CENTRAL HEALTH

CommUnityCare | Sendero

Healthcare Equity Action Plan - Operational and Financial Sustainability Implementation Planning

Board of Managers Presentation

August 2, 2023

Agenda

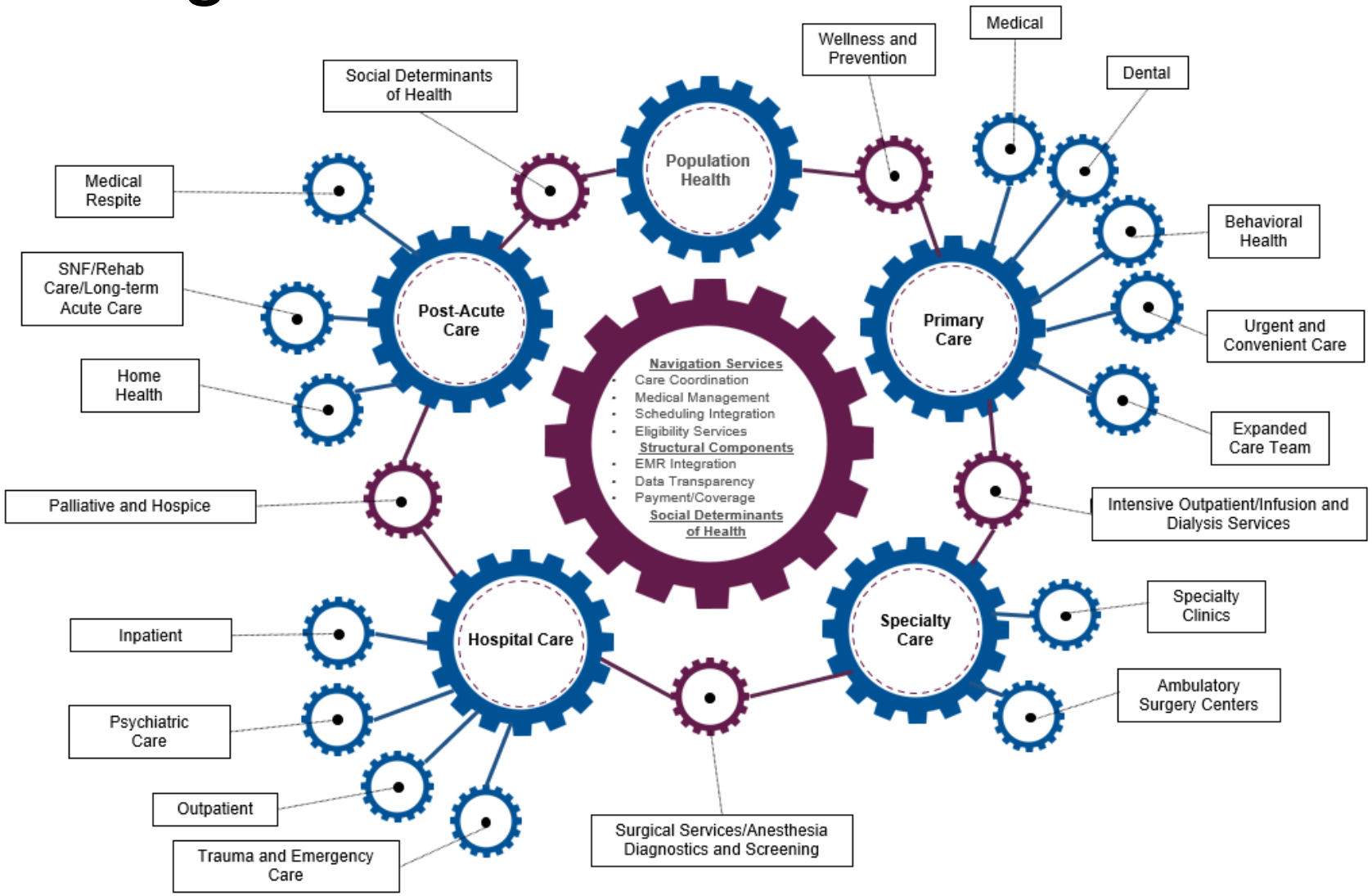
1. Healthcare Equity Action Planning process, development of projects, impact of initiatives through community engagement and patient journey mapping
2. Overview of Healthcare Equity Action Plan including gaps, prioritized community needs, projects, initiatives and staging
3. Operational Implementation 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

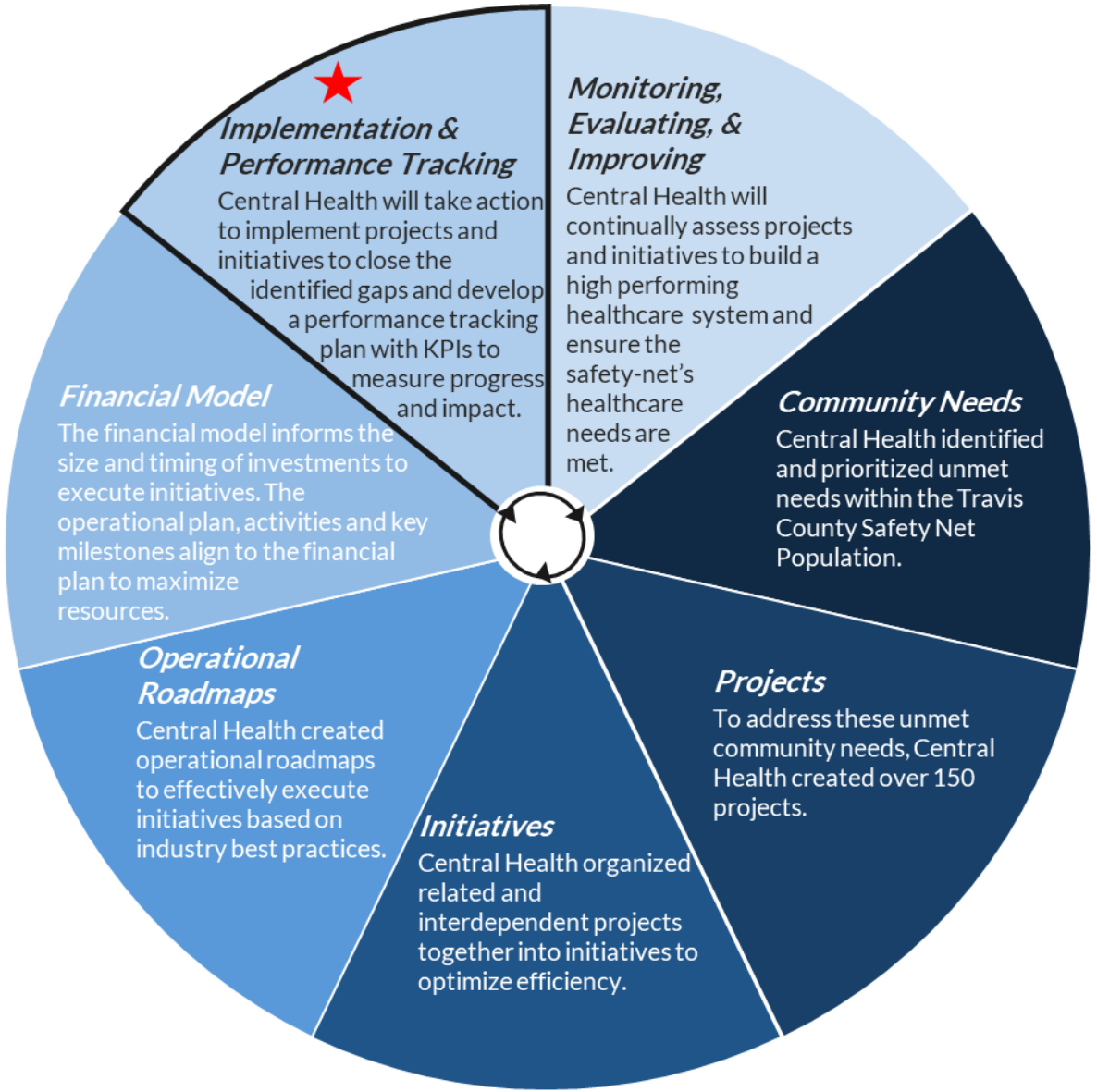
Tasks completed to date:

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

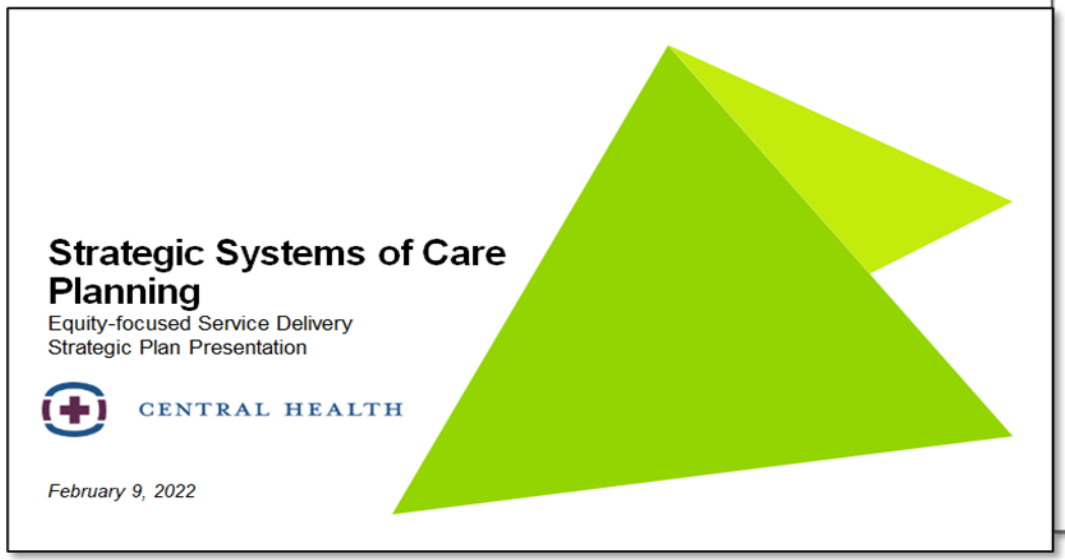


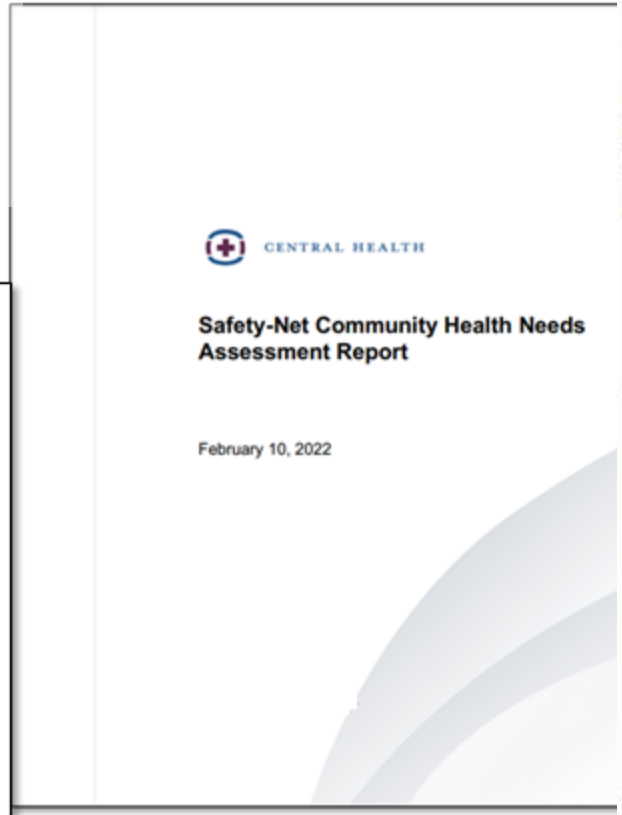
Over the Last 2 Years, Central Health Has Been Committed to Creating a High Performing Healthcare System

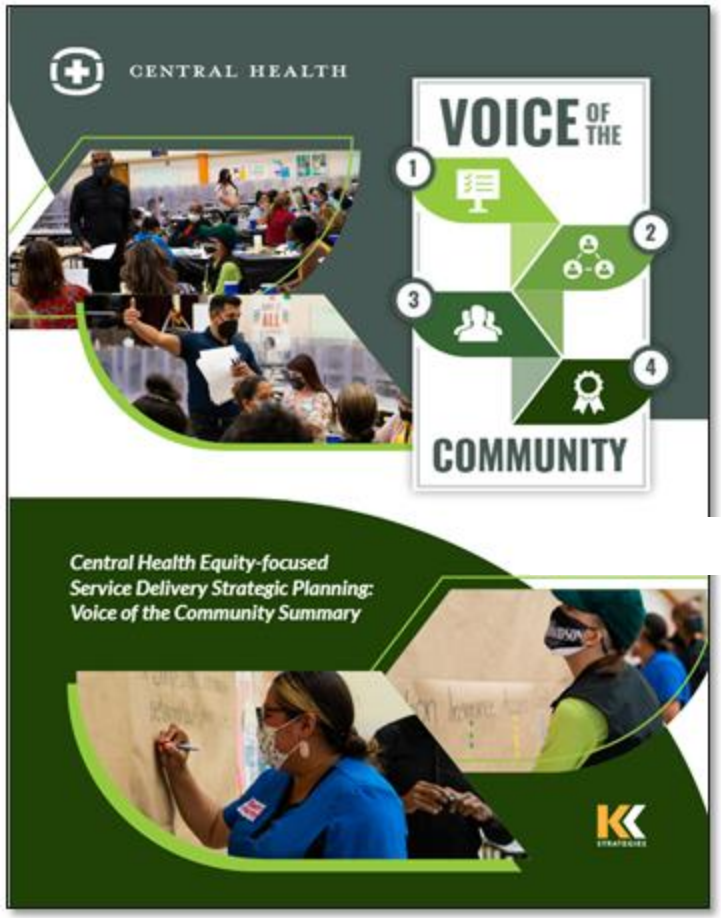


Central Health Engaged the Community at the Outset of Developing a Plan to Achieve a Comprehensive, Equity-Focused System of Care

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

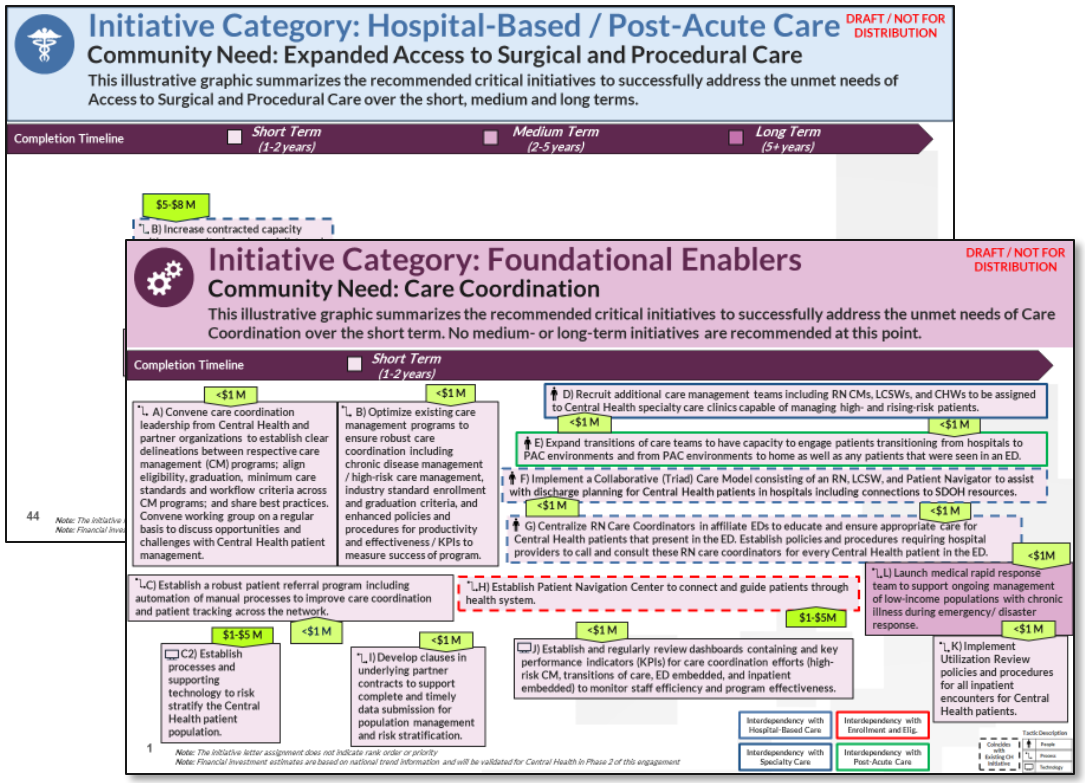
**Select services include but are not limited to these.*

Legend

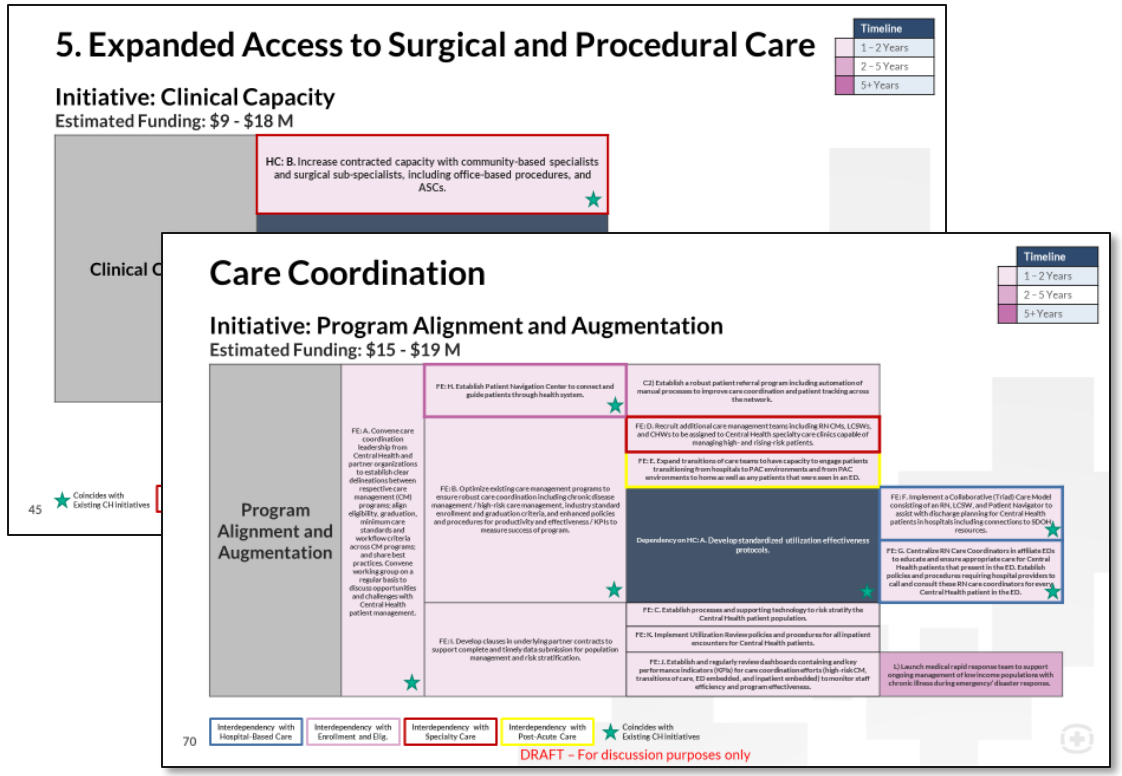
- **Significant Gaps** — **Less than 50%** of community needs are being met
- **Moderate Gaps** — Between 50-70% of community needs are being met
- **Minimal Gaps** — More than 70% of community needs are being met

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

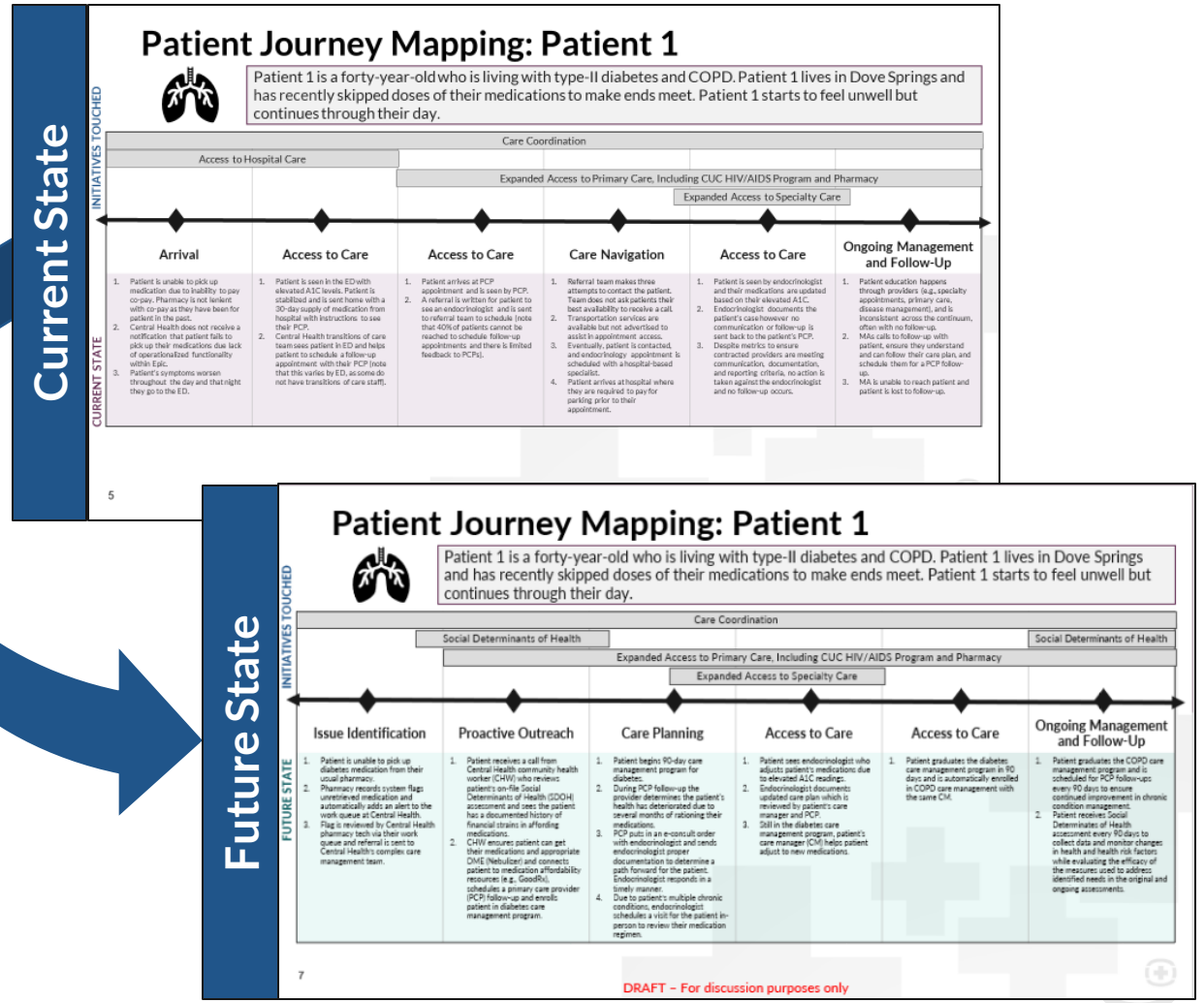
Central Health Created Patient Journey Maps To Further Understand How Patients Access and Engage with the Healthcare System

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*

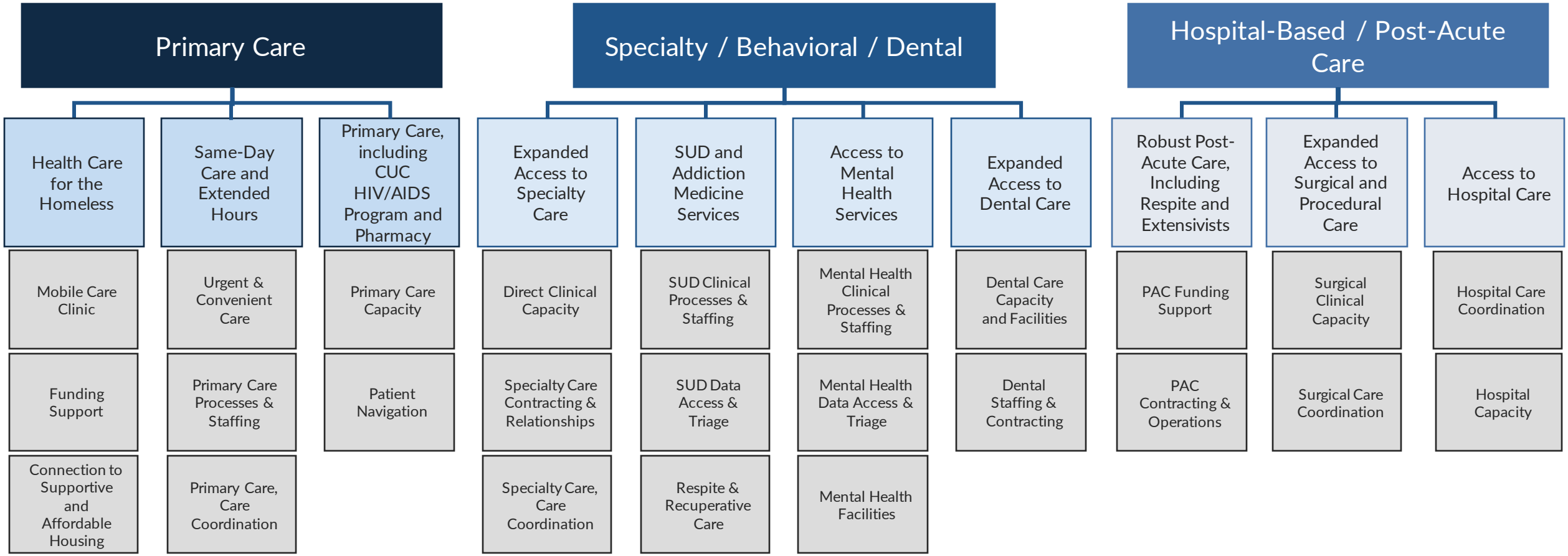
Coverage Programs, Benefits, and Structures

- 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

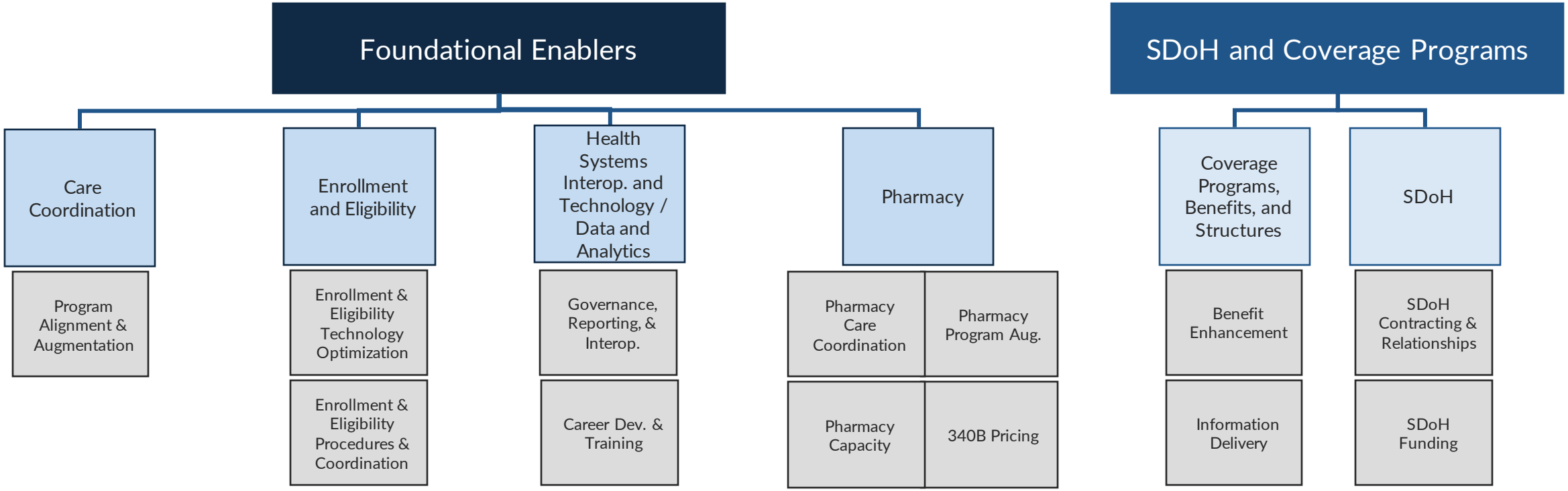
Social Determinants of Health

- 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



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



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 ▪ Integrate ED Care Coordinators to Reduce Inappropriate Utilization and Preventable Admissions ▪ Train Patient Navigators to Connect Patients to Housing Assistance Services ▪ 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 ▪ Create a Collaborative Care Model with CBSOs and Housing Authorities to Connect Unhoused Patients to More Permanent Housing and SDoH Resources ▪ Provide Wraparound Medical Services to Unhoused Individuals Through Additional Service Locations ▪ Expand Mobile Care Clinic Services Along I-35 Corridor ▪ Establish a High Risk Care Clinic
Same-Day Care and Extended Hours	▪ Expand Capacity of Urgent and Convenient Care Contracts to Enhance Services ▪ Expand RN / CHW Care Coordinator Dyad in ED to Triage Patients Appropriately ▪ Establish Joint Quality Review Board to Review ED Utilization ▪ Initiate Marketing and Communications Campaign to Educate Patients on Available Same-Day Resources ▪ Expand Convenient Care Footprint including Limited Urgent Care, Screening, Wellness, etc.	▪ Expand Telehealth Services by Determining Number of Patients Accessing Convenient Care ▪ Expand Convenient Care Telehealth Services ▪ 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 ▪ 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 ▪ Expand Pharmacy Services through Telehealth and Collaboration with Mobile Care Clinics ▪ Establish Multi-Disciplinary Care Approach to Expand Care for Medically Complex Patients ▪ Expand Hours for Primary Care Clinics including Same Day, Next Day, Weekend, and Evening ▪ 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 ▪ Expand DME Capacity to Address Outpatient DME and Supply Gaps ▪ Build and Internalize Vendor Capabilities In-House Expand Clinical Services Footprint ▪ Increase Diagnostic Capacity in RZ Clinic and/or with Contracts ▪ Expand Ambulatory Contract Capacity in Key Specialty Areas ▪ Establish Governance Processes for Specialty Care Service Contracts ▪ Local Medical Assistant and Registered Nurse Programs to Build Adequate Staffing Capacity ▪ Implement Evidence-Based Care Delivery Model	▪ Extend Care Coordination Efforts with CHWs to Specialty Care Environment ▪ Operationalize Hancock Center including Services, Processes, Space Needs, etc. ▪ Evaluate and Right Size RZ Clinic Phase 2, including Proposed Specialties ▪ Increase Advanced Imaging Capacity ▪ Build Surgical Office and Consultation Capacity for High- Volume Low-Acuity Surgeries ▪ Build Data Sharing Capacity with FQHCs and Other Partners ▪ Develop Chronic Disease Programs with Multidisciplinary Approach to Improve Patient Quality of Life ▪ Address Future Specialty Care Access Needs and Site of Service ▪ 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 ▪ Improve Substance Use Disorder Data Sharing, Quality Metrics and Communications for Providers to Effectively Monitor and Triage Patients ▪ Increase Contracted Capacity with Community Medical Services for Methadone MAT ▪ Develop Care Models for Alcohol and Stimulant Addiction including Detox Services ▪ Addiction Medicine Specialist to Assist Overseeing Service Line and Work with Local Entities	▪ Suboxone Medication-Assisted Treatment Program ▪ Medically-Supervised Detox for Opioid Use Disorder ▪ Medically-Supervised Detox for Alcohol / Stimulant Use ▪ Build Team-Based Provider Capacity for Substance Use Disorder Treatment in Ambulatory Care Setting, including Home or Tele-Rooms ▪ Develop Model for Virtual Team- Based Substance Use Disorder Treatment in Ambulatory Care Environment

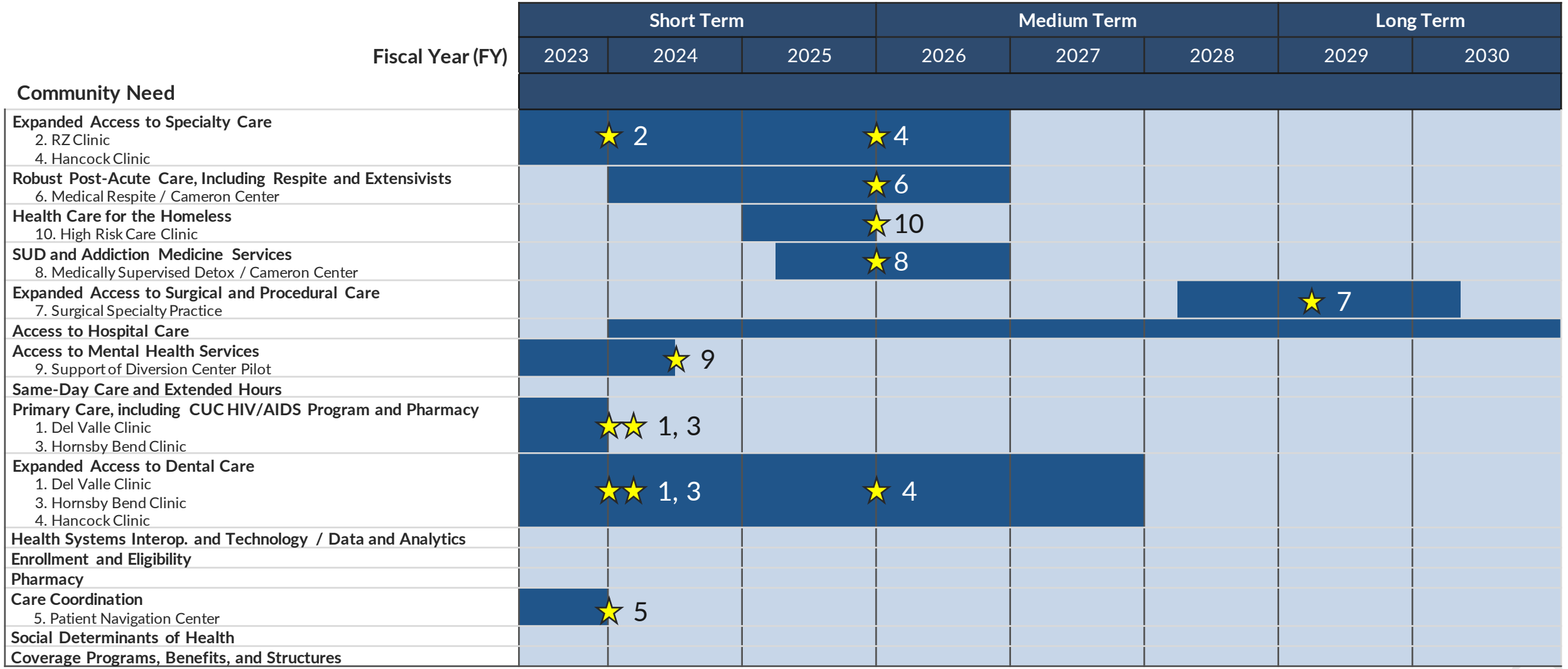
Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

Community Need	Projects	
Access to Mental Health Services	▪ Develop Training Program for Primary Care Providers on SUD and Mental Health Screening and Referrals ▪ Contract/Hire Psychiatrist with Prescribing Capabilities and Coordinate Medication Management for Mental Health Patients ▪ Hire Director of Mental Health (MH) Services to Coordinate MH Service Line ▪ 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 ▪ Co-locate Therapists at Central Health Ambulatory Care Sites ▪ Co-locate Therapists at FQHC Locations ▪ 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 ▪ Hygienist Recruitment and Retention Opportunities with Austin Dental Hygiene Schools ▪ Build Dental Capacity at New Clinic Sites, Operated by CommUnityCare ▪ Proactive Dental Outreach and Education Efforts on Routine Screenings and Cleanings	▪ Expand Dental Services for Unhoused Patients through Mobile Dental Clinics ▪ Align Dental Surgery Services
Robust Post-Acute Care, Including Respite and Extensivists	▪ Advance PAC Capacity by Evaluating and Aligning Available Community Resources ▪ Development of Comprehensive Post-Acute Care Strategy ▪ Determine Capacity of Community Based Services Available to Unhoused Individuals ▪ Right-Sized PAC Portfolio to Ensure Quality and Cost of Care Management ▪ Identify Preferred PAC Partners with Access and Committed to Value-Based care ▪ Contract with Local Area Agencies on Aging to Provide In-Home Care for Low-Acuity Hospital Discharges ▪ Expand SNFist Program to Provide 24/7 Coverage	▪ Improve Critical PAC Operations, Transitions of Care, Staff Training, and Technology ▪ Research and Source PAC Waiver Programs ▪ Deploy Service Line specific Initiatives that Drive LOS, Excess Days and Readmissions ▪ Integration of Post-Acute Nurse Care Managers in IRF and LTACH Settings ▪ Strengthen PAC Clinical Governance and Accountability to Sustain Post-Acute Strategy ▪ Expand Recuperative Care Access and Partners to Increase Bed Capacity ▪ Expand Post-Acute Care Management to Ensure Patients Transitioned to Appropriate Settings Post Discharge ▪ 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 ▪ Assess potential for Increased Contracted Capacity with Local Hospitals ▪ Conduct Long-Term Operational and Capital Planning re Safety-Net Hospital	▪ Future Partnership Options for Supplemental and Transitional Hospital Access ▪ 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 ▪ Care Management Optimization to Ensure Robust Care Coordination ▪ Establish Processes and Technology to Support Risk Stratification ▪ Recruit Additional Care Management Teams for Specialty Clinics to Manage High-Risk Patients ▪ Expand Transitions of Care Teams to Engage Patients Transitioning to PAC Environments and/or Home ▪ 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 ▪ Timely Data Submission from Partners to Support Population Management and Risk Stratification ▪ Dashboard Development to Enable Care Coordination Efforts and Monitor Staff Efficiency and Program Effectiveness ▪ Implement Utilization Review Policies and Procedures for Inpatient Encounters ▪ Launch Medical Rapid Response Team ▪ Establish Central Health Patient Navigation Center ▪ Establish Robust Patient Referral Program to Improve Care Coordination and Patient Tracking

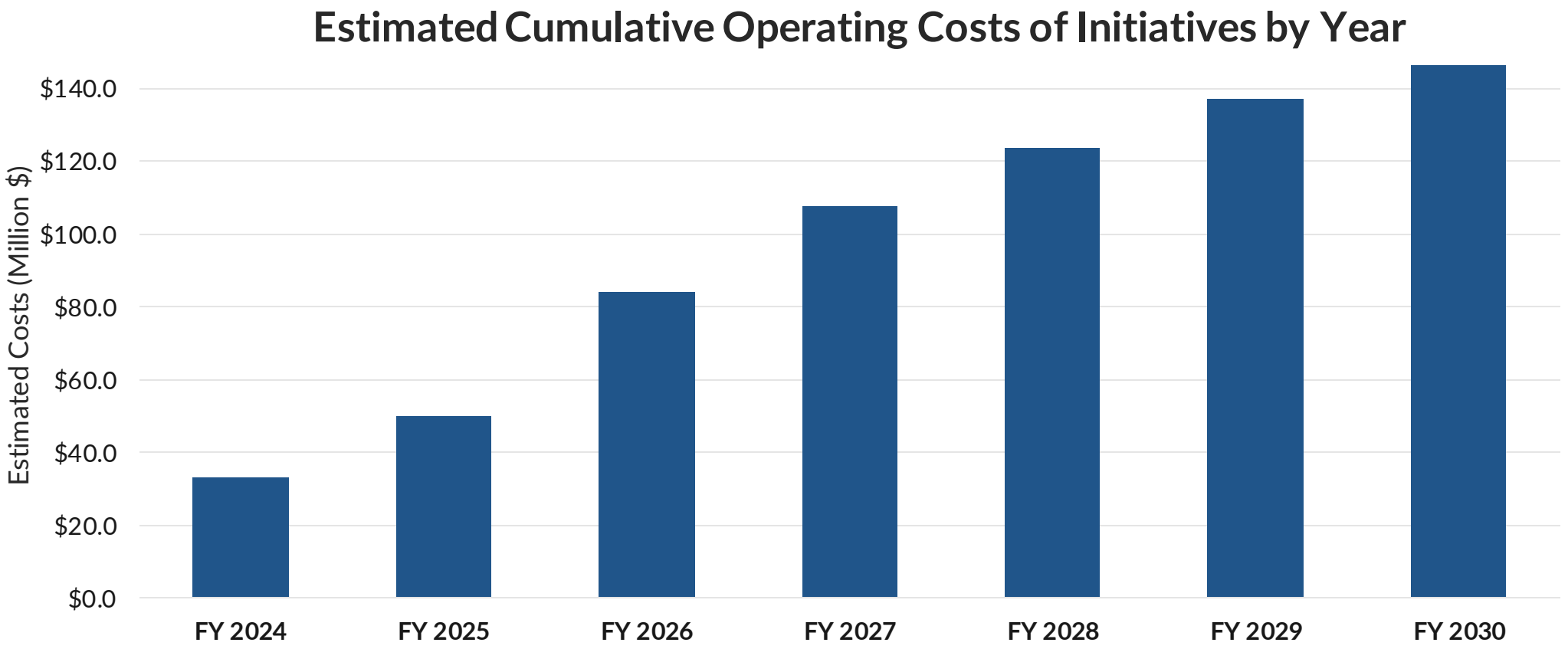
Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

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



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



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* • *Specialty Care, Care Coordination* • *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* • *Mental Health Data Access and Triage* • *Mental Health Facilities*							
Robust Post-Acute Care, Including Respite and Extensivists	• *Post-Acute Care Contracting and Operations* • *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* • *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* • *SUD Clinical Processes and Staffing* • *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* • *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* • *Funding Support* • *Mobile Care Clinic and High Risk Care Clinic*	See Note 3 below	$ 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* • *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* • *Enrollment & Eligibility Procedures & Coordination*							
Coverage Programs, Benefits, and Structures	• *Coverage Program Benefit Enhancement* • *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.

Note 3 : Additional funding for services related to Healthcare for the Homeless is reflected in Specialty Care, Post-Acute including Respite, Primary Care and SUD.

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* • *Pharmacy Capacity* • *Pharmacy Program Aug.* • *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* • *Primary Care Processes and Staffing* • *Urgent and Convenient Care*	$ -	$ -	$ 105,000	$ 161,250	$ 220,000	$ 281,250	$ 287,500
Expanded Access to Surgical and Procedural Care	• *Surgical Clinical Capacity* • *Surgical Care Coordination*	$ -	$ -	$ -	$ -	$ 3,335,833	$ 7,356,794	$ 10,044,058
Social Determinants of Health (SDOH)	• *SDOH Contracting and Relationships* • *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* • *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* • *Finance* • *Communications* • *General Administration* • *Strategy* • *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.

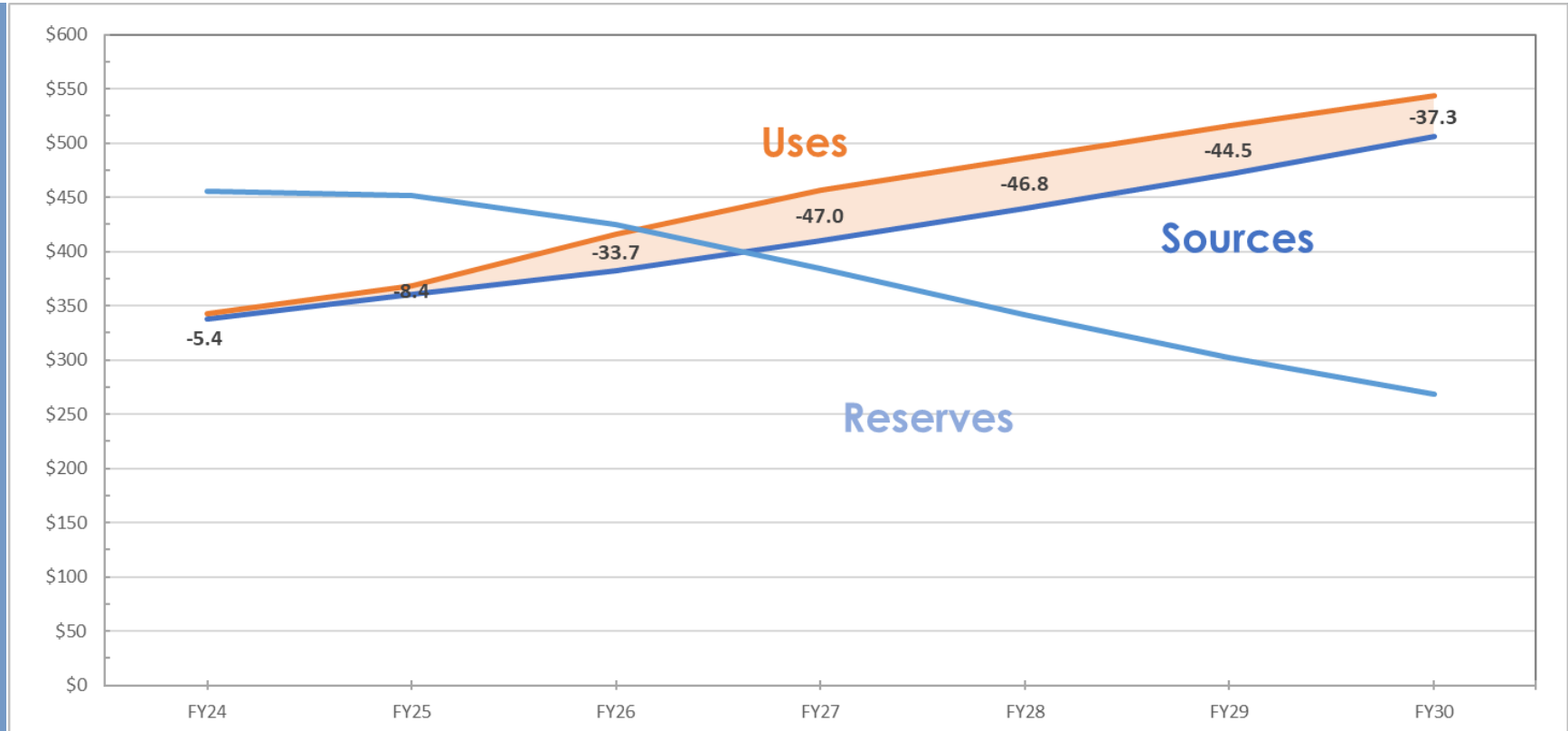
Note 2: Cost estimates associated with crosscutting projects and initiatives are attributed to one community need to promote efficiency and maximize available resources.

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

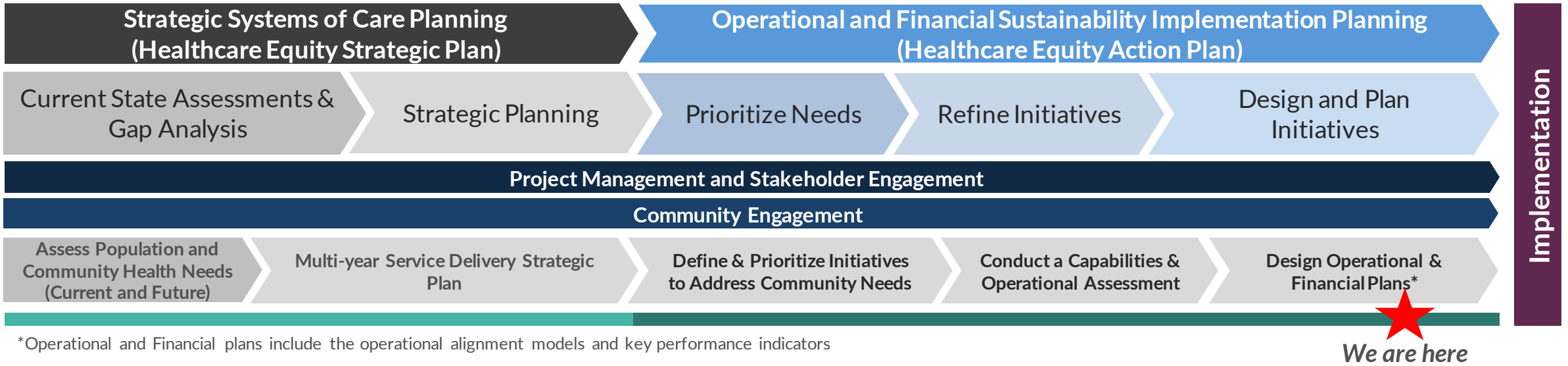


	FY24	FY25	FY26	FY27	FY28	FY29	FY30
Sources	337.8	360.2	382.9	410.1	440.0	471.9	506.0
Health Equity Action Plan New Uses	47.5	68.2	102.3	127.1	143.2	156.4	166.0
Ongoing HCD and Operations Uses	295.6	300.5	314.3	330.0	343.6	360.0	377.4
Total Uses	343.2	368.6	416.5	457.0	486.8	516.4	543.4
Total Reserves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