CENTRAL HEALTH

**Our Vision**
Central Texas is a model healthy community.

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

# SPECIAL CALLED BOARD OF MANAGERS MEETING
## Wednesday, August 2, 2023, 4:00 p.m.

## Videoconference meeting[1]

## A quorum of the Board and the presiding officer will be present at:

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

Members of the public may attend the meeting at the address above, or observe and participate in the meeting by connecting to the Zoom meeting link listed below (copy and paste into your web browser):
https://us06web.zoom.us/j/89724953870?pwd=amllQTN2RjFocmJpWERmT2RpemhRQT09
Meeting ID: 897 2495 3870
Passcode: 312391

Links to livestream video are available at the URL below (copy and paste into your web browser):
https://www.youtube.com/@tchealthdistrict/streams

Or to participate by telephone only:
Dial: (346) 248 7799
Meeting ID: 897 2495 3870
Passcode: 312391

The Board may meet via videoconference with a quorum present in person and will allow public participation via videoconference and telephone as allowed under the Open Meetings Act. Although a quorum of the Central Health Board will be physically present at the location posted in the meeting notice, we strongly encourage all members of the public to observe the meeting virtually and participate in public comment, if desired, through the virtual meeting link or telephone number listed on each meeting notice.

Members of the public who attend in person should conduct a self-assessment before coming to the building to ensure they do not have a high temperature or any symptoms of COVID-19. Anyone who is symptomatic and/or has a fever should contact their healthcare provider for further

instructions. Symptomatic members of the public can still participate, if desired, through the virtual meeting link or telephone number listed on each meeting notice. Resources related to COVID-19 can be found at the following link https://www.austintexas.gov/covid19.

A member of the public who wishes to make comments virtually during Public Communication for the Board of Managers meeting or the Executive Committee meeting must properly register with Central Health ***no later than 2:30 p.m. on August 2, 2023***. Registration can be completed in one of three ways:

- Complete the virtual sign-in form at https://www.centralhealth.net/meeting-sign-up/;
- Call 512-978-9190. Please leave a voice message with your full name and your request to comment via telephone at the meeting; with the name of the meeting at which you wish to speak; or
- Sign-in at the front desk on the day of the meeting, prior to the start of the meeting.

Individuals who register to speak on the website or by telephone will receive a confirmation email and/or phone call by staff with instructions on how to join the meeting and participate in public communication.

## REGULAR AGENDA[2]

1. Review and ratify the proposed Healthcare Equity Operational and Financial Sustainability Action Plan. (*Action Item*)

2. Discuss updates and take possible action on a Performance Review contracted by Travis County, including delegations to the President & CEO to execute necessary agreements between Central Health, Travis County, and Mazars USA.[3] (*Action Item*)

3. Confirm the next regular Board meeting date, time, and location. (*Informational Item*)

Notes:

[1] This meeting may include one or more members of the Board of Managers participating by videoconference. It is the intent of the presiding officer to be physically present and preside over the meeting at Central Health Administrative Offices, 1111 E. Cesar Chavez, Austin, TX 78702, Board Room. This meeting location will be open to the public during the open portions of the meeting, and any member participating by videoconference shall be both visible and audible to the public whenever the member is speaking. **Members of the public are strongly encouraged to participate remotely through the toll-free videoconference link or telephone number provided.**

[2] The Board of Managers may take items in an order that differs from the posted order and may consider any item posted on the agenda in a closed session if the item involves issues that require consideration in a closed session and the Board announces that the item will be considered during a closed session.

[3] Possible closed session discussion under Texas Government Code §551.071 (Consultation with Attorney).

A recording of this meeting will be made available to the public through the Central Health website (www.centralhealth.net) as soon as possible after the meeting.

Any individual with a disability who plans to attend this meeting and requires auxiliary aids or services should notify Central Health at least two days in advance, so that appropriate arrangements can be made. Notice should be given to the Board Governance Manager by telephone at (512) 978-8049.

Cualquier persona con una discapacidad que planee asistir o ver esta reunión y requiera ayudas o servicios auxiliares debe notificar a Central Health con la mayor anticipación posible de la reunión, pero no menos de dos días de anticipación, para que se puedan hacer los arreglos apropiados. Se debe notificar al Gerente de Gobierno de la Junta por teléfono al (512) 978-8049.

Consecutive interpretation services from Spanish to English are available during Public Communication or when public comment is invited. Please notify the Board Governance Manager by telephone at (512) 978-8049 if services are needed.

Servicios de interpretación consecutiva del español al inglés están disponibles durante la Comunicación Publica o cuando se le invita al público a comentar. Notifique al Gerente de Gobierno de la Junta por teléfono al (512) 978-8049 si necesita servicios.

# Central Health Board of Managers Shared Commitments
# Agreed adopted on June 30, 2021

Whereas, the Board of Managers of Central Health has come together as a governing body to ensure the Vision of Central Health: Central Texas is a model health Community;

Whereas, the Board of Managers of Central Health bring this vision into reality by enacting the mission of caring for those who need it most and thereby improving the health of our community;

Whereas, the Board of Managers of Central Health achieves excellence toward this vision and mission through the stated values of Stewardship, Innovation, Respect, and Collaboration;

Whereas, the Board of Managers of Central Health further known as *we* in this document understand that systemic racism is the root of health inequities that emerge from a history of racism in Texas including Travis County that contributes to the social determinants of health that play a primary role in producing inequitable health outcomes;

Whereas, as an organization, Central Health is anti-racist and committed to a diverse and inclusive culture that seeks equity and social justice in the pursuit of its mission:

1. We Commit to informing all of our actions as Board Managers with the understanding that we are accountable to recognizing and to interrupting systems of oppression. This includes understanding the power structure in the United States, and Texas, and Travis County, that advantages certain community members and has historically disadvantaged other community members based on the color of their skin, race, ethnicity, language, and/or other characteristics. We further understand that to disrupt this power structure and the health inequities it produces, we must collaborate to collectively respond to the lived realities of all ethnicities, races, and identities disadvantaged within this system and all historically oppressed identities and communities disadvantaged within this system. We Commit to understanding that when disadvantaged communities compete against each other, we all lose in this system, and the only way forward is to work together for the benefit of all oppressed communities collectively.
2. We Commit to a model of Generative Leadership which requires us to understand and practice collaboration and accountability demonstrated by following our agreed upon meeting procedures and ensuring all members have the opportunity for comparable speaking time. We further Commit to intentionality prior to speaking including: considering: what is the goal of what I

want to share; is this the right time to share it; and is this in keeping with our collective goal for this particular moment within this particular meeting?

3. We Commit to Generative Conflict which includes engaging in disagreements and differences in perspective in a way that deepens relationships and trust by expanding knowledge and understanding of each other, including expecting our ideas to be expanded and enriched by learning and engaging with other Board Manager ideas, choosing curiosity over competition of ideas, and anchoring our conversations in our common purpose.
4. We Commit to practicing emotional intelligence as leaders which includes being aware of our own emotions and reactions and managing them, as well as being aware of our impact on others and managing this impact for the collective good when we are in our role as Board Managers.
5. We Commit to being aware of our own privileges and advantages in the sociopolitical and economic structure of the United States, Texas, and Travis County to use these for the benefit of interrupting inequities across historically disadvantaged identities.
6. We Commit to preventing the commission of microaggressions through the awareness of the history and oppression of diverse identities and communities. To this end, we Commit to strive to learn the historical context informing the lived realities of all historically oppressed identities and communities, and to use this to prevent use of language and commission of actions that can be harmful given these histories.
7. If we inadvertently commit a microaggression, we strive to immediately become aware on our own of the harm we have caused. If another Board Manager generously helps us become aware of a microaggression we have committed we welcome the support in our learning and growing process as a leader and immediately express appreciation for having made us aware, own the mistake we have made, acknowledge the impact of the harm we have caused, and engage repair through apology and the articulation of what we will do to avoid the repetition of such harm in the future.
8. If we observe one of our fellow Board Managers commit a microaggression, we Commit to calling them in by letting them know in a respectful and kind manner of the mistake that has been made.
9. We understand that many of us, as survivors of historically oppressed identities and communities, carry internalized narratives of oppression, and we can inadvertently express these oppressions against others in ways that cause harm and we Commit to the same process identified in 7 and 8 to engage repair and return to generative collaborative processes.
10. We understand that even without the history of oppression potentiating the weight of harm, expressions of prejudice and rudeness can also cause harm to our shared aims, and we Commit to the same process identified in 7 and 8 to engage repair and return to generative collaborative processes.

11. We Commit to using our Racial and Social Justice Framework (next page) for decision-making as we work together for the collective good of our communities as we eradicate health inequities and create a model healthy community.
12. We understand that we are entrusted with a vital responsibility for our communities and are accountable stewards for the time and resources available to our Board of Managers. We understand that these commitments are entered into to ensure responsible stewardship of this time and resources through generative collaborative processes to reach our vision and mission and we agree that if we do not follow any one of these commitments we welcome our Board Manager colleagues to bring this to our attention through the agreed upon process reflected here and when this occurs, we commit to immediately acknowledging the mistake and engaging in a repair and correction process as indicated in these commitments so that our work to dismantle systemic racism and resulting barriers and achieve health equity can move forward.

Be it adopted that the above agreements will be honored and acted upon by each Board Manager as of 6/30/2021 and henceforth forward as indicated by signature below.

________________________________________ _________________________

Board Manager Signature Date

___________________________________________

Board Manager Printed Name

# Calling In and Repairing Harm

### Calling In after Harm in Groups with Shared Values and Aims Stance

Hey, this thing you said/did hurt some folks or could hurt some folks.
A) Here's why that can be hurtful or,
B) Please do some research to learn the history of why that's hurtful.

Implied message: I know you are good and are on this journey with us and we are all going to make mistakes as we unlearn things.

### Calling In after Harm in Groups with Shared Values and Aims Sample Language

- I know it wasn't your intention, but what you just said minimizes the horror of ________ e.g. the history of racism, enslavement, the holocaust, etc.
- I know it wasn't your intention but what you just said has the impact of implying that _________ are not competent or as intelligent as others.
- What you just said suggests that ______________people don't belong.
- That phrase has been identified as being disrespectful and painful to ____________people and it's important that we not use it.
- Oh, I have also used that term, but I have now learned that when we use it we are leaving out people who_____________ or we are implying that________________and the word people are learning to use now is _____________________.
- The term used now by people living with that identity is ______________________.

### Repairing Harm after Microaggressions, Mistakes, and expressions of Prejudice

- Own / Name it
- Recognize the Impact
- Apologize (Do not share context or explanations)
- Make any amends that are possible
- State what you are going to do to learn and do better in the future.

Sample Language: Thank you so much for letting me know. You are right, I used this term or said that phrase and realize that it has the impact of minimizing the experience of __________ or implying that____________. I am deeply sorry and will practice learning the correct language and will research and learn more about this to ensure that I do not make this mistake and cause this harm in the future.

# RACIAL and SOCIAL JUSTICE FRAMEWORK

### Values and Anti-Racism/Anti-Oppression

- Is this consistent with our values?
- Are we taking steps so we cannot predict outcomes by race and other systemically disadvantaged characteristics?

### Intentional and Accountable Storytelling

- What data are we using and has it been disaggregated by race? What is the source of the data? Who is it making visible and invisible? Whose experience is being centralized and whose is being marginalized in the data? Does the way we are using the data reflect the complexity of the issues and reflect the issues accurately?
- What are the stories and narratives we are telling? What is the purpose? Who is interpreting the meaning? Who's it meant for? Who's impacted and how?
- Are we refusing to be ahistorical? Are we fully considering history and the impacts of the historical context?

### Power Analysis

- What are the power dynamics in this situation? What are the intersecting spheres of oppression at work in this situation?
- What are the cultural norms of white supremacy at work in this situation?
- Who would benefit and who would be harmed by this action/decision?
- Does this interrupt/disrupt or collude with/reinforce oppressive systems/power structures?
- If this is attempting a solution, where are we locating the problem?
- Does the solution/strategy we are proposing change the system or the individual?
- Who are we asking to change and why?

### Relationships

- Who is in the room and who isn't and why? Who is sharing and who is not and why?
- Whose perspective is represented/who is left out? And who is doing the representing? Who do we believe, who do we find credible? Why? Why not?
- Whose experience is being centralized and whose experience is being marginalized? Who is gazing and who is being gazed upon?
- Are we boldly leading toward our racial justice aim by building a broad coalition of support?
- Are we operating from a similar/shared understanding of anti-racism work? Do we have a shared anti-racist understanding of where the problem is located and a shared anti-racist theory of change to generate a solution? Have we agreed upon a shared goal?

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# SPECIAL CALLED BOARD MEETING

# August 2, 2023

# REGULAR AGENDA ITEM 1

Review and ratify the proposed Healthcare Equity Operational and Financial Sustainability Action Plan. (*Action Item*)

CENTRAL HEALTH

**AGENDA ITEM SUBMISSION FORM**

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

| | |
|---|---|
| Agenda Item Meeting Date | 8/2/2023 |
| Who will present the agenda item? (Name, Title) | Mike Geeslin (CEO), Jeff Knodel (CFO), Monica Crowley (CSO & Sr. Counsel), Dr. Abhi Sharma (Partner, Guidehouse), and Danielle Sreenivasan (Director, Guidehouse) |
| General Item Description | Review and ratify the proposed Healthcare Equity Action Plan. |
| Is this an informational or action item? | Action Item |
| Fiscal Impact | Not applicable |
| Recommended Motion (if needed – action item) | Ratify the Healthcare Equity Action Plan as proposed in this presentation. |

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Central Health worked with Guidehouse to develop and prioritize projects, initiatives and the critical capabilities needed to address identified gaps in medical and health care services for the Travis County safety-net population.
2) Central Health validated the anticipated impact of initiatives through community engagement, patient interviews and surveys, patient journey mapping and input from stakeholders and SMEs.
3) Central Health worked with Guidehouse to develop the Healthcare Equity Action Plan, which includes an overarching operational roadmap of strategic initiatives by Community Need, major milestones, and estimated financing by fiscal year, phased over a 7-year period.
4) Oversight and operational alignment models are in progress along with development of performance tracking plan, including KPIs, continuous monitoring, evaluation, and improvement which will be shared with the Board of Managers in October.
5) 

| | |
|---|---|
| What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.) | PowerPoint presentation |
| Estimated time needed for presentation & questions? | 1.5 hours, consisting of 45 mins for presentation and 45 minutes for discussion |

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Is closed session recommended? (Consult with attorneys.)

Is closed session recommended? (Consult with attorneys.) No

Form Prepared By/Date Submitted: Monica Crowley, 7/25/2023

CENTRAL HEALTH

CommUnityCare | Sendero

# Healthcare Equity Action Plan - Operational and Financial Sustainability Implementation Planning

Board of Managers Presentation

August 2, 2023

# Agenda

1. Healthcare Equity Action Planning process, development of projects, impact of initiatives through community engagement and patient journey mapping
2. Overview of Healthcare Equity Action Plan including gaps, prioritized community needs, projects, initiatives and staging
3. Operational Implementation Roadmap of Initiatives and Estimated Costs for Next Seven Years
4. Critical Success Factors and Key Decisions
5. Next Steps

# Progress and Achievements Towards Healthcare Equity Action Plan

**Tasks completed to date:**

1. Completed catalogue of community needs faced by the Travis County safety-net.
2. Identified, refined, and organized projects into initiatives that rely on similar capabilities for implementation.
3. Validated the anticipated impact of initiatives through community engagement, interviews and patient journey mapping.
4. Validated Operational Implementation Roadmap, including organizational capacity assessment to execute Healthcare Equity Action Plan.
5. Validated high-level financial pro-forma templates and refined early-phase cost estimates to ensure phasing of initiatives to meet the most pressing and impactful needs over a seven-year period.
6. Began work to develop oversight models, reporting structures, and performance tracking plan with Key Performance Indicators.

# Designing a High Performing Healthcare System to Meet the Healthcare Needs of Travis County's Safety Net Population Means Providing Patient-Centric Care

Population Health
Social Determinants of Health
Wellness and Prevention
Medical
Dental

Post-Acute Care
Medical Respite
SNF/Rehab Care/Long-term Acute Care
Home Health
Palliative and Hospice

Primary Care
Behavioral Health
Urgent and Convenient Care
Expanded Care Team
Intensive Outpatient/Infusion and Dialysis Services

Navigation Services
- Care Coordination
- Medical Management
- Scheduling Integration
- Eligibility Services

Structural Components
- EMR Integration
- Data Transparency
- Payment/Coverage

Social Determinants of Health

Hospital Care
Inpatient
Psychiatric Care
Outpatient
Trauma and Emergency Care

Specialty Care
Specialty Clinics
Ambulatory Surgery Centers
Surgical Services/Anesthesia Diagnostics and Screening

# Over the Last 2 Years, Central Health Has Been Committed to Creating a High Performing Healthcare System

*Community Needs*
Central Health identified and prioritized unmet needs within the Travis County Safety Net Population.

*Projects*
To address these unmet community needs, Central Health created over 150 projects.

*Initiatives*
Central Health organized related and interdependent projects together into initiatives to optimize efficiency.

*Operational Roadmaps*
Central Health created operational roadmaps to effectively execute initiatives based on industry best practices.

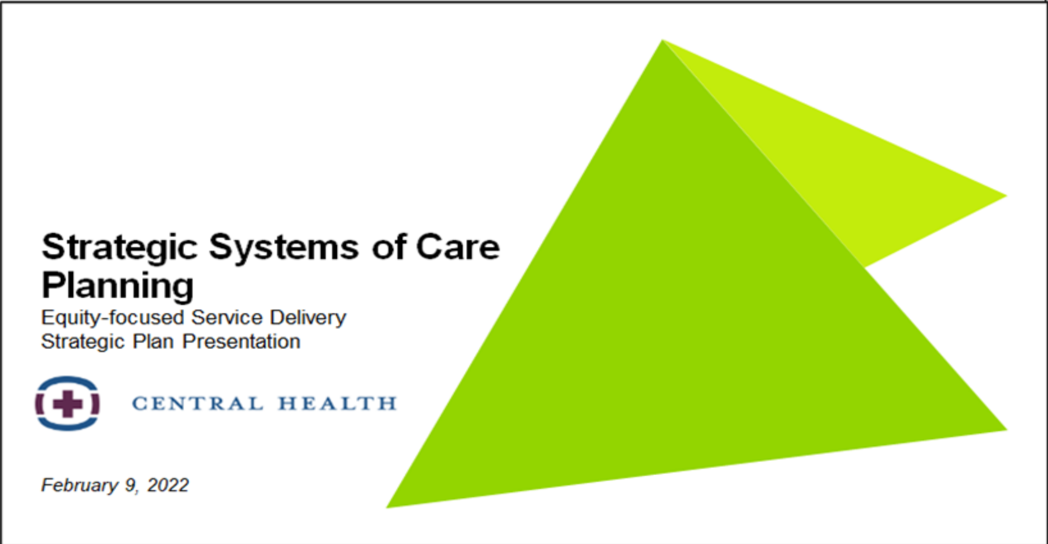
*Financial Model*
The financial model informs the size and timing of investments to execute initiatives. The operational plan, activities and key milestones align to the financial plan to maximize resources.

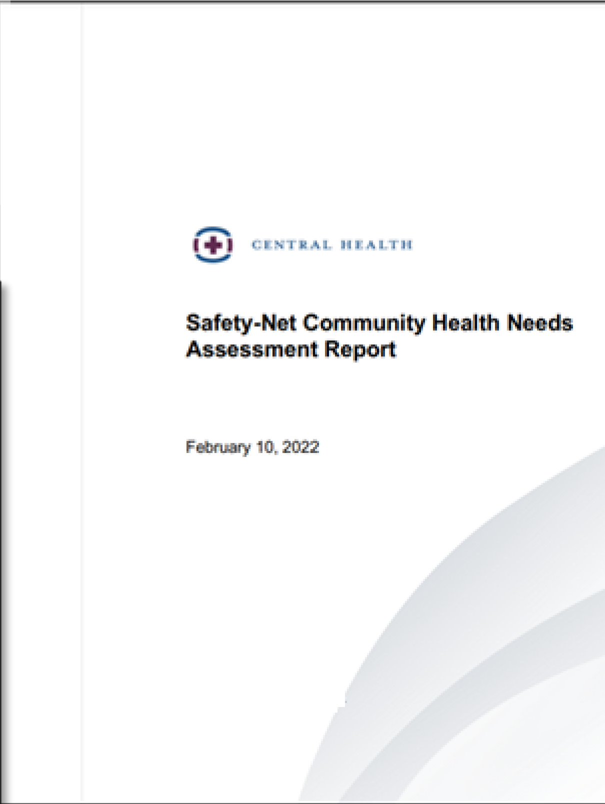
★ *Implementation & Performance Tracking*
Central Health will take action to implement projects and initiatives to close the identified gaps and develop a performance tracking plan with KPIs to measure progress and impact.

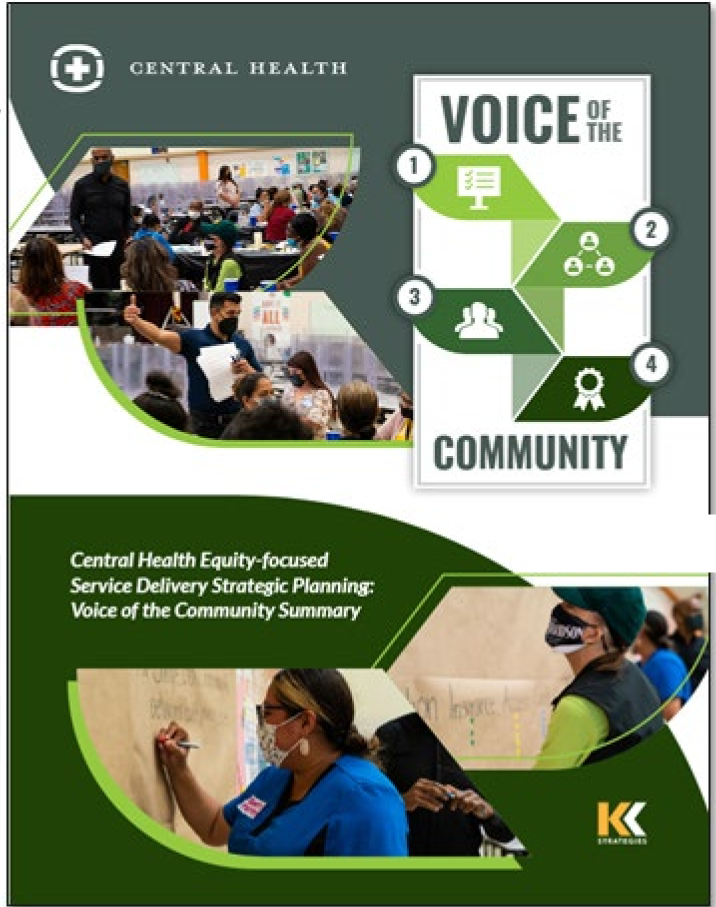
*Monitoring, Evaluating, & Improving*
Central Health will continually assess projects and initiatives to build a high performing healthcare system and ensure the safety-net's healthcare needs are met.

# Central Health Engaged the Community at the Outset of Developing a Plan to Achieve a Comprehensive, Equity-Focused System of Care

February 2022: Completed assessment of community health needs to develop Healthcare Equity Strategic Plan




*Data-Driven and Community - and Stakeholder-Focused Processes*

# Central Health Identified Significant Unmet Needs Which Demanded a Strategic Approach to Prioritize Needs and Utilize Resources

## Primary Care/ Wellness

### ① *Primary Care*

- *Timely service access*
- *Access to social services*
- *Quality care*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ② *Wellness and Prevention*

- *Patient communication and education*
- *Prevention and screening*
- *Diet, nutrition & exercise*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ③ *Urgent & Convenient Care*

- *Virtual options*
- *Same day and convenient access*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

## Specialty Care/ Behavioral/ Dental

### ④ *Specialty Care*

*Select services* include Cardiology, GI, Hem/Onc, Nephrology, Neurology, Ortho, Gyn Surgery, ENT, Ophthalmology, Psych, Radiology*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

### ⑤ *Behavioral Health*

*Substance use disorders, serious mental illness, anxiety, depression, also includes psych hospitals*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ⑥ *Dental*

*Primary and specialty dental access*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

## Hospital Based/ Post Acute

### ⑦ *Hospital*

*Surgical Services, ASC Access, Hospital transitions, hospital-based specialty care, diagnostics, infusions, ED Services*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

### ⑧ *Post Acute*

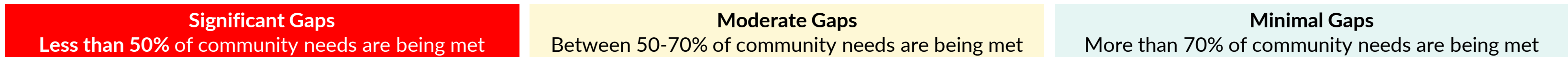
*Respite care, home health care, custodial care*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

*Select services include but are not limited to these.*

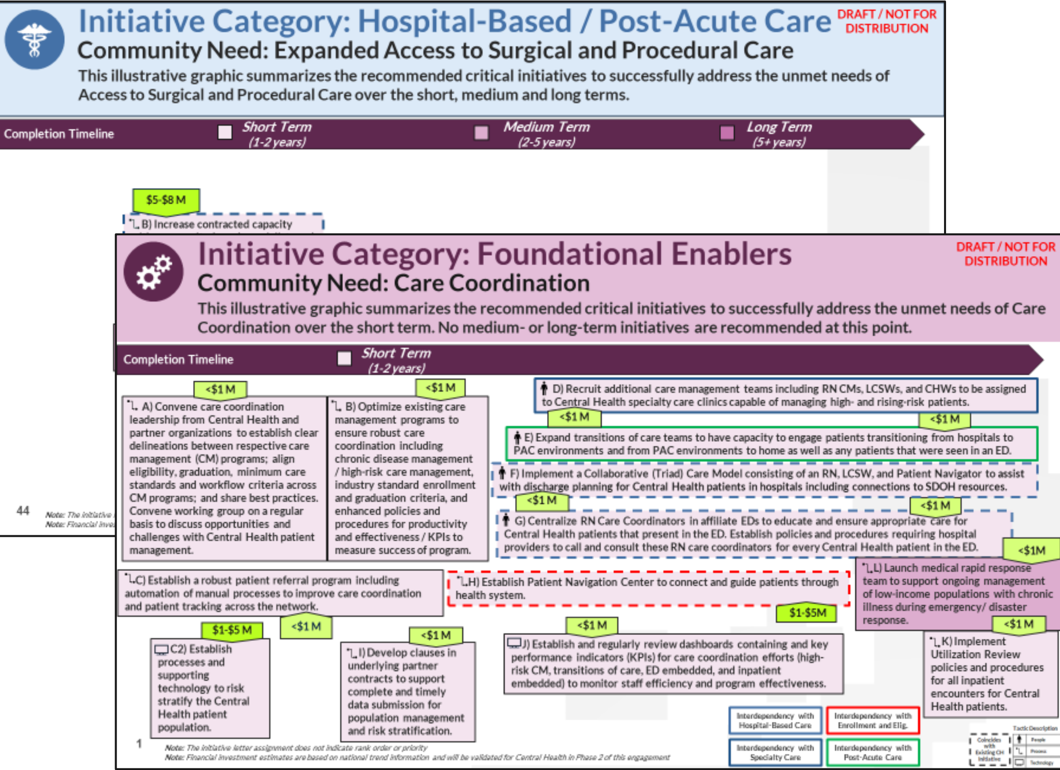
Legend

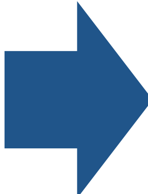
| Significant Gaps | Moderate Gaps | Minimal Gaps |
|---|---|---|
| Less than 50% of community needs are being met | Between 50-70% of community needs are being met | More than 70% of community needs are being met |



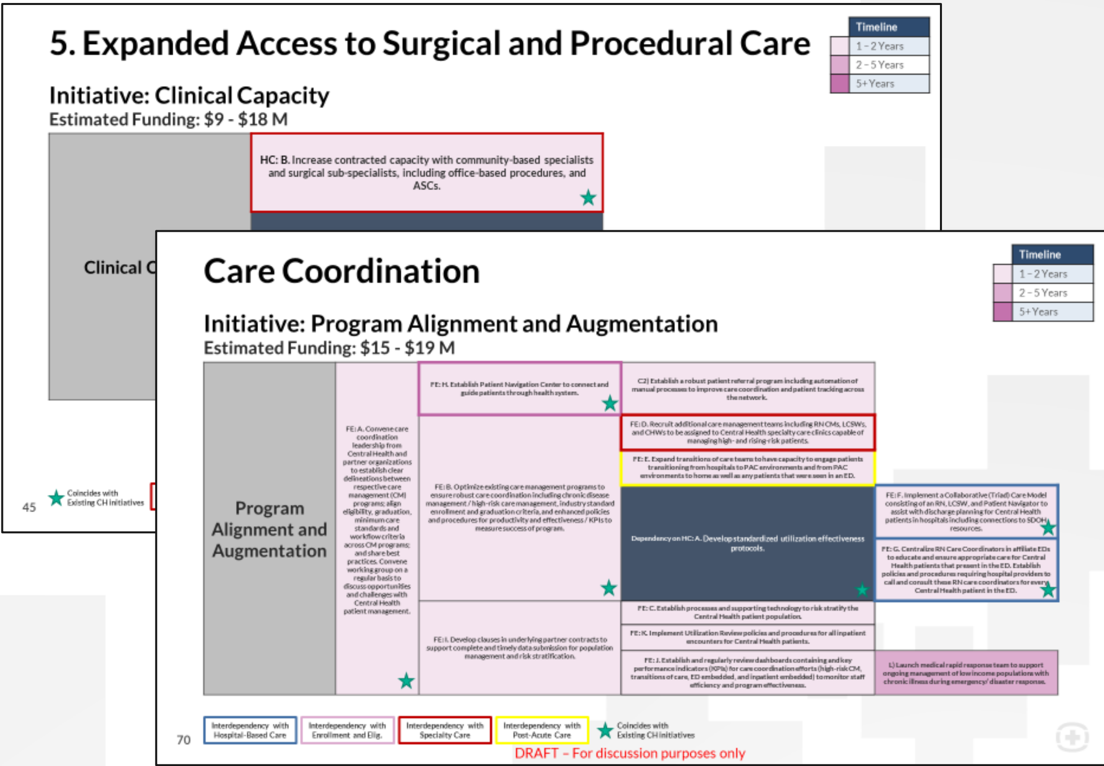
# Initiatives and Projects Were Developed For Patients to Get the Right Care at the Right Time in the Right Place

## January 2023: Identified, prioritized and sequenced projects



## March 2023: Organized related and interdependent projects into initiatives to develop operational and financial roadmaps




*Data-Driven and Community - and Stakeholder-Focused Processes*

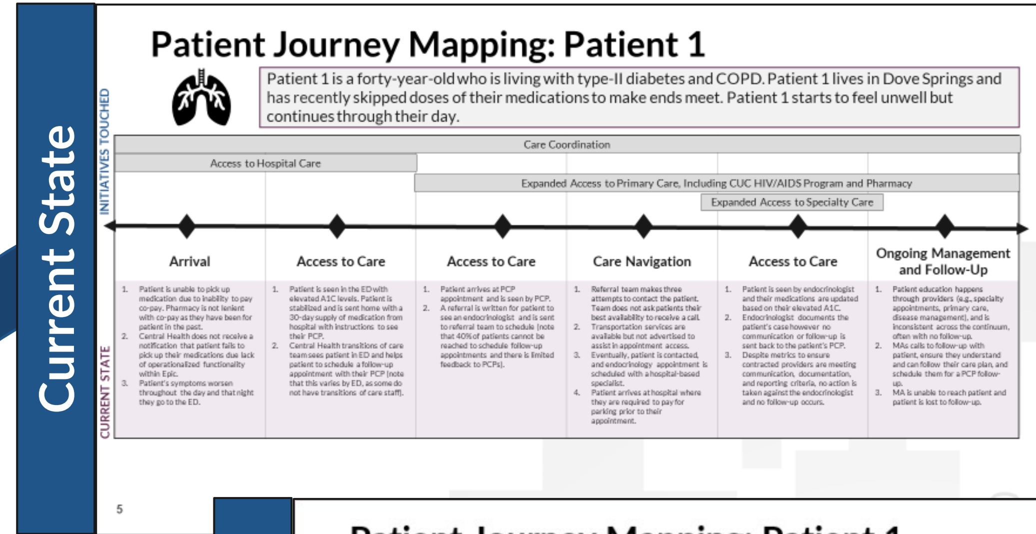
# Central Health Created Patient Journey Maps To Further Understand How Patients Access and Engage with the Healthcare System

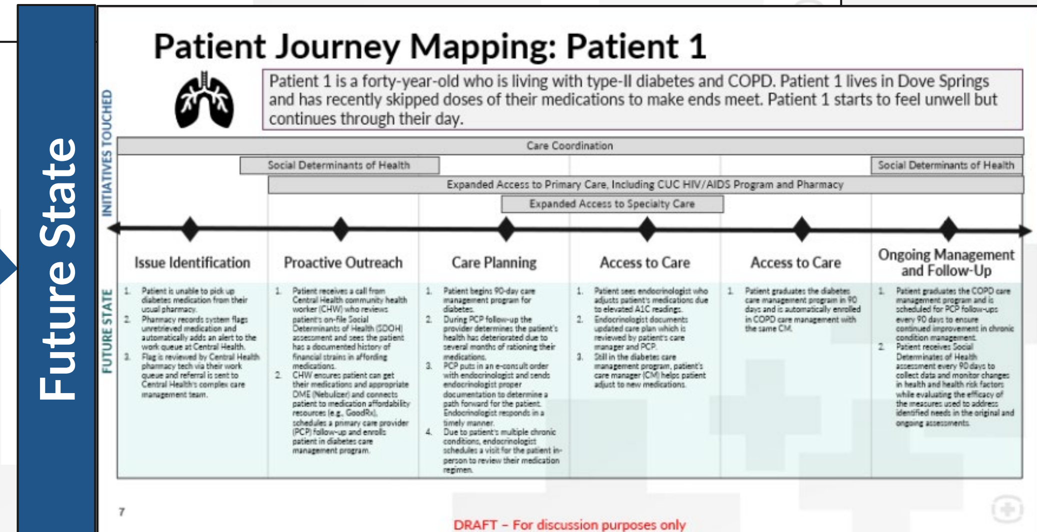
## Guidehouse and Central Health Underwent a Patient-Validated Approach to Create Patient Journey Maps to:

1. Compare desired future state with current state **from a patient experience perspective**

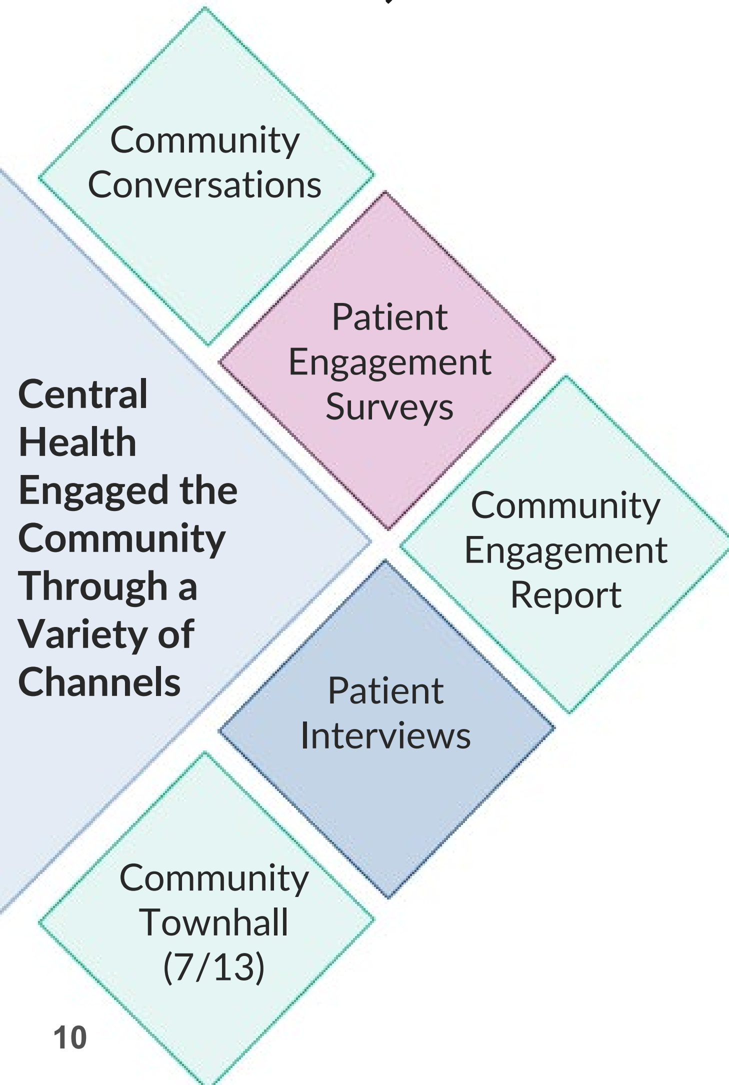
2. Identify current-state gaps in the safety-net healthcare system

3. Develop initiatives to create **better access, quality, and experience for patients** for Travis County's safety-net population



# Central Health Engaged the Community to Ensure We Deliver a Healthcare System that Meets Our Patients' Medical, Cultural, and Social Needs




## …Which Uncovered Opportunities for Central Health to Focus on and Incorporate into the Operational Roadmaps

1. Overall quality of care and patient experience scores were high, however, **patients speaking languages other than English or Spanish reported lower quality of care**

2. Most patients overcome potential barriers **but wait times, cost, transportation, and getting lost in the system remain significant barriers to care** for patients

3. While some patients experienced language barriers, **high subjective scores were reported for all patient-centered and culturally-aligned care**

# Central Health Created a System-Wide Roadmap and Financial Model to Optimize Use of Resources and Meet the Needs of Patients

*Key Considerations to Implement Central Health's Healthcare Equity Action Plan*

1. There is substantial unmet need for the Travis County safety net population. Central Health has undergone a comprehensive, data-driven process, including a safety-net focused Community Health Needs Assessment and Community Engagement, to develop a plan that prioritizes critical unmet needs within Central Health's operational and fiscal capacity.

2. In order to optimize the use of available resources and yield the greatest impact, Central Health designed the roadmap through a multi-disciplinary lens to leverage resources to extend beyond singular initiatives, potentially freeing funds for future initiatives and programs.

3. We will continue to rely on ongoing feedback from our community as we execute on our operational roadmaps to deliver a healthcare system that considers our patients' medical, cultural, and social needs.

4. In FY2023, Central Health began critical funded projects that align to the initiatives presented today. Guided by the Healthcare Equity Action Plan, this work will continue and evolve.

# Central Health Prioritization of Needs Began with Addressing Significant Unmet Needs

## Primary Care/ Wellness

### ① Primary Care

- *Timely service access*
- *Access to social services*
- *Quality care*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ② Wellness and Prevention

- *Patient communication and education*
- *Prevention and screening*
- *Diet, nutrition & exercise*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ③ Urgent & Convenient Care

- *Virtual options*
- *Same day and convenient access*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

## Specialty Care/ Behavioral/ Dental

### ④ Specialty Care

*Select services* include Cardiology, GI, Hem/Onc, Nephrology, Neurology, Ortho, Gyn Surgery, ENT, Ophthalmology, Psych, Radiology*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

### ⑤ Behavioral Health

*Substance use disorders, serious mental illness, anxiety, depression, also includes psych hospitals*

Significant Gaps | **Moderate Gaps** | Minimal Gaps

### ⑥ Dental

*Primary and specialty dental access*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

## Hospital Based/ Post Acute

### ⑦ Hospital

*Surgical Services, ASC Access, Hospital transitions, hospital-based specialty care, diagnostics, infusions, ED Services*

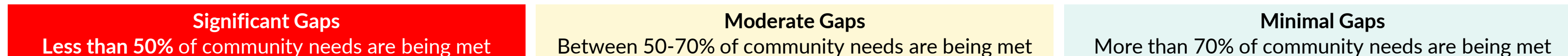
**Significant Gaps** | Moderate Gaps | Minimal Gaps

### ⑧ Post Acute

*Respite care, home health care, custodial care*

**Significant Gaps** | Moderate Gaps | Minimal Gaps

**Select services include but are not limited to these.*



| Legend | Significant Gaps | Moderate Gaps | Minimal Gaps |
|---|---|---|---|
| | Less than 50% of community needs are being met | Between 50-70% of community needs are being met | More than 70% of community needs are being met |

# To Close These Gaps, Central Health Identified and Prioritized the Community Needs and Developed Projects to Address the Needs

## Primary Care

3. Health Care for the Homeless

8. Expanded Access to Same-Day Care and Extended Hours, Including Virtual Options

9. Expanded Access to Primary Care, including CUC HIV/AIDS Program and Pharmacy

## Specialty Care / Behavioral / Dental

1. Expanded Access to Specialty Care

4. Substance Use Disorder and Addiction Medicine Services, Including MAT and Alcohol Addiction

7. Access to Mental Health Services

10. Expanded Access to Dental Care

## Hospital-Based Care / Post-Acute Care

2. Robust Post-Acute Care, Including Respite and Extensivists

5. Expanded Access to Surgical and Procedural Care

6. Access to Hospital Care

## Foundational Enablers

- **Additional Access Points and Infrastructure (e.g., Facilities, Technology, etc.)***
- Care Coordination
- Comprehensive Multi-Disciplinary Care
- Eligibility and Enrollment Services
- Expanded Access to General Prevention and Wellness
- Health Systems Interoperability and Technology
- Management of Chronic Conditions
- Pharmacy
- **Physician and Clinical Workforce Supply, Including Demographically-Diverse Workforce***

** Denotes Workforce Planning and Organizational Infrastructure Resources*

## Coverage Programs, Benefits, and Structures

- Extended Enrollment Period for MAP
- Increased Enrollment of Eligible Populations
  - People experiencing homelessness, justice involved individuals, and communities where English and Spanish are not the primary language
- Restructure copays to remove patient barriers
- Additional coverage services and benefits
- Patient education (benefits, how and where to use MAP, copays)
  - Language access

## Social Determinants of Health

- Improved Community Transitions for Justice-Involved Individuals
- Culturally Competent Materials and Communications
- Affordable Housing
- Access to Transportation
- Access to Healthy Foods
- Technology and Internet Access
- Stable and Consistent Employment Opportunities
- Educational Support Programs

# Central Health will Implement 38 Initiatives to Operationalize the Healthcare Equity Action Plan and Ensure Equitable Access and Quality of Care for Every Patient

## Primary Care

- **Health Care for the Homeless**
  - Mobile Care Clinic
  - Funding Support
  - Connection to Supportive and Affordable Housing
- **Same-Day Care and Extended Hours**
  - Urgent & Convenient Care
  - Primary Care Processes & Staffing
  - Primary Care, Care Coordination
- **Primary Care, including CUC HIV/AIDS Program and Pharmacy**
  - Primary Care Capacity
  - Patient Navigation

## Specialty / Behavioral / Dental

- **Expanded Access to Specialty Care**
  - Direct Clinical Capacity
  - Specialty Care Contracting & Relationships
  - Specialty Care, Care Coordination
- **SUD and Addiction Medicine Services**
  - SUD Clinical Processes & Staffing
  - SUD Data Access & Triage
  - Respite & Recuperative Care
- **Access to Mental Health Services**
  - Mental Health Clinical Processes & Staffing
  - Mental Health Data Access & Triage
  - Mental Health Facilities
- **Expanded Access to Dental Care**
  - Dental Care Capacity and Facilities
  - Dental Staffing & Contracting

## Hospital-Based / Post-Acute Care

- **Robust Post-Acute Care, Including Respite and Extensivists**
  - PAC Funding Support
  - PAC Contracting & Operations
- **Expanded Access to Surgical and Procedural Care**
  - Surgical Clinical Capacity
  - Surgical Care Coordination
- **Access to Hospital Care**
  - Hospital Care Coordination
  - Hospital Capacity

# Central Health will Implement 38 Initiatives to Operationalize the Healthcare Equity Action Plan and Ensure Equitable Access and Quality of Care for Every Patient

## Foundational Enablers

- **Care Coordination**
  - Program Alignment & Augmentation
- **Enrollment and Eligibility**
  - Enrollment & Eligibility Technology Optimization
  - Enrollment & Eligibility Procedures & Coordination
- **Health Systems Interop. and Technology / Data and Analytics**
  - Governance, Reporting, & Interop.
  - Career Dev. & Training
- **Pharmacy**
  - Pharmacy Care Coordination
  - Pharmacy Program Aug.
  - Pharmacy Capacity
  - 340B Pricing

## SDoH and Coverage Programs

- **Coverage Programs, Benefits, and Structures**
  - Benefit Enhancement
  - Information Delivery
- **SDoH**
  - SDoH Contracting & Relationships
  - SDoH Funding

# Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

| Community Need | Projects | |
|---|---|---|
| Health Care for the Homeless | ▪ Develop Mobile Care Clinic Processes, Technology, and Staff to Support Expanded Mobile Care Clinics<br>▪ Integrate ED Care Coordinators to Reduce Inappropriate Utilization and Preventable Admissions<br>▪ Train Patient Navigators to Connect Patients to Housing Assistance Services<br>▪ Expand Mobile Care Services to Include Access to Mental Health Services and Chronic Diseases Management | ▪ Research and Source Grant Funding Opportunities for Primary Care Services<br>▪ Create a Collaborative Care Model with CBSOs and Housing Authorities to Connect Unhoused Patients to More Permanent Housing and SDoH Resources<br>▪ Provide Wraparound Medical Services to Unhoused Individuals Through Additional Service Locations<br>▪ Expand Mobile Care Clinic Services Along I-35 Corridor<br>▪ Establish a High Risk Care Clinic |
| Same-Day Care and Extended Hours | ▪ Expand Capacity of Urgent and Convenient Care Contracts to Enhance Services<br>▪ Expand RN / CHW Care Coordinator Dyad in ED to Triage Patients Appropriately<br>▪ Establish Joint Quality Review Board to Review ED Utilization<br>▪ Initiate Marketing and Communications Campaign to Educate Patients on Available Same-Day Resources<br>▪ Expand Convenient Care Footprint including Limited Urgent Care, Screening, Wellness, etc. | ▪ Expand Telehealth Services by Determining Number of Patients Accessing Convenient Care<br>▪ Expand Convenient Care Telehealth Services<br>▪ Expand Access to Community- Based Urgent Care |
| Primary Care, including CUC HIV/AIDS Program and Pharmacy | ▪ Optimize Contracts by Instituting Quality Metrics and Innovative Payment Models<br>▪ Expand HIV/AIDs Screening, Treatment, and Education at CommUnityCare and Hancock Center | ▪ Expand Primary Care Capacity by Evaluating High Volume Areas for Primary Care and Aligning on Location and Physical Space for Sites<br>▪ Expand Pharmacy Services through Telehealth and Collaboration with Mobile Care Clinics<br>▪ Establish Multi-Disciplinary Care Approach to Expand Care for Medically Complex Patients<br>▪ Expand Hours for Primary Care Clinics including Same Day, Next Day, Weekend, and Evening<br>▪ Medication Therapy Management (MTM) Program to Optimize Patient Outcomes, Improve Drug Adherence and Prevent Costly Medication Problems |
| Expanded Access to Specialty Care | ▪ Operationalize RZ Clinic including Processes, IT Capabilities, and Recruit Staff and Providers<br>▪ Expand DME Capacity to Address Outpatient DME and Supply Gaps<br>▪ Build and Internalize Vendor Capabilities In-House Expand Clinical Services Footprint<br>▪ Increase Diagnostic Capacity in RZ Clinic and/or with Contracts<br>▪ Expand Ambulatory Contract Capacity in Key Specialty Areas<br>▪ Establish Governance Processes for Specialty Care Service Contracts<br>▪ Local Medical Assistant and Registered Nurse Programs to Build Adequate Staffing Capacity<br>▪ Implement Evidence-Based Care Delivery Model | ▪ Extend Care Coordination Efforts with CHWs to Specialty Care Environment<br>▪ Operationalize Hancock Center including Services, Processes, Space Needs, etc.<br>▪ Evaluate and Right Size RZ Clinic Phase 2, including Proposed Specialties<br>▪ Increase Advanced Imaging Capacity<br>▪ Build Surgical Office and Consultation Capacity for High- Volume Low-Acuity Surgeries<br>▪ Build Data Sharing Capacity with FQHCs and Other Partners<br>▪ Develop Chronic Disease Programs with Multidisciplinary Approach to Improve Patient Quality of Life<br>▪ Address Future Specialty Care Access Needs and Site of Service<br>▪ Buy/Build/Partner to Build Ambulatory Surgical Center with Dedicated Safety-Net Capacity |
| SUD and Addiction Medicine Services | ▪ Centralize Substance Use Disorder Resources to Connect Patients to Services and Resources<br>▪ Improve Substance Use Disorder Data Sharing, Quality Metrics and Communications for Providers to Effectively Monitor and Triage Patients<br>▪ Increase Contracted Capacity with Community Medical Services for Methadone MAT<br>▪ Develop Care Models for Alcohol and Stimulant Addiction including Detox Services<br>▪ Addiction Medicine Specialist to Assist Overseeing Service Line and Work with Local Entities | ▪ Suboxone Medication-Assisted Treatment Program<br>▪ Medically-Supervised Detox for Opioid Use Disorder<br>▪ Medically-Supervised Detox for Alcohol / Stimulant Use<br>▪ Build Team-Based Provider Capacity for Substance Use Disorder Treatment in Ambulatory Care Setting, including Home or Tele-Rooms<br>▪ Develop Model for Virtual Team- Based Substance Use Disorder Treatment in Ambulatory Care Environment |

# Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

| Community Need | Projects | |
|---|---|---|
| **Access to Mental Health Services** | ▪ Develop Training Program for Primary Care Providers on SUD and Mental Health Screening and Referrals<br>▪ Contract/Hire Psychiatrist with Prescribing Capabilities and Coordinate Medication Management for Mental Health Patients<br>▪ Hire Director of Mental Health (MH) Services to Coordinate MH Service Line<br>▪ Improve Data Sharing and Communications with Integral Care to Effectively Triage and Refer Patients | ▪ Expand Mental and Behavioral Health Virtual Services Through Local and National Organizations<br>▪ Co-locate Therapists at Central Health Ambulatory Care Sites<br>▪ Co-locate Therapists at FQHC Locations<br>▪ Consideration for Psychiatric Urgent and Crisis Care Facility, including support of Diversion Center Pilot |
| **Expanded Access to Dental Care** | ▪ Improve Dental Access by Hiring/Contracting Dental Providers in with CommUnityCare<br>▪ Hygienist Recruitment and Retention Opportunities with Austin Dental Hygiene Schools<br>▪ Build Dental Capacity at New Clinic Sites, Operated by CommUnityCare<br>▪ Proactive Dental Outreach and Education Efforts on Routine Screenings and Cleanings | ▪ Expand Dental Services for Unhoused Patients through Mobile Dental Clinics<br>▪ Align Dental Surgery Services |
| **Robust Post-Acute Care, Including Respite and Extensivists** | ▪ Advance PAC Capacity by Evaluating and Aligning Available Community Resources<br>▪ Development of Comprehensive Post-Acute Care Strategy<br>▪ Determine Capacity of Community Based Services Available to Unhoused Individuals<br>▪ Right-Sized PAC Portfolio to Ensure Quality and Cost of Care Management<br>▪ Identify Preferred PAC Partners with Access and Committed to Value-Based care<br>▪ Contract with Local Area Agencies on Aging to Provide In-Home Care for Low-Acuity Hospital Discharges<br>▪ Expand SNFist Program to Provide 24/7 Coverage | ▪ Improve Critical PAC Operations, Transitions of Care, Staff Training, and Technology<br>▪ Research and Source PAC Waiver Programs<br>▪ Deploy Service Line specific Initiatives that Drive LOS, Excess Days and Readmissions<br>▪ Integration of Post-Acute Nurse Care Managers in IRF and LTACH Settings<br>▪ Strengthen PAC Clinical Governance and Accountability to Sustain Post-Acute Strategy<br>▪ Expand Recuperative Care Access and Partners to Increase Bed Capacity<br>▪ Expand Post-Acute Care Management to Ensure Patients Transitioned to Appropriate Settings Post Discharge<br>▪ Co-located Respite and Subsidized Housing to Expand Health and Social Services to Patients |
| **Expanded Access to Surgical and Procedural Care** | ▪ Increase Contracted Capacity with Community-Based Specialists | ▪ Recruit and Employ Surgical Specialty Providers to Provide Consultations and Surgical Services |
| **Access to Hospital Care** | ▪ Develop Standardized Utilization Effectiveness Protocols<br>▪ Assess potential for Increased Contracted Capacity with Local Hospitals<br>▪ Conduct Long-Term Operational and Capital Planning re Safety-Net Hospital | ▪ Future Partnership Options for Supplemental and Transitional Hospital Access<br>▪ Monitor Services Potentially Impacted by Changing Hospital and Programmatic Landscape |
| **Care Coordination** | ▪ Establish Clear Delineations Between Central Health and Partner Care Management Programs and Convene Working Group to Align Standards of Care<br>▪ Care Management Optimization to Ensure Robust Care Coordination<br>▪ Establish Processes and Technology to Support Risk Stratification<br>▪ Recruit Additional Care Management Teams for Specialty Clinics to Manage High-Risk Patients<br>▪ Expand Transitions of Care Teams to Engage Patients Transitioning to PAC Environments and/or Home<br>▪ Implement Collaborative Care Model to Support Discharge Planning in Hospitals, including connections to SDoH Resources | ▪ Centralized RN Care Coordinators in ED to Ensure Appropriate Care<br>▪ Timely Data Submission from Partners to Support Population Management and Risk Stratification<br>▪ Dashboard Development to Enable Care Coordination Efforts and Monitor Staff Efficiency and Program Effectiveness<br>▪ Implement Utilization Review Policies and Procedures for Inpatient Encounters<br>▪ Launch Medical Rapid Response Team<br>▪ Establish Central Health Patient Navigation Center<br>▪ Establish Robust Patient Referral Program to Improve Care Coordination and Patient Tracking |

# Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

| Community Need | Projects | |
|---|---|---|
| Enrollment and Eligibility | ▪ VeritySource Optimization<br>▪ Expand Enrollment Efforts Along I- 35 Corridor to Decrease Enrollment Gaps Identified in CHNA<br>▪ Alignment of Enrollment and Eligibility Efforts with CommUnityCare to Improve Coordination<br>▪ Optimize Enrollment, Eligibility, and Patient Verification Efforts within Patient Navigation Center | ▪ Assess Need for Advanced CRM to Streamline Enrollment and Eligibility Processes<br>▪ Assess CRM Optimization to Effectively Track Patient Journey, Lead Engagement, and Enrollee Retention<br>▪ Expand Virtual Enrollment and Eligibility Services, Resources, and Activities |
| Health Systems Interop. and Technology / Data and Analytics | ▪ Data Governance Committee to Establish Compliant and Common Operating Procedures, Data Sharing Standards, etc.<br>▪ Formalize Data Governance Model<br>▪ Career Development and Growth Resources to Retain Data and Analytics Talent<br>▪ Oversight and Accountability Provisions to Ensure Access to Partner EMR Data to Improve Patient Care<br>▪ Enable Real-Time Utilization and Productivity Tracking within Enterprise EPIC Systems for Improved Reporting<br>▪ FindHelp Referral Integration into Managerial Reporting Initiatives<br>▪ Oversight and Accountability to Gain Access to Utilization and Financial Data<br>▪ Develop Managerial Reporting Processes<br>▪ Utilization and Financial Data Analytics to Evaluate and Report on Efficacy of Initiatives<br>▪ Internal Data Governance Formulation and Improvements for Managerial Reporting | ▪ Optimize Epic System (Primary Care) to Allow Self-Scheduling and Referrals<br>▪ Staff Training on Data Sharing and Data Management Expectations<br>▪ Data Sharing with Partners to Optimize Specialty Care Utilization Between Central Health and Partners<br>▪ Interoperable Hospital Data Exchange with Partners to Ensure Care Coordination and Successful Patient Referrals<br>▪ Dashboard Development to Monitor Acute Care Utilization<br>▪ Two-Way Data Exchange with CommUnityCare Pharmacies<br>▪ Two-Way Data Exchange with Primary Care Partners<br>▪ PAC Clinical Information Exchange Across EMRs<br>▪ Dashboard Development to Address Performance Issues and Track Quality Metrics<br>▪ Review and Improve Critical Data Processes, Procedures, Governance, and Policies to Ensure Secure Data and Effective Data Sharing |
| Pharmacy | ▪ Establish Patient Assistance Program (PAP) to Optimize Copay Programs and Offset Drug Cost<br>▪ Pharmacist Integration into Care Coordination Teams, Mobile Clinics, and Patient Navigation Center<br>▪ Drug Cost Review and Evaluation of Contracts<br>▪ Expand Drug Courier Service to Additional Target Communities and PAC Facilities<br>▪ Expand Drug Formulary for High Need Drugs<br>▪ Improve Process, Policies, Procedures to Improve Drug Utilization and Management | ▪ 340B Optimization Opportunities<br>▪ Optimize Pharmacy Services Footprint Through Partnerships, Consolidation, and Building Additional Pharmacy Capacity<br>▪ Evaluate and Enhance Pharmacy Benefits Plan to Meet Patient Needs<br>▪ Bolster Specialty Pharmacy Footprint and Improve Access by Co-locating/Near Clinics<br>▪ Expand Retail Pharmacy Footprint |
| Coverage Programs, Benefits, and Structures | ▪ Incorporate Coverage and Benefits Services in Patient Navigation Center<br>▪ Extend MAP Enrollment Length to Align with MAP Basic<br>▪ Expand MAT Coverage to MAP Basic | ▪ MAP Handbook Augmentation including Different Languages, Expanded Patient Financial Responsibility Information, etc.<br>▪ Implement MAP/ MAP Basic Initial Touchpoint<br>▪ Pilot Maximum Out-of-Pocket Spend Program for Prescriptions to Reduce Cost Barriers for Patients with Multiple Prescriptions |
| Social Determinants of Health | ▪ Define SDoH Strategy Using Evidence-Based Approach<br>▪ Connect Patients to SDoH Resources via Care Navigators in Patient Navigation Center<br>▪ Improve Medical Transportation Program to Provide Lyft Rides and CapMetro Tickets<br>▪ Catalogue Partner SDoH Capabilities, Services, and Initiatives<br>▪ Update and Review Healthcare Information and Communication to Provide More Culturally Affirming Materials and Care<br>▪ Connect Patients to Employment and Recidivism Programs for Formerly Incarcerated Patients | ▪ Leverage Collaborative Care Model to Connect Patients to SDoH Resources<br>▪ Expand Loaner Cell Phone Device Program to Additional Target Populations<br>▪ Partner with Community Based Organizations to Connect Patients to Healthy Foods<br>▪ Connect Patients to Adult Education and Literacy Programs<br>▪ Research and Source SDoH Grant Program Funding Opportunities<br>▪ Partner with local non-profits (e.g., subsidized housing organizations) to connect unhoused individuals to shelters and supportive housing. |

# Select Projects are Highlighted as Milestones Over the Next 7 Years To Respond to Unmet Community and Patient Needs

| Fiscal Year (FY) | Short Term | | | Medium Term | | | Long Term | |
|---|---|---|---|---|---|---|---|---|
| **Community Need** | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 |
| **Expanded Access to Specialty Care**<br>2. RZ Clinic<br>4. Hancock Clinic | | ★ 2 | | ★ 4 | | | | |
| **Robust Post-Acute Care, Including Respite and Extensivists**<br>6. Medical Respite / Cameron Center | | | | ★ 6 | | | | |
| **Health Care for the Homeless**<br>10. High Risk Care Clinic | | | | ★ 10 | | | | |
| **SUD and Addiction Medicine Services**<br>8. Medically Supervised Detox / Cameron Center | | | | ★ 8 | | | | |
| **Expanded Access to Surgical and Procedural Care**<br>7. Surgical Specialty Practice | | | | | | | ★ 7 | |
| **Access to Hospital Care** | | | | | | | | |
| **Access to Mental Health Services**<br>9. Support of Diversion Center Pilot | | ★ 9 | | | | | | |
| **Same-Day Care and Extended Hours** | | | | | | | | |
| **Primary Care, including CUC HIV/AIDS Program and Pharmacy**<br>1. Del Valle Clinic<br>3. Hornsby Bend Clinic | | ★★ 1, 3 | | | | | | |
| **Expanded Access to Dental Care**<br>1. Del Valle Clinic<br>3. Hornsby Bend Clinic<br>4. Hancock Clinic | | ★★ 1, 3 | | ★ 4 | | | | |
| **Health Systems Interop. and Technology / Data and Analytics** | | | | | | | | |
| **Enrollment and Eligibility** | | | | | | | | |
| **Pharmacy** | | | | | | | | |
| **Care Coordination**<br>5. Patient Navigation Center | | ★ 5 | | | | | | |
| **Social Determinants of Health** | | | | | | | | |
| **Coverage Programs, Benefits, and Structures** | | | | | | | | |

Planning, Execution and Scaling of Major Projects Only
Operating Projects
★ Major Project Go-Live

# Initiatives Were Phased Over the Next 7 Years To Respond to Unmet Community and Patient Needs

## Estimated Cumulative Operating Costs of Initiatives by Year



| Total Estimated Operating Costs | $ 682,392,474 |
|---|---|

Note 1: Financial estimates were prepared in conjunction with Central Health leadership based upon agreed upon assumptions.

Note 2: Cost estimates associated with crosscutting projects and initiatives are attributed to one community need to promote efficiency and maximize available resources.

# Initiatives Were Phased Over the Next 7 Years To Respond to Unmet Community and Patient Needs

## *Estimated Cost by Fiscal Year For Initiatives by Community Need*

| Community Need | Initiatives | FY 2024 | FY 2025 | FY 2026 | FY 2027 | FY 2028 | FY 2029 | FY 2030 |
|---|---|---|---|---|---|---|---|---|
| Expanded Access to Specialty Care | • *Direct Clinical Capacity*<br>• *Specialty Care, Care Coordination*<br>• *Specialty Care Contracting and Relationships* | $ 12,191,280 | $ 18,204,033 | $ 34,075,825 | $ 45,872,649 | $ 51,335,031 | $ 54,596,707 | $ 57,170,949 |
| Access to Mental Health Services | • *Mental Health Clinical Processes and Staffing*<br>• *Mental Health Data Access and Triage*<br>• *Mental Health Facilities* | | | | | | | |
| Robust Post-Acute Care, Including Respite and Extensivists | • *Post-Acute Care Contracting and Operations*<br>• *Post-Acute Care Funding Support* | $ 2,007,566 | $ 3,773,148 | $ 6,410,173 | $ 8,890,371 | $ 9,892,545 | $ 12,198,492 | $ 13,484,543 |
| Primary Care, including CUC HIV/AIDS Program and Pharmacy | • *Patient Navigation*<br>• *Primary Care Capacity* | $ 2,000,000 | $ 3,050,000 | $ 3,775,200 | $ 4,358,144 | $ 5,284,791 | $ 6,039,411 | $ 6,512,896 |
| SUD and Addiction Medicine Services | • *Respite and Recuperative Care*<br>• *SUD Clinical Processes and Staffing*<br>• *SUD Data Access and Triage* | $ 833,750 | $ 2,168,166 | $ 4,687,813 | $ 7,282,079 | $ 7,535,751 | $ 7,786,153 | $ 8,041,888 |
| Access to Hospital Care | • *Hospital Capacity*<br>• *Hospital Care Coordination* | $ 750,000 | $ 768,750 | $ 787,500 | $ 3,493,750 | $ 3,575,000 | $ 3,656,250 | $ 3,737,500 |
| Health Care for the Homeless | • *Connection to Supportive and Affordable Housing*<br>• *Funding Support*<br>• *Mobile Care Clinic and High Risk Care Clinic* | $ - | $ 405,410 | $ 1,672,159 | $ 1,891,316 | $ 1,943,442 | $ 1,995,345 | $ 2,048,206 |
| Expanded Access to Dental Care | • *Dental Care Capacity and Facilities*<br>• *Dental Staffing and Contracting* | $ 400,000 | $ 704,688 | $ 1,275,750 | $ 1,644,750 | $ 1,980,000 | $ 2,227,500 | $ 2,484,000 |
| Care Coordination | • *Care Coordination Program Alignment and Augmentation* | $ 2,876,863 | $ 5,592,723 | $ 9,195,487 | $ 10,825,531 | $ 12,011,684 | $ 12,962,561 | $ 13,750,123 |
| Enrollment and Eligibility | • *Enrollment & Eligibility Technology Optimization*<br>• *Enrollment & Eligibility Procedures & Coordination* | | | | | | | |
| Coverage Programs, Benefits, and Structures | • *Coverage Program Benefit Enhancement*<br>• *Coverage Program Information Delivery* | | | | | | | |

Note 1: Financial estimates were prepared in conjunction with Central Health leadership based upon agreed upon assumptions.

Note2 : Cost estimates associated with crosscutting projects and initiatives are attributed to one community need to promote efficiency and maximize available resources.

# Initiatives Were Phased Over the Next 7 Years To Respond to Unmet Community and Patient Needs

## *Estimated Cost by Fiscal Year For Initiatives by Community Need*

| Community Need | Initiatives | FY 2024 | FY 2025 | FY 2026 | FY 2027 | FY 2028 | FY 2029 | FY 2030 |
|---|---|---|---|---|---|---|---|---|
| Pharmacy | • *Pharmacy Care Coordination*<br>• *Pharmacy Capacity*<br>• *Pharmacy Program Aug.*<br>• *340B Pricing* | $ - | $ - | $ 3,300,000 | $ 3,300,000 | $ 5,600,000 | $ 5,600,000 | $ 5,900,000 |
| Same-Day Care and Extended Hours | • *Primary Care, Care Coordination*<br>• *Primary Care Processes and Staffing*<br>• *Urgent and Convenient Care* | $ - | $ - | $ 105,000 | $ 161,250 | $ 220,000 | $ 281,250 | $ 287,500 |
| Expanded Access to Surgical and Procedural Care | • *Surgical Clinical Capacity*<br>• *Surgical Care Coordination* | $ - | $ - | $ - | $ - | $ 3,335,833 | $ 7,356,794 | $ 10,044,058 |
| Social Determinants of Health (SDOH) | • *SDOH Contracting and Relationships*<br>• *SDOH Funding* | $ 1,024,375 | $ 1,312,043 | $ 1,808,618 | $ 1,899,756 | $ 1,956,748 | $ 2,015,451 | $ 2,075,914 |
| Health Systems Interop. and Technology / Data and Analytics | • *IT Governance, Reporting, and Interoperability*<br>• *IT Career Dev. & Training* | $ 6,844,420 | $ 8,122,919 | $ 9,623,362 | $ 10,293,991 | $ 11,105,906 | $ 12,036,995 | $ 12,571,620 |
| Support Functions | | | | | | | | |
| General Support Costs | • *Human Resources*<br>• *Finance*<br>• *Communications*<br>• *General Administration*<br>• *Strategy*<br>• *Compliance* | $ 4,069,065 | $ 6,040,577 | $ 7,531,054 | $ 7,756,986 | $ 7,989,695 | $ 8,229,386 | $ 8,476,268 |
| **Total Operating Expenses** | | **$ 32,997,319** | **$ 50,142,455** | **$ 84,247,942** | **$ 107,670,572** | **$ 123,766,427** | **$ 136,982,295** | **$ 146,585,465** |
| Capital Expenditures | • *Debt Service* | $ 14,653,762 | $ 18,130,282 | $ 18,132,747 | $ 19,491,882 | $ 19,491,349 | $ 19,491,217 | $ 19,495,810 |
| **Operating Expenses + Capital Expenditures** | | **$ 47,651,081** | **$ 68,272,737** | **$ 102,380,688** | **$ 127,162,454** | **$ 143,257,775** | **$ 156,473,513** | **$ 166,081,274** |

| | | |
|---|---|---|
| Total Operating Expenses (FY24-FY30) | $ | 682,392,474 |
| Capital Expenditures (FY24-FY30) | $ | 128,887,048 |
| Total Estimated Cumulative Costs | $ | 811,279,522 |

Note 1: Financial estimates were prepared in conjunction with Central Health leadership based upon agreed upon assumptions.

Note 2: Cost estimates associated with crosscutting projects and initiatives are attributed to one community need to promote efficiency and maximize available resources.

# Initiatives Sustainable Within Central Health's Long-Term Financial Forecast

7 YEAR FORECAST

**6.5% Year Over Year increase in No New Revenue Rate**

CENTRAL HEALTH



| | FY24 | FY25 | FY26 | FY27 | FY28 | FY29 | FY30 |
|---|---|---|---|---|---|---|---|
| Sources | 337.8 | 360.2 | 382.9 | 410.1 | 440.0 | 471.9 | 506.0 |
| Health Equity Action Plan New Uses | 47.5 | 68.2 | 102.3 | 127.1 | 143.2 | 156.4 | 166.0 |
| Ongoing HCD and Operations Uses | 295.6 | 300.5 | 314.3 | 330.0 | 343.6 | 360.0 | 377.4 |
| Total Uses | 343.2 | 368.6 | 416.5 | 457.0 | 486.8 | 516.4 | 543.4 |
| Total Reserves | 455.3 | 451.5 | 425.0 | 384.0 | 341.9 | 301.8 | 268.6 |

# Critical Success Factors

- Strategy-Focused Organization
- Appropriate Operational Capacity and Organizational Structure
- Continuous Engagement with Community and Key Stakeholders
- Appropriate Oversight and Accountability, Including Tracking of Measures
- Sustainable Community Investment

# Next Steps

*Operational and Financial plans include the operational alignment models and key performance indicators

## Key Upcoming Tasks:

- ❑ Finalize operational and financial models, including:
  - ❑ Development of Oversight Models and Reporting Structures
  - ❑ Development of Performance Tracking Plans, Including Key Performance Indicators (KPIs)

CENTRAL HEALTH

**Our Vision**
Central Texas is a model healthy community.

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

# SPECIAL CALLED BOARD MEETING

# August 2, 2023

# REGULAR AGENDA ITEM 2

Discuss updates and take possible action on a Performance Review contracted by Travis County, including delegations to the President & CEO to execute necessary agreements between Central Health, Travis County, and Mazars USA.[3] (*Action Item*)

CENTRAL HEALTH

## AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

| | |
|---|---|
| Agenda Item Meeting Date | August 2, 2023 |
| Who will present the agenda item? (Name, Title) | Mike Geeslin, President & CEO |
| General Item Description | Discuss updates and take possible action on a Performance Review contracted by Travis County, including delegations to the President & CEO to execute necessary agreements between Central Health, Travis County, and Mazars USA. |
| Is this an informational or action item? | Possible action |
| Fiscal Impact | N/A |
| Recommended Motion (if needed – action item) | N/A |

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Finalize the Interlocal Agreement (ILA), pending receipt from Travis County.

| | |
|---|---|
| What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.) | Verbal update |
| Estimated time needed for presentation & questions? | TBD |
| Is closed session recommended? (Consult with attorneys.) | Yes |
| Form Prepared By/Date Submitted: | Briana Yanes/ July 21, 2023 |

CENTRAL HEALTH

**Our Vision**
Central Texas is a model healthy community.

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

# SPECIAL CALLED BOARD MEETING

## August 2, 2023

# REGULAR AGENDA ITEM 3

Confirm the next regular Board meeting date, time, and location. (*Informational Item*)