Community Care
COLLABORATIVE

Board of Directors

Meeting

Tuesday, October 22, 2013

2:00 p.m.

Central Health Administrative Offices

1111 E. Cesar Chavez St.

Austin, Texas 78702

AGENDA*

I. Call to Order and Record of Attendance

II. Public Comments

III. General Business

A. Consent Agenda

All matters listed under the Consent Agenda will be considered by the Board of Directors to be routine and will be enacted by one motion. There will be no separate discussion of these items unless members of the Board request specific items to be moved from the Consent Agenda to the Regular Agenda for discussion prior to the time the Board of Directors votes on the motion to adopt the Consent Agenda.

1. Approve minutes from the September 10, 2013 CCC Board of Directors meeting.

B. Regular Agenda

1. Announce appointment of the Advisory Committee Chair.
2. Announce appointment of Jeff Knodel to replace Juan Garza on the CCC Board of Directors.
3. Present and discuss new CCC logo.

4. Discuss and take appropriate action on the CCC Strategic Plan Mission, Vision, Values, Foundational Elements, and Goal Statements.

5. Discuss and take appropriate action on a new CCC Three-Year DSRIP Project.

6. Present and discuss CCC Financial Statements as of September 30, 2013.

IV. Closed Session

V. Closing

**The Board of Directors may take items in an order that differs from the posted order.*

The Board of Directors may consider any matter posted on the agenda in a closed session if there are issues that require consideration in a closed session and the Board announces that the item will be considered during a closed session.

Consecutive interpretation services from Spanish to English are available during Citizens Communication or when public comment is invited. Please notify the front desk on arrival if services are needed.

Los servicios de interpretación consecutiva del español al inglés están disponibles para la comunicación de los ciudadanos o cuando se invita al público a hacer comentarios. Si necesita estos servicios, al llegar sírvase notificarle al personal de la recepción.

Community Care
COLLABORATIVE

Board of Directors Meeting

October 22, 2013

AGENDA Item III-A-1

Approve minutes from the September 10, 2013
CCC Board of Directors meeting.

NO BACKUP

Community Care
COLLABORATIVE

Board of Directors Meeting

October 22, 2013

AGENDA Item III-B-1

Announce appointment of the Advisory Committee Chair.

NO BACKUP

Community Care
COLLABORATIVE

Board of Directors Meeting

October 22, 2013

AGENDA Item III-B-2

Announce appointment of Jeff Knodel to replace Juan Garza on the CCC Board of Directors.

NO BACKUP

Community Care
COLLABORATIVE

Board of Directors Meeting

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AGENDA Item III-B-3

Present and discuss new CCC logo.

NO BACKUP

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Board of Directors Meeting

October 22, 2013

AGENDA Item III-B-4

Discuss and take appropriate action on the CCC Strategic Plan Mission, Vision, Values, Foundational Elements, and Goal Statements.

Proposed Initial Strategic Plan for the Community Care Collaboration (CCC)

Proposed Vision (Desired End State):

A healthcare delivery system that is a national model for providing high quality, cost-effective, person-centered care and improving health outcomes

Proposed Mission (How to reach Vision):

Create an integrated healthcare 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

Foundational Elements and Goal Statements:

To more effectively and efficiently serve its target population, the CCC is committed to creating an integrated delivery system that demonstrates –

- Person-Centered and Population-Focused Care Delivery
- Clinical Integration and Care Coordination
- Continuous Quality Improvement and Innovation
- Continuity of Information
- System Alignment and Accountability

CCC Values:

- *Person Centered:*
  - We are responsive to the needs and interests of the people we serve.
- *Accountable:*
  - We are responsible to our patients, our partners and the public.
- *Innovative:*
  - We encourage new ideas and creativity at every level of the organization.
- *Collaborative:*
  - We partner to improve the delivery of care and health outcomes for people we serve.
- *Adaptable:*
  - We are flexible and resilient.

CCC High-Level Strategic Plan FY14-FY19

Foundational Element	Goal Statement	Strategy(ies)	Measures
Person-Centered and Population-Focused Care Delivery	Provide person-centered and population-focused care by creating a system that facilitates timely access to appropriate care, keeps the individual at the center of care planning and treatment, provides care in a culturally competent manner, and continually uses system data to proactively improve the health of populations.		

Foundational Element	Goal Statement	Strategy(ies)	Measures
Clinical Integration and Care Coordination	Treat the whole person by facilitating access to an effective range of care services, providing care in the most appropriate setting, establishing team-based care homes, and efficiently coordinating care between service locations.		

Foundational Element	Goal Statement	Strategy(ies)	Measures
Continuous Quality Improvement and Innovation	Ensure the effectiveness/quality of healthcare services by implementing a clear, well-developed Continuous Quality Improvement framework, establishing evidence-based protocols and guidelines, and empowering all members of the care team to employ innovative strategies to enhance individual care experience and improve outcomes.		

Foundational Element	Goal Statement	Strategy(ies)	Measures
Continuity of Information	Improve care delivery by designing and implementing an effective health information exchange (HIE) that supports easy and timely access to individual and system-level data in order to inform point-of-care decisions, track health outcomes, and evaluate effectiveness of services.		

Foundational Element	Goal Statement	Strategy(ies)	Measures
System Alignment and Accountability	Establish the foundation for a leading edge, integrated healthcare delivery system through comprehensive strategic, financial, and operational planning, system-wide alignment with goals and strategies, dedication of sufficient resources, and demonstration of accountability.		

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AGENDA Item III-B-5

Discuss and take appropriate action on a new CCC Three-Year DSRIP Project.

Three Year DSRIP Project Summary

CenteringPregnancy Program

The Community Care Collaborative

General Information

- ***African American*** *women have* ***significantly worse birth outcomes*** *than their Caucasian or Latina counterparts. This is true nationally, in Texas, and* ***in Travis County****.*
- *This project will provide* ***group-based prenatal care*** *and education to at least* ***170 low-income African American*** *women in Travis County via the* ***CenteringPregnancy*** *model.*
- *CenteringPregnancy provides women close together in gestational age with* ***10 two-hour group sessions****, and* ***individual meetings*** *with their ob-gyn provider worked into meeting time.*
- *Sessions include* ***facilitated discussions*** *of topics related to* ***pregnancy, birth and newborn care*** *as well* ***overall health and self-management****, handling stress, and relationships.*
- *Program outcomes include: increased* ***rate and duration of breastfeeding****; improved* ***patient satisfaction****; increased* ***birth weights****, and reduced* ***preterm births****.*
- *The* ***preterm birth rate*** *is the selected* ***Category 3*** *outcome.*

Community Need

- *RHP 7 CNA: "Compared with Hispanic and White mothers,* ***Black mothers*** *... have more than* ***twice*** *the rate of* ***low birthweight*** *babies and* ***infant mortality.***"
- ***CN 12****: Lack of adequate prenatal care*
- *Complements Seton OB* ***Navigation****, City of Austin* ***MIOP*** *and* ***Healthy Families*** *DSRIP Projects*
- *Provides* ***prenatal group*** *and* ***clinical care*** *that is* ***not included*** *in existing or proposed projects*

Patient Impact by Demonstration Year

Quantifiable Patient Impact	DY 3	DY 4	DY 5	Total
Total Medicaid/Uninsured	20	50	100	170 patients
Total Served in Project	20	50	100	170 patients
% Medicaid/Uninsured	100%	100%	100%	100%

System Transformation and Likelihood of CMS Approval

- *CenteringPregnancy achieves the triple aim: improves **health outcomes**, reduces the **cost of care**, and increases **patient satisfaction**.*
- *CMS just **awarded** over $4m in "Start Strong" grants to new **CenteringPregnancy** sites.*
- ***100%** of the women served will be **low-income Medicaid** or **un/underinsured**.*
- *Project addresses a **glaring health disparity** within our community with a **proven intervention** that can be replicated elsewhere.*

RHP 7 PROPOSED NEW 3-YEAR DSRIP PROJECTS

3YR Project Short Form – ***UPDATED 10/3/13***

Performing Provider Name, TPI: Community Care Collaborative. 307459301

Category 1 or 2 Project Option: 2.7.3: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.

Brief Project Description:

The preterm birth rate among African-Americans in central Texas mirrors the national rate, at about 16.8% births occurring before 37 weeks, compared to 10% for the White population. Preterm birth is highly correlated with low birth weight, infant mortality, and long-term disability; in Austin, African-Americans represent only 8% of births, but 14% of admissions to the NICU, and have a rate of infant mortality 2.5 times higher than Whites and Hispanics. (DSHS data) This disparity in birth outcomes is not only a pressing social justice issue, but also has a significant medical-economic impact.

This initiative will implement a *CenteringPregnancy* program tailored to meet the unique needs of the African American population. *CenteringPregnancy* is an evidence-based, multifaceted model of prenatal care that integrates three major components of care: health assessment, education and support. Following the IOM Rules for Healthcare Redesign, *CenteringPregnancy* offers these components in a unified program within a group setting designed to empower women to choose health-promoting behaviors and improve health outcomes for pregnancy. *CenteringPregnancy* care starts around the beginning of the second trimester and goes through delivery. Eight to twelve women with similar gestational ages meet together, learn care skills, participate in a facilitated discussion, and develop a support network with other group members. Specific topics covered in the group sessions will include: the importance of breast-feeding; finding social supports; birth spacing and contraceptive options. The practitioner, within the group space, completes one-on-one standard physical health assessments. Each Pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum.

Project Goals:

1. Enroll 170 women into the *CenteringPregnancy* program.
2. Reduce the preterm birth rate in our African American cohort.
3. Improve satisfaction with prenatal care by creating a patient-centered experience unique to the needs of the African American population.
4. Create an evidence-based curriculum for *CenteringPregnancy* specific to African Americans which can be disseminated nationwide through the Centering Healthcare Institute, in the hopes of improving outcomes on a national level.

IGT Entity (*please attach written confirmation from IGT Source*): Central Health

Valuation

	Category 1 or 2 Valuation	Category 3 Valuation	Total

3YR Project Short Forms due to sarah.cook@centralhealth.net by COB Friday October 11th.

DY 3	667,643	74,182	741,825
DY 4	1,018,364	179,711	1,198,075
DY 5	1,281,751	631,310	1,913,061

Description of Community Need(s) Addressed (Include Reference Number from the CNA Needs Table):

CN.12- lack of adequate prenatal care

Target Population:

Pregnant African American women who are on Medicaid or are low-income uninsured.

Anticipated Medicaid and Un/Underinsured Population Impact by DY:

- DY3: 20 enrollees
- DY4: 50 enrollees
- DY5: 100 enrollees

Category 1 or 2 Expected Patient Benefits:

170 pregnant African-American women will receive care under the model.

Category 3 Outcome(s):

[IT-8.12] Pre-term birth rate: decrease the percent of births delivered preterm (singleton live births delivered with less than 37 completed weeks of gestation).

Relationship (if any) to:

Provider's existing DSRIP projects

- *None*

Other existing DSRIP projects in RHP 7

- 137265806.2.1 – University Medical Center Brackenridge - OB Navigation
- 176692501.1.1 - St. Mark's Medical Center - Expanding Access to Specialty Care (Obstetrics)
- 201320302.2.4 – City of Austin Health & Human Service Department - Prenatal & Postnatal Improvement Program
- 201320302.2.5 - City of Austin Health & Human Services Department - Healthy Families Program Expansion

This project can be implemented immediately upon CMS approval:

Check one:

Yes	**YES**
No	

Include the number and description of the Improvement Milestone from the Category 1 or 2 menu you will implement in DY 3: I-5: Identify number or percent of patients in target population receiving innovative intervention consistent with evidence-based model.

3YR Project Short Forms due to sarah.cook@centralhealth.net by COB Friday October 11th.

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October 22, 2013

AGENDA Item III-B-6

Present and discuss CCC Financial Statements as of September 30, 2013.

Community Care Collaborative

Financial Statement Presentation
FY 2013 – as of September 30, 2013

CCC Board of Directors

OCTOBER 22, 2013

Community Care COLLABORATIVE

General

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- **Preliminary financial statements**
  - Amounts subject to change
  - September 30th – end of fiscal year 2013
  - Four months of operations – June 1 – Sept 30, 2013
  - Audited financial statements as of September 30, 2013 to be produced

Balance Sheet

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Assets	
Current Assets	
Cash & Cash Equivalents	13,399,444
Total Current Assets	13,399,444
Total Assets	13,399,444
Liabilities	
Short-term Liabilities	
Accounts Payable	1,005,703
Total Short-tem Liabilities	1,005,703
Total Liabilities	1,005,703
Net Assets	
Total Net Assets	12,393,741
Liabilities and Net Assets	13,399,444

Budget vs. Actual *(preliminary)*

As of September 30, 2013

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	Amended Budget	*Estimate*	*Preliminary Actual*
Sources			
DSRIP Revenue	8,994,823	8,994,823	8,994,823
Seton Indigent Care Payments	17,000,000	17,000,000	17,000,000
Central Health Indigent Care Payments	3,578,889	3,578,889	3,578,889
Total Sources	29,573,712	29,573,712	29,573,712
Uses - Programs			
Healthcare Delivery	20,578,889	16,824,796	15,759,136
DSRIP Project Costs	8,994,823	2,230,000	1,420,835
Total Uses	29,573,712	19,054,796	17,179,971
Ending Balance	0	10,518,916	12,393,741

Highlights

1. *Total sources at Budget*
   - *DSRIP DY1 Revenue*
   - *Both Seton and Central Health Indigent Care Payments at budget*
2. *Uses*
   - *Healthcare Delivery approx. $1m less than estimate*
   - *DSRIP Project costs $800,000 less than estimate*
     - *A portion of project management costs will be paid in FY 2014*
     - *Fewer DY2 DSRIP contracts than estimated*
3. *Anticipate $12.5 m as beginning operations contingency in FY 2014*

Healthcare Delivery *(preliminary)*

As of September 30, 2013

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	Amended Budget	Estimate	Preliminary Actual
Uses - Healthcare Delivery			
Provider Contract Services	$ 16,824,796	16,824,796	15,759,136
Operations Contingency	3,654,093	0	0
Service Expansion Funds	100,000	0	0
Total - Healthcare Delivery	$ 20,578,889	16,824,796	15,759,136

Highlights

1. Provider Contract Services

Provider	Amended Budget	Prelim Actual
CommUnityCare	12,964,584	12,964,584
Lone Star Cir of Care	1,091,248	1,097,921
El Buen	1,404,400	546,764
Paul Bass Continuity	236,549	128,728
Paul Bass Specialty	154,000	37,908
Blackstock	87,348	89,995
Insure-a-kid	11,667	16,260
Sendero	875,000	875,000
Other		1,976
TOTAL	16,824,796	15,759,136

DSRIP Project Timelines

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Questions? Comments?