Strategy Map: Jan – Dec 2020

WEST MOUNTAIN REGIONAL HEALTH ALLIANCE

	Advocacy & Education	***Integrated Health***	***Social Determinants of Health***	***Align Initiatives***
Collaborative Strategies	1. Establish Advocacy Agenda 2020 2. Share knowledge and facilitate dialogue of health initiatives and issues facing our region	1. Increase integrated health and coordination of care (physical, behavioral, dental, and social) 2. Redesign and reestablish data dashboard. Align key dashboard outcomes, targets, and metrics 3. Survey care coordinators and mental health organizations to identify resources and gaps 4. Disseminate information and provide ongoing support to primary care practices that serve Medicaid patients and enroll to participate in the Innovations Support Project (ISP) Regional Health Connector Program (2020 – 2023)	1. WMRHA Community Lead, engage & coach practices with social needs screening, maintain resource lists, and gaps analysis - Accountable Health Community Model (AHCM) 2017-2022 (Eagle, Garfield, Pitkin, & Summit) 2. Connect clinical and community organizations. Maintain and/or align SDoH resource lists in region and by county 3. Work with Quality Health Network on implementation of the Community Resource Network (CRN), social health information exchange. a. Discuss, align and collaborate with Garfield County Public Health 4. Discuss alignment and collaboration with Garfield County Public Health Community Connector Network for AHCM care coordination process management	1. Facilitate & Convene Plan for Permanent Supportive Housing (PSH) regional project--The Colorado Health Foundation Housing Readiness Pilot 2020 2. Leading Built for Zero effort as Community & Data Lead to convene and coordinate partners, develop the By-Name List, a detailed, real-time list of chronically homeless individuals 3. Support Hospital Transformation Program implementation in our region through data collection, facilitation and planning to bring together our regions' hospitals, public health, human services and community organizations 4. Leading treatment workgroup for St. Mary's Opioid Rural Network Planning Grant with 11 counties 5. MidValley Family Practice Opioid Rural Network Planning Grant: coordinating the creation of a Substance Use Dashboard 6. Supporting partner in City of Glenwood Springs Detox planning efforts and development

Outcomes	1. Implementation of Advocacy Agenda 2. Sending letters of support advocacy agenda around 5 integrated health care and SdoH issues to state legislators 3. Holding 2 educational legislative sessions (April and October) 4. Attending 6 city council and county commissioner meetings in our region 5. Holding 4 Quarterly Meetings in 2020, tracking number of participants, presenting educational topics, based on current WMRHA initiatives/programs 6. Present WMRHA initiatives at 4 regional, state and national meetings	1. Assisting three practices to move into Tier 1 of the Regional Accountable Entity Practice Care Management tier structure 2. Release to community new and improved dashboard with key measures in June 2020 3. Care Coordination and Mental Health survey completed May 2020. Report included resources and gaps that will be used to prioritize an action plan that will improve current resources and mitigate gaps 4. Assisting 3 primary care practices to improve quality of care while enhancing opportunities to succeed in new payment models a. Select and implement a local priority project that aligns with ISP practices and the community's goals	1. Tracking WMRHA AHCM Screenings & Navigation– 2019: 4,205 screens completed; 18 Participating Practices, 295 patients qualified for navigation, 53% Opt-In 2020 Goal: 7,500, 9 additional practices are expected to start screening, 500 patients expected qualified for navigation; 65% Opt-in rate 2021 Goal: 10,000, 5 additional practices are expected to start screening, 750 patients expected qualified for navigation; 75% Opt-In rate 2. Connect up to 10 clinics with community organizations and government partners around social determinant resources identified by the screening 3. Implement QHN's Community Resource Network (CRN), social health information exchange with 5 key partners by Dec 2020 4. AHCM Care Coordination Action Team assembled to increase number of evidence-based practice trainings and opportunities	1. Completed written action plan for Permanent Supportive Housing (PSH) regional project (Dec 2020) 2. Quality by-name list of individuals experiencing homelessness to determine affordable housing needs and those requiring PSH by Dec 2020 3. Align regional hospital HTP Plans with community interests by July 2020 4. Completed needs assessment and collaborative development a strategy plan to reduce and stop use of opioids by May 2020 5. Ongoing support of implementation and alignment of the Opioid Strategy plan in our region 6. Release and presentation to the community of a Substance Use Dashboard by Dec 2020 7. Supporting the implementation of the action plan results for detox resources in Garfield County