Introduction

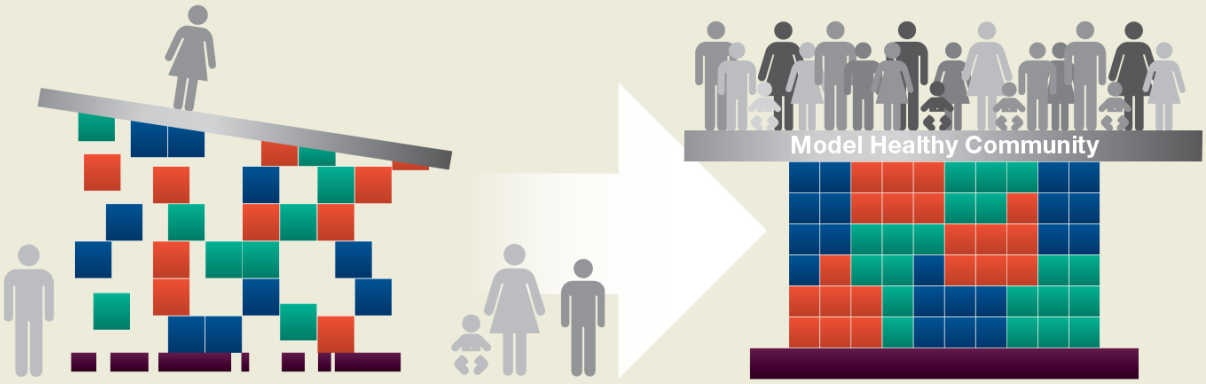
Central Health develops a strategic plan every third year to guide its work and budgeting process. The fiscal years 2014-16 Strategic Plan recognized the need to keep up with the changing health care environment by focusing on increasing access to care and transforming how that care is delivered.

The initiatives in the fiscal years 2014-16 Strategic Plan address five key issues:

- Lack of adequate access to critical services such as primary, dental, and behavioral health care,
- A fragmented health care delivery system,
- Rise in preventable chronic conditions among the population,
- Shortage of health care providers, and
- Outdated physical infrastructure and lack of technological infrastructure.

This Year 2 report of the fiscal years 2014-16 Strategic Plan targets documents progress in transforming our health care system.

Building a coordinated approach

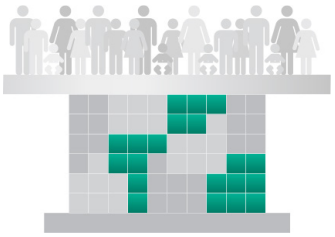


CURRENT STATE ›› Fragmented, uncoordinated care that is not adequate or sustainable in its current form. This results in people falling out of the safety net and a system that is treating people once they are sick, often with preventable conditions.

FUTURE STATE ›› A stronger infrastructure that serves as a solid foundation upon which to establish a more coordinated person centered system that provides higher quality care and preventative services at a lower cost to more people.

The fiscal years 2014-16 Strategic Plan laid out a bold vision for health care in Travis County and is organized under four foundational pillars approved by the Central Health Board of Managers – Health Care, Health Promotion, Health Coverage, and Health Infrastructure. These four pillars are the framework within which the strategic targets and outcomes are measured.

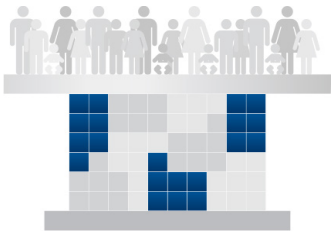
Strategic Plan Pillars



Health Care

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

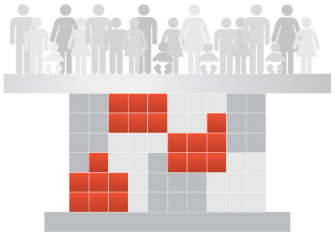
Central Health increases access to care and implements innovative approaches to restructure and transform the health care delivery system to make services more effective, efficient, and responsive to the needs of our target population.



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.

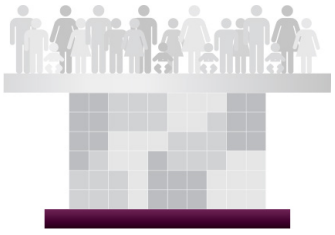
Central Health recognizes that simply increasing the amount of clinical services is not sufficient to improve the health of the community. In partnership with a broad range of community stakeholders, Central Health expands access to health promotion and prevention efforts and promotes policies that support community health.



Health Coverage

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

While maintaining the existing role of offering a local health benefit plan for low-income populations with no other access to coverage, Central Health expands outreach and education services to help individuals access new coverage options available through the Affordable Care Act (ACA). In addition, Sendero Health Plans, our local health maintenance organization, offers products through the new Health Insurance Marketplace specifically targeted to the population Central Health serves.



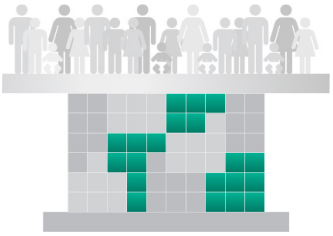
Health Infrastructure

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 health care delivery.

A strong health infrastructure is necessary to support the current and future health care needs of our community. Central Health is significantly upgrading the local health care infrastructure to align with the changes in the health care environment, supports health care transformation and ensures we are prepared to meet the needs of our target population today and in the future.

Strategic Plan Targets

Health Care



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

Initiative 1.1: Create the Community Care Collaborative (CCC)

1. Create a Health Information Exchange (Disease Management Registry or DMR)

progress	met	exceeded
	✓	

Target - 50% of health centers will use DMR

Two of the four (50%) main ambulatory care clinic systems, CommUnityCare and Lone Star Circle of Care, have launched and expanded the use of DMRs.

2. Implement a Patient Centered Medical Home (PCMH) Model

progress	met	exceeded
	✓	

Target - 75% of Community Care Collaborative (CCC) Providers will use the PCMH model as defined by the certifying agency.

Three of the four (75%) CCC Provider networks, including CommUnityCare, Peoples Community Clinic, and Lone Star Circle of Care, have adopted and implemented the CCC's Patient Centered Medical Home Principles.

3. Implement a Chronic Disease Management (CDM) Model

progress	met	exceeded
		✓

Target - Enroll an additional 5,000 patients in the CDM (a total of 6000 patients for Strategic Plan years 1 & 2)

25,033 patients were enrolled and treated under CCC chronic care protocols.

4. Measure: Implement a Coordinated Patient Navigation Program

progress	met	exceeded
		✓

Target - Train an additional 10 patient navigators on CCC patient navigation protocols (15 total navigators for Strategic Plan years 1 & 2)

The CCC trained 21 patient navigators from CommUnityCare and all contracted providers.

NOTE - *the "progress/met/exceeded" scale next to each Target indicates if it was met, exceeded, or if significant progress was still achieved even though the target was not met.*

Initiative 1.2A: Increase Access to Primary Care and Dental Care

1. Increase Primary Care Capacity at Community Health Centers

progress	met	exceeded
	✓	

Target - A. Begin operation of the Southeast Health & Wellness Center by end of Year 2

The Expanded Access Delivery System Reform Incentive Payment (DSRIP) project was added to the Southeast Health & Wellness Center in FY15. An additional 1,431 visits were completed in FY15 as a result of the expansion. The CommUnityCare North Central Health Center also participated in the initiative, expanding operations from 55 to 75.5 hours a week, an increase of 20.5 hours a week. The increase of these health center hours provided an additional 6,576 visits in FY15. As a result, the total number of visits for participating health centers increased 6.8% from FY14 to FY15.

progress	met	exceeded
		✓

Target - B. Provide 16,000 primary care visits over baseline (21,000 total visits over baseline for strategic plan years 1 & 2)

Through the Community Care Collaborative (CCC) DSRIP project, CommUnityCare provided 21,790 encounters over baseline (6,069) in FY15, exceeding the target by 790 visits.

2. Implement Mobile Health Clinics

progress	met	exceeded
	✓	

Target - A. Establish a third mobile health clinic

Through the CCC DSRIP project, in FY15 CommUnityCare added a third mobile health team. The DSRIP project required inclusion of 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 Travis County's homeless population, completing 302 encounters. Many of the homeless patients did not have health insurance so the team also began to enroll patients into the Medical Access Program (MAP).

progress	met	exceeded
		✓

Target - B. Provide 2,000 mobile health clinic visits over prior year (3,300 total visits for strategic plan years 1 & 2)

Through DSRIP in FY15 CommUnityCare delivered 4,406 mobile encounters.

3. Increase Access to Regular Dental Care

progress	met	exceeded
		✓

Target - 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 strategic plan years 1 & 2)

Through DSRIP in FY15 CommUnityCare provided dental services to 7,266 adult patients with chronic conditions, 4,207 over baseline.

Initiative 1.2B: Increase Access to Specialty Care

1. Increase Gastroenterology (GI) Care

		progress	met	exceeded
Target - A. Add 0.5 full-time employee (FTE) GI provider over prior year	Through DSRIP, CommUnityCare contracted an additional 0.5 FTE in FY15, bringing the total GI provider capacity to 1.5 FTEs at CommUnityCare.		✓	
Target - B. Provide 128 GI visits over the prior year (1,450 visits over the baseline)	3,889 GI visits were provided at CommUnityCare in FY15, or 1,224 more visits than the prior year (2,546 visits over the baseline).			✓

2. Increase Pulmonology Care

		progress	met	exceeded
Target - A. Add 0.5 FTE pulmonology provider over prior year	Through DSRIP, CommUnityCare contracted an additional 0.5 FTE in FY15, bringing the total Pulmonology capacity to 1.5 FTEs at CommUnityCare.		✓	
Target - B. Provide 1,294 pulmonology visits over the prior year (2,768 visits over the baseline)	3,003 pulmonology visits were provided at CommUnityCare in FY15, or 1,529 more visits than the prior year (2,867 visits over the baseline).			✓

Initiative 1.2C: Increase Access to Women's Health Services

1. Increase Pregnancy Planning Services

		progress	met	exceeded
Target - Provide Long-Acting Reversible Contraception (LARC) to 500 patients.	The DSRIP pregnancy planning program provided LARC to 901 women in FY15, a 220% increase from pre-program expansion.			✓

Initiative 1.2D: Increase Access to Behavioral Health Services

1. Community-Based Services – Telepsychiatry

		progress	met	exceeded
Target - Provide telepsychiatry visits to an additional 700 patients over prior year (1,200 total patients for strategic plan years 1 & 2)	Through DSRIP, CommUnityCare provided 2,045 telepsychiatry visits in FY15 and served 1,214 patients, nearly double the visits and patients served in FY14.			✓

2. Community-Based Services – Integrated Behavioral Health

		progress	met	exceeded
Target - Ensure an additional 500 individuals with both diabetes and depression receive instructions according to health intervention care protocols (800 individuals total for Strategic Plan years 1 & 2)	In FY15, 447 individuals with both diabetes and depression received treatment and support according to health intervention care protocols from CommUnityCare (902 individuals total for Strategic Plan years 1 & 2).	✓		

progress	met	exceeded
✓		

3. Crisis Services — Psychiatric Emergency Department for Crisis Stabilization Services

Target - Provide 5,500 additional patient visits over prior year for psychiatric emergency services through University Medical Center Brackenridge (8,000 total visits for strategic plan years 1 & 2)	The department served 5,103 individuals in FY15 (7,104 total visits for strategic plan years 1 & 2).

progress	met	exceeded
	✓	

4. Crisis Services — Increase Psychiatric Inpatient Beds

Target - Construction of new teaching hospital underway	Construction of the new teaching hospital is underway and is expected to open May 2017 with medical psychiatric inpatient beds.

progress	met	exceeded
	✓	

5. Crisis Services – Mental Health Crisis Center

Target - Finalize the plan for the new mental health crisis center.	Planning continued for a new mental health crisis center that will be built by Austin Travis County Integral Care (ATCIC) on Central Health property to divert patients from inpatient psychiatric services. The center plans are finalized and groundbreaking is scheduled for early 2016.

Initiative1.3: Collaborate on Planning for Comprehensive Cancer Care

progress	met	exceeded
N/A	N/A	N/A

1. Comprehensive Cancer Care

Target - Implement plan identified in Year 1	Central Health participated in interviews for the Dell Medical School at The University of Texas at Austin Cancer Institute director. The Cancer Plan was re-directed to the Dell Medical School at UT Austin.

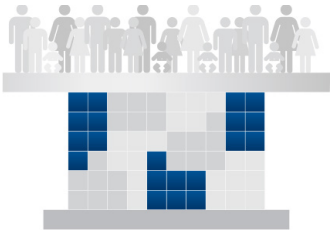
Initiative 1.4: Leverage Health Care Investments

progress	met	exceeded
	✓	

1. Leverage Health Care Investments

Target - 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 $132.3 million in local funds as inter-governmental transfer for three programs: Delivery System Reform Incentive Payment (DSRIP), Uncompensated Care (UC), and Disproportionate Share(DISH). These three programs returned a total of $319.8 million to the Community Care Collaborative (CCC), Seton Healthcare Family, and St. David's, consisting of local funds and federal and state matching funds. For every local $1 sent as intergovernmental transfer (IGT), $2.42 was earned for hospital care and transformational DSRIP programs.

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.

Initiative 2.1: Develop and Implement Health Promotion Programs that Support Community Care Collaborative (CCC) Clinical Services

1. Implement Health Promotion in Support of Health Care

	progress	met	exceeded
Target - 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 at CommUnityCare health centers. The workgroup also created a pre-diabetes protocol and piloted a training on motivational interviewing for 34 nurses, medical assistants, and providers at the Central Health Southeast Health & Wellness Center (SEHWC).

	progress	met	exceeded
Target - B. Achieve milestone based on identified health promotion goal		✓	

The CCC Population Health Workgroup reviewed and improved tobacco use screening, and referrals to cessation programming in support of a Delivery System Reform Incentive Payments (DSRIP) Category 3 outcome measure. By the end of the measurement period, all of the CCC's contracted providers reported more than 94% of Medical Access Program (MAP) enrollees were being screened and receiving cessation counseling—exceeding the outcome measure by 14%.

Initiative 2.2: Establish and Communicate Community Health Indicators

1. Community Health Indicators

	progress	met	exceeded
Target - A. Report health status via multiple channels		✓	

Central Health, the City of Austin Health & Human Services Department, and Travis County Health and Human Services Department entered the Healthy ATC partnership, with an initiative to share data, plan, and align goals and activities related to critical health issues and the social determinants of health. The partners chose four priority health indicators (diabetes, obesity, tobacco, and HIV) based on local health disparities. Healthy ATC has aligned with additional local groups focusing on health initiatives to increase promotion.

Initiative 2.2: Establish and Communicate Community Health Indicators

progress	met	exceeded
	✓	

Target - B. Through partnerships, identify one goal to improve over baseline based on indicators	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.

progress	met	exceeded
	✓	

Target - C. Launch community indicators project	Healthy ATC was launched at a major press event on Aug. 19, 2016 as a collaborative effort among Central Health, the 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 a new website, www.healthyatc.org. The Healthy ATC website empowers Travis County residents with data, tools, and resources about the health of the community.

Initiative 2.3: Develop a Health Policy Council

1. Health Policy Council

progress	met	exceeded
	✓	

Target - A. In collaboration with community partners, launch council and establish foundational documents to govern operations	The Central Health Equity Policy Council was launched in September 2015 with more than 60 community partners. Foundational documents were created to govern council operations.

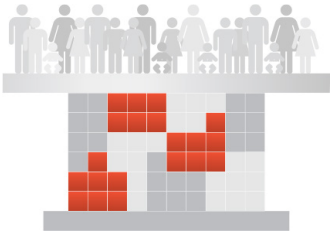
progress	met	exceeded
	✓	

Target - B. Identify first year goals	The Central Health Equity Policy Council identified its first year goal; select an evidence-based policy that will move the needle on one of the four priority health indicators.

Central Health, the City of Austin, and Travis County launched Healthy ATC, a new partnership tackling our community's prioritized health disparities.

Central Health launched the Central Health Equity Policy Council with 60 community partners.

Health Coverage



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

Initiative 3.1: Expand Eligibility and Enrollment to Support New Health Coverage Options

1. Expand Eligibility and Enrollment services

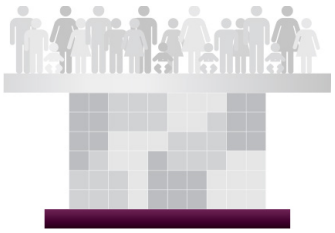
		progress	met	exceeded
Target - A. Maintain operations of Central Health Call Center for calls related to the Patient Protection and Affordable Care Act (PPACA) Health Insurance Marketplace	In FY15, Central Health's Health Care Navigation Center received 1,420 PPACA related calls. In addition, during the open enrollment period of the Health Insurance Marketplace the United Way for Greater Austin 2-1-1 call center received 4,005 inbound calls related to PPACA, resulting in a combined 5,425 callers seeking assistance with health coverage.		✓	
Target - B. Increase the number of outreach efforts by 5%	In FY15, Central Health's Community Outreach staff participated in 188 outreach activities to promote enrollment in local, state and federal health care programs, an increase of 181% over the FY14 baseline of 67 activities.			✓

Initiative 3.2: Offer Health Coverage Options through the Patient Protection and Affordable Care Act (PPACA) Health Insurance Marketplace

1. ACA Qualified Health Plan

		progress	met	exceeded
Target - Enroll 2,500 members	Sendero Health Plans, Inc. created a call response program with outreach and enrollment specialists available 8 a.m.-8 p.m., six days a week during open enrollment, which handled 18,000 calls in FY15. As a result of these efforts, the coordination of Sendero Central Health resources, and the attractive product design, 6,000 members were enrolled in Sendero's IdealCare in FY15, more than double the target for FY15.			✓

6,000 members were enrolled in Sendero Health Plan Inc.'s IdealCare in FY15.



Health Infrastructure

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

Initiative 4.1: Support Planning for New Medical School

progress	met	exceeded
	✓	

1. Medical School

Target - Participate in readiness assessment for school

The Seton Healthcare Family's ground lease for the teaching hospital was implemented in FY15. Central Health, Seton, and The University of Texas System instituted and held Joint Affiliation Committee meetings pursuant to the affiliation agreement. The first Community Benefit Report was published in FY15, highlighting value to the community derived from public investment in the Dell Medical School at The University of Texas at Austin and its impact in developing our integrated delivery system.

Initiative 4.2: Help Plan and Implement New Teaching Hospital

progress	met	exceeded
	✓	

1. New Teaching Hospital

Target - Monitor development and implement transitional care plans as needed to ensure timely completion of Teaching Hospital

Central Health and Community Care Collaborative staff participated in regular and ad hoc meetings involving the transition of University Medical Center Brackenridge 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 UMCB settings in late 2017.

Initiative 4.3: Repurpose the Existing UMC Brackenridge Campus

progress	met	exceeded
	✓	

1. Redevelopment of the Current UMCB Campus

Target - Develop necessary contractual arrangements to implement approved re-purpose plan

In FY15 Phase 2 planning progressed and the Master Plan neared completion with extensive input from Central Health partners, subject matter experts, and more than 8,400 individuals. 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.

Initiative 4.4: Open the Southeast Health and Wellness Center

1. Southeast Hub Community Health Center

		progress	met	exceeded
Target - A. Execute service provision agreements	The Central Health Southeast Health & Wellness Center began hosting CommUnityCare services Oct. 13, 2014, including primary and specialty care, behavioral health, dental, and pharmacy services. Complimentary wellness services were provided through service provision agreements, including cooking classes, breastfeeding support groups, tax services, summer meals to children and families, and program enrollment in Supplemental Nutrition Assistance Program (SNAP), Medical Access Program (MAP) and CommUnityCare Sliding Fee Scale.		✓	
Target - B. Complete renovations	Phase 1 of the building was completed in FY15.	✓		
	The Phase 2 renovations neared completion, progress included: the Community Resources Center opened July 2015; the Graduate Medical Education and Administrative area of the building opened June, 2015.			

Initiative 4.5: Enhance Health Information Technology Infrastructure

1. Expand Health Information Technology Infrastructure

		progress	met	exceeded
Target - A.1 Develop components of the Health Information Exchange (HIE) to identify target population for chronic disease management and supported coordinated care efforts	To drive appropriate care coordination for CommUnityCare patients, Central Health Joint Technology Team developed reports of patients that recently used the emergency departments or hospitals. These reports were sent to the CommUnityCare Patient Navigation Center (PNC) for patient follow-up and noted in the patients' electronic health record (EHR) to keep the patients' primary care providers informed.		✓	
Target - A.2 Develop, test and launch patient navigation and care management software	The Community Care Collaborative partnered with the Aunt Bertha website to develop an online community resources directory (CRD) that allows users to search for federal, state, and local social service programs. The CRD provides patient navigators and care managers with easy access to information to better address patients' needs.		✓	
Target - B. Test and refine reporting capabilities of data warehouse.	Selected and implemented a new analytic tool, Tableau, as the preliminary phase of developing a data warehouse.	✓		

Initiative 4.6: Coordinate the 1115 Waiver Regional Healthcare Partnership Activities

1. Coordinate the 1115 Waiver Regional Healthcare Partnership (RHP) 7 Activities

progress	met	exceeded
	✓	

Target - A. Convene at least two learning collaboratives for RHP 7 partners

Central Health hosted two learning collaborative meetings for RHP7 members on Feb. 17 and Sept. 3, 2015. The meetings focused on developing and enhancing cross-organizational partnerships to improve patient engagement. In addition, conference calls were held to keep RHP7 participants engaged between meetings.

progress	met	exceeded
	✓	

Target - B. Submit all required reports within designated timeframes

RHP7 coordinated and provided technical assistance to providers as they reported performance activity to the Texas Health and Human Services Commission (HHSC), completed the required Annual Anchor Report, and responded to all HHSC requests for information.