Community Care COLLABORATIVE

DRAFT Integrated Delivery System Plan

1 | INTRODUCTION

This document transmits the plan to develop and coordinate the Integrated Delivery System (IDS) the Community Care Collaborative (CCC) board commissioned in a Sept. 26, 2014 resolution. The plan should serve as a framework for work to be done during the remainder of the CCC's fiscal years 2015 and 2016. It will be expanded to include plans for future years once its implementation begins. The plan will remain in draft form as further changes are anticipated throughout the performance period.

In summary, the plan is intended to provide or accomplish the following:

1. Centralized care coordination resources and services for the CCC population: navigation, case management, utilization management, benefits screening, eligibility and enrollment
2. A Health Information Technology (HIT) infrastructure that enables near-time clinical data integration, data-driven population health initiatives, and timely and efficient reporting on IDS performance
3. Expanded access to specialty care services and IDS system delivery redesign
4. A structure for evaluating IDS effectiveness
5. A framework for moving away from a fixed-rate reimbursement system for Federally Qualified Health Centers to a value-based reimbursement methodology

The work to fully develop the IDS will be very hard and will take three to five years–if Central Health, Seton, and the provider network begin collaborating now.

THE COMMUNITY CARE COLLABORATIVE

Health care made smart

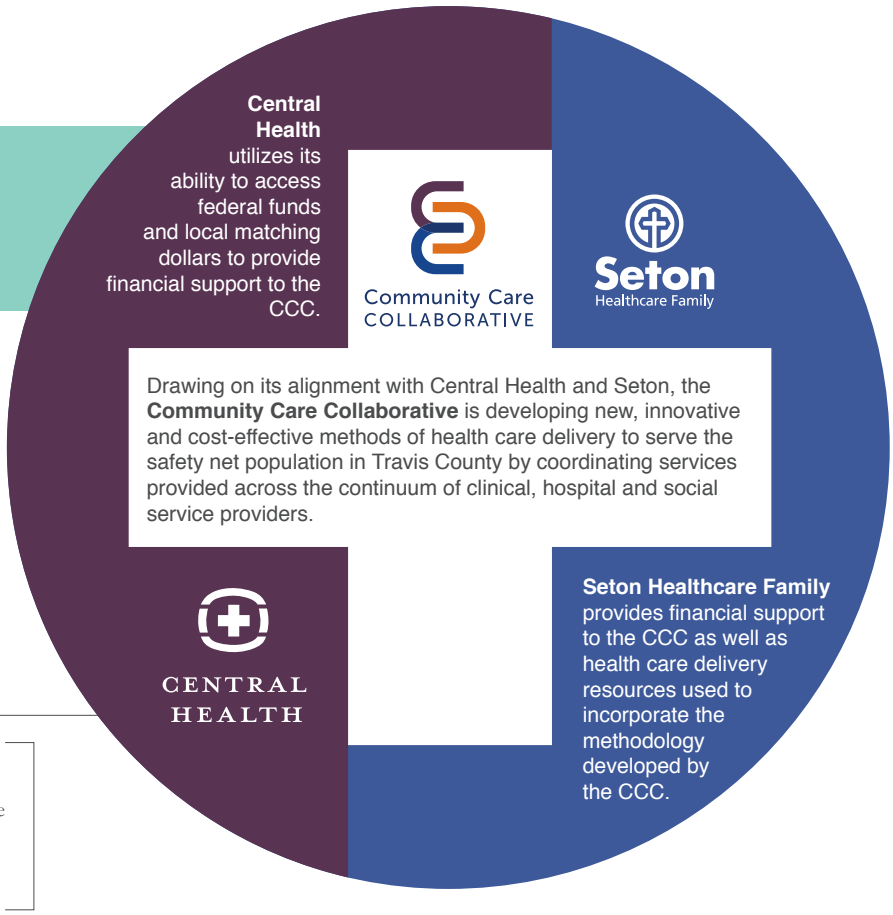
The **Community Care Collaborative** is a 501(c)(3) nonprofit corporation created in 2013 by an agreement between Central Health and Seton Healthcare Family.

The CCC is focused on improving health outcomes of Travis County target populations by developing an integrated delivery system to:

- better manage care coordination among patients and providers
- upgrade the use of technology
- reduce waste across the system
- focus on the prevention of illness, management of diseases and health promotion

THE MISSION:

Create an integrated health care delivery system for identified vulnerable populations in Travis County that considers the whole person, engages patients as part of the care team, focuses on prevention and wellness and utilizes outcome data to improve care delivery.



2 | HISTORY OF SAFETY NET HEALTH CARE DELIVERY IN TRAVIS COUNTY

Until 1995, the city of Austin owned and operated Brackenridge Hospital (now known as University Medical Center Brackenridge or UMCB) and provided funding for operations.

In 1995, the city of Austin transferred the license to operate Brackenridge and the local children's hospital to Seton in exchange for Seton's agreement to provide indigent care in the county, including inpatient hospital care. Seton also agreed to provide acute care and some specialty care services to those served by the Medical Access Program (MAP) and to charity care patients in Travis County.

MAP is a long-time feature of Central Health and the city of Austin. The program provides health care coverage, including a medical home, for low-income residents of Travis County (most of whom earn below 100 percent federal poverty level) and are ineligible for other government assistance. Seton provides acute care and some specialty care for MAP, while other safety net providers—including federally qualified health centers, or FQHCs—funded by the CCC, provide primary care.

Through the charity care or sliding-fee scale program, health care services are provided by Seton to Travis County residents who are not MAP-eligible but are either financially or medically indigent. Primary care providers such as El Buen Samaritano, and FQHCs including CommUnityCare, Lone Star Circle of Care and People's Community Clinic, also provide services to charity care patients.

Creation of Central Health

In 2004, Travis County voters approved the creation of Central Health. As prescribed by its governing legislation, Central Health inherited a portion of the tax rates formerly levied by the city and county.

Title to UMCB and the accompanying Seton lease were also assigned to Central Health. Rent payments pursuant to the lease totaled slightly more than $300 million from 2005 to 2014. These payments supported Central Health's funding for expanded services Seton and others provided to increasing MAP and charity care populations in Travis County.

The 1115 Waiver

In 2011, Texas received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Texas Healthcare Transformation and Quality Improvement Program through a waiver of Section 1115 of the Social Security Act. There are two funding streams within the 1115 Waiver:

- Uncompensated Care (hospital payments) and
- Delivery System Reform Incentive Payments (DSRIP).

Local public funding and matching federal Medicaid dollars serve as the funding sources for the program. The 1115 waiver provided Central Health and Seton the opportunity to make significant enhancements to the health care safety net, including:

- A new teaching hospital to replace the aging UMCB;
- A medical school on The University of Texas at Austin campus;
- Improved and expanded specialty care services; and
- An infrastructure to create an integrated delivery system.

In 2012 Central Health asked Travis County voters for an increased tax rate to provide adequate local matching funds for the waiver. Following a successful referendum, Central Health was able to increase its tax rate in fiscal year 2014 by five cents to 12.9 cents.

Central Health is the anchor entity for Texas Region 7 in the 1115 waiver and provides administrative support for the six counties' participation. Through the five-year 1115 waiver program, over $700 million in local and federal matching dollars will fund more than 70 health care reform projects in the Central Texas Region.

Creation of the Community Care Collaborative

The CCC is a 501(c)(3) nonprofit corporation established by Central Health and Seton in 2013 to provide a framework for implementing the Texas 1115 Medicaid waiver and an IDS for the uninsured and underinsured populations of Travis County. The IDS will involve many health care organizations and will evolve into a coordinated continuum of health care services with clinical and financial accountability for the health care of the population being served. The CCC will be the linchpin of the safety net IDS in Travis County through efforts to coordinate and improve health care services.

The University of Texas Dell Medical School and the CCC

In 2014, The University of Texas at Austin committed to support efforts to build an integrated delivery system through an affiliation agreement with the CCC and Central Health. Pursuant to this agreement, the CCC commits to make payments of $35 million annually to The University of Texas in support of the Dell Medical School. These payments are guaranteed by Central Health. The University of Texas at Austin agrees to use the Dell Medical School to support the integrated delivery system that is being created by the CCC by:

- Providing cutting edge clinical services to the safety net population in community-based clinical settings;
- Conducting research programs focused on improving health care service delivery;
- Coordinating care to achieve better individual health outcomes; and
- Focusing on preventive, culturally competent care to reduce population health disparities.

BUILDING THE COMMUNITY CARE COLLABORATIVE

By working with local health care partners, the Community Care Collaborative is laying the groundwork for an integrated delivery system—a centralized resource of services to provide more and better health care for Travis County's vulnerable population.

Central Health/Seton Healthcare Family
Central Health and the Seton Healthcare Family partnered in 2013 to create the Community Care Collaborative, a 501(c)(3) nonprofit. The vision of the partnership is to knit together fragmented pieces of the Travis County health care system to create a continuum of care for the safety net population.

Infrastructure and clinical care expansion
The CCC supports numerous initiatives to improve local health care facilities, train additional providers and staff, and improve patient care.

The Dell Medical School
- Opening in 2016
- The CCC pays $35 million annually to the medical school, which assists in creating new models of service delivery and in providing care for the safety net.

Dell Seton Medical Center at UT
- Scheduled to replace University Medical Center Brackenridge in 2017
- Will provide a new, state-of-the-art home for acute and specialty care, as well as a training facility for the Medical School students and residents

Innovative community clinics
- Includes the Southeast Health and Wellness Center, which opened in 2015

Performance-based funding
Delivery System Reform Incentive Payment, or DSRIP, programs utilize local and matching federal funds to incentivize new and innovative health care programs that achieve measurable performance goals. The programs are designed to improve patient outcomes and address inefficiencies in the health care system.

DSRIP programs
The CCC is overseeing 15 DSRIP projects, including programs offering telepsychiatry at local clinics, increasing pregnancy planning services, and implementing new mobile health teams.

Community Care Collaborative
The CCC draws local funding support from Central Health as well as matching federal dollars. Seton provides funding and patient health care delivery resources to help fulfill the CCC's goals. The CCC is also working with local partners who share access to the safety net population, including; the Dell Medical School at The University of Texas at Austin; Austin Travis County Integral Care; the city of Austin; St. David's HealthCare; and numerous community based direct care providers. In 2015 the CCC contracted with local providers to deliver more than $70 million in direct patient care.

3 | IDS WORK PLAN OVERVIEW

The early work detailed in the IDS work plan provides the foundational elements to transform health care safety net services in Travis County into an integrated delivery system, or IDS, in which the CCC becomes accountable for the health of a defined population.

Clinical service delivery work

The IDS will coordinate sufficient and timely access to a range of **services** that allows each person to be served in the most appropriate setting for their needs. The system will focus on expanding and enhancing services on the front end—including health promotion—to reduce the need for critical care services later on.

Integrators refer to critical activities that link separate care services to create a networked system of care. To promote use and because these components are critical to tracking accountability of care outcomes, much of the prioritized work for Year 1 will focus on creating or enhancing these integrators.

THE INTEGRATED DELIVERY SYSTEM:
Connecting patients with the help they need

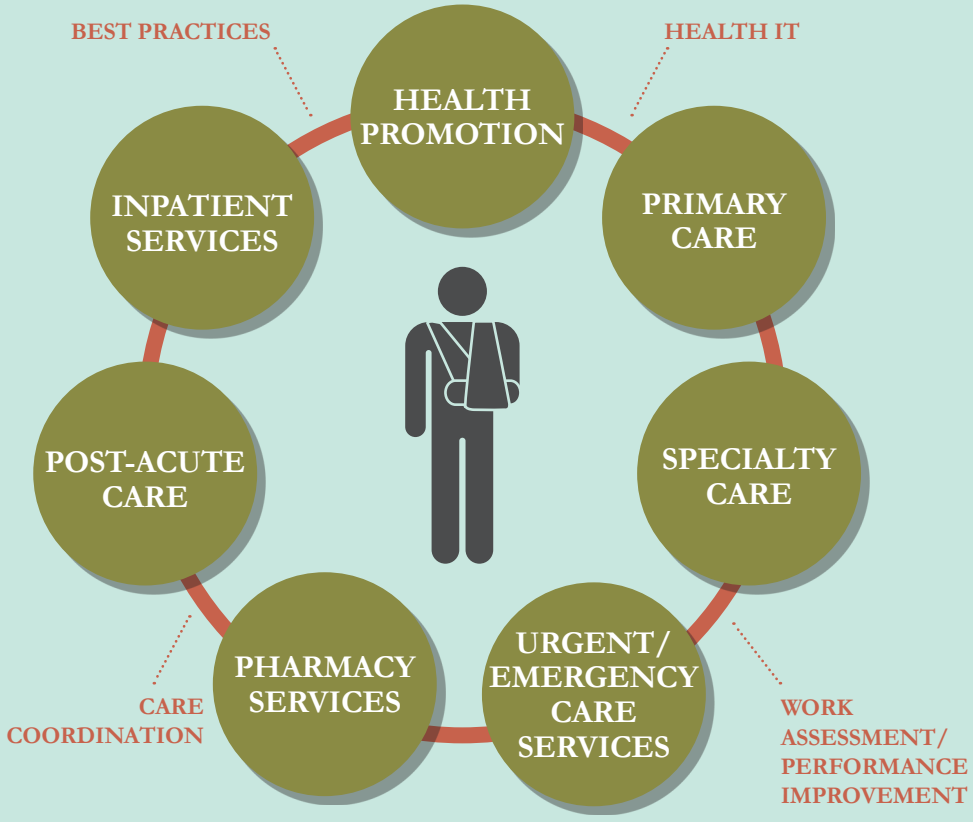
The vision of the CCC's **integrated delivery system**, or **IDS**, is to create a seamless health care delivery model for patients, regardless of which CCC provider is providing their care. The IDS will focus on providing more and better services on the front end of patient care to help reduce the need for intensive critical care services later on.

ENHANCED SERVICES:
Tailored to patient needs

The IDS seeks to enhance front-end services across the patient care continuum. Examples include community health programs focusing on tobacco use cessation as well as expanding access to urgent care clinics to reduce strain on emergency rooms.
The services will be interconnected, allowing care providers the ability to address all areas of health—physical, behavioral and social—and allow for whole-person care.

INTEGRATOR SERVICES:
Connecting the services

The CCC is developing new health information technology platforms to allow health care and social services providers to share patient information. The IDS will also create evidence-based best practices to care for and work with patients being treated for a wide variety of conditions. These integrator systems will serve as the connecting web for the enhanced services within the IDS.



Lead elements of the CCC integrated delivery system

The following is a sample of specific tasks or outcomes that will be undertaken during the remainder of fiscal year 2015 and throughout the new fiscal year 2016.

Develop centralized care coordination services that will:

- Ensure patients are assigned to a medical home upon enrollment;
- Standardize care coordination across the IDS;
- Perform health risk appraisals and identify at-risk/high-risk members;
- Perform inpatient case management and utilization management;
- Manage referrals to and among system providers;
- Manage patients with complex care needs, with an emphasis on diabetics;
- Connect patients to the appropriate service along the continuum of care;
- Increase rates of preventive health services and screenings; and
- Ensure all IDS sites use the same documentation to determine eligibility.

Expand select specialty care services with goals to:

- Reduce wait time for designated clinics;
- Pilot alternative methods of service delivery;
- Create a streamlined process for referrals; and
- Account for true cost of provision of specialty care.

Develop CCC measurement, assessment, and performance improvement capability that will:

- Determine how we measure our work (Evaluation & Measurement workgroup);
- Assess quality of services provided (Medical Committee);
- Improve system performance (Office of Performance Excellence).

Continue work on a health information technology (HIT) platform including:

- Launch patient navigation software, provide access to a centralized community resources directory, and launch a patient portal;
- Deliver analysis projects for IDS planning and support of DSRIP projects, finalize the CCC data analytics and research architecture, and launch tools focused on performance metric tracking;
- Complete additional collaboration projects to strengthen the technical capabilities of IDS participants; and
- Continue to work in partnership with the Integrated Care Collaboration (ICC) to improve the timeliness and usability of data feeds that support all other technology initiatives ("One Button").

Carry out other key initiatives that will provide opportunities to collaborate with our IDS partners and advance the mutual goals of the CCC:

- Plan for the opening of an Ambulatory Surgery Center (ASC) in 2017 in the UT Medical Office Building, with the CCC as an equity partner;
- Work with our largest federally qualified health center partner, CommUnityCare, to analyze changes to the federal prospective payment system (PPS), with the goal of achieving a payment reform transition plan by December 31, 2015;
- Analyze care delivery systems, health information technology, care coordination and other administrative and support systems that already exist in the IDS to determine feasibility of "shortcutting" the development of the IDS infrastructure through sharing arrangements; and
- Continue work on a redesigned benefit plan based on medical need rather than financial status

4 | MEASUREMENT, ASSESSMENT AND PERFORMANCE

Measurement, assessment and performance is an umbrella label for all work related to defining measures, setting goals, tracking process, evaluating IDS programs, and delivering performance improvement projects.

This work will demonstrate the value of IDS programs by providing accurate, transparent, and consistent assessments of their methods and performance. The work also provides a structured way to improve programs where the root cause of issues is unclear (via Six Sigma) or to remove waste from programs (via Lean Concepts).

The guiding principles of the CCC's measurement, assessment and performance work is to develop capabilities that will:

- Clearly define the measures that are jointly derived from the clinical guidelines and operational goals;
- Define clear systems for evaluating and tracking work progress; and
- Improve system performance and optimize processes.

Measurement, assessment and performance definitions

- *Measures and Standards* work will define a set of metrics and goals for the IDS
- *Tracking and Assessment* work will monitor all measures via clear dashboards or reports, and includes the processes used to collect data
- *Management & Improvement* work checks progress and executes improvement projects–typically using Lean and Six Sigma methods
- *Research* will be informed by the preceding three focus areas and other IDS work and will be launched in partnership with the Dell Medical School

These four focus areas, or workstreams, are detailed below along with projected deliverables and budget requirements.

Measures and Standards

This agreed-upon set of measures and standards will allow the IDS to align its work across all participants and will:

- Clearly communicate what the measures and standards are at a level of detail that informs participant operational and technical staff (e.g. our measures come from clinical/operational goals, which drive technical work);
- Develop a library that clearly states what the guidelines are and how they map to measures and standards;
- Establish a subject matter expert (SME) to rollout and advise on the successful spread of protocols and other guidelines of the IDS;
- Form and operate a Medical Committee to regularly convert clinical guidelines into measures and standards, identify best practices, and define performance indicators and goals. The Assessment Steering Committee in the next workstream will have overlapping membership and meeting schedules with this group. IDS development starts with patient care, and also factors in financial and operational components in assessments.

Whenever possible, the CCC will identify local, national, or international benchmarks for the selected metrics to allow CCC system performance to be measured against established standards of excellence.

Such metrics and benchmarks shall include measures in the areas of patient experience, care coordination, preventive health, clinical care improvement, financial, and other mitigating factors.

The majority of this workstream is operational—in that we will establish a clear definition of measures and standards early on, then keep them updated through a clear process.

Projected deliverables

The list below represents major deliverables in the next 18 months:

- *Measure Library*—online library of measures for all IDS and DSRIP areas—including metrics, milestones, and goals
  Estimated date: July 2015
- *Medical Committee Plan*—define the plan for the formation and operations of a CCC Medical Committee and clear structure for goals
  Estimated date: September 2015
- *Project Portfolio*— defined list of all projects within DSRIP and IDS for FY2016
  Estimated date: October 2015
- *Training Plan*—plan for delivering ongoing training of guidelines and measures (including DSRIP measures and clinical protocols)
  Estimated date: January 2016

Tracking and Assessment

To establish a method for tracking our progress and taking action, we will need to:

- Create and/or maintain current status of projects, processes, and outcomes via metric dashboards, control charts, or reports;
- Define a clear process for prioritizing assessment work to ensure that groups are aligned to properly order the work backlog;
- Maintain an executive report on status of projects so that executive and governance levels have a transparent view into IDS performance;
- Establish a cross-functional (clinical, operations, and financial) Assessment Committee that will review IDS projects and define recommendations. This could include:
  - Simple heuristics: doing basic interviews on what is working;
  - Advanced heuristics: defining methods to evaluate a project;
  - Business ROI and support: looking at the level of support by the community and the financial costs vs. effect;
  - Starting a statistical analysis request related to questions (e.g. can we show that our additional navigation calls have a causal relationship to improved measures?);
  - Triggering a performance improvement project request to improve flow and remove waste from a process (Lean);
  - Starting a performance improvement project request to search for root cause and identify defects and recommendations (Six Sigma).

This workstream relies heavily on resources from other areas of the IDS Workplan, particularly OPEx staff, DSRIP program specialists, HIT staff for data analytics, and IDS-clinical staff for our review groups (committees).

Projected deliverables

The list below represents major deliverables in the next 18 months:

- *Assessment Framework*—a clear definition of what our process looks like for assessing work, including success-parameters and assessment approaches
  Estimated date: July 2015
- *Display System(s)*—launch a collaborative web-based environment that houses displays of current status of measures–including reports, dashboards, and updates on assessment projects
  Estimated date: September 2015
- *Establish NPHO and Peer Review*—Establish a Medical Peer Review Committee and Nonprofit Health Organization (NPHO), so that participants can appropriately evaluate improvements to IDS programs
  Estimated date: October 2015

Management and Improvement

We will establish a team to dig into identified issues and make changes, which will include:

- Creating a centralized Office of Performance Excellence (OPEx) for the IDS, ensuring the CCC and its contracted providers have the technical support to implement the CCC's improvement framework
- Create a CCC performance improvement plan that guides the work of the OPEx team and related workstreams:
  - Facilitate the groups defined in other workstreams (Medical Committee, Assessment Steering Committee), to ensure all measures and assessment work is actionable and provides operational value
  - Maintain the measures and standards knowledge library
  - Deliver improvement projects for the CCC and provide technical support to IDS participants

This workstream also includes ongoing training on improvement techniques and practices to IDS participants.

Projected deliverables

The list below represents major deliverables in the next 18 months:

- *Staff onboarding/shift*—define and execute a staffing plan to expand the scope of OPEx staff to the IDS
  Estimated date: May 2015
- *Facilitate other workstreams*—facilitate and drive milestones/deliverables in this section
  Estimated date: ongoing
- *Deliver improvement projects*—deliver improvement projects and actionable recommendations.
  Estimated date: ongoing

Research

This workstream is the smallest in this section, and represents the newest capability. Our work will include:

- Establishing a framework for when assessment work should be scaled to a research opportunity
- Documenting an agreement and ongoing contract framework between Dell Medical School, the CCC, Seton, and Central Health as to how research projects will be conducted and governed
- Accomplishing some initial research projects in concert with Dell Medical School/UT staff to develop a cadence for long-term work.

This workstream is less about accomplishing work than it is about preparing ground for our long-term approach to research.

Projected deliverables

The list below represents major deliverables in the next 18 months:

- *Research Vetting Process*—establish a written process for scaling an assessment effort into a research project
  Estimated date: September 2015
- *Contract Framework*—define a contract with our partners so we can easily engage in research efforts with minimal overhead/ramp-up to the process
  Estimated date: September 2015
- "*Mini*" *projects*— execute at least three starter projects to get in a cadence for long-term work. These projects are targeted as business goals to help build the capability in the CCC and with our research partner(s)
  Estimated date: September 2016

TAKING STEPS TO BETTER PATIENT CARE COORDINATION

Merging the best tools of technology and health service delivery

Efficient care coordination requires a system that allows case managers, health care providers, enrollment systems and social service agencies to share up-to-date patient information. By working together—instead of in isolation from one another—these agencies are able to track patients' health history and devise a whole-health plan for care. Improving care coordination is a cornerstone of the Community Care Collaborative's integrated delivery system.

PATIENT INTRODUCTION

ONE

When a patient is introduced into the IDS, the primary goals will be to identify what resources they are eligible for and assess their health care needs.

A COLLABORATIVE TEAM

TWO

The patient's information will be entered in the CCC's navigation system, which will allow all members of a patient's care team to easily share information across the continuum.

FINANCIAL SCREENING

THREE

Patients will receive an insurance consultation to determine eligibility and options.

ESTABLISHING A HOME

FOUR

Patients will be given a "warm handoff" to a convenient primary care provider if they do not already have one.

WHOLE HEALTH ASSESSMENT

FIVE

If the patient has extenuating circumstances, navigators can use a CCC database to connect the patient with a social services agency that may provide assistance beyond the typical clinical setting.

CONTINUED ASSISTANCE

SIX

Patients needing additional case management or ongoing navigation will be connected to the appropriate resources to facilitate a better experience and outcome of care.

A RECORD OF CARE

SEVEN

All of the patient's medical, social and situational history is recorded in the system. This allows care teams to utilize a richer picture of a patient's health history—allowing for more holistic care in a variety of settings.

5 | CARE COORDINATION

Care coordination includes enrollment, navigation, case management, utilization management, disease management, and medical management. Care coordination is a crucial integrator that connects patients to various services and ensures their efficient movement through the system. Care coordination is essential to meet the CCC's mission.

Entrance into the integrated delivery system

When a person enters the integrated delivery system the CCC's two primary goals are to: screen them for the full range of program resources for which they are eligible; and evaluate their level of medical acuity to place them for care in the most appropriate setting. Upon entrance into the IDS, people will undergo two main activities—financial screening and health risk assessment.

The CCC will standardize screening guidelines across providers so all patients will have the opportunity to access programs for which they are eligible—including health care and social services. The CCC will develop the capacity for all screeners at all provider organizations to share information.

As part of this process, enrollees will undergo a health risk assessment to identify at-risk and high-risk users so that their needs may be met in the most appropriate setting. After the health risk assessment is complete, people will be assigned a patient centered medical home.

The CCC will:

- Improve financial screening methods, including;
  - Standardizing financial screening guidelines across providers; developing a list of accepted documentation such as proof of income and residency to be eligible for various health care and social service programs
  - Building network capacity so that screeners at all provider organizations are able to share information with other providers. This includes assessing the feasibility of implementing the same screening software across all providers in the IDS
  - Enhancing the screening process to include all potential sources of health care and social service resources
- Improve the system's ability to identify risk and place patients in the most appropriate setting, including;
  - Initiating a health risk assessment to determine the level of acuity of care and urgency of need
  - Assigning patients to a patient centered medical home that can best meet their needs
  - Arranging a patient's first appointment with a care provider

Outputs/Deliverables

The list below represents major deliverables in the next 18 months:

- *List and rollout*—standardized guidelines for verification of income, residency status, and other information to determine eligibility
  Due dates: Dec. 31, 2015 (list); March 31, 2016 (rollout)
- *Database for sliding fee scale registry*—create a database of financial screening results to be shared across providers
  Due date: Dec. 31, 2015
- *Recommendation on financial screening software*—implement standardized financial screening processes across all providers
  Due date: June 30, 2016
- *Mini-Nav and community resource directory*—limited release to a pilot audience
  Due dates: Jan. 31, 2016 (Mini-Nav); Aug. 31, 2015 (community resource directory)

BREAKING THE MOLD

Using care coordination to produce better health outcomes

PATIENT X

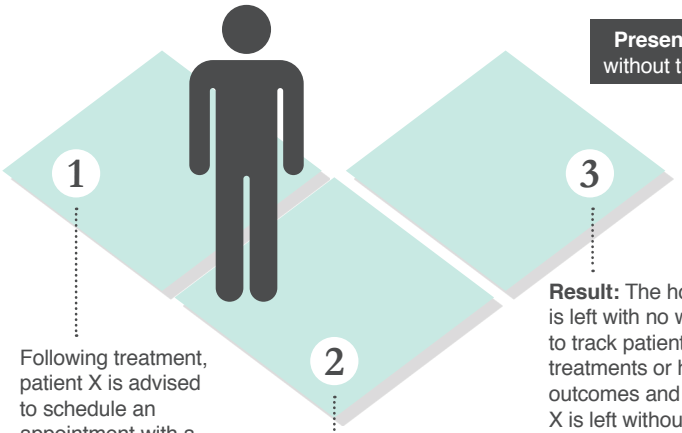
- ☑ No insurance
- ☑ No primary care provider
- ☑ Admitted to emergency room for blurred vision and fatigue
- ☑ Diagnosed with diabetes type 2 and given prescription

Today patients are often depended on to schedule their own appointments, coordinate the sharing of their health information, search for resources to meet other social needs, and communicate between all of their different care providers. The goal of the integrated delivery system is to develop seamless communication channels between patients and all of their health care and social services providers. This coordination results in better health outcomes for the patient and more efficient practices for the health care providers.

A TALE OF TWO SYSTEMS:

The integrated delivery system in action

Present care/ without the IDS



Following treatment, patient X is advised to schedule an appointment with a primary care provider

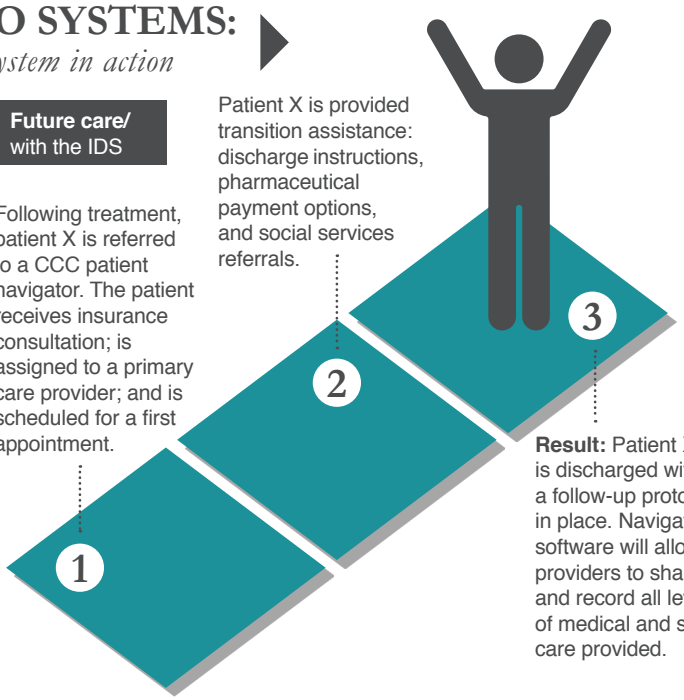
Patient X is discharged from the ER without follow-up protocol in place

Result: The hospital is left with no way to track patient X's treatments or health outcomes and patient X is left without health care system guidance.

Future care/ with the IDS

Following treatment, patient X is referred to a CCC patient navigator. The patient receives insurance consultation; is assigned to a primary care provider; and is scheduled for a first appointment.

Patient X is provided transition assistance: discharge instructions, pharmaceutical payment options, and social services referrals.



Result: Patient X is discharged with a follow-up protocol in place. Navigator software will allow providers to share and record all levels of medical and social care provided.

- *Health risk assessment tool*—create tool and electronic health record integration
  Due date: Sept. 30, 2015
- *Clinic attribution process*—develop and implement a process that is clinic neutral, assesses patient needs and matches patients to a medical home that factors in personal preferences
  Due date: Feb. 28, 2016
- *Centralization plan*—a plan to standardize intake and assessment functions
  Due date: Aug. 31, 2015

Patient use and navigation of IDS system

Delivering the right level of services at the best location is critical. To ensure this occurs, the CCC proposes to improve both patient and provider access to information.

Four significant efforts will pave the way to the CCC's goal:

- Create, own, and share a comprehensive inventory of community-based resources called the Community Resource Directory;
- Identify patients with complex care needs (pregnancy, diabetes, people who are homeless, high ED utilizers, people with two or more chronic conditions, people who require transitions to care after an inpatient hospitalization) and assign to appropriate level of case management and utilization management;
- Standardize care coordination across the IDS through:
  - Development, distribution, and implementation of care coordination guidelines that support CCC clinical protocols, and/or
  - Merge with the CCC's centralized care coordination services;
- Enhance provider ability to navigate patients across the IDS through:
  - The implementation and use of Mini-Nav,
  - Creation and deployment of referral guidelines among settings and providers (such as between hospitals and clinics) and among service types (such as social services and basic needs), and
  - Improve providers' ability to execute health promotion strategies through outbound calls.

Outputs/Deliverables

The list below represents major deliverables in the next 18 months:

- *Community Resource Directory*—limited release to a pilot audience
  Due date: Sept. 30, 2015
- *Care Coordination Plan*—a plan that details the design, inventory, and implementation of care coordination services in the IDS
  Due dates: Sept. 30, 2015 (staff hired); March 31, 2016 (design and inventory); June 30, 2016 (implementation)
- *Mini-Nav*—limited release to pilot audience
  Due date: Jan. 31, 2016
- *CCC Case and Utilization Management Department*—hire Phase I lead staff to plan, operate, and open Care Coordination Center
  Due date: Sept. 30, 2015

6 | EXPANSION OF SPECIALTY CARE

Specialty care is provided by physicians or other care providers whose training focused in a specific field. This level of care is required for individuals assessed as having complex care needs on either a short-term or long-term basis.

The CCC aims to ensure timely and convenient access to an array of specialty care services which are closely coordinated with the individual's primary care home.

The majority of specialty care services for the CCC population are provided through the Specialty Care Clinic at Brackenridge with additional clinics, in limited specialties, provided through two CommUnityCare (CUC) health centers. Minimal additional services are provided through other network and private providers. The contracted services for some specialties are insufficient to allow timely access to care.

For optimal patient clinical outcomes and to reduce unnecessary utilization of emergency and/or inpatient care, access to specialty care services must be managed in a manner that maximizes limited resources while accounting for the true costs of providing this care.

The specialty care goals for the CCC within this plan are to **manage demand** for specialists and **expand access to care**.

Manage Demand

Demand management consists of ensuring that only patients whose care cannot be appropriately managed within their medical home are referred to a specialist.

Based on a review of specialty care access and service utilization data, as well as consideration of the impact of lack of services and co-morbidities, a specialty care workgroup and the CCC Clinical Delivery Steering Committee prioritized seven specialties to be considered for expansion/enhancement in Year 1: **cardiology, endocrinology, gastroenterology, neurology, orthopedics, rheumatology and urology**.

Within Year 1, our plan to implement best practices for referrals from primary care to specialty areas will be undertaken. This will prevent people whose care could be managed within a medical home from being put in the lines of those waiting for specialty care.

Once referral guidelines and procedures have been established, specialty specific methods to enhance support for primary care providers will be identified. Possible solutions could include:

- Identifying a mid-level provider that could rotate sites to provide specialty focused clinics—such as injection clinics for orthopedics—or services within community based sites to assist with continuity of care, or
- Purchasing specialists' time to provide consults—via phone or telemedicine—to primary care providers on a regular basis to assist with determining next steps in care. This option could provide an initial introduction for the patient to the specialist, expedite care decisions, and enhance collaboration between critical system providers.

Expand access to care

For Year 1, specialty care expansion work is focused on increasing access to care through DSRIP-funded projects and non-DSRIP contracted services.

DSRIP projects

The CCC has two specialty care expansion DSRIP projects—gastroenterology, specific to Hepatitis C, and pulmonology. The CCC is contracting with CommUnityCare for both of these projects.

For Year 1, both of these projects are focused on:

- Hiring additional providers
- Expanding access to these services in community clinics
- Training CommUnityCare providers and staff on how to refer patients to new clinics
- Increasing the number of clinic visits

Non-DSRIP projects

The CCC is planning the expansion of services in the five identified specialty areas that have the longest wait times. These specialties include: gastroenterology, neurology, orthopedics, rheumatology and urology.

The goal is that between the demand management work and expansion of services that the third next available appointment time for these specialties could be significantly reduced, with a goal of no more than 60 days wait.

SPECIAL NEED FOR SPECIALTY CARE

There is an urgent need to expand access to specialty care services for the Community Care Collaborative's target population. The CCC is targeting seven specialty fields for expansion and enhancement within the next fiscal year. The net desired result is to significantly decrease wait times for the next available appointment.

GOALS

MANAGE DEMAND

Specialty clinics can become overwhelmed with patient demand as a result of unnecessary referrals. The CCC will work with primary care providers and specialists to create evidence-based referral strategies. Primary care providers will also receive the support needed to provide the appropriate care. This will help ensure patients receive as much care as appropriate within their medical home.

EXPAND ACCESS

The availability of many specialty care services is insufficient to ensure timely patient care. The CCC's goals for specialty care include hiring more providers, increasing the number of available clinic appointments and expanding access to specialty services at community clinics.

Appointment days available per month	Specialty	Days until third next available appointment
7	CARDIOLOGY	38
4	ENDOCRINOLOGY	52
4	GASTROENTEROLOGY	156
11	NEUROLOGY	365+
8	ORTHOPEDICS	365+
12	RHEUMATOLOGY	365+
4	UROLOGY	365+

7 | HEALTH INFORMATION TECHNOLOGY (HIT)

Health information technology (HIT) is the umbrella term describing the management of health information and the technology tools used by health care professionals in the delivery of care and system planning.

HIT Principles

To continue work on a health information technology (HIT) platform, including:

- Launch patient navigation software, provide access to a centralized community resources directory, and launch a patient portal to serve the CCC population;
- Deliver analysis projects for IDS planning and support of DSRIP projects;
- Complete collaboration projects to strengthen the technical capabilities of IDS participants; and
- Continue to improve data feeds that can support all other technology initiatives—particularly the "One Button" concept to bring a patient's longitudinal record to the point-of-care.

HEALTH INFORMATION TECHNOLOGY

Providing the digital platform for more and better health care

Health information technology, or HIT, provides the tools to effectively share individual and population across a spectrum of users. The CCC's integrated delivery system will rely on the development of new and innovative HIT data to ensure patients receive the best possible care, regardless of the provider.

FOUR FOCUSES OF HEALTH IT

The CCC has broken down its HIT priorities into four areas, each with a clear focus on improvement.

PATIENT NAVIGATION AND ENGAGEMENT

Health providers and patients need user-friendly tools to navigate the continuum of health care services. These tools will allow for direct messaging between patients and care team members; referral systems between providers; a community services directory of social services; and patient portals to allow better access to their own health care information.

BUILD DATA COMMUNICATION

Health care providers need to be able to access and share patient information to provide the best level of care. This area will focus on developing feeds that can be easily accessed across a variety of software platforms.

COLLABORATION

This area of work will focus on projects to ensure health care providers' respective HIT systems can work in concert with one another with a legal structure for sharing data.

ANALYTICS AND RESEARCH

The CCC will rely on data gathered from patients and health care providers to make decisions on the future of health care, such as where to locate new health care infrastructure, what services are most needed, and which are the most cost effective models.

Patient navigation and engagement

Our goals are to drive the launch of patient navigation software, provide access to a centralized community services directory, and launch a patient portal capable of serving the entire CCC population.

This workstream is made up of many smaller projects. A core navigation system—"Mini-Nav"—will allow navigators to view a timeline of a patient's navigation touch-points, manage task lists, add/update/delete information, and document patient consent.

Additional navigation features will be developed in Mini-Nav or as software add-ons for external systems. These additional modules will include:

- Secured messaging: allows navigators, patients, and care team members to securely message each other;
- Referral management: allow for easy referral between users, including clinical use cases (clinic and specialty appointment requests) and related population health care functions (dietitian, food bank, legal aid, etc.);
- Community resources directory (CRD): provides a clear directory to all users that displays the menu of services a particular patient is eligible for based on their location, needs, and financial status;
- Reminders/alerts: drives alerts and reminders to users via text message and/or email; and
- Integration into external systems, including:
    - Community Health Information Exchange (iCare) will input data into the patient navigation database, rolling up electronic health record data from IDS participants
    - Other navigation source systems will both input and export data from the patient navigation database
    - A patient portal will also be developed to allow patients to access their information and update as appropriate.

This workstream may also include smaller projects related to engaging patients and navigators, such as mobile applications and device integration. Our focus over the next eighteen months is on foundation systems, but research for future projects will also take place.

Projected Deliverables

This workstream is a multi-year initiative, which has been divided (and then prioritized) by the CCC Navigation Steering Committee into more than 15 functional areas. The list below represents major deliverables in the next 18 months:

- *Community resources directory pilot release*—limited release to a pilot audience
  Estimated date: August 2015
- *Patient portal pilot release*—limited release of the software to a pilot audience
  Estimated date: September 2015
- *Mini-Nav pilot release*—limited release of the software to a pilot audience
  Estimated date: January 2016
- *User adoption plan*—plan for rolling out the software to users
  Estimated date: February 2016
- *Software and application governance*—provide clarity for other systems to plug into the navigation database
  Estimated date: May 2016
- *Operations plan and roadmap*—details of who will administrate the system, operational responsibilities, and future plans for updates
  Estimated date: July 2016

Build data communications—the "One Button" concept

Our goal is to improve the timeliness and extent of data feeds that can support all other technology initiatives—particularly the "One Button" concept to bring patients' longitudinal record to the point-of-care.

This workstream has many task areas, including to:

- Review and improve the Integrated Care Collaboration, or ICC, iCare community health information exchange (HIE) platform by:
    - Improving modularity and robustness so that the components of the HIE can be scaled to support CCC projects
    - Analyzing where areas of the HIE technology can be replaced by less expensive modules to support better sustainability
    - Increasing knowledge of leading-edge methods for interoperability
- Explore options and establish an interface between the Seton/Ascension and ICC health information exchanges so the systems can query each other for data;
- Establish quality control tools to ensure that we know when a data-flow issue exists and procedures to correct these issues;
- Build a prototype system to show IDS participants how to plug into the HIE directly so other systems can pull data into their workflow.

This workstream may also include smaller projects related to connectivity to other IDS participant systems including regional, state or federal HIEs.

Projected Deliverables

This workstream is a multi-year initiative, focused initially on the stabilization and improvement of the iCare community HIE and data integration into the Seton private HIE, CCC data warehouse, and CCC patient navigation database. The list below represents major deliverables in the next 18 months:

- *Architecture plan*—complete evaluation of the iCare HIE and make recommendations on improvements
  Estimated date: June 2015
- *Connectivity pilots*—incrementally roll out connectivity to IDS participants
  Estimated dates: February-June 2016
- *Operations plan and roadmap*—details who will administrate the system, operational responsibilities, and future plans for updates
  Estimated date: July 2016

HIT collaboration of systems

Our goal is to complete collaboration projects to strengthen the technical capabilities of IDS participants, pilot basic data-exchange initiatives, strengthen community data feeds, and advance the legal framework for data sharing.

This workstream includes operational, policy, and outreach work to IDS participants. This complements our work in the streamlined communications area. In that area we are trying to improve the "plumbing" between systems used by IDS participants. This work represents improvements made to those source systems and other activities to ensure organizations adopt the plumbing.

Task areas include:

- Work with IDS participants to improve their internal technical capabilities, including group technical training events, and help in hiring/interviewing technical staff
- Provide collaboration systems to CCC staff. These systems are developed in concert with Central Health or Seton so that they have an infrastructure home
- Provide assistance to improve data-feeds into the HIE, specifically with CCC participants
- Analyze policies and establish governance for systems including how users onboard to any CCC system and what governs their usage/connectivity
- Carry out technology pilots to begin sharing data while we build the long-term systems in parallel. These incremental/small projects are critical to reveal issues with the data and establish new operational procedures as early as possible

Projected Deliverables

This workstream is a multi-year initiative, focused initially on small projects to encourage collaboration and strengthen technology capabilities. Long-term, this stream strengthens legal, policy, and governance agreements. The list below represents major deliverables in the next 18 months:

- *Expand ED follow up pilot*—expand the reach of the emergency department follow up project to include all primary care participants in the ICC
  Estimated date: May 2015
- *Governance and user adoption planning*—establish methods for what policies, training and procedures are needed to get users onboarded to new CCC systems
  Estimated dates: Varies by deadlines
- *Implement pilots*—this work is where we explore and deliver pilot projects one or two at a time. We are targeting completing five to seven projects per year
  Estimated dates: May 2015 and ongoing

HIT analytics and research

Our goals are to deliver analysis projects for IDS planning and support of DSRIP projects, finalize the CCC data analytics and research architecture, and launch tools focused on performance metric tracking, geographic utilization, and chronic care analysis.

Within this workstream, we have two main types of work:

- Build the new CCC data platform, which can be divided into three tiers of functionality:
  - Source/Import: create feeds as needed from individual data sources and aggregate data sources, such as iCare
  - Quality and formation: match data elements around the Master Patient Index (MPI) and take specified steps to verify it is high-quality
  - Outputs: purchase and customize tools for viewing the data
- Deliver data analysis tasks with current procedures and convert into using new tools as the platform is implemented

This workstream has significant dependence on our tasks to evaluate, improve, and connect the iCare community HIE. The more data we can pull from the ICC, the less we have to pull ourselves.

Projected Deliverables

This workstream is a multi-year initiative, focused initially on acquiring data from IDS participants and performing analysis to support IDS planning. As we move through the next 18 months, we shift our priority to building a new data platform. The list below represents major deliverables in the next 18 months:

- *Release plan*—document selected vendors, the work each is responsible for, and the software release plan of the CCC data platform
  Estimated date: May 2015
- *Metrics dashboard*—launch a limited pilot of a dashboard tool focused on integrating key IDS and DSRIP metrics
  Estimated date: June 2015
- *Operations plan and roadmap*—details who will administrate the system, operational responsibilities and future plans for updates
  Estimated date: July 2016

8 | BENEFIT PLAN REDESIGN AND ENHANCEMENT

The benefit program outlined below provides a high-level comprehensive method to serve the safety net population of Travis County.

Covered Population

The CCC covered population for purposes of benefit plan design may include anyone living in a Travis County household with a household income less than 375 percent of the federal poverty level (FPL) who does not have access to another benefit plan. However, we are working now to determine whether this goal is financially feasible, and if not, we will reconsider this approach. For those eligible for another form of coverage, including an Affordable Care Act (ACA) Marketplace plan or Medicaid/Medicare, benefits will only be provided as a bridge plan until enrolled in the available plan. The CCC will also offer financial support for those who enroll in coverage but do not have the financial means to meet premium, copay or deductible payments.

Benefits available to the CCC covered population

Today safety net health care coverage is provided by a variety of sources in Travis County. The available programs are:

Medical Access Program (MAP): Travis County residents who make less than 100 percent of FPL with no access to care from another benefit program are eligible. Central Health funds these benefits and operates an outreach, eligibility and enrollment department to administer the program.

Sliding fee scale (SFS) and charity care: Central Health and Seton Healthcare Family offer versions of SFS/charity care programs for Travis County residents ineligible for MAP. Other safety net providers also offer SFS programs that reduce costs to patients. These plans, which are managed independently, have varying eligibility and enrollment processes and criteria.

Financial assistance: Central Health and Seton are collaborating on premium assistance programs for select populations enrolled in the Marketplace.

These benefits will be included in the new benefits proposal. There will be continued community advantages from ensuring people are enrolled in other benefit programs outside of the CCC (Marketplace, Medicaid, etc.).

Proposed Benefit Design Structure

The major design elements of the proposed benefit plan structure are outlined below. Benefits will be provided based on medical need rather than financial status. However, enrollees will be screened for financial eligibility, and costs to the patient will be based on their household financial situation (i.e. percent FPL).

- *Tier 1—Health and Wellness*
  No ongoing uncontrollable medical condition
  Benefits: pharmacy, primary care, wellness checks, age-appropriate cancer screening, behavioral health screening
- *Tier 2—Chronic Disease*
  Ongoing medical condition such as diabetes; not well controlled
  Benefits: medical testing/diagnostics, specialty care, hospital and emergency care, post-acute care, care coordination
- *Tier 3—High Utilizers (two or more chronic conditions)*
  Ongoing medical conditions; not well controlled and require specialized care
  Benefits: Same as Tier 2 but with a higher level of care coordination