

CENTRAL HEALTH COLLABORATIVE STRATEGIC PLAN



**CENTRAL
HEALTH** *Collaborative*
Ada, Boise, Elmore & Valley Counties

January 2016 - January 2019

A MESSAGE FROM THE COLLABORATIVE

In February of 2014, Governor Otter's Executive Order 2014-02 established the Idaho Healthcare Coalition (IHC) to guide Idaho's healthcare system transformation efforts to a well-integrated model focused on patient health outcomes. The IHC oversees the implementation of the Statewide Healthcare Innovation Plan (SHIP), a four-year State Innovation Model Test Grant funded by the Centers for Medicare and Medicaid. The SHIP mission is to redesign Idaho's Healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. In response to the SHIP initiative, Idaho's seven Public Health Districts were tasked with establishing Regional Collaboratives (RC) in each district. The RCs are overseen by two local physicians and the Public Health District Director. In addition to the leadership team, the RCs are comprised of community leaders and healthcare stakeholders.

The mission of the Central Health Collaborative (CHC), which encompasses a geographic area that includes Ada County, Boise County, Elmore County, and Valley County, is to support primary care practices to become Patient-Centered Medical Homes (PCMHs). The CHC is also focused on improving the coordination of care within the Medical-Health Neighborhood (MHN). The CHC will meet this mission by providing a structured forum for sharing valuable knowledge, finding common solutions, and identifying resources. The collaborative plays an important role in identifying and sharing promising practices for successful care coordination, including improving strategies for communication between medical providers and community service organizations in the MHN (e.g., specialty care, hospitals, behavioral health, elder care services, and social service organizations).

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STRATEGIC PLANNING PARTICIPANTS

CDHD SHIP TEAM

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PURPOSE

The purpose of this strategic plan is to define roles, responsibilities, priorities, and the direction of the Central Health Collaborative for four years (01/2016-01/2019). The strategic planning process was started by the Public Health District 4 (PHD4) Statewide Healthcare Innovation Plan (SHIP) Team and the Central Health Collaborative Executive Leadership through the development of a Charter that is aligned with the SHIP Operational Plan. The Charter was approved and adopted by the CHC Leadership in February of 2016 and provided a foundation from which the strategic plan is built.

The CHC has identified five overarching goals and subsequent objectives to help develop foundational and enhanced infrastructure for PCMH transformation and improved coordination in Medical-Health Neighborhood. Each objective is coupled with strategies, time frames, target measures, status indicators, and responsible parties to ensure the CHC remains on track for goal completion and to strive for the triple aim - lower cost, better health, and better health outcomes for the region.

The CHC Strategic Plan was reviewed and approved by the CHC Executive Leadership Team on (date) and functions as a roadmap to the future.



STRATEGIC OVERVIEW

2016-2019

MISSION: The Central Health Collaborative (CHC) provides a structured forum for sharing valuable knowledge, finding common solutions and identifying resources to improve health outcomes, improve quality and patient experience of care, and lower costs of care in Region 4.

To convene and organize health care stakeholders to:

A. Develop a Sustainable Regional Collaborative

- Identify stakeholders from the Patient-Centered Medical Homes (PCMH) and Medical-Health Neighborhood (MHN) to convene CHC
- Identify and establish partners to support CHC
- Seek recommendations from members, the Idaho Healthcare Coalition (IHC), and other Regional Collaboratives (RC) for sustainability
- Communicate the CHC mission through outreach
- Engage in impactful work

B. Support PCMH Transformation

- Encourage practices to participate in PCMH Model Test Program
- Provide coordination and integration solutions to PCMHs
- Identify opportunities for shared resources and provide targeted assistance for clinics
- Develop a standard method/platform for PCMH practices to communicate successes, improvement strategies, and solutions

C. Strengthen the Medical-Health Neighborhood

- Improve common understanding of Medical-Health Neighborhood in Region 4
- Identify unmet health, behavioral health, wellness, and social needs
- Build and support relationships with community partners and resources
- Encourage care management and care coordination for PCMHs with other secondary providers with a collaborative approach

D. Support Population Health Initiatives

- Review community health needs assessments
- Review regional data from data analytics contractor
- Identify unmet needs using PCMH feedback, data reports, and other reliable data sources

E. Communicate Regional Efforts, Successes, and Challenges

- Provide regular status updates to all RCs and the IHC
- Maintain awareness of clinic activities, status, and needs
- Communicate supports offered by the CHC to the PCMHs

| Strategic Goal A: Develop a Sustainable Regional Collaborative | | | | | | |
|--|----------------------|--|--------|------|------|---------------------------|
| Objective 1: Identify stakeholders from PCMHs and MHN to convene CHC | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Leverage existing and new partnerships and networks to identify healthcare transformation champions and innovative community partners | 1/11/16, 03/31/16 | Complete membership roster | ☑ | | | CHC Leadership |
| | 1/11/16, 12/31/18 | Ensure at least 50% of combined cohort clinics are represented on the CHC | ☑ | | | CHC Leadership, CHC |
| 2. Assess CHC membership to ensure adequate representation | 1/11/16, 12/31/18 | Assess membership annually, add or replace members as needed | ☑ | | | CHC Leadership, CHC |
| Objective 2: Identify and establish partners to support CHC | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Identify areas for collaboration based on community need and resources/assets | 1/11/16, 12/31/18 | Promote CHC efforts in the community to gage partnerships and interested parties as needed | ➡ | | | CHC Leadership, CHC |
| Objective 3: Seek recommendations from members, IHC and other RCs for sustainability | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Complete sustainability proposal/assessment draft | 7/1/16, 9/1/16 | One completed draft | ☑ | | | CHC Leadership, PHD Staff |
| 2. Review other state Health Collaborative Models and report to CHC | 1/1/16, 12/31/18 | Review at least three models per year | ➡ | | | PHD Staff |
| 3. Pursue sustainability recommendations | 1/11/16, 12/31/18 | Identify and review 1-2 sustainability components | ➡ | | | CHC Leadership, PHD, CHC |
| Objective 4: Communicate the CHC mission through outreach | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| Share information on CHC Mission | 1/11/16, 12/31/18 | Share mission and successes with community partners three times per year | ➡ | | | CHC Leadership, CHC, PHD |

| Objective 6: Engage in impactful work for CHC members | | | | | | |
|--|----------------------|--|--------|------|------|-----------------------------|
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Action items created for CHC members during meetings | 1/11/16, 12/31/18 | Identify 1-2 action items per meeting for individuals outside executive leadership and PHD | | | | CHC Leadership, CHC Members |
| 2. Encourage and promote efforts that are quantifiable to measure success | 9/1/16, 12/31/18 | Capture and share information with CHC, MHN, and community | | | | PHD Staff |
| 3. Collect qualitative information (e.g. success stories, relationships established, and programs developed) | 9/1/16, 12/31/18 | Capture and share information with CHC, MHN, and community | | | | PHD Staff |

Not Started
 Deferred
 On Target
 Off Target
 Waiting on Someone
 Critical
 Achieved

| Strategic Goal B: Support PCMH Transformation | | | | | | |
|---|----------------------|--|--------|------|------|---------------------------|
| Objective 1: Encourage practices to participate in PCMH Model Test Program | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Assess provider and/or clinic interest regionally | 9/1/16, 12/31/17 | Review non-selected clinics for previous cohort applications | → | | | CHC Leadership, PHD Staff |
| | 6/1/16, 12/31/18 | Coordinate with PHD staff on interests based on other Quality Improvement (QI) efforts | → | | | PHD Staff |
| 2. Communicate benefits of PCMH transformation | 9/1/16, 12/31/18 | Share details of SHIP goals, PHD supports, and other SHIP contractors | → | | | PHD Staff, CHC |
| 3. Respond to interested party inquiries | 9/1/16, 12/31/18 | SHIP participation by at least two non-SHIP clinics per year | → | | | PHD Staff, CHC |
| Objective 2: Provide coordination and integration solutions to PCMHs | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Invite PCMH clinics or those working toward PCMH to attend CHC meetings | 1/1/16, 12/31/18 | Invite cohort clinics and interested non-cohort clinics | → | | | CHC Leadership, CHC, PHD |
| 2. Share training opportunities and existing Subject Matter Expert (SME) resources with cohort clinics | 9/1/16, 12/31/18 | As needed and as opportunities are available | → | | | CHC, PHD Staff |
| | 9/1/16, 12/31/18 | Explore local and national SME to speak to collaborative or host educational opportunities | → | | | CHC, PHD Staff |
| 3. Develop and foster communication opportunities for peer-to-peer support | 9/1/16, 12/31/18 | Ongoing, as needed and as opportunities are available | → | | | CHC, PHD Staff |
| 4. Increase awareness of the virtual PCMH concepts of SHIP (Community Health Worker, Telehealth, and Community Health Emergency Medical Services) | 9/1/16, 12/31/18 | Education to CHC as information is available and evolves | → | | | PHD Staff |
| 5. Identify opportunities to leverage SHIP contractor and other agency support to enhance capacity for coordination and integration. | 2/1/17, 12/31/18 | Offer one training opportunity for coordination or integration per year | ○ | | | PHD Staff |

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services

| Objective 3: Identify opportunities for shared resources and provide targeted assistance for clinics | | | | | | |
|---|----------------------|--|--------|------|------|-----------------------------|
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Evaluate cohort priorities, needs, and gaps | 2/1/16, 12/31/18 | Report on clinic efforts two times per year | → | | | PHD Staff, CHC |
| | 2/1/16, 12/31/18 | Identify two potential solutions (benefits and risks) per year to present to the CHC/PCMHs | → | | | CHC Leadership, PHD, CHC |
| 2. Receive direct feedback from QI staff on clinic needs via participation in PCMH transformation efforts and HMA coaching calls | 2/1/16, 12/31/18 | Monthly reports to SHIP Manager; bi-annual reports to CHC | → | | | |
| 3. Explore suggestions from CHC for shared-resourcing opportunities | 2/1/16, 12/31/18 | Review other state community care team models and/or accountable communities of health. | → | | | |
| Objective 4: Develop a standard method/platform for PCMH practices to communicate successes, improvement strategies, and solutions. | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Coordinate and host CHC meetings | 1/1/16, 12/31/18 | Host 10-12 CHC meetings throughout the year | → | | | CHC Leadership PHD Staff |
| 2. CHC website | 6/1/16, 8/31/16 | Purchase CHC website domain | ✓ | | | PHD Staff |
| | 8/1/16, 12/31/18 | Update website content monthly | → | | | PHD Staff |

 Not Started
  Deferred
  On Target
  Off Target
  Waiting on Someone
  Critical
  Achieved

| Strategic Goal C: Strengthen the Medical-Health Neighborhood | | | | | | |
|---|----------------------|---|--------|------|------|-------------------|
| Objective 1: Improve common understanding of the Medical-Health Neighborhood in Region 4 | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Create common understanding of Medical-Health Neighborhood (MHN) | 2/1/16, 12/31/16 | Establish definition of MHN for Region 4 (i.e. by county, city, or region) | ⊕ | | | CHC |
| Objective 2: Identify unmet health, behavioral health, wellness and social needs | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Work with MHN participants to identify priority health, behavioral, and social needs | 2/1/16, 12/31/18 | Identify two unmet needs annually | ⊕ | | | CHC MHN |
| 2. Survey cohorts for MHN needs | 2/1/16, 12/31/18 | Identify 1-2 survey topics per cohort (e.g. diabetes, behavioral health, specialty) | ⊕ | | | PHD Staff |
| 3. Communicate Behavioral Health Integration (BHI) and Population Health Workgroup (PHW) efforts | 2/1/16, 12/31/18 | Report on BHI/PHW twice per year | ⊕ | | | PHD Staff |
| Objective 3: Build and support relationships with community partners and resources | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Host targeted MHN meetings or stakeholder events | 2/1/16, 12/31/18 | Host two meetings/events annually | ⊕ | | | CHC PHD Staff |
| 2. Meet with identified partners where gaps exist | 2/1/16, 12/31/18 | Meet with community partners to discuss solutions (as needed); invite to CHC | ⊕ | | | CHC PHD Staff |
| Objective 4: Encourage care management and care coordination from PCMH's with other secondary providers with a collaborative approach | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Engage PCMH representatives in identifying and organizing community resource tools. | 2/1/2016-12/31/2018 | Identify and/or organize resource guides based on feedback from PCMHs | ⊕ | | | PHD Staff |

| | | | | | | |
|--|--------------------|--|---|--|--|---------------|
| 2. Support care management and coordination training opportunities | 06/01/16, 12/31/19 | Share training opportunities and peer-to-peer linkages |  | | | CHC PHD Staff |
|--|--------------------|--|---|--|--|---------------|

 Not Started  Deferred  On Target  Off Target  Waiting on Someone  Critical  Achieved

| Strategic Goal D: Support Population Health Initiatives | | | | | | |
|---|----------------------|---|--------|------|------|--------------------------------|
| Objective 1: Review community health needs assessments | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Report on community health needs using local data and resources | 9/1/16, 12/31/18 | Annual presentation on CHNA summary to CHC using available data sources (St. Luke's/St. Al's CHNA, ALICE Report, County Health Rankings, Get Healthy Idaho) | ○ | | | PHD Staff, CHC Leadership, CHC |
| Objective 2: Review regional data from data analytics contractor | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Utilize data from data analytics contractor, HealthTech Solutions, when available | 9/1/16, 12/31/18 | Review regional reports quarterly | ⦿ | | | PHD Staff, CHC Leadership, CHC |
| Objective 3: Identify unmet needs using PCMH feedback, data reports, and other reliable sources | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Review available payer data | 9/1/16, 12/31/18 | Review Regional Medicaid Dashboards at CHC annually | ○ | | | CHC PHD Staff |

○ Not Started ⌚ Deferred 🟢 On Target 🟡 Off Target ⦿ Waiting on Someone 🔴 Critical 🟩 Achieved

| Strategic Goal E: Communicate Regional Efforts, Successes and Challenges | | | | | | |
|--|----------------------|--|--------|------|------|----------------------------------|
| Objective 1: Provide regular status updates to all RCs and IHC | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Communicate CHC updates to IHC | 02/01/16, 12/31/18 | Provide monthly updates to IHC via monthly RC SHIP reporting and CHC Exec Leadership presentations | 🟢 | | | PHD Staff, CHC Leadership |
| 2. Communicate CHC updates to all RCs | 02/01/16, 12/31/18 | Provide monthly updates to Regional SHIP Mangers | 🟢 | | | PHD Staff |
| 3. Communicate other RC efforts to CHC | 02/01/16, 12/31/18 | Bi-annually report workgroup activities for presentation to CHC | 🟢 | | | PHD Staff |
| Objective 2: Maintain awareness of clinic activities, status, and needs | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Receive status updates and requests from clinics using QI Staff, PCMH Transformation Plan, PCMH Portal | 02/01/16, 12/31/18 | Bi-annually report on clinic efforts to CHC | 🟢 | | | CHC PHD Staff |
| 2. Receive direct feedback from clinic transformation teams on successes and barriers | 02/01/16, 12/31/18 | Bi-annually connect with clinic teams | 🟢 | | | PHD Staff |
| Objective 3: Communicate supports offered by CHC to PCMHs | | | | | | |
| Strategy | Start Date, End Date | Target Measure | Status | | | Responsible Party |
| | | | YR 1 | YR 2 | YR 3 | |
| 1. Routine communication with cohort clinics via email, sharing CHC minutes, and PHD participation in HMA coaching calls | 02/01/16, 12/31/18 | Quarterly updates to all cohort clinics on CHC supports and direction | 🟢 | | | PHD Staff CHC Leadership, CHC |

 Not Started
  Deferred
  On Target
  Off Target
  Waiting on Someone
  Critical
  Achieved

Project Risks, Assumptions, and Dependencies

| Risk Identification | Event | High - (H) Medium - (M) Low - (L) | Potential Mitigation |
|-------------------------------------|---|--|---|
| | Large number of CHC members due to high number of clinics participating in SHIP in Region 4 | L | Extension of CHC support by working with health systems that impact a number of clinics, refining membership to manageable number by selective representation |
| | Inability to schedule CHC meeting times with members | L | Convene live meetings with conference calling capability |
| | Competing agendas/ priorities | M | Reflect consistently on CHC mission and goals |
| | Lack of funding | H | Pursue partnerships, becoming an LLC, recognized non-profit, grant funding opportunities |
| | Lack of consensus on priorities and initiatives from CHC members | M | Keep efforts clearly defined and within reasonable parameters |
| | General guidance from IHC/IDHW; lack of concrete expectations | M | Maintain ongoing requests to IHC and communication with IDHW on status, progress, barriers |
| | Large number of Medical-Health Neighbors inhibits coordination; needs vary by location | M | TBD |
| | Balancing state-wide goals and expectations with regional efforts | L | Provide ongoing advocacy for regional solutions |
| Assumptions | <ul style="list-style-type: none"> • Each Regional Collaborative may be structured differently in its membership • Effective communication between the Regional Collaborative, IHC, and IDHW is critical to success • The members of the CHC may expand and change over time as PCMH transformation needs change | | |
| Dependencies and Constraints | <ul style="list-style-type: none"> • CHC members are volunteering their time and have other jobs • CHC members have multiple professional responsibilities and priorities that may compete with those of SHIP • CHC is relying on the Idaho Health Data Exchange and the data analytics contractor to support and provide appropriate data collection • PCMHs accept supports provided by the CHC • Transformation needs have a high degree of variability and CHC efforts should to remain focused and measurable | | |