CENTRAL HEALTH

Performance Assessment conducted by

Germane SOLUTIONS

&

whitecap HEALTH ADVISORS

with Communications/Outreach support provided by:

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1. INTRODUCTION

Disclaimer: The findings, recommendations and other opinions expressed by the consulting team are related solely to the operational effectiveness of Central Health. This report and the consulting team did not (and cannot) determine the legal, regulatory or other issue beyond the scope of operational effectiveness.

Central Health is a hospital district established under Chapter 281 of the Texas Health and Safety Code in 2004, pursuant to an election by Travis County voters. Central Health's primary goal is to provide healthcare services to eligible residents who are at or below 200% of the Federal Poverty Level. The nine-member volunteer Board of Managers ensures that the funding base of more than $240M annually is deployed to meet the healthcare needs of the most vulnerable. Central Health serves more than 140,000 unique residents. Central Health's mission statement is "By caring for those who need it most, Central Health improves the health of the community."

In April 2017, Central Health issued a Request for Proposal seeking consulting services to evaluate the effectiveness and efficiency of the organization and make recommendations about opportunities for performance improvement. After a rigorous selection process, Germane Solutions (Germane), a national healthcare consulting firm with significant experience working with public health systems, was chosen to complete the requested engagement. Germane initiated the work in July 2017, and this report represents the culmination of those efforts.

Before delving into the methodologies that underpin this report, it is critical to note that Central Health is a relatively unique hospital district when compared to similar systems across the country. This is due to its creation with the objective of largely supporting the delivery of care through partnerships – prioritizing dollar deployment on the development of clinical programs instead of seeking to build, own and operates its own healthcare platform through the construction and management of bricks-and-mortar assets. While Central Health owns and manages the facilities of over 20 clinics through its public entity model Federally Qualified Health Center, along with assets related to the University Medical Center Brackenridge campus, hospital services and other ambulatory services are delivered through partnerships.

Central Health's Partnership Model Central Health's partnership model can best be described as a multi-tiered system of relationships. Within the first tier are three entities, which are referred to as members of the Central Health's "Enterprise." These are the entities that collectively provide the majority of Central Health-directed healthcare services to the community. Central Health exercises a level of influence over the governance of all three entities, as well as influence their strategic direction and operations based on Central Health's mission:

- **Community Care Collaborative (CCC)**

  The CCC is a separate 501(c)(3) corporation established through a partnership between Central Health and Seton Healthcare Family (SHF) to provide a framework for implementing the Texas 1115 Medicaid Waiver and to serve as an Integrated Delivery System (IDS) for the provision of healthcare services to the uninsured and underinsured populations of Travis County:

- **CommUnityCare (CUC)**

  CUC is Central Health's affiliated Federally Qualified Health Center (FQHC) system, structured as a co-applicant model, that provides the majority of CCC ambulatory care. With over 20 locations in Travis County, it is one of the largest FQHC systems in the United States. Although Central Health does not intend to provide the CUC with direct funding in FY18, Central Health performs Human Resources, Information Technology and facilities management functions for CUC and owns a number of CUC's clinical assets.

- **Sendero Health Plan (Sendero)**

  Sendero, created in 2011, is a community-based health maintenance organization (HMO) that Central Health uses to coordinate healthcare services and enhance the provider network for Medicaid STAR and CHIP programs. Sendero is also a Qualified Health Plan under the Affordable Care Act that offers individual plans through the Health Insurance Marketplace.

Central Health's second tier of partners known as "Affiliated" partners consists of external organizations that have executed affiliation agreements with Central Health, and indirectly receive funding from Central Health via its Enterprise members and supplemental Medicaid funding. These organizations include Seton Healthcare Family (SHF), The Dell Medical School at The University of Texas at Austin (DMS), and St. David's Healthcare.

Central Health has additional partners that receive funding for the provision of direct healthcare services from Central Health and/or its enterprise and affiliate members. These organizations include but are not limited to Integral Care (IC), Lone Star Circle of Care (Lone Star) and the United Way.

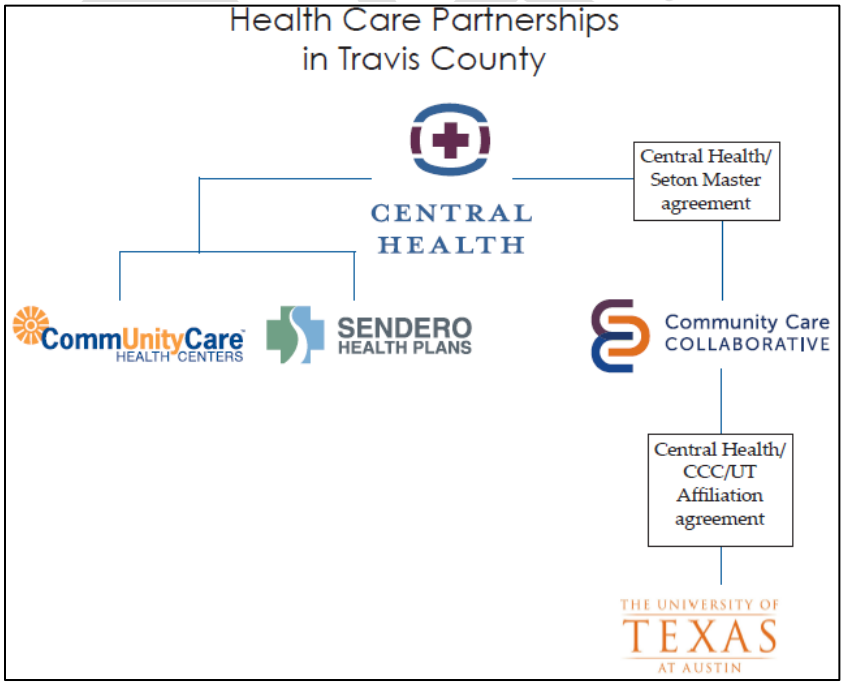


Figure 1: Central Health's Partnership Structure

Because of Central Health's unique operating structure, an assessment focused solely on the core Central Health entity would not truly evaluate the organization's performance in areas like access, population health and open communication with the public. Therefore, we extended the scope of our project to include an evaluation of the operational effectiveness Central Health's Enterprise and Affiliated partners within the area of their ongoing interactions with Central Health. Additionally, to gain the full picture of Central Health's involvement with providing healthcare within the Austin Community, we also included information gathered from non-affiliated or enterprise partners but did not extend the performance evaluation to these entities as they are independent organizations from Central Health.

2. EXECUTIVE SUMMARY WITH FINDINGS

This performance assessment for Central Health, initiated in July 2017, utilized information gathered through stakeholder interviews, internal data assessments, and peer benchmarking analyses to populate Germane's Assessment Tool that helped identify areas of strength and opportunities for improvement for the organization across six key domains: Access, Planning, Communications/Outreach, Population Health, Organizational Governance and Funds Flow.

Overall, Central Health is a well-functioning hospital district that compares favorably to similar systems across the country. However, there are several key areas where Central Health has opportunities to improve performance significantly. Those findings are summarized below, with substantially more detail regarding each provided in the Internal Assessment section later in this report.

1. **The public-private partnership model embraced by Central Health does come with some tradeoffs, and continued dialogue may be needed to articulate its effectiveness in fulfilling community priorities.**

- Central Health is a hospital district that has chosen to deliver services through a partnership model. This has allowed it to be very efficient in terms of expense management, providing a wide range of services while maintaining one of the lowest tax rates in the State. However, there is a trade-off associated with this model, in that Central Health delegates control over care delivery to its partners, which can limit Central Health's ability to make immediate changes to its service portfolio or communicate potential changes in advance to the community.
- There is confusion among constituents regarding the actual relationship between Central Health and its various "Enterprise" and "Affiliated" partners. Central Health needs to ensure that that the community understands its role as the "hub" of a broad network of care – so that the community recognizes the value it provides through its network. A marketing strategy similar to the "Intel Inside" campaign may be needed.
- Since Central Health provides many of its services through partnerships, it has some limitations in terms of its level of control and visibility into how those funds are deployed by its partners. In some cases, there are regulatory restrictions on Central Health's ability to "mandate" how funds transferred to its partners can be utilized. But there are no restrictions on Central Health's ability to demand transparency in terms of how it's funding is being used by its partners, which might help strengthen the alignment between the final use of these funds and Central Health's core mission.

- Ultimately, Central Health needs to encourage continued community dialogue as to whether the current public-private model, or a model which encourages more direct control over care delivery, best meets the community's needs moving forward. And if the community determines that the current public-private model should continue, then Central Health needs to do a better job of communicating its value and working with its partners to introduce an enhanced level of transparency in how its funds are deployed.

2. **There is a significant need for Central Health to have a more defined plan to address physician shortages, particularly related to specialty care.**

- Metro Austin is one of the fastest growing major cities in the country, adding new population at a rate of more than 2% annually. This level of growth tends to put a strain on the existing healthcare infrastructure. As the number of potential patients increases in lockstep with population growth and aging, existing healthcare providers can be more selective about the patients they wish to treat… leading directly to a reduction in overall access for the most vulnerable population cohorts.

- Specialty care has been the most impacted by the supply-demand imbalance, and access to select specialty care for vulnerable populations in Austin is very limited. Patients experience long wait times – often into the months instead of weeks – to get appointments, and the availability of these specialists is often restricted to very few sites, which makes it difficult for patients with limited transportation options to access care even when it is available. While the gap between supply and demand of specialists is an issue across the country, the metro area's projected growth makes it far more critical for Austin. Central Health cannot just sit and wait for the supply-demand imbalance in specialty care to sort itself out, and needs to be more creative in findings ways to create new specialty access for its patients.

- A "make and buy" plan needs to be accelerated to help address the shortage. In the short term, Central Health needs to commit to creating more specialty care access through the use of Advanced Practice Professionals (APPs) and, when legally available, through the expanded use of technology (i.e. E-Consults). Longer term, Central Health needs to work with the city and other institutions to dramatically boost the number of providers in the metro area though initiatives that coordinate expansion of Graduate Medical Education (GME) programs that specifically address specialties with the greatest gap between supply and anticipated demand.

3. Minor changes to the governance and oversight structure for Central Health and the CCC would bring governance in line with best practice.

- Central Health has a solid governance model Its Board appropriately represents the diversity of its community, while still maintaining an excellent depth of healthcare specific knowledge. The lack of term limits for Central Health's Board of Managers is the only aspect of its governance structure that is not contemporary – which introduces the risk of an ineffective member adversely impacting the long-term success of Central Health, with limited avenues for removal. While it is important to note that the Travis County Commissioners Court and the Austin City Council ultimately appoint the Members and determines the term limits for the Members of the Board of Managers, Central Health should potentially raise this issue with the Commissioners Court and the Austin City Council in a future dialogue.

- From an oversight perspective, the one gap identified in the assessment of Central Health's governance model is the Board's limited ability to track the progress of approved initiatives without relying solely on management report-outs. Central Health needs to consider the development of a structured process for Board review of critical, new investments as well as a data-driven decision process to potentially defund existing initiatives.
- The overall strategic direction for Central Health is set at the Board level and communicated to its Enterprise and Affiliated partners, but due to the inherent strong relationships between partners, there are opportunities to improve the linkages between downstream planning and implementation efforts that occur at the entities that deliver care.
- Across Central Health and its Enterprise partners, the governance models largely reflect best practice. The one suggestion is to expand the current size of the CCC Board (5 members) to provide some flexibility if a key member is absent for unanticipated reasons and to broaden the perspectives around the table.

4. **Explore opportunities to diversify Central Health funding sources.**

- There remains continued scrutiny of, and confusion about, the role of Inter-Governmental Transfers (IGT) in optimizing local funding. It may be time for Central Health to simplify the IGT discussion by calculating the decrease in overall funding that would accompany an elimination of IGT, and the programs/services at Central Health that would have to be significantly curtailed or eliminated entirely as a result.
- While Central Health owns some clinical assets (UMCB campus property and some clinic sites), many of the sites through which it provides clinical services are owned by other entities. With a relatively narrow capital asset base, and a corresponding lack of reliance on fee-for-service reimbursement as a critical revenue source, Central Health has a unique opportunity to embrace the transition to fee-for-value care. This can be accomplished without worrying about the potential near-term detrimental impact to its financial viability – an advantage not shared by most of its peer hospital districts that were analyzed in the benchmarking exercise.
- Central Health has done a good job at trying to diversify its sources of funds away from relying exclusively on tax dollars, but there are certainly opportunities to increase funding from two areas – external grants and philanthropy/fundraising, both of which are relatively underdeveloped at Central Health when compared to its peers. To really support fundraising efforts, Central Health needs to consider setting up its own Foundation.

Other Findings:

- Central Health still lacks some of the "linking" infrastructure (i.e. processes and technology that can help provide smooth the transfer of care across partner entities) necessary to provide highly effective population health management. Examples of potential linking infrastructure for Central Health include upgraded EMR interfaces, and access to longitudinal patient data across partners.
- Central Health tracks the efficiency of its initiatives, but there is relatively limited benchmarking associated with its overhead functions. A quick assessment of Central Health's overhead model suggests that the institution is running fairly lean, which is likely impacting the institution's ability

to support new initiatives in areas like marketing and decision support. While the efficient use of overhead resources is always desirable, there is a minimum threshold below which there are diminishing returns.

- Central Health's social media efforts have a great amount of potential but are still relatively nascent in terms of development. Central Health's LinkedIn, Twitter and Facebook accounts are all surprisingly underutilized, with few followers and limited content when compared to the peer healthcare and hospital districts.

3. METHODOLOGY

The methodology for Germane's performance assessment of Central Health includes information gathered from multiple sources, all of which was then integrated into a proprietary Assessment Tool that helped identify and prioritize areas for improvement. A summary of each source of information and its overall purpose in the assessment is described in this section. Details regarding each are then provided in subsequent sections of this report.

- **Public input process including focus groups and secondary research:**
  - **Focus Groups:** Two different public meetings (one done in English, one in Spanish) in order to receive feedback directly from community members
  - **Extensive review of secondary research including patient surveys performed by Central Health:** We conducted an analysis of the previous patient satisfaction surveys conducted at CommUnityCare locations over the past two years to determine areas that need to be addressed by Central Health in the provision of care

- **Stakeholder Interviews**
  Germane had the privilege of interviewing more than 20 different Central Health stakeholders – each with a different history and unique perspective on Central Health's performance. The interviews included all nine members of Central Health's Board of Managers, members of Central Health's senior executive team, and representatives from three of Central Health's Enterprise entities and from multiple community partner organizations. In addition, Germane interviewed several at-large members of the community and held two public input sessions.

- **Internal Assessment (linked to the Assessment Tool)**
  Germane created a structured tool consisting of six (6) critical domains and fifteen (15) key indicators to assess the overall performance of Central Health, the CCC, and CUC. This assessment was completed based on findings from the interviews, data collection, a literature review and the benchmarking analysis described below.

- **Benchmarking Analysis**
  Despite its unique care delivery model, Central Health shares many similarities in terms of its mission and governance structure to other public health systems across the country. Germane has had the privilege of working with many of these institutions and completed a benchmarking assessment of six (6) Texas-based healthcare and hospital districts (Christus-Nueces, City of El Paso Public Health District, Harris Health System, JPS Health Network, Parkland Health & Hospital System, University Health System-San Antonio) and thirteen (13) public health systems from other parts of the country. Findings from this benchmarking analysis were also incorporated in the scoring of Central Health's performance in select domains of the Assessment Tool.

- **Literature Review**
  While not a key part of the analysis, it was determined that a literature review might prove beneficial in a few select areas where Central Health had specific questions. To that end, Germane pulled publicly-available articles, studies and reports on issues related to (1) access, (2) the development of new medical schools, (3) public health district governance and

communication best practices, and (4) community benefit. This literature review helped guide the development of the Assessment Tool in select domains and provided examples of best practices for comparison purposes.

4. STAKEHOLDER INTERVIEWS

Germane completed one-hour interviews with more than 20 different Central Health stakeholders. These included all Board of Managers members, members of Central Health's Executive Staff and representatives from key Enterprise and Affiliated partners.

Overall, two key themes emerged from our interviews related to Central Health's performance:

Theme #1: Concerns about how Central Health can address and track the changing needs of the Austin/Travis County Community

- Concerns about the lack of access to select specialties, and a discussion about the continued imbalance between supply and demand of physicians for the growing metro Austin market;
- Interest in establishing higher standards for performance metrics, such as health outcomes, patient satisfaction and cost of care;
- Questions regarding how/where care is currently being delivered and how that care delivery will be impacted by potential changes in the healthcare landscape, particularly around risked based payments;

Theme #2: Concerns about how beneficial the partnership model is currently for both Central Health and the Austin/Travis County Community

- Because of its unique model of delivering care through its partners, there were concerns that Central Health was doing an inadequate job of communicating how its dollars are being utilized on behalf of the community;
- Concerns about communication with the public and accountability related to the use of Central Health funds once they were received by partner organizations:
    - This was especially true of Central Health's financial support for the Dell Medical School at the University of Texas at Austin, and a desire to understand how this funding supports Central Health's primary mission to the underserved;
- Desire to understand whether Central Health's various partnerships were in fact generating a "positive return on investment" in terms of incremental community benefit;
- Questions regarding the role of the CCC in care delivery on behalf of Central Health, and whether the objectives of Central Health and SHF are aligned around the willingness to go at-risk for the care of the population;
- Some frustration from leadership at Central Health that the community does not recognize how far Central Health has progressed in the past ten years in terms of the breadth and efficiency with which it supports healthcare to the underserved in Travis County because of its "behind the scenes" role in the partnerships

These interviews led Germane to adjust its assessment tool to provide more detailed analysis around these themes.

5. INTERNAL ASSESSMENT

The internal assessment was focused around six key domains that are highly correlated to overall public health system performance. Each domain or category is comprised of Assessment Measures (AM). The six domains as described in the graphic below are:

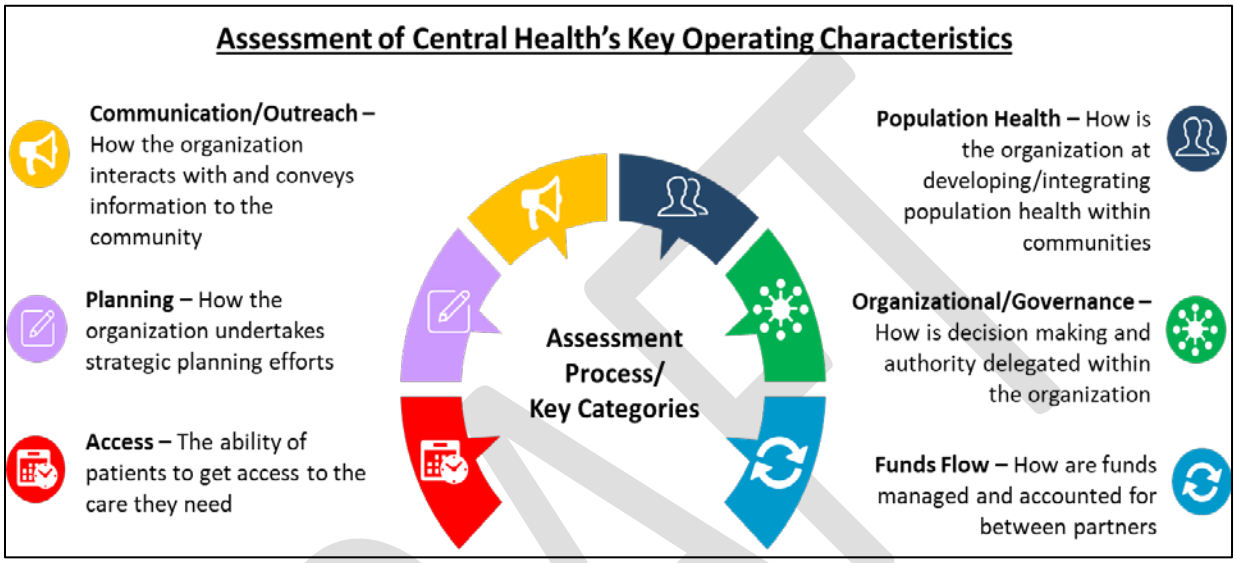


Figure 4: Six Key Domains of the Central Health Internal Assessment

Within these six domains, Germane has developed a series of specific questions (included in the appendix) that help provide a comprehensive assessment of Central Health's current performance. Evaluations for each question were developed based on both current state (reflecting existing operational models) and future state (reflecting in-process changes already approved by the Central Health Board). These evaluations were based on qualitative feedback from interviews with a broad set of Central Health stakeholders, quantitative assessments based on publicly available and internally aggregated data, and Germane's experience working with public health systems across the country.

These responses were scored using a quartile system (25, 50, 75, 100) based on how effectively Central Health met the criteria set forth in the question. The scoring system reflects the following scale:

- A score of 25 indicates that Central Health has either demonstrated no ability to address the identified issue, or does so in a limited, retroactive and/or ad hoc manner that could not be easily duplicated if the issue were to arise again;
- A score of 50 indicates that Central Health has actively attempted to address the underlying issue in a proactive manner, but that the attempt has not proven to be particularly effective and there is no planning/process in place to improve the outcome;
- A score of 75 indicates that Central Health has actively and successfully addressed the issue in a proactive manner, and that there is standardized planning/process in place to proactively address the issue moving forward;

- A score of 100 indicates that Central Health has developed an innovative and/or "best in class" approach to addressing the issue

Note that the form and format of these assessment questions differ across the six domains. Some questions are "process" oriented, designed to determine whether Central Health has a standardized mechanism in place to address the issue (e.g., maintaining wait list for patients). Others are "outcome" oriented, with the purpose of determining whether Central Health has successfully moved the needle on key metrics that are critical to its mission (e.g., wait times to see a specialist).

Based on the quartile score for each question, and the aggregate score for the domain, Germane was then able to compile an assessment matrix that can be used to help Central Health prioritize issues that require near-term rectification vs. long-term investment.

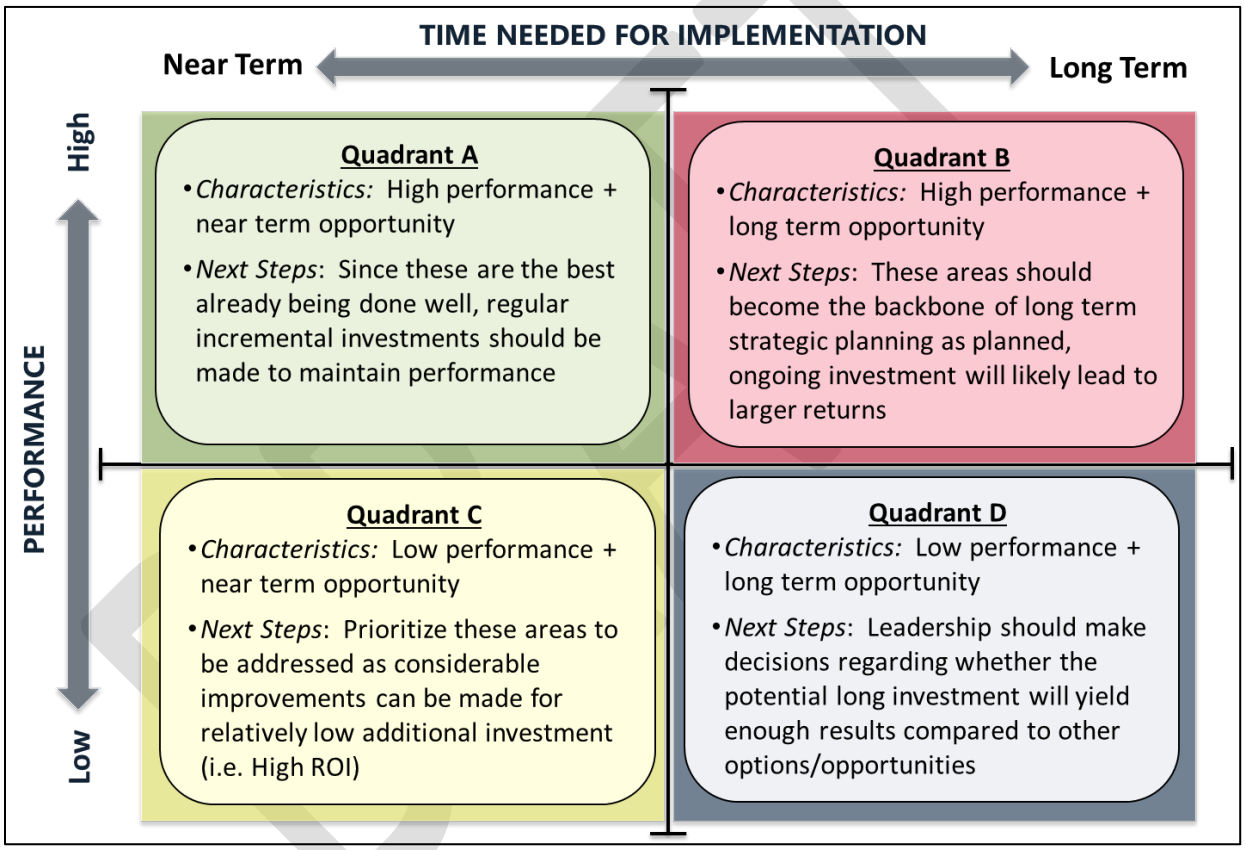


Figure 5: Performance Assessment Matrix

Internal Assessment Key Findings: Access

One of the primary goals of a hospital district is to provide access to care for eligible residents, especially for traditionally underserved populations, and specifically in Texas, the Health and Safety Code Chapter 281 requires hospital districts "…to furnish medical aid and hospital care to the indigent and needy persons residing in the district..." With those parameters as a guide, our internal assessment evaluates the overall level of access created/maintained by a hospital district in three ways:

1. Does the hospital district have systems/monitoring in place to provide ongoing tracking of access to inpatient, ambulatory and specialty care throughout its care delivery network?
2. Is the quality and cost of the access provided by the health district adequate given the size of the population they are serving?
3. How effective is the health district at planning and executing initiatives that create either a greater level of overall access or more targeted access within specific communities/populations?

The first question for analysis is designed to determine the health district's level of awareness about its community and its care needs. Tracking of key access metrics such as appointment wait times, number of active providers to underserved population ratios, strategic position of access points, and patient quality/satisfaction scores provide valuable data to the health district about how to utilize its resources to provide care within the community.

The second question for analysis tries to determine whether the access being provided is at the appropriate level for the size of the population, is provided in a cost-effective manner and with the level of quality needed to address or prevent public health issues (such as substance abuse, heart disease etc.) within the communities. Both quality and cost are intertwined areas that need to be balanced to provide effective care, as high costs are not necessarily indicative of higher quality care, nor is lower cost correlated with better patient outcomes.

The final question for analysis is a measurement of how effective the health district is at addressing the issues raised from the data/metrics. Health districts that have lower performance levels tend to acknowledge that they have issues with access but do not have a coordinated plan to address these issues. Conversely, high performing organizations not only acknowledge their shortcomings, but have plans to make adjustments in key areas to start to resolve the access issues.

Overall, Central Health's score in the Access domain is average to above average, though there is significant variability in terms of its performance across areas of care. Key findings include:

- Central Health scores well in terms of monitoring. The institution consistently measures and tracks key access metrics like wait times for specialists and primary care, as well as trending changes in these measures to proactively identify access concerns.
- Access to inpatient care for Central Health patients appears to be sufficient, even though Central Health does not own or control the inpatient platform. This should continue with the recent opening of the Seton-Dell Medical Center. Quality of inpatient access appears to be reasonable,

and average length of stay and 30-day readmission rate metrics are at or near CMS benchmarks (although SHF is still paying a penalty for readmissions).[1]

- From an outpatient/ambulatory prospective, Central Health is very mixed in terms of its performance.[2] The organization provides adequate access for primary care patients, but is considerably lacking in its ability to provide appropriate levels of specialty care access for the sizeable population it serves:
    - Access to primary care is fairly robust, as Central Health supports 26 FQHC sites in medically underserved areas within Austin through the CUC, along with other ambulatory sites provided by other FQHC and non-FQHC partners. Additionally, the integration of DSRIP (Delivery System Reform Incentive Program), clinics within the FQHCs and non-FQHC sites has brought an increased level of cost effectiveness and quality to Central Health's primary care access. Primary care wait times are reasonable as the average wait times for a primary care visit is fewer than 30 days.
    - Access to specialty care is very limited, patients experience long wait times to get appointments, and access to specialists is often restricted to very few sites (i.e., most of the specialty care is provided at SHF). The cost of access for select specialties is also quite high, largely tied to the lack of options for patients. While the gap between supply and demand of specialists is an issue across the country, Central Health needs to be more creative in finding ways to create new specialty access for its patients.
- Central Health has an opportunity to mitigate some of its specialty access issues by leveraging its integrated care delivery system (i.e. a planned coordination of care between entities providing inpatient, outpatient and specialty services to patients), location, and community support to create a short-term strategy (coordinated recruitment, telemedicine) that helps improve wait times. During the interviews, several stakeholders discussed planning efforts being undertaken at Central Health in coordination with its partners around this issue, but the reality is that Central Health's partners often have their own priorities in terms of geographies and specialties where they wish to enhance access, which don't always correspond with Central Health's focus on the underserved. This, along with limited resources, often limits the speed with which a solution can be put in place (i.e., recruitment model, physician type, responsibility for salary support).

Internal Assessment Key Findings: Planning

Planning represents an organization's process of defining its strategic direction, including prioritization of resource allocation and operational efforts to achieve this direction. Most public health systems go through strategic planning exercises (and in many cases, are mandated to do so), but the real hallmarks of an organization with strong planning are:

1. The level of rigor associated with the development of the strategic direction;

[1] Centers for Medicare & Medicaid Services, Average Length of Stay and 30-day readmission rate data, https://www.statista.com/search/?q=ALOS+by+hospital; https://www.statista.com/search/?q=30-day+readmission+rates+by+hospitalrelevance&statistics; accessed December 22, 2017. **(2015 data)**

[2] www.hrsa.gov, https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=**2016**&state=TX#glist, accessed December 2017.

2. The ability of leadership to focus its efforts and resources on strategies that were prioritized through the planning process;
3. The level of commitment to implementation, and accountability for execution;

Overall, Central Health scores very well in the Planning domain. There is not a single category within the Planning domain where Central Health's score is not in the 75th percentile or higher. Key findings from the assessment include:

- The organization undertakes extensive planning efforts – both on a scheduled basis (e.g., enterprise strategic planning) and in support of key strategic initiatives. Recent planning efforts include the development of the 2017-2019 Central Health Strategic Plan, planning associated with Central Health's role as the anchor entity for Regional Healthcare Planning District 7 under the 1115 Medicaid waiver or DSRIP (Delivery System Reform Incentive Program), and the development of a Community Health Assessment in collaboration with the City of Austin and the Travis County.
- Central Health does an excellent job of monitoring the health needs of its community and adapting its service portfolio to try and fill the most urgent gaps. The most recent Community Health Assessment was completed in 2017 and is being used to help inform program resourcing for 2018. Central Health's budget process is aligned with its strategic planning processes which ensures that resource allocation mirrors strategic focus. This is especially noteworthy given Central Health's partnership/collaboration model.
- Central Health has also started to incorporate the social determinants of health within their planning efforts. As the healthcare landscape move from reactionary to preventative care, there will be a corresponding shift in focus towards determining the causes and prevention of health issues, rather than just identifying how to treat the conditions. Central Health has demonstrated a desire to try to incoproate social determinants of health by hosting forums and events on related public health issues and routinely plans jointly with other community-based organizations to brainstorm solutions that span multiple social needs. It maintains a directory of potential partner community organizations, with a culture that encourages collaboration on community wide efforts.
- The overall strategic direction for Central Health is set at the Board level and communicated to its Enterprise and Affiliated partners, but due to the inherent strong relationships between partners, there are opportunities to improve the linkages between downstream planning and implementation efforts that occur at the entities that deliver care.

Internal Assessment Key Findings: Communication & Outreach

As a function of the performance assessment, hundreds of documents and data sources provided by Central Health were reviewed, including but not limited to, Annual Reports and Strategic Plans, input from community forums, community/patient surveys, social media outlets, informational pamphlets/flyers, newsletters, and the website. These sources provided Germane with the raw material needed to assess Central Health's ability to communicate its strategic intent and service offerings to its stakeholders and constituents.

Overall, Central Health scores above average in the Communication & Outreach domain. It gets high marks for the quality and frequency with which it communicates with its stakeholders. On the other hand, there are definite opportunities for continued improvement in terms of outreach. Key findings from the assessment include:

- Compared to many healthcare districts nationally, Central Health is very open in its provision of information to its constituents – from Annual Reports and Strategic Plans, to financial reports and budgets, to funds flows and tax rate changes.
- Central Health engages the community and solicits feedback regarding strategic priorities. In addition to making Board and committee meetings open to the public, it proactively solicits community feedback on other strategic issues through the use of surveys, community forums, and workshops.
- Central Health has a robust health education/health promotion function and coordinates more than 300 service-related outreach activities in the Austin community annually. However, there does seem to be some disconnect between organizing these activities, and effectively communicating the activities beforehand and reporting on the results afterwards. Improvements in this area would strengthen community engagement and make the outreach events even more successful.
- There is confusion among constituents regarding the actual relationship between Central Health and the multiple organizations it supports in some way. Because Central Health is not a direct provider of healthcare services, its critical importance to the healthcare safety net in Austin and Travis County is lost. Central Health can improve by ensuring that the community understands its role and commitment. This would ensure credit for services provided through its network. A marketing strategy similar to the "Intel Inside" campaign may be needed.
- Central Health is very professional in the use of its website and printed materials to help communicate with its constituents, but its social media efforts are relatively nascent. Central Health's LinkedIn, Twitter and Facebook accounts are all surprisingly underutilized with few followers and limited content. Given the growing population in the 18-44 age cohort in Travis County, this is an area where enhanced communication should be pursued.

Internal Assessment Key Findings: Population Health Management

One of the prevailing trends in healthcare is to focus on population health as a method to improving care within communities. Population health has multiple definitions, but generally population health is defined as an institution or institutions that use evidence-based technologies and processes to coordinate the provision of healthcare services, related to either specific diseases/conditions or segments of the patient population, with the goal of reducing healthcare costs and reinvesting the savings in targeted diseases/conditions and/or populations. In our experience, population health initiatives are especially critical for hospital districts, since they typically serve large populations of underserved patients with multiple comorbidities.

Within the context of our analyses, we sought to determine the role(s) that Central Health plays in supporting populations health initiatives within the Austin community. We also recognize that population health has traditionally fallen within the purview of the Public Health Department, and as a result the scope of population health services provided by hospital districts is usually limited.

Overall, Central Health scores average in the Population Health Management domain. It appears they have embraced the move towards population health with tangible, progressive steps, but are still in the process of putting some of the needed infrastructure and investments in place to support a successful transition. Key findings from the assessment include:

- Through its partner entities, Central Health provides a full complement of primary care, specialty care, behavioral health, dental care and substance abuse services – along with many of the critical wraparound services (e.g., education, coordination) that are critical to population health management. Many population health status measures are being actively tracked through UDS reporting requirements because of CUC's status as a co-applicant FQHC. However, because these services are provided in partnership, Central Health does not always have direct control over the scale or level of access to these services (e.g., substance abuse), an issue that was addressed in the Access domain of this report.

- While Central Health owns some clinical assets (UMCB campus property and some clinic sites), many of the sites through which it provides clinical services are owned by other entities. With a relatively narrow capital asset base, and a corresponding lack of reliance on fee-for-service reimbursement as a critical revenue source, Central Health has a unique opportunity to embrace the transition to fee-for-value care. This can be accomplished without worrying about the potential near-term detrimental impact to its financial viability – an advantage not shared by most of its peer hospital districts that were analyzed in the benchmarking exercise. Central Health has already shown an institutional willingness to pursue population health initiatives and participate in risk-sharing arrangements. Within its Strategic Plan, Central Health emphasized the need to align with national accountable care organization (ACO) and patient-centered medical home (PCMH) principles to more effectively manage the care of its populations. It has made the integration of dental care and mental health care a critical emphasis of its care delivery efforts. And it has taken financial risk as part of Seton Healthcare's Accountable Care Organization (ACO), which generated $5M in shared cost savings, 70+% of which was distributed back to members in 2016[3].

- Central Health is the coordinating entity for Texas Region 7's DSRIP programs, which have multiple initiatives that tie directly to population health – including clinical cultural competency training, preventive screening, mobile clinics for primary care and telepsychiatry services.

- Central Health still lacks some of the "linking" infrastructure (i.e. processes and technology that can help provide smooth the transfer of care across partner entities) necessary to provide highly effective population health management. The most concerning is the fact that Central Health and its partners are not all on the same EMR systems, nor have they developed the ability through interfaces to successfully transmit patient information to coordinate large scale population health initiatives. While the Health Insurance Portability and Accountability Act, the Texas Medical Records Privacy Act, and various other health information privacy statutes also inhibit data

[3] https://www.seton.net/medical-services-and-programs/seton-accountable-care-organization/

sharing, it is still important to note that Central Health lacks the ability to track patients longitudinally as they move through various partner care sites.

Internal Assessment Key Findings: Governance & Organization

Central Health's governance and organizational structure ultimately drive decision-making, and as such have a huge role to play in the overall success of the institution. Hospital districts with strong governance and organizational models have the appropriate level of checks and balances to ensure that the institution is making the best possible use of public funds in service of the mission and can make appropriate changes to the organization's strategic direction to reflect the changing needs of the community. Well-functioning governance and organizational models support a balance of compliance rigor and strategic nimbleness – without allowing the pendulum to swing too far in either direction.

Overall, Central Health scores above average in the Governance & Organization domain. Key findings from the assessment include:

- Central Health's governance structure is in line with expectations for a hospital district. The nine-member Board of Managers appropriately reflects the gender and racial diversity of the community, and the majority of the Board of Managers have a background in healthcare. This allows for a high-functioning Board that has perspective on the differential needs of different sub-groups within the community. In this regard, Central Health would serve as a best-in-class example for other hospital districts across the country.
- The lack of term limits for Central Health is the one aspect of its governance structure that is not contemporary – though it is still common in many hospital districts and has not proven to be an issue for Central Health to this point. Nevertheless, good governance practices suggest that putting term limits in place could help to ensure an appropriate level of continuity in governance without allowing a small subset of long-standing Board members to monopolize decision-making long-term, to the detriment of new/different viewpoints. As stated prior, while Central Health does not have any control over the appointment of Members or the term limits for the Board of Managers, it would be advantageous to take note of the flaws in the system and work with the Travis County Commissioners Court and the City of Austin, if possible, to work towards a more contemporary governance structure.
- As mentioned in the Communication & Outreach domain, the public has an appropriate window into Central Health's deliberations, and there are multiple forums to elicit input and debate. But there does need to be a more formalized process for non-patient stakeholders to request input.
- One gap identified in the assessment is the Central Health Board's current inability to track the progress of approved initiatives without relying solely on management report-outs. Central Health needs to consider the development of a structured process for Board review of critical, new investments as well as a data-driven decision process to potentially defund existing initiatives.
- Central Health is in the process of revising a well-articulated conflict of interest policy, and the processes for enforcing it are in place as both internal and external legal counsel support the Board.

- An evaluation process has been established for the Board of Managers to assess the performance of the CEO of Central Health.
- Unlike the governance model for Central Health, the Board of the Community Care Collaborative (CCC) serves more as an operating Board and has a much smaller membership. 3 of the 5 CCC Board members are appointed by Central Health, and the other 2 are from Seton Healthcare Family. While there are no ex-officio positions, the Board members are essentially selected from management of the two parent entities with no term limits or rotational requirement. As an operational Board, most strategic issues are reserved powers that are left to the parents for approval, but even operational decisions can be delayed due to differences in the way Central Health and SHF representatives evaluate and process decisions. One recommendation would be to expand the size of the Board to seven (7) to provide some flexibility in the event that a key member is absent for unanticipated reasons and to broaden the perspectives around the table.
- CommUnityCare (CuC) has a strong governance structure that meets or exceeds what is required by HRSA for an FQHC.

Internal Assessment Key Findings: Funds Flow

The issue of funds flow to Central Health's Enterprise and Affiliated partners was the most frequently raised issue during the interview process. Stakeholders want to know that Central Health has a robust process for evaluating and executing the "investment" of public funds into various initiatives that support the institution's mission to enhance healthcare access and services to the underserved in Travis County. We estimate that 73% of Central Health funds are used for patient care[4]. At the same time, there is no shortage of demand for healthcare services among the underserved, and since many within the community would resist any increase in the tax rate, there is even greater scrutiny on whether Central Health can appropriately account for the manner in which existing funds are spent.

Overall, Central Health scores above average in the Funds Flow domain. It is among the best in the country, in our estimation, in terms of how it tracks and records sources and uses of its own funds. But while it is more cost-effective than the ownership model, the trade-off of having a partnership model for care delivery is that the level of openness related to partner funds flows (once the funds are absorbed by the partner) diminishes significantly. Key findings from the assessment include:

- Central Health excels at tracking sources and uses of funds and is proactive at trying to deploy resources to meet anticipated community need. It is a best-in-class example for hospital systems in this regard.
- However, since Central Health provides many services through partnerships, it does not have full control over how funds allocated to its partner institutions are used. This is the core of the issue with Dell Medical School at the University of Texas at Austin. While Central Health has set restrictions on its ability to dictate how funds are used by its Enterprise and Affiliated partners once they've been distributed, there are no limitations on Central Health requesting public

[4] Community Care Collaborative Financial Statements Years Ended September 30, 2016, and 2015

transparency of their Enterprise and Affiliated partners regarding the actual use of the funds provided by Central Health.

- Central Health has diversified its sources of funds, but still has opportunity in two areas – grants management and philanthropic fundraising. In both cases, Central Health could learn from the experiences of other public health systems.
- There remains continued scrutiny of, and confusion about, the role of Inter-Governmental Transfers (IGT) in optimizing local funding. It may be time for Central Health to simplify the IGT discussion by examining the decrease in overall funding that would accompany an elimination of IGT, and the programs/services at Central Health that would have to be significantly curtailed or eliminated as a result.
- Central Health does track the efficiency of its initiatives, but there is limited benchmarking associated with its overhead functions. A quick assessment of Central Health's overhead model suggests that the institution is running extremely lean in support areas. While the efficient use of overhead resources is desirable, there is a minimum threshold below which there are diminishing returns. As Central Health considers various strategic and communications initiatives, there will need to be careful expansion of select functions (e.g., decision support, marketing) to ensure that these initiatives are successfully executed.

6. BENCHMARKING ANALYSIS

There are hundreds of public health systems across the country, and while there are differences in terms of structure and scale, they have similar missions and target populations to Central Health. As part of this performance assessment, Germane completed a benchmarking assessment of six (6) Texas-based hospital districts and ten (10) national public health systems.

Texas-based Healthcare and Hospital District Comparators

- Bexar County Hospital District (University Health System-San Antonio)
- Dallas County Hospital District (Parkland Health & Hospital System)
- El Paso County Hospital District (University Medical Center-El Paso)
- Harris County Hospital District (Harris Health)
- Nueces County Hospital District (CHRISTUS Spohn)
- Tarrant County Hospital District (JPS Health Network)

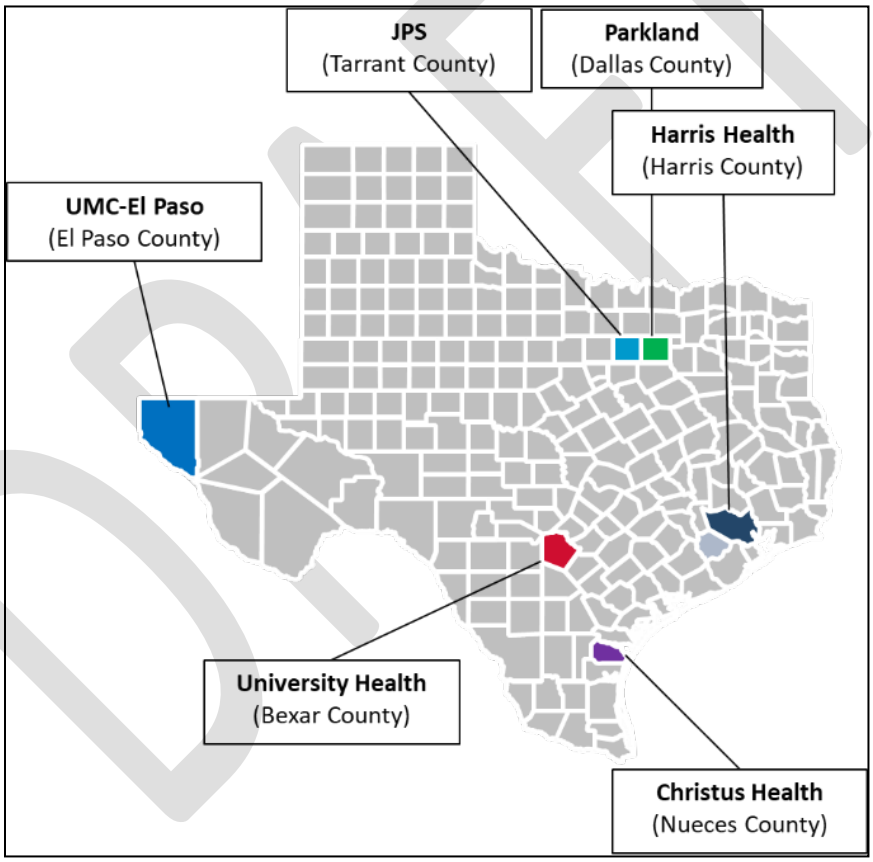


Figure 2: Select Texas-Based Public Health Systems

National Public Health System Comparators

- Cook County Health & Hospitals
- Denver Health
- Jackson Health System

- Maricopa Integrated Health System
- NYC Health + Hospitals Corporation
- Orlando Health
- Palm Beach Health Care District
- Riverside University Health System
- Spartanburg Regional
- Zuckerberg San Francisco General Hospital

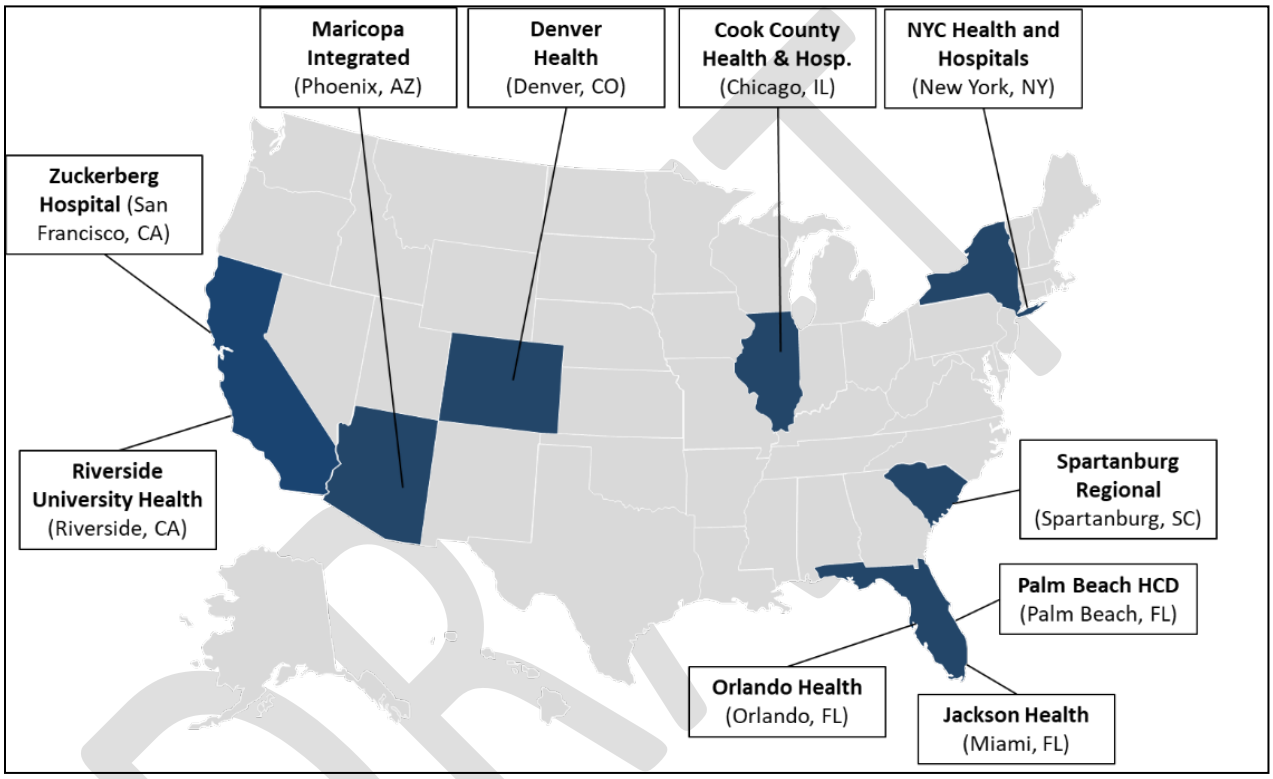


Figure 3: Select National Public Health Systems

The goal of the benchmarking exercise is to provide both quantitative and qualitative information regarding how other hospital districts and public health systems manage the challenges of providing healthcare services. This benchmarking analysis IS NOT intended to provide specific judgment of Central Health's existing capabilities or to rank Central Health vis-à-vis these institutions on a specific characteristic, but instead to identify potential solutions and best practices that could potentially be used to enhance Central Health's performance in the future, as shown in the next graphic.

Gather/ Analyze Data
Obtain data from comparators in six assessment areas

Focus Points/ Metrics
Create generalized areas that frame benchmarking structure

Develop Rankings
Develop rankings of Central Health relative to its comparators for each focus area

Identify Best Practices
Provide best practices from similar and top overall comparators

Provide Recommendations
Determine if there are ideas that can be adopted into Central Health's model

There are several other considerations about this benchmarking exercise that are important to understand before going through the findings:

- The benchmarking exercise followed the same six domain areas that are incorporated in the Assessment Tool: Access, Planning, Communications/Outreach, Population Health, Organizational Governance and Funds Flow
- The benchmarks used to evaluate Central Health may be descriptive, quantitative or qualitative in nature, but the intent is to provide Central Health with information that can be used for further improvement in all cases
- Differences between the comparators based on whether they benefited from Medicaid expansion was factored into the benchmarking exercise
- Due to the considerable variability that exists in each comparator organizations' processes, infrastructure and care delivery model, not all comparators could be assessed across every metric
- Details regarding the Texas based comparators are reflected in the figures that follow this section. Similar details are available regarding the national peer organizations but have not been included in this report in an effort to keep the report size manageable.

Benchmarking Results: Comparison of Service Area Metrics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Population (County/MSA)	1,190,186	2,554,528	4,573,568	1,971,711	1,913,559	840,597	361,320
Annual Pop. Growth Rate	3.0%	2.0%	1.9%	2.0%	2.2%	0.7%	1.1%
Uninsured Rate	21%	29%	27%	23%	22%	31%	23%
Ad Valorem Property Tax (cents per $100)	11.05	27.94	17.18	22.79	27.62	23.45	12.97

Benchmarking Results: Comparison of Service Area Metrics with Texas-Based Peers

BENCHMARK	Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (Miami, FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
Population (County/MSA)	5,203,499	3,075,701	2,693,000	4,192,887	8,538,000
Annual Population Growth Rate	0%	2%	2%	2%	1%
Uninsured Rate	9%	10%	34%	13%	8%

BENCHMARK	Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
Population (County/MSA)	1,443,810	2,361,000	890,000	1,500,000	2,000,000
Annual Population Growth Rate	2%	2%	2%	1%	3%
Uninsured Rate	19%	17%	20%	8%	20%

Central Health is in the fastest growing service area of all the Texas based peer comparators, while also having the lowest uninsured rate. The rapid growth rate will likely strain services over the next few years, but will also result in an expansion of the tax base to allow for greater investment of resources in care for the under- and uninsured.

Central Health has a much lower property tax rate due to its unique partnership model of care delivery, with its only close analog being the model in Nueces County where care is provided through a management contract with CHRISTUS Health-Nueces County,.

Benchmarking Results: Comparison of Access Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Inpatient access	Do not own a hospital. I/P care provided through partnerships with SHF and St. David's	Own a 870 bed hospital. Includes a Level 1 Trauma Center & 2nd largest burn center in US	Own 2 acute and 1 rehab hospital – total of 700 beds; includes Level 1 & Level 3 Trauma Centers	Own a 573 bed hospital	Own a 456 bed hospital	Own a 394 bed hospital	Own 3 hospitals
Outpatient access	26 clinic locations through CUC, Peoples Community Clinic (2), Lone Star Circle of Care (multiple locations), UT Health Austin (1), Austin Regional Clinic (1) and Integral Care (3 Locations)	12 school-based clinics and 12 health centers, which have services in FM, IM, Peds, Women's, Behavioral Health, Dental and some specialties	5 school-based clinics, 10 homeless shelter clinics, 19 CHCs, which have services in FM, IM, Peds, Dental, Women's, Behavioral Health and some specialties	40 CHCs (including 20 school-based clinics), which have services in FM, IM, Peds, Women's, Behavioral Health, Dental and some specialties	21 outpatient centers with services in FM, IM, Peds, Women's, Behavioral and some specialties	10 outpatient clinics, which have services in FM, IM, Peds, Women's and other specialty services	6 primary care clinics, with services in FM, IM, Women's, Peds and some specialties

Benchmarking Results: Comparison of Access Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (Miami, FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
Inpatient: 2 hospitals: Total beds ~500 Outpatient: 16 clinics which have services in FM, IM, Peds, Women's, Behavioral, and some specialties	Inpatient: 1 hospital, Total beds: 525 Outpatient: Seventeen school-based health centers and nine family health centers, including services such as IM, FM, Peds, Women's, Dental, Behavioral Health	Inpatient: 6 hospitals, 15 specialty care centers. Total beds: 1,550 Outpatient: 8 health clinics, including services such as IM, FM, Peds, Dentistry, Women's, and some specialties.	Inpatient: 1 hospital: 515 beds Outpatient: 2 behavioral health centers, 13 family health centers, including services in: IM, FM, Peds, Behavioral, Women's, and some specialties	Inpatient: 11 acute care hospitals Outpatient: 70 community-based clinics, which have services in FM, IM, Peds, Women's, Behavioral, Dental, and some specialties.

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
Inpatient: 1 hospital with two trauma centers; Number of beds in system: 1,426 Outpatient: 8 primary care clinics, which have services in Peds, Dental, IM, FM, Women's, Behavioral	Inpatient: 1 hospital, which includes a Stroke Center, Level 2 Trauma Center, and the only Pediatric ICU in the region. Total beds: 439 Outpatient: 10 FQHCs which have services in FM, IM, Peds, Women's, Behavioral, Dental, and some specialties	Inpatient: 4 hospitals: 700+ beds Outpatient: 24 primary care clinics and various other specialty, cancer, OB/GYN clinics which include services in IM, FM, Peds, Women's, Behavioral, and some specialties. Dental not included.	Inpatient: 1 hospital including Level 1 Trauma Center: ~400 beds Outpatient: some outpatient services (primary care and some specialties) offered within hospital	Inpatient: 6 hospitals and 2 affiliated hospitals. Total beds: 2,145 Outpatient: 100+ clinics with services in: IM, FM, Women's, Peds, Behavioral, and some specialty services. Dental not listed.

Access to care has been a hot-button issue in Austin and Travis County, as the growth of the population has put an ever-increasing strain on the gap between supply and demand in many key specialties. But that gap is not unique to Central Health, and is a broader issue faced by all the peer comparators. In terms of

access, Central Health must rely on its hospital partners (Seton Healthcare Family, St. David's) to provide inpatient capacity – which means that it does not have the same level of control over census and inpatient occupancy compared to its peers (i.e. directing admissions within system). But Central Health has a very robust outpatient network through CommUnityCare and other partners which provides a more expanded set of services (inclusive of dental and behavioral health) when compared to many of the peer institutions. In terms of outpatient new access improvements, consideration should be given to opening clinics in areas where existing populations are beginning to transition as a result of the continued population growth in Austin and Travis County.

Benchmarking Results: Comparison of Planning Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Planning	Details provided in Internal Assessment – p. 14	Strategic Plan through 2020 is available on website, with articulation of vision and priorities Each focus area within Strategic Plan contains specific, clear goals	Bridge to 2020 Strategic Plan recently completed with associated goals and initiatives	Website gives timeline of planning meetings, and multiple relevant documents (e.g., Needs Assessment, Town Hall minutes) with specific plans for expansion 2017 Implementation Plan identifies community efforts and focus areas	Website shows Board meeting agendas and minutes Annual Report is readily available and very detailed	Website shows detailed Community Health Needs Assessment, highlighting deficiencies No strategic plan readily available	Unclear, the information is not readily available on the website CHRISTUS manages health services in the county, Nueces County oversees admin. Separation of duties difficult to ascertain

Benchmarking Results: Comparison of Planning Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
1) 2017-2019 strategic planning involved five principles to incorporate in the coming years 2) Budget appears to be in line with strategic planning	1) While it is clear that there the health district has collected a large amount of data on the populations in Denver (i.e. Denver Health Report, it is unclear if the community members'/patients' opinions were taken into consideration for future plans	1) Annual Report to Community displayed on website with accomplishments, however it does not touch on goals or plans going forward. Nothing comparable to a Strategic Plan available.	1) Excellent website and Annual Report summarizing accomplishments and areas in which the health system is flourishing and improving 2) "Care Reimagined" is name of current plan to rebuilding health system by improving outpatient and behavioral health care and to expand the teaching hospital	1) Extensive planning and input for current "Transformation" process - Based on "One New York plan" from Mayor de Blasio's office, the goal is to improve infrastructure and delivery of care while focusing on quality care regardless of patient's ability to pay.

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
1) Community Benefit Report is outdated and not-detailed (last provided in 2013-2014). Neither Strategic Plan nor Community Needs Assessment shown on website. 2) Notice of public committee meetings on website	1) Community Needs Assessment identifies several issues within community and the goals on how to conquer these issues. Report is informative, but somewhat hidden within larger website.	Could not find annual report/community benefit report	1) Have mostly broad goals in 2015 Annual Report (ie. implementing strategic deployment; executing on new value; Building 5 renovation). 2) Could not find Community Needs Assessment 3) Not transparent in planning processes;	1) 2013 and 2016 Community Needs Assessments that are very detailed and are incorporated into future planning for the health system 2) Community Benefit Reports highlights accomplishments and areas found in Community Needs Assessment that need improvement

Central Health has a very robust planning function with a clearly articulated Strategic Plan and provides regular strategic updates to the community. In this regard, it is similar to most of its Texas based peer comparators. However, a few of the comparators also included implementation details and metrics tracking related to key planning efforts for the public to review – which provided an additional level of planning rigor that Central Health might be interested in replicating in the future. One potential adaption for Central Health was a more defined theme for the strategic plan such as Maricopa's "Care Reimagined" plan which is the name of the project that is in progress to transform the health system. Both in its site description and in the Annual Report, Maricopa's accomplishments and future goals are clearly outlined, with an emphasis on improving behavioral health and expanding the current teaching hospital. Given Central Health's many initiatives, a theme based strategic plan might help to tie the initiatives all together for easy digestion by the public.

Benchmarking Results: Comparison of Communications Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Communication & Outreach	Details provided in Internal Assessment – p.15	Numerous outreach & education programs Website displays a Community Calendar and Events Strong presence on social media: LinkedIn (21,825 followers); Facebook (20,271 followers)	Lots of partnerships with health promotion & community outreach events Reasonable presence on social media: LinkedIn (17,190 followers); Facebook (4,577 followers)	Lots of partnerships with health promotion & community outreach events Reasonable social media presence: LinkedIn (12,750 followers); Facebook (7,875 followers)	Making efforts to improve outreach to community Making community aware of specific health risks in geographic locations (Zika virus) Moderate social media presence: LinkedIn (7,590 followers); Facebook (15,625 followers)	Community programs geared toward at-risk populations, (e.g. El Paso Occupant Protection Program, Community Coalition Partnership) Limited social media presence: LinkedIn (1,072 followers); Facebook (3,601 followers)	Limited community outreach programs are offered 3 different websites, all difficult to navigate (old site and new site for health district, plus one for CHRISTUS Weak social media presence: LinkedIn (no account); Facebook (290 followers)

Benchmarking Results: Comparison of Communication Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
1) Held four community town hall meetings for strategic planning input 2) Weak social media presence: LinkedIn (1,891 followers), Facebook (2,480 followers).	1) Numerous outreach/education programs. Also provides education on certain health topics within clinics 2)Easy access to information online 3) Moderate social media presence: LinkedIn (13,353 followers); Facebook (12,220 followers)	1) Provides education on a variety of areas, including injury prevention (schools), infectious diseases, smoking, etc. 2) There is a good amount of educational information on the website, but no specifically about whether there are actual outreach programs to the community 3) Strong social media presence: LinkedIn (21,244 followers); Facebook (9,221 followers).	1) Excellent statistics provided within Annual Report on the number of events and the participants throughout the years. Examples include health fairs, medical/dental screening, distribution of bicycle helmets. 2) Moderate presence on social media: LinkedIn (5,514 followers); Facebook (11,165 followers).	1) Several community forums to engage community in ongoing transformation within health system 2) Provides easily-accessible statistics and reports on website 3) Strong presence on social media: LinkedIn (17,503 followers); Facebook (41,038 followers)

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
1) 9 Sponsored Programs (community agencies/programs that have a funding agreement to provide health services to uninsured or underinsured) 2) Funding requests available online for qualified organizations in community 3) Weak social media presence: LinkedIn (2,369 followers), Facebook (801 followers)	1) High amount of community awareness/education, public relations, and fundraising activities through the Riverside University Health System Foundation (non-profit) but actual health system seems to perform very few events 2) Website is very difficult to navigate - documents/ info are in very hard to locate 3) Extremely weak social media presence: LinkedIn (207 followers); Facebook (743 followers)	1) Website has listed several of programs available for community members (via hyperlinks) 2) Strong presence on social media: LinkedIn (5.695 followers); Facebook (23,111 followers).	1) Large community impact community due to the ZSFG Foundation, (non-profit aimed in providing charity and education towards the SF community). 2) Strong social media presence (on Facebook): LinkedIn (899 followers); Facebook (20,502 followers)	1) Multiple affiliations, events, health screenings, etc. 2) Very strong social media presence: LinkedIn (26,691 followers); Facebook (37,878 followers)

Central Health's communication and outreach to the community is solid, but there are several peers that are doing just as good a job or better at spreading the word regarding various community outreach and education programs. Parkland, Harris Health and JPS all have robust websites and social media communications vehicles to better connect with their constituents (by way of comparison, Central Health has between 2,000 and 3,000 Facebook and Twitter followers).

Benchmarking Results: Comparison of Population Health Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Population Health Management	Details provided in Internal Assessment – p.17	Aware of different cultural and health needs for segments of population Offer unique services and programs tailored to different cohorts – cultural and disease centric "Diversity Dialogues" to understand cultural and health needs within community	Extremely aware of differences in populations within Harris County (e.g., website is offered in Spanish) Community Health Workers must receive training on cultural differences	Population health listed as one of JPS' pillars in its most recent Community Report Large focus on social determinants of health	Major focus on population health associated with mental health, pediatrics, Zika prevention & trauma Offers language services for all patients Variety of services to community to monitor health status	Some focus on population health, but delivery system still oriented towards acute care Very aware of population differences, including language needs, socio-economic levels and at-risk groups	CHRISTUS completed a Community Health Needs Assessment to identify population health needs, but specific programs are hard to distinguish

Benchmarking Results: Comparison of Population Health Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
1) Strategic Plan states how data have been analyzed on social determinants of health and describes many programs/processes on how to improve health equity. 2.) Have created CountyCare for support of seniors with behavioral health needs	Developed "21st Century Care" project which uses integrated teams (Core Team, Clinical Teams, IT Team, Evaluation Team, ACS and Executive) to provide seamless care to the population - funded by CMS grant	Has dedicated case managers for patients who have been targeted for population health initiatives, but information on the program is limited	Have Case Management Department comprised of social workers and RN care managers working cooperatively in teams to try to provide care in a seamless and cost effective manner	Have OneCity Health initiative which is provider performance program that focuses on avoidable hospital stays

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
Very little information provided on population health initiatives	Very little information provided on population health initiatives	Have developed a strategic plan for assessing 5 "key health" priorities across the 40 agencies which they manage/interact; Won Essential Hospitals 2017 Population Health award	Partner with population health focused San Francisco Health Department to support population health initiatives	Have a variety of population health initiatives including clinical/nutrition services, wellness and prevention programs and community health planning and statistics

As all the comparators are other hospital districts, they all have a focus on population health – and the benchmarking assessment only reflects the institution's ability to articulate that focus through its publicly available content, as opposed to truly reflecting population health interest and resource allocation. The best performer, Spartanburg Regional, was successful because of the practice of permeating health priorities into all agencies with which it interacts. Given its already extensive relationships with community providers, this type of process could be duplicated and implemented at Central Health, and could be used to strengthen both the partnership and simplify the message to the community.

Benchmarking Results: Comparison of Governance Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Governance and Organization	Details provided in Internal Assessment – p.17	7 member Board of Managers, appointed by Dallas County Commissioner's Court Three-year terms, members limited to two terms (six years total).	9 member Board of Trustees appointed by Harris County Commissioner's Court Each term is two years, and there are no term limits	11 member Board of Managers, appointed by Tarrant County Commissioner's Court Terms are two years, and there are no term limits	7 member Board of Managers, appointed by the Bexar County Commissioner's Court Terms are two years, and there are no term limits	7 member Board of Managers, appointed by El Paso Commissioner's Court Three-year terms, with no term limits	7 members Board of Managers, appointed by the Nueces County Commissioner's Court All members serve staggered three-years terms

Benchmarking Results: Comparison of Governance Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
11 Board Members; term length and limits unclear	Board of Directors with 11 members who are appointed by the Mayor of Denver. Members serve five-year terms. Term limits are unclear.	Utilizes Public Health Trust Board of Trustees - seven members with what appears to be unlimited amount of time to serve	1) Board of Directors with 5 members. The members are elected officials; elected to office by voters of Maricopa County. There is one member for each district of the county. Board members serve a four-year term. 2) A Governing Council maintains oversight of the 13 family health centers/clinics. Currently 12 members - no specifics provided as to how they are chosen.	1) 15 members on Board of Director - Term length and limits unclear 2) Board is comprised of senior executives + facility CEOs

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
Board of Commissioners containing 7 members. Terms are four years, and members may hold their appointments for a maximum of eight years. Three appointed by Governor of FL, three appointed by Palm Beach County Board of Commissioners, and one is a representative of the State Department of Health	Riverside does NOT have a Board of Directors for the health system itself. It DOES, however, have a Board of Directors for the Riverside University Health System Foundation	1) Board of Trustees with only three members (Chair, Vice Chair, and Secretary). 2) Similar to Riverside, there is also a Board of Trustees for the Spartanburg Regional Health System Foundation	ZSFG does NOT have a Board of Directors, but it DOES have a Board of Directors for its Foundation	Orlando Health does NOT have a Board of Directors for the entity, but the Central Health Hospital DOES - composed of 10 members

As Texas-based hospital districts, all the comparators have relatively similar governance models. All have a Board of Managers appointed by either a Commissioner's Court or a combination of a Commissioner's

Court and City Council. The Travis County Commissioners Court and the City of Austin have done an excellent job of seeding its Board with representatives that reflect the diversity of the community while also having excellent healthcare knowledge. Central Health Board members do not have term limits, which is similar to most of the other peer comparators, but not contemporary best practice – and it could consider urging the Travis County Commissioners Court and the City of Austin to adopt the model in place at Parkland.

Benchmarking Results: Comparison of Funds Flow Characteristics with Texas-Based Peers

Metric	Central Health	Parkland	Harris	JPS	UHS-San Antonio	UMC-El Paso	CHRISTUS-NUECES
Funds Flow	Details provided in Internal Assessment – p. 19	$772M in revenues (~50%) from patient services $536M in revenues (~33%) from ad valorem property taxes There is a significant funds flow to a medical school affiliate (UTSW) Has a Foundation, with net assets of ~$73M	Net patient services account for $391 M (29% of revenues) $699M in property tax revenues (51% of total) There is a significant funds flow to two medical school affiliates (Baylor, UTH) Has a Foundation, with net assets of ~$35M	Property tax and patient service both almost identical in terms of contribution Property tax revenues total $349M and patient service revenues account for $344M (each ~39% of total) Has a Foundation, with net assets of ~$3M	$693M of revenue (49% of total) comes from patient services $325M in property tax revenues (23% of total) There is a significant funds flow to a medical school affiliate (UTSA) Has a Foundation, with net assets of ~$7M	Recent increase in tax rate from $0.2226 to $0.2345, raising overall tax revenues to $95M (16% of total) There is a funds flow to a medical school affiliate (Texas Tech) Has a Foundation, with net assets of ~$5M	Nueces County has very little revenue since it has outsourced service provision to CHRISTUS Does not have a Foundation

Benchmarking Results: Comparison of Funds Flow Characteristics with National Peers

Cook County Health & Hospital System (IL)	Denver Health (CO)	Jackson Health (FL)	Maricopa Integrated Health System (AZ)	NYC Health + Hospitals (NY)
1) About 6% of funding comes from tax payers. Has been consistently reducing reliance on taxpayers. $481M in tax funding in FY09 and $110M for proposed FY17. 2) Large investment recently in renovating and restructuring of current health centers	1) $505 M (over 50% of total revenue) came from net patient services	1) $1.1 Billion (61% of total revenue) came from patient services 2) $252 M (14% of total revenue) came from the half penny sales tax 3) $161 M came (9% of total revenue) came from county taxes	1) $323 M (68% of total revenue) came from patient services, where $203 M (43% of total revenue) came specifically from Medicare/Medicaid 2) Ad Valorem Tax totaling $69 M (15% of total revenue)	1) Majority of revenue received from "charges for services" ($8.3 Billion).

Palm Beach Health Care District (FL)	Riverside University Health System (CA)	Spartanburg Regional Health System (SC)	Zuckerberg San Francisco General Hospital (CA)	Orlando Health/West Orange County Health District (FL)
1) Ad valorem tax for 2017-2018: $0.078. Has been consistently reduced for 20 years. Nearly half of funding comes from this tax 2) Largest expenditure: providing health coverage for the uninsured in Palm Beach County; 92% of budget is used to fund health care services and prescription pharmaceuticals 3) Request available on	Could not find detailed financials	1) The health system is a self-funded, political subdivision of the state and does not receive tax dollars from the community 2) Could not find detailed financials	1) Operating revenue for FY15 is $950 M	1) Net patient revenue ($2.326 Billion) accounted for 93% of total revenue in FY2016 2) "Community Sponsorship Form" where Orlando Health gives funding to qualified organizations in the community.

Open communication and accountability related to Central Health's funds flows with its partners were a major issue that came out of the interview process, and the reason can largely be linked to the fact that Central Health is highly dependent on its tax base for its sources of revenue, unlike many of the other peer comparators that have much larger patient service revenues and operating costs. Central Health does an excellent job of tracking and communicating its sources and uses of funds to the Board, but once those funds are disbursed to its partners, it does not have mechanisms in place to accurately determine how all dollars are being used by each partner, and whether they are being deployed in a manner that is consistent with its mission. This is an area where Central Health has opportunities for improvement.

It is important to note that almost all the comparators have dollar flows to an affiliated medical school – in many cases far more substantial (e.g., Harris Health's contract with Baylor and UT-Houston exceeds $250M annually) than the dollars that flow from Central Health to the Dell Medical School. The difference is that for the other peer institutions, these dollar flows can be cleanly linked back to the costs associated

with physician and resident time and overall program support – whereas this linkage is less concrete in the case of Central Health.

Finally, most of the peer comparators have Foundations which raise money to help support the activities of the public health system. Central Health can clearly learn from some of the practices in place in Dallas and Houston, where the Foundation scale and activity is an order-of-magnitude larger than at Central Health.

7. LITERATURE REVIEW

Based on findings from the interviews, Germane did some additional research around several key focus areas that were highlighted during our discussions with stakeholders. Below are high-level findings from that review. A list of sources for the literature review, by topic, are included in the appendix.

Key Theme: Access

- The major goal of population health for Central Health should be to "deliver care that improves the health of individuals and populations."
- Timely access to preventive, acute and chronic care is one of the primary enablers of improved health outcomes
- Access to care can be measured both in terms of timeliness and affordability; good access requires improvements in both areas
- There are well-documented disparities and inequities in access to care based on income, educational attainment, race or ethnic background, and other social determinants of health – all of which must be considered when designing a care delivery system
- Lack of access in the US is often a result of relatively low investment in primary care services compared to the funding associated with specialty care
- Confusing benefit design, limited information about doctors and hospitals, and surprises in bills for unbundled services all have an impact on access, since they discourage potential patients from accessing the care delivery system in a timely manner

Key Theme: Medicaid Expansion

- Medicaid expansion was associated with a 12% increase in Medicaid coverage and corresponding declines in un-insurance rates
- The numbers of patients served after the implementation of ACA increased in both expansion and non-expansion states, and the magnitude of increase did not differ significantly between the groups of states
- Medicaid expansion was associated with improved quality on four of eight measures examined: asthma treatment, Pap testing, body mass index assessment, and hypertension control
- Access to health insurance benefits reduced poverty by 3.7 percentage points**.** Public health insurance benefits (from Medicare, Medicaid, and ACA premium subsidies) accounted for nearly one-third of the overall poverty reduction from public benefits
- Poor adults with neither children nor a disability experienced little poverty relief from public programs, and what relief they did receive came mostly from premium subsidies and other public health insurance benefits
- Medicaid had a larger effect on child poverty than all non-healthy means-tested benefits combined

Key Theme: Development of New Medical Schools

- Population growth, aging and the increasing chronicity of the US population are all causing experts to project a growing gap between the supply and demand for physicians over the next ten years – just as practicing physicians from the Baby Boomer generation start to retire
- There has been a relative explosion in the number of new accredited medical schools in the past decade as many states have proactively tried to address the imbalance through the creation of new medical school capacity
- Four major challenges exist in the establishment of a new medical school:
    - Those leading the effort must be able to convince various stakeholders (university faculty, trustees, community leaders, and government officials) of the value of establishing the school
    - They must be able to obtain the funds required to cover the costs of the initial planning process and the actions required to prepare for implementation of the school's education program, primarily the recruitment of administrative staff and faculty
    - They must develop a realistic plan for meeting the school's administrative and instructional space needs, including how funds will be obtained to cover the costs of any facility renovation or new construction that will be required
    - They must be able to enter into clinical affiliation arrangements with various healthcare organizations to ensure the school's ability to provide appropriate clinical education experiences for its students
- As in Austin and Travis County, to achieve stakeholder support, the rationale provided to support the creation of new medical schools across the country is the same:
    - Enhances the academic standing of the university;
    - Has a favorable impact on the economy of the community and region where the medical school is located;
    - Increases the supply of physicians inclined to practice in the community, region, or state, and
    - Provides citizens in the community with greater access to certain kinds of healthcare services.

Key Theme: Impact of Accountable Care Organizations

- Population-based payment models are becoming increasingly common; however, health outcomes are not as well-documented as the impact of ACOs on cost of care
- One study evaluated the health care quality and spending among enrollees in areas with lower versus higher socioeconomic status in Massachusetts before and after providers entered into the Alternative Quality Contract - a two-sided population-based payment model with substantial incentives tied to quality
- The study showed that quality improved for all enrollees in the Alternative Quality Contract after their provider organizations entered the contract. Process measures such as wait times or readmission rates improved 1.2 percentage points per year more among enrollees in areas with

lower socioeconomic status than among those in areas with higher socioeconomic status. Improvement in outcome measures for quality was no different between the subgroups; neither were changes in spending

Key Theme: Partnerships Involving Hospitals, Public Health Departments & Other Parties

- In order to be successful, the partnership's vision, mission, and values must be clearly stated, reflect a strong focus on improving community health, and be firmly supported by the partners
- The partners must demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust
- The partners should ideally have a culture of participating in collaborative arrangements and not seek to control all issues
- The partnership's goals, objectives, and programs must be based on community needs with substantial community input
- The goals and objectives should include meaningful and measurable outcomes and a timeline for achievement. Information regarding progress towards the partnership's goals and objectives should be regularly provided to the partners, the community, and other key stakeholders
- The partnership needs to have a durable structure: this can take the form of a legal entity, affiliation agreement, memorandum of understanding, or other less formal arrangements such as community coalitions
- The partners must jointly have designated highly qualified and dedicated persons to manage the partnership and its programs
- Partners must identify resource requirements (human and financial), build capital and operating budgets that are sufficient, and successfully secure those resources
- There must be mechanisms to identify and resolve conflicts or issues that are well-established and used proactively
- The partnership must monitor and measure its performance periodically against agreed-upon goals, objectives, and metrics
- The partners and staff should be deeply committed to ongoing evaluation and continuous improvement
- The partnership's goals, objectives, and programs should be assessed regularly; findings are reported to the governing body; and actions are taken to improve the partnership and its performance

8. Conclusion

Central Health is a strong organization that from all appearances takes pride in trying to serve the Austin/Travis County community and maintaining a high level of open communication in all the areas where it retains direct control. However, Central Health is also incredibly reliant on its partnership model and, as a result can at times become a "behind the scenes" organization within its own care delivery model because of the they are not the ultimate deliverers of care to the population. Central Health needs to make concerted efforts to take more control of the care delivery process through structural changes

(where available), demand increased open communication/ follow up from its partners, and enhanced feedback mechanisms that allow them to remain in touch with the needs of the community.

Appendix

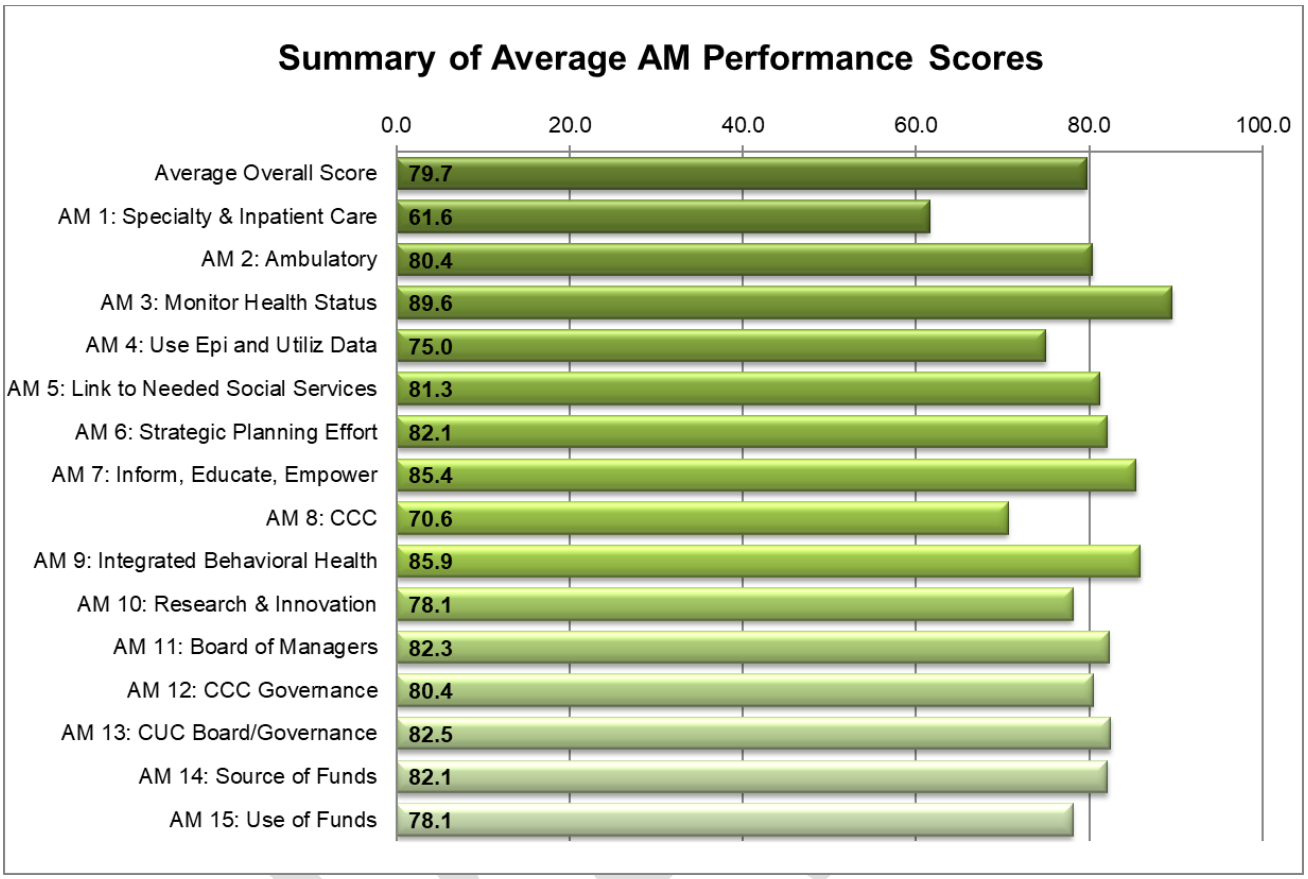
Current Performance Summary

The bar graph below displays the average performance score for each Assessment Measure, along with an average overall performance score across all Assessment Measures. Examining the scores can immediately provide insight into the greatest strengths and weaknesses of your health system.

The proceeding 15 areas of analyses were graphed on the following pages displays the average score for each of the specific performance Model Standards within each Assessment Measure. This level of analysis enables you to identify specific activities that contribute to high or low performance within each Assessment Measure.

Model Standards by Assessment Measure
AM 1: Specialty & Inpatient Care
1.1 Wait Times - Specialty Care
1.2 Specialist Availability
1.3 Cost & Quality of Care
AM 2: Ambulatory (Community Care, LoneStar, Peoples, etc.)
2.1 Accessibility
2.2 Sufficient Providers
2.3 Quality Care
2.4 Cost Per Visit
2.5 Utilization by Eligible Population
2.6 DSRIP
AM 3: Monitor Health Status to Identify Community Health Problems
3.1 Population-Based Community Health Assessment (CHA)
3.2 Current Technology to Manage and Communicate Population Health
3.3 Maintenance of Population Health Registries
AM 4: Use Epidemiologic and Utilization Data to Guide Service Delivery
4.1 Model Service Delivery on Disease Burden in Target Population
AM 5: Link People to Needed Social Services
5.1 Identification of Personal Health Service Needs of Populations
5.2 Assuring the Linkage of People to Personal Health Services
AM 6: Develop Strategic Planning Effort with Policies and Plans
6.1 Public Health Policy Development
6.2 Community Health Improvement Process and Strategic Planning
AM 7: Inform, Educate, and Empower People About Health Issues
7.1 Health Education and Promotion
7.2 Health Communication
AM 8: Community Care Collaborative - CCC (IDS)
8.1 Integration of Service Partners
8.2 Risk-sharing or Accountable Care Organization?

Model Standards by Assessment Measure
AM 9: Integrated Behavioral Health: Physical Health
9.1 Integrated Behavioral: Physical Health
9.2 Disproportionately Impacted Communities for Integrated Health
9.3 Early Diagnosis
9.4 Levels of Care
AM 10: Research New Insights and Innovative Solutions
10.1 Fostering Innovation
10.2 Linkage with Institutions of Higher Learning and/or Research
AM 11: Board of Managers
11.1 Formation/Structure
11.2 Decision Making
11.3 Oversight
AM 12: CCC Governance
12.1 Board Formation/Structure
12.2 Decision Making
12.3 Oversight
12.4 Organizational Structure
AM 13: CUC Board/ Governance
13.1 Board Formation/Structure
13.2 Decision Making
13.3 Oversight
13.4 Organizational Structure
AM 14: Source of Funds
14.1 Tax Dollars
14.2 Grant Dollars
14.3 Other Sources of Funding
AM 15: Use of Funds
15.1 Service Portfolio
15.2 Overhead


Summary of Average AM Performance Scores
0.0
20.0
40.0
60.0
80.0
100.0
Average Overall Score
79.7
AM 1: Specialty & Inpatient Care
61.6
AM 2: Ambulatory
80.4
AM 3: Monitor Health Status
89.6
AM 4: Use Epi and Utiliz Data
75.0
AM 5: Link to Needed Social Services
81.3
AM 6: Strategic Planning Effort
82.1
AM 7: Inform, Educate, Empower
85.4
AM 8: CCC
70.6
AM 9: Integrated Behavioral Health
85.9
AM 10: Research & Innovation
78.1
AM 11: Board of Managers
82.3
AM 12: CCC Governance
80.4
AM 13: CUC Board/Governance
82.5
AM 14: Source of Funds
82.1
AM 15: Use of Funds
78.1

Quadrant	Model Standard	Performance Score (%)
Quadrant A	12.3 Oversight - CCC	100.0
Quadrant A	9.4 Levels of Care (inpatient+outpatient) - Behavioral Health	100.0
Quadrant A	2.6 DSRIP Management and Administration	100.0
Quadrant A	3.1 Population-Based Community Health Assessment (CHA)	93.8
Quadrant A	13.4 Organizational Structure - CUC	91.7
Quadrant A	6.2 Community Health Improvement Process and Strategic Planning	89.3
Quadrant A	14.1 Tax Dollars	87.5
Quadrant A	13.3 Oversight - CUC	87.5
Quadrant A	11.2 Decision Making - Board of Managers	87.5
Quadrant A	9.3 Early Diagnosis Ability	87.5
Quadrant A	2.3 Quality of Care - Ambulatory	87.5
Quadrant A	5.1 Identification of Personal Health Service Needs of Populations	87.5
Quadrant A	3.3 Maintenance of Population Health Registries	87.5
Quadrant A	3.2 Availablity and Use of Technology to Track Pop. Health Data	87.5
Quadrant A	7.2 Health Communication	87.5
Quadrant A	11.1 Board Formation/Structure - Board of Managers	84.4
Quadrant A	12.4 Organizational Structure - CCC	83.3
Quadrant B	8.2 Risk-sharing or Accountable Care Organization?	85.0
Quadrant B	7.1 Health Education and Promotion	83.3
Quadrant B	15.1 Service Portfolio - Use of Funds	81.3
Quadrant B	12.1 Board Formation/Structure - CCC	81.3
Quadrant B	9.1 Integrated Behavioral Health Services (including SA)	81.3
Quadrant B	13.1 Board Formation/Structure - CUC	80.0
Quadrant B	14.2 Process to Obtain Grant Dollars	80.0
Quadrant B	2.4 Cost Per Visit	75.0
Quadrant B	11.3 Oversight - Board of Managers	75.0
Quadrant C	1.1 Wait Times - Specialty Care	81.3
Quadrant C	1.3 Cost and Quality of Care - Inpatient	78.6
Quadrant C	10.2 Linkage with Institutions of Higher Learning and/or Research	75.0
Quadrant C	5.2 Assuring the Linkage of People to Personal Health Services	75.0
Quadrant C	15.2 Overhead	75.0
Quadrant C	9.2 Disproportionately Impacted Communities for Integrated Health?	75.0
Quadrant C	2.5 Utilization by Eligible Population	75.0
Quadrant C	2.1 Accessibility	75.0
Quadrant C	2.2 Sufficent Providers - Ambulatory (Primary Care + Specialty)	70.0
Quadrant C	14.3 Other Sources of Funding - Fundraising	68.8
Quadrant C	8.1 Integration/Tracking of Patient Care Across Service Partners	56.3
Quadrant C	1.2 Specialist Availability	25.0
Quadrant D	10.1 Fostering Innovation	81.3
Quadrant D	4.1 Disease Burden Modeling For Targeted Population	75.0
Quadrant D	6.1 Input into Public Health Policy Development	75.0
Quadrant D	13.2 Decision Making - CUC	70.8
Quadrant D	12.2 Decision Making - CCC	57.1