EXECUTIVE SUMMARY

Central Health is a local governmental entity dedicated to ensuring the provision of healthcare services for individuals in Travis County, Texas, who lack access to needed services. Central Health is a separate political subdivision of the state of Texas, as allowed under Chapter 281 of the Texas Health and Safety Code. It was created in May 2004 by a vote of Travis County residents and is governed by a nine-member volunteer Board of Managers.

Central Health's **Vision:**	**Central Texas is a model healthy community**.
Central Health's **Mission:**	**We create access to care for those who need it most**.

Central Health expands access to and improves the delivery of healthcare services for vulnerable individuals in Travis County. Our efforts are focused on individuals whose incomes are at or below 200% of the Federal Poverty Income Guideline[1] and who lack the coverage necessary to access needed healthcare services.

Central Health uses a strategic planning process to inform and guide its priorities and annual budget development. A formal strategic plan is developed every 3 years with updates completed annually. Each plan is developed to proactively address the evolving healthcare needs of Central Texans within the current funding and policy environment.

Today, the healthcare environment is changing rapidly, shifting from fragmented, episodic, fee-for-service care to a new system that provides coordinated person centered care, improves quality and reduces cost (see Institute for Healthcare Improvement, for example). These changes are essential to create a system that is economically sustainable and that improves patient health outcomes.

Since inception, Central Health has focused on providing access to more care by expanding its network of providers. This plan marks a significant change for the organization in keeping with the changing healthcare environment. Central Health's new strategic plan focuses on not just increasing access to care but transforming how that care is delivered with the ultimate goal of improving the health of the community. In this way, Central Health is shifting to achieve its vision: Central Texas is a model healthy community. Central Health has always worked in partnership to achieve its goals and this plan continues that strategy in new ways.

The development of this Strategic Plan is informed by a variety of national, state and local data and reports and community planning activities. A few of the sources of information include –

- *Health and Health Care Trends & Innovations in Central Texas* (October 2011),
- The Texas Medical Association's *Healthy Vision 2020 Report* (October 2012),
- Regional Health Partnership 7 *Community Needs Assessment* (2012), and
- A *Community Health Assessment* for Travis County (December 2012).

[1] 200% of the Federal Poverty Income Guideline in 2013 is approximately $23,000 annual income for a single individual.

Collectively, the data reviewed identified the following community needs to be addressed to help ensure the viability of the health care delivery system, as well as the health and vibrancy of the Central Texas community, today and in the future.

- Continued expansion of healthcare services to support timely access to care, in appropriate healthcare settings, for the region's growing and aging population.
- Enhanced access to shared data and increased coordination between providers within the care continuum to reduce inefficiencies created by the current fragmented system.
- Increased access to healthcare coverage to ensure that individuals can access preventive and regular care within a primary care medical home instead of seeking treatment in emergency rooms for non-emergent conditions.
- Stronger prevention and health promotion activities as well as policies to reduce the prevalence of preventable chronic conditions and/or support patient self-care management.
- Enhanced modern healthcare infrastructure within the region sufficient to meet current and projected needs – in terms of number of providers, timely access to shared patient care data, and modern facilities.

Central Health's strategic plan has been further informed by Texas State Senator Kirk Watson's 10 goals in 10 years, an initiative to position Central Texas as a center for accessible, world-class healthcare for everyone, to create jobs and increase economic prosperity, and to make new scientific discoveries that are globally competitive and aimed at improving quality of life.

This bold initiative, of which Central Health is a part, resulted in the identification of the following 10 Goals to be achieved in 10 Years–

1. Build a medical school
2. Build a modern teaching hospital
3. Establish modern, unique health clinics in Austin neighborhoods
4. Develop laboratories and other facilities for public and private research
5. Launch a new commercialization incubator
6. Make Austin a center for comprehensive cancer care
7. Provide needed psychiatric care and facilities
8. Improve basic infrastructure
9. Bolster the medical examiner's office
10. Solve the funding puzzle

As will be reflected in the plan below, Central Health will play a lead or collaborative role in the planning and implementation of many of these efforts.

With this initial information, Central Health developed a strategic plan framework around four priority areas – health care, health promotion, healthcare coverage, and healthcare infrastructure. The ability to address the identified community needs as well as the visionary goals established in the 10 in 10 is significantly helped by two recent healthcare funding changes – one at the local level and one at the state/federal level.

Expanded Local Tax Dollars. In the fall of 2012, Travis County voters approved Proposition 1 to increase the local tax for healthcare services from 7.89 cents per $100 valuation to 12.89 which will provide an estimated additional $54 million annually. These additional local dollars will be used to bring new federal funds to Travis County through participation in the 1115 Medicaid Transformation Waiver discussed below.

1115 Medicaid Transformation Waiver. In December of 2011, the Texas Health and Human Services Commission received federal approval of a waiver that allows the state to expand Medicaid managed care while preserving hospital funding, provide incentive payments for healthcare improvements, and direct more funding to hospitals that serve a large number of uninsured patients.

For Travis County residents, this means that the increased local tax dollars can be matched by federal funds, thereby expanding the amount of money available to expand services and transform the delivery system. For each local $1.00 sent to the federal government, Travis County will receive $2.40. Central Health is leveraging the opportunity presented by this waiver to bring as many funds as possible to Central Texas.

The Patient Protection and Affordable Care Act, or the Affordable Care Act (ACA), is another opportunity that will support improved access to care. A federal act signed into law by President Obama in March of 2010, the ACA aims to increase the rate of health insurance coverage for Americans and to decrease overall healthcare costs.

The Affordable Care Act allows for the significant expansion of health coverage to currently uninsured Americans through two vehicles –

- Private health coverage through approved Qualified Health Plans available through a Healthcare Marketplace and
- Medicaid expansion to all legal residents living at or below 133% FPL.

While Texas opted not to participate in the Medicaid expansion, enrollment into the private health coverage options will begin in October 2013 for coverage in January 2014 for individuals above 100% FPL. Central Health will leverage this opportunity by helping individuals access coverage through the Healthcare Marketplace.

Together, the efforts outlined above, support Central Health to pursue bolder, transformative actions than it has been able to do in the past. This strategic plan details the prioritized efforts identified to help us transform the care delivery system to improve patient experience, improve care quality and reduce cost.

For FY14-FY16, Central Health has created a strategic plan that is transformational, comprehensive, consistent, and outcome-oriented. The plan is structured around the four priority areas that Central Health has identified for the next three years.

1. **Health Care** – Providing access to high quality, patient-focused, coordinated clinical services

   This priority area will demonstrate Central Health's work to increase access to care as well as its innovative approaches for restructuring and transforming the health care delivery system to make health care services more effective, efficient, and responsive to patient needs.

2. **Health Promotion** – Aligning health education and policy efforts to support the ability of individuals to improve their own health and that of their families

   Central Health recognizes that simply expanding and 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, we must invest in keeping people healthy by expanding access to health promotion and prevention efforts and promoting policies that support community health.

3. **Health Coverage** – Increasing enrollment in health coverage products that can support access to care

   While maintaining our existing role in offering a local health benefit plan for low-income populations with no other access to public coverage, Central Health will expand our work over the next three years to include more outreach and education to help our community learn about and access new coverage options available through the Affordable Care Act.

4. **Health Infrastructure** – Ensuring that sufficient facilities, providers, and systems are in place to support the health of Travis County and the region over the long term

   A strong health infrastructure foundation is needed to support the current and future healthcare needs of our community. To meet this need, Central Health will participate in significant upgrades to the local healthcare infrastructure.

These four priority areas form the basis of Central Health's strategic plan for 2014 to 2016. Each priority area has a stated goal and multiple initiatives as well as metrics to measure the achievement of the initiatives.

Some important notes about this plan:

1. Many of the initiatives identified within the plan are collaborative in nature, so each may be implemented and funded exclusively by Central Health or in partnership with one or more other community entities. A new organization that will play a major role in the implementation of the proposed work, especially within the healthcare section, is the Community Care Collaborative (CCC). This is a new non-profit organization, created by Central Health and Seton Healthcare Family, to help develop an Accountable Care-Type organization to enhance the coordination of care across the continuum of services.

2. For the most part, the plan focuses on **new** activities that build upon existing Central Health work.

3. This strategic plan is being created in an exciting, but rapidly evolving environment. The information proposed in this plan reflects our best knowledge at this time. We will continue to refine this document over the next few months to reflect updated information. Updated versions will be posted on our website – www.centralhealth.net

Central Health FY14-FY16 Strategic Plan Priority Areas and Draft Initiatives
The following is a listing of the initiatives within each priority area. Each area is color coded in the plan for easier reading.

Priority Area 1: Health Care
- Initiative 1.1: Create the Community Care Collaborative (CCC) to Help Transform the Local Healthcare Delivery System
- Initiative 1.2: Expand Health Care Capacity for Current and New Services
- Initiative 1.2a: Increase Access to Primary Care including Dental Services
- Initiative 1.2b: Increase Access to Specialty Care
- Initiative 1.2c: Increase Access to Women's Health Services
- Initiative 1.2d: Increase Access to Behavioral Health Services
- Initiative 1.3: Collaborate on Community Planning for Comprehensive Cancer Care
- Initiative 1.4: Leverage Healthcare Investments

Priority Area 2: Health Promotion
- Initiative 2.1: Provide Health Promotion in Support of Community Care Collaborative Clinical Efforts
- Initiative 2.2: Develop a Community Health Indicators Report
- Initiative 2.3: Develop a Local Health Policy Council

Priority Area 3: Health Coverage
- Initiative 3.1: Provide Eligibility and Enrollment Support for New Health Coverage Options
- Initiative 3.2: Provide a Health Coverage Option through the Affordable Care Act Health Insurance Marketplace

Priority Area 4: Health Infrastructure
- Initiative 4.1: Help Plan for the Development of a Medical School
- Initiative 4.2: Plan for a New Teaching Hospital
- Initiative 4.3 Repurpose the existing UMC Brackenridge campus.
- Initiative 4.4 Plan and Implement the Southeast Health and Wellness Center
- Initiative 4.5: Enhance Health Information Technology Infrastructure
- Initiative 4.6: Act as 1115 Waiver Regional Healthcare Partnership Anchor Entity

STRATEGIC PLAN

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: Establish 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; assist patients in better understanding their health and care requirements and assist them in the most appropriate use of the healthcare delivery system; 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 multiple projects to help transform the healthcare services delivery system to meet the goals identified above. These projects include the creation/implementation of the following programs or resources –

- health information exchange (HIE)/disease management registry,
- patient-centered medical home model (PCMH),
- chronic disease management model, and
- comprehensive patient navigation.

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

4: Implement a Coordinated Patient Navigation Program

Year 1	**Target:**	Train X patient navigators on CCC patient navigation principles/protocols
Year 2	**Target:**	Train X additional patient navigators on CCC patient navigation principles/protocols (X total navigators for Years 1-2)
Year 3	**Outcome 1:**	Reduce inappropriate utilization of ED – percent reduction to be determined with CMS in fall 2013
	Outcome 2:	Reduce preventable hospital readmissions with 30 days of discharge – percent reduction to be determined with CMS in fall 2013

Initiative 1.2: Expand Health Care Capacity for Current and New Services

Central Health has prioritized four major healthcare service areas – primary care (including dental), 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 ensure 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 and Dental 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 3rd 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 3provides 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 partners, ATCIC, Seton Healthcare Family 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 ensuring that 14 medical psychiatric beds are provided in the new facility. These beds will fill a significant gap by ensuring appropriate care is available to individuals with co-occurring psychiatric crisis and major medical issues. 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

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:**	New beds are included architectural plans for hospital
Year 2	**Target:**	Construction of new hospital underway
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 1.3: Comprehensive Cancer Care

Strategy. In 2012, a group of local community and business leaders, led by State Senator Kirk Watson, developed a list of 10 goals to be achieved in 10 years (10 in 10) to enhance the health and economic vitality of Central Texas. One of these goals was to make Austin a center of comprehensive cancer care. Results of the 2009 Behavioral Risk Factor Surveillance System (BRFSS) survey show that cancer has overtaken heart disease as the number one cause of death in the Austin Metropolitan Statistical Area (MSA) - including Bastrop, Caldwell, Hays, Travis, and Williamson counties. While Austin is now the 11th largest city in the nation, it does not have a National Cancer Institute (NCI)-designated Comprehensive Cancer Center nor an academic medical center affiliated with a medical school to specialize in the treatment and research into this set of diseases. With the many resources that the community has, the local perception was that Central Texans are traveling outside of the area to receive the best cancer care.

To identify the current state of cancer care in the local community, Central Health, the LiveStrong Foundation, and the Shivers Cancer Foundation funded a study which was published as the *Greater Austin Region Cancer Care Paper* in January 2013. The purpose of the paper was to review quantitative data and obtain qualitative community input on -- current perceptions about the quality of cancer care in the greater Austin area; level of access to and use of local resources for cancer care; the patient's perspective of care services; gaps in services for cancer patients and survivors across the cancer care continuum; and identify next steps. The paper identified 14 statements that indicated that while quality cancer care resources are available within the community, a number of improvements are needed to support the excellence in comprehensive cancer care that each individual deserves. Identified areas of focus include –

- Increasing timely access to quality care for all individuals regardless of insured status or geographic location (rural, urban, etc.);
- Need to recruit additional providers to support the increasing level of need for the growing and aging population;
- Improving access to prevention and screening services to decrease prevalence of late stage diagnosis;
- Increasing level of coordination and collaboration across providers and expanding and enhancing patient navigation services;
- Committing to continual improvement of system through development and tracking of shared metrics;
- Enhancing technology that supports research for innovative care;
- Increasing and promoting awareness of palliative care and support services.

To further this work, the community collaborative is working with a consulting team to formalize recommendations and develop implementation strategies to help make Austin a center of comprehensive cancer care including addressing the gaps identified in the Cancer Care Paper. It is anticipated that the recommendations will be complete by September of 2013.

Project(s) and Funding. During the period of this strategic plan, Central Health will continue its work as a lead collaborative partner in the planning of comprehensive cancer care in Central Texas. Central Health will review the recommendations developed to determine the most appropriate role for future funding in terms of additional studies and/or increased services. Additional planning work will be funded with general fund revenue in collaboration with other community partners. Services supported will be funded with either with general fund revenue or federal matching funds.

2: Implement Integrated Behavioral Health Services for Targeted Patients

Year 1	**Target:**	With community partners, review recommendations received and prioritize work.
Year 2	**Target:**	TBD
Year 3	**Target:**	TBD
	Outcome:	TBD

Initiative 1.4: 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 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.
	Outcome:	By the end of 2016, X% of total estimated federal funds will have been received based on project performance.

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 landscape 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, and the opportunity exists to create a focused coordinated effort among all partners that maximizes impact of all partners.

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 better collaborate with community partners on implementing health policy and measuring community health status. This will be done through --

- 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 at Houston 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, among others, 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. During the period of this strategic plan, Central Health will work with the CCC Health Promotion workgroup and with individuals with appropriate expertise including data analysts and clinicians to build this new priority area. Within the period of the three year plan, Central Health will launch at least one evidence based health promotion activity. Central Health will use general fund dollars and/or federal matching funds 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:**	Establish a CCC Health Promotion work group to plan strategies
	Target b:	Identify at least one health promotion goal and associated milestones to support CCC clinical efforts.
Year 2	**Target a:**	Develop a process for integrating input from community partners into the CCC Health Promotion work group.
	Target b:	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 information about the health status of the community. Central Health plans to work collaboratively with community partners to develop a Community Health Indicators Report that is accessible and available to the community.

Central Health will convene appropriate stakeholders and partners such as the Austin/Travis County Health and Human Services Department and the Travis County Health and Human Services and Veterans Services Department to establish a collaborative approach for identifying, collecting and monitoring key community health indicators. Through this collaborative approach, partners will ideally use data to educate the community and identify health priority areas for collaborative intervention. A stronger alignment among partners focused on improving health status in Travis County based on shared data and priorities is intended to lead to improved community 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. During the period of this strategic plan, Central Health will work with partners to develop and launch a community health indicator project. Second, Central Health will work to identify effective strategies to disseminate information to the public. Third, in partnership, Central Health will work to identify a shared community health issue, based on the data, on which to act to improve outcomes. Central Health will use general fund 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. A number of governmental entities have at least some jurisdiction over health policy in our community, yet there is not a single advisory body responsible for identifying and promoting health policies for the Austin and Travis County geographic area. 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 to establish a Health Policy Council to serve in an advisory capacity to community decision and policy makers. Ideally, this Council would become the community authority on health policy issues within Travis County and make recommendations on the best strategies for improving individual and community health based on research and best practices. The work of the policy would be informed by the community health indicators project described previously.

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 and 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. During the period of this strategic plan, Central Health will work in collaboration to develop and launch a Health Policy Council within Travis County. Central Health will use general fund 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 (still to be determined) by 2016.

Initiatives:

Initiative 3.1: Expand 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 the 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 general fund 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	**Target a:**	Establish baseline call volume to call center around health coverage through ACA.
	Target b:	X # of people apply for coverage in ACA plans through outreach efforts.
	Target c:	Eligibility system functional for eligibility determinations for ACA and expanded MAP by X (date).
Year 2	**Target a:**	Increase in call volume of X over prior year to Central Health Call Center for calls related to the ACA/Marketplace.
	Target b:	Increase the number of individuals enrolled in the ACA marketplace by X and in the expanded MAP by X.
Year 3	**Target b:**	Increase by X over prior year the number of individuals enrolled in the ACA marketplace by X and in the expanded MAP.
	Outcome 1:	Increase the number of people enrolled in the Health Insurance Marketplace by X%.
	Outcome 2:	Goal enrollment for all expanded MAP initiatives identified in the 1115 waiver will be achieved.

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.

1. 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: Support Development of a 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: Support Construction of a 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 (to be determined) and services provided at the UMCB campus will be supported with X (to be determined) 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 Open the 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 (to be determined) 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: Expand 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	**Target a:** Continue with any needed refinements to HIE capabilities. **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.

Initiative 4.6: Coordinate the 1115 Waiver Regional Healthcare Partnership Activities

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 Central Health
	Target b:	All required reports are submitted
Year 3	**Outcome:**	XX% of potential DSRIP funds across the region are achieved