CENTRAL HEALTH

SERVICE DELIVERY STRATEGIC AND OPERATIONAL IMPLEMENTATION PLAN OVERVIEW INCLUDING SERVICES FOR PEOPLE WHO ARE UNHOUSED

2023

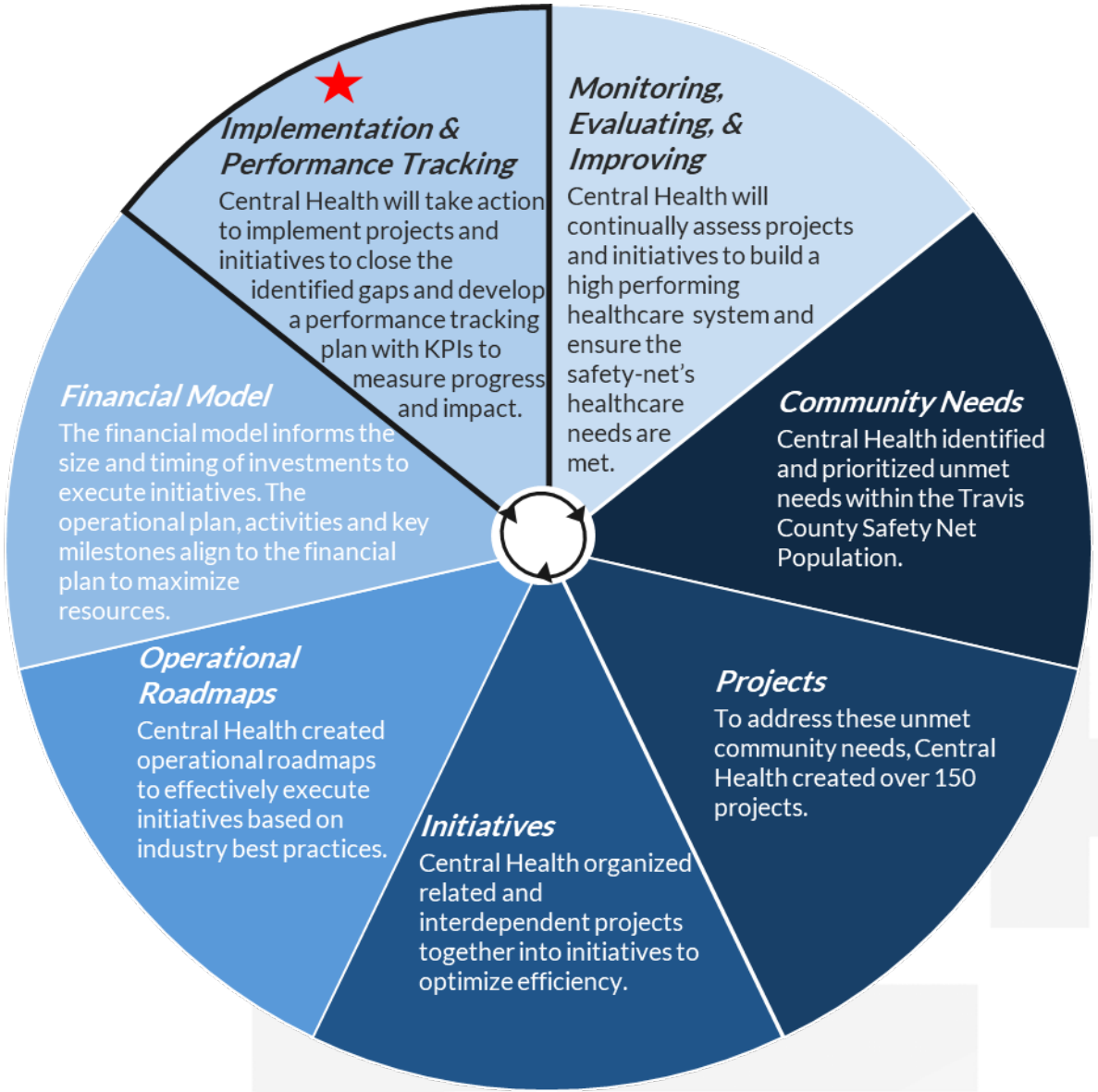
CENTRAL HEALTH

WHAT IS CENTRAL HEALTH?

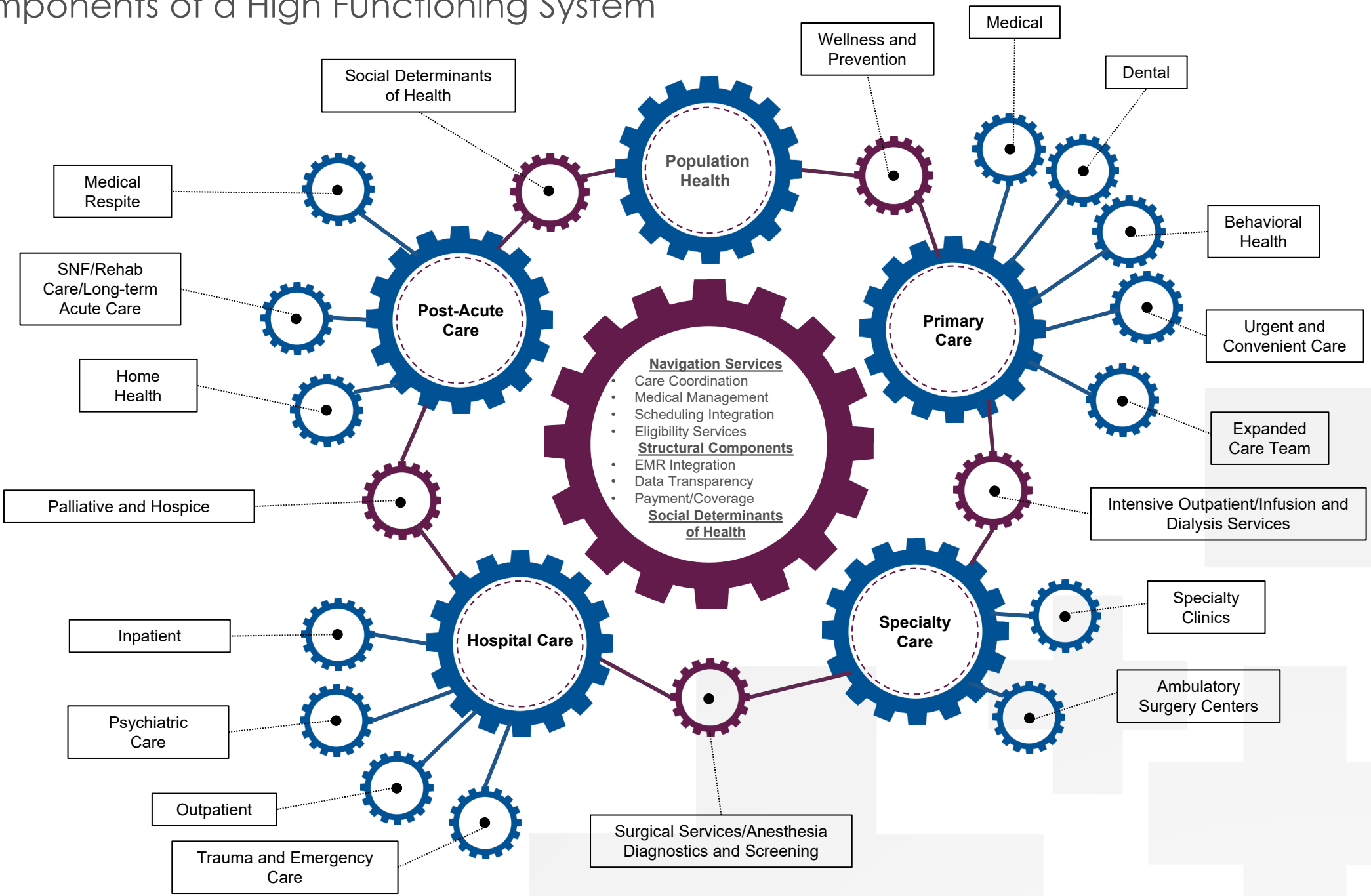
CENTRAL HEALTH

- Central Health (CH) is the local hospital district created by the Texas legislature and the voters of Travis County in 2004
- Governed by a nine-member volunteer Board of Managers with four-year terms
  - Four board appointments by Austin City Council; four by Travis County Commissioners Court; one joint appointment
- Central Health must coordinate the delivery of basic health care services and provide health care assistance
  - *"Beginning on date taxes are collected for the district, the district assumes full responsibility for furnishing medical and hospital care for indigent and needy persons residing in the district."*
  - *"County or municipality located in the district may not levy taxes for medical care or hospital purposes."*
  - Central Health must retain sufficient control over funds expended to comply with state Constitutional limitations
    - Documented by showing that the expenditure supports CH's mission and
    - Meets Central Health's obligations and responsibilities to the population it serves

Over the Last 2 Years, Central Health Has Been Committed to Creating a High Performing Healthcare System

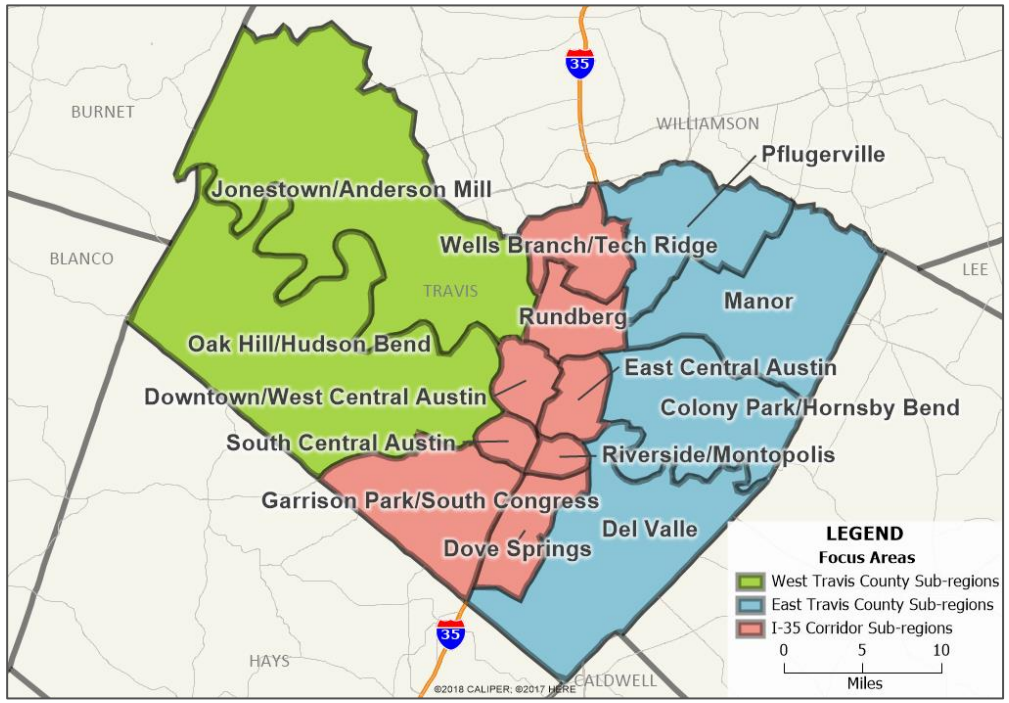


Components of a High Functioning System



The Planning and Assessment Regions align to three focus areas: I-35 Corridor, East Travis County, and West Travis County

Travis County: Focus Areas



Overview

I-35 Corridor

- **Total Population: 808,534**
- **~ 74% of the total population <200% FPIL** in Travis County
  - **Rundberg makes up 17%** of the total <200% FPIL population
- **Total MAP, MAP Basic and SFS enrollment makes up 67% of total enrollment in Travis County**, and families in poverty make up **71% of the total families in poverty** in Travis County

East Travis County

- **Total Population: 216,404**
- **~ 18% of the total population <200% FPIL** in Travis County
- **Total MAP, MAP Basic and SFS enrollment makes up 28% of total enrollment in Travis County** and families in poverty make up **19% of the total families in poverty** in Travis County

West Travis County

- **Total Population: 282,970**
- **~ 8% of the total population <200% FPIL** in Travis County
- **Total MAP, MAP Basic and SFS enrollment makes up 5% of total enrollment in Travis County,** and families in poverty make up **9% of the total families in poverty** in Travis County

Sources: Planning Regions defined in partnership with Central Health; Poverty Level data from 5-Year estimates obtained from the American Community Survey (2019); Total MAP, MAP Basic, and SFS Enrollment data is received from Central Health.

The scale and scope of unmet clinical needs for the safety-net is substantial across Travis County and is forecasted to increase

Primary Care/ Wellness

① *Primary Care*

- *Timely service access*
- *Access to social services*
- *Quality care*

Significant Gaps | Moderate Gaps | Minimal Gaps

② *Wellness and Prevention*

- *Patient communication and education*
- *Prevention and screening*
- *Diet, nutrition & exercise*

Significant Gaps | Moderate Gaps | Minimal Gaps

③ *Urgent & Convenient Care*

- *Virtual options*
- *Same day and convenient access*

Significant Gaps | Moderate Gaps | Minimal Gaps

Specialty Care/ Behavioral/ Dental

④ *Specialty Care*

Select services include Cardiology, GI, Hem/Onc, Nephrology, Neurology, Ortho, Gyn Surgery, ENT, Ophthalmology, Psych, Radiology

Significant Gaps | Moderate Gaps | Minimal Gaps

⑤ *Behavioral Health*

Substance use disorders, serious mental illness, anxiety, depression, also includes psych hospitals

Significant Gaps | Moderate Gaps | Minimal Gaps

⑥ *Dental*

Primary and specialty dental access

Significant Gaps | Moderate Gaps | Minimal Gaps

Hospital Based/ Post Acute

⑦ *Hospital*

Surgical Services, ASC Access, Hospital transitions, hospital-based specialty care, diagnostics, infusions, ED Services

Significant Gaps | Moderate Gaps | Minimal Gaps

⑧ *Post Acute*

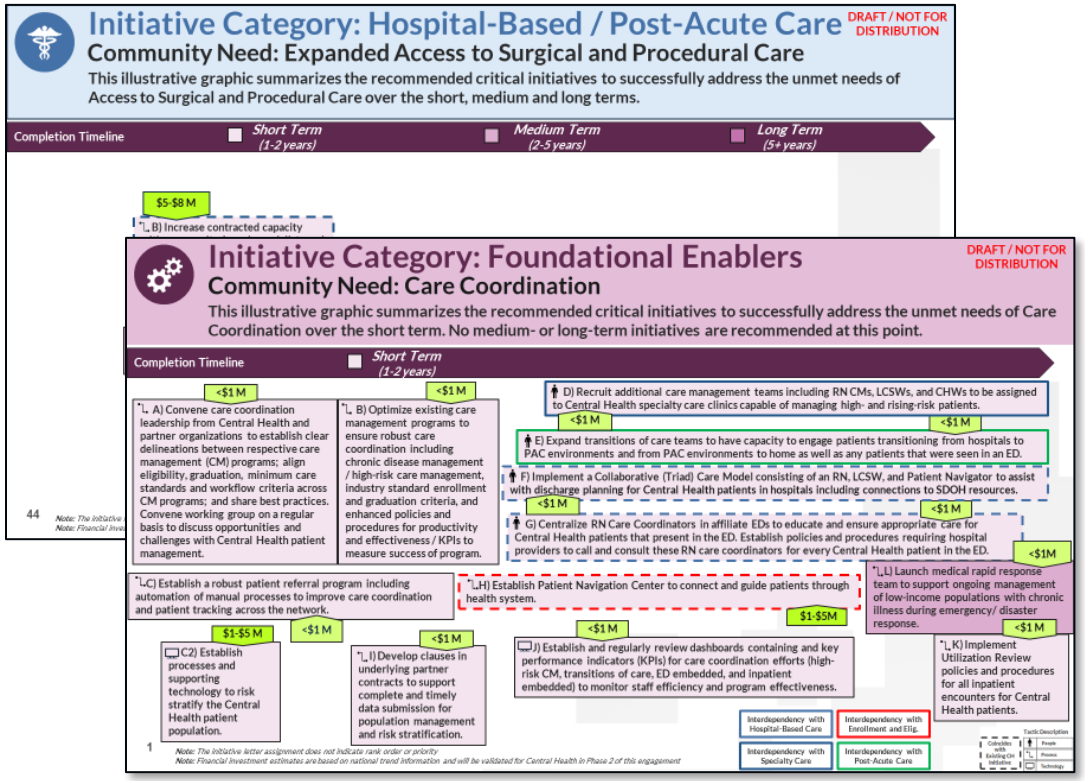
Respite care, home health care, custodial care

Significant Gaps | Moderate Gaps | Minimal Gaps

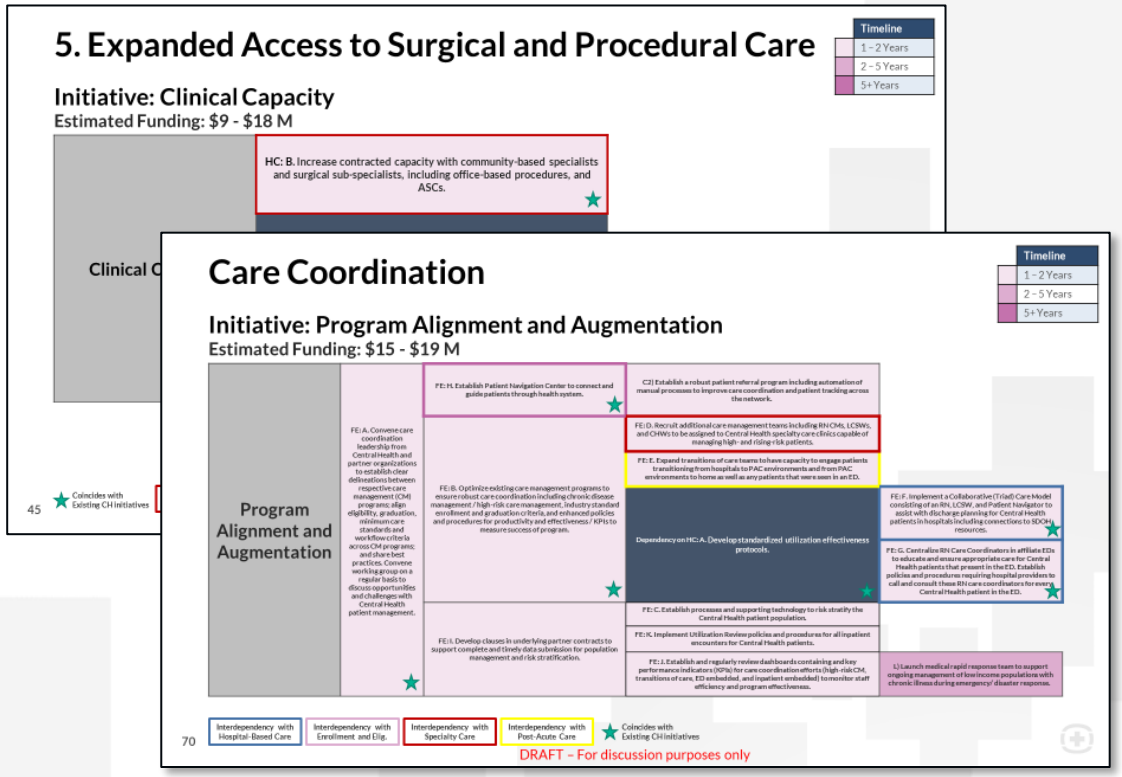
Legend Significant Gaps | Moderate Gaps | Minimal Gaps

Initiatives and Projects Were Developed For Patients to Get the Right Care at the Right Time in the Right Place

January 2023: Identified, prioritized and sequenced projects



March 2023: Organized related and interdependent projects into initiatives to develop operational and financial roadmaps



Data-Driven and Community - and Stakeholder-Focused Processes

Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

Community Need	Projects	
Health Care for the Homeless	▪ Develop Mobile Care Clinic Processes, Technology, and Staff to Support Expanded Mobile Care Clinics ▪ Integrate ED Care Coordinators to Reduce Inappropriate Utilization and Preventable Admissions ▪ Train Patient Navigators to Connect Patients to Housing Assistance Services ▪ Expand Mobile Care Services to Include Access to Mental Health Services and Chronic Diseases Management	▪ Research and Source Grant Funding Opportunities for Primary Care Services ▪ Create a Collaborative Care Model with CBSOs and Housing Authorities to Connect Unhoused Patients to More Permanent Housing and SDoH Resources ▪ Provide Wraparound Medical Services to Unhoused Individuals Through Additional Service Locations ▪ Expand Mobile Care Clinic Services Along I-35 Corridor ▪ Establish a High Risk Care Clinic
Same-Day Care and Extended Hours	▪ Expand Capacity of Urgent and Convenient Care Contracts to Enhance Services ▪ Expand RN / CHW Care Coordinator Dyad in ED to Triage Patients Appropriately ▪ Establish Joint Quality Review Board to Review ED Utilization ▪ Initiate Marketing and Communications Campaign to Educate Patients on Available Same-Day Resources ▪ Expand Convenient Care Footprint including Limited Urgent Care, Screening, Wellness, etc.	▪ Expand Telehealth Services by Determining Number of Patients Accessing Convenient Care ▪ Expand Convenient Care Telehealth Services ▪ Expand Access to Community- Based Urgent Care
Primary Care, including CUC HIV/AIDS Program and Pharmacy	▪ Optimize Contracts by Instituting Quality Metrics and Innovative Payment Models ▪ Expand HIV/AIDs Screening, Treatment, and Education at CommUnityCare and Hancock Center	▪ Expand Primary Care Capacity by Evaluating High Volume Areas for Primary Care and Aligning on Location and Physical Space for Sites ▪ Expand Pharmacy Services through Telehealth and Collaboration with Mobile Care Clinics ▪ Establish Multi-Disciplinary Care Approach to Expand Care for Medically Complex Patients ▪ Expand Hours for Primary Care Clinics including Same Day, Next Day, Weekend, and Evening ▪ Medication Therapy Management (MTM) Program to Optimize Patient Outcomes, Improve Drug Adherence and Prevent Costly Medication Problems
Expanded Access to Specialty Care	▪ Operationalize RZ Clinic including Processes, IT Capabilities, and Recruit Staff and Providers ▪ Expand DME Capacity to Address Outpatient DME and Supply Gaps ▪ Build and Internalize Vendor Capabilities In-House Expand Clinical Services Footprint ▪ Increase Diagnostic Capacity in RZ Clinic and/or with Contracts ▪ Expand Ambulatory Contract Capacity in Key Specialty Areas ▪ Establish Governance Processes for Specialty Care Service Contracts ▪ Local Medical Assistant and Registered Nurse Programs to Build Adequate Staffing Capacity ▪ Implement Evidence-Based Care Delivery Model	▪ Extend Care Coordination Efforts with CHWs to Specialty Care Environment ▪ Operationalize Hancock Center including Services, Processes, Space Needs, etc. ▪ Evaluate and Right Size RZ Clinic Phase 2, including Proposed Specialties ▪ Increase Advanced Imaging Capacity ▪ Build Surgical Office and Consultation Capacity for High- Volume Low-Acuity Surgeries ▪ Build Data Sharing Capacity with FQHCs and Other Partners ▪ Develop Chronic Disease Programs with Multidisciplinary Approach to Improve Patient Quality of Life ▪ Address Future Specialty Care Access Needs and Site of Service ▪ Buy/Build/Partner to Build Ambulatory Surgical Center with Dedicated Safety-Net Capacity
SUD and Addiction Medicine Services	▪ Centralize Substance Use Disorder Resources to Connect Patients to Services and Resources ▪ Improve Substance Use Disorder Data Sharing, Quality Metrics and Communications for Providers to Effectively Monitor and Triage Patients ▪ Increase Contracted Capacity with Community Medical Services for Methadone MAT ▪ Develop Care Models for Alcohol and Stimulant Addiction including Detox Services ▪ Addiction Medicine Specialist to Assist Overseeing Service Line and Work with Local Entities	▪ Suboxone Medication-Assisted Treatment Program ▪ Medically-Supervised Detox for Opioid Use Disorder ▪ Medically-Supervised Detox for Alcohol / Stimulant Use ▪ Build Team-Based Provider Capacity for Substance Use Disorder Treatment in Ambulatory Care Setting, including Home or Tele-Rooms ▪ Develop Model for Virtual Team- Based Substance Use Disorder Treatment in Ambulatory Care Environment

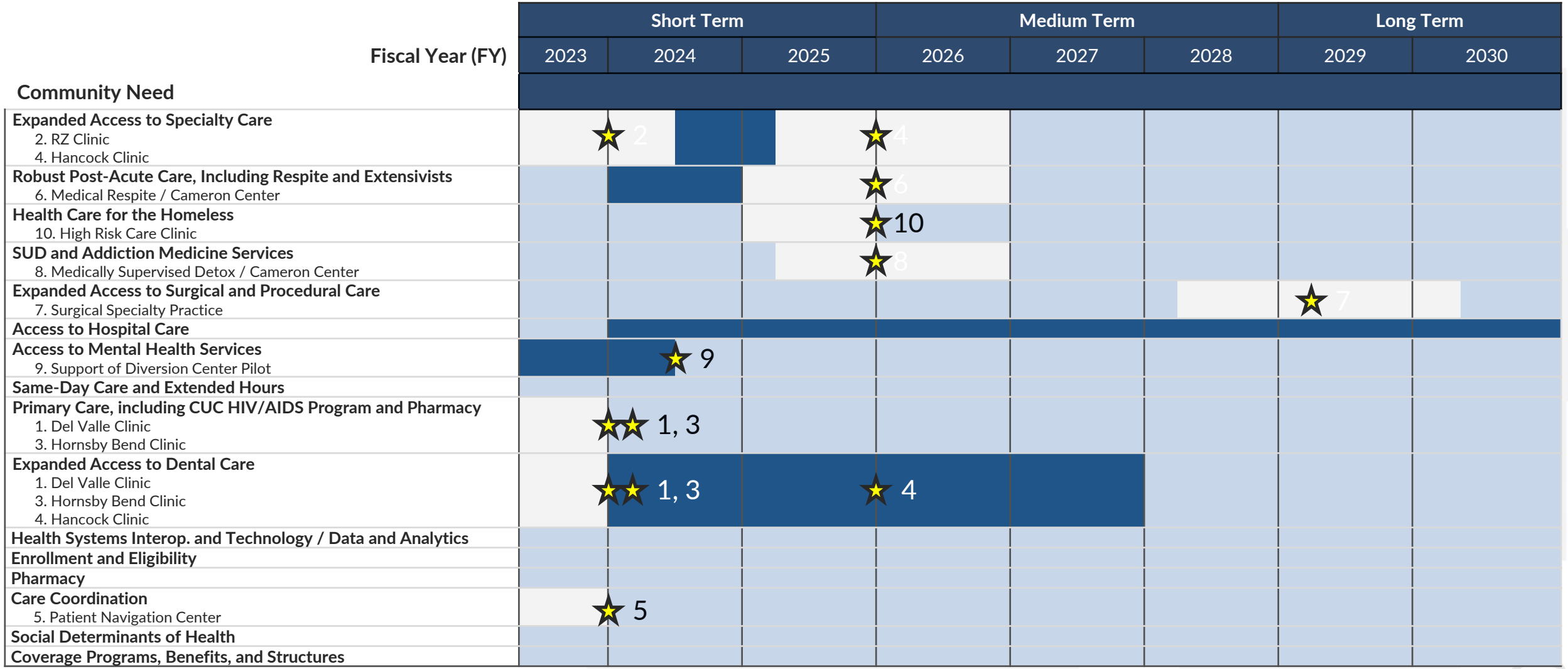
Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

Community Need	Projects	
Access to Mental Health Services	▪ Develop Training Program for Primary Care Providers on SUD and Mental Health Screening and Referrals ▪ Contract/Hire Psychiatrist with Prescribing Capabilities and Coordinate Medication Management for Mental Health Patients ▪ Hire Director of Mental Health (MH) Services to Coordinate MH Service Line ▪ Improve Data Sharing and Communications with Integral Care to Effectively Triage and Refer Patients	▪ Expand Mental and Behavioral Health Virtual Services Through Local and National Organizations ▪ Co-locate Therapists at Central Health Ambulatory Care Sites ▪ Co-locate Therapists at FQHC Locations ▪ Consideration for Psychiatric Urgent and Crisis Care Facility, including support of Diversion Center Pilot
Expanded Access to Dental Care	▪ Improve Dental Access by Hiring/Contracting Dental Providers in with CommUnityCare ▪ Hygienist Recruitment and Retention Opportunities with Austin Dental Hygiene Schools ▪ Build Dental Capacity at New Clinic Sites, Operated by CommUnityCare ▪ Proactive Dental Outreach and Education Efforts on Routine Screenings and Cleanings	▪ Expand Dental Services for Unhoused Patients through Mobile Dental Clinics ▪ Align Dental Surgery Services
Robust Post-Acute Care, Including Respite and Extensivists	▪ Advance PAC Capacity by Evaluating and Aligning Available Community Resources ▪ Development of Comprehensive Post-Acute Care Strategy ▪ Determine Capacity of Community Based Services Available to Unhoused Individuals ▪ Right-Sized PAC Portfolio to Ensure Quality and Cost of Care Management ▪ Identify Preferred PAC Partners with Access and Committed to Value-Based care ▪ Contract with Local Area Agencies on Aging to Provide In-Home Care for Low-Acuity Hospital Discharges ▪ Expand SNFist Program to Provide 24/7 Coverage	▪ Improve Critical PAC Operations, Transitions of Care, Staff Training, and Technology ▪ Research and Source PAC Waiver Programs ▪ Deploy Service Line specific Initiatives that Drive LOS, Excess Days and Readmissions ▪ Integration of Post-Acute Nurse Care Managers in IRF and LTACH Settings ▪ Strengthen PAC Clinical Governance and Accountability to Sustain Post-Acute Strategy ▪ Expand Recuperative Care Access and Partners to Increase Bed Capacity ▪ Expand Post-Acute Care Management to Ensure Patients Transitioned to Appropriate Settings Post Discharge ▪ Co-located Respite and Subsidized Housing to Expand Health and Social Services to Patients
Expanded Access to Surgical and Procedural Care	▪ Increase Contracted Capacity with Community-Based Specialists	▪ Recruit and Employ Surgical Specialty Providers to Provide Consultations and Surgical Services
Access to Hospital Care	▪ Develop Standardized Utilization Effectiveness Protocols ▪ Assess potential for Increased Contracted Capacity with Local Hospitals ▪ Conduct Long-Term Operational and Capital Planning re Safety-Net Hospital	▪ Future Partnership Options for Supplemental and Transitional Hospital Access ▪ Monitor Services Potentially Impacted by Changing Hospital and Programmatic Landscape
Care Coordination	▪ Establish Clear Delineations Between Central Health and Partner Care Management Programs and Convene Working Group to Align Standards of Care ▪ Care Management Optimization to Ensure Robust Care Coordination ▪ Establish Processes and Technology to Support Risk Stratification ▪ Recruit Additional Care Management Teams for Specialty Clinics to Manage High-Risk Patients ▪ Expand Transitions of Care Teams to Engage Patients Transitioning to PAC Environments and/or Home ▪ Implement Collaborative Care Model to Support Discharge Planning in Hospitals, including connections to SDoH Resources	▪ Centralized RN Care Coordinators in ED to Ensure Appropriate Care ▪ Timely Data Submission from Partners to Support Population Management and Risk Stratification ▪ Dashboard Development to Enable Care Coordination Efforts and Monitor Staff Efficiency and Program Effectiveness ▪ Implement Utilization Review Policies and Procedures for Inpatient Encounters ▪ Launch Medical Rapid Response Team ▪ Establish Central Health Patient Navigation Center ▪ Establish Robust Patient Referral Program to Improve Care Coordination and Patient Tracking

Central Health Identified and Created Over 150 Projects to Address the Most Critical Unmet Needs for Patients

Community Need	Projects	
Enrollment and Eligibility	▪ VeritySource Optimization ▪ Expand Enrollment Efforts Along I- 35 Corridor to Decrease Enrollment Gaps Identified in CHNA ▪ Alignment of Enrollment and Eligibility Efforts with CommUnityCare to Improve Coordination ▪ Optimize Enrollment, Eligibility, and Patient Verification Efforts within Patient Navigation Center	▪ Assess Need for Advanced CRM to Streamline Enrollment and Eligibility Processes ▪ Assess CRM Optimization to Effectively Track Patient Journey, Lead Engagement, and Enrollee Retention ▪ Expand Virtual Enrollment and Eligibility Services, Resources, and Activities
Health Systems Interop. and Technology / Data and Analytics	▪ Data Governance Committee to Establish Compliant and Common Operating Procedures, Data Sharing Standards, etc. ▪ Formalize Data Governance Model ▪ Career Development and Growth Resources to Retain Data and Analytics Talent ▪ Oversight and Accountability Provisions to Ensure Access to Partner EMR Data to Improve Patient Care ▪ Enable Real-Time Utilization and Productivity Tracking within Enterprise EPIC Systems for Improved Reporting ▪ FindHelp Referral Integration into Managerial Reporting Initiatives ▪ Oversight and Accountability to Gain Access to Utilization and Financial Data ▪ Develop Managerial Reporting Processes ▪ Utilization and Financial Data Analytics to Evaluate and Report on Efficacy of Initiatives ▪ Internal Data Governance Formulation and Improvements for Managerial Reporting	▪ Optimize Epic System (Primary Care) to Allow Self-Scheduling and Referrals ▪ Staff Training on Data Sharing and Data Management Expectations ▪ Data Sharing with Partners to Optimize Specialty Care Utilization Between Central Health and Partners ▪ Interoperable Hospital Data Exchange with Partners to Ensure Care Coordination and Successful Patient Referrals ▪ Dashboard Development to Monitor Acute Care Utilization ▪ Two-Way Data Exchange with CommUnityCare Pharmacies ▪ Two-Way Data Exchange with Primary Care Partners ▪ PAC Clinical Information Exchange Across EMRs ▪ Dashboard Development to Address Performance Issues and Track Quality Metrics ▪ Review and Improve Critical Data Processes, Procedures, Governance, and Policies to Ensure Secure Data and Effective Data Sharing
Pharmacy	▪ Establish Patient Assistance Program (PAP) to Optimize Copay Programs and Offset Drug Cost ▪ Pharmacist Integration into Care Coordination Teams, Mobile Clinics, and Patient Navigation Center ▪ Drug Cost Review and Evaluation of Contracts ▪ Expand Drug Courier Service to Additional Target Communities and PAC Facilities ▪ Expand Drug Formulary for High Need Drugs ▪ Improve Process, Policies, Procedures to Improve Drug Utilization and Management	▪ 340B Optimization Opportunities ▪ Optimize Pharmacy Services Footprint Through Partnerships, Consolidation, and Building Additional Pharmacy Capacity ▪ Evaluate and Enhance Pharmacy Benefits Plan to Meet Patient Needs ▪ Bolster Specialty Pharmacy Footprint and Improve Access by Co-locating/Near Clinics ▪ Expand Retail Pharmacy Footprint
Coverage Programs, Benefits, and Structures	▪ Incorporate Coverage and Benefits Services in Patient Navigation Center ▪ Extend MAP Enrollment Length to Align with MAP Basic ▪ Expand MAT Coverage to MAP Basic	▪ MAP Handbook Augmentation including Different Languages, Expanded Patient Financial Responsibility Information, etc. ▪ Implement MAP/ MAP Basic Initial Touchpoint ▪ Pilot Maximum Out-of-Pocket Spend Program for Prescriptions to Reduce Cost Barriers for Patients with Multiple Prescriptions
Social Determinants of Health	▪ Define SDoH Strategy Using Evidence-Based Approach ▪ Connect Patients to SDoH Resources via Care Navigators in Patient Navigation Center ▪ Improve Medical Transportation Program to Provide Lyft Rides and CapMetro Tickets ▪ Catalogue Partner SDoH Capabilities, Services, and Initiatives ▪ Update and Review Healthcare Information and Communication to Provide More Culturally Affirming Materials and Care ▪ Connect Patients to Employment and Recidivism Programs for Formerly Incarcerated Patients	▪ Leverage Collaborative Care Model to Connect Patients to SDoH Resources ▪ Expand Loaner Cell Phone Device Program to Additional Target Populations ▪ Partner with Community Based Organizations to Connect Patients to Healthy Foods ▪ Connect Patients to Adult Education and Literacy Programs ▪ Research and Source SDoH Grant Program Funding Opportunities ▪ Partner with local non-profits (e.g., subsidized housing organizations) to connect unhoused individuals to shelters and supportive housing.

Select Projects are Highlighted as Milestones Over the Next 7 Years To Respond to Unmet Community and Patient Needs



Services for unhoused populations

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	Existing Efforts	Current & Upcoming Initiatives
Behavioral Health and Substance Use Disorders	**Medication Assisted Treatment (suboxone) for cooccurring substance use and serious mental illness (Integral Care)**	**Addition of psychiatry and behavioral health to street medicine teams (CommUnityCare)**
	Medication Assisted Treatment (suboxone) for opioid use (CommUnityCare)	Detox/substance use treatment at Cameron medical complex (2026) (Central Health)
	Two contracted methadone providers for MAP patients with opioid use disorders (Central Health)	Contract for substance use treatment holdovers (Sobering Center)
Medical respite, post-acute and transitional services	**Three contracted medical respite facilities (Central Health)**	**50-bed medical respite facility at Cameron medical complex (2026) (Central Health)**
	Hospital-based case management and transitions of care teams (Central Health)	High-risk clinical services and physical/occupational therapies at Cameron medical complex (2026) (Central Health)
Jail, Diversion and related healthcare services		**Specialty care for eligible Travis County jail inmates (Travis County)**
		Diversion pilot supporting expansion of psychiatric emergency services to 24/7 operations (Integral Care)
		Diversion pilot supporting medical services for 15th St. psych respite (Integral Care)

	Existing Efforts	Current & Upcoming Initiatives
Medical, Dental and Behavioral Health	**Mobile and street medicine (CommUnityCare)**	**Operationalizing additional street medicine team (CommUnityCare)**
	Transitional dialysis program for MAP patients with end-stage rental disease (Central Health)	Launch of dedicated safety-net specialty care services: GI – pulmonology – podiatry – cardiology – neurology – nephrology – surgical optimization – palliative care – infectious disease – diagnostics (Central Health)
		Expanded dental capacity: Chalmers (2023) – Del Valle (2024) – Colony Park (2025) – Hancock (2026) (CommUnityCare)
		Purchase of purpose-built vehicles for street teams (CommUnityCare)
Other	**Ongoing outreach and point-of-service streamlined MAP enrollment for individuals experiencing homelessness: local Ascension hospitals – COA EMS – Austin Transition Center – Travis County Jail and SMART program**	**Transitioning EMS agreement to support healthcare services instead of ground transport (City of Austin)**
	Zero copays for MAP patients experiencing homelessness	
	Transportation assistance including ride-share, bus passes, taxi vouchers, wheelchair and stretcher transport (Central Health)	

Dialysis services

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DASHBOARD OVERVIEW

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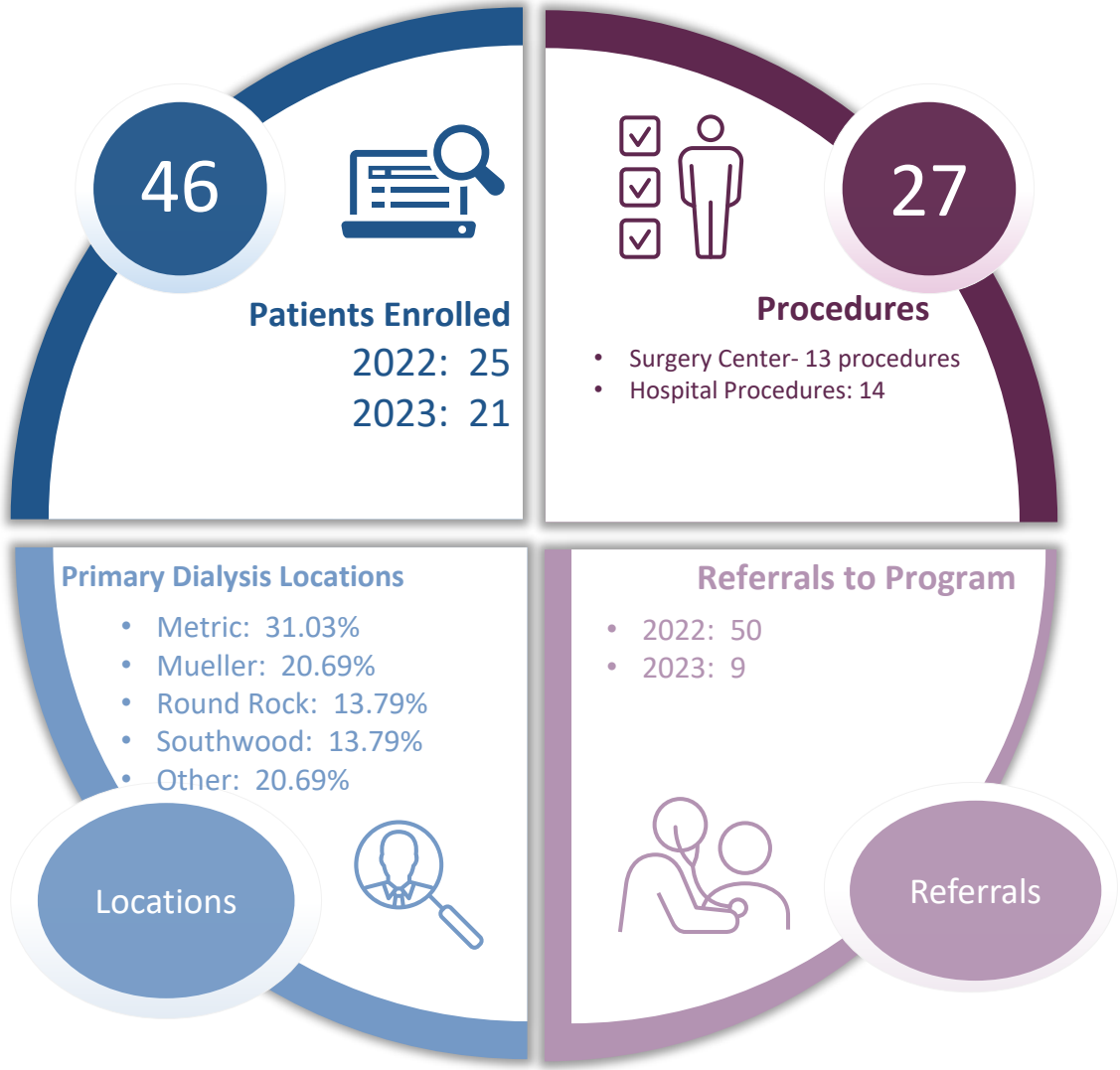

PODIATRY SURGICAL SERVICES

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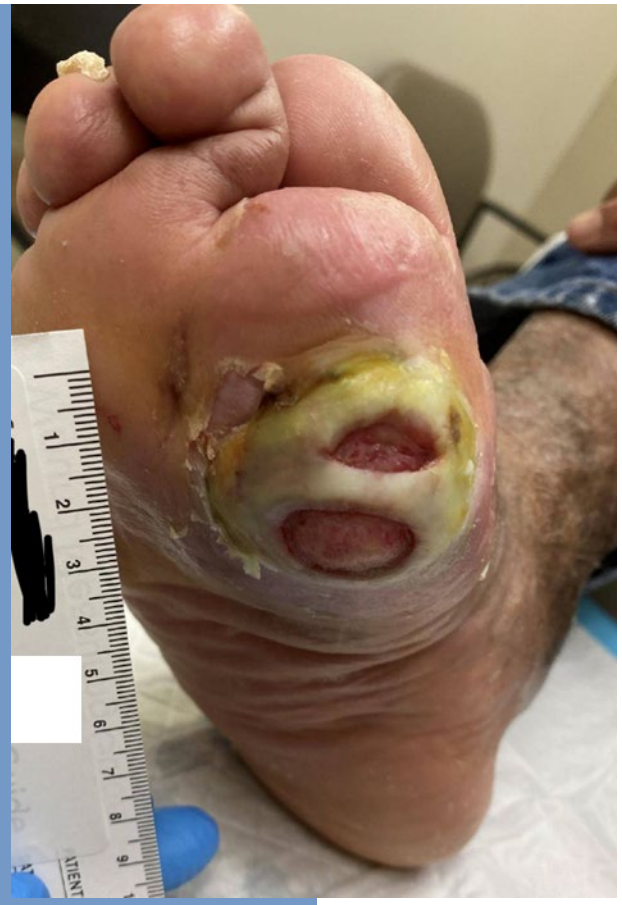

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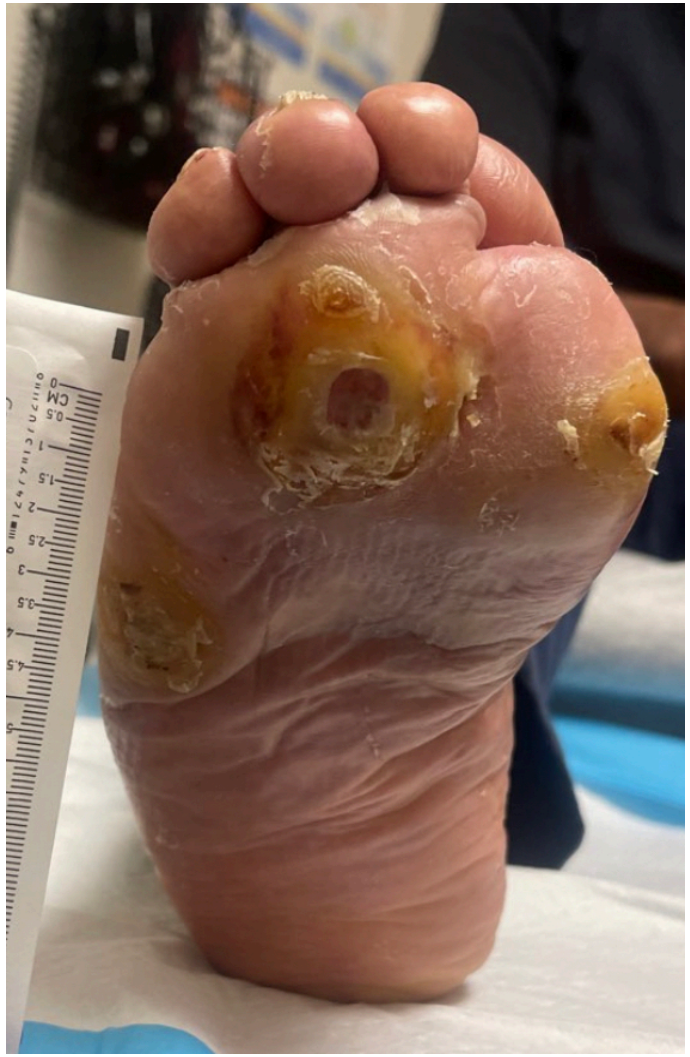
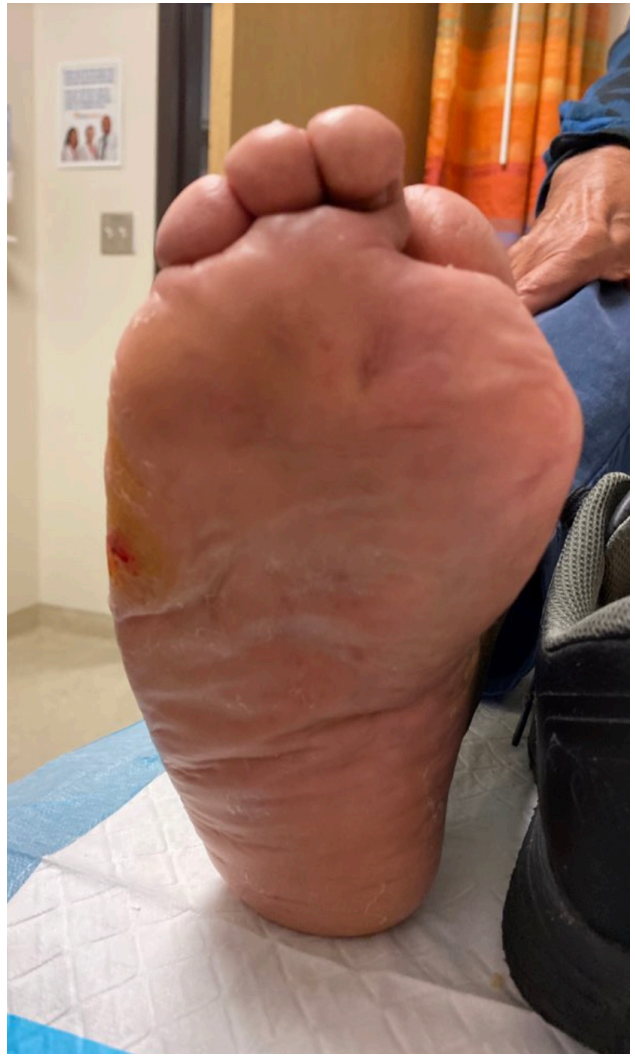
CASE:

- 65+ y/o Male
- History of DMII, HTN, Hx of Osteo and chronic ulcer to Right foot (over 3 years)
- Failed Local wound care, offloading, DM shoes
- Can't miss work, dishwasher and afraid of losing his job
  - Sends money back to family in Mexico, but afraid to go back without a healed wound (possible worsening and amputation) and needs to keep working to support family.
- Equinus
  - Tight achilles
  - Causing pressure to forefoot

- **Remains healed**
  - Last seen three months post-op





CENTRAL HEALTH

DASHBOARD OVERVIEW PODIATRY

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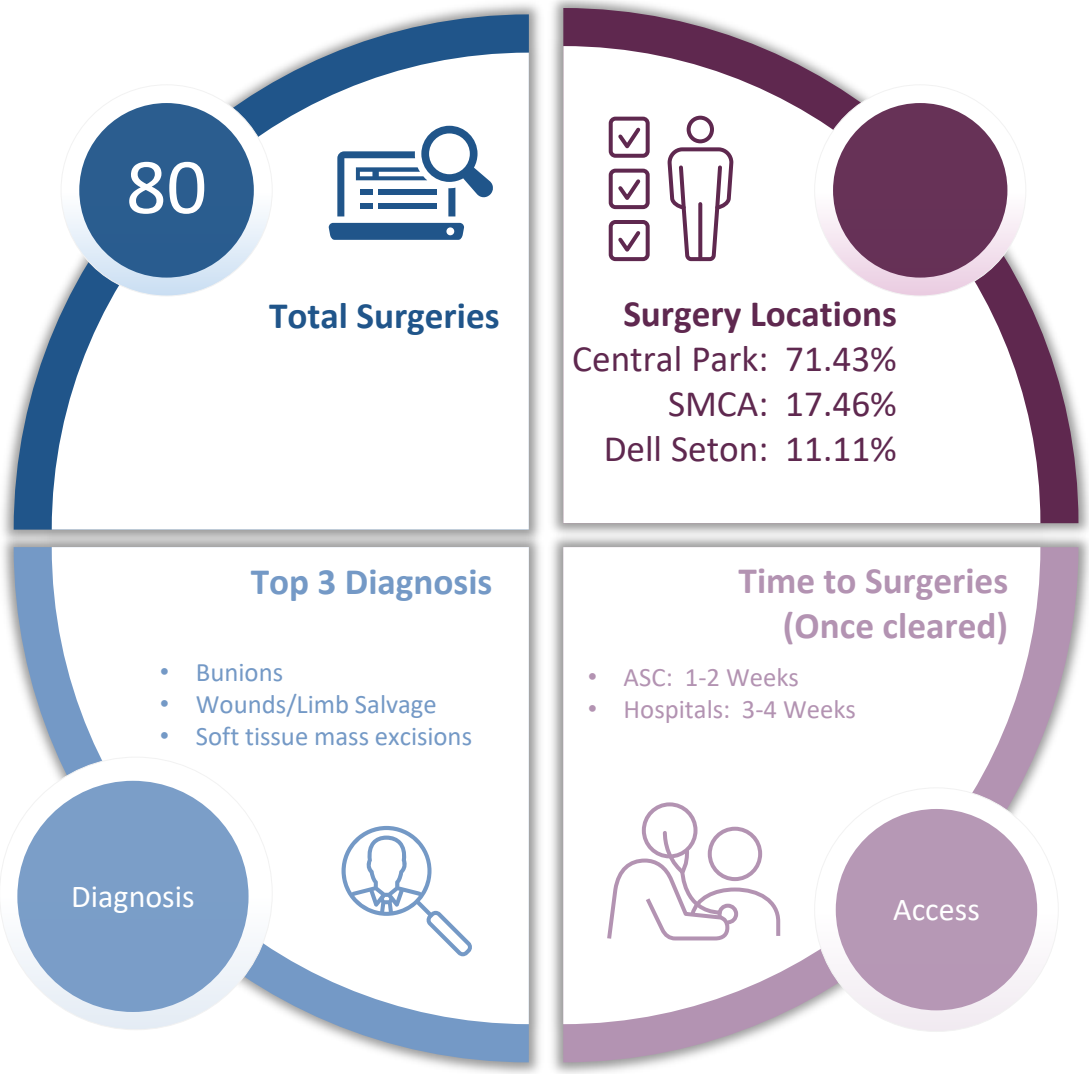

MEDICAL RESPITE

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Mr. P: From Hospital to Respite to Housing

64 year old man who had been experiencing homelessness for >15 years

- Hit by a car, broke over 10 bones in his body, Stayed in the hospital 39 days, then to a nursing home for 48 days. Instead of being discharged to the street, went to medical respite
- At medical respite, continued recovery with physical therapy, worked on his disability and housing application, treatment for alcohol use disorder.
- After 50 days in medical respite, moved to his own tiny home at CFV

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- 50-bed medical respite
- Dedicated medical services
- Wound care
- Clinical pharmacy services
- Case management, peer support and social work services
- Mental and behavioral health services
- Physical and occupational therapy
- SDOH resources
- Specialty care via-telemedicine/onsite rotation
- Opioid use disorder treatment
- Alcohol use disorder treatment
- Outpatient pharmacy
- PAP services

- Navigation and care coordination services
- Eligibility & enrollment services
- Connections to housing
- Disability application assistance
- Transportation assistance

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TRANSITIONS OF CARE

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THE FUTURE FOR TRANSITIONS OF CARE

- Optimization of Evidence Based Warm Handoff Processes
- Skilled Nursing Facility Direct Care
- Transitions of Care Inpatient Nurses
- Care at Home
- MAP Tele or Virtual Enrollment in the Hospitals
- Most Visited Patients Program in the Emergency Departments

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SUBSTANCE USE DISORDER TREATMENT

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SUBSTANCE USE DISORDER TREATMENT

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- Since 2019
  - Central Health, CommUnityCare and Integral Care provide Medication Assisted Treatment (MAT) program.
- May 2022
  - Travis County Commissioners Court declare opioid overdose epidemic a public health crisis.
- July 2022
  - Central Health contracts with Community Medical Services in July 2022 to provide expanded methadone treatment for MAP enrollees.
- FY 2023
  - Central Health expanded available funding and entered into an agreement with Addiction & Psychotherapy Services for methadone treatment services, serving more than sixty individuals in the first seven months.
  - Central Health supported CommUnityCare's efforts to expand care teams, add psychiatric support and operationalize additional service locations including street medicine teams.

Central Health continues to work with multiple partners to expand treatment capacity.

MULTISPECIALTY CLINICS

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2023 Central Health Rosewood-Zaragosa Multispecialty Clinic

- 6 Specialties
  - Pulmonology
  - Gastroenterology
  - Nephrology
  - Neurology
  - Podiatry
  - Gastroenterology
- 27 Exam Rooms
- 2 Procedure / 2 Telemedicine Rooms
- Diagnostic Exam Rooms
- Reading Room
- Collaboration Space
- Onsite Eligibility Office

MULTISPECIALTY CLINIC PROJECTS

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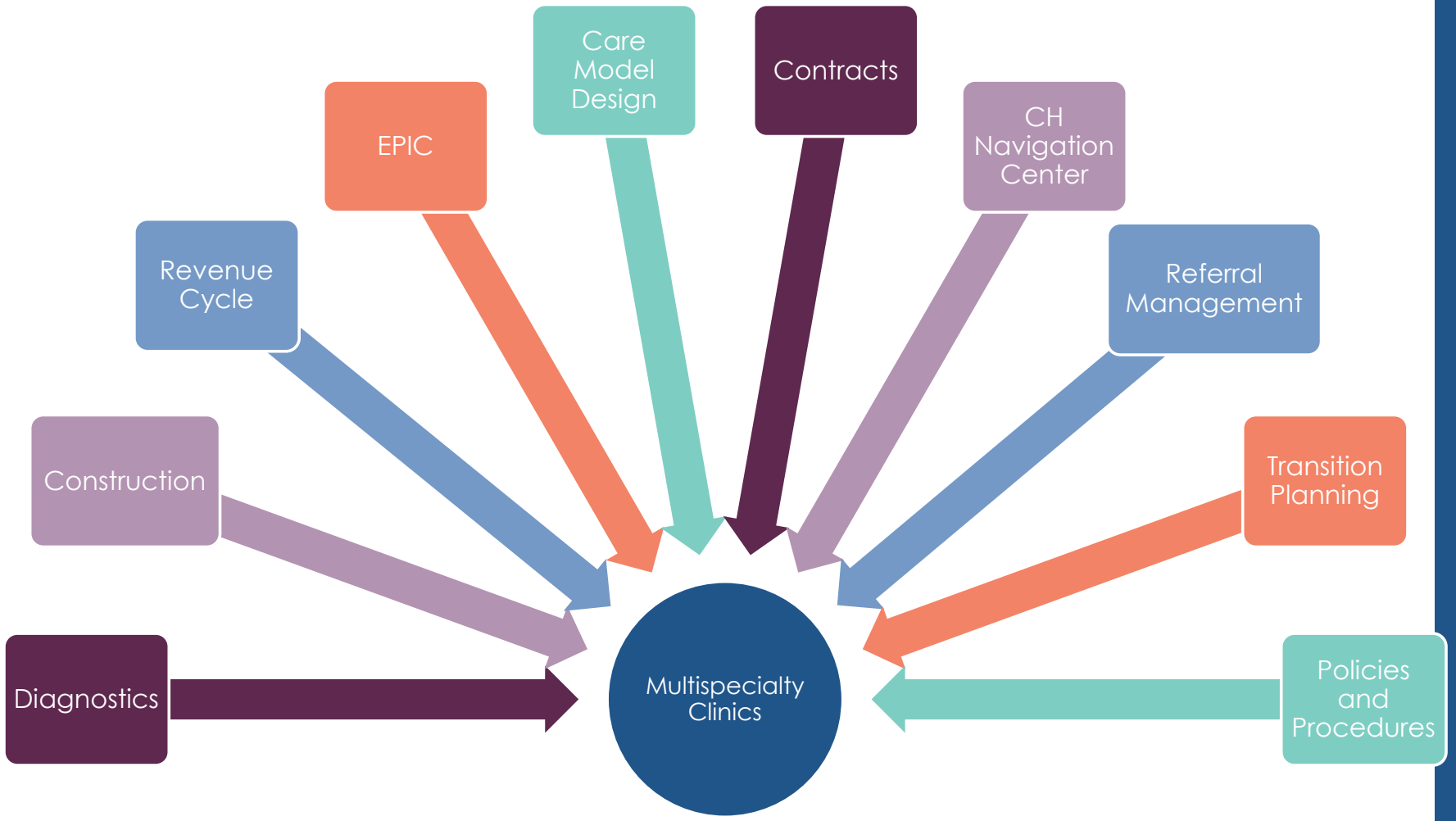

Hancock

Central Health Clinics
Cardiology
Nephrology
Neurology
Pulmonology
Gastroenterology
Podiatry
Non-Oncology Infusion
Compound Pharmacy
Endoscopy
Diagnostics
Eligibility and PAP services

CommUnityCare Clinics
Primary care
Urgent Care
Pharmacy

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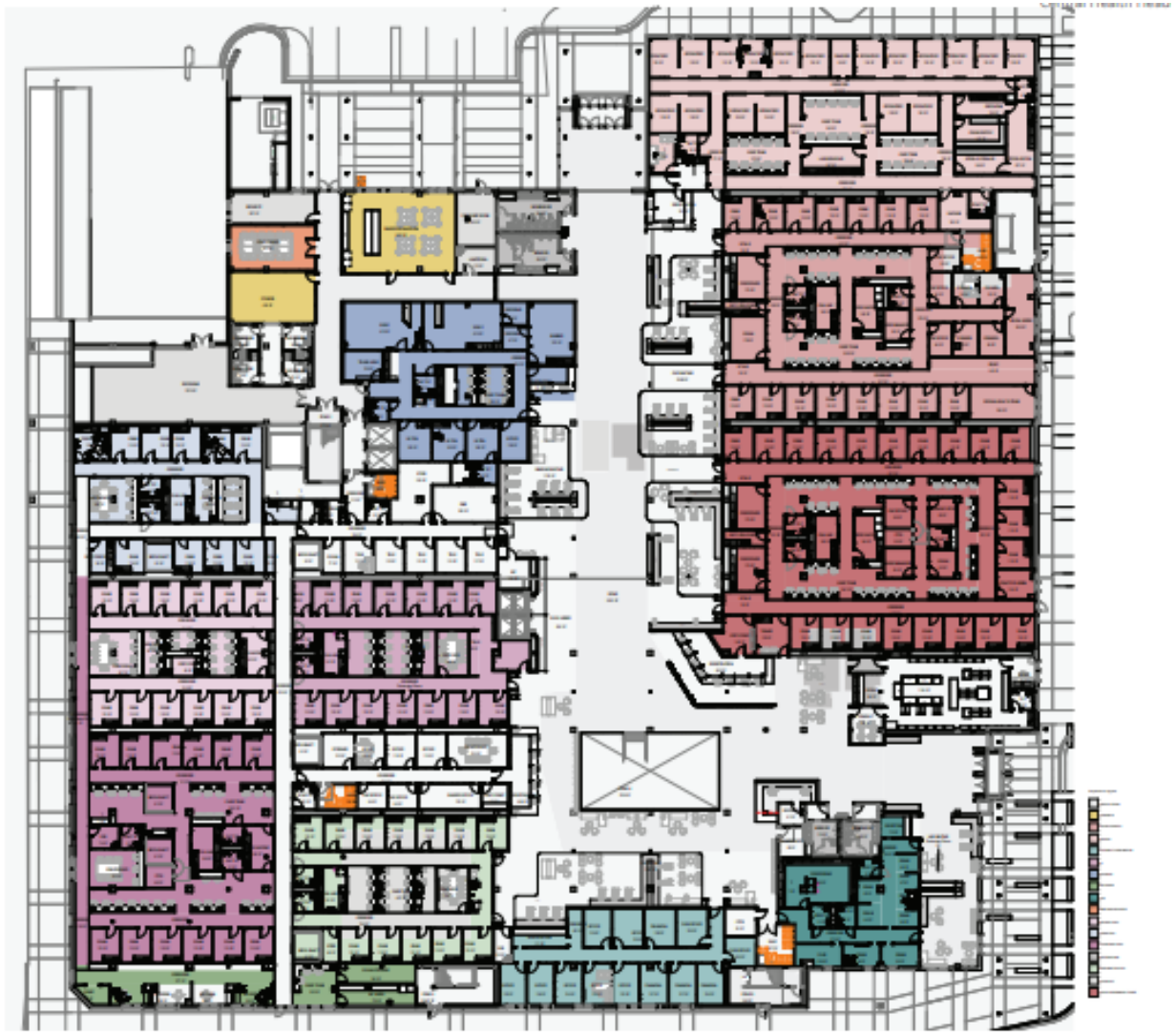

CONTRACTED SERVICES

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PRIMARY CARE

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- **Enhanced reimbursement to support expanded access including after-hours, weekends and holidays at FQHCs**
- **Welcomed Manos de Cristo to contracted network**
- **Launched periodontal services at LSCC, PCC, and Manos de Cristo**
- **Increased access to mammograms to Eastern Travis County via LSCC Pink Bus**
- **Integrated Pain Management Pilot at PCC**
  - Acupuncture
  - Massage therapy
  - Substance use disorder brief interventions
  - Group yoga
  - Group Medical visits

PRIMARY CARE

- Doula Services pilot with CUC and Black Mamas ATX
- Black Men's Health Clinic at CUC
- Upgrading ultrasound, x-ray and 3D mammography equipment at CUC
- Expanded urgent care access to MAP Basic enrollees
- Access to additional gynecological procedures through CUC and PCC

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SPECIALTY CARE

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- **Master Services Agreement (MSA) executed with UT Health Austin/Dell Medical School**
  - Tubal ligations
  - Ophthalmology services
  - Musculoskeletal services
  - Complex Gynecology services
  - Ambulatory Surgery Center services
  - Long-haul COVID clinic
  - Advanced Imaging
- **Expanded access to radiation therapy**
  - Texas Cancer Specialists and Texas Integrated Medical Specialists
  - Texas Oncology

SPECIALTY CARE

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- **Central Health Transitional Dialysis Program**
  - Transitioned 25 patients to alternative, long- term coverage in 2022
  - Averaging 3 new patients per month
  - Currently 21 patients enrolled since January 2023
- **Access to corneal transplants**
- **Expanded access to Methadone**
- **Access to general surgery for MAP Basic**
- **Expanded access to retina procedures through Austin Retina Associates**
- **Access to vasectomy services**
- **Expanded access to ENT and audiology services**

QUESTIONS?

CENTRAL HEALTH