Community Health Improvement Plan (CHIP): 2019-2021

Implementation Strategy

Our Lady of Lourdes Memorial Hospital

LOURDES | ASCENSION

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INTRODUCTION

The Lourdes Community Health Improvement Plan (CHIP) is the final phase of the Community Health Needs Assessment (CHNA) process and is guided by that body of work. A CHNA is a collaborative process that collects and analyzes data and information from various sources to develop a health profile for a given area, highlighting factors that impact health outcomes for community residents. The basis is to understand not only the needs of the area and major health issues, but to also identify community assets and resources that can be mobilized for health improvement efforts.

Utilizing statistical analysis of quantitative and qualitative primary data (collected directly from focus groups, surveys and interviews of community residents and stakeholders) and secondary data, the Lourdes CHNA reflects the three prioritized needs chosen for targeted improvement within the Broome County area over the next three years. Those needs include:

1) Improve Access to Healthcare Services within the Lourdes Primary Care Network and Among its Clinical Partners

2) Increase Efforts to Improve Both Preventive Care and Education Regarding Health and Wellness

3) Improve Communication and Care Coordination Among Providers and Across Electronic Systems

The Lourdes Community Health Improvement Plan is our long-term commitment to strategically addressing the needs stated above and the culmination of all of the strategies developed by Lourdes staff that delineates exactly how we will execute this work.

PRIORITIZED NEED #1: *Access to Healthcare in the Community*

GOAL: *Improve Access to Healthcare Services within the Lourdes Primary Care Network and Among its Clinical Partners by 2021.*

ACTION PLAN

STRATEGY 1.1: ***Promote the use of online appointment scheduling tools (i.e. In-Quicker and Online Patient Portal), amongst our patient population, as alternatives to over-the-phone scheduling for primary care appointments.***

BACKGROUND INFORMATION:

- ***Target Population:*** All Current and Future Lourdes Patients
- ***General Info:*** As Lourdes works towards growing its primary care patient volumes, it is critical that all patients have the ability to schedule appointments with a provider through a quick and hassle-free process. However, in an effort to reduce high call volumes we are currently experiencing at our primary care sites, it is equally important for Lourdes to diversify the modalities in which patients are able to schedule appointments. In terms of workflow and productivity, front desk staff often field avoidable calls and handle extensive on-hold queues instead of channeling their energy and focus towards addressing other critical patient needs. Effectively managing patient calls helps to ensure the needs of every patient, emergent or otherwise, can be met.
- ***SDOHs Addressed:*** Barriers to accessing healthcare is the major SDOH being addressed through this strategy.

RESOURCES:

- **Resources:** Data Analytics Team, Data Programming Tools, Avaya Phone System Reporting Tool, In-Quicker User Statistics, Patient Portal User Statistics, Marketing Staff Support, Digital and Print Marketing Materials
- **Strategy/actions built into annual budgeting/ISOFP:** Budgeting = YES, ISOFP = *YES*

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Develop the architecture for an electronically automated process to collect Avaya System call data for each primary care practice.	Lourdes	Avaya	Data Process Developed	N = 0 / Q3 2019	One (1) process / Q3 2020	Data Analytics Reporting Tool
2	Consistently disseminate monthly call volume, patient portal usage, and in-quicker usage statistics by site to all practice managers to discuss with front desk staff.	Lourdes	N/A	# of Reports Sent	Report Sharing is Inconsistent / Q3 2019	12 reports/ practice/year through Q4 2021	Data Analytics Reporting Tool

3	Develop a phone script for front desk staff fielding calls (specific to scheduling an appointment) that promotes the use of online scheduling tools available to patients.	Lourdes	N/A	Completed Script	N = 0 / Q3 2019	One (1) Script/ Q2 2020	N/A
4	Develop and execute marketing campaign to promote the use of In-Quicker and Patient Portal as alternative methods of scheduling appointments with providers.	Lourdes	N/A	# of Ads/ Promotions Disseminated	N = 0 / Q3 2019	Three (3) Promotions a year through Q4 2021	Marketing Report

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Work to increase the annual number of appointments scheduled online through In-Quicker by 5%, from 5,346 appointments in FY19 (July 1, 2018 – June 30, 2019) to 5,615 appointments in FY20 (July 1, 2019 – June 30, 2020).*

II. *By end of Q2 2020, increase the total number of unique users of the Patient Portal by 5%.*

III. *By Q2 2021, reduce average quarterly practice call volume across all practices by 5%.*

ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1 - 4					# of Appts. Scheduled Online	5,346 Appts Scheduled in FY19	5,615 (5%) Increase in Appts. Scheduled/ FY20	In-Quicker Reports	# of Over-the-Phone Calls	N = Over 54,200 Calls across All Primary Care Sites / Jul 2019 – Sept 2019	5% Reduction in Quarterly Call volume / Q2 2021	Avaya Phone System
					# of Patient Portal Users	36,323 Portal Users / Q2 2019	5% Increase in Users / Q2 2020	Patient Portal Report				

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: ***Access to Healthcare in the Community***			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**

I, II		***Objective # HC/HIT-2030-04***: Increase proportion of persons who use health information technology to track health care data or communicate with providers.

ACTION PLAN

STRATEGY 1.2: ***Work to optimize provider schedules, increasing the availability of open appointment slots for acute and same-day appointment types.***

BACKGROUND INFORMATION:

- ***Target Population:*** All Current Lourdes Patients and Community Residents Looking to Become New Patients of Lourdes
- ***General Info:*** Ensuring an adequate number of appointments are available per primary care provider each day—utilizing the industry standard of the third next available appointment, developed by the Institute for Healthcare Improvement—allows our patients to receive timely and effective care when they need it; helping to reduce delays in care that could potentially threaten quality and outcomes.
- ***SDOHs Addressed:*** This strategy will directly address barriers to accessing healthcare services

RESOURCES:

- ***Resources:*** Athena Scheduling System, Primary Care Access Committee, Primary Care Operations Managers, Support from Primary Care Providers
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = *YES*

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Add Third Next Available Appointment reporting discussions as a standing agenda item at each monthly Primary Care Access (PCA) meeting.	Lourdes	N/A	# of PCA Meetings a year	N = Six (6) Meetings, but not w/ modified agenda	N = Six (6) Meetings w/ Modified Agenda/ yr. through end of Q4 2021	Meeting Minutes
2	Assemble a team to review and validate the Third Next Available Appointment Report produced in our Athena Scheduling System for accuracy.	Lourdes	N/A	Validation Team Assembled	N = 0 / Q3 2019	N = One (1) Team Assembled / Q1 2020	Athena System
3	Standardize a process for allocating open same-day primary care appointment slot types to align with the Third Next Available Appt report logic in Athena.	Lourdes	N/A	Standard Process	N = 0 / Q3 2019	N = One (1) Process / Q2 2020	Athena System

4	Work with operations managers for each primary care site to share primary care access reports with providers and discuss scheduling optimization strategies.	Lourdes	N/A	# of Operations Managers Sharing Reports w/ Providers	N = 0 / Q3 2019	Operations Managers for all 11 Primary Care Sites / Q3 2020	Athena System

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q4 2020, improve the accuracy of the third next available appointment in Athena and work to get to zero days across all primary care providers.*

II. *By Q4 2021, attain a Professional Research Consultant (PRC) patient satisfaction norm score within the Timely Appointments category.*

ACTIONS:	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1 - 4					Avg. # of Days to Third Next Available Slot for All PCPs	N = Avg of 12 Days to Third Next Available Appt for All PCPs / Q3 2019	N = Zero (0) # of Days to Third Next Available Appt for All PCPs	Athena Reporting System	PRC Patient Satisfaction Score	Currently below Norm Score	Norm Score (Dynamic Target) / Q4 2021	PRC Reporting System

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: *Access to Healthcare in the Community*			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I		***Cross-Cutting Objective:*** Increase the age-adjusted percentage of adults who have a	***Objective # AHS-2030-R01:*** Increase the capacity of the primary care workforce to

		regular healthcare provider (ages 18+) from 82.6% to 86.7%.	deliver high quality, timely and accessible patient-centered care.
II			***Objective # AHS-2030-05***: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.

ACTION PLAN

STRATEGY 1.3: ***Address Major Social Determinants of Health (SDOH) for Individuals Within the Lourdes Primary Service Area (PSA).***

BACKGROUND INFORMATION:

- ***Target Population:*** Patients attributed to a Lourdes-associated primary care provider, who are at least 18 years of age with 1 or more chronic diseases and/or are high utilizers of the ED and Inpatient services.
- ***General Info:*** Social Determinants of Health (SDOH) are becoming more important to address in a value-based paradigm where healthcare organizations are responsible for patients beyond traditional provider-patient interactions that transpire within the clinical setting. The conditions in which our patients work, live and thrive begin to provide context for why some patients may be healthier than others or may have more favorable health outcomes. To better understand the impact SDOHs have on a patient's clinical outcomes, the Lourdes Community Health Worker (CHW) Cohort Project was birthed. It is a collaboration between Our Lady of Lourdes Memorial Hospital, the Rural Health Network of CNY, the American Civic Association, and Broome County Healthy Neighborhoods Program—and is steered by the hospitals DSRIP PPS, Care Compass Network. This pilot project focuses on addressing the SDOHs for patients specifically attributed to a primary care provider at the 303 Main Street location, whom have one or more chronic disease and/or are high utilizers of the ED. The overall aim is to address the top social determinants of health for patients that may demonstrate a negative impact on overall health indicators.
- ***SDOHs Addressed:*** Three specific SDOH will be targeted through this strategy: transportation, food security and housing stability. However, other SDOH (i.e. insurance navigation, childcare, etc.) will be addressed based on individual patient needs.

RESOURCES:

- ***Resources:*** Project Manager, Community Health Worker, Data Analyst, Care Compass Network (CCN), Rural Health Network, American Civic Association, Broome County Health Department (Healthy Neighborhoods), Budget for Unfunded Services Support, SFTP File Transfer System
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = *NO*

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Recruit and up to 150 patients in the 303 Main Street CHW Cohort project.	Lourdes	Partnering Community-Based	# of Enrolled Participants	N = 0 / Q2 2019	N = 150 Enrollees / Q1 2020	Enrollment Tracking Sheet

			Organizations (CBOs)				
2	Perform a one Needs Assessment (NA) and one Patient Activation Measure (PAM) survey on every patient that enrolls in 303 Main Street CHW Cohort project.	Lourdes	Partnering CBOs	# of NA and PAM Surveys Completed	N = 0 / Q2 2019	N = 150 Each Completed / Q1 2020	NA Tracking Sheet
3	Assign each CHW Cohort project enrollee to an organization that will actively manage at least one (1) identified SDOH for that individual.	Lourdes	Partnering CBOs	# of Patients Assigned for Active Management	N = 0 / Q2 2019	N = 150 Assignments / Q1 2020	Project Tracking Sheet
4	Track and Report (once a month at partner meetings) ED visits, inpatients readmissions, and primary care visits for each enrolled member of the CHW Cohort project.	Lourdes	Partnering CBOs	# of Reports Given	N = 0 / Q2 2019	N = One (1)/month through Q1 2020	Meeting Agendas
5	Redirect and expand the Lourdes Population Health Committee to identify the appropriate infrastructure and types of collaborative partnerships needed to effectively address SDOH issues within the community beyond the CHW project period.	Lourdes	Primary and Specialty Providers (Internal and External)	# of Active Members On Pop. Health Committee	N = 8 Current Members / Q2 2019	N = 10 Members / End of Q2 2020	Member List
6	Begin promoting the use of Lourdes' EHR system as the primary, user-friendly data collection tool for patient SDOH data among front desk staff at weekly staff huddles.	Lourdes	N/A	# of Pts w/ SDOH Data in Cerner	N = 0 / Q2 2019	N = 2,500 Pts / End of Q4 2021	Cerner

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By end of Q1 2020, decrease the average number of ED visits and inpatient readmissions for CHW Project enrollees by 10% from the previous year.*

II. *By end of Q2 2021, work to ensure navigation and care coordination staff are utilizing the SDOH Power Form in Lourdes' EHR System to collect SDOH data on at least 2,500 new or current patients.*

III. *By end of Q4 2021, work with at least two community partners to develop a sustainable collaborative strategy to address SDOH needs of community members beyond CHW project period.*

ACTIONS:	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***

1 - 6	# of ED visits and IP Readmissions	N/A (Baseline Calculated Once Enrollment Begins)	10% Reduction in Each / Q2 2020	Cerner	# of Pts w/ SDOH Data in Cerner	N = 0 / Q2 2019	N = 2,500 Pts / End of Q2 2021	Cerner	Developed Strategy	N = 0 / Q1 2019	N = One (1) strategy / Q4 2021	Internal SharePoint Site (where document will be stored)

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: *Access to Healthcare in the Community*			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I		***Cross-Cutting Objective:*** Reduce preventable hospitalizations among adults from 121 per 10,000 to 115 per 10,000.	

ACTION PLAN

STRATEGY 1.4: ***Increase Access to Primary and Specialty Care Services for an Increased Number of Patients/Residents from Baseline in Remote Locations of Broome County and the Surrounding Areas Through the New Mobile Health Primary Care Unit.***

BACKGROUND INFORMATION:

- ***Target Population:*** Lourdes Patients/County Residents across the entire age spectrum that reside in remote, hard-to-reach locations.
- ***General Info:*** Our healthcare system in the Broome County area continues to transform its delivery of care model in continued efforts to increase healthcare accessibility and improve health outcomes for all. Many chronic diseases disproportionately affect remote populations, due to disparities in healthcare access and social determinants of health faced by this population. Bringing primary and specialty care to traditionally hard-to-reach areas allow us to better engage and manage the healthcare needs within these communities.
- ***SDOHs Addressed:*** Transportation is the major SDOH that will be targeted through strategy 3, in an effort to address one of the most common barriers to accessing quality healthcare in remote and rural locations around the county and beyond.

RESOURCES:

- ***Resources:*** Mobile Unit Driver, Medical Supplies, Laptop on Lourdes Computing Network, Marketing Support, Community Partners
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = *YES*

ACTIONS:			**PROCESS MEASURES – OUTPUTS**

		LEAD ORG / STAFF	COLLAB ORG / STAFF	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
1	Acquire the basic resources needed for the new mobile unit to clinically function (i.e. provider, driver, medical supplies, and IT equipment).	Lourdes	N/A	Completed Resource Checklist	N = 0 / Q1 2019	N = One (1) Completed Checklist / Q1 2020	Mobile Unit Resource Checklist
2	Develop and institute a clinical schedule for the new primary care unit.	Lourdes	Orgs. in Areas Mobile Unit Will Visit	Completed Annual Clinical Schedule	N = 0 / Q1 2019	N = One (1) Schedule / Q4 2020	Mobile Unit Schedule
3	Dispatch the new Mobile Health Unit to provide primary care and/or preventive screenings at monthly medical missions and other scheduled locations.	Lourdes	Identified Community Partners	# of events dispatched to	N = 0 / Q1 2019	N = 15 Events/Yr through Q4 2021	Mobile Unit Schedule
4	Meet with identified community organizations that target rural, underserviced populations to discuss a potential partnership to bring mobile health services to that area.	Lourdes	Identified Community Partner(s)	# of Meetings Held	N = 0 / Q1 2019	N = At least One (1) Meeting w/ Two (2) Orgs / Q4 2020	Meeting Schedule
5	Create direct-mail, email, and digital marketing campaigns around the new primary care unit to promote upcoming health and screening events.	Lourdes	N/A	# of Campaigns (based on # of events)	N = 0 / Q1 2019	# of Campaigns Dependent On Clinical Schedule / Q4 2021	TeaLeaves Marketing

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q2 2021, establish a community partnership with at least one (1) new organization that services a rural population to visit monthly and provide mobile health services to individuals within their service area.*

II. *By Q4 2021, provide primary care and/or prevention screenings to at least 750 individuals through the new mobile health unit.*

ACTIONS:	**SHORT-TERM OUTCOMES**	**MEDIUM-TERM OUTCOMES**	**LONG-TERM OUTCOMES**

	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
1 - 6					MOU	N = 0 / Q1 2019	At least One (1) new MOU / Q2 2021	Internal SharePoint Site	# of Individuals Reached	N = 0 / Q1 2019	N = 750 Individuals / Q4 2021	Athena

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: *Access to Healthcare in the Community*			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II			***Objective # AHS-2030-08:*** Increase the proportion of persons who receive appropriate evidence-based clinical preventive services.

------ End of Prioritized Need 1 ------

PRIORITIZED NEED #2: *Preventive Care and Health Education*

GOAL: *Increase Efforts to Improve Both Preventive Care and Education Regarding Health and Wellness by 2021.*

ACTION PLAN

STRATEGY 2.1: ***Expand Prevention Efforts Around Type II Diabetes Within the Lourdes Primary Care Network through the Lourdes Diabetes Prevention Project (LDPP).***

BACKGROUND INFORMATION:

- ***Target Population:*** Lourdes Adult Patients (18+ Years), Who Are Identified as Prediabetics
- ***General Info:*** Diabetes Mellitus is a prevalent issue within the Broome County area and beyond. According to the most recently published Community Health Needs Assessment conducted by the Broome County Department of Health, Broome County ranked in the third quartile (among all NYS counties) for diabetes. Major Diabetes prevention efforts often include time-intensive, didactic programming. However, participation has a tendency to be low in these types programs. To try and combat this issue, the Lourdes Endocrinology Department has designed the Lourdes Diabetes Prevention Project (LDPP), a program that delivers the evidence-based components of Diabetes Prevention in a minimalistic interventional approach. LDPP staff work hand-in-hand with Lourdes primary care providers to identify patients with A1C levels within a prediabetic range to counsel them about diabetes prevention at routine office visits. In addition, patients who are referred to the LDPP are connected with an interventional team consisting of dietitians and health coaches that counsel patients on ways to improve lifestyle risk factors (i.e. diet and nutrition, physical activity, and weight management), and nurse navigators to assist in coordinating the care for enrolled patients. The overall objective is to produce a more cost-effective way to prevent Type II Diabetes amongst our patient population.
- ***SDOHs Addressed:*** Food security is one of the major SDOHs addressed through this strategy.

RESOURCES:

- ***Resources:*** Endocrinology Department, Nurse Navigator, Data Manager, Primary Care Providers, Health Coaches, Dieticians, EHR System, Stata Statistical Software, Educational Materials.
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = *NO*

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Develop a standardized definition of the term "prediabetes" and a range of A1C values to identify patients who may be prediabetic within our primary care network.	Lourdes	N/A	Defined Definition	N = 0 / Q1 2019	N = One (1) Definition / Q4 2019	Project Outline
2	Standardize the definition of a "nudge" as an intervention specific to prediabetics that is light and ad libitum, utilizing the following types: - Diabetes Education from Provider at Visit	Lourdes	N/A	Defined Definition	N = 0 / Q1 2019	N = One (1) Definition / Q4 2019	Project Outline

	- Diabetic Medication Prescriptions - Self-Reported Physical Activity - Contact by Lourdes DPP Staff - Health Coach Interaction - Education at Lourdes Diabetes Center - Nutritional Counseling						
3	Provide guidance and/or outreach support for enrolling patients identified as prediabetics into the Lourdes DPP.	Lourdes	N/A	# of Prediabetics Enrolled in DPP	N = 926 Patients / Q1 2019	N = 1,200 Patients / Q4 2021	DPP Data Tracking Sheet
4	Bring new and existing providers into awareness of their attributed patients meeting the defined criteria for prediabetes, and alert them whenever those patients have upcoming appointments.	Lourdes	N/A	# of Primary Care Providers Engaged	N = 95% of Providers / Q2 2019	N = 100% of Providers / Q4 2020	Provider Checklist
5	Consistently collect data on the frequency and types of nudges received by patients enrolled in Lourdes DPP, as well as all relevant, real-time clinical data for these patients.	Lourdes	N/A	# of Monthly Data Updates	Inconsistent Data Collection / Q3 2019	N = Three Data Updates /Month Through Q4 2021	Cerner / DPP Data Tracking Sheet
6	Develop a clinically defined statistical model to measure the impact of the Lourdes DPP approach to preventing Diabetes.	Lourdes	N/A	Developed Statistical Model	N = 0 / Q3 2019	N = One (1) Model / Q4 2020	Stata Software

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q4 2020, ensure each patient in the Lourdes Diabetes Prevention Project receives an average of Three (3) "nudges" each month.*

II. *By Q4 2021, utilize the Lourdes Diabetes Prevention Project to assess the correlation between "nudges" received and the progression to diabetes amongst the prediabetic population at Lourdes.*

ACTIONS:	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***

1 - 6		Avg. # of Nudges/Pt /Month	N = Two (2) Nudges/ Month Across Enrolled Patients / Q1 – Q3 2019	N = Three (3) Nudges/ Month Through Q4 2020	Cerner/ DPP Data Tracking Sheet	Longitudinal Study Results	No Results to Report / Project was retooled Q2 2019	Statistically Significant Inverse Correlation / Q4 2021	Stata Software

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #2: Preventive Care and Health Education			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II			***Objective D-2030-01:*** Reduce the annual number of new cases of diagnosed diabetes in the population.

ACTION PLAN

STRATEGY 2.2: ***Enhance Focus on Controlling Hemoglobin A1C Levels for Adults with Type II Diabetes within the Lourdes Primary Care Network.***

BACKGROUND INFORMATION:

- ***Target Population:*** Adults (Ages 18+) with a Diagnosis of Type II Diabetes
- ***General Info:*** As previously mentioned, Diabetes Mellitus, specifically Type II, is a prevalent issue within the Broome County Area. According to the Broome County Health Department, there is an average of 59 deaths per year due to Diabetes, higher than that of New York State. In Broome County, diabetes accounts for an average of 317 hospitalizations per year and there are about 4,750 hospitalizations per year in which an individual has a diagnosis of diabetes, though it may not be the primary reason for admission. Within the Lourdes Primary Care Network, more than 20,000 patients have had at least one diabetes-associated diagnosis at a primary care visit, precipitating the need to mobilize resources around strategically targeting and improving the management of this chronic disease.
- ***SDOHs Addressed:*** Healthcare Access and Health Literacy are the major SDOHs addressed.

RESOURCES:

- ***Resources:*** Microsoft PowerBI Software, Data Analyst, Patient Navigator, Patient Outreach Coordinator, Health Coach, Dietician, Endocrinology Department, Educational Materials.
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = *YES*

ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Work to convert canned diabetes tracking reports to real-time, digital data dashboards, improving our ability to provide timely interventions and coordinated services to type II diabetics served by the primary care network.	Lourdes	N/A	Developed Dashboard	N = 0 Digital Dashboards	N = One (1) Data Dashboard / Q2 2020	Microsoft PowerBI Software
2	Work with primary care providers to discuss new, evidence-based strategies for improved Type II Diabetes management—to guide the development of a standard Care Pathway for the disease.	Lourdes	N/A	# of Identified Providers Reached	N = 0 Providers / Q3 2019	N = At Least One (1) Primary Care Provider from Each Primary Care Location.	Meeting Notes
3	Develop and produce monthly outreach reports of patients (by provider) with uncontrolled A1C levels so they may be contacted by staff for follow-up.	Lourdes	N/A	# of Patient Outreach Reports Produced	N = 0 Reports / Q3 2019	N = One (1) Monthly Report for Each Provider Through Q4 2021.	Optum Data System
4	Coordinate efforts to perform follow-up and outreach to all individuals with uncontrolled Type II Diabetes, prioritizing those with A1C levels of 9.0 or higher.	Lourdes	N/A	# of Patients Outreached To	N = 0 Providers / Q3 2019	N = 65% of Patients / Q4 2021	Cerner

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q2 2020, adopt the care pathway in the Type II Diabetes Toolkit aimed at improving the management of adults with Type II Diabetes.*

II. *By Q4 2021, reduce the number of Type II Diabetics with A1C levels measuring greater than 9.0 by 2%.*

ACTIONS:	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***

1 - 4		Care Pathway Developed	N = 0 / Q3 2019	N = One (1) Pathway Developed / Q2 2020	Network Procedures	# of Adults w/ A1C levels > 9.0	N = 30.6% / Q1 2019	N = 2% Reduction / Q4, 2021	Optum System

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #2: Preventive Care and Health Education			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II	***Goal 4.3:*** Promote evidence-based care to prevent and manage chronic diseases including diabetes and prediabetes.	***Objective 4.3.1:*** Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)	***Objective D-2030-04:*** Reduce the proportion of adults with diagnosed diabetes with an A1C value greater than 9%.

ACTION PLAN

STRATEGY 2.3: ***Develop a Consistent Way to Effectively Manage and Coordinate Community Outreach and Engagement Activities Across the Organization by 2021.***

BACKGROUND INFORMATION:

- ***Target Population:*** All Patients and Broome County Community Residents
- ***General Info:*** At Lourdes, there are many departments and positions that perform valuable outreach activities in an effort to bring awareness and services to our community. At the root of our cost-savings structure is efficiency, thus we have recognized the need to plan and execute these events in a more coordinated manner to receive the greatest impact from dispatched resources, to yield greater collaboration across departments and specialties.
- ***SDOHs Addressed:*** Health Literacy and Awareness is the major SDOH addressed.

RESOURCES:

- ***Resources:*** Marketing support, Ascension Technologies Team Support, Data Analytics Support, Fiscal Support (for potential new hire), Events Calendar Tool
- ***Strategy/actions built into annual budgeting/ISOFP***: Budgeting = YES, ISOFP = NO

ACTIONS:	**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
			Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***

1	Appoint/hire a community outreach coordinator to oversee all outreach activities throughout the hospital and practice locations.	Lourdes	N/A	Appointed/ Hired Associate	N = 0 / Q3 2019	N = One (1) Coordinator / Q3 2020	Human Resources
2	Open up access to monthly events calendar for various departments to record events they are hosting throughout the year.	Lourdes	N/A	Calendar Availability	N/A	N = One (1) Central Outreach Calendar / Q4 2020	Network Shared Drive
3	Initiate a committee that will focus on planning, coordinating and executing outreach/engagement events.	Lourdes	Community-Based Organizations	# of Committee Meetings	N = 0 / Q3 2019	N = 12 meetings/yr through Q4 of 2021.	Meeting Schedule
4	Identify 3-5 consistent metrics to begin tracking outreach activities across the organization (i.e. # of participants, resource utilization, # of marketing collaterals distributed, etc.)	Lourdes	N/A	# of Metrics Developed for Tracking	N/A	N = 3-5 Metrics / Q4 2020	Data Tracking Tool
5	Work with Ascension Technologies (AT) Team to create an electronic data management tool for outreach activities.	Lourdes	N/A	Tool Created	N = 0 / Q3 2019	N = One (1) Tool / Q1 of 2021	Network Shared Drive

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By End of Q3 2020, through improved coordination, increase the number of community events and activities Lourdes participates in by five (5) (Baseline = 39 between October 1, 2018 – September 30, 2019).*

II. *By 2021, be able to gauge impact/patient engagement at community events through the development of a data tool with trackable metrics specific to outreach activities.*

ACTIONS:	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1 - 5	# of Events/ Activities	N = 39 Events /	N = 44 / Q3 2020 (Oct 2019	Event Calendar					Outreach Data	N = 0 / Q3 2019	N = One (1) Tool / Q1 2021	Network Shared Drive

		Oct, 2018 – Sept, 2019	– Sept 2020			Tracking Tool			

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #2: Preventive Care and Health Education			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II			

------ End of Prioritized Need 2 ------

PRIORITIZED NEED #3: *Care Coordination*

GOAL: *Improve Communication and Care Coordination Among Providers and Across Electronic Systems by 2021.*

ACTION PLAN

STRATEGY 3.1: ***Transition to, and promote the usage of, the new Regional Health Information Organization (RHIO), HealtheConnections (HeC), and actively work to increase the number of RHIO patient consents.***

BACKGROUND INFORMATION:

- ***Target Population:*** All Current and Future Lourdes Associates and Patients (Of Consenting Age 18+ Years).
- ***General Info:*** Lourdes was a participant in the HealthLinkNY RHIO, which has recently merged with HealtheConnections (HeC) forming a health improvement organization that spans 26 counties of the Central New York, Southern Tier and Hudson Valley regions. For Lourdes to adapt and survive in a healthcare landscape that is becoming increasingly more data-driven, it is imperative that we transition our data systems to enhance our ability to better manage the care for our attributed patients—irrespective of where they may seek care within the region.
- ***SDOHs Addressed:*** Health literacy levels of the patients we serve will be impacted, allowing for more informed decision-making in matters regarding their health.

RESOURCES:

- ***Resources:*** Cerner EHR System, HealtheConnections (HeC) RHIO System, Ascension Technology (AT) Cerner Interface Team, AT Clinical Informatics Team, HeC Integration Services Team, Associate Orientation/Reorientations, Lourdes Marketing Support
- ***Strategy/actions built into annual budgeting/ISOFP:*** Budgeting = YES, ISOFP = YES

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Complete the migration of current Continuity of Care Documentation (CCD) data from HealthLinkNY to HealtheConnections.	Lourdes	HeC	Data Migration Process Developed	N/A	All CCD Data Migrated to HeC	Data Migration Report
2	Validate CCD file volume to ensure data accuracy and migration process integrity.	Lourdes	HeC	# of Errors Flagged	N/A	CCD Data Migrated with 0 Errors / Q2 2020	Data Validation Report
3	Configure and deploy MyData analytics platform offered by HeC.	Lourdes	HeC	# of MyData Users	N/A	N = 3 Trained Users / Q4 2020	HeC System Tool

4	Develop and execute quarterly marketing and educational campaigns for the new health RHIO, with the intent to increase the number of patients who consent to share their patient data through the RHIO.	Lourdes	HeC	# of marketing events	N/A	N = Four (4) a year through Q4 2021	Events Schedule
5	Add educational information regarding RHIO to annual Lourdes Associate Reorientation (and New Associate Orientation) presentation content to increase internal awareness of RHIO.	Lourdes	HeC	# of Associates Reached	N/A	N = 75% of assocs. / Q4 2021	Reorientation Sign-In Sheets
6	Hold formal trainings for new RHIO users (Lourdes Associates Only) on the last day of each month to include a basic overview of what a RHIO is, as well as how to access, navigate, and use the system.	HeC Customer Engagement	Lourdes	# of Trainings Held	N/A	N = 12 trainings a year through Q4 2021	HeC System Tool

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By end of Q2 2020, fully transition from HealthLinkNY to HealtheConnections (HeC), and ensure HeC is a reliable source for patient data.*

II. *By end of Q4 2021, increase the number of patient consents in HealtheConnections, from baseline, by 5,000 unique patients.*

III. *By end of Q4 2021, maintain the current average number of active monthly unique users (a user that logs into use the system within a given month) of the new health RHIO amongst Lourdes associates during the transition period.*

ACTIONS:	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1, 2, 3	Patient Data Available in HeC	N/A	All current data within HealthLinkNY / Q2 2020	Data Validation Report	Associates trained to use HeC	N = 131 Assocs. / Q2 2019	N = 250 Assocs. / Q4 2021	HeC System Tool	Avg. # of Monthly RHIO Users (Lourdes Assocs.)	N = 13 avg. monthly users/ *78 system users between May and Oct, 2019*	N = 13 average monthly users / Q4 2020	HeC System Tool
4, 5, 6	Int. and Ext. Marketing/ Educational	N/A	15-17 a year through Q4 2021	Marketing Schedule					Patients consenting to HeC	N = 95,299 patients / Q2 2019	N = 100,299 patients	HeC System Tool

	/ Training Events					data-sharing		/ Q4 2021	

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #3: Care Coordination			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II, III			***Objective #HC/HIT-2030-D08:*** Increase the percentage of persons that can view, download, and transmit their electronic health information.

ACTION PLAN

STRATEGY 3.2: ***Once Transition to HealtheConnections (HeC) is complete, Develop and Execute a Comprehensive Strategy to Establish Effective Bi-Directional Data Sharing Between the Lourdes EHR System and HeC.***

BACKGROUND INFORMATION:

- ***Target Population:*** N/A
- ***General Info:*** Sharing of health data across networks plays a key role in monitoring our patients throughout their episode(s) of care and is a critical element in a wider infrastructure that supports data access, use and sustainability. However, there remains limitations to sharing data amongst systems when our patients utilize healthcare-related services outside of the Lourdes network. Not having insight into the types of care patients receive outside of the Lourdes Network may impede the hospital's ability to ensure effective and timely continuity of care, which may compromise quality and health outcomes. It is important to develop a sustainable process to bi-directionally send and receive critical patient-level data that can be accessed by Lourdes' clinical staff to deliver the appropriate care and/or services to the patient.
- ***SDOHs Addressed:*** No SDOH will be directly impacted.

RESOURCES:

- **Resources:** Cerner EHR System, HealtheConnections (HeC) RHIO System, Ascension Technology (AT) Cerner Interface Team, AT Clinical Informatics Team, HeC Integration Services Team
- **Strategy/actions built into annual budgeting/ISOFP:** Budgeting = YES, ISOFP = *YES*

ACTIONS:	**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**

				Indicator	Baseline Value / Date	Target Value / Date	Data Source
1	Execute new contract with Cerner to establish bi-directional Clinical Documentation Architecture (CDA) within the Cerner EHR system (for PAMI data only).	Lourdes	Cerner, HeC	Executed Contract	N/A	One (1) contract / Q4 2020	Internal SharePoint
2	Work to develop and fully implement CDA framework within Cerner EHR system for bi-directional data flow.	Lourdes	Cerner	CDA Framework	N/A	One (1) CDA Framework / Q2 2021	Cerner
3	Hold meetings with Cerner and HealtheConnections teams to discuss HL7 V2 design and system requirements for implementing the Results Delivery product offered by HeC (starting with laboratory data).	Lourdes	Cerner, HeC	# of Meetings	N/A	At least Two (2) Planning Meetings / Q1 2021	Meeting Log
4	Develop a technical implementation strategy for the integration of the Results Delivery product.	Lourdes	HeC	Completed Technical Strategy	N/A	One (1) Approved Technical Plan / Q2 2021	Internal SharePoint
5	If applicable, develop and execute a new contract with Cerner for Results Delivery process, based on technical implementation strategy.	Lourdes	Cerner	Executed Contract	N/A	One (1) Contract / Q2 2021	Internal SharePoint
6	Work to complete the implementation strategy, fully establishing Results Delivery data flow from RHIO to Cerner.	Lourdes	Cerner, HeC	Results Delivery Config.	N/A	Completed Data Flow / Q4 2022	Cerner

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q2 2021, establish bi-directional patient data flow (of PAMI Data) between Cerner and HealtheConnections for 100% of patients that have a signed RHIO consent on file.*

II. *By Q4 2021, develop and implement data architecture for Results Delivery from RHIO directly into discreet computable fields in Cerner, for 100% of patients that have signed RHIO consents on file.*

ACTIONS:	SHORT-TERM OUTCOMES	MEDIUM-TERM OUTCOMES	LONG-TERM OUTCOMES

	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1 - 6					PAMI Bi-Directional Data Flow	N = 0 / Q3 2019	100% of Patients w/ PAMI Data in Cerner / Q2 2021	Cerner, HeC	Results Delivery into Cerner	N = 0 / Q3 2019	N = Results Delivery for 100% of Patients w/ RHIO Consents/ Q4 2021	Cerner, HeC

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: Care Coordination			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I, II			***Objective # HC/HIT-2030-D07:*** Increase the percentage of clinicians that have necessary information electronically available at the point of care.

ACTION PLAN

<u>**STRATEGY 3.3:**</u> ***Develop Necessary Population Health Infrastructure Throughout the Lourdes Healthcare Network to Provide Appropriate and Comprehensive Care Coordination Services.***

<u>**BACKGROUND INFORMATION:**</u>

- ***Target Population:*** All Current and Future Lourdes Patients That Qualify for Care Coordination Services.
- ***General Info:*** Population health management is a collection of healthcare services, from prevention and wellness to disease management, that focuses on the health status of a group as opposed to an individual. Effective care coordination is critical to population health management. The National Quality Forum (NQF) defines Care Coordination as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people and sites are met over time.” Investing in a sustainable population health platform will allow Lourdes to achieve a framework for high-performing care coordination, challenging our providers to think beyond single-disease treatment and/or management and begin thinking in terms of coordinating a patient’s complete episode of care. Being more adept at managing patient care within, as well as beyond, the four walls of the hospital will better prepare Lourdes for the ongoing shift from fee-for-service financial models driven by volume to a value-based payment system driven by quality.

- ***SDOHs Addressed:*** Bolstering our population health infrastructure at Lourdes to improve our care coordination services will give us the expanded capacity to more effectively address the major SDOHs our patients face.

RESOURCES:

- **Resources:** Population Health Team, Data Analytics Support, Outreach Support, Patient Navigators, Care Coordinators, Funding for Additional Resources/Services
- **Strategy/actions built into annual budgeting/ISOFP:** Budgeting = YES, ISOFP = NO

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Identify and acquire the resources needed (i.e. IT support, staffing, programming, etc.) to improve care coordination services for patients.	Lourdes	N/A	# of Resources Acquired	N/A	As many resources deemed necessary / Q2 2021	Care Coordination Services Log
2	Develop a standard method for risk stratification to screen and identify patients eligible for care coordination services – Define “Rising Risk” and “High Risk” patients and how to prioritize them appropriately.	Lourdes	N/A	Risk Stratification Process	N/A	One (1) process / Q4 2021	Organizational Shared Drive
3	Conduct outreach to patients identified as being eligible for care coordination services—as a means of recruitment.	Lourdes	N/A	# of Patients Reached	N/A	At least 5% of Eligible Patients / Q4 2021	Outreach Tracking Sheet
4	Create and implement a data dashboard to support the management of patients engaged in care coordination, as well as predict adverse events.	Lourdes	N/A	Data Dashboard Developed	N/A	One (1) Dashboard / Q3 2021	Microsoft PowerBI Software
5	Develop an evaluation tool with identified metrics to adequately assess the effectiveness of care coordination interventions.	Lourdes	N/A	Evaluation Tool	N/A	One (1) Tool / Q2 2021	Organizational Shared Drive

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q4 2021, provide integrated care coordination services to at least 5% of those who qualify based on need.*

ACTIONS:	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1 - 4									# of Patients in Active Care Coordination	N/A	5% of Eligible Patients / Q4 2021	Care Coordination Dashboard

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: Care Coordination			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I			

ACTION PLAN

STRATEGY 3.4: ***Strategically identify and submit funding applications to diverse funding sources to help support the improvement of the population health infrastructure at Lourdes.***

BACKGROUND INFORMATION:

- ***Target Population:*** N/A
- ***General Info:*** Given the expenses that are invariably linked to infrastructure improvements, the need for identifying multi-stream funding opportunities—and subsequently pursuing those opportunities—is evident. Lourdes research potential funding opportunities at the state and federal levels and leverage our relationships with payer to potentially help alleviate some of the financial burden of making necessary additions to our patient care management structure to improve outcomes.
- ***SDOHs Addressed:*** Bolstering our population health infrastructure at Lourdes to improve our care coordination services will give us the expanded capacity to more effectively address the major SDOHs our patients face.

RESOURCES:

- ***Resources:*** Access to State and Federal Grants Database(s), Grant-writing Support, Managed Care Department, Population Health Team Support
- ***Strategy/actions built into annual budgeting/ISOFP***: Budget = YES, ISOFP = YES

ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Research applicable grant Requests for Proposals (RFP) via state and/or federal grant databases, Grants Gateway and Grants.gov, respectively, that could potentially cover the cost of population health infrastructure improvements	Lourdes	N/A	# of RFPs Researched	N/A	No set target for this action / Q3 2020	Log of Researched Grant Opportunities
2	Research applicable payor foundation grant opportunities to potentially cover the cost of Population Health Infrastructure Improvements.	Lourdes	N/A	# of Payer Foundations Researched	N/A	No set target for this action / Q3 2020	Log of Researched Grant Opportunities
3	Develop a detailed list of identified funding opportunities, including: organization contact info, applicant eligibility criteria, award amounts, funding period(s), application deadlines, and any applicable requirements.	Lourdes	N/A	Listing of All Opportunities Identified	N/A	N = One (1) Finalized List / Q4 2020	Grants Spreadsheet
4	Form a grant writing team to assess and discuss each grant opportunity for relevance and feasibility of applying.	Lourdes	N/A	Grant-Writing Team Formed	N/A	N = One (1) Team / Q4 2020	N/A
5	Hold meetings with select major insurance payers to discuss possible value-based payment opportunities to help bolster population health improvement activities aimed at driving better health outcomes.	Lourdes	Identified Payer Organizations	# of Payers Engaged	N/A	Minimum of Two (2) / Q4 2020	Meeting Minutes

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By Q4 2021, submit funding applications to at least three (3) diverse funding sources to help support the improvement of the population health infrastructure at Lourdes.*

ACTIONS:	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***

1 - 4		# of Completed Funding Applications	N/A	Three (3) Applications / Q4 2021	Submission Confirmation

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – PRIORITIZED NEED #1: Care coordination			
SMART OBJECTIVE	**LOCAL/COMMUNITY PLAN**	**STATE PLAN**	**HEALTHY PEOPLE 2030/OTHER NATIONAL PLAN**
I			

------ End of Prioritized Need 3 ------