University Medical Center Brackenridge/

Dell Seton Medical Center at The University of Texas at Austin

Community Health Implementation Strategy

Prepared by Seton Family of Hospitals.

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For questions or comments on this report, please visit https://www.seton.net/chna-feedback/

Overview

University Medical Center Brackenridge is a hospital facility that is part of the Seton Family of Hospitals (Seton), a 501(c)(3) nonprofit corporation with a long-standing history of serving Central Texas, not only as a health care provider, but as a leader and advocate for improving the health of the population as a whole. In May 2017, University Medical Center Brackenridge will be replaced by and transition to the new Dell Seton Medical Center at The University of Texas at Austin, which will assume responsibility for this Implementation Strategy to address the needs identified in the Travis County Community Health Needs Assessment.

> *Seton's Mission:*
>
> *Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.*

The 2010 Patient Protection and Affordable Care Act included an IRS mandate that changed Community Benefit reporting. Non-profit hospitals must now engage in a three-year cycle of addressing community health needs, beginning with a Community Health Needs Assessment (CHNA) for the communities it serves. Once the CHNA is complete, each hospital must create and adopt an Implementation Strategy that describes the actions the hospital plans to address the health needs identified in the Community Health Needs Assessment. These mandates are required as a condition of maintaining the hospital's federal tax exemption.

Community Health Needs Assessment (CHNA)

In 2016, Seton and its partners conducted eight CHNAs for the communities served by the Seton Healthcare Family. The methodology for conducting the CHNAs included two main components:

(1) Analysis of demographic and health data using primary sources such as the U.S. Census and the Behavioral Risk Factor Surveillance System and;

(2) Collection of secondary data from community stakeholders (including residents, public health officials, nonprofit organizations, government and business stakeholders) through focus groups, community forums and surveys.

A detailed description of the methodology Seton used to conduct the 2016 CHNAs is included in the CHNA reports. The CHNA report that corresponds to the population each hospital serves is posted on the website of each respective hospital. The 2016 Travis County CHNA, used for University Medical Center Brackenridge and Dell Seton Medical Center at The University of Texas at Austin, can be found here.

Community Health Implementation Strategy

Seton has developed 15 Community Health Implementation Strategies, one for each of its hospitals and joint venture facilities. Each plan identifies the actions the hospital, with the support of the Seton, plans to take to address the prioritized needs identified in the CHNA of its

service area. As required by the IRS, the Implementation Strategies also address any needs that will not be met.

Since Seton has multiple sites, both inpatient and outpatient, throughout Travis County, the actions described in the Implementation Strategies are not strictly operated by University Medical Center Brackenridge or any one facility. The majority of these Seton-led actions are designed to serve Travis County residents regardless of where they live or seek health care.

About University Medical Center Brackenridge

Located in downtown Austin, University Medical Center Brackenridge has served the citizens of Central Texas area for more than 130 years. Previously run by the City of Austin, the hospital has been part of Seton Family Healthcare for more than two decades. The busy urban hospital has earned magnet designation for excellence in nursing by the American Nurses Credentialing Center. Magnet designation is awarded to hospitals that offer the highest level of nursing excellence.

University Medical Center Brackenridge is a hub for clinical education and recently celebrated 75 years of providing graduate medical education and was the site for the region's first nurse residency program. The renowned Clinical Education Center at University Medical Center Brackenridge trains interdisciplinary teams of caregivers in the latest medical procedures with state-of-the-art equipment.

University Medical Center Brackenridge operates the only Adult Level I Trauma Center in the Central Texas area and is one of the fourth busiest emergency departments in the nation. The hospital is home to many outstanding programs including the nationally renowned Brain & Spine Center, which is pioneering research and treatment of injuries and diseases of the spine, brain, and cardiovascular system. University Medical Center Brackenridge is also a Certified Stroke Center.

University Medical Center Brackenridge and Seton are part of Ascension, the largest nonprofit health system in the U.S. and the world's largest Catholic health system.

University Medical Center Brackenridge will be replaced and transitioned in May 2017 to the new Dell Seton Medical Center at The University of Texas at Austin.

About the Travis County CHNA

In addition to St. David's Foundation (SDF) and Baylor, Scott & White, Seton collaborated with the Austin/Travis County Health and Human Services Department (ATCHHSD) and Central Health to gather data and community input for the 2016 Travis County Community Health Needs Assessment.

Prioritized Health Needs for Travis County

After carefully reviewing the data and community input, Seton prioritized five main health needs for Travis County in the 2016 CHNA:

Need 1: Mental and Behavioral Health.

Need 2: Chronic Diseases.

Need 3: Primary and Specialty Care.

Need 4: System of Care.

Need 5: Social Determinants of Health.

Seton recognizes that the five needs listed above are inter-connected and that many Travis County residents, especially the poor and vulnerable, have cross-cutting needs.

The needs prioritized in the 2016 plan are similar to the needs identified in the 2013 Travis County CHNA, which was led by the Austin/Travis County Health and Human Services Department. The 2013 CHNA highlighted priorities including obesity, chronic diseases and disease management, behavioral health, access to care and community collaboration.

Overview of Community Health Implementation Strategy for University Medical Center Brackenridge

The following Community Health Implementation Strategy for University Medical Center Brackenridge and Dell Seton Medical Center at The University of Texas at Austin addresses all of the above needs. As required by IRS Guidelines, for each need, Seton has identified:

- Key actions to address the need.
- The anticipated impact of these actions.
- Available resource.
- Potential collaborations.

The Implementation Strategy begins with a discussion of five of Seton's most significant overarching strategies to transform health care in the region and address Travis County's prioritized health needs. Next, we have included a logic model that provides more detailed information on several Seton projects that address one or more Travis County prioritized health need. A logic model is a tool used to create a framework to evaluate the effectiveness of a strategy or initiative.

The various actions included in the Implementation Strategy are not intended to be exhaustive or inclusive of every single Seton strategy, initiative or program. Instead, the plan highlights the most significant actions that Seton has undertaken to address the health needs prioritized in the Community Health Needs Assessment, including those overarching strategies that are expected to make the most significant impact on the delivery of health care in the region for the poor and vulnerable.

Overarching Strategies

The following section of the Implementation Strategy describes the most significant overarching strategies Seton is pursuing to transform the delivery of health care in Central Texas and better fit our role of delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable.

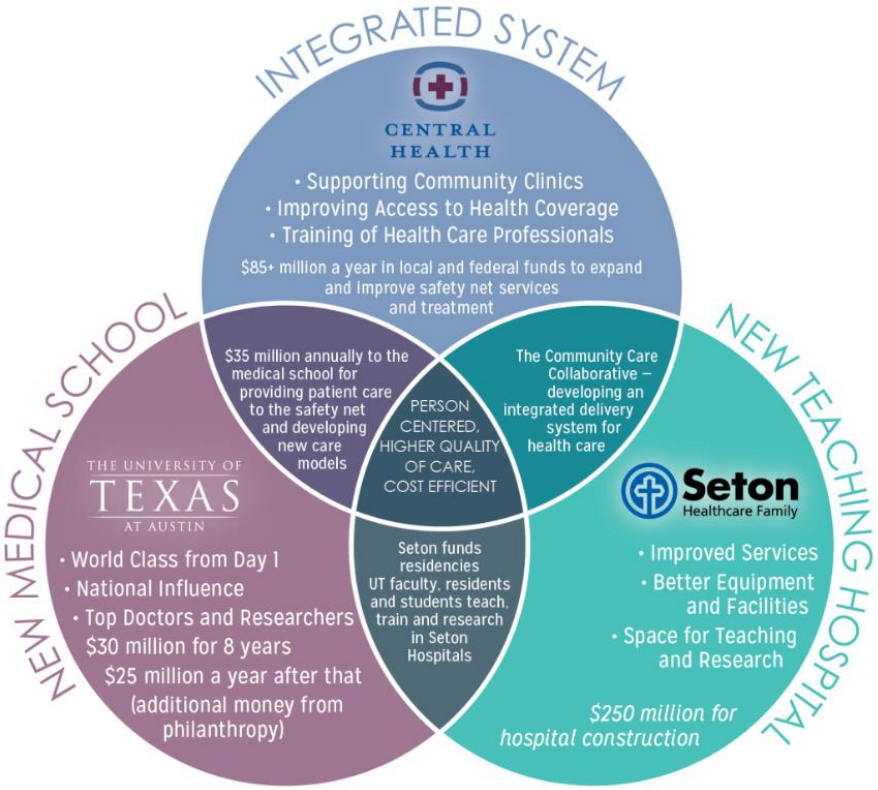
These strategies include:

- Community Care Collaborative/Central Health.
- Dell Medical School/ Dell Seton Medical Center at the University of Texas.
- 1115 Medicaid Waiver Delivery System Reform Incentive Program (DSRIP) projects.
- Telehealth.
- Population Health Command Center.

These overarching strategies address all of the five prioritized health needs identified in the Travis County Community Health Needs Assessment.

A New Model of Health care

The three-way partnership between Seton, Central Health and The University of Texas at Austin Dell Medical School is the foundation of Seton's significant investments to transform care delivery, improve the health of individuals and address community health needs.



Community Care Collaborative

Background:

The Community Care Collaborative (CCC) is a 501(c)(3) nonprofit corporation formed in 2013 by an agreement between Central Health—the healthcare district serving Travis County—and the Seton Healthcare Family.

The CCC represents one of Seton's most significant, overarching investments in addressing all the prioritized needs identified in the Travis County CHNA, including improving primary and specialty care, systems of care, chronic diseases, mental and behavioral health and social determinants of health. The CCC is addressing many of the issues raised by the community during creation of the Travis County CHNA regarding uninsured, low-income individuals, such as expanding patient navigation services and improving health management. The CCC is also committed to transforming health care delivery by focusing on the needs of patients, including prevention of illness and management of chronic diseases—resulting in demonstrably improved health outcomes and overall population health.

Community Care Collaborative Mission Statement:

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

Vision Statement:

The CCC's vision is to create a healthcare delivery system that is a national model for providing high quality, cost-effective, person-centered care and improving community health outcomes.

Actions:

For its first three years of operation, the CCC focused on planning, infrastructure and the creation of an Integrated Delivery System Plan. For more information on the integrated delivery system, visit: www.ccc-ids.org.

In 2017, the CCC plans to focus on core operational and delivery issues, including redesigning the Central Health Medical Access Program (MAP) benefit program, improving primary care services payment and delivery and enhancing specialty care services including behavioral health. The CCC will also plan and develop a comprehensive strategy to address social determinants of health and will continue to forge strategic partnerships with other nonprofit organizations to address needs that affect individuals' health.

At the time of this report, the CCC has outlined six strategic priorities areas for the next three years. Each priority and goal is listed in the table below along with the Travis County community health needs they will address. The CCC is developing specific strategies, tactics and measurements to ensure success in achieving each priority. These priorities are dynamic as they are responsive to the needs of the CCC covered population.

CCC Three Year Priorities 2017-2019

Priority	Goal	Addresses Travis County Community Health Need
Transformation:	Transform ambulatory care delivery system into a model that empowers the patient, emphasizes prevention and wellness services, sees care delivered through multidisciplinary teams, and rewards quality.	• System of Care • Primary & Specialty Care • Mental & Behavioral Health • Chronic Disease
Update Local Coverage Programs:	Update local coverage programs (Medical Access Program, MAP) eligibility rules and covered services to serve residents most at risk of poor health outcomes.	• Primary & Specialty Care • System of Care • Mental & Behavioral Health • Chronic Disease
Specialty Care Improvements:	Reduce time to diagnosis and treatment within specialty care.	• Specialty Care • System of Care • Mental & Behavioral Health
Value:	Increase value to patients and the public by improving patient outcomes while lowering the per capita cost of care.	• System of care • Primary & Specialty Care • Mental & Behavioral Health • Chronic Disease • Social Determinates of Health
Equity:	Reduce health disparities within CCC population.	• Social Determinates of Health • System of Care
Stewardship:	Ensure the fiscal strength of the Community Care Collaborative to continue care and services to the CCC population.	• System of Care • Primary & Specialty Care

Anticipated Impact:

The goal of the CCC is to radically transform how health care is delivered and improve health outcomes in Travis County, particularly for low-income and vulnerable populations. Through better-designed health care interventions, coordinated care and adding resources to address social determinates of health, the CCC with create better health for Travis County's patients and communities.

Resources:

Seton has committed executive, clinical, staff, financial and operational resources to ensure the CCC's strategic priorities are achieved. In fiscal years 2014, 2015 and 2016, Seton made significant investments in support of the CCC strategic objectives and intends to continue these investments in the years to come. In addition, Seton plays an active leadership role in terms of governance and community engagement with partners to ensure alignment around the common goal of improving the health of the community.

Collaborations:

Seton and Central Health partnered to establish the CCC to radically transform health care delivery in Travis County, particularly for low-income and vulnerable populations. Critical to the CCC's success is collaboration and contracting with key partners, including Dell Medical School, Austin Travis County Integral Care, federally qualified health centers (FQHCs), community-based providers, local social service organizations and Austin-Travis County Emergency Medical Service**.**

Dell Medical School & Dell Seton Medical Center at The University of Texas at Austin

Background:

In November 2012, Travis County voters passed Proposition 1 to support investments in the health of the Austin community, including building the new medical school at The University of Texas at Austin, Dell Medical School (DMS). At the same time, Seton committed to fund and build a new state-of-the art teaching hospital, Dell Seton Medical Center at The University of Texas, to replace University Medical Center Brackenridge, the aging public hospital Seton partnered with the city and county in 1995 to operate. Dell Seton will open in spring 2017.

This historic partnership between Seton and the Dell Medical School is one of Seton's most significant, overarching strategies to transform the delivery of health care in the region and better serve the poor and vulnerable.

Actions:

Dell Medical School will play a central role in addressing many of the prioritized needs in the Travis County CHNA, including increasing access to specialty care for the poor and vulnerable. Specifically, Seton and the Community Care Collaborative (CCC) will work with population health experts among the medical school faculty to develop more efficient care pathways. These efforts work to address community health needs including, primary and specialty care, systems of care, chronic disease and mental and behavioral health.

For example, in June 2016, Dell Medical School, Seton, the CCC and community physicians launched a pilot project to reduce wait times for high-quality musculoskeletal care such as hip and joint pain. In three months, the pilot pruned the waiting list and more than 250 patients securing appointments with musculoskeletal specialists.

Anticipated Impact:

Seton was a driving force behind the campaign to bring a medical school to Travis County and to build an adjacent modern teaching hospital because data show that hospitals affiliated with top-tier universities raise the standard of care in a community. Many of Seton physicians will serve as faculty for DMS medical students, residents and fellows.

Data also show that medical schools play a major role in a community's health care safety net. Seton expects its partnership with DMS will have a positive impact on the local safety net and will expand access to specialty and other health care services for the poor and vulnerable. In addition, DMS will help alleviate the physician shortage in Travis County and surrounding areas because, nationally, a large percentage of residents choose to practice medicine in the community where they received training.

Resources:

Seton has invested significant funding, time and leadership to support the creation of the Dell Medical School. Seton played a role in defining the new school's curriculum, employs area medical residents and funds graduate medical education. Medical students and residents will complete rotations in different specialties Seton hospitals (Dell Seton, Dell Children's Medical Center of Central Texas, Seton Medical Center Austin, Seton Shoal Creek Hospital) and clinics.

Collaboration:

Building a new medical school and teaching hospital is an historic collaboration between Seton, multiple schools at The University of Texas at Austin, and Central Health. This three-way partnership with Central Health and Dell Medical School will drive our efforts to innovate address the prioritized health needs in our community.

Delivery System Reform Incentive Payments (DSRIP)

Background:

Since 2012, Seton has operated 20 Delivery System Reform Incentive Payment (DSRIP) projects through the Texas 1115 Medicaid Waiver, administered through the Texas Health and Human Services Commission (HHSC) and the Centers for Medicare and Medicaid Services (CMS).

These projects address the varied health care needs of Medicaid recipients or low-income, uninsured individuals in Travis County. They share a common goal of improving health outcomes and lowering health care costs by reducing inefficiencies in the health care system.

All of these projects were chosen because they specifically address prioritized health needs identified in the 2012-2013 Travis County CHNA conducted by Austin/Travis County Health and Human Services Department: access to care, chronic disease, mental and behavioral health, obesity and community collaborations. These prioritized needs are nearly identical to the 2016 CHNA needs: mental and behavioral health, chronic diseases, primary and specialty care, system of care, and social determinates of health. As such, all of Seton's DSRIPs individually address one or more of the prioritized health needs identified in the 2016 CHNA and are a continuation of prior investments.

Of the 20 Seton-led DSRIPs, four focus on pediatric populations and 19 of the 20 serve residents of Travis County. There is one project in place at Seton Highland Lakes Hospital (SHL) that supports qualified Burnet County residents. Seton also is involved in 15 other DSRIP projects funded through the Community Care Collaborative (CCC), our partnership with Central Health.

Together, the DSRIP projects represent one of Seton's most significant investments to address health needs in Travis County.

Actions:

All of the DSRIPs represent actions taken by Seton and our partners to address the health care needs of Travis County residents in a way that reduces costs and improves care delivery. To

read case studies about some of the Seton DSRIPs, visit: https://www.seton.net/about-seton/healthcare-program-funding-initiatives/dsrip-case-studies/.\

The logic models under each community health need below provide additional detail about the DSRIP projects that are in place in Travis County. The projects are listed as strategies to address all of the prioritized health needs identified in the Travis County CHNA. Seton realizes that many of the DSRIP projects address multiple health needs, and for the purpose of organizing the information for the reader, we have categorized DSRIP projects by the health need they most directly address.

Anticipated Impact:

The overall goal and anticipated impact of Seton's DSRIP projects is to provide better health care at a lower cost in the right setting. Seton's DSRIP projects have been highly successful and have met or exceeded most of their stated goals. At the time of writing, federal funding for Seton's 20 DSRIPs will continue through December 2017. Because these projects have been so successful in meeting the challenges facing Travis County, Seton and its partners are advocating at the state and federal level to educate decision-makers about the value and importance of extending funding for this program. If the DSRIPs are allowed to continue, Seton plans to continue to build on success and fine tune existing projects to better serve individuals in the community.

Resources:

Seton provides organizational infrastructure and funding to implement and sustain projects. Clinical and administrative staff are provided to deliver care and services. A team of improvement advisors and business system analysts monitor projects, set measurements, collect data, analyze outcomes and identify improvements and best practices. Executive leaders provide guidance and decision-making on strategic and operational alignment of projects. If metrics are met, Seton is eligible to receive incentive funding from the state and federal agencies to reinvest in improving community health.

Collaborations:

Seton has partnered with a wide range of entities on its varied DSRIP projects. Examples include: community physicians, CCC, Central Health, Federally Qualified Health Centers, nonprofits, faith-based organizations, Dell Medical School, local mental health agencies and the Austin Independent School District.

Telehealth

Background:

Telehealth, also known as Virtual Care, is another cross-cutting, high priority network-wide strategy Seton is using to address all of the prioritized health needs identified in the 2016 CHNAs. Telehealth is a broad term that encompasses three core modalities: telemedicine, digital clinics and remote patient monitoring. Each of these modalities address one or more of the health needs prioritized in the Travis County Community Health Needs Assessment. All telehealth services are designed to be culturally competent by offering translation for non-English speakers and verbal instructions for individuals who are not able to read.

Actions:

The actions that Seton is taking in the area of telehealth fall into three broad categories: telemedicine, digital clinics and remote patient monitoring.

Telemedicine has been an important Seton strategy to improve the overall system of care, while increasing access to primary, specialty and behavioral health care, since 2008. Telemedicine involves a video consultation between a patient (who is in a clinical setting) and a health care provider located at a different physical location. An example of this is a patient with a complex condition who is hospitalized at Seton Highland Lakes, but can be examined virtually by a specialty physician at University Medical Center Brackenridge. As illustrated by this example, the impact of telemedicine is significant. Telemedicine can increase access to specialty care, reduce wait times for specialist appointments and eliminate the need for extensive travel. Tele-pharmacy is a form of telemedicine that allows patients at rural hospitals to receive a pharmacy consult via video. Tele-psychiatry services are already offered at Seton's community-based clinics that serve the poor and vulnerable through DSRIP projects. In 2017, Seton is planning to launch a telemedicine pilot program in Travis County jails to provide health care services to inmates. In the next three to five years, Seton plans to establish and expand telemedicine services for rural care, specialty care, pharmacy, psychiatry and inmate care.

Digital clinics are a second form of telehealth similar to telemedicine except the patient does not need to be in a clinical setting. Instead, the patient can be at work, home or another non-clinical setting. Seton is in discussions with the CCC about providing digital clinics for their patient population, which includes the poor and underserved.

A third modality of telehealth is **remote patient monitoring**. Beginning in 2017, patients who meet designated criteria at Seton hospitals will be sent home with a special kit containing a tablet and, depending on the patient's condition, peripheral devices to help manage a patient's condition, like a scale, glucometer or blood pressure cuff. These devices will be set up with a blue-tooth connection to automatically send patient readings to the Seton Population Health Command Center monitored 24/7 by professional staff. Triggers like blood pressure spikes, rapid weight gain or elevated blood sugars will alert the medical team to take appropriate action. In the initial roll-out of the program, remote patient monitoring will be used with pre- and post-surgical patients and individuals who have been to the emergency department more than twice in a year with Diabetes or Chronic Heart Failure. Remote monitoring is especially promising for patients who may not need or have access to full home health support services.

Anticipated Impact:

Each of the telehealth modalities described above is designed to have a positive impact on a broad segment of the population, including the poor and vulnerable. Specifically, the programs are expected to improve access to both primary and specialty care and reduce wait times for medical appointments, especially with specialists. Telehealth is also expected to improve patient compliance following hospital discharges, resulting in fewer readmissions, emergency room visits and overall better health. Seton is in the process of developing meaningful metrics to measure health outcomes for patients receiving telehealth services.

Notably, telehealth addresses needs identified by citizens in Travis County. Telehealth increase access to primary and specialty care as well as behavioral services; provides additional options to the system of care in this community; addresses and monitors chronic disease; and

addresses social determinants of health like transportation. All forms of telehealth greatly reduce the need for patients to travel and diminish geographic barriers. For example, a patient living in a rural area who had surgery in Central Austin could use telemedicine or digital clinics for follow-up visits saving a long trip into the city.

Resources:

Seton's Telehealth Program is supported by the Seton Population Health Command Center staff who ensure the connection between the physician and patient and who follow up with both physicians and patients to ensure the continuum of care. Seton will also provide the technology devices and infrastructure needed to provide care via telemedicine, digital clinics and remote patient monitoring.

Collaborations:

Seton is collaborating with many different entities on its Telehealth strategy, including community physicians, the Community Care Collaborative (CCC), Community-based clinics, Federally Qualified Health Centers and Dell Medical School. Seton is also exploring collaborations with Travis County jails and the Austin Independent School District.

Population Health Command Center

Background:

As a leading provider of health care in Central Texas, Seton is also deeply invested in improving population health. The Seton Population Health Command Center (Command Center) is one of Seton's newest strategies aimed at ensuring that patients receive the right care in the right place at the right time. Within our Humancare 2020 strategic plan, this is a strategic priority we call Optimized Delivery System. The Population Health Command Center is a key overarching strategy to addressing multiple community health needs for all the communities we serve. Telehealth, described in a separate section, is an important element of this strategy.

Actions:

The Command Center is a network-wide initiative that serves patients at all Seton hospitals and facilities. This new strategy directly addresses prioritized community health needs identified by 2016 CHNA for Travis County, including system of care, primary and specialty care, chronic disease and social determinates of health. During focus groups both community members and providers identified the need for better case management, coordination of care, patient navigation and outreach, which all fall into the CHNA need, system of care. The Command Center provides these types of care and coordination services by phone or video, in the home and out in the larger community.

Anticipated Impact:

The Command Center plays a large role in Seton's ongoing strategy to improve population health by extending its reach to new locations, while addressing complexities in the population such as chronic disease prevalence, the social determinants of health and an aging population.

The Command Center, like telehealth, is expected to have a profound and positive impact on quality and cost of care for the Central Texas community and beyond. We expect to see lower

hospital readmission rates, fewer unnecessary emergency room visits, reduced wait times for specialists and earlier detection and better management of chronic illnesses. In the long-term, we believe that people will be healthier because they have access to more convenient and affordable health care services. Seton is in the process of developing meaningful metrics to measure health outcomes for patients receiving support through the Command Center.

Resources:

Seton has invested in the staff, technology and infrastructure needed to seamlessly connect patients and providers through a wide range of centralized care and coordination services. The Command Center is staffed by an interdisciplinary team of health care professionals, including: registered nurses, nurse practitioners, clinical social workers, registered dietitians, certified diabetes educators, health promoters and patient access representatives. These professionals are all employed by Seton and work as a team to provide care coordination and navigation to strengthen the continuum of care. Services are available to Seton patients and the community 24/7.

Collaboration:

The Command Center is collaborating with many different entities, including community physicians, the Community Care Collaborative (CCC), Community-Based Clinics, Federally Qualified Health Centers and Dell Medical School. Seton also is exploring collaborations with Travis County jails and the Austin Independent School District.

Initiatives Addressing Prioritized Community Health Needs:

1. Mental and Behavioral Health

PRIORITIZED NEED: 1. Mental and Behavioral Health

STRATEGY 1A: Navigate individuals at risk of a substance use disorder to intervention and treatment.

BACKGROUND INFORMATION:

- Many individuals present at state medical facilities with substance abuse issues who would benefit from substance abuse assessments and referral to early intervention and community treatment providers.
- The target population is UMCB inpatient or emergency patients with an identified mental health and/or substance abuse need or recent history of mental health and/or substance abuse issues.

RESOURCES:

- Staff: Social workers and licensed chemical dependency counselors.
- Budget: Operational budget and DSRIP incentive funds.
- Materials: Patient assessment, education and marketing materials.

COLLABORATION:

- Seton hospitals
- Community Care Collaborative
- Central Health
- Seton Health Plan
- Other Seton DSRIP projects: Seton Total Health and Diabetes Chronic Care.
- Seton Behavioral Health
- Seton Case management
- Seton Trauma Services certification (Williamson)
- Seton Mind Institute
- Austin-Travis County EMS Community Health Paramedic Program
- High Alert Program
- Austin Travis County Integral Care

ACTIONS:

- Screen and assess patients for substance abuse and risk factors.
- Collaborate with hospital-based treatment team to ensure discharge plan includes substance abuse referrals.
- Refer patients to community agencies and treatment providers or facilitate assessment and admission at Seton Behavioral Health's Intensive Outpatient Program (IOP).
- Contact patients post-discharge to reinforce discharge plan and provide navigation services.

ANTICIPATED IMPACT:

- Reduced readmission rates for substance abuse.
- Decreased emergency room utilization.
- Increased number of patients receiving substance abuse assessments and referrals.

PRIORITIZED NEED: 1. Mental and Behavioral Health

STRATEGY 1B: Provide free behavioral health assessments and navigate individuals to community health providers.

BACKGROUND INFORMATION:

- Many individuals present at state medical facilities with mental health and/or substance abuse issues that would benefit from further assessments and navigation to treatment.
- The target population for this program is UMCB inpatient or emergency patients with an identified mental health and/or substance abuse need or recent history of mental health and/or substance abuse issues.

RESOURCES:

- Staff: Social workers and licensed chemical dependency counselors.
- Budget: Operational budget and DSRIP incentive funds.
- Materials: Patient assessment, education and marketing materials.

COLLABORATION:

- Community Care Collaborative/Central Health
- Seton Health Plan
- Seton Communication Center
- Other Seton DSRIP projects: Seton Total Health and Diabetes Chronic Care.
- Seton Behavioral Health
- Seton Case management
- Seton Trauma Services certification (Williamson)
- Seton Mind Institute
- Austin-Travis County EMS Community Health Paramedic Program
- High Alert Program
- Austin Travis County Integral Care

ACTIONS:

- Provide free mental health and substance abuse assessments and referral to early intervention and community treatment providers for individuals needing behavioral health.
- Provide navigation services that encourage patients to follow through with treatment recommendations.

ANTICIPATED IMPACT:

- Increase access to needed mental health and substance abuse assessments and referrals.
- Increase patient follow through with recommended treatments.

PRIORITIZED NEED: 1. Mental and Behavioral Health

STRATEGY 1C: Expand access to psychiatric services through telemedicine technology.

BACKGROUND INFORMATION:

- Behavioral health comorbidities impact a significant percentage of the population.
- The target population for this project is patients at all Seton hospitals in Travis County.
- About 60% of patients served are low-income, uninsured or on Medicaid.

RESOURCES:

- Staff: Physicians, nurses, social workers, technology staff.
- Budget: Operational budget, DSRIP funds.
- Materials: Technology equipment and infrastructure.

COLLABORATION:

- Seton Telemedicine Department
- Seton Travis County hospitals' inpatient and ED departments
- Seton Transfer Center
- JSA Health

ACTIONS:

- Establish systems and technology to allow for 24/7 video consultations of patients with mental health specialists.
- Train social workers and emergency room physicians on the availability and use of telemedicine psychiatric evaluations.
- Deliver video consultations to patients with identified mental health needs.

ANTICIPATED IMPACT:

- Improve access to mental health assessments and referrals, improve health outcomes and reduce costs.

PRIORITIZED NEED: 1. Mental and Behavioral Health

STRATEGY 1D: Create a new psychiatric emergency department.

BACKGROUND INFORMATION:

- The target population for this project is patients in psychiatric crisis who present at Travis County emergency rooms.
- Approximately 62% of individuals served are low-income, uninsured or on Medicaid.

RESOURCES:

- Staff: Medical Director, Psychiatrists, Advanced Practice Registered Nurses, Physician Assistants, Clinical and Administrative support staff
- Budget: Operational budget, DSRIP incentive funds.
- Materials: Medical equipment and supplies, space, technology equipment and infrastructure,

COLLABORATION:

- Seton Travis County hospitals
- Non-Seton Travis County hospitals
- Central Health
- Community Care Collaborative
- Austin Travis County Integral Care
- Dell Medical School
- Travis County
- Austin Police Department

ACTIONS:

In April 2014, Seton and partners established a psychiatric emergency department at University Medical Center Brackenridge to:

- Conduct psychiatric assessments
- Provide emergency nursing care
- Provide social work assessment and/or crisis intervention
- Provide safety and discharge planning
- Provide pharmaceutical intervention, including emergency medications
- Coordinate referrals to additional and higher levels of care

ANTICIPATED IMPACT:

- Diversion of psychiatric crisis patients away from community emergency departments into a more clinically appropriate, cost effective, and centralized psychiatric emergency department.
- Reduction in the percentage of patients who leave the emergency room without being seen.

PRIORITIZED NEED: 1. Mental and Behavioral Health

STRATEGY 1E: Increase access to mental and behavioral health care services by expanding post-graduate training (residencies and fellowships) for psychiatric specialties/psychiatric residency programs in Travis County.

BACKGROUND INFORMATION:

- Central Texas has a shortage of psychiatrists, which impacts access to mental and behavioral health care.
- Residents and fellows will serve outpatients at all Seton Travis County hospitals.

RESOURCES:

- Staff: Faculty, residents, fellows.
- Budget: Operational budget, DSRIP funds.

COLLABORATION:

- Seton Travis County Hospitals
- Dell Medical School
- University of Texas College of Pharmacy
- Seton Telemedicine Department
- Austin State Hospital

ACTIONS:

- Conduct a qualitative and quantitative gap analysis to identify needed behavioral health specialty vocations lacking in the health care region and issues contributing to gaps.
- Develop plan of action to increase size of post graduate training programs for identified psychiatric specialties.
- Recruit additional faculty to supervise trainees and also provide direct patient care.
- Provide treatment to identified patients.

ANTICIPATED IMPACT:

- Improved access to mental and behavioral health assessments and treatment for Travis County's poor and uninsured.

2. Chronic Diseases

PRIORITIZED NEED: 2. Chronic Diseases

STRATEGY 2A: Provide treatment and care coordination for adults with chronic conditions or serious injuries using a multi-disciplinary team of providers.

BACKGROUND INFORMATION:

- The target population is low-income or uninsured adult patients with one or more chronic conditions or serious injury who are discharged from Seton hospitals in Travis County.

RESOURCES:

- Staff: Nurse case managers, social workers, health promoters, dieticians, Advanced Practice Nurses, medical director, administrative staff.
- Budget: Operational budget, DSRIP incentive funds.
- Materials: Medical equipment and supplies, space, educational and outreach materials.

COLLABORATION:

- Seton hospitals in Travis County
- Community Care Collaborative
- CommUnity Care
- Seton Mind Institute
- Seton Case Management
- Austin Travis County Integral Care

ACTIONS:

- Consult with patients to determine specific needs and level of cognitive function.
- Assist patient with obtaining coverage, medication access, transportation services and necessary medical services. Support patient in addressing social determinates of health.
- Provide patient with needed services, such as nutritional counseling, psychosocial support and disease and self-care related information.
- Facilitate access to psychiatric services.
- Provide a structured hand-off to the next provider after discharge, to ensure continuity of care.

ANTICIPATED IMPACT:

- Reduce emergency department utilization.
- Reduced hospital readmission rates.
- Better health outcomes and care provided at the right time in the right setting.

PRIORITIZED NEED: 2. Chronic Diseases

STRATEGY 2B: Improve outcomes for adult inpatients or observation patients diagnosed with diabetes through implementation of standardized, evidence based protocols.

BACKGROUND INFORMATION:

- This project targets adult inpatients or observation patients at UMCB, SMCA, SSW and SNW who are either at risk for diabetes, or diagnosed with diabetes, and who are at risk for readmission.
- More than half of individuals being served by the program are low-income, uninsured or on Medicaid.

RESOURCES:

- Staff: Advanced Practice Nurses, Health Promoters, Nurse Navigators, administrative support.
- Budget: Operational and marketing budgets, DSRIP incentive funds.
- Materials: Medical equipment and supplies, space, evidence based protocols, educational and outreach materials.

COLLABORATION:

- Seton Travis County Hospitals
- Other Seton DSRIP Projects
- Seton Outpatient Diabetes Education Program

ACTIONS:

- Identify potential inpatients to participate in the program.
- Evaluate and treat patients using a set of evidence-based interventions (called the Diabetes Care Bundle).
- Provide patient with diabetes survival skills education prior to discharge.
- Schedule appointment for patient with follow up-provider prior to discharge.
- Communicate discharge plans to follow-up provider.
- Identify and refer patient to appropriate community resources to promote overall patient wellness.
- Follow up with patient within 72 hours of discharge.

ANTICIPATED IMPACT:

- Reduced hospital readmissions for diabetes patients.
- Reduced emergency room visits.

PRIORITIZED NEED: 2. Chronic Diseases

STRATEGY 2C: Provide treatment and care coordination for adults with one or more chronic conditions (including diabetes, heart disease, asthma, HIV-AIDS).

BACKGROUND INFORMATION:

- The target population for this program is primarily the low-income uninsured and under-insured individuals treated at the Seton Community Health Centers who have one or more chronic health conditions.

RESOURCES:

- Staff: Physicians, nurse case managers, dietician, program manager
- Budget: Operational budget, DSRIP incentive funds
- Materials: Medical equipment and supplies, space, evidence based tools, patient education and outreach materials

COLLABORATION:

- Seton McCarthy, Kozmetsky and Topfer clinics
- Seton Community Clinic Providers
- Community Care Collaborative (CCC)
- CommUnity Care

ACTIONS:

- Conduct individualized chronic care assessment on identified patients.
- Develop chronic care management plan for patient.
- Provide case management.
- Provide education and coaching on optimal self-care.
- Refer patient to appropriate ancillary services and/or community care providers.
- Coordinate care between patient and care team.
- Provide ongoing medication management.
- Provide ongoing monitoring of disease-specific indicators, such as blood pressure, blood sugar levels.

ANTICIPATED IMPACT:

- Reduce emergency department utilization.
- Reduced hospital readmission rates.
- Increase health outcomes and care provided at the right time in the right setting.

3. Primary and Specialty Care

PRIORITIZED NEED: 3. Primary and Specialty Care

STRATEGY 3A: Expand timely access to breast and cervical cancer screening via a mobile unit.

BACKGROUND INFORMATION:

- This program targets uninsured and underinsured women in Travis County.

RESOURCES:

- Staff: Mammographer, nurses, Advanced Practice Registered Nurses and support staff.
- Budget: Operational, marketing and public relations budget, DSRIP funds.
- Materials: Mobile unit, medical equipment and supplies, technology and infrastructure, educational and outreach materials.

COLLABORATION:

- Medical and community clinics
- Public service and government agencies
- Civic and business organizations
- Service and social clubs
- Places of worship
- Community and senior centers
- Migrant worker centers

ACTIONS:

1. Promote availability of screenings via community partners and media.
2. Conduct patient screenings via mobile unit.
3. Provide navigation services and support for women with abnormal screenings and/or cancer diagnoses.

ANTICIPATED IMPACT:

- Improved access to mammograms for women age 40-64.
- Improved access to cervical cancer screenings for women age 21-64.
- Increased follow-up among women with abnormal screenings.

4. Systems of Care

PRIORITIZED NEED: 4. System of Care

STRATEGY 4A: Provide navigational services from cancer diagnosis to treatment and survivorship services for women.

BACKGROUND INFORMATION:

- This program targets Texas County women receiving treatment for gynecologic cancer (ovarian, uterine, and cervical) at the Shivers Cancer Center Gynecologic Oncology Clinic and survivors over age 40 who are at high risk for disconnect from institutionalized health care.
- Approximately 77% of women served are low-income, uninsured or on Medicaid.

RESOURCES:

- Staff: Nurse navigators, health navigators.
- Budget: Operational and marketing budget, DSRIP funds.
- Materials: Patient education and outreach materials.

COLLABORATION:

- Seton Community Health Centers
- Seton Shivers Cancer Center Gynecologic Oncology Clinic
- CommUnity Care
- LIVESTRONG

ACTIONS:

- Coordinate newly diagnosed patient's connection with treatment and support services.
- Address patients social service needs, including basic necessities such as food and shelter.
- Create a survivorship plan after patient's initial treatment
- Link patients with health coverage and specialty care for surveillance of long-term side effects of cancer treatment.

ANTICIPATED IMPACT:

- Reduced cancer-related hospital admissions.
- Increase patient satisfaction and health outcomes.

PRIORITIZED NEED: 4. Systems of Care

STRATEGY 4B: Increase language translation and quality of communications between the health care provider and patient to achieve greater patient involvement in shared decision-making.

BACKGROUND INFORMATION:

- Seton provides in-person interpretation services for Spanish and ASL at all locations. Additional languages are available through phone and/or video relay interpretation.

RESOURCES:

- Staff: Interpreters, administrative support.
- Budget: Operational budget, DSRIP funds.
- Materials: Educational, outreach and training materials, technology devices and infrastructure.

COLLABORATION:

- Community patients/physicians
- Seton leadership
- Hospital leadership
- Language Services Department

ACTIONS:

- Acquire new technology to deliver video interpretation in over 200 languages.
- Provide training opportunities for bilingual staff.
- Engage and educate leadership about availability of language services.
- Provide quality language services to patients from hospital admission to discharge.

ANTICIPATED IMPACT:

- Enhanced access to interpretation services.
- Better quality communication between the clinical care team and patients.
- Greater patient involvement in shared decision making.

1. Social Determinants of Health

PRIORITIZED NEED: 5. Social Determinants of Health
STRATEGY 5A: Provide a diverse population of patients with access to health care delivered by culturally competent professionals.
BACKGROUND INFORMATION: • The target population is all patients at University Medical Center Brackenridge, Seton Medical Center Austin, Seton Northwest Hospital, and Seton Southwest Hospital.
RESOURCES: • Staff: Instructors and project coordinator. • Budget: Operational budget, DSRIP funds. • Materials: Educational, outreach and training materials.
COLLABORATION: • Community patients/physicians • Seton leadership • Seton Hospital leadership • Language Services Department
ACTIONS: • Hire trainers and develop cultural competency curriculum. • Engage and educate leadership about culturally competent care training. • Conduct training to Seton associates.
ANTICIPATED IMPACT: • Better quality communication between the clinical care team and patients. • Greater patient involvement in shared decision making.

Social Determinants of Health

Background:

The Centers for Disease Control and Prevention define social determinants of health as "conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes." During the CHNA process, when asked to identify the most pressing health needs facing Travis County, community members frequently cited social determinants of health such as transportation, affordable housing and poverty.

Actions:

As part of Ascension, the largest non-profit health system in the U.S. and the world's largest Catholic health system, Seton is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. Seton acknowledges the impact environmental and life factors have on a person's health outside health care settings. Seton executives, physicians and associates are both leaders and active participants in strategic discussions about many of the most pressing social and economic issues impacting communities we serve. This includes many of the social determinants of health raised by the community during the 2016 CHNA process, such as transportation and housing.

Seton is directly addressing social determinants of health in several ways:

- Seton is evaluating the effectiveness of its procedures for social service referrals to better support underserved populations.
- Several of the Seton 1115 Medicaid Waiver DSRIP Project address social determinants of health, such as the cultural competency project that is later detailed in a logic model
- Seton's Telehealth and Command Center strategies described above address transportation issues by allowing patients to receive care in their community or even in their own homes.
- Seton has established collaborations, including the CCC and has provided monetary donations and funding to agencies that align with our mission and address social determinants of health.

Anticipated Impact:

By building internal capacities, partnering with different agencies and providing leadership in the community, Seton anticipates our efforts will work toward addressing social determinates of health and have a positive impact on the communities we serve. We will identify initiatives that align with our mission and strategic plan, have measurable outcomes, demonstrate social and economic impact, and meaningfully address social determinates of health.

Resources:

Seton plans to continue to identify partnerships and invest with monetary donations in community organizations and nonprofits to address social determinants of health and other community health needs. All donations and sponsorship requests are currently reviewed by a formal Donations and Sponsorships Committee, composed of Seton associates and executive leaders. The Committee reviews requests and seeks partnerships with organizations that share Seton's mission, vision and values and can demonstrate the positive impact of their programs.

Planned Collaborations:

Seton recognizes we cannot fully address social determinants of health alone. Collaborations with agencies that have expertise serving a broad range of social determinants of health are one of the most effective ways to serve these varied needs in our community. Through these community partnerships and financial investments, we will maximize community impact in addressing social determinants of health.

In Travis County, the Community Care Collaboration (CCC), our non-profit with Central Health, represents a major strategic effort to address social determinates of health. The CCC will

continue to identify initiatives to address social determinates of health and will contract with social service organizations to address pressing needs that impact an individual's' health.

Seton also has several ongoing collaborative projects designed to improve the overall health of the community. In fiscal year 2017, Seton will explore opportunities to address the health care needs of Travis County Jail inmates. Seton also plans to collaborate with homeless support agencies in Travis County, particularly those that provide affordable, permanent housing to the disabled and chronically homeless, to improve access to health care services. Seton also is planning to identify and implement new partnership agreements with major social services partners to achieve shared goals.

Conclusion

Developing this Community Health Implementation Strategy was a collaborative effort of many areas within Seton and our partners. Seton views this document as dynamic and evolving plan of how we serve our communities. As we learn more from our community and build new investments and capabilities, this plan will change and grow. Substantive modifications and additions to this plan will be brought to our boards for review and approval.