Community Care Collaborative Strategic Planning, 2018-2020

Vision	A healthcare delivery system that is a national model for providing high quality, cost-effective, person-centered care and improving health outcomes for the vulnerable population we serve.
Values	Our work is governed by the values of innovation, person-centeredness, equity, accountability, and collaboration.
Mission	Optimize the health of our population while using our resources efficiently and effectively.

Three Year Mission Metric 1:	Quality of life and longevity
Three Year Mission Metric 2:	Cost of care

Three Year Activities & Associated Indicators

STRATEGIC FOCUS 1	STRATEGIC FOCUS 2	STRATEGIC FOCUS 3	STRATEGIC FOCUS 4
BUILD AN INTEGRATED DELIVERY SYSTEM	**REDESIGN COVERAGE PROGRAMS**	**IMPROVE VALUE IN CARE**	**OPTIMIZE HEALTH OF COVERED POPULATION**
Ensure access to appropriate services for enrollees, while enhancing care coordination and continuity of care.	***Redesign local coverage programs (Medical Access Program, Sliding Fee Scale, Seton Charity Care), eligibility rules and covered services to better serve residents for whom the CCC is responsible.***	***Use primary care setting to support value, contracting with partners for better patient outcomes, including maintaining wellness and optimizing the health of chronically ill patients; improve value within specialty care while reducing time to diagnosis and appropriate treatment.***	***Improve health outcomes for the patients for whom we care.***
1. Launch unified payment and associated programming.	**1. Expand coverage programs to more of population for whom partners currently pay for care.**	**1. Work with partners including Dell Medical School to develop, test and launch innovative and transformative initiatives for system of care.**	**1. Require annual Health Risk Assessment for all patients leading to protocol-driven Comprehensive Plan of Care.**
2. Develop IT platform that includes all data from sites of care and different service types, and is accessible to all appropriate providers.	**2. Design patient financial responsibility to induce appropriate utilization of healthcare system.**	**2. Develop competitive contracts that pay for outcomes that matter to patients.**	**2. Reduce incidence and improve management of chronic diseases, including diabetes, CHF, COPD, renal disease, liver disease.**
3. Add access to necessary services through expanded partnerships.	**3. Design benefit package that optimizes wellness for chronically ill patients and maintains wellness for healthy people.**	**3. Develop competitive contracts that incentivize use of the whole care team.**	**3. In conjunction with partners, including the Livestrong Institute at DMS, create and launch plan to offer improved cancer care to CCC population.**
4. Better connect hospital services to primary care homes.	**4. Adapt eligibility and enrollment experience to bring value to the patient and ensure patient and system engagement.**	**4. Encourage, empower, and enable primary care physicians to manage specialty care issues within primary care setting; encourage appropriate utilization and reward high-value care.**	**4. Collaborate with community partners to ensure provision of women's health services.**
5. Optimize system Case Management, Medical Management and Utilization Management functions.	**5. Increase engagement with patients to identify, address and improve the outcomes that matter to covered population.**	**5. Improve access to and quality of specialty care services that our patient population needs.**	**5. Improve delivery of behavioral health, prevention, and dental services.**

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Approved by Central Health board
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