



Central Health Equity-Focused Service Delivery Strategic Plan

PROPOSED

February 9, 2022

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1.0 Conclusion

As Central Health progresses toward its strategic goals, economic challenges and regulatory complexity will require continued commitment and capital to mature its capabilities. Central Health must work internally and in collaboration with partners to develop and deploy a high-functioning system of care that meets the health needs of Travis County’s safety-net population and improves health equity. These initiatives are long-term and require dedicated investment in resources to deliver results in the upcoming years. These initiatives are critical to the collective success of Travis County’s health care safety-net system. This work will have a significant impact on the access, capacity and quality of care Central Health patients deserve to receive. Central Health and its Board of Managers are committed to providing high-quality and equitable care for its patients. Therefore, Central Health will continue to bolster partnerships with community-based organizations while addressing social determinants of health and building an equity-focused health care delivery system designed to meet the unique needs of Travis County’s safety-net population.

2.0 Overview

2.1 About Central Health

As the hospital district serving Travis County, Central Health was created in 2004 to provide access to and coordinate the high-quality health care low-income residents need to get well and stay healthy. Central Health’s mission states: “By caring for those who need it most, we improve the health of the community.” To fulfill its mission, Central Health partners with local health care organizations to extend access to a broad array of health care services for low-income Travis County residents. Collectively, Central Health’s partners provide health care services spanning the care continuum for patients at approximately 190 locations. Key services provided include primary and preventative care, inpatient and outpatient hospital care, specialty care, recuperative and hospice care, and services for patients discharged from in-patient and acute settings transitioning back into daily life.

Our Vision ... Central Texas is a model health community.

Our Mission ... By caring for those who need it most, Central Health improves the health of the community.

Our Values ... **Central Health will achieve excellence through:**

Stewardship - We maintain public trust through fiscal discipline and open and transparent communication.

Innovation - We create solutions to improve healthcare access.

Right by All - By being open, anti-racist, equity-minded, and respectful in discourse, we honor those around us and do right by all people.

Collaboration - We partner with others to improve the health of our community

Figure 1. Our Mission, Vision, and Values

Today, Central Health serves approximately 100,000 patients each year through the Medical Access Program (MAP) and Medical Access Program - Basic (MAP-Basic). A comprehensive review of Travis County’s safety-net population found Central Health-enrolled patients represent a little more than one-half of those that may be eligible for services. Significant opportunity exists to expand reach and strengthen the impact on health and wellness for those that are low-income and particularly the most marginalized populations across Travis County.

Central Health patients face high poverty rates, unemployment rates, and metrics of poor health. The assessments conducted to develop this Equity-focused Service Delivery Strategic Plan indicate Central Health’s patient population fares worse than Travis County and Texas averages in a number of measures of health. With significant health care access challenges across Travis County, patients struggle to receive essential preventive, primary, and specialty care services across the care continuum, and often use the Emergency Department in place of these services due to limited access and transportation barriers. Further, educational opportunities and access to healthy, affordable food, and housing are scarce and act as additional barriers to health.

In 2018, Central Health worked closely with community members to identify and refine the healthcare district’s strategic objectives for the years ahead. These objectives are defined as follows:



Figure 2. Central Health Strategic Plan Objectives FY2019-FY2024

Recognizing that economic opportunities, environmental factors, and social networks are key determinants of health, Central Health continues to focus on opportunities that will expand access to critically needed health care services across the continuum of care – while building health equity and improving outcomes for the low-income populations that are currently Central Health patients or are potentially eligible for services.

To support this effort, Central Health completed a comprehensive Equity-focused Service Delivery Strategic Plan to best position itself to meet the immediate and evolving health-related needs of its eligible population and work toward long-term solutions that maximize use of community resources to improve the health of those populations. Central Health conducted an in-depth safety-net community health needs assessment (CHNA), a voice of the community analysis, and a capabilities and gap analyses in collaboration with community members, activists, stakeholders, and partners to systematically identify and prioritize health needs in low-income populations and to understand the safety-net health care delivery system across Travis County. The outputs of these assessments are foundational to the comprehensiveness and effectiveness of an Equity-focused Service Delivery Strategic Plan.

2.2 Our Community

For the purposes of the safety-net CHNA, Central Health divided Travis County into 14 planning and assessment regions to understand health care needs at a more local level. These planning and assessment regions were developed based on census tract analysis and other characteristics, including geographic borders, level of urbanization, transportation resources, and population density.

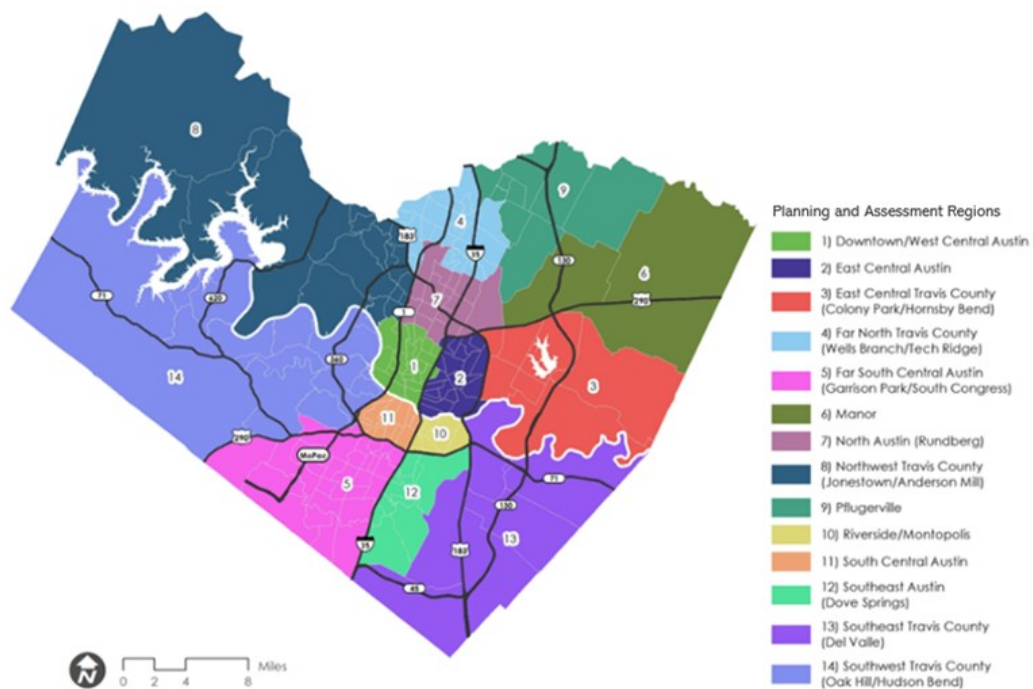


Figure 3. Central Health Planning and Assessment Regions

Source: Planning and assessment regions defined by Central Health

Core to this analysis is understanding the scope, scale and severity of health care needs of low-income Travis County populations at the local level. The map below illustrates the geographic distribution of the healthcare district’s low-income population,

specifically those with incomes less than or equal to 200% of the FPIL, across each of the 14 planning and assessment regions.

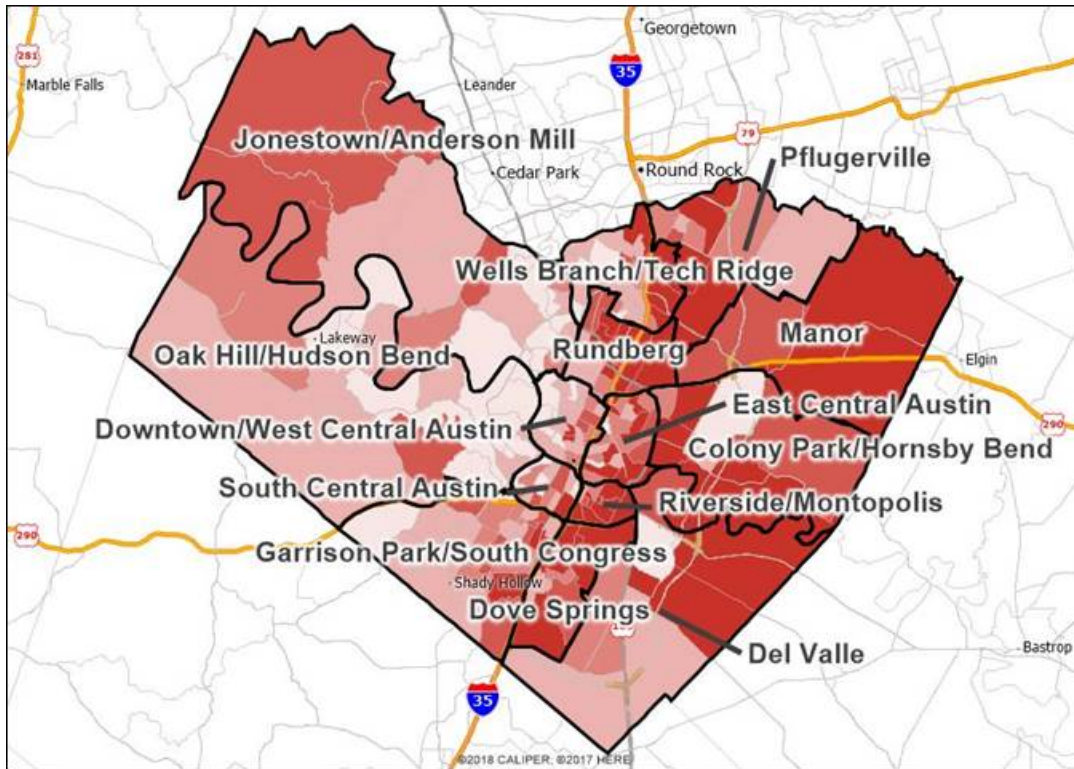


Figure 4. Absolute Population below 200% of FPIL by Census Tract

Source: American Community Survey (ASC) 2015 -2019

74% of Travis County’s 241,774 residents with incomes below 200% FPIL reside in the I-35 corridor. Central Health’s current enrollment is highest (*total and percent eligible enrolled*) in this I-35 corridor focus area. This focus area also represents the area with the greatest opportunity to expand Central Health’s enrollment to low-income residents (69,230 residents), as home to approximately 75% of additional currently unenrolled residents who may be eligible for Central Health or other safety-net services in Travis County.

	Planning and Assessment Region	# of Census Tracts	Square Miles	Total Population - 2021	Enrolled Population - FY20	Families in Poverty - 2025	% of Population Below 200% FPIL - 2019	Enrollment Opportunity
I-35 Corridor	Rundberg	20	25.4	127,323	21,022	4,905	17.2%	16,233
	Garrison Park/South Congress	31	67.0	199,593	8,335	2,406	11.2%	12,683
	East Central Austin	20	17.5	80,803	7,161	2,968	9.3%	8,550
	Dove Springs	11	27.9	72,963	10,701	2,219	8.2%	8,331
	Wells Branch/Tech Ridge	24	30.6	120,717	8,471	1,944	8.1%	8,558
	Downtown/West Central Austin	22	16.3	97,596	1,259	770	8.1%	2,433
	Riverside/Montopolis	10	7.5	53,514	7,487	1,938	8.0%	6,720
	South Central Austin	12	9.7	56,025	2,459	850	3.7%	5,722
East Travis County	Pflugerville	9	63.0	112,254	7,311	1,431	6.2%	5,334
	Colony Park/Hornsby Bend	7	81.8	43,465	9,207	1,632	5.9%	4,792
	Del Valle	8	120.4	32,432	8,353*	1,044	3.2%	2,025
	Manor	3	100.0	28,253	3,532	781	2.3%	1,255
West Travis County	Jonestown/Anderson Mill	22	218.6	155,652	2,681	1,188	5.1%	3,267
	Oak Hill/Hudson Bend	19	206.4	127,318	2,606	1,211	3.3%	5,192
	Grand Total	218	992.2	1,307,908	100,585	25,287	100.0%	91,095

Figure 5. Central Health Enrollment and Opportunities for Enrollment Expansion by Planning and Assessment Region

Sources: Central Health Census Tract Planning and Assessment Region; Land area data obtained from the U.S. Census Bureau. Total population of families in poverty data obtained from Claritas ©. Population <200% FPIL data obtained from American Community Survey (ACS) Table S1701.

Notes: Enrolled population counts are based on patients with addresses that could be geocoded. Consequently, the Downtown/West Central Austin Planning and Assessment Region likely represents an undercount of enrolled patients. * Travis County Correctional Complex/Austin Transitional Center is in Del Valle and a significant number of inmates were enrolled into MAP when they didn't have a permanent address

3.0 Key Findings from the Voice of the Community

The Voice of the Community engagement is critical to health equity efforts for marginalized and underserved patients. This process highlighted factors influencing patient access, connectedness, continuity, and trust from those with lived experience as well as the groups who serve or advocate for them. As a result of intentional and focused engagement efforts, the participants of the Voice of the Community were diverse, reflecting voices of the general population, advocacy groups, institutions and various people served by Central Health. Their input is broadly summarized as follows:

- People appreciated the opportunity to provide input
- MAP is making a positive difference in people’s lives
- There is a need for added education about benefits and resources
- Language barriers exist when accessing and navigating the system
- Wait time for appointments and patient provider communication are both critical issues for patients

3.1 Profile of Patients Engaged through the Voice of the Community

Through the voice of the community, Central Health engaged in conversations with 320 total participants. Among them were people from marginalized communities and their advocates including:

PARTICIPANTS

There were 320 total participants. Among them were people from marginalized communities and their advocates including:

- 186 MAP/ MAP Basic members
- 29 participants experiencing homelessness
- 15 community-serving organizations (CSOs)
- 10 Institutions



Responses by Gender

n=272



Female
69.4%



Male
29.9%



Non-binary
0.4%



Prefer not to answer
0.4%

TYPES OF ACTIVITIES

In-Person and Virtual Focus Groups	105
Phone Surveys	120
Online Surveys	47
Community Conversations*	48

Responses by Race/Ethnicity

n=272

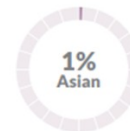
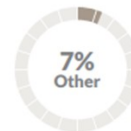
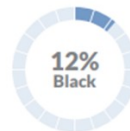
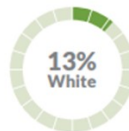
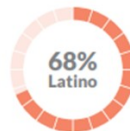


Figure 6. Profile of Patients Engaged through the Voice of the Community

Overall, all groups expressed (1) the need for more education and information about preventive care and resources related to chronic disease and mental health; and (2) a high desire to work with Central Health in the community to help families learn how to access medical care and support each other in becoming healthier.

3.2 Findings from Conversations with Various Focus Groups

Findings from conversations with Asian, Latino, African American, and unhoused participants specifically are summarized below.

Asian Participants

- Language barriers may be reduced by building stronger communication systems that translate documents and diagnosis in the native language of patients
- Patient-serving organizations in this community go the extra mile providing rides, assistance with diagnosis and even helping patients pick up prescriptions
- Patients served are older, do not speak English, and require assistance navigating all steps to accessing medical care
- There is a desire among this patient population to work with Central Health on preventive workshops at faith-based centers and in the community to help improve health

Latino Participants

- Latino patients have a desire for more education on disease prevention programs and available resources
- This patient population calls for compassionate relationships that understand the culture, geographic challenges, and language when considering the health care needs of safety-net populations across the county
- There is a need for community alliances to solve larger social and political issues in accessing health care

African American Participants

- African Americans place an emphasis on patient experience before, during and after doctor visits
- This patient community would like to receive more information on chronic disease, nutrition, and mental health
- The African American community desires opportunities to partner with families, churches and organizations to build education and outreach programs for African American men, and to teach families how to help African American men maintain consistent care and seek more frequent medical attention

People Experiencing Homelessness

- Community partnerships provide structure, access to information and resources that help people living in transition
- Churches have a unique position because of location and in partnership with medical providers can be great spaces where unhoused people can consistently connect with needed resources

- Most respondents were current or former MAP members and are able to access the program through faith-based organizations

3.3 Summary of Significant Health Needs from the Safety-Net Community Health Assessment

The primary objective of the safety-net CHNA is to understand the magnitude and distribution of health care needs of Travis County’s low-income, safety-net population. Using various sources, the CHNA evaluated quantitative data and trends for Central Health’s current patient population and low-income residents who are potentially eligible patients to identify opportunities to better serve these communities. Significant areas impacting health needs were identified based on a comprehensive review of publicly available and proprietary quantitative data collected throughout the CHNA process. Areas for significant opportunity impacting health needs are:

<p>1. Access to primary and preventative, and specialty care across the continuum</p> <p>Health outcomes data indicates Travis County’s safety-net population is vastly underserved and experiences greater challenges trying to access health care services. Large shortages of physicians and access points, result in limited timely and inadequate access to critical preventative, primary, and specialty care services, including hospital-based, for safety-net patients</p> <p><i>Ex: Central Health patients residing in East Travis County and along the I-35 Corridor have proportionally fewer opportunities because of the density of need for primary prevention services, including annual check-ups, dental care, mammograms, pap smears, and colorectal screenings. For Central Health patients in total, screening rates for breast cancer, cervical cancer, and colorectal cancer are lower than Healthy People 2030 Program targets</i></p>	<p>2. Management of Chronic Health Conditions</p> <p>Patients served by Central Health have higher rates of chronic disease and delayed receipt of critical health care services; opportunities exist to improve population health and chronic disease management through advancement of care models</p> <p><i>Ex: Central Health patients who reside along the I-35 Corridor had the highest rates of chronic conditions, thereby demonstrating a greater need for access to health care services in these locations</i></p>
<p>3. Behavioral Health</p> <p>Many factors leading to mental health episodes and substance abuse disproportionately impact patients served by Central Health. Further, stigma related to behavioral health in a highly minority community affects residents’ willingness to seek help from mental health care providers specifically (as opposed to within a primary care model)</p> <p><i>Ex: Central Health patients in West Travis County have higher prevalence rates of behavioral health issues and substance abuse when compared to County averages. This is not aligned with the health status of the total patient population in West Travis County</i></p>	<p>4. Social Determinants of Health (“SDOH”)</p> <p>Racial and ethnic minority populations are more likely to be socially vulnerable due to their increased likelihood to have an income below FPIL, to live in substandard housing, and to have low access to health care providers and services</p> <p><i>Ex: Regions where 50% or more of the population is Hispanic (i.e., Del Valle, Dove Springs, Colony Park/Hornsby Bend, and Riverside/Montopolis) face greater SDOH-related needs than other regions</i></p>

Figure 7. Summary of Significant Health Needs for the Safety-Net Community in Travis County

- 1. Access to preventative, primary, and specialty care across the continuum:** Health outcomes data indicates Travis County’s safety-net population experiences greater challenges trying to access health care services compared to other populations in the county. Major disparities and health care inequities continue to exist across the care continuum for Central Health’s patients, making it nearly impossible to achieve the objectives of the Institute for Healthcare Improvement’s Triple Aim™ Initiative of better health outcomes, improved patient experiences, and lower costs of health care. The health care disparities faced by the safety-net population in Travis County continue to be substantial and include:
 - An overall and increasing need for more comprehensive, multidisciplinary health care, treatment planning and care coordination across providers and settings for the safety-net population. Overall capacity for primary care including walk-in and same day access should be increased to meet more of the enrolled population’s

needs. More robust post-acute services are needed, especially in East and West Travis County.

- Large shortages of physicians exist in some primary and across most medical and surgical specialties, and will most likely increase in the future across all payors and patients seeking medical services. The shortage will be exacerbated for the safety-net system as it attempts to compete for the necessary level of physicians to meet the service levels required for patient care. Shortages will limit timely access to critical preventative, primary, and specialty care services for safety-net patients, which will likely result in undesirable health outcomes. This is demonstrated on a micro-level, with patients residing in East Travis County and along the I-35 Corridor having lower utilization for preventive services, including annual check-ups, dental care, mammograms, pap smears, and colorectal screenings. For Central Health patients in particular, screening rates for breast cancer (64.0%), cervical cancer (73.5%) and colorectal cancer (47.0%) are lower than target rates set by the Healthy People 2030 Program (77.1%, 84.3% and 74.4%, respectively).⁵
- A limited number of health care providers: (1) treat the safety-net population, which results in delays in care; and (2) demographically resemble the diverse nature of Travis County's safety-net population today and can care for residents in their language and through their specific cultural lens.
- 74% of Travis County's residents (241,774) with incomes below 200% FPIIL reside in the I-35 Corridor. By a significant margin, the Rundberg area is home to the highest number of residents below 200% FPIIL in Travis County (56,132 individuals). As Central Health considers strategies that expand access to care for Travis County's safety-net community, it must ensure that geographic distribution and health care needs of its patient population are aligned with sufficient access to meet demand for services.

2. Management of Chronic Health Conditions:

- Patients served by Central Health need additional resources to address chronic diseases. From a geographic perspective, Central Health patients who reside along the I-35 Corridor had the highest rates of chronic conditions, thereby demonstrating a greater need for access to health care services in these locations.
- Further, there is a need to expand comprehensive, multi-disciplinary care, treatment planning, and care coordination across care settings and providers to facilitate individualized care management planning with seamless coordination across settings. This is further compounded by the fact that there is not a central electronic health record or robustly utilized health information exchange to tie providers together through data sharing and encourage seamless transitions in care. Additionally, opportunities exist to improve population health and chronic disease management by leveraging advanced care models for the safety-net population.

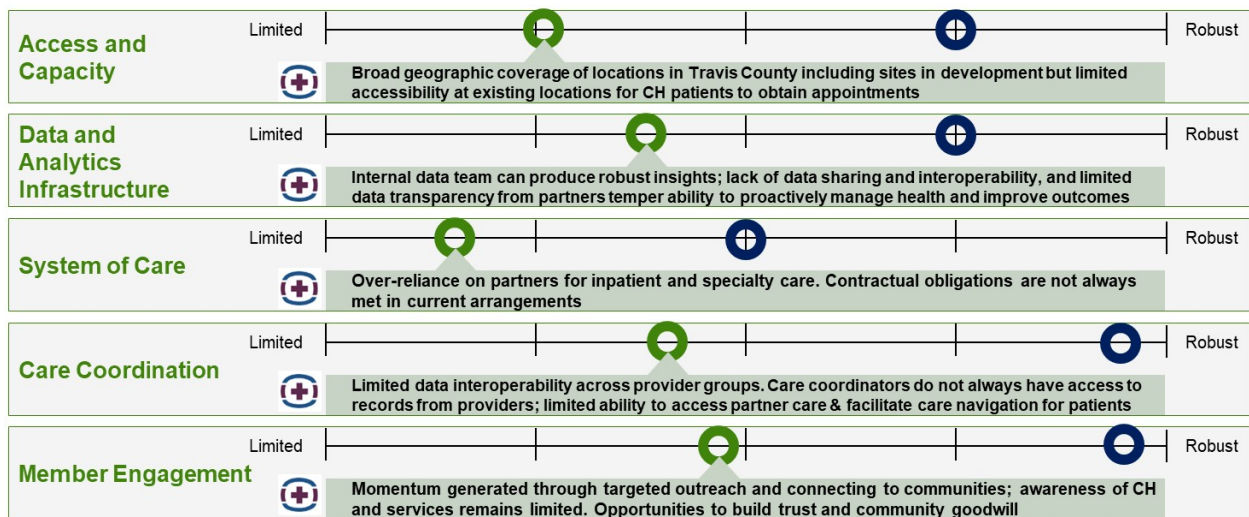
3. **Behavioral Health:** Many factors leading to mental distress and substance abuse impact patients served by Central Health disproportionately. Inequity, low-income, poor physical health, unemployment, and high cost of living are common in the county. The prevalence, incidence and severity of these illnesses has been exacerbated further by the ongoing COVID pandemic. On a micro level:
 - Most of the regions in the I-35 Corridor (five out of eight) and all regions in East Travis County have a lower rate of local mental health providers per 100,000 residents (i.e., credentialed professionals specializing in psychiatry, psychology, counselling, child, adolescent, or adult mental health, or clinical social work) than the county overall. However, these areas represent some of the highest needs for mental health services in the county.
 - The safety-net population needs additional access to behavioral health services. In East and West Travis County, access and capacity to serve the safety-net are limited.
 - Central Health patients residing in the West Travis County communities of Jonestown/Anderson Mill and Oak Hill/Hudson Bend have less access to substance abuse providers when compared to the overall patient average, yet these patients have some of the highest substance abuse rates among the organization's patient population.
4. **Social Determinants of Health:** Safety-net patients are facing many social and economic disparities impacting physical and mental wellness. Regions where 50% or more of the population is Hispanic (i.e., Del Valle, Dove Springs, Colony Park/Hornsby Bend, and Riverside/Montopolis) face greater SDoH-related needs than other regions. Specific to the communities served by Central Health:
 - Lower median income, high unemployment rates, and high rate of households below FPIL in the I-35 Corridor and East Travis County are indicative of populations that may have limited access to adequate preventative care and lack other necessary resources to achieve health and wellness.
 - A larger proportion of adults in East Travis County and in the I-35 Corridor do not have high school diplomas. Research shows that not having a high school diploma is an indicator of limited ability to secure employment resulting in lower wages, and poverty, and can lead to negative health outcomes.
 - High housing costs, substandard housing, and overcrowding are prominent issues in Riverside/Montopolis (I-35 Corridor) and Colony Park/Hornsby Bend (East Travis County). These challenges can exacerbate certain chronic illnesses as they often limit a household's ability to allocate sufficient income to necessities, such as food and health resources, in addition to creating housing instability and potential homelessness.
 - A large portion of patients residing in East Travis County and along the I-35 Corridor speak Spanish as their primary language. It is important that health care providers offer written medical information in different languages, including Spanish, to ensure patients can read and understand health care information that is critical to improving their health (e.g., discharge instructions, treatment

plans, phone numbers for providers so that patients can ask follow-up questions).

- Households in the I-35 Corridor and East Travis County are less likely to have stable access to computers and the internet. These challenges must be considered as Central Health's network of providers begin to deploy innovative technologies to expand access to health services for safety-net communities.

4.0 Capabilities Assessment

The magnitude and distribution of community health needs mandates focused and effective strategies to address gaps in the care delivery system. A comprehensive understanding of Central Health’s capabilities is foundational to the design and efficient execution of these strategies. Central Health’s capabilities were assessed in five key areas: (1) access and capacity; (2) data and analytics infrastructure; (3) system of care; (4) care coordination; and (5) member engagement. Overall, Central Health has foundational capabilities in all five assessment areas. However, significant opportunities exist to bolster capabilities and processes across all five assessment areas as critical components in Central Health’s Equity-focused Service Delivery Strategic Plan. A summary of findings from this assessment are provided below.




 Benchmark State
 Note: Benchmark is related to and determined by GH assessments and experience working with large urban hospital districts in Texas

Figure 8. Summary Characterization of Central Health’s Opportunities

5.0 Clinical Gap Analysis

Access to health care services across Central Health’s system of care was evaluated based upon eight clinical service categories: primary care, wellness and prevention, urgent and convenient care, specialty care, behavioral health, dental, hospital services, and post-acute care. Overall findings indicate that each of these service categories exhibit significant or moderate gaps that represent opportunities to be addressed in the Equity-focused Service Delivery Strategic Plan. Findings specific to each clinical service category are summarized below.

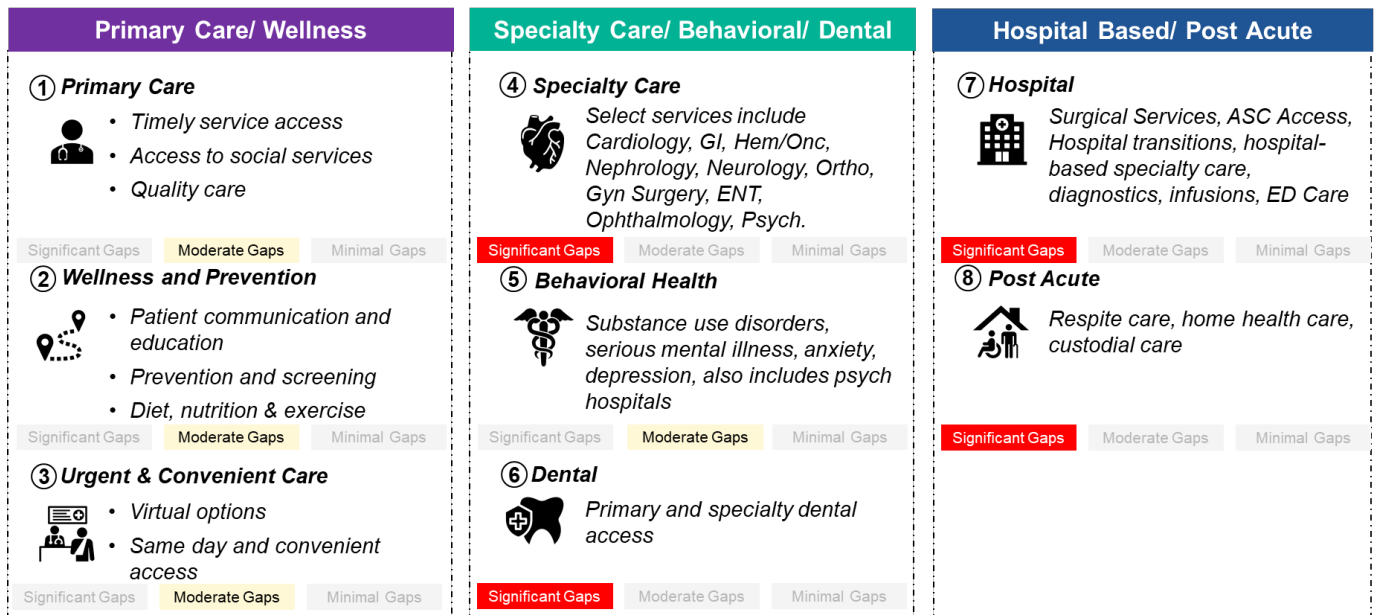


Figure 9. Summary Characterization of Central Health’s Clinical Service Gaps

6.0 Planning for the Future

As the healthcare district serving Travis County, Central Health is both responsible for and uniquely positioned to leverage its assets, partnerships, affiliations and capabilities to improve health care delivery for the county’s safety-net population. The degree of unmet needs in the community is forecasted to grow in the coming years. Further, the COVID-19 pandemic has accelerated the gap between supply and demand of health care services across the United States. Travis County has been uniquely affected by virtue of the size and the unique demographic and epidemiological profile of its safety-net population. Thus, the magnitude of unmet need for the low-income residents of Travis County necessitates realistic, collaborative and forward-looking solutions as Central Health is working to address gaps in the existing safety-net health care delivery system and strategically develop a comprehensive, high functioning, system for the future. The urgency of execution of these solutions demands a targeted strategic approach by leveraging and optimizing the use of the core competencies and strengths of Central Health, its partners and community safety-net providers. The overarching guiding principle of the Equity-focused Service Delivery Strategic Plan is to improve access to timely quality health care services for Travis County’s low-income patients through the formation of a comprehensive, high functioning health care delivery system.

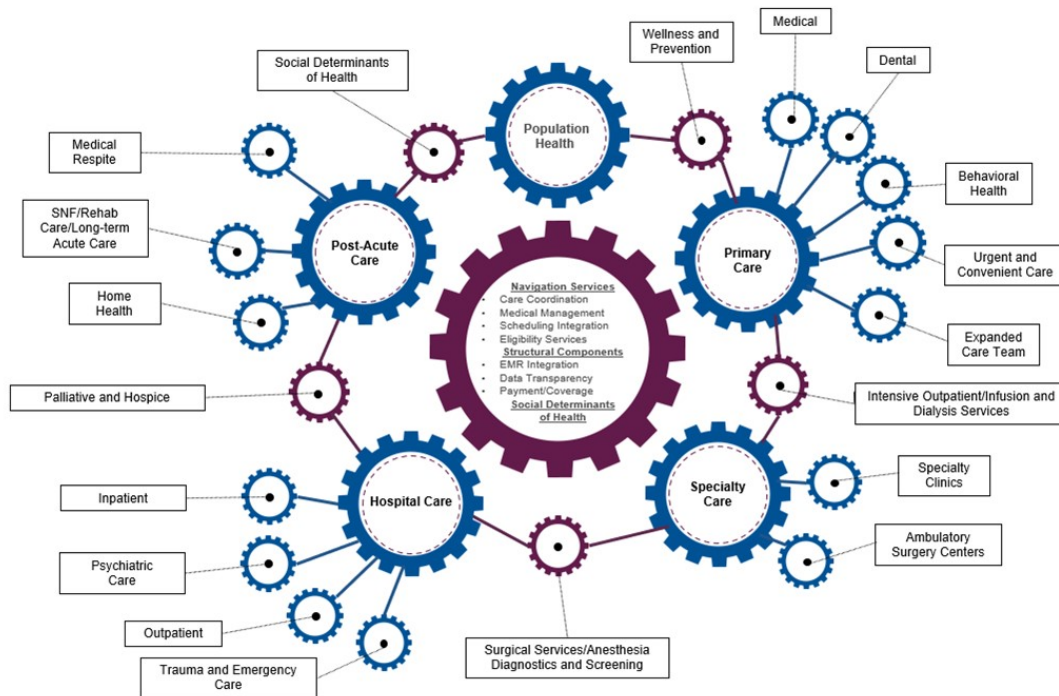


Figure 10. Components of a High Functioning Health Care Delivery System

Addressing access issues to primary care, specialty care and inpatient care through a variety of access channels will have the most immediate impact on the health of Travis County’s low-income communities. Central Health has traditionally outsources service provision and relies on partner provider systems to meet the health care needs of its

eligible populations. Although outsourcing of services is helpful to address immediate needs, Central Health must also identify the types and volumes of services it should directly provide as part of its future strategy. An in-depth assessment of the financial impact and planning for operational implementation that considers both the viability of outsourcing and direct provision of selected services will be critical to Central Health's financial sustainability. The implementation planning process will immediately follow this strategic planning process.

There are four strategic imperatives that will allow Central Health to achieve its service delivery strategic goal to develop an equitable system of care that is comprehensive and accountable, while maximizing the collective use of capabilities and resources to serve Travis County's safety-net population. The four strategic imperatives are: (1) access and capacity, (2) care coordination, (3) member engagement, and (4) system of care. These imperatives will form the structural foundation of the Equity-focused Service Delivery Strategic Plan. Each imperative has enabling and supporting goals and objectives to enforce accountability. Further, these goals and objectives will serve as the means by which the organization measures its success over the next five to seven years in achieving its mission. The design and execution of initiatives that fall under these strategic imperatives will be guided by tactics specific to the overarching imperatives.

6.1 Service Delivery Strategic Plan Strategic Imperatives

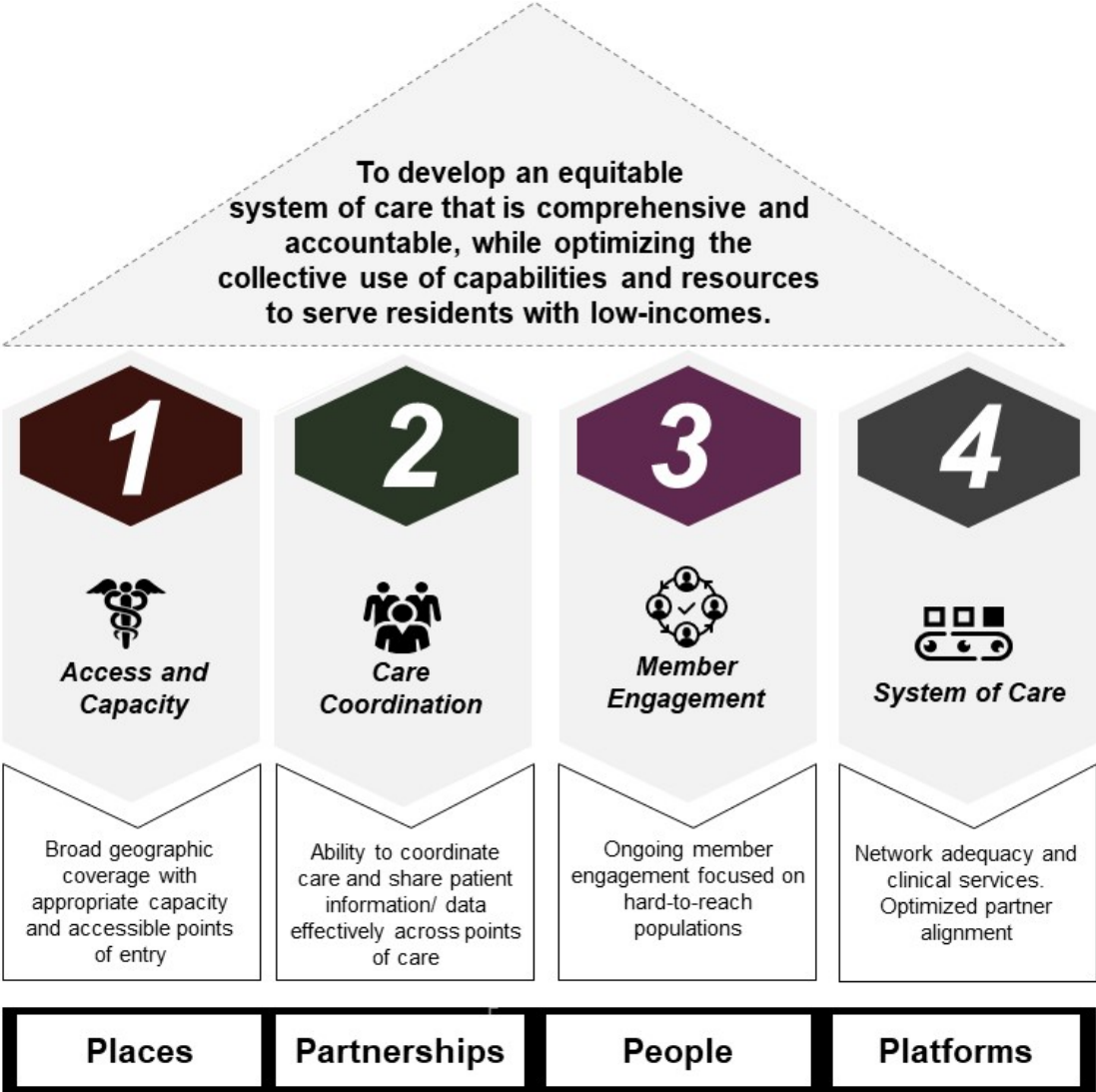
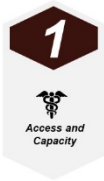


Figure 11. Equity-Focused Service Delivery Strategic Plan Goal and Imperatives

6.2 Imperative 1: Access and Capacity

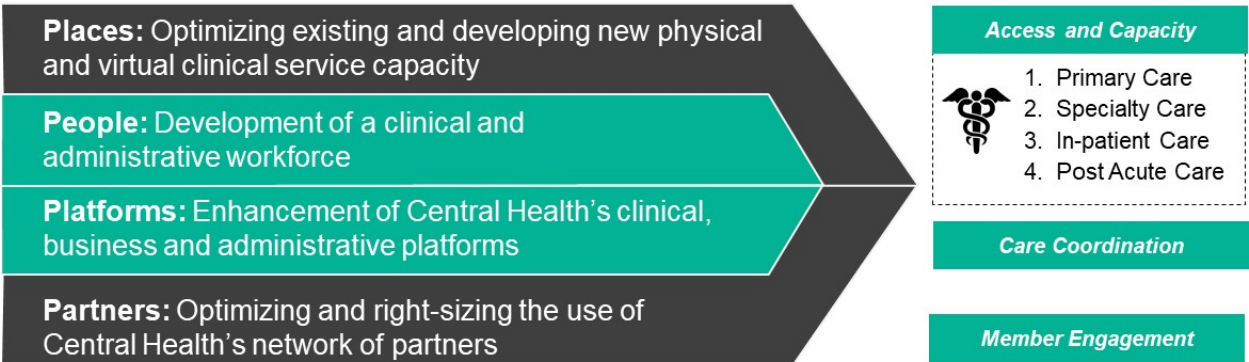


Imperative 1: Access and Capacity

Central Health will more equitably meet the health care needs of Travis County residents with low incomes, by increasing the number of providers and care teams and the availability of comprehensive, high-quality and timely care.

- **What is Access:** The ability of a patient to utilize appropriate services in the most appropriate setting within a clinically appropriate timeframe. Addressing barriers to care improves access.
- **What is Capacity:** The ability of a system of care to provide services within a clinically appropriate timeframe. Building new or optimizing the use of existing resources improves capacity.

The improvement of access and capacity will be driven through the enhancement of one or more of the following capabilities:



Text

Goal 1: Assure appropriately sized and timely access to primary care.

Strategic Priority 1: Expand access for existing patients; high priority efforts concentrated in areas of greatest need.

This will be measured through:

1. Reduction in appointment wait times for primary care services
2. Decrease in third available appointment wait times
3. Increase in clinical (Providers) and physical (Sites) primary care capacity
4. Increase in percentage of patients receiving recommended preventive care screenings

Strategic Priority 2: Offer same day appointments for patients with acute needs.

This will be measured through:

1. Increase in number of same day appointments
2. Increase in percentage of total primary care appointments that are same day
3. Decrease in the utilization of Emergency Care

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Expanding access points in Eastern Travis County in Del Valle, Hornsby Bend, Colony Park, and Pflugerville
2. Increasing availability for same day appointments and extended hours capacity
3. Closing current physician and provider gaps based on needs assessment results
4. Enhancements and improvements to technology

Goal 2: Optimizing use of system capacity to improve access to specialty care.

Strategic Priority 1: Create access to specialties with significant unmet needs.

This will be measured through:

1. Reduction in wait times for specialty appointments
2. Increase in clinical (providers) and physical (sites) specialty care appointment and procedural/surgical capacity



Multiple Surgical Specialties are experiencing significantly low provider counts. (e.g., Neurosurgery, Cardiac Surgery, etc.)

Strategic Priority 2: Optimize the use of existing specialty service capacity through contractual and operational initiatives.

This will be measured through:

1. Reduction in wait times for specialty appointments
2. Increase in clinical (Providers) and physical (Sites) specialty care appointment and procedural/surgical capacity
3. Increase in available capacity for existing providers and through new contracted provider agreements

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Developing strategically located multispecialty facilities that are accessible to the safety-net community
2. Expanding ambulatory diagnostic and therapeutic capabilities

3. Developing capacity and optimizing use of ambulatory surgery centers
4. Designing specialty care programs that are tailored to address the disease burden impacting our patients
5. Closing physician and provider gaps based on safety-net needs assessment results
6. Enhancements and improvements to technology

Central Health provides access to about 100,000 enrolled patients through its system of care. CommUnityCare provides care to additional patients that are not included in this calculation. The Central Health current enrolled need alone is approximately 89 primary care and 79 specialist physicians. In the current state, Central Health’s primary care and specialty care physicians are expected to meet 55-60% of the currently enrolled population’s primary and 35-40% of specialty care needs respectively. Sustaining this level of staffing, in an era of significant physician and nursing shortages, will require an estimated \$20 million to \$25 million per year in physician salaries alone. This expense will increase significantly as we aim to increase capacity and provide access to more patients and meet a greater proportion of the safety-net population’s unmet clinical needs. /to increase the number of available physicians, Central Health will have to provide additional facility, equipment, technological and personnel resources to help them work at the top of their license. These resources by themselves will require funding equivalent to 5 to 10 times the amount of the projected physician salaries that are shown in the table below.

Annualized Cost Estimate of Physician FTEs (Cumulative Primary and Specialty Care)	
Maintaining Current State Capacity in 2022	\$21.09M
Meeting 70% Community Need in 2022	\$61.89M
Meeting 70% Community Need in 2023	\$67.67M
Meeting 70% Community Need in 2024	\$74.00M
Meeting 70% Community Need in 2025	\$80.91M
Meeting 80% Community Need in 2030	\$116.58M

Physician need estimates are based on increases in enrollment in Travis County’s population and inflation of physician salaries.

Goal 3: Assure appropriate access to hospital and post-acute services.

Strategic Priority 1: Assure appropriate and timely access to acute and post-acute services, supported by effective transitions in care.

This will be measured through:

1. Reduction in readmissions for chronic conditions

2. Reduction in Level I and II Emergency Department visits (low acuity visits that can mostly be completed in a physician office or other outpatient site)
3. Diagnosis-specific length of stay that is within median ranges (case-mix adjusted)
4. Increase in proportion of overall health care spend in non-hospital settings

Strategic Priority 2: Shift services from hospital settings to ambulatory surgery centers or other outpatient locations as appropriate.

This will be measured through:

1. Increase in proportion of overall health care spend in non-hospital settings

Strategic Priority 3: Create access to post-acute services with significant unmet needs. Examples include skilled nursing, respite, and rehabilitation.

This will be measured through:

1. Diagnosis-specific length of stay that is within median ranges (case-mix adjusted)
2. Increase in proportion of overall spend in non-hospital settings

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Expanding access points to shift appropriate care from the hospital to more appropriate sites
2. Expanding access to same day (walk-in) and post-discharge follow-up appointments
3. Designing specialty care programs that are tailored to address the disease burden impacting our patients in collaboration with our hospital partners
4. Obtaining accurate, timely, and actionable hospital data

6.3 Imperative 2: Care Coordination

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Imperative 2: Care Coordination



Care coordination will allow Central Health to manage transitions of care and improve medical information transfer between providers or points of care. This will improve patient health outcomes by optimizing a cross-continuum approach to health that is anchored in high-impact preventive, virtual, and community-based services deployed in coordination with clinical and social services partners and underwritten by actionable population health analytics and technology.



- **2,185** patients engaged by Hospital Transitions of Care every year
- **8,792** outpatient follow-up appointments scheduled every year

Goal: Coordinate care for Travis County’s safety-net population by optimizing transitions of care by facilitating communication within patients’ care teams across the care continuum and enabling meaningful information sharing.

Strategic Priority 1: Develop a standardized care coordination model for the system of care.

This will be measured through:

1. Number of providers and systems having data sharing agreements that include enforceable near-real time access to patients’ medical documentation
2. Number of patients with an annual care plan

Strategic Priority 2: Improve the timeliness and effectiveness of patient transitions of care between providers and/or between points of care.

This will be measured through:

1. Percentage of no-shows for follow up appointments
2. Number of warm handoffs for transitions of care
3. Number of instances where patients’ medical documentation was shared between providers per 1,000 transitions of care
4. Number of patients with discharge plans

Strategic Priority 3: Proactive, timely and relevant communication between care teams/providers involved in care of the patient.

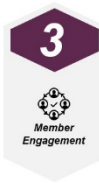
This will be measured through:

1. Instances of dropped care per 1,000 transitions of care
2. Number of scheduled appointments where patient was referred or transferred to a new point of care or provider

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Development of risk stratification processes and solutions that allow for the delivery of personalized care and the optimized use of clinical resources
2. Further development of processes and solutions to enable timely sharing of health care information and medical documentation (EHR)
3. Development of centralized communication platforms to enable and enhance provider communication
4. Development and training of care coordination work force (care coordinators, disease managers, case managers, etc.)
5. Active alignment of system, provider organization, and care team incentives to enhance care coordination processes

6.4 Imperative 3: Member Engagement and Enrollment



Imperative 3: Member Engagement and Enrollment

Central Health will focus on enrollment in identified high-need planning and assessment regions and enhance engagement for the enrolled population, with special emphasis on care transitions, people experiencing homelessness, justice-involved individuals, and communities where English and Spanish are not the primary language.

Strategic Priority 1: Enhance language and culturally appropriate outreach about available programs and services (including the number of languages we print educational materials in).

This will be measured through:

1. Increasing number of patient engagement events and programs
2. Increasing volume of multilingual and culturally appropriate printed material
3. Increasing number of multilingual and culturally competent providers

Strategic Priority 2: Improving enrollment through screening and identification of appropriate programs.

This will be measured through:

1. Increasing percentage of eligible populations enrolled in programs with timely access to care

Strategic Priority 3: Improving education and awareness of types of programs and utilization of services.

1. Increasing percentage of eligible populations enrolled in programs with timely access to care

Strategic Priority 4: Empower patients to seek out care once they are engaged and to remain active in the care delivery process.

This will be measured through:

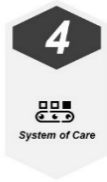
1. Capacity aligned with increase in incoming enrollment and appointment queries
2. Decrease in number of missed appointments

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Increasing the duration of the enrollment period
2. Deploying centralized helpdesks with multilingual staff to answer queries

3. Development of clinical and non-clinical staff to deliver culturally competent care that is tailored to meet the social and linguistic needs of the patient
4. Leveraging multi-channel technologies (e.g., patient portal, emails, calls, texting) to effectively engage the safety-net population
5. Expand health and wellness programs in the community

6.5 Imperative 4: System of Care Infrastructure



Imperative 4: System of Care Infrastructure

Central Health will develop a high functioning system of care to improve health for Travis County's safety-net population via alignment of relationships including joint service-delivery planning and facilitation of timely sharing of health care data.



- Central Health is relying on two provider systems (CUC and Ascension Seton) for specialty and inpatient care
- Additional contracted providers provide limited but necessary access that enables the closure of key gaps in clinical care

Strategic Priority 1: Bolster and encourage the strategic and effective use of capital.

This will be measured through:

1. Increased quality and/or access to demonstrate the value of capital expenditure (e.g., initiatives, agreements, specialties, etc.)

Strategic Priority 2: Recalibrate and redesign the scale and scope of Central Health's dependence on partners.

This will be measured through:

1. Number of specialties and services exclusively available at less than two partner, affiliate, or contracted organizations
2. Number of service expanding or enhancing programs and initiatives that come out of collaborative alignment meetings

Strategic Priority 3: Create an inclusive and accountable governance model across the system of care.

This will be measured through:

1. Number of service expanding or enhancing programs and initiatives that come out of collaborative alignment meetings

Strategic Priority 4: Enhance the coordinated use of Central Health's assets and partners.

This will be measured through:

1. Number of specialties and services exclusively available at less than two partner organizations
2. Number of service expanding or enhancing programs and initiatives that come out of collaborative alignment meetings

The achievement of these strategic priorities will be enabled through execution of the following prioritized tactics:

1. Identifying gaps in the System of Care and determine areas of highest priority
2. Assessing operations to identify and leverage system synergies and complementarities
3. Design systems to track cost of care
4. Collaborative design and alignment around centralized models.
5. Establishing financial and operational benchmarks that will guide system performance