators and establishing a Health Policy Council.

Context: Poor health status, limited funding, a growing demand for services and a shift in policy are transforming the healthcare system to include a new emphasis on wellness and prevention. To improve health outcomes and reduce demand for healthcare services, individuals and the community need to be supported to take greater responsibility for their own and the community's health. Multiple local entities have health promotion strategies, but the community lacks a focused coordinated effort among all partners that serves to leverage a collective effort.

Desired Outcome: Central Health will undertake new work in health promotion to both help maximize the effectiveness of funded healthcare services as well as to collaborate with community partners on improving health policy and measuring community health status. This will be done through the --

- Provision of health promotion programming informed by clinical providers to support better clinical care outcomes and improved population health as defined by CCC providers;
- Identification and reporting of key indicators to stakeholders and the community on community health status over time; and
- Support for the alignment of health promotion efforts on a community-wide basis through the establishment of a Health Policy Council.

Initiatives:

Initiative 2.1: Health Promotion Support for CCC Clinical Efforts

Strategy. Central Health will explore and plan for health promotion programming in partnership with CCC clinical design staff that will complement and extend CCC clinical efforts. This effort will help ensure that direct clinical services are supported by evidence based health promotion efforts. This initiative will expand the focus from exclusively direct clinical care to incorporate wellness and prevention among populations.

Central Health staff will establish an ongoing process to coordinate health promotion planning activities with CCC development and clinical design workgroups. Staff will also reach out to community partners that have expertise in health promotion research and program implementation, such as the University of Texas School of Public Health, the St. David's Foundation, the Michael and Susan Dell Foundation, and the Austin/Travis County Health and Human Services Department to identify opportunities for collaboration. Ideally, these partnerships would result in the identification of community best practices for health promotion

programming. These would then be prioritized based on CCC input and coordinated community-wide to maximize results.

Project(s) and Funding. Central Health will use local tax dollars to support this initiative.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1. Implement Health Promotion in Support of Health Care

Year 1	Target a: Target b:	Establish a CCC Health Promotion work group to plan strategies Identify at least one health promotion goal and associated milestones to support CCC clinical efforts.
Year 2	Target a: Target b:	Develop a process for integrating input from community partners into the CCC Health Promotion work group. Achieve milestones selected based on identified health promotion goal.
Year 3	Outcome:	Targeted evidence based health promotion effort implemented.

Initiative 2.2: Community Health Indicators Report

Strategy. The achievement of Central Health’s vision of a model healthy community requires the engagement of all sectors in understanding the health challenges facing the community and developing a unified approach to addressing those health challenges. The first step is to provide a shared understanding of the health status of the community. Central Health is proposing to develop this shared understanding through the development and communication of a Community Health Indicators Report.

Central Health will convene appropriate stakeholders to identify key health indicators in order to make a major step towards supporting a better aligned and more collaborative approach to improving health status in Travis County. Working with key community partners such as the Austin/Travis County Health and Human Services Department, the Travis County Health and Human Services and Veterans Services Department, and others, Central Health will identify health priority areas and associated key health indicators to measure the community’s health status. In recent years, partners have conducted multiple assessment efforts, information from which can be used to inform this initiative. Existing work may be supplemented and updated with current information. Effort will be coordinated and aligned with other indicator projects in the region.

Once the priority areas and indicators have been developed and approved, Central Health will regularly report on the status of each indicator through a variety of communication channels so that the community can know the current state as well as be able to track progress over time. These health indicators can also enable policy makers to assess needs, evaluate program/service impact, coordinate strategies across organizations to maximize impact, and refine strategies to better address local health needs.

Project(s) and Funding. Central Health will use local tax dollars to support this initiative.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1. Community Health Indicators Report

Year 1	Target a:	Convene stakeholders to develop agreed upon list of community health indicators
	Target b:	Establish process for collecting and reporting information
Year 2	Target a:	Report health status via multiple channels including an interactive web portal
	Target b:	Partner with city and county to identify one goal for which to make measurable improvement over baseline
Year 3	Target a:	Develop collaborative intervention to measurably improve goal identified in Year 2.
	Outcome:	Increase community's awareness of community health status by X%.

Initiative 2.3: Health Policy Council

Strategy. While there are a number of governmental entities that have at least some jurisdiction over health policy in our community, there is not a single advisory body responsible for identifying and promoting health policies for Austin and Travis County. Instead, health policy is addressed, at various levels, by organizations across the individual's life span (wellness program at work, health messages at school, policies enacted community-wide), but these policies are not always consistent or coordinated in a way that achieves a lasting impact.

Because health policy is one of the most effective ways to influence changes in behavior and lifestyle and to address the current lack of coordination, Central Health proposes to partner with a wide range of organizations including other governmental jurisdictions, education authorities, and others to develop a Health Policy Council to serve in an advisory capacity to community decision makers. Ideally, this Council would become the community authority on health policy issues in Travis County and make recommendations on the best strategies for improving individual and community health based on research and best practices.

The establishment of such a group could help maximize the effectiveness of health promotion efforts or health care services conducted locally by advising and promoting policies and programs that could have the greatest impact on the health of the county population. Ideally, this body could help ensure that all organizations interested in promoting and supporting improved health status have an opportunity to coordinate efforts to promote a shared message to their respective target populations.

To enhance buy-in for the creation of a Health Policy Council and take advantage of a collaborative discussion on the best model for the Council's formation and work, Central Health proposes to lay the groundwork for the planning and implementation of the Council over the three-year period of the strategic plan. This groundwork will include, but is not be limited to –

- Conducting research on the appropriate scope and model for the Council;

- Working with local government partners to identify key partners for the initiative;
- Discussing and proposing the idea with non-governmental community leaders;
- Identifying potential leadership champions for the project;
- Vetting the idea with local elected officials;
- Convening the initial meetings of partners to develop areas of responsibility and roles for the Health Policy Council; and
- Developing formal agreements among partners to establish Health Policy Council.

Project(s) and Funding. Central Health will use local tax dollars to support this initiative. The investment will be maximized as the community works towards the coordination of policies that support consistent messaging and reinforce services.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1. Health Policy Council

Year 1	Target:	Collaboratively identify a Year 1 plan for the Health Policy Council.
Year 2	Target a:	Launch Council and establish foundational documents to govern Council operations.
	Target b:	Identify first year goals
Year 3	Outcome:	Community will achieve a measurable positive impact on goals as identified by health policy council.

Priority Area 3: Health Coverage

Goal: Maximize enrollment in health coverage by Travis County residents through enhanced navigation, eligibility, and enrollment services

Context: The Affordable Care Act (ACA) enacted in 2010 is changing the health coverage environment through the provision of more affordable health coverage options for individuals who are not offered employer-based insurance and do not qualify for existing public programs. Beginning in October of 2013, these individuals will be able to enroll in new health coverage options to be offered through the ACA Marketplace.

Desired Outcome: Because individuals who have health coverage have better access to healthcare services and overall better health status, Central Health is committed to helping uninsured individuals learn about new opportunities through the ACA marketplace, including how to apply for coverage, the most appropriate coverage for which to apply, receive the support they need (via computer, phone, or in-person) to complete their applications, and understand their responsibilities/role in maintaining coverage and reporting any changes in family status.

Central Health will work collaboratively with community partners to increase the number of Travis County residents with health coverage by X by 2016.

Initiatives:**Initiative 3.1: Eligibility and Enrollment Support for New Health Coverage Options**

Strategy. Central Health’s Eligibility Services staff will help individuals and their families identify and apply for health coverage programs for which they may be eligible. Historically, staff have provided eligibility and/or enrollment services for publically-funded programs targeting individuals/families whose income is at or below 200% of the federal poverty level (FPL) including –

- Central Health’s Medical Access Program (MAP)
- Children’s Health Insurance Program (CHIP)
- Medicaid; and
- Other State Health Assistance Programs.

There are two efforts that will increase the availability of health coverage options for Travis County residents, and the Central Health Eligibility Team is committed to coordinating and/or providing eligibility and enrollment services for each.

Affordable Care Act. As of October 1, 2013, all qualifying individuals, regardless of income, who are not offered employer-based health coverage will have new health insurance options available through the ACA Marketplace with coverage to begin on January 1, 2014. Because this is a new health coverage effort, Central Health will coordinate a collaborative, community-based strategy to maximize the enrollment of Travis County residents in health coverage plans through the new ACA Marketplace.

As there is a defined enrollment period for ACA health coverage plans and a possible penalty for individuals who do not take up coverage, it is critical to provide timely and accurate information and help individuals and families in obtaining coverage. Central Health will work with its community partners to ensure that there are staff and volunteers throughout the county who are trained to assist uninsured individuals to --

- Understand the need for health insurance and how to use it;
- Understand how and when to apply for coverage;
- Know where to obtain assistance in applying for and enrolling in coverage;
- Understand the financial responsibilities associated with their coverage as well as any financial assistance for which they may qualify;
- Know how and when to report a change in their family or income status that may impact their eligibility or cost of coverage; and
- Know how and when to reapply for health coverage.

Due to the large number of uninsured individuals within Travis County that could benefit from the new health coverage options, Central Health will work closely with community partners to maximize the success of these efforts by drawing on each organization’s strengths in terms of the role that each can provide, working with a variety of organizations to help ensure that all parts of the population are being reached, and ensuring that services are linguistically and culturally appropriate.

These ACA-focused efforts will be responsive to the unfolding development of the Marketplace. Central Health’s eligibility staff will identify and use best practices and conduct a multi-faceted community outreach and in-person application assistance strategy that meets consumers where they are including in non-traditional settings, such as schools, tax centers or going door-to-door.

Initial activities to be undertaken include:

- Expanding the function and hours of the Central Health Navigation Center (Customer Call Center) to act as the main local referral resource for answering high-level questions about the ACA and providing appropriate referrals for services (application assistance, enrollment facilitation, etc.) to community partner resources convenient for the caller;
- Certifying staff as Navigators and/or Certified Application Counselors for the Marketplace;
- Collaborating with the federally-funded Navigator(s) grantee and national outreach programs on messaging around the Marketplace to help ensure that Travis County residents are receiving a consistent message about the ACA and how to apply for coverage;
- Identifying new partner entities and any areas/populations within the County that may not be being reached and then working to identify funding or other resources needed to be able to adequately reach these areas; and
- Providing for targeted outreach and application assistance activities in identified areas of need within the community.

Community Care Collaboration (CCC). Central Health is taking the opportunity presented by the 1115 Medicaid Transformation Waiver to develop and implement a number of new health care programs (See Initiatives 1.2 – 1.3) as part of the work to enhance the care provided to the most vulnerable of our residents. These programs may potentially expand current eligibility guidelines for the Medical Access Program (MAP) to include targeted individuals up to 200% FPL with two or more chronic illnesses.

In response to these new requirements, as well as Central Health’s desire to maintain a high level of customer service for the individuals we serve, the following activities have been prioritized for the Eligibility Services Team over the course of the next three years --

- Continue to identify and implement best practices around eligibility services for MAP and all programs that CH supports;
- Identify new processes to determine eligibility for and facilitate enrollment in the expanded MAP programs; and
- Continue to identify new partners, as needed, that can determine potential eligibility for MAP to ensure there is “no wrong door” for access to health care coverage.

As the initial point of contact for access to Central Health coverage and providers, the Eligibility Services Team and the Central Health Navigation Call Center will continue to play a key role in increasing access to health coverage and services for Travis County residents.

Project(s) and Funding. Central Health will support the expanded eligibility and enrollment services with local tax dollars (?). These funds will be maximized through on-going analysis and implementation of best practices to ensure the most effective use of resources.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1. Travis County ACA Health Coverage Navigation

Year 1	<p>Target a: Establish baseline call volume to call center around health coverage through ACA.</p> <p>Target b: X # of people apply for coverage in ACA plans through outreach efforts.</p> <p>Target c: Eligibility system functional for eligibility determinations for ACA and expanded MAP by X (date).</p>
Year 2	<p>Target a: Increase in call volume of X over prior year to Central Health Call Center for calls related to the ACA/Marketplace.</p> <p>Target b: Increase the number of individuals enrolled in the ACA marketplace by X and in the expanded MAP by X.</p>
Year 3	<p>Target b: Increase by X over prior year the number of individuals enrolled in the ACA marketplace by X and in the expanded MAP.</p> <p>Outcome 1: Increase the number of people enrolled in the Health Insurance Marketplace by X%.</p> <p>Outcome 2: Goal enrollment for all expanded MAP initiatives identified in the 1115 waiver will be achieved.</p>

Initiative 3.2: Provide a Health Coverage Option Through the Affordable Care Act Health Insurance Marketplace

Strategy. Central Health developed Sendero Health Plan in 2011 to provide a local, non-profit option to improve access to care for individuals eligible for publicly funded health insurance programs. Currently, Sendero provides a local, non-profit health coverage option for Medicaid and CHIP participants in the 8-county Travis Service Delivery Region -- Burnet, Bastrop, Travis, Fayette, Hays, Williamson, Lee, and Caldwell counties.

Beginning in October of 2013, the Affordable Care Act will expand the availability of public funding for health insurance for a larger group of individuals. This expansion will be offered through the establishment of a Health Insurance Marketplace in which Qualified Health Plans will be selected to offer improved access to various insurance plans for eligible applicants. Sendero is moving towards participating in the Marketplace to help area residents take advantage of this expanded access and funding for healthcare.

Sendero is currently completing the application process to participate as a Qualified Health Plan in the ACA Marketplace. Upon successful completion of this process, Sendero will be able to offer commercial health insurance policies to individuals in Travis County and the surrounding area. These policies will offer substantial medical benefits that are equivalent, and in many

cases better, than group and individual policies that are currently available. Additionally, policies purchased through the Exchange by individuals with incomes below 400% of the Federal Poverty Level come with substantial subsidies that reduce premiums and cost sharing for the individual, making it much easier for these individuals to afford health insurance.

By participating as a health plan in the Marketplace, Sendero will be expanding the access to healthcare for residents who were previously unable to secure coverage due to health status or financial constraints. Additionally, every member that enrolls with Sendero and has an income of less than 400% of the Federal Poverty Level brings increased federal funding for healthcare into the Travis county area. For those below 200% of FPL the subsidies are most significant, with the subsidy paying for over 80% of the costs of care for these members.

Project(s) and Funding. Initial funding to provide a health coverage plan through the ACA Marketplace is being covered by funds that were allocated as part of Sendero’s startup capital. Total spending for this project is not expected to add more than \$845,000 to Sendero’s original 2013 budget. Approval for this funding was obtained from both Sendero’s and Central Health’s Boards, and continued spending is contingent on reaching milestones and ongoing Board review.

Performance Measures. The following specific, measurable targets will be tracked for each project of this initiative. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

ACA Qualified Health Plan

Year 1	Target:	Process all health plan enrollees with all systems (claims, premium processing, medical management, etc.) operational
Year 2	Target:	Enroll 2,500 members
Year 3	Outcome:	Break even on a pro-forma financial basis

Priority Area 4: Health Infrastructure

Goal: Improve the health of the Travis County population into the future by expanding the number providers, increasing and improving health care facilities, implementing enhanced technology, and serving in a coordinating capacity for the transformation of regional healthcare delivery.

Context: The 2014-2016 Strategic Plan falls at a time when a convergence of events has positioned our organization to make major, transformational change to the health care delivery system in Travis County. These events include –

- Texas State Senator Kirk Watson’s vision of ten transformational healthcare goals to be achieved within the next ten years;
- The 1115 Medicaid Transformation Waiver which provides an unprecedented opportunity to reform our fragmented, disconnected safety net delivery system into a system driven by improved patient health outcomes through a significant expansion of available healthcare financing;
- The implementation of the Affordable Care Act mandating health coverage for all qualifying individuals; and

- Promotion at the federal level for more accountable types of care.

Desired Outcome: Central Health is working to transform the local healthcare delivery system. In order for this to be possible, the necessary infrastructure must be in place. Central Health is taking advantage of the current healthcare environment to build now for the healthcare future of Travis County residents. Each of the identified projects will take a number of years to develop and complete but all have the potential to significantly improve availability and quality of care. These initiatives will help --

- Increase the provider base for Travis County;
- Support provision of healthcare in a new, modern hospital which will help train new providers and advance research;
- Repurpose an important public property;
- Create a health and wellness hub in a historically underserved community;
- Ensure that providers have timely access to the data they need to provide appropriate care; and
- Support Regional Health Partnership 7 to achieve planned projects and draw down the maximum amount of available federal funds.

Initiatives

Initiative 4.1: Medical School

Strategy. Local stakeholders have long recognized that the creation of a medical school in Austin could help address a critical shortage of doctors available to provide care for the underserved in Travis County. It would also support the creation of a more efficient, integrated, innovative and patient-centric model of care in the form of multidisciplinary community care teams including medical students, nurses, care workers, dentists, case managers, pharmacists and other health professionals. As such Central Health and other stakeholders are collaborating to support the development of The Dell Medical School to be housed at the University of Texas at Austin.

Project(s) and Funding. A community effort to raise the local tax rate to help fund the transformation of the local healthcare system and support services to Central Health patients through a new medical school was put to a vote in November 2012. The voters approved this measure.

The medical school building will be financed by The University of Texas – Austin and private philanthropic dollars. The Seton Family of Hospitals will provide financial support for the graduate medical education program. Central Health’s increased local tax dollars will be used to support additional services provided to Central Health target populations by faculty, students and residents.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Medical School

Year 1	Target:	Serve on identified committees – Steering Committee, Dean Selection Committee, Women’s Engagement Committee.
Year 2	Target:	Participate in readiness assessment
Year 3	Outcome:	Initial class of 50 medical students begins in 2016.

Initiative 4.2: New Teaching Hospital

Strategy. Since 1995, Seton has operated the Central Health-owned University Medical Center Brackenridge (“UMCB”) as the safety-net hospital in Travis County. UMCB is an aging outmoded facility and both Central Health and Seton have decided that it is necessary to replace UMCB with a modern hospital better able to serve as a state-of-the-art teaching facility for the new medical school and existing and future residency programs.

Central Health and Seton view the construction of a new teaching hospital as an excellent opportunity to integrate the hospital services under the CCC and to ensure that care is delivered in the least costly setting with the greatest expertise. As such, Central Health and Seton will collaborate to determine the optimal site for provision of services currently provided at UMCB. Some of these services will continue to be provided in the new teaching hospital. Other services will either be provided in centers of excellence located at other Seton hospitals or in the CCC.

Central health will accomplish the following action steps necessary to ensure successful construction of the new teaching hospital.

1. Collaborate with Seton to create a plan for services at the new teaching hospital that meets the needs of the safety net population
2. Develop a long-term ground lease for the land where the Teaching Hospital will be located,
3. Implement a master agreement with Seton related to the teaching hospital including mutually agreeable terms for then teaching hospital lease and the post-termination use of the UMCB property, facilities, services, and programs.

Project(s) and Funding. Seton will fund the construction of the replacement hospital for UMCB and Central Health will have a ground lease for the property on which the hospital is located.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: New Teaching Hospital (Under Development)

Year 1	Target a:	Develop and implement plan for services to be provided at the hospital and location for other services currently provided at UCMB
	Target b:	Execute all necessary agreements for hospital
Year 2	Target:	?
Year 3	Outcome:	All services are operational at Teaching Hospital.

Initiative 4.3 Repurpose the existing UMC Brackenridge campus.

Strategy. As the owner and steward of our community’s public hospital, University Medical Center Brackenridge (UMCB), Central Health will develop a plan for the use of the existing UMCB campus and related facilities that complements and enhances work done at the new medical school, teaching hospital, and other health infrastructure improvements that support local health system transformation. This plan will lay out specific uses for the existing UMCB campus that contribute to a coordinated, innovative health system in Travis County and achieve better health, better care, and lower costs for the people of Travis County.

Central Health staff will work internally and with community partners to design the highest and best use for the existing UMCB campus resource. After defining high-level priorities for the facility, staff will develop detailed implementation plans for transforming the facility to meet the needs of an innovative healthcare delivery system and medical district.

Project(s) and Funding. Central Health will continue to own the current UMCB facility and land. These costs will be supported with X and services provided at the UMCB campus will be supported with Y funds.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Redevelopment of the Current UMCB Campus

Year 1	Target a:	Engage consultant to develop a master plan for the existing UMCB campus
Year 2	Target a:	Develop necessary contractual arrangements to implement approved re-purpose plan
Year 3	Outcome:	Services initiated in coordination with opening of new teaching hospital

Initiative 4.4 Southeast Health and Wellness Center

Strategy. In 2011, Central Health purchased a 67,577 square foot building from the Veterans Administration. The facility is located at 2901 Montopolis Drive in zip code 78741 in southeast Austin. Central Health plans to renovate the building to create and operate a state of the art health and wellness center serving individuals at or below 200% of the federal poverty level who are under and uninsured. The Southeast Health and Wellness Center will be an important site for implementation of multiple 1115 Wavier projects including expanded hours and expanded specialty care, as well as expanded integrated behavioral health and dental services. This site will be the model for how cares delivery will be transformed through the new integrated delivery system under development.

The site is anticipated to be fully operational by the end of FY15. Once fully operational, it is anticipated that over XX,XXX encounters can be achieved annually. This will expand primary, specialty, and behavioral health care services in an underserved area of the county that is experiencing rapid population growth. This site will also offer health promotion activities that focus on disease management and prevention.

This facility, owned by Central Health, will be operated as a Federally Qualified Health Center and serve as a Primary Care Medical Home, a best practice for improving delivery of care and patient experience. Central Health will undertake the following specific activities:

- Engaging necessary expertise to develop plans for remodeling facility;
- Establishing and monitoring the timeline for project completion;
- Managing the Contractor(s) hired to renovate the facility;
- Ensuring facility is renovated according to specifications;
- Purchasing necessary equipment and ensuring proper installation;
- Identifying providers of health and wellness services;
- Negotiating agreements to provide services; and
- Overseeing implementation of 1115 Waiver projects at the Southeast Health and Wellness Center.

Project(s) and Funding. Central Health is financing the renovations of the facility through the issuance of Certificates of Obligation approved by its Board of Managers in 2011. Services will be supported with local tax dollars and supplemented with funds drawn down through the 1115 Medicaid Waiver.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Southeast Hub Community Health Center

Year 1	Target a: Complete service delivery plan Target b: Complete plan for renovations
Year 2	Target a: Service provision agreements are executed Target b: Renovations are completed
Year 3	Outcome: All 1115 Waiver projects to be performed at Southeast Health and Wellness are initiated according to target timelines

Initiative 4.5: Health Information Technology Infrastructure

Strategy. In conjunction with community partners, Central Health will work to develop and implement a Health Information Technology infrastructure that will support the delivery of quality care by the Community Care Collaborative (CCC). The infrastructure is necessary to support enhanced patient care management by providing “actionable” information and supporting functionality to point-of-care clinicians that will assist with the next clinical decision and care coordination. In addition, it will facilitate the measurement and reporting of intended outcomes required for accountability to the public and the CCC’s 1115 Medicaid Waiver projects.

The operational objectives of the CCC’s Health Information Technology infrastructure are to:

- create effective coordination between providers across the continuum of care;

- integrate capabilities of provider’s electronic health record (EHR) with the CCC’s Health Information Exchange (HIE); and
- support CCC analytics and reporting, patient care, care team management and patient navigation

A team has been created to plan and manage the overall implementation in order to ensure the technological structures are in place to support all proposed projects under the CCC and the integrated delivery system. The strategy for implementing this project includes the following major steps:

- Perform an assessment/inventory of existing technology base;
- Review available options for enhancing or replacing the technology base, as needed;
- Develop a strategy for integrating all of the technologies for creating the HIE that will meet the service delivery and reporting needs of the CCC and integrated delivery system;
- Identify project tasks for each of the identified project areas (HIE core, point-of-care, EHR enhancement, patient navigation, care management teams, and analytics) and develop a timeline to launch system;
- Develop a detailed list of technology improvements or changes needed by each participating organization to create a well-functioning HIE system;
- Plan and implement a data warehouse to support reporting and analytic capabilities;
- Draft budgets by major project area to accomplish launch; and
- Identify gaps and solutions beyond launch date.

An effective HIE system is critical for the transformation of the health care system as it will better inform providers of patient care history and diagnoses, services received, medications prescribed, etc. to help reduce the risk of duplicative, unnecessary tests/procedures and to better inform care decisions. This should create a higher level of satisfaction among patients, reduce systems costs, and facilitate care decisions for providers.

Project(s) and Funding. Both the Seton Healthcare Family and Central Health will contribute to the funding of this project. Central Health is leveraging the opportunity presented by the 1115 Medicaid Transformation Waiver to fund and implement this project. Once approved by CMS and successfully implemented, Central Health will use local tax funds to make an intergovernmental transfer (IGT) to CMS to be matched with federal dollars for the support of these projects.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: Health Information Exchange (HIE)

Year 1	Target a: Develop, test, and launch HIE to include HIE core and point-of-care capabilities to support clinical decision-making capabilities.
	Target b: Initiate and complete planning for data warehouse.
Year 2	Target a: Develop, test, and launch patient navigation and care management components of HIE to identify target population for chronic disease

	management and supported coordinated care efforts.
	Target b: Test and refine reporting capabilities of data warehouse.
Year 3	<p>Target a: Continue with any needed refinements to HIE capabilities.</p> <p>Outcome: Maximize provider use of 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.</p>

Initiative 4.6: 1115 Waiver Regional Healthcare Partnership: Anchor Entity

Strategy. In December 2011, the State of Texas received federal approval to implement the “Texas Healthcare Transformation and Quality Improvement Program”, known as the 1115 Waiver. Local entities that are eligible to participate in the Waiver Program were required to join the state-designated local Regional Healthcare Partnership (RHP), twenty of which were created by HHSC along Texas county lines.

Travis County is part of the six-county RHP 7, which also includes Bastrop, Caldwell, Fayette, Hays, and Lee Counties. Each RHP was assigned an anchor organization: a public hospital or local governmental entity charged with helping administer some aspects of the waiver program in the RHP. Central Health was designated as the anchor for RHP 7. As the anchor, Central Health serves as the administrative coordinator for the regional plan.

Beginning in late spring 2012, Central Health began its role as RHP anchor, visiting public officials in the six-county RHP and assembling eligible organizations at RHP Planning sessions. From these efforts, Central Health developed a RHP Plan that provides an overarching vision for the RHP, details the region’s healthcare needs, and lays out the participants’ DSRIP Projects over the remaining life of the Waiver. This plan, submitted first on December 31, 2012, and in revised form on March 11, 2013, has received presumptive approval from the State and has been sent to the Federal government for review.

Moving forward, Central Health will be responsible for a number of activities, some of which are not yet clearly defined. Some of the required activities that are known include –

- Facilitating the IGT process;
- Coordinating regional reporting;
- Providing training and technical support to RHP participants;
- Facilitating regional Learning Collaboratives for RHP members; and
- Producing an annual report detailing RHP activities and achievements.

Each of these efforts will allow for the identification of best practices and more coordinated planning of services across counties.

Project(s) and Funding. As the anchor, Central Health receives some reimbursement funds from the federal government, which are drawn down by providing local IGT. Administrative costs will be reimbursed on a 50-50 basis.

Performance Measures. The following specific, measurable targets will be tracked for this project. Additionally, at least one outcome will be tracked for Year 3 to ensure that the desired results of the initiative are being realized.

1: 1115 Medicaid Waiver RHP 7 Anchor Entity

Year 1	Target a: Receive approval for DSRIP activities and RHP plan
	Target b: All required reports are submitted
Year 2	Target a: At least 2 learning collaboratives have been convened by CH
	Target b: All required reports are submitted
Year 3	Outcome: 80% of potential DSRIP funds across the region are achieved