2018

Strategic Plan

Population Health Improvement Program (PHIP)

Healthy Capital District Initiative | 175 Central Avenue, Albany, NY 12206

Overview

The Healthy Capital District Initiative (HCDI) Population Health Improvement Program (PHIP) Strategic Plan is a blueprint to achieve the Triple Aim of better care, better population health, and lower health care costs. Healthy Capital District Initiative (HCDI) forges collaborative partnerships with regional stakeholders to reduce risky health behavior, determine major barriers to health services, and develop initiatives to overcome them. As the regional contractor for the New York State Department of Health (NYSDOH) Population Health Improvement Program in the Capital Region, HCDI assists stakeholders in Albany, Columbia, Greene, Rensselaer, Saratoga and Schenectady counties in their efforts to advance ongoing activities related to the Prevention Agenda (PA), the State Health Innovation Plan (SHIP); and serves as a resource to local Performing Providers Systems (PPS) under the Delivery System Reform Incentive Payment (DSRIP) program. Healthy Capital District Initiative supports health systems change, shared measurement, and assessment practices by engaging a range of stakeholders. At the core of much of HCDI's work lies an effort to build the capacity of stakeholders to use population health data, evidence-based research, and promising practices.

The following goals will help us achieve our mission to effectively advance the healthcare transformation goals of the New York State Department of Health.

Strategic Goal 1

Create a Robust PHIP Governance Structure

Healthy Capital District Initiative (HCDI) supports the development of strategies to transform health care delivery, improve population health, and eliminate health disparities by identifying, sharing, disseminating, and facilitating the implementation of evidence-based practices and strategies. A steering committee, with broad representation from sectors across healthcare and human services in the Capital District, provides direction to the PHIP. The Healthy Capital District Initiative PHIP Steering Committee members are selected from the HCDI Board of Directors, collaborating partners, and others in the region who represent different sectors that impact or are impacted by health care issues. The steering committee meets bi-monthly as part of the HCDI Population Health Improvement Program.The Steering Committee and HCDI have identified subcommittees necessary to accomplish goals of the Prevention Agenda, DSRIP, and SHIP. The Prevention Agenda Work Group (PAWG) and the Population Health Improvement Advisory Committee (PHIPAC) and the Education Committee meet quarterly,the Coordination Task Force meets monthly, to support the advancement of their charge.

- The Prevention Agenda Work Group (PAWG) consists primarily of local health departments and hospitals. The work group addresses issues critical to make the most of broader community collaboration working on task forces to advance Community Health Improvement Plan (CHIP) and Community Service Plan (CSP) processes.
- The Population Health Improvement Advisory Committee (PHIPAC) provides recommendations on PHIP activities, raises consumer health needs, and identifies data needs, access to care issues and prevention opportunities from a broad constituency base.
- The Care Coordination Task Force improves cross-institutional understanding of the scope of care coordination services, strengthens the pipeline between care coordination educators and employers, identifies, and aligns care coordination, information referral, and self-management resources.

- The Education Committee, a subcommittee of the Care Coordination Task Force, consists of local colleges and workforce development programs in, but not exclusively, the Capital Region. The work group identifies and promotes educational opportunities that align with the skills and competencies needed for either the community health worker or care coordinator.

Objective:

Objective 1.1 Increase the engagement of providers and consumers for the PHIP.

Objective 1.2 Create a forum to share resources, recruitment practices and foster collaborative partnerships to support emerging healthcare professions.

Ojective 1.3 Engage target audiences with activities and resources of the PHIP

Action:

1.1.1 Expand the Consumer Health Network and recruit consumers representative of the population in the Capital District Region to advise the PHIP and its partners on cosumer priorities for services to improve patient engagement, coordinate care, and self-management.

1.2.1 Establish the Education Committee to advise the Care Coordination Task Force on education opportunities in the Capital Region that support the advancement of the community health worker and care coordinator.

1.3.1 Update the Strategic Communications Plan that defines the goals and strategies of the PHIP by December 31, 2018.

Outcome:

1.1.1 Maintain fully functional committees to provide feedback and direction on consumer resource development by December 31, 2018.

1.2.1 Connect employers and local colleges to strengthen education pipeline for community health workers and care coordinators.

1.3.1 Maintain engagement with target audiences to accelerate the development of effective public health initiatives.

Strategic Goal 2

Increase Consumer Engagement in Care

There are many challenges transforming a health system from one that predominantly treats sickness into one that supports prevention and wellness. A central challenge is the need to create engaged and informed consumers. Consumer engagement is essential to increase quality, improve outcomes, and reduce costs.

Healthy Capital District Initiative recognizes that increasing consumer engagement in care requires a firm understanding of the needs, issues, and engagement strategies that work for consumers. It also requires that this information be shared with providers and incorporated into treatment and self-management strategies. Toward this end, HCDI will collect and perform consumer research, share consumer engagement and self-management resources and integrate health consumer priorities in health reform decision-making activities.

Objective:

Objective 2.1 Empower the consumer to have a voice in delivery system transformation.

Objective 2.2 Develop a consumer research library to inform PHIP partners of the existing health consumer knowledge base; establish and expand upon a comprehensive heath consumer research library

Objective 2.3 Develop resources and strategies that support greater consumer engagement in care (e.g., patient activation, health coaching, adverse childhood experiences (ACEs), social determinants of health,patient advocacy and consumercare model strategies).

Action:

2.1.1 Maintain the Consumer Engagement Strategic Plan that identifies and addresses health consumer priorities; represent consumer priorities on health reform decision-making activities to bring the results of consumer research into practice.

2.2.1 Conduct and assemble consumer research to inform PHIP partner efforts, public health, healthcare and the Consumer Health Network about consumer priorities.

2.3.1 Gather, develop, and promulgate resources to support PHIP partners' strategies to integrate promising practices for increasing patient activation and engagement in self-management; make presentations and distribute materials to healthcare provider networks, grassroots community coalitions and community-based organizations throughout the region to increase awareness and utilization of available patient supports.

Outcome:

2.1.1.1 Update the Consumer Strategic Plan to reflect research findings and the priorities of the Consumer Health Network by December 31, 2018; represent consumer priorities, or recruit and support consumers to fulfill this role, on DSRIP, PA,SHIP, and other appropriate committees.

2.2.1.1 Utilize research results to clarify for providers refining health-reform strategiesand consumer views on new service models and desired services.

2.3.1.1 Perform research on patient activation challenges and promising practices that result in reports, aids, and health coaching tools and resources to support PPS initiatives; promote and present patient activation resources, and chronic disease self-management guides of programs, tools, and resources on the PHIP website and share broadly to community-based organizations and provider groups.

Strategic Goal 3

Provide Public Health Data to Inform Strategies

Regional partners striving for more impact require public health data that identifies clearly where health issues are most prevalent and which groups of people are disproportionally impacted.In order todrive change, public health professionals,and organizations must use data-driven strategies to advance, target, monitor, and modify prevention initiatives and increase buy-in.Healthy Capital District Initiative maintains a data-driven culture to support decisions and optimize outcomes.

Healthy Capital District Initiative supports the data needs, evidence-based practice identification,and development of performance measurement systems for regional stakeholders. Overall, the appropriate interventions, data, and performance metrics are essential to build public health strategies for which success is likely.

Objective:

Objective 3.1 Identify data needs and establish processes to support community partners.

Objective 3.2 Support stakeholders in efforts to leverage data into actionable interventions.

Objective 3.3 Illuminate health disparities in the Capital Region.

Action:

3.1.1 Acquire, process, and analyze relevant types of data, and report findings to Steering Committee, Consumer Health Network and other work groups; post findings publicly on HCDI's PHIP website when data is available.

3.2.1 Produce Ad hoc reports on health needs of targeted subpopulations in the Capital Region to support the development of projects, proposals, or talks with PHIP partners; produce reports from health consumer surveys to support the Consumer Health Network and inform regional stakeholders.

3.3.1 Produce quarterly health equity reports focused on the differential health needs of subpopulations throughout the Capital District to inform discussion, service development, grants, and strategic responses.

Outcome:

3.1.1.1 Update relevant data-related landing pages on thewebsitewith local, state, and national sources, planning and programming documents, and HCDI studies and reports that focus on targeted health needs.

3.2.1.1 Produce ad hoc data reportsthat inform strategic local or regional population health improvement initiatives.

3.3.1.1 Complete, post on the PHIP website and share broadly the results of quarterly health equity reports.

Strategic Goal 4

Support the Development of Health Prevention Strategies

Collaborative partnerships with regional health departments, hospitals, and other organizations will support the New York State Prevention Agenda's overarching goals to improve health status in designated priority areas, reduce health disparities, and become the healthiest state in the nation.

Healthy Capital District Initiative, with the Prevention Agenda Work Group, strives to strengthen Prevention Agenda activities by sharing information on consumer health behaviors, evidence-based practices;facilitating meetings; engaging missing stakeholders; providing assistance with performance measurement, and addressing implementation challenges.

Objective:

Objective 4.1 Support the implementation of the Prevention Agenda at the county level.

Objective 4.2 Provide assistance for engaging general and high need populations.

Objective 4.3 Support the development of baseline and tracking indicators to measure success of local interventions.

Action:

4.1.1 Identify and prioritize Prevention Agenda initiatives that will be supported and use technical assistance tools to clarify the scope of PHIP services for each intervention to advance local plans.

4.2.1 Identify initiatives that are having trouble engaging hard to reach populations, clarify technical assistance plan, perform research, and provide tools to address identified problems.

4.3.1 Work with Prevention Agenda priority work groups in each county to establish and implement a measurement plan; provide performance measurement support and easily accessible data reports on Prevention Agenda priorities in the region.

Outcome:

4.1.1.1 Post up-to-date summaries of the health needs, priorities, plans, and points of contact for each county on the PHIP website; provide technical assistance as requested.

4.2.1.1 Work with the six counties to identify problematic initiatives and provide technical assistance on these issues.

4.3.1.1 Provide guidance with the development of appropriate outcome and process measures; monitor results and advise on initiative implementation and provide relevant data as available.

Strategic Goal 5

Support Workforce and Care Coordination Activities to Advance the State Health Innovation Plan (SHIP)

Healthcare Reform, as advanced in New York through the SHIP and DSRIP, requires new roles for providers to adequately support consumers and integrate care. Central to this reform is significantly greater investment in care coordination. As an emerging profession, care coordination, and related professions such as community health workers, has an insufficient definition, professional standards, degree programs, continuing education, and professional resources such as robust information and referral sources.

Healthy Capital District Initiative aims to support the development of the care coordination profession through three project areas: pipeline, professional development, and information and referral resources. *Pipeline activities* include: conducting monthly surveys to assess the professional development needs of community health workers and care coordinators, reviewing evidence-based practices to define the scope of practice between community health workers and care coordinators, and developing public health detailing of the emerging titles. *Professional development activities* include an environmental scan of post-secondary educational offerings, feedback on findings from area employers to strengthen preparatory programs, identification, and delivery of continuing education for the current workforce. *Information and Referral activities* include collaborating with United Way 2-1-1 to strengthen referral resources to reflect care coordinators scope of practice through surveys, collaboration with PPSs and engaging sectors under-represented in the current information and referral database.

Objective:

Objective 5.1 Assess care coordination needs and resources to inform the prioritization of capacity development priorities.

Objective 5.2 Identify best practices, tools and reources that support the integration of Community Care teams

Objective 5.3 Strengthen communication between employers and local colleges around the emergence of non-clinical community health titles.

Action:

5.1.1 Develop care coordination capacity and priorities based employer feedback

5.2.1 Promote best practices, tools and resources needed to train and support community care teams; develop a series of professional development opportunities for community care teams to access resources available in the Capital Region to support social determinants of health and self-management..

5.3.1 Advance the Capital Region Education Guide to include certificate and degree programs that support care coordination professionals.

Outcome:

5.1.1.1 Clarity on the skills, competencies and education needs for care coordinators in the Capital Region.

5.2.1.1 Access to evidence-based practices, tools and resources on the HCDI Care Coordination Resource Center web page; community care teams receive training on how to navigate regional directories in the Capital Region.

5.3.1.1 Employers and local colleges collaborate to meet the training and development needs of the current community care workforce.