Community Care Collaborative Strategic Planning, 2018-2020

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

Three Year Mission Metric 1:	Quality of life and longevity	Indicator: Patient-reported quality of life; years of potential life lost
Three Year Mission Metric 2:	Cost of care	Indicator: Per member per month cost

Three Year Activities & Associated Indicators

STRATEGIC FOCUS 1	STRATEGIC FOCUS 2	STRATEGIC FOCUS 3	STRATEGIC FOCUS 4
BUILD AN INTEGRATED DELIVERY SYSTEM	**REDESIGN COVERAGE PROGRAMS**	**IMPROVE VALUE IN CARE**	**OPTIMIZE HEALTH OF COVERED POPULATION**
Ensure access to appropriate services for enrollees, while enhancing care coordination and continuity of care.	***Redesign local coverage programs (Medical Access Program, Sliding Fee Scale, Seton Charity Care), eligibility rules and covered services to better serve residents for whom the CCC is responsible.***	***Use primary care setting to support value, contracting with partners for better patient outcomes, including maintaining wellness and optimizing the health of chronically ill patients; improve value within specialty care while reducing time to diagnosis and appropriate treatment.***	***Improve health outcomes for the patients for whom we care.***
Metric: Ambulatory visits vs Hospital Visits	***Metric: PMPM by Segment or PMPM Index***	***Metric: Value (Outcomes/Cost)***	***Metric: Health Outcomes by Segment***
1. Launch unified payment and associated programming.	**1. Expand coverage programs to more of population for whom partners currently pay for care.**	**1. Work with partners including Dell Medical School to develop, test and launch innovative and transformative initiatives for system of care.**	**1. Require annual Health Risk Assessment for all patients with associated, protocol-driven Comprehensive Plan of Care.**
Three Year Indicator(s): Adoption and implementation of unified payer agreements ; # of contracts with care providers including reporting and quality metrics.	*Three Year Indicator(s): % of subsidized patients enrolled in coverage programs.*	*Three Year Indicator(s): Improved value within system, measured to include factors such as cost, quality, access, satisfaction.*	*Three Year Indicator(s): % of patients with completed annual HRA; % patient adherence to CPOC.; % providers accessing CPOC at point of service.*
2. Develop IT platform that includes all data from sites of care and different service types, and is accessible to all appropriate providers.	**2. Design patient financial responsibility to induce appropriate utilization of healthcare system.**	**2. Develop competitive contracts that pay for outcomes that matter to patients.**	**2. Reduce incidence and improve management of chronic diseases, including diabetes, CHF, COPD, renal disease, liver disease.**
Three Year Indicator(s): launch of functioning data warehouse; # participants in OHCA; % providers accessing records at point of care.	*Three Year Indicator(s): % visits at sites that are appropriate for condition treated.*	*Three Year Indicator(s): % contracts w pmts tied to: appointment availability, improved/maintained health, other PROMs.*	*Three Year Indicator(s): % of patients in pre-disease status who do not convert; % patients with chronic disease with optimized health.*
3. Add access to necessary services through expanded partnerships.	**3. Design benefit package that optimizes wellness for chronically ill patients and maintains wellness for healthy people.**	**3. Develop competitive contracts that incentivize use of the whole care team.**	**3. In conjunction with partners, including the Livestrong Institute at DMS, create and launch plan to offer improved cancer care to CCC population.**
Three Year Indicator(s): Expand provider networks and type of services as needed; decreased inappropriate use of Emergency Department and Inpatient services; increased use of urgent, convenient and digital care.	*Three Year Indicator(s): % of patients with adherence to clinical standard of care; % patients with addressed SDOH.*	*Three Year Indicator(s): % primary care visits by mid-level provider; % visits rendered by other health professionals; % FFS contracts at Medicare rate.*	*Three Year Indicator(s): Plan developed and launched; improve time to diagnosis and time to treatment; improvement in age-appropriate cancer screenings.*
4. Better connect hospital services to primary care homes.	**4. Adapt eligibility and enrollment experience to bring value to the patient and ensure patient and system engagement.**	**4. Encourage, empower, and enable primary care physicians to manage specialty care issues within primary care setting; encourage appropriate utilization and reward high-value care.**	**4. Collaborate with community partners to ensure provision of women's health services.**
Three Year Indicator(s): % of patients accessing hospital care for whom care alerts are transmitted and received; reduction in PPRs, PPCs.	*Three Year Indicator(s): % of enrollees with initial clinic visit completed within determined appropriate time period; client satisfaction surveys.*	*Three Year Indicator(s): # of e-consults provided; reduction in specialty referral rates; % reduction in inappropriate diagnostics and procedures.*	*Three Year Indicator(s): Improvement in provision and quality of women's health services; improved satisfaction with services.*
5. Optimize system Case Management, Medical Management and Utilization Management functions.	**5. Increase engagement with patients to identify, address and improve the outcomes that matter to covered population.**	**5. Improve access to and quality of specialty care services that our patient population needs.**	**5. Improve delivery of behavioral health, prevention, and dental services.**
Three Year Indicator(s): Lower costs of care for highest annual users of system; reduced duplication of care management payments.	*Three Year Indicator(s): Quarterly meetings with patients; set of Patient Reported Outcome Measures; satisfaction survey.*	*Three Year Indicator(s): # of specialty care lines expanded; # of telemedicine encounters; wait time to first encounter for those who require a face-to-face visit with a specialist; time to treatment with appropriate care.*	*Three Year Indicator(s): % of patients with behavioral health need receiving timely services and reporting improvement; % patients with appropriate vaccinations and age-appropriate screenings; reduced ED use for dental problems.*