Delivery System Reform

GOAL	TARGETS	SECONDARY DRIVERS	ACTIVITIES LOCAL	ACTIVITIES: STATE (DHS, IDPH, IHC)
Patients are empowered and supported to be healthier.	Reduce the rate of potentially preventable readmissions in Iowa by 12% Reduce the rate of potentially preventable ED visits in Iowa by 20% Reduce the rate of the Hospital Acquired Conditions (HAC) to met the national goal (97/1000) by focusing on a 20% reduction to Clostridium Difficile and All Cause Harm measures Increase the rate of provider organizations financially successful in Alternative Payment Models (higher quality, lower costs)	Utilize the Iowa Health Information Network and the Statewide Alert Notification System to optimize transitions of care	Use available HIT resources to allow access to patient care information from all appropriate members of the patient care team	• Develop & maintain Health IT infrastructure for ADT submission & alert messaging • Recruit hospitals to send ADTs to the SWAN system (see Section C. for details) • Provide technical assistance to effectively use the IHIN & SWAN alerts to reduce the rate of potentially preventable readmissions & ED visits
		Provide Technical Assistance to providers engaged in transformation and value based payment models	Deliver onsite technical assistance to providers in C3 communities on the role of community services in care transitions and responsibilities in health transformation (including social needs and referral processes) to increase efficiency, prevent service duplication, and reduce the rate of potentially preventable readmissions and ED visits.	• Conduct 3 statewide SIM Learning Community conferences • Conduct implementation strategies from the Population Health Roadmap within and among Iowa health systems and communities • Conduct whole system alignment through technical assistance to large provider health systems, including tools to support health systems in advancing clinicians and ACOs in the Quality Payment Program • Conduct clinic and community workgroup sessions to optimize processes for detection & prevention of Hospital Acquired Conditions (HAC) due to high harm medications
		Develop a community scorecard for process improvement that emphasizes and raises the standards of care	Provide process improvement to the C3s through utilization of their Community Scorecards and resources from the Roadmap to Improve Population Health to support and align population health within their communities	Plan facilitated networking, sharing and brainstorming to engage larger health systems in the SIM work to facilitate participation in statewide health improvement efforts, including utilization of a Community Scorecard
		Implement Accountable Communities of Health pilot to prepare communities for value based delivery models	Develop and maintain the C3 infrastructure, identify target population by risk (Hgb A1c >9, co-occurring conditions: vascular disease, tobacco use, obesity), and use evidence-based resources and data reporting to improve diabetes management, improve healthcare transitions, decrease the incidence of diabetes, and address community-wide prevention	Require the use of tactics from the statewide strategy plans within the C3s and provide technical assistance for the application of the tactics. Provide 1) technical assistance for common structure and function of local governance, 2) support for workforce capacity and infrastructure, and 3) resources for evidence-based indications for referral and treatment. Ensure statewide alignment through multi-departmental engagement, align priority areas and metrics, and identify and address policy barriers (e.g. reimbursement for DSME and NDPP).
		Develop common language and shared vision for delivery system reform across sectors		
		Address patient social needs through linkages to community based resources/Improve use of HRAs	Link to community resources and clinical-community programs and services through a documented referral system to existing state-certified DSME program and a documented referral system for SDH, increasing provider referrals for clinic patients with social and health needs through linkages with C3, and promoting the implementation of AssessMyHealth HRA to identify patient clinical, social, and community needs	Require the use of tactics from the statewide strategy plans within the C3s and provide technical assistance for the application of the tactics to address SDH. Provide resources and technical assistance on using the C3 data dashboards to inform process improvement and increase closed-loop referrals for social needs. Increase the use of AssessMyHealth HRA statewide through expansion to the general population to foster better communication between individuals and their healthcare providers, provide technical assistance to healthcare providers to incorporate the HRA into their workflow. Use aggregated data from the HRA to inform decision-makers about SDH needs across Iowa.