KNOW THE FACTS

THE COMMUNITY CARE COLLABORATIVE

CENTRAL HEALTH

HEALTH CARE FOR ALL

Central Health fulfills its objective **to implement a coordinated and patient-focused health care system** primarily through the Community Care Collaborative.

Community Care Collaborative

A Central Health and Seton partnership

The ***Community Care Collaborative*** (CCC) is Central Health's nonprofit partnership with Seton Ascencion formed in 2013 to better manage the care of Travis County residents with low income and/or no health care coverage.

The Community Care Collaborative makes its work possible through partnerships.
Following principles and activities laid out in its strategic plan, which is closely aligned with Central Health's community-supported strategies and objectives, the CCC works with service providers who are committed to building an integrated delivery system for the benefit of Travis County residents with low income.

Since 2013, the Community Care Collaborative has successfully:

Launched a first-of-its-kind partnership with a local rideshare nonprofit to ensure patients can get to their medical appointments.

Partnered with UT Health to launch an innovative integrated practice unit to treat muscle, bone and joint conditions using a patient-centered care team. The wait time for new patients to receive services has dropped from more than 12 months to less than 30 days.

Cured over 1200 patients of Hepatitis C through new best-in-class oral medications.

Launched mobile and street health care initiatives to bring basic medical care to hard-to-reach residents of Travis County.

Co-sponsored community-based Pop-up Resource Clinics to provide persons experiencing homelessness a variety of health and social services.

Implemented 15 transformation projects to increase access to a wide variety of care options and support delivery system reform, earning nearly $150 million in new federal funds, by achieving important project milestones and health outcome metrics.

In 2016, the Community Care Collaborative[1]:

supported the care of
95,578
patients

enrolled
41,654
people in the
Medical Access Program

[1] *Source: Central Health FY 2016 Services Report*

Community Care COLLABORATIVE

a partnership of Central Health and Seton Healthcare Family

VISION

A healthcare delivery system that is a national model for providing high quality, cost-effective, person-centered care and improving health outcomes for the vulnerable population we serve.

VALUES

Our work is governed by the values of innovation, person-centeredness, equity, accountability, and collaboration.

MISSION

Optimize the health of our population while using our resources efficiently and effectively.

STRATEGIC PLANNING **2018-2020**

THREE YEAR MISSION

IMPROVE THE QUALITY OF LIFE AND LONGEVITY OF OUR COVERED POPULATION WHILE CONTROLLING THE COST OF CARE.

STRATEGIC FOCUS 1

BUILD AN INTEGRATED DELIVERY SYSTEM

Ensure access to appropriate services for enrollees, while enhancing care coordination and continuity of care.

METRIC

Encounters by location and type

1. Launch unified payment and associated programming.
2. Develop IT platform that includes all data from sites of care and different service types, and is accessible to all appropriate providers.
3. Add access to necessary services through expanded partnerships.
4. Better connect hospital services to primary care homes.
5. Optimize system Case Management, Medical Management and Utilization Management functions.

STRATEGIC FOCUS 2

REDESIGN COVERAGE PROGRAMS

Redesign local coverage programs (Medical Access Program, Sliding Fee Scale, Seton Charity Care), eligibility rules and covered services to better serve residents for whom the CCC is responsible.

METRIC

Monthly cost per enrollee

1. Expand coverage programs to more of population for whom partners currently pay for care.
2. Design patient financial responsibility to induce appropriate utilization of healthcare system.
3. Design benefit package that optimizes wellness for chronically ill patients and maintains wellness for healthy people.
4. Adapt eligibility and enrollment experience to bring value to the patient and ensure patient and system engagement.
5. Increase engagement with patients to identify, address and improve the outcomes that matter to covered population.

STRATEGIC FOCUS 3

IMPROVE VALUE IN CARE

Use primary care setting to support value, contracting with partners for better patient outcomes, including maintaining wellness and optimizing the health of chronically ill patients; improve value within specialty care while reducing time to diagnosis and appropriate treatment.

METRIC

Value (Outcomes/Cost)

1. Work with partners including Dell Medical School to develop, test and launch innovative and transformative initiatives for system of care.
2. Develop competitive contracts that pay for outcomes that matter to patients.
3. Develop competitive contracts that incentivize use of the whole care team.
4. Encourage, empower, and enable primary care physicians to manage specialty care issues within primary care setting; encourage appropriate utilization and reward high-value care.
5. Improve access to and quality of specialty care services that our patient population needs.

STRATEGIC FOCUS 4

OPTIMIZE HEALTH OF COVERED POPULATION

Improve health outcomes for the patients for whom we care.

METRIC

Health Outcomes

1. Require annual Health Risk Assessment for all patients leading to protocol-driven Comprehensive Plan of Care.
2. Reduce incidence and improve management of chronic diseases, including diabetes, CHF, COPD, renal disease, liver disease.
3. In conjunction with partners, including the Livestrong Institute at DMS, create and launch plan to offer improved cancer care to CCC population.
4. Collaborate with community partners to ensure provision of women's health services.
5. Improve delivery of behavioral health, prevention, and dental services.